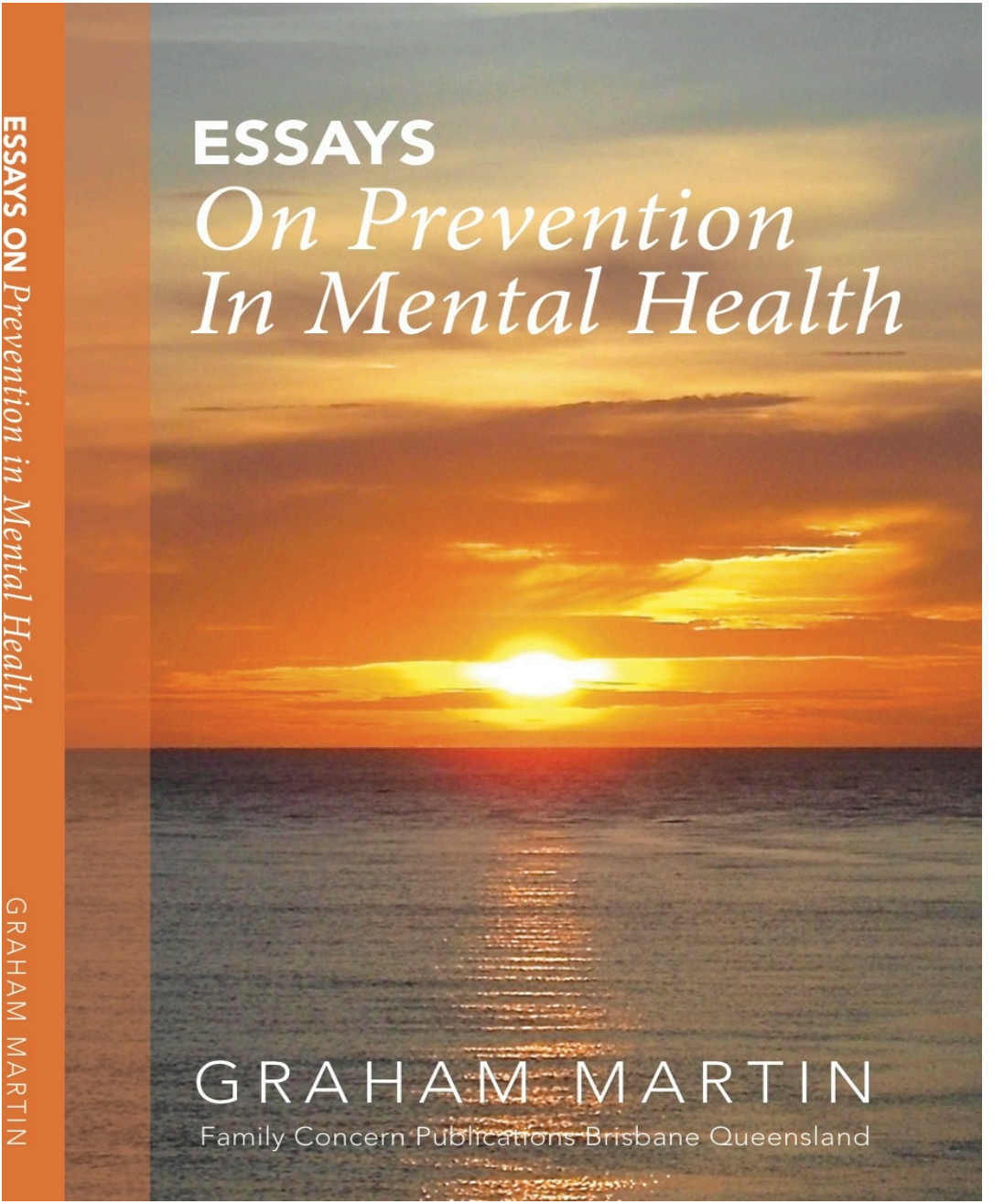
ESSAYS
On Prevention
In Mental Health
GRAHAM MARTIN
Family Concern Publications Brisbane Queensland
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PTO

Preface

Prevention as an issue in Mental Health is popular in the rhetoric of governments, organisations seeking funds, and in the press. The reality of how to pursue it is complex and costly, and takes time, as well as shifts in conceptual frameworks. I acknowledge governments (both national and state) have included prevention as the number one issue in Mental Health. For instance, in Australia, the National Mental Health Strategy[1] (endorsed in April 1992, affirmed in 1998 and 2003 with mental health plans, revised in 2008, and with a 4th national mental health plan released in November 2009) aims to:

- Promote the mental health of the Australian community
- Where possible, prevent the development of mental disorder
- Reduce the impact of mental disorders on individuals, families and the community, and
- Assure the rights of people with mental illness.

The latest plan[2] is comprehensive, providing 5 action areas (Social inclusion and recovery; Prevention and early intervention; Service access, coordination and continuity of care; Quality improvement and innovation, and Accountability - measuring and reporting progress). Each of these has a clear set of outcomes, with action statements. So for the 2nd action area (Prevention and Early Intervention), the Outcome is stated as:

> "People have a better understanding and recognition of mental health problems and mental illness. They are supported to develop resilience and coping skills. People are better prepared to seek help

[1] http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-strat (accessed July 7th 2014)
[2] This can be downloaded as a pdf from: http://www.health.gov.au/internet/main/publishing.nsf/Content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/$File/plan09v2.pdf (accessed July 7th 2014)

> for themselves, and to support others to prevent or intervene early in the onset or recurrence of mental illness. There is greater recognition and response to co-occurring alcohol and other drug problems, physical health issues and suicidal behaviour. Generalist services have support and access to advice and specialist services when needed."

In the actions to support this, there are terms like 'Develop', 'Implement', 'Expand', 'Coordinate' and 'Work with', and a focus on increased education and working together across jurisdictions. Even in the detailed examination of these later, there is little guidance as to *how* to 'Develop', 'Implement', 'Expand', 'Coordinate' and 'Work with'. There are no guides to what works best, no examples of what is most cost-effective. The problems are beautifully explored with well-explained graphs, and lovely flow diagrams about how we should all work together. However, the solutions - actual practical advice for those working at the mental health coalface – are seriously limp...
If we take the important area of accountability (Priority area 5; measuring and reporting progress), the stated outcome is that:

> "The public will able to make informed judgements about the extent of mental health reform in Australia, including the progress of this Fourth Plan, and have confidence in the information available to make these judgements. Consumers and carers will have access to information about the performance of services responsible for their care across the range of health quality domains and be able to compare these to national benchmarks".

It concludes with 'Indicators for which data are currently available: "N/A"', and then 'Indicators requiring further development: "Proportion of services publicly reporting performance data"'.
This is all very sad is it not? That 'Indicators currently available' are not available, and the 'Proportion of services publicly reporting performance data requires further development', is really an outrage. After 20+ years of endeavour, perhaps we might rightly expect that we could say something like: "If, in X circumstance, you do Y, you will reduce the incidence or prevalence of anxiety or depression in Australia." Or, perhaps: "Best practice for the reduction of child abuse is X. If we support programs which do this, we can reduce not only the development of child abuse but also the serious sequelae which traumatise young people as a result."
I acknowledge there are 'technical notes' later in the plan purporting to

expand on how some of this may be achieved, but nowhere is there reference to international research work in any area reducing the incidence or prevalence of mental health problems in the community, or having a positive impact in support of the rhetoric.

It has been complex to get traction at the national, state and local levels in terms of the 'reality' of what we should be doing in Australia. What do we actually mean by Mental Health (dot point 1 above)? Is it simply the absence of mental ill health? Or are we willing to acknowledge such constructs as wellness, resilience, optimism and social support and connectedness? Is any definition universally accepted across our diverse multicultural society? Do we have clear and convincing measures of health as 'Health'? Are such measures sensitive to change, such that we can all agree that a positive change nationally of x% is meaningful in the short or medium term? Finally, do we have any universally accepted and agreed strategies that are known to improve health and wellness, and are we agreed on how best to target comprehensive programs, and in what environments these strategies work best? Can we get governments and other funding bodies to understand the central importance of health as 'Health', and be prepared to endorse and fund the programs nationally to achieve 'Health'?

If we only accept a limited definition of mental health as the absence of mental illness, then there is a central problem. How do we measure the absence of a problem? If we could gain an agreed reduction in depression or anxiety at the national level, how would we know that it was the instituted program, and not just some natural variation over time?

A further problem is to do with the size of research program necessary to measure such change to everyone's satisfaction. Others have addressed this in detail, but my understanding is that you need multiple thousands of baseline subjects to be able to measure such change, and compare the change against national figures and trends. This argument has always been significant to those of us attempting to evaluate suicide prevention programs. An example of a multi-tiered national program that may be having a major impact on suicide rates is Mates in Construction[3]. This program has reached the stage of sufficient numbers (in excess of 40,000 construction workers in Qld alone completing a base level mental health promotion program). It has been sustained over 8 years, such that a comparison of rates of suicide in this population can now be made against rates in Queensland and nationally for the construction industry, taking

[3] www.matesinconstruction.com.au/ (accessed 7th July 2014)

into account other variations in the industry. It takes time, and it takes energy and commitment to sustain such a program over time. It also takes considerable funding. What is it that will convince researchers and governments that the program genuinely 'works'? How can we prove that a reduction in suicides is genuinely the direct result of the program? How do you then gain the energy, commitment and funding to promulgate such work further afield. These are all important questions; particularly in the face of evidence suggesting that less than 9% of nationally funded suicide prevention programs have been evaluated in terms of outcomes. This suggests, sadly, that it is not only governments who need to be persuaded that mental health promotion, and prevention, can be shown to work. The mental health workforce needs to 'grasp the nettle', and allow serious evaluation of what they do in therapy, and in so-called prevention programs. If we do not evaluate seriously, and simply go on using the same old approaches, all we can expect is the same old outcomes.

Introduction

'*Essays on Prevention in Mental Health*' was never conceptualised as a comprehensive text on Prevention. It is simply a book of essays wrestling with some of the constructs of prevention, and trying to apply them to issues that a mental health professional might come across in everyday practice. The book was completed during my tenure as Professor of Child and Adolescent Psychiatry at the University of Queensland. It traces the development of my own understanding of Mental Health Promotion, Prevention in Mental Health, and Early Intervention, reflected in presented work, essays and editorials over 20 years from 1995 to 2014. Given my earlier background as Clinical Director of a very active, enthusiastic and expanding service in Child and Adolescent Mental Health in South Australia, the book begins with a presentation about Child and Adolescent clinical work - an address at the 1995 conference '*From Rhetoric to Reality*' which we convened in Adelaide to reflect and discuss the emerging place of prevention in mental health. This initial chapter raises the central issue of the relatively hidden work of Child and Adolescent Mental Health services. It also addresses the complexity of how a local level service can grapple with discussions at the national policy level; that is to literally translate rhetoric into reality.

At the core of this is the dilemma between doing high quality clinical work with children and their families to solve problems in the here and now (the focus of our work every day), yet being mindful that children are on the early part of a trajectory through life (the wider perspective of prevention). What happens in childhood, and how children learn to cope with problems, forms the basis for how they will cope as adults. So therapy in childhood *is* early intervention for adult life. We do not just seek to eradicate a set of problems and symptoms; rather we attempt to help the child develop skills and coping strategies for later, should old problems re-occur or new problems emerge. I would go further with this thinking. Over the years, I have come to believe that every professional contact, every single episode of therapeutic endeavour, has within it the seeds of prevention for problems in the future.

This is not a popularly accepted view, and many types of therapy are designed simply to eradicate the presenting problems. They do not either implicitly or explicitly seek to provide some sort of immunity into the future. At the heart of this is that therapy is framed as being about problems and ill health. Mostly it is not geared toward development of mental health as wellness, or resilience. In part, this may be driven by funding sources or bodies, who are willing to pay for reduction or eradication of serious problems or illness, but would be horrified to find out they were, in part, paying for wellness development.

Mental Health is confusing as a term. When we talk about mental health services, we really mean services to help people with mental 'illth' or illness. Mostly, this is well understood by people in the community. So, I have had experience of working in a school and suggesting a young person could usefully be referred for assessment and appropriate care, with the young person replying they would not attend our mental health service because they were "not mad". Even children know that the primary work of a mental health service is to seek out some mental illness to fix. We often soften the illness issue by using the term 'mental health problem'. Nobody is fooled.

So is Mental Health a continuum with health at one end, and mental illness at the other? Historically, this is how our professions have thought, and this has led to stigma in the community. 'Once you have an illness like Schizophrenia, you always have that illness, and can never again be normal or healthy'. You become 'a schizophrenic', never quite to be trusted. We now know this is rubbish, given spontaneous resolution occurs in many (if not most) early cases, and even if it does not, modern medications can reduce symptoms and behaviours to allow a relatively acceptable life in the community.

I believe we are gradually beginning to accept that Mental Health and Mental Illness are on separate continua, even if they can influence the other. So, if you have had a loving supportive early life with very few psychological trauma, and a solid education, you may be considerably better off, if and when an illness strikes, you may be able to cope better, have much more in the way of ongoing family and community supports, and be much more likely to return to a relatively normal life. The converse is also true. If you have had a deeply scarred childhood, have few or extremely ambivalent connections, to family, have had a disrupted education then, if and when illness strikes, you may have much more of struggle.

What has been emerging over the last twenty years is the idea that promotion of mental health (as 'health' or 'wellness') might be an

extremely useful strategy to reduce the immense national and state costs of mental illness. We still have long way to go with this, and not until we have substantial, irrefutable, evidence will funding bodies be reassured that Mental Health Promotion is not just ill conceived waffle, but a group of clearly articulated, well understood, and appropriate strategies that will support illness recovery, reduce the likelihood of recurrence, and reduce episodes of inpatient care.

Much of the debate on these issues has been driven by organisations like Auseinet (the Australian Early Intervention Network for Mental Health) that (as we garnered convincing evidence) morphed into a network explicitly addressing PPEi (Promotion of Mental Health, Prevention of Mental Illness, and Early Intervention).
Auseinet developed and was funded in the mid 90s by the Commonwealth Government; we owe a considerable debt of gratitude to staff at the Mental Health Branch who provided funding, and were prepared to support a highly innovative program of work as a collaborative between Finders University and the University of Adelaide in South Australia. I pay tribute to my colleagues Professor Robert Kosky, Dr. Ann O'Hanlon, Ms Cathy Davis, and later Ms. Jenny Parham, who were part of turning the dreams of a truly national network into a reality with over 6,000 members, over 80 seminars across Australia, several seminal national conferences, an internet site and clearinghouse, a fortnightly email alert service and 3 editions of a national newsletter disseminated yearly, a national academic journal, two national stocktakes of community activity, a number of novel research programs, many relevant publications of international standard, and production of a national mental health promotion literacy package 'Understanding Mental Health and Wellbeing' with a train-the-trainer program to deliver the module in different sectors across Australia.
This book is, in part, a tribute to the work of Auseinet and the passionate people who developed it and worked for many years to change the face of Mental Health in Australia. People like Abbie Patterson (Communications and Workforce Development), Jill Knappstein and Gwyn Elson (Office Administration), Joy Sims (Information Management), Lou Morrow (Project Officer Academic Input and Quality Control), Chris Alliston (Project Officer Consumer and Carer Issues), Warren Milera (Project Officer Indigenous Issues), Brodie Millsteed, and Susan Mitchell. To all of you I owe a considerable debt of gratitude for your support, commitment, encouragement and sheer hard work in what were, often, confusing and troubling times breaking new ground. In addition, we have to thank Steve

Trickey and David Robley, our 'can do' IT gurus, who kept our online presence active throughout the life of the project. Finally, I need to thank members of our national AusEinet Board, ably chaired by Professor Steve Zubrick. He was always there to provide high-level advocacy, sage advice, and pour oil on the troubled waters of often heated debates.

Chapters in '*Essays*' are sequential in time. They vary in length from short editorials taken from the AusEinet newsletter *(Auseinetter)* to the longer editorials of later issues of the *Australian eJournal for the Advancement of Mental Health (AeJAMH),* to the consistent length of editorials from *Advances in Mental Health (AMH)*. All editorials are reproduced with the agreement of James Davidson from eContent Management, the publisher for AMH. I am sincerely grateful to James for his support for this project.

In general these 'Essays' have not been altered in terms of the content, simply edited to clarify the English, or correct typos. Most are written in the present tense, and in a conversational style, as if talking with a colleague. Some readers may find this irritating, but it was never my intent to produce an academic treatise each time I sat down to write. My intent was always to try to make sense of what was being said in government or academic meetings, an attempt to translate the academic literature to make it palatable, and also usable. What this means is that 'Essays' was never intended to be a comprehensive scientific treatise on all aspects of Promotion of Mental Health, and Prevention and Early Intervention in Mental Illness. Others have done that far better than I ever could. 'Essays' is what it is; series of attempts to help mental health workers at the coalface appreciate what might be possible if you can broaden your focus and mind set.

What has been important given the passage of 20 years, is to add references to allow the reader to gain access to primary sources if they want to track the development of ideas. In addition, I have provided footnotes to allow for further study if warranted. This might reference some of the original documents developed under Auseinet, and now held as online documents in 'Pandora' at the National Library of Australia. In the middle of the book, where an editorial discusses original papers published in the Australian eJournal for the Advancement of Mental Health (AeJAMH), I have provided online address links to enable direct access to these papers now held under the new name of the journal 'Advances in Mental Health' (AMH - under the management of eContent Management Pty Ltd). Similarly, my later editorials all have footnotes with

links to provide access to the original versions, as well as all of the papers for each associated issue of AMH.
My hope is that this book, and the essays, do justice to twenty years of trying to get Australia to develop sensible targeted prevention programs in mental health that get properly evaluated to confirm they not only have impact, but can make a long term difference in the incidence and prevalence of mental illness – that is a long term cost-effective outcome.

It must be obvious that I have been obsessed by suicide prevention. I have been party to national discussions about suicide and its prevention since the mid 1990s, but my research interests and programs go back much further than that to the mid 1980s. I was privileged to be National Chairman for Suicide Prevention from 1995 to 2001, and led annual national conference development for those years. Latterly, I have also been privileged to collaborate with some outstanding researchers studying the area of non-suicidal self-injury, as a precursor to suicidality that can be managed well if caught early.

While this book of Essays is my own work, and for which I gladly take full responsibility, the work of developing new ideas, translating them into practice and promoting them widely is never done alone. You always need a team of passionate people with a mix of skill to enhance your own skill, fill in for the deficits, and from time to time remind you of your defects. You also need that personal support that listens attentively to your ideas and passions, tolerates your frequent, and sometimes lengthy, absences at national and international conferences and seminars, and is prepared to put up with the hours of interpersonal silence that occur when the other party is concocting presentations, professional papers, and editorials. I have been overwhelmingly loved and supported by Jan, my partner in life for 50 years. I cannot ever thank you enough, my dear.

Graham Martin
July 2014.

So, Graham, what do you do for a living?
I build bridges
That must be so interesting...
It is.

One

"Yes, but what do we do?"[4]
The Development of a Comprehensive Regional Child and Adolescent Mental Health Service

Visibility
Mental Health for Children and Young People is not a flashy endeavour. It is only rarely dramatic or newsworthy, does not use radically new technologies or vastly expensive diagnostic and therapeutic equipment, uses few resources in terms of inpatient beds and the infrastructure necessary to support them, and uses only a limited range of medications in a sparing way.
These two issues, the lack of flashiness and the privacy of the processes, make Mental Health for Children and Young People relatively invisible to governments and other funding bodies.

Southern CAMHS
In South Australia, Mental Health for Children and Young People receives somewhat less than 7% of the total Mental Health budget while servicing 29% of the population. Despite this, the two services - Northern CAMHS based at Women's and Children's Hospital and Southern CAMHS based at Flinders Medical Centre _ are relatively autonomous and have their own management teams and major control over their own budgets.
Our own budget (1995) is about $2.8 m. servicing about 160,000 young people. I count myself fortunate to have been with Southern CAMHS since mid 1986, because despite the limitations in our funding we have been

[4] I am grateful to Kym Crettenden and Andrew Wood (both then at Southern Child and Adolescent Mental Health Services, South Australia) for their contributions to this presentation (15.2.95) at the '*From Rhetoric to Reality*' Child and Adolescent Mental Health National Conference we convened in Adelaide.

able to develop a comprehensive service providing a continuum of care from community through to inpatient and liaison services. In particular we have been able to translate the rhetoric of policy dictates into the reality of service. I have to say that we were often able to play an active part in the development of policy either in the original thinking or through our considered responses. However what was often surprising to us was to find we had been doing for some time what policy eventually told us we should be doing.
Since inception we had been an 'equal opportunity employer' - we were interested in whether the task could be done and the quality of the outcome rather than gender or racial background. In developing our regional teams we were keen to meet principles of 'social justice' and incorporated 'principles of primary health care'. Finally, over the last three years our management process has gained from regular meetings with an advisory committee that includes referrers and consumer representatives from both metro and country areas. The committee is chaired by a member of Brighton and Glenelg Health and Social Welfare Committee.

Reasonable Questions...
1. What does the clinician do in the consulting room?
2. What does the general public expect a child and adolescent mental health service to do?
3. What do child and adolescent mental health workers do that no-one else does?
4. What should child and adolescent mental health workers be doing?

Mental Health for Children and Young People
Mental Health Problems and Disorders in childhood, adolescence and young adulthood are expressed through emotional symptoms, behavioural disorders and/or social difficulties. These are often accompanied by, or underpinned by, cognitive difficulties, speech and language problems and disorders, and psychomotor difficulties. Certain developmental life transitions, physical and intellectual disability, and a range of medical disorders are known to be associated with mental health problems.
The clinician who specialises in the area of Mental Health for Children and Young People seeks to assess, manage or intervene through counselling or

therapy with disorders that:

- cause problems in living in the here and now;
- can reasonably be predicted to cause problems in living in the future;
- are known to be (or where there is a high index of suspicion that they are) symptoms of, or precursors to, mild, moderate or severe mental disorder;
- where there is a fear in the young person, their parents, other professionals or the community that they may be symptoms of, or precursors to mild, moderate or severe mental disorder.

Although I believe it is inappropriate to go into it for this paper, we conceptualize mental disorder for statistical purposes in terms very close to those of the multi-axial approach of DSM IV. There is some dissonance between our beliefs about therapy and the problems inherent in labeling, but we have come to an uneasy compromise. Clinically we diagnose little as such; it is only rarely useful to therapeutic process. However, we report statistically in a formal diagnosis based way.

Personnel

Professional workers in Community Mental Health Services for Children and Young People must:

- understand mental health problems and disorders;
- understand child development;
- understand the child's inner world and be capable of working with the child;
- understand family dynamics and be able to work with the child's family;
- take a broad bio-psycho-socio-cultural view of any symptom, problem or disorder presented to them;
- be able to liaise with, or intervene in, the wider system (ie peer group, school or community) in which the child is involved;
- be trained in a wide range of assessment techniques and therapeutic interventions, or...
- have ready access to that expertise.

There are two issues here that are crucial to the further development of Mental Health for Children and Young People. First, the general area of 'prevention'. Both primary and secondary prevention of mental health problems are feasible. In addition to good quality clinical work during, and relapse prevention after, an early episode of mental disorder, 'thinking prevention' may well lead to fewer and less serious episodes later in life. The second issue is 'psychoeducation' as one form of mental

health promotion, which if applied consistently and early, can be shown to change the long-term course of mental disorder.
Mental Health Problems and Disorders are less likely to be complained of by the child who is more likely to be brought by, or sent by, others - parents, teachers, doctors, family services workers, residential care workers, police or courts. The child may not agree there is a problem or may be unable to express what the nature of the problem is. Because the child is in the process of development, the overall presentation may be diffuse or not quite fit the full-blown picture of a clear-cut mental disorder. Symptomatic presentations, descriptions of emotion, behaviour, and social behaviours, all differ with age and stage. Because the child lives in a family the symptoms may be underpinned by, the direct result of, distorted by, or perpetuated by the family dynamics.
Major reform is occurring in Mental Health Services throughout Australia. However, at this time there is no national or state policy or plan written specifically for the mental health of children and adolescents. Inferences on what is thought by the community to be important have to be drawn from the National Mental Health Policy (1992) and Plan (1993)[5], National Goals, Targets and Strategies for improving Mental Health (Feb, 1994), the Health Goals and Targets for Australian Children and Youth (1992) and the Health of Young Australians (1994).

To research or not?
As previously noted our service is funded for clinical activity. Up until last year we were not able to gain outside funds for specific projects because we did not have a track record, we did not have the experience. But as clinicians we could not gain the experience without being able to fund some programs that would give us the experience. We are now at the stage where, small as we are, in several different ways we are contributing to international knowledge. We now attract funding. This has been a hard road, but our clinicians can now choose to take part in what is often a fun and creative enterprise. This contribution to the field of mental health for children and young people is crucial if we are to answer those four hard questions.
You can see from this that we believe we have developed a responsive service carefully tailored to the needs of the community. To add to this we have completed two client satisfaction surveys and a public awareness survey in recent years to assist us in our planning. The feedback from

[5] http://www.health.gov.au/internet/main/publishing.nsf/Content/9840D506800C819ECA257BF00020440D/$File/plan92.pdf (accessed June 1014)

these suggested both professional referrers and client families were well pleased with what we did. So it came as a shock when, as part of the review team for Queensland's community mental health services for children and young people[6], the question was repeatedly asked: "Yes, but what do you do ?" In describing a reasonably functional service, I thought I had explained. In fact I had probably assumed that everyone *knew* what we do. We sit down with young people and their families in a private and confidential context and explore the problems that are presented, trying to help them find acceptable solutions. But something more was required, and it seemed that there were several dimensions to this question.

Preservation of Staff

We are specifically funded by Government for clinical activity. Yet, as clinicians, we all know the basic truths that:

- further education enriches our clinical functioning;
- the best learning often derives from our teaching of others;
- research activity - both personal and as a service - answers the critical questions that derive from our clinical work and fuels our teaching.

How can we continue to afford to encourage further education, maintain a tenth of our staff doing masters level courses, fund clinical meetings, bring over international guests to enrich our thinking, support peer supervision and promote meaningful staff appraisal?

When the tools of this particular trade are the professionals themselves how can we address the special occupational health and safety issues surrounding professional mental health, particularly for instance in isolated or country regions ?

Getting the information right

It has taken an immense amount of effort to create a statistical database which reflects what we actually do, can answer some of the questions we are asked by the Health Commission and our own management process. We must begin to know what cases we see, how much time and energy we devote to them, and what therapeutic interventions promote the best outcomes. Facts and figures are anathema to the clinician but the process of data collection can be made relatively painless especially if we all can begin to see the results; that is, if we get reasonably prompt feedback

[6] Martin, G., Behan, S. & Lee, E., 1994. Commissioned Review of Queensland Community Mental Health Services to Children and Young People. Mental Health Branch, Queensland Government.

about our work.
The core work of Mental Health Services for Children and Young People is assessment of emotional, behavioural or mental disorder, the development of a management plan in association with relevant others and, where appropriate, therapy or counselling. These are essentially private and confidential processes, which occur behind closed doors, and are difficult to monitor or measure. In addition they are discussed infrequently in the media or by the press compared with the often dramatic cures from surgical intervention, or the poignant medical cures for childhood cancer or leukaemia. Mental Ill Health still carries a marked stigma in the community, and ethical mental health professionals do not discuss the work they do privately, in public forums.

Let us just consider 'accessibility'
From the point of view of the client family, and the local services that already support them, accessibility to relevant services is paramount. If young people with potentially serious mental health problems need to be seen, they need to be seen as soon as possible. The costs, and the time used up by travel to city clinics, may be just enough to delay assessment and relevant therapy, and reduce the possibilities of early intervention.
At the time of writing, we have two metropolitan clinics (Oaklands Regional Team and Morphett Vale Regional Team) with about ten staff in each, added to the team at Flinders Medical Centre. There is easy access from bus routes and they are placed in metropolitan areas of high density population. We took as a planning basis for 'a team' a population of about 100,000 or about 30,000 children under 19 years.
Five years ago we developed a Country Regional Team based at Murray Bridge. This has a local child population of only 15,000, but we argued successfully on grounds of social justice that there should be 2 resident clinicians (in part so that they could provide support to each other, in what is a complex and hard job).
We now have 2 permanent staff at Mount Gambier (child population 13,000) and shortly will have 2 permanent staff in the Riverland (child population 11,000), including a half time aboriginal worker. Finally we argued that the total numbers of children in the country exceeded the numbers which would normally warrant a full team and we have recently been successful in gaining national mental health funding to provide a psychiatrist, a psychologist and an occupational therapist - who will be based at Murray Bridge but support all our other country staff.
Finally, we have both a policy of support for our country workers with relevant professional visiting teams and, a number of outreach teams to

the smaller communities of Mount Barker, Willunga, Victor Harbour and Kangaroo Island. We have just begun planning for a new full team in a rapidly growing area south of Noarlunga.

The Multidisciplinary Approach

As a service we have adopted a multidisciplinary approach. This permeates management as well as the clinical process.

Twenty years ago, services specialising in the mental health of children and young people used the range of professional disciplines in an 'interdisciplinary' discipline-specific way; social workers worked with parents, psychologists tested children for intelligence and skills, psychiatrists assessed the presence or absence of mental disorder, psychiatric nurses acted as child therapists. The more modern multidisciplinary approach has acknowledged that there is overlap in clinical function between professions and a blurred area where all professions may do pretty much the same work in the same way. This has provided more richness of professional interaction and a higher level of clinic skill, an increase in efficiency (more therapists to do the therapy) while retaining the discipline-specific skills for when these are necessary. It has also promoted professional pride, and increased understanding and interaction between the professional specific groups.

We have also tried to promote and maintain the multidisciplinary approach for management. That is, each of the professional disciplines has a senior representative contributing to the overall management process, and feeding back management decisions to their staff colleagues. The outcomes of this have been greater understanding, as well as fewer disputes between professions.

Within all of this, the primary goal for all staff has been to intervene in a therapeutic way effectively with children and their families. To this end we have developed orientation and training programs, we have brought outstanding international figures to Australia to inform our staff and we have programs of team work and peer review which constantly enrich the clinical thinking and lead to more 'effective' work.

Thus far, we have had an open door policy for referrals; with certain limitations we have accepted all of those who present to a clinic whatever the mental health problem or disorder. Given our steadily increasing referral rate, we have therefore had to give special thought to not just effectiveness, but also 'efficiency' as a principle. Our focus has been on the steadily growing range of brief therapies, particularly for the area of multidisciplinary clinical functioning we call the 'area of common (or core) clinical practice'. This does not exclude extensive and thorough

specialist assessment where it is needed, nor other and perhaps longer-term therapies where appropriate. However, based on a number of assumptions, we do talk openly of a maximum number of sessions being 10 and the most usual number being around 3-5. Clearly this cannot occur with more serious disorder, or where young people are admitted to hospital in crisis, or where there is a need for medication or special programs of rehabilitation. At this time our 'did not attend' (or 'DNA') rate has dropped to about 17% and our waiting lists are at a *maximum* of only two months for most cases. We have built in systems that allow emergency referrals to be seen almost immediately.
This complexity and the improbability of finding all the assessment and therapeutic requirements in the one person or professional group accounts in part for why the most functional services are fully multidisciplinary with child psychiatrists, clinical psychologists, social workers, psychiatric nurses, occupational therapists and speech pathologists all working together in the same clinic. A comprehensive service can be offered to the young patient and their family in the one place, and even possibly within one day or so.

The Context of Reform
One way of answering the question about general public expectation of a Child and Adolescent Mental Health Service, is to review policy and strategic plans where these exist. Agreed, these are developed by local, state or national bureaucrats, but they would all say that they base their decision-making on consultation with large numbers of relevant members of the general public.
We must make the field of Mental Health for Children and Young People more visible - to the general public and to both state and federal fund-holders. If we are to do this, we must be clearer, and more explicit, about what we do. It may seem silly, but I do not believe we will be able to provide a satisfactory answer to the questions about what we should be doing until 'as a field' we have had the opportunity to define a range of Health Goals and Targets which make sense to us.

Universal Clinical Service
A Focused Illness/Disorder Service
We understand the pressure to spend the public health dollar on those conditions which appear to warrant it most. However, we are the only remaining public service that provides an open door policy. All services are moving toward prioritisation. Can we continue to be both human problem solvers, therapists and managers for mental disorder (especially

focused on the more serious disorders), as well as provide mental health promotion and prevention?
We struggle with this issue daily. Clinical referral provides immense pressure on us to respond. That then raises questions... How can we maintain special time to ensure that we address issues of mental health promotion? Do we have any evidence that prevention does actually work in the mental health field? Can we really work on the basic tenet that 'an ounce of prevention is worth a pound of cure'?

Multidisciplinary line management?
This dilemma has caused more pain for our service than almost any other issue. A management meeting with all professions fully represented may not look very efficient, and may not appear to be good use of scarce professional time. However, our experience suggests that in the long run as far as the service is concerned this cumbersome process pays dividends again and again. Line management may look lean and streamlined on paper, but confusion and inter-professional mistrust soon surfaces if full representation is not seen to occur.
The Policy Environment
The National Mental Health Policy (1992) states explicitly that:
'priority in the allocation of resources should be given to people with severe mental health problems or mental disorders who, because of the nature of their condition, require ongoing and, at times, intensive treatment.'
The implication for Mental Health Services for Children and Young People is that we should seek to deal predominantly with those disorders that may be clearly defined as 'severe', and possibly 'in need of long term care'. Such conditions are often 'complex', 'difficult to diagnose in their earliest presentations', but more likely to have ultimately a clear cut 'psychiatric diagnosis'
In contrast the National Mental Health Policy also states:
> *'The policy also recognises the impact of mental health problems more generally on individuals, their families and the community...'*

This statement fits well with Mental Health Services for Children and Young People where a broad bio-psycho-socio-cultural view is routinely taken to understand both the aetiology and perpetuation of disorder.

The National Mental Health Policy adds:
> *'The development of effective mental health promotion, prevention and early intervention strategies and the enhancement of training and support for primary care service providers, is fundamental to the achievement of these objectives.'*

In the draft of the National Goals, Targets and Strategies for improving

Mental Health (Feb, 1994), five areas were 'chosen to focus attention', areas which met the following criteria (p.3.):

- high public health impact of the disorder including cost and distress both to people experiencing mental ill health and their carers;
- achievability - the availability of demonstrably effective strategies and interventions to engender change;
- the capacity to measure and monitor change;
- the ability to engage consumer support; and,
- the ability to engage community support.

These criteria challenge our thinking in the area of Mental Health for Children and Young People. Historically we have not been good at monitoring our activities and we have not been active in engaging consumer or community support. Further, the symptomatology which appears in childhood or adolescence, and which underpins the development of serious mental disorder, has not been totally elucidated and we have not universally heeded the policy imperative to prioritise those conditions that have a high public health impact. Finally, we have not prioritised those conditions for which a demonstrably effective strategy is available; rather community clinics have tended to accept all referrals from whatever source.

Five specific areas were prioritised, including:

- community attitudes to mental health (p.3.);
  (It was noted that activities in this area would be informed in part by work currently underway such as the National Consumer Advisory Group (NCAG) media projects. The 'ARAFMI school project' was noted).
- Child and Adolescent Mental Health (p.4.);
  (It is clearly demonstrated in the literature that mental health problems and mental disorders experienced early in life place individuals at greater risk for the development of mental health problems later in life...
  (Within this goal specific targets were set to address suicide, depression, and behaviour disorders)

As far as the Mental Health of Children and Young People is concerned the specific Indicators, Targets and Strategies to address the Goal: 'reduce the prevalence of mental health problems and mental disorders in children and adolescents' were detailed further in the draft report (pp. 22-26).
Two other reports are worthy of mention here.
First, the *Health Goals and Targets for Australian Children and Youth*

(1992) defines several goals which have implications for Mental Health Services for Children and Young People:

Goal 1.2

'Reduce the frequency of Adolescent Suicide by at least a third by the year 2000' (to18/100,000 for males and 2/100,000 for females, p.17.);

Goal 2.

'Reduce the impact of disability'

While the emotional, behavioural and social impacts of physical disability (p.29), chronic illness (p.31) and intellectual disability (p.32) on children and young people are not detailed, they are often referred at some time for mental health assessment and counselling;

Goal 4.2

'Reduce the morbidity in adolescence and adulthood associated with alcohol and tobacco use' (p.44).

Both of these and other drug use/abuse are more common in young people with mental health problems and mental disorder.

Goal 5.

'Enhance Family and Social Functioning' (p.52).

The impact of family break-up, and/or alternate care, are well known to mental health services specialising in children and young people.

Key Action Areas

The draft policy paper - *The Health of Young Australians* (1994) takes note of these goals and targets and develops seven 'Key action areas' (pp 16-23.):

'Putting people first';

To promote and enhance the health and well being of young Australians through adequate resourcing of their health care and their increased participation in decisions about their health care at all levels.

'A balanced approach';

To improve health outcomes for young Australians through an integrated and comprehensive approach to health planning and service delivery.

'Addressing inequities';

To ensure that all young Australians are able to achieve optimal health through provision of a full range of health care services appropriate to their needs, with a focus on those most at risk of poor health.

'Coordination and collaboration';

To develop cooperative, targeted and cost-effective health strategies for

both children and young people.

'Information';
To promote well-informed and skilled consumers, workers, and managers involved in the provision of health care.

'Research, data and monitoring';
To develop a clear focus - in research, data collection and monitoring - on the health needs of children and young people as a major group within the Australian population and on the health needs of special sub-groups within that group.

'Training';
To equip health professionals to

- work effectively in the maintenance and enhancement of the health of children and young people.
- be comprehensive with a continuum of care from the community through to intensive inpatient care;
- be mainstreamed;
- be available in all regions with an equitable distribution which reaches those in most need;
- be responsive to consumer needs;
- have strong links with primary health care as well as good intersectoral links;
- have good quality data from a clear monitoring process and regular evaluation of services;
- address the most serious mental disorders (those disorders which are complex, severe, more psychiatric, and likely to have the greatest impact subsequently on the community);
- be able to respond to mental illness and its precursors (predisposing factors) as they present in the Child, Adolescent and Young Adult population in a timely, effective and appropriate manner;
- have clear early detection and early intervention programs for serious mental disorders and mental health problems;
- have programs for psychoeducation and mental health promotion for patients, carers and the community;
- be well staffed according to population base;
- have staff who are experienced, competent, well trained and well supported.

None of these documents focuses in detail on the overall field of Mental

Health for Children and Young People, nor do they provide a comprehensive list of the priorities that a mental health service should address. However, they do inform our thinking, and provide a basis for a process toward the development of specific mental health goals and targets for Children and Adolescents.

Conclusions
The conclusions that may be drawn at this stage are that Mental Health Services for Children and Young People should at least be able to focus on those specific disorders already agreed on by the community, in the Health Goals and Targets documentation, as of national importance. At this stage the list contains:

- Depression
- suicide;
- drug and alcohol problems;
- the effect of all forms of abuse;
- the impact of chronic illness and disability;
- the sequelae from parental separation and alternate care.

Clearly this list is inadequate from the point of view of a worker in the field of Mental Health for Children and Young People, since there has been - as yet - no process of broad national discussion on what should be targeted for this field. There is a need for a national effort to define Health Goals and Targets for the Mental Health of Children and Young People based on the combined experience of mental health workers in this specialised area of children and young people; presumably this would greatly expand the above list of targets.
I return to my own service. In exploring some of these issues, we are left with some dilemmas with which to struggle:

Regionalized Service vs Statewide Specialist Service?
South Australia is in the process of moving toward regionalization. It is not yet clear how regions will be defined. However, we believe we have been successful as a service because we have had relative autonomy, a passion for mental health in children and young people, and a commitment to support and further education of our staff. Is it possible for us to maintain our standards if the sense of statewide identity is watered down and dissipated?

To research or not?
As previously noted our service is funded for clinical activity. Up until last

year we were not able to gain outside funds for specific projects because we did not have a track record, we did not have the experience. But as clinicians, we could not gain the experience without being able to fund some programs that would give us the experience. We are now at the stage where, small as we are, in several different ways we are contributing to international knowledge. We now attract funding. This has been a hard road, but our clinicians can now choose to take part in what is often a fun and creative enterprise. This contribution to the field of mental health for children and young people is crucial if we are to answer those four hard questions.

If we are to translate Rhetoric into Reality, we must in the process develop an appropriate rhetoric for a reality we know so well but find so hard to express.

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Two

The Early Intervention Network for Mental Health in Young People[7]

In June 1997, Commonwealth funding of $1.95 million was provided through till 1999 under the National Mental Health Strategy and the National Youth Suicide Prevention Strategy for the establishment of a National Early Intervention Network to promote early intervention in mental health problems specifically with children and young people.
The focus of the project was the development of a national network involving consumers, carers, clinicians, researchers and policy makers, with the development of resources and training programs to promote best practice in early intervention in mental disorders specifically with children and young people. The network was to have a Clearinghouse function to link people, gathering and disseminating information electronically and via other media. With the assistance of the network the project was to promote and enhance the development of early intervention services nationally through identifying and enhancing key service structural and intersectoral issues, and further developing best practice in specific areas.
The project was divided into three streams:
Stream One focused on the development and maintenance of a national communications network, as well as training issues. This included the establishment of the National Clearinghouse for Early Intervention in Mental Health; an international literature review; a National Stocktake of work in this area; the development and dissemination of an early intervention newsletter; production of best practice resources and training kits on early intervention - generally, and with particular disorders experienced by children and young people.

[7] First published 1997. Martin, G. (1997). Adapted from the Editorial to the First Edition of AusEinetter 1, 1.

Stream Two worked with a variety of mental health and key intersectoral service providers to re-orient service delivery in the area to an early intervention focus. This included a re-orientation consultancy examining potential in other systems to develop greater understanding of mental health problems and stronger links with mental health services. In addition, clinical project officers worked within various systems to identify and address structural and system constraints to enable the services to enhance early intervention for those with mental health problems.
Stream Three addressed specific mental health problems requiring further development of best practice in early intervention. This stream included a review to identify evidence-based practice in early intervention; provide support for existing early intervention programs; and develop further best practice models in early intervention for specific disorders.

AusEinet Program Launch
The AusEinet project was launched in Canberra at the first of the national AusEinet workshops on Friday 24th October 1997 by Dr. Andrew Southcott. Approximately 120 participants attended from a variety of agencies and services including ACT Mental Health, CAMHS, Centacare, Calvary Hospital, The Canberra Hospital and the education department. Professor Robert Kosky, joint project director of AusEinet presented a paper on health gains in early intervention and Associate Professor Graham Martin gave a presentation on the AusEinet project and a demonstration of the AusEinet Website. Other presentations were given on national early intervention projects: Professor Mark Dadds from the Griffith Early Intervention Project discussed early intervention with emotional problems in children and adolescents, Ms Bronwyn Dagg discussed the National Early Psychosis project, Mr. Peter Humphries presented a paper on a practitioner's perspective on early intervention, and Ms Kerry Borewitz, aided by a consumer, Sian, offered insights into, and implications from `The Young Ones' program. Several group discussions were held with participants to inform the AusEinet project. Small group discussions based on a set of key questions followed. A summary of the findings from the groups follows:

What do you want to get out of the Auseinet project?

1. *Information networks*
   - information to support early intervention activities

- more information on good practice (including international developments)
- more information/discussion re early warning signs and interventions when early symptoms overlap
- information on the validity of models of early intervention and optimum times for intervention (windows of opportunity)
- information on evidence of efficacy of early intervention programs
- information on centres of excellence
- access to training/materials/contacts
- provision of teaching modules linked with case studies, research, projects
- information on sources of funding
- information on the costs (particularly for other systems such as juvenile justice system) of not intervening
- links with the media (include guidelines for accurate reporting)
- communication between researchers and practitioners
- provision of opportunities for collaboration
- provision of child and family friendly information on the site
- establishment of an early intervention directory of services and service providers (that would continually be updated)
- provision of contacts within a state on particular areas of expertise
- dissemination of information on what other agencies are doing with the same population (eg specific programs for boys)
- interactive possibilities eg e-mail and a Website for young people to dialogue on mental health issues

2. *Assistance*
   - in implementing new programs of interest
   - in allowing for a range of views and philosophical viewpoints to be presented
   - in enabling agencies/workers to gain access to information generated by the AusEinet project
   - in providing recognition, support and validation of opinion of professionals outside of mainstream health care services
   - in influencing evaluation of current early intervention programs
   - in influencing policy and practice to prioritise early intervention with research projects
   - in reducing competition and increase contact with other agencies
   - with accessing the funding dollar
   - in promoting implementation of known interventions into schools

3. AusEinet was viewed as an avenue for:

- the provision of information to disseminate to other school counsellors and schools and all workers in the mental health field
- providing recognition of the early intervention work/roles of school counsellors in mental health in schools in the ACT
- the establishment of one area in the web site which would cover school practice in early intervention
- improving co-operation between schools and other agencies
- providing information on telepsychiatry sites
- translating what is happening in schools nationally into local settings
- clarifying/expanding the definition of early intervention for different disorders

What conditions/problems / issues should Auseinet address?

- vulnerability and risk factors (and screening) and relationship of these to developmental stages
- resilience and protective factors
- parenting techniques and preparation for parenthood
- attachment problems
- intellectual disability
- children of parents with a mental disorder
- children of parents with a substance abuse problem
- post abuse problems for children
- ADHD/conduct disorders/delinquency
- shyness, social isolation, loneliness
- grief and loss issues
- school problems and learning difficulties
- addictive disorders (including computer addiction)
- self-injurious behaviour
- adolescent sexuality
- prodromal symptoms of psychosis, depression, anxiety, suicidal behaviour
- personality disorders
- eating disorders
- working with challenging clients: eg engaging fathers/families
- information on medication

In addition, it was suggested that early intervention programs needed to be explored across different contexts (eg cross-cultural) and in different sites (recognising the impact of service provision) and that material presented on the web site needed to be as jargon-free as possible, and incorporate the latest relevant research.

What are some barriers/challenges to reorientation of services to early intervention?

- resources: lack of beds, staff, dollars
- short term funding arrangements
- children and young people's needs are easily ignored
- time (to network) and to lobby
- commitment (by governments and services - important!)
- ethical and clinical issues around mass screening
- stigma attached to mental illness in society and among peers
- existing case management ideology
- difficulties in defining early intervention
- ownership (of clients and client groups)
- competition between services
- the shifting boundary from mental health to community health
- lack of top-down support for early intervention and early detection/case finding
- lack of knowledge and expertise about indicators of early intervention (for teachers, mental health professionals, parents, the media)
- lack of training of GPs.

AusEinetter[8]

What we hope this newsletter will do is to provide you with a really useful guide to what is happening in Australia and elsewhere in Early Intervention. We will try to provide information about:

- best practice in mental health around the country and world;
- the National Stocktake of Early Intervention programs;
- helpful resources including Internet sites; seminars, workshops and training opportunities;

[8] Ultimately between 1997 and 2009, 32 issues of *AusEinetter* were produced. Originally, these were archived at AusEinet.com.au. With termination of the AusEinet program, all *AusEinetters* are currently archived at http://pandora.nla.gov.au/tep/10581 (accessed 17th September 2013).

- contacts to spur you on to adopt programs from elsewhere;
- possible avenues of funding,

.....and a whole lot more.

AusEinet National Stocktake of Early Intervention Programs
The Commonwealth Department of Health and Family Services through its National Mental Health Strategy, has recently funded a national stocktake of programs and young people that utilise the strategy of early intervention to enhance mental health. The stocktake will also include programs which are to be implemented in 1998. Findings from the national stocktake will be disseminated through the AusEinet Clearinghouse and will be used to inform recommendations about training needs, policy change and research strategies necessary to inform early intervention in Australia.
Whilst the project team is most interested in programs which are explicitly designed to provide early intervention in mental disorders impacting on the mental health of children and young people (up to age 24 years), it is clear that there are many programs in the mental health, education, early childhood and community sectors (government and non-government) which do utilise early intervention principles and strategies in their work with children and young people.
The first stage of the national stocktake[9] has involved *identification* of possible early intervention programs. The project team is now seeking more detailed information about these early intervention programs and has developed a detailed questionnaire, which is being systematically

[9] Two national stocktakes were eventually completed.
The first stocktake (published 1998) is available from http://trove.nla.gov.au/work/8999887?q=Auseinet&x=46&y=7&c=book&versionId=45707871 (Accessed 17th September 2013). Alternatively, go to http://trove.nla.gov.au/website/result?q=Auseinet&x=46&y=7 and check the right hand side bar for AusEinet stocktake 1998.
The second stocktake (published 1999) is available from http://trove.nla.gov.au/work/6574901?q=Auseinet&x=46&y=7&c=book&versionId=44947677 (Accessed 17th September 2013). Alternatively, go to http://trove.nla.gov.au/website/result?q=Auseinet&x=46&y=7 and check the right hand side bar for AusEinet stocktake 1999.

disseminated to a variety of agencies and service providers throughout Australia.[10]

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Davis, C., Martin, G., Kosky, R. & O'Hanlon, A., 1999. Second National Stocktake of Early Intervention Programs for Mental Health in Young People. Adelaide, Auseinet. ISBN 0 725 808276

[10] The *AusEinet* network no longer exists, having been defunded in 2009. In its heyday, there were 6800 members in Australia and other countries, each of whom received regular issues of our 32 *AusEinetter* newsletters.

The network was supported by an internet site: 'http//www.Auseinet.com.au'. Unfortunately, this is no longer supported, and therefore no longer active - but has been archived at the National Library of Australia Pandora site. Go to the NLA at http://pandora.nla.gov.au put the title 'Auseinet' into 'Search Trove', and you will find (http://pandora.nla.gov.au/pan/107363/20091002-1309/auseinet.com/index.html) - '257 sites containing 18,846 page versions', with all of the books and pamphlets (44 of them) to which I will refer in this book of Essays.

For the 32 *AusEinetters*, alternatively go to http://pandora.nla.gov.au

Put 'AusEinetter' in 'Search Trove', and track through (accessed 17th September 2013).

Three

The Meaning of Early Intervention in Mental Health[11]

As we develop the *Auseinet* network several of you have contacted us about exactly what we mean by Early Intervention. Some of you were `ho hum' about the whole thing ("well everybody gets in as early as you can with serious mental illness; all of us do the best we can to respond as quickly as possible"). From others there was concern that we might be usurping early childhood intervention networks and programs. From others we had questions about what possible relevance AusEinet could have to adults with serious or chronic mental disorder if we were talking about just some new aspect of Child Psychiatry. The fact that AusEinet is headed up by two child psychiatrists compounds this last point[12]. The last issue relates to the funding, of course: "Why would the Commonwealth be putting nearly $2m into that just to duplicate a whole range of current interventions"? All these responses are understandable, but we need to try to clarify parameters of the task (and I have to admit, this exercise is probably as much in our interests as yours).

First, if we use a well-known (if somewhat abused) model (Commission on Chronic Illness, 1957)[13] we are not purely into primary prevention. Further, we are unlikely to have much to say about tertiary prevention. The focus is most likely to be on that somewhat fuzzy interface between primary and secondary intervention. Changing models to the US Institute

[11] First published 1997 – Martin, G. (1997). Editorial. AusEinetter. 2, 1.

[12] Professor Graham Martin, FRANZCP, then at Flinders University, and now at The University of Queensland; and Professor Robert Kosky, FRANZCP, University of Adelaide, now retired and living in Perth.

[13] Chronic Illness in the United States, Volume 1. (1956). Published for the Commonwealth Fund. Oxford University Press, Amen House, Warwick Sq., London, EC4, England. 338 pages. (For A commentary, see Editorial, 1957. Chronic Illness in the United States. Volume I: Prevention of Chronic Illness. Journal of the American Medical Association. 1957;165(11):1513. doi:10.1001/jama.1957.02980290153030.)

of Medicine's (1994)[14] adaptation of Gordon's (1983)[15] work, we are not talking about universal prevention as such. That is, at this point we will not focus on Mental Health Promotion or Mental Health Education for the entire Australian community as such; there are other programs and passions for that. At the other end of the spectrum, there may be discussions about standard treatment for known mental disorders and also compliance with long-term treatment, but again these are not the main focus of our developments. Finally, we may have little to say about aftercare and rehabilitation.

What we will be attempting to clarify is Early Intervention deriving from work with individuals or subgroups in the population known to be at higher risk for mental disorder (*Selective Prevention*). Examples of this might include children of parents with mental illness or a problem with substance abuse, children with certain medical illnesses, or young people who have been abused. They may not show signs of developing problems, symptoms or illnesses, at the point of intervention in any given program. The focus of the AusEinet program is to assist in the clarification of which interventions applied with these groups provide clearly improved outcomes. Some of the programs we will support may contribute to this, the open discussions we will encourage at seminars, on the Internet site, and in this newsletter will certainly help, and the Clearinghouse will be crucial to providing a database of what works best.

Second, we clearly have an interest in individuals known to be at higher risk because they have early signs of illness, a high number of risk factors for a given illness, or biological markers known to predispose to mental illness (*Indicated Preventive interventions*). A number of current programs actively seek to intervene with young people with early signs of illness and/or an accumulation of risk factors and early signs. The Griffiths Early Intervention Program[16] is a fine example, as is some of the work at the Centre for Adolescent Health in Melbourne[17], as well as the Early Detection of Emotional Disorder Program at Flinders Medical Centre.[18]

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

[15] Gordon, RS., Jr., (1983). An operational classification of disease prevention. Public Health Reports. Mar-Apr; 98(2): 107–109.

[16] Dadds, MR., Spence, SH, Holland, DE, Barrett, PM, and Laurens, KR., (1997). Prevention and Early Intervention for Anxiety Disorders: A Controlled Trial. Journal of Consulting and Clinical Psychology. 65:4, 627-35.

[17] This project was completed in 2006, but is well described in Patton, G., Glover, S., Bond, L., Butler, H., Godfrey, C., Di Pietro, G. & Bowes, G., (2000). The Gatehouse

Again, with each disorder we will be seeking to define what works best in terms of outcomes, what the best point for intervention is, as well as what is cost effective. We may be able to provide some support for existing programs to clarify some of these issues; we may also commission programs in important areas where no program currently exists.
Finally, a major focus of the AusEinet program will be on *Case Identification*. This is probably the area that will make most sense to clinicians in terms of early intervention. It seems like stating the obvious that we should be able to discover those with illness at the earliest possible time and whatever their age, that we should know what the best treatment and support programs are, and that we should be clear about how to reach out and maintain access for those struggling to come to terms with a first clearly defined episode of illness. What we know in practice is that the whole area is much more complex than that, if only because of funding constraints.
And this is where my attempted clarification gets undermined. For some disorders, it may be impossible to intervene until the illness is blatantly obvious. An example might be a young man with increasing school difficulties in year 9 (don't they all?), who has increasing conflict with his parents (don't they all?), who has tried Marijuana to excess (well, a lot of them do!), and only after six months of increasing difficulty acknowledges some of his paranoid delusions. Here the problem is to provide early intervention in the form of rapid response, safe care, accurate treatment, and careful thorough and active follow-up. But what conditions at the school, for the parents, for the general practitioner and school counsellor (for example) might have helped to recognise and deal with the problem earlier?
For other problems like conduct disorder, as a society we cannot afford to wait for the blatantly obvious, because we know that there is no treatment as such, care and therapy may be resisted (and may be ineffective anyway), and the best early intervention is probably to do with parental education, educational assistance as soon as problems arise at school, and a range of other (usually school-based) programs targeted at the errant conduct. If you don't get in early (in terms of age here) the behaviours

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Project: a systematic approach to mental health promotion in secondary schools. Australian and New Zealand Journal of Psychiatry. 34:4, 586–593.

[18] Martin, G., Roeger, L., Dadds, V., & Allison, S., 1997. Early Detection of Emotional Disorders in South Australia; the first two years. Adelaide, Southern Child and Adolescent Mental Health Service. ISBN 0 646 31337 1. Report available for download from http://www.familyconcernpublishing.com.au/category/resources/

may become more and more entrenched. There is also increasing evidence that programs which address multiple issues in a comprehensive way are superior to those only focusing on one of the problems. We need to understand all of this better.

Again, what AusEinet is trying to focus is the energy and discussion to clarify just what approaches are warranted, at what point, in what way, and with what resources.

Too hard? We don't think so. Complex? Yes, very - and that's why we need your help, your discussion, your feedback. Help us to get this right. Help us to help the worker at the coal face in some remote area who might not have access to the resources that others have, may not have the opportunity to access training programs, but could draw on our combined wisdom - distilled through clear brief texts, audio- and video-taped programs, and the Internet site.

If you haven't replied to the National Stocktake - we need you. If you didn't see the Expressions of Interest advertisement (or couldn't be bothered to reply over Christmas) contact us. You have the ideas, the projects, and the programs. We may be able to help - but only if we know about you and your work (and only if you can squeeze into our definition of Early Intervention).

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Four

Early Intervention in Youth Suicide in Australia[19]

The Commonwealth Youth Suicide Prevention Advisory Group (YSPAG) has met for its last meeting in Canberra; up to that point it had advised Mental Health Branch, and through them the Federal Minister for Health and Family Services, on the National Youth Suicide Prevention Strategy (NYSPS). In fact YSPAG had responsibility over two and a bit years for the $13m of the Youth Suicide Prevention Initiative (most of which reaches completion by the end of 1998), but had less to do with the more recently allocated $18m, or the targeting of the programs which are just now beginning to get off the ground. Responsibility for the total package will now reside with a new Ministerial Advisory Committee (MAC), which will have more formal representation from each state and territory and, it is hoped, will be able to ensure better coordination of funding and projects for Suicide Prevention between the Commonwealth and the States. YSPAG, as a committed and representative group, was ever mindful in its deliberations of the possible legacy from the Strategy and repeatedly focused on the possible long-term outcomes for young people from investing such a sum of money; how could we be sure it was spent wisely? The Evaluation Working Group (previously a subcommittee of YSPAG) will continue to liaise with the 34 individual programs[20], assisting the external evaluators for each program with their evaluations, and will report to the MAC about both the outputs from the Strategy and the outcomes gained. A major literature review is in train[21]. In addition, the

[19] First published 1998. Martin, G. (1998). Early Intervention in Youth Suicide in Australia. AusEinetter, 3, 1.

[20] Department of Health and Family Services (Mental Health Branch), (1997). Youth Suicide in Australia: the national youth suicide prevention strategy. Australian Government Publishing Service, Canberra. 34 pp.

[21] Department of Health and Family Services (Mental Health Branch), (1999). National Youth Suicide Prevention Strategy. Setting the Evidence-based Research Agenda for Australia: A Literature Review. Available for download from: http://www.nhmrc.gov.au/guidelines/publications/mh12

Australian Institute for Family Studies is evaluating the whole NYSPS - as a strategy and in terms of overall outcome[22]. These processes should, between them, provide most of the answers to two major questions: "Did we in Australia get it right?" and "Where do we go from here?" In the early days YSPAG was criticised for what appeared to be somewhat of a random process of funding projects. Nothing could be further from the truth. Admittedly in the first few months there was pressure to fund some major initiatives in training for general practitioners. As a consequence, some felt that the funding had occurred before an overall funding model was clear. However, the rationale for each of the major areas of funding was clear (Mental Health Branch, 1995a & 1995b), each of the processes followed due tender process, and the many applications for each major area were carefully scrutinised in depth by subcommittees of YSPAG which co-opted professionals with special expertise where necessary. The overarching model adopted was that of Mrazek and Haggerty (1994), and a basic tenet within this was to attempt at least some innovative programs - not just replicate previous work from overseas. The focus of course has been on prevention - more primary and secondary perhaps than tertiary. Within this have been funded some Universal preventative programs which include mental health promotion and education to both young people, their carers, and the professionals who deal with them.

There are many programs targeted at Selective prevention - that is at populations thought to be at increased risk (indigenous young people, rural youth, or gay and lesbian young people are good examples). Further programs have addressed Indicated (or Targeted) prevention with young people who may be showing signs of early illness (homeless and marginalised youth, with previous suicidal behaviours, provide a good example). A number of programs have been funded for young people with early or first episode illness (for instance those identified as Cases of depression). Finally a smaller number of programs have been funded to examine innovative approaches in case management or rehabilitation in the community.

If you read Maris et al. (1992), it becomes clear that there is a process that unfolds leading up to the final behaviour of suicide; it doesn't just come out of the blue. We could call this a pathway or a 'trajectory'. It is complex and different for each individual, but background cultural, community,

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[22] The Australian Institute of Family Studies, (2000). Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy Available for download from: http://www.aifs.gov.au/institute/pubs/ysp/evaluation.html

family or personal historical factors prepare the ground, a series of negative events over the course of time may escalate the person along the trajectory, gathering pace in the context of an illness or (for example) a personal loss, reducing the options for healthy change. At some point there is a spark that ignites the process to a speed and final direction where no intervention is likely to change the trajectory – what has been called 'the tipping point' (Gladwell, 2000).

Where we intervene as individual professionals in part depends on at what point we come across the trajectory; we do the best we can at that time. For the community, taking an overall view of the issue, it is different; there are some points along the trajectory that may be more likely (that is the evidence would suggest this is the best place) to allow change in direction. To a certain extent the earlier we can intervene, the more likely we may be to change the trajectory. In contrast, if we intervene too early, we may not have clear evidence for just who is most at risk; our targeting may be poor, and we may 'waste' effort and resources. As individuals we need to know what works best at any given point along the trajectory so that we can do our best. As a community we probably need to know more where to place the available resources; if you like, we need to know the 'best buy'. The National Youth Suicide Prevention Strategy can be expected to provide some of the Australian evidence clarifying what may be done at which point along the trajectory. As a community we can expect that it will also clarify the best buy or 'best combination of buys' to achieve reduction in the outrageous level of young suicides in this country.

At AusEinet we believe this model of 'trajectory' may assist us to define similar issues for early intervention in a range of mental health disorders and problems. Two of our tasks are to collect the available evidence in each case to clarify the 'trajectory', and then see whether we can move toward defining 'best buy'.

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Primary Health Care Group, Mental Health Branch, (1995b). Here for Life: A national plan for youth in distress[24]. Commonwealth Department of Human Services and Health, Australian Government Publishing Service.

[23] Copies may be found through the National Library of Australia Pandora Archive at http://trove.nla.gov.au/website/result?q=Youth+Suicide+in+Australia%3A+a+background+monograph&x=33&y=9 (accessed 17th September 2013). Alternatively try going to the Pandora site (http://pandora.nla.gov.au) and putting 'Youth Suicide in Australia: a background monograph' into Search Trove.

[24] Copies may be found through the National Library of Australia Pandora Archive at http://trove.nla.gov.au/work/16903300?q=Here+for+Life%3A+A+national+plan+for+youth+in+distress&x=87&y=10&c=book&versionId=45484672 (accessed 17th September 2013). Alternatively try going to the Pandora site (http://pandora.nla.gov.au) and putting 'Here for Life: A national plan for youth in distress' into Search Trove.

Five

On Drug Abuse[25]

Having attended the National Drugs Round Table in March 2001, I am perhaps sensitised to issues of prevention related to alcohol abuse, the impact of tobacco use and the awful waste of lives from the use of illicit drugs. So then last Sunday on Channel Nine's *"60 Minutes"*[26] I watched with concern as Ray Martin tried in vain to reflect the debates and seek some direction: "Perhaps no other nation on earth is as addicted to heroin as Australia. Heroin is flooding our big cities and our country towns. It is responsible for our surging crime rate, our crowded jails, and for too many families devastated by addiction. It is thought that as many as 300,000 Australians have used it and it is estimated that 100,000 Australians are currently addicted to it."

Despite the obvious effort by all to make a meaningful contribution to the debate, the hour-long program was a mess. I am not saying that the images of young drug addicts wanting help so desperately was not painful to watch, or that young Australians having to seek treatment in Sweden at their family's expense did not stir mixed emotions of hope that treatment was available and could work but, conversely, outrage that it was not available in Australia and to those in need whether they have money or not. I am not saying that the passion of recovered addicts, of parents, professionals and politicians on the program was not obvious. But there was such confusion. The key issue of **zero tolerance** versus **harm minimisation** was mentioned repeatedly without clear explanation of their meaning or implications. The debate raged from the need for better treatment programs (whether they are about one or other form of withdrawal from drugs), to cryptic and somewhat acid criticism of others' views (without adequate moderation or explanation), through to very unclear ideas about what prevention (in the general sense) might mean. I suppose the program developers had some idea that the Prime Minister's

[25] First published 2001 – Martin, G. (2001). Editorial AusEinetter 12, 4-5.
[26] http://sixtyminutes.ninemsn.com.au/article/258789/the-fix-drug-nation

initiative in circulating information to every household in Australia, and the very clever and evocative advertisements on television, mean that everyone understands the issues. So how come *"60 Minutes"* could not get past the passion to some clearly enunciated and comprehensive package of interlocking programs?

In stark contrast, but also on Sunday, I was playing with two of my grandchildren; Ben is nearly three and Rory is just over one. They love the outdoors, get excited about little things like raking up leaves or slyly feeding the dog half a chewed sandwich, and clearly adore the adults in their lives. What happens between such a healthy mutual outpouring of love of the world and their family, and the wretchedness we see on television? At what point do the life trajectories begin to move away from the 80% of young people who will grow into averagely healthy adults. Can we define anything with sufficient certainty and general agreement that parents and the community will listen and provide corrective measures? The truth is so often that the pain and inconvenience has to reach severe levels before we take collective action; we just cannot believe it is going to happen to us. Then, there is often such passionate disagreement about what works best, in which circumstance and at what time. We are left in the confusion that can breed hopelessness. Often it is too late to apply whatever meagre resources we have available, and funders are left uncertain where dollars should be spent.

The story is repeated over and over with regard to the prevention of mental illness generally, but especially in the areas of drug abuse, depression, delinquency, and suicide. Increasingly questions are asked about whether we are taking these matters seriously. A key issue is the importance of establishing which treatments and service-delivery models work and which do not, and it is to be hoped that recent advances stemming from the evidence-based practice approach will, over time, do this for us.

The dilemma is: "What do we do in the meantime?" The answer in broad terms is that we have to do the best that we can with the knowledge and tools that we have. We must not retreat into isolated camps believing that our area of social and health problems are either separate or more important than others; we must collaborate on lowering risks and enhancing protective factors that clearly are involved in many life outcomes. We must not work alone in the belief that we are the only ones with the knowledge to alter life's pathways; rather we must engage the community in what has to be a joint endeavour. Finally, we must take note

of the developments in promoting mental health (for instance National Action Plan, 2000[27,28] and Raphael, 2000[29]). The relationship between mental health and mental illness is complex. Can mental health co-exist with an illness?

Can improving individual aspects of mental health alone influence the course of illness? What specific programs to enhance mental health are most likely to reduce the ever-increasing problems we are seeing, and which are likely to be the most cost effective? Some of these issues are explored in a forthcoming the book (published as *Mental Health Promotion and Young People,* Rowling, Martin and Walker, 2004 [30]). AusEinet aims to contribute to the debates, but also provide the best available information in understandable language and with a strong focus on program development. Having been refunded till 2002, in adding mental health promotion, prevention, and suicide prevention to the focus on early intervention, in broadening out from young people to all of the life span, we hope we can be of service to you. Through our clearinghouse activities, our support of State and Territory special interest groups. And through the Internet we hope to translate the passion of the debates into conceptual clarity toward effective action.

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[27] Available for download from: http://www.health.gov.au/internet/main/publishing.nsf/Content/E928EC03E74510DDCA257BF0001DAE48/$File/promote.pdf

[28] Also see Promotion, Prevention and Early Intervention for Mental Health. Available for download from: http://www.health.gov.au/internet/main/publishing.nsf/Content/98B143F838F20C88CA257BF00021794A/$File/prommon.pdf

[29] Available for download from: http://www.health.gov.au/internet/main/publishing.nsf/Content/FD5457D8A42CD368CA257BF0001CAD82/$File/promdisc.pdf

[30] Now sadly out of print, though at the time of writing, some copies are available through the author.

[31] Available for download: http://www.agws.com.au/Drug/Docs/OSD.pdf

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Six

Healthy, happy young people don't suicide, do they?[32]

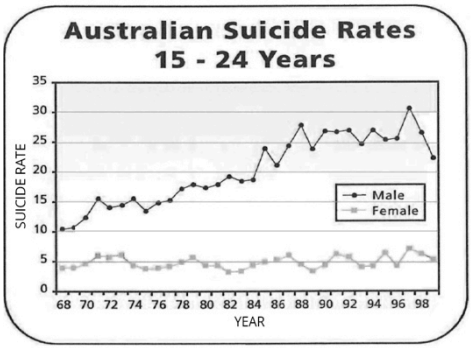
Suicide continues to be a major problem in Australia; 2,492 people (a rate of 13.0 per 100,000) died in this way in 1999. Surprisingly, while the rate for the Australian population has shown variation over time, it remains at about the overall rate of 80 years ago. With all of the improvements in management of mental illness, with vastly improved and more accessible services, with increased clarity about specific risk factors for suicide and with dedicated programs to reduce rates for suicide, we still have made little impact. This suggests two questions (at least): *"What social change needs to occur in Australia to provide a sustained reduction in rates?"* and *"Are we missing something?"*

Suicide is a behaviour; it is not an illness to be treated.

As a behaviour, suicide is usually an individual event, the last act in a life path filled with despair, hopelessness and loss, accompanied by a belief that nothing can be changed. If we are to prevent suicide, then presumably we must intervene in the life trajectory well before a person begins to consider suicide as an option. But at what point should we intervene, how early does this have to be, and how should we focus what we do?

Within the overall rate, changes do occur. For instance, the rate for young men aged 15-24 years has trebled over the last 30 years, and recent trends suggest that high rates in men now occur up to the age of 40. So, we have a specific problem: *"How do we stop men (particularly young men) from dying impulsively?"*

[32] First published 2001 – Martin, G. (2001). Editorial, AusEinetter 13 (September pp8-9). But also relates to the chapter "Suicide Prevention in Young People: The Place of Mental Health Promotion" from the book Rowling, L., Martin, G., and Walker, L., (eds.) 2001. Mental Health Promotion and Young People: Concepts and Challenges. McGraw-Hill Sydney (also translated into Korean (Young Sook Kwak) and Italian (Pompeo Martelli).



The majority of literature on suicide prevention has focused on the individual and intervention at times of crisis. This puts immense pressure on families and professionals who, after a death, focus on the central question: *"Could we have stopped him?"*

Given that suicide is not only a behaviour but an *unpredictable* behaviour, the answer to the question is usually "No", and focusing just on the time of crisis is really 'too little, too late'.

More recently, the national focus has been on reduction of individual and accumulated 'risk factors' (Beautrais, 1998). These biological, family, community or societal characteristics – each of which has been shown to be associated with suicidal behaviours, are often built into pathways or trajectories that tell us something about where we can intervene (Davis et al., 2000). So for instance we know that people with a mental illness, particularly depression or a psychosis, are vulnerable to feelings of hopelessness. At times of stress or isolation – such as the few days after leaving hospital after being treated for a mental illness – they may feel life is not worth living. This places a special responsibility on Mental Health or Community Services to provide adequate supports in a timely fashion.

A different example concerns when a certain group are at increased risk – for instance young people who are severely abused, or young people known to be abusing large quantities of illicit drugs. Here there is a responsibility for society to provide adequate services to ensure such people get back on track and never get to the point of thinking about suicide as an option.

At another level, we know that a societal issue such as unemployment – often very high for young people – can be important in making men (particularly) feel they can never measure up to expectations. Here it may take the whole community and some changes in national policy to change the risk factor and reduce its impact (Commonwealth 2000).

Reviews of the Australian National Youth Suicide Prevention Strategy (NYSPS, 1994-1998) show that more than 70 programs were spread

across the whole prevention spectrum (Mitchell, 2001[33]). Some have argued that the resulting increased skills of professionals, the improved awareness in the community, and the improvements in accessibility of services have begun to show up in the figures. The reduction in young male deaths from 1997 to 1999 was 25%, and was the first time for many years that a reduction had occurred over two years.

But remember that no sustained *long-term* reduction in Australia's loss through suicide has yet occurred in the 20th century. We must be missing something. It is my belief that mentally healthy people very rarely consider taking their own life. Emerging evidence suggests that young men with high self esteem, a sense of purpose, resilience, interpersonal skills, support from parents, family and community, a commitment to life and a connectedness to mates don't think about suicide; it literally never crosses their mind. How do you get to that point? Well, we have to support family life, school life, and community life. We have to support the transition to adulthood, and find meaning for all the young people struggling with their future. In particular, resilience and connectedness may be key factors (Resnick et al., 1997).

And none of this is any consolidation to those families who have lost a young person to suicide.

Suicide is a behaviour. It is hard to stop a suicide either when it is impulsive, or once someone has made a final decision to take their life. Our best opportunity may be to improve the level of mental health (sometimes called social and emotional wellbeing) in Australia; we have good public policy in place, we have the tools to promote community capacity, and at the individual level we have more clarity about what elements make up mental health, better evaluation measures, and a history of innovative and effective programs. We have to develop programs that lead to an increase in the numbers of Australians who are, and can be shown to be, mentally healthy. It may take more than a generation, but it may be the best chance we have to reduce the long-term intergenerational burden of suicide.

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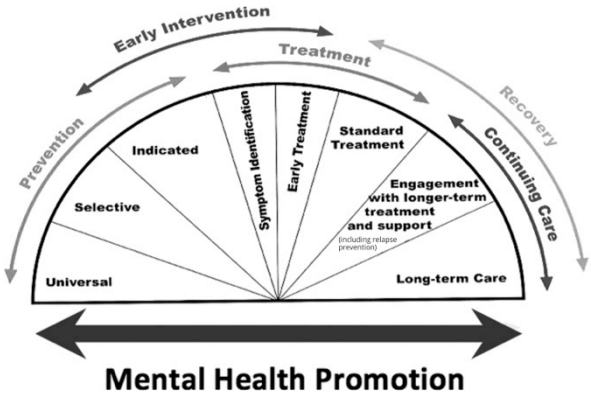
Seven

Resilience: The Ability to Bounce back from Adversity[34]

The Monograph on *Promotion, Prevention and Early Intervention for Mental Health* (2000)[35] suggests that mental health promotion is not exclusively a 'Universal' preventative activity to be used only prior to the emergence of risk factors, or for the first symptoms of mental illness. Rather it is a set of theoretical perspectives and methodologies to be applied right the way across the lifespan (Monograph, 2000), and right the way across the 'Spectrum of Intervention' (Mrazek & Haggerty, 1994).



Mental Health Promotion can be targeted purely toward the development of specific aspects of health. Alternately, it can be seen in a more general

[34] First published 2002. Martin, G. (2002). Editorial AusEinetter, March 14:3-4.
[35] Available for Free Download
http://www.health.gov.au/internet/main/publishing.nsf/Content/98B143F838F20C88CA257BF00021794A/$File/prommon.pdf
Alternative download site http://www.familyconcernpublishing.com.au/category/resources/

way as enhancing protective factors or reducing risk factors; this is the more common view in the literature given the 'driver' of the costs of ill health to the community, and the need to find ways of reducing the burden of mental illness.

Part of the problem in definition of Mental Health derives from initial conceptualisations that health and ill health were part of a single continuum (Kendall, 1994). If this were so, those with life-long illnesses such as Bipolar Affective Disorder would be precluded from ever gaining or re-gaining mental health, and would be further stigmatised. More recent conceptualisations prefer two separate (but linked) continuums (Martin, 2001).

Most mentally healthy people are resilient, and research has demonstrated that resilience building in a healthy whole school environment may even be protective of suicidal thoughts and behaviours in young people (Resnick et al., 1997). Resilience appears to develop best in the context of a safe nurturing environment, but there are those who survive hardship, adverse parenting, abuse and ill health. They, too, can be seen as resilient and differ from non-resilient young people on a wide range of parameters.

Separating health from illness is particularly important in mental health work with children to combat pessimism in the child, families and workers. Children are only part way along a developmental trajectory, and while in some cases childhood mental illness is known to have continuity to adult illness, this is not invariable. Accurate treatment, if combined with carefully tailored programs to assist the child 'back on track' is likely not only to reduce the length of an episode, but reduce the sequelae from an episode, as well as the possibility of later relapse. Given the child's dependent state such programs need to be directed as well to the family, the school and the community, and have to be predicated on the belief that there is still time and opportunity to develop health promoting feelings, thinking and behaviours which will protect against adverse life events including the sequelae of further episodes of illness.

It is a sad fact that many young people from age 4-18 years are admitted to psychiatric units each year. In addition, child psychiatrists, paediatricians and general practitioners may admit young people with problems to other public hospitals outside the metropolitan area, as well as to private facilities in both the metropolitan and rural areas. For instance, many children are admitted with psychosocial sequelae of physical illness (particularly chronic illness such as diabetes). This group forms a recurring annual population at major risk; they are more likely to come from socio-economic disadvantage, broken homes, parental

unemployment, adverse parenting styles, a history of abuse or recurrent trauma. Psychiatric ill health and admission to psychiatric hospital provide further difficulties to overcome.

A preliminary literature search produced 231 articles and references related to rehabilitation of children. The majority of these related to physical ill health, disability (such as blindness) and physical handicap. A large number of papers related to recovery after sexual abuse. Only five papers could be found related to rehabilitation of children after admission for psychiatric illness (Bickman, 1996, Bradley & Clark, 1993; Jerrell, 1998; Joshi & Rosenberg, 1997; Szajnberg & Weiner, 1996). Recovery (meaning from the illness and any sequelae of the illness, as well as generally getting lives back on track) is clearly an issue which has not received anywhere near the attention it deserves.

Consultation with key professionals suggests that while every effort to assist resettlement into family and community is made on a case by case basis, there is no routine guideline, nor any manualised programs, to guide rehabilitation of children after a hospital admission for psychosocial or psychiatric problems. Inadequate rehabilitation is likely to lengthen episodes of ill health, reduce acceptance of the child back into the family, the school and the community, increase the likelihood of educational and social difficulties as a response to an episode of ill health, increase the likelihood of stigma for the child, and increase the possibility of relapse. The primary aim of rehabilitation is clearly the resolution of the illness. But then we have to ask the question: "Now what can we do to not only keep you well, but also ensure that you are able to live the best quality existence you can?"

The literature suggests that most successful mental health promotion programs include multiple strategies delivered through multiple channels in multiple contexts. Multiple targets would include the child, the family, the school and the community. So this is an area full of complexity, and if we are to persuade funders to support mental health promotion programs, we will have to develop clear guidelines which can be shown to produce clear benefits for the child, the family and the community.

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Eight

Spirituality and Suicide Prevention[36]

As I have suggested in previous articles, there are many people for whom the thought of suicide is anathema. They are happy, active, an accepted part of their family, contributing to their school, work and/or community, and committed to an appropriate range of life tasks. They know they have options and the right to take decisions about their life and its path within their abilities. They maintain a hope for the future right through their lives, and may even maintain this sense of a better future right up to the point of death. At each stage of life they maintain a trust in the process, come to terms with changed circumstance, and have a sense of where they fit in, what their part in the whole is about. They react with joy to fun events, to success and to new birth. They are appropriately saddened by loss of any kind, but this rarely translates into depression and despair. They do not lose their sense of hope, the balance in all things, and natural cycle of life.

One word that has been explored to describe these individuals is 'resilient', the 'ability to bounce back from adversity'. We are beginning to be much clearer about the elements that make up resilience; the contributions of genetic factors such as female gender, good temperament and natural intelligence, 'good enough' parenting at critical stages, the absence of overwhelming stress in a context where neither the individual nor the environment have the ability to reduce anxiety and fear, and the presence of plentiful opportunity. But there may be more.

I have a younger colleague who survived many weeks of isolation, deprivation and hunger while lost in Nepal. He recounts that he was able to use memories of his family and his partner to maintain his sense of self. In addition he used the discipline of a previously learned martial arts ritual to maintain some of his physical wellbeing, and when his muscles began to fail, he used visualisation of the same ritual to maintain his sanity. Throughout, and despite times of great despair, he maintained a

[36] First published 2002. Martin, G. (2002). Editorial AusEinetter, July 15:3-4.

belief in himself, a belief in something bigger than himself, a belief in his place in the world, and a hope that he would be rescued.
He told his story at a recent congress to a hushed and awed audience of psychiatrists. Prior to the congress there was a well-attended workshop on spirituality and psychiatry; subsequently there was a whole day given to papers and discussions about research and reflections of spirituality. Many of the known faiths were represented, but the discussion focused more on a beginning distillation of what spirituality might mean to the recovery of people with mental illness. Turns out the answer is 'Quite a lot', many commenting that it was time for psychiatry to understand what may previously have been hidden in our somewhat secular discipline.
There are links between spirituality and 'belief'. Belief in a higher order being, in stories about the beginning of humankind, lead to a sense of meaning and purpose. Regular practice of worship in any form, with the associated prayer or meditation leads to forgiveness of wrongs committed or received, a belief in specialness or purpose, and a sense of personal acceptance and peace. In slightly reductionist psychiatric terms, prayer or meditation may lead to reduction of guilt or shame, those twin evils that can drive depression and despair.
It is the sense of peacefulness and acceptance that we so often associate with those whom we see as spiritual. They can acknowledge what may be wrong in the world, may be realistic about their own failings, but have the capacity to not allow either to weigh them down to the point of despair and hopelessness, but most of all inactivity. They are still able to function, to love, to contribute, to work, and to see where they may be able in a small way to make a difference.
Belief may, however, be less spiritual but still able to sustain us in hard times. Recent work on 'narcissism' has shown that the belief in self, or the importance of the self, can protect from adversity. Further, research has shown that when the going gets tough, it may not be the tough that get going – it is in fact those who believe that their own survival is important. They maintain personal standards and habits, expect the best of support from others, and continue to seek the best for themselves in order to survive.
So, where does that all come from? To a certain degree there may be some circularity. Families who are connected, manage their lives well, transmit effective parenting practice down the generations, also are more likely to have membership of a faith, and/or a set of personal beliefs, which increase spirituality. On the other hand, most of the world's faiths preach family strengths as basic to the future of humankind.

So let us return to consider suicide. Religion as such may not be a protection against suicide; after all some devout or religious countries have much higher rates than others not known for religious affiliation. But spirituality, as something that crosses all religions, perhaps transcends them, may well protect against despair in the face of the world's ills. Central to this may be belief – in the self, in the family, in the peer group, in the country, or in some higher force. And promotion of the regular rehearsal or practice of belief in any of these may be the key to survival in those who, for whatever reason, have personal or contextual risk factors for suicide that increase the odds of life time suicide. Any belief may be better than none, and strongly held beliefs may provide the central core around which a meaningful life can be rebuilt.

ADDENDUM

If this is a topic which interests you, then you may wish to read more recent work completed at the University of Queensland:

Colucci, E. & Martin, G., 2008. Religion and Spirituality along the Pathway to Suicide. Suicide and Life-threatening Behavior. 38: 2, 229-44.

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Sheehan, N., Martin, G., Krysinska, K. & Kilroy, K., 2009. Sustaining Connection: Towards a Cultural Strengths Framework for Aboriginal and Torres Strait Islander Community, Spiritual, Social and Emotional Wellbeing. Centre for Suicide Prevention Studies, Discipline of Psychiatry. The University of Queensland, Brisbane. ISBN 978-0-9808207-3-7 Downloadable as a pdf from http://www.familyconcernpublishing.com.au Go to Resources...

Krysinska, K., Martin G. & Sheehan N., 2009. Identity, Voice, Place: A Framework for Suicide Prevention for Indigenous Australians based on a Social and Emotional Wellbeing Approach. Centre for Suicide Prevention Studies, Discipline of Psychiatry. The University of Queensland, Brisbane. ISBN 978-0-9808207-1-3. Downloadable as a pdf from http://www.familyconcernpublishing.com.au Go to Resources...

Nine

Mental Health Promotion[37]

This is the inaugural issue of the *Australian electronic Journal for the Advancement of Mental Health (AeJAMH).* We hope it is of interest to you the reader and challenges your thinking in the area of prevention of mental health problems and the promotion of mental health. We also hope it contributes to the information and debates in the field.

It is important to thank several people. Lou Morrow, AusEinet project officer for academic matters, has beavered away both at the world wide level to advertise our venture and garner contributions, but at the local level she has also provided energy, perceptive comment and editing skill, to ensure we went 'to press'. Lou also worked closely in the early stages with Professor Robert Kosky and Brodie Millsteed, our project officer for information, to ensure our guidelines and online practice was consistent with current thinking, and Internet law on intellectual property, privacy and ethics. Abbie Patterson, project officer for communication, in addition to providing editing skill, has worked closely with Steve Trickey, our IT guru, to develop the journal online, making it easily downloadable but also consistent with the current design of the AusEinet site.

And now to the content for this issue which provides a smorgasbord of rich delights for your edification. Janet Meagher in her challenge to the consumer movement in fact provokes all of us to get past the personal and contribute to the greater good. Only if we truly learn to work effectively in a range of partnerships will we be able to translate both rhetoric and the debates in mental health into action. Michael Murray expands the need for

[37] First published 2002. Martin, G. (2002) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 1:1.

Each of the peer reviewed articles referred to in this chapter are available for download from the renamed online journal '*Advances in Mental Health*' at http://amh.e-contentmanagement.com/archives/vol/1/issue/1/

collaboration to the global level, noting that we need an organisational structure to 'manage' the bringing together of knowledge derived from model projects, as well as 'the different parties and professions working in the field of mental health promotion and prevention of mental disorders'.
Kathleen Stacey and Sandy Herron in a typically thoughtful and erudite paper examine the practical issues which derive from professionals acknowledging *'the critical place of consumers in the dialogue over how we conduct mental health promotion'*. They conclude that effective consumer involvement *'must become a routine process if it is to be experienced and witnessed by consumers across all mental health areas'.*
Gregg and colleagues describe the *Balancing Out* stress management program developed in Bunbury, Western Australia, in response to expressed needs of the local community. Conducted on a small sample, the pre-post-evaluation results are good enough to remind us that we can develop straight forward, cheap and effective tools, soundly based on working models, and suitable for use at the local level.
Rhonda Brown suggests that community ignorance, prejudice and discrimination are key contributing factors to the ongoing invisibility and isolation of same-sex attracted youth. *'Affirmative and sensitive practice by mental health practitioners can assist young people and their families adjust to their new identity and lifestyle'.* This paper is a timely update review of the literature on same-sex attracted young people and risk for self-harm or suicide.
Jim Kevin concludes, from preliminary qualitative work, that telephone triage has made a significant contribution to mental health care, but notes in his research that clients may not be satisfied with the ability to gain access – particularly if they are in need of discussion, but not in crisis. Professionals also have concerns and were unanimous in suggesting that the more experienced clinicians should be the ones to provide such a service.
Finally, in a brief research report, Karen Plant and colleagues from John McGrath's Queensland Centre for Schizophrenia Research, describe self-perceptions of parenting from a pilot group of 21 people with psychosis. Much of the current debate in this important area of selective prevention is focused on responding to the needs of the young person, and the upcoming national conference *Holding it all Together* in Melbourne in April will also focus more at this level. This research report reminds us of just how much work needs to be done if we are to both understand the issues from all sides, and provide a balanced response out of our limited resources.

Are there themes that emerge from the papers in this issue? Well, clearly a considerable challenge exists in the area of professional-consumer collaboration. If we are to respond effectively to the expressed needs of consumers of mental health services then, on both sides, we must foster a new respect that involves a good deal of empathic listening. But we can cross the divide, and we can develop responsive, suitable and effective systems of care within our limited resources.

We started off this issue with comment about Mental Health Promotion. What has been expressed is the need for as much collaboration in the area of health promotion as in responding to clinical need. What has not been discussed in any detail is the debate for mental health professionals and for consumers over whether scarce resources should only be focussed on ill health, and those most at need – as specified in Australia's first national strategy – or whether mental health services have a responsibility to be involved as much in the promotion of mental health. In addition, there is still a considerable need for discussion about what mental health actually is, and just how it influences mental illness. The conceptual unpacking of the construct will have to await a later issue of this journal.

What is delightful to see in this inaugural issue is beginning research in the area of health maintenance. Reading journals on Mental Health Promotion and the reports of many conferences over the last 10 years, what becomes clear is that there is always more rhetoric than substance. What we hope we have started is a movement to rebalance this equation. At this juncture we may not be reporting studies at the higher levels of evidence demanded by rocket scientists. But we are taking some first steps. What we need is solid evaluation of practical programs. In addition we need research into aspects of Mental Health Promotion that builds on early or pilot efforts to inform us of the directions to take in what has been quite a foggy conceptual area. Along the way we may challenge what have been fluffy descriptions of mental health, and we may challenge those who say that the evidence for mental health promotion does not exist.

Ten

Sustainability[38]

It is interesting to reflect at this time on the issue of Medical Insurance with the demise of United Medical Protection (UMP) so much in the press recently. I am not going to focus on the pros and cons of insurance as such, or on the world-wide insurance industry with its lack of concern for social equity and the genuinely disadvantaged, alongside the obscene payouts to those managers at the top of the scale whether they succeed or fail the companies. I will not dwell on the concerns of doctors who may be sued for genuine mistakes or negligence or malpractice on the one hand, or those in the medical profession who have used the issue to grandstand about the issue of premiums and whether the government should provide cover for all doctors (preferably at cheaper premium rates). Any or all of these issues may have a serious impact on the fiscal and mental health of our nation. Rather what I want to consider is what I understand to be a core issue.

It appears that doctors can be sued for mistakes up to 25 years after the event. At some point insurance companies have failed to consider the implications of this and have not set aside sufficient to maintain their ability to pay out for the original injury and the consequent personal and social disability over a lengthy time. They have focused more on recent events, the here and now if you like. With this and the increasing size of payouts, premiums no longer cover the cost.

This is where life begins to emulate art (or in this case insurance). The issue for all of us as people in communities, is that we should be enabled and supported to set up a sufficiently healthy personal system so that we can survive any adverse event that comes along. The more risky or stressful our lives turn out to be, the more we need to have a personal account full of physical health, personal strength and resilience, a will to

[38] First published 2002. Martin, G. (2002) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 1:2.

recover, an optimistic attitude, and the wherewithal to make change as necessary. In addition we need others from whom we can temporarily borrow to assist the process. So often this burden falls on the family. In many circumstances in this country with its intent of free health services to those in need, the cost falls on governments, which spreads the burden across all of us. And most of us would agree that this is how it should be.

But there is an issue of responsibility. When is the development of that 'sufficiently healthy personal system' the responsibility of the family, and at what point is this handed over to the individual? In what areas is the local community responsible for contributing to the 'health bank' by defining what public areas, processes and people best contribute to 'personal strength and resilience' of the individual and individual family? Who should take responsibility for setting up sustainable systems to ensure the 'will to recover, an optimistic attitude, and the wherewithal to make change as necessary'? And there are so many other questions that emerge as you think about these issues.

I raise these issues because we face a dilemma of responsibility in mental health. More and more, governments are expected to shoulder the burdens of providing services. And the issue of what services is often a top down process based on current advice and, sometimes, rhetoric. What we know is that if the individual, family and local community do not see the need for services - particularly at the early intervention or health promotion end of things - or if those services are a low priority until something serious occurs, then the sustainability of the services is undermined.

As professionals we have shifted the debate to consider mental health (that is 'wellness') and how it may reduce the likelihood of ill health. The government has picked up on the issues and now funds preventative services. But at some point the individual has to come to believe that health is like insurance. You may resent paying in on a regular basis (with careful diet, physical exercise and exercises for the mind), and you may not be aware of the quality of the bank until ill health strikes. But we all need as much health as we can develop, and it is a personal responsibility to pay in what each of us can afford. It is a family responsibility to see that this occurs in the developing child (who does not understand the need), and the developing adolescent (who may not care at this point). It is a community responsibility to ensure that those without the capability are helped to 'build the bank'. If we don't take up these responsibilities, then the system will crash and no longer be available for those in genuine need.

Sustainability is explored in the first article in this issue[39]. The services and communities targeted did not necessarily know they needed early intervention services, nor how these might look. Seed funding for project staff was necessary to kick start the process, but each service then had to take over the responsibility of continuing the service, and this often depended on the managers and the policies. It also depended on the links with the communities served. This preliminary report is a matter of some pride to AusEinet, reflecting four years work, and particularly the developmental work of Anne O'Hanlon. We are grateful for the assistance of Deepika Ratnaike in completing the follow-up, and look forward to the full in-depth report[40].

What follows are two articles which address issues for psychiatric nurses and the mental health of professionals. The article by Lam investigates the impact of violence experienced in the work environment and its impact in terms of post-traumatic stress. Nursing staff frequently report aggressive encounters, and are at major occupational risk as a result. It has major implications for practice in mental health facilities and for protecting a scarce resource. The second article by Morrall & Muir-Cochrane investigates the issue of seclusion of patients with mental illness, and considers whether seclusion is a medical necessity or an inappropriate method of social control.

Then we have two program reports on aspects of education in mental health. Wade, Davidson & O'Dea explore some of the complexity of working with adolescents to reduce risk factors for eating disorders. Their pilot work suggests that a media literacy intervention may be most acceptable and provide the best results. Tse reports on a program of cross-cultural education in the community, concluding that bilingual community workers are in a prime position to assist mental health workers in addressing the needs of women from a minority ethnic background with mental health problems.

Finally, Lennings provides a thought provoking review of management practice in the area of child abuse, concluding that clinical decision making and the adversarial process of the court largely determine outcome, and that so much more is necessary to maximise the best interests of the child.

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[39] This issue of AeJAMH is available at http://amh.e-contentmanagement.com/archives/vol/1/issue/2/

[40] O'Hanlon, A., Kosky, R., Martin, G. & Davis, C., 2000. Model Projects for Early Intervention in the Mental Health of Young People: reorientation of Services. Adelaide, Auseinet. ISBN 0 957 7915 1 8

Eleven

Work[41]

Over the past two years, AusEinet has shifted its focus from early intervention with children and young people to include prevention of mental disorder and mental health promotion for all ages across the life span.

AusEinet has also been committed to producing high quality information, resources and research that supports and facilitates the implementation of mental health promotion, prevention and early intervention initiatives. This is demonstrated by one of AusEinet's most recent publications 'Mental Health and Work: Issues and Perspectives' launched at the AusEinet National Forum in September 2002[42]. It addresses an issue that affects the whole population. We all do work in the sense of effort directed to making or doing something. Without such effort all human systems fall apart from the natural process of entropy. Relationships need work to maintain communication and understanding. Homes need work to create and maintain some semblance of cleanliness and order; gardens certainly need repeated work. Families need to work together on common goals to solve daily problems, and to maintain roles, communication, understanding, involvement and standards of behaviour.

Work in the more traditional sense of a job (that usually provides income to allow us to develop and maintain standards of living) also affects us all. We spend time at school learning to learn and satisfying the human craving for novelty and knowledge. More, school and college or university

[41] First published 2002. Martin, G. (2002) Editorial Australian e-Journal for the Advancement of Mental Health (AeJAMH) 1:3.

[42] 'Mental Health and Work: Issues and Perspectives' is out of print.
A review of the book is available at http://hsr.e-contentmanagement.com/archives/vol/12/issue/1/review/45/mental-health-and-work-issues-and-perspectives
'Mental Health and Work: Issues and Perspectives' can be downloaded in pdf format from http://www.familyconcernpublishing.com.au/category/resources/ An alternative source is http://www.mentalhealthpromotion.net/resources/mental_health_work.pdf

prepare us for work and a career. Hopefully the skills we gain, and the promise we demonstrate fit us to a position in the workforce. For those not able to fit into the workforce there are extra training programs and/or some sort of social support met through a tax on the income from the work of those of us more fortunate. There is clear evidence that better education on the whole leads to better work opportunities. Further, there is now clear evidence from longitudinal studies that better education and work protect us from depression, despair and self-harm. So if we are not working, we are actively seeking work or working for the dole, while working (in the other sense) to fill in the time. In general we all seek better or more satisfying jobs until the retirement, after which many people continue to work part time or in community service.

But the nature of formal work has changed. Since the mid 1880s, more people are actively engaged in formal work, but the percentage of useful daily time spent in work has reduced from about 70% to just over 40% with a consequent halving of the annual hours worked (p.83 in Lomborg, 2001). In part this may be due to the trend from full time work to more part time employment. In addition, over the last 40 years, more women have been able to take up or re-enter formal work, although housework continues to take up nearly four hours per day compared with nearly six hours per day in 1965, despite labour saving devices and an extra half an hour a day contribution from men (Robinson and Godbey (1999), cited in Lomborg, p83).

Other changes are to do with the nature of the work. There are shifts from rural types of industry to more jobs in metropolitan areas. There are fewer manual labouring jobs resulting from developments in machinery. More jobs are white collar and are sited in buildings. More jobs are to do with the transfer of information, or the leisure, fitness and holiday trades. All of this has led to change including the development of new physical illness such as 'repetitive strain injury' and the results of 'sick building syndrome'. Compensation claims against companies have increased exponentially and, as a result, Occupational Health and Safety regulations have burgeoned over the last 10 years in an effort to reduce preventable accidents, and work-related ill health.

Work may be protective of mental health, but it may also lead to mental ill health. Stress has often been related to personality type, but more recently is said to occur more in those in middle management, striving to do their best and meet expectations, but blocked from taking meaningful decisions about how they work. Workplace relations may not be all they could be, and workplace bullying has now been exposed at all levels of the working environment.

And work appears to have meaning far beyond the status it brings or the pay packet. Connell (1995) describes how heavy manual labour calls for strength, endurance, a degree of insensitivity and toughness. He discusses this in part for its impact on gender relationships, these factors possibly being used at home to provide a superiority over women. But what happens if the nature of work changes. If physical work prowess is in some cases crucial to male identity, and it is lost, it may take considerable work on the self to rediscover an acceptable identity which does not involve or lead to violence. In an equally complex way, Faludi (2000) describes poignantly the impact of loss of work.

Although the husband was part of a department which was retrenched, he could not bring himself to discuss the situation with his wife until almost all the family finances had been spent, and the next house payment was due: 'I'll be very frank with you, I feel I've been castrated.' (p.65) And the wife: 'felt hurt, like I couldn't trust him anymore. I just felt that maybe it was him who goofed up, even though it was the whole department was laid off.'

The original intent for the book was to consider the workplace as a target for Universal approaches to Mental Health Promotion and record a range of successful national programs. What emerged from discussion, and from a seminar hosted by VicHealth in Melbourne, was a need to consider Work more broadly, and Mental Health and its promotion in more depth. I am profoundly grateful to Lou Morrow for all of her work in bringing together such a wide group of authors, and for seeing this work through with the help of her co-editors Irene Verins and Eileen Willis. What has resulted is a rich archive of contemporary issues surrounding work in Australia as well as seminal work on work from abroad. I commend it to you the reader.

In this issue of the Australian eJournal for the Advancement of Mental Health we reprint, with permission, four of the chapters from the book[43]. Rosemary Hoban reports on a round table discussion on work held at the Rumbalara community in the Goulburn Valley in Victoria. The work acknowledges the fact that Aboriginal people are less likely to be employed and less likely to have the necessary qualifications, and considers work within and outside the community, and finally the issue of leadership.

Stephen Pavis, Stephen Platt and Gill Hubbard review the current state of youth employment noting that young people are arguably the group of

[43] All of the articles mentioned in this editorial can be accessed at http://amh.e-contentmanagement.com/archives/vol/1/issue/3/

workers to have experienced the most change over the last 15 years with consequent effects on psychosocial health.

Suzette Dyer and Maria Humphries and reflect that while career management and development planning may be viewed as a useful guide to aid and facilitate choosing the right job to satisfy the individual, in light of the current employment context, such a unitary perspective is challenged by recent critical reading in the context of contemporary career discourse.

Maureen Dollard and Tony Winefield provide a thorough overview of the current status of work and the possible impact of this and recent globalisation and regional economic imperatives on mental health. They explore aspects of the ideal work environment, and the agenda for research, evaluation and policy for implementation.

Three new papers complete this issue of AeJAMH. Orme Hodgson and colleagues report on an important survey of carers of the mentally ill in Queensland, focusing on their relationships with professionals. Based on a Masters project, 157 carers completed the survey. Consistent with a number of other studies, they report that carers continue to feel excluded from the treatment process, feeling their knowledge is not valued, but rather wasted. They conclude that in a number of areas, and despite clear guidelines that favour communication and partnership with carers, mental health professionals have yet to develop skills and attitudes consistent with genuine involvement.

John Mathai and colleagues provide a preliminary report on the use of the Strengths and Difficulties Questionnaire (SDQ, Goodman et al., 1999) on a small Australian clinical sample. They compare parent and teacher reports, and parent and child reports. Consistent with Goodman's findings they recommend the SDQ for use in child and adolescent work, noting that it 'is sensitive in detecting emotional and behavioural problems and therefore can be implemented to screen referrals at intake'.

To complete this issue, Simone Fullagar and Suzy Gattuso 'draw upon the work of governmentality and risk theorists and feminist research into women's experience of depression to develop an analysis of mental health policy that recognises the power- knowledge relations shaping how depression is conceptualised in terms of causality, risk, treatment and prevention'. They ask, where in this regime of truth is there room for women to ask critical questions about their experiences of emotions and selfhood in contemporary culture and importantly be heard? They argue more needs to be known about how depressive experiences are interpreted, what actions women take as a consequence of those interpretations, and the results of those actions.

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Twelve

Self-injury in Context[44]

Much has been discussed about suicide and its risk and protective factors. However, the connected problem of self-injury is little discussed, yet at the clinical coalface and in Emergency Departments it causes more difficulty more often than suicide attempts themselves. Why do people self-injure? What are the implications? What is the connection to risk of suicide? How do you handle someone who harms their body for what often feels like incomprehensible reasons?

My first contact with the phenomenon was during my first ever job as a doctor. A man came across the road from the Maudsley Hospital, to our Emergency Department at King's College Hospital; he had over 50 fresh cuts across both arms, some quite deep and many bleeding freely and requiring closure. The registrar told a nurse and I to sew him up without anaesthetic; 'That will stop him wasting our time!' When we argued, we were told to get on with it or take the consequences. Contrary to our expectation, whenever I put a suture in place the man cried out 'Oh, oh, doc, do it again, doc!' We were totally nonplussed. (Yes, I do now feel a great sense of shame in putting this into print.)

More recently I worked with a young woman who in one session sat and, in silence, scraped at her skin with a nappy pin. After five minutes of silent concentration she looked rather coyly (or perhaps challengingly) at me and asked; 'Aren't you going to stop me?' I replied that she obviously had a need to demonstrate the depth of her pain to me, yet so far had not been able to find the words. The following day she approached me on the ward, 'You know that nappy pin? I gave it to a friend who had a hole in his jumper.' She turned on her heel and walked away, but in the session that followed she began to tell me her story.

[44] First published 2002. Martin, G. (2002). Editorial AusEinetter 16, 9-10.

It is said that over two million Americans use self-injury to express or control inner pain, and I would guess the situation to be very similar in Australia. The US Office of National Statistics study of 10,000 parental reports of mental health, suggests that by the age of 15 years 2-3% have self-injured. Rates are higher in anxious (9.4%) and in depressed young people (18.8%). We can conclude that this is a common problem.
As an exhibition in 2000 at the Australian Museum demonstrated, the body has been used since early times and across many cultures to express a range of experience. The frozen human Ötzi, found in the Austrian Alps and dating back 5,300 years, is the oldest tattooed body known. He has 57 tattoos, some around the ankles, knees and lower back – thought to be medicinal. Evidence of ancient tattooing in Japan comes from figurines called 'dogu' – 3,000 years old. The Maori facial markings (Ta Moko) is said to be a history of a person's achievements and represents their status in their tribe. The left side of the face relates to the father's history and the right side to the mother's history. Originally, Ta Moko was chiselled into the skin using an albatross bone, with pigment added later. In Papua New Guinea, scarification is related to initiation. The skin on the chest, back and buttocks of the initiate is cut with a bamboo sliver to test their physical strength and self-discipline. As a young man says: 'I wear the marks of the ancestral crocodile.' Healed scars are a power mark, a spirit, a security used for protection and connection with the totems and ancestors of the clan. In Aboriginal culture, scarring also occurs. An elder says: 'The cuts are a stamp or a seal. Our people have two cuts on each shoulder, two on the chest and four on the belly. You must have the cuts before you can trade anything, before you can get married, before you can sing ceremonial songs'.
These ideas translate to the present day westernised culture: 'My body adornments are about my inner spirit, love, trust, strength and beauty, which in turn makes up my outward spirit, enabling me to be the strong, brave, loving woman I am' (Pauline). 'Body modification (cutting and branding) can be viewed as a topographical map of a person's emotional and spiritual history. Your whole body can be used to prevent yourself from ever forgetting your mistakes and victories. Each time you look in a mirror, you give yourself the positive reinforcement you have designed for yourself' (Andrew).
So while many of us are anxious about body scars from cutting and branding and see them as expressing pain, there are alternative views – they can be seen as tribal belonging, a rite of passage, representing myth, or the body adornment of art, or memories of failure and success. It could be argued that while the context of the making of the marks is crucial to

our understanding of them, perhaps we should be less anxious when confronted by clients who cut... and simply more curious.
When should we worry? Earrings, belly button rings and eyebrow art have achieved an acceptable status in young people in modern Australia. But are 10 earrings in one ear, or tongue studs, or multiple piercings of lips or noses or nipples, of more import than just the possibility of infection? Last year a young man was referred to me by his parents for a range of strange behaviours; they were concerned he might have early psychosis. He was morose, not sleeping at night, struggling at school (but doing well at part-time work), rejecting of parental rules to the point he had moved into the garage and decorated it 'his way', and admitted to frequent marijuana smoking 'to forget all his troubles' (which he claimed derived from his parents). He was particularly upset by their attitude to his eyebrow rings (four). When I suggested he was obviously into 'body art' he became animated saying; 'That's it! I just want to express my art through my body. Would you like to see my chains?' He lifted his t-shirt to demonstrate nipple rings joined by a (painfully?) heavy chain, and then turned around to show me his quite extensive tattoos and cuttings. He wanted to leave school to work and earn more money to spend on his body. 'But how can I tell my parents? They want me to go to University....'
However, cutting is not always benign. A few cuts on the arms may fill us with horror, but may be the only way to express inner pain or old rejected memories. We can be told that the first pain, or the first flow of blood, somehow removes the psychological pain or 'lets the old problem out'. This is often associated with depressive affect, and our initial acceptance can lead to ultimate expression in what we could feel are more acceptable ways. But many cuts, or cuts elsewhere to the body like chest or abdomen, can suggest more complex problems. Special designs may have particular meaning – sometimes this can express affiliation or religious belief, but it can also derive from psychotic thought. And attacks on the genital region usually mean serious disturbance.
How can we understand what mechanism drives particular self-injury? Well, asking our patient is the simplest way, but this can be uncomfortable (for them and maybe also for us). In our adolescent unit we have recently gained ethics approval to trial a US questionnaire with young people who cut themselves (Osuch et al., 2000). It resolves into six factors or subscales:

- Affect Regulation (e.g. 'To distract myself from emotional pain by experiencing physical pain' and 'To punish myself for feeling bad')

- Desolation (e.g. 'To diminish a feeling of being utterly alone' and 'To keep bad memories away')
- Punitive Duality (e.g. 'To please an important figure (God, the Devil etc.) who wants me to do it' and 'To punish myself for telling secrets')
- Influencing Others (e.g. 'To seek support and caring from others when I won't ask them directly' and 'To irritate or shock someone in my life')
- Magical Control (e.g. 'To hurt someone important in my life' and 'To control the reactions and behaviour of others')
- Self Stimulation (e.g. 'To diminish feelings of sexual arousal' and 'To experience a high like a drug high')

We believe this may go some way to exploring new understandings[45]. But what to do, and when should we worry about suicide? Some simple rules may help:

- If the self-injury needs medical attention then seek appropriate help. Ensure the young person is not treated badly, roughly or with disdain my medical or other staff. Explain, if you have to, that at this time this is the only way they can seek help.
- If a professional complains that the young person is 'attention seeking' then gently and respectfully explain that is exactly what they need – attention. If it is just that, at this time, we have not been able to help them share their inner pain.
- If you are anxious about helping, managing the process, or doing the therapy, then trust your own feelings. Seek alternative care for the young person or alternatively, seek regular supervision to enable you to cope with confidence.
- Do not focus, at this time, on the self-injury more than you have to in ensuring safety. Focus on developing a supportive relationship and a clear plan for ongoing care.
- If you feel the young person is (for instance) depressed then try to get some simple measure of this.
- There is then an obligation to check if the young person has had suicidal thoughts. Or whether the self-injury was part of a plan to die, and whether they have attempted before.
- If the outlook is bleak (and it may be felt to be so) then the young person may be not only self-harming, but also at serious risk of

[45] This work was later published. See References at the end of this chapter

suicide. You may have to organise brief hospitalisation for further assessment and immediate protection from self.

- Space does not allow discussion of crisis management and therapy at this time, but the resources listed previously (page 8 of this issue of AusEinetter) may offer some guidance. The American Academy of Child and Adolescent Psychiatry site has a range of useful brief guides to practice.

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Swannell, S., Martin, G., Scott, J., Gibbons, M. & Gifford, S., 2007. Motivations for self-injury in an adolescent inpatient population: development of a self-report measure. Australasian Psychiatry, 2:98-103.

If you are interested in this topic, a set of more recent practical 'guides' are available to address the needs of young people, families, school staff, emergency departments, and family doctors:[46]

Martin, G., Swannell, S., Hasking, P. & McAllister, M., 2014. ***Seeking Solutions to Self-injury: A Guide for Family Doctors.*** Centre for Suicide Prevention Studies. Discipline of Psychiatry. The University of Queensland. ISBN 978-0-9875603-6-0.

Martin, G., Swannell, S., McAllister, M., & Hasking, P., 2014. ***Seeking Solutions to Self-injury: A Guide for Emergency Staff.*** Centre for Suicide Prevention Studies. Discipline of Psychiatry. The University of Queensland. ISBN 978-0-9808207-6-8.

Martin, G., Hasking, P., Swannell, S., McAllister, M. & Kay, T., (2013). ***Seeking Solutions to Self-injury: A Guide for Young People*** SECOND EDITION. Child and Adolescent Psychiatry, The University of Queensland, Brisbane, Australia. ISBN 978-0-9875603-3-9

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[46] These guides are available in book or downloadable pdf format from http://www.familyconcernpublishing.com.au/products-page/

Thirteen

Rhetoric and Reality: Development and Maintenance of Mental Health[47]

This is a great honour, and I thank the organisers of the 2003 AW Jones Lecture for inviting me to speak. I hope tonight lives up to the spirit and intent for the Lecture set down by Alby Jones so many years ago.

I am going to be talking about Mental Health. In addition I will present models of how mental illness emerges, and how it may be prevented at the individual, group or population level. As part of this, I will be taking the risk of trying to clarify what I think the role of the teacher is in all of this; I hope you will forgive me.

When I use the term 'Mental Health', you are just as likely to think of Mental Illness or Disorder as think of Health as such. If we add the word Services to make it Mental Health Services, then most of you in South Australia will think of Glenside Hospital or a local clinic. There are 2 issues here. The first is the issue if stigma. As a humane society, we have tried hard to remove negative connotations from Mental Illness to make it easier for those who suffer. As a result, in changing the name from Psychiatric Services to Mental Health Services we have ultimately confused the issues.

I have spent the last 6 years involved with a national organization called Auseinet – the Australian Network for Promotion, Prevention and Early Intervention for Mental Health – based at Flinders University. Funded by

[47] This chapter is adapted from the invited 2003 A W Jones Oration delivered in Adelaide on 26th March 2003 to the SA Branch of The Australian College of Educators. The Oration serves both as a celebration of the contribution of one of the state's most distinguished educators, the late Dr Alby Jones (1913-2003), a founder member of the College, and as a continuing contribution to educational debate at state and national levels.

the Commonwealth, Auseinet has developed a solid network for information exchange, and attempted to translate some reality out of the tenets of the Second Mental Health Strategy.

A part of this has been to raise the profile of the Mental Health, but I have often wondered why it is so difficult to help people get their head around the issue of Mental Health (as health) and its Promotion. On the one hand I think I am probably seen erroneously as a sort of super salesman for our existing services; when I do get the conceptual differences across, then Mental Health Workers (that phrase again) raise the issue that they are too busy, they don't want to take on something 'extra'. The best strategy I have found to combat this has been to demonstrate just how much of our core work is already the building or rebuilding of Mental Health after we have fixed up the Mental Health problems. Confusing isn't it.

Professor Rob Donavan from Curtin University and HealthWAY (the Health Promotion organization in Western Australia) has recently completed some research on this. He notes that by adding one letter – a 'y' – we make all the difference to public understanding. People understand the term Mentally Healthy. They relate it to such terms as 'normal, happy, emotionally stable, mentally alert, content in themselves'. So I want to be clear that my central theme tonight is about developing and maintaining mentally healthy young people. I wish we could take on the term adopted by our indigenous peoples – 'Social and Emotional Well-being'; there is so much less opportunity for confusion in that. Ah well….

The standard definition of Mental Health, based on international definitions, accepted by the Australian Health Ministers in 1991, is:

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

This is as relevant to those of you who teach, as it is for us as Mental Health workers. I am sure you have a prime focus on "ways that promote optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals". Let me try and unpack this whole thing a bit further for you.

You can freely download two very relevant government documents: 'Promotion, Prevention and Early Intervention Monograph', and its companion the 'Action Plan 2000'[48]. These were developed by a working

[48] Both of these documents are available, in pdf format, as a free download from http://www.familyconcernpublishing.com.au Go to 'Resources', and scroll down.

group of the National Promotion Prevention Working Party and authored by Dr. Deborah Rickwood from the University of Canberra. We have had the opportunity to consult on them in every State and Territory around Australia, where they have met with great acclaim. They represent the cutting edge of Mental Health and have been part of a Strategy that has placed Australia at the forefront of reform around the world. I commend them to you. The Action Plan, in particular, lays out very carefully and clearly just how we should be going about prevention across the age range and within a wide range of environments. Within the Monograph, are listed a range of well-researched protective factors for being mentally healthy. They are:

Genetic givens

Easy temperament
Above - average intelligence

Family factors

Supportive caring parents
Family harmony
Secure and stable family
Small family size
More than two years between siblings
Responsibility within the family (for child or adult)
Strong family norms and morality
Adequate nutrition
Attachment to family
Moral beliefs and Values

Learned Factors

School achievement
Problem - solving skills
Internal locus of control
Social competence
Social skills
Good coping style
Optimism
Positive self-related cognitions

There are some other factors, somewhat less well researched:

Good judgment
The ability to trust
An ability to manage guilt about actions without turning it to shame about our total self

If we leave the obviously genetic and family factors to one side, then my bet is that as teachers you work on the others every single day. You may not necessarily consciously seek to promote them, they may not be part of a formal program, but you know that children and young people who have these factors learn better and achieve better, and so you promote the factors.
Schools, of course, do differ. Several schools across the country go out of their way to address issues outside of learning. Some are struggling with the very basic issue of nutrition. For many young people from complex and difficult environments, breakfast has to be supplied at school before adequate learning can begin. Another school has recently been featured on television as it supports young women with babies to stay in school.

There is another construct which is central to being mentally healthy, and to our survival in this world. The construct is Resilience – probably best defined as the ability to bounce back from adversity. David Fergusson, an eminent researcher in Christchurch, New Zealand, has completed a 20-year longitudinal survey of 1000 young people from birth, in which he has demonstrated several factors that promote resilience.
They are:

Genetic Givens
- female gender
- intelligence
- easy early temperament
- positive parental attachment and bonding

Learned Factors
- problem solving ability
- external interests/affiliations
- good peer relationships

Bonny Benard from the West Coast of the US, in her work in High Schools, has unpacked resilience further. She has 4 broad categories with key descriptors for individual resilience:

Social Competence
Responsiveness, flexibility, empathy, caring, communication skills, sense of humour;

Problem Solving Skills
Critical thinking, generating alternatives, planning, produces change;

Autonomy
Self-esteem, self-efficacy, internal locus of control, independence, adaptive/healthy distancing;

Sense of Purpose and Future

Goal-directedness, achievement orientation, high motivation, educational aspiration, persistence, hopefulness, coherence;

Benard also has 3 key descriptors for family resilience:

Caring and Support

Close relationship with one person, affection expressed physically and verbally;

High Expectations

Structure, order, discipline, values, explicit expectation, faith, hope for the future

Participation

Valued participant, domestic responsibility, independence encouraged, autonomy respected.

You should by now begin to see or hear the common factors across all this work. Particularly within Benard's work, again leaving family issues to one side, you should be able to identify those issues as the ones you work on every day.

So, what is the point I want to make here? This may be uncomfortable, but it will not come as a shock. As teachers, at whatever level, you are probably the prime promoters of mental healthy young minds in our society. It is an integral and necessary part of your work. At the very least it is work that you do because you have to - to ensure adequate learning. It is not an add-on! Well, so what?

When we come to consider national programs like '*MindMatters*' or the '*Resourceful Adolescent Program*' or '*Aussie Optimism*' or '*Friends*', I would like to suggest that each contains variations on some good conceptual clarifications, each with clear pointers toward everyday practice and integrated program development. But at the end of the day, they are tools to assist you to do the job you are already doing - but better!

I need to say at this point that Mental Health Promotion has often been criticised for being poorly conceptualised, an expensive exercise with limited outcomes, poorly measured. Whether it occurs at the individual level, the group level or the public health level, nothing could be further from the truth.

Durlak and Wells (1997) report a meta-analysis of 177 primary prevention programs for children and youth, very carefully chosen against 51 set criteria. The majority of programs were true randomised experiments, had little sample attrition, and used multiple outcome measures. The mean effect sizes ranged from 0.24 to 0.93 – such effects

have rarely been reached by trials of antidepressant medication!
One last point about resilience. In a large scale, multi-site, multi-State study in the United States, Resnick and colleagues have demonstrated that the programmed development of resilience in schools can significantly reduce the rate of suicidal thinking in young people in school. This is a profoundly exciting and important conclusion if, like me, you have had concerns about increasing rates of suicidality in school, and you understand the links between early suicidality (including thoughts, threats to others, plans, acts of deliberate self-injury) and those apparently inexplicable acts of later suicide. Resnick also includes in his formulation 'connectedness to the school', and this has implications for the whole school approach – we will return to this later.
So we have now operationalised parts of being mentally healthy, and there is emerging evidence that being mentally healthy can to a certain extent protect from negative outcomes of ill health. How does it all go wrong? How do we get to the situation where as a world community, depression is currently the 4th most costly illness in terms of death and disability, and unipolar major clinical depression will be the 2nd most costly illness in the world by the year 2020 (World Health Organisation, 1997). What does a prediction like this actually mean? Does it mean that we are breeding for depression as a race? I am not sure that makes much sense, so I don't think so. So let us take a brief look at our best understanding of how these things go wrong.

Case Discussion: **David**.
This 14yr old adolescent talked about suicide for some weeks, left a suicide note, stole his girlfriend's parents' car and drove at an estimated speed of 157kms an hour down a highway, turning the car over on a sandy verge and strangling in the seatbelt. His parents were understandably distraught, blamed child and youth services in another state for not doing a good job, and set out to sue the state government. I was asked to review the circumstances, and available case files, and advise the state.
In fact the child and youth services had seen David 6 months before his death, and had struggled to engage him and his family in some sort of therapy. The family pulled out, events escalated, and David was eventually turfed out of home by his father, about 3 weeks before his death.
The story is a lengthy and complex one, but I would like to briefly review the history as I found it out. David was a 'blue baby' with a low APGAR score at birth. As a result he spent several days in a humidicrib in the nursery before being handed over to his Mother's care. Through the first 2 years of his life he was slow to develop. All of his milestones were delayed

– he sat at about 7 months, stood at about 14 months and walked at about 16 months. When David started tantrums about the age of 2 they were really serious. He often threw things or hurt himself by banging his head with some force on the floor. At other times he would stare into space and not recognise family members for a minute or two. At Kindergarten at the age of four he was described as aggressive to other children, unsocialised, at times uncontrollable, and overall a poor learner. From ages 5-7 he frequently soiled his pants at school, and was teased, I suppose understandably, by his peers. His literacy skills were poor, he had few friends - and even they were from the rough bunch. He was clumsy and attained poorly at sports. He was prone to lying, and there were several episodes of stealing. This latter gradually worsened over the years from home stealing to school stealing to stealing from supermarkets – bigger and better... Punishment rarely seemed to have any kind of impact.

By age 10 he had a history of setting small fires, was violent to friends, had broken school property, and had his first brushes with the law – just the sort of child you'd like in your school... The family frequently moved, David frequently changed school even after they had moved, and parents overall had the view that nobody was able to help them, and nothing they tried seemed to make a difference. There was never a history of harming animals (a cardinal early sign of delinquency), but David did take great joy in hurting his much younger sister, and his first referral to child psychiatry was at the age of 12 for reputedly sexually abusing her. Throughout his life he continued to have the 'absences' originally noted at the age of 2.

So, what I have described is the emergence of a disruptive behaviour disorder – and you can take your pick from that or oppositional defiant disorder or conduct disorder. I don't mind which one you call it. I have described a life pathway or trajectory inevitably going off the rails, and with a tragic premature ending.

My questions are multiple:

- At what stage would intervention have been most beneficial?
- Should the GP or paediatrician who first assessed these problems have urged the family to maintain their contact with helping services?
- Should the Kindergarten have been more active in seeking assessment and professional care?
- Should the schools have maintained Learning Assistance Programs, and sought early help for the emerging conduct disorder?
- Should the clinician treating the soiling have taken a broader view of

David's problems?

- Should the various GPs have demanded carefully coordinated programs of care between the schools and the other professionals?
- How do you maintain any kind of consistent help with a family that moves around so much, and when their view of helping services is that they actually don't help?
- And what of the family? Should they have not repeatedly seen the possible disastrous future and repeatedly sought help? Well, to a certain extent they did, but their skills were relatively poor, their persistence at a very low level, and their application of interventions was, of course, inconsistent.

I am sure you can think of many more questions that need to be answered. It must be said that the poor Child Psychiatry services in the last year of David's life, never had a chance. Our skills at dealing with conduct disorder are abysmal, and only the most resource intensive programs seem to have much impact.

Let me just make a point here. We are terrific at working with depression, anxiety, post traumatic stress disorder, psychosis if you like, but we are rotten at working with conduct disorder or anti-social behaviour disorder. Most treatment is in fact too little too late. I say this advisedly because, if you think about the school environment, it's these kind of kids that you want to refer and it is these kinds of kids that mental health services won't want to accept because we are rotten at treating them.

So, the only intervention that is going to make sufficient change in working with anti-social behaviour of any sort is early detection followed by early intervention. But, who of the many professionals could have foreseen the result, when so many other blue babies, antisocial kids with delayed milestones, soilers, and even fire-setters seem to get back on track? How do you predict which ones will not? And if you apply Early Intervention methods and resources to all of them, is that cost effective? Well, I would argue it is, particularly if you take a long-term perspective of the possible later costs to society.

One consistent problem through all of David's history was limited and/or poor communication between professionals. But then, the parents often told partial or inconsistent stories. So one professional would get a bit of the story, another professional would get another bit of the story. There is a part of me that longs for an Electronic Personal Health Record Card carried by the patient or their family, and providing always-available complete information about the life story. But then who would be allowed access? Would employees of the education system be allowed to view the

health material, or is it confidential?
Confidentiality, and the often confused understanding of it, is one of the major problems that we face at the moment. You know, it's been described as an ethical cloud – you can't grasp it, there is no clarity, can't see your way through it. I am not sure that the new Privacy Legislation will make things any clearer. I have to say that it is ridiculous that we should not be able to communicate our opinions between professional groups to ensure care of the child. Poor communication gets in the way of comprehensive care. It is a matter we should argue at another time.
Anyway, what you have just heard is an exposition of the way that things can go wrong in a life path. The theoretical model is probably that of 'Stress-Vulnerability', in which a series of stressors over time really wear down the protective factors, exposing the underlying vulnerabilities which then may appear as disorder. And you will note that I am not saying anything about the medical model here. What I am talking about is some underlying vulnerability and then a series of major stresses over time.
If we can generalise for a moment, this explanation is also probably the only reasonable explanation we can have for the predictions of the steep increase in depression toward the year 2020. Falloon has said "impairment becomes manifest when vulnerability and stress factors overwhelm the biopsychosocial responses" (Falloon, 1993).
In the context of my brief comment about depression as a World disorder, George Brown has commented: "social factors interact with prior maternal loss and current vulnerability factors to produce a cognitive set of low self esteem, reducing the ability to work through the current loss and this leads to a sense of hopelessness." (Brown, 1994). Aaron Beck says: "Depression is based on the development of a negative sense of self from childhood loss, reinforced over time and leading to cognitive distortions." (Beck, 1973), and Seligman says somewhat more simply : "Helplessness is a learned maladaptive style." (Seligman, 1975).
Okay, so things go wrong. David's case of suicide is probably quite rare – I mean, it is rare for us to hear a story that young and it is rare for us to hear about the issue of conduct disorder as a risk factor for suicide. More likely you are going to hear about depression or other internalizing problems or disorders. But, in fact, when you look at those who suicide many of them do have a history of anti-social behaviour and underneath that, there are often these factors of basic vulnerability and the kind of 'reactive' depression that goes with multiple stresses. I think we often miss this because we are turned off by the 'acting out' behaviour, the provocativeness, the oppositional defiance, the sheer confrontation.
My own studies into youth suicide and its prevention began in 1988 when

my CAMHS team were invited into a school to consider helping counsellors and chaplains, parents and young people, after 2 suicides within weeks of each other about 2 months prior. Another service had completed very good small group grief-work with those young people who were the friends and classmates of the deceased.
The critical question from the school at that time was: "Is there a connection between the death of the boy in year 11 and the boy in year 8 several weeks later?" Over the next few weeks, a small group of us had several discussions with the school staff concerned and amongst ourselves. Following this we set up an education program for parents about adolescent behaviour – not necessarily explicitly directed at suicide itself. In 1988, we were very cautious not to talk about suicide, because there was a belief that if you talked too openly, you might cause what you most feared. So, we just talked about parent education.
Both boys came from severely troubled family situations. Both boys had been depressed and had tried illicit drugs in an attempt to assist their feelings. Neither was good at seeking help or reaching out. The best understanding we could reach was that the boy in yr 8 was 'vulnerable'. He may well have been influenced by the other boy's death even though he did not know him well. So the issue of influence (or 'copycat' if you like) was already planted in my mind when in April 1989, I was asked into a second school, following another suicide. On this occasion we were called in ten days after the death.
We completed a three-hour group program of grief work for friends and class mates, which included completion of the Achenbach Youth Self Report, and some other questionnaires, to see whether we could find any serious problems for the young people concerned. We also planned 'grief work' for staff.
We reasoned that:

- Grief work is necessary to assist students, staff, and the school as a whole, to work through the loss.
- Around the dead student there might also be a group of young people who were (in my mother's words) 'birds of a feather' – that is, they might have similar feelings and experiences and might have an increased level of suicidal thinking and behaviours.

This latter idea (of influence or 'contagion') was started by Christina's family. I mention her name because her father has always wanted me to acknowledge her in my presentations of the research work evolving from those first discussions with the family in their grief. When they first came to see me for help, they gave me a shoebox of handwritten notes and her

diary. I spent the whole of Anzac Day that year reading them and trying to make sense of the information that she was giving - in an effort to understand her suicide, but also in the effort to support the family.
Many of the staff at school were clinically as distressed as the students, although we didn't use questionnaires to assess them. Perhaps we should have done. I'm left with the powerful memory of the class teacher who asked me: "What do I do with the desk?" Having recovered from the shock of the question, my response was to get her to ask the opinion of the other students, and follow their expressed need. That apparently worked very well, and the desk stayed there for some weeks while they worked through their mourning. Every day one of the students placed a flower on the desk. After a month it was moved to the back of the class until the end of that term.
The father in one of those first bereavement sessions asked me 2 questions: "Could I help them understand why a bright talented successful and much loved 15 yr old would jump off a car park roof?" They also asked me "if it were possible to use her death in some way to reduce the number of suicides of young people generally?" In other words, what could I learn from her death that might help us to prevent others doing the same thing. At that stage I responded to each question that I did not know... *but I would find out*.
I was left with my own questions:

- "If we can find distressed suicidal young people after a suicide, why can't we find them before they take such a tragic step?"
- "Why had Christina not sought help?
- "Why had none of the other students sought help on her behalf?"
- "Why had none of the teachers noticed the notes passed backwards and forwards amongst the students? (about 20% of the notes had mentioned the word suicide)
- If teachers had noticed, why hadn't they done something about it?"

Based on these questions, we began a series of unfunded cross-sectional research programs. We focused on risk. We were looking for risk factors, with the ultimate plan of developing a composite questionnaire that might be used in a prospective study in schools. We did 17 studies and some of these have been published in one form or another (See References on Suicide in Young People 1992 – 1997) and then we spent 2

years designing and setting up a 3-year prospective program called the 'Early Detection of Emotional Disorder' (EDED)[49].
We eventually gained funding for this, and cooperation from 27 schools, and we studied over 3000 students from the south of Adelaide, incorporating all the risk factors we had previously examined in small cross-sectional studies. This program essentially brought together all of our findings in a composite questionnaire. The idea was to do a repeated measures design to track students each year from 13yrs through the time when suicidality begins to increase sharply from about the age of 15yrs.
I won't go into all the questions we asked but, where we could, we used reliable, well-validated international scales for depression, anxiety, hopelessness, delinquency, parenting and a range of other parameters.
We devised an algorithm of nine key risk factors for suicidality, and then ranked all of the students. We weighted the results for depression and all young people who admitted any aspect of being suicidal were included in what we thought was the 'vulnerable group'. We were very careful in our definition of this group.
What we found was that 13.9% - roughly 14% of students - were possibly 'vulnerable' to adverse outcomes including suicide. There was little variation between schools – something which shocked us at first. But, private and public, both had about 14%. Now, if you have been following some of the national work in child mental health, you will realise that 14% is kind of right. Professor Michael Sawyer from Adelaide Women's and Children's Hospital has led a team to do a national study of 4000 randomly chosen representative young people across Australia. The study concluded that 14% of students are seriously distressed, and had some sort of mental health problem or disorder, and were in need of care.
So, with some enthusiasm, we returned with our results on 'vulnerability' to the schools and, as planned, each of the identified young people was subsequently assessed by a school counsellor. We had spent part of the 2-year planning process training school counsellors so that they felt at least reasonably competent to do this assessment.
Despite all our care, the excellent science, and our prior training of school staff, only about 10% of the 14% (that is 1.4% of all the students in the study) were ever referred back to mental health services. Yet we were providing an open door to assessment and high quality follow-up care free of charge! School Counsellors said: "Yeah, okay – we knew about that kid – Oh, Yeah, we know about that" "Oh, it's not much of a problem" "Well, it's

[49] A report on this research, in pdf, is available for free download from http://www.familyconcernpublishing.com.au/category/resources/, and scroll down.

actually gone away" and a whole range of other reasons for not actually going ahead with full assessments. They also said things like: "The kid doesn't want to come to mental health services – he doesn't believe he's mental – the parents don't want him to come either". There were a whole range of reasons for not referring on - and it worries me.

Don't misunderstand me. I am not blaming school counsellors. I am actually suspicious that our process was not quite right. Coming from Mental Health, we just had not appreciated what the problems might be. Despite all our experience and hard work, we had not appreciated that the interface between schools and Mental Health Services is complex. I think overall, we are dealing here with the issue of pervasive societal stigma. No-one wants to think of a young person having a mental health problem, and there is always a fear that labelling may somehow create an even bigger problem. And, 'help-seeking' for a mental health problem is an equally complex process.

Two matters of interest need to be added.

First, over the next few years we had the opportunity to review the research result for young people referred independently through other pathways to CAMHS. They were referred by GP's and other professionals, or directly by the parents. Where relevant, we sought and gained permission from the young person and their family to looked back at the results from our longitudinal study. Many of these young people had clearly scored in our 'vulnerable range' 2 or 3 years before referral, and we had provided this information to the relevant school 2 or 3 years before referral.

Second, we managed to gain some funding from the JD Gunn Foundation to complete a 5-year follow up of the young people. The numbers we were able to interview with a semi-structured interview were somewhat small, but there was good evidence that many of those troubled at 13 do indeed develop mental health problems within 5 years. The best predictor of mental health problems in this follow-up is surprising, I think. It seems to be that **alcohol or drug abuse at the age of 13 (two well-known indicators of conduct disorder) predicts disorder 5 years later**, and there is other work to confirm that it is this way round, and not that disorder predicts later substance abuse. Oh, of course, I forgot, underage drinking doesn't occur that much – does it? Oh, yes it does...

Despite these later results, in the few years after the initial research work, you can imagine that our enthusiasm for Early Detection was slightly dampened, and we even developed serious doubts about the process that we had evolved. Despite 2 years of preparatory work prior to the study, it seemed that students, parents and schools really did not want to be

identified early and accept high quality Early Intervention. Somehow or other we have to get past this if we are genuinely to be able to prevent adverse outcomes.

I could talk about anxiety, depression and a whole set of problems that we might prevent, including suicide in young people. But what I'd like to do is to choose one example drawn from the questionnaire on delinquency, the focus of a paper that we completed only last week[50]. In our sample of 2,600 1st year High School students aged 13, there were 153 young males who admitted to lighting fires in a public place 'just for fun' (about 11.2%). In addition there were 35 young women (about 3.2%) who admitted the same thing. More than half of these young people have very serious levels of anti-social behaviour.

American research reports that the majority of fires in the US are lit by adolescents. In addition, the international research is clear that **young fire-setters are highly prone to become adult fire-setters**. Given the loss of property and life in the last few years through bushfires, why would you not like to know this fact? Why would you not like to be able to identify these young people early? Why would you not want to institute some kind of intervention program with young fire-setters to ensure that you break the cycle of young fire-setters growing into older or adult fire-setters? How much does it cost this State in burned down schools every year? It is an enormous expense. If we could prevent it – it might be cost effective. To ignore the problem, clearly identified at age 13, is dangerous and very costly.

So the issue then is how do you organise referrals and the programs? I can't imagine the particular young people we are talking about being very keen to accept referrals, so we might have to make the process as easy and non-stigmatising as possible. One of the better programs for dealing with crises in schools in South Australia over the last 15 years has been the Interagency Referral Program; very good bridges have been forged between schools and CAMHS. However, if they had to deal with all of those referrals of fire-setters, they would quickly become overwhelmed. We would have to consider extra resources for such a program – not popular in these hard times. Considerable work would have to be done to find the best practice interventions and train relevant staff. However, I would argue that if you set the cost of the fires against the cost of an ongoing

[50] Martin, G., Bergen, H., Richardson, A., Allison, S. & Roeger, L., 2004. Correlates of firesetting in a community sample of young adolescents. Australian and New Zealand Journal of Psychiatry. 38:148-154.

program that reduces the likelihood of school and other fires, governments would still come out very much on the credit side.
Do the problems of conduct disorder, stigma, and early detection, particularly in the context of suicidality, suggest the need for an alternative way to think through the relationship between CAMHS services and schools?
Given the numbers of possible problematic young people we discovered in our study, would it make sense to transfer some of our personnel and collaborative work actually into the school? **Could we have CAMHS staff actually sitting there as part of the school, relating to teachers daily, beginning to learn the new bridging language, forging those bridges, seeing the kids in a non stigmatising way?** Would it be easier for all concerned? Would it be easier for parents? Would it be easy to refer young people? I think it would.
I believe that by having CAMHS separate and by putting distance and bus fares and protocols in the way, we actually limit the number of kids who get proper care. The funding would probably need to continue to come from the health budget, and not from Education. Historically, education department funding has meant that school counsellors can be asked at times of teacher absence, to go and do some more teaching, rather than counselling, and that takes them away from the opportunity to counsel or develop relevant programs in school.
So, let me raise a couple of final issues that have implications for teachers and their involvement in development and maintenance of mentally healthy young people. We have just had a paper[51] accepted for press, again based on this large Early Detection study I have described. A single question (3 parts) about Perceived Academic Performance seems capable of making an independent contribution to predicting vulnerability to suicidality.
Well, that seems a long shot. The question is a variant on: "How do you think you are doing; how do you think you are going to go in the end of year exams; do you think you are going to pass? Do you think you can make it?" If the young person says "no" – they have a three fold increased chance of later becoming seriously distressed and/or suicidal. If you put that simple, and easily asked, series of questions together with some informal assessment of self-esteem (which many of you can judge very adequately), and together with locus of control (the belief in the young person that they are in charge of their life), you actually can predict around 70 % of those claiming suicide attempts – and that's not bad for 3

[51] First of 3 on Perceived Academic Performance (see References at end of this chapter)

contextually safe questions for a teacher to ask.
Now we come to a serious issue. Should teachers, in any way, do counselling for those vulnerable to mental health problems or later suicidality? I would answer "No!" I don't think teachers are trained for this. I don't think the resources exist to train teachers for this role. I don't believe it is fair to add counselling to your teaching load (even though you may believe you are good at counselling, and will need some counselling skills in a crisis situation).
You are here to teach. **But, draw a distinction between mental health, and mental health problems.** I have previously argued that mental health is your daily bread and butter - with good reason. You, as teachers, promote young people being mentally healthy every day in your routine work. That is appropriate, and other professions should acknowledge you and support your work. Professional Development should focus on these issues.
In terms of mental health *problems*, I believe a teacher needs to be enabled to say: "I am anxious about this young person. I know the pathway for referral. I know that I can get access. I know I can trust the care if and when it happens". Mental health problems are an increased burden inappropriately dumped on teaching staff, when they are better dealt with by those with lengthy formal appropriate training. That burden should be lifted. Professional development should focus on skills to assess quickly and accurately *the possibility* of future trouble, and then referral pathways, and promotion of more effective relationships with CAMHS therapists.
Okay, if we got all of this right, if we were able to identify young people, make appropriate referrals swiftly, provide good quality care – would we make a difference? Well, the answer is absolutely "Yes!" At a clinical level with the right programs, we (that is CAMHS) can make a difference to those young people's lives. The earlier we actually pick up on some of these problems or the risk factors for problems or illness as in the case of David, the better we can help the young person back on to their life path.
The really serious question is – would any of that make a difference to suicide rates at a national level? Sadly, the answer may be "No". It is very unlikely that the best clinical care of those who are struggling mentally makes that much differences to rates. What does make a difference to rates are very large shifts or changes in the way our society behaves.
Those last two sentences seem to be undermining much of what I have been saying. But, let me explain.
During World War II, rates of suicide for men fell. In the thirties, as a result of the Great Depression, rates for men climbed. In the sixties, rates

of suicide for women were very high for about fifteen years. My probably slightly banal explanation for the latter is that a marked disparity existed at that time between women's views of emerging feminism compared to the reality of their lives. They realised the level of disadvantage, many became depressed and with easy accessibility to barbiturates and coal gas, they chose not to work through the dilemma but, in fact, to die. When that was realised, an equally large change in our society came about - putting drugs into bubble packs, reducing the prescription of barbiturates, getting rid of coal gas in favour of natural gas. These measures at a global level actually reduced rates for women over a period of time.

If that logic follows, what global change would actually make a difference to reduce suicide in Australia now? I think we come back to Resnick's work, previously quoted. If programs to enhance resilience and connectedness across many states of the US can make a difference to suicidal thinking in young people in schools, reducing rates significantly, could similar work in Australia have the same effect? Would that make a difference? This is not a popular view yet, but I would argue that we can now define the elements of being mentally healthy very clearly. The research (contrary to popular belief) has clear and good quality outcomes, with large effect sizes. I would urge you to adopt programs like '*MindMatters*', like '*RAP*', like '*Aussie Optimism*', like '*Friends*'.

I would urge you to continue the fantastic work you do every day at the class level, at the school level, at the University level, at the Kindergarten level to promote mentally healthy young people. Being a mentally healthy person is most likely to make the difference for people struggling with everyday problems, but never even considering suicide, over the long term for Australia.

So, as a coda, let me address the question of War in Iraq, and the current War on Terrorism. What is it that teachers could or should be doing in this? What makes the difference? What do our young people need?

If we follow the argument I have tried to put to you, I think we need two things. We need very good mental health – that is we need for young people to be mentally healthy in all the ways I have described earlier. We need to continue to support the development of optimism, skills, options, resilience, judgment, moral reasoning. If we continue to develop programs for those and put our energies there, rather than continuing with our current focus on risk factors, the majority of young people will survive all of the dreadful things that are happening across the world at this time. Secondly, we need for education people to be enabled to discern in Kindergarten, School and University, those people who are particularly troubled by events like War or the terrorist attack on New York (9/11).

We need to enable referral pathways. We really do need to rethink how we use our Child and Adolescent Mental Health Services.
There is an innovation in Queensland called the School-based Youth Health Nurse. It's not really an innovation – it is actually something that was there 50 years ago and it has come back again. Despite being health professionals, they are acceptable in schools, and seem to be able to deal with young people in a non-stigmatising way within the school environment. Conversely, and again because they are health professionals they find it very easy to make the referral to mental health services. They know who to contact. I believe we need to re-think the School/Mental Health Service interface. I would like you to think very seriously about the possibility of transferring CAMHS people into the school environment and improving our links, our referral pathways, our in-school programs. It is not going to be a popular view – I have probably upset my CAMHS professional colleagues. But we have problems that at this time we are not resolving, and I offer you these alternatives to consider.
Should you be doing anything else? I have a very strong view that Media is toxic. One of my colleagues once called television: "the sewer we allow in our lounge room". I would suggest to you respectfully that you advise parents to turn the bloody thing off. The images that are available to us are offensive. Iraq has been a media war. It is as if they are playing a war game on the television. That gives young people entirely the wrong view. It would also be a good thing for you to cancel the newspapers for the next couple of months as well, for the same reasons. I think the more access young people have to those images, the more disturbed some of them will become and, again, it is the vulnerable who will be stressed and may develop the disorders.
Now, there is an age difference. Young people under 5 will react more to their parents' distress than actually to the images or the context of what is going on. They won't have a context. They won't have an understanding of what all the images mean. Those between 7 and 12 might have some interest and may need programs in school to draw or write about or work through the difficulties that they are experiencing if they are experiencing difficulties.
Adolescents, young adults, will certainly need to discuss the issues at a more formal kind of level, and for you to help them think through the issues in an age appropriate way. Is it appropriate for young children to be marching against war? I don't know. I'll leave that up to you to answer. In teaching, as in all professions, one of the major problems that we have to avoid is projecting our needs into the children. Our job, in fact, is to provide children with the best available opportunity to develop health

paradigms, healthy ways of living, and help them and the world survive in hard times. Thank you very much.

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[52] Many of these are available as free downloads from http://www.familyconcernpublishing.com.au/category/resources/

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Fourteen

On Remaining Mentally Healthy During War[53]

Unfortunately my family has a long association with war. My maternal grandfather joined the Guards in 1914 and was gassed at Ypres in Belgium in 1917, subsequently getting tuberculosis and dying in 1921, at the age of 23, two weeks before the birth of his second child. My other grandfather was in the Royal Flying Corp from 1917, saw some action, and created his own flying school in the south of England after the First World War. This led to his writing the first book on air navigation – later taken up by the Air Ministry. He was involved in the training of Second World War pilots and navigators. Four of his sons (including the oldest, my father) and an adopted son, joined the RAF and saw action. My father was a radio technician rescued from the beaches of Dunkirk in June 1940, and was later involved in the development of radar. The adopted son, my great uncle and godfather (after whom I am named Douglas), was also in the RAF and was captured and imprisoned in Changi in Singapore for four years.

They all survived the war, but none of them liked to talk about it, even in the context of my searching questions focused on resilience, and just how you can survive such terrible times. I tried many times to get the full story from my father, but he was anxious not to remember and, I suspect, anxious that his remembering might have brought back fear, anger and sorrow.

War is not fun. It is certainly not glamorous in the way the war in Iraq is being portrayed on television and in the press at this time. Over the last weeks we have been overwhelmed with pictures of men in fantastic uniforms toting weapons of destruction along with images of bombs exploding, prisoners being taken, and detailed maps to show the progress toward Baghdad. More troubling, we have repeatedly been shown dead bodies – both soldiers and civilians, and families searching through rubble for possessions in some ways very similar to the images of the devastation

[53] First published 2003. Martin, G., (2003). Editorial AusEinetter, April 17:4-5.

caused by bushfires around Canberra some months ago. We have heard allied leaders expound on how right this war is, how soon it will be over and how large the obligation will then be to help the population of Iraq rebuild. We have heard the surprise in people's voices that the Iraqi's should fight back so strongly, and the surprise at a range of 'dirty tactics' used to resist our own troops. To the contrary, we have heard little from the Iraqi side. In a sense the cards are stacked; the reporters all seem to be on the allied side.

Whatever the outcome, let me remind you that war is not fun. It has a profound impact on all those who take part and the civilians who are involved, long after the last shot is fired. The reports on the health of veterans who survived the war in Vietnam show just how much people suffer physically and mentally. They also show the impact on families of veterans long after the war is over. As an example a recent survey of children of Vietnam veterans suggests they are three times more likely to end their lives through suicide, however we come to understand this statistic[54,55].

After the disasters of September 11th and Bali, I wrote to the Einet discussion list suggesting that we are all prone to reactions to the loss of life, the loss of security, the loss of innocence. I suggested some simple steps we could all take to maintain our mental health:

- Sleep on average an extra hour a day.
- Don't use the sadness and sense of loss, emptiness and futility to either eat more or eat less. Just eat sensibly – a balanced diet of cereals, meat, vegetables, fruit and milk products.
- Don't use the sadness and sense of loss, emptiness and futility to drink more alcohol or take more medications or other drugs. If anything cut back a little, and use little triumphs to help your self-control generally.
- Take a special quiet time each day (say 30 minutes) and, possibly with your best friend, just think about you, each other, the family, your place in things and Australia's place in the world. Yes, do it every day – it may take some weeks.
- Before during or after this, meditate, pray or just relax for 15-20 mindful minutes.
- Then do some gentle exercise. Swim or go for a walk.
- Turn off the television at least an hour earlier than normal.

[54] http://www.dva.gov.au/aboutDVA/publications/health_research/morbidity/children/Pages/chindex.aspx

[55] http://www.abc.net.au/worldtoday/stories/s160344.htm

- Phone a friend, a loved one, or a member of the family you haven't seen for ages.
- Smile at, and talk to/listen to the neighbours.
- Continue to believe in yourself, your contribution and purpose, your meaning.

But there is more to these issues than *our* mental health. I would like to suggest that the war and its images will have a profound impact on children and young adults in our society. I recently had a brief discussion about these issues with a colleague who is a teacher. She asked my opinion about an anti-war rally in Adelaide mainly consisting of teachers from a number of schools, with their charges – children ranging from 5 to 18. Apparently parents were rather conspicuous by their absence. On the other hand, she wanted my opinion of a school that had barred any discussion of the war during school hours. I have to say that I believe both of these extremes are wrong.

The first is wrong because many young children will not understand the issues, but may be made unnecessarily aware of them through the public rally, and may as a result become distressed or traumatised. I believe as professionals we have to be careful of projecting our own ideas or passions into young people's minds. We have to be extra careful about using young people to score political points unless the ideas are their own, coming out of group discussions with age-appropriate peers.

The second is wrong, because many young people will already be fully aware of the war, the issues and the aftermath. They may already be traumatised and in need of age-appropriate discussion.

I use the term age-appropriate because adolescents and young adults are quite likely to want to voice opinion and, possibly, seek to take action at the group level; strong opinion is often what adolescence is about. On the other hand, under about the age of seven, young people in general are unlikely to be aware of the issues, and are much more likely to want to focus on personal, peer-related and family issues. Remote issues should remain remote. Those in-between may from time to time have the need to raise issues, particularly if they have seen media reports, and may need to take part in activities to assist understanding and reduce anxiety and trauma. This should always address *their* needs and not our own, and should be kept to the minimum that allows the young person to continue with their own day to day activities. As much reassurance as possible should be given as to the physical and time-course limits to the war, and to the fact that Australia is unlikely to be invaded or suffer frequent acts of terrorism at this time. This reassurance may of course be difficult with

young people who have family members directly involved in Iraq or who have been sensitised to these issues through personal knowledge or someone who died in the Bali tragedy.

On the one hand, we need to continue with all those activities that are productive of mentally healthy young people. The best way to prevent trauma is to have as good a level of mental health as we can, promoting resilience, and connectedness to family, school and the community. On the other hand, all of us need extra awareness for those young people who are more vulnerable and who begin to show anxiety, or evidence of trauma. Frequent acting out of war-related activities, poor sleep or nightmares might be cues (among many others) that some more intensive assessment needs to take place. In rare cases, some young people may have to be referred for appropriate therapy with suitably trained professionals. One issue here is that teachers do not need to take on this burden themselves. It is sufficient that they recognise the need for further assessment, and ensure that access to counselling takes place, either within or outside of school.

Overall, I would recommend we advise parents to switch off the television – particularly those programs, like the news, likely to show images of death, or those programs purporting to provide up to-the-minute commentary about the war. Parents need to remain vigilant for errors on television – for instance when advertising for an up-coming report on the war is screened during children's programs. These episodes may be reported to the Australian Broadcasting Tribunal.

Make no mistake; the war, the reporting, and images will profoundly affect all Australians. To update an old saw, 'a milligram of prevention is worth a kilogram of cure'.

Fifteen

On War and Survival[56]

As this issue of the Australian e-Journal for the Advancement of Mental Health goes to press, Australia has joined a coalition of forces at war with Iraq. The central reason presented for this action is preventive – a sort of global 'stitch in time saves nine'. It is argued that Iraq has weapons of mass destruction, has refused to divest itself of these despite 20 years of United Nations discussions and resolutions, and is led by an unstable leader with malign intent to the West. Whatever the rights and wrongs of war, whatever the ultimate result, and however history in the future rewrites the events leading up to it, the world-wide repercussions are likely to be felt for a very long time. Our sense of security as humans is under massive threat, there is increased long-term economic uncertainty, international organisations and agreements seem on the verge of collapse and new alliances on religious grounds seem to be gaining force. Activities we had come to accept as routine and relatively safe – like international air travel – now demand compelling reasons other than fun.

War is not fun; and this war is a media event like no other. Journalists and video cameras are an integral part of the advance on Baghdad, and extended television, radio and newsprint commentary assails us daily. The images are part heroic – reflecting the courage of the small band of Australians directly involved with coalition forces. On the other hand there are confusing images of the Iraqi people's response to the allied advance, the immense structural damage inflicted, the pictures of Iraqi families suffering lack of food and water, but most of all suffering loss.

[56] First published 2003. Martin, G. (2003) Editorial Australian e-Journal for the Advancement of Mental Health (AeJAMH) 2:1. The complete issue and the papers in it available at http://amh.e-contentmanagement.com/archives/vol/2/issue/1/

As a community with varied interests in mental health, we must all wonder what the future holds, and what our role can be to sustain ourselves and others through these events.

The first issue is one of self-preservation. We must give serious consideration to how we look after our own physical and mental health so that we can be available. Some months ago after the tragedy of Bali, I suggested on the AusEinet discussion list (Einet[57]) a number of very simple rules. These have recently been included in an editorial written for the AusEinet newsletter[58]. In broad terms they are aimed at physical health and resilience, avoidance of stress, and connectedness to family and friends. For those of us who are change agents it is all too easy to become overwhelmed by the international tragedy, the national implications, and the increased need from clients (a set of problems taken up later in an article in this issue by Zammuner and colleagues). First do no harm to the self.

The second must already be obvious to those of you actively engaged in counselling and therapy. There is increased demand for service, and the quality of the demand is more strident, more needy. I am reminded of a patient of mine who, within weeks of the Port Arthur massacre, attempted suicide. When challenged as to the reasons, after recovery, she explained how much she had been affected by not only the event but more so by the media coverage which had described Martin Bryant as mentally ill. She had reasoned that if he had been ill and had murdered, then she having an illness could murder; not wanting to do this she had therefore attempted to kill herself 'before something awful happened'. If we apply this logic to current world events then we could judge these events as our previously safe world having gone mad. If we believe in a model of mental illness based in stress-vulnerability, then those who are most vulnerable are like to suffer the impact of stress more, and episodes of illness will increase. We need to be aware of this, be sensitive to individual clients who may react most, and be available. We may have to set up our services to take into account the overload. Those with current illness may incorporate war into their thinking; those with sufficient risk factors may be tipped over into ill health.

Then there are groups who may be more vulnerable to the impact of war. Obvious examples are the families of those who are fighting in Iraq, veterans of previous wars and their families, those in our multicultural nation who derive from the general geographic area of this war or who

[57] Sadly Einet is no longer available to professionals. AusEinet was defunded in 2009.
[58] See previous chapter (Fourteen)

have a cultural or religious affiliation with Iraq and its allies. All of these will need special consideration and planning.

I think we should also be very thoughtful about how we advise those who have the care of children and young people. Very young children up to the age of five or six may not be much aware of the issues or the implications, and will be much more focused on what is happening in the family or what mischief their peers did at school today. Raising the issue at this point, or having some spurious belief that everyone should be aware of the war and its images is probably not only wrong, but potentially dangerous. Young minds may be much more open to the impact of stress. Clearly issues raised spontaneously by children should be heard and dealt with briefly and sensibly, but it is more important to reassure the young that Australia (at least for the moment) is safe, that their family, school and peers are safe, and that life just needs to go on.

For those aged between seven and 12, there is a much higher likelihood they will have seen the images, and been disturbed by them. They may raise the issues more frequently, may play out the violence they have seen in schoolyard games, and may need a mix of reassurance, containment and open forum discussion with some exploration of the issues.

From adolescence, young people are fully aware of the issues and passionate about the rights and wrongs; they will need many opportunities to work through the global implications of Iraq. What is true through all of this is that as adults, parents and professionals we should be wary of imposing our ideas on young people.

The final issue relates to the mental health of Australia. The war throws many of the recent changes in society, as well as our beliefs about our place in the world, into stark relief. In the short term this is confusing and at times very uncomfortable. In the long run it has the potential to help us think through what we want for this great country and its peoples. We are forced to consider what other religions believe, what our neighbour nations want or do not want of Australia. We may be forced to reconsider who Australians are and who we wish them to be in the future. We are already much more aware of family and our needs for the protection of the group; many of us communicate more with family and friends at these times than previously – particularly if we have family members living abroad.

But life goes on, and with it the discussion of old ideas and the communication of new ones. This issue of AeJAMH, the first of our second volume, continues to struggle with an array of issues to do with advancing mental health and a mentally healthy society.

We begin with two fine editorials. The first is from Peter Sainsbury, currently Chair of the Public Health Association. He addresses the central issue of the pursuit of happiness, but sets it into the context of a dilemma that affects us all – how we set up our society is an integral part of how we achieve happiness as individuals. This is very much part of current debate around mental health and its promotion - should we focus at the individual level as clinicians, or should we think at the public health and universal level of how we can influence the health of the nation?

Sven Silburn in a typically thoughtful and wide-ranging editorial addresses the improvement of development of health in children, noting the effort that has been put into risk-based strategies to improve health even though the evidence is somewhat weak and much more complex than at first thought. He flags the future importance of the national longitudinal study just begun and sets it into a context of our growing understanding of social capital.

Mark Sanbrook and colleagues take us back to one of the pillars of preventive activity in Australian mental health – early intervention in first episode psychosis. Assertive case management by a dedicated team is carefully compared to standard mental hospital care. They explore, in a retrospective survey, changes in service after creation of an early intervention team, the increased use of novel antipsychotics, and significant factors in recovery.

One of the problems for the National Suicide Prevention Strategy has been the relative lack of quality evaluations of programs, and the lack of professional publication of what results do exist. We are therefore proud to publish the paper by Pearce, Rickwood & Beaton who report on training of the participants in a peer-based suicide intervention program in a university. Preliminary results from this careful piece of work appear good with changes in mental health literacy, greater confidence in discussing issues with peers, and increased intention to talk with troubled students.

Helen Winefield and her team from Adelaide University address the key issues of partnerships in mental health care. Mirroring similar work in Britain, the study reports on placement of clinical psychologists in primary care General Practice, and explores the work, and the reactions of GPs, other practice staff and patients. Overall the acceptability of the program seems to be high, particularly once issues around payment for service are successfully resolved.

To conclude this issue we reprint two chapters from the joint AusEinet and VicHealth publication *Mental health and work: issues and perspectives*

(Morrow, Verins & Willis, 2002). Zammuner and colleagues report on some important work from Padua in Italy in which they consider how professionals appropriately modulate both work congruent emotions and those emotions that stem from their private life. Five experimental scales were adapted from their English equivalents and used with 180 workers in a private hospital. The study provides a fascinating exploration of how we maintain our wellbeing in the face of others' illness and problems.

Last but not least, Cath Roper provides a consumer perspective on the complexities of working life for those who are employed 'precisely because' they have had experience as consumers of psychiatric services. In particular she addresses issues of safety and unsafety, and concludes that consumers need a clear place in the system with dedicated resources to develop consumer driven projects and services.

Once again then we are publishing a smorgasbord of ideas across the range of promotion and prevention in mental health. At this point in our development of AeJAMH, we depend on the papers sent to us; we of course urge you to send us more. However, for 2003 and 2004 we also are planning AeJAMH issues that address particular topics and themes. One special issue is likely to address Indigenous social health and wellbeing. A further proposed issue centres on mental health and the aged. We would welcome contributions to these, as well as ideas from you about key topics you would like to see explored.

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Morrow, L., Verins, I. & Willis, E. (2002). Mental health and work: issues and perspectives. Adelaide, AusEinet: The Australian Network for the Promotion, Prevention and Early Intervention for Mental Health.[59]

[59] The complete book 'Mental Health and Work' can be downloaded, free of charge in pdf format, from http://www.familyconcernpublishing.com.au/category/resources/
Scroll down to the upload for 17th February 2014.

Sixteen

The Application of the Promotion, Prevention and Early Intervention Framework to Severe Conduct Disorder[60]*

David was 12 years old when he was referred to a Child Guidance Clinic for supposedly interfering sexually with his younger sister. While paediatric examination assured the parents she was not damaged physically, Emily was distressed because she had tried to stop her brother's exploration, and he had rather roughly refused. David was hard to engage in an assessment. On the one hand obviously scared by being interviewed by police officers and child protection staff, David showed little remorse, and seemed unprepared to accept that he had done anything wrong, defiantly stating it was not his problem.
The parents were initially relieved to think they would get some help, but over the next four months found it hard to keep appointments, seemed reticent to accept advice or interventions from the two therapists working with the family, did not follow through with agreed homework, and became more and more abusive about what they saw as lack of progress in their son. The therapist working individually with David tried all sorts of ideas and techniques to interest him in changing his behaviour, but felt repeatedly like giving up, and was not-so-secretly pleased when the father terminated contact after one angry outburst.

David's problems did not just happen. The oldest of three children, labour was difficult and long, and he spent several days in a humidicrib after being born 'a bit blue'. Mum found it hard to like her new son, especially after he 'refused' to breast-feed. She complained that he cried frequently, did not sleep much, and was different to her friends' babies –

[60] First published 2003. Martin, G. (2003) Editorial Australian e-Journal for the Advancement of Mental Health (AeJAMH) 2:3.

*Based on an invited presentation to a national two day workshop on 'Severe Conduct Disorder, June 2003, Auckland, New Zealand.

he was late to crawl, stand and walk, did not seem to understand things, and could not put more than two words together until nearly three years old. He had frequent violent outbursts, breaking ornaments, smashing toys and banging his head repeatedly on the floor.

At kindergarten David was not much liked by the staff, and even less liked by some children whom he was seen to bully to get toys. The pattern continued at school with frequent complaints from parents of other children. He gained no close friends, was disruptive in class, and 'behind everyone in reading'. From the age of seven he stole objects from school, and ever increasing amounts of money – first from his parents, then from others and, finally by the age of ten, from shops. He seemed always to be in trouble, had frequent accidents resulting from taking risks, and lit at least two known small fires in derelict buildings. Explanation, rewards, reprimands from teachers and at times the police, loss of privileges, 'time out', all seemed to have little impact. Beatings at home simply alienated him from his father.

David's parents sought help from many professionals over the years, but nothing seemed to work. They increasingly felt like failures, and saw David's abuse of his sister as just the end of a long string of difficulties they had been unable to manage. When troubles escalated over the next year, in desperation after a physical fight with David, the father physically threw him out of the house. David lived briefly with a friend's family, but after becoming more and more morose, he stole the family's car and drove it at high speed until a crash led to his death.

This is an extreme story based on true life – hopefully sufficiently disguised. What we can see here is a trajectory toward impending disaster, an accident literally waiting to happen. And much of the, at times, intensive therapy and other intervention toward the end seems to have made no corrective change. There is a paradox here. Over 60% of referrals to the Child and Youth Mental Health Service are to do with behaviour problems ranging from opposition to parental control in small children, through to more serious problems of theft, property damage, violence, and fire setting. However, Mental Health Services are historically not very good at engaging young people like David or their families, and have limited skill, knowledge, time and energy to apply to the kinds of problem presented. We are good with depressions, the anxieties and to a certain extent the post traumatic states, but we find it hard to like conduct disordered young people, harder to keep them in any sort of therapeutic alliance, and almost impossible to bend the trajectory back to something more socially acceptable.

So where could intervention have produced consistent change? If we step backward through David's life story using our preventative framework, the first question relates to case management – can better and more comprehensive intervention make change? There is now an extensive literature on secondary and tertiary prevention in conduct disorder. Correctional approaches appear to make little difference (Whitehead & Lab, 1989), and some programs like 'Scared Straight' can even make the situation worse (Petrosino, Turpin Petrosino, & Finckenauer, 2000). However, despite the fact that conduct disordered young people frequently drop out of therapy (Bennett & Offord, 2001), intensive family and parenting interventions have a positive impact (Bruce, 2002). More specifically, approaches like multisystemic therapy (Henggeler, Cunningham, Pickrel et al., 1996), while resource intensive and costly, seem to be effective (Woolfenden, Williams, & Peat, 2002). But the expertise for these approaches is not yet widespread, and services are loath to allocate such large amounts of intensive therapy time.

What stands out from David's history is that many opportunities for early intervention were missed. While there might have been the very best of perinatal care, attachment with mother could have been assisted to improve, as could the poor affect regulation seen in the early rage attacks. We know that these two issues underpin the development of empathy (Saltaris, 2002), a central issue in later conduct disorder (Frick, Cornell, Bodin et al., 2003). Developmental delays are clear indicators of need for intensive intervention, and flag the later learning problems. The social and educational difficulties in kindergarten were noted but no remediation was advised to the parents, nor was a comprehensive assessment suggested when these continued into early school life. Not all children with these difficulties progress, but the pathway from oppositional behaviours through conduct disorder to delinquency is now clear (Loeber, Burke, Lahey et al., 2000), and intervention is indicated. The need for a collaborative approach to prevention does not appear to have been discussed between the school and the parents and other systems of care like the general practitioner or paediatrician. When David began to have frequent accidents, nobody seemed to see the complete emerging picture, yet we know that young people with conduct disorder are more impulsive, prone to accidents, and have higher mortality (Werry, 1997). Even when the stealing and other behaviours become publicly obvious, the responses continue to be negative or punitive. A key issue here is whether David's life path could have been changed. Recent

longitudinal work suggests this is possible (Lacourse, Cote, Nagin et al., 2002).

David's story is individual, but many of the issues presented suggest his heightened risk, and provide a case for selective intervention. He is a boy with birth trauma, early physical difficulties, poor social skills, learning problems and a tendency to impulsive violence. Agreed, there are some protective factors evident. Neither of his parents had a criminal record or a mental illness; neither of them had a history of alcohol or other drug abuse. Despite all of their difficulties, they were still an intact family unit. They cared enough about their son to seek help on many occasions, even if they struggled to follow through. What is evident throughout the story is their ongoing need for education and support with improvement in parenting skill. Parent management training could have made a considerable difference to the outcome (Kazdin, 2002), and there are so many points along the pathway when parents could have been advised to seek out a comprehensive behaviourally based program. One such program, the Triple P - Positive Parenting Program (Sanders) is examined in some depth in this issue of the Australian e-Journal for the Advancement of Mental Health (AeJAMH)[61].

Werry has suggested (1997) that up to 5% of young people may develop conduct disorder, and the incidence rises steeply with adolescence. With these numbers in our society, and the resulting costs, there is a clear need for universal preventive approaches to the problems. Parenting management support can be seen as selective - that is parents can be referred when they are seen to be struggling. It can also be universal - it can be made widely available for new or young parents or those where intergenerational knowledge of how to provide the best of care for children has been lost in an increasingly fragmented society. One need is for carefully developed, evidence based approaches, easily learned by therapists and capable of being applied in a range of circumstance. It is our hope that this issue of AeJAMH contributes to that evidence by considering one of the many approaches to parenting management. Another need is for professionals to have clear knowledge of risk and protective factors, and the comparative effectiveness and cost-effectiveness of programs, along the trajectory of early life. A final need is for improved communication between the systems working closely with children and their families, which in turn may contribute to better collaboration. Conduct disorder is complex and expensive to treat, and

[61] Papers mentioned in this chapter are available from http://amh.e-contentmanagement.com/archives/vol/2/issue/3/

the more we miss the clues in the early stages, the more entrenched the condition becomes, the less likely it is to be amenable to change. There is now substantial evidence that early recognition and early intervention at key points provide us with the best opportunity for long term success.

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Seventeen

Internet, Media and Mental Health[62]

The recent Internet, Media and Mental Health conference in Brisbane (22-24 April 2004) seems to have been a great success with overwhelmingly positive feedback from participants, five spontaneous offers of collaboration from both organisations and individuals to assist development of the next biennial conference in 2006, and a flood of acceptances from speakers to publish chapters in a proposed book (which will be more than a proceedings, yet reflect all the themes discussed). All of this reflects the enthusiastic response at the conference to keynotes, symposia and individual papers, and the intense level of discussion around what was a complex set of overlapping ideas.

The conference themes originated in many ideas and experiences. First, the work over many years which has shown that violence in children may be influenced in part by the amount of violence they see on television, other work over 30 years suggesting that newspaper stories about (particularly celebrity) suicide might act to 'tip' vulnerable people into the act, and a considerable body of work suggesting that media in general might not simply reflect what we the public need to know but, in turn, has the power to influence our mental state. A contrasting theme related to the increasing need for the use of technology in mental health programs both to service the ever-increasing burden of illness, but also to respond to the particular needs of those living in rural and remote areas who might not have easy access to diagnostic or therapeutic programs except through the telephone, Internet, or newer videoconferencing and telemedicine.

More practical and personal influences derived being part of a team which

[62] First published 2004. Martin, G. (2004) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH), April Vol. 3, No. 1: 1–4.

developed 'Achieving the Balance'[63] for the Commonwealth, and subsequent membership over the last four years (2000-04) of the National Media and Mental Health Advisory Committee which redeveloped the current Mindframe[64] guidelines. This work repeatedly suggested the need for wider dialogue of the issues around media reporting of mental illness and, in particular, suicide.

Of more theoretical importance was a shift away from criticism of media for their perceived role, to the more constructive idea that media and mental health might work in partnership toward mental wellness and an improved lifestyle for Australians. This shift, of course, parallels development from a focus purely on illness and risk factors, toward better understanding of both the role of protective factors and mental health promotion – as seen in major Commonwealth developments in the three Mental Health Plans to date.

Further, being part of the original team which developed AusEinet (The Australian Network for Promotion, Prevention and Early Intervention for Mental Health) cemented not only the importance of these theoretical shifts but provided personal experience in the use of Internet and media of various types in the development of the Communications Strategy for AusEinet.

As a final influence, much of the early thinking, planning and program development for AusEinet was presented to the inaugural Internet and Mental Health conference in Genoa, Italy in 1998 – a conference which focussed directly on the need for wide discussion of the use of technology in mental health.

These complex ideas and paradigm shifts were reflected in the difficulty of 'selling' a conference on what are 'cutting edge' methodologies. In the original promotional and funding application materials, the increased interweaving (and perhaps interdependence) of media and Internet in today's society was pointed out, as were the possible influences of each on mental health. The now well-researched negative influences were balanced with ideas about how constructive approaches might benefit

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[63] Penrose-Wall, J., Baume, P., & Martin, G., 1999. ACHIEVING THE BALANCE; A Resource Kit for Australian Media Professionals for the Reporting and Portrayal of Suicide and Mental Illness. Commonwealth Department of Health and Family Services, AGPS, Canberra. ISBN 0 642 39426 1.
This kit is now superseded, but information about accessing it can be found at http://trove.nla.gov.au/book/result?q=+ACHIEVING+THE+BALANCE%3B+A+Resource+Kit+for+Australian+Media+Professionals+for+the+Reporting+and+Portrayal+of+Suicide+and+Mental+Illness.+ (accessed 12th July 2014)

[64] http://www.mindframe-media.info (accessed 12th July 2014)

future Australians, their mental health and their lifestyle. The need for the conversations was stressed. As it turns out, mental health professionals (apart from the 120 who registered) found it hard to choose this conference over the plethora of other conferences available each year, hard to gain the funding to attend, and perhaps hard to see how the ideas might have relevance to their day-to-day practice.

On the other hand, the response from media professionals was irretrievably mired in their need to gain simplistic one-liners related to a single idea that might sell newspapers, or increase ratings for television. From editors down to working journalists, the response to a request for dialogue was either none or, in some cases, a response tinged with hostility. Even trying to sell the line that cadet journalists or journalism students might gain a lot from consideration of the complexity of the issues, was met with profound resistance and/or silence. Yet, the conference must be rated a success, and the need for a further conference on the issues was voiced by many participants.

The three daily Keynote sessions achieved the original aim of providing, within each, differing views using the three lenses of 'problem', 'advances', and 'collaboration'. In the first session, Senator Andrew Bartlett, leader of the Australian Democrats, opened the conference with a unique report of his personal experience at the hands of media, having publicly admitted to suffering depression. Michael Ebeid from Optus explored the rapid developments in communications technology and what they might mean for practitioners in mental health. Michael Flood from the Australia Institute reported on a serious problem – that of the ease of both deliberate and accidental access for young people to pornography on the Internet. Finally, an example of national collaboration between media and mental health (the Ybblue program) was explored by Jane Burns from Beyondblue, and Brad McKewan from Channel 10 television.

In the second day Keynote session, Beth Haller from the United States presented an intriguing keynote called 'Roasted Nuts' - the headline in a newspaper after a tragic fire at a mental hospital. The essence of her paper was that following a public outcry about the reporting, a long lasting collaboration with the newspaper led to a positive and sustained series of constructive reports on mental health problems. Psychiatrists Louise Newman and Michael Dudley then examined media reports on detained refugees in Australia, and the impacts on the mental health of the children. Finally, Jo Mason presented the national whole school approach to resilience - MindMatters – and the way in which the Internet plays a central role in the program.

The third day Keynotes were equally extraordinary and rich. Michael Vaughan from New Zealand presented their national mental health advertisements using famous sporting figures and reported on the striking outcomes achieved – particularly in help-seeking by men. Richard Eckersley from the Australian National University provided a broad perspective on the need for social change if we are to gain mental health for future Australians. Finally, Philip Castle and Trina McLelland explored the complexity of being a working journalist, but also the impact of disaster on journalists' personal health.

The quality of symposia and papers was equally good, and the promotion of the conference as attracting some of the finest minds in Australian mental health was no idle boast. Fifteen papers addressed counselling on the 'Net or through email, with high quality clinical and research reports. There were thought-provoking symposia on collaborations with media, mental illness and the role of professionals as presented in film, suicide and the media, IT approaches to multicultural mental health, and creative approaches to reaching young people (for instance the Somazone program presented by film-maker Richard Jones) or hard to reach groups. Of importance there were two fine papers specifically exploring ethical issues as we grapple with these cutting edge approaches. It is to be hoped that many of the papers from the conference will find their way into this journal.

So are there lessons to be learned from the conference? The answer is of course 'many' at many different levels. The first lesson is that innovation is alive and well in Australian mental health, and many groups are actively embracing electronic means of advancing clinical practice in dealing with mental illness.

The second lesson derives from this. While there were some outstanding (if not mind-blowing) examples of programs addressing the potential for mental wellness and lifestyle, the predominant theme was the creativity in approaches to mental ill health. Despite the rhetoric of national policy and strategy, we still have a long way to go in the advancement of mental health (as 'health').

The third lesson is that collaboration with a wide variety of media is possible at the Universal level as well as more local targeting of selective groups. Again though, we have a long way to go to engage relevant media groups in the discourse. The level of suspicion is high; media is largely unconvinced of their role in influencing ill health and, as yet, find it hard to grapple with their possible role in collaborations for mental wellness and lifestyle. A part of this relates to our ability as mental health professionals to translate the complexity and the breadth of the debates

into acceptably simple and unambiguous language suitable for daily reporting. Conversely there is a need for media to get past the need for crass and sometimes inflammatory (if occasionally clever and alliterative) one-liners. How this can occur in such a massive and wealthy industry with a focus on aggressive marketing is beyond the scope of this editorial (and probably the scope of national committees and several more conferences).

A further lesson, then, is that there is a long way to go in this area if we are to achieve what this journal seeks to achieve – the advancement of mental health. We need to continue to focus on the novel possibilities for using information technology approaches, we need to be cognisant of the ethical complexities in what can be a very exciting area of creativity, and we need to find new ways of developing understanding and collaboration with potential industry partners in film, television, the Internet, and all forms of the print media.

A final lesson is about the process of running a conference about technology. An assumption was made, in the context of keeping costs down, that email advertising of the conference, with registration online, would be a viable alternative to printed promotional material. Ironically given the theme of the conference, this assumption proved wrong. Many mental health professionals use their emails intermittently and may fail to take notice of one email amongst many others. Despite the frequency of email promotions to a list in excess of 8000 addresses, many claimed they were unaware of the conference until it was almost too late to get funding. Emails to senior professionals and administrators just did not filter down their systems, or provide notices for coffee tables (as printed materials might). Conversely, many professionals complained about the frequency of emails, suggesting it resembled SPAM. Of note, these somewhat hostile responses were more likely from media professionals and media academics than mental health professionals. Given the new laws about SPAM, great care must be taken in future to comply with the rules, and the printed medium may still be best in the lead up to the 2006 conference.

Turning to this issue of the journal[65], it is exciting to note that papers relate to the themes of the conference. In a wide-ranging and erudite editorial, Nicholas Procter explores the impact of globalisation on health systems with an emphasis on the implications stemming from education.

[65] Articles from this issue of the AeJAMH journal can be accessed at http://amh.e-contentmanagement.com/archives/vol/3/issue/1/

He notes: “Educators and their students need to process information, derive knowledge, and disseminate the knowledge into clinical practice in ways unanticipated before the introduction of computer technology and the internet”. He suggests we may be in danger of losing the influence of local culture in our health systems, the art that balances the evidence from global research, and goes on to argue for glocalisation – the idea that some activities have to be initiated within the context of local culture.

Jonathan Nicholas and colleagues examine help- seeking behaviour in adolescents and the internet. What is clear is that awareness of Reach Out[66] as a program was high, and acceptance of its usefulness was also high. There were gender differences in help seeking behaviours, and whether the Internet was used depended on the nature of the problem, but active programs to increase knowledge of the availability of such programs on the ‘Net remains an important strategy.

In a rather nice counterpoint, two editorials explore the issue of recovery from mental illness, an essential part of national mental health policy, but something not discussed as often as it should be in the context of prevention. Mary O’Hagan’s paper suggests that New Zealand may have grappled with the essential issues somewhat earlier than Australia, but that “although recovery is widely accepted as a concept by people in the mental health sector in New Zealand, the Commission still has a long way to go to ensure that recovery as we have defined it becomes embedded in mental health services". Debra Rickwood notes that the term recovery has been contentious – as much for consumers as for mental health professionals, but concludes that: “Australia is slowly but surely moving toward a mental health service system that empowers and promotes the well- being of people with mental illness”, using a model of recovery.

Jeffrey Chan and colleagues from New South Wales explore the availability of mental health services for those with intellectual disability, using case studies to illustrate some of the issues. They conclude that while emerging evidence suggests that services are improving, there is still a place to re-examine clinical services and ‘get it right’.

A second paper by Chan and colleagues (An exploratory study of crime and brain injury: Implications for mental health management pp. 30-35) explores another area of human existence in which mental health issues need to be reviewed – that of people who offend and may have had

[66] ReachOut continues as an influential program to the present day and can be accessed at http://inspire.org.au/reachout-com/

traumatic brain injury. Again, a small clinical sample is explored to examine the issues. The authors conclude that a strong case can be made for early intervention.

The final paper in this issue (Janet Costin and colleagues from Maroondah CAMHS in Victoria) reports on a clinical trial of two interventions for oppositional defiant disorder. Both interventions are shown to improve outcome, but specific targeting of symptoms is shown to be important by the extra improvement in the ODD symptoms for those groups where parents gained specific management skills for ODD rather than just non-specific stress management skills.

This issue of AeJAMH marks the beginning of the third year of the journal. Hits to the site and downloads would suggest that the journal is widely known, and has gained some credibility in the field. We believe that we can maintain the standard of the journal. Our eternal thanks go to our Editorial Advisory Board, our Assessment Panel for their quick reading of papers and their clear responses, and of course to those of you who provide papers. We look forward to continuing to provide a rich online resource toward the advancement of mental health in Australia.

Eighteen

On Accountability[67]

This happens to be a fascinating, rich and very thought-provoking edition of the Australian eJournal for the Advancement of Mental Health. While the papers reflect different contexts and differing struggles, there is actually a common thread running throughout – that of accountability. Robert Kosky in his guest editorial[68] reflects on the 10th European Association for Suicide Prevention conference in Copenhagen, noting a certain seriousness. He suggests that, overall, considerable progress in suicide prevention has been achieved with reductions in rates in many countries – just cause for celebration. Yet participants at such conferences are perhaps recently even more aware of just how much remains to be done – and this has an impact on us individually and collectively as professionals. This is good, I would suggest. It means that we are taking some responsibility for the work that we do as individuals toward some group defined goal. In a sense we are feeling some accountability.

In the face to face clinical situation, there are always processes in place to hold us accountable, particularly in public services. Consumers and carers may directly challenge a clinician's interventions as 'not working'; in some cases in recent years this has led to legal sanction. There may be accountability processes in place through supervisors, or through audit process. Of course in Australia a considerable amount of clinical work occurs in the private practice context, and there may be fewer formal systems, yet there is still direct accountability to the client, and some accountability to the referring agency. By contrast in research there is little in the way of accountability except to a funding body in terms of the way the dollars are spent. But no-one leans over the researcher's shoulder to point out that a particular piece of work has not contributed

[67] First published 2004. Martin, G. (2004) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 3:2.

[68] All the papers mentioned in this editorial can be found at http://amh.e-contentmanagement.com/archives/vol/3/issue/2/

to the national effort. In fact many completed programs of research may not ever get to scrutiny in the public arena, simply because the process of publication is so onerous and competitive. And there is some evidence that research with a negative result may be less likely to find its way into an international journal. Researchers may be dispirited and keen to move on, the writing up may feel as though it is less important (even though a strong case can be made that we need to know about our failures so that we can learn from them, and not have future researchers repeating the same processes), and journals may be less inclined to publish something that did not appear to work. So to have a conference where the collective reflection is aware of the magnitude of the task yet to be done is important. And to have researchers feeling some sense of responsibility for a task which is defined nationally, or by the community, or simply by the available statistics, is terrific and bodes well for future efforts.

Paola Mason, in her guest editorial, comes from a different perspective, that of personal experience. In reflecting on her own story as the child of a parent with a mental illness, and the way in which this experience drove a program for change, Mason notes the way in which an increasingly humane system of mental health acknowledges the needs of the child when a parent is ill. In exploring the broadening of our accountability to include others in the family system, especially those more vulnerable to the impact of illness in a family, she leaves us with a message of hope – systems can change, and all the personal effort is worthwhile.

The paper by Elizabeth Fudge and Paola Mason takes us further down a path of listening to the needs of need of young people. The paper adds further reality to the consumer mantra 'nothing about us without us'; how can we develop programs for young people if we don't listen to their ideas and then incorporate those ideas into the final design? There are often refreshing surprises, which on reflection end up being much more influential than what we as caring professionals had thought needed to be done. I was reminded, reading the paper, of a piece of my own learning which took a considerable time to sink in. Several professionals in a country town set out to bring young people together to consider their own community, and what might be necessary to make change. The primary expressed need ended up being an area in which young people could let rip without sanction – what came to be known as a 'rage cage'. How would a community mental health service have ever have got to the point of both spending a considerable amount of money on this, and also helping to engineer a community partnership which eventually raised an enormous amount of money, without asking those to whom it

mattered. What was crucial in the end, was the impact on a large number of young people who took part in the program over several years. Behaviours in the community became less extreme, school performance for many just seemed to improve, and all sorts of people reported how much they were impressed by the changes in the young people.

This kind of idea is explored further in the paper by Chris Lloyd and colleagues, who describe seeking the opinions of young men toward development of a rehabilitation program. It is the young men who identify the areas of need, and this is likely to lead ultimately to a more successful program. Why should this come as a surprise? Yet it still does sometimes. If a program is set up based on client identified need it is so much easier to be accountable.

In exploring the variability with which community programs for first episode psychosis are implemented, other solutions emerge for Richard O'Kearney and colleagues. In noting that psycho-education and relapse planning may be less well done over a period of time compared to the more medical responses, the authors suggest that, among other things, some management process like formal registration of the patient in the program may improve sustainability of delivery.

To return to the theme of children who have a parent with mental illness, the struggles we all experience are explored carefully and thoughtfully by Cousins in her paper about the protection of such children, and the tensions which may arise for the therapist in balancing competing needs. In the section on judgement she says: 'To come to a decision that a situation is not good enough, to feel the true weight of responsibility this involves, provokes anxiety, fear and conflict within us. And it should! This should never be an easy decision. It is good to question, talk the situation over with others and debate it.' This, for me, exemplifies the issue of accountability. Whether the situation in question is a clinical one, a community one or a national one, this 'feeling of the true weight of responsibility' is what makes most of us reach out to change things. I suppose it can go too far, and perhaps lead to burnout when support from colleagues or family is not there to ground us. But as professionals in the human services, one of the things that makes us special is this ability to 'come to a belief that a situation is not good enough', and decide that it is up to us to begin some sort of change process. I understand the need for checks and balances in services to ensure corporate accountability. But it is often that seriousness described by Kosky which emerges from reflection, that drives us to become accountable to a client, a system or a national effort.

Nineteen

On Social Justice[69]

Before moving to Queensland three years ago to take up the Chair of Child and Adolescent Psychiatry, I had worked for sixteen years in a clinical organisation in South Australia which was passionate about social justice, community focused to a fault, with some experience in early intervention, prevention and mental health promotion before they were on the national agenda. Client centredness and a solid philosophy based on systems thinking and family dynamic approaches, meant that within our management process we were always searching for ways to meet the expressed community need while matching it to our clinical abilities. An example of this was when no money was available for rural services. We simply decided to allocate money from elsewhere in the budget to set up skeleton rural services with monthly visiting specialists to support on-the-ground staff. With the obvious success of the program (and with ever increasing factual knowledge of the real need of rural communities in our patch), we were able to persuade the state government to fund the extra positions needed to fully meet the need. In putting the cart before the horse that is in providing the services before we had fully fledged operational plans and the attached new financial resources we were never able to recoup the money we spent in those first few years. Despite this we always seemed to come in on budget. And we had a fully-fledged 'country team' operating out of three rural hubs, with a team leader dedicated to making it all work. The city teams and their services suffered a bit, the visiting clinicians were asked to break a golden rule and work out of four and sometimes five centres rather than the expected three and were often exhausted after a frenetic tour of a country region, and occasionally we sailed close to the political wind. But it worked; we

[69] First published 2004. Martin, G. (2004) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 3:3.
All papers in this issue are accessible at http://amh.e-contentmanagement.com/archives/vol/3/issue/3/indigenous-mental-health

had translated our beliefs and our passion into action. The fact that it was at some extra cost to us as individuals, and our overall service, was irrelevant.

A part of this story is relevant to this current issue of AeJAMH. In developing services to the Riverland, we became aware from a number of sources that the Aboriginal community consisted of some 2,500 people, had a high level of mental health problems, and was provided with almost no relevant service. An opportunity arose to employ an Aboriginal person who was still completing his training; we were excited at the possibilities and leapt to employ him in a specifically created position. Of course we employed him at a rate similar to other non-Aboriginal staff in the service. After all, we expected him to become a regular team member and fulfil a role equivalent to our other workers. This led to uproar. We were abused by several sources claiming we were undermining the current pay scales, and setting up unrealistic expectations for other Aboriginal health workers and their services. The assimilation into the service was also hard on both sides. Our expectations were probably set too high, bridging to the Aboriginal community proved far more complex than we had expected, and supervision and mentoring were hard because we did not have a wide range of Indigenous Mental Health Workers to call on. The local small rural team was very welcoming and supportive, and had worked hard to gain a sense of local indigenous issues. Certainly our worker stayed the course; but at some cost to him and probably all concerned. Our less than perfect start led to the subsequent development of a full time position, which was filled by a fully trained worker who built well on the previous processes. We all survived what was a very steep learning curve. Did we assist the local Aboriginal community? Yes and no! We did improve pathways to care somewhat, but with both of our workers being male, and both from differing tribal backgrounds, the entry to the community was complex and fraught with misunderstanding. Women's business was not well dealt with, and suspicion and reticence were a daily battle. More than that, there were issues raised which were perplexing, or at the time made little sense; fifteen years of reading and experience later (and having had the opportunity to read the papers in this issue of AeJAMH), I find myself understanding things a little better.

As an example, let me share one story. Our second worker felt it was crucial for several of the management team to visit the community in question and meet with the Elders. This sharing of history, views and beliefs in the community hall went well overall. Afterward, standing outside in the sunshine with one of the male elders, there was a lengthy

pause. Then he said: 'Of course the problem with you white people is that you think about the body, and you think about the mind, but you never think about the spirit'.

The phrase sat with me for a long time, and began to make some sense as several of us at Flinders University, including an Aboriginal project officer, later began to think through the development of a master's level course on Social and Emotional Wellbeing - aiming to provide education and training for Indigenous health workers. However, it was not really until quite recently that the evidence for spirituality in the context of both understanding, and therapy, began to be presented at national conferences. For me this culminated last year in a conference I convened in Brisbane on 'Spirituality and its Place in Suicide Prevention', hosted by SPA (Suicide Prevention Australia), attended by 340 people. The Indigenous input throughout was prominent and influential, apart from being immensely moving. So have we advanced much?

Currently, I am involved with a clinical service in Brisbane which sees itself as having some responsibility statewide – especially where gaps in services need to be filled. Recently we have begun some supportive consultation services to far North Queensland – no extra funding of course, just some commitment to social justice! There are services which have developed at a local level, largely supported by Ernest Hunter and staff from his service from Cairns. But some expert help was thought to be needed in Child Psychiatry.

We are doing the best we can do, with the resources we have at our disposal, but when I reflect on what we are doing in the light of having read this issue of AeJAMH, I am appalled at what might be called our 'arrogance'. A senior child psychiatrist visits one of three centres, for a week each, to support local staff and to do some direct clinical work where asked. In between, there is availability of videoconferencing and email consultation. Do we meet the requirements suggested by Tracy Westerman in her paper in this issue? I fear nowhere near all. How do we work with local staff? I know the people concerned and they are all sensitive, with some local knowledge, and with deep respect for Aboriginal and Torres Strait communities. But do they meet the standards suggested by Tom Brideson in his two papers in this issue? I fear we have a way to go. We will learn, and now we will consider the issues raised here and adopt what we can. We are at this time providing so little really, but it is a start. And my experience from South Australia suggests that in time we will have fully funded resources available, be fully trained and well supported.

This issue of the AeJAMH is part of AusEinet's commitment to Indigenous mental health, particularly in the area of prevention and mental health promotion. We are immensely grateful to Tracy Westerman who has acted as Guest Editor for the issue. It is fitting that such a powerful, thought-provoking, and challenging issue marks the end of our third year of publication; it reminds us that we still have a lengthy journey ahead if we are to advance mental health for all Australians in a context of Social Justice.

Given we have got to '3', I would like to pay tribute at this point to Lou Morrow who began the journal as our first manager, and to Anne O'Hanlon who has continued to raise the editorial standards of the journal and seen it to the point where we are now abstracted by PsycINFO! I also thank Jennie Parham for her ongoing support, and all the assessors who give so much of their time freely. Thank you.

As I have said, this issue is challenging. Ernest Hunter provides a broad overview of the history, and recent changes in the sociopolitical context. In a typically powerful style, he reminds us of how policy has affected the development of services, how complex the issues are in developing services which acknowledge the learned wisdoms of the western traditions of psychiatric care, but are also sensitive to the learned wisdoms of Indigenous communities. He reminds us that we are involved in a struggle to grow away from the separateness and tensions 'between commonwealth-funded, local community-controlled organisations, and state- based mental health services which adhered to conventional understandings and were, generally, defensively dismissive'. Further we are reminded of the 'critical importance of the social determinants of health'. Ultimately he challenges us as Australians to understand that mental health services will never be able to operate successfully unless we are 'aware of particular cultural practice', but at a higher order get the sociopolitical context right.

Tracy Westerman provides a guest editorial which is thoughtful and erudite, yet offers solutions and points the way to possibilities for change in the clinical arena. The advice about the use of cultural consultants is timely, the need for attainment of cultural competence sensible, and the recommendations for cultural supervision both novel and obvious at the same time. She points out that there are 'few published examples of effective preventative programs or therapeutic interventions with Indigenous people', and a 'lack of empirically grounded conceptual frameworks that have proven their efficacy with Indigenous people with specific mental health issues. But if we work our way through the idea of 'cultural competence as eleven different counselling competencies',

solutions for effective engagement emerge, as do appropriate culturally sensitive clinical as well as preventive interventions.

Tom Brideson's guest editorial is slightly tongue in cheek, but the humour cuts through our defences to force us to acknowledge the difficulties traditional services have in accepting and working with trained Aboriginal Mental Health Workers. His use of the American Psychiatric Association's DSM-IV is exquisite. But his points around limited recognition, and under-valuing, of the role of the Aboriginal worker leading to stress, frustration and limited opportunities are cogent.

Vicary and Westerman's interviews with Aboriginal people expose very well the deficits in services. They balance the equation by suggesting that on the one hand, more effort needs to be spent in educating Aboriginal people about mental illness and overcoming stigma about seeking assistance, but on the other hand a wide range of issues must be dealt with by therapists in services. An interesting issue raised is that Aboriginal clients need to be heard, and also want to have a practical solution provided for their problem, and may not want to return for more than one visit. This paper, like Westerman's editorial is full of clear, sensible suggestions for practice.

Petchkovsky and colleagues' paper looks at some of the survivors of the 'Stolen Generation'. It describes the long term and ongoing symptomatology of a group of nine adults, and is a sensitive, thorough, poignant and, at times harrowing, account. And these are the survivors. A strong case is made for these people being severely traumatised, yet sociopolitically and legally there is no recourse or, if there is, it is too hard to meet requirements of western law. Another strong case is made for dealing with the ongoing needs for therapy of these people. The paper is accompanied by two delightful and meaningful paintings which depict indigenous understandings of the working of the mind.

Some of what is presented in this issue may seem to be 'just too hard' for western trained practitioners. However, there is clearly a need for those willing to cross the bridge to meet a social obligation, to immerse themselves in Aboriginal culture, and take the advice available to begin to solve the immense problems which remain. If it is too hard, then the paper by Brideson and Kanowski suggests an alternative way to solve the problem – development of large numbers of Aboriginal Mental Health Workers. The paper describes the approach the Djirruwang Aboriginal and Torres Strait Islander Mental Health Program at Charles Sturt University from which a large number of graduates have now emerged successful 'with consistent skills, knowledge, values and attitudes of like-minded mental health professionals, whilst maintaining a deep sense of

cultural integrity'. The serious issue of the paper, though, is not the detail of the course (which is made available), but the obligation on the rest of us to provide respect and recognition for students and graduates of the Program, and 'the need for professional organisations and service management and staff to take responsibility in their responses to Aboriginal mental health issues'.

Finally, Terri Elliott-Farrelly reviews the evidence on Aboriginal suicide in the context of the argument for an Aboriginal suicidology. Having considered facts and figures to do with both suicide and suicidal behaviours, she reviews risk factors, drawing on Colin Tatz's work as well as others in acknowledging those factors which may have special significance in Aboriginal suicide; 'a lack of a sense of purpose in life; a lack of publicly recognised role models and mentors outside of the sporting realm; the disintegration of the family and lack of meaningful support networks within the community; sexual assault; drug and alcohol misuse; animosity and jealousy evident in factionalism; the persistent cycle of grief due to the high number of deaths within many communities; and illiteracy, which results in exclusion and alienation'. She considers the cultural meaning of methods of suicide, and finally offers possible preventive strategies which may be culturally appropriate.

This issue of AeJAMH is at times not comfortable to read. It challenges us, and the writing of many of the authors gets through our defensive guard. Good.

Twenty

On Evaluation[70]

Earlier this month (May 2005) saw the two-day meeting of the National Advisory Council on Suicide Prevention in Canberra, and there are several issues worth noting. First, the new national website for suicide prevention (www.livingisforeveryone.com.au) was launched in Parliament House by Senator Christopher Pyne, Parliamentary Secretary for Health. The site is clearly linked with the national Suicide Prevention Strategy (LiFe: Living is For Everyone), and will become an electronic repository of everything to do with suicide and its prevention in Australia, including Council proceedings which will be published on the site, and details on all of the 170 programs funded under the strategy. Of course there will be links to relevant international sites, other national programs (for instance www.mindframe-media.info for journalists) and state-based programs in Australia. The site will be maintained by the AusEinet team (www.auseinet.com) who will ensure both high standards and up to date information. Keeping things up to date was a major issue of discussion at the Council with reference to the LiFe framework documents originally published in 2000 (Commonwealth Department of Health and Aged Care, 2000). Clearly there is a need for upgrading the information that underpins the strategy, and there was agreement that this should be undertaken.

A recurrent theme at Council was evaluation. Urbis Keys Young have been appointed to evaluate the overall LiFe strategy, and considerable discussion surrounded the kinds of questions that need to be answered. At one level, the questions relate to how we ensure that each funded program is evaluated. Some programs funded under the strategy (for instance MindMatters or AusEinet) are large enough to be able to fund

[70] First published 2005. Martin, G. (2005) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 4:1.
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comprehensive external evaluations, with expert evaluators who have provided a competitive tender to get the job. There is little doubt that these experts come with experience, a well-honed framework in which to embed the questions, and an ability to provide answers about process, impact, outcome and (important for us as tax-payers) value for money. It is already clear from the developmental stage of some of these evaluations that the information provided will play a clear role in guiding further development (and therefore will also guide further funding).
For other programs funded under the strategy, evaluation has been (or currently is) more of a struggle. The program may be smaller (and therefore the available finance for evaluation more limited), the program designers may have a conceptual or even an ethical struggle with the idea of evaluation, the pool of local expertise to develop and guide an evaluation is just not available, or more simply the questions asked are impossible to answer in the context of the program of interest. For a few programs there seem to have been difficulties with just how to go about the process of evaluation. This latter problem should be helped by two recent publications. The simplest guide to evaluation is *Evaluation: A Guide for Good Practice* (Commonwealth of Australia, 2001)[71]. Brief, written in a clear style, and well illustrated, this guide follows a simple stepwise framework which should allow easy discussion. A slightly more daunting guide is based on program logic, and developed by the Australian Institute for Primary Care (Mitchell & Lewis, 2003)[72] specifically for the programs funded under the LiFe strategy. I say daunting because, at first sight, it appears comprehensive (perhaps complex), and is full of diagrams and tables. In fact, it is written in a clear style, follows a very logical pathway, and once you get past the prejudice of having to read something about evaluation, it provides a very good framework in which to embed the questions you need answered.
I recommend the struggle. There may still be a need for a guiding hand or some support to enable local evaluations. But somehow we have to get there; we must gain a clear idea of how each and every one of the programs contributes to the overall strategy. After all, how can we advance mental health in this country unless our ideas and programs are both thoroughly evaluated and the results published, for everyone else to make up their own mind. One last point: if a program ends up not

[71] This guide can be downloaded from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-e-evalgde
[72] This guide can be downloaded from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-evalplan

working, or if (worse than that) it ends up causing some harm to an individual, a family or a community, then we need to know – if only to ensure that the same program does not get reinvented elsewhere.

There is one question about the whole National Suicide Prevention Strategy that at some stage must be answered, and that relates to the overall change in the number of suicides experienced in the last few years. When we first began 10 years ago the consensus was that the outcome of major interest was a reduction in rates of suicide. There was a hesitancy to put some percentage figure on this, because of the fear of a public backlash if the target was not reached. But many of us had in mind a reduction of about 20% suicides during the life of the first strategy. What was clear to the original Evaluation Working Group of the National Youth Suicide Prevention Strategy was that it would take some time for the impact of any program to lead to the outcome of a reduction in suicide rates. At that time we had many robust discussions around the proxy measures that might indicate possible future success, and of course there were indicators like fewer attempted suicides, or a lowering of the rates of suicidal thinking in various groups, or lower rates of depression.

However, we are now 10 years down the track and success appears to have occurred. The very high rates of suicide from the early to mid 1990s have now been reduced. Overall, for all ages, there is a reduction of around 25% in the number of suicides. For young people aged 15-24 years, the reduction from the highest rates of 1997 is a staggering 40% in round figures.

But now we have a serious problem. To what can we attribute the change? Are the evaluations we have at the program level good enough for us to have confidence that they have contributed to the overall change? What combination of programs provides the strongest evidence and the highest confidence in that evidence, to allow us to conclude that changes are due to the enormous efforts, and considerable costs, at the national and state level? Are there other factors in Australia, or in our world, that may have contributed to the reduction in suicide rates?

To give a couple of examples, in Australia for some time there have been relatively low rates of unemployment. Is it this, alone or in some combination with other factors, which has improved suicide rates? We have some evidence that war seems to reduce suicide rates at the country level. Has global terrorism in some way contributed to a lowering of the suicide rates in Australia?

At this stage we can only surmise.

But this is not good enough, and we have a fantastic opportunity to make sense of the debates that will rage around the impressive reduction in our suicide rates. We must gain the best knowledge, evidence and wisdom that we can. We must be able to state with confidence that a combination of factors x and y and programs a, b and c (if supported and funded in the long term) will maintain the tremendous progress that has occurred. We must be as clear as we can about value for money. And yes, I am fully aware we are talking about stemming the loss of human life, and not just some bean counting exercise! So this in part is the task taken on by Urbis Keys Young. They have to assist the Council to make sense of the result that we always wanted when we began 10 years ago. I don't envy them the responsibility. But I do hope that evaluators around the country will support the process, and collaborate to get the best understanding we can of what is a very complex set of issues.

Turning to this issue of AeJAMH[73], it is a delight to welcome back Lou Morrow (a founding editor and current Editorial Advisory Board member) with a typically pithy challenge around where our health services may be going. Masood Zanganeh, also a member of our Editorial Advisory Board, and editor of a sister online journal (www.ecommunity-journal.com/), explores the issue of suicide and gambling. David Webb reflects on the crucial place of spirituality in bridging the gap between the lived experience of suicidality and the academic and professional discipline of suicidology. Craig Murray and colleagues report on an internet- based study that identifies the salient characteristics of adolescent self-injurers. Chris Lennings thoroughly explores a novel approach to improving our ability to assess the risk of child abuse, with implications for our clinical practice. And finally, Janki Shankar provides a thought provoking piece on employment support for people with psychiatric disabilities. We hope that you enjoy this rich smorgasbord of issues toward the advancement of mental health.

[73] Papers from this issue of AeJAMH are accessible at http://amh.e-contentmanagement.com/archives/vol/4/issue/1/

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Twenty One

On Quality of Mental Health Care: Is Australia Getting it Wrong? [74]

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

We do try to address many of these issues. In our service we have had the good fortune to gain specific funding, for instance, to set up community outreach services for young people involved in the juvenile justice system (CYFOS); we have a clinical team working in Queensland's Youth Detention Centre; and we have a collaborative program with the Drug and Alcohol service (MHATODS). We provide good orientation programs for new staff, and regular staff update sessions – often with responsibility for organising the presentation sessions being taken by community teams themselves ('in teaching we learn'). We have ongoing focused therapy

[74] First published 2005. Martin, G. (2005) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 4:2.

training for various groups, and are planning update training courses in specific modalities such as Interpersonal Therapy. But I still have nagging questions about what actually does go on in the clinical consulting room. Of course we have clinical accountability. Regular supervision occurs with senior practitioners in the service, and some form of supervision is available in an ongoing manner for all staff. Even with new consultant psychiatrists, who theoretically have 'jumped through all the hoops' to become good safe practitioners, I provide 12-18 months of what we call 'transition to consultanthood' (ie mentoring) – which allows us to talk about clinical, interpersonal and administrative issues, and gives me both insight into the consultant, and some security in their ability to manage. In addition to supervision, we have an electronic record keeping system (which does occasionally provide feedback), and we have written notes. We have regular team discussions about both new and follow-up cases, and of course we have the Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA) and the Strengths and Difficulties Questionnaires (SDQ), and other scales to tell us about our outcomes. But I still have nagging questions about what actually does go on in the clinical consulting room.

Do we provide enough time, and in particular 'thinking time', for our clinicians? Are they accurate enough in the response to the sequence of minute issues brought up in sessions, voice inflections, body language, and other indicators of therapeutic alliance? In applying sometimes formulaic therapeutic interventions are they still able to assist the young client, and/or their family, to gain a sense of meaning? When we apply evidence-based practice to the consulting room and the individual case do we really get to the essence of solving clinical problems? What is the evidence for that? Are we really being effective and efficient if certain clients keep on coming back? This is a real question based on a real case.

Recently I did an internal review of a long-term case with a young person with a mix of intellectual, speech and conduct problems in the context of a separated mother with bipolar disorder, and a dysfunctional extended family. Several therapists had spent about two years each on the set of problems not to mention the inpatient admissions, the case review sessions, and the ongoing angst about the emerging diagnosis. The therapists had been caring and supportive to the family, and certainly responded to all the crises in an appropriate manner. But the case had been part of our service for 11 years. Is that an efficient use of time and very scarce resources? Had we actually achieved any change? By what yardstick do we measure these things?

As a service we have adopted the complexities of promotion, prevention and early intervention (PPEI) - we are 'early adopters'. We have allocated considerable resources to training clinicians in somewhat new ways of thinking, as well as setting up specific programs. As examples, we now have a very active (and prize winning) program for children of parents with mental illness (KOPING), a superb collaborative program for the families of young children with multiple problems (Future Families), and a wide range of regular education programs for professionals in the community (which attract large crowds). Like all clinicians, ours have bemoaned the new national direction in the Second Mental Health Strategy (Oh no, not something else we have no time to do! On top of everything else...!).

We now have a new opportunity for integration of some of the ideas about mental health promotion drawn from Public Health being applied in North Lakes, a new comprehensive suburb 35 minutes north of Brisbane. With new *recurrent* money to build a Child and Youth Mental Health Service from the ground up (alongside community health and adult mental health), we are being challenged to think through what we need to consider in building the very best service we can. We are using the PPEI framework and, in a series of workshops with broad representation from services and the community, looking at the kinds of collaboration we will need to ensure we can both manage the preventive frame (from Universal through Selective to Indicated approaches) as well as the pressure of clinical work in what will become a catchment of 150,000 people with a wide range of socio-economic backgrounds. And, of course, we *must* make it sustainable. I am not yet sure what we will end up with, but even with my long-term commitment to PPEI, I will continue to have to ask all of those difficult clinical questions.

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

previous service because they were disaffected with the apparent daily clinical overload, we may well be in trouble.
So this brings me to the issue of quality and some of the pitfalls that may be emerging in Australia. There are more than rumours that the length of nurse training may be reduced in universities to increase the numbers of available nurses and replenish the obvious need in our hospitals and the community. At one level you can see the logic, but does shorter training by implication mean that these people will come with fewer skills, and less experience? There is also more than just talk that the current graduate medical degrees may be shortened to a two-year graduate degree. Again you can see the logic given Australia is currently so short of primary care and specialist doctors. But does less training, and less time to reflect on a professional career, less time to weed out those who perhaps should not be practicing in one of the helping professions, mean that we get professionals who are less effective, less efficient, and more prone to give up under the sometimes intense pressures with which we all at times have to struggle. Leaving aside some of the current debates about professional incompetence (as if we can leave them aside with all the international media coverage) what is it about training that might protect professionals from burnout?
Personally, I believe it is something to do with quality of training, the building of commitment and a passion for what it is that we do, a thorough knowledge of what it means to be ethical, and learning how to be both effective and efficient. Sometimes surviving a lengthy and somewhat arduous training is important to the quality of the end result.
Which brings me to the final area I want to discuss. I have recently had the privilege to bring together a Consortium to complete an application for the proposed National Youth Mental Health Foundation (I am sure we are one of many groups to tender). Again this is a fantastic opportunity to address issues to do with literacy in young people and access for those young people with mental health problems. It is a fantastic opportunity to provide training to general practitioners, and allied health professionals who may have the opportunity to work in primary care with GPs. It is also an opportunity to consider carefully the models that can be promoted, improved, or developed as initiatives to improve service access for young people. And the stated framework is one of PPEI! Hurrah!
But there are some questions emerging for me about the program. It is three and a half years of funding, and therefore whoever gains the large grant will have the enormous task of building sustainability into the Foundation and its programs. Another issue is that there are already

many groups – State and Territory-based as well as national – whose work already impinges on the area. Somehow all of these groups will have to be drawn together – a 'joining of the dots' I have heard it called. But the question in mind is about quality.

The pointy end of this whole process is that young people deserve the very best of care that can be made available, which includes the quality of engagement, the optimum development of a therapeutic alliance, and the ability to do effective, efficient and meaningful therapy to solve the problems presented by the young person. I have been a general practitioner, and we have recently been working with general practitioners to provide an audit of their ability to recognise mental health problems. What emerged from this process was the tremendous pressure that GPs are under to provide a rapid throughput of casework. We are asking a lot of GPs, even those committed to mental health issues who have trained through the Better Outcomes in Mental Health Care program, to expect that they will be able to make time to do a quality job. And coming back to my repeated question, how will we be able to assess just what occurs in the consulting room?

I wish the successful tenderers every success in developing this massive venture. The challenge may be to develop the quality of general practice mental health care and allied health care within primary care, or the quality of care in some innovative youth access programs. But we still must continue to improve access to care in dedicated mental health services and ensure that the professionals there are able to deal with the most serious of mental health issues in a timely, effective and efficient way because they are experienced, well trained and well supervised. The focus of the exercise really is the whole system and its quality.

Which brings me finally to this issue of AeJAMH[75], where it will be abundantly clear that we do have some high quality articles. We have two thoughtful guest editorials which record the changes occurring in our mental health system. Lynne Freidli reflects on the launch of the UK National Framework for Improving Mental Health and Well-being. She notes that 'tackling discrimination and social exclusion have received a stronger focus than promoting mental health' thus far in England, and that this fine focus may have stopped the wider lens view of what factors in a society may be toxic to mental health and well-being. There are high hopes that there will be a refocusing on 'how we live', and its

[75] All of the papers in this issue can be accessed at http://amh.e-contentmanagement.com/archives/vol/4/issue/2/

impact on 'care of children, care of the self and social relationships'. Jennie Parham reflects on the recent Dublin conference '*Mental Health Promotion: Going from Strength to Strength'*, and her discussions with colleagues in the UK, who believe that Australia may be 10 years ahead in the development of preventive activity in mental health. Jennie rightly asks why we in Australia may not feel that this is so. After reviewing the current status in Europe, and then in Australia, she examines the 'report card' for Australia against a recent WHO framework document, noting that the complexity of our federation makes for difficulty in the translation of national policy into practice, concluding that considerable effort is still necessary to maintain the momentum we have with regard to mental health and its promotion against the pressure of the need for clinical service.

Two articles (Reid et al. and Maybery et al.) address the two sides of the care coin. Darryl Maybery and colleagues' research on children of parents with a mental illness, reminds us of the need to develop and improve support and coping mechanisms such as 'problem focused coping, developing adaptive cognitive styles, fostering social skills with peers and siblings'. However the children in the research also provide us with a challenge - to enhance the natural supports of the child; that is the peer group, especially in times of crisis when a parent is newly ill. Joanne Reid and colleagues report on 'the other side of the coin' in a timely, challenging article based on phenomenological research on the needs of parents of adult children with mental illness. In recent years, we have heard so much about the children of parents with mental illness, that this is a refreshing reminder of a contrasting area of need. In focusing on psychoeducation, they address educational needs, barriers to accessing information and support, and other unmet carer needs, including the need for managing stress and emotional needs. My own experience is of being bailed up after Rotary forums where desperate parents frequently bewail a system of pseudo-privacy which attempts to lock them out of the information system while expecting them to provide ongoing support and care. This paper is a timely reminder to think again.

Janice Chesters and colleagues explore the perspectives of fifteen residents on a supported housing program for people recovering from low prevalence mental health disorders, and address the importance of such accommodation in the community. The semi-structured interviews provide a sometimes poignant richness of comment. Overall, supported accommodation provides a treatment and living place, but more than that

a venue in which to put together the right ingredients to help facilitate recovery.

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

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

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

Twenty Two

On Uniqueness[76]

‘Always remember that you are absolutely unique. Just like everyone else’.

(Margaret Mead, 1901-78, Anthropologist)

This pithy quote addresses a number of issues occurring in Australia at the present, as well as several issues brought up in this issue of our journal. As we approach the end of this year, the world remains in turmoil, the war in Iraq seems to be going on and on despite recent democratic elections, terrorism continues despite best efforts to curb it, AIDS remains a scourge (for instance affecting 1 in 8 people in South Africa) and leaving millions of children to fend for themselves, and it is hard to grapple with these global issues without feeling some anxiety for the human race.

Closer to home, we struggle with many large-scale issues, and terrorism is never far from the front pages of our newspapers. Recent race based riots have shocked us, many of our most prominent business men have been shown to have clay feet, public services have been the subject of review after review, and now we are told that mental health services are under increasing pressure, with costs for antidepressants skyrocketing. Despite the challenge of a Commonwealth Games which promise to bring us together as a nation once again (doesn’t sport always seem to have this ability?), we are increasingly fearful for our way of life as Australians. There is a sense of pressure in the system, which seems to centre around our inability to meet the needs of large numbers of people. And yet when you work with an individual patient or client or when you discuss in a ward round the work being done with an individual, there is usually a sense of optimism that improvements can be made. Globally it feels like

[76] First published 2005. Martin, G. (2005) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 4:3.

we may be defeated in our ability to sustain services, yet individually there are few times when we are clinically pessimistic.

To my mind it seems like many other issues have similarities. Take the race riots. The impression from what can be gleaned from media is that the problems emerged from group misunderstanding and anger. My bet would be that one on one, the young people concerned could be brought to understand their differences and perhaps work together. One on one we recognise and take pleasure in the other person's unique background, personality and skills. In a group we lose sight of the uniqueness, and labelling glosses over all those things we might attempt to recognise and take pleasure in.

Similar strands emerge at this time of year with families getting together for celebration. At this time I have just moved into a newly renovated house, and we have 6 or 7 different groups of tradesmen all working at the finishing touches. I have been listening to what they have been saying about the forthcoming holidays and the family get togethers. The story is similar for each of them, no matter the trade; they look forward with a mixture of anticipation and dread. When they talk about an individual relative (say, a grown up child), they often brag about the exploits or the successes, glowing with pride. When they discuss the Christmas lunch (attended by all of these much loved individuals), they often groan with anticipation at the well-worn arguments that will likely appear, or the old feuds that never can be stopped. When the group gets together, we lose sight of the uniqueness of the individuals forming the group.

Many have addressed these issues in much more depth, and much more eloquently. I am sure there is a solid body of literature that explores all of the issues. But the points I want to make at this time are fairly simple. With all the global furore going on, don't forget that we still live in 'the lucky country' – this 'wide brown land' is unique. With all of the troubles at all levels in systems in Australia, never lose sight of the fact that your work with individuals needs to be the best that you can manage – after all they need you to work with their unique contexts, personalities, problems, and possibilities for the future. And at this time of getting together with family members try to hold onto your own uniqueness, and maintain your sense of their uniqueness, even if the whole family together gets overwhelming. Relax, stay safe, and return fully energised for 2006. There is a lot to be achieved - individually, service wide, countrywide.

In our first guest editorial for this issue of AeJAMH[77], Abe Ata and Glenn Morrison suggest that it is time for us to come to terms with multiculturalism and what this might mean for mental health services. They suggest that if we are to formulate culturally appropriate treatment plans, then this necessitates adjusting perception and awareness to different cultural and religious values. Using bereavement as a central idea, they explore the range of emotion that can be presented in different cultures, noting that what may appear to us in the west to be illness, may in another culture not be construed as such. They conclude that we must step outside our usual expectations and develop 'a sense of otherness', not just allowing ourselves to become exposed to the different forms of expressions of feelings and behaviour, but to accept a wider range of meaning attached to them.

Helen Glover, in her guest editorial, examines recovery as a construct and asks the question whether mental health services are ready to adopt the ideas inherent in a recovery orientation. She challenges our self-importance as professional organisations, noting that some people recover in spite of what we do. In everything we do, it is the individual's resources that are important and our job is not so much to treat (from the perspective of the expert), but to support people to utilise their own resource base, find meaning in their illness and take personal responsibility for their recovery.

Vicki Cowling and colleagues describe an 'opportunistic and effective multi-systemic collaboration' for a Disruptive Behaviours project with a central focus on how schools manage these problem children. Schools appear not to be well resourced in this regard, and a clear need was demonstrated for the information strategy and capacity building approach used. The seminar program, using pooled information provided an impetus for development of a shared framework and language between mental health and school personnel.

Karen Graham and Robert King report on an exploratory study within the general area of the needs of children of parents who have mental illness. In a context of a literature suggesting the difficulties that mothers with schizophrenia have in separating their own needs from the needs of their child, the focus is on how the illness might affect attachment between a mother and a young child, in particular during the potentially stressful, everyday attachment experience of the child's bedtime. The paper focuses on a very small sample, but uses an in-depth qualitative

[77] All of the papers in this issue of AeJAMH can be accessed at http://amh.e-contentmanagement.com/archives/vol/4/issue/3/

approach alongside a novel use of the parental bonding instrument to suggest a working methodology for future studies in this complex area of attachment.

The paper by Mubarak explores quality of life of people with schizophrenia living in the northern region of Malaysia, and provides us with a window onto some of the problems existing elsewhere in our region. A careful clinical survey demonstrates the struggles that occur in the areas of social functioning and quality of home environment and how deficits are significantly associated with low quality of life. The results of the study suggest that Malaysia has achieved a satisfactory level of progress in reducing severity of psychotic symptoms for the majority of people with schizophrenia through community services, but at some cost to families.

In the delightfully refreshing paper by Yasaman Mottaghipour and Annemaree Bickerton, we are reminded of the need to keep therapy consistent with what families both want and need. Within a hierarchy of needs framework for the family of a patient with severe mental illness, the authors argue that engagement, and communication of basic information, must be accomplished before moving up the hierarchy toward more complex intervention, and that each of the different levels are negotiated depending on the complexity of the situation and the family's readiness and need to progress to the next level. The model presented is both practically useful and easy to teach and guides the adult mental health worker in involving families in their everyday practice.

Finally we present you with a major supplement on help-seeking in young people, prepared by Deborah Rickwood, Frank Deane, Coralie Wilson, and Joseph Ciarrochi. This team has explored this issue over many years, and now has a major international reputation for their work and for their insights into why young people do or do not seek help, and what we can do to improve help-seeking. Not only is this a thorough review of the area, but it also explores future directions for research and practice.

Twenty Three

On Caring[78]

The renewed focus on Mental Health in Australia through the discussions at the Council of Australian Governments (COAG) is to be applauded. The promise of $1.9 billion in new funds from the Australian Government, with the expectation of matched funding from the States and Territories, will go a long way to solve many of the resource issues which have plagued mental health services since the first Mental Health Strategy. With the explicit focus on PPEI - promotion of emotional wellbeing, prevention of mental illness and early intervention - this is also an opportune time for us to develop coherent strategies in prevention to stem the ever-increasing burden of mental health problems.

My hope is that the funding will be used specifically to enhance core clinical services, and not used to seek any more supposed alternative methods of addressing the problems – which have so often been based on flimsy evidence or the wishful thinking of transitory employees of health bureaucracies. In other words we need to focus firmly on enhancing existing services which have been so starved of funds, and not forever look outward, away from existing services in the vain hope we can find (or perhaps train up) some other group to meet the shortfalls in service delivery.

Let me give you an example of how the poor resources led to apparently sound decisions that, in turn, led to new problems demanding solution. As the funding contracted (against the ever burgeoning demand for clinical services), managers had to take decisions (rightly) to focus resources on those with 'serious and complex' needs. This is eminently defensible. With many services, what this meant was that to get in (as a patient) you either needed to be acutely ill, or you needed to have a clear cut diagnosis of a serious mental illness (for instance 5 out of 9 of the symptoms of clinical major depression). In turn, not only have we

[78] First published 2006. Martin, G. (2006) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 5:1.

provided endless frustrations for consumers trying to get a service, but we have also had to repeatedly frustrate those trying to refer to mental health services. What do you say to someone who has four symptoms of major depression and therefore does not meet the entry requirements? "I'm sorry, please go and get another symptom and then we can treat you!" The frustrations have not just existed for those trying to get a service; they have also been immense for those in clinical services who could see that an ounce of prevention would have been worth a pound of cure, and that treating someone with four symptoms might stop them gaining five.

I have argued elsewhere that if you want the best of prevention in mental health then, as with prevention in other areas of medicine, you need to use (and further develop) the knowledge and expertise of the professionals who understand the trajectories of disorders, and have the passion to continue to work in mental health services even against the odds. Early intervention (primary prevention and early secondary prevention which may include some selective prevention and the majority of indicated prevention) is comparatively easy for those with clinical experience and expertise, as long as they have the time, energy and permission to take on the challenges. Rehabilitation (late secondary prevention and tertiary prevention) is also relatively easy for experienced mental health professionals – again, as long as they have the time, energy and permission to take on the challenges. You do not need some new breed of preventive health professional; you need to make sure that those with a passion for mental health are not overwhelmed by the number, acuity, and severity of the cases they are obliged to see day in, day out.

There may be an exception to this argument, and that is in the area of Mental Health Promotion. I have a firm belief that mental health promotion can be done in the consulting room with individual patients: "OK, it looks to me like we have got your symptoms and illness under control, now let's take a look at all of those lifestyle factors that could have an impact on whether you get a recurrence in the future". I also have a firm belief that mental health promotion is an activity for individuals. A father taking his 4 year old son down to the park for a game of footy can be promoting health. A mother stroking, patting, and talking to her unborn child through her pregnant tummy is promoting the attachment relationship, the basis of all human mental health. A teacher helping a child in class is promoting skills and attitudes that build every day toward resilience, that ephemeral grail of mental health promotion.

However, I can understand when Mental Health Promotion is also seen as a Universal preventive activity, and when arguments are made for it to be within the duty statements of Public Health or Population Health as professions. It certainly makes good sense to think in terms of large-scale population-wide education programs to improve aspects of the mental wellbeing of the Australian population. My own view would be that the partnership between public health professionals and mental health professionals (the mix of large scale technologies with the passion drawn from having worked extensively in the field) will provide the most sensible and effective solutions. We may ultimately see a new profession of population mental health emerge, but at this time we need to ensure that current mental health professionals have the conceptual frame and training to ensure they are able to consider developing mental health promotion in the context of their daily clinical lives, and then provide them with time, energy and permission to allow them to take on the challenges.

With the opportunities, of course, come obligations. And this brings me to the title of this editorial, which may not be comfortable for some to think about. Increasingly I hear stories in health circles about the level of care, and the quality of caring, provided to our patients. Much seems to centre around whether an illness or problem is self-induced. So recently I heard several stories about fat people in hospital. One story was that nursing staff, without any discussion, unilaterally ordered a weight reducing diet from the hospital kitchen, and arranged to place a patient on Optifast - a complete, weight reducing, food. This was not in the context of a carefully planned strategy to continue after discharge, just the whim of a prejudiced professional. When the patient complained, first the nurse ridiculed them, and then attacked them for not doing better with their weight. Underlying the situation was the belief of the nurse that the patient was fat, lazy and stupid, and deserved to be fixed; that the obesity was self-inflicted. Whatever the truth of the situation, the attitude is based on stigma.

A second story is about a group of elderly people in a hospital who got infective diarrhoea. The burden on staff was considerably increased, and tensions arose with relatives who were naturally worried about their kin. Placed on water to allow the infection to run its course, the elderly people felt they were being starved. Complaints led to ridicule, and an unwarranted extension of the fluids-only regime. The underlying attitude seemed to be based in a belief of some staff that the elderly people would be better put out of their misery, and that the gastroenteritis provided an

opportunity to assist. Again there is stigma here, and considerable lack of care.

A third example is unfortunately all too common. A young woman was presented to an emergency department of a hospital with an overdose that she had believed would be fatal. The staff assessed the lethality and time since ingestion, put a drip into a vein, and left her on a barouche in a corner for several hours until she could be discharged. Regular observations were done, but no-one took the time to try to understand the issues, provide comfort or suggest solutions. There was a disdain for the young woman's problems in the actions of the staff. They rated her as not serious about suicide, as 'wasting their time', and as not worthy of further exploration. I have heard worse stories around people who self-injure. Not only are they reviled and rejected as time wasters, not only do staff jump to the conclusions that they are 'borderline personality disordered' on little evidence, but they are often brutalised further by being stitched up without anaesthetic. Just what you need when your background history may have been of extensive physical abuse.

A final example will suffice. A colleague recently told me about a series of suicides which had occurred – all within the first 2-3 weeks after hospitalisation; a time of great danger for those with serious mental illness on the way to recovery. Somehow, many of the patients had not been followed up by mental health professionals, to make sure everything was going well. Somehow, communications to the GPs and to other community health supports had just not got through. And somehow, people in a fragile transition phase had been left to get on with their lives alone.

All of these examples are to do with caring, that quality of professional life that should be central to what we do. A very strong argument could be put forward that because our resources in health services across the country have been decimated, because we are all working harder than we have ever done before, because the quality of casework is harder and more complex than ever before, because we all have more paperwork to complete than ever before, we don't have time to care. I sympathise with those who put such arguments forward, but that does not make them right. I think there are other elements also contributing to this style of working. 'Case management' to my mind has been a very dangerous way of trying to organise our professional lives under pressure. It seems to me that care has become fragmented, that there are lots of people involved in a program of care or a management plan. The case manager spends a lot of time running around coordinating everyone, but no one person is doing the therapy, the listening to the patient, the caring.

Another element relates to the forms of therapy that have emerged as evidence-based over the last few years. They are largely short term, often manualised, and sometimes mechanistic. They are about the tasks to be completed, not about the human being struggling to complete the tasks, but also struggling to make some meaning of their lives. I have recently heard a story from a young woman who ended up leaving a group for Dialectical Behaviour Therapy, because 'all the therapist did was to read from the manual in her lap'.

Well, now is the time for us to consider a radical change in direction. If the whole process of COAG is not just smoke and mirrors, and if the new funding genuinely comes through to mental health services, we may have sufficient resources to train our personnel better, supervise them more often and, with more time available, support them in the very hard tasks they are expected to perform. They may have time left over from direct casework to consider what they are doing clinically, or what they have achieved. More than that they may have the time to consider developing skills in early intervention, prevention, or mental health promotion, and time to apply them during the working week. Through all of this we have to make sure that our staff recover their ability to care, and not just see the patients they work with as throughput toward some sort of output.

And so to this issue of AeJAMH[79], another extraordinary achievement. Our guest editorial this issue comes from Denmark with Eva Jané-Llopis, from the World Health Organization mental health program, making several strong points. In reviewing the literature she suggests that the evidence of the effectiveness of mental health promotion is good; however there is an evidence-dissemination gap that must be resolved. Even then, training programs, and the political will to fund programs, will be needed to put the evidence into large-scale practice.

Annette Beautrais, from the Canterbury Suicide Project in New Zealand is one of the foremost international researchers and authorities on suicide prevention. She reviews the idea of national strategies, noting that the unique profile of suicide in each country tends to shape its national suicide prevention strategy, despite a common international evidence base. She examines areas of action for which we have strong evidence of effectiveness, and in a challenging conclusion, somewhat against Rose's theorem and current community based approaches, argues strongly that we should continue to focus our efforts on those clinically at high risk.

[79] All of the papers from this issue may be accessed at http://amh.e-contentmanagement.com/archives/vol/5/issue/1/

In a welcome and really useful re-evaluation of psychotherapeutic approaches in psychosis, Richard Lakeman from Townsville, in an excellent overview of current approaches, argues that health professionals involved in the care of people with psychosis ought to interact in a psychotherapeutic manner and further develop psychotherapeutic skill. Taking an eminently rational approach but well grounded in the available literature he argues that, in utilizing psychotherapy, we must understand the client's current capacity, carefully match the interventions, and overall enhance coping skill.
The paper on building resilience in young people by Kylie Oliver and colleagues suggests that meaningful participation is a key to resilience because it can enhance a young person's sense of connectedness, belonging and valued participation, and thereby impact on mental health and well-being. The paper draws on 10 years of experience with the Reach Out! Program (auspiced by Inspire Foundation), particularly focusing on the Youth Ambassador program. In concluding, the authors argue that the program meets all elements of a resilience building program in developing interpersonal and communication skills, increasing young volunteers' confidence, self- esteem, and self- efficacy, encouraging connections to other young people and adults in the community, and fostering caring and compassion.
Karla Hayman-White and colleagues from The University of Melbourne remind us that the current proportion of health expenditure afforded to mental health is not comparable to the prevalence of mental illness or the related burden of disease, and this makes it almost impossible for us to match the quality of care available to people experiencing a mental illness to those suffering physical illness. Having explored the facts regarding costs in some detail, they argue cogently that this represents discrimination, and conclude that it may be the mental health nursing workforce who could act to redress the balance.
Tricia Nagel, a Northern Territory psychiatrist, argues for relapse prevention strategies in the context of remote indigenous mental health service delivery challenges of isolation, staff recruitment and retention, and cultural, language and literacy issues. From a telephone survey of service providers she explores training, ability and confidence, and concludes that both policy- related strategies and community-level activities are needed to provide a template for best practice in relapse prevention.
In a literature review exploring the links between domestic violence and suicidal ideation in women, Marika Guggisberg from Perth notes that

women who have been abused by their intimate partners are almost four times more likely to have suicidal ideation and are also more likely to develop mental illness compared to non-abused women, and that domestic violence is more damaging than street violence. In conclusion, it appears that historically rooted victim-blaming attitudes may still exist in society and in health professionals, and these established prejudicial attitudes may increase the risk of abused women becoming suicidal.

In a paper on the impact of the attitudes of professionals in a position of authority on the mental health in others, Rob Donovan and colleagues, from Curtin University in Perth, report on a fascinating piece of large-scale telephone interview based research. They note that within the sample there may be different pairings of authority, but that 'providing stimulation' and 'positive reinforcement' were the top two behaviours for ensuring the mental health of those in their care. There are admitted limitations in this predominantly qualitative research, yet the authors are able to conclude that the data do identify areas where awareness and understanding need to be increased to facilitate an increase in behaviours that support good mental health and decrease behaviours that negatively impact on mental health.

In the final paper of this very rich edition of AeJAMH, Robert King and colleagues from the University of Queensland describe in detail the development and evaluation of a Clinician Suicide Risk Assessment Checklist, specifically aimed at assessing the effectiveness of risk assessment training programs, and a possible accreditation process. With only a small number of expert raters to test the questionnaire, there is still further work to be done to validate and test the reliability, but the authors conclude that preliminary results indicate that the questionnaire advances the evaluation of risk assessment competency and provides a basis for further development.

Twenty Four

On Disadvantage[80]

As a clinician I am often confronted by disadvantage. Mary is a good example; a 14 year old from a rural background who gets admitted to our Adolescent Unit repeatedly when she overdoses, or following an episode of cutting. She is the oldest of five children to three of mother's partners. Her own father hanged himself in the bathroom and was found by Mary when she was five years old. Since then, for one reason and another, she has had a difficult relationship with her mother and eventually was placed in care at about 11, which led to a cycle of running away, living on the streets, committing various minor acts of vandalism and theft, being picked up by the police and returned to a new foster placement. Over recent months, behaviours have escalated with episodes of prostitution, a number of people being physically abused and cars being stolen for a joy ride.

Despite being of above average intelligence, and very verbal (if poorly educated), Mary is difficult to engage toward making any sort of supportive and therapeutic relationship. She does not trust easily, is often difficult, provocative and rude, and you just think you are making progress when some small thing goes wrong and it is all blamed on you. Of course with a highly traumatised background, and a variable emotional state, she has been labelled with many diagnoses and personality problems, the latest being that ragbag of psychiatry 'borderline personality disorder'. Of course the real problems are in the trajectory of her life, the lack of secure attachment, the recurrent traumas, and the need for a young person to attempt prematurely to survive on their own. I state the problem as survival, because I have a certain admiration for Mary. She is a survivor, even though at times she does place herself in the way of serious potential dangers. She has an admirable determination to remain autonomous (despite the fact that this often blocks her from

[80] First published 2006. Martin, G. (2006) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 5:2.

accepting help and support), along with a set of attitudes, knowledge and strengths that allow her not just to live on the streets, but actually thrive on the streets. Many of her life choices are uncomfortable to hear about, and may have long-term adverse consequences. You wish there were other ways to survive, that she would accept one supportive foster carer, that she could find just one trustworthy life guide to help her get back on track. But for the time being you have to just hope she lives long enough to find some new ways; if she does she will be one tough woman. As many of you would recognise, at this point in the game, even taking a strengths-based perspective, it is very hard to intervene. Through the course of her life you can see so many times earlier on when intervention may have been possible. But, then the cards were stacked against her very early on. Poverty, living in a rural community, poor family education, a predominantly single parent family, repeated family traumas, multiple episodes of abuse, frequent changes of school, and then four years of being in and out of the welfare system. Given who we are, and what we do, we keep on trying to do the best we can, when we are allowed.

This brings me to a very interesting new report from the National Centre for Social and Economic Modelling (NATSEM) based at University of Canberra. Poverty and Disadvantage Among Australian Children: A Spatial Perspective, presented at the 29th General Conference of the International Association for Research in Income and Wealth, Joensuu, Finland (20-26 August 2006)[81]. What Ann Harding and her group have done is to take 2001 Australian census microdata (Australian Bureau of Statistics) focussed on well-being and disadvantage from the child's perspective. They developed a composite index of child social exclusion at the small area level and then analysed the regional differences for risk – with some stunning results. In developing the index for social exclusion they drew on international research that identifies four dimensions of social exclusion – consumption (the capacity to purchase), production (labour force status and occupation), involvement in local and national politics and organisations (social capital and educational attainment), and social interaction and family support. The actual measures that NATSEM used are Income, Family Type, Education in family, Occupation in family, Housing tenure, Parents speaking English at home, Labour force status of parents, Personal computer usage, Motor vehicle ownership - and together these contribute about 52% of the

[81] Report available for download from http://www.natsem.canberra.edu.au/publications/?publication=poverty-and-disadvantage-among-australian-children-a-spatial-perspective

variance of the social exclusion index. The point that Harding and her group make is that this gives a much more comprehensive understanding of disadvantage than just poverty on its own.

What emerges is a rather stunning map of child social exclusion in Australia – clearly evident in some suburbs of all of our cities (page 17 of the report). Overall, as expected perhaps, capital cities do better than the remainder of states and territories (that is other towns, and rural and remote areas), and some states and territories can be shown to be doing very well compared with others. So, small percentages of the child population appear in the overall bottom social exclusion (high disadvantage) decile for Australian Capital Territory (0%), Victoria (2.1%), New South Wales (5.3%), and Western Australia (5.7%) compared with high percentages for South Australia (17.6%), Queensland (25.1%) and Tasmania (36.3%). Conversely, looking at the highest decile (low disadvantage) there is a continuation of the story. High percentages appear for ACT (24.3%), NSW (13.3%) and Victoria (11.0%), and lower percentages for South Australia (5.8%), WA (6.4%), Queensland (6.7%) and Tasmania (0%). In summary, ACT, Victoria and NSW contribute disproportionately to the highest decile (low disadvantage); South Australia, Queensland and Tasmania contribute disproportionately to the lowest decile (high disadvantage). Of interest in these latter three states, although less than 3 per cent of all Australian children live in Tasmania, 9.2 per cent of all those children are in the bottom child social exclusion decile. Similarly while 20 per cent of all Australian children aged 0 to 15 live in Queensland, almost 49 per cent of all those children are in the group at greatest disadvantage.

Where does this lead us? Well, if we return to Mary's story, it is unlikely that she has a genetic loading for mental illness as such. She is very much the victim of social disadvantage. If we want to change the story, that is reduce the numbers of people with similar struggles to those of Mary, it will be too little too late, and too difficult, if we only consider what is necessary in terms of sufficiently resourced mental health services. We must begin to think strategically as to where to place resources for family life, early childhood programs and education, and translate the excellent NATSEM report into relevant action. Within this it is clear that South Australia, Queensland, and Tasmania have considerable room for improvement for those 0-15 year olds at major disadvantage and likely to swell the referrals to mental health services in due course. Once again we have evidence that shouts out to us the need for the promotion of mental health, and relevant early intervention. In moving to action, we must continue to focus on resilience building and connectedness (Oh,

those old things) and have the courage of our convictions in promoting what we know is needed to enhance attachment, parenting skills and supports for family life. In addition, we must have the resources and collaborative partnerships to be able to intervene much earlier at strategic points along the early life pathway. Two things I have not addressed, which are discussed further in the report, are the obvious fact that large numbers of our indigenous peoples live in what are areas of highest social exclusion. And also, there is the intriguing fact that English not being the primary language spoken at home (one of the items in the NATSEM composite index) may contribute to disadvantage.
This, of course, is relevant to the topic of this issue of the journal[82]. My point is that we are disrespectful of anyone outside a particular frame, and like many of the papers in this issue, I am calling for change at a wide level to move toward true multiculturalism.
We owe a considerable debt of gratitude to Nicholas Procter from the University of South Australia for acting as Guest Editor for this multicultural mental health special issue of AeJAMH; he has worked tirelessly to draw together the papers, assisting our editor Anne O'Hanlon to produce what is an immensely important issue. In his editorial, Nicholas reminds us forcefully of the complexities of immigration to Australia, problems in our detention system which so often lead to adverse outcomes, and difficulties faced by mental health systems in becoming truly culturally competent. The messages are strong in that we must learn to recognise and value diversity. More than that, both as individuals and as parts of systems, we need respect for what those from different backgrounds may teach us about life and how to live it.
There are two other guest editorials. Meg Griffiths from Multicultural Mental Health Australia, comments on mainstreaming, and the complexities of building capacity and partnerships to meet the policy rhetoric. MMHA provides information and training to both multicultural consumers and carers on the one hand, and mainstream professionals on the other, often working in partnership with the wide range of government and non-government organisations in the field.
Leslie Swartz, from South Africa, discusses the move toward multilingualism at Stellenbosch University. She describes deep suspicions that may arise in native speakers when academics begin to reach out and learn languages such as Xhosa. Even with experience, it is still easy for misunderstandings to occur. Goodwill

[82] Papers from this issue of the AeJAMH journal can be accessed at http://amh.e-contentmanagement.com/archives/vol/5/issue/2/multicultural-mental-health

alone, it is suggested, is unlikely to be accepted simply for what it is. Some lessons for multiculturally sensitive work in Australia are clear.
The first of our papers for this issue is reproduced with permission from 'Medicine Today'. Jill Benson, a general practitioner, drawing on her work with both migrants and aboriginal people, describes implications of three key issues necessary for cultural sensitivity – an appreciation of our own ethnocentrism, the consumer or carer's need for health literacy, and transcultural perceptions of illness. Having admitted that it impossible for any one of us to grasp the nuances of all cultures, Jill describes a culturally aware approach with roots in narrative, solution focussed, and 'one down' approaches, where the clinician begins any interview by seeing the 'clients as experts' in what they know and want.
In a fascinating account of Somali women living in New Zealand, Pauline Guerin form the University of South Australia, and her colleagues, describe how weddings, parties and ritual can contribute to mental wellbeing, and therefore be of importance in protecting migrants from trauma based illnesses. The authors argue that professionals taking an active part in supporting such events, as well as supporting refugees more generally in their resettlement, is an investment for everyone.
Melinda Redmond and her colleagues from Curtin University describe an important piece of research focused on the understanding of depression across cultures. Using an open-ended questionnaire approach with 11 international experts, they derive insights from a three-phase consensus Delphi approach. From a very careful and thoughtful piece of work it emerges that there are clearly symptoms of unipolar depression which are truly transcultural. In contrast there are aspects that are culture related, and it would appear that we still have a long way to go before we understand these culture-derived aspects, and the complexity of making meaningful comparisons of depression across cultures.
Rita Prasad-Ildes and Elvia Ramirez from the Queensland Transcultural Mental Health Centre describe a consultation process with a broad cross-section of culturally and linguistically diverse consumers, reporting what was is of importance to them from a mental illness prevention approach. Not surprisingly, an improvement in the understanding of mental illness amongst family, friends and colleagues was of major importance, and this related to stigma and its possible reduction. However, in this remarkably rich read, an enormous number of other issues are discussed and reported in the words of particular individuals from various ethnic groups.
In counterpoint, Rosanna Rooney from Curtin University, and colleagues, examine perceptions of carers from culturally and linguistically diverse

(CALD) backgrounds regarding their conceptualisations of mental illness, stress and support, stigma, and pathways to seeking help. Again, perhaps, only some of the issues that emerge are surprising, in that they are similar to those that might be complained of by other Australians - lack of involvement in the treatment process, insufficient communication from health professionals, lack of understanding about mental illness, lack of support, and so on. However, in addition, there were other more specific obstacles echoing prior research - language barriers, a lack of knowledge about service availability, and the incongruence between their culture and that of mainstream culture.

Pauline McLoughlin from the University of Adelaide returns to one of the themes raised by Nicholas Procter's editorial: Australia's inhumane approach to asylum seekers in our immigration detention centres. The author argues that effective mental health promotion efforts are likely to be bound to the setting, in itself a profoundly negative barrier to emotional wellbeing. Detained asylum seekers, marginalised and excluded, then have to suffer the prolonged experience of what is often a punitive system. In a carefully argued and well referenced paper, McLoughlin concludes, in part, that the efforts of externally-acting advocates and community groups represent the only force as yet significantly capable of overcoming the obstacles. There is clearly much work to be done at multiple levels.

In the final paper of what is a rich overview of current transcultural thinking and activity, Ruth DeSouza from the Auckland University of Technology explores the efforts being made for improvement in the mental health of Asian people in New Zealand, in a context where one in five New Zealanders are migrants. A major issue explored is that migrants to New Zealand may be caught up in the current dissonance between the colonial ideal of a homogenous society, and the desire of Maori people for recognition as people of the land, with specific rights. The author ends a very instructive paper on an optimistic note - that while there are still challenges in the operationalisation of how mental health services ensure they are responsive in both policy and practice for 'migrants, refugees and Asians', progress is being made.

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Twenty Five

On Suicide and Subcultures[83]

A recent group of suicides in young people has caused grief in a number of specific schools, a fear of further suicides in the local school community in general, concern in the community as a whole, and questions and some soul searching in the media.

The story thus far is that one young person died about a year ago. Some connections can be traced to a second person who killed themself more recently, and a further suicide from the same school occurred shortly after this. Within two weeks a young person from another school died and a very short time after this, a second young person from the same school completed suicide. All of the suicides are said to have chosen hanging as the method of suicide. All of the suicides were high school age, and the two most recent schools are geographically close.

The suicides have caused considerable grief for each of the families, as well as the immediate friends and classmates. Questions have been raised about whether other students at the same school should be publicly informed (they should in the simplest manner possible, to provide a basis of fact and to avoid confusion); whether the funeral should be public (while the needs and wishes of the family must be met, in most cases it allows the expression of appropriate public grief, the offering of tributes from family and friends, as well as providing some sense of closure for all of those involved) and, whether there should be some public memorial on school grounds (in most cases this is not done, unless it IS the practice of the school to create memorials for all students who die during their time at school). Professionals from local mental health services have been called in to provide appropriate advice, and have turned to a readily available booklet called euphemistically 'Education for Life' which is part of the Mind Matters suite of resources available in all schools (Howard & Taylor, 1996). There have been meetings with student groups (to provide

[83] First published 2006. Martin, G. (2006) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 5:3.

a safe context for discussion and grief), with teachers (also to provide some grief work, but in addition to allow some planning for the return to normal teaching), with school authorities (to plan the whole school approach to bereavement), and with parent groups (to allay some fears, and to answer a vast number of appropriate questions). Questions have been raised about whether the events can be called 'contagion' (possibly), 'copycat suicide' (possibly), or a 'cluster' (this term is usually reserved for when all suicides occur in the same school or other 'closed' institution, as a group and/or within a short time frame).

Of course there has been much speculation and rumour. It is said that all of the young people had had some contact between themselves prior to death, possibly through SMS. Much has been read into the fact that all of the suicides used hanging, even though this is the most common method used nationally. There is some evidence that all of the students identified themselves as being 'Emo' – that is that they thought of themselves as emotional or depressed, preferred mixing with their own group, and had particular preferences in music ('post-punk', 'emotive hardcore', or 'heavy metal' styles) and clothes (tartans, black tight jeans, and the use of scarves), used eyeliner to darken the eye sockets, and combed their (sometimes greasy) hair in a particular fashion (usually down over one eye). Some in the community and in the media, on the basis of these connections and similarities, have raised the possibility of an agreement or a pact to die. There have also been suggestions that influences may not have been just personal, but rather that identifying with Emo culture may in itself influence toward suicidal behaviours.

We should really begin by examining whether any subculture increases the risk for suicide. Although there is a paucity of research looking at this aspect of subcultural groups, recent work suggests that compared with other subcultures, identification with being a Goth may be problematic. Robert Young and his colleagues (2006) from Glasgow in a longitudinal study found that the lifetime risk for self-harm and for suicide attempts was significantly increased, with close to 50% of the young people giving a positive history. This of course does not mean that any particular Goth will ultimately suicide, but self-harm and suicide attempts are known to be factors along pathways to suicide, and are often used as proxy measures for suicide in program outcome research.

It may be problematic to compare Goths and Emos, given that Emos become enraged with people who suggest they are similar to Goths. In fact one website exploring and explaining Emo culture has suggested a critical difference between the two groups – *Emos hate themselves, while*

Goths hate everyone. If this hating the self is true, then it might be argued that Emos are at more risk of hurting the self than their Goth counterparts, so there could be some risk in identifying with Emo culture. Certainly (and while there is no formal research on this) the reported incidence of cutting behaviours is said to be high in the group, and a key feature of Emo culture.

Of course, such associations with suicidality are not just found in youth subculture. Stephen Stack has suggested that opera buffs as a group, because of their experience with suicide in Grand Opera, are more than twice as likely to believe that suicide as an outcome is acceptable where honour has been lost (Stack, 2002b). Again this does not necessarily mean that any particular fan of opera will actually have a higher likelihood of suicide, despite the fact that suicide acceptability has been associated generally with suicidality. We would certainly not jump to such conclusions simply based on identification with a group of fans of opera.

Some people have suggested the possibility that the music to which Emos listen may be the crucial part of the influence – either because of its dark, driving style, or because of the words which often discuss death and pain and sometimes suicide. This kind of argument was used some years ago to suggest that certain rock or heavy metal groups were in some way increasing the risks for suicide, but little of this was ultimately substantiated either in formal research or in the courts. Our own work has certainly found associations between heavy metal music and depression and suicide attempts (Martin, Clarke & Pearce, 1993). However, our best understanding of this was that young people seek out the music which best resonates with their own feelings. For most, this was a validating experience – 'What a relief, others have felt like I do' – and led to improvement. Only a tiny proportion were made to feel worse, and they had a range of other contributing factors as well. Again, Stephen Stack (2002a) has shown an association between liking blues music and suicide acceptability, his suggestion being that the liking for blues music with its themes of death, depression and pain led to lowered religiosity levels, the most important predictor of suicide acceptability. Once again we would have to say, that this association at the group level would not necessarily lead us to believe that a particular fan of blues music was more likely to suicide simply because they preferred that kind of music, and Stack supported our reasoning about seeking out the music because it echoed something inside, rather than the music per se directly causing any suicidal feelings.

One other piece of this jigsaw is worth brief discussion. Part of the National Suicide Prevention Strategy is based in connectedness to

another human being or to a group or to an institution being protective. So, Resnick and colleagues (1997) found that connectedness to school reduced suicidal thinking significantly. Other research has supported the fact that belonging provides protection. The key question for us is then does belonging to a group which identifies as Emo provide some protection? I know of no research to support this, but general principles would suggest that it may.

The next question is: 'Should parents, schools and professionals be concerned about self harm when they discover that a young person identifies with Emo culture?' From what has been said above I would recommend that parents should be pleased that the young person is connected to some sort of group. However, clearly they then need to acknowledge that the young person may have joined the group because the emotion in the others in the group resonates with their own thinking. That is they may be struggling or frankly depressed. This may need exploration, and/or referral for professional assessment, on the grounds that any opportunity to reach out and assist a troubled young person should be grasped.

In this issue of AeJAMH[84], Craig Murray and Jezz Fox from the United Kingdom struggle with similar problems in their paper on self-harm and whether contact with an internet group can help or hinder. Internet groups centred around particular issues have appeared rapidly over the last few years, and our knowledge about their role is still somewhat spartan. The current paper appears to conclude that in general participants gain support, and there are overall reductions in self harm. For some, though, the risks may be heightened, and our problem as professionals may be how to intervene with this particular group. Considerable more work is needed here.

Erminia Colucci addresses related issues to do with culture more broadly and its influence in suicide. She reviews what is known about the impact of culture, explores in depth some of the meaning and interpretation of suicide in cross- cultural research, and makes the case that these issues are in need of further work to understand the prevailing culture-specific norms, meanings, social representations and attitudes regarding suicide in various cultural (and sub-cultural) communities of the world.

Alan Headey and Jane Pirkis from the University of Melbourne, along with other colleagues, present an overview of the 156 local projects funded under the National Suicide Prevention Strategy, and report on lessons

[84] Papers from this issue of AeJAMH are accessible at http://amh.e-contentmanagement.com/archives/vol/5/issue/3/

learned. They note the need to 'maximise gains in Australian suicide prevention activities by highlighting promising processes and impacts and minimise repetition of less successful elements'. Overall, they conclude that the projects 'achieved improvements in knowledge about risk and protective factors for suicide, social connectedness and mental health literacy, and reductions in depressive symptomatology', but were somewhat constrained by their short-term funding.

But this issue is not all about suicidal behaviours and, in fact, covers a wide range of current issues in mental health. Desley Casey in her guest editorial thoroughly explores the current status of consumers who contribute to mental health systems, noting that we still lack clear frameworks for engagement, clear expectations, position descriptions, and a set of ethical guidelines on both sides. In making the case that the expectations, roles and responsibilities must be clear so that the very important contributions which can be made by our consumers do not leave them feeling used and abused, she makes a strong argument for ongoing and wider debate.

Brenda Happell and Cath Roper explore some of these issues further in their paper focused on what they call the 'myth of representation', that is the key question as to whether one consumer can represent the wider range of consumer needs. They argue that such an expectation is actually discriminatory, something that would not be expected of professionals sitting on committees in other services, and that in any case there is no way of testing whether an individual has canvassed wider opinion. They conclude that a shift in models may be necessary, perhaps toward what is termed consumer leadership in services, a concept explored further in the paper.

Chris Lloyd, Samson Tse and Frank Deane explore how the concept of social inclusion can be applied in the everyday practice of health professionals working with people with psychiatric disabilities. They describe practical strategies in a range of areas: addressing attitudes and beliefs, promoting employment opportunities, supporting families, and addressing issues around housing, finances, transport, access and information. They conclude that there are many opportunities for practitioners to facilitate social inclusion, but it may require a willingness to shift to a more recovery-oriented approach.

Later in this issue, Sujata Satapathy and Ajinder Walia take us to the heart of clinical work with a child who was burned in a school fire. An in-depth case study, this paper provides us with a fascinating insight into mental health services in India which are still to be incorporated into the main primary health care system. The disaster specific piece of work both

reminds us that clinical intervention works, but also points to the immense need for counselling services in India.

Another international paper, from Canada, examines cross cultural work which has implications for our own indigenous peoples. William Thomas and Gerard Bellefeuille report on a qualitative study of the healing circle, which incorporates elements of experience, relationships, spirituality and connectedness, empowerment, and self-awareness. A key issue explored is the need for researchers to respectfully incorporate Aboriginal needs into the research plan, and Aboriginal knowledge into the research process, and for Aboriginal communities be given the opportunity to decide what the research priorities should be for their communities.

Mike Cunningham, Ron Rapee and Heidi Lyneham from Macquarie University report on a novel computer-based therapy to help reach the many adolescents who have an anxiety disorder but who do not access traditional psychological services. While the reported pilot study has small numbers, overall the results are promising, suggesting that further exploration using a larger sample is warranted.

Sue Outram and her colleagues from the University of Newcastle explore a very large sample of women where they used logistic regression to examine factors associated with medicine use for psychological problems. A high proportion of the women were taking medications related to both mental health issues and recent life events, and this was despite their concerns about dependency and the possibility that medication does not solve the actual life problem. One major conclusion explored in the paper is that many women would prefer to have had their problems discussed, rather than medicated.

Larne Wellington and colleagues from Brisbane explore the beliefs underlying intention to take part in parenting groups. Their research demonstrates a number of key factors (perceived costs and benefits, as well as the views of key others) which may inhibit participation. They conclude that both attendance at groups, and successful resolution of the issues in parenting may depend on working with these control beliefs, and finding clear strategies to overcome them.

Susan Fealy and Ian Story report on RAMP (a comprehensive Risk Assessment and Management Process), a systematic set of processes for schools that promote early identification and intervention for children and adolescents at risk of mental health problems. The authors describe the three domain risk and protective factor framework, a team-based approach to pastoral care, structured team processes, protocols and solution focused strategies tailored to the school setting, and the provision of professional development in mental health for school staff.

The authors note that such an approach can help to begin to address the unmet needs of at-risk young people using current resources.

In the final paper in this, the largest AeJAMH issue to date, Susan Fealy then joins her colleagues Alison Shortt and John Toumbourou in a second paper which reports on the evaluation of the program. The paper describes the process of implementing RAMP in nine schools, where it assisted in identification of students not previously known to be at risk, improved staff knowledge of risk and protective factors, and continues to be used.

As this issue goes to press in December, we at AeJAMH offer our very best wishes for the season. We hope you have a good rest, safe travel, and a return to work that is fully refreshed, and committed to producing more papers for this now important, abstracted and widely distributed online mental health journal.

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Twenty Six

On Rural Services for Mental Health[85]

Sometimes it helps to go elsewhere and see other clinical services; on reflection you can gain perspectives on your own service or state, which can then lead to positive change. In the last few months I have had the privilege to be part of a team reviewing an interstate child and adolescent mental health service. As part of this we travelled to country areas and spoke not only with clinicians within the service, but administrators and others from connecting services. I suspect that much of what we were told is typical of rural services across the country, although some may wish to challenge what I am about to say, and perhaps clarify my ignorance about what is done in other states.

First (and it seems banal to mention it) distance is a real problem. One clinician travelled over 400 kilometres by car to present some of the issues. Because she was a sole practitioner for an area, she was based in a group of not very connected services, and had to fight to get, and maintain, sufficient infrastructure to do her job. She had to plan well ahead for her interview, argue cogently why she was needed to be present, and then sign several forms to gain access to a car. Similarly she had to sign forms and argue her case to get hold of a mobile phone with distance coverage. Strangely, she actually did not need to arrange for someone to cover her, because she did not have a direct clinical role. Someone had been creative in gaining funding from a new state wide pot of funding for health promotion officers in remote areas, and so our colleague was placed in position as a 'body' – big tick in a bureaucratic box somewhere! It did not seem problematic that what the community wanted was a 'jack of all trades' clinician who could meet local need in terms of crisis intervention, and provide early intervention and some therapy, as well as very much needed local education in mental health. Because of distance, this sole clinician had few colleagues with skills in

[85] First published 2007. Martin, G. (2007) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 6:1.

the mental health of young people, so supervision was a problem. A local supervisor was not available, so face-to-face supervision was limited, and although telephone supervision was possible, because of limited local technology, videoconferencing was rare. My previous experience tells me that if you create this sort of situation, then professionals burn out very quickly, whatever their commitment, experience and skill; and if they are primarily not meeting the community's expressed needs, then this happens much more quickly. A minimum for a rural team in a region with, say, about 15,000 people seems to be three clinicians with a skilled and knowledgeable advisor visiting on a regular basis. The primary focus of such a group should be the community's expressed needs, but mental health promotion is often a part of the job for at least one clinician.

This issue to do with sole practitioners was not the only problem, of course. Over half the positions in the regional child and adolescent service (as a whole) were empty. People left after a relatively short time, and replacements were hard to find, particularly those with seniority and experience. Younger clinicians often took the jobs because they could gain experience, and because they were often given a post at a level above what they might have been able to gain in a city. But rural work was only a stepping stone to return to the city as soon as possible. Under pressure of clinical referrals, remaining clinicians had naturally adopted a 'siege mentality', and attempted to manage the workload by providing access to only a limited number of new cases who could be managed in office practice with the skill mix available. There was not really the capacity to meet crisis intervention needs, and so, with much resentment, acute cases had been managed by local adult mental health services and/or paediatric services, as appropriate for age. Of course the pressure often fell on psychiatric and paediatric registrars in training whose experience with young people and mental health problems was rather limited.

There are some underlying issues here. First, it seems to me that rural workers are an interesting mix. Many are committed to rural practice because of prior experience; they are often those who grew up in the country, and go away to gain qualifications mainly to bring the knowledge and skill back 'home'. Then there are those somewhat older clinicians who seek a pre-retirement change to a quieter environment. Finally, there are the younger clinicians I have mentioned above, out to gain rapid experience and seniority. I am not sure that administrators necessarily think through the targeting of advertisements to attract these differing groups. Clearly more stability in rural services could be gained by targeting the first two groups, and I am sure that many more creative ideas would emerge from a strategic planning session.

Then there are the issues to do with salaries, infrastructure and special inducements. I have already mentioned the younger on-the-move clinicians who gain seniority early. But there are precious few other reasons to work in rural areas; you really do have to be committed, and you can expect your commitment to be used against you. Very few clinical mental health services offer salary enhancements, there are few in the way of infrastructure perks, and few special inducements. However, other systems do offer these. For instance many education services offer free housing (or at least rental or housing assistance), good infrastructure, and salary enhancements - which increase annually the longer you stay in the area. If we are serious about a mental health service commitment to rural and remote Australians why do we not positively discriminate to enable a stable, committed, highly skilled, well-supported and well-supervised workforce?

Within days of getting back home, I was visiting Mount Isa, a mining town of about 20,000 people about two hours flying time northwest of Brisbane. I visit to do some face-to-face supervision and clinical work about every four months to enhance fortnightly videoconferencing to the clinicians there. This arrangement is similar to many colleagues in my service who each service a rural or remote area in the same kind of way – a minimalist supportive service, but the best that can be managed within current resources. At the time of my visit, 9 of the 14 adult mental health service positions were empty, so the one and a half co-located child and youth mental health clinicians were left with no back-up, no capacity to manage crisis cases, and not many colleagues with whom they could discuss difficult cases in an emergency. This has changed recently with three new people appointed including a full time adult psychiatrist (which is a miracle in a community like this) so things are looking up. Six other positions have been advertised, and we live in hope. However, on the second day of the visit, I was talking with a group of school counsellors, and one mentioned she had previously worked with Child and Youth Mental Health Services (CYMHS) in the Isa. I asked why she had left and got an answer I should have expected. In education, she gets a better salary, free accommodation, better perks, and a bonus for each year she stays with the service. Mmmm.

Last week I was teaching 35 CYMHS workers from around Queensland, many from rural areas. In the second session, I was talking about the need for a supportive environment in the work we do, how important our own mental health and resilience can be, and just how crucial supervision is. A young person at the back of the room appeared to be wiping away tears, so at the break I tentatively tried to see what she was

experiencing. There was relief that I was asking, but also more tears. She is a sole worker in a rural town, and my comments had sparked a flood of regret at moving there. At times she is unable to cope with debt, based in part on the costs of moving to the country area. She feels unsupported, and is coping with a large caseload and the kind of serious problems with which many experienced practitioners would struggle. She is on a second level salary, but having to do administrative tasks in excess of her experience and ability. And guess what? She is not getting any extra income for what she sees as her commitment and sacrifices. I would give her town a couple of months before they are scratching their heads to work out why professionals leave so often.

The need for mental health services and support in rural areas is immense. In a previous editorial I referred to Ann Dunning's work on Social Exclusion in Australia. I was intrigued by her ability to measure the stark differences between rural and city people. But over the last few years, the rural downturn as a result of the drought has begun to bite really hard, and made it even more difficult for those with fewer personal, family and community resources. Several rural towns I have visited to speak at Rotary meetings have mentioned the numbers of suicides they are experiencing in young to middle aged males, and this was brought sharply home to me in Warwick a couple of weeks ago. The Southern Downs in Queensland has experienced a marked increase in suicides over the last 18 months, and interestingly not one under the age of 25. Four out of five of the suicides are male, and again of interest, the vast majority would appear to have had a clearly diagnosed mental illness. This was not a spurious diagnosis made post hoc to assist the relatives to grieve; several of those who had died had been admitted to hospital in prior years. What it might say to us is that in hard times we all struggle, but those who have had mental health problems in a context of social exclusion, and under the severe pressure of unchangeable events like the drought, may get to despair more deeply, and for longer than the rest of us. My presentation was meant originally to be with 15 or so general practitioners. When it was opened up to the local professional community, more than 80 people turned up, some from over a 100 kilometres away. Not only do the problems seem overwhelming, but local professionals all recognise them as such, and are desperate for input, ideas, possible solutions, and support.

All of these examples suggest to me that we must give urgent consideration to the plight of rural communities. In particular we must give thought to those with mental illness within those communities. We

cannot simply work away at our everyday lives, keep our heads down, and say that 'life is hard in the bush'. Rural people have the right to mental health services every bit as good as those for city people. To achieve this, we must seriously analyse the way we go about providing these services, and develop a range of appropriate strategies to entice and retain good quality clinicians. As previously noted, I believe we need to positively discriminate for rural services, and of course it is going to cost us more.

And so to this issue, the first of 2007[86], and the beginning of our 6th volume, once again ably, caringly produced by our Editor, Anne O'Hanlon.

In the first paper, Judith Fairlamb and Eimear Muir-Cochrane describe the development of a rural Community Health Service Health and Wellbeing Team with a mix of clinicians, and the development of a common philosophy and values base. The model takes a primary health care approach and works towards practical outcomes in people's lives which concur with the PHC determinants of health, secure housing, employment and social connection, while reducing more traditional mental health assessment processes, and less of a focus on case management practices. The outcomes appear to be a consistent paradigm shift toward a consumer focused approach.

The paper by Amanda Harris and Gary Robinson draws on three years' experience of evaluating the Northern Territory's Aboriginal Mental Health Worker Program. The authors stress the critical impact of support for mental health workers on program sustainability, and go on to describe the factors which undermine. They outline many of the problems that the program has faced in differing and complex communities, and note the tensions in views about what the role of the AMHWs should be. 'Should it be culturally informed, clinically-related mental health work or community 'wellbeing work', and how should each role be supported?'

The next paper focuses on the role of an Indigenous health worker in contributing to equity of access to a mental health program in a youth detention centre. Stephen Stathis and his colleagues provide a retrospective and descriptive account of the development of the role, and the strategies used to assist Indigenous young people. Overall the program has been shown to bring Indigenous access to mental health services and drug and alcohol services up to a level comparable to non-Indigenous young people in detention. Close clinical and cultural

[86] Papers from this issue of AeJAMH are accessible at http://amh.e-contentmanagement.com/archives/vol/6/issue/1/

supervision play an important part in the development and maintenance of such programs.

The paper by Malkanthi Hettiarachchi is a single case report, and describes a treatment which has had quite a contentious history. The case study, telling a very moving story, describes a young female university student traumatised by the 2004 Asian Tsunami. The three sessions of combined CBT and EMDR are described in detail and a number of reliable scales are used to track progress. The combination of treatments appears to provide the opportunity to evoke painful memories and place them in context. The result challenges us to consider the use of brief focused novel treatments, and particularly in resource poor contexts.

The next paper relates to our ongoing struggle to help those with emotional problems in the most efficient and effective way. Fiona Green and John Malouff add to the literature on self-help books in a study exploring the impact of such books in the community. They stress that the more closely a book is read, and the more changed behaviour that occurs, the more likely the improvement in psychological problems. Their preliminary work raises several issues that warrant further investigation.

Working mothers as a construct has provided challenge and discussion for many years. Work, of course is a right; but does it enhance personal identity and enable family management and does it improve personal energy or simply add a burden to the family system. In a tightly written paper, Karen Elgar and Andrea Chester provide a critique of the literature to date, examine two major models that have led to somewhat oversimplified arguments, and suggest that the benefits for maternal psychological wellbeing need to be explored in a more complex way if we are to truly understand them.

Peer support programs have been operating for many years but, as noted by John Dillon and Anne Swinbourne in their paper on 'Helping Friends' (a peer support program for senior secondary schools), few have evaluated their effectiveness beyond satisfaction levels of participants. This is in part because schools are complex environments, and research in the real world is hard to set up and complete. The peer support program reported has been continuing for many years, but has only recently been subject to evaluation, which does appear to show significant increases in knowledge of helping behaviours and perceived social support within and across peer groups. 'Helping Friends' is a welcome addition to our efforts to improve mental health of young people in schools.

The final paper in this rich issue of AeJAMH also describes efforts to improve mental health in schools, in this case a collaboration between child and adolescent mental health and the school. CAST is an evidenced-based program treating children with emerging disruptive behaviour disorders in primary schools, and Denise Corboy and John McDonald here report on the implementation and the satisfaction of school personnel. They utilise an adaptation of an American model of process evaluation, which appears to transfer well to Australia. Despite the complexity and multiple levels of the school environment, the CAST program appears to have been acceptable to staff, and well implemented in Victorian primary schools.

Twenty Seven

On the Impact of Television on Young People[87]

I wandered out of the bedroom about 6am on a Saturday morning several weekends ago, and greeted two of my grandchildren aged five and three, both curled up on a settee watching the television. No response. I moved in closer to sit down and give the older one a hug, and she sort of responded, but kept her head to one side, eyes glued to the screen. The younger one seemed half asleep, mesmerised by the images. So I moved on. About half an hour later a physical fight broke out over the choice of cartoon program; hair was pulled, scratches occurred, tears shed, and the older one left to complain about her little brother to her mother. Yet again it made me reflect on the wisdom of putting in a wide screen and attaching it to a Foxtel box. On the one hand we adults all get a little more sleep at the weekends but perhaps at the temporary expense of a meaningful relationship. And both of my grandchildren can sing classical tunes remembered from the Baby Einstein series – which is good fun and highly educational (but comes with an American accent).

But exactly what does several hours a day of flashing lights and wizardry do to the growing brain of a small child? Will television watching at a young age lead to a life-long obsession with watching a screen? Are younger people more vulnerable to the messages and adverts that pour off the screen, and do these messages represent the values of parents or grandparents?

By the age of three, the older grandchild, having recently returned permanently from the UK, could switch on the computer, click on a browser and find CBBs, an English children's site she knew which is full of games and fun with stories and rhymes with music. 'Isn't she clever?' we all exclaimed. But at the back of my mind lurks a raging argument

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Original papers from this issue of AeJAMH are accessible from http://amh.e-contentmanagement.com/archives/vol/6/issue/1/

that I wish I could resolve. If the way of the future is through electronic media and media skill (at least until the electricity all runs out), then my granddaughter will be in the race, and we should encourage her efforts and broaden her skill. But is it all that simple? It could be crucial to the future of young people to have the requisite skills. It is possible, of course, that they will grow through their current passion with things electronic, and move on – in the way that children often do when learning to play an instrument. One day they are passionate about the violin, and allow the family to enjoy their new found skill, another day and they have moved on to the drums, or tired altogether of the need for practice. They may just use the skills when appropriate, like you and I when we 'Google' a person's name, a paper, or a new idea. But my worry is that they may become obsessed and use the Internet as a way of avoiding anxious aspects of daily life.

And then there are the recent worrying discussions about online contact lists (for instance MySpace and Facebook). MySpace has recently apparently been able to recognise up to 27,000 paedophile addresses in its listings. Does this mean that our cleverness in developing the Internet and the web will increasingly expose our children and grandchildren to predators online?

I have had a long-term interest in the influence of media on young people (Martin, 1990, 1996, 1998). However, I was reminded of the problems forcefully the other day in a discussion about a complaint that had been lodged against a worker who spent a considerable part of his work day online exploring his 'second life' to the detriment of his first life and his work output. This is what Michael Hong has named 'Internet Addiction' (see Lee, Oh, Cho et al., 2001), and there do appear to be serious and growing problems in this area. There are lots of questions to be answered if 'addiction' is the right word. If a child has a gene for addictive personality, and/or the set of circumstances to bring out their addiction, then could Internet addiction be an early sign of later addictions, and could it be used for early intervention purposes to build in protections against later chemical addiction?

It is timely then to consider several recent papers published by the *Archives of Pediatrics*. First, though, we need to note the American Academy of Pediatrics (2001) consensus statement that reported on the then facts and figures to do with children's viewing, and then described the possible negative health effects of television viewing on children and adolescents, such as violent or aggressive behaviour, substance use, sexual activity, obesity, poor body image, and decreased school performance. They did acknowledge some positive aspects of viewing,

but predominantly came down on the side of television having long-term negative impacts. Their recommendations were, among other things, for media education both for young people and their parents, limiting the time children spend watching television, removing television from the bedrooms of young people, and for the use of the v-chip to control the types of programs that children watched.

An early paper by the Johnson group (Johnson, Cohen, Kasen et al., 2004) examined sleep disorders in adolescents and young adults. The work is based on the Children in the Community Study, a prospective longitudinal epidemiological investigation of 759 New York families when their adolescents were 14, 16, and 22 years. Adolescents who watched three or more hours of television a day during adolescence were at a significantly increased risk of frequent sleep problems by early adulthood. This remained significant after age, sex, previous sleep problems, psychiatric disorders, neglect, parental educational level, parental annual income, and parental psychiatric symptoms were controlled statistically. Adolescents who reduced their television viewing to less than one hour per day gained a significant reduction in sleep problems.

In an often quoted study, Clare McCarty's group (see Christakis, Zimmerman, DiGiuseppe & McCarty, 2004) used the US National Longitudinal Study of Youth to examine the hyperactivity subscale of the Behavioral Problems Index in participants at age seven, comparing with hours of television watched daily at ages one and three years. Ten per cent of children had attentional problems at age seven. In a logistic regression model, hours of television viewed per day, at both ages one and three, was associated with attentional problems at age 7 (odds ratios 1.09 [1.03–1.15] and 1.09 [1.02–1.16] respectively). They concluded that television viewing in young children was associated with later attentional problems. Based on this study, many authors have subsequently suggested that television may have some impact on the 'wiring' of the brain that may lead to ADHD.

Hancox, Milne & Poulton (2005) studied educational achievement at 26 years of age in the Dunedin prospective birth cohort study of 1,000 unselected individuals born between April 1, 1972, and March 31, 1973. Similar for men and women, increased television viewing during childhood (ages 5-11 years) and adolescence (ages 13 and 15 years) had adverse associations with later educational achievement. Increased adolescent viewing was a stronger predictor of leaving school without qualifications, whereas childhood viewing was a stronger predictor of not getting a university degree.

A later paper by Johnson, Cohen, Kasen & Brook (2007) looks at the same area of educational attainment. It is based on the same Children in the Community Study as their 2004 study, but on this occasion with a reduced sample (628) of the New York families. Young people who watched one or more hours of television per day at mean age 14 years were at elevated risk for poor homework completion, negative attitudes toward school, poor grades, and long term academic failure. Those watching three or more hours of television a day were at increased risk for subsequent attention problems and were the least likely to receive post secondary education. The authors' careful longitudinal work suggests that the television watching had a direct causal effect rather than reflecting prior history.

There is now a large body of longitudinal work suggesting that high television usage in childhood leads to obesity and poor food choices in adolescence (e.g., Jago, Baranowski, Baranowski et al., 2005; Proctor, Moore, Gao et al., 2003; Salmon, Campbell & Crawford, 2006).

Finally, recent work suggests that adolescents who watch lots of television may be put in danger of early sexual activity. Sarah Ashby and her colleagues (Ashby, Arcari & Edmonson, 2006) drew on the US National Longitudinal Study of Adolescent Health data from 1994-1996 on 4,808 students younger than 16 years who had not initiated intercourse before baseline interview. By 1-year follow-up, 791 (15.6%) subjects had initiated intercourse, despite strong parental disapproval. Sexual initiation was associated with high television use (adjusted odds ratio, 1.35) - usually unmonitored television use.

There is hope we can intervene, and of interest the strongest effects may be in the realm of the school. Jason Fletcher (2006) also used the National Longitudinal Study of Adolescent Health. He set out to examine whether social interactions influence the television viewing choices of 4,532 students in grades 7 through 12 in 132 US public and private schools. The number of hours of television that adolescents reported viewing per week was associated with their peers' reported hours of television viewing. A one hour increase in average school-level television viewing was associated with an extra half an hour of television viewing at the individual level. This suggests that social interactions within schools influence the hours of television that adolescents report viewing and, by implication, that interventions affecting the social norms of television viewing within schools could also change individual television viewing.

This little selection of papers provides some cogent evidence that television watching can be harmful in many ways. There is considerable other work in this field, and little of it shows positive outcomes. High

levels of television watching (more than 3 hours a night) affect sleep, increase the likelihood of poor attention, certainly appear to have strong implications for learning and educational attainment, and may influence choices – for instance dietary intake and sexual initiation. There is good evidence that it may lead to a familiarity with or even an addiction to the small screen, and this can have life-long implications. The hopeful note is provided by the Fletcher paper, suggesting that education at the school level to influence peers may reduce hours of watching, and therefore some of the sequelae. The 2001 Pediatrics guidelines, while appearing somewhat draconian, remain important and relevant. The advice we (as professionals) should be giving to families is to reduce the hours of watching overall, be careful what they allow young people to watch (i.e., monitor) and not give them free access (e.g., a TV in their bedroom), discuss what they have seen most recently, and provide them with guidance according to family norms.

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Finding a place for healing: Women survivors of childhood sexual abuse and their experience of accessing services (Louise O'Brien, Corinne Henderson, Jenna Bateman)
Detection and management of eating disorders by general practitioners in regional Australia (Candice P Boyd, Damon L Aisbett, Andrew Howard, Toula Filiades)
The construction of youth suicide as a community issue within urban and regional Australia (Simone Fullagar, Heidi Gilchrist, Gerard Sullivan)
AIMHI NT 'Mental Health Story Teller Mob': Developing stories in mental health (Tricia Nagel, Carolyn Thompson)
Reducing risk factors for adolescent behavioral and emotional problems: A pilot randomised controlled trial of a self-administered parenting intervention (Helen M Stallman, Alan Ralph)
'They just don't care': The experiences of mental health consumers in a Queensland bush community (Lisa McColl)

Twenty Eight

Success! The Australian National Suicide Prevention Strategy (1995-2000) Worked. But What Exactly Made the Difference? [88]

An intriguing, recently published, paper by Stephen Morell and his colleagues (2007), suggests that, having excluded all other possibilities, the only reasonable explanation for the nearly 50% reduction in suicides of young males (aged 20-24 years) from 1997 to the present day, in Australia, is the fact of the National Youth Suicide Prevention Strategy (NYSPS) from 1995-2000[1]. To quote from their conclusions:

> *The recent sudden turnaround in Australian young male suicide trends, and its extent appears to preclude explanations centring on slow-moving social indices traditionally associated with suicide, or on possible cohort effects. This sudden decrease has occurred mainly in non-impulsive means, and at the same time has broken a long-standing secular link between 20 and 24-year-male suicide and unemployment, lending plausibility to the case for the NYSPS having had an impact on young male suicide in Australia.*

If we accept the overall conclusions of Morell et al.'s careful work, then we should be exultant that a broadly based national strategy using $31m over 5 years may have had such an outcome. But what is it about the strategy that created the effect? Surely we need to examine the strategy more closely to understand, if we can, the possible links between individual programs and impacts. Programs were on the whole set up to deal with particular issues; have any of these issues changed in a measurable way such that we could at least suggest that specific programs, or combinations of programs, have been a clear part of the

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success. In addition, we need to understand whether extraneous (or perhaps random) factors in our society could have had some impact on Australian rates of suicide.

Let us begin with the latter issue; changes in our society. While Australia is a wealthy country, poverty and social exclusion have not gone away (Harding, McNamara, Tanton et al., 2006), and while suicide is not just related to socio-economic factors, states and/or regions with high social exclusion do appear to have higher rates of suicide. Divorce rates in Australia have not reduced (de Vaus, 2004), child abuse continues to occur in all its forms (Ainsworth & Hansen, 2006), homelessness in young people continues to rise (MacKenzie & Chamberlain, 2003). In addition, the overall prevalence of self-reported mental and behavioural problems increased in 2005 to10.7% (from 9.6% in 2001, and 5.9% in 1995). Somewhat confusingly, and despite all the poor social family and mental health parameters, overall self-assessed general health status (ages 15-24yrs) appears to have marginally improved since 1995 (Very Good + Excellent 68%) through 2001 (VG+E 66.9%) to 2005 (VG+E 70.9%) (Australian Bureau of Statistics: ABS, 2006). There is a parallel reduction in those reporting only fair or poor health status (F+P 6.2% in 2005, down from 8.2% in 2001 and 8.3% in 1995).

While there are many risks that need to be taken into account at the individual, family and societal level, there is general agreement that depression is a step along the pathway to suicide, whether it is of innate biological origin or due to stress-related factors working through levels of serotonin in the brain or, conversely, through cognition. The incidence of mood disorder (depression) in 2005 rose to 144,600 referrals for care in the age group 15-24, an increase of over 2% over 10 years (ABS, 2006). While it would be good to examine these figures in more depth, and perhaps put them in the context of international trends, it would appear that both the overall existing number of depressed cases, and the new cases, have both increased. This may suggest we have not been able to get on top of mental health problems, particularly depression, in the period of interest regarding suicide (i.e., since 1997). This is a surprise finding, going against what might have been expected, given the known links between depression and suicide; if depression continues to rise we could have expected suicide to rise accordingly. An alternative, and more optimistic, explanation for the apparent rise in 'cases' may be that help-seeking has increased, and we (community plus professionals) are recognising depression better, and improving access to care through referral.

The next issue to be considered is whether known or new cases of depression are being better managed. One measure of this might be the level of antidepressant prescribing. In 1995 in Australia, an estimated 14,500 people in the 15-24 years age group were prescribed antidepressants (ABS, 1999). They were more likely to be taking amitryptiline, doxepin and dothiepin (i.e., tricyclics – 4,800) than the first selective serotonin reuptake inhibitor (SSRI: fluoxetine – 2,997). Ten years later, in 2005, about 80,000 of the 15-24 years age group can be estimated to have used antidepressants (ABS, 2006). These were more likely to be SSRIs (77.1% - including sertraline, citalopram, and paroxetine) than tricyclics (7.5%). So, not only has there been a large increase in prescribing, but there has also been a shift away from tricyclics (which have the potential to be lethal in overdose) toward SSRIs (which may overall be safer).

There has been international debate about the role of antidepressants in suicide, with many noting that the research-based results in young people have not been convincing until recent studies (March, Silva, Petrycki et al., 2004; Riggs, Mikulich-Gilbertson, Davies et al., 2007). Research in some countries (e.g., Sweden) has clearly demonstrated an association between increased prescribing of SSRIs and reduction of national suicide rates (Carlsten, Waern, Ekedahl & Ranstam, 2001), although such results have more recently been refuted (Reseland, Bray & Gunnell, 2006). There has also been a recent flurry of interest in supposed increased risk of suicidal behaviours in young people prescribed SSRIs, with the US FDA providing black box warnings about prescribing SSRIs for young people. The most recent meta-analysis of this, by Dubicka, Hadley & Roberts (2006), does suggest a marginal increase in risk of suicidal behaviour (an odds ratio of 1.70 - or perhaps 2 people out of 100 treated being at increased risk), although it should be noted that there have been no suicides attributed to SSRIs alone.

Setting aside these complexities, and in summary, despite the ongoing somewhat gloomy parameters of social exclusion and other increasing social problems in Australia, we may be recognising, referring and treating depression better. Could this be part of Morell et al.'s (2007) proposed impact of the NYSPS, and have contributed to the decline in suicides in young people, despite the apparent increase in depression in young people? Maybe.

Are there programs within the NYSPS that may have contributed to the better recognition and management of depression? As Penny Mitchell (2000) reports in *Valuing Young Lives*, one of the problems with answering a question like this is the generally poor level of evaluation of

the 71 individual programs, and the subsequent lack of peer reviewed, published papers. 'Process evaluations' are available for professional training programs (e.g., in parenting), gatekeeper training (e.g., for GPs), curricula for schools, the Media Resource Kit, training for telephone counsellors, crisis intervention in hospital emergency departments, and community development projects. Some 'impact evaluations' are available for the more clinical programs and for the population level programs. 'Outcome evaluations' are available for the three programs in mental health services, a program in hospital emergency departments, the parenting programs, the telephone counselling services, for some programs for marginalised youth and, more recently, the *MindMatters* program. Much of the work showed promise, and much of it led to better understandings that have, in turn, led to better and perhaps better-targeted programs. But it is almost impossible to have any confidence in linking impacts and outcomes directly to the reduction in suicide, and this was predicted in the interminable discussions of the Evaluation Working Group, convened 18 months into the strategy (see Penrose-Wall, 2000). Even with programs demonstrating reasonable outcomes, their impact and influence is likely to have been local to any given program rather than across the country. A further dilemma is that the majority of programs finished up when the funding for the youth strategy dried up. Some major national programs *have* continued to the present day, and it could be argued that they play an ongoing role in influencing suicide reduction. Our own *Auseinet*, while the primary role was to develop the field of promotion, prevention and early intervention in mental health more generally, has continued to inform professionals about conceptualisation of prevention of suicide. The *Mindframe* media resource (www.mindframe-media.info), derived from the original Media Resource Kit *Achieving the Balance*, continues to provide up to date information and clear guidelines for journalists reporting on suicide and mental health problems. *MindMatters* (http://www.mindmatters.edu.au) has now reached a generation of young people in 86% of Australian high schools, with over 52,000 teachers receiving professional development in mental health. The *Education for Life* resource, as part of the kit available to all schools, remains internationally one of the clearest texts for teachers facing problems of suicidal behaviours in school, or the aftermath of a young suicide. *Reach Out!,* an online information source developed by young people for young people (www.reachout.com.au), continues to receive multimillions of unique contacts every year, and is now breaking into the US market. Again this program is much more than suicide prevention, but did begin as a result of funding under the NYSPS,

and has maintained integral, ethical approaches to suicide prevention. The new *Reach Out! Central* (http://au.reachout.com/reachoutcentral) program is likely to maintain the influence toward mental health. *Kid's Help Line* (www.kidshelp.com.au) is now at the forefront of telephone counselling programs for young people internationally, and has been an innovator in the field of online web-based counselling. *Kid's Help Line* continues to receive thousands of calls each month from young Australians in distress. Each of these national programs has been evaluated to the limits of our ability, yet we would be hard pressed to draw direct links to the overall reduction in suicide rates. We know they have contributed, but cannot yet prove it.

There are some extraneous factors and programs that need to be considered. First, *beyondblue*: the national depression initiative (www.beyondblue.org.au) must have played some role in the ongoing reduction of suicide – through increasing recognition and referral of depression. *beyondblue* was not created until October 2000, somewhat after the beginning of reductions in young suicide rates, but has had enormous reach into and recognition from the community. Again, we know it has contributed, but cannot prove it.

A further factor has to be related to the gun 'buy back' scheme, begun in Australia after the Port Arthur massacre. A recent paper by Chapman and colleagues (2006) demonstrates that since 1996, the rate of decline in firearm-related deaths has accelerated since the reforms - for total firearm deaths (p 0.04), firearm suicides (p 0.007) and firearm homicides (p 0.15). They state that no evidence of substitution effect for suicides or homicides was observed. How much has this contributed to the overall reduction in young suicides? We don't know, but it is an intriguing contribution to the picture.

Finally, there is one more change in our broader society since 1997 which could be having an impact on youth suicide rates; again hard to prove. In the last 10 years, mobile phone ownership has increased to almost 90% of Australians, and phone ownership by young people has been a conspicuous part of this growth. Scholarly work by Resnick, Bearman, Blum et al. (1997) was able to show that connectedness in and to the school (along with resilience) was able to produce a vast decrease in suicidal thoughts in young people, and subsequently connectedness has become a central plank in our strategies to reduce suicide. Young people have grasped the opportunity of the mobile phone; it is their new connectedness. To the chagrin of many of us who quite like the English language, they are developing a new shorthand of connectedness. But in our own recent work with groups of young people who self-

harm, communication through SMS between even the most troubled young people has been shown to provide some of the support they need to stop self-harming behaviours.

So, what a complex mix! It would be wonderful to be able to tease out the differential attributable protection that may have been provided by any one program, but this may never be possible. What is important is that the overall mix, over the last 10 years, has worked as a whole to reduce suicides. Ultimately, those of us who are left-brained may be most convinced that our ability to recognise, refer and manage depression in young people is what matters; the evidence, such as it is, is most clear here. However, my personal view is that we need to keep as much of the whole program as we can working – at the level of the population with education and awareness programs, for professionals with regular updates about evidence-based practice and how to maintain pathways to care, for journalists to maintain the cautions in reporting, but most importantly in the area of continuing to build resilience, connectedness and capacity for mental wellness, in our population of young people.

NOTES

1. Professor Martin was a member of the Advisory Board for the NYSPS, a member of the Evaluation Working Group, and was one of the originators of several programs funded under the strategy (*Out of the Blues*, *Keep Yourself Alive*, *Auseinet*, and the Media Resource Kit *Achieving the Balance*).
2. This 'best estimate' has been derived conservatively from the available ABS published figures, and further analysis is necessary to confirm the precise figure.

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Master your mood online: A preventive chat group intervention for adolescents (Rob S Gerrits, Rianne AP van der Zanden, Renske FM Visscher, Barbara P Conijn)
Employment status, attributional style and psychological well-being: A study of Vietnamese employed and unemployed in Queensland (Toan Nguyen, Kathryn Gow, Richard E Hicks)
A post-Jungian perspective on 55 Indigenous suicides in Central Australia: Deadly cycles of diminished resilience, impaired nurturance, compromised interiority; and possibilities for repair (Leon Petchkovsky, Nigel Cord-Udy, Laurencia Grant)
Exploring hope: Its meaning for adults living with depression and for social work practice (Sue Houghton)
The role of the occupational therapist in adolescent mental health: A critical review of the literature (Laura Hardaker, , Rhonda Griffiths, Natalie Bolzan, Karen Arblaster)
The role of the family therapist and health professional in mental health promotion and youth suicide prevention (Annette Woodhouse)
A randomised controlled trial of a group intervention to reduce engulfment and self-stigmatisation in first episode schizophrenia (Elizabeth McCay, Heather

Beanlands, Robert Zipursky, Paul Roy, Molyn Leszcz, Janet Landeen, Kathy Ryan, Gretchen Conrad, Donna Romano, Daphene Francis, Jennifer Hunt, Lucia Costantini, Eugene Chan)

'A very individual thing': On drug therapy in psychiatry from the perspective of Australian consumers (Pam McGrath, Michael Bouwman, Vaidyanathan Kalyanasundaram)

Twenty Nine

On Therapist Despair[89]

As part of my clinical duties with Brisbane North Child and Adolescent Mental Health Services (and like other psychiatrists in my service), I do a regular fortnightly videoconference (eCYMHS) to a rural area of Queensland. We have a very small full time resident staff of one clinical child and adolescent psychologist, and two part time Aboriginal health workers for an overall population of 30,000. There is an adult mental health team, with a full time psychiatrist who can provide some backup in emergencies, but in general our service has very limited capacity. We supplement the videoconference program with phone calls, emails and visits (although the best I personally can manage is a visit every 3-4 months). During the two days I usually see a number of current families or some new and/or urgent assessments, and provide some ongoing support and supervision. In the evening the team and some other colleagues usually dine together, which allows ongoing clinical discussion, an improved understanding of local issues, and some strategic planning. On the second day we usually have a large-scale consultation with other services working with young people. I would like to share some of the cases from the most recent visit because there is something quite terrifying about their severity and complexity but, in addition, I think there are some important learnings that we need to consider in our quest to advance mental health in Australia.

The first child was a 7-year old boy who about three weeks before had tried to hang himself - with intent to die. Luckily he was discovered very quickly and transferred to the base hospital for immediate assessment, being discharged the next day with no obvious sequelae except the rope burns. He attended my interview with his grandmother and an aunt, having driven about 150 kilometres from his community. The precipitant appeared to be teasing by an older boy building up over some weeks,

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and this has now been dealt with successfully by the local school. The boy lives with his grandma and two younger siblings, another sibling living elsewhere with an aunt and her family. His natural mother seems to travel a great deal, and had been around with a new baby for some weeks, although she had moved on by the time of the most serious bullying incident, and was therefore not available to her son when he needed support. Grandma and another aunt with some professional training had been supportive, but had many other calls on their time. During the interview, the boy sat quietly near me, personable, friendly, playing with some toys, but not offering comment. He did later on become animated and responsive during a shared drawing game that led to a symbolic intervention about confidence and self-esteem. Assessment suggested he is bright, managing his education and development well in the absence of the bullying; there were no current symptoms, no formal diagnosis, no immediate treatment, and very limited possibility for ongoing professional care. The best we could do was to ensure that the school issues were sorted, and that the family supports remain strong and vigilant.

There are many issues here. How can the boy's self-esteem be maintained? Who will monitor his progress into the future? How can the boy be helped to reach his optimum? Do we review and, if so, when? How do we manage such a situation at a distance, with such limited capacity? But the key issue for me was the lack of primary attachment figures, leaving him vulnerable into the future, despite his kindly (but overwhelmed) grandma. Another issue for me was the general disappointment from the family and from professionals that I had not supplied a diagnosis, a label. There is no formal therapy, no quick fix, and no medication. Agreed, if we had the resources and could manage the distance, it might help to develop an ongoing relationship in which we could come to understand better how this very interesting and articulate boy thinks, and how we could help him to avoid such an impulsive gesture in the face of future challenge, and work on his relationships and the supports. But that is pie in the sky.

The second case had some similarities, if somewhat less drama. The parents reported they are increasingly troubled by their 7-year old son who has become angry, with some physical lashing out. Many questions had been raised by the school, and others, as to whether he has ADHD or emerging conduct disorder, and whether medication would be helpful. Again, my assessment showed a boy of average ability, pleasant, polite, funny, easy to interact with, and with very few signs of any formal disorder. He did not seem to have any understanding of why he became

so angry. The family context slowly emerged at my questioning, and was complex. Dad had been a binge drinker over many years and this was often accompanied by violence to his wife to the point where he had been convicted of domestic violence and stayed in gaol for six months some 18 months prior. Somewhat reformed, he now worked hard for his family, had gained tolerance for complexity, had not been violent for the best part of a year, but claimed that Friday night was his to drink with his mates if he wanted to. His wife is of Aboriginal family background, and over the last year or so had housed her extended family – which had become one focus of conflict. During the interview she said that this was just what you did, even if it led to overcrowding and conflict. She agreed that this had been central to the marital discord, but explained that it was just about to change, and a date had at last been set. A further difficulty, central to the parenting, was that the father had ongoing doubts that he was in fact the father of the boy, and despite all evidence to the contrary, this had acted to alienate him from his son. This was a pivotal point in the interview, and the father became visibly upset and choked up. The boy moved over to hug him and eventually sat on his lap during a discussion of how his father parented him (poorly) and the importance of 'psychological parenting' and transmission of life skills. Our dad agreed (much to the delight of his son) that he could play a much clearer role in the parenting, would help his son to learn how to control anger and violence (given his expertise), and would seek out some shared 'mates' experiences. The mother looked alternately relieved and choked up herself, but both physically and emotionally appeared to move closer to her husband.

I am not sure what the long-term outcome will be, but clearly we need for our psychologist (who played a part in the interview) to review and reinforce what was decided. This *is* possible given the family lives in town, and has agreed to follow-up. Again, though, there are questions to be raised. Why this need (from all sorts of other services) for a label? And why does everyone leap to the idea that some sort of medication will be helpful? We seem to have lost our understanding of how young people develop psychologically, and how they respond to complex family dynamics, and the fact that they may not *be* the problem, but rather they are 'the symptom of the family problems'. Everyone wants what I call 'tick a box' child psychiatry – tick off the symptoms, make a quick diagnosis, based on how many criteria can be conjured up – however thinly they are described and however poorly corroborated by multiple sources. Then you can slap the kid on methylphenidate or risperidone, brush your hands, and move on to the next case.

But then there is the other side of the story. Families seem to be under increasing pressures, but have not gained (or have lost) the ability to solve problems and keep their lives together and on track. Central to this again is the issue of attachment; if the parents themselves have experienced limited attachment or shaky, anxious attachment (and cannot get their own needs met), then they do not understand the need for (or perhaps do not have the capacity for) closeness, find it hard to focus on the child's developmental needs, and have no idea about the importance of shared mentalisation. It is striking how often there is a sense of relief when you begin to explore these issues, when you can draw parallels between how the parents were parented and how they are parenting, can gain agreement for the need for change, and then begin to discuss simple ways of managing the behaviours in a way that avoids repeated negativity, and the ongoing development of shame in the child. On this latter point, I have been re-reading a small, delightful and largely forgotten text by Haim Ginott (1965), *Between Parent and Child*. A delightful read, full of simple wisdoms to be shared with parents, this should be required reading for every professional dealing with children. It could also be required reading for every parent raising a child. The third case was again very complex; a 12- year old girl with cerebral palsy and marked speech impediment who is at a special education centre and causing emotional and physical pain to the dedicated staff members. She had escalated her verbal abuse over the previous months, was well known to fight with other young people, and anyone else who tried to intervene. Staff members were unsure they could contain her any longer, and begged for medication. I saw the mother and daughter together with our psychologist and then saw them with the two teachers. Once again no one had thought to explore the background family issues, which were severe. A single parent mother in a very depressed state, was struggling with our girl at home, but had four other children of her own at home. In addition she had her sister and *her* five children living with them. The whole system seemed overloaded, and Mum just had no time or emotional room for dealing with her daughter's problems, and no one else seemed to care. In the consulting room, after exploring some practical and financial options, as well as considering the mother's sister's options, we were able to (at least temporarily) re-engage Mum and daughter – with appropriate displays of affection. It seemed clear to all that the (somewhat understandable) neglect had left the daughter feeling that no one cared, and so she acted out at school. An extensive examination of the management program at school discovered a range of behavioural options that the staff

apparently had not tried and, for the time being, we have been able to avoid medication. The two staff members attended the second day professional discussions and seemed pleased with what they had gained and re-committed to the program of care. Again I was reminded of Haim Ginott's (1998) elegant and delightful book *Teacher and Child* – simple wisdom, without being simplistic.

Again there are the issues similar to those already discussed – the need for an additional label, and then medication, with little sense that family dynamics may play a role – and may be amenable to change. The impact of rural issues (discussed in an AeJAMH editorial last year - Martin, 2007), in this case were lessened by having a service with dedicated staff available locally.

The last case was one I had originally assessed in Brisbane a month prior, and then referred on for extensive tests; a 4-year old girl with possible Autism. I say 'possible', because she has delays in several areas of development, and a marked expressive speech problem where she speaks in a very eloquent gobbledegook. However, she is friendly, plays well on her own and with her brother, makes good eye contact, and has few mannerisms. In this case we *have* to make a diagnosis; this child will need considerable help with education over her years of schooling, and the only way to get the extra resources from the Education Department is to provide a label – possibly 'pervasive developmental delay' would be sufficient.

There was something very different about this presentation compared to the others. This girl is the cutest little person, and everyone's heart melts when they see her. She has some engaging behaviours, and is rarely difficult or angry, though she can get cross if a routine is upset. But the engaging personality makes her very easy to like, and to want to help. The other issue is that her mother is absolutely bonded, has energy, personal resources and support in the home. The special kindergarten school has also engaged her well and she finds their strategies helpful at home. Another point is that our client is fully attached to her mum. So, we have some hope for change. And finally, by chance, an excellent Brisbane service for Autism has an outreach to the country centre and is willing to provide ongoing and appropriate care after kindergarten.

When I review this set of experiences, I am struck by the sheer difficulty and complexity of the clinical problems, and the way in which living in a rural or remote situation can make life extra difficult – with the tyranny of distance, and the very limited capacity of local helping services. I am also struck by the difference that a caring, well-resourced, and child-focused family can make to either the outcome, or our sense of hope

for the outcome. Central to this is the issue of attachment. When this does not exist for whatever reason, I feel despair. I felt despair for the young suicidal Aboriginal boy, cared for in an instrumental way, and with some love, but without that deep sense of knowing that he was cared about. Despite the small change visible in therapy, I despaired for the young boy with the Dad who was not committed because he wasn't sure of the paternity, and thought biological parenthood more important than psychological parenthood. Despite all of the resources provided to the young lady with cerebral palsy, with the quality of family emotional neglect, and despite the microscopic change in therapy, I despair for her future. There is a tide of poor parenting in Australia that is reaching the proportions of a tsunami. I am not sure that we have been able to get either State or Australian governments to fully comprehend the devastation and the intergenerational legacy that will occur over the next generation if we cannot support families with children under 3 years to develop that close bond of caring attachment.

All families and young people have challenges. Our job as therapists is to do our very best to help to set things back on track when overwhelming challenges occur. A 'tick a box' approach does not help – only a genuine therapeutic alliance and an attempt at deep understanding of the complexities can work. And if we don't spend the time to get it right, the need for resources will get greater, the demands for labels and spurious medication approaches will get louder, and service costs will skyrocket. Our job as Australians is to shout loudly about Social Exclusion, and the needs of an economy that is undermining good attachment, and sound family values. We must ensure that we provide the best opportunities for future Australians to gain the resilience they will need to overcome the adversities of a muddled and troubled world.

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Thirty

The Struggle to Evaluate Prevention Programs[90]

Evaluation, particularly of complex or multi-component community prevention projects, is a struggle. For a start, there are so many ways to avoid doing a really good evaluation that will tell us something about a program. We may be resistant from the start, resentful of funders who expect or demand an evaluation because 'of course' the program will work – it is the best answer or the only feasible answer to the problem everyone is trying to solve! We could argue up front that it is going to be too complex to evaluate our special program, or too costly, or that (and we have heard this) it would be too intrusive or against privacy and/or confidentiality to ask detailed questions, or that young people (in particular) are poor informants and so any results would be spurious. We could be so enthusiastic about the development of the program itself, that we quietly forget to think about evaluation until we are into the last quarter of the project and then there is a mad scramble to seek responses from co-workers and/or the clients we access to demonstrate that we have been busy and productive; even if we cannot say exactly what we have achieved in detail or that the program has had a specified impact on the target problem, or an outcome in terms of change for the better. Those who are enthusiastic about evaluation may put together a bevy of fancy instruments that we have always wanted the opportunity to try, and/or that look good up front to the funder, but then struggle to be able to sort out something statistically meaningful from the tangle of results. At worst we may have little skill at evaluation, but not want anyone to know. Or we may have some experience and skill but then be too embarrassed to ask when we get into a statistical mire. OK, to a

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certain extent we may be exaggerating, but our bet is that you will have heard some of this discussion before.
So where to from here? Well first we want to argue that we have an obligation to evaluate. Then we want to walk you through two programs that have demanded careful thought, yet still involve us in a struggle. Finally we propose an overarching schema, drawing on literature from other fields of human endeavour.

The Obligation to Evaluate
The obvious place to begin here is that commonly we are using other people's money, most often public funds of some sort. The funds are not always recurrent, and if we want the funder to keep on funding programs (for us or others) there is a realistic expectation that they are entitled to a clear understanding of how the funds were used. It is unusual for funders to be happy with just naming rights, or the knowledge that people were employed. Most funders want to know what resulted from their outlay; at the very least was the proposed result achieved?
There is more. Within human services, we really want to end up knowing whether Program A is better than Program B, or under what circumstances Program A is better than Program B. Cost often comes into this. Can we achieve a really good result as achieved with Program A, but much more cheaply with an apparently similar but less costly Program B. Finally, we really do want to know whether Program A does achieve a result as intended but unfortunately has some short or long term side-effects, whereas Program B achieves the same result without causing any harm.
Of course, there is an overall issue of contributing to human knowledge, perhaps even the evidence base, but this should not be the primary aim of evaluation. We are not talking here about science for science's sake. We simply want to know whether something works (however we define that). Sometimes there are surprisingly simple ways to find this out, and we may only need to ask a group of people – as in a focus group – for it all to be abundantly and satisfyingly clear to all. But at other times we do have to work harder than that and follow some formal protocol for the world to be convinced that we have discovered something special.

Keeping it simple
We want to make it clear from the beginning that we are trying to offer some relatively simple steps, even where there is complexity. We are perhaps more addressing the philosophy of doing evaluation, than providing a guide. There are a number of accessible national documents

which provide guidance and/or a much more in-depth discussion of evaluation (for instance Commonwealth of Australia, 2001; Mitchell & Lewis, 2003). What we want to do most of all is to examine the struggle. To do this best, we want to share a couple of programs where we have struggled with evaluation – one where we are managing, and one where at the moment we are not (but must continue).

Optimism Plus Queensland

This program trains, and provides ongoing supervision for, class teachers to teach 10 weeks (1 term) of one hour a week optimistic thinking, followed by 10 weeks (1 term) of one hour a week social skills development. So, overall it lasts 20 weeks or the equivalent of two school terms (one semester). The program is based on original work from Martin Seligman's group in the United States, and was adapted for Australia by Clare Roberts from Curtin University in Western Australia, where it has been thoroughly evaluated as a universal program (and given a high ranking by the new *KidsMatter* program - Australian Principals Associations Professional Development Council: APAPDC, 2008), but also more recently as a preventive program (Rooney, Roberts, Kane et al., 2006). Because all children in a given year get the program, it is non-stigmatising and 'universal', and the primary aim is to develop an optimistic thinking style that may have longer term implications for the prevention of specific problems such as anxiety or depression. Our Queensland trainers have been trained and supervised by the Curtin group to maintain some faithfulness in program delivery. The program may be delivered in Years 6, 7 or 8 with minor variations.

The first question for which we want an answer is whether the program is acceptable to teachers, and also to students. The answer appears to be 'Yes', and on both sides it is described as fun. Not only do students gain the constructs easily; teachers often describe change in their own ways of thinking. Oh, and so far in five years of running the program, we have not had any complaints from parents.

The next question is whether we can measure change, and perhaps replicate what others have shown. At one level this is easy; you simply ask the same questions before you start the program, and then again at the end of the program. The obvious target for this is optimism itself, so we chose to use the Life Orientation Test – Revised (LOT-R), a very brief instrument which directly measures optimism (Scheier, Carver & Bridges, 1994). In a recent sample school, we have been able to show an improvement in scores for 85 students from a mean 14.5±4.1 to a mean 16.2±4.4, and the probability of this being a chance result is statistically

very small ($p<0.0001$). Of interest we were also able to show some change in the range of scores. While the highest score remained 23, the number of students scoring 20+ rose from 10 to 27. Conversely, and perhaps of more clinical importance, those scoring 10 or less reduced from 13 to 9 students. So it looks like the program does what it is supposed to, and fits the model of prevention described by Rose (1992).

The next question of interest is whether anything else changes. We chose to look at this using a simple, free, publicly available and easily scored 25-item measure, which has been chosen as an outcome measure for child and adolescent mental health across Australia – the Strengths and Difficulties Questionnaire (SDQ: Goodman, Meltzer & Bailey, 1998). The advantage of this is that we can compare our population with large national and international databases, and get a very good idea of which young people in our sample may be more like young people who attend mental health clinics. Again we were able to show big change in overall scores – from a mean of 10.0±5.3 down to 8.7±5.0 ($p<0.005$), as well as a reduction in the numbers scoring into what could be called the clinical end – again producing a change which fits Rose's idea of shifting the overall population away from the problem end of things. There is much more that could be discussed here (for instance to do with the sub-scales), but it is part of a current paper about to be sent for publication.

Finally we wanted to know whether the program had some impact on depression itself. Again we have been able to show a reduction in the overall mean Center for Epidemiologic Studies Depression (CES-D) scores from 13.2±10.4 down to 9.3±7.1, and within this shift there is a remarkable reduction in young people scoring over 30 (down from 6 of 85 to nil). So if we put these three results together, a picture begins to emerge which should satisfy an evaluator and a funder. Change is possible as expressed in both an improvement in wellness, (or at least that bit measured by the LOT-R), and also, conversely, reductions of mental health problems, measured using valid and reliable instruments.

There are all sorts of further questions that then need to be asked. First, what would have happened if we had done nothing? Luckily, there is now quite a body of work suggesting that the percentage of emotional or mental health problems begins to steadily increase from about 12 or 13 years of age (for instance see Fergusson & Horwood, 2001). Further, there is a body of scientific and controlled work on this particular program showing that if you do nothing, things get steadily worse.

Admittedly we ourselves have not yet done the scientific research thing; to do a randomised controlled trial. If we had the resources, (people, money, time etc.), we would very much like to complete this kind of

study. On the other hand, given the international experience over the last 20 years with programs like this one, it could be argued that it is immoral to withhold such a program, despite rather poor longer-term results from a somewhat similar recent large-scale program. And this of course raises further questions, among them that of dose. How many sessions over what sort of time do you need to actually get a result that can be sustained? Well this, for the future, enters much more into the realms of research proper, and moves away from evaluation as such. In any case that is not where our interest has been.

What we have been trying to do is to build bridges with schools to support them in the work with young people. So we have made some additions to the original optimism program which we believe are exciting, and meaningful to students, their families, and the schools. In addition to the Universal program, we have tried to add a 'Selective' tier, and if necessary then add an 'Indicated' tier (using the language of Mrazek & Haggerty, 1994). In detail, we decide which young people appear (as the result of their three questionnaire scores at the end of the 20-week program) to be at some risk. We then sit down with senior staff and counselling staff at the school. We are not (and should not be) privy to the student names, but the school uses the identity number of the student to assist the process. We ask if the school has identified any given young person, and what they have tried in the way of helping to find a solution. About 50% of the young people we identify as having ongoing problems, are already known to the school counsellor or psychologist. The other half are not. We proceed to discuss possibilities for the school to assess and/or intervene. Over time we then jointly track this process. This is the Selective process around a group of young people identified as at risk; most can be managed at school using various supports and usually engaging the parents. For those where we think the situation is outside the school's ability to manage we have a couple of choices – assist with referral direct to mental health personnel or services (which schools really appreciate), or a strategy we are increasingly using which is to use the MINI Kid (Sheehan, Lecrubier, Sheehan et al., 1998), a semi-structured brief diagnostic questionnaire which takes 30 minutes, and gives us information about DSM-IV diagnostic categories. Armed with school information, three sets of scores and the MINI Kid, we are able to smooth referral processes to relevant services, and gain rapid access for the young person and their family.

We are adding levels of complexity here, and have still not yet designed a satisfactory way of evaluating how much we assist those who need more than the school can offer, or need frank mental health care. From

the feedback so far, we are fairly convinced we are doing no harm to the young people; rather, we are speeding up access to required help. Parents seem mostly satisfied with the process, but schools have been truly delighted by the level of co-operation we have been able to achieve. Now we have a new struggle to evaluate the program because it diverges from most other similar basic programs. We also have the massive problem of persuading a large number of schools to take on the comprehensive program, and fund the evaluation and discussion process. But that may be in another life...

CadetLife

Let us tell you about the second situation – *CadetLife*. This is a program devised collaboratively over three years, which aims to raise emotional wellbeing in the 22,000 cadets (ages 12-17 years) (army, navy and air force) across Australia. A second component of the program is to improve pathways to care outside the services for any cadets who present emotional problems. The major target is reduction of emotional problems and serious outcomes like suicidal behaviours (though suicide is not specifically discussed unless informally brought up by cadets). The program is based on facilitated group discussions of 13 key areas of problems identified in a Delphi process. Thirteen DVD based 3-minute scenarios are used in a series of 45-minute group processes to engage cadets in semi-structured discussion. We have supplied training to facilitators, and a beautifully produced glossy manual with directions that can be taken up during discussion, along with exercises for cadets to complete. In addition, a number of adult mentors have been identified for each service to provide support for a geographic group of facilitators, processes for management within each of the services and for accessing relevant services outside of the Cadets when necessary.

On the face of it we have a similar process to *Optimism Plus*. We have a specified input with school age young people (admittedly not within the school environment), where we should be able to do a pre–program questionnaire and follow up with an identical post–program questionnaire. Simple eh? No! The *CadetLife* program is a busy one, and it is proving difficult to get local groups to insert discussions into their once a week program because of all the other things they have to do.

So what is a minimum dose? Do we need to demand all 13 scenario discussions are completed before we can evaluate sensibly? For the pilot we set a minimum dose of six scenario discussions, but even this proved complex. Then there is the issue of which scenarios. Six are essentially about problems that could lead to referral. The other seven are about

aspects of mental wellbeing. But, unlike the optimism program, they do not follow one theoretical principle – they were devised from the committee discussion process, and are therefore cogent (and brilliantly filmed and emotionally moving), but a bit of a mish-mash. Supposing an individual service chooses all of the pathways to care scenarios rather than the mental wellbeing development ones?

We should tell you that we have had phenomenal support from top brass, each of the three services, strong support for the program from the staff we have trained, good feedback from the cadets who have been through the program, and the beginnings of strong support from parents. We may well see some change on our pre post questionnaires (if we can get there).

But this brings us to the final point we want to make. We are adding a program on top of an existing program (or even more than one). Young people, being of school age, may well be influenced by the programs that exist in the school. They may be influenced by programs added to the school ethos – such as *MindMatters*. Cadets choose to join up. They may already be strong minded and positive thinking young people. The *CadetLife* program develops fine young people in part through the forces' environment and chain of command, but also through the personal development that occurs as cadets work through the individual sessions and the process of gaining seniority and rank. We think we can add something to that! And those associated with the program have some of that belief too. But how do you evaluate a program that is flexible and may promote individual paths for cadets? How do you evaluate layer upon layer upon layer to understand the unique contribution you have sought to make? We are committed to an evaluation, but have to acknowledge we may not be able to prove the unique contributions of *CadetLife*.

The Preventive Fraction

Fortunately, there is now an emerging science around this very issue, which concerns the Preventive Fraction (PF). It has occurred mainly in spheres outside of mental health in other medical sciences, but some work is beginning to appear in mental health (e.g., Cuijpers, Riper & Lemmers, 2004), and eventually we may all have to begin to get our heads around it, or perhaps get assistance from someone who has done the groundwork to understand the complexity. The essential question relates to the number of 'cases' prevented by exposure to preventive factors or specific interventions in combination.

The other side of the coin, Population Attributable Risk (PAR) - that is teasing out at the population level (or large group level) exactly how much various risks contribute in combination - is quite well understood (see Goldney, Dal Grande, Fisher & Wilson, 2003 for a discussion in the area of suicide prevention). Conversely, studies in suicide prevention using the calculations of Preventive Fraction are practically non-existent. An exception is a study evaluating the impact of the US Air Force suicide prevention program (Knox, Litts, Talcott et al., 2003) in which the Preventive Fraction was calculated. In the study, this was defined as the percentage of risk reduction. This is calculated as 1-RRx100; where RR is relative risk calculated as:

$$\mathbf{(RR)=Risk_{(exposed)}/Risk_{(unexposed)}=[a/(a+b)]/[c/(c+d)],}$$

and a=subjects who had the outcome and were exposed to the program, b=subjects exposed to the program without the outcome, c=subjects with the outcome but not exposed to the program, and d=subjects not exposed to the program without the outcome. Results in the Knox study, from what was a very large population-based intervention were very promising, with 33% suicide risk reduction, 51% reduction for homicide, as well as 54% reduction in severe family violence.

But the construct, and in particular the mathematical formula, make your eyes cross. And yet, if we in Australia seek to produce work of international importance in prevention of adverse outcomes, and begin to understand the complexity where layered protective factors may exist, we may have to come to terms with Preventive Fraction and the mathematics behind it. We are struggling with the possibility that this may help us to come to grips with our *CadetLife* program, and if you too are struggling to evaluate preventive programs, then PF may be coming to a statistician near you.

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Guest Editorial: Too important to ignore: Siblings of children with special needs (Kate Strohm)
Evaluation of a family-based intervention for siblings of children with a disability or chronic illness (Rebecca Giallo, Susana Gavidia-Payne)
Can identified stressors be used to predict profession for mental health professionals? (Robert King, Chris Lloyd, Verina Holewa)
The recovery journey: Employment support for people with depression and other

mental illnesses (Ian Munro, Karen-Leigh Edward)

Challenges to relapse prevention: Psychiatric care of Indigenous in-patients (Tricia Nagel, Carolyn Thompson, Neil Spencer)

The response of children to the psychiatric hospitalisation of a family member (Harry J Sivec, Patricia Masterson, Janice G Katz, Sandra Russ)

Thirty One

On Social and Emotional Wellbeing and Indigenous Australians[91]

For the last year, I have had the privilege to work with an Aboriginal Australian academic Dr Norm Sheehan, who joined us to complete a post-doctoral thesis on Social and Emotional Wellbeing (SEWB) and Indigenous Australians. The work was funded by Health Promotion Queensland, through the Centre for Rural and Remote Mental Health Queensland, and we have been assisted by an eminent expert advisory group drawn from national interests. The primary output is a framework for action and possible funding, and there are two parts. The main document *('Sustaining Connection'*) is about SEWB as a construct with implications for the future of Indigenous Australians and their communities (Sheehan, Martin, Krysinska and Kilroy, 2009[92]). A second linked document (*'Identity, Voice. Place'*) is about SEWB and implications for suicide prevention in Indigenous Australians (Krysinska, Martin & Sheehan, 2009[93]); this will be handed to the Queensland Government Suicide Prevention Strategy Expert Advisory Group, and may have some influence on funding approaches over the next few years.

As might be expected, with both frameworks, the task has been primarily an academic one. We have scoured available national and international published literature as well as reading every other relevant policy and strategy document we could access. We have emailed and teleconferenced

[91] First published 2008. Martin, G. (2008) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 7:3.

[92] Downloadable as a free pdf from http://www.suicidepreventionstudies.org/index.html An alternative free source is http://www.familyconcernpublishing.com.au/category/resources/page/4/ Scroll down to July 1st 2013

[93] Downloadable as a free pdf from http://www.suicidepreventionstudies.org/index.html An alternative free source is http://www.familyconcernpublishing.com.au/category/resources/page/4/ Scroll down to July 8th 2013

with a large number of national and international experts in Indigenous matters, and followed both their advice and leads to others with strong opinions. But behind all of this has been (at least for me) a steep learning curve in Indigenous history and culture. Norm (who won a Dean's commendation for his PhD; Sheehan, 2004) has strong views on the last 200 years of Australia's history, and has confronted us repeatedly with the reality of genocide in this country.

Genocide is such a strong word, implying as it does a purposeful strategy of destruction of Indigenous culture and peoples; it has been hard to accept. But there is sufficient historical documentation providing evidence of not just neglect, not just attempts at assimilation, not just a stealing of children to 'save' them, not just an accidental mass infection with a myriad of diseases, but an intent to actively wipe out thousands of years of what we have seen as primitive cultures, cultures which in fact have been able to live in comparative harmony with the harsh realities of Australia rather than trying to fight it and change it. What has emerged is the need for us to reverse this trend, and develop a respect for Indigenous cultures, and assist them to rebuild their own families, their own communities, and their own culture in their own way.

Of course we are not the first to have said this, and within our searches we found any number of policy and strategy documents saying somewhat similar things, many of them not publicly well known, and many of them apparently ignored as far as funding and further action are concerned. So it will be interesting to see how our framework for social and emotional wellbeing is received and just how many of our recommendations see the light of day and/or receive funding.

The framework on suicide prevention has had some additional challenges. There is a considerable amount written about Australian Indigenous suicide, but so much of it has been more in the way of rhetoric rather than researched fact. This is nothing to do with the goodwill and expertise of those who have worked in the area over many years; rather it emerges out of the constraints that seem to exist in any approach to research or evaluation in Indigenous Australian communities. So, one issue is that we have had to rely on basic research work from abroad (for instance Boothroyd, Kirmayer, Spreng et al., 2001; Chandler, Lalonde, Sokol & Hallett, 2003; Chandler & Proulx, 2006; Kirmayer, Brass & Tait, 2000), which may not translate well to Australian conditions.

Nevertheless, there does seem to be international evidence that suicide prevention in Indigenous communities may not be about diagnosis of mental health problems and suitable pathways to care, but rather is about connectedness to family and community, a strong sense of cultural

identity, and self-governance. These do make sense, and much has been translated to the program level for Indigenous Australian communities. As yet, on the whole, we need stronger evidence from these programs before they can be accepted as successful. Further we need to understand how successful programs elsewhere can be translated successfully to other clan or mixed origin communities. One of our recommendations concerns funding of training programs for Indigenous workers given that it appears important both for the development of SEWB programs in communities, as well as crisis intervention and maintenance of pathways to care in communities, that there is a critical mass of trained and highly trained workers who are committed to working within their own community of origin. Another major recommendation has been that we need to fund a number of open meetings at which there is universal and high level representation from communities, at which we can share what is known about SEWB, and what is known about what might work well for Indigenous communities. It is unlikely that much headway can be made unless there is general acceptance of the recommendations, the framework, and the steps for a way forward.

There is of course an urgent need to move this work along. Some months ago I had the painful privilege to review some 22 Queensland cases of suicide in young people under age 18. Some of these were young people well known to mental health systems in that they had lengthy histories of contact, often a multitude of diagnoses or at least one serious mental illness, were on medication, and had been hospitalised at some point. The deaths raised issues about how generally we care for young people, how we work with the most difficult acting out young people, how we maintain our contact in a complex system of care, what signs we must look for to avoid an adverse outcome.

The stories were all painful to read; such a sad loss of young Australians. However, in many of them there was a sad inevitability to the suicide, as if the young people had suffered way too much in a very short time. On the other hand there were many young people for whom the suicide came as a surprise to everyone, an impulsive act often related to an adverse circumstance, and neither predictable nor inevitable. The most painful ones were several young (11-14 year old) Aboriginal Queenslanders and one young person from the Torres Strait Islands, where the knowledge of circumstances, the story, the attached professional notes of contact, were so limited that no real sense could be made of the death. How do we ever begin to advise on prevention when we have so little to go on?

Once again, I was persuaded that suicide prevention in young people is not about mental ill health, and pathways to care; more it is about their personal upbringing, the quality of family life, connection to parents, friends, school and culture, and the overall building of social and emotional wellbeing – more than, but inclusive of, resilience. This is our best chance; but where to begin and, in particular, where to begin for our young Indigenous Australians?

About a month ago I was intrigued by a rapid response to a sequence of five suicides of young people (over a year, but with a gathering crescendo over a few weeks). The community of Mackay was stunned - both professionals and lay people. As the services began to discuss and address the issue, given the number of Aboriginal young people, elders from local clans took a number of friends and contacts (about 15 or so I understand) away for five days of intense discussion in an attempt to avoid further copycat deaths. At the point of writing, I do not know the detail of what transpired, but it does appear to have begun the process of healing for the young people concerned, and would appear to have been an entirely appropriate response - so far, so good. I have been invited to Mackay next week to follow up with medical and community services, and I hope to have some discussion with elders; I want to learn more.

And then last week I visited Mornington Island (traditional home of the Lardil people) with two colleagues to scope how our eCYMHS[1] service might provide some clinical consulting or mental health promotion service to young people and their families. My psychiatrist colleague, who has three years experience with Aboriginal Australians in the Northern Territory, had spent several preparatory weeks communicating with professionals working on or visiting the island, major services on the island, as well as with elders from the community. Overall we were well received, and well cared for in accommodation inside the hospital compound; we were even allocated a 4-wheel drive to provide easier access around the island. We were able to meet key professionals (psychologists, nurses, Aboriginal health workers, and child safety, community health and Royal Flying Doctor Service workers) working directly with young people and their families. We heard about several innovative programs. One was a program from the local library, which had found a large number of old photos of people from the island in a mainland collection, and copied and enlarged to engage people in reconnecting with historical family. Apparently the response was terrific, and enduring. Another was a large group meeting for older women - ongoing, and providing both support and the opportunity to rediscover

connectedness, as well as have the odd whinge about grand-parenting issues and other things! There was reserve in some quarters, although we did not meet open suspicion; but I guess people are naturally wary about services visiting for the first time, wondering whether they will return, have the capacity to do anything useful in the longer term, and have the grace to work in collaboration with all of the myriad other services on their island.

There are, of course serious problems. Much of the residential area looked like a war zone, with little evidence of pride in garden or house. Many residents were attending the 'casino' – an ordinary house with a large veranda area - where gaming seemed to be in full swing for most of the day and night. Many others, with several generations in evidence, were sitting on other verandas doing not very much. We had to drive at about 15kms/hr. at twilight on each evening to avoid small children and dogs, and adults the worse for wear from 'home brew'. The 'canteen' (which sold limited amounts of beer) was removed from the island a year ago and now, we were told, residents make their own alcohol using yeast garnered from Vegemite or Weetbix! There is a high percentage, then, of Foetal Alcohol Syndrome, marital violence, and all of the results of alcohol driven impulsivity.

And there is a painful history, with loss of the traditional prawn fishing, the death of a market garden recently from too much salt in the water, some available work in the mines on the mainland, but little else to provide role, meaning, and worked-for income. More serious was the loss of a number of elders in a plane crash about eight years ago, which seems to have ripped the heart out of the community. No work, nothing to do, no-one to manage community life and pass on traditional culture. When we talked with two elders on the last morning, they both had similar messages – there is no respect for traditional culture, no respect for elders, no respect for the old ways, no respect for language, and no respect for the land. There is an immense need to return to country, but there are problems here, too. The internationally famed Mornington Island dance troupe is failing for lack of community interest, the one remaining 'Songman' feels unable to pass on the traditional songs because there is no interest from the younger people. These are Australians, and you get the strong feeling we have failed them, and (despite all the different services trying their best) we continue to fail them. So what can we do that might make a difference?

Given our child and adolescent focus, we put some faith in the school, and had a lengthy discussion with three teachers. Two key issues emerged. First there is a large amount of bullying, which seems to have provided a

reason for non-attendance. And the second issue is that only about 100 of the 230 children registered attend school on any sort of regular basis. And when you think about it, why would they – given what they see and hear, what they live, and what they must be told of their future with no hope for work or meaningful role? A few young people have succeeded fairly well, and then left the island for further study. The local Police-Citizens Youth Club (PCYC) is running sports programs in a fairly new gym set on a struggling oval. Again some young people have succeeded at sport and left the island to pursue a future. We suggested to the teachers that one strategy might be to offer breakfast to bring the kids in; they are doing that, but with only some success. We explained that, elsewhere, successful programs ran a bus, and collected the young people to bring them in for the breakfast; they told us they were doing that. We then talked about a third strategy that I have seen work elsewhere – building of a pool on school grounds, only available in school hours to those who have attended all day. There is no pool on Mornington, and young people swim in the sea, at some risk from sharks and from salt-water crocodiles. Although there have been discussions, I understand, and although many others believe a pool might be a good idea, nothing has happened at this point. A pool might have other spin-offs for the community in bringing people together in a more positive way than the casino; maybe. There might be physical spin-offs for young people – not just in terms of physical exercise and fun, but in terms of reduction in ear and skin infection; maybe.

When I suggested that the death of the elders had ripped the heart out of the community, there is an odd irony. The local art group and gallery have a very successful program of art training and sales. Recently, a beautiful glossy book (Evans, Martin-Chew & Memmott, 2008) was created to show off the art of many people from the present back to the past of the Roughsey brothers and others. The book is called *The Heart of Everything*; ironic in a community with no heart.

Yesterday, I was phoned by one of the island's doctors seeking advice about a 14 year old boy who had been smoking regular, excessive marijuana. After a fight, he tried to hang himself. We explored the immediate risk, and the possible need for assessment in Mt Isa, two hours flying time away. Can we change things for this young man with current resources? Maybe, but he is the tip of a very large iceberg, I suspect. And this is not about classic mental health care. This is about someone helping the community to reclaim country, community, family, identity and role. There is a need for collaboration between services to build on what exists to provide relevant programs. There is a need for productive

work; available on the island. There is a need for meaningful pathways to adulthood. We need to assist the school with some collaborative programs. And someone needs to help the 'Songman' pass on his skills before it is too late. And they need a pool; now.

NOTE

1. **eCYMHS** is a service to rural and remote areas of Queensland, run from Royal Children's Hospital CYMHS for several years. The mainstay of the service is regular (fortnightly, or in some cases weekly) videoconferencing by a psychologist, and a child and adolescent psychiatrist, supplemented by face to face consultation, support and supervision visits every 3-4 months or so.

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'Sometimes it's harder to speak out things': How first year New Zealand tertiary students use informal online communication to help solve significant problems (Fleur Piper, Barbara MacDonald)

In young people with a depressive disorder, does diagnostic specificity matter in the prediction of suicidality? (Sarah E Hetrick, Alasdair Vance, Nicole Hall)

Polarisation and political correctness: Subtle barriers to consumer participation in mental health services (Brenda Happell)

Increasing child and adolescent mental health content in undergraduate occupational therapy, social work and nursing programs: Lessons learnt (Mathijs Lucassen, Iain Doherty, Sally Merry)

Sleep disruptions and mental health of primary caregivers of persons with disability due to chronic mental and physical conditions in the Australian population (Lawrence T Lam)

Improving mental health and wellbeing in Scotland: A model policy approach (Jennifer Smith-Merry)

Does family intervention for adolescent substance use impact parental mental health? A systematic review (Eva YN Yuen, John Winston Toumbourou)

Use of the Strengths and Difficulties Questionnaire in identifying emotional and behavioural problems in children of parents with a mental illness in Australia (John Mathai, Sean Jespersen, Angela Bourne, Tony Donegan, Akinsola Akinbiyi, Kelly Gray)

The psychic disequilibrium of adoption: Stories exploring links between adoption and suicidal thoughts and actions (Susan Gair)

Letter to the Editor: Equity of access for Indigenous young people to detention centre based mental health and substance use services: Revisited (Stephen Stathis, Paul Letters)

Thirty Two

On Ethics and Research[94]

Once again several issues seem to have coalesced in my thinking, and brought me to the point of writing this editorial. The first is that this morning I was reading about a piece of research on soup. A 2008 study in the United States 'found that eating soup 30 minutes before eating lunch resulted in a 20% decrease in the amount of kilojoules eaten at lunch. And it doesn't matter whether the soup is chunky or pureed' (reported by Carr, 2009). This was apparently a serious piece of funded research. Now is there anyone out there who could not have guessed this, or actually would not have known the result for certain (give or take a couple of per cent)? I assume someone wrote a formal grant application, and some poor ethics committee had to give serious consideration to the ethics of making people wait 30 minutes before getting their main course. All to wrap some supposed science around what my grandmother always knew – that soup is nourishing, fills you up, and reduces the craving for sweets later in the meal.

In the immediate post-war years, with the context of rationing, my mother was an expert in this, and vegetable soups were plentiful in our house, because anything using sugar (or indeed butter, eggs and meat) was rationed. Why do we need such research, when there are so many serious issues to be examined? Is it ethical to use up research time, energy, ethics committee time, grant funds, subject time and energy eating soup and then lunch, reviewers' time, and space in journals, on a frivolous approach to proving the wisdom of ages?

Ah well, I guess we should be grateful next time we are in a busy restaurant, and it seems an endless wait between soup and the main course. We have both a talking point, and a possible 20% decrease in the amount of kilojoules we may later crave to eat.

[94] First published 2009. Martin, G. (2009) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 8:1.

But seriously, my group is currently doing battle with various ethics committees, so the issues are in the forefront of my mind. I have been working hard with four psychology honours students over the last couple of months, helping them to devise studies in the general area of self-injury. Studies that might excite them, keep them focused over the next 6 months, lead to some unique contribution to our scientific knowledge in this hard area of clinical practice, but also provide them with a good process of science to get them a first class honours degree rather than a second class honours. Anyone who has been there will know how important this is for their future career in psychology – particularly if they seek to do postgraduate study.

Why self-injury? Because that is our general area of scientific study at the present, we believe it is an important area of work toward suicide prevention, we have just completed a large national study as well as a video-based professional training manual, and because we have a plethora of unanswered questions. We had developed about 10 suggested studies in rough form, so when the students arrived we at least had something to discuss. One student decided to investigate her own interest about culture and its influence on coping style and the influence to self-injure. This is a classic study; a straightforward online survey of first year psychology students, and we have had no problems getting through the ethics process because the methodology is ordinary and acceptable. There is an ethical issue though; one that is not much talked about. Students are invited to complete questionnaires in first year psychology ostensibly as part of their learning; they get credit for each bit of research they do. So there is a form of persuasion to get research done – although of course students can choose which online surveys they complete. Because we are investigating self-injury, I have personal anxieties about raising such an issue when there is no pre-arranged follow-up. So we have had to work this through, and made students aware that in the 'exit interview' (historically just a handout about the study) they may, if necessary, have to refer a student to the campus medical centre.

Another study was developed after a week or so of student thought (not liking our pre-set ideas) and is asking an intriguing question – why do people cease to self-injure? Again, a simple cross-sectional survey design with first years, and quickly through ethics (despite the focus). Within hours of going online, 39 surveys had been completed, and there is a sprinkling of ongoing self-injurers as well as some who have stopped. A way to go still, but we are very hopeful of sufficient numbers to allow us to analyse the data with a degree of confidence. Some of you may be

surprised that university students self-injure, but in a recent study from our collaborators (Hasking, Momeni, Swannell & Chia, 2008), 43.6% of university students reported having self-injured, 10% frequently and severely.

The third study was unable to be put through the psychology ethics process and has, understandably, had to go through a more rigorous process because we are seeking to examine a program of novel group therapy. If you review the literature on treatment of self-injury in young people, you will see that therapies are less than convincing, although there is some promising work on Dialectical Behaviour Therapy (DBT) (Binks, Fenton, McCarthy et al., 2006). We recently spent three years doing a collaborative replication of some United Kingdom CBT-based group therapy that looked promising (Wood, Trainor, Rothwell et al., 2001). We had to get ethics approval from nine different ethics committees in New South Wales and Queensland, went through an arduous process of training, gaining subjects, faithfully following the British design, and trying to manage a one year follow-up. The results are less than satisfactory, and do not support the UK program (Hazell, Martin, McGill et al., 2009).

So, on the basis of our hard won experience, we are working with our honours student to do a randomised controlled trial on another therapy program – initially in university students who self-injure. Hopefully, we will gain enough interest to trial a waitlist design this time, then move to a comparison with DBT down the track, and then a third study in the clinical context. The ethical problems of course are about bringing a group of self-injuring people together, and what this may create. Our experience is contrary to that of inpatient or closed units; we have found the group process to be positive, with few pitfalls. In fact, many of our young people continue supporting members outside the group through SMS and personal contact. Another issue supposes that a problem arises deriving from the therapeutic process – a provoked crisis; we have made provision for a clinical psychologist and a psychiatrist to be immediately available. Another issue derives from our wish to reimburse both test and waitlist groups according to University principles; we have had to detail the process of this very carefully to try to get it right. I am certain there will be other hurdles we will have to overcome (this work is now published – see Martin, S., 2013).

The program that has caused most ethical concern has been one that you might imagine would be easiest. By looking at the electronic records of our Child and Family Inpatient Unit over five years, we discovered that 32% of the 7-14 year olds had self-harmed. Of course, we were intrigued

but did not have the clinical person power to analyse this further. So we have asked one of the students to analyse 79 sets of electronic records and case notes. The psychology ethics group was not happy, on the grounds that the student is not a clinician within our service. The problem would be that although the electronic records would be de-identified, every single page of case notes would have an identifying sticker. So how could privacy and confidentiality be maintained? All data extracted, of course, would later be de-identified. But had the parents of the patients on the ward given signed permission for the notes to be examined at some later date? What would happen if the student gained information about someone she knew – if remotely? So, we have had to take advice, and look closely at our ethics process and application; we may well have to have a clinician present while notes are examined, and provide some surety that no individual details will be taken outside the service. Complicated, isn't it? You would have thought that a fourth year psychology student could be seen as nearly a clinician, and counted as ethical. So how do you go about what is essentially an evaluation of service, as much as case review, in a way that satisfies ethics committees? You might think evaluation of clinical service would be a priority, with clear ethical guidelines to assist services to do the work.
The final issue I want to raise about our student studies is that all of them should be published. There is so much data stored in filing cabinets that never sees the light of day. Sadly, I am as guilty as other researchers, and we have completed several studies for which we do not have the time or people resource to work up publication. Most students just want to get their honours degree, have a restful summer break, and then rapidly move on to masters or PHD studies. Mostly they have not had the experience of publishing, and don't have the drive. Often they don't believe that their work is good enough to publish, and are intimidated every time the issue is raised.
But I believe it is unethical to use time developing an ethics application for a good study, take up the time of ethics committees, supervisors, subjects and markers, and then not publish what may be an important contribution to our knowledge. Our students should publish if only to stop someone else doing the same study down the track.
I raised this array of issues with our senior child psychiatry trainees last week in a presentation on Ethics. Of course, our College of Psychiatrists has a guide on ethical behaviour (RANZCP, 2004). Principle 10 relates to research, and is that we are bound to 'adhere to ethical principles embodied in national and international guidelines as implemented by the relevant institutional ethics committees'. Although there are 15 dot

points, none of them drills down well enough to help with, for instance, retrospective reviews of case notes. There is nothing that refers to retrospective case note review in the National Statement on Ethical Conduct in Human Research (NHMRC, 2007), and only a single oblique reference in Challenging Ethical Issues in Contemporary Research on Human Beings (NHMRC, 2006). Given my interest in research in Aboriginal social and emotional wellbeing, I also looked at Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (NHMRC, 2003), with no luck. Despite this, a brief online review reveals hundreds of case note reviews that have been given approval over the years, many relating to childhood. I guess the devil is in the detail, and we will just have to accept the interpretation of ethics, and meet the requirements of our local institutional ethics committee (which we have now done).

The final issue to prompt me to consider writing about ethics is that I have been asked, as part of my new role as national advisor on suicide prevention to the Australian Government, to present a keynote summarising the research to date on Bereavement after Suicide. I will be chairing a plenary discussion at the upcoming 2nd Australian Postvention Conference 'Connectedness – A Link to Hope' at the Melbourne Convention Exhibition Centre, 21-23 May 2009. Following this, I have been tasked to draw together a summary position statement. In preparation, I have been reviewing the literature available through PubMed and other databases, reflecting on the months of work we put into the national consultation and review for the national bereavement strategy (unpublished work by Peter Bycroft, Judith Murray, Sue Scheinpflug and others), and contacting colleagues who are active in bereavement support programs (e.g., Jill Fisher from the Standby program[95]).

So I was intrigued to read the Botha, Guilfoyle and Botha (2009) article in this current issue of AeJAMH (see list of papers at end of this editorial). I am in agreement with much of their synthesis of the research, and in broad terms with their conclusion. However, I am somewhat concerned at the call for further research, and I would like to go through some of the issues they raise to explain why. There can be no doubt that grief and bereavement are issues that cause humans both acute and ongoing distress. It is a truism that each loss we suffer adds to our store of

[95] Details on this exceptional program can be found at http://www.unitedsynergies.com.au/index.php%3Foption%3Dcom_content%26view%3Darticle%26id%3D39%26Itemid%3D23

expectation of our own demise, which is not comfortable to have to think about at any stage of life. Further, there is a wealth of research to demonstrate the physical and mental health associations with complicated or unremitting grief. Botha et al. and other reviewers provide extensive lists of research reports to support this and, despite all the academic arguments, it makes me wonder whether we need more research. Why do we have to go on and on proving the 'bleeding obvious'?
The second issue relates to whether the grief and the process of bereavement, after an expected death such as suicide are worse than, or potentially more dangerous than grief from other deaths. Again, there is now an immense amount of research, most of which has led to argument and, of course, further research. (If I am cynical, or if you have recently accessed the Cochrane Review Database, it is always amazing that review conclusions always seems to call for more or 'better' research.) There are always individual case differences, but anyone who has spent time with people or families bereaved through suicide knows about the impact of the shock, the perplexity, the sense of alienation from friends and society, and the restriction of subsequent life activity. The need, it seems to me, is not for further research to keep on 'understanding things better'. A strong case can be made for ongoing evaluation of programs to ensure we meet the expressed needs of patients or clients and their families, rather than some projected 'need to know' of clinicians or researchers.
As I am fully aware from our work with self- injuring young people, extraordinary care needs to be taken to ensure that we are ethical in every way when we seek to create a new piece of research. I think this begins with the 'soup principle'. If everyone pretty well knows the answer before the research even begins, then the research process is frivolous, and should be blocked – hopefully early on by a supervisor or a colleague. If not, then later by an ethics committee. If there are genuine and serious questions that remain to be answered and ultimately are important for the quality of care we can provide, then we do need careful research that has been through the peer review process of an ethics committee that has been clearly informed of the needs.
One last point. In our randomised controlled replication of the UK work on self-injury, several young participants told us that the two-hour interview using the K-SADS semi-structured questionnaire, was 'the longest that anyone had spoken to them about their problem', or 'the most interest that someone had shown'. This is sad. If we translate this to the issue of bereavement after suicide, it is worth noting that several research groups have argued that the research process has been beneficial for the subjects! It is always important to know that our

research process is not harmful, and it is always good to have positive feedback; but this is not an argument for continuing research. It is an argument for more universal, best quality, well evaluated, and ethical, programs of immediate and longer term care for those in distress.

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The role of empowerment in setting a foundation for social and emotional wellbeing (Komla Tsey, Desley Harvey, Teresa Gibson, Liz Pearson)

A review of engagement of Indigenous Australians within mental health and substance abuse services (Stacey L Berry, Trevor P Crowe)

Solving suicidal problems online: Who turns to the Internet for help? (Keith Harris, John McLean, Jeanie Sheffield)

Beyond normal grief: A critical reflection on immediate post-death experiences of survivors of suicide (Kelly-Joy Botha, Andrew Guilfoyle, Derek Botha)

Research priorities in suicide prevention: A qualitative study of stakeholders' views (Sara Niner, Jane Pirkis, Karolina Krysinska, Jo Robinson, Michael Dudley, Emily Schindeler, Diego De Leo, Deborah Warr)

'Who cares?' An exploratory study of carer needs in adult mental health (Donna McAuliffe, Laurie Andriske, Elva Moller, Mary O'Brien, Pam Breslin, Paul Hickey)

The experience of being a peer outreach volunteer: Benefits and challenges (Robert King, Chris Lloyd, Alexis Clune, Rowena Allan)

Development and preliminary evaluation of an employment resource for mental health service consumers, families and carers, and clinicians (Meredith Harris, Catherine Cleary, Joanne King, Geoff Waghorn)

A survey of occupational therapists providing services under the Better Access to Mental Health initiative (Danielle Hitch)

Farm Advisors' reflections on Mental Health First Aid training (Delwar Hossain, Don Gorman, Rob Eley, Jeff Coutts)

An assessment of family care for people living with schizophrenia in Delta State of Nigeria (Christian Ewhrudjakpor)

Thirty Three

On Remembering and Forgetting in Prevention[96]

As many of you will have realised from previous editorials of mine, I have a passion for suicide prevention, which has been actively maintained for over 20 years. As part of this I try to keep aware of emerging issues both in Australia and abroad, and try to make sense of patterns and trends. I belong to an international email discussion list 'SUICIDOLOGY@LISTS.APA.ORG' (listserv maintained by the American Association of Suicidology – www.suicidology.org), and a recent post and the subsequent discussion may be relevant for us in Australia.

The post related to press coverage of a report from the US Department of Labor (www.google.com/hostednews/afp/article/ALeqM5iGUMhWYHz9Q2O0A37Qd4DK_motmg). With the title: 'US workplace suicides jump 28 per cent', the article went on: 'Washington - The financial meltdown is taking its toll on the workplace, where the US Labor Department found a record 28 per cent rise in suicide rates last year amid widespread layoffs and overall belt-tightening.' Apparently, '251people committed suicide at the workplace in 2008', despite 'a 10 per cent drop in the total number of people who died on the job' from all causes, a 20 per cent drop in 'fatal work injuries in the construction sector', and an 18 per cent drop 'in workplace homicides'.

The report goes on: 'Several other studies have shown the psychological impact of the economic recession on the US population'. Then, in the next to last paragraph, the report reminded readers: 'More than 30,000 people commit suicide each year in the United States, where suicide is the second highest cause of death for men aged 25 to 34.'

The increased rate of workplace suicide is in the context of overall reductions in deaths at work (which may result from the overall smaller workforce in the US). So the suicide rate increase against the overall population of workers could be higher still. If this is so then, despite the

[96] First published 2009. Martin, G. (2009) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 8:2.

cushioning of the impact of recession in Australia, we should be taking notice, and be prepared for an increase in suicides in the workplace, but also an overall slowing in our current rate of reduction in suicide rates in Australia, or a real increase. I note in the original press report that the spokesperson for the Department of Labor did not comment on the suicides, but used the reduction in figures as a caution 'that strong safety enforcement remained key to prevent such incidents. In fact, today's report prompts us to step up our vigilance, particularly as the economy regains momentum.' That is, as the workforce recovers, the trend might be reversed.

The worry is the lack of comment on suicide, and how this can be dealt with. Will 'vigilance' about safety matters in general have an impact on suicides, or do we need specially designed programs? If we need specially designed or targeted programs, then what would these look like? How come these are not already in place given we have been working hard at suicide prevention internationally for many years?

I took notice of all of this because I am fortunate to be a board member of a potentially great program beginning to show quite interesting results in the early evaluations. Ozhelp Queensland's 'Mates in Construction' (MiC) has just won a Suicide Prevention Australia 2009 LIFE Award (category: Business and Industry), despite the fact it has only been going for a year. The program developed out of perceived need. Construction workers (mostly males) consistently have rates of suicide in Australia at least 2-3 times the rates of men in general (compared age for age). Not only do they have the well-known problems of men (not recognising or necessarily having words for feelings; not wanting to reach out and talk to anyone; being generally dismissive of professional help; not following through with help when it is offered), they work in a fickle industry which is physically hard, with very long days, where dismissal may be instant - at the end of any day.

The Building Employees Redundancy Trust[97], which provides redundancy benefits and training grants for employees in the Queensland building and construction industry, were horrified by the figures and worked with unions to gain initial funding for a trial program. Queensland Health has subsequently provided considerable support, but essentially this is a program 'by the industry for the industry'. I would argue this is one of the reasons it looks like working.

MiC is already working with over 30 large construction sites around Brisbane, based on management and union agreement. The program

[97] www.bert.com.au

(based on the existing OzHelp model[98] which includes programs such as ASIST[99], and a Life Skills Toolbox begins with general awareness training, and so far about 2,500 workers, managers and apprentices have completed this in South East Queensland. Within each workplace, volunteers take on the key role of 'Connectors', identifiable and available to talk to any troubled worker and help link them to appropriate support at a site level. Nearly 400 connectors have been trained in 'SafeTalk' in Queensland.

A common misconception is that 'blokes' will not access help, but MiC[100] has already undermined this idea. From each of the awareness trainings, up to ten per cent seek some further discussion locally or with OzHelp Queensland, which now carries a caseload of active clients. About five per cent of these deal primarily with suicidal thoughts, and two per cent overall have needed an active intervention against suicide. Has the program had an impact on rates of suicide in the construction industry? It is too early to tell. Will it stem a rising tide of recession related problems? Maybe. The program aims to spread rapidly across the whole of Queensland, and provide the necessary supports for a troubled industry. So, we will see! (please see reference list at the end of this editorial for two more recent publications which provide updates of the program after 5 years).

What I like about the program is that it was not designed by experts in mental health, but draws on knowledge and principles that Auseinet has been promoting for more than 12 years. It is clearly a Prevention program; which raises awareness not just of the targeted problem, but of problems in living more generally. In addition, it has a synergy with existing programs targeting safety, and this has enabled a strong and rapid uptake. It has immediately obvious benefits for both workers and managers. It includes a strong basis of Mental Health Promotion geared to the audience, in language that is easily understood and acceptable. Finally, there is a carefully constructed (sorry about the pun) Early Intervention program, which has already saved lives.

Many people stumble over the phrase 'Mental Health Promotion, Prevention, and Early Intervention', and have problems sometimes describing what is meant because of the jumble of theoretical ideas involved. 'MHPPEi' is now rather glibly thrown around as a short form, and sometimes sounds like we have two tongue studs combined with

[98] www.ozhelp.org.au
[99] www.livingworks.net
[100] For the latest information please see http://www.matesinconstruction.com.au

dysarthria. But when you come across a program like the one I have described, it elegantly draws together all the remembered elements from what Auseinet has been trying to promote for a long time.
Of course there is a history to this awkward terminology, which began over 12 years ago with Early Intervention being translated to 'Ei' for a Logo for Auseinet. Easy, we all knew what it meant. When Auseinet was broadened out to include promotion and prevention, it seemed so simple to add PP at the front and continue the theme of the logo. But eventually we had to distinguish ourselves from all those preventers of physical illnesses. Now we have 'MHPPEi'. The problem is that if we just use the 'Prevention' (which would be technically correct), it is possible we would have to keep deconstructing the word to help people remember all of the elements that need to be included in a comprehensive program.
I am in the middle of developing an opening keynote for a prevention conference in Brisbane. The title of the conference ('Priority One') reflects the fact that MHPPEi is now priority one at the Queensland State level. Through the Council of Australian Governments, prevention is at the forefront of thinking about mental health in all of the States and Territories. So the dreams of the early '90s are now a reality. I guess we are stuck with a piece of awkward terminology.
Returning to the suicide prevention listserv discussion, one writer made the point that these deaths are at the workplace, but may not be related directly to work; we carry our problems from home and elsewhere into the work place. So the deaths may or may not tell us about conditions at work. An eminent suicidologist Dr Lanny Berman responded to this (and I hope he does not mind being quoted): 'we do not know what proportion had been laid off, were about to be laid off, were told by their spouse that morning that their marriage was over, lost retirement funds with Bernie Madoff, were gainfully employed but hated their co-workers, were about to be exposed for accessing child pornography on an office computer, were chronically depressed and currently suffering from several days of acute insomnia, or any of several hundred other competing hypotheses. Sound bite = Whoa! Don't jump to compulsions (sic)…"
All of this is true, and as the OzHelp Queensland program has evolved, it is clear that the underlying problems that workers face are not just from the construction industry, but very much the problems of everyday living. A wide range of problems has been dealt with, and this suggests just what may be needed. Perhaps ordinary blokes need to have resources made available more generally, geared to the right level, and which assist them to solve every day problems in a straightforward way

rather than throwing their arms up in frustration and disappearing off to the pub. At the hard end (i.e., with suicidal men), we have needed to collaborate with existing services to ensure ongoing safety and therapeutic help. This interface between the program and mental health services has caused some problems. Men are not good at using the right key words to access services, often minimise their problems when faced with a professional, and are all too happy to accept the problem may have gone away when they are faced by professionals who are rushed, tired, and not used to dealing with men's problems.

Another contributor to the listserv noted how their local newspaper had picked up and republished the story in a less than critical way, and 'with "increased suicide" in the title' speculated that there seems to be an increased public and media interest in the US around suicide.

Consonant with this, I am noticing a recent change in the reporting of suicide in Australia, with what appears to be a loosening of the media's sense of responsibility; I don't know whether other countries (in addition to the US) are noticing this too. As you will know we have had a media strategy as part of our Australian National Suicide Prevention Strategies since 1995 or so. There is a National Media and Mental Health Committee, which continues to meet around the issues, and provide a platform for discussion between mental health practitioners and the full range of journalists (radio, TV, newsprint etc.). We have an online site for journalists[101] that provides up-to-date knowledge and stats, as well as advice on how to frame articles and what tags to place at the end. There are also several watchdog organisations (e.g., SANE Australia - see their site www.sane.org) who are active in trying to damp down stupidity. Many of us believe that these processes have made a strong contribution to the overall reduction in Australian suicide rates that has occurred since 1997.

Despite all this ongoing activity, it seems to me there has been some recent corporate forgetting in the context of lowered rates. So, there was the extended beat-up over two supposed 'Emo' suicides in Victoria which left us gasping at the explicit reporting. There is no evidence as far as I know that suggests an increase in suicide related to this press coverage, but why take the risk of other young people copycatting.

There have been some recent idiotic cartoons in national press, like the one by Bill Leak showing our Prime Minister (after a series of public gaffes over whether the Chinese had paid for international holidays) handing our then Minister for Defence a gun and telling him to 'do the

[101] www.mindframe-media.info

right thing' (if he could find the bullets)! I understand that our PM does not sanction ritual suicide. But the publication by a national paper does suggest this by association. And I would argue that such cartoons, while reflecting an existing societal belief we have been fighting for ages (that falling on your sword is the correct response to public failure), then perpetuates the myth.

More recently there were four suicides in one school where the reporting has been 'crazy'. I use the word advisedly. Too much comment, too many photos, every rule devised to protect young people from the influence to copycat broken in the still strongly held belief that 'it is in the public interest'. Yes, but so is reducing the likelihood of suicide in young Australians 'in the public interest'.

The latest one was a supposedly comic segment in a television show, about special high schools that had special programs to develop bullies for the corporate sector, but where '..our failures top themselves...'. Again, such idiocy just adds one more reminder of the spurious belief that failure should lead to immediate self-removal from the gene pool.

It amazes me how soon people forget the lessons forged in this hard area of preventive work over the last 20 years. Of course it may be that the older generation who had responded to awareness and education programs have moved on, and we need to be mindful of the need for educating a new generation of journalists. We have to be constantly vigilant and active against the 'forces of darkness', provide constant reminders to new generations. Occasionally we may need to smack people publicly.

Prevention is a hard area of endeavour. It demands that we have a full understanding of the facts and pathways to a particular outcome, and in mental health, this is often hard to achieve. Conceptually prevention is complex. It is always difficult to work out how to get the best result for the available funding. Should we use an Early Intervention approach that is more understandable to funders because they can see the link between a set of risks and the possible outcome? Should we use a Health Promotion approach which may be difficult to argue when evidence is less than convincing as yet, and we may still be basing the approach on the opinions of experts? It is always hard to gain sufficient funding in the first place because of the time it takes to gain a reasonable result. Why would funders or governments fund programs for generational change where they may not be around to see the results.

With MHPPEi as 'Priority One' in the rhetoric of policy, we have achieved much. But, we must continue to be clear about the reality of what we have learned about prevention. We must remember the lessons of the past. We

must not allow others to forget the hard won knowledge gained over the last 20 years.

I think there is one more item to consider. Sometimes when the passions of visionary professionals are corporatised, they take on a life of their own, and are prey to all of the bureaucratic processes which get applied – formulaic responses, endless committees, repetitive reporting, loosely construed evaluations and so on. In this we can easily lose some of the lessons we have gained. It behoves us as individuals to remember, to take every opportunity to remind others of the value of prevention work, continue to add to the research in this complex field, continue to publish our successes and our failures, and help a new generation of mental health professionals come to terms with complexity, tolerance of uncertainty, and the drive toward innovation. In addition, we must remember that we do not have to do all the work. Sometimes others outside our own field of mental health can adapt the principles we espouse to their own environment and create a sustainable program where you and I would not even reach first base.

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Martin G. & Gullestrup, J. 2014. Help-Seeking and Men: an innovative suicide prevention program from the Construction Industry. Chapter 26 In *Men and Suicide*. David Lester (Editor). CHARLES C THOMAS, PUBLISHER, Illinois, USA.

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and their family carers (Jeffrey Chan, Trevor Parmenter, Roger Stancliffe)
Investigating the strengths and difficulties of children from families with a parental mental illness (Darryl Maybery, Andrea Reupert, Melinda Goodyear, Rani Ritchie, Peter Brann)
Fathers as informants of children's fears and worries (Marilyn Campbell, Linda Gilmore)
Toward an understanding of how art making can facilitate mental health recovery (Theresa Van Lith, Patricia Fenner, Margot Schofield)
Volunteering as a community mental health educator: Positives and negatives for recovery (Shelly Read, Debra J Rickwood)

Thirty Four

On Managing Change[102]

I have been struggling to find something suitable to write about for this Editorial in the final issue of the *Australian e-Journal for the Advancement of Mental Health*. In part this relates to the pressure to complete a submission for the April 2010 Senate Inquiry into Suicide and its Prevention in Australia, and another submission to the Children's Commission in Queensland on how we can reduce suicide in young people in Queensland, where the rate seems to be much higher than other states of Australia. Prior to these, I had been tasked by the Department of Health and Ageing to write a comparison of national suicide prevention strategies across the world to see what might influence our thinking[103]. I wanted very much to have this one complete so that I could use parts of it for my arguments about suicide prevention in the two submissions. Were there some useful threads that came together? Of course, in a broad sense they will not surprise many of you. What appears to have made change in successful strategies around the world is 'help-seeking'. Underpinning this is an educated and knowledgeable general public (including young people) allowing them to know when it is critical to seek help, and know how they might go about it. Second is an educated and relevant workforce, regularly updated about best practice in crisis work, clinical management, and prevention strategies that will reduce the likelihood of suicidal behaviour. Third is a critical mass of accessible

[102] First published 2009. Martin, G. (2009) Editorial. Australian e-Journal for the Advancement of Mental Health (AeJAMH) 8:3.

[103] Martin, G. & Page, A., 2009. National Suicide Prevention Strategies: a Comparison. Centre for Suicide Prevention Studies, Discipline of Psychiatry. The University of Queensland. ISBN 978-0-9808207-9-9. Commissioned review, DOHA, Canberra. Downloadable in pdf format (accessed 14.1.2014) http://www.livingisforeveryone.com.au/Library-Item.html?id=82 Alternate source (scroll down to paper): http://www.familyconcernpublishing.com.au/category/resources/page/4/

clinical and support services in all communities, available to deal with help-seeking appropriately as soon as it occurs. How we achieve all this in our massive country is perhaps for a future editorial after we have completed the Inquiries. Anyway that is not what I wanted to write about at this time.

Something else I do not want to write much about in this last and very special issue of *AeJAMH*, is to do with the content; the editorials and papers. While I have written about my extended family experience of children of parents with mental illness in the past, and continue to have clinical experiences of relevance to the area, I think I should leave it to the experts who have contributed to the issue. I owe a considerable debt to Andrea Reupert and Darryl Maybery who have worked hard as our guest editors (and under some uncertainty at times) to bring together a group of authors from around the world who have broad expertise in, and clear understanding of, the complexities. I thank them, the authors and those who have written editorials for this special issue. I know this will be a major contribution to our field and both reflect and drive advances in mental health (please see list of papers at the end of this chapter).

What I want to write about is 'change'. Let me begin with some recent personal experiences, move on to two recent clinical cases, and then return to this journal.

My daughter has recently made changes in her career from being an actor with a singing voice 'to die for' to a Voice and Movement Therapist with a flourishing private practice, trained in Martha's Vineyard in the United States, and now completing her Masters degree. VMT[104] is one of the expressive therapies and incorporates work on the voice, with body awareness and movement, artwork, diaries, and aspects from a range of other therapies including cognitive behavioural work.

Sophie has recently worked with our team at The University of Queensland and a small group of self-injuring young women. The results have been surprising and encouraging, and have given us enthusiasm and courage to do more research on what is a very integrative therapy, balanced between right and left brain ways of doing things. Thus far our previous experience (and our clients' experience) of proven therapies like CBT, applied to self-injury, has not been good (Hazell, Martin, McGill et al., 2009). The research on Dialectical Behaviour Therapy (DBT) does

[104] Voice and Movement Therapy was developed by Paul Newham (http://www.paulnewham.com/). Also see http://www.iavmt.org/index2.html. And for Australians, see http://vmtoceania.com/about-voice-movement-therapy-oceania.html

seem quite good in this area (Linehan, Comtois, Murray et al., 2006), but young people find the commitment to a lengthy program of therapy, and the demands of the intensive nature of the therapy, too much and often drop out. Expressive therapies are more engaging and more fun, and may go some way to holding the young people in therapy for the requisite sessions needed to make consistent change.

We are already asking the question 'What makes change?' Our consensus is that expressive therapies seem more comfortable from the start, despite the presence of others in the room, and the anxiety about sharing. Group cohesion occurs rapidly, and the acceptance by others of bits of the young person's story *and* their pain (as told through art or dance or song) provides early relief. So, is it the shared experience of a novel process supporting exposure of pain that leads to change, ('We are all in this together')? Or is it acceptance by others that leads to finally being able to box up the issues and store them, not allowing them the space to intrude into daily living? Certainly there are parallels in individual psychotherapy where the acceptance and 'holding' by the therapist of the pain of personal experiences provides acknowledgement of 'OK-ness' and the ability to move on in daily life.

Sophie has just returned from two weeks in Kenya where she was working with a group of therapy colleagues in a program for severely abused women. 'Why go to Kenya', I ask, 'when you can find severely abused women in Australia?' to which of course the answer was 'Because I was asked'. Past this, and my relief that she was home safe and sound, Sophie had an extraordinary set of stories to tell. What intrigued her most was that women could be so severely and repeatedly abused (and physically damaged), but have reached a point of acceptance and have moved on. 'That was in the past; I need to get on with my life'. And they did, leading as full a life as they could in the context of the slums outside Nairobi. And their spirit shone through the videos I have seen.

My father has just passed his 90th birthday and we had a large, extended family celebration to mark the occasion, and honour a survivor. He is ex Royal Air Force (like his father and four of his brothers) and during World War II spent 15 months as a radio operator in northern France. In 1940, he was chased and shot at by the advancing armies, and eventually rescued off the beaches of Dunkirk in the 5th wave. I cannot imagine the terror that must have existed in the exit from France, the ever-present danger, at the age of 23, of being killed. He has never spoken to me of his experiences until one night about four years ago when we were watching the movie 'Dunkirk' on the TV. He sat

impassive with a tear trickling down the side of his face. I asked if he was okay. 'Yes, of course...it's stupid of me…but I was there'. When I asked him to tell me more he gave me the bare bones in three sentences, refused to discuss what happened to his colleagues, and then said 'Well, all of that is in the past…you just have to leave it behind…and get on with your life'. He has done just that. He has never suffered from psychosomatic illness, or post-traumatic stress, and is robust enough to have survived a recent severe bout of toxic shock from an infected gallbladder while travelling through the United States on holiday to see one of his surviving brothers. He had surgery, recovered over two weeks, then just got on a plane to the United Kingdom to see more relatives.

Is it the shared experience of War that helped him to box it all up? I don't know. Is it that he worked the process through in the first few years afterward with colleagues over a drink? I don't think so. He was back at work with the RAF after three days leave. I don't think he was ever seen for any sort of psychological assessment; the duties of war were all too consuming. He, like many others, just accepted the personal cost of war, and moved on. And his spirit shines through.

So how should people react to immense trauma and change at a personal or family level? Are some people just stoic enough to get on with life, if left alone? Should we be seeking to explore the events that changed their lives, then help them celebrate their ability to incorporate all those changes in their life and survive? Or do we just need to not make a big fuss, hold their story, hold their pain, and encourage them to get on with life?

I have assessed two young people in the last couple of weeks for whom the emotional pain must be intolerable at times; yet their spirit shines through. The first is 14 and the daughter of professional parents. She has had an insidious onset of dysthymia over 18 months, and is now in a full-blown first episode of major depression. She has all the neuro-vegetative features, and no relevant past or family history to suggest how she came to get this illness. Of note there is a quality to her nihilism that I have not seen for a long time in someone so young. In the middle of a rational conversation she will suddenly drop into: 'I am empty. I am not worth anything. I am never going to be anyone or do anything worthwhile. I have no skills. Why don't my parents let me just die?' She has self-injured, but so far not attempted suicide. She has been in regular therapy with a psychologist, and recently I put her on an SSRI, from which she got side-effects within two weeks. We switched to an SNRI ('What happens if that doesn't work? You see, my body is just useless!').

On the other hand there is an observing self which arrives with a wry smile ('I suppose I am just going to have to put up with this until *you* get the medication right. Perhaps I just need to do some extra sessions at work'). She has just completed the school year and not done too badly considering her cognitive processing and memory problems. One saving grace is the number of friends she has; she is well liked, even admired. The other is a guitar she plays regularly in a band. At one session she told me how bad she is at this – 'it's a useless heap of shit, and so am I'. Then the wry grin appeared, 'I suppose it *is* keeping me sane'. At the most recent session she admitted she wants to make music a career, go to the local conservatorium, can see herself playing professionally. She began for the first time to plan what sounds like a reasonable career path, her parents have supported this. She is taking something that everyone else says she does amazingly well, and using it to stay on track, to cope. Her spirit shines through.

The second young person is a boy of roughly the same age. He is bright, academically doing well, but developing some delinquent traits, particularly at school where he has been 'on report'. The psychologist who treats him thought he lacked empathy, and was at times cold and distant, though engaged in an ongoing therapeutic alliance, and wanting to continue. At first he was not easy to interview, as is true of many 14yr old boys. He was edgy, fidgety, avoided eye contact, and responded with monosyllabic answers. When I suggested he tell me the worst delinquent thing he had done, a slow smile crossed his face, and he opened up. A long-term close friend had been abused at school by a teacher, and he and the friend had shouted rude words from outside her room, then run away (he laughed at the memory). We investigated several other episodes, none of them any worse (he smiled warmly with each telling). Then, gradually, the awful story emerged of an older brother suiciding last year after a very lengthy history of delinquency, violence, and drug abuse. It seems that the older brother had done some very nasty things to our young man over the two years before his death, and this had left him with awful memories, mixed feelings about his grief, and severe doubts about himself. He hates the brother, but feels guilt at his hatred. His 'naughtiness' could be seen as taking on the traits of his brother as a way of coming to terms with the loss, but I suspect the history of a very happy boy till the age of 11, the fact of achievement despite his complex grieving, the presence of close friends and that he is well liked by loads more, all mitigate against this becoming a long-term and dangerous pattern that might repeat tragic history. Once we broke through in assessment he changed and his bright spirit showed through. I was able

to reassure parents and the therapist that he will be okay. He probably needs to work through some detail of the horrors over the two years prior to the brother's death. The therapist will need to acknowledge his courage and resilience, and will need to 'hold' his pain; then let him get on with his life.

Change is the only constant in our lives. That is both a truism, but also an oxymoron if you think about it. Heraclitus of Ephesus (535-475BC) is reckoned to be the first who said: 'All is flux; nothing stays still.' And it seems that this is increasingly true in our modern world. You can look for your favourite cordial in the supermarket, but the maker can't get the lemons; they are not in season. Or the maker of your favourite cereal has changed the box, and you just can't quickly find what you are used to. Or the supermarket has moved all the shelves around because the new manager thinks it is more logical. I live an hour north of Brisbane, and both the main and subsidiary roads seem to have been in evolution for years. Every time you drive, the barriers are in a different place, or there are flagmen waving you over here or there and slowing us all down. And then, of course, living on an island we are all anxious about the rising sea level and what this might mean for our homes. A report comes out that says it is only rising a little each year; another comes out saying that global warming is having a catastrophic effect on the ice at the South Pole and the sea level will rise a metre or so over the next 50 years.

The modern update is probably Isaac Asimov (1920-1992) who wrote: 'The only constant is change, continuing change, inevitable change, that is the dominant factor in society today. No sensible decision can be made any longer without taking into account not only the world as it is, but the world as it will be.'

Given the purpose of this editorial, I quite like what Marcus Aurelius (121-180, Roman Emperor from 161) is reputed to have said: 'The universe is transformation; *our life is what our thoughts make it* [my emphasis].' We can react to change in so many ways; what we have to work out is how to get the best from life whatever comes along. At some level this is easy. If I know the lemons run out every year, and want my favourite cordial I can make a note to remind me to store enough to take me through the lean times. If I can't find something in the supermarket, then I need to have the confidence to be able to ask and get help, and not just feel stupid. I understand many stores change arrangements every few months to avoid shop-lifting; I guess we have to live with such things.

We have to learn patience around road rebuilding; it all comes good in the end. We have to have some faith in others (perhaps elected

representatives) who are in a better position to influence our lives for the better. Hopefully the 2009 Copenhagen ('Hopenhagen') Conference will guide us individually, as a country and as 'spaceship Earth', toward solutions for global warming and its consequences.

When something more serious happens to us personally we need a store of inner strength, we need to be able to ask for help, we may need patience, and sometimes we will need the indomitable spirit that is present (if sometimes hidden) in all of us as our human right, and we may need to trust that others at all sorts of levels will be there to do the best they can to help.

What do these stories tell us, and what is their relevance to this editorial? The demise of Auseinet had been on the cards for some time, particularly since suicide prevention was removed to a new host and a special program of its own with a loss of funding from the LiFe Strategy[105]. Despite phenomenal success in raising the profile of Mental Health Promotion, Prevention and Early Intervention over many years, through an excellent communication program, through newsletters, and the journal, through email alerts and the website, Auseinet has perhaps done the job we all hoped it would do. We have run that race, and we all need to move on, even if the principles and the practice need to be further developed. Many of our states have now made policy decisions, taken strategic action and applied more funding than ever to prevention in mental health.

The *Australian e-Journal for the Advancement of Mental Health* has been a very important part of that original communication strategy, and our thanks go to Jennie Parham and the Auseinet team for seeing its present and future worth and maintaining that part of the funding necessary for our three issues per year. We owe an immense debt of gratitude to Anne O'Hanlon who almost single-handed over all the years has provided dedication to a world-class product through clear vision, high standards, a supportive board, good choice of reviewers, and that eagle eye that editors develop. Not only have we been able to publish many excellent papers from those at the forefront of this important field, sometimes in themed issues, but we also have been able to help and guide so many new authors to share their work with others. Sometimes clinicians or emerging researchers are reticent to publish what they do; they feel the planned resources were outstripped by the clinical demand, or the program was not quite fully developed, or the results did not quite work out as expected. Without knowing what people do at all levels, we

[105] see http://www.livingisforeveryone.com.au

are destined to repeat history. So we have always believed a key part of the work of a journal has been to develop the field as a whole, but within this, to develop the skills of those who might not yet have had the opportunity to publish.

Behind the scenes, of course, we have had a small army ensuring that the style continued (thanks to Jill Knappstein's superb editorial assistance), and that issues were translated to the Internet allowing for smooth downloads of high quality PDF versions of papers. I would like to pay personal tribute to Steve Trickey and David Robley from Flinders University who have maintained the Auseinet site so well over so many years (on a shoe-string budget), but specifically have helped to drive the journal to a world-class product and have provided so much assistance in the current change environment.

So *AeJAMH* has to react to change, and after this last issue (Volume 8, Issue 3) becomes simply *Advances in Mental Health*. We have negotiated with James H. Davidson at eContent Management[106] (where there is a stable of other world-class journals) to take on the journal and guide its commercial development. Yes, I mention that word 'commercial'. Thus far the Australian Government has seen the need for a journal as part of a communication strategy for prevention in Mental Health, and explicitly supported the venture. How often do governments fund journals over so many years? It has been an extraordinary journey, we have been well supported, and we owe an immense debt to the Department of Health and Ageing for holding faith and being prepared to fund us for so long. Even at this point, they have been prepared to provide some transition funding to enable us to keep back issues free to download for a time-limited period; commitment indeed!

If we are to go forward, continue to build the field, continue with our precepts about building the science of 'advances in mental health', then we need you. We need you to write for the journal, we need your comments and feedback; we need you to contribute (if you can) through encouraging professional writing, or perhaps agreeing to review articles. We will need you to get used to some very upmarket, online ways of managing your articles, consistent with international best practice (we have a great team of experienced people just waiting to help you at eContent Management). Most of all we need you to come with us on this journey. You or your service, or library, can subscribe to the journal per annum, which allows free download of articles. Or you can browse

[106] http://www.e-contentmanagement.com/

and pay per download for individual articles or for whole issues of interest.

Our promise to you is to provide a high-class product to continue *Advances in Mental Health*. We want you to consider it worth your while to publish in *AMH*. We do understand the need for international journal ranking systems, but this will never outweigh our passion to advance the field, and those working in it. Of course we will publish Australian articles, but equally we will be searching for international content of relevance to us here; we live in a global environment. The current special issue on 'children of parents with a mental illness' demonstrates how well we can do. We will continue with the theming of issues, and will draw together guest editors as needed. Our planning cycle will extend so that you can see what we have coming up in future issues as you go online to browse.

So, change is inevitable. We had a good infancy and early childhood, and will survive this shift of attachment. We have a history of strengths, know who to ask for support, and have skilled people around us. We have a future, and an indomitable spirit to take us on the next part of the journey. Please stay with us.

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Also see a recent publication on VMT:

Martin, S., Martin, G., Lequertier, B., Swannell, S., Follent, A. & Choe, F., 2013. Voice Movement Therapy: Evaluation of a Group-based Expressive Therapy for Non-suicidal Self-injury in Young Adults. *Music and Medicine*. 5:1, 31-38. doi: 10.1177/1943862112467649

Papers from Volume 8 Issue 3 Australian eJournal for the Advancement of Mental Health are available from (http://amh.e-contentmanagement.com/archives/vol/8/issue/3/)

Guest Editorial: Practice, policy and research: Families where a parent has a mental illness (Andrea Reupert, Darryl Maybery)
Guest Editorial: Children aged 0-5 with a parent who has a mental illness: The need for early intervention (Nick Kowalenko)
Guest Editorial: Building the evidence base for families living with parental mental illness (Joanne Nicholson)
Guest Editorial: A message from Britain: Inquiries into child deaths – will it ever change? (Michael Göpfert)
Estimating consumer parenthood within mental health services: A census approach (Deb Howe, Samantha Batchelor, Katarzyna Bochynska)
Taking a closer look: A cross-sector audit of families where a parent has a mental illness (Sabin Fernbacher, Melinda Goodyear, John Farhall)
Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: I. The scientific basis to a comprehensive approach (Clemens MH Hosman, Karin TM van Doesum, Floor van Santvoort)
Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: II. Interventions (Karin TM van Doesum, Clemens MH Hosman)
Australian programs and workforce initiatives for children and their families where a parent has a mental illness (Andrea Reupert, Melinda Goodyear, Kylie Eddy, Chris Alliston, Paola Mason, Darryl Maybery, Elizabeth Fudge)
The Koping Program: A decade's commitment to enhancing service capacity for children of parents with a mental illness (Sophie Morson, Denisse Best, Nikki de Bondt, Mary Ellen Jessop, Thy Meddick)
CHAMPS: A peer support program for children of parents with a mental illness (Melinda Goodyear, Rose Cuff, Darryl Maybery, Andrea Reupert)
Commentary on consumer and carer participation in a national mental health promotion initiative (Chris Alliston, Cecelia Kluge, Elizabeth Fudge)

Thirty Five

On Bullying in Australia[107]

Everywhere I turn at the moment, I seem to be faced with bullying. The first opportunity for action in recent times was four years ago when we were asked to devise a suicide awareness program for the Australian Defence Force Cadets (ADFC), which includes some 20,000 army, air force and navy cadets across Australia. The request was in response to the suicide of a young female cadet, who had been bullied very seriously by a staff member, and could see no other clear way out of her predicament.

I have grave reservations about simply providing 'awareness' to adolescents, in any environment, because there is always the risk of encouraging what you most fear. I proposed that we devise a mental health promotion program that would essentially lead to lowered suicide risks, while actually never directly addressing the issue. We spent two years getting to understand the programs of ADFC, and the way that each separate service operates, and finally developed a series of thirteen probe video scenarios to be used in small group discussion with two trained facilitators for each group of ten cadets (Martin, G. et al., 2008). Half the scenarios covered some awareness of how mental health problems arise, and how to avoid stigmatising those who struggle. We devised clear 'stepped' pathways to care, and provided training for staff and senior cadets - who are essentially volunteers. The other half of the scenarios covered development and maintenance of wellness, resilience and connectedness.

One complex issue we tackled was how to maintain confidentiality in a youth centred military organisation, while involving parents and outside agencies in following up mental health problems. This model of both addressing promotion of mental wellness, while acknowledging, accurately recognising, and finding appropriate care for problems has

[107] First published 2010. Martin, G. (2010) Editorial. Advances in Mental Health 9:1.

been shown to work elsewhere, and can directly lower a population's suicide rate (Knox, 2004).

I consult to a Burns Unit, and one recent referral for assessment was a young man with a chronic abrasion to the forearm that refused to heal over many weeks despite escalating and heroic efforts by members of the Unit. Our patient had been in a woodworking class at his school, when he was attacked by another student with sandpaper which was rubbed up and down the forearm, with the enquiry: 'Does that hurt?' This was far from the first time our patient had been bullied; he describes almost daily slights, negative comments, jokes at his expense, and physical attacks. Increasingly he had not wanted to attend school, and the burn-like damage to his arm, with all the medical, nursing, and extra maternal care that was needed, had offered some respite from school and feral students.

The epidermis had been initially quite damaged but, strangely, lack of healing continued despite specially coated coverings and the use of a portable negative pressure machine. Burns specialists were worried to the point of seriously considering admission to hospital, and splinting of the forearm with a plaster cast to avoid ongoing suspected wound interference.

So why did this occur to this young man, from his particular background, at this time in his life? Well, for a start, our patient has red hair. As we know, in Australia, anyone who is remotely different can be the butt of teasing, and teasing related to being a 'ranga' had continued almost daily from day one of schooling. You only have to look up the definition on UrbanDictionary.com (accessed 2.8.10) to find out just how abusive language can become around this issue. He and his parents at one stage had gone as far as to dye his hair, but from time to time this itself had led to negative and bruising comments, so more recently he had decided to 'just put up with it'.

The second issue was that our patient had been adopted (by a childless couple), from Romania, at the age of 4. He had been in an institution almost from birth. From the pioneering long term work by Michael Rutter and the English and Romanian Adoptee (ERA) study, we know that infants adopted prior to six months of age can do quite well, but those who are older may struggle in a range of different ways (Rutter & Sonuge-Barke, 2010). Our patient not only had to learn a second language (and continues to the present in a special class for those with English as a second language (ESL)), but also needed extraordinary care from his parents and the extended family to get to the point where he can trust

others (somewhat, and sometimes). So, if he had been adopted in an humane country where people have respect for others, his adoptive parents' work might have been respected and supported. But Australia is not like that, is it? We expect that anyone will be able to stand up to anything – after all this a 'pioneering' country; our forebears could survive anything! 'If you can't stand the heat in the kitchen, then get out!' It seems increasingly as a nation that we tend toward xenophobia, and we stigmatise anyone who is remotely different, despite the fact that Australia has ostensibly welcomed over 200 different cultures to live within our society.

So our young patient has been bullied for being 'dumb', which in fact he is not. He does have some problems word finding, and there are lapses in his ability to memorise, but he shows quite high natural ability in a wide range of areas. While he does not particularly like school, he manages overall quite well. He really enjoys sport, particularly basketball which he plays before school and at each break in the daily routine. He is good at Australian Rules football, and without his current medical problem might well have been chosen for a recent special training camp. But there is an additional problem here related to his rather short size, which may be familial, but also related to long-term effects of malnourishment as a baby and young child before adoption. At present, of course, he is also hampered by a need to avoid body contact that may upset healing.

At a recent session he finally began to share the full depth of his feelings of being aggrieved. He has a deep sense that his life has been unfair, that he is a victim and cannot see a way out of this. He has developed a barely concealed, and barely contained, almost murderous rage toward the boy who attacked him, and believes that the apology, and the punishment (three days suspension), were nowhere near enough. He is almost as angry with the principal and several staff at school, whom he sees as not providing protection or acting quickly enough after each episode of bullying.

Clearly the primary issue here for me, as his therapist, is to work toward resolution of his wound so he can get back to being active and regain some esteem from his sporting mates. But I worry about the depth and longevity of his anger, particularly as we have recently been sensitised in Queensland by another student who was repeatedly bullied, and ultimately reacted by murdering his teenage assailant at school (Courier Mail, 29.04.2010).

Bullying is not a new issue of course. We ran a public forum on 27th July 2010, entitled 'Self-injury in schools: is zero tolerance the answer?' and one of our panelists (a long-time recovered self-injurer now in her 50s)

recalled that she had been bullied almost every day in school, could get no protection either from the school or her parents, and found that 'dissociation' was the only way to manage. She now finds it difficult to recall much else about school, which she describes as 'a blur'. She feels that much of her self-injury was caused by the bullying but, in turn, her self-injury made her 'different' and may have led to bullying.

My research team has a number of programs focused on this issue of self-injury at present, having just completed a large national study (Martin et al., 2010). Our previous work, and the publicity, has led to contact with a large number of young people who self-injure, and a history of bullying is frequently, and spontaneously, reported as a precipitant for episodes of self-injury.

One aspect of our work is trying to re-educate medical, nursing, and paramedical professionals who seem to think of self-injury as 'attention-seeking'. This seems to lead to bizarre responses like leaving the young person on a barouche (trolley) in a corridor for several hours before they are attended to – because their problem is 'self-inflicted' and 'attention-seeking'. Apparently, '…that will teach them a lesson.' I have heard several stories of professionals sewing up self-inflicted cuts with no anaesthetic, for similar reasons – 'to teach them a lesson', 'well, they seem to like pain', and 'well they did it to themselves in the first place'.

We recently interviewed a large number of young people on video for a training program in managing self-injury. One young person described how when she was on a high dependency ward, the button for her toilet was at the nurses' station. A particular night nurse had taken a dislike to her and, every 30 minutes or so through the night, would press the button so that the toilet flushed in the room, thus waking her patient. Another young woman (a self-injurer with recurrent anorexia nervosa) described being held down by four male attendants so that a naso-gastric tube could be inserted to feed her when she refused to eat.

All this seems to amount to 'medical (or professional) bullying', and certainly shows a considerable lack of empathy for human suffering, and a lack of understanding of the underlying issues. As well, the fact of such (un)professional behaviour 'proves' to the young person that they are unworthy, and therefore is likely to contribute to their need to continue to self-injure. And this is not the only area in which bullying occurs in hospitals. Having just myself spent some months in hospitals with a paraplegia, I was amazed on several occasions to find myself the subject of bullying; let me just give you one example. Because I am a doctor and work in the hospital in which I had become a patient, there were loads of visitors. I had continued to see staff and students and my secretary (after

all my brain was still sort of alright!). I asked for a single room – as a private patient. Eventually after repeated requests, one became available, and I was wheeled in. That evening I was told by a junior nurse I was to be moved out on the grounds they had a palliative care patient who required nursing in a single room. When I argued that I was sure they could find another bed elsewhere, the charge nurse was called, and I continued to do battle. She left very angry, and some hours later, at 9.30pm at night, the bed state manager appeared, very hot and bothered. He too was very confrontative, telling me I had no choice; I would be moved. When I refused, I was told he 'would take it to the powers that be'.

Nothing happened until 2 nights later when I was told I would be moved (appropriately) to the neurological ward for further care. I was moved at 11.00pm at night, and (guess what?) I was moved to a four- bedded ward. Again I had to rather sneakily chat up the senior night nurse (at midnight) to regain a (very available) private, single room (one of two!). Then, three nights later nursing staff were again trying to move me. Why do they move you at night? I suspect because there are no relatives to provide support or to witness the ruckus...

Australia seems to be experiencing a resurgence of bullying since the early work of Rigby and Slee (1991), and since McCarthy and colleagues wrote their seminal book Bullying from Backyard to Boardroom (1996). This resurgence seems to be almost universal with reports from primary schools (ABC News, Dec 2008; Martin, M. et al., 2008), high schools (Delfabbro et al., 2006; Martin, M. et al., 2008), families (Bullyonline.org, 2010; Reachout, 2010; Family Matters, 2010), workplaces (Safetyatworkblog, 2010; Wallace, 2009; Salusinszky, 2009), commerce (Schaper, 2010; Blundell, 2009), communities (ABC News, July 2010; Antibullying.net, 2010 – not about Australia, but has a good list of references), and politics (Peter Hallam, 2010).

Finally, let me make mention of a harrowing Channel 7 video (World Kindness Week, 2010, under Latest News), with transcript, that explores the terrible sequelae of bullying, and begins to address some of the preventive issues. Watch it if you can.

What is extraordinary is that we have recognised the problems from bullying for a very long time. The arguments against bullying are cogent, and policies and programs have been developed in almost all of the above arenas over the last 15 years (See Mindmatters, 2000; Australian Defence Force Cadets, 2010; Scouts Australia, 2009 for examples). There are tremendous online advisory sites with very sound advice (see Bullyingnoway), and a National Centre Against Bullying (NCAB) with all

the latest updates and research. Reports in the press occur almost daily, and there was a national conference organised by NCAB in April 2010, opened by the then Deputy Prime Minister with a very comprehensive address (Gillard, J. 2010).

Yet bullying continues. An increasing number of young people referred to child and adolescent mental health services relate being bullied to the genesis of their emotional problems. Perhaps all this activity is contributing to the problem, creating some sort of excitement. Certainly the possibility that Media may be increasing the likelihood of bullying, was suggested by a recent international speaker (David Bickham from Harvard Medical School), at a conference at Adelaide's Flinders University. He reported that Harvard's Centre on Media and Child Health has found that children learn socially acceptable behaviour from television and movies, and then model it in the playground. The researchers found that even the behaviour of heroes in storylines could be used by children as justification for standover tactics (ABC's Radio program PM with Mark Colvin, 18th February 2012). But does it begin with silly TV programs like 'Hannah Montana' where the kids use adult scripted lines to abuse each other as if they were smart? I don't think so.

Overall, the consensus of the literature is that bullies are often as insecure as those they bully. Both bullies and the bullied can come from families where bullying is the way of getting children to do what adults want them to do. Evidence from studies (e.g., Rigby et al., 2007) shows that girls who are bullied at home are more likely to be bullied at school (but *may* also bully), while boys who are bullied at home are more likely to become perpetrators. Research has also shown that parents who bully often have a history of being bullied themselves. In other words if their experience of being parented was one which included bullying techniques, then when they get to be parents themselves, they may (automatically) use these techniques without thinking.

So, I hate to seem as if I am blaming parents, again. But it does appear as if those early years of parenting may have an influence in whether or not later bullying occurs. If parenting is caring, sensible, informed and helps the child to understand and make sense of their world, then they are likely to develop secure attachment. Neglect, abuse, severe ongoing criticism and/or bullying may lead to insecure or anxious attachment, or even avoidant/disordered attachment to the parents. If this is not corrected then it will show up in all future interactions in that person's life. We are currently seeing increasing evidence of the long term effects of poor parenting in our child and adolescent services with many more anxious

young people, many more behaviourally disordered or out of control young people, and many more children with 'Reactive Attachment Disorder' which may emulate ADHD or autism spectrum disorders.

If we are serious in Australia about wanting to improve our society, increase the respect for others, reduce some of the ills we see every day, then we must focus our efforts to support parents in the complex and difficult task that is parenting – especially in the first three years of life. If we don't do this, or if we expect schools to make the necessary corrections, we may well have missed the boat, and Australia may well be destined to become an increasingly feral and dangerous country.

It is interesting that the Shorter Oxford English Dictionary does have a range of definitions for the word 'bully' – including of course the classic 'using strength or power to coerce or intimidate a weaker person'. Strangely, it records an earlier definition drawn from Middle Dutch or High German – 'sweetheart' or 'darling'. In men this translates to 'good friend' or 'mate'. Life and language are both strange really, are they not? Such a pity that we cannot apply the idea of 'mate' and 'mateship' or 'friendship' as much as we used to in this great country of ours. Well, you can't trust anyone these days, can you? Or would you like to prove me wrong? Perhaps we could attack bullying through lifelong acts of kindness. Nah. Silly idea.

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FURTHER INFORMATION OF VALUE

Australian bullying law http://www.caslon.com.au/cyberbullyingnote6.htm.
Cyber bullying law Trove http://trove.nla.gov.au/result?q=cyber+bullying+law.
Cyber bullying in school and the Law http://eprints.qut.edu.au/31602/.

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Thirty Six

On Self-injury[108]

Three more stories have recently been contributed to the Australian Broadcasting Corporation's Special Broadcasting Service (SBS) '6 million stories and counting'. These reflect on three quite different young women who self-injure, and are included as part of a new documentary in the SBS Science series to be launched in Adelaide at a public forum on 23rd November, and then publicly aired on SBS on the 12th December. As they note on their site: "The Silent Epidemic; the Science of Self Harm 'lifts the veil' on the widespread heath problem of the secret world of self-injury among young people in Australia and the emerging science behind the identification and treatment of these adolescents" (SBS, 2010a). The documentary was directed by Ili Bare, produced by Mark Hamlyn, Sue Clothier and Renée Kennedy, and lasts an hour with ad breaks, 52 minutes without. Other information is available from the Facebook site 'The Silent Epidemic' (2010).

As you may imagine, working with media has been a complex, lengthy, but ultimately very satisfying endeavour. In particular, we had lengthy discussions about the just what to include to both provide an interesting and moving documentary, the human stories, but also the available science (such as it is) translated for the general public. Including young adults who self-injure (and their families) in a television documentary is fraught with ethical issues, and we have had to work through these carefully and sensibly, while always having recourse to the basic tenet of 'first do no harm' (primum non nocere, attributed to Hippocrates, [460–370 BCE]). One story tells about a personal ongoing struggle with self-injury, one focuses more on the ongoing family reactions to a young person self-injuring, and the final story tracks a young woman through a course of meditation - measuring on fMRI (functional magnetic resonance imaging) the brain changes that appear to occur over ten weeks, but also tracking her reflections on her journey. Several international experts

[108] First published 2010. Martin, G. (2010) Editorial. Advances in Mental Health 9:2.

contribute their thoughts about the emerging science, and overall the program promotes a good understanding of the issues and some hope for the future.

So what is self-injury? Is it really in epidemic proportions? And what are some of the issues in the emerging science?

Self-injury is deliberate damage to the body without suicidal intent. This issue of the absence of suicidal intent is important. As we have noted elsewhere (Martin et al., 2010a), the first problem is that many studies combine self-injury and suicide attempts together as 'deliberate self-harm' (DSH). This clouds both the clinical and the research pictures.

Consider the research issue first. The best available research concludes that the long term outcome for 'deliberate self harm' is a higher risk for completed suicide. The best longitudinal study (Hawton and Zahl, 2003) reported that risk in the first year of follow-up was 0.7%, higher for men than women, increasing with age and, overall, 66 times the annual risk of suicide in the general UK population. Risk after 5 years was 1.7%, at 10 years 2.4% and at 15 years 3.0%. Another British study essentially agreed (Cooper et al., 2005) and US studies have similar emerging results (Claassen et al., 2006).

As clinicians we have to believe the research. So, not surprisingly, professionals in an emergency department have an immediate expectation that every person who self-injures must be suicidal. This leads to serious concern and, given our poor ability to predict exactly who may complete suicide, as caring professional people, we play it safe. We get into extensive questioning about suicidality and other possible underlying mental health issues.

When we find little other evidence of risks for suicide, we may be dismissive of what sometimes appear to be minor cuts or burns. We call it 'attention seeking', and may dismiss the person who self-injures - in part for supposedly misleading us. But in reality it is the research that has been misleading us. While there may be overlap, self-injury and a suicide attempt are essentially for different purposes. An attempt to suicide is most often for that purpose - to suicide (although we have to admit that some attempters may simply wish to escape their current circumstance 'for a time', and are often grateful when they survive the attempt).

From the clinical point of view, we have to consider a wide range of self-injury. If you interview young people at school who have cut themselves only once or twice, they may quickly admit they did it 'to be part of a group', or 'to feel what it was like', or even 'just for a laugh'. A few will say something more complex like: 'I saw this person cutting their arm in the toilet, and asked them why they were doing it. They said they felt like

crap, had all these awful memories they could not shake off, had a fight with their mum the night before, and cutting had made them feel better in the past. Well I've had some bad times and got bawled out the night before, so I thought I might give it a go…' This is in no way akin to suicidality, and appears to be about control over upsetting emotions. Yes, there is an element of imitation ('copycat' or even perhaps a case of 'contagion') that may cause us anxiety in a closed environment like a school. But the story allows us perhaps to empathise with the young person, engage them, and assist them with what they are telling about the background problem, exploring with them some other way of controlling their feelings. It provides us with an opportunity to prevent worse problems developing (to 'nip things in the bud'), and may also be a gateway to prevention in the wider community of the school, if there are others likely to be influenced in a similar way by the original cutter.

At the other end of the scale, there are people who are long past this. They have damaged their skin more times than they can remember, and the pathway from emotional overload to cutting is a single step. In addition, over time they may have had to injure themselves much more seriously to get the same effect of regaining control or feeling better. The story begins to sound much more like an addiction. Perhaps they only need a minimal current difficulty to re-evoke the need to self-injure, or the time since last self-injury may become important - with the interval, as it were, driving the need to damage ('I haven't cut for a week; no wonder I feel like crap!'). From a clinical perspective, the seriousness of the situation may be associated with a whole range of other psychological symptoms and begin to sound like a syndrome, or drive us to find a diagnosis to fit the picture. It may sound much more difficult for us to treat at the individual level, unless we have specific skills and prior experience. Perhaps if we thought of this level of self-injury as an addiction, then we might gain by considering what the field of addiction has in terms of successful evidence-based treatment programs from which we could borrow (Glasner-Edwards et al., 2010). Again though, it needs to be said that even at this level the primary purpose is not suicide-related.

Matthew Nock (2010) reminds us that 'People have engaged in self-injury … in the absence of suicidal intent … for thousands of years; however, systematic research on this behavior has been lacking.' Despite this, recent research has clarified differences between self-injury and suicide attempts - in their correlates, response to therapy, and long-term outcomes (Klonsky, 2007; Muehlenkamp & Gutierrez, 2007). This has led to discussion that non-suicidal self-injury should be recognised as a

unique syndrome within the planned 5th edition of the DSM (American Psychiatric Association, 2010).

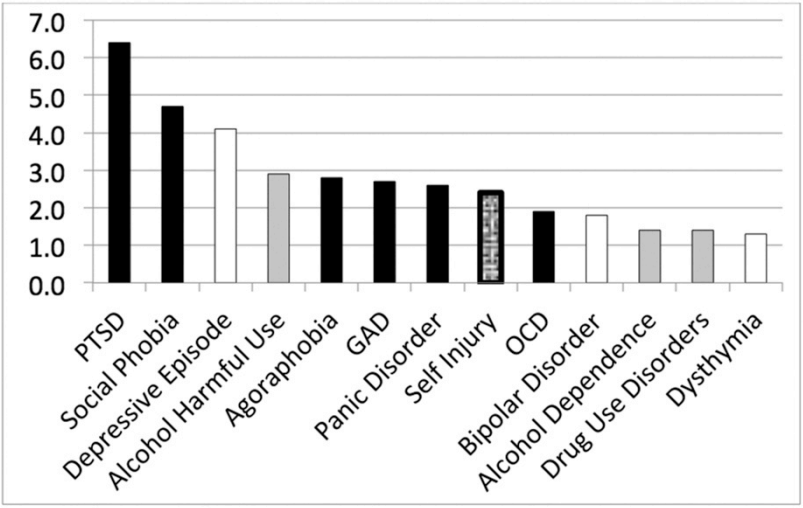
So, self-injury is more about control over inner states of emotion for which other cognitive skills seem to have failed, or perhaps not been well-developed - for instance in adolescents (Jacobsen & Gould, 2007; Hasking et al., 2010; Swannell et al., 2007). This builds on the earliest work in this field of study (Favazza & Conterio, 1989). Recent work of ours (Martin et al., 2010b; based on the Australian National Epidemiological Study of Self-Injury - ANESSI) confirms 'to manage emotions' as the most commonly reported motivation for self-injury reported across the life span, with the exception of the 10-17 year age band where 'to punish oneself ' is more common. Our nationally representative study also confirms that much self-injury occurs in the absence of suicidal thoughts (51.9%) and in the absence of a lifetime history of suicide attempts (73.7%).

Many studies have reported self-injury in hospital samples, as well as community cohorts, often with widely differing rates. Among high school students, lifetime prevalence rates have been reported to range from 14% to 47% (Ross & Heath, 2002; Muehlenkamp & Gutierrez, 2004; Laye-Gindhu et al., 2005; Lloyd-Richardson et al., 2007; Muehlenkamp & Gutierrez, 2007; Yates et al., 2008). Our equivalent lifetime figures for 15-19 year olds were 16.6% for females and 11.6% for males. Similarly, studies among university students have reported lifetime prevalence rates ranging from 17% to 41% (Gratz et al., 2002; Whitlock et al., 2006; Gollust et al., 2008; Hasking et al., 2008). Our equivalent value was 13.1% for the age range for Australian university students (Martin et al., 2010b).

Only one previous nationally representative study has been conducted (Briere & Gill, 1998). This was a postal survey (response rate 64%) of 927 US adults (range 18-90; mean age 46). 'Self- mutilation behavior' was based on Item 48 from the Trauma Symptom Inventory - 'intentionally hurting yourself in the absence of suicidal intent'. Occasional instances were reported by 4% of participants, and 0.3% reported often self-mutilating in the previous six months. There were no gender differences in frequency, but those reporting self-mutilation were younger (mean age 35). Our equivalent six month prevalence of 1.8% may relate to greater specificity of our survey questions (Martin et al., 2010b).

Just to complete the picture, our overall lifetime rate ('Have you ever…') was 8.1%, and the rate for the previous month was 1.1%. In all of this morass of figures can we discern 'an epidemic'? Probably not. There does not appear to have been a rise in frequencies over the last 10 years, and any differences are probably related to the style of questions. But the rates are surprising and concerning, and we could say that self-injury

appears to be endemic: that is it may well be at a maintained rate in the Australian and other populations. It is little acknowledged publicly, but is a serious problem for health and other services, and there appears to be a good deal of stigma surrounding the problem (perhaps related to fear and ignorance), both in the community and in health services. We believe that our survey is representative of the Australian population, and if we just consider the rate of 1.1% over the month previous to survey, this translates to about 200,000 people (Martin et al., 2010b). This is not a small number, and suggests an enormous possible impost on health services, and a large cost to the public purse. Out of interest, we can compare the 12-month prevalence self-injury with other mental health problems (Australians, 16-85)(courtesy Dr. S. Swannell).



Self-injury has a12 month prevalence very similar to a wide range of other mental health problems. Yet because it goes unrecognised as a serious problem, or perhaps because it is more stigmatised, there is little attention or funding made available to address issues of therapy or prevention. This has to change.

So what are the areas of research endeavour? Early work reported on the influence of childhood sexual abuse in developing reduced pain perception and dissociation (van der Kolk et al., 1991). More recent work has shifted the focus away from early sexual abuse (Klonsky & Moyer,

2008) more toward physical abuse (Swannell et al., 2012). Low levels of serotonin have been investigated as important (Crowell et al., 2008), and may be of genetic origin (Pooley et al., 2003). Dietary lipids may be implicated in depression and impulsivity (Garland et al., 2007), and improvements in some aspects of deliberate self-harm may occur from Omega-3 supplementation (Hallahan et al., 2007). James Harris (2003), and Glen Gabbard (2005) have broadened our view of how the brain may work, and raised possibilities for further work - perhaps to do with mirror neurons and their implications in self-injury.

A particular issue for further research is that we struggle to find therapies that work well for self-injury, particularly in young people. Despite early promise in the UK (Wood et al., 2001), results from group-based brief Cognitive Behavioural Therapy of adolescents could not be replicated in Australia (Hazell et al., 2009). Dialectical behaviour therapy, with its inclusion of mindfulness training, may well be the treatment of choice for adults (Linehan et al., 2006), but its length and intensity may not suit younger people. Despite some progress, we still have a way to go to get the best available therapies for any given individual (Muehlenkamp, 2006). Perhaps mindfulness training (Gratz, 2007; Nock et al., 2007) may prove to be the core of future therapies for self-injury. But, as with all therapies for self-injury, we need a large number of trials to confirm what works well, for which people, at what stage in their therapy.

As for preventive approaches and programs, one might simply ask: 'What prevention?' Where suicide has had vast amounts of money applied to its prevention in national strategies, using comprehensive models of prevention that are now tried and true (for instance the Mrazek and Haggerty (1994) model so central to the conceptualisation of the Australian Living is for Everyone [LiFe] strategies), at this point, this level of thinking or funding has not been applied to self-injury.

All of these new frontiers suggest areas for further research in which Australia could and should be involved. But this will not occur unless self-injury, as an entity, is taken more seriously by the community, clinicians, politicians and our research funding bodies.

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Robinson)
Cutting on-line: Self-injury and the Internet (Sarah Swannell, Graham Martin OAM, Karolina Krysinska, Tracey Kay, Katherine Olsson, Aung Win)
The evolution of the study of life trajectories in social sciences over the past five years: A state of the art review (Marie Robert, Monique Séguin, Kieron O'Connor)

Papers from Advances in Mental Health Volume 9, Issue 3 (Migration and Mental Health) are available from
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Child wellbeing and protection concerns and the response of the alcohol and other drugs sector in Australia (Samantha Battams, Ann Roche)

Impact of a mental health promotion program on substance use in young adolescents (Clare Roberts, Rachel Williams, Robert Kane, Yolanda Pintabona, Donna Cross, Stephan Zubrick, Sven Silburn)

Linking young homeless people to mental health services: An exploration of an outreach clinic at a supported youth accommodation service (Caitlin Dixon, Leticia Funston, Catherine Ryan, Kay Wilhelm)

Workforce shortages and their impact on Australian youth mental health service reform (Stephen Carbone, Debra J Rickwood, Chris Tanti)

Thirty Seven

On Being Online[109]

Data is not necessarily Information.
Information is not necessarily Knowledge,
Knowledge is not necessarily Wisdom
And none of the above is Action.

You are most likely to be reading this editorial online, though some of you may have printed it off to wait for a later and quieter moment. Either way, we have to acknowledge that *Advances in Mental Health* (AMH) is now an independent and fully online journal, and has successfully made the transition from the *Australian eJournal for the Advancement of Mental Health* (AeJAMH) previously developed and managed by *Auseinet*. Unfortunately, Auseinet (*The Australian Early Intervention Network for Mental Health Promotion, Prevention and Early Intervention*) was defunded in 2009 after 12 years of driving prevention debates about mental health in Australia; it is now only an incompletely retrievable memory (National Library of Australia Archives, 2009).
Subscribers to AMH (ISSN 1837-4905) volume 10, in print and online, have access to all research papers and commentaries from volumes 1-9 in full text. In addition to original research papers and up to the moment commentary, we have added a 'Book Review' section (managed and edited by Karolina Krysinska from Belgium) and, as from this issue a 'Letters to the Editor' section where we will invite relevant responses to letters received. We are keen to foster informed debate.
We see the journal as going from strength to strength, having a long future, and contributing internationally to prevention of, and early intervention in, mental illness, as well as the development of Mental Wellness. As a peer reviewed, emerging international journal we are abstracted into a large number of databases (such as APA's PsychINFO, CINAHL and most recently Scopus), and have recently gained an ERA

[109] First published 2011. Martin, G. (2011) Editorial. Advances in Mental Health 10:2.

ranking. While we acknowledge that we encourage and publish Australian researchers and authors, you will note in recent issues that we also increasingly publish relevant papers of international origin. Regular readers will know that we have an issue planned for August 2012 focussed on Substance Use and its influence in poor mental health; this is edited by Masood Zanganeh and Christine Wekerle from Canada (to whom we owe a considerable debt of gratitude).

So we are now part of a morass of online journals all clamouring for suitable papers and committed subscribers. We will need to ensure that our themes about prevention maintain focus to ensure 'brand loyalty' for authors and readers alike. And as publishers we have a problem about our visibility; like everything else in the online cloud we could get lost. Part of this is about having a brand that stands out, but also it is about ensuring we are known as a journal of substance with something special to say. Another part of this will be to ensure that we are meeting the needs of readers passionate about advancing mental health. So we will from time to time be seeking your guidance and comments to ensure we are on track. After all, many of you supported the development and maintenance of *AeJAMH*, and have helped us to make the transition to *AMH*.

All of this has made me give consideration to the online environment. Increasingly we in the West live a large part of our lives online. Almost everyone has a computer, and every day we check and respond to Email, see what news there is in our various groups on Facebook, add something to or respond to someone on a Blog, spin through the Tweets on Twitter and maybe contribute to a special interest group discussion, read the national daily newspaper on an iPad, a book on Kindle, and try to restrict ourselves to just a couple of games of Angry Birds or your own little addiction. In Australia, over 35% of the population have a smartphone, so much of this can also be done online while we are on a bus or a train going to work or (for those of us who are rude enough) during a conversation with a group of friends.

We can purchase almost anything online – food, clothes, furniture, books, electronics and a wide range of other things (and even avoid local taxes if we are clever). We don't buy gifts for others anymore; we buy an online gift voucher which allows them to purchase their own choice in music, electronics and those other things. We pay bills online, transfer money between bank accounts, and buy and sell stocks and shares. In fact, regarding the latter, there are now automated programs that sense or predict movement in stock markets and buy and sell without immediate human interaction (very scary – who really is in charge of the world's economies?). I was recently checking out a bank account and saw an

amount I did not recognise. There was a button to 'see cheque' and, sure enough, there was my instantly recognisable signature on an image of an old fashioned cheque; I had forgotten, but the evidence was before my tired eyes. Of course that will change as the venerable cheque is phased out over the next few years. So many other things will go with it. We are no longer buying CDs – we can get the music cheaper through iTunes or a similar program. DVDs will be phased out as more and more of us get access to the latest films (and a vast library of older ones) via Foxtel or some other set top box attached to the television. Of course the newer generations (Y and Z) don't even bother with the TV; they simply watch the film on a smart phone or their iPad. Not quite such a grand all encompassing experience, but 'you get the picture'.

Access to information is blindingly fast and amazing. Can't remember a name? Type in the nearest you can get, and Google or Yahoo will suggest alternatives. If it is a person, no doubt there will be reams of information about them on Wikipedia (although not all of us are on there yet – you have to be an historical figure of importance, or narcissistic enough to think you are of importance). Is it a place you wanted to remember? Then Google Earth or some other mapping program can take you there, provide detailed maps of the locality, and images of the front door if you so wish. You can even manipulate the image to see the third floor balcony if that intrigues you. Want to buy the house in question, then there are real estate or other programs that will provide you with photos from inside as well as outside and, in addition, tell you the price at which the property last sold, and the current mean price of property in the area.

Is it a medicine you have been prescribed? Want to know the side-effects? It is all there, although somewhat variable depending on the source. Eponyms, pseudonyms, acronyms – all no problem. Just pop the letters or words into your browser... Want to know about the phase of the moon, or the time of high tide, or the pollen count – all no problem. Most of them have some sort of app(lication) that provides the info(rmation) in sec(ond)s, and all of them tracked to your locale – '"Hayfever" wants to use your current location. Please press "agree" or not'.

This latter issue can be quite a worry for some; it goes to the heart of the fantasy we all have about privacy. Do you want your current location accessible to the world? How much information do you want available on the various programs that collect it? Do you want your personal details like home address, mobile phone number, marital status, and a lengthy list of all of your purchases in the last year available to deviants thinking naughty thoughts about how to use it? Well you can switch off the 'location finder' on your smart phone, but actually you probably missed

out about 2-3 years ago. The information is all up there somewhere for those with the skills and desire to find it. In an online world there is probably no such thing as privacy, and you had better get used to that. If you are doing something naughty yourself, then someone will end up knowing; it may already be in some archival footage from a street Cam(era). If you don't want to be found out, it might be better to not be doing whatever it was... Of course this begs the question as to whether anyone would really want to know everything about our sad little lives. Let's face it most people are too busy stemming the rising tide of junk email, learning how to transfer information between their iPhone and their computer, and wondering how to upload a photo from their camera.
You will note that thus far I have focused on what I have called 'Information'. That is, we are sent, or come across, or actively seek bits of 'data' from which we make some sort of sense. We have to do something with that to turn it into 'information', and in particular meaningful information. As an example, an email is comprised of chunks of 'data'. Several years ago I occasionally used to get emails from colleagues, who use PCs, and attached text would appear to be rubbish until I copied it, put it into a Microsoft Word program on my Mac, and it would become information. It was not meaningful text, then I had to decide whether it was meaningful information.
More recently I have been receiving an ever-increasing stream of emails about conferences that have no meaning to me. The first group are seemingly about all sorts of cybernetic ideas, at one level fascinating but of no real interest as my ageing brain tries to cope with fewer and fewer themes in my life rather than too much expansion. I often don't understand the titles of the conferences, let alone some of the proposed papers, so regrettably they go into the trash bin. The second group are most likely scams (for instance from EPS, whatever that is). Because of my vast knowledge and experience, as well as a lengthy list of publications, I have been picked up as someone of relevance to a conference in Asia or China. I can be flattered in this way, or they may mention a recent paper by its full title. Would I care to be a Keynote Speaker – all expenses paid? Mmmm, this seems to be information of interest. If you go to the site, there is a convincing write-up of the intent of the current conference, and photos from previous conferences, with the conference convenor shown on friendly terms with all sorts of eminent people (backlit and slightly dark or slightly out of focus). Then it gets interesting – because you are asked to provide a deposit on accommodation (to be repaid by the conference when you attend, of course). If you pay up, then you have been scammed. The conference does not exist and, in the process of being

flattered, you missed one important piece of information in the array of very convincing data and information. The conference is scheduled for one month ahead.

Now, what idiot would invite you to be a Keynote with only a month to go? So, information on the net may be grossly misleading, or you may find that you just miss critical details in the search for personal meaning (and being flattered some more). The information you glean is not the truth. It is (spurious) information, just more dross to be added to the junk pile being of no worth, and it may have cost you to find all this out!

Online information is intriguing. Coming back to an issue raised above, I may be able to get all sorts of information about you, may even be able to translate this into some knowledge of the real you, but the truth is I will not *know* you. I can really only come to know you through the synthesis that comes with working hard at a personal relationship with you. I can use the tools made available on the Internet or through technology to gain and foster this relationship, but ultimately I will only come to truly know you through a personal, ongoing, and face to face relationship, in which we can share or live through experiences.

This is of some importance in mental health, because social connectedness is increasingly being shown to be of importance in development and maintenance of wellness. It is also of importance in recovery from episodes of illness, and as prevention against recurrence or the sequelae of illness. But the evidence we have suggests that this social connectedness comes from being with knowing and trusting other humans. There is evidence that family connectedness may be of more importance than connectedness with friends or peers, and all of these seem to have more power than being connected to an institution.

There are emerging discussions about whether the institutions of social media like Facebook, Linkedin, Twitter and others can provide support and the connectedness we crave as human beings. In the absence of anything else, they may be of some value but, in my view, they pale into insignificance when compared with face to face connectedness and genuinely shared experience. They may be useful as a tool to assist us to maintain real relationships and meaningful connectedness, or conversely they may introduce us to others with whom we later develop meaningful knowledge-based relationships, but as standalones, they are chimera – that is wild illusions of connectedness. They do not contain that sense of deep knowledge about other humans that we all need.

'Knowledge' is much more stable than 'Information', even though new information may over time make changes to our knowledge. I am reminded of my wife's grandfather who was a London taxi driver. Before

he was allowed to drive one of those iconic black London cabs he had to study for a long time, and then pass a difficult exam in what was called 'The Knowledge'. This was a personal visual map of the streets of London, and the ability to decide on the quickest and most efficient way to travel from A to B. You will realise that the majority of streets in his time were stable, and major changes – particularly in Central London – occurred rarely. As he gained experience, his personal Knowledge grew, and through endless repetition was confirmed. There is an apocryphal story of him driving a passenger from A to B using his usual efficient route. Half way up a particular street he was pulled over by a policeman who challenged him that he was driving the wrong way up a one way street. His response, of course, was that he 'was only driving one way!' In those days he was allowed to get away with it, especially because of his trade; you would never get away with that now. The problem was that he had not been given the information of change by his office. Having been challenged he learned the uncomfortable way, and was forced to change that bit of his Knowledge.

Knowledge is defined as being based in facts, truths, or principles, which are clear and agreed by the majority of people. There is some certainty and stability in Knowledge; what is true today is highly likely to be true tomorrow. If I cut myself with a knife accidentally, it is highly likely I will bleed. If I cut myself with a knife tomorrow, the same outcome is almost certain. What is also certain is that I am a clumsy fellow, but that is another issue. If I drop a ball, it falls to the ground (the principle of gravity), and usually will bounce back a certain amount (a truth I learned very early on – though I can never remember the formula to tell me how high it will bounce). There is some predictability, and everyone knows this.

So I was intrigued recently to read an article (Wright, 2011) on Google whose mission in 1999 was 'to organise the world's information and make it universally accessible and useful'. Apparently, those who work for Google are now 'being urged to understand that turning uncounted trillions of pieces of data into more trillions of pages of retrievable information was a mere baby step in a march towards something much grander and less tangible: the getting and dissemination of knowledge'. So as an example, a large PhD study could ultimately be synthesised by a supercomputer down to two or three central ideas – synthesised information – which if it has meaning and duration may contribute to or become knowledge. Apparently the people at Google think that ultimately they will be able to take this model even further and become the store for

the world's Wisdom – which may be good, but could be problematic. Supposing someone got the idea that they own the wisdoms of the world? Wisdom of course can be thought of in various ways – having, and being able to reflect, experience and knowledge, or being able to access sound judgment about what is likely to be true or lasting. We think of it being attached to older people, or great thinkers, or those who have taken mindfulness to the ultimate – the sages of this world. It will be interesting to see what Google makes of this, what they do with it, and ultimately what difference it makes to this ageing Planet Earth.

So what does this have to do with AMH? From this issue you will see that people have struggled with data to make sense of it and turn it into useable information. Others have struggled with various bits of information and tried to add to our store of knowledge about Mental Health and Wellness. Our mission is to assist this process and encourage our field to move towards enduring knowledge, and help us to gain (or recover) Wisdoms about how to live our lives as best we can.

I began this editorial with four lines of text about the interrelationship of data, information, and knowledge and wisdom, and of course there is so much more than can (and will) be said. But it finishes with the line 'And none of the above is action'. The truth is that we often have heaps of information provided to us when working with clients, and we know a lot about theories of how to understand all this. But it seems to me that we are losing the knowledge and wisdoms that may help us to act in the most positive way with people to create the change they need. Our theories have been dumbed down, and (at least in the medical field), our actions are prescribed by formulae from nosological texts, and driven by the pressure from big pharma. Part of the mission of AMH is to explore the wisdoms behind sound action. Perhaps I could explore this further in my next editorial.

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Papers from Advances in Mental Health Volume 10, Issue 2 available from http://amh.e-contentmanagement.com/archives/vol/10/issue/2/

Psychological distress among Australians and immigrants: Findings from the 2007 National Survey of Mental Health and Wellbeing (Sanjay Sharma)

Improving access to psychological therapies: An account of recent policy aspirations in the UK and Australia (David Pilgrim, Timothy A Carey)

Parenting program uptake: Impacts of implementation factors on intention to enrol (Emily Hindman, Anna Brooks, Rick van der Zwan)

Mental health promotion in childcare centres: Childcare educators' understanding of child and parental mental health (Margaret R Sims, Elise Davis, Belinda Davies, Jan Nicholson, Linda Harrison, Helen Herrman, Elizabeth Waters, Bernie Marshall, Kay Cook, Naomi Priest)

A consultation service for Adult Mental Health Service clients who are parents and their families (Mary Ellen Jessop, Nikki de Bondt)

Consumer and carer consultants in mental health: The formation of their role identity (Patricia Barkway, Krista Mosel, Alan Simpson, Candice Oster, Eimear Muir-Cochrane)

A cognitive behavioural intervention for case managed clients (M Louise Lergesner, Marie Louise Caltabiano)

Better access to mental health: Mapping the evidence supporting participation in meaningful occupations (Danielle Hitch)

The girl least likely – A linguistically informed media case review (Thomas Cheuk Wing Li)

'It's mean!' The views of young people alienated from mainstream education on depression, help seeking and computerised therapy (Theresa Margaret Fleming, Robyn S Dixon, Sally N Merry)

Letter to the Editor: Terminology shift signals a new age in mental illness thinking (Anna Brooks)

Reply: Mental illness, brain disease and stigma (Ian Webster)

Reply: 'Terminology shift signals a new age in mental illness thinking' (Barbara Hocking)

Thirty Eight

On Wisdom in Mental Health Care[110]

Data is not necessarily Information.
Information is not necessarily Knowledge,
Knowledge is not necessarily Wisdom
And none of the above is Action.

In my previous editorial in this journal (Advances in Mental Health 10(2): 'On being online'), I addressed some aspects of an aphorism – specifically Data, Information and Knowledge, and if you did not read that, it may be useful to do so prior to reading this one. In the present editorial I want to examine some recent works that draw on these three constructs, but take the additional leap toward suggesting wise ways in which we should be working in mental health and in mental health services. Finally from this perspective, I want to examine a proposed set of National Health and Medical Research Council (NHMRC) guidelines that (to my mind, and at least at this time) may fall short of wisdom.

A recent prospective multi-site randomised controlled trial on emerging psychosis (Morrison et al., 2012), the largest of its kind, should have a profound impact on our thinking about how to manage young people with signs of being at risk for psychosis. From five UK sites, they included 288 people between 14 and 35 years seeking help for psychotic symptoms. A major exclusion was being on antipsychotic medication. They randomised half to Cognitive Behavioural Therapy (CBT) plus monitoring of mental state, the other half to simply monitoring mental state, and followed participants up for between 12 and 24 months. Their outcome measure was the Comprehensive Assessment of At-risk Mental States (CAARMS), an internationally accepted measure that can indicate whether participants 'transition to psychosis' or not. The results are intriguing.

[110] First published 2011. Martin, G. Editorial. Advances in Mental Health 10:3.

Where previous studies have suggested that those 'at high risk for psychosis' have up to a 50% chance of becoming psychotic, Morrison's group found only 8% 'transitioned'; that is over 90% may have had anxiety about symptoms, or have been depressed, but they did not become psychotic. As clinicians, we should find this very reassuring.
The second equally intriguing point is that effectively there was no difference between the two randomised groups as to whether people became psychotic. Again, as clinicians, we should find this very reassuring. The routine care group (what they term 'active monitoring' – which may have included 'supportive listening, access to crisis care, and signposting') did just as well in not becoming psychotic. The single difference was that participants in the CBT group were significantly overall less distressed about their symptoms. Morrison et al. (2012) discuss their own study very carefully, critiquing it from many standpoints (sampling, intervention, statistical approach), but we are left with some very strong data from which they extract useful information to add to our knowledge about this complex group of clients.
Morrison et al. (2012) go further. They suggest their study has implications for prevention, and that perhaps there is a need for review of the 'ultra high risk' strategy; that perhaps there is a problem with our ideas about the cost–benefit from providing highly specialised treatment to a group of whom 90% are going to improve with routine care and monitoring.
They raise two more issues that need much more discussion.
The first relates to premature prescribing of anti-psychotic drugs, for which they provide three recent references citing anti-psychotics as the cause of changes in brain volume previously ascribed to schizophrenia itself. The second is the move toward a category of 'psychosis risk syndrome' in the proposed 5th version of the Diagnostic and Statistical Manual for Mental Disorder due for publication and distribution in 2013.
So there are wisdoms for mental health practice in this work: 'Don't jump to conclusions about outcome' even where there are psychotic symptoms or what may appear to be high or ultra high risk for psychosis. A second might be: 'Very little is likely to be lost by a period of (what Morrison et al. call) "watchful waiting" and cautious monitoring in the context of routine supportive care'. A third might be: 'Don't leap to prescribe antipsychotics until it is certain that this person either has psychosis, or will transition to psychosis'. Even then, a fourth wisdom might be: 'In the light of structural brain damage which may possibly be caused by anti-psychotics (rather than schizophrenia), don't over-prescribe'. Finally, there is: 'A talking

therapy targeting anxiety about symptoms (such as CBT) may be helpful in those presenting with high or ultra high risk for psychosis'.
All of these can be considered under the umbrella of that very ancient wisdom 'Primum non nocere' ('First, do no harm').
A second recent paper of note also comes out of Manchester, UK. This relates not to specific Axis 1 diagnosis of a mental disorder, but one of the most worrying of long term outcomes of mental illness – that of suicide (While et al., 2012).
In 1996, a National Confidential Inquiry (NCI) into suicide and homicide was begun at the University of Manchester, collecting information about all cases in the UK, and turning the information gleaned into recommendations to improve mental health services. The current paper concerns nine recommendations about service-related risk factors for suicide to be implemented in services. These include what we could call 'hanging points' in wards, assertive outreach, 24-hour crisis teams, 7-day follow-up, managing non-compliance, written policy on dual diagnosis management and sharing information with criminal justice agencies, multi-disciplinary review and sharing of information with families after a suicide and, finally, training of staff. Clearly not all services implemented all recommendations, but over time there was generally an increase in the overall number of implementations.
This is a very thorough, carefully managed national level study, taking into account a range of confounders such as socio-economic variability across England and Wales. For the four years 2003–2006, the study shows a significant difference between annual suicide rates per 10,000 patients in contact with mental health services implementing 7–9 recommendations, compared to those implementing 0–6. There were statistically more suicides in patients attending the latter services. In addition, the study was able to show convincingly that a 24-hour crisis team, a dual diagnosis policy, and multi-disciplinary review after a suicide, played highly significant roles in the lowering of suicide rates for those teams implementing them.
Obviously the amount of data in the study was immense, and the authors have been able to derive information from these results that clearly contribute to our knowledge base about suicide prevention. The overall process developing the study must have been equally immense, and followed many years of steady scientific work toward defining recommendations. Searching for the political will to support such studies, moving toward national implementation, and then waiting 10 years to be able to do the follow-up studies, are a tribute to the researchers' passion

to find ways to reduce suicide, and should leave us open-mouthed in admiration.

More than that we can perceive wisdoms for mental health in this work. They are not rocket science, and most of the recommendations are not exactly costly compared to the immense cost of loss of life to suicide. Essentially the recommendations are about quality of service care, ensuring quality community services exist to follow up after admission in a timely, comprehensive and caring manner, and communicating meaningfully with other services to whom our clients go for care. It seems to me there is also a large element of awareness-raising that must have occurred throughout the implementation of recommendations.

Of course, improving mental health services based on implementation of internationally accepted guidelines deriving from years of careful research work will, however wise, not reduce suicide rates on its own. There are many other aspects of suicide prevention to be considered, as evidenced by a report in the weekend Sydney Morning Herald (April 21st – 22nd 2012, page 19 'World', and quoting The New York Times). This reports 18 suicides in teenagers, but includes an 11-year old. A large number seem to have been youngsters who jumped from high buildings, and the report quotes the Russian president as being alarmed and taking it seriously, but also saying: 'This must be treated gently'.

I am not sure what relevance the report from Russia has for an Australian audience, and perhaps we could criticise the SMH for reporting, with some relish, something suitably bizarre about suicide. We could rightfully suggest it is lacking in wisdom. However, they did technically follow the reporting guidelines for media (Australian Government, 2012; Australian Press Council, 2011) by including telephone numbers for Lifeline (131114) and for Kid's Helpline (1800 55 1800) just in case we, the readers, found ourselves upset by the content of the article. Luckily, it is unlikely that young Australians will have been influenced to 'copycat' by the report, given the probability that very few people under the age of 45 will have read the Sydney Morning Herald article.

However, the point to be made is that making sure Mental Health Services have adopted guidelines relevant to suicide prevention is unlikely to have affected these young suicides (although to be honest the report does not discuss their mental health status). Prevention of *young* suicides may be much more about raising awareness of health problems and encouraging 'help-seeking behaviours'. In addition it may be more about improving wellness, resilience and connectedness; but that is outside the scope of this Editorial.

Raising awareness and encouraging 'help-seeking behaviours' brings me to a piece of work that a colleague and I completed in 2009, from a somewhat different perspective (Martin & Page, 2009). There is a serious question to be considered regarding National Suicide Prevention Strategies, particularly given the multi-million dollar price tag. Do they work? How do you measure whether they work? If fewer suicides do occur after the introduction of a national strategy, how do you know that if the strategy had not been introduced, the fewer suicides would have occurred anyway? We acknowledge it is impossible to measure a negative quantity; but you can consider trends.

We decided to analyse the trends in national strategies that had been in place preferably for 10 years or more. This is partly that (as we saw in the While et al., 2012 work) it takes some time for services to 'gear up', or for new programs to get going. I had been part of the Australian Government Youth Suicide Prevention Advisory Group in 1995 as we began to fund services, new programs, and develop guidelines. But it took about two years for us to see even the beginnings of real progress. It can be argued that there are several more years before the public may be aware that a strategy is in place. Suicide data for our study was drawn from the World Health Organisation mortality database[111], up to and including the year 2007.

We considered national strategies from Finland (who got their strategy going from 1992), Norway (1994), Australia (1995 – acknowledging the original strategy targeted youth rather than all ages), Sweden (1997), New Zealand (1998 – which also began with a youth strategy), France (2000), United States (2001), England and Wales (2002), Japan (2000 – where it can be argued that it was regional prefecture-based rather than a national strategy), and Canada (where there has been considerable national work done over many years, but no formal government 'owned and funded' policy). For each country we considered the percentage change in suicide rate following strategy introduction, considering changes for males overall, then the male 15–24 age group, then females overall, and finally the female 15–24 age group.

There were two main patterns we could perceive. First, in countries where there had been marked rate rises up to the start of a strategy, there were significant reductions in the first five years, and these appeared to continue through the next five years taking into account annual fluctuations. So, for Finland in the first five years post-strategy, rate reductions were 7.1% for males overall, and 32.1% for males aged 15–24

[111] http://www.who.int/healthinfo/morttables/en/index.html

years. For females the change was an overall 11.4%, with 10% for females aged 15–24 years. These were all statistically significant. Similar patterns could be seen for Norway, Australia, New Zealand, and Scotland.
The other pattern was where rates had not seen such dramatic pre-strategy rises, but there was either an ongoing reduction from a peak several years before, or there was a rather flat ongoing suicide rate for all groups. In both of these we could perceive that the strategy arguably had continued to support a trend of reduction; Sweden, France, the United States, England and Wales fitted this pattern.
Taking into account this complexity, if we consider the total change in rates, adding all national rates together, and including Japan, the combined reversal of rates post-strategy is highly significant. Comparing post-strategy to the overall long-term rate (50 years pre-strategy), the probability of the change being a chance result was $p < 0.001$. Comparing the combined reversal of rates post-strategy to the shorter equivalent pre-strategy rates (that is comparing five years pre-strategy with five years post-strategy, or eight pre- and eight post-, and so on), the result was still impressive (probability of a chance result $p < 0.05$). The results are particularly impressive against a backdrop of World Health Organisation reports suggesting suicide rates continue to rise across the world, with over 1 million people losing their lives in this way each year.
We were left convinced that strategies overall reduce rates – that is, the data we had analysed gave us sufficient information to allow us to conclude that we now know that strategies work. We can assume that it is wise for countries concerned about rising suicide rates, to institute a strategy targeting local issues for their country. More recent work based on national strategies in 21 OECD countries with national suicide prevention programs (Matsubayashi & Ueda, 2011) supports our conclusions.
The next problem, of course, is to determine which bits of the national strategies may be having the greatest effect, and therefore should form part of universal recommendations to countries considering developing, or redeveloping, national programs of work strategically targeting issues to do with suicide and its prevention. Matsubayashi and Ueda (2011) did not examine this, rather quoting a list from Anderson and Jenkins (2005, 245–253). In our review, to understand the 'why' of suicide prevention, we explored policy from each of the eleven national strategies in some detail as well as all other relevant reviews such as the influential one from Mann et al. (2005) which had concluded that national strategies could not be shown to work, were too complex, and had insufficient research to back them up. In contrast, we concluded (Martin & Page, 2009, p. 75.) that

strategies not only worked, and could produce a statistically significant reduction in suicide rates over time, but that from the eleven national strategies studied, we could also define a number of the common elements necessary for this to occur:

1. '… the best national strategies have a clear framework, explicitly stated. Within this there are broad goals, usually consistent with best understanding of international research and wisdoms in the prevention of suicidal behaviour. For each of the goals, there are clearly stated outcomes, and these may be in the form of targets'.
2. 'The best strategies take a nationwide approach. They aim to provide a communication program to the whole population, with education targeted at all relevant groups. In particular there is large scale specific education for all groups defined as 'gatekeepers''.
3. '… there is an attempt to provide a critical mass of clinical services with relevant and sufficient highly trained professionals at all levels'.
4. 'The best strategies address the issue of access to means … Australia was fortunate in that gun control (1996) almost coincided with the emergence of the strategies (from 1995), and has clearly contributed to Australian changes in suicide rates … Means are not only to do with guns, and the best strategies have considered barriers on high buildings and bridges, constraints on common poisons such as paracetamol, and suitable changes to reduce lethal emissions from the exhausts of cars'.
5. 'The best strategies are clear on contributions to suicide from illicit drugs and from alcohol … and have incorporated alcohol controls into their strategies, or at least developed strong links between different strategies'.

We believe these statements reflect 'international wisdoms' in suicide prevention.

As I noted in the previous Editorial, 'Wisdom of course can be thought of in various ways – having, and being able to reflect, experience and knowledge, or being able to access sound judgment about what is likely to be true or lasting. We think of it being attached to older people, or great thinkers, or those who have taken mindfulness to the ultimate – the sages of this world'. But we can also think of it as being based in deep knowledge derived from the extensive synthesis of information from repeated episodes of trial and effect, correction of error, and then further trial, as we have described in several examples above.

Conversely, we can make a case for wisdom being defined by universal consensus. For those who are interested, the 'Arete Initiative at The University of Chicago has launched a $2 million research program on the

nature and benefits of wisdom' (http://wisdomresearch.org/) in part, about the development of universal consensus. The site contains recent publications, a range of current research projects, a developing network of people interested in discovering (or perhaps re-discovering) wisdom, and recent news and discussions; I commend it to you.

So this brings me to a recent document which found its way to my desk via several colleagues – Draft Clinical Practice Guideline for the Management of Borderline Personality Disorder (NHMRC, 2012). The question is whether this document is based in sound enough knowledge and reflects wisdom? It is a very large and complex document with two even larger appendices, has had a very short time frame for consultation (ending on 14th May 2012), and potentially has major implications for management of BPD in Australia.

Borderline Personality Disorder is not an Axis 1 clinical illness likely to have a relatively short course (if sometimes recurrent), and likely to have clear-cut interventions to assist the return to normal. It is an Axis 2 personality disorder; these diagnoses have historically been made only after the age of 18, and after considerable experience of the patient. Making a diagnosis about any personality disorder implies that the symptoms and problems are deeply embedded in the personality, are likely to cause societal, social and interpersonal problems, and are quite resistant to change. In a sense they can be said to be for life, and many clinicians have been reticent to label people for life. The guideline makes an error in calling BPD a mental illness (p. 32: 1.1.1); it is not an illness, it is a disorder.

There is confusion in the purpose of the guideline, which targets 'management' but strays into early intervention and seems to target young people aged 12–18 years from this perspective. It states: "After appropriate assessment, health professionals should make the diagnosis of BPD in a person aged 12–18 years who meets the diagnostic criteria" (Recommendation 5, p. 21). In diagnostic terms this might mean possibly labelling 12 year olds as having the disorder – which will leave many experienced clinicians feeling very uncomfortable. In a sense it also contains an error of logic given that so many young people do not transition to full-blown illness and disorder (as discussed above in the context of psychosis).

There are nine criteria given for this diagnosis we are urged to make in young people. For instance: 'A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation'. This might describe a large number of young people simply related to the fact they are in adolescence.

Another example is: 'Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)'. Again, at a guess, this might capture 20–30% of adolescents. Criterion 3 is: 'Identity disturbance: markedly and persistently unstable self-image or sense of self'. In a sense it could be said that this is what adolescence is all about. Criterion 6 is: 'Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)'. These criteria for BPD are actually drawn from DSM4 (the revised text). There is another issue here, which is that they have been undergoing review by eminent international panels for both DSM5 and the International Classification of Disease Version 11. Why is NHMRC not waiting for the new classification criteria before producing a set of guidelines?

The guideline states: 'Young people often experience relief when they learn that the difficulties they have been experiencing can be attributed to an identified syndrome and that effective treatment is available' (p. 61), and quotes a single reference to 'Project Air Strategy' at Wollongong University. An extensive search of their site did not reveal any research to back up this statement, and no other international research was quoted in the proposed NHMRC guideline.

A further issue is that current therapies for adults are nowhere near best practice according to the Cochrane Collaboration. Therapies for young people aged 15–24 years have very limited research, so as yet we do not know what effective therapy to use.

The list of references in the guideline
looks impressive, but seems to have large holes in it. Only four of a possible 15 Cochrane and other reviews directly linked to borderline personality disorder have been picked up. Further, in not broadening the search criteria to include major troubling symptom targets such as self-harm, the guideline misses an immense amount of important information for clinicians, and a large number of relevant references.

Guidelines for clinical practice are good things, and assist in ensuring consistent quality of care. They should be based on sound research information, widely canvassed knowledge in the field, *and the synthesised wisdoms of consensus.* At this point, we can perceive many problems in the draft guideline – errors of logic, missing knowledge, and a lack of wisdom in some areas. We have a long way to go...

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Yarning about Indigenous mental health: Translation of a recovery paradigm to practice (Tricia Nagel, Rachael Hinton, Carolyn Griffin)

Cross cultural education in suicide prevention: Development of a training resource for use in Central Australian Indigenous communities (Jessica Lopes, Melissa Lindeman, Kerry Taylor, Laurencia Grant)

Use of the Westerman Aboriginal Symptoms Checklist - Youth (WASC-Y) to screen

for mental health problems in Indigenous youth in custody (Stephen Leslie Stathis, Ivan Doolan, Paul Letters, Amanda Arnett, Storm Cory, Laura Quinlan)
Alive and Kicking Goals!: Preliminary findings from a Kimberley suicide prevention program (Joe Tighe, Kathy McKay)
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Maternal fatigue and depression: Identifying vulnerability and relationship to early parenting practices (Catherine Wade, Rebecca Giallo, Amanda Cooklin
Is there a difference? A comparative study of mobile intensive treatment team and continuing care team consumers' clinical and other characteristics (Jo Suggett, Chris Lloyd, Tom Meehan, Robert King)
Spirituality: The neglected dimension of holistic mental health care (Shephard Chidarikire)

Thirty Nine

On Help-seeking[112]

In a recent review of international suicide prevention strategies (Martin & Page, 2009, op. cit.), we concluded that strategies in place for more than 10 years appeared to significantly lower suicide rates (particularly for male rates). We suggested that: 'the best strategies take a nation-wide approach. They aim to provide a communication programme to the whole population, with education targeted at all relevant groups. In particular there is specific education for all groups defined as 'gatekeepers'. There is an attempt to both improve existing services that may have to deal with suicidal people, as well as the linkages with the community in general. In addition, there is an attempt to provide a critical mass of clinical services with relevant and sufficient highly trained professionals at all levels' (p. 75).

This critical mass of professionals trained in managing suicidal people is central, but exactly what it is they do to make a difference is somewhat unclear. If we consider admission of suicidal people to dedicated mental health services (as I did in my last editorial 'On wisdom in mental health care', Martin, 2012), there is strong UK evidence that several key organisational strategies (removing 'hanging points' in wards, assertive outreach, 24-hour crisis teams, seven day follow-up, managing non-compliance, written policy on dual diagnosis management and sharing information with criminal justice agencies, multidisciplinary review and sharing of information with families after a suicide, and training of staff) in combination contribute significantly to saving lives (While et al., 2012). Of note, the type and quality of the individual's therapy were not discussed.

However, the majority of people with suicidal thinking will never be admitted to a mental hospital; they are managed by community based organisations or individual practitioners with relevant skill. The

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commonly accepted wisdom here is that it is the quality of the therapy that makes the difference, and this may be understood to be the type of interpersonal therapy provided, perhaps based in the therapeutic relationship or, in medical systems, the type of medication. The type, dosage and duration of specific talking therapies and the type, dosage and duration of particular medications have become the somewhat obsessive focus of research and clinical training in recent years. Recently, though, both have been called into question in the context of suicide prevention. Again referring to our review of national strategies, we said: 'we think we know that antidepressants (particularly selective serotonin reuptake inhibitors [SSRIs]) not only improve depression, but also reduce the likelihood of suicide attempts (e.g., Simon, Savarino, Operskalski, & Wang, 2006). Increased SSRI prescribing appears to have reduced suicide rates in some countries (e.g., Isaacson, 2000). However, more recent research has disputed the direct causal effect of increased prescribing on suicide rates, noting that rates began to fall prior to the onset of increased use of antidepressants (Reseland, Bray, & Gunnell, 2006)'. That is, something about 'putting the strategy in place' (in this case in Finland in 1992) began to reduce the deaths from suicide. Could it have been the general increased awareness of suicide and its prevention that led to increased knowledge that help was possible, which in turn led to help-seeking and a subsequent increase in prescribing?

Similarly, as we noted in our review: 'We think we know that psychotherapy and psychosocial treatments (e.g., cognitive behavioural therapy or dialectical behavioural therapy) for mental disorders reduce suicidal behaviour (e.g., Brown et al., 2005)'. However, recent work suggests the impact of psychotherapy in a community or population could be simply the availability of psychotherapists (as a proxy for relevant healthcare services) in that community, as much as the actual therapy (Kapusta et al., 2009). Perhaps people have heard that increased or improved services are available, and are more likely to stop and think, and then possibly seek help rather than going through with an impulsive act. Could help-seeking be a crucial or perhaps even a central part of suicide prevention? What do we mean by help-seeking?

A recent World Health Organisation review of adolescent help-seeking (Barker, 2007) suggests the following comprehensive definition: 'Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services – for example, clinic services, counsellors, psychologists, medical staff,

traditional healers, religious leaders or youth programmes – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. The "help" provided might consist of a service (e.g., a medical consultation, clinical care, medical treatment or a counselling session), a referral for a service provided elsewhere or for follow-up care or talking to another person informally about the need in question'. Barker's work focuses on adolescents, but it appears to me that the principles apply across the age range. Barker also goes on to distinguish positive forms of help-seeking from possibly negative ways of self-help such as drug use and abuse. Further, he distinguishes 'health-seeking' (for specific symptoms or illness) from 'help-seeking' (which might include personal stress or family crises, or perhaps financial problems). This latter distinction may be too detailed for the purposes of this editorial.

There are a number of issues that may encourage or discourage help-seeking.

Illness Awareness and Public Knowledge

If you have an accident and break a bone, you will be whisked to relevant help whether you ask for it or not. If you have a lump or bump that is unsightly, or an itchy rash in an obvious place, you may be driven quickly by vanity to see your local doctor. If the itchy rash is in a non-obvious place, and even a little embarrassing, you may still seek help quickly. If you have recurrent heartburn or headaches or sleeplessness you will probably seek help after you have run out of remedies suggested by relatives or friends. If a lump ulcerates, or you pass blood in your urine, or you have sudden intolerable pain for no obvious reason you may be driven by fear to seek help. The ever-present fear of cancer and its consequences is always in the news and social media.

But signs and symptoms of a mental illness may be more subtle, and creep up on you over time; you may continue to dismiss them as tiredness, over-work, or someone else's fault, and the full awareness that you have something serious may occur very late in the piece. We all suffer from a sad mood from time to time, especially in the context of grief or loss of status or function, and this may be accompanied by loss of pleasure in life, a lack of energy and enthusiasm – but it is usually all self-limiting. We have sleepless nights when facing an exam, or an important interview, and our concentration may suffer. At the same time we may temporarily go off our food, and our weight can fluctuate. We all have reasons for some guilt and self-blame from the past, but most of us leave these in the past – they do not constantly intrude into, or consume, our thoughts. In clinical depression all these symptoms persist, each may be more troublesome,

and the combination over time may get us to the point where life is no longer worth living.
The symptoms, combination of signs, and persistence of clinical depression (and other disorders) have all been well described and information about accessing help is freely available online at places like Beyondblue and – for young people, ReachOut – to name only two of many useful sites. There is every reason to believe that public awareness of depression, and a wide range of other mental illnesses, may have improved over the last 12 years since Jorm's (2000) paper on mental health literacy. In fact, there may even be a problem emerging, in that some people are likely to have a few symptoms suggestive of disorder and, in the context of heightened anxiety, imagine they have the full blown serious mental illness. They may expect instant curative medication, when reassurance and minor modification of daily life may sufficiently change the problem. This is drawn from clinical practice, and there is little research to suggest what the impact is overall on help-seeking behaviour.

Knowing there is a Treatment or Cure
Part of this issue of awareness (or literacy) is not just about the capacity to put the symptoms and signs together, and realise you may have a problem that needs help. Rather, there is a need to know that your set of problems can be helped; there are treatments available, and they work. As mental health professionals we are not particularly good at getting this message across to the public. We are so busy critiquing the quality of other people's research work, so obsessed with needing the highest level of evidence before we recommend any treatment, so bound up in the ungenerous politics of our professional practice, we often forget to translate what we do know into simple terms for ordinary folk. Talking about mental health problems may be helpful, whatever the professional background of the clinician. Therapeutic alliance may be a key to a positive outcome (Martin, Garske, & Davis, 2000). Various forms of cognitive behavioural therapy appear to work – especially when tailored to the particular condition (Butler, Chapman, Forman, & Beck, 2006). Psychodynamic psychotherapies work, when given time (Leichsenring & Rabung, 2011). Mindfulness based therapies work, though quality research is in its infancy (Tan & Martin, 2012). Even expressive therapies can be shown to work, though few randomised controlled studies have been completed (Martin et al., 2012).
The issue here is that if we do not promote a variety of possible therapies for the full range of mental health disorders to the community, they may

assume that their particular problem does not have a cure, and just not bother to seek help.

Access to Therapy

There are a number of issues here needing to be explored. First, in Australia, one of the main barriers to care can be the geographic distance to any sort of professional help. New strategies are emerging to meet the need. For instance, video-conferencing to remote sites, to assist local primary clinicians, seems to be a powerful way to provide best available care (which also has inherent in it the extra training and supervision available to those rural clinicians). There is a long way to go before formal evaluation and research is possible, but early results are promising (Wood, Stathis, Smith, & Kraus, 2012).

Even if systems like this exist, there can still be serious problems from the tyranny of distance. I have previously reported my clinical despair at having to manage a seven year old boy who had made a serious suicide attempt, and his family had to travel over 150 km into Mount Isa to be seen for a single session (Martin, 2007), with severely limited possibilities for follow-up.

But there are other problems in accessing care relevant to the problem. You may not have access to personal (or sometimes even) public transport. You may not have the finances to even consider paying for professional assessment and care, even with Medicare support.

Finally, there may be cultural constraints in terms of language, expectation, problem definition, and expectations of both the informal and formal systems of care. Even if some sort of care is available in geographical proximity, finding the help responsive and knowledgeable about how your symptoms and problems may fit within cultural norms, or may have been dealt with in the past using culturally appropriate methods, remains a problem in Australia today. How do we translate any of the therapies that we know have reasonable research on efficacy or outcomes into a culturally acceptable frame? Conversely, how do we help other cultures to develop acceptable and effective interventions for some of our mental health diagnoses, or for mental health problems that seem to emerge from substance abuse like petrol sniffing?

Stigma

As a final issue I believe we have to consider how stigma and help-seeking may interact. Eisenberg, Downs, Golberstein, and Zivin (2009) recently reported that 'personal stigma' (e.g., 'I would think less of someone who has received mental health treatment') was associated with lower help-

seeking (perceived need and use of psychotropic medication, therapy, and nonclinical sources of support); 'perceived stigma' (e.g., 'Most people would think less of someone who has received mental health treatment') was not significantly associated with help-seeking. Subjects with high levels of personal stigma were less likely to decide on their own to seek help.

Elsewhere (Martin, 2010), I have commented that if we have a socially unacceptable behaviour driven by our mental health problems, we may be stigmatised. We may be as stigmatised by professionals as much as the members of the community. So, if you have self-injured and your wounds need medical care you may have to go to an emergency department of a local hospital. If nursing and other staff do not understand the mechanism behind self-injury (i.e., control over emotion), they may see you as attention seeking, or just a nuisance. Because your wounds may be of less importance than road trauma or a coronary thrombosis, you may be left on a barouche in a quiet dark corner for a number of hours until they get around to dealing with you. I have now heard numerous recent reports of self-injurers being sewn up without anaesthetic, on the grounds that the original injury was self-inflicted, so the patient will not be worried by a little more pain. This is effectively a 'punishment' for seemingly 'wasting professional time'. In fact, it re-traumatises people who already may have had a lifetime of trauma. How does that help us to prevent further self-injury? How is it therapeutic, when it can be seen as grossly inhumane? How does it help us to encourage people with mental health disorders to seek help?

Self-injury appears to be a common disorder, and may be somewhat more common that current studies have reported (Martin et al., 2010). People with mental disorders such as depression or anxiety may be more likely to answer research questionnaires, whereas those with health risk behaviours such as alcohol abuse may be less likely to do so or only likely to respond with subsequent reminders (Said, Kypri, & Bowman, 2012). This may be driven by personal stigma, and the authors suggest it may lead to underestimates of prevalence in large-scale studies, as well as less active help-seeking. So, the exact prevalence of behaviours like alcohol abuse, or drug abuse or self-injury may be in some doubt. Our own work suggested that 8.1% of the Australian population may have self-injured at some stage in their lives (Martin et al., 2010), and we thought this was surprisingly high. To gain the sample was complex, and we did have over 14,000 refusals before gaining our final sample. Given the issue of personal stigma, perhaps self-injurers were a part of the group who refused; perhaps self-injury is a bigger problem than even we thought.

Either way it demands considerable focus in terms of how we get sufferers to seek help and maintain their care.

The recent RU OK? Day (September 13th, 2012) in Australia was the fourth year of a national campaign to increase the likelihood of ordinary Australians reaching out to other Australians with a simple enquiry. With one in three Australians estimated to have taken some part in the day (up from 19% in 2011), an independent survey suggested that 67% of people asked someone face-to-face: 'Are you OK?' However, older men were less aware of the campaign and less likely to participate than women of a similar age, and this reflects other issues for older men where stigma of having problems may be one of the issues stopping them seeking help. It remains to be seen with a national day of action such as RU OK? Day (2012) can ultimately lead not just to increased awareness, but also to active help-seeking, especially for at risk groups. If we can demonstrate that this occurs, then perhaps this kind of day of action needs to become part of a suite of programmes within our national suicide prevention strategies.

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Forty

On Guns and Suicide[113]

In a 1997 editorial in the Medical Journal of Australia, Robert Goldney and I reflected: 'Since Friday the 10th May 1996, Australia has become a natural experiment in suicide prevention with the unified approach to State and Territory gun laws engineered by Prime Minister John Howard in the wake of the Port Arthur massacre.' While Port Arthur was a devastating moment in Australia's history with 35 dead and 21 injured, pressure toward better control gun availability had been growing from lobby groups since the 1987 Hoddle Street and Queen Street massacres, and the murders in Surry Hills (1990), Strathfield (1991) and Central Coast (1992). A balanced review of guns and violence in Australia, drawing in part on prior Canadian experience of reducing available weapons, concluded: 'Australia is poised on the brink of change with regard to its firearms policies. Further debate on the most appropriate course of action will inevitably occur. Existing evidence suggests that a national gun control strategy would lead to a significant reduction in the incidence of gun-related accidents, gun suicides, and some of the more deadly consequences of criminal activity. The ultimate resolution of these issues rests with the elected representatives of the Australian people.' (Chappell et al., 1988)

Despite ongoing unnecessary deaths, sporadic research and government reports, and press and public argument about the issue, it was Port Arthur (28th April 1996) that galvanised public opinion, acting as a 'last straw' in the debates about civilian gun ownership and possible consequences in loss of innocent lives. The number and nature of weapons owned by one young man was perplexing, the number of ordinary people murdered was beyond comprehension, and the random nature of the event was terrifying. Prime Minister Howard acted quickly after Port Arthur to argue for a National Firearms Program Implementation Act 1996 (10th May), with an amnesty period of 17 months, a government buyback targeting

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semi-automatic rifles, and semi-automatic and pump-action shotguns, and uniform firearms licensing across all states and territories.

There was division, of course. In parliament, in the Liberal cabinet, and across the country, but many lobby groups, such as the Australian Medical Association (1996) provided clear support for the government proposals. Others who use firearms as part of their livelihood, rightly drew together to oppose the program, pointing out the myriad of underlying causes that can influence whether random violence occurs. PM Howard acknowledged this complexity in his speech to the Sporting Shooters Association of Australia rally held in Sale on the 16th June 1996 (qv); problems in licensing laws, mental health laws, 'mind-numbing' television violence. He also remained firm under strong criticism and persistent questioning, returning to the core values of a safer Australia, while supporting the rights of individuals to be supported in their daily work, and for sporting shooters to be allowed to continue with their recreation.

Leigh & Neill (2010) suggest Australia's gun buyback of more than 650,000 firearms reduced Australia's firearms stock by about one fifth overall. So by 2001, for instance, the number of individual licence owners was 764,518 (5.2% Australian adults), the number of registered firearms was 2,165,170, a rate of 3 per licence owner (Mouzos, 2002). Of course, this does not help us to count unregistered owners or guns. They note that the Australian gun buyback was across all states and territories, and large by international comparison with five times as many guns as the United Kingdom buyback of the same year. Despite variations in firearm death rates from year to year, the sheer size of the buyback should have been large enough for us to reliably demonstrate an impact on both homicide and suicide, despite the plethora of other well known and multilevel risk factors for either (Leigh & Neill, 2010).

Based on there being fewer guns available throughout Australia, the increased difficulty in accessing guns because of more stringent required assessments prior to purchase, and the reduction specifically in semi-automatic weapons, one measure of success of such a large policy change may be the rate of mass murders. As noted above, prior to Port Arthur there had been a number of massacres (a total of thirteen for the years 1979-1996). Since Port Arthur in 1996, Chapman et al. (2006) suggest there were no massacres for the next 10 years.

However, on 21 October 2002, a commerce student at Monash University, armed with six loaded handguns, opened fire in a class containing twelve students, killing two students and injuring five other people. It is of note that he used handguns; this may have protected others compared to what may have happened using semi-automatic guns. To the author's

knowledge there have been no other mass shootings up to the date of writing. It seems reasonable to say that this is impressive, even if it is problematic to be certain of a causal link. However, despite arguments against linking policy change with this as an outcome, at the very least it seems to be a very big coincidence.

Based on cause of death figures available from the Australian Bureau of Statistics, there is evidence to suggest that firearm homicides overall have reduced by about 40 each year from 1995, with a reduction in rates from 0.37 per 100,000 people in1995 to 0.15 per 100,000 people in 2006, an overall reduction of 59%. It has to be noted that this is in the context of a similar reduction in non-firearm homicides (59% over the 10 years) which may suggest there has been an ongoing cultural change in Australia; cause unknown.

When we come to consider changes in the suicide rate, we can see that suicides increased steadily from about 1978 to a peak in suicides in 1997. Subsequently there has been a reduction to date to below the rates of the late 1970s. Within this, non-firearm suicides account mostly for the shape of the graph. Firearm suicides, in fact, have been reducing steadily for many years, with a small peak in the 1980s, but with a steady reduction ever since. Leigh and Neill (2010) note specifically that firearm suicides dropped from 2.2 per 100,000 people in 1995 to 0.8 per 100,000 in 2006, a drop of 65%, representing a reduction of firearm suicide deaths of 300. Alongside this, the non-firearm suicide rate fell by 27%.

I noted that the causes for the ongoing reduction of homicides in Australia may not be easy to determine. For suicides, there may have been a wide range of social changes occurring from 1997, but in addition, there has been a large scale National Suicide Prevention Strategy in addition to all the state and territory strategies. A Ministerial Council for Suicide Prevention began work in Western Australia in 1988, with a specific youth suicide prevention strategy; one by one, all states and territories mental health administrations followed suit. In July 1995, the Commonwealth created a Youth Suicide Prevention Advisory Group, which advised on management of the initial $35m allocated to a range of large and small programs across the country. As the states and territories gradually developed strategies, suicide program funding was allocated to all ages and a range of special groups. So, too, the Commonwealth created an overall Australian strategy 'Living is for Everyone' (LiFe) which has continued to be well funded to the present day (see references for the 'LiFe' online site, and the official Australian Government site for the NSPS).

Of course alongside this government activity, there was a considerable groundswell of community anxiety about rates of suicide, particularly in youth, and also in men. Organisations like R.O.S.E Education in Sydney, and Suicide Prevention Australia (SPA) had been providing commentary about suicide and its prevention since the late 1980s, with SPA running annual national conferences to showcase advances since the early 1990s, drawing together those with a passion for reducing unnecessary deaths, and supporting forums for other community organisations providing prevention programs or support for the bereaved through suicide.

I believe we need to acknowledge this admixture of groundswell opinion, community organisation voluntary commitment, the energy put into national conferencing, as well as formal funding of programs from states and the Commonwealth as possible contributions to reductions in suicide rates.

So how can we then tease out the relative contribution of all this, versus the national application of a reduction in one method of suicide? If we agree that something has actively contributed to reduction in rates of suicide (and there are some who are uncomfortable with this), perhaps we can acknowledge the overall 40% or so drop in suicide rates as derived from composite action, that includes one of the best and most comprehensive national strategies plus related state-based strategies. If we accept this view, it would be consistent with the measureable impact from other long-term strategies around the world referred to in previous editorials and recent scientific papers (Martin & Page, 2009; Matsubayashi & Ueda, 2011).

The work of Leigh & Neill (2010) seems to suggest we can perceive the differential drop in suicides from 1995 to 2006 in the non-firearm related (27%) versus the firearm related (65%). That is we can conclude that the reduction in guns and the other associated control measures have contributed to the reduction of suicide in Australia.

Was the type of gun important? Was it important to remove long guns or semi-automatic weapons? In their very careful analysis, Leigh & Neill (2010) show (Table 1, p521 (drawn from ABS data)) that for the 5-year time period 1998-2003 compared with 1990-95, within the overall 65% reduction in firearm suicides recorded, there was a drop in the use of rifles to suicide (down 51.9%), other firearms (down 67.3%), but a small *increase* in the use of handguns (up 18.1%). This mirrored the pattern in the overall 59% reduction in the reduced overall homicide rate – use of rifles (down 57.8%), other firearms (33.7%) but an *increase* in handguns (up 71.5%).

Of course all of this has been brought into sharp focus in the aftermath of the Sandy Hook Elementary School shootings in Newtown, Connecticut, USA, in December, when 20 children aged six to seven years, and six school staff lost their lives. A newly elected, and courageous President Obama moved to do what no previous US administration had been able to do; to reduce unnecessary shootings through a raft of measures. His moving speech in response to the shooting named the dead making them very real for the American public, and had the key words: "these tragedies must end, and to end them we must change".

Within all of the hysterical debate to follow, there have been some very sane voices. Ezra Klein for the Washington Post, in an article well worth reading, reviewed twelve facts about guns and mass shootings (December 14th) (Klein, 2012). He concluded by quoting a study by economist Richard Florida into the correlations between gun deaths and other kinds of social indicators: "Some of what he found was, perhaps, unexpected: Higher populations, more stress, more immigrants, and more mental illness were not correlated with more deaths from gun violence. But one thing he found was, perhaps, perfectly predictable: States with tighter gun control laws appear to have fewer gun-related deaths."

Ishaan Tharoor (2012) from Time Magazine (17th December) went to the heart of this editorial in reflecting on the actions taken in Australia and Scotland following shooting massacres, and how this might reduce both homicides and suicides. Of course the problems for the US administration are slightly bigger than in the United Kingdom and Australia. Leaving to one side the apparent power of the National Rifleman's Association, and the basic difficulties attributed to the US Constitution Second Amendment and its 'right to bear arms', there are 50 states in the US who will have their own views, and need change in their own laws – slightly larger than the eight states and territories in Australia.

It has been estimated that to get an effect equivalent to the one we believe we have achieved in Australia, it would take the removal of over 40 million guns in the US. The cost of this, whether it is at cost price of the guns, or some agreed on price, will be in billions of dollars.

President Barak Obama has forged ahead despite the difficulties. In his speech 'Now is the time to do something about gun violence' (see reference), he has laid out the reforms that will be necessary. They include: requiring and strengthening background checks prior to purchase, passing new bans on assault weapons, limiting ammunition rounds to 10, getting armor-piercing bullets off the streets, giving law enforcement additional tools to prevent and prosecute gun crime, ending the freeze on gun violence research, making schools safer with new

resource officers and counselors, better emergency response plans, and more nurturing school climates, and ensuring quality coverage of mental health treatment, particularly for young people (Obama, 2012).
Presumably the ban on assault weapons (a previous ban lapsed in 2004 with apparently dire consequences) will require some sort of 'buyback'. Of course the 'devil is in the detail', and there is a long way to go before we see what transpires in the US.
The latest figures in the US show there were 38,364 suicide deaths (12.4 per 100,000) overall, with just over 50% of those firearm related (19,392 deaths, or 6.3 per 100,000) CDC, 2013). If the US were able to emulate the changes managed in Australia, and reduce the rate of suicide by 65%, that would save the US 12,600 deaths from gun related suicide, which in turn would reduce the 'Bereaved through suicide' grief burden for a large number of families.
The evidence for Australia suggests that our 'natural experiment' has worked to not only reduce gun-related suicides, but has contributed to an overall reduction in the rate of suicide and homicide. The United States may be just about to begin their own 'natural experiment'. It would be good to watch what happens to suicide rates over the next 10 years.

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Forty One

On Mindfulness and Mental Health[114]

Before launching into this editorial, I need to come clean - to allow doubters to immediately wipe off what I am about to say, and find something more amusing to read. I trained in Transcendental Meditation about 30 years ago, and have been a meditator (perhaps not as formally or as regularly as I should be) since that time. I have not been back for 'tune-ups', and my practice when I do 'sit' follows the process I learned originally, and uses the same mantra. In those early days I read all the research I could find (precious little) which seemed to be focused on measurable physiological processes like blood pressure and pulse rates. There was a lot of discussion about calmness and relaxation, but clinical report, skin conductance and palmar sweat tests seemed a bit primitive even then. We have come an immense distance since, and with work around the world focused on providing us with pretty pictures of the brain using fMRI and other methodologies, the science around meditation and mindfulness seems to be more persuasive. Yet, it remains little discussed, a bit obscure, still something that may not be acceptable to mainstream psychology or psychiatry, or even in the general population. I have made mention of mindfulness in a previous editorial on self-injury (Martin, 2010). I also referenced some of our own work (Tan & Martin, 2012) in the editorial on help-seeking (Martin, 2011), but I want to explore mindfulness in much more detail.

Mindfulness is 'awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment' (Kabat-Zinn, 2003). Let's just explore that, because it has been carefully constructed to encompass all the elements. 'Awareness that emerges' clearly tells us that we may think we are aware of ourselves, but most of us are too busy rushing headlong through the day to give much mind space to truly being aware of our inner world, or our surroundings with all its sounds and images and smells, and

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the ways we are interacting with the world. That may be from the press of daily life; but it may also emerge from not wanting to pay attention to our inner world, deliberately avoiding doing so because it is too troubling, too complex, too overwhelming. Why would you want to get into that? Because, says the theory, and aeons of commentary on personal practice, if you focus and let it go, you go through a tunnel of possibly dark issues, and come out again into the light and fresh air.

I used the word focus then, but Kabat-Zinn's phrase is 'through paying attention on purpose'. So, you have to stop the outside rush hour, and find a place and time to pay attention. I understand that many people are not prepared to do that, too scared to try, or too distractible. Hence the 'on purpose' bit. You have to make a decision this is what you are going to do, and make a time, and find a space in which to do it where you will not be too distracted for a time. You have to have been persuaded it is in your best interests. You have to believe it is important for your mind health, your physical health, your wellbeing. And then most of us, these days, would want to know what evidence exists that mindfulness is helpful in those domains. Well, hold on, I will get there.

The next bit is 'in the present moment'. What Kabat-Zinn is describing here is a need to listen to the sounds around you, feel the temperature of the room, the comfort of the chair in which you are sitting, the softness of clothing, the ambient smell of surroundings, and perhaps the residual taste of the drink you had before you sat down. You need to listen to the stream of ideas running through your mind, with the associations they bring, and feel the emotions they arouse. The first bit may be easier, if you can allow yourself time. The second bit may be scary; many people don't like some of the thoughts that run through their minds, or are reminded of painful events, and may be fearful of being overwhelmed by the accompanying rush of feelings. So we need the next bit 'and nonjudgmentally'. This is critical to change, and involves noticing even the worst of thoughts, the most angry, destructive wishes, the most painful of feelings; acknowledging them as a part of you, and not adding any value to them. You let them go, knowing that some of them may return, and you will have to let them go again. The thoughts over time do lose their power to cause heartache, and simply become part of your individual journey. "That happened, it was painful, it was a long time ago, I have moved on, and life is different now." Not letting the thoughts have a value or power also gets applied to good plans or happy memories; they simply become an accepted part of your history.

The final piece of the jigsaw is 'to the unfolding of experience moment by moment'. When you avoid old and painful memories, the theory goes, you

give them power by trying to stuff them somewhere deep down inside. The more you avoid the pain, the more it presses to come back into consciousness. Conversely if you observe the memories and feelings non-judgmentally, with acceptance, they can be superseded by the constant stream of new experiences you allow into your awareness in the here and now.

So where do these ideas come from? Some would acknowledge they have been around for thousands of years. They are represented in Eastern religions like Buddhism and often associated with the formal practice of meditation. Equally they are found in more Western religions in the practice of ceremonies, but also in prayer. But they are more universal than that. Some might suggest I am going too far, but I would argue that they are present in the practice of singing – for instance in choirs, in crowds at football stadiums. They are present in the playing of instruments, in dance, in the development of art or poetry. Anything that allows you to enjoy and stay in the moment, allows you to release old troubles. Watch people who have just finished any of those activities, and you will see some of the greatest spontaneous joy in mankind (except when things go awry, or your team loses of course).

So that is the theory; how good is the research? Is mindfulness helpful in developing mental health? Is mindfulness useful in helping people who have mental health problems and, if so, which ones?

In an early meta-analysis of studies on Mindfulness Based Stress Reduction (MBSR), Grossman and colleagues (2004) found 64 empirical studies, but only 20 met their criteria of acceptable quality or relevance. They were able to show that both controlled and uncontrolled studies had similar effect sizes for reduction of stress levels of approximately 0.5 ($P<.0001$) across a wide range of conditions (pain, cancer, heart disease, depression, and anxiety). They concluded that despite the small number of acceptable studies, results suggested MBSR could help a broad range of individuals to cope with clinical and nonclinical problems. A more recent meta-analysis (Bohlmeijer et al., 2010) of eight randomised controlled studies of depression, anxiety and psychological distress in somatic disease, showed an overall small effect size on depression of 0.26. The effect size for anxiety was 0.47, but when studies of lower quality were excluded, this reduced to 0.24. A small effect size of 0.32 was found for psychological distress.

Fjorback and colleagues (2011) also report meta-analytic work, but focused on randomised controlled trials using both standard MBSR and MBCT programs, and each with a minimum of 33 participants. Of 72 studies, they included 21 that met their criteria. MBSR improved mental

health in 11 studies compared to wait list control or treatment as usual (TAU), and was as efficacious as active control group in three further studies. Mindfulness Based Cognitive Therapy (MBCT) reduced the risk of depressive relapse in two studies compared to TAU and was as good as TAU or an active control group in two further studies. Overall, studies showed medium effect sizes. They concluded that evidence supports MBSR can improve mental health and MBCT can prevent depressive relapse.

Similar careful meta-analytic work by Klainin-Yobas et al. (2012) drew on 39 studies from ten countries. Most used single group pretest-post-test quasi-experimental design, convenience sampling, and self-reported questionnaires. Mindfulness based therapies were superior to standard care in reducing depressive symptoms and preventing relapse (effect sizes from 0.11 to 1.65). Exposure-based cognitive therapy (d=2.09) did slightly better than the MBSR program (d=1.92), acceptance-based behaviour therapy (d=1.33), and 'stress less with mindfulness' (d=1.31). Effect sizes were significantly associated with the length of intervention sessions, but not related to methodological quality of studies.

Mindfulness based therapies are used for a wide variety of mental health problems. Skanavi and colleagues (2010) examined six studies of the impact of MBSR on addictive disorders, five of which were controlled and four randomised. Dropout rates were somewhat high (up to 55%), but in five studies substance use was significantly reduced. In four of the studies, mindfulness proved more effective than control conditions. They noted that both effectiveness and the differential improvement were greater when follow-up was longer, and concluded that these first clinical studies testing mindfulness-based interventions in substance use disorders did show promising results.

In the first randomised, controlled trial comparing a manualised MBSR program with an active control for generalised anxiety disorder (Stress Management Education (SME)), Hoge and colleagues (2013) found both interventions led to highly significant ($p < 0.0001$) reductions in scores on the Hamilton Anxiety Scale. MBSR, however, was associated with significantly greater reduction in anxiety as measured by the Clinical Global Impressions scales, and the Beck Anxiety Inventory (all $p<0.05$). MBSR led to greater reductions than SME in anxiety and distress ratings in response to a stress challenge ($p < 0.05$) and a greater increase in positive self-statements ($p=0.004$). This research is in some contrast to a very recent RCT by Arch & Ayers (2013), which demonstrates we still have a long way to go to clarify all the issues. They suggest that standard CBT outperformed adapted MBSR in mild depression and, at post-treatment

only, in those with high anxiety sensitivity, but MBSR outperformed CBT for moderate to severe depression and for those with average anxiety sensitivity. Complex isn't it?

Mindfulness has been used recently in programs for post-traumatic distress disorder, which may prove of importance in treatment of returned servicemen. Two very recent studies (King et al., 2013 and Kim et al., 2013) have both shown promising results from randomised controlled studies. Larger studies will be necessary to prove these results conclusively.

Mindfulness based programs are also being used with professionals under stress. Shiralkar et al., (2013) in a recent review examined 13 randomised, controlled trials or controlled, non-randomised trials used to reduce stress in medical students. Interventions that worked well to reduce stress included self-hypnosis, meditation, mindfulness-based stress-reduction, and changes in the grading system. In a similar vein, Fourer et al., (2013) report a pilot study of a one-day workshop on mindfulness, following which nurses agreed to meditate every day for eight weeks. The quantitative findings included significant improvements on the GHQ-12, SOC and the stress subscale of the DASS. Qualitative findings support the acceptability of the intervention.

Finally, we need to consider the neurobiology of mindfulness, where our knowledge appears to be advancing rapidly. Chiesa and Serretti (2010) discuss neurobiological and clinical features of mindfulness derived from their systematic review of studies. They concluded EEG studies show a significant increase in alpha and theta activity during meditation; neuroimaging studies show mindfulness activates the prefrontal cortex and anterior cingulate cortex; and long-term meditation enhances cerebral areas related to attention. All of those are considered to improve a sense of wellbeing. They note that from a clinical viewpoint, MBSR has shown efficacy for many psychiatric and physical conditions and also for healthy subjects, Mindfulness-Based Cognitive Therapy (MBCT) has efficacy in reducing relapses of depression in patients with three or more episodes.

It is clear from all these recent studies that mindfulness based therapies do have a place in treating a wide range of conditions – anxiety, post-traumatic stress disorder, depression, the stress that comes from having a range of physical illness. Of major importance to clinicians, not one of these studies or meta-analytic reviews of studies reported any adverse outcomes from meditation, despite its apparent power. In addition, mindfulness clearly has a place in maintaining wellness in the face of work-related stress.

What is interesting here is that it has taken such a long time for the science around mindfulness to develop to the point where it supports the mindfulness-based programs as having some respectability. There is still a long way to go.

A further point can also be made. Not one piece of the research work reported here made mention of using mindfulness with children and adolescents. In addition, I could not find other research in the various databases I accessed that reported such work. If mindfulness is being shown to work with a range of stress-based conditions, as well as a number of formal mental illness diagnoses in adults, why should we not consider its use with young people? If it has so far not shown any adverse effects it seems it might be an ideal approach to mental health work with young people.

Let me return to the work of clinical psychologist Lucy Tan, whose PHD has been awarded. I have had the immense honour of being Lucy's PHD supervisor. Her first published work was a large study of normal adolescents looking at mindfulness itself, whether it could be measured in adolescents, and whether it overlapped with other constructs like self-esteem and resilience or was in itself a discrete construct for this age group. Further to that a recently published second paper reported a pilot study of a five session manualised program on mindfulness with young people randomly chosen from child and adolescent mental health clinics. This work showed surprisingly good results in a small sample, and gave Lucy the confidence to go on to a randomised controlled study of 100 young adolescents from child and adolescent mental health clinics, and with a range of psychiatric problems. The randomisation was to treatment as usual (TAU) or to the therapy group *plus* TAU. Again the results from this work show great promise, and the third paper from Lucy's PHD study has now been published.

I have taken the liberty of describing Lucy's three-year process in a little detail, because it is important to consider the patience and elaborate care that studies with young people need. It is important to acknowledge the possible risks of such a study and the need for small steady steps in the process. It is important to acknowledge the possible risks to a professional career that need to be taken to achieve novel programs of care. It is important to dream about the possible impact such a manualised program of care will have in the future on mental health problems in young people. Finally, it is also delightful to have had the opportunity to indulge in a review of the available research in mindfulness for adults and appreciate that Lucy's struggle to complete this work in a clinic environment is at the cutting edge of the science of

mindfulness. All of this is what the Advancement of Mental Health is about.

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Forty Two

On Deliberate Self-harm and Emergency Departments[115]

In a previous issue of this journal (Martin, 2012) I wrote about help-seeking, suggesting that a critical barrier to future seeking help might arise if you went to an emergency department, and were criticised or stigmatised for self-injury, told that you were wasting staff time, left alone until staff could be bothered to see to you or even worse, punished by being sewn up without anaesthetic.

What I didn't say at that time was that I remember, with some chagrin, an episode from my own early career. Many of you will have seen the television program '24 hours' about King's College Hospital Emergency Department in Camberwell, London; a fascinating insight into emergency medicine, but also into human beings at their best and at their worst.

I qualified in Medicine in 1967 at King's, and my very first house officer job was in King's Emergency Department. So, it is kind of weird seeing the TV program, and remembering... In my time, we had lengthy rosters that included one week of 96 hours on duty, during which on nights (if we were lucky) we got some sleep in a tiny bed at the back of the department. We saw up to 140 patients a day, everything from small abrasions through to the man who was dumped at the back door, and crawled up to the reception claiming he had been shot in the head; on Xray he did indeed have two bullets visible, and after surgery, miraculously he survived. An immersion in acute medicine; certainly an education for a 23 newly qualified doctor who new very little about medicine or indeed the world, despite winning the medicine and psychiatry prizes for his final year.

The people who did have the knowledge were the nurses, and this certainly shows up in episodes of '24hours'. I admit to being 'rescued' frequently during those 6 months, but gained an immense respect for the nurses, and learned that very important lesson: "If you don't know, ask!"

[115] First published 2013. Martin, G. (2013) Editorial. Advances in Mental Health 12:1.

One case has come to the fore in my memory during the last 10 years; during which the focus of my clinical, teaching and research work has been self-injury. I have told this story many times during seminar and conference presentations. It was mid evening, and 'John' walked up to reception and showed his bleeding arms. There were 74 cuts of varying depth on his forearms, and he was steered rapidly to a cubicle. A nurse and I were assigned to clean up John's arms, and sew up cuts where necessary. The nurse collected a trolley with all the necessary equipment, and John lay on his back, arms akimbo with a nurse on one side and me on the other. The registrar poked his head round the curtain and said commandingly: "Sew him up without anaesthetic!" I looked at him and asked: "Are you serious?" to which the response was a confirmed "Yes!" "But..." "Look," said the registrar "He obviously likes pain, and won't mind a bit more." "But..." "Do what you are told! Or I will report you!"
The nurse and I looked at each other, disturbed and confused, and were just about to get to work when the registrar poked his head back through the curtains: "OK, look, you can't put lignocaine into all those cuts. You will use so much he will end up with heart block." "Are you serious?" "Yes, now get on with it!" And so we did.
With each needle entering flesh, poor John let fly verbally: "Oh, oh, oh... do it again doc! Do it again!" The nurse and I looked at each other repeatedly, totally bemused. But we completed the job, covered the arms in antiseptic non-stick dressings and bandages, made an appointment for John to return to have stitches removed, and moved on sheepishly to the next allocated job. We did not have the experience and curiosity (or perhaps the empathy) to ask John what he was experiencing, why he had done this to himself, and what his life story was? We did find out he had wandered over unaccompanied from the Maudsley Hospital, one of the great mental hospitals in the world, quite literally over the road from King's. We assumed he wandered back. We assumed he would be followed up psychiatrically, when back at the Maudsley. I never saw John again, but I regret sincerely we did not treat him like a human being, were not interested enough to enquire about him as a person. We had nothing to offer him by way of humane intervention, and we offered it – nothing.
So, I am bemused from time to time when I tell that story publicly, and someone approaches me quietly later, and says: "That happened to me. I was at such and such a place, and they sewed me up without anaesthetic." Over the last 10 years there would have been about a dozen of these experiences. So it seems that with all of the advances of medicine over the last 46 years, there are still medical people prepared to punish people perceived as wasting their time.

Does it help in any way? Yes, it stops people returning for further episodes of care; it helps the hospital staff... Does it help our patients? No! It provides a fresh trauma to add to all the trauma experiences of their lives. It blocks them from further seeking help.
So, is there evidence to back up my concerns about how we treat people who self-harm? And, what could we or should we be doing differently, and why?

Studies of follow-up after Emergency visits
Repetition of self-harm is known to occur in about 12% of those who overdose, and usually within 3 months of the index episode (Boyes, 1994). Deliberate self-harm (DSH) patients, despite their risk of suicide, are often discharged directly from accident and emergency (A&E) departments without undergoing a psychiatric assessment (Gunnell et al., 2005; Hickey, Hawton et al., 2001; Ebbage et al., 1994; Owens et al., 1991) or having received only a limited assessment (Dennis et al., 1997; Ebbage et al., 1994).
In a matched control design, over a 2-year period, characteristics and outcomes of 145 DSH patients discharged directly from an A&E department without a psychiatric assessment were compared with those who were assessed (101) (Hickey, Hawton et al., 2001). Non-assessed patients were more likely to have a past history of DSH, to be in the 20-34 year age group, and to have exhibited difficult behaviour in the A&E department. Patients presenting between 5pm and 9am were less likely to be assessed than those attending between 9am and 5pm. Further DSH during the subsequent year occurred in 37.5% of the non-assessed patients, compared with 18.2% of matched assessed patients. They were also more likely to have psychiatric treatment.
It should be noted that generally the risk of death is subsequently increased in those attending emergency departments, particularly in frequent users (Gunnarsdottir & Rafnsson, 2006), or in those recently discharged from hospital (O'Hara, 1996). However, there is a significant association between suicide and a previous attendance at Emergency with deliberate self harm, especially among younger socially isolated males and older females (Ryan et al., 1996), and this occurs also in those not formally assessed for their mental health prior to discharge (Owens et al., 1991). Patients of no fixed abode may be at some special risk (Haw et al., 2006), as may be men who self-discharge (Bennewith et al., 2005). Non-assessed patients may be at greater risk of further DSH and completed suicide than those who are assessed, although this has been disputed (Waterhouse and Platt, 1990).

Of note, the vast majority of patients not assessed by the emergency department do attend their GP within the month after discharge (Gunnell et al., 2002). However, 50% (11/22) of those who repeated their attempt had attended the GP in the previous week.
In a recent large-scale multicentre cohort follow-up study (Bergen et al., 2012), 6.1% patients died before the end of the mean 6-year follow-up. The authors noted: "The underlying cause of death was suicide in 20.6% patients, intentional self-harm in 13.4% and undetermined (7.2%), or accidental (13.2%)". But they also reported that deaths due to natural causes were 2–7.5 times more frequent than was expected. That is, physical conditions may have been more prevalent, suggesting perhaps that patients had not sought as much timely help as they needed for either mental heal or physical problems.

Hospitalisation
Psychosis, a past suicide attempt, and a current plan appear to be important factors in the decision to hospitalise (Goldberg et al., 2007), although a number of other factors may be relevant (Baca-Garcia, 2006; Baca-Gracia et al., 2004), and hospitals still vary in their approaches (Suominen & Lonnqvist, 2006). Simple assessment tools are available to assess relevant risks (Cooper et al., 2006), and a case can be made for the use of recognised suicidality assessment scales like the Beck (Healy et al., 2006). Criteria for admission to Intensive Care Units are beginning to be more clear (Novack et al., 2006). Overall, emergency clinicians may be more conservative in their decision-making than psychiatric professionals (Drew et al., 2006).

Children and Adolescents
Much of the present body of literature describing suicidal behaviour does not separate children from adolescents for analysis and discussion. While they may be a small proportion of the work of an emergency department (Starling et al., 2006), they represent an opportunity for Early Intervention – intervening early in he trajectory toward mental health problems. In recent reviews of the literature about suicidality in young children (Tishler at al., 2007; Wintersteen et al., 2007) problems with available data, as well as epidemiology, risk factors, typical motivations, methods, assessment, and disposition for suicidality in young patients are discussed. A child who has ideation without a clear plan, or has made an attempt of low lethality, can sometimes be discharged home provided that a supportive, responsible caregiver is willing to monitor the child and take him or her to outpatient mental health appointments. If the home

environment is detrimental, or the child has used a method of high potential lethality, inpatient treatment is the most appropriate course of action. Routine mental health screening is conducted infrequently by most paediatric emergency physicians (Habis et al., 2007).
Although suicidal adolescents are frequently treated in emergency departments, there are few publications about their emergency department management. The professional resources needed may be large, the work intensive, and security incidents may be more common (Stewart et al., 2006). Kennedy et al., (2004), recommend hospitalisation for adolescents who have attempted suicide and cannot be adequately monitored and kept safe outside of an inpatient setting. Discharge home can be considered for a subset of adolescents with suicidal thoughts - if urgent follow-up mental health care can be ensured and responsible caregivers can adequately supervise and protect the youth. This subset includes adolescents who are not actively suicidal, do not have access to lethal methods, and have a supervising adult who can closely monitor their behaviour. Overall about 56% of adolescents get admitted after an attempt (Ofson et al., 2005).

Older People
Repeat risk screening within 72 hours by a community nurse in a Queensland sample led to fewer returns to emergency (Hegney et al., 2006).

Consumer Experience
Patient experience of Emergency Departments after a suicide attempt may be negative, as may be the experience of relatives (Cerel et al., 2006). This may be improved when psychiatric personnel work closely with emergency staff or within the emergency department (Summers and Happel, 2002).

Prevention
Telephone contact after attending an Emergency Department may reduce the risks (Brown et al., 2006)' although this may need to occur within the first month rather than later (Vaiva et al., 2007). Prescription of medication from initial assessment in the emergency department may not necessarily increase rates of success (Ernst et al., 2006).

Arguments for better mental health services to emergency departments
There is a clear need for increased access to mental health professionals (Baraff et al., 2006), and a better relationship between emergency

departments and mental health services. In a retrospective study of 219 suicides, Gairin et al. (2003) showed that 39% (58) had attended an accident and emergency department in the year before death, 15% because of non-fatal self-harm, although 20% were recorded as 'not in contact' with local mental health services.

Australian Guidelines, 2000

"It is recommended that patients presenting to emergency departments with evidence of deliberate self harm should:

- Be triaged on presentation to an appropriate category on the Australian Triage Scale (ATS). Staff performing triage should have training and experience in mental health triage and may use a Mental Health Triage Scale consistent with the ATS. A presentation with evidence of acute deliberate self harm is normally assigned to ATS 3 or higher.
- Assessment and management by all staff should take place in a timely manner having regard to the triage category.
- Be assessed by an emergency physician or a doctor acting as their delegate who will perform a physical examination and a basic mental health assessment.
- Be reviewed by a psychiatrist or a mental health clinician acting as their delegate who will take a mental health and social history and conduct a mental health examination.
- Wherever possible a collateral history should be obtained from a family member, partner, or friend. Where the patient is an adolescent, a family assessment may be indicated.
- Hospital and other health service records should be searched for a past history of psychiatric illness or self-harming behaviour.
- The current presentation should be thoroughly documented and include a suicide risk assessment.
- At the time of discharge, patients of all 3 groups should be provided with a card or pamphlet informing them of:
    - The identity of the mental health clinician who assessed them (unless contra-indicated).
    - The time and place of their follow-up appointment.
    - Other relevant information, including contact details for help in crises.
- A database to facilitate tracking and outcome analysis should be developed. This may require intersectoral cooperation. As a part of quality assurance there should be regular record audits to assess the quality of information and the appropriateness of clinical decisions. (Guidelines for the management of deliberate self-harm in young people, Australasian College for Emergency Medicine (ACEM) and The Royal Australian and New Zealand College of Psychiatrists (RANZCP) May 2000)

All of these guidelines are written in such a way that they are measurable.

However, unfortunately we do not know how much these guidelines have influenced Australian Emergency Department practice, either in terms of care for people with mental health problems or those with self-harm. It may be time for further detailed study of this area.
A recent set of guidelines written as the fourth in a series of guides to practice in the area of self-injury (Martin et al., 2014) has been disseminated to all emergency departments in Australia free of charge. Unfortunately, these do not come with a local training program to enhance their impact, nor is there money available to measure their short term impact on practice, or their long term effect on the appalling loss of life that occurs in the aftermath of visiting an emergency department for an episode of self-harm.

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Developing the Perth Charter for the Promotion of Mental Health and Wellbeing (Julia Anwar McHenry, Robert J Donovan)
Operationalising Recovery-oriented services: The challenges for carers (Catherine L Hungerford, Fiona Richardson)
The views of lesbian, gay and bisexual youth regarding computerised self-help for

depression: An exploratory study (Mathijs F G Lucassen, Simon Hatcher, Karolina Stasiak, Theresa Fleming, Matthew Shepherd, Sally N Merry)

Longitudinal analysis of the emotion self-confidence model of suicidal ideation in adolescents (Stephanie Tamsin Deeley, Anthony W Love)

Suicide exposure, awareness and attitudes in college students (Julie Cerel, Mary Chandler Bolin)

Validity of the children's Yale-Brown obsessive compulsive scale in Singaporean children (Suet Bin Chai, Weining C Chang, Yoon Phaik Ooi, Daniel Fung)

Parental influence on the mental health-related behaviour of young people with mental illness: Young people's perceptions (Anne Honey, Vikki Fraser, Gwynnyth Llewellyn, Philip Hazell, Simon Clarke)

Disconfirmed expectations of therapy and young people's clinical outcome, help-seeking intentions, and mental health service use (Clare Watsford, Debra J Rickwood)

GRAHAM MARTIN

Graham Martin OAM, MD, MBBS, FRANZCP, DPM, qualified in Medicine from King's College Hospital, London in 1967, and began his career in psychiatry in 1969, emigrating to South Australia with his family in 1974, and working at the Adelaide Children's Hospital until 1982. He was at Flinders University and Medical Centre from 1986-2001, and has been Professor of Child and Adolescent Psychiatry at The University of Queensland since 2001. Graham is a dedicated clinician, teacher, mentor and supervisor in child and youth mental health.

Best known for his work in prevention of suicide in young people, Graham has researched the problem and possible solutions since 1987. He contributed extensively to Australia's national suicide prevention strategy from 1994 through state and national committees and, latterly, as a national advisor. Chairing Suicide Prevention Australia from 2003-8, he has been a driving force behind over 20 national mental health conferences, and a commentator on television and radio for over 30 years.

Graham is the innovator behind a range of audio-visual training programs *(Doctors and Nurses, 1979), (Special People, 1982), (Youth Suicide: Recognizing the Signs, 1994), (a Distance Course in Community Mental Health, 1994-2001), (SOS, 2005), (Keep Yourself Alive, 1997), (Out of the Blues, 2000), (CadetLife, 2008) and (Seeking Solutions to Self-injury, 2009).* He has been creator and an editor for *Interface* (the AWCH journal, 1975-81), *the Australian & New Zealand Journal of Family Therapy* (1979-86), *the Child Psychiatry Bulletin* (RANZCP, 1984-91), *AusEinetter* (1997-2000), *the Australian eJournal for the Advancement of Mental Health* (2001-10), and *Advances in Mental Health* (2010 to date). *Graham has co-authored over 120 papers in academic journals, 19 books and reports, and 18 chapters in books.*

This book brings together papers and editorials reflecting development of ideas over the years 1995-2014. The book also acts, in part, as an historical record for the development of the nationally funded Australian Network for Promotion, Prevention and Early Intervention *(AusEinet, 1997-2009).*

These 'Essays' are written in a direct conversational style, yet grounded in emerging theory and international practice of the time. It is hoped that some of the essays will be of sufficient interest to provoke others to consider the broad implications and applications for prevention in mental health.

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