ACT Health

Building a Strong Foundation

A FRAMEWORK FOR PROMOTING MENTAL HEALTH AND WELLBEING IN THE ACT 2009–2014

The vision for mental health in the ACT

For the people of the ACT to achieve and maintain mental health and wellbeing.

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Foreword

Promoting mental health and wellbeing is everyone's business. *Building A Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009-2014* brings together the activities of a range of ACT Government departments and community agencies who deliver services that influence mental health and wellbeing to form an integrated framework to promote and enhance the mental health and wellbeing of all Canberrans over the next five years.

Many of the determinants of community and individual mental health and wellbeing are affected by factors outside of the health portfolio. These include, but are not limited to, transport, education, employment, social inclusion, housing, financial security, sport and recreation and the built environment.

The ACT Government is committed to working to reduce homelessness, to ensure that every child receives a good education, to provide employment opportunities for those who wish to work and to provide education about mental health and wellbeing to prevent the development of mental illness in the community.

Increasing mental health and wellbeing literacy, supporting children and families, enhancing services to those who are or have received cared in closed settings and reducing the inequalities associated with mental health are key areas of focus in *Building A Strong Foundation*.

I invite all Canberrans to take an active part in implementing *Building A Strong Foundation*–to actively promote mental health and wellbeing in the communities in which they live, work and play, to encourage people to look after their own mental health and to seek help early when they need it.

I am confident that *Building A Strong Foundation* will provide a strong foundation for strengthening the mental health and wellbeing of all Canberrans.

Katy Gallagher

Katy Gallagher, MLA
Deputy Chief Minister
Minister for Health

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1. Introduction

The ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention 2006–2008[1] (the 2006–2008 Plan) was developed in recognition of the need to accompany clinical treatment for mental illness with actions that promote mental health and resilience across the whole of the community. The 2006–2008 Plan was launched by the Minister for Health in 2006.

The Mental Health Promotion, Prevention and Early Intervention Working Group (the Working Group) guided the implementation and evaluation of the 2006–2008 Plan and was tasked with developing priorities for and guiding the development of the 2009–2014 Framework.

Building A Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014 (Building A Strong Foundation) provides a framework to guide a coordinated approach to the implementation and development of activities that promote mental health and wellbeing, prevent mental illness, and provide timely early intervention for those experiencing mental illness in the ACT.

Building A Strong Foundation builds on the work and learning of its predecessor and provides a collaborative and co-operative whole of community approach to mental health promotion, prevention and early intervention (PPEI) in the ACT.

Building A Strong Foundation sets out the ACT Government's commitment to:

- Promoting mental health and wellbeing;
- Preventing mental illness;
- Intervening early in the course of an episode of mental illness; and
- Providing timely early intervention for those experiencing mental illness.

Building A Strong Foundation sits within a broader mental health policy environment. Two documents of particular note are The ACT Health Mental Health Services Plan 2009–2014[3] (the ACT MHSP) and Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014 (Managing the Risk of Suicide).[2]

Managing the Risk of Suicide[2] is also a sub-plan of the ACT MHSP, and is a companion document to *Building A Strong Foundation*. Managing the Risk of Suicide provides a service development framework to guide an integrated, whole of community approach to suicide prevention across the lifespan in the ACT.

The ACT MHSP identifies the vision and the strategic directions for the development of the ACT mental health sector as it moves towards 2020. *Building A Strong Foundation* is a sub-plan of the ACT MHSP and articulates the specific strategies and activities that will be implemented in relation to mental health promotion, prevention and early intervention, to achieve this vision in the ACT as directed by the objectives of the ACT MHSP.

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The ACT MHSP envisages that in 2020, the mental health system of the ACT will be consumer orientated, consumer driven and will focus on recovery and rehabilitation. Consumers and carers will have improved access to a coordinated and inter connected network of services provided by the consumer, community, public and private sectors that is designed to meet the mental health and psychological needs for individual health and wellbeing.[3]

Building A Strong Foundation begins by providing a summary of the development of the 2006–2008 Plan and a review of mental health PPEI activities that occurred during this same time period. Feedback from community consultations, findings from contemporary literature and directives from recent national polices relating to PPEI and mental health all contribute to the development of *Building A Strong Foundation*. Focus areas of service and sector development are identified, with specific strategies and actions for implementation. Finally, an evaluation strategy is also provided.

ACT Health would like to thank everyone, including members of the Working Group (Appendix 1), members of the community, consumers and carers, clinicians, support workers, sector representatives and members of emergency and counselling services who freely gave their time to assist in the evaluation of the 2006–2008 Plan and the development of *Building A Strong Foundation*.

2. A Framework for Building a Strong Foundation

Figure 1 provides a conceptualisation of the Framework for *Building A Strong Foundation*.

2.1 Purpose

As a sub-plan of the ACT MHSP,[3] *Building A Strong Foundation* is a framework to guide investment in the development and implementation of activities to promote mental health and wellbeing in the ACT over the next five years.

2.2 Goals

The goals of *Building A Strong Foundation* are to:

- Build awareness and capacity to enhance mental health and wellbeing across the community;
- Reduce the incidence and prevalence of mental health problems and mental illness through the implementation of prevention strategies;
- Enhance effective early intervention; and
- Enhance the social equities and reduce social inequities that influence mental health and wellbeing.

2.3 Scope

Building A Strong Foundation extends the outcomes resulting from the 2006–2008 Plan and seeks to fulfil the objectives relating to PPEI as outlined in the ACT MHSP. As suicide prevention initiatives are being addressed specifically in the companion document *Managing the Risk of Suicide*, this area will not be a core focus in this document.

The ACT MHSP prescribes the use of a recovery focus as a foundation to future mental health care (see Appendix 4). Recovery in the context of mental illness focuses on minimising the impact of the illness as well as supporting individuals to optimise wellbeing and live meaningful and valued lives in the community. *Building A Strong Foundation* embraces the seven principles for recovery, as outlined in the framework *Mental Health Recovery in the ACT*[133] and will direct investment in effective promotional activities under the recovery care model. This includes addressing stigma, raising community awareness about mental health and increasing the education of those working in the area of mental health and wellbeing, including government and community sector employees. Towards this end, *Building A Strong Foundation* addresses mental health

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and wellbeing across the entire care spectrum, from people who are well through to those who have had or are currently experiencing a mental illness (i.e. the scope of *Building A Strong Foundation* lies beyond the mental health service sector and is relevant across the ACT Community).

Recognising contemporary views that PPEI activities can occur across a dynamic continuum, *Building A Strong Foundation* guides a coordinated approach to the implementation and development of strategies to promote mental health, prevent mental health problems and mental illness, and provide timely early intervention for those experiencing mental illness in the ACT.

As reflected in the *Social Compact*[119] and *Building our Community: The Canberra Social Plan*[118] a whole of government/whole of community approach to service development and delivery is a requirement for effective strategies to enhance the mental health and wellbeing of the community. However, further commitment at the highest levels of local government is required to make this a reality. In moving towards a coordinated, whole of government approach to mental health PPEI, responsibility for establishing and driving the implementation of *Building A Strong Foundation* will initially remain with ACT Health with a view towards the development of an integrated approach across all Government activity. The ACT Government in its entirety has committed to a coordinated implementation Framework that identifies the strategies and actions relevant to each Department which will be reported on over the life of *Building A Strong Foundation*.

Mental health promotion and illness prevention will be undertaken by agencies best placed to communicate effectively and implement strategies across the whole population of the ACT. Notwithstanding the role of government described above, it is more appropriate for the community mental health sector to take a leading role in this area, in conjunction with public health experts and associated social and education services. Activities to address general stigma and community awareness about mental health and increased education of personnel from social and other support services would be effective promotional activities and are consistent with a recovery promoting model of care.[3]

2.4 Objectives

Building A Strong Foundation sets out the key objectives for mental health promotion, prevention and early intervention in the ACT during 2009–2014.

The four key objectives are to:

- Guide and strengthen activities to promote mental health and wellbeing, increase mental health literacy and understanding of mental illness, and reduce stigma;
- Guide and inform the development and implementation of programs to prevent mental illness and enhance mental health and wellbeing, and resilience;
- Guide and inform the development and delivery of evidence-based early intervention services; and
- Guide a coordinated, partnership approach to these activities across a range of sectors within the ACT, including an integrated approach across ACT Government activity.

2.5 Core Elements of *Building A Strong Foundation*

In the development of the ACT MHSP, three foundation areas were established to ensure that the ACT will be the leading jurisdiction in Australia for the delivery of consumer centred services, with the best outcomes for mental health service consumers. To this end, the ACT mental health services system of the future will be focussed on the consumer and developed on:

- Foundation Area 1: Recovery Focus
- Foundation Area 2: Consumer and Carer Participation
- Foundation Area 3: Partnership and Collaboration

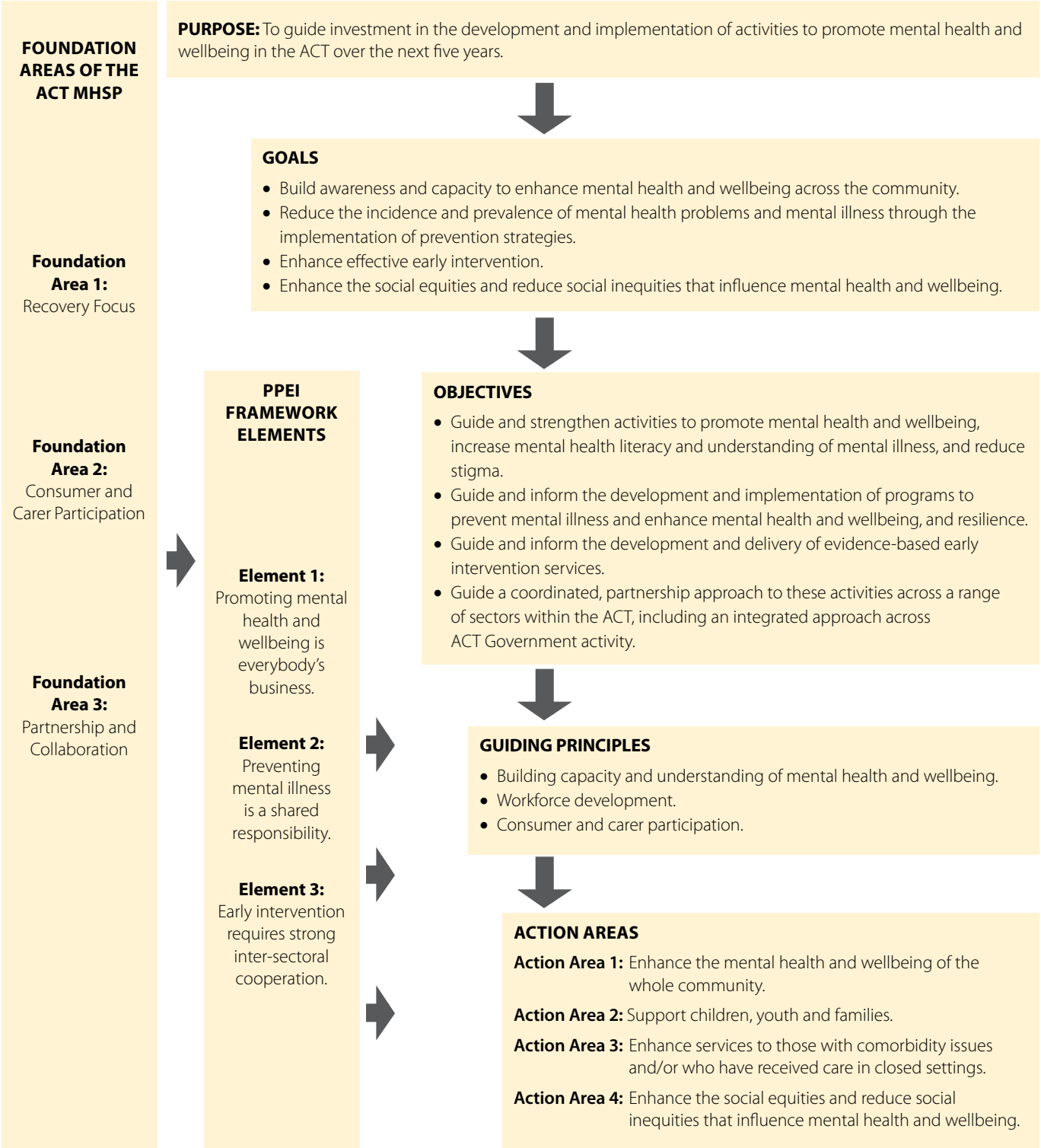

Figure 1: Framework Conceptualisation

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The ACT MHSP further acknowledges that consumers' experiences are unique to consumers and that carers have a distinct and valuable experience in relation to the consumers they care for. Both perspectives have critical value in supporting the growth of a mental health service system.

The ACT MHSP identifies a number of explicit activities to be addressed through *Building A Strong Foundation*. These include:

- Coordinating and integrating the services provided by, and between, different elements of the mental health services sector;
- Providing ongoing development of opportunities for:
  - Processes that support and strengthen a community sector role in mental health promotion;
  - Enhanced linkages with the primary care sector and whole of community participation;
- Exploring opportunities for linkages with the Women's and Children's Hospital, particularly in the areas of mental health promotion and early intervention;
- Extending services for youth including a step up/step down service and dedicated inpatient unit that is physically distinct from the adult inpatient unit, having a specific focus on early intervention and recovery; and
- Integrate PPEI activities with primary care and community service providers.

These activities are addressed in various sections of *Building A Strong Foundation*. For example, implementation of *Building A Strong Foundation* will contribute to the development of an integrated, whole of government approach to mental health promotion, prevention and early intervention. Similarly, actions to reduce Post Traumatic Stress Disorder (PTSD) include reducing school bullying, trauma experienced by refugees and those detained involuntarily, and taking actions to address and respond to domestic violence (Action areas one, three and four).

Given the broad scope of the ACT MHSP relevant to *Building A Strong Foundation*, three key elements have been identified for focus to ensure the integrity of the goals and objectives of *Building A Strong Foundation* are maintained:

Element 1: Promoting mental health and wellbeing is everybody's business.

Element 2: Preventing mental illness is a shared responsibility.

Element 3: Early intervention requires strong inter-sectoral cooperation.

These elements provide additional depth to the foundation areas of the ACT MHSP, and ensure a whole of community approach to enhanced mental health and wellbeing.

2.5.1 Element 1: Promoting mental health and wellbeing is everybody's business

Optimal mental health and wellbeing stem from actions and approaches that are adopted by the whole population in all environments, including workplaces, schools and homes. Both government and community sector organisations have a responsibility to create environments and opportunities for people to engage in activities to improve their wellbeing. Individuals and communities have much to gain from participating in activities aimed at enhancing their mental health and social and emotional wellbeing.

2.5.2 Element 2: Preventing mental illness is a shared responsibility

It is widely acknowledged that more can be done to prevent mental illness or, where mental illness does occur, reduce the severity and impact of symptoms and promote recovery. Broad strategies are required. The following have been shown to be effective in reducing risk factors and enhancing protective factors relating to mental health and wellbeing:

- Access to community and social support;
- Stable housing;
- Education;
- Employment; and
- Health care services which address basic needs.

2.5.3 Element 3: Early intervention requires strong inter-sectoral cooperation

Service will need to work cooperatively and be proactive in identifying activities to promote mental health and wellbeing, prevent mental illness and employ effective, evidence based approaches to early identification of people who may be experiencing a mental illness.

ACT Health is strongly committed to a collaborative approach to current and future service delivery and to the ACT MHSP guiding inter-service cooperation that encompasses the full range of services relevant to an individual's wellbeing.[3]

This commitment is equally relevant to *Building A Strong Foundation*. The ACT MHSP[3] articulates a range of domains across which collaborative partnerships will be fostered, including:

- Across the whole of government;
- Between Government and Community Sector mental health services;
- With related social services;
- With primary care services, and in particular, general practice;
- Utilising the expertise and priorities of consumers and carers;
- Nationally and across government jurisdictions; and
- With local, interstate and international research organisations and universities.

In developing *Building A Strong Foundation,* ACT Health worked closely with stakeholders from across the community to identify strategies and actions to promote mental health and wellbeing, prevent mental illness and provide early intervention for those displaying the early signs and symptoms of mental illness. One key outcome of this consultation is a commitment from ACT Government Departments to implementing and reporting on identified relevant actions to enhance the mental health and wellbeing of the community. Similarly, the expertise of consumers and carers is identified as a central partner in providing community education about mental illness.

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2.6 Guiding Principles

To further direct future PPEI activity towards the proposed objectives, the following guiding principles have been identified. These principles address the fundamental capacity requirements of the care systems in the ACT community that will provide the platform for more prescribed PPEI activity. Appropriately, each of these areas have been similarly identified on a broader scale in the ACT MHSP, thus ensuring *Building A Strong Foundation* remains aligned with the strategic vision of the future.

2.6.1 Building capacity and understanding of mental health and wellbeing

Developing a whole of government approach to promotion, prevention and early intervention will require capacity building across the ACT. This includes:

- Increasing "the range of people, organisations and communities"[4] that have a good understanding of the factors that affect mental health and wellbeing;
- Increasing understanding of the impact that stigma (often associated with mental illness) has on consumers, their families and the wider community; and
- Increasing understanding of the roles and responsibilities in promoting mental health, preventing mental illness and reducing stigma.

This requires a wider understanding of the social determinants of health (see chapter 4), and particularly the impact of social inequities and social exclusion on the development and persistence of mental health problems and mental illness. Achieving this will require commitment from all sectors which have an impact on factors that influence mental health and mental illness. Government and community sectors will work together to make the most of opportunities to build resilience, develop mental health literacy and ensure that what is known to contribute to mental health and wellbeing is put into practice.

2.6.2 Workforce development

Engaging in activities to promote mental health, prevent mental health problems, and intervene early in the development of mental illness requires a highly skilled workforce across the entire human service and welfare sectors. It also requires a range of skills from public health and education through to recovery-oriented continuing care and relapse prevention. In practice, this means that all staff having contact with members of the public (including those providing housing, employment and educational assistance), require the skills to recognise when an individual may be at risk of mental illness and have the knowledge of how to guide them to appropriate support services.

The ACT MHSP identifies strategies and mechanisms required to support comprehensive workforce development and expansion. These include:

- Enhanced engagement with the consumer and carer sector, with enhanced capacity for consumers and carers to participate at an individual and sector level; and
- Development of a localised sector workforce strategy that addresses:
  - Workforce leadership, capability and performance (including increasing student places and attracting overseas professionals);
  - Organisational climate across the clinical and social service sectors (eg. creating or expanding roles); and the
  - Service development framework, models of care, and new and emerging technologies.[3]

A number of actions have been identified within *Building A Strong Foundation* that will contribute to the achievement of these strategies, including:

- Developing a scholarships scheme to support consumers complete approved mental health courses to enhance their ability to secure employment in the mental health sector;
- Providing training in mental health promotion, prevention and early intervention for MHACT staff and staff of Government Departments; and
- Strengthening the focus on promotion, prevention and early intervention across the continuum of care.

2.6.3 Consumer and carer participation

With effective skills and resources, people can be empowered to take responsibility for maximising their mental health and wellbeing, to live well with mental illness and have a hopeful and positive view of the future.[5]

The ACT MHSP recognises the consumer as the primary reason for mental health services and therefore the central focus is on the consumer experiencing the best outcomes from mental health services.[3] This recognition remains equally so in *Building A Strong Foundation*.

Similarly, the mental health sector remains committed to engaging the valuable and diverse experience and expertise of carers in recognition of their valued role in advocacy and support for consumers and in their right.

The following are key understandings relating to consumer and carer participation that have informed the development of *Building A Strong Foundation*:

- Consumers and carers have a valuable role to play in policy development, service planning, implementation and evaluation, individual advocacy and systems advocacy, staff development and research. Central to effective participation is reciprocal learning between consumers, carers and service providers from both government and community sectors. It is important to recognise that consumers, carers and service providers have varying capacities for participation, and that constant reflection and evaluation is required to ensure genuine and effective participation is achieved.
- It is necessary to consider the unique requirements of young people, persons of culturally and linguistically diverse background and Aboriginal and Torres Strait Islanders when designing activities for consumer and carer participation.
- Strategies for achieving genuine participation will consider all parts of the ACT community. An important way that consumers and carers engage in promoting mental health is their willingness and ability to talk openly about their experience of living with and recovering from a mental illness, which contributes to reducing the stigma of mental illness.

Consumer and carer representatives have been involved in the development of *Building A Strong Foundation* and will continue to have an active role in the implementation and evaluation of actions and strategies. The principles for consumer and carer participation in the ACT are set out in *Consumer and Carer Participation across Mental Health ACT: A Framework for Action*[6] and will guide ongoing participation.

Additional considerations are required when engaging Aboriginal and Torres Strait Islander peoples. Further details of these considerations can be found in *Guidelines for Consulting with the Aboriginal and Torres Strait Islander Community.*[7]

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2.7 The policy context

Building A Strong Foundation is implemented within a policy context composed of national and local initiatives. As illustrated in figure 2, *Building A Strong Foundation* sits within a broader mental health policy environment. Two documents of particular note are the *ACT Health Mental Health Services Plan 2009–2014*[3] (the ACT MHSP) of which this document is a sub-plan and *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014* (Managing the Risk of Suicide)[8], which is also a sub-plan of the ACT MHSP and companion document to this framework. It is envisaged that the suicide prevention and PPEI frameworks will be combined in future years as initiatives progress.

The foundation national policy documents guiding PPEI policy development in Australia include:

- The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*,[6] which outlines a strategic framework and plan for action to address promotion, prevention and early intervention priorities; and
- The Second National Mental Health Plan[9]

Figure 2 illustrates the relationships between key national and ACT initiatives relevant to *Building A Strong Foundation*. A brief description of key policy documents can be found at Appendix 4.

2.8 Action Areas

Four key action areas provide the direction and framework for *Building a Strong Foundation*:

Action Area 1: Enhance the mental health and wellbeing of the whole community.

Action Area 2: Support children, youth and families.

Action Area 3: Enhance services to those with comorbidity issues and/or who have received care in closed settings.

Action Area 4: Enhance the social equities and reduce social inequities that influence mental health and wellbeing.

Details of the rationale and evidence for choosing these focus areas are provided in Section Four.

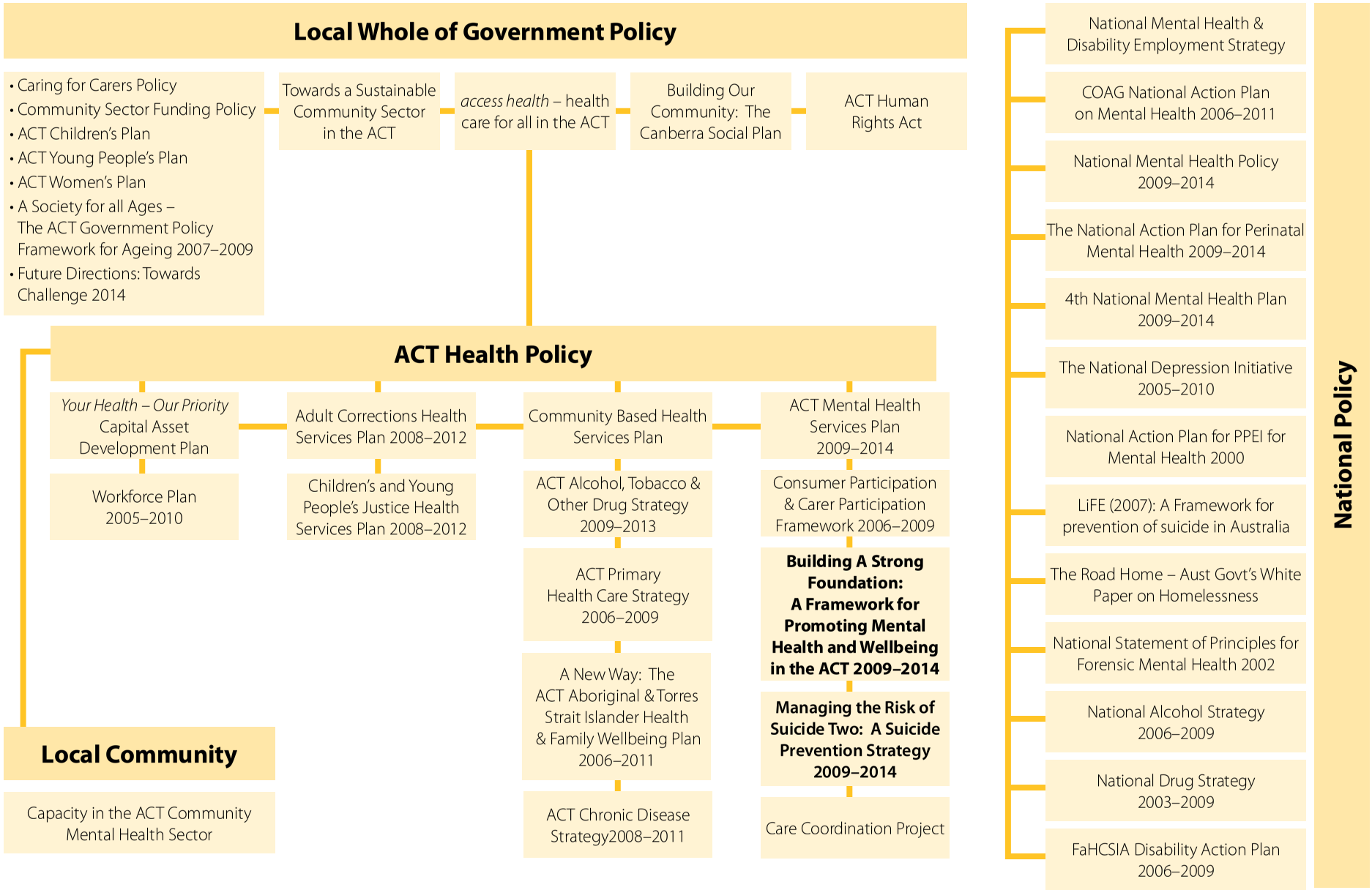

Figure 1: Building a Strong Foundation: Related Policy Framework (Selected policies)

3. Background Information

Development of this document began with the review of the *ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention 2006–2008*. The review of the outcomes of the 2006–2008 Plan allowed assessment of remaining gaps and resource issues. Combined with evidence based research, a consultation process to establish current community priorities informed the development of *Building A Strong Foundation*. This section outlines the key areas of interest pertaining to the development of *Building A Strong Foundation*.

3.1 Review of progress under the 2006–2008 Plan

The 2006–2008 Plan[1] was developed in recognition of the need to accompany clinical treatment of mental illness with actions that promote mental health and resilience across the community, and reduce the likelihood and severity of illness.

The 2006–2008 Plan was informed by several local and national documents and aimed to guide a coordinated approach to mental health promotion, prevention and early intervention activities in the ACT. In order to engage the whole community and the broadest possible range of organisations in promoting mental health and wellbeing, the 2006–2008 Plan used the following strategies:

- Creating and extending mental health networks;
- Broadening community 'wellbeing literacy';
- Strengthening and supporting mental health awareness among organisations and groups; and
- Raising awareness of positive mental health.

The priority groups covered in the 2006–2008 Plan were:

- Whole of population;
- Children;
- Young people;
- Aboriginal and Torres Strait Islander peoples;
- Culturally and linguistically diverse communities;
- People who have experienced mental illness and their carers;
- People at risk of abusing alcohol and other drugs;
- Media and public affairs;
- Health professionals and the health workforce; and
- Workplaces.

3.1.1 Evaluation of the 2006–2008 Plan

Evaluation of the Plan comprised of four components:

- Review of ACT Health funding for promotion, prevention and early intervention activities;
- A survey of government and community stakeholders (August 2007);
- A survey of sectoral participants regarding implementation of the 2006–2008 Plan (October 2008); and
- Review by the Working Group and other invited stakeholders.

Funding for Promotion, Prevention and Early Intervention Activities

The ACT Government increased funding for PPEI activities over the past four years by 16 per cent. As can be seen from Figure 3, ACT Health expenditure on PPEI activities grew from $1,662,640 in the 2006–2007 financial year, to $1,926,150 in the 2008–2009 financial year (further details of expenditure can be found at Appendix 2).

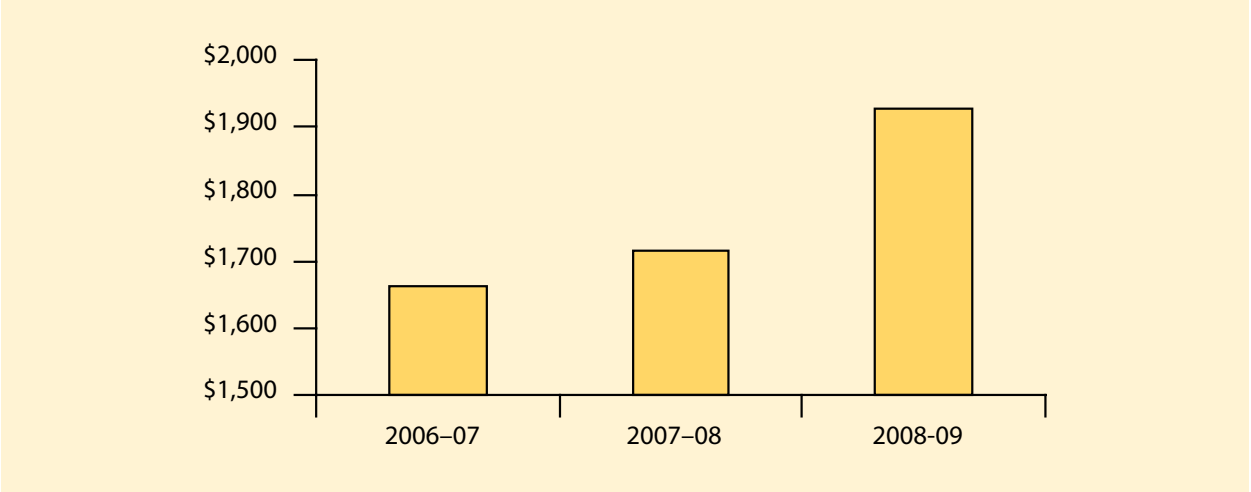

Figure 3: ACT Health Expenditure on Mental Health Promotion Prevention and Early Intervention 2006-2008 ($'000)

Additionally, $339,092 was invested in health promotion grants to organisations engaged in promotion, prevention and early intervention activities during the life of the 2006–2008 Plan. This includes:

- Funding for schools to provide peer support programs and training in the Mental Health First Aid program;
- Funding for community service organisations for community mental health and wellbeing activities; and
- Funding to consumer organisations to provide peer support and education programs.

Survey of ACT Government and community respondents

A survey of ACT Government and community respondents, conducted in August 2007, indicated that many organisations within the ACT were not aware of the Plan. Those who were aware of the 2006–2008 Plan held diverse understandings of the meaning and aims of promotion, prevention and early intervention activities.

The following gaps were identified in PPEI activities in the ACT:

- Poor coordination of services;
- Insufficient support for specific population groups;
- Insufficient professional learning for whole of school staff; and
- Lack of a secure mental health facility.

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Community respondents' PPEI priorities identified for the ACT included:

- Strategies to develop a positive school culture and to address issues of promotion and prevention;
- Increased focus on:
  - Therapy opportunities for people with disabilities, particularly those with autism and Asperger's disorders;
  - Interventions for those experiencing a first episode of disorder;
  - Education for prison populations about comorbidity of mental health problems and problematic alcohol and other drug use;
  - A separate forensic facility; and
  - Continued research into the effectiveness of early intervention programs.

Survey of sectoral participants regarding implementation of the 2006–2008 Plan

A survey of sectoral participants delivering promotion, prevention and early intervention activities during the life of the 2006–2008 Plan, conducted in October 2008, revealed that progress had been made in delivering activities and interventions addressing many of the actions identified in the 2006–2008 Plan.

Review by Working Group

During the consultation process for the development of the *Building A Strong Foundation*, members of the Working Group and other invited participants reviewed the strengths and weaknesses of the 2006–2008 Plan.

Strengths included:

- The strategic framework, which provides a useful mechanism to educate others about promotion, prevention and early intervention;
- The success of the Plan in raising awareness about mental health literacy; and
- The concept of whole of government/whole of community involvement in PPEI.

Weaknesses included:

- The broad scope of the Plan (i.e. it was felt that the 2006–2008 Plan endeavoured to address too many target groups);
- The lack of an embedded evaluation strategy, with identified measurement tools and reporting requirements;
- A need to carefully consider the language used; and
- The need to increase sector engagement (i.e. while the Plan claims to be a whole of government plan this was not reflected in strategies and actions).

3.1.2 Learnings from the evaluation of the 2006–2008 Plan

Analysis of the evaluation indicated that some important methodological issues required careful consideration in the development of *Building A Strong Foundation*.

The short duration of the 2006–2008 Plan, coupled with the imprecise wording of many of the actions and the lack of both an implementation and evaluation strategy, hampered measurement of progress in its implementation.

These issues have been addressed in *Building A Strong Foundation* by:

- Extending the duration of *Building A Strong Foundation* to cover a five year period;
- More precise wording of actions, to allow meaningful measurement of outcomes; and
- Development of an implementation strategy, agreed outcome measurements and an evaluation plan which have endorsement by agencies responsible for implementation of specific actions.

3.2 Consultation process for development of *Building a Strong Foundation*

During the development of the *Building A Strong Foundation*, extensive community consultation occurred. Two workshops with the Working Group and invited representatives were held in February and March 2009 to review the 2006–2008 Plan and develop *Building A Strong Foundation*.

Themes emerging from the workshops can be summarised as follows:

- A need to implement a whole of government approach to the promotion of mental health and the prevention of mental illness, with a philosophy of social and emotional wellbeing to be embedded in all ACT Government department work practices;
- A desire to build upon existing inter-sectoral collaborations;
- A need to further enhance mental health literacy and reduce stigma across the community, with a particular focus on increasing access to mental health education and services to vulnerable and disadvantaged groups; and
- An ongoing need to build sector capacity through workforce development.

A draft of *Building A Strong Foundation* was released for public consultation in June 2009. See Appendix 3 for the Consultation Participant List.

Feedback from the consultation process was considered by the Working Group and incorporated into this document.

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4. Promotion, prevention and early intervention for mental health and wellbeing

4.1 Defining mental health and mental illness

It is important to define what is meant by mental health and mental illness, as these terms are used in different ways in different contexts. Mental health and wellbeing is more than the absence of mental illness.

> *Mental health* is increasingly being defined as a positive attribute. Mental Health is described by the World Health Organization as: …a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[138]
>
> A *mental illness or disorder* is a health problem that significantly interferes with a person's thoughts, feelings or social behaviour. It is diagnosed according to standardised criteria, usually the DSM[136] or the ICD[137].Some of the major types of mental illnesses are depressive disorders, anxiety disorders, psychoses and eating disorders. The terms 'illness' and 'disorder' tend to be used interchangeably.[10]
>
> A *mental health problem* also interferes with a person's thoughts, feelings and social behaviour, but to a lesser extent than a mental illness. Mental health problems are more common and include the mental ill health that may be temporarily experienced as a reaction to the stresses of life. While mental health problems are less severe than mental illnesses, they still can have a significant impact on a person's future opportunities and sense of wellbeing, and may develop into a mental illness if not effectively treated.[10]

4.2 The need for action

The promotion of mental health, prevention of mental health problems and mental illness, and early intervention for mental illness are central to the maintenance of a happy, healthy and productive community. *The National Action Plan for Promotion Prevention and Early Intervention for Mental Health (2000)* states:

> It is becoming increasingly clear that treatment interventions alone cannot significantly reduce the enormous personal, social and financial burdens associated with mental health problems and mental illnesses, and that interventions are required earlier in the development of these conditions. There is a compelling need to make promotion, prevention and early intervention priorities in global, national and regional policy, and to develop a clear plan for progressing activities in these areas.[11]

Mental health and behavioural disorders affect more than 25 per cent of all people at some time during their lives.[12] In Australia, in 2003, mental illness was listed as the third most common form of chronic disease, estimated to be responsible for 13 per cent of the total burden of disease in Australia.[13] The *2007 National Survey of Mental Health and Wellbeing: Summary of Results* found that one in five Australians reported having a mental illness in the past 12 months.[14] Those in the younger age groups were particularly affected, with 26 per cent of people aged 16–24 years and 25 per cent of people aged 25–34 years diagnosed as having a mental illness within the previous 12 months. Among those aged 16–85 years, 20 per cent suffer from a mental illness, and the prevalence of anxiety, depression and substance use disorders was 14.4 per cent, 6.2 per cent and 5.1 per cent, respectively.

The impacts of mental illness on the individual, their family and community are wide ranging. Research shows that individuals experiencing mental illness generally experience lower levels of educational attainment, poorer employment prospects, lower socio-economic status, poorer housing, and poorer general health than those who perceive themselves to be mentally healthy.

Stigma, which is often associated with mental illness, is pervasive and can impede recovery.[15] More than 40 negative consequences of stigma have been identified, including discrimination in housing, education and employment and increased feelings of hopelessness, loneliness and distress.[16] Education campaigns, including those identified within this Framework, are one mechanism of reducing the stigma associated with mental illness within the community.

The economic cost to the community, both in terms of treatment costs and loss of productivity, is also large. It is estimated that mental illness costs the Australian community approximately $20 billion per year.[17] [18] In addition to the financial burden, the capacity of health departments internationally to care for people with mental illness is seriously overstretched.

The global burden of mental illness is beyond the treatment capacity of developed and developing countries, and the social and economic costs associated with this growing burden will not be reduced by the treatment of mental illness alone.[11]

These findings highlight the need to develop and support models that promote mental health and wellbeing and enhance recovery from mental illness.

4.3 The social determinants of health

The population health approach adopted by the *Ottawa Charter*[18] and subsequent documents emphasise the underlying fundamental social determinants of health. Social determinants of health are factors or characteristics that can bring about a change in health, either for the better or for the worse.

Three social determinants are recognised as having a more direct impact on mental health and wellbeing. These are:

- Social inclusion;
- Access to economic resources; and
- Freedom from violence and discrimination.[19]

These social determinants of mental health and wellbeing are identified in the PPEI section of the ACT MHSP[3] and underpin many of the strategies and activities identified in this Framework to promote mental health and wellbeing, prevent mental illness and provide access to timely, evidence based early interventions. Each of these determinants is a focus of the fourth action area of *Building A Strong Foundation, to enhance the social equities and reduce social inequities that influence mental health and wellbeing*.

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4.3.1 Social inclusion

Social inclusion refers to the level to which individuals have access to supportive relationships, involvement in group activities and engagement within their community.[20] A socially inclusive society can be defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. Social exclusion is the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of a person in the community.[21]

Social inclusion promotes mental health and wellbeing in two ways:

1. Involvement in social networks and connection with others improves general wellbeing; and
2. Supportive social networks act as a protective factor when individuals experience stress.[22]

Individuals experiencing social exclusion often find it more difficult to connect with others, struggle to share in many activities those who feel more connected participate in, and may find it more difficult to obtain an education or participate in ongoing life learning.

One means of promoting social inclusion is to ensure that individuals have access to good public transport to participate in community activities. Such actions are addressed in more detail under the first action area of this Framework, enhancing the mental health and wellbeing of the whole community.

4.3.2 Access to economic resources

Access to economic resources includes access to:

— Employment and meaningful engagement;
— Education;
— Adequate housing; and
— Adequate financial resources.[23]

Lack of access to economic resources can impact on all aspects of life and often determines one's social standing or position in society. Occupying a lower social position may limit one's access to material and psychosocial resources, including education, housing and health care. Lack of access to these resources can create and perpetuate a cycle of poverty. For example, children of parents with limited economic resources often find it harder to participate in all aspects of school life, can feel socially isolated, may not reach the same levels of educational attainment as their more financially secure peers and may find themselves employed in lower paying jobs.[24] Similarly, those with a chronic illness who do not have the financial resources to access timely and adequate health care may face further financial hardship if their deteriorating health reduces their capacity to work.

Access to employment does not simply refer to being employed or unemployed, but also to the quality and security of the work environment. It is well documented that stressful work environments, in terms of the actual environment and concerns about the work environment (such as lack of control over work and instability or insecurity of employment), can have significant impacts on mental health and wellbeing.[25]

Strategies and actions to enhance access to economic resources are identified in each of the action areas of this Framework.

4.3.3 Freedom from violence and discrimination

Violence is defined as:

> The intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.[25]

Discrimination occurs when a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his or her or their membership of that group.[26] Unlawful discrimination is defined in the *Discrimination Act 1991* (ACT) to include unfavourable treatment on grounds including sex, race, sexuality, pregnancy, disability (defined widely to include mental health) and sexual harassment, in specified areas of public life such as employment, education and provision of services.

There are strong links between violence and discrimination and mental health and wellbeing. Violence and discrimination often co-occur, with discrimination frequently involving violence. Violence and discrimination can have negative effects on an individual's sense of connection with others and his/her ability to participate in many social activities. For example, children who experience bullying may have a limited friendship circle, their experience of school may be negative, and this may lead them to drop out of school, which in turn will affect their employment opportunities. The mental health and wellbeing of victims of violence and discrimination is often negatively affected, and pre-existing mental illness is likely to be exacerbated by this abuse.

The right to be free from violence is recognised under the *Human Rights Act 2004* (ACT) as well as under civil and criminal law in the ACT. The *Human Rights Act* also recognises the right to equality, and the *Discrimination Act 1991* provides remedies for unlawful discrimination in public life.

Specific actions to address bullying and violence within school communities are identified in action area two, with actions to reduce violence and discrimination in the wider community as a focus of action area four.

4.4 The spectrum of interventions

Mrazek and Haggerty conceptualise the range of interventions that can occur to promote mental health and wellbeing and provide interventions for those experiencing a mental illness via the *Spectrum of interventions for mental health problems and mental illnesses*.[28] Figure 4 provides a modification of their original model, which has been recognised in Australia as clearly portraying the continuum of mental health interventions within a population health framework.[29] The spectrum comprises promotion, prevention, early intervention, treatment and continuing care.

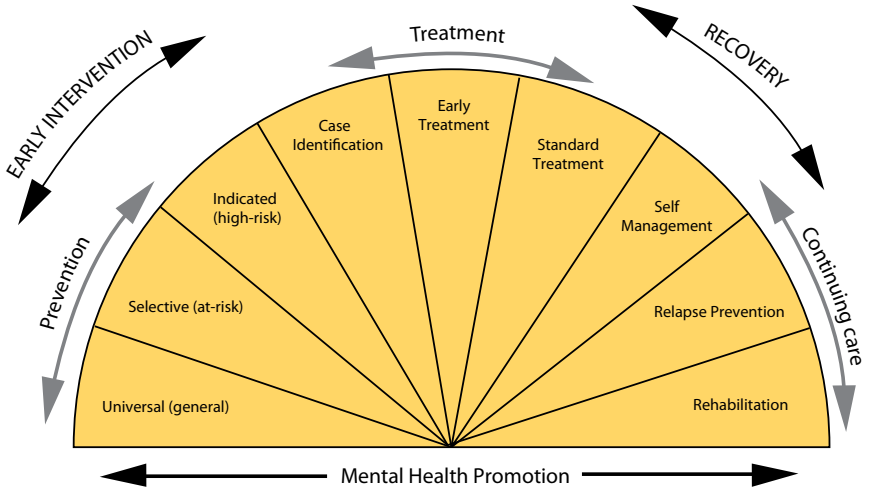

Figure 4: The spectrum of possible Interventions for Mental Health Promotion, Prevention and Early Intervention[30]

4.4.1 Mental health promotion

Mental health promotion aims to enhance the factors that influence mental health and wellbeing across the continuum of care before, during and after the onset of a mental illness.[11] It is about improving wellbeing for all people, regardless of whether they are currently well or ill. It is also about optimising people's mental health by developing environments that are good for us all.

The *Ottawa Charter* (1986) defines health promotion as 'the process of enabling people to increase control over, and to improve, their health.[18] It comprises of:

> Any action to maximise mental wellness in a population or for individuals through managing environmental conditions for those who are currently well, those at risk and those experiencing illness. Promotion is a process of enhancing the coping abilities of individuals, families and the wider community by providing power through knowledge, resources and skills.[31]

Mental health is affected by the events that happen in our normal day-to-day lives, as well as by the stressful events that inevitably occur from time to time. Mental health and wellbeing can be promoted by ensuring that public policies support the social and emotional wellbeing of individuals and communities.[32]

All environments—social, physical, economic, and cultural—need to be supportive of mental health. Community life is important and communities need to be empowered to take the actions that they decide are needed to build their capacity to support their members. All people need help to develop skills to understand, enhance and respond to their mental health needs. Furthermore, mental health services need reorientation to ensure they adopt a recovery-oriented approach to service provision, and acknowledge that they have a responsibility for promoting the wellbeing of individuals and communities, as well as treating illness.

Each of these factors is addressed throughout the course of *Building A Strong Foundation*, with additional strategic direction offered through the ACT MHSP for areas outside the scope of this document and in *Managing the Risk of Suicide* for those relating specifically to suicide prevention.

4.4.2 Prevention

The prevention of mental illness focuses on reducing the risk factors contributing to the development of a mental illness and enhancing the protective factors that promote mental health and wellbeing.[33]

The level of risk of an individual developing a mental health problem or mental illness can be determined by their exposure and vulnerability to risk factors and the presence and strength of protective factors associated with the development of mental health problems and mental disorders.[11]

In reference to Figure 3, prevention interventions can occur at three levels–universal, selective and indicated.

> *Universal prevention interventions* aim to improve the mental health and wellbeing of the whole community, e.g. increasing social connectedness.
>
> *Selective prevention interventions* aim to improve the mental health and wellbeing of individuals and groups who have been identified as being at higher risk and may include the provision of parenting programs during the peri- and ante-natal period.
>
> *Indicated prevention interventions* aim to improve the mental health and wellbeing of individuals who are identified as having minimal but detectable signs of mental disorder and may include programs for children showing signs of behavioural problems.[11]

Another way to conceptualise prevention is in terms of the three levels of:

Primary prevention includes activities to prevent the onset or development of a disorder or illness in the general community, populations recognised as at risk of developing a mental health problem and individuals identified as being at high risk or having minimal but detectable signs of mental illness.

Secondary prevention includes activities which seek to lower the prevalence of a disorder or illness through early detection and treatment.

Tertiary prevention includes activities aimed at reducing the disability or negative consequence of an existing disorder on an individual.[33] This includes *relapse prevention*, which aims to assist those who have experienced a period of disorder to recognise the early signs and symptoms of illness and to implement effective strategies to reduce the likelihood of a further period of disorder.

Prevention activities target everyday factors that influence health and wellbeing that can be modified. They may include parenting programs to enhance parent-child attachment, community education programs about coping and stress management and relapse prevention programs for those recovering from an episode of mental illness.

4.4.3 Early intervention

Early interventions are activities and strategies targeted to occur when an individual first displays signs or symptoms of a mental health problem. Early intervention can occur:

- Early in the life span;
- Early in the development of a mental health problem or mental illness; or
- Early in an episode of illness.

Early intervention activities focus on individuals and aim to prevent the progression to a diagnosable disorder for people experiencing signs or symptoms of mental health problems and to reduce the effects (shorten the duration and reduce the potential damage to the wellbeing of a person) of the illness on an individual experiencing an episode of mental illness. Early intervention activities include early assessment and diagnosis of individuals displaying signs and symptoms of mental illness and early treatment for people experiencing an episode of illness. Early intervention includes the early identification of individuals displaying the signs and symptoms of an emerging mental illness in order that timely, effective, evidence based treatments may be provided to reduce the disability and the severity of symptoms associated with the mental illness.

While Mrazek and Haggerty's model identifies boundaries between each stage along the continuum, the reality is much less clear with many of the interventions overlapping and being relevant to different stages. For example, a mental health promotion intervention aimed at increasing wellbeing in a community may also have the effect of shortening the duration and reducing the disability caused by a mental illness for an individual who has received early intervention.

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4.5 The strategic context

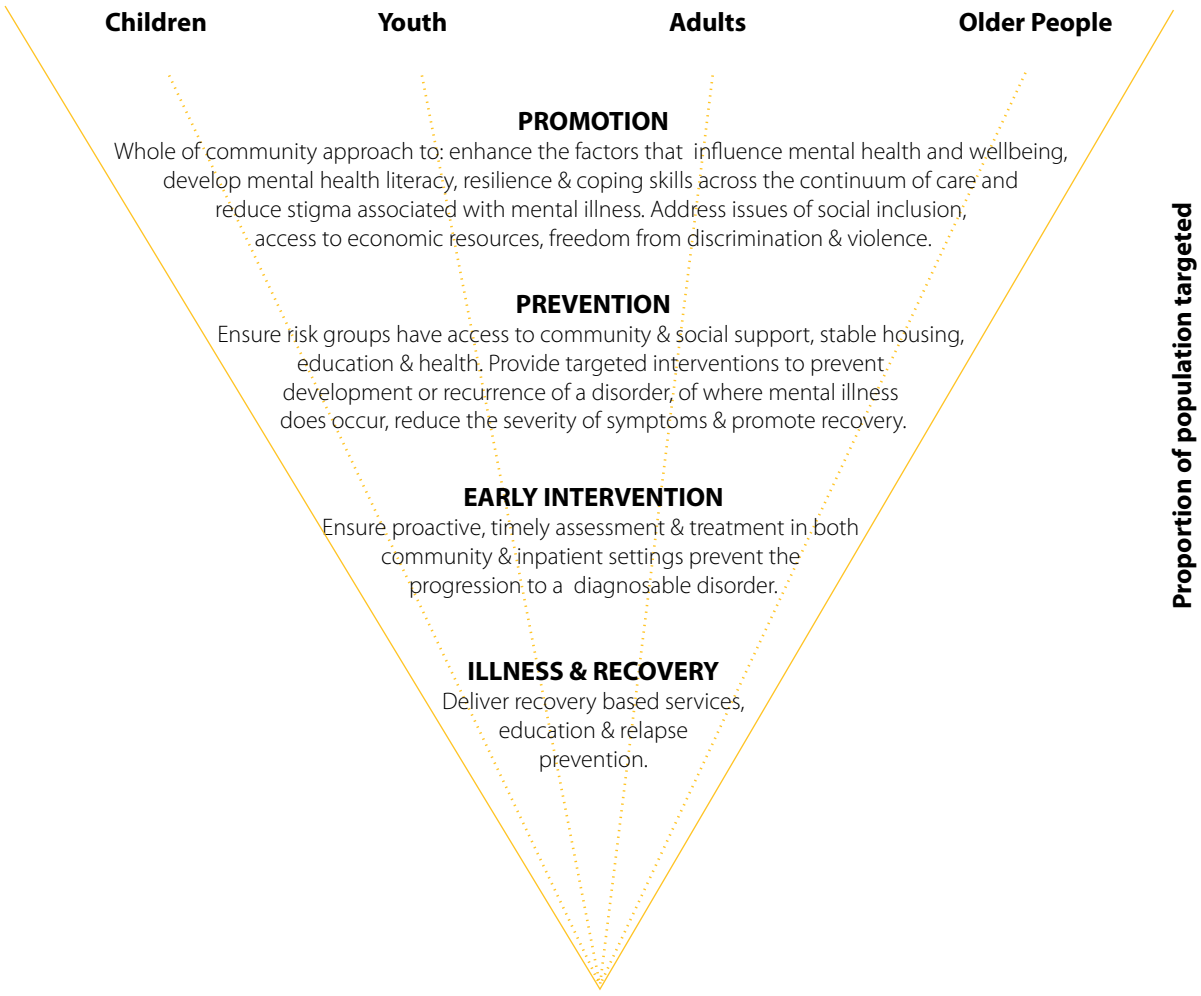

Figure 5: Promotion of mental health and prevention and early intervention for mental illness across the lifespan

The ACT MHSP outlined the intent to transition specialised mental health services to a four stream model to better support the developmental needs of individuals, in contrast to a simplified age based model. Under the four stream model of care, each stream has an indicative age range that is supplemented with descriptive developmental milestones, to better accommodate the individual characteristics that influence treatment and care approaches (eg maturity, personality, attitudes etc). Figure 5 above illustrates the proportion of the population targeted for each area of PPEI. The greater community has mental health promotion and prevention activities, in line with the whole of community approach, whilst the early intervention and illness and recovery foci are only applied to more targeted population groups who require these interventions.

5. Action areas and implementation plan

This section sets out the areas that will be the focus of this *Building A Strong Foundation*, provides the rationale and evidence-base to support these, identifies the agencies responsible for implementation of actions and the outputs anticipated.

Results from the review of the 2006–2008 Plan, feedback from consultations, and changes in Australian Government mental health policy through the new *National Mental Health Strategy 2008* have identified the following four action areas as a focus for *Building a Strong Foundation*:

1. Enhance the mental health and wellbeing of the whole community;
2. Support children, youth and families;
3. Enhance services to those with comorbidity issues and/or who have received care in closed settings; and
4. Enhance the social equities and reduce social inequities that influence mental health and wellbeing.

In reading *Building a Strong Foundation*, it should be recognised that many of the strategies and activities identified could fall under two or more of the focus areas. The approach has been to locate strategies and activities under the area which most closely aligns to the literature regarding evidence-based interventions for the groups being targeted.

Action Area 1: Enhance the mental health and wellbeing of the whole community

Much of the effort in mental health promotion needs to occur beyond the healthcare system, in sectors that impact on the daily lives of individuals and communities to support the development of resilience and maintenance of mental well-being. These include the areas of housing, education, employment, welfare and justice.[34]

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Rationale: Views about mental health and wellbeing have changed over the past decade. The growing burden of mental illness, a greater understanding of the impact of the social determinants of health on mental health and wellbeing, along with new evidence of effective ways to prevent mental illness and promote mental health and wellbeing, are driving a shift towards a whole of community or population health approach to mental health and wellbeing. A population or whole of community approach to mental health and wellbeing '*promotes health and prevents and intervenes early in the pathways to mental illness through strategies involving individuals, communities and whole population groups*.'[11]

These activities occur across the range of wellbeing and illness and across the lifespan. The benefits of a whole of community approach to the promotion of mental health are many and include improvements in physical health and productivity, as well as reduced mental illness and the associated social and economic costs.

Evidence: *The National Survey of Mental Health and Wellbeing* (2007)14, in which 16 million Australians were surveyed found that:

- 45 per cent of participants reported a mental illness sometime during their lifetime and one in five reported having a mental illness in the past 12 months;
- People experiencing socioeconomic disadvantage or other adverse life circumstances reported higher levels of mental health problems compared to those who are more fortunate;
- 29 per cent of unemployed individuals, 54 per cent of those who were homeless and 41 per cent of people who had previously been incarcerated reporting mental health problems in the previous 12 months.[14]

Furthermore, other evidence reveals that:

- Serious mental illness is associated with substantial role disability for individuals and may be a significant burden on the family, who are often primary carers;[35] and
- Mental health problems are associated with increased exposure to health risk factors, poorer physical health and higher rates of death from many causes, including suicide[1]3

Outcome	Strategies	Actions	Outputs	Agencies responsible
1.1: Progress is made towards a whole of government approach to the promotion of mental health and wellbeing for the 2015 plus Framework.	• Implement strategies to promote mental health and wellbeing within existing ACT Government Departments, social service and community service organisations strategic plans and frameworks. • Increase Government and community organisation awareness and understanding of mental health promotion, prevention and early intervention.	**1.1.1:** Embed strategies to promote mental health and wellbeing in relevant ACT Government Departments, social service and community service organisations strategic plans and strategies.	Number of Government Departments, social service and community service organisations embedding strategies to promote mental health and wellbeing.	All ACT Government Departments, social service and community service organisations
		1.1.2: Deliver the Auseinet Understanding Mental Health and Wellbeing training course to ACT Government Departments and community service organisations.	Number of training courses delivered. Range of organisations attending. Number of participants attending. Increased understanding of how the business of the participants organisation influences mental health and wellbeing, measured through feedback survey. Identification of opportunities and intent to modify clinical practice.	ACT Health Policy Unit , Government Departments, Community Service Organisations

Outcome	Strategies	Actions	Outputs	Agencies responsible
1.2: Increased mental health and wellbeing literacy, reduced stigma concerning mental illness and increased capacity of the community to maintain and support better health and wellbeing.	• Develop and deliver a broad-based social marketing campaign which takes an integrated approach to promoting mental and physical health and wellbeing.	**1.2.1:** Review existing marketing campaigns, explore possible theoretical frameworks for a marketing campaign and identify a campaign model appropriate for the ACT.	Options paper on campaign models suitable for the ACT.	ACT Health Policy Division
		1.2.2: Develop an integrated marketing campaign to promote mental and physical health and wellbeing.	Marketing campaign developed.	ACT Health Policy Division, Health Promotion Division
		1.2.3: Develop fact sheets to on issues relevant to mental health promotion, prevention and early intervention as identified by stakeholders and the community.	Number and type of fact sheets developed. Feedback on fact sheets.	ACT Health Policy Division
		1.2.4: Continue delivery of *Open Minds,* the mental health radio show.	Number of programs delivered.	MIEACT
1.3: Increased mental health and wellbeing via greater community access and engagement with the ACT natural environment.	• Promote the importance of the relationship between mental health and wellbeing and access to ACT parks, recreational and environmental activities.	**1.3.1:** Use established communication channels to promote access to parks and open space facilities.	Healthy Parks; Healthy People research activities inform decision makers and frontline individuals working in health and parks.	Parks Conservation and Lands; ACT Health; Sport and Recreation Services; Chief Ministers' Department; Treasury; and other Government Agencies and Departments.
		1.3.2: Produce the ACT's Outdoor Recreation Strategy including all facets of community health.	ACT Outdoor Recreation Strategy developed and implemented.	Sport and Recreation Services; Parks, Conservation and Lands; ACT Health; Chief Ministers' Department; Treasury; and other Government Agencies and Departments.
		1.3.3: Continue to work with Volunteer Groups working in parks. Encourage staff and volunteers to develop programs based upon use of the parks and open spaces system.	Number of new volunteers. Number of new programs developed.	Parks, Conservation and Lands; ACT Health; Sport and Recreation Services; Chief Ministers' Department; Treasury; and other Government Agencies and Departments.
		1.3.4: Ensure that frontline staff have appropriate information on the relationship of Healthy Parks; Healthy People.	Number of health professionals who have an understanding of the benefits of accessing healthy ACT parks and urban spaces to maintain mental health and wellbeing.	Parks, Conservation and Lands, ACT Health, Sport and Recreation Services, Chief Ministers' Department, Treasury and other Government Agencies and Departments.

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Outcome	Strategies	Actions	Outputs	Agencies responsible
1.4: Relevant Government Departments and community agencies have the knowledge, skills and capacity to implement and sustain a mental health promoting approach in service delivery and workplace practices.	• Provide skills training in mental health literacy for Government Departments and community service organisations interacting with members of the public to increase awareness of: the signs and symptoms of mental illness; factors that influence stigma; and knowledge of where to seek help. • Develop the skills and capacity of organisations and communities to sustain mental health promotion activities. • Increase availability and uptake of workplace mental health promotion programs. • Continue funding Mental Illness Education ACT (MIEACT) to deliver mental illness education sessions to relevant ACT Government Departments and community organisations. • Support MHACT and clinicians working in community sector organisations to undertake training in Drug, Alcohol and comorbidity issues.	**1.4.1:** Continue efforts to have mental health literacy training included in all ACT Government Department OH&S training.	Number of ACT Government Department's including health literacy training in OH&S training. Number of participants in training courses.	ACT Health, ACT Government Departments, MIEACT
		1.4.2: Continue to provide mental health literacy training sessions to frontline workers in Government and community agencies interacting with the public.	Number and type of agencies receiving training. Participant identification of ways of modifying practice to promote mental health and wellbeing.	ACT Health, MIEACT
		1.4.3: Relevant organisations continue to provide programs such as *Mental Health First Aid* (MHFA) for their staff.	Number and type of programs delivered. Type of organisation delivering training. Number of participants attending training. Implementation of learnings from training.	ACT Government Departments, relevant community sector organisations.
		1.4.4: Facilitate the delivery of mental health promotion training in the Territory, eg Auseinet *Understanding Mental Health and Wellbeing* and VicHealth *The Short Course: Promoting Mental Health and Wellbeing*.	Number of courses run annually. Number of participants attending training. Feedback from participants. Implementation of learnings from training.	ACT Health, relevant ACT Government Departments and community sector organisations, ACTDGP
		1.4.5: Continue to support the beyondblue *Workplace Mental Health Promotion Project*.	Outputs of beyondblue project. Findings from project evaluation.	ACT Health, beyondblue, OzHelp
		1.4.6: Develop strategies to implement programs similar to the beyondblue Workplace Mental Health Promotion Project.	Strategies developed. Number and type of programs implemented.	ACT Health, relevant ACT Government Departments and community agencies
		1.4.7: Continue to deliver mental illness education sessions to educate target communities about the signs and symptoms of mental illness and the effects of stigma on people experiencing mental illness.	Number of training sessions delivered each six months. Feedback from training sessions.	ACT Health, MIEACT
		1.4.8: Support MHACT and community sector clinicians to complete core units of the Certificate IV in Alcohol and Other Drug Work.	Number of MHACT clinicians completing core units of the Certificate IV in Alcohol and Other Drug Work.	MHACT, CIT
		1.4.9: Explore additional mechanisms to increase clinical experience in the alcohol and other drug sector for MHACT clinicians, e.g. reciprocal work placements.	Mechanisms for increasing experience. Number of people gaining experience. Impact on clinical practice, as reported by Team Leaders.	MHACT, Drug and Alcohol Sector
1.5: Improved service delivery for people with a mental illness.	• Provide contemporary and informed advice to government and community sector organisations on legislation, policies, practices and services that affect people with a mental illness.	**1.5.1:** Make recommendations to government and community sector organisations on legislation, policies, practices and services that affect people with a mental illness.	Number of recommendations made. Outcomes of recommendations made.	ACT Government and non-government sector. Human Rights Commission
		1.5.2: Explore means of encouraging government and community sector organisations to adopt the principles of *Consumer Participation and Carer Participation Across Mental Health ACT: A Framework for Action.*	Number of government and community sector agencies adopting the principles. Identified impact on work practices.	ACT Government and community sector organisations.

Action Area 2: Support children, youth and families

The early years of life are crucial in establishing attachment and resilience to later life stressors.[36]

As identified in the ACT MHSP[3] infant mental health is a key early of promotion, prevention and early intervention. Supporting families and children during the early years will lessen the risk of later development of mental health problems. Effective, evidence based support can be provided at various points during the child's life course. This Framework will focus on three specific areas of childhood development to provide promotion, prevention and early intervention activities. These are:

— Support parents and children during the perinatal period;

— Support children, youth and families during the school years; and

— Support children of parents with a mental illness.

Support parents and children during the perinatal period

Rationale: Up to one in seven Australian women will develop Post Natal Depression.37 The National Perinatal Depression Initiative recognises that depression is common in the perinatal period and that maternal wellbeing is critical for early attachment.38

The provision of preventative health care, particularly for those experiencing poor socioeconomic circumstances, prior to birth and in the post-natal period, is vital to intervening early to support families and children. This requires universal screening programs for post-natal depression, and other mental health disorders. There is also a need for the provision of parenting programs that improve parent-child attachment and that increase parents' awareness and knowledge about their children's needs.

Evidence:

- Over half a million Australian children have significant mental health problems;[39]
- Maternal psychological health can have a significant effect on the mother-infant relationship, and this can have consequences for both the short and long-term mental health and wellbeing of the child;[40]
- Provision of parenting programs has been a common way of supporting parents and enhancing parent-child relationships. In particular:
  There is growing evidence for the effectiveness of programs designed to enhance parenting capacity and confidence through promoting increased sensitivity towards children, increasing parental responsiveness, and promoting secure parent-child attachment for families at high risk of poor parenting practices;[41]
  Programs designed to increase parents' capacity and confidence to manage specific childhood problems such as sleep and behavioural problems have strong scientific evidence;[25]
  Parenting programs designed to solely change parental knowledge and attitudes do not reliably demonstrate improved outcomes for children;[42]
- Delivery of programs during pregnancy is recommended, as this is a period when parents are more receptive to accessing services and information.[43]
- Family-focussed interventions significantly improve outcomes for the parent with the mental illness, reduces the subjective burden of care for the family and increases children's knowledge about mental illness.[44]

Outcome	Strategies	Actions	Outputs	Agencies responsible
2.1: Expectant mothers at risk of developing PND or another mental illness receive appropriate mental health assessment, treatment and support.	• Provide universal screening, for PND for all expectant mothers and establish and implement referral pathways for those identified at risk of developing PND or another mental illness through implementation of the *National Perinatal Mental Health Action Plan*. • Provide training to clinicians caring for expectant mothers in the use of screening tools. • Continue implementation of the Aboriginal and Torres Strait Islander Maternal Health Program.	**2.1.1:** Expand the clinical capacity of perinatal mental health services to provide early intervention, treatment and support to expectant mothers who have been identified as at risk of developing PND or another mental illness.	100 per cent of expectant mothers receive screening for PND. Reduction in the number of new mothers developing PND. Reduced incidence of behavioural and emotional problems in children.	MHACT ACT DGP, relevant private clinicians
		2.1.2: The ACT identifies an agreed risk assessment tool for assessing expectant mothers.	By June 2010 the ACT has agreed upon a risk assessment tool that will be used by all clinicians.	MHACT
		2.1.3: Train Midwives and MACH Nurses in the use of the *Edinburgh Post Natal Depression Scale* and an agreed risk assessment tool.	By June 2012 100 per cent of ACT Midwives and MACH Nurses are trained in the use of the *Edinburgh Post Natal Depression Scale* and an agreed risk assessment tool.	MHACT, ACT Health
		2.1.4: Ensure that the development of the model of care at the new Women's and Children's Hospital contains the principles of promotion, prevention and early intervention.	Demonstrate how the principles of promotion, prevention and early intervention are embedded within the model of care by 2010.	ACT Health
		2.1.4: Provide antenatal and postnatal support to Aboriginal and Torres Strait Islander mothers through outreach clinical and non-clinical assessments at home; referral to, and support in accessing mainstream and specialist services and the provision of information on mainstream services.	Number of Aboriginal and Torres Strait Islander mothers receiving support.	Winnunga Nimmityjah Aboriginal Health Service
2.2: Parents and caregivers have the knowledge, skills and capacity to meet the emotional and social needs of infants and young children and know where to seek support when necessary.	• Broaden the availability of evidence-based parenting programs. • Families have access to a comprehensive array of programs that support children's early learning and that build family capacity. • Early intervention programs for parents with young children that improve social connectedness of parents, improve access to mainstream services and improve child development.	**2.2.1**: Deliver or fund evidence-based parenting programs across a range of geographic locations in the ACT.	Number and geographical range of courses run annually.	OCYFS
		2.2.2: Identify, develop and implement regionally based, integrated services for children and their families that support children's learning strengthens the capacities of parents and improves overall family wellbeing.	Number and type of programs developed and/or implemented. Number of participants in programs.	DET - Early Childhood Schools
		2.2.3: Provide facilitated programs for children and parents that improve connectedness of parents, child development and access to services.	Number of participating children and parents.	OCYFS
2.3: Women and children have enhanced mental health and wellbeing and improved social connection.	• Continue to support organisations running programs to enhance the physical and emotional wellbeing of women and children.	**2.3.1**: Support a range of programs and activities to enhance the physical and emotional wellbeing of women and their children.	Number and type of programs/activities and the number of participants reported six monthly.	OCYFS

Outcome	Strategies	Actions	Outputs	Agencies responsible
2.4: Improve social connectedness for vulnerable parents including parents with a mental illness; parents isolated due to domestic violence; Aboriginal and Torres Strait Islander parents and; young parents and parents with a history of problematic alcohol or other drug use.	• Provide programs which connect parents with other parents and the services facilitating improved referrals as required.	**2.4.1:** Provision of or funding for programs and or services for vulnerable parents.	Improved participation for vulnerable families in community activities that are focused on parenting education and improved child development outcomes.	OCFYS; MHACT

Support children, youth and families during the school age years

Rationale: Childhood represents an important time to develop protective foundations for positive mental health and to enhance mental health outcomes, extending from children's functioning in school and their relationships with peers to connections in society more broadly.[45]

As children spend a large part of their time at school, it is appropriate to implement universal mental health promotion activities in the school setting. Bullying is a significant issue facing many children both at school and, with new electronic technologies, in the home. Adolescent psychologist Michael Carr-Gregg considers bullying to be 'the most important public health issue impacting on adolescent mental health in Australia today'.[46] Bullying can affect a child's self-esteem and can lead to a range of mental health problems, including mood, anxiety and eating disorders, and in extreme cases can contribute to suicide. A Victorian study found that participants identified school as the most common place where they experienced bullying, yet only 30 per cent of people were aware of bullying policies in schools.[47]

School based programs to promote mental health and wellbeing can be delivered across three areas:

Whole school approach - interventions which take a holistic approach focusing on factors such as school values, organisational environment, policies and practices, and partnerships between school, home and community. Whole school approaches involve all levels of the school community including school staff, students, parents and the broader community including services and professional networks. Whole school approaches commonly provide a 'framework for action' which can be used as a guide and tailored to the needs of individual schools.[48] The ACT Department of Education is rolling out *KidsMatter* and *MindMatters*. In 2008, seven primary schools participated in the *KidsMatter* pilot. By the end of 2008, 43 of 44 secondary schools and colleges (756 participants) had undertaken training in the MindMatters program

Classroom-based interventions - these interventions involve the specific implementation of a set of curriculum resources or programs to support the development of good social, emotional and life skills. Some classroom-based interventions focus on general social competency building, while others may also have a specific focus such as preventing anxiety, anti-bullying etc.[48] Schools with the ACT are currently using a number of programs, including: *Restorative Practices; PATHS; M&M Pathways; Bounce Back; Rock and Water; Bully Buster; Stop, Think, Do; Friendly Schools; Habits of Mind*; and *You Can Do It*.

Targeted interventions - interventions or programs which focus on the needs of children and young people who are considered at higher risk for mental health problems. The primary aim is to foster the development of improved coping skills and to ameliorate against the development of negative mental health outcomes.[48] Education about health promotion, including mental health and wellbeing and a specific focus on bullying, is built into *Every Chance to Learn: Curriculum Framework for ACT Schools Preschool to Year 10*.[49] Two specific learning outcomes of relevance are: the student takes actions to promote health; and the student acts with integrity and regard for others.

As identified under the new *Four Life Stages* model of care outlined in the MHSP, there are many emerging mental health issues that become evident in teenage years. Impacting on mental health state are also various social and environmental issues pertinent to this age group. These might include care and protection issues, increasing independence and associated safety concerns, and the need for social connection as mental illness may promote isolation. Youth services are described to be predominantly community based and have an early identification / intervention pre-crisis focus, with education, family / carer involvement (part of therapeutic treatment team), crisis options (respite, safe houses) and support to schools and workplaces. Sub-age specific services under this model allow services to be tailored for the younger and older cohort, thus addressing different developmental and maturational issues.

Evidence:

- A positive educational experience, where children feel connected can contribute to enhanced self-esteem and confidence, can lead to better employment opportunities, life opportunities and social support;[50]
- Poor engagement and support during the schooling years is considered to be a risk factor for mental health and other behavioural problems;[51]
- 20 per cent, children report cyber bullying;[46]
- Whole school approaches to the promotion of student health and wellbeing aim to include teachers, school administrators, parents, members of the community and children, and have been found to be more effective than brief classroom-based programs.[52]

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Outcome	Strategies	Actions	Outputs	Agencies responsible
2.5: Increased individual understanding of positive mental health and mental health literacy, reduced stigma of mental illness and increased capacity of school communities to maintain and support better health and wellbeing.	• Build the capacity of whole school communities to promote mental health and wellbeing and respond to mental health problems. • Raise awareness of the nature and incidence of bullying and its mental health impacts across a range of sectors.	**2.5.1:** Build upon the existing PPEI focus in school counselling and support programs via the roll out of *MindMatters* in all ACT public Secondary Schools and Colleges.	Number of Secondary Schools and Colleges participating in MindMatters or equivalent training each financial year.	DET
		2.5.2: Build upon the existing PPEI focus in school counselling and support programs via the roll out of KidsMatter in all ACT Primary schools.	Number of Primary Schools participating in KidsMatter or equivalent training each financial year.	DET
		2.5.3: Promote and implement anti-bullying programs in schools eg, *Restorative Practices, Friendly Schools and Families*.	Reduced incidence of bullying and violence in schools.	DET
		2.5.4: Expanded funding to MIEACT to deliver mental health education sessions to senior secondary schools, college students.	Number of training sessions provided.	MIEACT
		2.5.5: Continue delivery of *Any Body's Cool* body image and disorder eating health education sessions to junior secondary school students.	Number of training sessions provided.	MIEACT
2.6: People in identified 'at risk' groups have increased access to programs and initiatives to increase resilience and reduce the incidence of mental illness.	• Access to early intervention programs for children and young people aged 5–18 is increased across the ACT. • Access to early intervention for mental health and AOD problems for youth and adolescents aged 12-25. • Access to training on the detection and identification of anxiety disorders for those working with young people. • Continue to identify and promote programs and initiatives that increase resilience and reduce the incidence of mental illness among identified children of parents with a mental illness.	**2.6.1:** Expand the Belconnen Bungee program to the Tuggeranong region through the Bungee Southside Youth Resilience Program.	By June 2010 the Bungee program is expanded to the Tuggeranong region.	Belconnen Community Services
		2.6.2: Consider ways to support progress of the pilot headspace ACT program and its integration with CAMHS and adult mental health services, as a way to improve early intervention.	Number of young people accessing headspace.	MHACT, headspace ACT Consortium
		2.6.3: Investigate mechanisms to train those working with young people in the detection and identification of anxiety disorders.	By December 2010 report on existing mechanisms, gaps, possibilities.	ACT Health PPEI Working Group
		2.6.4: Continue to build on the work of COPMI project to meet the needs of children of parents affected by mental illness across services and sectors.	Increased health and wellbeing of dependent children who have a parent with a mental illness.	DET, OCYFS, community youth and family support services, MHACT

Support children of parents with a mental illness

Rationale: Between 21 and 23 per cent of Australian children live in a household where at least one parent has a mental health problem.[53] Many of these children, particularly those in single parent households, take on the role of carer for their ill parent. Evidence suggests that between 40 to 60 per cent of these children are at risk of mental health problems themselves.[54] A range of interventions have been adopted to support families and the children of parents with a mental illness.

Parenting programs have been found to show beneficial outcomes for parents and children. Programs need to be tailored to the needs of clients.[55] These include:

- Home visiting programs, which have been found to be most beneficial for high-risk mothers, for families where the initial need is greatest, and where parents perceive that their children need the service;[56] and
- Whole family interventions, which provide information about mental health and wellbeing, communication and problem-solving skills training and crisis or care planning for all family members, have been found to be a key form of intervention. These services have been found to be limited.[62]

Interventions for children focus primarily on relieving the burden of caring and on providing support and 'someone to talk to'.[63] The COPMI website www.copmi.net.au provides information on a range of support services available to young people, including access to camps, newsletters, telephone and/or face-to-face counselling, telephone support and information and referrals, chat rooms and other forms of link-up for young carers.

Within the ACT, all school counsellors received training in the COPMI package.

Evidence and Needs

- Many children caring for a parent with a mental illness hide their distress because of fear, shame, loyalty or stigma and fail to receive support either because their parent is not receiving care or because case workers are not aware that their client is a parent;[57]
- Research consistently shows a higher rate of behavioural, developmental and emotional problems in children of parents with a mental illness compared with those in the general community;[58 59]
- Children whose parents have depression or anxiety are six times more likely to experience depression or anxiety themselves;[39]
- While children of parents with a mental illness may experience increased risk factors as described above, this is not always the case. A child's level of risk is tempered by the level of insight that the parent has into their mental illness, the severity of the illness and the frequency of episodes of illness;[63]
- Social and emotional connections with others significantly moderate the effects of parental mental illness.[60]
- In considering the needs of children of a parent with a mental illness, a recent literature review conducted by the NSW Department of Community Services in 2008 found that when asked what they need most, children of parents with mental health problems have identified the following needs:
  More information about their parent's mental health problems;[61 53]
  To be informed and consulted by professionals who often focus exclusively on the parent's needs;[62]
  Someone to talk to; and
  Help with practical issues around parent hospitalisation and respite.'[63]

Outcome	Strategies	Actions	Outputs	Agencies responsible
2.7: Increased resilience and reduced incidence of mental illness among children of parents with a mental illness.	• Increase the identification of parents or guardians of dependent children who have a mental illness. • Increase the number of COPMI families provided with support, information and interventions, responsive to their needs. • Promote better mental health outcomes for children of parents with a mental illness through maximising the ACT community's capacity to identify and respond to their needs.	**2.7.1:** MHACT to collect data concerning dependent children of consumers with a mental health problem.	COPMI field in MAGIC mandatory. Number of MHACT consumers identified with dependent children.	MHACT
		2.7.2: MHACT Adult Mental Health and CAMHS conduct joint assessment and management of COPMI families.	Number of COPMI families receiving joint assessment and management.	MHACT
		2.7.3: MHACT case managers encourage all consumers who are identified as parents to complete a MHACT Recovery Plan, including the *Child and Young Person's Support Plan*.	100 per cent of MHACT COPMI families are offered the opportunity to develop an active *Child and Young Person's Support Plan*.	MHACT, MHACT clinically managed consumers who are parents
		2.7.4: Through the ACT COPMI Steering Committee, provide a forum for interagency and cross discipline discussion on issues related to the needs of the COPMI population and further develop the strategic direction of the COPMI project.	Development and implementation of COPMI Steering Committee action Plan.	COPMI Steering Committee
2.8: Increased skills and knowledge of the needs of COPMI families among those who may come into contact with them.	• MHACT staff receive training concerning the specific needs of COPMI families. • Deliver programs such as Vulnerable Families training in the ACT.	**2.8.1:** COPMI Officer provides in service training to relevant MHACT staff.	Number of MHACT staff receiving COPMI training. Feedback on usefulness of training. Implementation of learning from training.	MHACT, COPMI Officer
		2.8.2: Promote and deliver *Vulnerable Families* training for Government and community sector organisation employees who may come into contact with COPMI families.	Number of individuals and organisations receiving COPMI training. Feedback on usefulness of training.	MHACT, relevant Government and community sector organisations
2.9: Specialised advocacy provided to children, young people and families which supports early intervention, prevention, promotion efforts.	• PA ACT provides specialised advocacy (individual and systemic) for mothers and their children whilst incarcerated in the AMC. • PA ACT provides mental health specific advocacy for children and young people who may be admitted to the hospital for mental health reasons.	**2.9.1:** Systemic project undertaken to identify specialised needs in this area.	Systemic project completed and report tabled to the ACT Public Advocate.	Public Advocate
		2.9.2: The PA ACT to visit all young people admitted to hospital for mental health reasons regardless of legal status (eg voluntary vs involuntary).	Number of young people visited by the PA ACT.	Public Advocate

2.10: Maintain family relationships by providing family visits for prisoners at the AMC.	• Provide opportunities and supportive environment for family members to visit prisoners at the AMC. • Provide for private family visits for extended periods of time.	**2.10.1:** Provide extended visiting hours, six days per week, in family-friendly surrounds, and ensure bus services coincide with visiting hours.	Number of family visits.	ACTCS, families of prisoners
2.11: Maintain family relationships by having mothers and their young children remain together during mothers' incarceration.	• Develop and implement a Women and Children policy, allowing for children of up to 4 years of age to live within the prison, with their mother.	**2.11.1:** Provide all necessary facilities, management and support for the Women and Children policy to be put into operation.	Number of applications able to be facilitated.	ACTCS, Parenting and Children's Committee (comprised of representatives from the PA ACT; OCYFS; ACT Health; Corrections Health Program; and ACTCS.)
		2.11.2: Provide parenting and support programs for mothers.	Number of women who complete parenting programs.	ACTCS, Parenting and Children's Committee (comprised of representatives from the PA ACT; OCYFS; ACT Health; Corrections Health Program; and ACTCS.)
2.12: Children and families who are victims of family violence receive support for recovery from the effects of the violence.	• Develop a family care plan.	**2.12.1:** Provide thorough assessment and support for children and their families.	Children and their families receive appropriate referrals to support agencies.	ACT Community Health services

Action Area 3: Enhance services to those with comorbidity issues and/or who have received care in closed settings

Many individuals experience multi-faceted issues that influence their mental health state and ability to manage it. These issues may relate to social aspects (eg. homelessness, unemployment, or poor support networks) and/or might involve other factors such as alcohol and/or other drug use, violence or criminal activity. An identified priority group is people with comorbidity issues (specifically problematic alcohol and/or other drug use coexisting with mental illness), as this population has traditionally accessed separate services that, albeit with some service cooperation, primarily supporting one aspect of their comorbid condition. The ACT MHSP has prescribed the development of an ACT-wide Integrated Alcohol and Other Drug and Mental Health Comorbidity Strategy to establish the roles of AOD and mental health services and other stakeholders, address resource issues, improve service integration, articulate early intervention and prevention approaches and opportunities, and consider the special needs of those in custody.

A period of care in a closed setting (such as inpatient psychiatric care, in custody, immigration detention or other detention) can also have profound effects on an individual's sense of self and their physical and mental health and wellbeing. *Building A Strong Foundation* will considers actions to promote mental health and wellbeing and to prevent and intervene early for individuals experiencing mental illness, individuals with comorbidity issues, and individuals experiencing care in three closed settings:

— Individuals who are or have been an inpatient of a psychiatric facility;

— Individuals who are or have been incarcerated, including those coming into contact with the juvenile justice system; and

— Individuals who are or have experienced detention in immigration facilities or detention camps.

Individuals with comorbidity issues

Rationale: The National Alcohol Strategy 2006-2009[64] specifically states that the health impacts of alcohol often include multiple drug use and other issues including mental illness. It further states that long term high consumption of alcohol is a contributing factor in various mental health conditions, including alcoholic psychosis, alcohol dependence syndrome, alcohol related dementia and Wernicke-Korsakoff syndrome (a condition related to thiamine deficiency and results in reduced brain function to a point of permanent disability requiring long term care in a closed setting). The National Drug Strategy 2004-2009 recommends enhancing responses to co-existing drug and mental health problems and increasing the involvement of primary care services. Building on partnerships across the health, education, justice, community and research sectors was also identified as a response to reducing barriers in accessing help and promoting best possible treatment outcomes.

Evidence: The National Survey of Mental Health and Wellbeing 2007,[14] found that 62 per cent of those who had a drug misuse problem reported a comorbid mental illness in the 12 months prior to the survey. Of those who reported consuming alcohol every day, 21 per cent reported a comorbid mental illness. Of young people experiencing an affective disorder, 31 per cent reported a comorbid substance use disorder.

Outcome	Strategies	Actions	Outputs	Agencies responsible
3.1: Individuals with comorbidity issues will have access to a system of integrated services that will intervene early, prevent deterioration and offer continuity of care.	• Develop and implement an ACT wide AOD and mental health comorbidity strategy. • Maximise opportunities from Federal initiatives, particularly in the areas of workforce development.	**3.1.1:** Ensure the comorbidity strategy has a strong prevention and early intervention focus and aligns with the objectives in other policy frameworks (eg. Primary Care and ACT MHSP).	Comorbidity Strategy developed.	MHACT, alcohol and other drug sector, ACTDGP.
		3.1.2: Through a working group chaired by MHACT, explore means of supporting MHACT consumers to reduce or cease smoking.	Formation of working group. Recommendations and/or actions from working group.	MHACT
		3.1.3: Incorporate and utilise where possible and appropriate, any Federal initiatives relating to comorbidity, including workforce development and infrastructure initiatives.	Access to up-skilling GPs, nursing workforce, and community agencies.	MHACT, Alcohol and other drug Sector, ACTDGP.

Individuals who are, or have been, an inpatient of a psychiatric facility

Rationale: Involuntary detention in an inpatient psychiatric facility can have negative consequences on patients' long term mental health and wellbeing. Numerous examples of perceived inappropriate seclusion or excessive use of medication have been documented in the literature, as have reports of high levels of physical, verbal and sexual assault in inpatient units. However, few studies have examined this area in depth, particularly within Australia. Adoption of a recovery-based focus to treatment, with consistent opportunities for consumer and carer participation may alleviate many of these problems.

Evidence

- A US study examining consumers who had experienced at least one previous psychiatric hospital admission found that 47 per cent reported experiencing a DSM-IV-defined traumatic event while in hospital. This included witnessing a physical assault (22 per cent), experiencing a physical assault (18 per cent) and witnessing a sexual assault (5 per cent);[65]
- People who have been in an inpatient psychiatric unit are at greater risk of suicide:
- For men, the rate of suicide in the first 28 days after discharge has been found to be 213 times greater than would be expected in the general population;[66]
- At 12 months post discharge, suicide rates were found to be 27 times higher among men and 40 times higher in women, compared to the general male and female populations, respectively.[67]

Outcome	Strategies	Actions	Outputs	Agencies responsible
3.2: Individuals with a mental illness or emerging mental illness have the skills and resources to reduce the likelihood and impact of future episodes of illness.	• MHACT implements a recovery based approach to the provision of treatment and care. • Implement the *No Wrong Door* philosophy. • Implement the Commonwealth Government's Homelessness White Paper – *The Road Home* policy 'no discharge into homelessness.	**3.2.1:** MHACT clinicians work with clinically managed consumers to develop and maintain an up-to-date recovery plan, including a relapse prevention plan.	90 per cent of clinically managed mental health clients have completed a relapse prevention plan as part of their recovery plan.	MHACT, MHACT clinically managed consumers, carers, primary care providers
		3.2.2: Support all individuals who make contact with public and private mental health services to either receive a direct response from MHACT or to be linked to the appropriate service.	Awareness of *No Wrong Door* philosophy by public and private mental health service providers. Mechanisms used by service providers to develop and implement policy.	All public and private mental health service providers
		3.2.3: Begin discharge planning at the commencement of a consumer's admission to prevent the risk of discharge into homelessness.	100 per cent of consumers have a written discharge plan.	MHACT – PSU, BHRC, Housing ACT
		3.2.4: Through the Housing for Young People Program (HYPP) work with those transitioning to independent Housing ACT tenancies to ensure increased supports are available during this transition period.	Number of HYPP clients exiting youth detention and/or other closed care settings.	MHACT, Housing ACT
		3.2.5: Housing ACT continues to make MHFA Training available to housing managers as part of its regular training program.	Number of staff participating in programs. Staff feedback from programs.	Housing ACT
		3.2.6: Housing ACT to make additional mental health training available to housing managers and other staff involved in the Housing Assistance Support Initiative (HASI) program.	Type and number of programs made available. Number of staff participating in programs. Staff feedback from programs.	Housing ACT
		3.2.7: Housing ACT Client Support Coordinators (CSC's) play a role in early identification of people with a mental illness and link identified individuals to supports to sustain tenancies.	Number of individuals linked to supports by CSC's.	Housing ACT

Outcome	Strategies	Actions	Outputs	Agencies responsible
3.3: MHACT clinicians have the knowledge, skills and capacity to work respectively with consumers and carers/ families to promote the best outcomes for consumers.	• MHACT is committed to providing all clinically managed consumers and their carers with timely and evidence based information relating to services, mental illness, medications and other general aspects of mental health care. • Provide training in promotion, prevention and early intervention for all MHACT staff.	**3.3.1:** Regularly review, update and endorse evidence based information resources for mental health consumers and carers.	Feedback and outcomes of documents reviewed.	MHACT, Publications Committee
		3.3.2: Provide all MHACT clinicians providing direct clinical care with training regarding interactions with consumers and carers, including an understanding of the roles and limitations of confidentiality policies in working with and providing information to carers.	30 per cent of MHACT clinicians providing direct clinical care undertake training in standardised clinical processes as part of their continued professional development annually. 90 per cent of clinical staff participate at Orientation.	MHACT Professional Development and Training Committee
		3.3.3: MHACT develops and regularly updates resources to provide consumers, carers and the ACT community with accurate and up to date information reflecting current practice. This is provided by hard copy and/or e-based mental health information and links.	50 per cent of consumers and carers are provided with an option for hard copy or e-based mental health information. Increasing by 10 per cent annually.	MHACT
		3.3.4: Provide individual and group based psycho-education for consumers and carers.	Number and type of sessions provided. Frequency and geographic location of sessions. Participant feedback on sessions.	MHACT, Carers ACT.
		3.3.5: Through the *Carer Peer Support Program*, provide support and information to families and friends of consumers and inpatients	Provide a minimum of 3 hours per week in the inpatient wards. Number of initial carer counselling sessions provided. Number of referrals made. Feedback from carers.	Carers ACT
		3.3.6: Deliver the *Keeping Families Connected* program	Number of programs delivered. Number of participants. Feedback from participants.	Carers ACT
		3.3.7: Deliver Auseinet's *Understanding Mental Health and Wellbeing: An introduction* to mental health, health promotion, prevention of mental ill-health and early intervention to all MHACT staff.	20 per cent of MHACT staff participate in training by end of financial year 2010, 40 per cent by end of financial year 2011, 60 per cent by end of financial year 2012, 80 per cent by end of financial year 2013, and 100 per cent by end of financial year 2014. Impact on clinical practice, as reported by Team Leaders.	MHACT, ACT Health Policy Division

Outcome	Strategies	Actions	Outputs	Agencies responsible
3.4: Young people diagnosed with a mental illness receive recovery based services to reduce the impact of their illness on future function and increase their coping skills and resilience.	• Extend services for youth to include separate Step up/Step down services and a dedicated inpatient unit. • In accordance with guidelines for the treatment of Early Psychosis, provide early intervention and treatment for young people identified with an early onset psychosis.	**3.4.1:** Consider and address the principles of mental health promotion, prevention and early intervention in developing the model of care for the dedicated Adolescent and Young Adult Mental Health Inpatient Unit (AYAMHIU). **3.4.2:** Implement the model of care for the AYAMHIU, including strategies to address mental health promotion, prevention and early intervention. **3.4.3:** Specialist Early Onset Teams (SEOT).	By December 2009 produce a model of care which incorporates the principles of mental health promotion, prevention and early intervention. Demonstrate how the principles of promotion, prevention and early intervention are embedded within the model of care. Reduced impact of mental illness on the functioning of young people diagnosed with an early onset psychosis.	MHACT
3.5: Individuals with a severe and persistent mental illness and complex care needs are able to access a range of clinical and support services in an integrated and coordinated manner.	• Implement and evaluate the Care Coordination Model in the ACT.	**3.5.1:** Embed the Care Coordination Model within all MHACT Community teams.	Number of MHACT consumers participating in the Care Coordinatation Model. Improved mental health outcomes for participating consumers. Reduction in patient care days for clients.	MHACT, Government and community service organisations.
3.6: Mental health consumers have increased skills, knowledge and access to programs and resources to effectively manage their physical and mental health.	• Provide consumers with psycho-education resources. • Provide consumers with support to improve self-management. • Continue implementation of Advanced Agreements.	**3.6.1:** MHACT clinicians ensure clinically managed consumers have access to appropriate psycho-education resources.	100 per cent of MHACT consumers have been provided with psycho-education resources.	MHACT, MHACT clinically managed consumers
		3.6.2: MHACT clinicians ensure clinically managed consumers have access to resources to improve their ability to self-manage.	100 per cent of MHACT consumers are provided with resources to facilitate illness self-management.	MHACT, MHACT clinically managed consumers
		3.6.3: MHACT clinicians inform clinically managed consumers about Advanced Agreements, encourage and work in partnership with them to develop one.	Percentage MHACT clinically managed consumers who have an Advanced Agreement.	MHACT and MHACT clinically managed consumers
		3.6.4: Explore opportunities for expanding effective Consumer Peer Support services in the ACT.	Report on explorations efforts, including outcomes and recommendations.	ACT Health
3.7: Increase access to general health care for individuals with a mental illness.	• Expand the Better General Health program for people with mental illness to the Tuggeranong region. • Increase access to programs to enhance the physical health of MHACT clinically managed consumers.	**3.7.1:** Implement the *Better General Health* program for people with Mental Illness to the Tuggeranong region.	Number of MHACT clinically managed consumers participating in the *Better General Health* program.	MHACT, ACTDGP
		3.7.2: Expand the *Positive Steps* program to the Woden region.	Implement the *Positive Steps* program in the Woden region.	MHACT, YMCA

Individuals who are or have been incarcerated, including those coming into contact with the juvenile justice system

Rationale: People who come into contact with the criminal justice system through courts, prisons and community corrections are more likely to have mental health problems or mental illness than the general community.[34] The Australian Institute of Criminology asserts that:
If there is to be an effective system of mental health care, it is critical that there is systematic assessment leading to appropriate treatment in the criminal justice system. The justice system also provides an opportunity to identify and deliver treatment to people who are otherwise likely to remain outside the reach of services. In particular, the justice system is a key avenue for delivering the specialised assessment and treatment services required by those with concurrent mental illness and substance abuse.[68]

It is a requirement of all jurisdictions that every individual received into prison be examined by a qualified health professional upon entering prison. This assessment should include, at a minimum, a brief mental health screen and a risk assessment screen.[69] However, screening and assessment for mental illness in justice agencies across Australia is inconsistent.[70]

While many people entering the criminal justice system have an existing mental illness, the loss of contact with family, accommodation and employment associated with incarceration can exacerbate or lead to the onset of mental illness. [34] Individuals discharged from prisons are at significantly greater risk of suicide than the general community.

With the opening of the Alexander Maconochie Centre (AMC) in the ACT a focus on prisoner mental health and wellbeing is appropriate. Statistical modelling indicates the following profile of AMC prisoners in relation to mental health once operational:

- Approximately 90 prisoners will have received or will be receiving treatment or assessment by a psychiatrist or General Practitioner, for an emotional or mental health problem;
- Approximately 30 prisoners will have at one time been admitted to a psychiatric unit or hospital;
- 12 of these 30 prisoners will have been admitted for a period over eight weeks; and
- 54 per cent of women and 39 per cent of men will have been previously diagnosed as having a psychiatric problem, with depression being the most common.[71]

Mental health services at the AMC will:

- Have an emphasis on and support for mental health promotion, prevention and early intervention;[71]
- Provide all prisoners and remandees with a mental health and a risk assessment at the time of intake;
- Ensure that every prisoner with a mental illness has a care plan, including a release plan;
- Adopt a recovery-orientated approach to treatment; and
- Consult with appropriate services to manage mental health aspects of discharge planning.

Bimberi Youth Justice Centre will provide residents with:

- A mental health and a risk assessment at the time of intake;
- A case management plan addressing educational, health, and psychological needs; and
- A range of offence specific cognitive behavioural interventions to address offending behaviour and juvenile recidivism.[72]

Evidence: The 2007 National Survey of Mental Health and Wellbeing found that, of respondents who reported previously being incarcerated, 41 per cent had experienced a mental illness in the past 12 months;[73]A study of the mental health of prisoners in a NSW prison found:

- The prevalence of mental illness was 30 times higher for prisoners, compared to the general community;
- There was a strong positive association between being a prisoner and reporting symptoms of psychosis or PTSD in the previous 12 months along with an association between opioid or amphetamine use disorder and being a prisoner;[74]
- Another Australian study, conducted in 2003, found that 13.5 per cent of male prisoners, and 20 per cent of female prisoners, had reported having prior psychiatric admission(s);[75]
- Of the 15 000 people with major mental illnesses in Australian received care in closed settings during 2001, around one-third were in prisons;[70]
- 60 per cent of male children and young people and more than two thirds of young women in detention meet the criteria for a psychiatric diagnosis;[76] and
- There is an over representation of conduct disorders and Attention Deficit Disorder within the population of children and young people in detention.[77]

Outcome	Strategies	Actions	Outputs	Agencies responsible
3.8: Detainees in both juvenile and adult detention centres in the justice system have increased access to mental health risk assessment and evidence-based early interventions.	• Detainees in both juvenile and adult detention centres in the criminal justice system receive a mental health assessment, treatment and care appropriate to their mental health needs. • Detainees in both juvenile and adult detention centres have access to appropriate mental health promotion, prevention, and early interventions resources. • Provide links to community services prior to discharge for residents in Bimberi Youth Justice Centre.	**3.8.1:** All new residents at the AMC receive a mental health and drug and alcohol risk screening assessment upon arrival.	80 per cent of new detainees receive a mental health and risk assessment.	MHACT (Forensic), Corrections Health, JACS
		3.8.2: Provide skills training in mental health literacy for ACT Corrections and Bimberi operations staff to increase understanding of mental health promotion, prevention and early intervention, awareness of the signs and symptoms of mental illness, and stigma reduction.	Number of training sessions conducted. Number of corrections and Bimberi staff attending. Feedback from corrections and Bimberi staff.	ACT Health
		3.8.3: Develop and distribute information brochures, and other appropriate resources to increase the mental health and wellbeing literacy of detainees.	Number and type of resources developed.	MHACT (Forensic), Corrections Health
		3.8.4: Develop and implement psycho education programs to increase individual mental health literacy, knowledge, skills and resilience.	Number and type of programs developed and implemented. Number of participants. Feedback on participants on usefulness of programs.	MHACT (Forensic), Corrections Health, in consultation with OCYFS
		3.8.5: Where appropriate, link young people in the youth justice system with mental health and drug and alcohol and other drug support services in the community.	Number of agencies delivering programs in Bimberi Youth Justice Centre	OCYFS, MHACT, Ted Noffs Foundation; Gugan Gulwin Aboriginal Service.

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Outcome	Strategies	Actions	Outputs	Agencies responsible
3.9: Increase supports for people identified as 'at risk', who are transitioning between services.	• Develop procedures and protocols for the follow-up of individuals identified with a mental health disorder or problematic use of alcohol and other drugs on their exiting AMC and Bimberi. • Provide follow-up for all residents exiting AMC and Bimberi Youth Justice Centre. • Public Advocate ACT engaged in the provision of forensic advocacy services at the AMC. • Provide disability awareness training to all new operations staff at AMC and Bimberi Youth Justice Centre. • Support operations staff at AMC and Bimberi Youth Justice Centre to meet the needs of individuals with a disability. • Provide Indigenous Cross-Cultural training to all new operations staff at AMC and Bimberi Youth Justice Centre	**3.9.1:** Individuals assessed as having mental health problem requiring ongoing care by a tertiary MH service will be provided a recovery plan during their stay and upon exiting the facility.	100 per cent of individuals assessed as requiring ongoing care by a tertiary MH service will be provided a recovery plan during their stay and upon exiting the facility.	MHACT (Forensic), Corrections Health, ACT Corrective Services, Public Advocate.
		3.9.2: Individuals requiring medication as part of their recovery plan will be supplied with a script for their medication upon exiting the facility.	100 per cent of Individuals requiring medication as part of their recovery plan will be supplied with a script for their medication upon exiting the facility.	MHACT (Forensic), Corrections Health.
		3.9.3: Develop protocols and referral pathways to ensure follow-up of all individuals exiting AMC and Bimberi Youth Justice Centre.	100 per cent of released/discharged individuals clinically managed by MHACT Forensics received follow-up from MHACT within 7 days of release/ discharge.	MHACT (Forensics)
		3.9.4: Public Advocate undertakes regularly visits to AMC and is involved in through-care and discharge planning for forensic prisoners.	Number of visits undertaken and number of prisoners where the PA ACT has been involved in through-care and discharge planning processes.	Public Advocate
		3.9.5: All new operations staff at both AMC and Bimberi Youth Justice Centre receive *Disability Awareness Training*.	Number of operations staff trained. Feedback from training.	DHCS-ITAS
		3.9.6: Provide ongoing training and support to operations staff at AMC and Bimberi Youth Justice Centre to meet the individual needs of detainees with a disability.	Number of individual clients supported. Number of contact hours.	DHCS-ITAS
		3.9.7: Provide cultural education for all operational staff upon entry to ACTCS and Bimberi Youth Justice Centre.	Number of operations staff trained. Feedback from training.	JACS, OCYFS
		3.9.8: Provide training on Indigenous awareness and cross cultural awareness to operations staff upon entry to ACTCS and Bimberi Youth Justice Centre.	Number of courses held. Number of operations staff trained.	JACS, OCFYS

Refugees and immigrants who are detained or have experienced detention in immigration facilities or detention camps.

Rationale: For refugees and immigrants who have been detained, the decision to immigrate is often made hastily and in response to fear and need for survival. Traumatic experiences, such as human rights abuses, living in a war zone and facing mandatory detention affect mental health and wellbeing.

Over the past decade, there has been an increasing research focus on the consequences of the forced detention of immigrants and refugees. Particular attention has focused on the effects of mandatory detention on children.

The Australian Psychological Society's submission to the National Inquiry into Children in Immigration Detention maintained that:

Holding young people in immigration detention is a negative socialisation experience, accentuates developmental risks, threatens the bonds between children and significant caregivers, and limits educational opportunities. In addition, the detention experience has traumatic psychological impacts, reduces the potential to recover from pre-migration trauma, and exacerbates the impacts of other traumas.[78]

Intervention to support detainees should ensure equitable access to a full range of health, social care and legal services[79] and should integrate mental health treatment with rehabilitation including language training and cultural orientation, teaching of living skills such as banking, and training for employment.[80]

Education of those involved in caring for detainees and those released from detention, including non-health staff is also necessary. Relevant training should include an understanding of specific cultural needs and an understanding of how exposure to trauma affects health and mental health.[81]

Evidence

Research examining the mental health of refugees in immigration detention has shown the significant negative effects;[82]

Length of stay in detention centres has been found to increase referrals for mental illness;[83]

An Australian study investigating the mental health of parents and children who had been held in Australian immigration detention centres for approximately two years found that all detainees met the DSM-IV diagnostic criteria for at least one current mental illness;[84]

A recent Australian study of refugees released from detention in Australia found that 52 per cent were diagnosed with a current PTSD, 60 per cent were experiencing a current major depressive episode and 44 per cent were experiencing comorbid PTSD and a major depressive episode;[85] and

Many ex-detainees continue to use antidepressants and tranquilisers at high levels years after being released from detention.[86]

Outcome	Strategies	Actions	Outputs	Agencies responsible
3.10: People who have a mental illness and have been cared for in closed settings receive services that comply with human rights legislation.	Provide contemporary and informed advice to government agencies on legislation, policies, practices and services that affect people with a mental illness who have received care in closed settings.	**3.10.1:** Make recommendations to government agencies on legislation, policies, practices and services that affect people with a mental illness.	Number of recommendations made. Outcomes of recommendations made.	Human Rights ACT Commission; Health; ACT Corrective Services
3.11: Human Rights Commission - Resolution of complaints from people with a mental illness who have been cared for in closed settings.	Maintain a high level profile within closed care settings regarding complaints handling role.	**3.11.1:** Address complaints from people with a mental illness who have received care in closed settings.	Number of complaints resolved.	Human Rights ACT Commission; Health; ACT Corrective Services

Action Area 4: Enhance the social equities and reduce the social inequities that influence mental health and wellbeing

Building A Strong Foundation will focus on three social determinants of health that influence mental health and wellbeing:

— Enhance social inclusion;

— Enhance access to economic resources; and

— Reduce violence and discrimination.

Enhance social inclusion

Rationale: Social inclusion refers to the level to which individuals have access to supportive relationships, involvement in group activities and are engaged with their community.[20]

Individuals experiencing social exclusion often find it more difficult to connect with others, struggle to share in many activities those who feel more connected participate in, and may find it more difficult to complete their education or participate in ongoing life learning. These difficulties may be compounded for people who have had or currently have a mental illness.

There is strong empirical support to indicate that increasing individual access to social resources and enhancing community engagement can reduce or eliminate mental health problems.[87]

Social inclusion can be enhanced in many settings, including within the general community, in educational institutions and in workplaces.

Evidence

- Participation in education is a key means of reducing the risk of social exclusion and poverty;[88]
- People from lower socio-economic backgrounds are more likely to leave school early, have lower rates of literacy and numeracy and are less likely to continue on to higher education;[89]
- Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health. Supportive relationships may also encourage healthier behaviour patterns;[25]
- Young people reporting poor social connectedness (that is, having no-one to talk to, no-one to trust, no-one to depend on, and no-one who knows them well) are between two and three times more likely to experience depressive symptoms compared with peers who report the availability of more confiding relationships;[90]
- Social networks and social ties have a beneficial effect on mental health outcomes, including stress reactions, psychological wellbeing, and symptoms of psychological distress including depression and anxiety;[91] and
- The amount of emotional and practical social support people receive varies by social and economic status. Poverty can contribute to social exclusion and isolation. People who receive less social and emotional support are more likely to experience depression.

Outcome	Strategies	Actions	Outputs	Agencies responsible
4.1: Increased social connectedness for all Canberrans.	• Contribute to and develop policies and strategies to increase social inclusion, connection and economic participation such as the *Canberra Social Plan, the Crime Prevention Plan*, the *ACT Homelessness Plan* and the *Justice, Options and Prevention Framework*.	**4.1.1:** Implement social inclusion strategies to increase community mental health and wellbeing in relevant Canberra services plans.	Number of plans implementing strategies to enhance mental health and wellbeing.	All ACT Government Departments
4.2: Improved mental health literacy in services and agencies working with people experiencing social disadvantage and other 'at risk' population groups.	• Provide training in mental health literacy for those working with 'at risk' population groups.	**4.2.1**: Increase availability of training on mental health literacy specific to CALD, Aboriginal and Torres Strait Islander communities and those experiencing problematic use of alcohol and other drugs.	Number and type of training opportunities provided for those working with 'at risk' population groups. Number of participants attending training opportunities.	MHACT, MIEACT, Transcultural Mental Health Network, ACT Health, Winnunga-Nimityjah Aboriginal Health Service, Directions ACT, Alcohol and Drug Sector, eg Toora.
4.3: Reduce the incidence of young people with an emerging mental illness becoming socially isolated.	• Implement programs to increase social connection and participation for people with an emerging or identified mental illness.	**4.3.1:** Implement strategies to encourage young people to remain at school.	Number of young people participating in programs.	DET, Belconnen Community Services, Catholic Care, other community organisations
		4.3.2: Deliver community based arts and leisure programs.	Number of individuals participating in creative/ expressive resilience building activities.	Belconnen Community Service
4.4: People recovering from an episode of mental illness are able to more easily remain engaged or reengage with the community.	• Provide support to people recovering from an episode of illness to enable them to remain engaged or reengage with the community and community based rehabilitation services.	**4.4.1**: Provide activities such as daily living skills training and access to arts and leisure programs to people affected by mental illness.	Improved mental health and wellbeing, measured via the *Living Skills Profile*.	MHACT Richmond Fellowship, Belconnen Community Services. Other Community organisations

Enhance access to economic resources

Rationale: Lack of access to economic resources can impact all aspects of life. It may limit one's access to material and psychosocial resources, including education, employment, housing and health care. Lack of access to these resources can create and perpetuate a cycle of poverty. For example, children of parents with limited economic resources often find it harder to participate in all aspects of school life, can feel socially isolated, may not reach the same levels of educational attainment as their more financially secure peers and may find themselves employed in lower renumerated jobs.[92] Similarly, those with a chronic illness who do not have the financial resources to access timely and adequate health care may face further financial hardship due to their deteriorating health. A recent ACT Health project ***Better General Health for People with a Mental Illness*** found that simply linking mental health consumers who had a severe or enduring mental illness with a regular General Practitioner significantly improved both their physical and mental health.[93]

The type of employment people are engaged in can also influence their mental health and wellbeing. Work stress, defined as 'the combination of high job demands and low job control'[94] is predictive of poor physical and mental health. Poor mental health in the workplace is connected to aggression, bullying and workplace violence, precarious work circumstances, job insecurity, long working hours and increased absenteeism.[25]

There is growing interest in workplace health and wellbeing programs to improve employee and organisational health.

Evidence

- Adverse social conditions, including having limited economic resources and/or being unemployed are related to poorer mental health;[95]
- People with lower education levels, perceived low-status occupations and low incomes have relatively poorer mental health than their more affluent counterparts;[55]
- Unemployed people generally experience higher levels of depression, anxiety and distress, as well as lower self-esteem and confidence than employed people;
- Work-related mental health problems are more pronounced in individuals working long hours (greater than 10 hours per day at least once per month), those whose work does not fit family commitments and those who are dissatisfied with their job.[96] and
- More than 10 per cent of Canberra's children still live in poverty, suffer abuse or are unable to access the services they need.[97]

Outcome	Strategies	Actions	Outputs	Agencies responsible
4.5: Improved access to sustainable and affordable accommodation for people with a mental illness who have experienced or are at risk of homelessness.	• Develop and implement housing and support programs that enable people with moderate to severe mental illness and complex needs who have high levels of mental disability to maximise their participation in the community and sustain successful tenancies. • Increase awareness of mental health and wellbeing issues and reduce stigma associated with mental illness amongst Housing ACT Communities. • Reduce primary homelessness.	**4.5.1:** Develop service protocols between MHACT and Housing ACT to determine support and tenancy management models to enable HASI.	Number of registered HASI clients. Number of HASI clients sustaining their tenancy while receiving intensive support. Number of HASI clients sustaining their tenancy as they transition from intensive support to lower level support. Number of unplanned admission days. Total number of mental health support hours provided to clients in the period. Number of HASI clients exiting program. Number of Housing ACT managers participating in clinical coordination meetings.	ACT Health Policy Division, MHACT, Housing ACT. Community Sector Mental Health Support Agencies
		4.5.2: Housing ACT and MHACT support people with a mental illness to maintain their tenancy.	Number of HASI clients who maintain their tenancy.	Housing ACT
		4.5.3: Provide mental health literacy education sessions to Housing ACT communities.	Number of education sessions provided. Number of Housing ACT tenants participating. Feedback on usefulness of education from tenants and Housing ACT.	Housing ACT, MHACT
		4.5.4: Implement the Street to Home initiative to provide intensive community outreach to assist people experiencing chronic homelessness to maintain their housing.	Number of tenants supported to maintain tenancies.	Housing ACT
		4.5.5: MHACT develops and implements protocols to provide mental health services to rough sleepers.	Protocol developed and implemented. Number rough sleepers receiving services. Type and frequency of services received by rough sleepers.	MHACT
4.6: Improved participation in education and employment for people with a mental illness.	• Support participation of people with mental illness to enter or remain engaged in education and gain or maintain employment.	**4.6.1:** Through Northside Contractors and Café Pazzini provide paid work experience for adults affected by mental illness.	Improved mental health and wellbeing, knowledge, skills and confidence to manage future crisis through increased awareness of, and capacity to access, ongoing education, community resources and support networks, measured via the Living Skills Profile.	Mental Illness Fellowship of the ACT
		4.6.2: Through a scholarships scheme, provide funding to support consumers complete approved mental health courses which enhance their capability to seek employment in the mental health sector.	Number of consumers supported. Number of courses completed.	ACT Health Policy Division.
		4.6.3: Establish a pilot of an Individual Placement and Support program to enhance employment opportunities for mental health consumers.	Number of consumers engaged in ongoing competitive employment.	MHACT, relevant employment providers

Reduce violence and discrimination

Rationale

There are strong links between violence, discrimination and mental health and wellbeing. Violence and discrimination often co-occur, for instance physical violence is often associated with school yard bullying. Violence and discrimination can have negative effects on an individuals' sense of connection with others and their ability to participate in social activities. For example, children who experience bullying may have a limited friendship circle, their experience of school may be negative. This may lead them to drop out of school, which in turn will affect their employment opportunities.

Evidence

- Women are more likely than men to be the victims of sexual assault and intimate partner violence;[98]
- The 2005 Personal Safety Survey, a rigorous national study based on face-to-face interviews with over 17,000 Australians, found that:
  - In the twelve months prior to the survey, 6 per cent of women and 11 per cent of men experienced violence;
  - One in three women had experienced physical violence since the age of 15;
  - Nearly one in five women had experienced sexual violence since the age of 15;
  - 16 per cent of women had experienced violence by a current or previous partner since the age of 15;[99] and
  - 4 per cent of women experiencing violence by a current partner and 9 per cent by a former partner report that the violence was witnessed by children in their care;[92]
- Exposing children to violence increases their risk of mental health, behavioural and learning difficulties in the short term, increases their risk of developing mental health problems later in life and, in the case of boys, increases the likelihood of them perpetrating violence as adults;[100 101 102]
- Aboriginal and Torres Strait Islander women, are significantly more likely than other women to be the victims of violence;[103]
- Women who have been exposed to violence report poorer physical health, are more likely to engage in behaviour harmful to their health, have a greater risk of developing a range of health problems, including stress, anxiety, depression, pain syndromes, phobias, and somatic and medical symptoms;[92]
- Racial discrimination has been found to be associated with a poorer sense of wellbeing, lower self-esteem and sense of control or mastery, psychological distress, major depression, anxiety disorders and other mental illnesses;[104 105 106]
- People from culturally and linguistically diverse backgrounds have similar rates of mental illness to the general population, however they access services at significantly lower rates. People of culturally and linguistically diverse background usually present later in the course of their illness when they are more unwell;[107]
- There were 219 hospital separations for ACT Aboriginal and Torres Strait Islander peoples experiencing mental health problems and behavioural disorders between July 2000 and June 2005;[108] and
- It is hypothesised that discrimination also influences suicidality in some population groups. Suicide rates are significantly higher among Aboriginal and Torres Strait Islander109 and same sex attracted young people110 compared to the Australian population.

Outcome	Strategies	Actions	Outputs	Agencies responsible
4.7: Improving residents' actual and perceived sense of safety and security in their homes	• Provide information on home safety and assist vulnerable and at risk residents to improve the security and safety of their homes. • Women and children who are victims of domestic violence are able to maintain their Housing ACT tenancy.	**4.7.1:** Continue delivery of the ACT home safety program to assist residents to improve the security of their homes while endeavouring to minimise other preventable risks such as fire or injury caused by falls.	Number of information packs sent to residents. Number of 'at risk' and vulnerable persons assisted to undertake a home safety audit to improve safety in their homes.	SupportLink, ACT Policing, ACT Ambulance, ACT Fire Brigade, ACT State Emergency Service and the ACT Department of Justice and Community Safety
		4.7.2: In partnership with DVCS, Housing ACT enables women and children who are victims of domestic violence to retain the housing by removing the perpetrator from the lease where a final Domestic Violence Order is in place.	Number of tenancies maintained for women and children who are victims of domestic violence.	Housing ACT, DVCS
4.8: Improved processes and support for victims of sexual assault in the criminal justice system through the Sexual Assault Reform Program (SARP).	• Provide a multi-agency response to enhance the investigation, prosecution and support for victims of sexual assault as they progress through the criminal justice system.	**4.8.1:** Implement the package of SARP reforms.	Satisfaction of victims of sexual assault with criminal justice agencies. Participation rates of victims of sexual offences in justice processes. Increased proportion of reported sexual offences being charged and prosecuted. Number of victims of sexual offences accessing recovery services.	Courts, ACT Policing, DPP, Victim Support ACT, Victims of Crime Coordinator, Canberra Rape Crisis Centre Forensic and Medical Sexual Assault Centre, Child At Risk Assessment Unit, DHCS, Law Society, Legal Aid Commission, the ACT Bar Association and JACS.
4.9: Victims of crime receive individualised care and support to prevent the development of mental health problems subsequent to experiencing crime.	• Develop individualised care plans for victims of crime.	**4.9.1:** Conduct a comprehensive assessment and develop a care plan for clients presenting after experiencing trauma.	Number of assessments undertaken. Number of care plans developed.	VCS, Government health agencies Approved Providers
4.10: Victim Support ACT will provide recovery from the social inequality suffered because of crime.	• Access to information and services which allow victims of crime to take part in the social, economic and cultural life of their community.	**4.10.1:** Assess the needs and provide referrals to redress social inequality of victims of crime.	Victims of crime are more connected and integrated into their community.	VCS, Government health agencies Approved Providers
		4.10.2: Refer assessed clients to appropriate agencies and services to address mental health and wellbeing issues.	Number of establish contacts between client and agency.	VCS, Government health agencies Approved Providers
		4.10.3: Investigate means of providing training to MHACT staff about issues facing adult survivors of child sexual abuse and the impacts on mental health and wellbeing.	Number of training sessions provided. Number of people attending training sessions.	MHACT.

Outcome	Strategies	Actions	Outputs	Agencies responsible
4.11: Human Rights Commission - Resolution of complaints from people with a mental illness who have been subject to discrimination.	Maintain high level profile within the ACT re complaints handling role.	**4.11.1:** Receive complaints from people with a mental illness who have been subject to discrimination.	Number of complaints resolved.	Government and non-government sector
4.12: Aboriginal and Torres Strait Islander peoples have access to promotion, prevention and early intervention resources in a range of suitable formats.	Support the implementation of the social and emotional wellbeing and PPEI aspects of the ***ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011***. Develop strategies to promote the health and wellbeing services available to Aboriginal and Torres Strait Islander peoples. Increase sense of social and emotional wellbeing for Aboriginal and Torres Strait Islander youth.	**4.12.1:** Provide a Corrections Outreach Service to the AMC, which will provide medical care to Aboriginal and Torres Strait Islander peoples in custody.	Number of clients seen by correction facility Number of Aboriginal and/or Torres Strait Islander people seen by correction facility. Total number of clients seen.	Winnunga Nimmityjah Aboriginal Health Service
		4.12.2: Through the ***Social and Emotional Health Team***, provide case management to support the social and emotional needs of Aboriginal and Torres Strait Islander clients.	Number of Aboriginal and Torres Strait Islander people clinically managed case. Number of hours of case management provided.	Winnunga Nimmityjah Aboriginal Health Service
		4.12.3: Provide case management to support young Aboriginal and Torres Strait Islander peoples experiencing mental health problems to meet a range of wellbeing needs, including education, housing and employment.	Mental disorders diagnosed by doctors. Number of clients seen by the social health team. Occasions of service by social health team.	Winnunga Nimmityjah Aboriginal Health Service
		4.12.4: ***Bringing Them Home*** counsellors provide support to clients and descendants of Aboriginal and Torres Strait Islander peoples from the Stolen Generation who have experienced social and emotional displacement.	Number of Aboriginal and Torres Strait Islander people supported. Number of hours of support provided.	Winnunga Nimmityjah Aboriginal Health Service
		4.12.5: Create and maintain an Aboriginal and Torres Strait Islander peoples web page on the ACT Health Internet to promote the health and wellbeing services available to this community.	Number of hits to the web page. Feedback on web page.	ACT Health Aboriginal and Torres Strait Islander Health Unit
		4.12.6: Through the ***Dual Diagnosis*** Program provide culturally appropriate interventions to Aboriginal and Torres Strait Islander peoples experiencing comorbid mental health and alcohol and other drug problems.	Number of clients with a dual diagnosis supported. Occasions of service by social health team for dual diagnosis. Total number of clients seen by social health team for dual diagnosis.	Winnunga Nimmityjah Aboriginal Health Service
		4.12.7: Through the ***Shadow Men's Support Group***, provide a supportive contact point for gay, transgender and/or bisexual Aboriginal and Torres Strait Islander men	Number of monthly forum's held. Number of participants attending forums. Number and type of additional activities hosted.	Canberra Men's Centre.

		4.12.8: Create a youth outreach network to support early diagnosis, treatment and advice to at-risk young Aboriginal and Torres Strait Islander peoples.	Design and implement program by 2011. Number of additional health professionals (including drug/ alcohol/mental health/outreach teams) recruited and operational. Number of identified patients accessing the network.	ACT Health in partnership ATSIHF
		4.12.9: Consider and address the principles of mental health promotion, prevention and early intervention in developing the model of care for the *Aboriginal and Torres Strait Islander Rehabilitation Service*.	Demonstrate how the principles of promotion, prevention and early intervention are embedded within the model of care by June 2010.	ACT Health Aboriginal and Torres Strait Islander Health Unit
		4.12.10: Implement the model of care for the *Aboriginal and Torres Strait Islander Rehabilitation Service*, including strategies to address mental health promotion, prevention and early intervention.	Report against national social and emotional wellbeing indicators.	ACT Health Aboriginal and Torres Strait Islander Health Unit
4.13: Increased mental health and wellbeing literacy, reduced stigma of mental illness, and increased capacity of people from culturally and linguistically diverse communities to maintain and support better health and wellbeing.	• MHACT, in partnership with the ACT Transcultural Mental Health Network continues to participate in the Multicultural Festival and Mental Health Week activities. • Increase access to mental health promotion and stigma reduction programs for people of culturally and linguistically diverse backgrounds.	**4.13.1:** Provide information about mental health literacy and culturally appropriate mental health services.	Number of people from CALD backgrounds who receive information about mental health literacy and cultural appropriate mental health services.	MHACT, Transcultural Mental Health Network

Outcome	Strategies	Actions	Outputs	Agencies responsible
4.14: Culturally diverse groups have access to promotion, prevention and early intervention resources in a range of suitable formats and languages.	• Increase access to mental health promotion, prevention and early intervention resources for people of culturally and linguistically diverse backgrounds. • Consumers and carers accessing MHACT services receive assessment and treatment that is sensitive to their social and cultural beliefs, values and practices.	**4.14.1:** Review and identify gaps in availability and access to resources regarding the promotion of mental health and the prevention and early intervention for mental health problems for various cultural groups.	Report to Promotion, Prevention and Early Intervention Implementation and Evaluation Working Group from Transcultural Mental Health Network by December 2010.	ACT Health
		4.14.2: MHACT clinicians provide written information to consumers, carers and families in their own language when appropriate and if available. MHACT clinicians will engage the services of a translator from the ACT Migrant Health Unit Interpreter Service or the Translating and Interpreter Service during service provision when necessary.	Number of interpreter services required. Number of interpreter services utilised.	MHACT
		4.14.3: As part of a social marketing campaign integrating mental and physical health promotion, develop materials and implement a campaign targeting at risk groups including those who have experienced violence and discrimination, culturally and linguistically diverse populations and Aboriginal and Torres Strait Islander peoples.	Number and range of materials developed, and delivered. Number and type of resources distributed.	ACT Health

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6. Governance, implementation and evaluation of Building a Strong Foundation

The implementation of *Building A Strong Foundation* will be monitored and evaluated through the oversight of the Promotion, Prevention and Early Intervention Implementation and Evaluation Group (PPEIIEG), a group comprised of both community and government representatives.

The PPEIIEG will have responsibility for coordinating the implementation and monitoring of actions identified in *Building A Strong Foundation*, and will report to the Strategic Oversight Group of the ACT MHSP.

As the *Building A Strong Foundation* and *Managing the Risk of Suicide* documents are sub-plans under the ACT MHSP, the Oversight Group monitoring the implementation of the ACT MHSP will have the means to ensure that both *Building A Strong Foundation* and *Managing the Risk of Suicide* are fulfilling the objectives of the ACT MHSP and remain aligned with the overall vision.

6.1 Evaluation of the Action Areas and implementation Plan

Measuring the outcomes of the strategies and activities used to meet the goals identified in *Building A Strong Foundation* will not be straightforward for a number of reasons:

1. Change in patterns of mental health and wellbeing will occur over the long-term. Therefore, a comprehensive longitudinal evaluation design is necessary to capture change over an extended period. This will need to include the collection of pre- and post-intervention data on factors that may influence mental health and wellbeing.
2. It is not possible to attribute any observed change is a direct result of activities initiated under *Building A Strong Foundation*. This is because there are often confounding factors that cannot be controlled for when trying to measure the specific influence(s) of intervention activities on mental health and wellbeing.
3. Those working in the field of mental health promotion, prevention and early intervention already face significant reporting requirements. Therefore, every effort will be made to identify data measures that are already collected and reported. This will include, but not be limited to:
   - The Australia Bureau of Statistics National Survey of Mental Health and Wellbeing, which collects national data on a range of issues relating to mental health and wellbeing;
   - The ACT General Health Questionnaire, which collects Territory level data about a range of health issues, including psychological wellbeing and distress;
   - Information from the ACT Mental Health *Mental Health Assessment Generation and Information Collection* system (MHAGIC) data base; and
   - Specific data concerning the outcome(s) of programs and activities undertaken by ACT Government Departments and community service providers identified in the Action Areas and Implementation Plan, collected on a six monthly basis by ACT Health through a specifically designed survey distributed to relevant services and service providers. Data collected will be collated and reported to the Oversight Group six monthly.

A report summarising this data will be tabled in the Legislative Assembly annually.

A mid-term progress report providing a detailed analysis of progress in implementing *Building A Strong Foundation* to 30 June 2011 will be completed in the second half of 2011. This report will identify alterations and additions as necessary, including new and modified programs that have been implemented or are envisaged which reflect the fluid funding environment and the changing needs of the community.

7. Future directions

Through the ACT MHSP, its sub-plans and other related policies and strategic documents, ACT Health has embarked on an ambitious challenge towards a fully coordinated, accessible and quality service system. While there is some overlap across documents, ACT Health emphasised collaboration and many documents overlap in their objectives due to the inevitable complexity of an individual's health and wellbeing.

ACT Health asserts that some documents have an overarching strategic role, such as the *ACT MHSP*, whilst others are more detailed and provide the operational aspects of achieving the overall objective. To ensure coordination and efficiency of effort is maximised across the frameworks, the table below offers evidence of the awareness of how *Building A Strong Foundation* relates to other key policy documents either currently in implementation or in development. Through this awareness, the development of *Building A Strong Foundation* has considered other activity in the sector and will consequently avoid duplication and utilise any advantage of related activity through other plans.

The responsibility for ensuring that efficiency of cooperation exists between plans lies within the jurisdiction of the PPEIIEG during the implementation of *Building A Strong Foundation*. For example, Managing the Risk of Suicide prescribes the need for suicide awareness training across the community and Government. *Building A Strong Foundation* outlines the need for mental health training to community agencies. It is very reasonable to combine these activities towards the benefit of both objectives and develop a universal tool set that could be used in other care areas, such as alcohol and other drug services or comorbidity services (coexisting AOD and mental illness).

Building A Strong Foundation aims to emphasise the role that sectors other than health have in the promotion of mental health and wellbeing and the prevention of mental illness. Strategies and actions have been outlined and targeted to the relevant Departments of Education and Training; Housing, Disability and Community Services and Justice and Community Safety to promote the mental health of the community and prevent mental illness.

It is ACT Health's vision that, at the expiry of *Building A Strong Foundation* and *Managing the Risk of Suicide*, the subsequent Framework will combine the areas of mental health promotion and prevention and suicide prevention into one overarching Framework. With support from the Chief Minister, all ACT Government Departments and the community sector, a strong, integrated, whole of government/whole of community framework will continue the investment in mental health promotion, prevention and early intervention into the next decade.

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Plans and Strategies	ref no.	Objectives/Action items
Mental Health Services Plan 2009-2014	7.1.2	In conjunction with ACT Health, develop a framework for provision of ACT Government funded services in the community (including a services outcomes evaluation framework). Implement strategies for reinforcing and building capacity in the sector.
	7.1.3	Explore new models of participation and consumer led services under the new *Four Life* Stages model of care. Develop options for increasing capacity for individual and group based consumer and carer input. Review and modify the consumer and carer participation framework as appropriate to emerging evidence based practice and priority.
	7.1.4	Using a recovery promoting approach, work with consumers, carers and services to implement care coordination.
	7.1.5	Establish systems that ensure coordination and integration of services provided by different elements of the mental health services sector, and also between the sector and other Government providers.
	7.1.6	Develop and implement a comprehensive workforce strategy and action plan for the mental health sector to 2020 that links with other strategies in development and initiatives, considers the needs of consumer and carer workforce and promotes the development of innovative care initiatives, collaborative activity, and training/professional opportunities.
	7.2.1	Develop strategies for extension of the community sector in alignment with the four-stream care model. Fund the community sector according to the agreed alignment strategy.
	7.2.2	Develop a business case for an Access and Information Service.
	7.2.3	Develop extensions to the ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention (PPEI) and the Suicide Prevention Plan that take into account ongoing development of: • Consumer and carer participation; • Processes that support a strengthened community sector role in mental health promotion and prevention; • Enhanced linkages with the primary care sector and whole of community participation. Launch 2009-14 extensions of ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention (PPEI) and the Suicide Prevention Plan. Explore opportunities to expand Promotion Prevention and Early Intervention (PPEI) activities in the area of infant mental health in the context of the new child mental health service stream of the four stage life model. Explore opportunities for linkages with the Women's and Children's Hospital, particularly in the areas of mental health promotion and early intervention.
	7.2.4	Extend Crisis Assessment services including MH assessment units in Emergency Departments and explore home based options for care.
	7.2.5	Extend services for youth including a step up/step down service and dedicated inpatient unit that is physically distinct from the adult inpatient unit, have a specific focus on early intervention and recovery, and be integrated with primary care and community service providers.
	7.2.6	Extend services for adults including step up/step down places, new acute inpatient unit, new secure unit and development of ACT wide integrated Comorbidity Strategy.
	7.2.7	Extend services for older people that links with residential aged care facilities and implement an enhanced service model to support the care of older people with mental health problems.
	7.2.8	Develop a Strategy and Action Plan for the planning of rehabilitation and recovery support programs: • Ensure current programs offered by government and community sectors are complementary and comprehensive; • Identify gaps in current services and ensure these gaps are addressed in the development of rehabilitation and recovery support programs; • Develop the range of evidence based prevocational and vocational rehabilitation and education and employment support options as key factors that support and maintain a person's recovery.
	7.2.9	Extend the mental health system to address identified gaps in services to special needs groups.
	7.3.2	Review and update frameworks to support and enhance the involvement of consumers and carers in planning their own recovery and in planning service delivery. Investigate models of consumer-led services and prioritise actions to achieve the establishment of consumer led and directed services.

Plans and Strategies	ref no.	Objectives/Action items
Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009-2014	ALL	Suicide Prevention logically exists under the umbrella of mental health promotion, prevention and early intervention. It was recommended by the Suicide Prevention Working Group that a suicide prevention specific plan continue to be separated from the main mental health PPEI Framework to better establish a more solid foundation in suicide prevention skill and capacity across the sector. It is envisaged that at the end of the term of both the suicide prevention and PPEI Frameworks, that one combined document will draw all aspects of mental health PPEI together within an integrated whole of government and whole of community framework. In the interim, ACT Health will ensure that there is close collaboration during the implementation of both *Building a Strong Foundation* and Managing the Risk of Suicide to maximise efficiency of effort, resources and outcomes.

Plans and Strategies	ref no.	Objectives/Action items
ACT Chronic Disease Strategy 2008-2011	1.1	Promote and support the development of: • Affordable housing initiatives; • Well-planned, safe recreational and social spaces in local communities; • Accessible transport options; and • Early Childhood Schools and services.
	1.3	Develop and implement processes to ensure that current services provided through Maternal and Child Health (MACH) and Midwifery programs provide health promotion messages and support to take up those messages.
	1.4	Work with the community, general practice, community pharmacies and non-government organisations to consolidate and coordinate current health promotion messages and to ensure that messages are reaching a broad target audience, including people with a disability, their families and carers.
	2.1	In collaboration with relevant partners: • Develop a program to encourage the use of the MBS Aboriginal and Torres Strait Islander Child and Adult Health Check in the ACT; and • Support and encourage general practice to identify clients of Aboriginal and Torres Strait Islander background and offer health checks.
	3.2	Develop and promote the use of shared care guidelines and protocols for the management of people living with a chronic disease or with a number of chronic diseases.
	3.6	Develop and implement appropriate discharge planning and protocols, in line with the ACT Health Discharge Planning Policy, for people living with a chronic disease to ensure that care is integrated between acute and community settings.
	4.1	Review education, self-help, self-management and rehabilitation programs for people living with a chronic disease or at risk of developing a chronic disease in order to: • Produce a services directory; • Identify gaps, access and coordination issues, including issues around cultural accessibility; and • Identify options to enhance existing programs and to implement new ones.
	4.3	Implement the web-based tool being developed by Health Improvement Branch to provide self-management support to appropriate groups within the ACT community. This tool could also provide information and referral assistance to health professionals.

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Plans and Strategies	ref no.	Objectives/Action items
A New Way: The ACT Aboriginal & Torres Strait Islander Health & Family Wellbeing Plan 2006–2011	1.	Strengthen support services for families at risk, and improve coordination of services across government and the community .
	2.	Strengthen family-focused health promotion and early intervention programs.
	3.	Increase the scope of maternal and child health services according to identified need.
	4.	Strengthen maternal and child health promotion programs.
	5.	Conduct local research into social determinants contributing to chronic and infectious diseases, to identify areas of unmet need.
	7.	Strengthen health promotion and early detection programs targeted at chronic disease.
	8.	Conduct local research to identify unmet need in social health services.
	9.	Negotiate partnership agreements between Aboriginal and mainstream social health service providers.
	10.	Develop a culturally appropriate model for mental health screening and assessment.
	11.	Establish a drug and alcohol rehabilitation centre (bush healing farm).
	14.	Develop a partnership agreement between ACT Health and Winnunga Nimmityjah.
	15.	Develop partnerships between Winnunga Nimmityjah and other health providers, to promote joint activity in the areas of: Family support, Case management and Continuity of care.
	16.	Investigate ways to improve geographic access to health and wellbeing services across Canberra.
	19.	Develop and implement an Aboriginal Health Workforce Plan for the ACT.
	21.	Develop a process for evaluating, monitoring and reporting on health needs in a family and wellbeing context.
	22.	Conduct evaluations of need and identify emerging issues.
	26.	Review the provision of health services to Aboriginal and Torres Strait Islander people in custody, to account for the new ACT Prison (to be operational in 2007–08).
	27 & 28	Provide cultural awareness training for ACT Health staff and facilitate cultural awareness training for GPs and ACT Ambulance service staff.
	29.	Educate the Aboriginal and Torres Strait Islander community about health and wellbeing services available to them.
	30 & 31	Facilitate Aboriginal health service work-experience for mainstream health workers and develop and implement and Aboriginal employment strategy for mainstream health services.
	35.	Develop a mechanism for collaboration and coordination between ACT Health and relevant health-related government agencies, including: Justice- Housing- Disability- Ambulance Services- Children, Youth and Family Services – Education.
	36.	Establish a cross-government action team to develop and monitor health and wellbeing projects involving other government agencies.
	37.	Establish a Health & Wellbeing Alliance with representatives from organisations involved in Aboriginal wellbeing.
	41-43	Prepare and promote a statement to the health-related sector on holistic health and the roles and responsibilities of Aboriginal Health Workers. Facilitate cultural awareness training for staff in the health related sector. Support eh health related sector in developing an appropriately skilled and resourced workforce.

Plans and Strategies	ref no.	Objectives/Action items
Children's and Young People's Justice Health Services Plan 2008-2012	4.3.2	Upon entry to Bimberi the child or young person will: • Receive a comprehensive health assessment. This will incorporate: Mental health; Health risk and harm minimisation; Drug and alcohol management/withdrawal; Neurological chart/withdrawal monitoring form; Drug and alcohol follow up; Suicide risk assessment; Reception risk assessment; Authority to obtain information; and Medication. • The assessment will also look at other health determinants for the child or young person including: social/emotional health screens; family history; parenting support; living skills; educational background; substance abuse; employment; and Financial issues. Where mental health issues are identified or the potential for self-harm are identified appropriate steps for the care of the child or young person should be made. A CAMHS Mental Health Induction Officer will undertake a thorough mental health assessment as soon as practical after arrival at the youth detention centre.
	4.3.2	Protocols will be developed between ACT Health and the Office for Children, Youth and Family Support to allow for the sharing of information between agencies subject to the *Human Rights Act, 2004*; the *Children and Young People Act 1999, the Health Records (Privacy and Access) Act 1997* and ACT Health policies.
	4.3.7	The Drug and Alcohol service within Quamby and Bimberi, recognising that drug and alcohol addiction is a health issue, will be tailored towards harm minimisation, demand reduction and effective clinical management for substance misusers. The service will aim to reduce the demand for illicit drugs and move the residents away from the harmful effects of illicit drug use. The service will adopt the following principles: • Harm minimisation through health promotion. It is imperative that the harms associated with continuing use, whether in detention or upon release into the community, be reduced where possible. Efforts must be made to ensure that the child or young person has access to age appropriate information regarding illicit drug use and related harms. • Drug and Alcohol counseling – Drug and Alcohol counseling is seen as an important tool in the rehabilitation of the child or young person and will continue to be one of the tools used to effectively manage substance misuse.
	4.3.8	Health promotion is a unifying concept for health care within detention centres and is particularly important when working with children and young people. The service will aim to build the physical, mental and social health of the residents and staff. It will help to improve their health during their stay and assist them in adopting healthy behaviours throughout their lives. As part of the care coordinator's role linkages to and information on how to access medical care will be made available. Other information will be provided in appropriate languages and media and will be displayed in areas accessible to all residents. These displays will also make the most of the opportunity to share information on healthcare with them with particular regard to health promotion literature. Such information will also be included in the induction program. Health promotion will cover issues including mental health, well being, smoking, healthy eating and nutrition, healthy lifestyles (including safe sex and relationships), self examination including testicular and breast self-examination, and drugs and substance misuse. Services will be provided: • Upon entry; • At regular intervals during an individual's stay; and • To staff of Bimberi and the Office for Children, Youth and Family Support.
	4.3.9	To achieve the best outcome for those residents who have a mental illness and the community as a whole, the 12 principles adapted from Principles for Forensic Mental Health 2003 will be adhered to. A successful Mental Health program will: • Involve participation in the support team for the child or young person in detention; • Ensure that every young person with a diagnosed or diagnosable mental illness has a care plan through the service that includes a release plan that allows for the successful engagement with services in the community; • Have an emphasis and support for mental health promotion, prevention and early intervention; • Have an emphasis on access, quality and coordination of services both during and post incarceration; and • Adopt a recovery orientated treatment service that includes improved links between Bimberi and community based services such as supported accommodation, training and rehabilitative services.
	5.1	The training of general staff within Bimberi in the identification of young people with emerging mental health problems will be a priority. This will allow staff to have sufficient competence to identify and act appropriately if they have concerns about the health and well being of a resident.
	6.1	The services provided will aim to address Aboriginal and Torres Strait Islander peoples health in a holistic way and encompass mental, physical, family relationships, cultural and spiritual health.
	6.2	Mental health services are critical service for girls and young women with depression being a major issue for girls and young women in detention. Self-harming behaviours are more common with girls and young women than with boys and young men. These services will be provided in conjunction with the specific children's and young person's services.

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Plans and Strategies	ref no.	Objectives/Action items
Adult Corrections Health Services Plan 2008-2012	4.3.1	In order to meet these requirements ACT Health will aim to build a quality General Practitioner workforce by recruiting well, supporting and developing this workforce by providing opportunities for professional development and research. It will maintain this workforce through appropriate remuneration and succession planning.
	4.3.2	Upon entry to the prison the prisoner will: • Receive a comprehensive health assessment. This will incorporate: vaccinations; mental health; health risk and harm minimisation; drug and alcohol assessment; suicide risk assessment; reception risk assessment; and authority to obtain information. • Where mental health issues or the potential for suicide are identified, appropriate steps for the care of the prisoner will be made. Where practical, a thorough mental health assessment will be undertaken by a Forensic Mental Health Induction Officer within 48 hours of arrival to the prison.
	4.3.7	The service, recognising that drug and alcohol addiction is a health issue, will be tailored towards harm minimisation, demand reduction and effective clinical management for substance misusers. Harm minimization through health promotion - high levels of reported drug use and blood borne viral infection among prisoners have been documented. It is imperative that the harms associated with continuing use, whether in prison or upon release into the community, be reduced where possible. Efforts must be made to ensure prisoners have access to information regarding illicit drug use and related harms. Peer-based provision of information and/or education for illicit and injecting drug users will take place within the Alexander Maconochie Centre. Drug and Alcohol counseling – drug and alcohol counseling is seen as an important tool in the rehabilitation of prisoners and will continue to form part of the tools used to effectively manage substance misuse.
	4.3.8	The Corrections Health Program will aim to build the physical, mental and social health of the prisoners at the Alexander Maconochie Centre. It will help to prevent the deterioration of prisoners' health during custody and assist them in adopting healthy behaviours during their stay and post release. Information on how to access medical care will be made available, in appropriate languages and media, for all prisoners, and will be displayed in areas accessible to all prisoners, for example wing notice boards. These displays will also make the most of the opportunity to share information on healthcare with prisoners with particular regard to health promotion literature. Such information will also be included in the Prison Induction Program. Health promoting activities will be organized to provide healthy lifestyle activities for prisoners other than the traditional focus on building muscle.
	4.3.9	The mental health services within the correctional system will adhere to the 12 principles adapted from the ***National Statement of Principles for Forensic Mental Health 2002.*** A successful Mental Health program within the Alexander Maconochie Centre will: • Ensure that every prisoner with a diagnosed or diagnosable mental illness has a care plan through the service that includes a release plan that allows for the successful engagement with services in the community; • Have an emphasis and support for mental health promotion, prevention and early intervention; • Have an emphasis on access, quality and coordination of services both during and post incarceration; • Adopt a recovery orientated treatment service that includes improved links between the Alexander Maconochie Centre and community based services such as supported accommodation, training and rehabilitative services; and • Include enhanced data collection, monitoring and planning. There will also be a small number of people who will need 24-hour support, supervision and observation, because they are going through a particular crisis or need short-term intensive monitoring. These prisoners will be cared for in the Crisis Support Unit.
	5.1	All staff working in the prison need mental health training. This will ensure they have sufficient competence to identify potential mental health problems and have the skills to act appropriately on their concerns.
	6.1	ACT Health will work with Winnunga Nimmityjah to deliver a dedicated Aboriginal and Torres Strait Islander peoples service. ACT Health will promote the employment of culturally appropriate health service personnel.
	6.2	The women's health program will adopt a model of care that focuses on case managing or co-ordinating services that support and assist women in addressing issues that impact on their health and wellbeing.This model will adopt the following principles: • The woman, with assistance from her support worker, determines her health and well being goals. • Confidentiality of health and wellbeing information and the limitations of such will be discussed and agreed with the client. Information sharing across agencies occurs with the woman's consent unless in the instance where she is at risk of harming herself or others or, as compelled by law. • Women in custody are respected as individuals with unique needs. Mental health services are critical services for young women with depression being a major issue for young women in detention. Self-harming behaviours are more common with young women than with young men.

Appendix 1

Working Group Membership

ACT Council of Social Service	Caterina Giorgi
ACT Department of Education	Satish Singh
Policy Division, ACT Health	Richard Bromhead (Chair) Dr Johann Sheehan (Secretariat)
ACT Mental Health Community Coalition	Pam Boyer
ACT Mental Health Consumer Network	Michael Firestone
Alcohol & Other Drug Policy Unit, ACT Health	John Didlick
Health Promotion and Grants, ACT Health	Ros Garrity
Mental Health ACT, ACT Health	Melissa Lee
Public Advocate of the ACT	Trish Mackey
Social Policy and Implementation, Chief Minister's Department	Renate Moore
The Department of Disability, Housing and Community Services	Jolene Clinch
Faculty of Health, University of Canberra	Prof Debra Rickwood
Women's Centre for Health Matters	Robyn James

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Appendix 2

Relevant ACT Health Expenditure 2006–2009 ($'000)

Organisation	2006/2007	2007/2008	2008-2009
AUSEINET Contribution	8,000	11,000	15,000
Belconnen Community Service - Bungee Program	153,787	159,554	165,936
Beyondblue Workplace MH Promotion	130,000	130,000	130,000
Beyondblue Depression Initiative	70,000	70,000	70,000
Brindabella Women's Group	Funding not commenced	till 08-09	23,500
Carers ACT	119,820	124,312	190,284
Centacare - Youth Program	148,810	154,390	155,566
Marymead–Children's Circle of Security Programs	Funding not commenced	till 08-09	39,000
Majura Women's Group	Funding not commenced	till 08-09	23,500
Mental Health Foundation - Skills for Life	46,216	47,949	49,867
Mental Health Week	15,000	10,000	10,000
Mental Illness Education ACT	231,241	239,913	249,510
Oz Help Foundation & VYNE	421,022	436,810	454,282
PPEI Staff Position, ACT Health	90,000	95,000	100,000
Community Education Staff Position, ACT Health	90,000	95,000	100,000
PANDSI	138,744	143,947	149,705
TOTALS (Excludes GST)	**$1,662,640**	**$1,717,875**	**$1,926,150**

Appendix 3

Consultation Participants

ACT Mental Health Consumer Network
ACT Council for Social Service (ACTCOSS) – G. Wilson
ACT Division of General Practice
ACT Health Aboriginal and Torres Strait Island Health Policy Unit
ACT Health Drug and Alcohol Policy Unit
ACT Health GP Advisor
ACT Human Rights Commissioner
C. Allatt
A. Marie
Australian Red Cross
R. & B. Booth
P. Boyer
D. Briggs
G. Buckford
Carers ACT
Chief Ministers Department
Conflict Resolution Service – F. McIroy
Director, Corrections Health
Department of Disability, Housing and Community Services Intensive Treatment and Support Services
Department of Education and Training
Department of Justice and Community Safety
Department of Territory and Municipal Services
The Elected Elders Body
C. & G. Gerrity
Gugan Gulwan Youth Aboriginal Incorporation
B. Hausia
Headspace – Lisa Kelly
B. Hitchcock
Housing ACT
C. King
Men's Link
Mental Health ACT
Mental Health Community Coalition ACT
Mental Illness Education ACT
OzHelp – Irmgard Reid
J. Phillips
The Public Advocate
Transcultural Mental Health Network
Vietnam Veterans Federation ACT Branch - Geralad Mapstone
K. Wells
G. Willson
Winnunga Nimmityjah Aboriginal Health Service
Women's Centre for Health Matters

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Appendix 4

Relevant National and ACT Policies and Plans

Building A Strong Foundation: Promoting Mental Health and Wellbeing in the ACT 2009–2014 is informed by national and local plans and policies.

The National Action Plan on Mental Health 2006–2011[17] recognises the importance of promotion, prevention and early intervention in enabling the community to better manage its mental health and wellbeing. The National Plan identifies specific policy directions necessary to achieve effective promotion, prevention and early intervention, including:

- Building resilience and coping skills of children, young people and families;
- Raising community awareness;
- Improving capacity for early identification and referral to appropriate services;
- Improving treatment services to better respond to the early onset of mental illness, particularly for children and young people; and
- Investing in mental health research to better understand the onset and treatment of mental illnesses.

The National Mental Health Policy 2008[111] embeds a whole of government approach to mental health, first agreed to by the Council of Australian Governments in July 2006, within the National Mental Health Strategy. The policy provides a context for the development of national and state plans relating to mental health and wellbeing.

The 4th National Mental Health Plan[112] builds on the previous three plans and has a strong focus on a whole of government approach to future developments. The plan has five priority areas:

- Social inclusion and recovery;
- Prevention and early intervention;
- Services, access, coordination and continuity of care;
- Quality improvement and innovation; and
- Accountability–monitoring, reporting and evaluation.

The *National Depression Initiative*[113] aims to increase the capacity of the broader Australian community to prevent depression and respond effectively to it.

The *National Action Plan for Perinatal Mental Health 2008–2010*[114] provides a population approach to improving the perinatal mental health and wellbeing of women and their relationship with their infant.

The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*[11] outlines a strategic framework and plan for action to address promotion, prevention and early intervention priorities and outcomes in the Second National Mental Health Plan.[9]

The *National Living is for Everyone (LIFE) Framework*[115] is a framework for prevention of suicide in Australia provides the strategic direction for suicide prevention activities in Australia for the next five years.

The *ACT Mental Health Services Plan 2009–2014*[3] sets the vision and strategic direction for the mental health sector in the ACT to the year 2020. The Plan acknowledges that a strong emphasis on promotion, prevention and early intervention is required to optimise the mental wellbeing of all Canberrans.

Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2012[2] sets the overall priorities for suicide prevention in the ACT.

The *ACT Health Action Plan 2002*[117] sets the directions for public health services in the ACT. It highlights the need to 'strengthen the health of the community by leading whole of government action addressing the social determinants of health'.

Building Our Community: The Canberra Social Plan[118] identifies the social, economic and environmental improvements needed to support a stronger community and greater wellbeing for people of the ACT.

The *Social Compact*[119] recognises that the best way to achieve community is for the Government and community organisations to work in partnership.

The ACT Human Rights Act 2004[120] sets out human rights legislation in the ACT.

The *ACT Alcohol, Tobacco and Other Drug Strategy 2009–2013*[121] sets out the ACT Government's strategy to address the problematic use of alcohol, tobacco and other drugs.

The *ACT Alcohol and Other Drug and Mental Health Comorbidity Strategy* (in preparation). Bringing together priorities from all stakeholders, the Comorbidity Strategy will draw together service options from the diverse range of services and support options available. It will develop cross sectoral entry and discharge options to improve the identification, treatment and support options for individuals with comorbidity.

The *ACT Children's Plan*[122] sets out a whole of government approach to support the development of children in the ACT.

The *ACT Primary Health Care Strategy 2006–2009*[123] provides direction for the efficient and effective delivery of primary health care services in the ACT.

The *ACT Women's Plan*[124] identifies factors pivotal to the development of effective and responsive policies, programs and services to meet the needs of women and girls in the ACT.

A New Way: The ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011[125] outlines a commitment by all parties to work collaboratively to develop and implement innovative solutions that deliver measurable and meaningful change in the health status of Aboriginal and Torres Strait Islander communities in the ACT.

The *National Partnership Agreement of Closing the Gap in Indigenous Health Outcomes*[126] has been established to address targets set by COAG for closing the gap in health outcomes between Indigenous and non-Indigenous Australians. Six targets for closing the gap between Indigenous and non-Indigenous Australians across urban, rural and remote areas are identified:

- to close the gap in life expectancy within a generation;
- to halve the gap in mortality rates for Indigenous children under five within a decade;
- to ensure all Indigenous four years olds in remote communities have access to early childhood education within five years;
- to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade;
- to halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and
- to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

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To address these issues, a package of health reforms have been developed centred on five priority areas:

— tackling smoking;
— providing a healthy transition to adulthood;
— making Indigenous health everyone's business;
— delivering effective primary health care services; and
— better coordinating the patient journey through the health system.

Consumer Participation and Carer Participation across Mental Health ACT[127] is a Framework acknowledging the rights of consumers and carers to participate in decision making processes regarding mental health care.

Caring for Carers Policy[128] embodies the ACT Government's commitment to better acknowledge carers and address their needs.

Mental Health Recovery in the ACT: Recovery Principles[133] outlines seven principles of recovery:

1. Hope is fundamental to a person's recovery journey;
2. A person's unique life context – encompassing though not limited to, culture, spirituality, gender, age, life roles – is acknowledged and valued;
3. People are encouraged to take the lead in their recovery journey and collaborate with a range of services and supports as required;
4. Maintaining and developing connections to valued people and activities is critical to the recovery journey;
5. Partnerships are based on trust and mutual respect;
6. People are provided with the necessary information to enable them to make informed decisions about their recovery journey;
7. Everyone has responsibility for creating and sustaining a culture that promotes recovery.

Adult Corrections Health Services Plan 2008–2012[129] identifies a framework for the management of the health of remandees and prisoners in detention within the ACT correctional system.

Children's and Young People's Justice Services Health Plan 2008[130] identifies a framework for the management of the health of children and young people in detention within the youth justice system. The Plan defines the role of ACT Health in providing for the health needs of residents; identifies key health needs of the current and expected populations of Bimberi, the services required to appropriately meet these needs, best practice strategies for providing health care to residents, and linkages between government agencies and community services to assist in providing services for residents.

Appendix 5

Abbreviations and Glossary

Definitions have been sourced from the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) Glossary. http://auseinet.flinders.edu.au/ unless otherwise stated.

ABI	Acquired Brain Injury
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACTCOSS	ACT Council of Social Service
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
AMC	Alexander Maconochie Centre
AOD	Alcohol and Other Drug
ASIST	Applied Suicide Intervention Skills Training
Auseinet	Australian Network for Promotion, Prevention and Early Intervention for Mental Health
AYAMHIU	Adolescent and Young Adult Mental Health Inpatient Unit.
Building A Strong Foundation	*Building A Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009-2014*
CALD	Culturally and Linguistically Diverse: Can refer to individual people, communities or populations who have a specific cultural or linguistic connection through birth, ancestry, or religion.
CAMHS	Child and Adolescent Mental Health Services
Capacity building	Involves enhancing the ability of individuals and groups to mobilise and develop resources, skills and commitments needed to accomplish shared goals. Capacity building for health promotion: the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organisations, and; the development of cohesiveness and partnerships for health in communities
Carer	A person who has a caring or supportive role in the life of a (mental health) consumer
CATT	Crisis Assessment and Treatment Team
COAG	Council of Australian Governments
Continuity of care:	When a person moves from one agency or treatment environment to another (say from a GP to a specialist mental health service, or from hospital to the community), ensuring that appropriate service is provided by the new agency, and that it happens on time[131]
Co-morbidity	The occurrence of more than one disorder at the same time. Co-morbidity may refer to the co-occurrence of mental disorders and the co-occurrence of mental disorders and physical conditions. In this Strategy, the term co-morbidity generally refers to the occurrence of a mental disorder and the problematic use of alcohol of other drugs
Connectedness	A person's sense of belonging with others. A sense of connectedness can be with family, school or community
Consumer	A person who has used (or is using) a mental health service
COPMI	Children of Parents with a Mental Illness
DET	Department of Education and Training
DHCS	Department of Disability, Housing and Community Services
DGP	Division of General Practice
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders Four
DVCS	Domestic Violence Crisis Service

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Early intervention	Intervention activities that focus on individuals and aim to prevent the progression to a diagnosable disorder for people experiencing signs or symptoms of mental health problems and to reduce the affects (shorten the duration and reduce the potential damage to the wellbeing of a person) of the illness on an individual experiencing an episode of mental illness
ED	Emergency Department
Evaluation	The process used to describe the process of measuring the value or worth of a program or service.
Evidence base	A summary of the research that informs current understanding of possible directions for promotion, prevention and early intervention initiatives
FR-ESH	First Responders – Effective Suicide Help
Gatekeeper	A person who holds an influential position in either an organisation or a community who coordinates or oversees the actions of others. This could be an informal local opinion leader or a specifically designated person, such as a primary-care provider, who coordinates patient care and provides referrals to specialists, hospitals, laboratories, and other medical services
GP	General Practitioner
HASI	Housing and Accommodation Support Initiative
Health outcome	A change in the health of an individual or population due wholly or partly to a preventive or clinical intervention.
Health promotion	The process of enabling people to increase control over, and to improve their health[132]
HYPP	Housing for Young People Program
Indicated intervention	aim to improve the mental health and wellbeing of individuals who are identified as having minimal but detectable signs of mental disorder and may include programs for children showing signs of behavioural problems.[17]
JaCS	Justice and Community Safety
MACH	Maternal and Child Health
Managing the Risk of Suicide	*Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009-2014*
MHAGIC	Mental Health Assessment Generation and Information Collection
MHACT	Mental Health ACT
Mental health	A broad term that refers to how a person thinks, feels and acts in their day-to-day life. It is how people feel about themselves, their lives and the other people in their lives. It includes how a person handles stress, relates to other people, and makes decisions. It is increasingly being defined as a positive attribute, incorporating a state of emotional and social wellbeing that enables people to undertake productive activities, experience meaningful interpersonal relationships, adapt to change and cope with adversity (WHO, 1999). Mental health is not the absence of illness, but rather, the ability to cope and feel positive about people and events in life. The phrase mental health and wellbeing is used to refer to a positive state of mental health.[10]
Mental health and wellbeing	Any action to maximise mental wellness in a population or for individuals through managing environmental conditions for those who are currently well, those at risk and those experiencing illness. Promotion is a process of enhancing the coping abilities of individuals, families and the wider community by providing power through knowledge, resources and skills[10]
Mental health literacy	'The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking'[10]
Mental health problems	A problem that interferes with a person's thoughts, feelings and social behaviour, but to a lesser extent than a mental illness. Mental health problems are more common and include the mental ill health that may be temporarily experienced as a reaction to the stresses of life. While mental health problems are less severe than mental illnesses, they still can have a significant impact on a person's future opportunities and sense of wellbeing, and may develop into a mental illness if not effectively treated.
Mental health promotion	any action to maximise mental wellness in a population or for individuals through managing environmental conditions for those who are currently well, those at risk and those experiencing illness. Promotion is a process of enhancing the coping abilities of individuals, families and the wider community by providing power through knowledge, resources and skills.[31]
Morbidity	The incidence rate of illness or disorder in a community or population.
MHFA	Mental Health First Aid
MHSP	ACT Mental Health Services Plan
MIEACT	Mental Illness Education ACT
NGOs	Non-Government Organisations or Community Agencies

NSW	New South Wales
OCYFS	Office of Children, Youth and Family Support
OH&S	Occupational Health and Safety
Outcome	A measurable change in the health of an individual, or group of people or population, which is attributable to an intervention or series of interventions
OzHelp	Suicide prevention / life skills program for industry and community
PANDSI	Post and Antenatal Depression Support Incorporated
Perinatal	Relating to the periods shortly before and after the birth of a baby
Postvention	Interventions to support and assist the bereaved after a suicide has occurred.
PPEI	Promotion, Prevention and Early Intervention
Prevention	Interventions to reduce risk factors contributing to the development of a mental disorder and enhance protective factors that promote mental health and wellbeing. Prevention interventions may be classified according to their target group, as: *Universal*: provided to whole populations; *Selective*: targeting those population groups at increased risk of developing a disorder; and *Indicated*: targeting people showing minimal signs and symptoms of a disorder.
Primary care	In the health sector generally, 'primary care' services are provided in the community by generalist providers who are not specialists in a particular area of health intervention
Protective factors	Factors that give people resilience in the face of adversity and moderate the impact of stress and transient symptoms on the person's social and emotional wellbeing. Protective factors reduce the likelihood that a disorder will develop
PSU	Psychiatric Services Unit
Psychosocial rehabilitation	See: Rehabilitation (psychosocial)
PTSD	Post Traumatic Stress Disorder: A psychological disorder affecting individuals who have experienced or witnessed profoundly traumatic events, characterized by recurrent flashbacks of the traumatic event, nightmares, irritability, anxiety, fatigue, forgetfulness, and social withdrawal.
Public health	The science and art of promoting health, preventing disease, and prolonging life through the organised efforts of society. Public health (has a) comprehensive understanding of the ways in which lifestyles and living conditions determine health status.
RCT	Randomised Control Trial
Recovery	Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential[133]
Refugee	A person who is outside his or her country of nationality or habitual residence; has a well founded fear of persecution because of his or her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution (Article 1).[134]
Rehabilitation (psychosocial)	The process of facilitating an individual's restoration to an optimal level of independent functioning in the community.
Relapse prevention	A specific component of the recovery process. It entails maximising wellness for people with mental illness by reducing the likelihood and impact of relapse. It involves empowering people with mental illness to recognise early warning signs of relapse and develop appropriate response plans. It requires identifying risk and protective factors for mental health, and implementing interventions that enhance protective factors and eliminate or reduce the impact of risk factors.
Resilience	Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, good communication and social skills, optimistic thinking, and help-seeking.
Risk factors	Factors that increase the likelihood that a disorder will develop, and exacerbate the burden of existing disorder. Risk factors indicate a person's vulnerability, and may include genetic, biological, behavioural, socio-cultural and demographic conditions and characteristics. Most risk (and protective factors) for mental health lie outside the domain of mental health and health services- they derive from conditions in the everyday lives of individuals and communities. Risk and protective factors occur through income and social status, physical environments, education and educational settings, working conditions, social environments, families, biology and genetics, personal health practices and coping skills, sport and recreation, the availability of opportunities, as well as through access to health services.

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Risk-taking behaviours	Risk taking behaviours are behaviours in which there is some risk of immediate or later self-harm. Risk-taking behaviours might include activities such as dangerous driving, train surfing, and self-harming substance use.
Self-harm	Any behaviours causing destruction or alteration of body tissues, with or without the intent to die. It includes self-injury, attempted suicide and other forms of intentional injury to self.
SEOT	Specialist Early Onset Team
SPWG	ACT Suicide Prevention Working Group
Social determinants of health	The range of personal, social, economic and environmental factors which determine the health status of individuals or populations
Social support	Assistance available to individuals and groups from within communities which can provide a buffer against adverse life events and living conditions, and can provide a positive resource for enhancing the quality of life. Social support may include emotional support, information sharing and the provision of material resources and services. Social support is now widely recognised as an important determinant of health, and an essential element of social capital.
SPIEG	Suicide Prevention Implementation and Evaluation Working Group
Stakeholders	Stakeholders include all individuals and groups who are affected by, or can affect, a given operation. Stakeholders can be individuals, interest groups or organisations
STS	Secondary Traumatic Stress
Suicide	A death is classified as a 'suicide' by a coroner based on evidence that a person died as a result of a deliberate act to cause his or her own death. If there is contrary evidence, a coroner may classify the death as having been caused by someone else, or as accidental. If there is insufficient evidence, the coroner may not be able to reach a decision on the cause of death.[135]
Suicidal ideation	Thoughts or behaviours that focus on suicide.
Suicide attempt	A deliberate or ambivalent act of self-destruction or other life-threatening behaviour, that does not result in death.
Suicide prevention	Concerned with preventing suicide by reducing the risk factors associated with suicide and increasing the protective factors, such as promoting mental health and resilience within the community.
Suicide-related behaviours	Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death, and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicide-related behaviours.
Transcultural mental health	Extends the definition of mental health to look at the interactions of individuals and groups within a culturally diverse environment, to identify specific risk and protective factors for those individuals and groups who may be marginalised within the dominant culture, and to address societal and structural issues within the environment in order to promote their mental health and wellbeing.
TCH	The Canberra Hospital
Vocational rehabilitation	Services with a primary focus on interventions to assist people who have experienced, or continue to experience, a mental illness to enter or re-enter the workforce.
WHO	World Health Organization: The United Nations specialised agency for health.

References

1 ACT Government (2006) ACT Action Plan for *Mental Health Promotion, Prevention and Early Intervention 2006-2008*. Australian Capital Territory: Canberra.

2 ACT Health (2009). *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT, 2009–2014*. Australian Capital Territory: Canberra.

3 ACT Government *ACT Mental Health Services Plan 2009–2014* (2009). Australian Capital Territory: Canberra.

4 NSW Health Department (2001) *A Framework for Building Capacity to Improve Health*. Gladesville, NSW.

5 Auseinet (2007) *Promotion, Prevention and Early Intervention for Mental Health*. Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet), Flinders University: Adelaide.

6 ACT Health (2007) *Consumer and Carer Participation across Mental Health ACT: A Framework for Action, ACT Government*. Australian Capital Territory: Canberra.

7 ACT Health (2005) *Guidelines for Consulting with the Aboriginal and Torres Strait Islander Community.* Australian Capital Territory: Canberra.

8 ACT Health (2009). *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT, 2009–2014*. Australian Capital Territory: Canberra.

9 Australian Health Ministers (1998) *Second National Mental Health Plan,* Mental Health Branch, Commonwealth Department of Health and Family Services. Australian Capital Territory: Canberra.

10 Rickwood D. (2007) Conceptual framework for PPEI and applications in general practice: Overview of the literature. Monograph 1 in A. O'Hanlon, A. Patterson & J. Parham (Series Eds.), *Promotion, Prevention and Early Intervention for Mental Health in General Practice*. Adelaide: Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet).

11 Commonwealth of Australia (2000) *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000.* Australian Capital Territory: Canberra.

12 World Health Organization (2001) *Mental Health: new understanding, new hope*. The World Health Report. World Health Organization: Geneva.

13 AIHW (2008) *Australia's Health 2008*. Cat. No. AUS 99. Australian Institute of Health and Welfare: Canberra.

14 Australian Bureau of Statistics (2007) *National Survey of Mental Health and Wellbeing: Summary of Results,* Cat. No. 4236.0. ABS: Canberra.

15 Hocking B. (2003) Reducing mental illness stigma and discrimination – everybody's business. *Medical Journal of Australia*, 189(9): S47-S48, 2003.

16 Byrne P. (1997) Psychiatric stigma. Journal of Social Medicine; 90: 618-621.

17 Council of Australian Governments (COAG) (2006) *National Action Plan on Mental Health 2006–2011*.

18 World Health Organization (1986) Ottawa Charter for health promotion. World Health Organization: Geneva. http://www.who.dk/AboutWHO/Policy/20010827_2.

19 Victorian Health Promotion Foundation (2005) *A Plan for Action 2005-2007 Promoting Mental Health and Wellbeing*. Victorian Health Promotion Foundation. Victoria.

20 World Health Organization (2005) *Promoting Mental Health: Concepts, Emerging Evidence*. World Health Organization. Geneva.

21 Cappo D. (2002) *Social inclusion initiative. Social inclusion, participation and empowerment.* Address to Australian Council of Social Services National Congress, Hobart, 28-29 November 2002.

22 Kaplan G., and Lynch J. (1997) Whither studies on the social economic foundations of population health. *American Journal of Public Health*, 87(9): 1049–1411.

23 Victorian Health Promotion Foundation (2005) *Research Summary 4: Access to Economic Resources as a determinant of mental health and wellbeing.* http://www.vichealth.vic.gov.au/Programs-and-Projects/Mental-Health-and-Wellbeing/Mental-Health-and-Wellbeing-Publications-and-Resources/Resources.aspx

24 World Health Organization (2000) *Women's Mental Health: An Evidence Based Review*. Geneva: World Health Organization.

25 Wilkinson R., and Marmot M. (2003) *Social Determinants of Health: The Solid Facts.* 2nd edition World Health Organization, Geneva.

26 World Health Organization (1996) *Global consultation on violence and health. Violence: a public health priority*. World Health Organization: Geneva.

CED10-003

27 Krieger N. (2001) cited in Victorian Health Promotion Foundation 2005, *A Plan for Action 2005–2007: Promoting Mental Health and Well-being*. http://www.vichealth.vic.gov.au/~/media/ProgramsandProjects/MentalHealthandWellBeing/Attachments/VH%20action%20plan-web.ashx

28 Mrazek P. J., and Haggerty R. J. (1994) *Reducing the Risks for Mental Disorders: Frontiers for Preventative Intervention Research*, National Academy Press, Washington DC.

29 Commonwealth of Australia (2000) *National Action Plan for Promotion, Prevention and Early Intervention Plan for Mental Health–A Monograph*, Mental Health and Special Programs Branch, Canberra.

30 Rickwood D. (2006) *Pathways of Recovery: Preventing further episodes of mental illness (Monograph). Commonwealth of Australia*. Australian Capital Territory: Canberra.

31 Hunter Institute of Mental Health (2005) *Promotion, Prevention and Early Intervention within Mental Health Services in the Hunter: An initial scoping study by the Hunter Institute of Mental Health for the Hunter New England Area Health Service*. Hunter New England Area Health Service: Newcastle.

32 Rickwood D. (2006) Pathways of Recovery: 4As Framework for Preventing Further Episodes or Mental Illness. Commonwealth of Australia, Canberra.

33 Parham J., and Patterson A. (2000) Understanding Mental Health and Wellbeing: An introduction to mental health, mental health promotion, prevention of mental ill-health and early intervention; Participants booklet. Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Ausinet), Adelaide.

34 Commonwealth of Australia (2009) *National mental health policy 2008*. Australian Capital Territory: Canberra.

35 World Health Organization (2003) *Investing in Mental Health*. World Health Organization, Geneva.

36 Commonwealth of Australia (2009) *The Development of the 4th National Mental health Plan: A discussion paper*. 4th National Mental Health Plan Working Group.

37 Auseinet (2008) *Auseinetter December 2008*. Australian Network for the Promotion, Prevention and Early Intervention for Mental Heath. Flinders University; Adelaide.

38 beyondblue (2008) *National Action Plan for Perinatal Mental Health 2008–2010: Summary Document*. Beyondblue: Melbourne.

39 Royal Children's Hospital (2006) Policy Brief No 5: Translating early childhood research evidence to inform policy and practice. *www.rch.org.au/ccch/policybriefs.cfm*

40 The Cochrane Collaboration (2009) *Parent-training programs for improving maternal psychosocial health (Review)*. Wiley and Sons, Ltd.

41 Landry S., Smith K., and Swank P. (2006) Responsive parenting: Establishing Early Foundations for Social Communication, and Independent Problem-Solving Skills. *Developmental Psychology*, 41(4), 627-642.

42 Goodson B. (2005) Parent Support programs and outcomes for children. *Encyclopedia on Early Childhood Development* (pp 1-7), Melbourne: Centre for Excellence for Early Childhood Development.

43 Carbone S., Fraser A., Ramburth R., and Nelms L. (2003) *Breaking cycles, building futures: promoting access and inclusion in antenatal early childhood services: A review of literature*. Brotherhood of Saint Laurence.

44 COPMI (2008) *COPMI Gems: Children of Parents with a Mental Illness*. http://www.copmi.net.au/gems/documents/copmigems01.pdf

45 World Health Organization (2004) *Promoting Mental Health: Concepts, emerging evidence and practice*. World Health Organisation: Geneva.

46 Australian Broadcasting Commission (2008) *Bullying Epidemic*. Four Corners, 16 April 2009. ABC: Sydney.

47 Victorian Health Promotion Foundation (2003) *Beating up on each other–Bullying in Australia: Media Release*. Victorian Health Promotion Foundation.

48 Auseinet. Settings and Populations: Mental health promotion and illness prevention. *http://auseinet.com/ppei/schoolprogs.php*

49 ACT Government (2008) *Every Chance to Learn: Curriculum framework for ACT schools Preschool to year 10.* Australian Capital Territory: Canberra.

50 Barry M., and Jenkins R. (2007) *Implementing Mental Health Promotion*. Elsevier.

51 Department of Education (2001) *The Students at Educational Risk Strategy's Pathway to Health and Well-being in Schools*, Department of Education, WA.

52 Green J., Howes F., Waters E., Maher E., and Oberlaid. (2005) Promoting the Social and Emotional Health of Primary School-Aged Children: Reviewing the Evidence Base for School Based Interventions. *International Journal of Mental Health Promotion* 7(3) 30-6.

53 Maybery D., Reupert A., Patrick K., Goodyear M., and Crase L. (2005) *VicHealth Research Report on Children at risk in families affected by parental mental illness*, Victorian Health Promotion Foundation Mental Health and Wellbeing Unit.

54 Victorian Health Promotion Foundation (2006) *Promoting the mental health and wellbeing of children and young people from families with a parent with a mental illness: Key learnings and promising practices*. Melbourne: Australia.

55 Craig E. A. (2004) Parenting programs for women with mental illness who have young children: A review. *Australian and New Zealand Journal of Psychiatry*, 38, 923–928.

56 Barnet B., Duggan A. K., Devoe M., and Murrell L. (2004) The effect of volunteer home visitation for adolescent mothers on parenting and mental health outcomes: A randomised trial. *Archives of Paediatric Adolescent Medicine*, 156, 1216–22.

57 Corrigan P. W., and Miller F. E. (2004) Shame, blame and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*, 13, 537–548.

58 VanDeMark N. R., Russell L. A., O'Keefe M., Finkelstein N., Chanson D. N., and Gampel J. C., (2005) Children of mothers with histories of substance abuse, mental illness, and trauma. *Journal of Community Psychology,* 33, 445–459.

59 Beardslee W. R., Versage E. M., and Gladstone T. R. G. (1998) Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 1134–1140.

60 Beardslee W. R., Keller M. B., Seifer R., Lavori P. W., Staley J., Podorefsky D., and Shera D. (1996) Prediction of adolescent affective disorder: Effects of prior parental affective disorders and child psychopathology. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 279–288.

61 Maybery D. J., Reuport A. E., and Goodyear M. (2006) *Evaluation of a model of best practice for families who have a parent with a mental illness*. Wagga Wagga: Charles Sturt University.

62 Aldridge J. (2006) The experiences of children living with and caring for parents with mental illness. *Child Abuse Review*, 15, 79–88.

63 NSW Department of Community Services (2008) *Literature Review Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families.* Sydney: Australia.

64 Commonwealth of Australia (2006) National Alcohol and Drug Strategy 2006-2009. Canberra. http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/B83AD1F91AA632ADCA25718E0081F1C3/$File/nas-06-09.pdf

65 Cusack K., Frueh B., Hiers T., Suffoletta-Maierle S., and Bennett S. (2000) Trauma within the psychiatric setting: A preliminary Empirical Report. *Administration and Policy in Mental Health*, Vol. 30, No. 5, May 2003.

66 Goldacre M., Seagroatt V., Hawton K. (1993) Suicide after discharge from psychiatric inpatient care. *Lancet*, 31;342(8866):283–6.

67 Linehan M. M., Comtois K. A., Murray A. M., Brown M. Z., Gallop R. J., Heard H. L., Korslund K. E., Tutek D. A., Reynolds S. K., Lindenboim N. (2007) Two-year randomized controlled trial and follow-up of dialectical behaviour therapy by experts for suicide-related behaviours and borderline personality disorder. *Archives of General Psychiatry*, vol. 63, p 757-766.

68 Ogloff J. R. P., Lemphers A., and Dwyer C. (2004) Dual diagnosis in an Australian forensic psychiatric hospital: prevalence and implications for services. *Behavioral sciences and the law* 22: 543–562

69 AIHW: Belcher J., and Al-Yaman F. (2007) *Prisoner health in Australia: contemporary information collection and a way forward.* Cat. No. PHE 94. Australian Institute of Health and Welfare: Canberra.

70 Ogloff J., Davis M. R., Rivers G., and Ross S. (2007) *The identification of mental disorders in the criminal justice system: Trends and Issues in crime and criminal justice*: No. 334.

71 ACT Health (2008) *Adult Corrections Health Services Plan 2008-2012*. Australian Capital Territory: Canberra.

72 Department of Disability, Housing and Community Services ACT. *Bimberi: Services and Programs*. http://www.dhcs.act.gov.au/__data/assets/word_doc/0003/32592/08_09_02_FACTSHEET_Programs.doc

73 Australian Bureau of Statistics (2008) *National Survey of Mental Health and Wellbeing: Summary of Results*. Cat. No. 4326.0. ABS: Canberra.

74 Butler T., Andrews G., Allnutt S., Sakashita C., Smith N., and Basson J. (2006) Mental disorders in Australian prisoners: A comparison with a community sample. *Australian and New Zealand Journal of Psychiatry,* 40, 272-276.

75 Mullen P. E., Holmquist C. L., and Ogloff J. R. P. (2003) *National forensic mental health scoping study.* Department of Health and Ageing: Canberra.

76 Teplin L. A., Abram K. M., McClelland G. M., Dulcan M. K., Mericle A. A. (2002) Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 59 (12): 1133–1143.

77 ACT Health (2008) *Children's and Young People's Justice Health Services Plan 2008-2012*. ACT Government: Canberra.

78 Allan A., Davidson G., Tyson G., Schweitzer R., and Starr R. (2002) *Submission to National Inquiry into Children in Immigration Detention from the Australian Psychological Society*. Melbourne, VIC: Australian Psychological Society.

79 McKenzie K., McColl H., and Bhui K. (2007) *Position Statement by the Royal College of Psychiatrists by their Transcultural Special Interest Group.*

80 Beiser M. (2006) Longitudinal research to promote effective refugee resettlement. *Transcultural Psychiatry* 43(1) 56–71.

81 Silove D., Steel Z., and Watters C. (2000) Policies of deterrence and the mental health of asylum seekers. *Journal of the American Medical Association* 284(5) 604–11.

82 Dudley M. (2003) Contradictory Australian national policies on self-harm and suicide: The case of asylum seekers in mandatory detention. *Australasian Psychiatry*, 11(Supplement), S102-S108.

83 Hallas P., Hansen A. R., Stæhr M. A., Munk-Andersen E., and Jorgensen H. L. (2007) Length of stay in asylum centres and mental health in asylum seekers: a retrospective study from Denmark. *BMC Public Health* 7 288.

CED10-003

84 Steel Z., Momartin S., Bateman C., Hafshejani A., Silove D. M., Everson N., et al. (2004) Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian and New Zealand Journal of Public Health* 28(6), 527-536.

85 Silove D., Steel Z., and Susljik I. (2006) Torture, mental health status and the outcomes of refugee applications amongst recently arrived asylum seekers in Australia. *International Journal of Migration Health and Social Care* 2 4–14.

86 Blight K. J., Persson J-O., Ekblad S., and Ekberg J. (2008) Medical and licit drug use in an urban/rural study population with a refugee background, 7-8 years into resettlement. *GMS Psychosocial Medicine 5*.

87 Victorian Health Promotion Foundation (2005) *A Plan for Action 2005-2007: Promoting Mental Health and Wellbeing*. Carlton: Victoria.

88 Brotherhood of St Laurence (2004) Federal Election. Brotherhood of St Laurence Call to the Parties. BSL, Fitzroy.

89 Anglicare Australia (2003) *Education: Critical to Break the Cycle of Poverty*. http://www.anglicare.asn.au

90 Glover S., Burns J., Butler H., and Patton G. (1998) Social Environs and the Emotional Wellbeing of Young People. *Family Matters* No 49 Australian Institute of Family Studies.

91 Kawachi I., and Berkman L. F. (2001) Social ties and mental health. *Journal of Urban Health* 2001; 78(3):458-467.

92 World Health Organization (2000). *Women's Mental Health: An Evidence Based Review*. Geneva: World Health Organization.

93 ACT Health (2007) *Better General Health for People with Mental Illness,* Australian Capital Territory, Canberra.

94 LaMontagne A. D., Keega T., Ostry A., Shaw A. (2005) *Workplace Stress in Victoria: developing a systems approach*. Report to the Victorian Health Promotion Foundation.

95 Petticrew M., Chisholm D., Thomson H., Jane-Llopis E., in press. Generating evidence on determinants, effectiveness and cost, in *Promoting Mental Health: Concepts, Emerging Evidence, Practice, A Report from the World Health Organization*. Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (Vichealth) and the University of Melbourne, Herrman H, Saxena S and Moodie R (eds) World Health Organization, Geneva.

96 Organisation for Economic Co-opertion and Development (2008) *OECD Employment Outlook*. http://www.oecd.org/document/46/0,3343,en_2649_33927_40401454_1_1_1_37457,00.html

97 Department of Urban Services (2008) *The ACT Children's Plan 2004-2014*. Australian Capital Territory: Canberra.

98 World Health Organization (2002) *World report on violence and health*. World Health Organization, Geneva.

99 Australian Bureau of Statistics (2006) *Personal safety survey,* Cat no. 4906.0, ABS: Canberra.

100 Laing L. (2000) *Progress, trends and challenges in Australian responses to domestic violence, Issues Paper 2*, Australian Domestic and Family Violence Clearing House.

101 Indemaur D. (2000) *Young Australians and domestic violence: Trends and issues in Crime and Criminal Justice no. 195*. Australian Institute of Criminology, Canberra.

102 Edleson J. (1999) Domestic violence and children, *The Future of Children*, 9(3).

103 Mouzos J., and Makkai T. (2004) *Women's experiences of male violence: findings from the Australian component of the international violence against women survey, Research and Public Series no. 56*, Australian Institute of Criminology, Canberra.

104 Brown T. N., Williams D. R., Jackson J. S., Neighbors H. W., Torres M., Sellers S. L., and Brown K. T. (2000) Being black and feeling blue: the mental health consequences of racial discrimination. *Race and Society*, 2:117–31.

105 Kessler R. C., Mickelson K. D., and Williams D. R. (1999) The prevalence, distribution, and mental health correlates of perceived discrimination in the United States, *Journal of Health and Social Behaviour*, 40:208–30.

106 Williams D. R., and Williams-Morris R. (2000) Racism and mental health: the African American experience, *Ethnicity and Health*; 5:243–68.

107 Commonwealth of Australia (2004) Framework for the implementation of the National Mental Health Plan 2003-2008 in *Multicultural Australia*, Canberra

108 ACT Health (2007) *The Health of Aboriginal and Torres Strait Islander People in the ACT 2000 to 2005*, Health Series Number 40, Population Health Research Centre, Population Health Division.

109 CDHAC (2000) Learnings about suicide, in *Life: Living is for Everyone–A Framework for Prevention of Suicide and Self-harm in Australia*. Commonwealth of Australia.

110 Walker L., and Rowling L. (2002) 'Debates, confusion, collaboration and emerging practice', in *Mental Health Promotion and Young People: Concepts and Practice*, eds L Rowling, G Martin & L Walker, McGraw Hill, Australia pp1-8.

111 Commonwealth of Australia (2009) *National Mental Health Policy 2008*. Commonwealth of Australia: Canberra.

112 Commonwealth of Australia (2009) *4th National Mental Health Plan 2009–2014*. Canberra.

113 beyondblue: *The National Depression Initiative*. http://beyondblue.org.au

114 beyondblue (2008) *National Action Plan for Perinatal Mental Health 2008–2010*. http://www.gpsa.org.au/media/docs/mentalhealth/perinatal_national_action_plan.pdf

115 Commonwealth Department of Health and Ageing (2007) *Living is for Everyone: A Framework for Prevention of Suicide in Australia*. Commonwealth of Australia: Canberra.

116 ACT Health (2005) Suicide Prevention: Managing the Risk of Suicide, 2005–2008, Australian Capital Territory: Canberra.

117 ACT Government (2002) The ACT Health Action Plan 2002.

118 Chief Ministers Department (2004) *Building our Community: The Canberra Social Plan*, ACT Government: Canberra http://www.cmd.act.gov.au/policystrategic/canberraplan

119 Department of Urban Services (2004) *The Social Compact*. Canberra.

120 ACT Government (2009) *Human Rights Act, A2004-5 Republication no. 6*, Effective 2 February 2009, ACT Government, Canberra. http://www.legislation.act.gov.au/a/2004-5/current/pdf/2004-5.pdf

121 ACT Health DRAFT (at time of publication). *The ACT Alcohol, Tobacco and Other Drug Strategy, 2009-2013*. Australian Capital Territory: Canberra.

122 Office for Children, Youth and Family Support (2004) *ACT Children's Plan 2004–2014*, ACT Government: Canberra.

123 ACT Government (2000) *The ACT Primary Health Care Strategy 2006–2009*. www.health.act.gov.au/c/health?a=dlpol&policy=1159322632

124 ACT Government (2004) *The ACT Women's Plan*. ACT Office for Women, Chief Minister's Department. Canberra. www.actlabor.com.au/Documents/Policy/Women%20Policy.pdf

125 ACT Government (2006) *A New Way: The ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011*. ACT Health, Nimmityjah Aboriginal Health Service and Australian Government Department of Health and Ageing: Canberra. Canberra.www.health.act.gov.au/c/health?a=dlpol&policy=1153889980

126 Council of Australia Government (2008) *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*. Canberra. www. .coag.gov.au/coag_meeting.../NIRA_closing_the_gap.pdf

127 ACT Health (2007) Consumer Participation and Carer Participation across Mental Health ACT. Canberra.

128 Department of Disability, Housing and Community Services (2003) *Caring for carers policy*. ACT Government, Canberra. http://www.dhcs.act.gov.au/__data/assets/pdf_file/0019/7246/DHCS_Carers_Policy.pdf

129 ACT Health (2008) *Adult Corrections Health Services Plan 2008–2012*. ACT Government. Canberra. http://www.health.act.gov.au/c/health?a=dlpubpoldoc&document=911

130 ACT Health (2008) Children's and Young People's Justice Services Health Plan (2008) ACT Government, Canberra.

131 ACT Council of Australian Government Mental Health Group (2007) *Care Coordination Information Paper*. Australian Capital Territory Council of Australian Governments (COAG) Mental Health Group

132 WHO (1986) Ottawa charter for health promotion. World Health Organization: Geneva. http://www.who.dk/AboutWHO/Policy/20010827_2.

133 mental health Recovery ACT (a partnership between Government and Community Agencies in the ACT including consumers and carers), 2003. *Mental Health Recovery in the ACT: Recovery Principles*. Australian Capital Territory: Canberra.

134 United Nations High Commissioner for Refugees (2007) *2006 global trends: Refugees, asylum-seekers, returnees, internally displaced and stateless persons*. Geneva: Division of Operational Services, Field Information and Coordination Support Section.

135 Australian Bureau of Statistics (2003) Suicide: Recent Trends, Australia, 1992-2002. ABS: Canberra. http://abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3309.0.55.001Explanatory%20Notes11992%20to%202002?OpenDocument

136 American Psychological Association (2000) Diagnostic and Statistical Manual of Mental Disorder, 4th Editors TR. Washington DC: American Psychological.

137 World Health Organization (2008) International Statistical Classification of Diseases and Related Health Problems, tenth revision, (6th ed.). Geneva: World Health Organization, 1992.

138 World Health Organization (2001) Strengthening Mental Health Promotion. Geneva: World Health Organization (Fact sheet no. 220).

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CED10-003