A literature review: Prevention and possibilities

A focus on children and youth
Foreword

The Mental Health Commission’s purpose is to contribute to mental health and wellbeing for all New Zealanders. Its aim is to improve mental health and addiction services and to influence society’s overall response to mental distress and addiction.

This brief report explores prevention in relation to mental health and addiction and highlights the challenges around sustainability and funding. The literature review provides an overview of prevention in mental health with a focus on financial and funding implications. It highlights the importance of prevention as an activity that occurs before a problem or disease occurs rather than as a reaction to a fully developed problem. This report clarifies the definition of prevention and identifies social determinants and funding issues that impact on prevention activities.

In order to prevent or reduce mental disorders in adults, strategies need to be developed for the prevention of mental illness in infants, children and adolescents. Prevention requires ‘upstream thinking’ about how services are delivered and sustainable funding. Mental health and physical health services need to be closely aligned and integrated.

It is important that people responsible for policy, funding and planning are aware of the benefits of prevention and early intervention.

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Executive Summary

The purpose of this report is to influence funders and planners to direct funds to achieve not only wellbeing for children and young people but also to reduce long-term mental health and addiction costs.

A brief literature review on prevention in mental health in New Zealand and internationally was undertaken. This identified that emotional and behavioural disturbances in children and young people can be early predictors of mental illness. Prevention in this age range is seen to be critical in making a difference in adult mental health outcomes.

This report considers prevention with reference to the cost benefit and cost effectiveness of prevention. The following points are highlighted:

- There are financial benefits to early intervention and prevention.
- Prevention is different from promotion and early intervention.
- Prevention initiatives in New Zealand’s mental health and addition sector are underdeveloped.
- Some prevention measures, such as those in primary health organisations are not financed out of the mental health funding.
- Social and environmental factors such unemployment, poor housing and poverty are determinants of mental distress and need to be considered in prevention activities.
- There are a number of ways in which funders and planners of mental health services can establish a ‘prevention culture’ in their DHB such as:
  - Maternal mental health and addiction services
  - Targeted funding for families, whānau at highest risk
  - Developing expertise in primary health providers to ensure early identification
  - Programmes for children of parents with mental illness
  - Drop-in centres for young people
  - ‘Wraparound’ community-based services which strengthen the family, whānau resilience
  - Mental health and addiction services in schools
  - Collaborating with other agencies to address the impact of determinants of mental distress such as poverty and family violence.
Introduction

Literature indicates there is national and international recognition that prevention has a significant contribution to make to mental health. There is a growing body of evidence indicating the effectiveness of interventions which reduce risk factors, increase protective factors and reduce the incidence of mental distress. This literature review provides an overview of prevention in mental health with a focus on financial and funding implications. It highlights the importance of prevention as an activity that occurs before a problem occurs rather than as a reaction to a fully developed problem. The report aims to clarify the definition of prevention, social determinants and funding issues that impact on prevention activities.

The World Health Organization indicates that prevention is a key approach to improving the lives of people and the population. Knowledge has increased around risk factors and protective factors for mental distress. Studies have shown that preventative interventions can be successful in reducing risk factors and strengthening protective factors in terms of mental distress (World Health Organization 2002, 2004; O’Connell et al 2009; Academy of Medical Royal Colleges and Royal College of Psychiatrists 2009; Royal College of Psychiatrists 2010; Royal Australian and New Zealand College of Psychiatrists 2010).

This report has a focus on children and young people, because mental, emotional and behavioural disturbances in children can be early predictors of mental distress and, if unresolved, create a burden for the young people themselves, their families and communities. Research indicates that multiple factors contribute to mental, emotional and behavioural disorders, but interventions at an early age can be successfully targeted to intervene with positive outcomes (report from the Prime Ministers’ Chief Science Advisor 2011). Using multiple approaches such as policy, programmes and joined-up agency approaches, there is potential to reduce mental health, emotional and behavioural disorders (O’Connell et al 2009; Royal Australian and New Zealand College of Psychiatrists 2010; Zechmeister et al 2008).

Prevention requires a paradigm shift in the way services are delivered, sustainability of funding, dialogue on healthy lifestyles referring to mental health and addiction and the ability to respond as soon as mental, emotional and behavioural difficulties arise. It also requires services such as mental health and physical health to be more closely aligned and integrated as, inevitably one impacts on the other (Royal College of Psychiatrists 2010; O’Connell et al 2009). In order to prevent or reduce mental distress in adults, strategies need to be developed to prevent of mental health problems in infants, children and adolescents.

There is well established evidence that experiences during the early years of life have an impact on later health (Report from the Prime Ministers’ Chief Science Advisor 2011.)
Literature Search Strategy

The research strategy involved a review of the literature using the Medline database, the Ministry of Health’s online publications and World Health Organization’s website. Key words such as ‘mental health prevention’ were entered at each site, and full text documents were requested through Medline. The initial search phase was an iterative process to become familiar with the literature, then moving on to a more targeted approach searching for authors.
Cost-effectiveness of Prevention

The literature indicates that prevention and promotion in children and adolescents is cost-effective (Zechmeister et al 2008). The enduring cost of life-long illness indicates that benefits from early intervention and prevention could be substantial. There are a number of challenges in terms of funding for prevention. Perhaps the most challenging is to devise funding mechanisms that make it possible to invest for longer-term returns (Naylor and Bell 2010). Longer term investments will enable more impact on economic return and on health outcomes. Sustainability of funding is a key issue. There are challenges related to effectiveness of programmes provided (McCrone et al 2008, Naylor and Bell 2010). The literature indicates a growing body of evidence based and economically effective programmes. Given the current context of economic budget constraints information on the economic costs and consequences of any intervention is part of the funding requirements.

Research indicates that costs and economic pay-offs can be made in a range of interventions around prevention activities (Knapp et al 2011). In terms of young people, they found benefits in parenting interventions, reducing postnatal depression, prevention of conduct disorder, reducing bullying and early detection psychosis. They found that parenting interventions for the prevention of persistent conduct disorders had an impact to age 30 years compared with no interventions. Conduct disorders are the most common childhood psychiatric disorder and, in about 50% of cases, leads to adult antisocial personality disorders. Parenting programmes can be targeted to at-risk groups of parents and are designed to improve parenting styles and relationships between parent and child. Financial modelling indicates gross saving over 25 years to £9,288 per child. This figure exceeds the cost of intervention by a factor of 8 to 1. This modelling did not include the wider impact such as improved employment prospects, reduced adult health issues and improved family outcomes. These benefits, if factored in, are likely to be substantial. Figure 1 represents the rates of return to investment in human capital as a function of age when investment was initiated; r represents the costs of funds).
Recognising the importance of mental health both in terms of population and the costs is important in order to set a path for the future (McCrone et al 2008). They estimate that the current service cost for mental health in England at 1.7% of gross domestic product (GDP). The projected cost for 2026 is 3.5%. This figure does not include the cost of lost employment, which would further inflate the percentage figures given here. New Zealand does not have similar figures; however, we know that the total public funding for mental health and addictions has increased from $207 million in 1993/94 to $1.2 billion in 2008/09 (Ministry of Health 2010).

The overall prediction from United Kingdom studies suggests that (financial) costs in mental health are going to increase (Royal College of Psychiatrists 2010; Centre for Mental Health 2010; Naylor and Bell 2010). Reviews and evaluations of childhood and adolescent emotional and behavioural disorders, criminal activity related to conduct disorder, work-related ill health in which mental illness is the leading cause of incapacity benefit payment, and alcohol misuse are all areas where the costs are predicted to significantly increase. The researchers point out that relatively little evaluation has been done on the economic impact of good mental health on issues such as productivity at work and physical health.

Given the high costs of any programme and the need for accountability, evidence needs to be provided to show that investment is producing a positive return. There are challenges in developing an economic analysis of the benefits of prevention, and guidelines need to be developed to enable this to occur along with strengthening the evidence base (O’Connell et al 2009; Saxena et al 2006). The gold standard for quality of evidence is randomised controlled trials (RCT). The strengths of this approach are widely recognised as the highest standard and the best design in terms of the ability to

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1 Adapted from Knudsen et al 2006.
control the context. The use of RCT in prevention is being challenged, as the use of multi-component programmes in dynamic community settings means that contextual factors are not controllable (Saxena et al 2006). International exchange of evidence and the sharing of databases are essential for developing a strong evidence base and for understanding the impact of cultural as well as financial factors. Improved methodological approaches have led to better evaluation processes, programme design and interventions, etiological theories and theories of change (O’Connell et al 2009). In New Zealand developing a strong evidence base will require a “prolonged effort over several electoral cycles and cannot be held hostage to adversarial politics” Prime Ministers Chief Science Advisor (2011) pg 1.

Mental health expenditure in New Zealand has increased over the past 10 years. Service provision has also increased, as has the population accessing services. In New Zealand, the prevalence rates for children with mental disorders, hyperkinetic disorders, emotional disorders, conduct disorders or a combination of disorders has yet to be established. However, if we follow the UK trends, statistics estimate that one in 10 will encounter mental health problems. The elements used to estimate costs for disorders affecting children and adolescents are prescribed drugs, inpatient care, GP visits, and accident and emergency and outpatient appointments in the UK. These costs were generally seen as an underestimate; as coding was done conservatively – UK statistics indicate that, by 2026, costs are predicted to increase by 65%, excluding inpatient care (McCrone et al 2008).

The cost of mental health is often hidden in young people because they are not always found in health care settings, for example education, justice and physical health care. O’Connell et al (2009) estimate that more than one-quarter of the total cost for mental health treatment services among adolescents is incurred in education and juvenile justice systems. In this regard, prevention as an approach to healthier outcomes has ability to reach broad sections of the population.

Implications for future policy

Long term sustainable prevention funding along with evidence based programmes that impact positively on health outcomes are important strategic considerations. The Blueprint (Mental Health Commission 1998) outlines the FTE requires for mental illness prevention (10 per 100,000 population). Recent regional report of targets against Blueprint indicates that DHBs have fallen short of being able to meet Blueprint targets for prevention (Mental health Commission 2011). There is funding that falls outside the Blueprint funding and has been used for national initiatives such as suicide prevention, however the level of investment in specialist prevention falls short of blueprint targets. Implications for the future are clearly stated in Improving the Transition (Office of the Prime Minister’s Science Advisory Committee 2011) and the report provides a possible way forward. The funding strategy for prevention in mental health lacks a cohesive national infrastructure and therefore has developed unevenly across the country. While the funding issues lack a national strategic approach the issue of how to get traction in the area of prevention remains. Discussion on prevention in mental health is difficult in the current environment given the economic constraints and the lack of traction on blueprint FTE. There is a paucity of mental health prevention initiatives as highlighted in the recent Ministry of Health record of achievements against the leading challenge
‘Promotion and Prevention’, (Ministry of Health 2011). Some DHB are managing to undertake and successfully implement prevention programmes in mental health but generally prevention in New Zealand is in its infancy.

Planning, Funding Managers and Mental Health Managers are key influencers of innovation and change in DHBs and while there are economic constraints in the funding environments mental health planner’s funders and managers can influence the direction of prevention strategies within their DHB through advocacy for prevention and encouraging a linked up approach to achieve positive prevention outcomes. Prevention strategies in mental health may not necessarily sit within mental health services but a linked up approach with PHOs, education, government agencies and other agencies is key to achieving a comprehensive prevention approach.

There is good evidence internationally around the cost effectiveness of prevention programmes in mental health. While we have a number of prevention programmes in New Zealand research we have limited research resources to evaluate their effectiveness (Office of the Prime Minister’s Science Advisory Committee 2011). There is a need to have New Zealand based programmes adequately evaluated so as the gains in terms of costs, social factors such decreasing in crime and associated costs can be determined in terms of impact.
Mental Health Prevention a National Perspective

In regard to this project, the Mental Health Commission focus is on prevention in young people. Research indicates that specific interventions to increase resilience, positive parenting interventions and programmes for children at risk have shown to increase mental wellbeing and decrease depressive symptoms (Doughty 2005; Saxena et al 2006). Mental illness such as depression, conduct disorder and substance abuse in young people creates an enormous burden for families (O’Connell et al 2009). Across the whole population, 46.6% of the population are predicted to meet criteria for a disorder at some time in their lives (Oakley Browne et al 2006). In New Zealand, studies indicate that 0.25% (1300) children were diagnosed by a doctor with depression; similarly, 0.3% (2800) were diagnosed with anxiety disorder (Ministry of Health 2008). These statistics only account for diagnosed disorder; it is probable that these figures are higher.

There have been a number of national strategies to improve mental health services, and these have all included prevention with varying foci. The *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission 1998) proposed mental health prevention services to address the first goal of the national Mental Health Strategy – the reduction of the prevalence of mental illness. The Blueprint suggested that evidence-based mental illness prevention programmes have the potential to lower the likely prevalence of illness and therefore reduce demand. The Blueprint states that prevention services are needed to:

- provide education about risk factors and signs of developing mental illness, mental illness prevention and suicide prevention
- facilitate mental illness prevention in areas where there are higher levels of likely incidence of illness, for example:
  - children and young people who are socially disadvantaged from dysfunctional family environments, displaying problematic behaviours, and failing in their educational setting
  - people at risk of experiencing traumas which are known to have a high risk of a subsequent mental illness (Mental Health Commission, 1998, p49).

Since 2005 and 2006, two action plans – *Te Tāhuhu, Improving Mental Health* (Ministry of Health 2005) and *Te Kokiri, the Mental Health and Addiction Action Plan* (Ministry of Health 2006) have described the outcomes and actions government wants to achieve in mental health and addiction services. These action plans have had some focus on improving wellness for people, families, whānau and communities affected by mental illness and addiction. The focus of the current Mental Health and Addictions Action Plan (Ministry of Health 2010) in terms of prevention is on vulnerable families, effective interventions for conduct or behavioural problems and parenting programmes. Whānau Ora is a government initiative that offers an inclusive approach to health, providing services and opportunities to families across New Zealand. The approach is to improve families as a whole rather that have a separate focus on the individual. It requires a multi-agency approach to work together with families (Te Puni Kōkiri 2010).
Prevention Definitions

Historically, disease prevention has been categorised as primary, secondary or tertiary depending on whether the strategy prevented the disease itself, the severity of the disease or the associated disability. Prevention in mental health is not as well defined as in physical health, and its definition is often coupled with promotion (World Health Organization 2002). Physical health prevention strategies prevent disease or prevent the severity of disease or disability associated with a disease process. This definition is linked to known aetiology of disease. Mental health and illness does not fit well into this model, as interactions with the environment, biological factors and specific age issues make it difficult to determine exact causes or origins. It is often difficult to determine the exact time of onset, as the progression from asymptomatic to symptoms may be insidious. However, it is interesting to note that the costs and savings in regard to prevention in mental health are well documented, and fiscal issues often appear as clear drivers for change rather than the impact on people and communities (Centre for Mental Health 2010; Royal College of Psychiatrists 2010; McCrone et al 2008).

Promotion and prevention often overlap. While prevention emphasises the avoidance of risk factors, promotion strives to promote a supportive family, school and community environment to identify and strengthen protective factors that enhance wellbeing and provide tools to avoid adverse emotion and behaviours (O’Connell et al 2009). Promotion is aimed at promoting positive mental health. Prevention and promotion can be efficacious in reducing mental health problems and symptoms of mental disorders including child abuse (Jane-Llopis 2004). Promotion is oriented to building strengths, resources, knowledge and assets and is under control of the person concerned. It also aims to increase mental health wellbeing and resilience by creating supportive living conditions and environments. Mental health promotion programmes are primarily educational rather than clinical, and the ultimate goal is to increase people’s capacities or control over, and to improve, their health (World Health Organization 2002).

Prevention is distinguished from treatment, and while treatment may have some preventative aspects, it is still treatment and not prevention. Intervention studies often use strategies around promotion while assessing the prevention of mental disorders and related negative outcomes as a goal. The distinction between prevention and promotion may therefore be more apparent than real at the practical strategic level for inducing change. Prevention targets the reduction of symptoms and mental disorders. Prevention has a focus on risks prior to the onset of illness.

Prevention classification

- **Universal** – population based leading to the reduction of risk of disorders.
- **Selective** – directed to at risk groups or individuals.
- **Indicated** – targeting individuals with biological markers, early symptoms or problem behaviours predicting high risk.

Adapted from World Health Organization 2002; O’Connell et al 2009.
Definitions of promotion and prevention interventions

Although promotion and prevention are distinguishable in regard to their approaches, the following definitions put the two together as they share a common foundation:

- **Universal** – targeted to public or whole population not identified on the basis of risk, for example, substance abuse programmes based in schools.
- **Selective** – targeted to population or individuals where risk is higher than general population, for example, programmes offered to children exposed to risk factors associated with divorce, death or parents who have a mental disorder or addiction.
- **Indicated** – targeted to high-risk individuals who are having detectable signs or symptoms but do not reach diagnostic criteria, for example, children with early problems of aggression or elevated symptoms of depression or anxiety.

Mental health promotion is situated in the larger field of health promotion and sits alongside prevention of mental disorder, treatments and rehabilitation of people with mental illness and disabilities. Mental health promotion involves activities that allow people to adopt and maintain healthy lifestyles and create living conditions and environments that support health (World Health Organisation 2005). Promotion is seen as a broader separate concept with aspects of prevention. The Jakarta Declaration for Health Promotion (World Health Organization 1997) suggests that the aim of promotion is to reduce inequities, build social capital, create healthy outcomes and narrow the gap in health expectancy. The declaration includes five priorities for the 21st century, which are to:

- promote social responsibility for health
- increase investments for health development
- consolidate and expand partnerships for health
- increase community capacity and empower the individual
- secure an infrastructure for health promotion.

Promotion is similar to prevention in that it seeks to promote the wellbeing of those not at risk, those who are at increased risk and those suffering or recovering from mental illness.

Over the past 10 years, New Zealand has had a growing focus on mental health promotion strategies and, more recently, some prevention strategies. *Building on Strengths: A New Approach to Promoting Mental Health in New Zealand/Aotearoa* (Ministry of Health 2002) provides definitions of mental health and mental health promotion. It is aimed at dealing with the root causes and barriers to mental health and wellbeing and proposes actions that can be adopted to further mental health promotion work. Promoting mental health and preventing mental illness is a key component of other documents such as the Mental Health and Addiction Action Plan 2010, Te Tāhuhu (2006), Te Kokiri (2006), the New Zealand Suicide Prevention Strategy 2006–2016, Te Puawaiwhero: the second Māori mental health and addiction national strategic framework 2008–2015, the National Depression Initiative and the Like Minds, Like Mine programme.

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3 Adapted from O’Connell et al 2009; World Health Organization 2004.
Determinants of Mental Health

The determinants of mental health relate not only to individual factors but also social and environmental factors such as employment, education, income poverty, war and inequity (World Health Organization 2002, 2004; O’Connell et al 2009). Table 1 highlights the areas of risk and protective factors.

Table 1: Selected determinants of mental health

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<thead>
<tr>
<th>Social environmental and economic risk factors</th>
<th>Protective factors</th>
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<tbody>
<tr>
<td>Access to drugs and alcohol</td>
<td>Empowerment</td>
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<tr>
<td>Displacement</td>
<td>Ethnic minorities integration</td>
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<td>Isolation and alienation</td>
<td>Positive interpersonal interactions</td>
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<td>Lack of education transport and housing</td>
<td>Social participation</td>
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<td>Neighbourhood disorganisation</td>
<td>Social responsibility and tolerance</td>
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<td>Peer rejection</td>
<td>Social services</td>
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<td>Poor social circumstances</td>
<td>Social support and community networks</td>
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<td>Poor nutrition</td>
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<tr>
<td>Poverty</td>
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<td>Social injustice and discrimination</td>
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<td>Social disadvantage</td>
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<td>Unemployment</td>
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<td>Urbanisation</td>
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<td>Violence and delinquency</td>
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<td>War</td>
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<td>Work stress</td>
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Adapted from World Health Organization 2004.
<table>
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<tr>
<th>Individual and family-related risk factors</th>
<th>Protective factors</th>
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<tbody>
<tr>
<td>Academic failure</td>
<td>Ability to cope with stress</td>
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<td>Attention deficits</td>
<td>Ability to face adversity</td>
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<tr>
<td>Caring for chronically ill or dementia patients</td>
<td>Adaptability</td>
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<tr>
<td>Child abuse and neglect</td>
<td>Autonomy</td>
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<td>Chronic insomnia</td>
<td>Early cognitive stimulation</td>
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<td>Chronic pain</td>
<td>Exercise</td>
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<td>Communication deviance</td>
<td>Feelings of security</td>
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<td>Early pregnancies</td>
<td>Feelings of mastery and control</td>
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<td>Elder abuse</td>
<td>Good parenting</td>
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<td>Emotional immaturity and dyscontrol</td>
<td>Literacy</td>
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<td>Excessive substance use</td>
<td>Positive attachment, early bonding</td>
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<td>Exposure to aggression, violence and trauma</td>
<td>Positive parent-child interaction</td>
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<td>Family conflict or family disorganisation</td>
<td>Problem-solving skills</td>
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<td>Loneliness</td>
<td>Pro-social behaviour</td>
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<td>Low birth weight</td>
<td>Self-esteem</td>
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<td>Low social class</td>
<td>Skills for life</td>
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<td>Medical illness</td>
<td>Social and conflict management skills</td>
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<td>Neurochemical imbalance</td>
<td>Socio-emotional growth</td>
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<td>Parental mental illness</td>
<td>Stress management</td>
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<td>Parental substance abuse</td>
<td>Social support family of friends</td>
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<td>Perinatal complications</td>
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<td>Personal loss, bereavement</td>
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<td>Poor skills and habits</td>
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<td>Reading disabilities</td>
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<td>Sensory disabilities or organic handicaps</td>
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<td>Social incompetence</td>
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<td>Stressful life events</td>
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<td>Substance use during pregnancy</td>
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Risk factors are associated with increased probability of onset, greater severity and longer duration of major health problems. In young people, they are likely to be associated with negative health outcomes. Protective factors refer to conditions that improve people’s resistance to risk factors and disorders. Interventions are aimed at reinforcing protective factors and counteract risk factors. In a young person, it is associated with a positive transition into adulthood. The World Health Organization suggests that, where interventions are focused on generic risk and protective factors, then preventative effects are likely to occur. An example is child poverty and abuse, which can be related to depression and anxiety and substance abuse (World Health Organization 2004). Interventions that successfully address abuse and poverty can be expected to have an impact on all three disorders.
The World Health Organization (2004) suggests that, to make an impact on mental health, to improve quality of life and reduce risk, multiple approaches need to be made through legislation, policy formation and resource allocation. Their research indicates macro-preventative strategies such as nutrition, housing, education, economic security, positive environmental changes and good community networks have been shown to improve quality of life.

Successful programmes addressing risk and protective factors early in life are targeted at child populations at risk, especially families with low income and education (World Health Organization 2004). For the school-aged child, general skill-building programmes, changing the school environment and multi-component programmes form the main approaches. Other interventions may target facets such as dealing with family disruption, workplace interventions, supporting refugees and healthy ageing. Early interventions are a key prevention strategy and include promoting a healthy start in life via home-based interventions and preschool parenting interventions.

Preventing and reducing the burden of mental illness and physical illness in society has benefits for all of society. The Academy of Medical Royal Colleges and Royal College of Psychiatrists (2009) and the Royal College of Psychiatrists (2010) have a number of documents that indicate the importance of prevention and promotion in terms of the burden of mental illness. The ALERT summary report (Academy of Medical Royal Colleges and Royal College of Psychiatrists 2009) indicates quite clearly the need to address mental health and wellbeing if strategies to improve the nation are going to be effective. Mental illness in the UK costs the economy £105 billion a year in England and is the single largest burden of disease. The report calls on the government to make policy changes and to put mental health at the centre of the public health agenda and indicates that there is a need to improve lifestyles and reduce health risk behaviours, thereby preventing mental illness.
Conclusion

Prevention requires a paradigm shift in the way services are developed and offered. Working within the status quo will not effect change in prevention as it requires a different approach beyond traditional models of health care. While we are mostly used to waiting for disorders to manifest and then seek treatment, prevention seeks to look forward into the future to determine or prevent negative health outcomes. Prevention views physical health and mental health as inseparable – good mental health contributes to the maintenance of good physical health (O’Connell et al 2009; The Future Vision Coalition 2009; Saxena et al 2006).

Prevention has the potential to benefit society and healthy lifestyles. It needs to be integral to public health at both the national and local policy levels and requires interagency and intersectoral responses, including housing, employment, education, criminal justice and human rights. Sustainable funding is critical to this development along with programmes that evidence and accountabilities to show a return on investment.

There is good evidence that targeting infants, children and youth at the earliest stage possible prevents or can influence adult trajectories of illness and chronicity. The determinants of mental health and risk factors clearly indicate where the target populations and risk areas are located and programmes need to be directed into these areas.
Examples of Prevention in Mental Health Services Counties Manukau

**Mental Health First Aid**

The Mental Health First Aid (MHFA) programme was first developed in Melbourne, and in 2008, Counties Manukau District Health Board adapted the programme for Māori using the Aboriginal and Torres Strait Islander MHFA Australia programme. Since April 2005, the MHFA programme has been run from the ORYGEN Research Centre at the University of Melbourne. The programme is now widely used throughout the world.

This particular programme developed as a response to need in the community. It is seen as a tool that services can use to support better mental health outcomes and to support the development of knowledge and literacy around mental health. The aim of the programme is increase mental health literacy among whānau, develop capacity to identify mental health issues and provide basic support. It also aims to help people provide initial support for someone with a mental health problem, to enable whānau to assist people who have or are developing mental health problems to seek professional support. An MHFA training course has been developed with the aim to improve the mental health literacy. First developed in Australia, it has been evaluated using random controlled trials and found to be effective at improving the course participants’ knowledge of mental disorders, reducing stigma and increasing the amount of help provided to others.

The programme includes a five-day instructor training course to accredit suitable candidates to become MHFA instructors who deliver the 12-hour MHFA course to their communities. This 12-hour course is designed to give members of the public skills to help an individual developing a mental health problem or in a mental health crisis situation. The philosophy behind the course is that mental health crises, such as suicidal and self-harming actions, may be avoided through early intervention. If crises do arise, members of the public can take action to reduce the harms that could result.

Training was provided to four NGOs, and currently two non-mental health NGOs provide the service. The 12-hour programme provides information on various mental disorders and how they can be responded to in the immediate term. A workbook is provided, and the course works through symptoms, causes and evidence-based treatments for depression, anxiety disorder, psychosis and substance abuse. Similar to first aid, the course uses the acronym ‘MAURI’:

- Make an assessment of the risk of suicide or harm.
- Attentive, non-judgemental listening
- Understand and give reassurance and information.
- Remember to encourage the person to get appropriate professional help/awhi.
- Inform them of self-help/awhi strategies.
Currently, the programme is targeted towards Māori in the Counties Manukau region and over 18 years of age. It is for all whānau, community workers and members of the community who come in contact with mental health issues in their normal activities. There is potential to develop the programme for the wider community, in particular, teachers, Police, families, CYF and other agencies. It also has potential to be adapted for Pacific and Asian peoples.

Evaluation
An evaluation was undertaken and published in January 2010. The findings indicate that levels of mental health literacy had increased, stigma/whakamā had decreased, the programme action plan was being used in the real world and the tool is contributing to referral to mental health professionals.

Funding
The programme is provided through two NGOs at no extra funding costs. However, the DHB does provide training and ‘train the trainer’ courses. The programme focus is beyond the 3% mental health population and, in that regard, sits outside mental health funding in public health.

Infant Mental Health Service
Infant Mental Health Services (IMH) requires specific expertise to works with a range of services and people. Programmes need to adapt to context and community environments. Specifically there is a need to have a joined-up approach with people and agencies (Plunket, Family Start, neonatal, midwifery, CAMs primary care services that work with babies and GPs). Counties Manukau have developed a group of key stakeholders such as paediatricians, midwives, MSD, Education and others to move prevention forward in an integrated way. IMH provides specialist treatment for families with high needs, attachment difficulties, and significant violence and mental health issues. Intervention is early so as to prevent problems later on. Multiple agencies and services that deal with babies are working together to provide prevention programmes alongside treatment services.

DVD – Look At You, Aroha Atu, Aroha Mai
Provided as an education tool about bonding and parenting infants, Look At You, Aroha Atu, Aroha Mai is the first of a series of DVDs showing the ways in which babies are social and communicate right from birth. The DVD is aimed at helping parents, whānau and professionals understand and respond to the social and emotional needs of babies in the first three months of life. The DVD is given to every family, whānau who delivers a newborn baby in Counties Manukau via the lead maternity carers. It is given free to any agency or individual with the DHB. Outside of the DHB, there is a small charge to cover costs. Currently, Counties Manukau DHB is developing Māori and Pacific versions.

Funding
Mental Health Services provided one-off funding for the DVD.
References


