prescribing patterns and substances used in Australian homes.

As a result of poisoning there were 933 hospitalisations of children aged under five years in NSW in 1995–96.[1] For this age group there were more than 3,000 calls to the NSW PIC which were either made from a hospital or which resulted in advice to attend hospital. It is likely, therefore, that the NSW PIC database is adequately representative of most poisoning exposures in this age group.

CONCLUSION

Of more than 20,000 calls relating to young children in NSW each year, more than 80 per cent result in the advice to 'stay home', thus possibly avoiding a considerable additional burden on health services. The data that is currently collected provides limited but useful information which can assist in setting priorities in poisoning prevention activities, and guide the investigation of risk factors associated with poisoning. The NSW PIC is in a unique position to collect additional specialised poisoning risk information which could enhance prevention activities.

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PREVENTION INTERVENTIONS FOR CHILD AND ADOLESCENT MENTAL HEALTH: NSW RESOURCE DOCUMENT

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This article describes a new resource, *Prevention initiatives for child and adolescent mental health: NSW Resource Document*, produced by the Centre for Mental Health, that provides information on a range of programs designed to prevent the development of mental health problems and disorders in children and young people. Based on a literature review of the current research in prevention initiatives for child and adolescent mental health, it includes: initiatives aimed at the prevention of mental health problems, early intervention programs and services for young people with depression and related disorders, and first onset psychosis and suicide prevention.

BACKGROUND

Effective prevention programs have been identified which may help to reduce the risk of children developing a mental problem or disorder. Some prevention programs are even more effective than later treatments, particularly in the area of conduct disorders. Significant advancements can be made when both the early years of life and the early stages of disorders are targeted.

Mental health prevention and early intervention are relatively new fields in mental health. Progressing these initiatives involves supporting health and related staff and the community in the acquisition of the knowledge and skills needed to meet the challenges of new service directions and programs, including the provision of resources to assist implementation.

The NSW Department of Health is playing a leading role in national prevention initiatives in mental health, including the *National Mental Health Promotion, Prevention and Early Intervention Action Plan,*[1] for the *Second National Mental Health Plan*.[2] The *NSW Resource Document* will help to guide the implementation of the National Mental Health Reform Incentive Funding that has been provided to NSW over the next five years to help progress implementation of the Second National Mental Health Strategy.

THE NSW RESOURCE DOCUMENT

The *NSW Resource Document* is divided into eight sections:

Section 1 provides an introduction to the research and policies that have influenced the growing interest in evidence-based prevention initiatives for child and adolescent mental health.

TABLE 3

PREVALENCE OF MENTAL HEALTH PROBLEMS AMONG 4–16 YEAR OLD CHILDREN AND ADOLESCENTS, FROM THE 1996 WESTERN AUSTRALIAN STUDY*#

Mental Health Problem	Prevalence
Delinquent problems	9.5%
Thought problems	8.6%
Attention problems	6.3%
Social problems	5.9%
Somatic complaints	5.0%
Aggressive behaviour	3.7%
Anxiety/depression	3.6%
Withdrawn	2.6%
Overall Prevalence	18%

* Figures based on caregivers and teacher reports about 4–16 year olds using the Child Behaviour Checklist (CBCL).[5]

\# Many children and adolescents have multiple problems and therefore are represented in more than one category.

Source: Zubrick et al. (1996).[6]

Section 2 provides a general overview of prevention, partnerships and programs. The *Mental Health Intervention Spectrum for Mental Disorders* is introduced,[3] as are national and state policy and research frameworks. Classification systems for prevention are identified. Effective methods for successful partnerships and programs are discussed.

Sections 3, 4, 5 and 6 review the developmental life stages of children and adolescents. A summary of international and national research in mental health programs provides an appraisal of effective, evidence-based prevention initiatives. Risk and protective factors are discussed along with other positive child attributes for coping, such as resilience and optimism. Multiple components of these effective programs are outlined. Where possible, Australian programs have been described which demonstrate effective child and adolescent mental health interventions in progress.

Section 7 describes prevention and early intervention initiatives and programs for children, adolescents and their families experiencing traumatic and adverse life events. Families may be affected by events such as death of a family member, marital discord or separation, environmental disasters and economic disadvantage. Children and adolescents may require interventions to ameliorate the effects of abuse or neglect, parental substance abuse or mental health problems or domestic violence.

Section 8 provides a reference list of the literature and studies mentioned in the document.

EXTENT OF MENTAL HEALTH PROBLEMS AND DISORDERS

The recently completed Child and Adolescent Component of the National Survey of Mental Health and Wellbeing highlights the need for action.[4] Almost 20 per cent of all children and adolescents are affected by mental health problems and at least half of these show impaired schooling and social development. Mental health problems and disorders manifest in a wide range of emotional, behavioural and thinking difficulties.

When discussing ill health, two terms are useful. **Mental health problems** is used to describe a broad range of emotional and behavioural difficulties that may cause concern or distress. These problems are relatively common and encompass **mental disorders** which are more severe and/or persistent mental health conditions. The term

TABLE 4

INTERNATIONAL COMMUNITY-BASED PREVALENCE STUDIES OF MENTAL HEALTH PROBLEMS AMONG CHILDREN AND ADOLESCENTS

			Prevalence of DSM-III Disorders (rounded to whole percentages)							
Study	**Sample Size**	**Age**	**ADD**	**CD**	**OPP**	**OAN**	**SAN**	**PHO**	**DEP**	**ALL**
Anderson et al. (1987)	782	11	7%	3%	6%	3%	4%	2%	2%	18%
McGee et al. (1990) (NZ, longitudinal study)	943	15	2%	7%	2%	6%	2%	5%	2%	22%
Bird et al. (1988) (Puerto Rico)	777	4–16	10%	2%	10%	N/A	5%	2%	6%	18%
Costello et al. (1988) (Pennsylvania)	789	7–11	2%	3%	7%	5%	4%	9%	2%	22%
Offord (1987) (Canada)	2,679	4–16	6%	6%	N/A	10%	N/A	N/A	N/A	18%
Velez (1989) (New York)	776	11–20	4%	5%	7%	3%	5%	N/A	2%	18%

Note: ADD = Attention deficit disorder; CD = Conduct disorder; OPP = Oppositional disorder; DEP = Depression/Dysthymia; OAN = Overanxious; PHO = Phobia; SAN = Separation anxiety

Source: Costello (1989).[7]

TABLE 5

RISK EXPOSURES THAT MAY INTERACT TO PRECIPITATE MENTAL HEALTH PROBLEMS OR DISORDERS

Critical Risk Exposures	Protective Influences
Biological dysmaturation	Nurturing, affectionate and secure attachments
Unstable attachments	Affectionate and supportive family environment
Inadequate parental skills	Positive relationships with at least one parent
Poor quality child care	Supportive relationship with another adult, for example a teacher, aunt or uncle
Family discord, exposure to domestic and other violence and stress, and parental separation and family breakdown, and in some circumstances, sole parenting	Connectedness and positive and rewarding school environments
Experience of stressor effects of parental mental illness, personality disorder, substance use disorders or antisocial behaviours	Positive personal achievements such as academic or sporting
Lower levels of social support	Positive 'temperament'
Exposure to psychological trauma (eg. abuse, accidents, burns, disaster)	
Physical illness or disability	
Extended adolescent dependency	
Eroding social capital	
Poverty	

'mental disorder' describes a clinically recognisable set of symptoms or behaviours associated in most cases with distress and which interfere with personal functions.

Mental health problems will contribute significantly to the global burden of disease in the 21st century,[8] and for adolescents, are already as common as some physical health problems such as asthma. The tables summarise some of the morbidity findings. Table 3 presents the prevalence of common mental health problems as found by the Western Australian Child Health Survey (1996).[6] Table 4 summaries the findings of several international studies from which the prevalence of specific child and adolescent mental health problems and disorders has been estimated. In addition, it is estimated that one per cent of children and adolescents suffer from obsessive compulsive disorder, and a further one per cent of adolescents suffer from eating disorders (Kurtz et al. 1996).[9]

These figures suggest that mental health problems and disorders are of significant concern. They are increasingly contributing to the burden of disease across all age groups, both within Australia and internationally.[4,6,7] Among children and adolescents, problems such as child abuse and neglect, conduct disorders, alcohol and drug abuse, depression, attention deficit disorders, and suicide are all becoming more common.[10,11,12] Furthermore, mental disorders (notably depression) are appearing at an younger age and they also seem to be increasing in severity.[11,13]

Children and adolescents with mental health problems are:

- twice as likely to report feeling 'very stressed'
- three times more likely to have poor or fair physical health
- three times more likely to perform below grade level at school
- three times more likely to use alcohol and other drugs
- six times more likely to think about killing themselves.[6]

The major contribution of social and environmental variables to the development of disorders in children and adolescents remains a cause for concern. Further, there is a growing recognition of the potential contribution of genetic factors in increasing the vulnerability of some children and young people to environments of stimulus and stress.[14] Bearing in mind these issues, Zubrick et al. (2000),[13] and Nurcombe (2000),[15] have suggested risk exposures that may interact to precipitate mental health problems or disorders, as outlined in Table 5. Zubrick et al. (2000) highlight the need for further research of these variables with opportunities to develop appropriate measures and to explore gene-environment interactions.[13]

Supporters of the population health approach to mental health have consistently advocated primary prevention of children's problems. However, awareness, education and training is required for recognising that childhood and youth constitute defined developmental phases, and that problems in this period are often interactive, contributing to the escalation of vulnerability to mental health problems or disorders. The aim of prevention and early intervention is to be able to alter this trajectory. Thus, it is essential that a comprehensive prevention agenda build on an alliance of health, education and social agencies in our communities.[16]

For many health, education and community workers this requires a new way of thinking about mental health. The focus must shift from individual clinical casework to a broader population mental health understanding including:

- epidemiology
- multifactorial aetiology
- risk and protective factors
- socio-environmental determinants of health and mental health such as poverty and unemployment
- socio-cultural processes.

In particular, professionals employed in mental health services must be aware that in prevention, the proximal social environments that are most pertinent to population health problems are:

- family
- school
- workplace
- media
- social organisations
- professional organisations
- community organisations
- peer and other social groups.

CONCLUSION

The *Prevention initiatives for child and adolescent mental health: NSW Resource Document* was developed through extensive consultation conducted with child and adolescent mental health specialists, area mental health directors, child and adolescent mental health coordinators, as well as with other branches of NSW Health. It has collated information from national and international sources. As some of the programs outlined in the *NSW Resource Document* are still being developed and evaluated, contact details have been provided so that clinicians using the *NSW Resource Document* may follow up the outcomes from the programs and initiatives.

The next stage is the translation of these studies and findings to prevention programs in the community in order to extend these benefits to the population as a whole. This will require commitment to the integrity of programs, their adaptation for and engagement with local communities, and the incorporation of evaluations of program effectiveness. More attention is now being given to the need for programs to provide quality norms for good practice that are determined by theory, evidence-based outcomes, cost effectiveness and feasibility of widespread implementation.[17] The *NSW Resource Document* will provide an important resource to assist the implementation of innovative and effective mental health initiatives in this relatively new field in mental health services for children and young people across NSW.

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