MENTAL HEALTH IN NEW ZEALAND FROM A PUBLIC HEALTH PERSPECTIVE

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SECTION V: THE WAY FORWARD
Mental Health in New Zealand from a Public Health Perspective
CHAPTER 24: FRAMEWORK FOR MENTAL HEALTH PROMOTION AND ILLNESS PREVENTION: OBSTACLES AND OPPORTUNITIES

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Many of the major improvements in the health status of populations have been because of developments in prevention. The standard example is infectious diseases where immunisation, improvements in general living conditions, hygiene and nutrition have significantly reduced mortality. Mental disorders and psychological problems contribute substantially to reduced quality of life, compromised potential and, in some cases, lost lives. The situation is complicated by the fact that most disorders have many contributing causes. Even where biological factors appear to be necessary for the development of a disorder, there is evidence that psychosocial factors also make a substantial contribution. Incomplete knowledge about the aetiology of many disorders is a barrier to comprehensive prevention programmes. The science of prevention research is poorly developed and robust analyses of prevention strategies are rare.

The wider social environment is implicated in the development of most mental disorders (Sartorius 1989b; Mrazek and Haggerty 1994; Raphael and Burrows 1995). Changing this macroenvironment is often difficult, if not impossible, in the short term. For this reason, many prevention initiatives have focused on the individual or their family environment, attempting to enhance coping responses and resilience. Evidence to support the effectiveness of strategies that target wider societal structural change is difficult to obtain. Modifying the macroenvironment of a society and assessing accurately what contribution this has made to a reduction in illness is often impossible. However, many people would argue that to focus on individual or family change only, limits the potential of prevention strategies. For all these reasons the prevention of mental disorders is often dismissed as impossible because of inadequate knowledge.

While there have been attempts to apply prevention strategies to mental health problems, the full potential of prevention in this arena is yet to be realised. Health promotion tends to focus on the macroenvironment and is often regarded as distinct from illness prevention:

Promotion of mental health means different things to different people. To some, it means the treatment of mental illness; to others, preventing the occurrence of mental disorders; and to still others, increasing the ability to overcome frustration, stress and problems and enhancing resilience and resourcefulness. . . . promotion of mental health should be understood as a change in the position of mental health on the scale of values held by individuals, communities and societies.

(Sartorius 1989a: 3)
It has been asserted that mental health promotion programmes are primarily educational rather than clinical in conception and that their ultimate goal is to increase people’s capacities for dealing with crises and for taking steps to improve their own lives (Goldston 1977). The concept of prevention has been usefully divided into three subcategories that target different populations: those implemented universally, those for people with potential risk factors and those with early signs of problems (Jenkins 1994). In her conceptualisation, Jenkins argues that the term ‘health promotion’ is redundant. An alternative view is that health promotion is an important part of any strategy to improve the health of populations.

Society is changing its view of how we improve health, and health promotion is central to this change. These changes include: shifting from a focus on disease diagnosis and medical treatment, to disease prevention and health promotion; promoting healthy lifestyles as well as changing social conditions such as poverty, powerlessness, environmental damage, and discrimination, that shorten life and increase disease; and recognising health as a positive experience of well-being and not simply or even at all, the absence of disease.

(Labonte and Feather 1996)

In New Zealand, health promotion is a developing domain and the WHO consensus statement on health promotion underpins much of the work that has begun here. Definitions of health promotion that have wide acceptance, focus on applying strategies that enable people to take control over and improve their health. The Ottawa Charter for Health Promotion (WHO et al 1986) delineates five broad categories of action:

- promoting healthy public policy
- creating supportive physical and social environments
- co-ordinating and supporting community action
- developing personal skills
- reorienting health services.

Although effective prevention strategies may utilise these broad strategies, it may be more effective in the short term to increase coping skills with targeted personal skill development programmes. Such programmes may provide individuals with a broader range of strategies to manage life crises and conflicts. Longer-term changes, both to promote mental health and reduce mental disorder, will depend on broader social change to create environments that are more supportive and less violent, and that provide more nurturing and containing situations for children and young people. The role of health workers in macroenvironmental change has been questioned (Jenkins 1994). Jenkins presents the view that mental health workers and psychiatrists may be more effective in working at the microlevel of prevention with individuals and families. Much of the work will be secondary prevention. She argues that conditions such as unemployment, social discrimination, poverty and inequity may be outside the sphere of influence of health workers. Other prevention experts argue that wider community-based interventions should be considered (Catalano and Dooley 1980; Hawkins et al 1995). They contend that opportunities for community-based change are often ignored because psychiatry has traditionally taken the individual as its centre of focus. Mental health workers, however, have limited experience or skills to work at a community level.
This chapter will review the international and local literature pertaining to effective illness prevention strategies and programmes. Effective health promotion strategies that have been shown to reduce mental disorder will also be reviewed although it is recognised that mental health promotion does not always have illness reduction as its primary goal and its successes are not measured on this basis. Recommendations will be made regarding effective strategies for the future.

INTERNATIONAL EVIDENCE ON EFFECTIVE STRATEGIES FROM OTHER AREAS OF HEALTH

The traditional goal of prevention in the health arena has been the reduction of prevalence of a particular illness. Most prevention programmes have been founded on well-documented descriptions of the interplay of risk and protective factors. Determining these factors is seen as a critical scientific first step. The next step is to identify risk factors that can be altered through interventions. Such interventions should then be empirically tested in a systematic way to ensure they have the desired outcomes and do no harm. If risk factors can be decreased and protective factors enhanced, it is likely that the number of individuals who develop a particular disorder will decrease.

These strategies have produced significant changes in the health behaviour of individuals with resultant declines in the risk of morbidity and premature mortality. Progress has been most notable in the areas of cardiovascular disease, smoking cessation and prevention, and in injury prevention. Other examples include the dramatic changes that have occurred in infant and child mortality as a result of vaccinations for illnesses such as poliomyelitis, measles and diphtheria.

Following a review of physical prevention initiatives, the Institute of Medicine Committee on Prevention of Mental Disorders report (Mrazek and Haggerty 1994) made the conclusions listed below.

- Prevention interventions for specific disorders are typically developed through a series of phases, each step building on its predecessor and supporting its success. The general stages are:
  1. recognising and defining the problem
  2. delineating the risk factors involved
  3. conducting more detailed studies to describe the relative power of different risk factors (population attributable risk)
  4. developing and testing a variety of approaches to intervention to decrease risk and increase protection
  5. conducting large-scale confirmatory studies of the most promising interventions
  6. implementing and evaluating the interventions in large-scale demonstration projects at multiple sites
  7. transferring the knowledge gained from the intervention programmes into the public domain as widely and rapidly as resources allow.

- Preventive initiatives need not always wait for complete scientific knowledge of aetiology and treatment.
- Prevention interventions should be based on well-established theoretical frameworks.
- Prevention interventions typically are most effective when they consider multiple domains of intervention.
• Preventive interventions should focus on relevant communities, both in planning and in implementation.
• Preventive intervention programmes should be rigorously designed and the programme components evaluated extensively.
• Prevention efforts must increasingly recognise the many areas of overlap between physical health and mental health.

Prevention efforts require a significant and sustained commitment on the part of governments and co-ordination across disciplines and agencies.

It is clear that prevention strategies have progressed considerably from limited educative programmes where health workers attempted to modify the behaviour of a non-participating community. Strategies that engage communities as active partners, work with them to provide accurate information on risks and protective factors, and to develop appropriate solutions, then test and evaluate these and modify them on the basis of objective information, offer most chance of success.

EFFECTIVE MENTAL ILLNESS PREVENTION

The Institute of Medicine Committee on Prevention of Mental Disorders (Mrazek and Haggerty 1994) has undertaken the most extensive review of research on mental illness prevention strategies. This review concluded that while there is evidence that some risk factors may be specific to particular disorders, there are others that are common to many disorders. Some disorders appear to have a clear heritable risk. For other disorders, there is some evidence that genetic factors may increase vulnerability in particular individuals and that other variables interact to place an individual at increased risk. For example, low birthweight, low IQ, and sex can increase individual vulnerability to other risk factors (Rutter 1979; McGauhey et al 1991). Other factors are protective and increase resilience to environmental influences. These include positive temperament, above-average intelligence and social competence (Rutter et al 1970; Rutter 1985). Strong sibling and peer relationships as well as supportive parents who set adequate boundaries are also protective factors across a range of disorders (Werner and Smith 1982). Work on resilience in children has shown that protective factors for later adulthood include having effective social support and personal characteristics that enhance the individual’s ability to cope with stress (O’Grady and Metz 1987).

George Albee (1979, 1980, 1982, 1983, 1986) introduced concepts of community-based prevention of psychological disorders that included social, biological and psychological factors. He argues that while there are many similarities between physical disease prevention strategies and those to reduce psychopathology, there are important differences. Unlike most diseases, much psychological distress is not the result of discrete disease but learned patterns of socially deviant behaviour or idiosyncratic thought that results from stress, powerlessness and exploitation. Most epidemiological studies have found clear correlations between most forms of psychopathology and one of more of the following:

• emotionally damaging infant and childhood experiences
• poverty and degrading life experiences
• powerlessness and low self-esteem
• loneliness, social isolation and social marginalisation (Albee 1986).
Albee’s model (see also Chapter 11) ascribes incidence of mental illness to a ratio of contributing factors and protective factors (Albee 1983). Factors that contribute to mental disorder include organic factors (biological make-up, alcohol and substance use, nutrition); stress; and exploitation (poverty, sexism, racism, alienation, abuse, violence). Factors that are protective of mental health include coping skills (communication skills, conflict resolution skills); self-esteem; and social support or family/whānau/community support. Decreasing stress, organic vulnerability and exploitation while increasing the triad of coping skills, self-esteem and social support could decrease the incidence of mental dysfunction (Albee 1983, 1986).

A compatible psychosocial systems approach suggests that individuals are part of a complex multi-layered system with each part interacting with and responding to others (Bronfenbrenner 1979; Kelly 1979; Rappaport 1987), with interventions targeted at the individual, school, peer, family, and community levels, operating to reinforce the effectiveness of the others. The proponents of this approach believe that real change requires co-ordinated, comprehensive and collaborative efforts that impact on the individual and the environments in which they operate. The Ottawa Charter (WHO et al 1986), the Healthy Schools programme (PHC 1995) and many other health promotion strategies build on these basic principles.

Pardes and colleagues (1989) take a slightly different view when they claim that there is mounting evidence of a biological substrate for many mental disorders. Biological predisposition is seen as a necessary factor for some disorders, with environmental and social factors as critical determinants of whether the disorder will manifest.

The way in which mental disorders and their determinants are viewed has implications for prevention strategies. While each disorder has differing contributing and protective factors, there is evidence (Raeburn and Sidaway 1995) that a variety of strategies have the potential to reduce the incidence of a number of disorders.

In general, strategies that are of value in reducing mental disorders are those that reduce violence, and alcohol and substance abuse; promote more effective and supportive parenting; reduce poverty and disadvantage; enhance educational and personal skills learning opportunities; reduce social isolation; increase self-esteem and sense of worth; reduce discrimination; and increase personal control over individual and community life. These strategies can be applied in various ways to programmes that can be implemented across a population or targeted to those with specific risk factors for future disorder or those with existing early signs of disorder.

Effective prevention programmes need to be delivered in a context where they are accepted and understood. How people view mental illnesses and their conceptual framework of and understanding about these will influence the impact of any prevention programme. High levels of discrimination and stigma will also influence beliefs. Prevention programmes will need to be delivered in an environment where people more adequately understand the complex interplay between biological, social, spiritual and economic variables.
STRATEGIES FOR INFANTS AND PRESCHOOL CHILDREN

There is evidence that early positive nurturing family experiences, early learning opportunities, fewer childhood illnesses, and reduced isolation, poverty, abuse and social disadvantage all lower the risk of later mental disorder. Effective strategies (Mzarek and Haggerty 1994; Raeburn and Sidaway 1995) include:

- immunisation programmes to reduce the possibility of neurological damage, learning difficulties, psychological or behaviour disturbance
- intensive support programmes for children born to mothers who have a reduced potential to provide a supportive early environment (mothers with addictions, disability, or mental disorders, who are isolated or in unstable living situations)
- home visiting programmes that offer support and connection to resources
- early child education programmes and effective child care that incorporate a learning approach that includes communication, cognitive problem solving and social skills
- parenting enhancement programmes
- all strategies that minimise physical, emotional and sexual abuse.

STRATEGIES FOR SCHOOL-AGED CHILDREN

Strategies appropriate for young children tend to remain useful for older children. Additional strategies include:

- programmes to promote acquisition of language, reading and writing skills
- programmes to develop impulse control
- family preservation services to reduce out-of-home placement
- interventions to enhance social competence to reduce early behaviour problems
- programmes to reduce academic failure and enhance literacy and numeracy
- comprehensive programmes that work across family, school and peer environments targeting those with identified risks or early signs of behaviour disturbance
- Healthy Schools approaches such as school-based interventions to reduce violence
- social competence curricula that have a specific focus on prevention of substance abuse
- programmes to foster understanding of mental illnesses and increase understanding of emotional and psychological changes
- opportunities to better understand sex and social role
- strategies to promote emotional ‘literacy’ that provide young people with the opportunity to identify and express emotions safely.
STRATEGIES FOR YOUTH

Strategies for youth build on those that are effective for children. Other strategies that have also been shown to be useful, and which utilise peers, include:

- peer education programmes related to positive life skills
- community-based programmes for those in unsupportive neighbourhoods (e.g., ‘drop in’ or outreach type programmes)
- brief family systems intervention to alter communication patterns with young people who have offended
- family and school-based interventions that have components of training to promote better behavioural management strategies:
  - academic and school-based remedial programmes
  - social skills learning opportunities
  - social support to promote community involvement for young people with early signs of conduct disorder
- programmes that promote reduced substance use by peers and that teach skills to resist social influences to use alcohol and other drugs
- restricting access to alcohol and other substances through raising the legal age for drinking and limiting liquor distribution to young people
- Healthy Schools approaches that encourage schools to provide more supportive environments for young people with enhanced academic, cognitive and social learning opportunities
- violence reduction programmes
- strategies to reduce youth unemployment, which continue to build skills and options and to enhance self-concept.

Concerns about suicide and its prevention in this age group in New Zealand are raised frequently. A recent review of the British and United States literature on suicide prevention strategies concluded that the research on effective strategies was limited (Raeburn and Sidaway 1995). The most effective were those relating to secondary prevention, including effective intervention following a first suicide attempt or diagnosis of mental disorder. In the British context, Gunnell (1994) identified the following strategies as having potential to help reduce the rate of suicide:

- better follow-up and support of those who had recently been discharged from psychiatric care
- limitations being imposed on the quantity and packaging of paracetamol and aspirin
- limitations being set on prescription sizes and dosages
- general practitioner education on recognising and treating depression, with an emphasis on reducing the prescription of potentially lethal drugs
- media guidelines for reporting of suicide and portrayal of fictionalised suicides
- auditing of suicide and parasuicide
- design modifications to car exhausts and plastic bags.
The Centers for Disease Control and Prevention report (CDC 1992) on preventing suicides in the US identified the following approaches to prevention of youth suicide:

- school gatekeeper training directed at teachers and other school personnel to help identify high-risk students
- community gatekeeper training (clergy, police, recreation staff, youth workers)
- general suicide education through school-based programmes
- screening programmes using psychometric instruments to identify high-risk youth
- peer support programmes that provide counselling, referral and support in schools or community settings
- crisis centres and hotlines
- restriction of the means of suicide (pharmaceuticals, firearms, poisons)
- intervention after a suicide to support those at risk and limit contagion effects among young people
- closer linkages between existing suicide prevention programmes that utilise volunteers and professional mental health resources
- the combination of a number of potential strategies and not relying on one method to suit all
- increased efforts to reduce suicide in the 20–24 years age group
- promotion of evaluation of all strategies.

Intersectoral co-operation that ensures increased responsiveness is likely to be essential to reducing youth suicide rates (Lester 1992). The appropriateness of general suicide education in schools has been questioned, and is discussed further in Chapter 23.

**STRATEGIES FOR ADULTS**

There has been limited evaluation of mental disorder prevention programmes for adults. However, there is some evidence from projects targeting those with specific needs, for example, those who have become unemployed or been recently bereaved. Reviews of research (Mrazek and Haggerty 1994; Raeburn and Sidaway 1995) indicate the following strategies have potential for use with adults:

- workplace strategies promoting worker participation, and providing worker assistance programmes for substance abuse and mental health concerns
- strategies to enhance marital relationships and promote communication skills
- separation and divorce support programmes
- programmes supporting new mothers, particularly focusing on supporting mothers in adverse situations, including poverty and social isolation
- occupational stress reduction and enhanced stress-coping skills programmes for those who work in stressful occupations
- JOBS – a selective prevention programme to help those who have lost jobs to cope with the stresses of job loss, setback in the job search process and social isolation
• interventions to assist those who are at high risk of depression although not currently diagnosed. Such interventions include specific education to understand moods, self-control approaches, interaction skills and understanding mood and behaviour change.

• support programmes for those caring for others (new mothers; those caring for an older, ill or disabled person)

• programmes to promote better understanding of psychological and emotional distress and the relationship between these and poor mental health.

STRATEGIES FOR OLDER PEOPLE

Older people are vulnerable to mental disorder because of their increased isolation, having to deal with loss, grief and lifestyle changes, reduced physical health, changing social roles and often the burden of caring for a dependent spouse or family member. Strategies that enhance protective factors (such as social support, responsive social and health services for those in need and opportunities for new and productive social roles) provide potential for prevention of mental disorder. See also Chapter 6. Useful strategies are:

• bereavement support groups (widower-to-widower support programmes)

• a variety of mutual self-help support groups

• lifestyle enhancement programmes (keep fit; walking groups)

• continuing education programmes

• community volunteer and involvement programmes.

STRATEGIES FOR THOSE WHO HAVE BEEN TRAUMATISED

There is increasing evidence that early and appropriate support for those who have been victims of violence, abuse, sexual violation and torture is effective in reducing the later development of mental disorder. Particular strategies include:

• sexual abuse counselling and self-help support groups

• victim of violence/crime support programmes

• refugee torture and trauma survivor strategies

• bereavement support groups.
MENTAL HEALTH PROMOTION
AND COMMUNITY DEVELOPMENT

There are many programmes that take a community development approach to enhancing health by fostering individual and community action. Broad social factors including poverty, violence, powerlessness and isolation have been identified as contributing to the development of mental distress (Albee 1986). Community development approaches attempt to address such issues in a way that reinforces a value base of self-determination, empowerment and community control. These values are enshrined in New Zealand in the Treaty of Waitangi and therefore are especially significant to Māori. The Ottawa Charter (WHO et al 1986) identifies community development as a critical factor in effective health promotion, stating that, ‘Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters.’

Empowerment is an important facet of community development and organisation (Rappaport 1984). It has been said to operate on two levels (Minkler 1990). The individual involved in community-organising efforts may experience increased social support which in turn may provide a generalised sense of control or coherence. This sense of control may in turn have positive health benefits. Community involvement has been identified as a significant factor in improving perceived personal confidence, individual coping capacity and life satisfaction (Leighton and Stone 1974). Physical health benefits have also been identified (Cohen and Syme 1985; Dignam and West 1988; Johnson and Hall 1988). From a broader perspective, Minkler claims that community organisation can contribute to community-level empowerment and increased community competence. He argues that as communities become empowered they are better able to engage in collective problem solving, which in turn can be reflected in key health and social indicators like alcohol abuse, divorce and suicide.

There is evidence from developing countries that self-determined, community-controlled, community development enterprises are highly successful in the economic, social, health and mental health domains (Raeburn and Sidaway 1995). If measures like literacy, wellbeing and reduction of stress can be taken as indicators of mental health, then this is an effective strategy. In developing countries, the effectiveness of community development in addressing housing needs and enhancing general wellbeing in disadvantaged areas is well documented (Boye 1989).

In New Zealand, a number of initiatives have utilised a community development approach. The development of community houses nationwide and the strategies used by them have promoted wellbeing. They have also reduced juvenile crime rates and increased people’s satisfaction with the places in which they live. There are a number of Māori initiatives that have been evaluated and show potential for health promotion. Te Ringa Atawhai (Cooney and Jackson 1988), associated with Northland Health, has over 30 trained community workers working in their own communities on a variety of health and mental health projects with broad social and educational objectives. While an extensive outcome evaluation is under way, early indications are that these projects are both effective and popular. A broader example is supplied by the Ngati Hine Project in Northland which is a comprehensive economic, health and social development project which appears to be having a positive impact on the lives of local people (McKegg 1994). Similar work being undertaken by the Waipareira Trust in West Auckland is promoting wide-scale community development through a health and education focus (John Tamihere, personal communication, 1996). Such strategies focus on a broad range of social, educational, health, economic and psychological aspects of people’s lives and do not necessarily target reduction of mental disorder specifically.
The Northland pilot project to address youth mental health concerns also showed that with effective community development strategies, wide-scale commitment can be obtained from communities to work collaboratively to address issues of mutual concern (Coggan et al 1995).

The Safer Community Council strategies and the Healthy Cities programmes beginning to emerge across New Zealand are effectively employing community development strategies to engage communities in a wide range of activities. These promote reductions in violence, alcohol and substance use and create more supportive integrated communities. Evaluations are being done at present.

The Healthy Schools strategies, while in their infancy in New Zealand, also lean heavily on a community development approach. The Mental Health Foundation has begun an implementation project with mental health promotion using a Healthy Schools strategy. It is too early to evaluate the outcomes of this project. However early indications are that it has effectively engaged key stakeholders across a wide range of sectors involved with schools and young people and has the potential to enhance the wellbeing of all members of school communities (Dickinson and Liggins 1996).

While large-scale, long-term evaluations of the impact of comprehensive community development projects are not available to date, there is substantial evidence that these strategies are attractive to communities and can generate widespread co-operation to address a broad range of health and social concerns.

OVERVIEW OF NEW ZEALAND PROGRAMMES, RESEARCH AND CURRENT STRATEGIES

In New Zealand, a number of universal prevention strategies have contributed to better overall health for those who have participated. Unfortunately, there has been insufficient evaluation of these strategies and where programmes have been evaluated, the impact on mental health has not been a primary evaluation goal. Despite this, programmes that have been implemented will be described and their impact assessed as far as possible.

STRATEGIES FOR INFANTS AND PRESCHOOL CHILDREN

Universal access to well infant care programmes has operated in New Zealand for a number of decades. Programmes such as that provided by Plunket have focused on providing support to new mothers to ensure health care needs are met. While not focusing on mental health specifically, these programmes have provided mothers with information and support on infant health needs; provided support to and often referral for mothers with mental health concerns; and generally assisted in linking mothers and babies with health services.

Early childhood education programmes have also grown in prominence with the development of Köhanga Reo, Playcentre, Parents as First Teachers and kindergarten programmes. These programmes provide young children with early educational opportunities and also provide parenting advice and social support to parents. Such programmes are universal in their approach and do not target families and children at increased risk. There is concern that the children most at risk and the most isolated families do not participate in such programmes. Programmes like the HIPPY programme (Home Instruction Programme for Preschool Youngsters, a Department of Social Welfare and community agency project), where preschool children and their parents participate in a cognitive skills oriented programme and are provided with direct parenting education and support, have been shown to improve
children’s early school success and to also enhance parenting skills. The Kelvin Road project (Mental Health Foundation 1994) is one example where parents can access health care for their children as well as receive active encouragement to participate in early child learning experiences. The Healthy Homes project, which had been planned for implementation in the North Health region but is now on hold, was one strategy that has had some success internationally in connecting isolated families in disadvantaged circumstances to support agencies within the community. International evidence indicates that this strategy improves education and health outcomes for children and reduces violence and risk taking in children and families who participate (Breakey 1995).

Immunisation programmes reduce the incidence of childhood illness and sequelae that can adversely affect mental health. Unfortunately coverage is inadequate (Stehr-Green et al 1992). In particular, immunisation rates for Māori and Pacific people are lower than for the rest of the population. There is some evidence that overall rates have improved over the past three years, although substantial work is still to be done if the target of 95 percent coverage is to be achieved for all children under two years of age. Strategies to promote immunisation include public health messages, education through well child care programmes, and free access to immunisation programmes. The requirement for confirmation of immunisation status when children enrol at school or early childhood education centres and the development of appropriate information systems to enable monitoring of immunisation will also assist.

**STRATEGIES FOR CHILDREN**

Schools are the obvious place to start with health promotion/illness prevention as they have a captive audience of young people in an educational setting (Raeburn and Sidaway 1995). Healthy Schools approaches (see below) and violence reduction within schools have a positive impact on the behaviour, health and academic performance of students. The health curriculum allows teachers to address health education, social skills development and risk taking in a positive way. Unfortunately, an Education Review Office audit found only 50 percent of schools were implementing the curriculum, despite it being a compulsory curriculum area. The curriculum has recently been reviewed and the new draft curriculum substantially increases the focus given to mental health and health risk taking, personal and interpersonal skills development and whole-school health development. If the curriculum is taught, it has the potential to have a major impact on the health of those in school. The curriculum provides opportunities for students to develop problem-solving strategies, and to acquire conflict resolution skills and personal management and interactional skills. It also fosters understanding and tolerance of difference and diversity.

The Ministry of Health, some funders of health services and some health service providers are promoting Healthy Schools programmes. This is a health promotion strategy aiming to improve and protect the health of students. It has a specific focus on mental health. Implementation of the Healthy Schools concept is in its infancy, and evaluation and outcome data are very limited.

There is a focus on social skills development within many New Zealand schools. Overseas studies show that enhancing students’ social and personal skills promotes academic learning and reduces psychopathology in later life (Cowen et al 1973; Cowen 1985). Evaluation of the impact of particular programmes must be undertaken, and successful ones applied more widely.

A Healthy Schools approach should be a key component of programmes to reduce violence and protect children from sexual abuse. In New Zealand, the Kia Kaha (Standing Strong) programme, Cool Schools (New Zealand Peace Foundation), Eliminating Violence (Specialist Education Services) and the Keeping Ourselves Safe programmes have all been shown to be effective in reducing violence, promoting awareness of sexual abuse and providing young people with skills to protect themselves
Continued promotion of such programmes and strategies is important if violence and abuse are to be reduced. Such programmes need to be complemented by more effective strategies targeting adults and the perpetrators of violence.

New Zealand continues to have high levels of physical abuse of children (UNICEF 1994). While a range of parenting programmes does exist, such programmes may best reach those who least require them. Strategies that positively engage those parents most at risk of abusing their children and that encourage participation of families isolated within communities require more focused attention. These same strategies are as important to school-age children as they are to preschoolers. Schools can facilitate interaction with more isolated families but this requires real effort and determination on the part of the school and innovation in the ways in which families are integrated into school-based activities. Many schools run school camps, sporting and school outing days and these are the primary means used to engage all families. Utilising such activities to promote positive welcoming relationships with parents and encourage their participation is essential.

Kazdin reviewed prevention programmes that worked effectively to promote more positive mental health in adolescents and older children and commented that:

> Prevention programs directed early in life (e.g., pre- and postnatal counseling, continued contact with the family and child in the first few years of life) can reduce factors that increase risk for maladaptive behaviors (e.g., school dropout, antisocial behavior) and clinical dysfunction in childhood and adolescence . . .

(Kazdin 1993: 132)

**STRATEGIES FOR YOUNG PEOPLE**

Peer counselling has proved an effective means of providing health information to young people. Such strategies have been utilised in New Zealand, particularly in relation to sexual health and substance use. Overseas studies have shown these can lead to improvement in self-concept and more positive attitudes to school, along with decreased absenteeism (Nenortas 1987). Preliminary indications are that such strategies are effective for imparting information and providing a point of referral for students with concerns. More effective evaluation of such programmes and their outcomes in relation to mental health indicators or later disorder is required. Likewise, there has been international evidence supporting the value of life skills programmes that improve knowledge and skills to enable more effective social functioning and communication. Such programmes have positive outcomes in terms of reducing smoking and drug uptake and usage, reducing criminal offences, improving school performance and lowering school dropout rates (Botvin 1984; Englander-Golden et al 1986; Botvin and Dusenbury 1989; Resnick and Gibbs 1989).

**YOUTH SUICIDE PREVENTION STRATEGIES**

There has been little attention paid to the evaluation of strategies that might reduce the incidence of youth suicide in New Zealand. The Steering Group on Youth Mental Health and Suicide Prevention (Ministry of Health 1994) suggested ways in which government agencies could work together to promote a more positive environment for young people. Because of the many factors involved in suicide, primary prevention strategies are not easily implemented. Many New Zealand schools are providing more comprehensive social and personal skills programmes. These include counselling and support services for students, implementing peer education programmes and putting aftermath strategies in place to ensure adequate support is available to all affected by a suicide.
Gatekeeper training on suicide and aftermath strategies has been undertaken by a number of agencies including the Mental Health Foundation, although the impact on suicide rates is likely to be minimal in the short term. Some schools are implementing suicide awareness programmes that provide students with information on suicide and early warning signs, so they can better identify and support other young people at risk. Such strategies and programmes have not been shown to be universally effective and there is evidence that they can have adverse effects (Gunnell 1994). A range of such programmes has proliferated without adequate attention to the skill levels of the teachers or the impact on all students. There is evidence that while they can increase students’ knowledge of suicide, such programmes might also increase feelings of hopelessness and despair in the most depressed and vulnerable students. This can increase their risk and vulnerability to suicide. Until there is a comprehensive evaluation of the outcomes of such strategies, it is not recommended that suicide awareness programmes be implemented. Rather, efforts could be made to enhance the social and interpersonal skills of students, allowing them to cope with life stress better. Teachers, students and others could be provided with information that allows them to better detect adolescent depression and those at risk of alcohol and drug abuse. Services to support identified at-risk students could be made more accessible and available. See also Chapter 23.

Phone counselling and suicide prevention centres provide a contact point for young people in distress, thereby limiting the potential for suicide. Lifeline, Youthline and Samaritans operate such programmes and provide information, support and referral. There is no conclusive evidence that such programmes are used by those who are most likely to make serious suicide attempts or that they lead to a reduction in overall suicide rates. They do, however, provide an important contact and support service to people who are emotionally and psychologically distressed, which is likely to reduce later vulnerability to poor mental health. These organisations also provide counselling and self-help support services for those bereaved by suicide, and fulfil a valuable role in gatekeeper training and in training of community members to acknowledge and respond to distressed people.

Of real concern in New Zealand is the fact that the profile of suicide as a choice for young people has been high. Media depictions of suicide through news and documentary items and fictional portrayals have increased over recent years. There is some evidence from international studies which, while not conclusive, does indicate that depictions of suicide do lead to increased ‘copycat’ suicides and suicide attempts (Etzerdorfer et al 1992). Anecdotal evidence would indicate that this is also the case in New Zealand although conclusive evidence is not available. As a prevention strategy, it would appear to be useful to limit such media exposure.

**STRATEGIES FOR ADULTS**

Few programmes in New Zealand have the prevention of mental disorder in adults as their prime objective. Relationship counselling services, sexual abuse counselling and victim support services are strategies that would appear to have a positive outcome in respect of secondary prevention. Overseas evidence indicates that trauma counselling services play a significant role in the reduction of mental disorders in refugees and those who have been victims of violence (Mollica 1987). Such services for refugees in New Zealand are few and operate under severe resource constraints. Likewise, self-help support groups such as Grow, Gamblers Anonymous, Alcoholics Anonymous and similar programmes that support family members of those affected by another’s addictive behaviours, are likely to be effective in preventing or reducing the impact of disorders.
Stress management has potential for wider application within the workplace as well as within communities and with individuals. Small-group approaches to stress management have been shown to have a positive outcome on stress levels and satisfaction (Raeburn et al 1993).

There is growing interest in New Zealand in men’s health and in men’s mutual support groups. Living without Violence and men’s anger change groups have become more widely available. There is international and local evidence that such programmes can reduce violent behaviour and promote more positive interactions within relationships and families (Raeburn and Sidaway 1995). Such programmes have the potential to enhance the mental health of participants, spouses and children although more effective long-term evaluation of their impact is required.

**STRATEGIES FOR OLDER PEOPLE**

Social support and meaningful participation in one’s community are important components of mental health. Older people in New Zealand experience depression, dementia, alcoholism and suicide at rates that warrant intervention (see Chapter 6). Older men have a high suicide rate. International evidence indicates that anxiety and high levels of tranquilliser use are also of concern (Higginson and Victor 1994). In New Zealand, older people are becoming more politically active with an increasing number of mutual interest groups and older people’s support and leisure groups. There is also an increase in the number of higher education programmes that support older people to undertake study locally and as part of international study projects. Waikato University, for example, runs such programmes through their continuing education centre. Keep fit programmes also operate and while they do not target prevention of mental disorder, it is likely that such activities contribute to more positive health for older people.

An international model of a comprehensive mental health promotion programme was noted by Raeburn and Sidaway (1995) in their review. A programme in Boise, Idaho (a centre with a population of 102 000 people with 8600 people over the age of 65 years) developed from a coalition of major community agencies that worked with older people. The coalition resulted in two programmes: Growing Younger, a physical wellness programme that included stress management strategies; and Growing Wiser, a mental wellness programme in which large numbers of the older population participated and which assisted people to acquire skills to deal with grief and life changes, and to plan for these. Evaluation showed many positive changes, including improvements in fitness, weight, stress, blood pressure, social relationships and memory functioning. Depressive symptoms were less common in those who participated (Kemper and Mettler 1990). Although similar programmes already operate in New Zealand, there are no cohesive strategies for achieving wider population coverage or evaluation of effects.

Social isolation and loneliness have a major impact on older people’s health (Wenger 1994). Home visiting and befriending programmes that target isolated older people may have a substantial impact on wellbeing. Home help and home care programmes do operate in New Zealand although the focus is frequently on physical care and assistance within the home for those with a disability. With training and a small amount of additional resources, these existing services could reduce isolation of older people by providing greater attention to their emotional and psychological needs, and by fostering re-involvement of older people with some of the existing socialisation opportunities.
As with younger children, elder abuse is a growing concern. Many older people live in fear of violence, particularly those who are most isolated or who are dependent on others for their care (Pawson and Banks 1991; Pinkerton James 1992). It is important that caregiver support and education is available to reduce elder abuse. Respite care and support for family members and the informal carers of older people may help. Agencies that support victims of violence may be important links in the support of older people who experience violence. See also Chapter 6.

**STRATEGIES FOR THOSE WHO HAVE BEEN TRAUMATISED**

A high proportion of people who have experienced violence or abuse – including refugees – experience symptoms of post-traumatic stress disorder (PTSD), depression, suicidality, eating disorders, personality disorders, anxiety and dissociative disorders, and also psychosis (Mollica 1987; Mullen et al 1988; Kinzie and Boehnlein 1989; Mullen et al 1993, 1994). Programmes that assist traumatised refugees to adjust to their new environment and to deal with the trauma and violence they have experienced can make a substantial difference in prevalence rates of PTSD (Eisenbruch 1990; Fuller 1993). The World Health Organization has long been concerned about the welfare of refugees and has promoted the implementation of strategies at community, national and international levels to promote more positive environments and support structures for refugees. To date, New Zealand has not adequately addressed the psychological and emotional concerns of this group. If prevention of disorder within this population group is to be undertaken, then greater attention must be given to the purchasing of secondary prevention programmes. The Mental Health Foundation has established the first New Zealand torture and trauma centre, which aims to provide assessment, support and education for refugees, their families and others who work with them (Mental Health Foundation 1995). See also Chapter 11.

Programmes to assist victims of violence, including sexual abuse, are also critical in reducing all mental disorders and ameliorating ongoing psychological and emotional distress (Nadelson and Raphael 1995; Wilson 1995). In New Zealand, a range of post-trauma counselling and sexual abuse programmes exist. Counselling for sexual abuse is provided through the Accident Rehabilitation and Compensation Insurance Corporation (commonly known as ACC). The growth of Victim Support groups and the role they play in providing immediate and ongoing support for victims of violence and crime appears to be of great value. Likewise, the growth of programmes that aim to prevent violence and to change the way that men in particular respond to frustration and stress (Men for Non-violence; Men’s Anger Management; Prevention of Violence networks; SAFE) are important components of an overall violence prevention strategy. The contribution that physical and sexual abuse makes to major mental illnesses is still debated; however, there is increasing evidence that this contribution has been underestimated. Prevention of all forms of physical and sexual abuse must therefore be viewed as a potential strategy for reducing all mental disorders, including the more serious disorders.

**LIMITATIONS OF CURRENT KNOWLEDGE**

The science of prevention research is relatively new, and programmes that have been rigorously evaluated using robust research strategies are few. It appears that there is potential for a reduction in the prevalence of some mental disorders. However, with some serious and debilitating disorders like schizophrenia and major mood disorders, evidence for prevention initiatives is slim (Mrazek and Haggerty 1994). It is widely acknowledged that mental health professionals work mainly in the secondary prevention area. The role of this work is to reduce the impact of a disorder and to intervene as effectively as possible to prevent further debilitation, episodes of illness, or more long-term disability. Lack of proven prevention strategies for these more serious disorders has dominated and shaped attitudes to prevention research and resulted in an inconsistent application of prevention.
The development of public health approaches to mental health has also been limited by the knowledge base on risk and protective factors. The focus on mental disorders has been on treatment once a disorder is manifest. Longitudinal studies examining risk and protective factors over the life-span are essential if prevention strategies are to be adequately developed and implemented.

In New Zealand, mental health services have struggled to achieve adequate recognition of needs. Research in the mental health arena on intervention and treatments has been limited and that on prevention virtually non-existent. Much of the energy for prevention programmes has been generated outside the formal health sector, with programmes implemented by communities, social services workers and voluntary agencies. More objective evaluation of programmes, and more effective partnerships between mental health professionals and communities are required if current limitations in knowledge are to be overcome.

**BARRIERS TO IMPLEMENTING EFFECTIVE STRATEGIES**

The Institute of Medicine report on prevention of disorders (Mrazek and Haggerty 1994) identified a number of obstacles to effective prevention initiatives. These included:

- the stigma of mental disorders and its impact on prevention strategies
- inadequate dissemination of information on effective prevention strategies
- the belief that not having effective treatments for illnesses means that prevention will not work
- the lack of a coherent theoretical framework for prevention
- limited knowledge of the risk and protective factors for mental disorders
- difficulties in identifying, defining and classifying mental disorders.

These obstacles are relevant to New Zealand, and hinder the development of the field of prevention science. Extending the knowledge base is a critical factor for future progress in prevention.

There are also a number of universal obstacles to effective prevention initiatives (Kramer 1989):

- the rate of growth of the world’s population with increasing numbers who will have biological, social and economic characteristics that place them at high risk
- increasing urbanisation of world populations
- the impact of urbanisation on rural areas, often depleting rural populations of the young, able and educated with the result that there is an increasing shortage of human, material, communication, transport and financial resources and health delivery mechanisms
- changing household and family structures and living arrangements
- increasing numbers of refugees and homeless people
- higher levels of poverty
- confusion about what we are trying to prevent
- inadequate information support for planning programmes for prevention of mental disorders.

Each of these barriers applies in New Zealand and if we are to institute a public health response to mental disorders effectively, we must begin to dismantle each of them.
FUTURE DIRECTIONS

To move forward and begin to reduce the high levels of psychological distress and the growing incidence of mental disorders within our communities we need to consider those factors that contribute to them, as well as strengthen environments that promote positive mental health and protect our wellbeing. We must strike a balance between waiting for unequivocal evidence of effectiveness for every intervention, and an indiscriminate launch into primary prevention and mental health promotion activities. Every opportunity must be taken to evaluate the effectiveness of strategies in order to increase the scientific base on which future strategies are developed and purchasing decisions made.

In proposing strategies, it is practical to look at both universal strategies that target the whole population, and specific strategies that could be applied to groups at risk because of personal or social factors, and also to examine strategies that could be effective with groups already showing signs of psychological or mental distress or disorder.

Effective implementation of community development strategies is taking place in New Zealand to address issues related to violence and abuse prevention, and alcohol and cannabis abuse and its reduction; to reduce abuse of other addictive substances; to promote healthy environments within schools and communities, and programmes for youth at risk; and to aid crime reduction. Initiatives that enable communities to address these issues in a collaborative way may mean that multiple outcomes can be achieved more effectively. New ways of promoting community and individual wellbeing using community development approaches may prove more effective than specific issue-by-issue illness prevention strategies. Strategies to support communities to work in this way must be given greater priority in both purchasing and research.

UNIVERSAL STRATEGIES OF MENTAL ILLNESS PREVENTION AND MENTAL HEALTH PROMOTION

There is a range of early support programmes already operating that could focus on prevention across the broad spectrum of mental disorders in the long term. Well child and immunisation programmes and early childhood education and parenting programmes are protective for all. Ensuring that poverty is addressed; that all people have access to adequate accommodation, meaningful work or activity; that environments are free of violence and that the pressure to use and abuse substances is reduced will all promote more positive mental health. There is a wide range of programmes already in existence that provide information, education and support to individuals and families. The effectiveness of such programmes could be enhanced if greater knowledge of mental health issues and strategies to promote more positive mental health were incorporated into their delivery. Specific initiatives that could benefit from a more effective health promotion and illness prevention focus include:

- early well child programmes such as those provided by Plunket and other well child agencies; postnatal support services for new parents; immunisation programmes
- early childhood education programmes such as Playcentre, Playgroup, Kōhanga Reo, Parents as First Teachers
- Healthy Schools strategies where schools promote environments that enhance and promote the mental health of all in them
- comprehensive health education with emphasis on mental health, social and interaction skills and sexual health programmes
employment support programmes and school-to-work transition programmes

• violence reduction strategies including those that aim to reduce portrayal of violence in the media

• safer community projects that use a community development approach to working with a range of community agencies to prevent violence and promote cohesion

• programmes that promote reduced substance use by young people and teach skills to resist social influences

• legislation that restricts the availability of alcohol to young people and limits alcohol advertising

• stress reduction and stress management programmes

• physical fitness, stress reduction, recreation and education programmes for older people

• peer education strategies for life skills

• broad-based strategies that enhance workplace environments by promoting worker participation

• comprehensive remedial reading strategies to prevent early academic failure, which have been shown to enhance self-esteem and reduce later depression and aggression (Kellam et al 1994).

Such initiatives are likely to have a positive impact on the general mental health of all. They focus on reducing isolation and alienation, misuse of substances and violence and its effects. Strengthening individuals through increased opportunities to acquire personal and life skills is another focus of universal strategies.

STRATEGIES FOR AT-RISK INDIVIDUALS OR GROUPS

These strategies target those who have significant risk factors but no existing signs of disorder. They are designed to detect those at greater risk and take compensatory action to target those most in need. While there has been little New Zealand research evaluating the effect of such strategies, research such as that conducted by Fergusson and colleagues (1994) indicates that early disruptive and difficult family circumstances are implicated in higher levels of psychological disorder later. Intervening early to minimise the impact of family disadvantage is advocated by such researchers. Strategies include:

• postnatal support programmes for new mothers, particularly those who are young, without partners, or in adverse situations because of poverty or social isolation

• home visiting programmes for isolated parents or solo and older people

• early education programmes that target young children who display difficult behaviours and focus on teaching children to think, make decisions for themselves, and increase their social skills and impulse control

• family counselling services for families experiencing relationship difficulties

• increased awareness of the risk factors for various disorders (alcohol and substance abuse, depression, conduct disorder) and early support and encouragement of at-risk individuals to take steps to enhance protective factors

• identification of children displaying aggression and behavioural difficulties; implementing specific interventions to enhance these children’s capacities to co-ordinate cognition, affect and behaviour so they can respond adaptively to social tasks and challenges (Shure and Spivack 1982; Weissberg et al 1989)
• identification of children whose parents have a mental disorder (depression, schizophrenia, alcohol and substance abuse); increased support to these children to minimise the impact of family disorders and provide education on the disorders (these strategies have potential but are yet to be adequately evaluated)

• support and counselling for those who have been victims of violence, abuse or trauma.

Early intervention to assist children who have problems with attention in class and elsewhere appears to reduce the risk of them developing later difficulties in adolescence, such as antisocial behaviour and delinquency (Rebok et al 1996). Although more research is required, such studies provide support for intersectoral approaches addressing wider environmental blocks to opportunity. They emphasise the importance of educational opportunity for those who have early risk factors for mental disorder.

**STRATEGIES FOR THOSE WITH EARLY SIGNS OF DISORDER**

For some of the more severe disorders like schizophrenia, universal and selected strategies (see Mrazek and Haggerty 1994) are inappropriate and it is more effective to focus prevention initiatives on those who have early signs of the disorder. Early detection of symptoms and appropriate treatment with both pharmaceutical and social and emotional environmental supports seem to have greatest potential for changing the course of the illness. There is some evidence that some major disorders occur in families with histories of increased vulnerability. Screening to identify those at risk because of a family history of disorder, and early intervention both to reduce psychosocial stresses and enhance coping strategies, may prevent full-scale development of these disorders or reduce the impact of them on the individual, family and society.

A range of strategies have been evaluated that aim to reduce the likelihood of negative outcomes for those with early signs of alcohol and substance abuse. Strategies that promote early childhood education, enhance family cohesion and parenting skills, and facilitate academic achievement and social skills development within school settings have been shown to reduce the likelihood of alcohol and substance abuse by increasing the resilience of those with risk factors or early signs of disorder (Hawkins et al 1995). Risk factors for alcohol and substance abuse include: norms surrounding use; availability; extreme economic deprivation; neighbourhood disorganisation; use of drugs by family members; and family management and psychosocial factors. Given the breadth of factors implicated, it is important that strategies not only target individuals and enhance protective factors but also foster wider environmental change to reduce risk factors.

Likewise, similar strategies have been implemented to address conduct disorder in those most vulnerable. While full evaluation of such strategies is currently being undertaken, preliminary data indicate that effective prevention strategies require a multidimensional approach that includes parenting education, classroom-based strategies, teacher education, and strategies to promote enhanced social skill development and problem solving. In addition, the prevention strategies attempt to build supportive wider environments for vulnerable young people and to establish stronger and more supportive social networks for them. Such strategies acknowledge individual vulnerability as well as the wider social context in which behavioural patterns occur.
RECOMMENDATIONS FOR FUTURE APPROACHES

Extensive reviews of the prevention literature show there is no one approach that will prevent all mental disorders. There are, however, some common themes that offer hope for prevention of some disorders. Early disruptive, chaotic and unsatisfactory childhood experiences put any individual at increased risk of later mental disorder. A decrease in violence and all forms of abuse will reduce poor mental health outcomes. Increasing opportunities for participation in social networks and structures is protective of mental health, as are enhanced learning and educational opportunities. Reducing and eliminating poverty, and promoting environments that reduce inequity and serious financial hardship, will be protective of positive mental health.

There is evidence that socially disadvantaged groups are more vulnerable to mental disorders. Women, Māori, those who are socially isolated and new settlers experience high levels of discrimination and inequity and will therefore be more vulnerable. Strategies to remove all discrimination and promote true equity and self-determination opportunities must be comprehensive and work across all levels and all social institutions (political, social, educational, religious, cultural and family).

Although there are some prevention initiatives with the potential to reduce risk factors for disorders, there are still no studies clearly showing that particular interventions lower the overall incidence of mental disorders. There are several programmes that appear to have excellent potential for influencing life outcomes for individuals (FAST Track programme; PATHS Curriculum and other social skills programmes), yet their effectiveness in reducing psychological symptoms and mental disorders in the longer term must be tested.

In New Zealand, all prevention strategies will need to be developed in full consideration of the cultural context in which they are being delivered. There is a strong commitment within the current health and education sectors to involve communities and users of services in partnership. Such partnerships must also operate within the prevention arena if strategies are to be implemented effectively.

Because many risk factors operate across multiple domains including home, school, peer group, neighbourhood and work sites, effective prevention will require intervention across all of these environments in a consistent and integrated manner. Much of the international research in the prevention field has focused on increasing individual resilience rather than changes in social policy to reduce risk factors such as poverty, racism, discrimination, community disintegration and reduced opportunities. It may be appropriate for future prevention initiatives in New Zealand to do both.

Priorities for future development of prevention initiatives could include:

• increased research on and evaluation of effective strategies within the New Zealand context
• identification and support of families and children at risk of poor health outcomes (Healthy Homes project)
• implementation of broad-based community strategies that will reduce emotionally damaging childhood experiences; poverty and degrading life experiences; powerlessness, low self-esteem and loneliness; social isolation and social marginalisation across all ages, cultures and special needs groups
• school-based strategies that will enhance acquisition of language, reading and writing skills and reduce academic failure
• opportunities for those who show early signs of behaviour problems to acquire social skills that will enhance their social competence
• wider application of health promotion approaches that provide both wider environmental support
and personal skill support and development
• strategies across the age ranges that will enhance parenting and promote more effective family
dynamics
• broad-based health promotion strategies that target violence reduction and alcohol reduction
• mental health education that promotes wider awareness of risk factors for disorders and protective
strategies
• educative strategies that promote increased awareness of mental disorders and treatments
• support options for those who have experienced loss or trauma
• identification of an agency that has responsibility for co-ordinating mental health promotion/
ilness prevention strategies at all levels.

Priority will need to be given to developing a science of prevention that is relevant to New Zealand.
Research to validate approaches within our cultural and environmental context must be given greater
priority. Cross-sector collaboration that promotes wider application of strategies across health, education
and social welfare structures is needed. Earlier identification of those with risk factors, and more
effective responses, need to be facilitated. To date, no one agency has been clearly charged with the
responsibility for promoting mental health programmes that focus on prevention of mental disorders
and psychological distress. Without such clear responsibility it is unlikely any one agency will be able
to undertake the range of co-ordinated activity over the sustained period required to make a difference.
A comprehensive public health approach is required with one agency being allocated the resources
and given the mandate to take action.

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Developments in prevention have played a key role in improving the health of the community. In the nineteenth century, attention to hygiene had a major impact on the spread of infectious diseases and more recently, changes in behaviour in relation to smoking and some aspects of diet have also been productive. In contrast, progress in preventing mental illness has been much more hesitant and limited. This reflects a number of factors. Historically, the zeal of the mental hygiene movement in the 1920s and 1930s, which sought to produce lasting change in society through work with individual children, proved to be misplaced. Subsequently, the community mental health programmes of the Kennedy era in the United States failed to deliver promised changes, contributing to a cautious scepticism in some quarters. For example, Sir Richard Doll stated that:

A programme for intervention is, however, unlikely to be effective unless the illnesses can be defined and attributed to single factors or groups of factors that act synergistically and are amenable to intervention . . . it will, I suspect, be many years before we can design a programme for the prevention of mental illness, at either the individual or the social level, that will be more cost-effective than a programme that provides for the treatment and support of affected individuals.

(Doll 1983: 451)

Nonetheless, others have retained considerable optimism, albeit often on the basis of limited data. However, one might take issue with some of Doll’s presumptions. While mental illnesses are certainly multifactorial, and their causes are not well understood, there is a significant body of information about the social factors that contribute to many of these disorders. While some such factors influence the risk of developing several disorders, this does not mean that interventions based on them are not valuable or effective. Similarly, the causes of coronary heart disease are also multifactorial, but stopping smoking clearly reduces the risk of both respiratory and cardiovascular diseases.

It is clear from a number of contributions to this report that the effect of multiple risk factors tends to be greater than the sum of the individual risks. One example of this is the much increased risk of a suicide attempt where multiple adverse factors are present than when problems are more limited, as seen in the Canterbury Suicide Project (Beautrais 1996). This raises important issues for prevention programmes. There is an inevitable tension between trying to provide ‘a lot for a few’ because they are most at risk, or ‘a little for many’ because the overall benefit for the population may be greater. Determining which approach is best in a given situation requires appropriate cost-benefit analyses, which should include estimates of social as well as fiscal benefit.
It is also important to recognize the delayed effects of many factors contributing to mental illness and mental health. For example, while the basis for self-esteem is established in childhood, it is an important determinant of coping ability in the face of adversity as an adult. Childhood sexual abuse certainly has immediate psychological effects on children, but it also has enduring effects on the victims over a prolonged period of time. This has important implications for the evaluation of interventions to reduce such risk factors, as the full benefits will only emerge in the longer term, well beyond the immediate political horizon.

In considering future initiatives, it is important to recognize that many of those proposed in this report have not been demonstrated to have universal application. New Zealand society is unique, and of course is not homogenous, so initiatives that are appropriate in Mangere may not be appropriate in Mangakino. It would be prudent to establish carefully evaluated pilot projects rather than national initiatives in the first instance. It will be vital that the evaluation processes are well designed and comprehensive to ensure that appropriate programmes are selected for further development. These could then be further refined as demonstration programmes, in which the essential components are identified for implementation elsewhere. There would be merit in establishing an Academic Centre for Prevention Research in Mental Health, as in the US (Connor and Livengood 1991), to focus and develop such prevention.

Some concerns have been expressed that an increased emphasis on prevention of mental health problems may lead to a reduction in funding for treatment of mental illnesses. Clearly, such reductions would be foolhardy as the benefits of mental health promotion initiatives will only be seen in the relatively long term. While it is to be hoped that they would make measurable differences at a population level, there will still be major demands on New Zealand’s overstretched mental health services, which continue to fall short of professional and public expectations (Mason et al 1996).

**A FRAMEWORK FOR INTERVENTION**

The major models of intervention have already been discussed in Chapter 1. We suggest that these may be usefully merged to provide an overall structure for considering mental health interventions. Mrazek and Haggerty’s (1994) model of universal interventions (designed for everybody), selective interventions (for those with an increased risk of future disorder), and indicated interventions (for those with early symptoms or signs of illness), merges into secondary prevention, where early treatment is provided to limit the effects of an illness, and tertiary prevention, where established illness is treated to minimise relapse and long-term complications. However, within each level of this system we propose that the enabling strategies should be based on the Ottawa Charter model, with its focus on building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services, as discussed in Chapter 24. The mental health sector has already gone some way towards reorienting its health services and recognizing the importance of enhancing personal skills. However, more could be achieved by striving for healthy policy across all sectors (because of their direct and indirect effects on mental health), creating supportive environments and nurturing community action. Indeed, many of the proposals in the various chapters of this report propose interventions of these types. Applying these strategies across a variety of levels of intervention is more likely to result in enduring changes.
Epidemiology is the science of ascertaining the patterns of illness in populations and of discovering the relationships between risk factors and disease incidence. The discipline and practice of public health pools this information with other knowledge of social and environmental factors to intervene to prevent illness and enhance the health of the population. Epidemiology is commonly regarded as the basic science of disease prevention and is thus at the core of the public health approach. However, modern epidemiology has been said to be poorly integrated with other public health activities. In particular, it neglects social, economic, cultural and political factors, focusing instead on individual risk factors and rare diseases (Pearce 1996).

Psychiatric epidemiology has followed this pattern in some respects, although it has been far more difficult to ignore the importance of the context within which risk factors operate. However, after acknowledging the importance of factors such as socioeconomic status and minority group membership, psychiatric studies often use elegant methods to control for them, as if they were ‘noise’ obscuring understanding of the ‘real’ risk factors. At best they are regarded, safely, as risk factors in a complex web of causation, rather than as possible causes of mental ill health in their own right. By considering such factors in this way, they are relegated to the ‘too-hard basket’. What may be more dangerous is that this leads (maybe unwittingly) to the mistaken notion that epidemiology, as a science, is apolitical. Attempting to follow the trend and continuing to study decontextualised risk factors (Pearce 1996) may be the Achilles’ heel of a public health approach to the mental wellbeing of populations. This is because regarding these factors in this way reduces the likelihood that they will become a focus for intervention.

Perhaps we need quite deliberately to broaden our view and consider not only individual risk, but also the social structures and processes that lead to mental ill health (McKinley 1993). Risk factors clearly operate in a hierarchy of levels of observation, from the molecular to the macrosocial and environmental. Moreover, it is likely that there are interactions between risk factors, not only within a level but also between levels (Susser 1996b). The linear conception of proximal and distal risk factors does not suffice to explicate these kinds of relationships.

In order to use this thinking as a tool for improving the mental health of our population, we may need to focus on more careful formulation of research questions. Rather than developing ever more complex analytical tools, perhaps our study designs need to be more innovative, to adequately deal with the complexities outlined above (Susser 1996a). In particular, we must ensure that our research designs are appropriate for the level of observation (population or individual) at which we are posing our questions. The vexing question of youth suicide may provide an example. Excellent work has been done on identifying risk factors for the suicide of individuals, prompted by the population-level observation that rates have been increasing. However, it is difficult to target interventions to those most at risk. This means that the potential for intervention at a macrosocial level needs to be explored and evaluated.

However, this vision must be pursued in a rigorous way. There is no panacea. We must keep in mind the need to research and devise interventions at a variety of levels, simultaneously. A 61-year-old man who becomes involuntarily unemployed is at risk of mental health problems. As the utopian goal of genuine full employment is unlikely to be achieved, he will need an intervention focused at the level of the individual. However, unemployment is also a problem at a societal level. In the medium to long term, initiatives to shape commonly held views about the value of work and the value of older people would be of benefit to people in this position, and to the wider society.
There is a tension between the explanatory power of paradigms operating at micro levels of observation, such as the molecular or individual level, and the need for epidemiology to serve the public health (Susser 1996b). Research must meet the pragmatic demands, and limitations, of health promotion and clinical practice. At the heart of mental health perspectives, in contrast to those in other areas of medicine, lies an acknowledgement that the causes of human behaviours and emotional experiences are extremely complex and operate on many levels from the molecular to the political. Such a public health approach to the mental health of New Zealanders offers the opportunity to take the lead in the move back to a true population perspective for the discipline of public health.

**P R I O R I T I E S**

While it is not proposed to recapitulate the recommendations of each chapter of this report, certain themes have emerged. There is a serious lack of information about the state of mental health and extent of mental illness in New Zealand society, especially among those subgroups that experience a degree of alienation. This is preventing thorough evaluation of the effectiveness of national mental health initiatives. This must be addressed with some urgency as a prerequisite to much of the other proposed research and mental health promotion strategies.

The focus on mental illness and its treatment by the media and government has left the broader impact of government policy on mental health and illness largely unexplored. This is an area which is beginning to receive serious attention overseas (Scott-Samuel 1996). The European Commission has recently indicated that the European Union Treaty requires that proposals for policies, and implementing measures and instruments, should be examined to ensure that they do not have an adverse impact on health, or create conditions that undermine the promotion of health. These have been termed ‘health impact statements’, and would embrace mental health as part of health in general. These would be analogous to the now well-established environmental impact reports, which focus on the identification, assessment and management of risks arising from new initiatives that will affect the natural environment. It would seem timely to extend this approach to people’s lives as well as aspects of the natural environment, so that the social and economic costs of change can be examined in the context of the overall social contract between government and people.

**C O N C L U S I O N S**

Prevention has been the Cinderella of the health services as a whole for many years. The evidence for its effectiveness is probably as good within mental health as in many other settings, and the likelihood of critical evaluation and committed application of interventions may well be greater. Indeed, the failure to apply what is known could be seen as unethical. Just as the document that outlines strategic directions for the mental health services (Ministry of Health 1994) has provided a focus and agenda for developments in treatment services, there is a need for a ‘Charter for Prevention’ in the mental health arena, similar to that proposed elsewhere (Raphael 1993). There is a need for commitment at all levels – community, professional and political – to meet the challenge of improving the mental health of the community. New Zealanders, individually and as a community, deserve no less.
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<thead>
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<th>Term</th>
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<tr>
<td>ACC</td>
<td>Popular name for ARCIC.</td>
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<tr>
<td>Acute psychosis</td>
<td>A mental disorder characterised by gross impairment in reality testing as evidenced by delusions, hallucinations, markedly incoherent speech, or disorganised and agitated behaviour.</td>
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<td>ADHD</td>
<td>See Attention-deficit/hyperactivity disorder.</td>
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<tr>
<td>Adjustment disorder</td>
<td>A maladaptive reaction to identifiable stressful life events, such as divorce, loss of job, physical illness or natural disaster. Symptoms and behaviour are beyond the expected normal range of reaction to such stressors and interfere with social and occupational functioning.</td>
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<td>Aetiology</td>
<td>Study or theory of the factors that cause disease.</td>
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<tr>
<td>Affective disorders</td>
<td>Mental disorders, the essential feature of which is disturbance of mood manifested as a full or partial manic or depressive syndrome.</td>
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<tr>
<td>Affective episode</td>
<td>Period of disturbed mood. Either a period of depressed mood with loss of interest or pleasure in one’s usual activities and associated symptoms of a depressive syndrome, or a period of predominantly elevated, expansive or irritable mood accompanied by some of the associated symptoms of a manic syndrome.</td>
</tr>
<tr>
<td>Affective psychosis</td>
<td>General term to describe a mood disorder in which mental functioning is sufficiently impaired as to interfere grossly with a person’s capacity to meet ordinary demands of life and delusions and/or hallucinations are present.</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>An intense, irrational fear of crowded spaces, characterised by marked fear of being alone or of being in public places where escape would be difficult or help might be unavailable.</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome.</td>
</tr>
<tr>
<td>Aiga</td>
<td>Extended family or lineage in Samoa.</td>
</tr>
<tr>
<td>ALAC</td>
<td>Alcohol Advisory Council of New Zealand (formerly Alcohol and Liquor Advisory Council).</td>
</tr>
</tbody>
</table>
Alcohol dependence  A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress. Symptoms include tolerance and withdrawal phenomena; excessive alcohol intake; persistent desire or unsuccessful efforts to cut down or control alcohol use; a great deal of time spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects when giving up or reducing; giving up important social, occupational or recreational activities because of alcohol; and alcohol use continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

Alzheimer's disease  A progressive degenerative disease of the brain of unknown aetiology characterised by diffuse atrophy throughout the cerebral cortex. The first signs of the disease are slight memory disturbance or subtle changes in personality; there is a progressive deterioration resulting in profound dementia over a course of five to 10 years. Onset may occur at any age but is more common in older people.

Amenorrhoea  Absence or abnormal stoppage of menstruation.

Amnestic syndrome  An organic mental disorder characterised by impairment in memory, especially the ability to learn new information, occurring in a normal state of consciousness. The most common cause is thiamine deficiency associated with chronic alcohol abuse, but the syndrome may result from damage to certain brain structures. Causes include head trauma, brain tumours, cerebral infarction, cerebral hypoxia, carbon monoxide poisoning and herpes simplex encephalitis. Used synonymously with Korsakoff's syndrome or Korsakoff's psychosis.

Amygdala  1. Term used in anatomical nomenclature to designate an almond-shaped structure. 2. Corpus amygdaloideum, a small, ovoid complex of nuclei partly covered by the pyriform cortex, within the tip of the temporal lobe; it is part of the limbic system and is classified as a part of the basal nuclei.

Analgesic  An agent that alleviates pain without causing loss of consciousness.

Androgen  Any hormone that promotes the development of characteristics that occur normally in males.

Angaanaaua  A Tongan illness where the affected individual shows two different personalities.

Annual prevalence  The number of cases of a disease or condition that exist in a defined population at any time over a period of one year.

Anorexia nervosa  A mental disorder occurring predominantly in females, characterised by refusal to maintain a normal minimal body weight, intense fear of becoming obese that is undiminished by weight loss, disturbance of body image resulting in a feeling of being fat even when extremely emaciated, and amenorrhoea (in females). Associated features include denial of illness, markedly decreased interest in sex, eating binges, self-induced vomiting and purging, and unusual behaviour connected to food.
Anoxia
Total lack of oxygen supply to tissues.

Antipsychotic medication
Drugs used to treat severe mental illnesses, such as schizophrenia and other psychotic disorders. Common side-effects include sedation, a dry mouth, blurred vision, and parkinsonian symptoms.

Antisocial personality disorder (ASPD)
A personality disorder characterised by continuous and chronic antisocial behaviour in which the rights of others are violated. Associated personality traits include impulsiveness; egocentricity; inability to tolerate boredom or frustration; irritability and aggressiveness; recklessness; disregard for truth; and inability to maintain consistent, responsible functioning at work, at school or as a parent.

Anxiety disorders
Group of mental disorders in which anxiety and avoidance behaviour predominate. Included are panic disorder, agoraphobia, social phobia, simple phobia, obsessive-compulsive disorder, post-traumatic stress disorder and generalised anxiety disorder.

APA
American Psychiatric Association.

Årangi
Unsettled, anxious, perturbed.

Årangirangi
Listless, idle.

ARCIC
Accident Rehabilitation and Compensation Insurance Corporation.

ASPD
See Antisocial personality disorder.

Attention-deficit/hyperactivity disorder (ADHD)
A mental disorder usually first diagnosed in childhood or adolescence, characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals of a comparable level of development. The disorder interferes with developmentally appropriate social, academic or occupational functioning.

Autism
A severe, mental disorder with onset in infancy, characterised by qualitative impairment in reciprocal social interaction (eg, lack of awareness of the existence of feelings for others, failure to seek comfort at times of distress, lack of imitation), impairment of verbal and non-verbal communication, and a restricted repertoire of activities and interests.

Autonomic nervous system
That part of the nervous system concerned with regulation of the activity of cardiac muscle, smooth muscle, and glands.

Avoidant personality disorder
A personality disorder characterised by social discomfort, hypersensitivity to criticism, and an aversion to activities that involve significant interpersonal contact.

BADD
Brothers Against Drunk Driving.

Benzodiazepines
Group of minor tranquillisers that have antianxiety, sedative, hypnotic, amnestic, anticonvulsant and muscle relaxant effects. These medications have the potential to cause dependence and can be abused.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Bipolar I disorder</td>
<td>A mood disorder characterised by the occurrence of one or more manic episodes. In almost all cases, one or more major depressive episodes will eventually occur.</td>
</tr>
<tr>
<td>Bipolar II disorder</td>
<td>A mood disorder characterised by the occurrence of one or more major depressive episodes accompanied by at least one hypomanic episode, but never any manic episodes.</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>A personality disorder marked by a pervasive instability of mood, self-image, and interpersonal relationships. Impulsive and self-damaging acts are common, as are uncontrolled anger, fears of abandonment, chronic feelings of boredom or emptiness, and recurrent self-mutilating behaviour and suicide threats.</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>A mental disorder occurring predominantly in females, characterised by episodes of binge eating, self-induced vomiting and purging, fear of not being able to stop eating voluntarily, and self-deprecation and depressed mood following binges. The binges usually alternate with periods of normal eating or fasting. It differs from anorexia nervosa in that there is no extreme weight loss in those suffering bulimia.</td>
</tr>
<tr>
<td>Cardiac catheterisation</td>
<td>Passage of a small surgical tube through a vein in an arm, leg or the neck and into the heart, permitting the securing of blood samples, determination of intracardiac pressure, detection of cardiac anomalies, planning of operative approaches, and determination, implementation, or evaluation of appropriate therapy.</td>
</tr>
<tr>
<td>Cataplexy</td>
<td>A paroxysmal disorder of postural tone in which in response to an emotional stimulus, such as laughter or excitement, there is a sudden loss of function of some or all of the voluntary muscles.</td>
</tr>
<tr>
<td>Cathartic</td>
<td>An agent that causes evacuation of the bowels.</td>
</tr>
<tr>
<td>CD</td>
<td>See Conduct disorder.</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention.</td>
</tr>
<tr>
<td>Central nervous system (CNS)</td>
<td>That part of the nervous system consisting of the brain and spinal cord.</td>
</tr>
<tr>
<td>CES-D</td>
<td>Center for Epidemiologic Studies Depression Scale. A 20-item self-report depression scale developed to identify depression in the general population.</td>
</tr>
<tr>
<td>CHE</td>
<td>See Crown health enterprise.</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence interval.</td>
</tr>
<tr>
<td>CIE</td>
<td>Canberra Interview for the Elderly.</td>
</tr>
<tr>
<td>CIND</td>
<td>Cognitive impairment with no dementia.</td>
</tr>
<tr>
<td>Circadian rhythms</td>
<td>Regular cycles of activity of certain biological functions, repeated approximately every 24 hours.</td>
</tr>
<tr>
<td>Circular insanity</td>
<td>An old term broadly equivalent to bipolar disorder.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Claustrophobia</td>
<td>An irrational fear of being shut in; fear of enclosed spaces, such as lifts or tunnels.</td>
</tr>
<tr>
<td>CNS</td>
<td>See Central nervous system.</td>
</tr>
<tr>
<td>Cognitive-behavioural therapy</td>
<td>A directive form of psychotherapy based on the theory that emotional problems result from distorted attitudes and ways of thinking that can be corrected. The therapist actively seeks to guide the patient in altering or revising negative or erroneous perceptions and attitudes.</td>
</tr>
<tr>
<td>Cognitive disorders</td>
<td>Mental disorders characterised by clinically significant deficits in cognition or memory that represent a significant change from a previous level of functioning. See Amnestic syndrome, Delirium, Dementia.</td>
</tr>
<tr>
<td>Cohort</td>
<td>A group of people who share a characteristic, such as age or suffering from particular symptoms or diseases. A cohort study documents aspects of such a group over time.</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>Dual occurrence of more than one disease, condition or state.</td>
</tr>
<tr>
<td>Conduct disorder (CD)</td>
<td>A mental disorder of childhood and adolescence characterised by a persistent pattern of conduct in which the rights of others and age-appropriate societal norms or rules are violated.</td>
</tr>
<tr>
<td>Contagious</td>
<td>Capable of being transmitted from one individual to another, such as a contagious disease.</td>
</tr>
<tr>
<td>CPES</td>
<td>Christchurch Psychiatric Epidemiology Study.</td>
</tr>
<tr>
<td>Crown health enterprise (CHE)</td>
<td>Crown-owned entities that provide health and disability support services. There are 23 CHEs, which operate public hospitals.</td>
</tr>
<tr>
<td>CSA</td>
<td>Child sexual abuse.</td>
</tr>
<tr>
<td>CTS</td>
<td>Conflict Tactics Scale. A measurement of violence within family settings.</td>
</tr>
<tr>
<td>CYPFS</td>
<td>Children, Young Persons and Their Families Service.</td>
</tr>
<tr>
<td>DARE</td>
<td>Drug Abuse Resistance Education. A school-based educational programme that focuses on teaching pupils to resist pressures to use drugs.</td>
</tr>
<tr>
<td>DAT</td>
<td>See Dementia of the Alzheimer type.</td>
</tr>
<tr>
<td>Delirium</td>
<td>An organic mental disorder characterised by reduced ability to maintain attention to external stimuli, and disorganised thinking as manifested by rambling, irrelevant or incoherent speech. Other features include a reduced level of consciousness; sensory misperceptions; disturbance of the sleep-wakefulness cycle and of the level of the psychomotor activity; disorientation to time, place and person; and memory impairment. The condition is generally of rapid onset and reversible.</td>
</tr>
<tr>
<td><strong>Delirium tremens</strong></td>
<td>Delirium caused by cessation or reduction in alcohol consumption, typically in alcoholics who have been drinking heavily for at least 10 years. Symptoms include rapid heart rate; sweating; hypertension; a coarse, irregular tremor; delusions; vivid hallucinations; and wild, agitated behaviour.</td>
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<tr>
<td><strong>Dementia</strong></td>
<td>An organic mental disorder characterised by a global deterioration of intellectual abilities including impairment of memory, judgement and abstract thinking, as well as changes in personality. Dementia may be caused by a large number of conditions that cause widespread cerebral damage or dysfunction. Some of these are reversible and others are progressive. The most common is Alzheimer’s disease.</td>
</tr>
<tr>
<td><strong>Dementia of the Alzheimer type (DAT)</strong></td>
<td>A progressive degenerative disease of the brain of unknown aetiology. The first signs of the disease are slight memory disturbance or subtle changes in personality. There is progressive deterioration over the course of five to 10 years resulting in profound dementia. Onset can occur at any age but is more common in older people.</td>
</tr>
<tr>
<td><strong>Dependent personality disorder</strong></td>
<td>A personality disorder marked by feelings of helplessness when alone or when close relationships end, as well as a general preoccupation with fears of being abandoned. Other features include difficulty in decision-making without substantial advice and reassurance, low self-esteem, and hypersensitivity to criticism and disapproval.</td>
</tr>
<tr>
<td><strong>Deviant</strong></td>
<td>An individual with characteristics varying from what are considered normal or standard.</td>
</tr>
<tr>
<td><strong>DIS</strong></td>
<td>Diagnostic Interview Schedule.</td>
</tr>
<tr>
<td><strong>Dizygotic twin</strong></td>
<td>Two offspring developed from two separate ova (eggs) fertilised at the same time. They may be of the same or different sex.</td>
</tr>
<tr>
<td><strong>DMHDS</strong></td>
<td>Dunedin Multidisciplinary Health and Development Study.</td>
</tr>
<tr>
<td><strong>Dopamine</strong></td>
<td>A neurotransmitter in the central nervous system. It is also produced peripherally and acts on peripheral receptors (eg, blood vessels).</td>
</tr>
<tr>
<td><strong>Down’s syndrome</strong></td>
<td>A chromosome disorder characterised by physical malformations, for example, flat-bridge nose, widely spaced eyes, and moderate to severe intellectual handicap. Other physical anomalies may be associated with the condition, such as congenital anomalies to the heart.</td>
</tr>
<tr>
<td><strong>Drug dependence</strong></td>
<td>A maladaptive pattern of drug use, leading to clinically significant impairment or distress. Symptoms include tolerance; withdrawal; excessive drug use; persistent desire or unsuccessful efforts to cut down or control drug use; a great deal of time spent in activities necessary to obtain drugs, use drugs or recover from their effects; giving up important social, occupational or recreational activities because of drug use; and drug use continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by drug use.</td>
</tr>
<tr>
<td>Term</td>
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</tr>
<tr>
<td>DSM</td>
<td><em>Diagnostic and Statistical Manual of Mental Disorders.</em></td>
</tr>
<tr>
<td>Dysphoria</td>
<td>Disquiet, restlessness, malaise.</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>A mood disorder characterised by depressed feelings and loss of interest or pleasure in one’s usual activities, and in which the associated symptoms have persisted for more than two years but are not severe enough to meet the criteria for major depression.</td>
</tr>
<tr>
<td>EBAS</td>
<td>Even Briefer Assessment Scale for Depression. An instrument for identifying depression.</td>
</tr>
<tr>
<td>ECA</td>
<td>Epidemiologic Catchment Area study. A major community-based survey undertaken in the United States of America and since replicated in many other sites elsewhere.</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram.</td>
</tr>
<tr>
<td>ECT</td>
<td><em>See Electroconvulsive therapy.</em></td>
</tr>
<tr>
<td>EEG</td>
<td><em>See Electroencephalography.</em></td>
</tr>
<tr>
<td>ECT (ECT)</td>
<td>A treatment for mental disorders, primarily severe depression, in which convulsions are induced by application of low-voltage alternating current to the brain via scalp electrodes for a fraction of a second. The treatment is applied while the patient is anaesthetised. Some memory loss may be present for several weeks after treatment.</td>
</tr>
<tr>
<td>EEG (EEG)</td>
<td>The recording of the electrical currents developed in the brain, by means of electrodes applied to the scalp. In special situations the electrodes may be placed on the surface of the brain, or placed within the substance of the brain.</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>The science concerned with the study of the factors determining and influencing the frequency and distribution of disease, injury and other health-related events and their causes in a defined human population for the purpose of establishing programmes to prevent and control their development and spread.</td>
</tr>
<tr>
<td>EPPIC</td>
<td>The Early Psychosis Prevention and Intervention Centre. A centre in Melbourne that has developed a comprehensive service combining early detection with optimal early treatments for psychoses.</td>
</tr>
<tr>
<td>Ethnocentrism</td>
<td>An attitude whereby an individual assumes that his or her beliefs, values or group values are superior to those of others without adequate evidence to support their view.</td>
</tr>
<tr>
<td>Eugenic movement</td>
<td>The study of the improvement of a population by selection of its best specimens for breeding.</td>
</tr>
<tr>
<td>Externalising disorders</td>
<td>Includes conduct disorders and substance use disorders. Symptoms include antisocial behaviour and turning against others.</td>
</tr>
<tr>
<td>Extrapyramidal symptoms</td>
<td>Abnormal involuntary movements resulting from disturbances of the extrapyramidal nervous system resulting in alterations in the tone of muscle groups affecting posture and expression.</td>
</tr>
<tr>
<td>Fa’a Samoa</td>
<td>The Samoan way.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Fa’anoanoa</td>
<td>To be sad, mourn, regret. (Samoan term.)</td>
</tr>
<tr>
<td>FADE</td>
<td>Foundation for Alcohol and Drug Education.</td>
</tr>
<tr>
<td>FAE</td>
<td>Foetal alcohol effects.</td>
</tr>
<tr>
<td>Fakasesele</td>
<td>A Tongan term, referring to an individual who is totally insane and capable of doing ‘all sorts of absolutely wonderful things’.</td>
</tr>
<tr>
<td>FAS</td>
<td><em>See Foetal alcohol syndrome.</em></td>
</tr>
<tr>
<td>FAST Track</td>
<td>Families and Schools Together programme.</td>
</tr>
<tr>
<td>Foetal alcohol syndrome (FAS)</td>
<td>A syndrome of retarded growth and development occurring in infants born to women who abuse alcohol heavily during pregnancy. It includes cranial, facial and cardiovascular defects, and severe growth and mental retardation.</td>
</tr>
<tr>
<td>Folate</td>
<td>A vitamin that is essential for the normal development of a foetus. Research has shown that if a mother does not have enough folate in her blood, the foetus may develop a neural tube defect, such as spina bifida.</td>
</tr>
<tr>
<td>Fragile X syndrome</td>
<td>A syndrome linked to the X chromosome and associated with mental retardation, enlarged testes, a high forehead, a large jaw, and long ears in most males; and mild mental retardation in many heterozygous females.</td>
</tr>
<tr>
<td>GAD</td>
<td><em>See Generalised anxiety disorder.</em></td>
</tr>
<tr>
<td>GDS</td>
<td>The Geriatric Depression Scale. This was designed as a screening test for depression in elderly people.</td>
</tr>
<tr>
<td>Generalised anxiety disorder (GAD)</td>
<td>A mental disorder characterised by the presence of unrealistic or excessive anxiety and worry about life circumstances, for six months or longer.</td>
</tr>
<tr>
<td>Genotype</td>
<td>The entire genetic constitution of an individual.</td>
</tr>
<tr>
<td>GHQ</td>
<td>General Health Questionnaire. A self-administered screening instrument designed to detect current, diagnosable psychiatric disorders.</td>
</tr>
<tr>
<td>GMS-AGECAT</td>
<td>The Geriatric Mental State Examination. Derived from the Present State Examination (PSE), but more specific to the mental health of older people.</td>
</tr>
<tr>
<td>Grandiosity</td>
<td>The condition of being grandiose; an exaggerated belief of one’s importance or identity.</td>
</tr>
<tr>
<td>Ha a koro ma a kui ma</td>
<td>Inherited strengths.</td>
</tr>
<tr>
<td>Haematemesis</td>
<td>The vomiting of blood.</td>
</tr>
<tr>
<td>Hapū</td>
<td>Groups of whānau with common ancestral links; subtribe.</td>
</tr>
</tbody>
</table>
Haurangi
A term that is used generally to describe someone who is drunk or intoxicated but also can be used to convey madness.

He Matariki

High expressed emotion
A pattern of family interaction characterised by signs of emotion over-involvement with frequent critical comments, expressing hostility, towards the family member suffering a psychiatric disorder, (usually schizophrenia).

Hinengaro
Mental and emotional wellbeing.

Histrionic personality disorder
A personality disorder marked by excessive emotionality and attention-seeking behaviour. There is over-concern with physical attractiveness and sexual seductiveness; intolerance of delayed gratification; and rapidly shifting, shallowly expressed emotions.

HIV
Human immunodeficiency virus.

Homebake
Impure morphine produced by conversion of readily obtainable analgesics.

Homophobia
An irrational negative reaction to homosexuals.

HPA
Hypothalamic-pituitary-adrenal axis.

HRC of New Zealand
Health Research Council of New Zealand.

Hui
A meeting or gathering of people.

Huntington’s (chorea) disease
A relatively common autosomal dominant, hereditary disease characterised by chronic progressive chorea (involuntary jerky and rapid movements) and mental deterioration terminating in dementia. The age of onset is variable but usually occurs in the fourth decade of life. Death usually follows within 15 years.

Hydrocephalus
A condition marked by dilation of the cerebral ventricles and accompanied by an accumulation of cerebrospinal fluid. The condition may be congenital or acquired and may be of sudden onset or slowly progressive. In infants it is characterised by enlargement of the head, prominence of the forehead, brain atrophy, mental deterioration, and convulsions. In adults the syndrome includes incontinence, imbalance and dementia.

Hypercholesterolaemia
An excess of cholesterol in the blood.

Hypersomnia
Any of a group of sleep disorders characterised by the need for excessive amounts of sleep and sleepiness when awake.

Hypnagogic hallucinations
Hallucinations occurring during the transition between the waking and sleep states, such as a sudden sensation of falling while lying in bed just about to go to sleep.

Hypoglycaemia
An abnormally diminished concentration of glucose (sugar) in the blood.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Hypomania</td>
<td>An abnormality of mood resembling mania (persistent elevated or expansive mood, hyperactivity, inflated self-esteem, etc) but of a lesser intensity.</td>
</tr>
<tr>
<td>Hypothalamus</td>
<td>A part of the brain (the ventral part of the diencephalon that forms the floor and part of the lateral wall of the third ventricle). It activates, controls and integrates the peripheral autonomic mechanisms, endocrine activity, somatic functions (e.g., body temperature, sleep and appetite) and the development of the secondary sex characteristics.</td>
</tr>
<tr>
<td>Iatrogenic</td>
<td>Any adverse condition (physical or psychological) in a patient occurring as the result of medical or surgical treatment.</td>
</tr>
<tr>
<td>ICD</td>
<td>See International Classification of Diseases.</td>
</tr>
<tr>
<td>Icebreakers</td>
<td>National networks of peer support for gay youth initiated and supported by the New Zealand AIDS Foundation.</td>
</tr>
<tr>
<td>IMHC</td>
<td>Integrated mental health care. A standardised method of care that emphasises education about mental health for the whole family unit.</td>
</tr>
<tr>
<td>Impulse-control disorder</td>
<td>A group of mental disorders characterised by repeated failure to resist an impulse to perform some act usually harmful to oneself or to others. At the time of the act, the person feels pleasure or emotional release. Included are pathological gambling, kleptomania (pathological stealing) and pyromania (pathological fire setting).</td>
</tr>
<tr>
<td>Incidence</td>
<td>The number of new events (cases or deaths) of a specific disease or disorder occurring during a certain period.</td>
</tr>
<tr>
<td>Incidence rate</td>
<td>A fraction expressing the rate of new events (cases or deaths) of disease in a population over a period of time. The numerator of the rate is the number of new events during the specified time period, and the denominator is the population at risk during the period.</td>
</tr>
<tr>
<td>Institutionalisation</td>
<td>See Social breakdown syndrome.</td>
</tr>
<tr>
<td>Internalising disorders</td>
<td>Include depression and anxiety-related disorders. Symptoms include excessive inhibition, anxiety and depression.</td>
</tr>
<tr>
<td>Interpersonal psychotherapy</td>
<td>A type of therapy that views faulty communications, interactions and interrelationships as basic factors in maladaptive behaviour.</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine Committee on Prevention of Mental Disorders.</td>
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<tr>
<td>Iwi</td>
<td>Tribe, people.</td>
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<tr>
<td>Kai</td>
<td>Food.</td>
</tr>
<tr>
<td>Kaitiaki</td>
<td>Protector, caretaker.</td>
</tr>
<tr>
<td>Karakia</td>
<td>Prayer.</td>
</tr>
<tr>
<td>Karanga</td>
<td>Call of welcome to acknowledge a significant event.</td>
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<tr>
<td>Kaumātua</td>
<td>Wise and experienced older members of the whānau; elders.</td>
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<td>Kaupapa Foundation, rule.</td>
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<td>Kēhanga Reo Māori language ‘nests’; describes an organisation established by Māori in the 1960s to teach Māori language to preschool children.</td>
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</tr>
<tr>
<td>Korsakoff’s psychosis See Korsakoff’s syndrome.</td>
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</tr>
<tr>
<td>Korsakoff’s syndrome An organic mental disorder characterised by impairment in memory, especially the ability to learn new information, occurring in a normal state of consciousness. The most common cause is thiamine deficiency associated with chronic alcohol abuse but the syndrome may result from damage to certain brain structures. Causes include head trauma, brain tumours, cerebral infarction, cerebral hypoxia, carbon monoxide poisoning and herpes simplex encephalitis. Synonymous with Amnestic syndrome or Korsakoff’s psychosis.</td>
<td></td>
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<tr>
<td>Kuia Older woman or women.</td>
<td></td>
</tr>
<tr>
<td>Le saogalemu lelei Calmness of mind. (Samoan term.)</td>
<td></td>
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<tr>
<td>o le mafaufau</td>
<td></td>
</tr>
<tr>
<td>Lewy bodies Concentrically laminated, round bodies found in some of the neurones of the midbrain in people with Parkinson’s disease. It is suggested that they may characterise a particular form of dementia.</td>
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<tr>
<td>Lifetime prevalence The number of cases of a disease or condition that are present in a population over a period of a lifetime.</td>
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<tr>
<td>Lifetime risk The risk to an individual that a given health event/illness will occur at any time during their life.</td>
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<tr>
<td>Lithium A white metal. Lithium salts are used in treating the manic phase of bipolar disorder.</td>
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</tr>
<tr>
<td>Lymphocytes A type of white blood cell. Found in the blood, lymph, and lymphoid tissue.</td>
<td></td>
</tr>
<tr>
<td>Magnetic resonance imaging (MRI) A method of visualising the soft tissues of the body (organs and processes inside the body) by applying an external magnetic field and modulating this with radiofrequency energy.</td>
<td></td>
</tr>
<tr>
<td>Ma‘i aitu Spiritual illness or possession by spirits. (Samoan term.)</td>
<td></td>
</tr>
<tr>
<td>Ma‘i fasia An illness that occurs when a person visiting a place that is under the custody of a spirit guardian (fasia) does something untoward such as laugh. Features of this illness include hallucinations that may be present for an extended period of time. (Samoan term.)</td>
<td></td>
</tr>
<tr>
<td>Ma‘i Samoa Illness specific to Samoans.</td>
<td></td>
</tr>
<tr>
<td>Ma‘i valea Emotional sickness caused by contact with an object that belonged to a deceased person, disobeying the wishes of the family chief, breaking the Ten Commandments or lapsing from certain residual Samoan traditions.</td>
<td></td>
</tr>
<tr>
<td>Major affective disorders Classification of mood disorders that includes bipolar disorder and major depression.</td>
<td></td>
</tr>
</tbody>
</table>
Mākutu  
Curse, spell.

Malaaumatua  
The breaching of tapu and sa within the family. (Samoan term.)

Malaaunu'ua  
The breaching of tapu and sa placed by village elders. (Samoan term.)

Mana  
Status, prestige, influence.

Mana ake  
Unique identity.

Mania (manic episodes)  
A phase of bipolar disorder characterised by markedly elevated or irritable mood, associated with expansiveness, elation, agitation, hyperexcitability, hyperactivity and increased thought and speech.

MAO  
See Monoamine oxidase.

MAOI  
An antidepressant drug that inhibits the action of monoamine oxidase.

Marae  
Courtyard, enclosed space in front of a house, meeting ground; community and cultural centre.

Matavuvale  
Extended family or lineage in Fiji.

Mate  
Sick; death.

Mate Māori  
A sickness associated with breaches of cultural protocol.

Mauri  
Spiritual strength, life force.

Mavaega  
Samoan sickness attributed to a curse resulting from the failure of a person to fulfil a dying person’s final wishes.

Melancholia  
1. An old term for depression. 2. Currently, a term describing a cluster of biological symptoms of depression indicating more severe depression. These include marked loss of weight, diurnal variation in mood, early morning waking and other symptoms.

Mental disorder  
Any clinically significant behavioural or psychological syndrome characterised by the presence of distressing symptoms or significant impairment of functioning. Mental disorders are assumed to result from some psychological or organic dysfunction of the individual.

Meta-analysis  
Any systematic method that uses statistical analysis to integrate the data from a number of independent studies.

Mixed affective episode  
A condition where the criteria for manic and major depressive episodes are met at the same time nearly every day for at least one week.

Monoamine oxidase (MAO)  
An enzyme that breaks down biogenic amines (neurotransmitters) rendering them inactive.

Monozygotic twins  
Two offspring developed from one zygote or fertilised ovum (egg) which therefore have identical genomes. Synonymous with identical twins.

Mood disorders  
Mental disorders whose essential features are a disturbance of mood manifested as a full or partial manic or depressive syndrome. Included are bipolar disorder, major depression and dysthymia.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbidity</td>
<td>1. A diseased condition or state. 2. The incidence or prevalence of a disease or of all diseases in a population.</td>
</tr>
<tr>
<td>Morphology</td>
<td>The science of the forms and structure of organisms; the form and structure of a particular organism, organ or part.</td>
</tr>
<tr>
<td>Moso</td>
<td>A fearful god of the land below who is associated with sudden death. (Samoan term.)</td>
</tr>
<tr>
<td>MRI</td>
<td><em>See Magnetic resonance imaging.</em></td>
</tr>
<tr>
<td>Multi-infarct dementia</td>
<td>Dementia with a stepwise deteriorating course and a patchy distribution of neurological deficits caused by a series of small strokes.</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>Gross damage to the myocardium (heart muscle) as a result of interruption of the blood supply to the areas. Synonymous with heart attack.</td>
</tr>
<tr>
<td>Narcissism</td>
<td>Self-love.</td>
</tr>
<tr>
<td>Narcissistic personality disorder</td>
<td>A personality disorder characterised by grandiosity, a lack of social empathy combined with hypersensitivity to the judgement of others, interpersonal exploitiveness, a sense of entitlement, and a need for constant signs of admiration.</td>
</tr>
<tr>
<td>NCSDR</td>
<td>National Commission on Sleep Disorder Research.</td>
</tr>
<tr>
<td>Negative symptoms (of schizophrenia)</td>
<td>Characteristic symptoms present in people suffering from schizophrenia. The onset of negative symptoms are usually gradual or can follow repeated relapses with incomplete recovery. Symptoms include flattening of affect, social withdrawal, lack of motivation and interest, and poverty of thought and speech.</td>
</tr>
<tr>
<td>Neneva</td>
<td>A Cook Islands term meaning an intellectual disability or general sickness in the head.</td>
</tr>
<tr>
<td>Neuroendocrinology</td>
<td>The study of the interactions between the nervous system and the endocrine system.</td>
</tr>
<tr>
<td>Neuroleptic drug</td>
<td>A drug with antipsychotic action.</td>
</tr>
<tr>
<td>Neurological disorders</td>
<td>Disorders of the nervous system.</td>
</tr>
<tr>
<td>Neurosis</td>
<td>Former name for a category of mental disorders characterised by anxiety and avoidance behaviour.</td>
</tr>
<tr>
<td>Neurosyphilis</td>
<td>The central nervous system manifestations of syphilis, which may be asymptomatic or symptomatic.</td>
</tr>
<tr>
<td>Neurotic disorder</td>
<td>General term referring to disorders in which the symptoms are distressing to the person, reality testing is intact, behaviour does not violate gross social norms, and there is no apparent organic aetiology.</td>
</tr>
<tr>
<td>Neurotransmitters</td>
<td>Any of a group of substances that are released from a neurone of the central or peripheral nervous system and which then either excite or inhibit an adjacent target cell.</td>
</tr>
</tbody>
</table>
Ngā Pou Mana
A Māori health model which suggests that for a group of people to be healthy, certain appropriate social and economic health policies must be in place. These policies must recognise the importance of whanaungatanga, taonga tuku iho, te ao turanga and tūrangawaewae.

NHC
National Housing Commission.

NIMH
National Institute of Mental Health.

Noa
Free from tapu, ordinary.

NZAF
New Zealand AIDS Foundation.

NZHIS
New Zealand Health Information Service.

Obsessive-compulsive disorder (OCD)
An anxiety disorder characterised by recurrent obsessions and compulsions, such as hand washing, which are severe enough to interfere significantly with personal or social functioning. Performing compulsive rituals releases tension temporarily and resisting them causes increased tension.

Obsessive-compulsive personality disorder
A personality disorder characterised by an emotionally constricted manner that is unduly conventional, serious, and formal; by preoccupation with trivial details, rules, order, organisation, schedules and lists; by stubborn insistence on having things one’s own way without regard for the effects on others; by excessive devotion to work and productivity to the detriment of interpersonal relationships; and by indecisiveness due to fear of making mistakes.

OCD
See Obsessive-compulsive disorder.

Odds ratio (OR)
The odds ratio measures the increase in the risks (odds) of disorder given the presence of another disorder.

OECD
Organization for Economic Co-operation and Development. Its members include the industrialised countries of western Europe together with Australia, Japan, New Zealand and the US.

Oppositional disorder
A childhood disorder consisting of pervasive disobedience, negativism and provocative opposition to authority figures.

OR
See Odds ratio.

Ottawa Charter
The Ottawa Charter for Health Promotion was developed and adopted by the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986. This charter defines health promotion as the process of enabling people to increase control over, and to improve, their health. Health promotion action means: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services.

OWHS
Otago Women’s Health Survey.

Pākehā
A person of predominantly European descent.

Palliative coping reactions
Reactions that are aimed to relieve or lessen pain or other uncomfortable symptoms without resolving underlying problems.
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder</td>
<td>An anxiety disorder characterised by recurrent panic (anxiety) attacks, episodes of intense apprehension, fear or terror associated with somatic symptoms such as difficulty in breathing, palpitations, dizziness, vertigo, faintness or shakiness and with psychological symptoms such as feelings of unreality or fears of dying, going crazy or losing control. There is usually chronic nervousness and tension between attacks. This disorder does not include panic attacks that may occur in phobias when the patient is exposed to the phobic stimulus.</td>
</tr>
<tr>
<td>Panphobia</td>
<td>Fear of everything; a vague morbid dread of some unknown evil.</td>
</tr>
<tr>
<td>Paranoid personality disorder</td>
<td>A personality disorder marked by a view of other people as hostile, devious and untrustworthy, and a combative response to disappointments or to events experienced as rebuffs or humiliations. Notable features are questioning the loyalty of friends, the bearing of grudges, and a tendency to read threatening meanings into benign remarks.</td>
</tr>
<tr>
<td>Paranoid state</td>
<td>Behaviour characterised by well-systematised delusions of persecution, delusions of grandeur, or a combination of both.</td>
</tr>
<tr>
<td>Paraphrenia</td>
<td>Paranoia or paranoid schizophrenia in which there are fantastic, absurd, well-systematised delusions that persist for years without severe personality deterioration. A condition intermediate between paranoia and paranoid schizophrenia, usually developing late in life.</td>
</tr>
<tr>
<td>Parasonmia</td>
<td>A category of sleep disorders that includes abnormal events occurring during sleep, such as sleepwalking, nightmares and extreme anxiety occurring shortly after sleep onset.</td>
</tr>
<tr>
<td>Parasuicide</td>
<td>An apparent attempt at suicide, as by self-poisoning or self-mutilation, in which death is not the desired outcome. At times the term has included all attempts at deliberate self-harm, including non-fatal suicide attempts.</td>
</tr>
<tr>
<td>Parental Bonding Instrument (PBI)</td>
<td>A questionnaire to measure a person’s perception of their relationship with their parents during childhood/adolescence.</td>
</tr>
<tr>
<td>Parkinsonian dementia syndrome</td>
<td>The co-occurrence of dementia and Parkinson’s disease, usually in its advanced, severe stages.</td>
</tr>
<tr>
<td>Parkinson's disease</td>
<td>A condition of unknown aetiology, usually occurring in late life. It is a slowly progressive disease characterised by masklike facies, a characteristic tremor of resting muscles, a slowing of voluntary movements, a festinating gait, peculiar posture, and weakness of muscles. There may be excessive sweating and feelings of heat.</td>
</tr>
<tr>
<td>PAS</td>
<td>Personality Assessment Scale.</td>
</tr>
<tr>
<td>Pathological gambling</td>
<td>A persistent and recurrent maladaptive gambling behaviour that disrupts personal, family or vocational pursuits.</td>
</tr>
<tr>
<td>PATHS</td>
<td>Promoting Alternative Thinking Strategies. A teacher-led intervention directed towards the development of emotional concepts, social understanding and self-control.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------------</td>
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</tr>
<tr>
<td>PBI</td>
<td>See Parental Bonding Instrument.</td>
</tr>
<tr>
<td>PD</td>
<td>See Personality disorders.</td>
</tr>
<tr>
<td>PDD</td>
<td>Pre-menstrual dysphoric disorder.</td>
</tr>
<tr>
<td>Pellagra</td>
<td>A deficiency syndrome due to deficiency of niacin and characterised by dermatitis, inflammation of mucous membranes, diarrhoea, and psychiatric disturbances. Mental symptoms include depression, irritability, anxiety, confusion, disorientation, delusions and hallucinations.</td>
</tr>
<tr>
<td>Period prevalence</td>
<td>The number of cases of a disease or condition that exists in a defined population in a designated period of time.</td>
</tr>
<tr>
<td>Peripheral nervous system</td>
<td>That portion of the nervous system that is not part of the brain or spinal cord.</td>
</tr>
<tr>
<td>Peripheral neuropathy</td>
<td>A functional disturbance or pathological change to several peripheral nerves simultaneously. The aetiology may be known or unknown.</td>
</tr>
<tr>
<td>Personality disorders (PD)</td>
<td>A category of mental disorders characterised by inflexible and maladaptive personality traits that are self-perpetuating, generate subjective distress, and result in significant impairments in social functioning.</td>
</tr>
<tr>
<td>PET</td>
<td>See Positron emission tomography.</td>
</tr>
<tr>
<td>Pharmacological</td>
<td>Pertaining to pharmacology or the properties and reactions of drugs.</td>
</tr>
<tr>
<td>Pharmacotherapy</td>
<td>The treatment of disease by medicines.</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>The description of symptoms as experienced by the individual and the development of classification based on these symptoms.</td>
</tr>
<tr>
<td>Phenotype</td>
<td>The entire physical, biochemical and physiological make-up of an individual as determined both genetically and environmentally, as opposed to genotype.</td>
</tr>
<tr>
<td>Phenylalanine</td>
<td>An amino acid required for protein synthesis that cannot be synthesised by humans and must be obtained in the diet.</td>
</tr>
<tr>
<td>Phenylketonuria</td>
<td>The most severe manifestation of excessive levels of phenylalanine due to an enzyme deficiency (phenylalanine mono-oxygenase), with accumulation and excretion of phenylalanine and other related compounds, and inherited as an autosomal, recessive trait. It is characterised by severe mental retardation, tumours, seizures, hypopigmentation of hair and skin, eczema and mousy odour, all preventable by early restriction of dietary phenylalanine.</td>
</tr>
<tr>
<td>Phobia</td>
<td>A persistent, irrational, intense fear of a specific object, activity or situation; fear that is recognised as being excessive or unreasonable by the individual themselves. When a phobia is a significant source of distress or interferes with social functioning, it is considered a mental disorder. In DSM-IV, phobic disorders are subclassified as agoraphobia, social phobias and specific phobias.</td>
</tr>
</tbody>
</table>
Pick’s disease
A rare progressive degenerative disease of the brain similar in clinical manifestations and course to Alzheimer’s disease but more rapidly progressive and having a greater effect on personality and behaviour at an early stage. It predominantly affects the frontal lobes of the brain.

Plasma tryptophan

Platelets
Disk-shaped cells found in the blood of all mammals and chiefly known for their role in blood clotting.

Plunket
Royal New Zealand Plunket Society. An organisation founded in 1907 to assist parents and caregivers to maintain and improve the health of children up to the age of five years.

PMS
See Pre-menstrual tension syndrome.

Point prevalence
The number of cases of a disease or condition that exist in a defined population at a given point in time.

Polypharmacy
The administration of many drugs together for the same condition. This practice is generally seen as inappropriate.

Polysomnography
The polygraphic recording during sleep of multiple physiological variables, both directly and indirectly, related to the state and stages of sleep, to assess possible biological causes of sleep disorders. These include an EEG, ECG, pulse rate and measures of respiratory functioning.

Pörangi
Disturbed behaviour.

Positive symptoms
Characteristic symptoms present in people suffering from schizophrenia. These are most commonly seen in acute episodes of the illness, though they may occur at other times as well. The symptoms include distortions or exaggerations of inferential thinking (delusions), false perceptions (hallucinations), disturbances of language and communication (disorganised speech), and behavioural disturbances (grossly disorganised or catatonic behaviour).

Positron emission tomography (PET)
A type of radio-isotope scan that produces an image of the brain or other parts of the body indicating the level of metabolic activity rather than the structure of that part.

Post-partum depression
A subsidiary descriptor of an episode of major depression, where the onset of the episode is within four weeks after delivery of a child. There may be suicidal ideation, obsessional thoughts regarding violence to the child, lack of concentration, and anxiety as part of the depressive syndrome.

Post-traumatic stress disorder (PTSD)
A mental disorder caused by a traumatic event outside the range of normal human experience, such as rape or assault, military combat or bombing of civilians, natural disasters or terrible accidents, torture, or death camps. Characterised by re-experiencing the traumatic event in recurrent intrusive recollections, nightmares, or flashbacks, by
‘psychic numbness’ or ‘emotional anaesthesia’, by hyperalertness and difficulty in sleeping, remembering or concentrating, and by guilt about surviving when others have not or about things that had to be done in order to survive.

Pre-menstrual tension syndrome (PMS) A syndrome of unknown cause, typically occurring in the two weeks prior to menstruation, sometimes marked by bloating, oedema, emotional lability, headache, changes in appetite or cravings for selected foods, breast swelling and tenderness, constipation and decreased ability to concentrate.

Presenile dementia Primary degenerative dementia of the Alzheimer type, first evident before the age of 65 years.

Prevalence The number of cases of a disease that are present in a population. May be further specified as point prevalence (the number of cases at a given point in time); or period prevalence (the number of cases present during a specified period of time).

Proband A person included in a genetic study who has a given condition and who was identified directly, not through being related to another affected person.

Prodrome A warning symptom or precursor; a symptom indicating the onset of disease.

PSE Present State Examination. A well-established semi-structured interview, carried out by a trained clinician that establishes the range of symptoms experienced by a person and allows a diagnosis to be derived from this information.

Psychoactive substances Drugs that affect the mind or behaviour.

Psychogerontology The scientific study of the psychological and psychiatric aspects of aging.

Psychological Of the mind; of psychology (that branch of science that deals with the mind and mental processes, especially in relation to human and animal behaviour).

Psychomotor retardation Generalised slowing down of mental and physical activity.

Psychopathic personality Pertaining to antisocial behaviour or antisocial personality disorder.

Psychopathology 1. The pathology of mental disorders; the branch of medicine that deals with the causes and nature of mental disease. 2. Abnormal, maladaptive behaviour or mental activity.

Psychosis 1. A mental disorder characterised by gross impairment in reality testing as evidenced by delusions, hallucinations, markedly incoherent speech, or disorganised and agitated behaviour without apparent awareness on the part of the patient of the incomprehensibility of his or her behaviour. 2. The term is also used in a more general sense to refer to mental disorders in which mental functioning is sufficiently impaired as to interfere grossly with the patient’s capacity to meet the ordinary demands of life.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial factors</td>
<td>Pertaining to or involving both psychological and social aspects.</td>
</tr>
<tr>
<td>Psychosomatic</td>
<td>Pertaining to the mind–body relationship; having bodily symptoms of psychological, emotional or mental origin.</td>
</tr>
<tr>
<td>Psychotropics</td>
<td>Drugs that affect the mental state.</td>
</tr>
<tr>
<td>PTSD</td>
<td>See Post-traumatic stress disorder.</td>
</tr>
<tr>
<td>Puerperium</td>
<td>The period from the end of the third stage of labour until involution of the uterus is complete, usually lasting three to six weeks.</td>
</tr>
<tr>
<td>Pulsatile gonadotrophin</td>
<td>Rhythmical pulsation of any hormone that stimulates the gonads (ie, testes or ovaries).</td>
</tr>
<tr>
<td>Quasi-experimental</td>
<td>A study in which subjects cannot be randomly assigned to treatment conditions, although the researcher does manipulate the independent variable (the variable being studied) and exercises certain controls to enhance the internal validity of the results.</td>
</tr>
<tr>
<td>Rāhui</td>
<td>To place a ban.</td>
</tr>
<tr>
<td>Rangatiratanga</td>
<td>Chieftainship, authority, kingdom.</td>
</tr>
<tr>
<td>Rangimārie</td>
<td>Quiet, peaceful.</td>
</tr>
<tr>
<td>Rapid cycling</td>
<td>Rapid recurrence of mania or depression in individuals who suffer from bipolar disorder. This affects between 10 and 15 percent of individuals and is defined as four or more affective episodes (major depressive, manic or hypomanic) within a 12-month period.</td>
</tr>
<tr>
<td>Regional health authority</td>
<td>The four regional health authorities were purchasing agencies for publicly funded health and disability support services. They were disestablished on 30 June 1997. See Transitional Health Authority.</td>
</tr>
<tr>
<td>RHA</td>
<td>See Regional health authority.</td>
</tr>
<tr>
<td>Rongoā</td>
<td>Medicine, remedy.</td>
</tr>
<tr>
<td>Sa</td>
<td>Things that are sacred. (Samoan term.)</td>
</tr>
<tr>
<td>SADD</td>
<td>Students Against Drunk Driving.</td>
</tr>
<tr>
<td>Schizoid personality disorder</td>
<td>A personality disorder characterised by indifference to social relationships and a restricted range of emotional experience and expression. Includes persons who lack the capacity for social relationships, are cold and aloof, and are indifferent to praise, criticism, or feelings of others.</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>A mental disorder or group of disorders characterised by disturbances in: the form and content of thought (delusions and hallucinations); mood (blunted, flattened or inappropriate affect); sense of self and relationship to the external world (loss of ego boundaries and autistic withdrawal); and behaviour (bizarre, apparently purposeless and stereotyped activity or inactivity). Some symptoms have to be present for at least six months before diagnostic criteria are met.</td>
</tr>
<tr>
<td>Schizophreniform disorder</td>
<td>A mental disorder with the signs and symptoms of schizophrenia, but the duration is less than six months.</td>
</tr>
<tr>
<td><strong>Schizotypal personality disorder</strong></td>
<td>A personality disorder characterised by marked deficits in interpersonal competence and eccentricities in ideation, appearance and behaviour. Ideas of reference are common, as are odd beliefs or magical thinking, a lack of close friends, excessive social anxiety, suspiciousness and occasional paranoid ideation.</td>
</tr>
<tr>
<td><strong>SE</strong></td>
<td>Standard error.</td>
</tr>
<tr>
<td><strong>Segi's World Population</strong></td>
<td>A standard population that is merely an arbitrary, but convenient, set of figures against which other populations can be standardised to produce comparable rates of any given disorder.</td>
</tr>
<tr>
<td><strong>Selective intervention</strong></td>
<td>An intervention that targets individuals or subgroups of a population who are selected because they have an increased risk of having or developing a disorder or disorders.</td>
</tr>
<tr>
<td><strong>Senile dementia</strong></td>
<td>Primary degenerative dementia of the Alzheimer type, with onset after age 65.</td>
</tr>
<tr>
<td><strong>Seroconversion</strong></td>
<td>The change of a serological test (usually a blood test) from negative to positive, indicating the development of antibodies in response to infection or immunisation.</td>
</tr>
<tr>
<td><strong>Serotonin</strong></td>
<td>A monoamine vasoconstrictor found in many body tissues, including the intestinal mucosa, pineal body and the central nervous system. It inhibits gastric secretion, stimulates smooth muscle, serves as a central neurotransmitter and is a precursor to melatonin. Also called 5-hydroxytryptamine (5-HT).</td>
</tr>
<tr>
<td><strong>SES</strong></td>
<td>Socioeconomic status.</td>
</tr>
<tr>
<td><strong>Single photon emission computed tomography (SPECT)</strong></td>
<td>A type of radio-isotope scan in which gamma photon-emitting radionuclides are administered to patients and then detected by one or more gamma cameras rotating around the body. It provides an indication of metabolic activity rather than of anatomical structure.</td>
</tr>
<tr>
<td><strong>Sleep apnoea</strong></td>
<td>Transient attacks of failure of automatic control of respiration, resulting in a lack of air reaching the lungs, which become more pronounced during sleep. It may result in an accumulation of acid or depletion of the alkaline reserve in the blood and in narrowing of the pulmonary arterioles, producing pulmonary arterial hypertension.</td>
</tr>
<tr>
<td><strong>SMR</strong></td>
<td>Standardised mortality ratio. The percentage ratio of the number of deaths observed in the area studied to the number expected from the standard age-specific death rates.</td>
</tr>
<tr>
<td><strong>Social breakdown syndrome</strong></td>
<td>Behaviour shown by some people with psychiatric disorders following long-term hospitalisation. The symptoms include excessive passivity, assumption of the chronic sick role, and atrophy of work and social skills. Also referred to as institutionalisation.</td>
</tr>
<tr>
<td><strong>Social phobia</strong></td>
<td>Any phobic disorder involving fear and avoidance of social situations in which the individual fears he or she will be exposed to possible embarrassment and humiliation (e.g., fears of speaking or performing in public, using public toilets, or eating in public).</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Somatic</td>
<td>Pertaining to or characteristic of the soma or body.</td>
</tr>
<tr>
<td>Somatisation disorder</td>
<td>A mental disorder characterised by multiple somatic complaints that are not caused by a physical illness. The complaints may involve a general complaint of being sickly, or specific symptoms, such as gastrointestinal, female reproductive, psychosexual, or cardiopulmonary symptoms, or pain. Complaints are often presented in a dramatic, vague or exaggerated way. Typically, many doctors become involved and numerous diagnostic evaluations and unnecessary medical treatment or surgery may be performed. Most patients have symptoms of anxiety and depression and a wide range of interpersonal difficulties; many have histrionic personality traits.</td>
</tr>
<tr>
<td>Somatoform disorders</td>
<td>A group of disorders including somatisation disorder, conversion disorder (unexplained symptoms suggestive of a neurological or medical condition associated with psychological factors), pain disorder (pain where psychological factors are considered to have an important role in its onset, severity, exacerbation or maintenance), hypochondriasis (preoccupation with the fear of a serious disease based on the person’s misinterpretation of bodily symptoms or bodily functions), and body dysmorphic disorder (preoccupation with an imagined or exaggerated defect in physical appearance).</td>
</tr>
<tr>
<td>SPECT</td>
<td>See Single photon emission computed tomography.</td>
</tr>
<tr>
<td>Spina bifida</td>
<td>An abnormality of the development of the spine. In more serious cases the spinal cord is open to the surface of the skin, resulting in the nerves being damaged and the individual paralysed.</td>
</tr>
<tr>
<td>Spontaneous refugees</td>
<td>Refugees who seek asylum.</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective serotonin re-uptake inhibitor. A type of antidepressant drug.</td>
</tr>
<tr>
<td>Stress inoculation</td>
<td>A procedure useful in helping patients control anxiety by substituting positive coping statements for statements that bring about anxiety.</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>Mental disorders involving maladaptive behaviour associated with regular use of mood- or behaviour-altering substances. These include alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phenylcyclidine and sedatives, hypnotics, or anxiolytics.</td>
</tr>
<tr>
<td>Sundowner</td>
<td>An older person whose mental functioning is adequate during the day but at night is impaired by confusion and agitation.</td>
</tr>
<tr>
<td>Suprachiasmatic nucleus</td>
<td>A small nucleus in the hypothalamus in the brain. It influences rhythmical aspects of the hypothalamic functions (peripheral autonomic mechanisms, endocrine activity, and somatic functions, such as regulation of water balance, body temperature, sleep and appetite) in many vertebrate species, probably including humans.</td>
</tr>
<tr>
<td>Synapse</td>
<td>The site at which an impulse is transmitted from one neurone to another, usually by a chemical neurotransmitter released by the excited (presynaptic) cell.</td>
</tr>
</tbody>
</table>
Glossary

Taha tinana  Physical wellbeing.
Tangata whenua  People belonging to any particular place; the indigenous people.
Tangihanga  Ceremony for mourning the dead.
Taonga tuku iho  Cultural heritage.
Tapu  Sacred, forbidden.
Tardive dyskinesia (TD)  A side-effect produced by long-term administration of antipsychotic drugs. It is characterised by continual chewing motions with intermittent darting movements of the tongue and there may also be the ceaseless occurrence of a wide variety of rapid, highly complex, jerky movements. In some patients symptoms disappear within several months after antipsychotic drugs are withdrawn, in others symptoms persist indefinitely.
Tardive dystonia  A variant of tardive dyskinesia in which there is distortion or impairment of voluntary movements due to abnormal resting tone in different muscle groups.
Taulaitu  Healers within the Samoan community.
TD  See Tardive dyskinesia.
Te ao turoa  The physical environment.
Te'ia  A Tongan illness whereby the victim is ‘hit by’, and falls under the command of, a dead person’s spirit.
Te reo Māori  The Māori language.
Te taha hinengaro  The intellectual (thought) dimension; mental wellbeing.
Te taha tinana  The physical (bodily) dimension; physical wellbeing.
Te taha wairua  The spiritual dimension; spiritual wellbeing.
Te taha whānau  The familial dimension; family wellbeing.
Te Whare Tapa Whā  A Māori health model that suggests that good health is described in relation to the four walls of a strong house: te taha wairua, te taha hinengaro, taonga tuku iho and te taha whānau. A person is considered unwell if any of these foundations are weak. For a person to be healthy, all four walls need to be strong.
Te Wheke  A Māori health model that suggests that for total wellbeing to exist, all of the components – wairuatanga, hinengaro, taha tinana, whanaungatanga, whatumanawa, mauri, mana ake, and ha a koro ma a kui ma – must exist. These eight components are seen to represent the eight tentacles of the octopus.
THA  See Transitional Health Authority.
Tikanga  Customary practice, rule.
Tino rangatiratanga  Literally ‘chieflly authority’; Māori self-determination; to be in charge of one’s own destiny.
### Glossary

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<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tr>
<td><strong>Tipuna</strong></td>
<td>Ancestor.</td>
</tr>
<tr>
<td><strong>Tohunga</strong></td>
<td>Expert, specialist.</td>
</tr>
<tr>
<td><strong>Tomograph</strong></td>
<td>An apparatus for moving the x-ray source in one direction as the film is moved in the opposite direction, thus showing in detail a predetermined plane of tissue while blurring or eliminating detail in other planes.</td>
</tr>
<tr>
<td><strong>Tomography</strong></td>
<td>The recording of internal body images at a predetermined plane by means of the tomograph. In CAT scans (computerised axial tomography) the enhancement of detail in multiple planes is calculated mathematically rather than achieved by mechanical apparatus.</td>
</tr>
<tr>
<td><strong>To'oala</strong></td>
<td>Samoan life essence.</td>
</tr>
<tr>
<td><strong>Transitional Health Authority (THA)</strong></td>
<td>On 1 July 1997 the Transitional Health Authority replaced the four <em>regional health authorities</em>, and has responsibility for purchasing publicly funded health and disability support services. On 1 July 1998 a single national funding agency will take over this role.</td>
</tr>
<tr>
<td><strong>Tricyclic antidepressants</strong></td>
<td>A group of drugs that improves the mood of depressed patients and that share a similar chemical structure.</td>
</tr>
<tr>
<td><strong>Tūrangawaewae</strong></td>
<td>Literally translates to ‘a place to stand’; however, more broadly refers to one’s source of identity.</td>
</tr>
<tr>
<td><strong>Tyrosine</strong></td>
<td>An amino acid found in most proteins and synthesised metabolically from phenylalanine. It is a precursor of thyroid hormones, catecholamines and melanin.</td>
</tr>
<tr>
<td><strong>Wai</strong></td>
<td>Water, liquid.</td>
</tr>
<tr>
<td><strong>Waiala</strong></td>
<td>Song; to sing.</td>
</tr>
<tr>
<td><strong>Wairangi</strong></td>
<td>Someone who is overly excited, infatuated or foolish.</td>
</tr>
<tr>
<td><strong>Wairua</strong></td>
<td>Spirit; spirituality.</td>
</tr>
<tr>
<td><strong>Wairuatanga</strong></td>
<td>Spirituality.</td>
</tr>
<tr>
<td><strong>Wernicke-Korsakoff syndrome</strong></td>
<td>The syndrome caused by thiamine deficiency, most commonly due to chronic alcohol abuse and associated with other nutritional polyneuropathies. See Wernicke’s encephalopathy (the acute phase of the syndrome) and Korsakoff’s syndrome (the chronic phase of the syndrome).</td>
</tr>
<tr>
<td><strong>Wernicke’s encephalopathy</strong></td>
<td>A neurological disorder characterised by confusion; apathy; drowsiness; lack of muscular co-ordination of gait; involuntary, rapid, rhythmic movements of the eyes; or paralysis of one of the eye muscles. It is due to thiamine deficiency, usually from chronic alcohol abuse. It is almost invariably followed by Korsakoff’s syndrome if untreated.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Whaikōrero</td>
<td>To make a speech; speech.</td>
</tr>
<tr>
<td>Whakamā</td>
<td>Ashamed, shy.</td>
</tr>
<tr>
<td>Whakapuakitanga</td>
<td>National networks of peer support for gay youth initiated and supported by the New Zealand AIDS Foundation.</td>
</tr>
<tr>
<td>Whakawhangaungatanga</td>
<td>Establishing and/or improving relations between groups of people; kinship.</td>
</tr>
<tr>
<td>Whānau</td>
<td>Family.</td>
</tr>
<tr>
<td>Whanaungatanga</td>
<td>Extended family, family relationships, family cohesion.</td>
</tr>
<tr>
<td>Whare oranga</td>
<td>House of livelihood.</td>
</tr>
<tr>
<td>Whatumanawa</td>
<td>Emotions, feelings.</td>
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