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Foreword

The Western Australian mental health promotion and illness prevention policy is a joint project between the Mental Health Division, Public Health Division and the Office of Aboriginal Health of the Department of Health. It has now been endorsed by the Department's executive and commits the organisation to the promotion of mental health and prevention of mental illness as set out in this policy.

Department of Health interest in mental health promotion and illness prevention is based on a growing base of evidence and knowledge. As a consequence of this evidence, our emphasis must and has shifted toward a focus on the promotion of mental health and prevention of mental illness for the whole population.

Our aim for mental health promotion is to increase and improve community and workforce capacity, promote partnerships with other stakeholders, and reduce discrimination and stigma associated with mental illness. For mental illness prevention, we will aim to reduce conduct disorder, depression, alcohol and other drug use, and suicide.

The priority focus for the first three years of this policy will be to develop the capacity of the population health system in this area. A statewide network of key personnel will be developed to facilitate, enable and support services, programs and projects to improve social and emotional wellbeing, and reduce the incidence and prevalence of mental health problems and disorders. Throughout this process, we will ensure the community is informed and able to contribute.

Research priorities for the development of mental health promotion and illness prevention services in Western Australia will match the state's priorities and reflect community needs.

Implementation of this policy will not prevent all mental illness. However, an improved sense of emotional wellbeing and well targeted programs that promote resilience can positively influence our lives and reduce susceptibility to stress, anxiety and some forms of depression that can have serious adverse consequences.

I am pleased to present the Department of Health's mental health promotion and illness prevention policy to you and gratefully acknowledge the contribution of all those mental health professionals, individuals and organisations across the state who were involved in its preparation.

MIKE DAUBE
DIRECTOR GENERAL
DEPARTMENT OF HEALTH

31 May 2002

1. Introduction

1.1 Context

Western Australia generally has a strong commitment to public health, but mental health promotion is a relatively new field in Western Australia and Australia. Although prevention and promotion activities in mental health have probably been occurring for several decades (without it necessarily being formally labelled as such) there has been a rapid increase in the use of the terms 'mental health promotion' and 'mental illness prevention' over the past few years¹.

Justification for mental health promotion derives from the same charters and declarations supporting health promotion. These works provide frameworks for equivalent development in the field of mental health promotion².

Internationally, mental health is seen as fundamental to physical health and quality of life. The European Commission has explicitly underlined the importance of mental health for general health and wellbeing by forming the European Network on Mental Health Promotion to identify and disseminate good practice in mental health promotion and illness prevention³.

It is acknowledged internationally and in Australia that evidence based mental health promotion and mental illness prevention strategies have the potential to lower the incidence and prevalence of mental illness and consequently reduce demand for treatment services in the medium to long term. Mental health promotion and illness prevention strategies aim to improve the social, physical and economic environments that determine the mental health of populations and individuals. It is not assumed, however, that the approaches identified in this policy will prevent all mental illness.

In Australia, the *Mental health promotion and prevention national action plan under the second national mental health plan 1998-2003* ('National Action Plan'), endorsed by Australian Health Ministers in July 1998, provides a five year strategic agenda and plan of action for mental health promotion and illness prevention. The National Action Plan outlines the agreed initiatives that will be undertaken at a national level while enabling a range of specific activities to be developed by states to suit their needs. Supporting the National Action Plan is a monograph document *Promotion, prevention and early intervention for mental health*⁴, which provides the theoretical and conceptual framework for the Plan.



1.2 Background

In Australia, mental illness is estimated to affect over 18 percent of the adult population (aged 18-65 years and over) and around 14 percent of young people (aged between 4 and 17 years) in any one year⁵. In Western Australia, data reveals similar patterns to the Australia wide results. Almost one in five (19 percent) adult Western Australians had a mental illness during a survey – *Mental health and wellbeing: profile of adults*, conducted from September 1997 to May 1998⁶.

The Western Australian data also revealed that the prevalence of mental illness generally decreased with age. Young adults aged 18-24 years had the highest prevalence of mental illness (34 percent), declining steadily to 6 percent of those aged 65 years and over.

The prevalence of psychiatric disorder in children in Aboriginal communities ranges from 1.8 to 31.7 percent and in adolescents, between 25 and 51 percent⁷. Young Aboriginal people reported family disputes, feuding and marriage breakdowns, role confusion, sexual abuse and problems of sexual identity as issues that contribute to the alarming rate of Aboriginal youth suicide⁸.

The financial and personal burden of mental illness to sufferers, their families and the wider community continues to grow, both in Australia and worldwide⁹. In Australia, mental disorders accounted for 27 percent of the non fatal disease burden in 1996¹⁰. The social and economic costs of mental illness can be reduced through complementing treatment and maintenance initiatives with proven mental health promotion and illness prevention approaches. However, to date, there has been limited investment by Government in mental health promotion and illness prevention strategies (statistics show that 1.3 percent of the total mental health budget in Western Australia was directed to mental health promotion and illness prevention initiatives in 2000/2001¹¹). There is now great support for an enhanced role for mental health promotion and illness prevention initiatives.

This policy will focus on mental health promotion and mental illness prevention strategies that, as far as possible, provide evidence of an effective intervention or approach and are acceptable to the communities that would be involved in them. It recognises that the evidence base is not complete and there is a need to continue to support research in this area.

The development of effective partnerships with families and communities, and enhanced linkages between all services responsible for the wellbeing of children, families and individuals will be necessary to enable this policy to succeed.

**family disputes, feuding and marriage breakdowns, role confusion, sexual abuse and problems of sexual identity...
...contribute to the alarming rate of Aboriginal youth suicide**



(i) Mental Health Division 2000/2001 contract prices

1.3 Priority outcomes

The priority outcomes for mental health promotion in Western Australia are:

- developing community and workforce capacity
- developing and strengthening partnerships
- reducing discrimination and stigma.

The priority outcomes for mental illness prevention in Western Australia are reducing the incidence and prevalence of:

- conduct disorder
- depression
- alcohol and other drug use
- suicide.

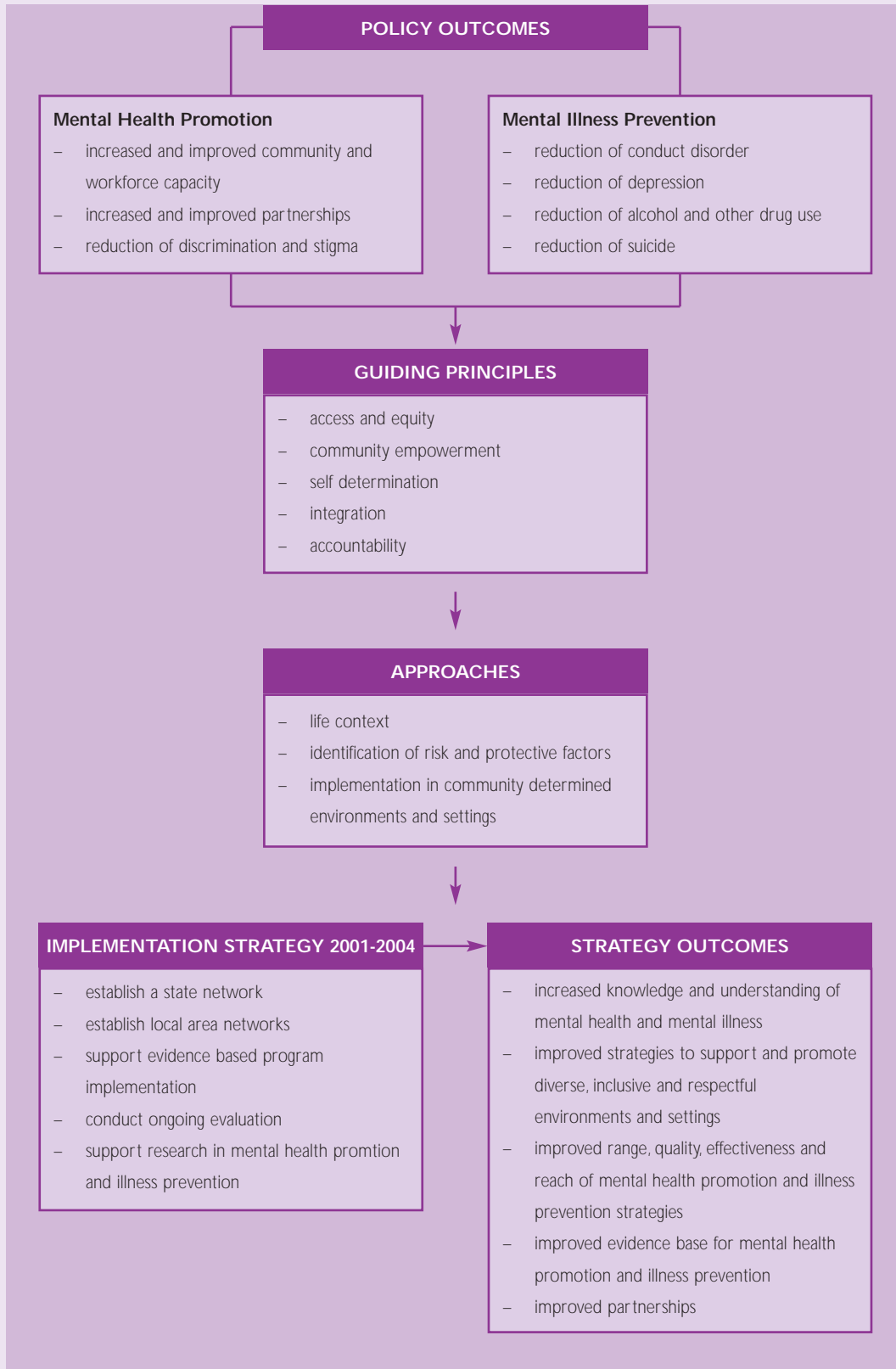
1.4 Supporting documents

This policy should be considered in the context of the following supporting documents:

- *Ottawa charter for health promotion* (1986)
- *Jakarta declaration on leading health promotion into the 21st century* (1997)
- Commonwealth Department of Health and Aged Care (1999), *Mental health promotion and prevention national action plan*, Canberra: Commonwealth of Australia
- Commonwealth Department of Health and Aged Care (2000), *Promotion, prevention and early intervention for mental health – a monograph*, Mental Health Branch, Canberra: Commonwealth of Australia
- Centre for Mental Health Services Research Inc (2000), *Mental health promotion and illness prevention in Western Australia: A study of service capacity*, Perth
- Swan, P and Raphael, B (1995), *Ways forward: National consultancy report on Aboriginal and Torres Strait Islander mental health – Part 1*, Commonwealth of Australia

2. Western Australian Policy Framework

WESTERN AUSTRALIAN MENTAL HEALTH PROMOTION AND ILLNESS PREVENTION POLICY FRAMEWORK



2.1 Defining mental health and mental illness



Many people have everyday problems such as worries, stress and self-doubt, without having a 'mental illness'¹¹. Protective factors, such as being employed, having solid social networks and positive self-esteem, have a strong impact on whether a person can maintain their wellbeing during times of stress and anxiety. Being mentally healthy is more than simply not having a mental illness, it is the embodiment of social, emotional, spiritual and cultural wellbeing.

2.1.1 Mental health

In 1991, Australian Health Ministers¹² defined mental health as:

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

Aboriginal peoples' concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. It refers to more than the 'whole body' and is infused in the inter-relations that constitute cultural wellbeing, such as the connection with the land. Words such as 'physical', 'social', 'emotional', 'spiritual', 'cultural', 'environmental', 'economic', 'family connectedness', 'identity' and 'belonging' were used in discussions about what mental health means to Aboriginal people.

In recognising the diversity that exists within the Aboriginal community, the importance of identity that determines a sense of belonging and ownership within kinship systems must also be recognised.

The national report *Ways forward*¹³ defines Aboriginal mental health as follows:

Health does not just mean the physical wellbeing of the individual but refers to the social, emotional and cultural wellbeing of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life.


Other specific cultural and community groups will also have specific definitions of mental health and should be encouraged to have access to the relevant knowledge and support to develop these. This process is consistent with the principle of community empowerment using a strategy of developing mental health literacy.

2.1.2 Mental illness

The National Action Plan defines 'mental health problem' as 'diminished cognitive, emotional or social abilities but not to the extent that it meets a disorder'. Mental health problems are more common than mental disorders and include temporary problems experienced as a reaction to life stressors, such as grief from the loss of a family member. Mental health problems are less severe and shorter lasting than mental disorders, but may progress into a mental disorder.

The definition of mental health problem in *Ways forward*¹⁴ recognises the individual's role in the wider community:





A mental health problem is a disruption of the interactions between the individual and the environment producing a diminished state of mental health.

'Mental disorder' is defined as 'a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities'. There are different types and varying degrees of severity of mental disorders, including depression, anxiety, substance abuse, bipolar disorder and schizophrenia. Universal classification systems are used to identify disorders, ie ICD-10 and DSM-IVⁱⁱ.

2.2 Objectives

The Western Australian policy primarily aims to:

- promote the mental wellbeing of Western Australians
- reduce the incidence and prevalence of mental illness through universal and selective prevention strategies focusing on mental health across the lifespan.

This will be achieved by:

- 1 Increasing understanding and knowledge of mental health and mental illness, and the importance of maintaining mental health within various environmentsⁱⁱⁱ and settings^{iv}.
- 2 Increasing understanding of the mental health benefits of creating diverse, inclusive and respectful environments and settings, and identifying and supporting processes to enhance social cohesion.
- 3 Improving the range, quality, effectiveness and reach of strategies that promote mental health and reduce mental illness among the Western Australian population.
- 4 Improving the evidence base for interventions aimed at promoting mental health and preventing mental illness.
- 5 Creating partnerships to foster strong mental health promotion and illness prevention activity across Western Australia.

2.3 Guiding principles

The following principles are intended to guide all mental health promotion and illness prevention policies and practices:

Access and equity

Programs and policies must recognise:

- the diversity of the population, both culturally and generationally, and the life context of the people who are to benefit
- the different meanings of mental health to Aboriginal and culturally and linguistically diverse people

(ii) Psychiatric classification systems such as ICD-10 and DSM-IV delineate specific symptomatology of mental disorders.

(iii) For the purposes of this policy, 'environment' refers to the social, psychological, spiritual, cultural and economic milieu in which population groups interact and can include the school system, and urban and remote areas.

(iv) A 'setting' can include the home, school, workplace, meeting places etc.

- people are able to use their intrinsic capacity to cope with and enjoy life within supportive and appropriately resourced environments
- all people equally deserve a good quality of life.



Community empowerment

Programs must incorporate aspects of social justice and community empowerment to ensure mental health promotion and illness prevention strategies lead to ongoing and transferable change. The concept of empowerment is to do with people having control over their own lives and destinies.

Self determination

People and their communities must be at the centre of action and decision making through active participation in problem identification, program planning, implementation, decision making and evaluation.

Integration

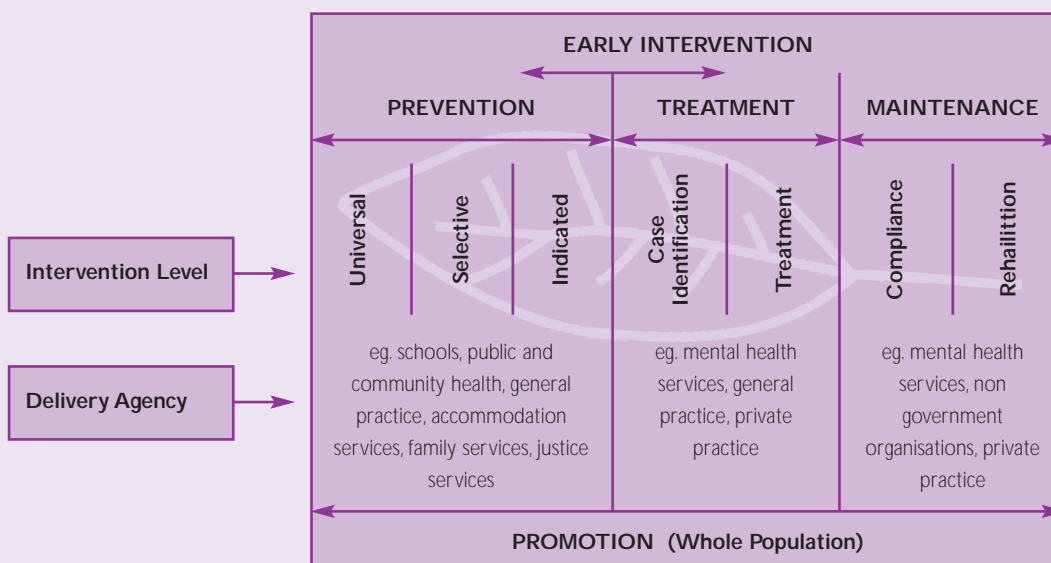
Interventions must be planned, developed and evaluated in a collaborative fashion by community based partnerships across sectors, including health, welfare, education, housing, corporate, sporting and recreational, and cultural.

Accountability

Accountability must be ensured through monitoring, quality improvement, evaluation and the development of performance measures that focus on outputs and outcomes.

2.4 Focus of this policy

The model¹⁵ below presents a continuum of care showing the spectrum of interventions available for improving mental health.





- Youthlink produced a magazine for families 'Growing Up With Young People' which targets parents of young people between the ages of 15 and 24, and provides useful information to assist parents to support their teenage and young adult children (versions of this magazine were specially adapted for Aboriginal families, and Vietnamese and Cantonese speaking families).

The needs of Aboriginal young people are being addressed in a number of ways:

- Half the funding under the Youth Counsellor Program has been allocated for Aboriginal positions provided in selected locations that have been chosen on the basis of risk of youth suicide.
- A universal prevention strategy for Aboriginal youth suicide is being developed as part of the implementation of the Government's Aboriginal Youth Suicide Prevention policy.

Government policy and strategies for Aboriginal youth suicide prevention commit the Department of Health in Western Australia to:

- increase the number of Aboriginal staff employed within the mental health services
- train non Aboriginal staff about Aboriginal mental health issues
- make scholarships available for Aboriginal people to undertake training in mental health professions.

Under the current National Suicide Prevention Strategy, initiatives undertaken by MCSP include:

- public education for suicide prevention
- developing a bereavement information and support pack
- sustaining the Regional Trainers program.

Appendix 9

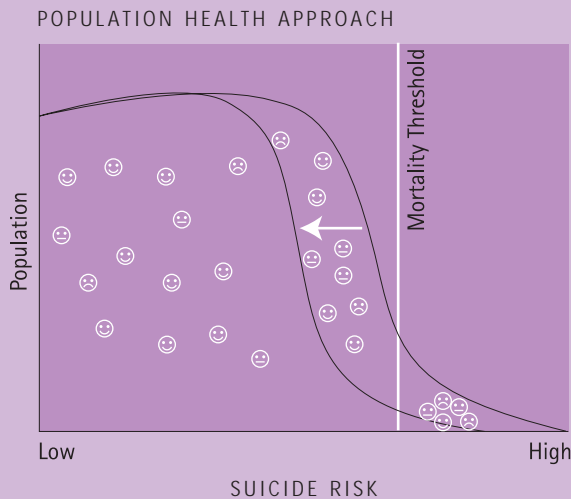
Suicide statistics

The figures below were taken from a study of suicide in Western Australia from 1986 to 1997⁷⁷ and a report on hospitalisation as a consequence of deliberate self-harm⁷⁸.

- Males complete suicide at around four times the average annual rate of females with the highest rate of suicide among males being in the 20-24 year age group.
- Conversely, the admission rate for deliberate self-harm, or attempted suicide, is higher for females than for males, with the younger age groups of both genders having the highest admission rates. However, after discharge from hospital, males are more likely to commit suicide than females. This is because males use more lethal methods.

An example of this approach using suicide risk is illustrated below.

In a hypothetical population of 100,000, it would be possible to identify 500 people with a high suicide risk of 10 percent. Although 99,500 will have a low risk of 0.1 percent (the approximate 10 year suicide risk in the population), 100 suicides will come from this low risk group while only 50 will come from the high risk group. As such, prevention interventions targeted at high risk people will miss most of the suicides²⁰.



The *Ottawa charter for health promotion*²¹ has been instrumental in shifting the focus away from an individual disease prevention approach toward the more fundamental population health approach focusing on the underlying influences on health.

Key components of the Ottawa Charter are:

- *Building healthy public policy* - health promotion goes beyond health care to all sectors and at all levels, directing policy makers to be aware of the health consequences of their decisions and to accept their responsibilities for health.
- *Creating supportive environments* - the inextricable links between people and their environment constitute the basis for a socio-ecological approach to health.
- *Strengthening community action* - health promotion works through the empowerment of communities, their ownership and control of their own endeavours and destinies.
- *Developing personal skills* - providing information and education for health and enhancing life skills increase the opportunities to enable people to exercise more control over their own health and environments, and to make choices conducive to health.
- *Re-orienting health services* - the role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services.





The *Jakarta declaration on leading health promotion into the 21st Century*²² later endorsed the strategies outlined in the Ottawa Charter, stating that using combinations of the five actions is more effective than single-track approaches. Indeed, mental health promotion and illness prevention is most effective when interventions build on social networks, intervene at crucial points in people's lives and use a combination of methods to enhance their psychological wellbeing, and tackle local factors that undermine mental health²³.

3.1.1 Approaches to mental health promotion and illness prevention

Integral to the population health approach is the recognition of the social factors that contribute to health and ill health. Evidence consistently demonstrates that the socially disadvantaged have poorer health in every domain of health including morbidity, disability and mortality indices, and less control over their environments and wellbeing²⁴.

The World Health Organisation's (WHO) approach to mental health promotion and illness prevention is fundamentally concerned with strategies that address the full range of potentially modifiable social determinants of health. These are outlined below.

Social connectedness:

- sense of attachment to family and community
- strong cultural identity and ethnic pride
- access to social support networks and supportive relationships
- stable and supportive environment.

Freedom from discrimination:

- opportunity for self-determination and control of one's life
- safe environment.

Economic participation:

- access to positive educational experiences
- access to adequate housing
- access to meaningful employment
- economic security²⁵.

This policy's outcomes, guiding principles and approaches are directly related to WHO's domains of modifiable social determinants of health. Although economic participation is outside the domain of health services, the issues of social and economic equity need to be recognised in all mental health promotion and illness prevention strategies.

Income inequalities within societies contribute to prejudice and social exclusion. Research on psychosocial links show that the stress of economic insecurity or relative deprivation may impact on health directly through the endocrine and immune systems and/or may cause

people to take up behaviours that are detrimental to health, including alcohol and drug use, accidents, crime and violence²⁶.

Communities that enable everyone to play a full and useful role in the social, economic, spiritual and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life have powerful affects on health in whatever area of life they arise.

The three approaches that will guide mental health promotion and illness prevention strategies in Western Australia are described below.

3.1.1.1 Life context approach

This policy uses a whole of life context approach to prioritising and targeting mental health promotion and illness prevention strategies.

A whole of life context approach involves recognition of risk and resilience, and the developmental path of illnesses and health in childhood, adolescence and adulthood.

Evidence generally shows that important foundations of adult health are laid in prenatal life and early childhood. Slow growth and a lack of emotional support during childhood raise the lifetime risk of poor physical and mental health and reduced physical, cognitive and emotional functioning in adulthood. Vulnerability to mental illness is also heightened during periods of major life change²⁷. Equally, these periods can be viewed as opportunities/targets for strategies to build on strengths and enhance protective factors.

The *Ways forward*²⁸ report, in developing an 'across the lifespan' overview of recommendations for Aboriginal mental health identifies four lifespan groups – Aboriginal children, young people and families; Aboriginal women; Aboriginal men; and elders. This lifespan approach, which is self determined, should also be considered for other communities.

Interventions may follow the life trajectory model or focus on lifespan groups. To ensure interventions are not paternalistic, their development must include consumer and community participation.

3.1.1.2 Identification of risk and protective factors

A range of risk and protective factors can be drawn from biological, psychological, social, cultural, economic and environmental factors (see Appendices 2 and 3).

Risk factors increase the likelihood that a mental disorder will develop. Risk factors interact, and multiple and persistent risk factors can predict more strongly the risk of mental illness than individual risk factors²⁹. Protective factors contribute to an individual's, family's or community's resilience. They can reduce the impact of stress and adversity, and therefore reduce the likelihood of mental disorders developing. Protective factors strengthen individual and collective capacities to help people face challenges.



the quality of the social environment and material security are often as important to health as the physical environment



3.1.1.3 Environments and settings approach

Supportive and safe environments that encourage diversity, inclusion and respect are required both to promote mental health and enhance mental illness prevention interventions. Social justice, equity, personal dignity and respect are associated with supportive environments³⁰.

In schools, businesses and other institutions, the quality of the social environment and material security are often as important to health as the physical environment. Institutions that can give people a sense of belonging and being valued are likely to be healthier places than those in which people feel excluded, disregarded and used.

Social support and good social relations make an important contribution to health. Social support, eg income protection and access to health care, helps give people the emotional and practical resources they need. Belonging to a social network, eg family and kinships, makes people feel cared for, loved, respected and valued. This has a powerful protective effect on health and mental health³¹ for individuals and the community as a whole.

Different goals and strategies are better suited to some settings than others. With some promotion strategies, it may be desirable to target more than one setting. For example, self-esteem programs designed for schools may include a component for parents to use in the home. In so doing, the influence of parents on the self-esteem of their children is recognised and built upon to enhance the school components.

Particular population groups can be reached across different settings where specific mental health issues can be addressed. The priority settings are:

- Home – focus on building healthy relationships
- Schools, technical colleges and tertiary institutions – provide opportunities to reach children and young people to increase skills and competencies, and provide opportunities for contribution and recognition
- Community – build and strengthen existing networks and resources
- Workplace – target administration to foster equity, recognition and contribution, and address workplace factors that influence mental health³².

3.2 Distinguishing between population and 'primary, secondary, tertiary' approaches

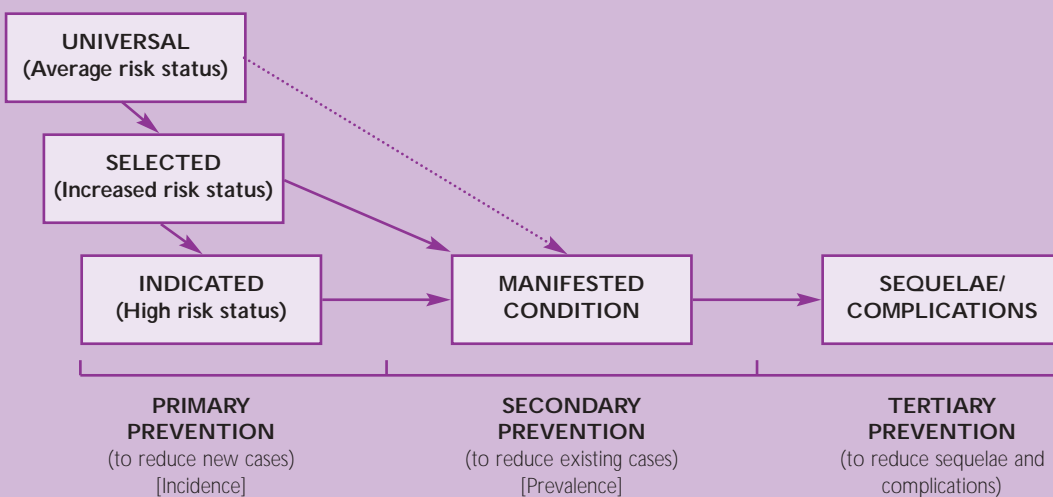
Within the clinical arena, prevention of mental illness can have a variety of meanings, including being part of the treatment and care of people diagnosed with a mental illness. Traditionally within the health sector, prevention programs have been defined in terms of primary, secondary and tertiary prevention³³ as follows:

- primary prevention aims to avoid the onset of illness through:
 - enhancing protective factors and minimising risk factors

- detecting high-risk individuals
- providing advice, counselling or other intervention
- secondary prevention aims to shorten episodes of illness and prevent its progression through early diagnosis and treatment
- tertiary prevention aims to limit disability or complications arising from irreversible conditions³⁴.

The following diagram shows the relationship between the population health approach that puts mental illness prevention interventions (universal, selected and indicated) at the 'primary prevention' end of the clinical model.

STRATEGIES OF PREVENTION (ADAPTED FROM SIMEONSON, 1994)



Opportunities for mental health promotion can occur as part of any of these strategies. For example, mental health services strengthening partnerships with families and community agencies to develop a whole of community approach to improving mental health.

4. Mental health promotion

Mental health promotion is any action taken to maximise mental health and wellbeing among populations and individuals. It focuses on improving environments (social, cultural, physical and economic) that affect mental health and enhancing the coping capacity of communities as well as individuals³⁵.

Mental health promotion targets the whole population and benefits everyone, whether or not they currently have a mental illness. It applies to everyone, including people who are at no greater risk of developing a mental illness than the majority of the population, those who are at greater risk of developing a mental illness and those who already have a mental illness.

Mental health promotion is most effective when strategies build on social networks and intervene at crucial points in people's lives. Mental health promotion strategies should use a combination of the approaches described in this policy to achieve the outcomes outlined below.

4.1 Developing community and workforce capacity

For the first three years of the implementation of the Western Australian policy, capacity building has been identified as the highest priority.

Capacity building is an approach to develop sustainable skills, organisational structures, resources and commitment to the improvement of mental health in health and other sectors³⁶. It occurs within programs or more broadly within systems and leads to greater skills, knowledge, understanding and confidence of people, organisations and communities to build independence and autonomy.

Capacity building can include activities as diverse as canvassing the opportunities for a program, lobbying for support, developing skills, supporting policy development, negotiating with management, building on partnerships, or contributing to organisational planning³⁷.

The consultation process^v undertaken in the development of this policy identified that mental health promotion strategies in Aboriginal communities must take place by strengthening existing communities and enhancing cultural awareness and affirmation. People within the community itself are a vital resource to the process of establishing and implementing mental health programs. These are the people who will best understand and have first-hand knowledge of the needs of the members of their community. Aboriginal communities tend to take an holistic approach to health care.

Strategies for developing capacity need to involve family and community participation³⁸.

4.1.1 Workforce capacity building

It is recognised that workforce capacity building will be required within organisations across all sectors and communities in response to this policy. Without opportunities for formal and informal education and training, professional and peer support, and leadership, the capacity to implement individual, organisational and community change will be limited.

A study of service capacity carried out by the Centre for Mental Health Services Research Inc³⁹ identified that although the workforce was willing to undertake mental health promotion and illness prevention strategies, they did not think they had the necessary skills^{vi}. The study identified the need for continuing education, professional development and training opportunities for staff.

This policy:

- advocates for employer investment in building the capacity of the mental health workforce regarding health promotion and population health principles, especially community participation and intersectoral collaboration

(v) See Appendix 4 for details of the consultation process undertaken in the development of this policy.

(vi) Survey respondents were from a variety of government and non government agencies including education, health, justice, police, and academic and research institutions.

- supports working with tertiary institutions to identify and provide flexible opportunities for training and development of mental health professionals in the concepts and practice of mental health promotion and illness prevention
- promotes inclusion of public health in undergraduate mental health and allied mental health curricula
- encourages universities to provide subjects in mental health and Indigenous health as part of undergraduate and postgraduate courses in public health
- encourages the inclusion of mental health training strategies into existing education programs for carers of the aged, Aboriginal health workers, early childhood workers, English as a second language specialists and school curricula
- supports initiatives that identify barriers and strategies for retention of mental health professionals in rural and remote communities.

Examples of current initiatives:

- The Department of Health in Western Australia has contracted the Curtin Indigenous Research Centre and Aboriginal Health Unit of the Centre for Aboriginal Studies at Curtin University, and the Marr Mooditj Foundation to undertake the development of a training program for mental health service personnel working with Aboriginal people.
- Several public health units have employed mental health promotion personnel whose role includes developing skills of health care providers in the promotion of mental health.

4.1.2 Community capacity building

An important element of strengthening communities involves building or enhancing community infrastructure, for example, the availability of adequate housing, good public transport and local employment opportunities. This can be achieved through identifying risk and protective factors for the local community and developing a partnership between relevant organisations to address these.

An example is the Healthy Community pilot project funded by Healthway^(vii). This project aims to increase individual knowledge and skills, as well as change behaviour, community and organisational policies and environments to improve health. This project is currently operating in two regional communities with the aim of promoting community health and wellbeing, which can be maintained within the community at the end of the pilot.

This policy:

- encourages health promotion environments and settings that promote positive relationships, for example, community development projects that reduce social isolation
- supports the development of universal promotional strategies which encourage participation and social connectedness, and encourage all people to remain physically, intellectually and socially active



(vii) Healthway is the Western Australian health promotion foundation that provides funding for health promotion activities.

- supports the tailoring of general health promotion strategies to specific populations
- encourages projects that promote healthy communities and the building and maintenance of social cohesion within communities.

Examples of current initiatives (see Appendix 5 for a description of these programs):

- Family Futures program.
- Investing in Bunbury's Youth.
- Healthy Community pilot project.

4.2 Developing and strengthening partnerships

The very nature of promoting mental health requires a multisectoral approach. This is because many of the determinants of health are outside the realm of health services (see Appendix 6 for examples of key strategic sectors and settings for mental health partnerships).

The National Action Plan recognises that building and strengthening partnerships between mental health services (public and private) and the broader community needs to be promoted. Government agencies need to work together and with community organisations to encourage the development and implementation of policies and programs that will help maintain and improve the mental health and wellbeing of communities. The opportunity to work collaboratively with other organisations or sectors is often missed when organisations do not have the capacity to initiate and sustain involvement⁴⁰.

This policy:

- prioritises the identification of appropriate partnerships and the clarification and strengthening of communication
- encourages the development of shared agreements such as memoranda of understanding that define the roles and responsibilities of agencies
- recognises the need to develop policy outcome measures
- prioritises the development of evaluation methods to review the effectiveness of policies and partnerships
- includes consumers and carers as key partners.

Examples of current initiatives:

- The State Government's Family Strength policy provides a range of programs including help for parents expecting or caring for a new baby or young child, intensive home visiting support for families with priority needs and other services. This is a joint initiative being implemented by the Departments of Health and Community Development. It is anticipated the Department of Education will become involved in the expansion of this program.



- The Mental Health and Public Health Divisions of the Department of Health in Western Australia participate in the Interagency Committee on Children's Futures together with the TVW Telethon Institute of Child Health Research, Disability Services Commission, Department for Community Development, Office of Youth Affairs, and Departments of Education, Justice and Police. The Committee develops strategies to promote optimal development of children and young people.
- Membership of the Ministerial Council for Suicide Prevention comprises representation from government and non government organisations with an interest in youth suicide prevention (see Appendix 8 for details of strategies developed or supported by the Ministerial Council to prevent suicide).
- There are also numerous regional and local initiatives involving partnerships across sectors.

4.3 Reducing discrimination and stigma

The need to reduce discrimination and stigma was identified as a high priority at the national and state levels, particularly by mental health consumers and carers.

There is a clear link between discrimination, stigma and mental illness, with discrimination and stigma resulting in low self-esteem, lack of control, helplessness, social isolation, depression and stress, alcohol and other drug use and suicidal feelings.

A poor understanding of mental health issues contributes to the discrimination and stigma experienced by people with a mental illness, discourages people from seeking early and appropriate help for mental illness and may perpetuate behaviours and environments which are risk factors for mental illness⁴¹. There is also increasing evidence that communities with high levels of social cohesion and the existence of mutual trust and respect between different sections of the community have better health than those with low levels of social cohesion⁴².

Strategies used to increase knowledge, understanding and awareness of issues related to mental health and promote supportive environments can help to reduce stigma and discrimination experienced by people with a mental illness and encourage people to seek appropriate help if they think they have emotional problems. Societies that enable all their citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation⁴³.

Potential barriers to effective community education and awareness-raising strategies within culturally and linguistically diverse communities include language and cultural factors, culturally specific beliefs and understanding of mental illness and its causes, and stigmatising attitudes to mental illness within the family and community⁴⁴.

This policy:

- supports the development and continued publication of information in a range of formats and languages about mental health conditions, such as conduct disorder, depression, stress and suicide, delivered in a universal manner and which include sources for help

- encourages the provision of information material to workplaces which informs staff about self help strategies and help seeking from general practitioners and other private practitioners
- supports the provision of information about mental illness and mental health issues at critical life transitions points (eg parenting clinics, schools)
- supports the development of culturally appropriate mental health information for people of Aboriginal and ethnic backgrounds
- supports a comprehensive approach including social marketing strategies
- supports the involvement of consumers and carers in delivering information regarding mental health and the affects of discrimination and stigma.

Examples of current initiatives (see Appendix 5 for a description of these programs):

- National Mental Health Week.
- The Commonwealth MindMatters program.
- Mental Illness Education Australia.
- The Commonwealth Department of Health and Ageing produces information pamphlets on various mental health issues.
- Broad public health promotion strategies such as media campaigns to prevent family violence, promote positive parenting skills and reduce the excessive consumption of alcohol.
- Education policies and programs to help students achieve the skills, confidence and understanding required to effectively deal with a range of social and mental health issues.

5. Mental illness prevention

Mental illness prevention includes interventions that aim to reduce the initial onset of a mental illness by reducing risk factors and enhancing protective factors⁴⁵.

For the purposes of this policy, mental illness prevention refers to preventing initial symptoms of mental illness, not the recurrence of mental illness.

The focus of the Western Australian strategy is on:

- universal interventions, which are designed for whole population groups, such as the school population or families
- selected interventions, which target those at increased risk of developing a mental illness, such as young children whose parents have a mental illness or who have experienced inconsistent parenting.

Current research⁴⁶ shows that conduct disorder and depression represent some of the most burdensome of mental health disorders in children. Alcohol and other drug use can increase the potential to develop a mental health problem, and can increase the likelihood of suicidal tendencies for vulnerable individuals.

Mental illness prevention strategies should use a combination of the approaches described in Part 3 of this policy to achieve the desired outcomes – reducing the incidence and prevalence of:

- conduct disorder
- depression
- alcohol and other drug use
- suicide.

5.1 The early years

The early years of life are critical in the development and future wellbeing of children, establishing the foundation for competence and coping skills that will effect learning, behaviour and health⁴⁷. It is during this time that the characteristics of the child and the social environment of child rearing can have a great impact on the emotional wellbeing of the child and whether a child develops conduct problems, which are becoming increasingly prevalent⁴⁸.

Childhood behaviours such as expressed aggression and mood changes are part of ordinary day-to-day behaviour. However, when these behaviours are sufficient enough to cause distress to the child or others, they are sometimes considered to constitute a mental disorder referred to as conduct disorder.

Low birth weight, maternal cigarette smoking during and after pregnancy, parental alcohol abuse, insecure attachment between the primary caregiver and infant, parenting behaviour, parental depression, marital conflict, poverty, unemployment, crowded living conditions, illness and stress⁴⁹ have been found to contribute to the development and maintenance of problem behaviour and other mental health problems.

There is clear evidence that mental illness or other illness in the parent has significant consequences for infants and small children, and that intervening early is likely to provide significant protection to children in such circumstances. For example, prevalence rates for postnatal depression in women are reported to be around 13 percent. Persistent depression during this time can be associated with social withdrawal, breakdown in family and social relationships and loss of the enjoyment of mothering, with a risk of self-harm or harm to the infant⁵⁰.

In the absence of prevention in the early years, conduct disorder can be entrenched by late childhood. Many studies have demonstrated that children and adolescents diagnosed with conduct disorder can be difficult to treat⁵¹. It is especially important to prevent conduct disorder because it is predictive of poor mental health and social outcomes in later life⁵².



The early years of life are critical in the development and future wellbeing of children

Young children's mental health is primarily dependent upon a secure and positive relationship with their parents or parental figures. For infants and young children, it is most important to support these positive relationships and ways for parents to gain or enhance their skills.

Preventive interventions for children are usually targeted at the parent. For example, providing information to women and their partners in the antenatal period to help prevent postnatal depression, supporting pregnant women, new parents and care providers, and promoting good parent/infant relationships can improve childhood experiences that can enhance resilience in later life.

This policy:

- recognises the importance of good communication in relationships and the ability to manage problems when they arise
- recognises the need to help people prepare for parenting and the changes in lifestyle that this entails
- highlights the importance of evidence based and culturally appropriate parenting programs that strengthen parent-child relationships and promote self-esteem
- recognises the value of high quality childcare that stimulates cognitive and social skill development
- supports strategies identified by the Interagency Committee on Children's Futures to reduce conduct disorder in children⁵³ (see Appendix 7)
- supports the development of programs for children of parents with a mental illness.

Examples of current initiatives (see Appendix 5 for a description of these programs):

- A range of programs under the Family Strength policy.
- Postnatal Depression programs.
- The Positive Parenting Program (PPP).
- Parent Help Centre.
- Best Start.
- Healthy Start.
- Aboriginal Family Support service.
- Best Beginnings.
- Parenting Information Centres
- Parent Link home visiting services.
- Early Education program.



5.2 Children and young people

Depression and anxiety^{viii} in children and young people is now recognised as a serious problem in Western Australia, with associated social and economic costs to the community⁵⁴.

Depression in children is associated with lower levels of social competence including friendship difficulties, limited coping skills, and poorer social skills including being less assertive. A national survey of mental illness in children and adolescents found that 3.7 percent, or an estimated 117,000 children aged 4 to 17 years, had a depressive disorder⁵⁵. A Western Australian survey⁵⁶ showed similar results. In early adolescence, depressive mood becomes more common in females⁵⁷.

Depression is more than feelings of sadness. It is a group of illnesses, some psychosocial and others biological, which result in a long-term lowering of mood and other symptoms such as sleep and appetite disturbance that affect a person's day-to-day life.

When children enter school, social skills and cognitive capacities are continually developing and it is possible to introduce more sophisticated approaches to address mental health problems. A range of developmentally appropriate programs that are implemented as part of an holistic ongoing health education program will promote long-term resilience and optimism.

School-based programs designed to promote resilience and optimism have been effective in preventing anxiety and depression in selected children⁵⁸. Linking parenting programs with school based programs should be investigated.

Initiatives such as the Aussie Optimism program are designed to complement existing school programs to promote resilience and optimism. Aussie Optimism has been trialed in rural schools from Geraldton to Albany and has proven to be effective for upper primary school children who are showing signs of anxiety and depression. This program is currently being developed as a universal program for all upper primary school students.

The level of anxiety and depression in mid to late adolescence approaches adult levels, and there is strong support for selective interventions. Programs that aim to build resilience and are designed to promote positive coping abilities in the face of stressful and difficult life circumstances are currently being trialed for selected groups of adolescents. For example, preliminary findings from an evaluation of the Resourceful Adolescent Program showed reduced levels of depressive symptoms at post-intervention and 10 month follow up, particularly for those adolescents who initially showed high or moderate levels of depressive symptoms⁵⁹.

Programs for young people who are out of school require further development and evaluation.

Young people with depression are more likely to misuse alcohol and other drugs, and display self harming and suicidal behaviours^{60, 61}. This reinforces the notion that an holistic approach to ongoing health promotion and education is needed in schools and communities, as well as targeted interventions and strategies that focus on issues like substance abuse. Indeed, the increased use of alcohol and other drugs among young people over the past few decades has been widely cited as one of the main factors contributing to observed increases in the rate of suicide. It is also quite common in young people attempting suicide⁶².

(viii) In children and young people, it is difficult to separate anxiety and depression. These are very similar conditions and respond to a similar range of strategies.



In the United States, a study of more than 12,000 secondary school students showed that strong connection to family and school, and perceived caring and connectedness to others, protected teenagers against a range of health risk behaviours, including suicidal thinking and behaviours, and harmful drug use⁶³.

The way in which the community influences individuals is seen as vital in explaining suicidal behaviour. The response involves identifying social risk factors and introducing social change to alleviate their impact on the population. Interventions are more effective if they use a combination of strategies that simultaneously target community, family and school settings. These may include strategies to reduce alcohol and other drug use, measures to reduce the availability of common means of suicide such as firearms and car exhaust emissions, life skills training and enhancing the connection between the individual, family, community and mainstream society.

This policy:

- encourages mental health promoting schools
- supports evidence based and culturally appropriate strategies that teach children and young people life skills and problem solving skills, eg social competencies, that assist them to make constructive choices when faced with problems
- supports evidence based and culturally appropriate strategies that help children and young people recognise and deal with emotional issues
- supports the strategies identified in the Department of Health's drug strategy 1999-2003 *InterAction*
- supports the strategies identified in the national action plan for depression
- supports the work of the Western Australian Ministerial Council for Suicide Prevention
- supports the implementation of the Aboriginal youth suicide prevention strategy
- supports the national suicide prevention strategy.

Examples of current initiatives (see Appendix 5 for a description of these programs):

- Department of Education's Students at Educational Risk strategy including the behaviour management in schools policy and guidelines, and pathways to health and wellbeing.
- ARAFMI Youth Services.
- The Department of Health is working with the Department of Education to develop the Aussie Optimism and Resourceful Adolescent programs.
- Bullying prevention programs focusing on bullying prevention skills for primary school children.
- See also Appendix 8 for details of suicide prevention strategies developed or supported by the Ministerial Council for Suicide Prevention.

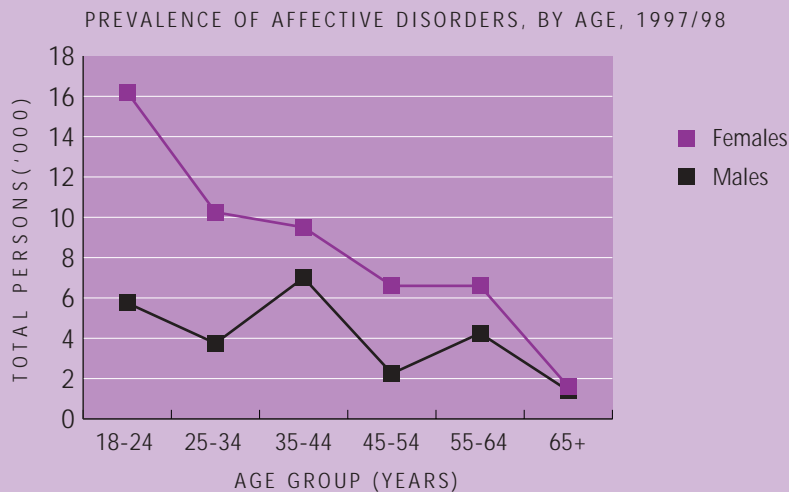


strong
connection
to family and
school, and
perceived
caring and
connectedness
to others,
protected
teenagers
against a range
of health risk
behaviours

5.3 Adults

The Western Australian profile of mental health and wellbeing in adults⁶⁴ found that depression and related disorders affected one in four women and one in six men.

The prevalence of affective disorders^{ix} was highest for women aged 18-24 years, and almost three times the rate for men of this age. For women, the prevalence of affective disorders declined with age, while for men, the rate peaked at 7 percent of those aged 35-44.



Stressful life events are associated with adult mental health problems.

After the home, the workplace is the primary location of adult life for the majority of people and plays a highly influential role in health and wellbeing. There is evidence of a significant increase over recent years in the level of reported workplace stress and associated mental illness⁶⁵. The prevalence of mental illness, however, was lower among those who were in the labourforce (15.1 percent for men and 14.7 percent for women) compared with those who were unemployed (26.9 percent for men and 26.4 percent for women)⁶⁶.

Divorce and relationship problems, bereavement, imprisonment, trauma and disability are other significant stressors during adulthood. Being a carer of a person who is highly dependent is increasingly recognised as being highly stressful.

The Western Australian Coroner's database recorded more than one stressor for each person who suicided in Western Australia from 1986 to 1997 (see Appendix 9 for statistics on suicide). The most frequently recorded stressor for males was a relationship breakdown and for females was a psychiatric illness (mental disorder). Two thirds of the males who completed suicide were reported by family and friends to have shown definite signs of depression in the three months before suicide. Increased alcohol and drug use was also reported to have frequently occurred in the period before suicide⁶⁷.

Positive and meaningful workplace and/or community participation, social support and positive coping skills are all considered important strategies for adults.

(ix) Most people with an affective disorder met the criteria for depression – 93 percent of women and 86 percent of men.

This policy:

- encourages health promoting environments and settings that promote positive relationships, eg changes to the workplace that reduce stress and community development projects that reduce social isolation
- supports relationship building programs
- supports skill building to manage anxiety and stress
- promotes the development of information to enable people to recognise the signs of depression and seek help where required
- supports the strategies identified in the national action plan for depression
- acknowledges the Centre for Primary Care Psychiatry and its role in educating general practitioners about mental disorders
- supports the *Bringing them home* initiative, which aims to address issues impacting on Aboriginal physical, psycho-social and emotional wellbeing.

Examples of current initiatives (see Appendix 5 for a description of these programs):

- Community health services.
- Building Better Relationships.

5.4 Older people

The age of the population is increasing. By 2021, it is estimated that nearly one in four Western Australians will be aged 60 years or over, representing 22 percent of the population⁶⁸

Older people are mostly active, in good physical health and financially secure. While few are in paid work, many are informal carers for grandchildren and disabled partners, or work as volunteers in hospitals, non government community services or social organisations. Such active participation in the community is one factor identified by older people as fundamental to their sense of wellbeing.

Overall, older people are satisfied with their life. They report fewer pressures and worries than younger people, and are appreciative of their free time and leisure activities. Indeed, mental health surveys show that symptoms of anxiety and depression decline with age⁶⁹.

Depression in older people is often associated with physical illness and incapacity, caring for someone with physical illness and incapacity, and social isolation⁷⁰. Depression can also be associated with retiring from work. The Department for Community Development, Office of Seniors Interests has conducted an extensive research project into the barriers and motivators for retirement planning. This research focuses on all aspects of planning for retirement, not only financial planning, and confirms that the quality of life of older people can be significantly improved when proper planning occurs.

Depression in older people is commonly under-diagnosed and under-treated⁷¹. In some cases, depression may be inappropriately assessed as a 'normal' psychological reaction to a physical illness and left untreated⁷².

International and national studies have found that depression is the most prominent risk factor for suicidal behaviour in older people. Declining mental and physical health are other common risk factors⁷³. Protective factors shown to be important for older people include economic security, concern for children and religion⁷⁴.

This policy:

- recognises that to help reduce depression and suicide in older people, it is desirable for older people to remain physically, intellectually and socially active
- recognises that adequate planning for retirement can increase older people's quality of life in later years
- acknowledges the work of the Department for Community Development, Office of Seniors Interests and Centre for Positive Ageing to encourage the continued involvement of older people in social, physical and intellectual activities
- supports the provision of evidence based counselling for those older people experiencing bereavement
- supports the development and expansion of programs to support carers, including respite care programs.

Examples of current initiatives:

- The work of the Department for Community Development, Office of Seniors Interests and Centre for Positive Ageing.
- Current public and private employer sponsored pre-retirement education sessions for workers.
- Carer respite centres and other carer respite strategies that contribute to the reduction in physical and emotional stress, and social isolation experienced by some elderly carers.

active participation in the community is one factor identified by older people as fundamental to their sense of wellbeing



6. Implementation Strategies

6.1 The first three years

The priority focus for the first three years of this policy is to develop the capacity of the health system in mental health promotion and illness prevention, consistent with the key components of the Ottawa Charter.

Key strategies for the first three years of this policy are to:

- develop, support, fund and/or commission strategies to improve mental health literacy throughout the state, including raising community awareness, educating service providers, disseminating culturally appropriate educational material and promoting positive media reporting
- identify barriers to active and informed participation in local networks and intersectoral partnerships, particularly for consumers, carers and Aboriginal and culturally and linguistically diverse communities
- develop, strengthen and support sustainable models and processes of active and informed participation in environments and settings
- develop a sustainable service development model for regional health services encompassing the full spectrum of mental health interventions
- promote workforce development through:
 - developing a guidance and mentoring structure for mental health promotion officers to provide support for achieving agreed outcomes
 - ensuring mental health promotion and illness prevention awareness, training and resources are included in primary mental health partnerships
 - working with tertiary education institutions to identify and provide training options for existing mental health professionals and new graduates in mental health promotion and illness prevention
- develop and strengthen mental health promoting public policies
- identify mental health promotion themes/priorities
- develop, strengthen and coordinate sustainable partnerships within the wider community, including health, welfare, education, housing, corporate, cultural, and sporting and recreational sectors, reflected in formal memoranda of understanding
- coordinate and facilitate local planning and priority setting, and implementation of identified interventions

- commission market research to gain information on key attitudes and beliefs about mental health to inform the development of strategies that reduce discrimination and stigma
- expand school-based programs targeting childhood depression
- pilot a program for children of parents with a mental disorder
- work with the Department for Community Development, Office of Seniors Interests to promote positive ageing.

To facilitate these key strategies, the Department Health in Western Australia will develop a statewide network of key personnel. The role of personnel within this network will be to facilitate, enable and support services, programs and projects to improve social and emotional wellbeing and reduce the incidence and prevalence of mental health problems and disorders.

The statewide network will be developed by:

- establishing a senior mental health promotion and illness prevention coordinator position to:
 - take on a coordinating and leadership role in statewide planning
 - develop research and evaluation strategies
 - review policy
 - develop best practice models in health promotion and illness prevention
 - develop performance indicators
 - develop and support the statewide mental health promotion and illness prevention network
 - facilitate the continuation, expansion and ongoing resourcing of the mental health promotion and illness prevention program by the Department of Health in Western Australia
 - facilitate strategic planning for ongoing policy implementation
- gaining the support of existing Department of Health mental health promotion personnel
- appointing three new mental health promotion personnel – focusing on a rural and remote setting, a metropolitan setting and an Aboriginal setting to be determined by the Aboriginal community (the Office of Aboriginal Health will identify personnel to assist with this process to ensure it is truly representative of the Aboriginal population in Western Australia)
- establishing an expert advisory group to be comprised of consumers and carers, and people experienced in health promotion, mental health, Aboriginal health, evaluation and research.

6.1.1 Research and evaluation

Research in the area of mental health promotion is relatively sparse. Up to now, most research and development has occurred in the area of raising awareness and changing attitudes to those with a mental illness. The lack of evidence based research in mental health promotion reflects an emerging field which is continually expanding.

The evidence base for mental illness prevention is considerably larger than that for mental health promotion. Even so, the evidence for mental illness prevention is uneven in its coverage of age groups across the lifespan⁷⁵.

A study conducted by the Centre for Mental Health Services Research Inc⁷⁶ recommended that research priorities for the development of mental health promotion and illness prevention programs in Western Australia should match state priorities and reflect community needs including:

- examining the long term effects of interventions and assessing the causal status of risk factors
- examining the essential components, length and change processes associated with effective interventions
- establishing the most effective developmental timing for particular interventions
- examining the benefits of interventions to people of differing risk levels (high vs low risk) and the characteristics of those that are most likely to benefit from what interventions
- testing through replication under non research conditions to determine whether the interventions are still effective
- identifying the best methods for finding and engaging groups at risk
- examining the impact on the social and economic context of risk
- developing and/or adopting specific criteria and instruments to operationalise and measure mental health
- developing and evaluating universally delivered mental health promotion programs
- developing and evaluating programs in residential, educational, workplace, community and social environments that promote mental health.

Research priorities will be identified in the first year of this policy.

Evaluation will be planned concurrently with all program planning. In addition, in the first three years of this policy, all new policy initiatives will be evaluated.

(Refer to guidelines for the development of mental health promotion and illness prevention programs – see Appendix 10.)





Appendix 1

Office of Mental Health

A Transculturally Orientated Mental Health Service for Western Australia (December 2001)

Confidentiality in mental health settings (1996)

Consumer and carer participation in planning, implementation and evaluation of mental health services (March 1999)

Emergency psychiatric services (1998)

Infancy to young adulthood: A mental health policy for Western Australia 2000 plus (February 2001)

Mental health complaints policy and procedures (1997)

Mental health, HIV and AIDS - policy statement (1998)

Mental health services: A framework for reform (1998)

Policy and strategic directions for mental health services for older people (1998)

Regional operations (1998)

Reports

Childbirth stress and depression information book, (reprint) by Sherryl Pope and Julie Watts (October 1999)

Enhancing mental health services 2000 conference proceedings (May 2000)

Mental health reform: Two years on (1998)

Mental health reforms in Western Australia: A report of the government reform program (October 2000)

Purchasing intentions 1998/99 (May 1998)

Purchasing intentions 1999-2002 (May 1999)

Regional boundaries: Discussion paper (1997)

Report of the international panel on Attention Deficit Hyperactivity Disorder (June 1999)

Secondary and tertiary mental health services planning review (November 1998)

Succeeding in post secondary education and training (May 1997)



Appendix 2

Risk Factors

This table presents risk factors that potentially influence the development of mental health problems and mental disorders. These are factors that increase the likelihood that mental health problems and mental disorders will develop.

It is, however, important to note that while the available evidence shows that these factors are associated with negative mental health outcomes, the strength of association and level of evidence for causation varies. Consequently, no causal relationship can be assumed for these factors: for some individuals there will be no impact of any particular factor or combination of factors, while for other people, a particular factor or combination of factors may be detrimental of their mental health⁷⁶.

INDIVIDUAL FACTORS	FAMILY FACTORS	SCHOOL CONTEXT	LIFE EVENTS AND SITUATIONS	COMMUNITY AND CULTURAL FACTORS
<ul style="list-style-type: none"> - prenatal brain damage - prematurity - birth injury - low birth weight, birth complications - physical and intellectual disability - poor health in infancy - insecure attachment in infant/child - difficult temperament - chronic illness - poor social skills - low self-esteem - alienation - impulsivity 	<ul style="list-style-type: none"> - having a teenage mother - having a single parent - absence of father in childhood - large family size - antisocial role models (in childhood) - family violence and disharmony - marital discord in parents - poor supervision and monitoring of child - low parental involvement in child's activities - neglect in childhood - trauma and abuse - long-term parental unemployment - criminality in parent - parental substance misuse - parental mental disorder - harsh or inconsistent discipline style - social isolation - experiencing rejection - lack of warmth and affection 	<ul style="list-style-type: none"> - bullying - peer rejection - poor attachment to school - inadequate behaviour management - deviant peer group - school failure 	<ul style="list-style-type: none"> - physical, sexual and emotional abuse - school transitions - divorce and family breakup - death/suicide of family member - physical illness/impairment - unemployment, homelessness - incarceration - poverty/ economic insecurity - job insecurity - unsatisfactory workplace relationships - workplace accident/injury - caring for someone with an illness/disability - living in nursing home or aged care hostel - war or natural disasters 	<ul style="list-style-type: none"> - socio-economic disadvantage - social or cultural discrimination - isolation - neighbourhood violence and crime - population density and housing conditions - lack of support services including transport, shopping, recreational facilities



Appendix 3

Protective Factors

This table presents protective factors that can effect the development of mental health problems and mental disorders. These are factors that reduce the likelihood of mental health problems and mental disorders and that can mitigate the potentially negative effects of the risk factors.

It is, however, important to note that while the available evidence shows that these factors are associated with positive mental health outcomes, the strength of association and level of evidence for causation varies. Consequently, no causal relationship can be assumed for these factors: for some individuals there will be no impact of any particular factor or combination of factors, while for other people, a particular factor or combination of factors may be protective of their mental health⁷⁶.

INDIVIDUAL FACTORS	FAMILY FACTORS	SCHOOL CONTEXT	LIFE EVENTS AND SITUATIONS	COMMUNITY AND CULTURAL FACTORS
<ul style="list-style-type: none"> - adequate nutrition - attachment to family - school achievement - problem-solving skills - internal locus of control - social competence - social skills - good coping style - optimism - moral beliefs/ values - empathy development - positive self-related cognition 	<ul style="list-style-type: none"> - supportive caring parents - family harmony - secure and stable family - small family size - more than two years between siblings - responsibility within the family (for child or adult) - supportive relationship with other adult (for a child or adult) - strong family norms and morality 	<ul style="list-style-type: none"> - sense of belonging - positive school climate - pro-social peer group - required responsibility and helpfulness - opportunities for some success and recognition of achievement - school norms against violence 	<ul style="list-style-type: none"> - involvement with significant other person (partner/mentor) - availability of opportunities at critical turning points or major life transitions - economic security - good physical health 	<ul style="list-style-type: none"> - sense of connectedness - attachment to and networks within the community - participation in church or other community group - strong cultural identity and ethnic pride - access to support services - community/ cultural norms against violence



Appendix 4

Consultation process

Consultations with a range of individuals and organisations were undertaken to inform the development of this policy. These are detailed below.

- 1 A discussion paper was distributed to over 600 government, non government and other stakeholders, and made available on the internet. Stakeholders contacted include:
 - all mental health, public health and Aboriginal health services
 - Disability Services Commission
 - Department of Education
 - Department for Community Development
 - Healthway
 - Department of Justice
 - Western Australian Association for Mental Health
 - Western Australian Council of Social Service
 - Western Australian Network of Alcohol and Other Drug Agencies
 - Western Australian Aboriginal Community Controlled Health Organisation
 - Ethnic Communities Council
 - mental health consumers and carers.

Almost 30 individuals and agencies provided written feedback on the discussion paper.

- 2 Working with peak bodies to consult with ethnic communities and non government organisations.
- 3 Conducting a workshop with the Coalition of Aboriginal Agencies.
- 4 Holding a forum with key stakeholders in Perth, Albany, Esperance, Geraldton, Kalgoorlie, Meekatharra, Merredin, Northam and the North West. Feedback from the consultations was generally positive and participants welcomed the policy as a way of working that complements what they are already doing. Some common themes emerged throughout the consultations including:
 - the need to build capacity to develop sustainable skills, organisational structures, resources and commitment to increasing wellbeing in health and other sectors



- the need to create a consistent approach to help guide mental health and public and community health working together
- sustainability of programs is very important.

Some concern was expressed by service providers that there could be many more children and young people identified with mental health problems as a result of universal programs promoting mental health, creating increased pressure on services.

Appendix 5

Description of existing programs

A range of agencies provide funding for programs to promote mental health and prevent mental illness. The main source of funding for the programs described below is shown in brackets.

ARAFMI Youth Services is a program aimed at building resilience and coping skills for children and young people who have a parent or sibling with a diagnosed mental illness (Department of Health).

The **Aboriginal Family Support Service** provides parenting advice and short-term support for the families and Aboriginal carers of children aged 0-2 years (Department for Community Development).

School based approaches to depression such as **Aussie Optimism** and **Resourceful Adolescent Program** have been and are tested in several schools across the state. These programs are designed to promote resilience and optimism, and positive coping abilities in the face of stressful and difficult life circumstances (Healthway and Department of Health).

The **Behaviour Management in Schools** policy makes Western Australian government schools responsible for:

- establishing an ethos which promotes a positive learning environment
- developing and implementing preventative programs and processes that result in socially acceptable behaviour
- developing specific programs for individuals or groups exhibiting difficult-to-manage behaviours (Department of Education).

Best Beginnings is an intensive home visiting service staffed by professional parent support workers for the parents of children aged 0-2 years at risk of poor life outcomes (Department for Community Development).



Best Start aims to improve life opportunities for Aboriginal children aged 0-5 years by focusing on projects and activities to improve their health, educational opportunities and social development (Departments for Community Development, Health and Education).

Building Better Relationships is a program to enhance couples' relationships (Healthway).

Community health services:

- include culturally secure antenatal and postnatal care, child health and development, mental health, alcohol and other drug use
- provide a community development role facilitating and coordinating one-to-one and group activities including reproductive health issues
- ensure access to appropriate services (Department of Health).

The **Early Education program** works with parents of children aged 0-8 to assist them to gain the communication, parenting and other skills they need to play an active and positive role in the development and education of their children (Department for Community Development).

The **Family Futures** program employs Aboriginal health workers to work with Aboriginal families to provide clinical, promotional, preventive, social and medical care, and community development and advocacy services (Department of Health).

The State Government's **Family Strength** policy provides a range of programs including help for parents expecting or caring for a new baby or young child, intensive home visiting support for families with priority needs and other services. (These initiatives are being implemented by the Departments of Health and Community Development. It is anticipated the Department of Education will become involved in the expansion of this program.)

Healthy Community pilot project involves Narrogin and Dongara/Port Denison identifying local issues that affect the health of their residents and developing ways to work towards improving their health and quality of life (Healthway).

The **Healthy Start** program in Albany works with parents and childcare centre workers to raise awareness of mental health issues and risk factors for mental illness (Healthway).

Investing in Bunbury's Youth is a program to develop community awareness of the value of government, local government, non government and service groups working together to address the issue of youth and alienation (Departments of Health and Education).

National **Mental Health Week** includes facilitating information sharing to agencies and individuals, developing publicity and marketing strategies, and encouraging community participation in the Week (Department of Health).

Mental Illness Education Australia provides information and resources on mental illness for secondary schools (Department of Health).



The Commonwealth **MindMatters** program provides a range of teaching resources, as well as an initial two-day professional development program for secondary schools. MindMatters employs a comprehensive approach that acknowledges the importance of the school as a setting for promoting mental health and wellbeing (Commonwealth).

The **Parent Help Centre** provides a range of services to parents from general advice and information to intensive parenting programs for parents experiencing extreme problems with their children's behaviour. The Centre also provides a free 24 hour statewide telephone service to provide advice about caring for children and teenagers (Department for Community Development).

Parent Information Centres (PICs) provide free information on parenting and child development through brochures, videos, books, magazines, audio tapes and touch screen computers. There are 13 PICs located in major shopping centres throughout the state and six mobile information centres. Indigenous props, books and information are on display to encourage more Aboriginal people to visit and a number of PICs employ Aboriginal staff (Department for Community Development).

Parent Link home visiting services assist parents to further develop their skills, particularly with children in the 0-5 age group (Department for Community Development).

The aim of the **Positive Parenting Program** (PPP) is to prevent conduct disorder by teaching parents how to manage problem behaviour and promote socially appropriate behaviour using non-coercive methods. PPP has been extensively field tested in randomised controlled trials which have demonstrated that it increases children's mental health status and parents' competence (Department of Health).

Postnatal Depression programs identify and support mothers who develop postnatal depression. Although these programs are often an early intervention for the mother, they can help to prevent problems in the child. Programs comprise several distinct but complementary strategies including postnatal screening for depression and stress, treatment and support groups, individual counselling, support and information packages, resource and service liaison, and community education (Department of Health).

The **Students At Educational Risk** strategy includes policy and guidelines for the prevention of educational risk, including mental health issues. The strategy includes a number of initiatives designed to address a range of mental health issues that place school aged children and young people at risk.



Appendix 6

Examples of key strategic sectors and settings for mental health partnerships

SECTORS	SETTINGS/KEY STAKEHOLDERS
Family	<ul style="list-style-type: none"> – community – schools
Community development	<ul style="list-style-type: none"> – early childhood services such as childcare and preschools, and child and family support services such as children's domestic violence and youth counselling, supported accommodation and intensive family and child treatment
Education	<ul style="list-style-type: none"> – school counsellors and teachers – principals – peers
Welfare	<ul style="list-style-type: none"> – welfare and social workers – crisis workers in street-based outreach services
Juvenile justice	<ul style="list-style-type: none"> – police – youth and welfare workers – parole and probation officers – detention centres
Drug/alcohol	<ul style="list-style-type: none"> – hospitals and community and mental health services – public health – specialist drug and alcohol services – sobering-up shelters – counsellors – peers – media
Accident and emergency	<ul style="list-style-type: none"> – ambulance officers – telephone counselling services – police
Migrant and refugee	<ul style="list-style-type: none"> – community groups – housing services
Religious organisations	<ul style="list-style-type: none"> – churches – youth and outreach workers
Employment	<ul style="list-style-type: none"> – public and private sector workplaces – employment agencies – social services
Housing	<ul style="list-style-type: none"> – youth housing
Aged care	<ul style="list-style-type: none"> – residential aged care services – home and community care services
Health	<ul style="list-style-type: none"> – general practice, hospital services, private practitioners – public and community health – mental health – Aboriginal health
Community	<ul style="list-style-type: none"> – community organisations, eg sport, arts – community centres, eg recreation, local government, shopping centres



Appendix 7

Strategies to reduce conduct disorder in children identified by the Interagency Committee on Children's Futures⁷⁶

Interventions for 0 to 2 years:

- media campaign including messages highlighting the significance of early behaviour problems, importance of parenting and good parent-child relationships, significance of family violence and postnatal depression
- identification and treatment of postnatal depression
- home visiting program for first time mothers and mothers experiencing problems
- child health nurse to identify difficult temperament in children aged between six weeks and four months
- expanding existing parenting services to new areas, training and supporting staff, improved management of complex cases.

Children aged between 1 and 2 years:

- childcare worker training to improve the quality of childcare
- additional funded childcare places for the children in the home visiting program to enhance cognitive stimulation and social skill development of the children.

Children aged between 2 and 4 years:

- continued communication strategies as outlined above
- increased coverage of parenting information throughout the State
- for 3 year old children living in areas of high socioeconomic disadvantage, developing problem-solving mastery skills and good home-school connections
- intensive parenting intervention which focus on the family and child needs.

Children aged 5 to 8 years:

- communication strategies as above, including zero tolerance of bullying and importance of social bonding
- positive parenting in pre-primary and year one
- creating a positive, supportive school environment
- rich language approach in school, phonemic awareness, literacy and reading problems
- academic skills training with individual tutors



- recognises the importance of providing support to parents and children who require additional help or who are facing particular difficulties due to mental illness, substance abuse and/or other physical conditions.

Appendix 8

Strategies developed or supported by the Ministerial Council for Suicide Prevention

Since 1989, the Ministerial Council for Suicide Prevention (MCSP) has undertaken triennial planning and coordination of suicide prevention activities. MCSP reports to the Minister for Health and its membership comprises representation from government and non government organisations with an interest in suicide prevention. Each of the member agencies have their own suicide prevention and intervention programs consistent with the overall strategy developed by MCSP.

The MCSP policy looks at approaches to reduce suicide in five areas:

- promoting wellbeing
- early identification and help
- crisis support and treatment
- support after a suicide
- developing community and scientific understanding of suicide and its prevention.

In 1994, youth suicide was recognised as one of the priority health conditions for Western Australia and nationally and in 1996, the Commonwealth introduced the National Youth Suicide Prevention Strategy. A National Advisory Council on Youth Suicide Prevention was set up in 1998 with representation from each State and Territory. The Advisory Council was responsible for developing and coordinating a five year plan to follow on from the National Youth Suicide Prevention Strategy. In 1999, the Commonwealth broadened the scope of its suicide prevention strategy to include all age groups and established a new National Advisory Council on Suicide Prevention.

Initiatives undertaken by the MCSP include:

- Establishing the gatekeeper trainer program for professionals who work with young people. The aim of this program is to help identify suicide risk and provide initial support.
- Developing a network of accredited Regional Trainers across the state to provide gatekeeper training in collaboration with regional suicide prevention networks.
- Developing the state Aboriginal youth suicide prevention policy in partnership with Aboriginal organisations and other government agencies.



- Working with senior high schools in Western Australia to support effective early identification, intervention and support following a completed suicide.
- Maintaining the Coroner's database and compiling research reports on suicide trends and issues.

Current initiatives undertaken by the Department of Health in Western Australia include:

- All mental health services provide services for people at high risk of suicide.
- Social worker positions within the emergency departments of teaching hospitals (Fremantle, Sir Charles Gairdner and Royal Perth Hospitals) ensure follow up of young people treated for deliberate self harm.
- Perth Central Coastal Division of General Practice and Sir Charles Gairdner Hospital and Joondalup Health Service provide an integrated suicide prevention service focusing on training of general practitioners, provision of crisis intervention and follow up contact and referral to community services for longer term support if this is needed.
- Samaritans Youth Liaison Program provides one-to-one support to youth at risk of suicide and their families, a 1800 Youthline providing 24 hour support using trained and supervised volunteer counsellors to rural young people, and the Country Link Up Newsletter that is distributed each quarter among health care workers in rural areas.
- Albany Samaritan Befrienders phonline provides support to young people in crisis.
- The Youth Counsellor Program works with marginalised young people aged 15-25 years to promote access to health, education and training, recreation, employment and cultural services and activities, provide individual and group counselling as required, and work with community organisations, local government, State and Commonwealth Government agencies to provide support and services for young people.

There are also a number of recently completed projects in Western Australia funded under the National Youth Suicide Prevention Strategy including:

- The National General Practice Youth Suicide Prevention Project which evaluated methods of training general practitioners in identifying youth suicide risk.
- The Sexuality and Youth Suicide Prevention Project which focused on gay, lesbian, bisexual and transgender young people at risk of suicide.
- The Professional Education and Training Project trained 95 people across the State to deliver gatekeeper training which helps professionals working with young people identify suicide risk and intervene effectively.
- A stocktake of youth suicide initiatives in Western Australia was completed and a report published.
- A project to educate gun owners about the risk of guns being used for suicide and to promote gun safety.





- The rate of suicide among males aged 25-34 is also high with around 30 completed suicides per 100,000, which accounts for 20 percent of the overall burden of suicide.
- From 1986 to 1997, the suicide rate for older males aged 75+ was the next highest following that for young adult males. The rate of suicide for females was highest in the 75-79 age group. International and national studies have found that depression is the most prominent risk factor for suicidal behaviour in older people. Other common risk factors are declining mental and physical health.
- There has been a steady increase in the 15-24 year old male suicide rate in almost all rural areas of Australia since the mid 1960s. Several factors would appear to be associated with this increase, including economic downturn and increased unemployment, family stress and dysfunction exacerbated by financial strain, social and geographic isolation, problems in accessing and using mental health services and the greater availability of lethal means of self-harm such as firearms. Female residents of remote areas have higher hospital admission rates than metropolitan females, despite their lower suicide rates.
- Suicide is a relatively recent phenomenon in the Aboriginal culture. Reports from Aboriginal groups indicate that deliberate self-harm and other suicidal behaviour among their young people appear to have increased substantially over recent years. Suicide rates among Aboriginal males were consistently higher (almost double) than the overall Western Australian male population averaging 37 per 100,000 population. The male to female ratio of suicide among Aboriginal people was 10:1 (in contrast to 4:1 in the overall population). Aboriginal male suicides are highest in the 20-24 year age group, double the rate for all the male suicides in this age group in the State. The 25-29 year age group was also high for Aboriginal males, again over double the rate for all males.
- The rate among Aboriginal people admitted to hospital for deliberate self-harm is also higher than among the overall State population. The highest rates of admission for deliberate self-harm were among Aboriginal young adults aged 30-34 years. Once discharged from their initial episode of deliberate self-harm, Aboriginal people were less likely to commit suicide or repeat than non Aboriginals.

Appendix 10

Guidelines for the development of mental health promotion and illness prevention programs

The Department of Human Services and Health identified the following defining factors for evidence based promotion and prevention strategies. They must:

- be underpinned by the principles of best practice
- incorporate satisfactory theoretical development



- be effective and efficient for both the target group and the group implementing the intervention
- be cost-effective
- be output and outcome focused.

Building on these strategies, the policy development process identified several criteria to be considered in the planning and implementation of mental health promotion and illness prevention programs. In this respect, the following program development guidelines should be used.

The program

In selecting individual programs, the following guidelines should be considered.

The program:

- provides clear specifications of the intervention and program design
- addresses factors in the environment and/or setting which can be modified
- provides evidence of an effective intervention or approach
- addresses a problem that affects a large proportion of the population and/or represents a significant burden of disease within a particular environment or setting
- targets a particular setting or population group
- is accessible to the intended recipients
- involves a collaborative approach and promotes inclusion
- contributes to the creation of diverse, inclusive, and respectful environments and settings
- is transferable to other areas
- strategy/change can be sustained
- potential impacts of the strategy on services for consumers and carers is evident
- does not duplicate, but may complement, an existing program
- has a population based outcome and/or evidence of social change
- is consistent with the Jakarta Declaration (see glossary)
- represents value for money in relation to opportunity costs of spending money elsewhere.



Evidence base

There is a need to develop a stronger evidence base from which funding decisions can be made.

Proposals to address the research priorities outlined in this policy should address the following criteria.

- The research project:
 - fills an important gap in knowledge and/or the evidence base
 - is able to justify relevance of research to mental health promotion and illness prevention (indication of likely benefit)
 - presents sound methodology
 - includes evaluation: process, impact and outcomes
 - indicates strong links from research to practice
 - shows evidence of relevant collaboration and inclusion of a multi-disciplinary research team.
- There is an available, proven provider to conduct the research.

Partnerships

Many of the mental health promotion and illness prevention strategies outlined in this policy involve a partnership between government agencies and/or government agencies and non government or private organisations.

This policy recommends that:

- partnerships involve appropriate groups or sectors and develop shared agreements
- all partners have meaningful roles and agreed outcomes
- all partners understand one another's roles
- all partners have the opportunity to contribute to planning, implementation and evaluation
- partnerships are flexible.

Accountability

Ensure accountability through monitoring, quality improvement, evaluation and the development of performance measures that focus on outputs and outcomes.

Glossary

Aboriginal: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander and is accepted as such by the community with which he or she is associated.

Carer: A family member, parent, sibling, partner or friend (including children under 16 who contribute to care giving for family members) who are affected by and/or have an investment in the wellbeing of the person with a mental illness.

Community: 'Community' can mean different things to different people. For the purposes of this policy, 'community' means a group of people who share common interests, for example, living in the same locality, having the same religion or culture, attending the same school or undertaking similar educational pursuits, having the same profession etc.

Conduct disorder: A condition characterised by antisocial behaviour, with aggression towards others, destruction of property, deceitfulness or theft and serious violations of rules. This may include bullying, physical fights, breaking into houses or cars, running away from home, or frequent truancy from school.

Connectedness: The sense of belonging and connectedness with others. There is evidence that connections with family, school or a significant adult can reduce risk of adverse mental health outcomes. Connectedness within a community has been linked to health and wellbeing.

Culturally and linguistically diverse (CALD): For the purposes of this policy, 'people from culturally and linguistically diverse backgrounds' refers to persons who meet one or more of the following descriptions:

- those whose country of birth has a national language other than English
- those who were born in Australia and have at least one parent born in a mainly non English speaking country
- those whose predominant social orientation or identification is with a non English speaking culture.

Depression: A mood disorder with prolonged feelings of being sad, hopeless, low and inadequate, with a loss of interest or pleasure in activities and often with suicidal thoughts or self-blame.

Early intervention: Refers to interventions targeting people displaying early signs and symptoms of a mental illness and people developing or experiencing a first episode of mental illness.

Environment: For the purposes of this policy, 'environment' refers to the social, psychological, spiritual, cultural and economic milieu in which population groups interact and can include the school system, and urban and remote areas.

Evidence base: The confidence obtained from a critical and systematic analysis of research findings that an intervention will lead to the desired change.

Incidence: In community studies of a particular disorder, the rate at which new cases occur in a given place at a given time.

Indicated interventions: A preventive intervention 'targeted to high-risk individuals who are identified as having minimal but detectable signs and symptoms foreshadowing mental disorder... but who do not meet DSM-IV diagnostic levels at the current time'^x.

Jakarta Declaration: The Jakarta Declaration endorses the strategies outlined in the Ottawa Charter. Additional strategies identified in the Jakarta Declaration are:

- comprehensive approaches to health development are the most effective
- particular settings offer practical opportunities for the implementation of comprehensive strategies
- participation is essential to sustain efforts
- health learning fosters participation.

Mental disorder: The National Action Plan describes 'mental disorder' as 'a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities'. There are different types and varying degrees of severity of mental disorders, including depression, anxiety, substance abuse, bipolar disorder and schizophrenia. Currently, universal classification systems are used to identify disorders, eg DSM-IV and ICD-10^{xi}.

Mental health literacy: 'The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available; and attitudes that promote recognition and appropriate help-seeking'^{xii}.

Mental health problem: The National Action Plan defines 'mental health problem' as 'diminished cognitive, emotional or social abilities but not to the extent that it meets a disorder'. Mental health problems are more common than mental disorders and include temporary problems experienced as a reaction to life stressors, such as grief from the loss of a family member. Mental health problems are less severe and shorter lasting than mental disorders, but may progress into a mental disorder.

Mental health promotion: Any action taken to maximise mental health and wellbeing among populations and individuals. It focuses on improving environments (social, physical and economic) that affect mental health and enhancing the coping capacity of communities as well as individuals.

Mental illness prevention: Includes interventions that aim to reduce the initial onset of a mental illness by reducing risk factors and enhancing protective factors.

(x) Mrazek and Haggerty, 1994, p25

(xi) Psychiatric classification systems such as DSM-IV and ICD-10 delineate specific symptomatology of mental disorders.

(xii) Jorm, AF (1997), 'Alzheimers disease: Risk and protection' in *Medical Journal of Australia*, Vol 167, p182

Ottawa Charter: Key components of the Ottawa Charter for health promotion are:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services.

Parent(s): The person or people who are a child's primary caregivers.

Population based interventions: Refers to interventions targeting populations rather than individuals. They include activities targeting the whole population as well as activities targeting population subgroups.

Postnatal depression: An episode of major depression occurring in the first 12 months following childbirth.

Prevalence: The percentage of the population suffering from a disorder at a given point in time (point prevalence) or during a give period (period prevalence).

Protective factors: Refers to characteristics that produce resilience to the development of psychological difficulties in the face of adverse risk factors.

Resilience: Capacities within a person that promote positive outcomes such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem solving, cognitive and emotional skills, communication skills and help-seeking.

Risk factors: Refers to characteristics, variables or hazards that, if present for a given individual, make it more likely that they, rather than someone selected at random from the general population, will develop a disorder.

Selective interventions: Preventive interventions 'targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average'^{xiii}.

Setting: A 'setting' can include the home, school, workplace, meeting places etc.

Social cohesion: Means cohesive community relationships with high levels of participation in communal activities and public affairs, and high levels of membership of community groups^{xiv}.

Universal interventions: Preventive interventions 'targeted to the general public or a whole population group that has not be identified on the basis of individual risk'^{xv}.

(xiii) Mrazek and Haggerty, 1994, p25

(xiv) Marmot and Wilkinson, 1999, p169

(xv) Mrazek and Haggerty, 1994, p25

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