



Government of **Western Australia**
Mental Health Commission

Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan **2018-2025**

An evidence-based and evidence-informed guide
for promotion and prevention activities
in Western Australia



**Government of Western Australia
Mental Health Commission**

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The Mental Health Commission acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of this country and its waters. The Mental Health Commission wishes to pay its respects to Elders past and present and extend this to all Aboriginal people seeing this message.

Important note

The Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan) is an evidence-based and evidence-informed document that can be used by the Commonwealth and State government agencies, Local Governments, non-government organisations and communities to guide investment, development, implementation and evaluation of promotion and prevention activity. Where appropriate, the Mental Health Commission will collaborate with stakeholders to facilitate their engagement in the implementation of the Prevention Plan.

The strategies contained within this document and subsequent investment required are dependent on Government's fiscal capacity and are subject to normal Government approval through budgetary processes. It should be noted, however, that strategies outlined in the Prevention Plan can also be funded by Commonwealth Government, Local Governments, private and not-for-profit sectors.

Note from the Minister

I am pleased to release the Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan) which has been developed by the Mental Health Commission in consultation with a broad range of agencies, organisations, stakeholders, consumers, families, carers and supporters.

The impact of mental illness and alcohol and other drug use on the Western Australian community remains an important issue to address, particularly in relation to co-occurring mental health and alcohol and other drug-related issues.

Supporting the wellness of West Australians and the return to wellness of those who are unwell, is one of my key focuses as Minister for Health and Mental Health. Similarly, I am aware that preventing illness and harm can have immense benefits to us as a community, from a health, social and economic perspective. Health promotion and preventative health strategies are paramount to ensuring we can place healthcare delivery on a more sustainable footing in our State and are featured within the interim report of the McGowan Government's Sustainable Health Review.

The McGowan Government is committed to supporting Western Australians to live healthy and fulfilling lives and to preventing illness and harm where possible. I am very passionate about the importance of mental health promotion, preventing mental illness and minimising harm associated with alcohol and drug use for the Western Australian community.

This Prevention Plan will guide the mental health, alcohol and other drug sectors in providing evidence-based and evidence-informed programs and initiatives. I encourage all organisations as well as the Western Australian community to consider how the initiatives and programs identified in this Prevention Plan can be implemented in their respective areas of responsibility.

Roger Cook MLA

Deputy Premier; Minister for Health; Mental Health



Note from the Commissioner

I am proud to present the Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan).

The Prevention Plan aims to address mental health, alcohol and other drug related issues by providing a range of evidence-based and evidence-informed mental health promotion, and mental illness, alcohol and other drug prevention initiatives and programs.

It is acknowledged that the programs and initiatives vary between mental health, alcohol and other drugs, although there is much we can do to promote good mental health and prevent alcohol and other drug-related issues.

Promotion and prevention initiatives can have a lasting impact on a person's life and it is vital that it remains a priority. Investment in prevention improves an individual's and the population's quality

of life. For every \$1 spent on prevention, there is a \$14 return on that investment.

I welcome this much needed plan and look forward to working with our stakeholders and the community to promote mental health, and prevent mental health, alcohol and other drug related issues amongst the Western Australian community.

Timothy Marney

Commissioner,
Mental Health Commission



Contents

EXECUTIVE SUMMARY	5
INTRODUCTION	7
Goal of the Prevention Plan	7
What's included in the Prevention Plan	8
Key Terminology in the Prevention Plan	9
Roles and Responsibilities	10
BACKGROUND	12
Development of the Prevention Plan	12
PROMOTION AND PREVENTION	13
What is Prevention?	13
Why Prevention?	15
Factors that Impact Mental Health and Alcohol and other Drug-related Harm	19
THE PREVENTION PLAN	22
Goals	22
Principles	22
Life Stages and Domains for Action	25
Strategies	27
Priority Populations	39
Prevention System Supports	42
MONITORING AND REPORTING	44
GLOSSARY	46
APPENDICES	48
Appendix A – Prevention Plan Contributors	48
Appendix B – Key Policies	49
Appendix C – Promotion and Prevention Models	52
Appendix D – Case Studies	54
Appendix E – Example Strategies for Population Groups	57
Appendix F – What Prevention Plan Stakeholders can do	58
REFERENCES	60

Executive Summary

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (the Plan) identified the requirement to develop a Prevention Plan to address mental health, alcohol and other drug-related issues in the Western Australian community.

The Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan) aims to provide an overview of recommended programs, strategies and initiatives that promote optimal mental health; reduce the incidence of mental illness, suicide attempts and suicide; and prevent and reduce drug use and harmful alcohol use in the Western Australian community.

The development of the Prevention Plan was led by the Mental Health Commission (MHC) in partnership with a range of key stakeholders, including academic experts, senior representatives from a range of government departments, key non-government agencies, the general public, consumers, families, carers and supporters of those with lived experienceⁱ of mental health and/or alcohol and other drug-related issues.

The Prevention Plan focuses primarily on activities relating to mental health promotion and the primary prevention of mental health, alcohol and other drug-related issuesⁱⁱ. Promotion and prevention actions target the general population and at-risk groups to promote optimal mental health and

wellbeing, keep people well and to prevent and reduce alcohol and other drug harm. They also aim to address co-occurring mental health and alcohol and other drug-related issues. Where considered appropriate, reference to secondary and/or tertiary prevention strategies are included in the Prevention Plan targeting people showing early signs of mental ill-health or alcohol and other drug-related issues.

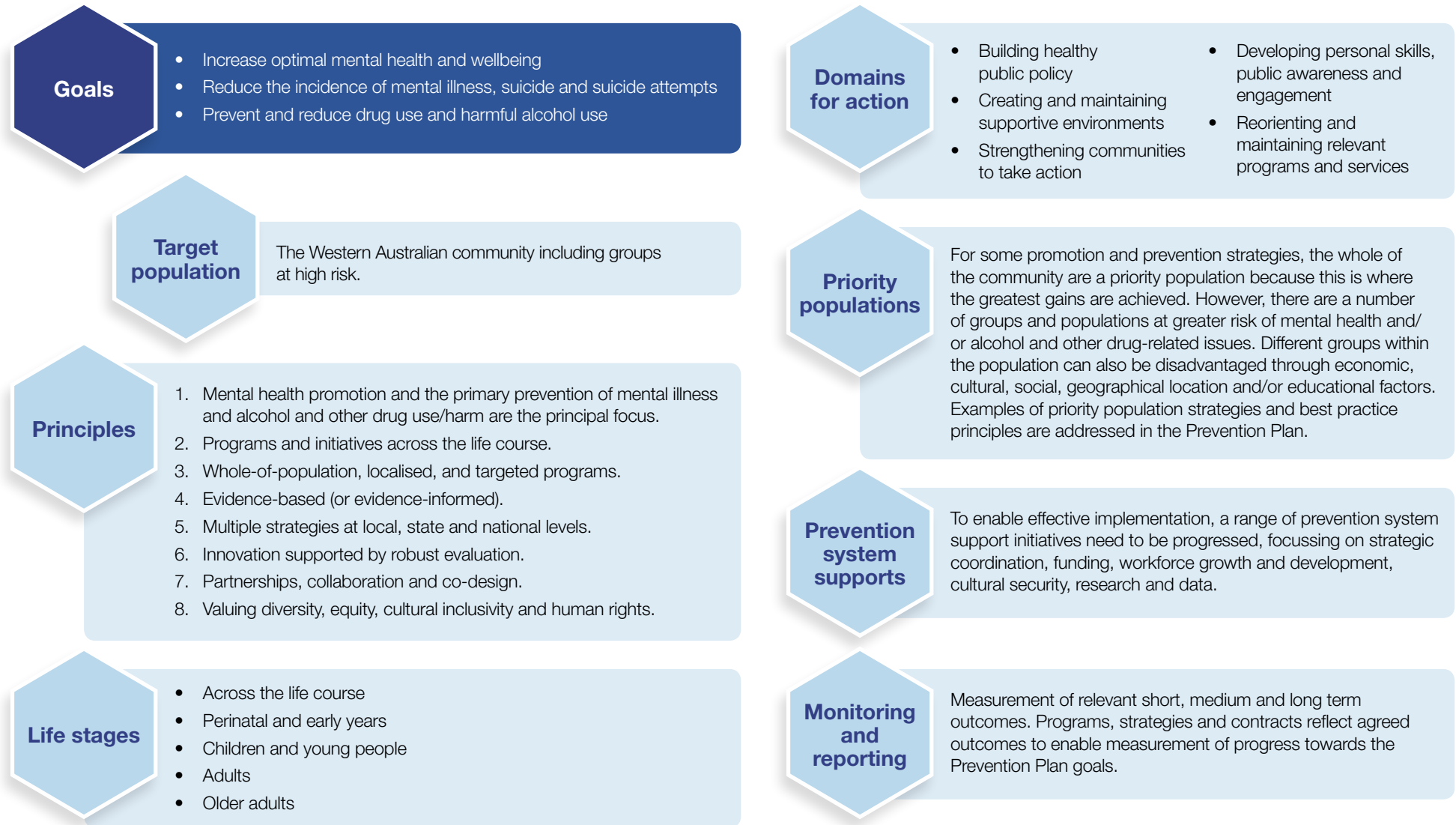
The Prevention Plan includes contextual background information, strategies categorised into domains for action across the life course, reference to priority populations, and a summary of prevention system supports that will support the implementation of the Prevention Plan.

Effective promotion and prevention requires comprehensive strategies across the whole population and for specific at-risk groups. With the combined and comprehensive efforts of government, the non-government sector and the community, optimal mental health and wellbeing can be attained by the community, and reduced incidence of mental health, alcohol and other drug-related issues can be achieved.

An overview of the Prevention Plan is provided in **Table 1**.

- i. 'Lived experience' can also be referred to as "people who identify as having experienced problems associated with alcohol and other drug use and/or mental health".
- ii. For ease of reading the term 'mental health promotion and the primary prevention of mental health, alcohol and other drug-related issues' is referred to as 'promotion and prevention'.

Table 1. Overview of the Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025



Introduction

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (the Plan) identified the requirement to develop a prevention plan for mental health, alcohol and other drugs. The Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan) includes evidence-based and evidence-informed strategies that can increase optimal mental health and wellbeing, reduce the incidence of mental illness, suicide attempts and suicide, and prevent and reduce alcohol and other drug-related harm in the Western Australian community.

Optimising mental health and wellbeing, and preventing mental health, alcohol and other drug-related issues are important for all Western Australians. Experiencing optimal mental health and wellbeing, and minimal alcohol and other drug-related harms, can enable individuals to fully participate in community and family life, contribute socially and economically, and live long, happy and meaningful lives.

Goal of the Prevention Plan

The Prevention Plan provides a guide for all stakeholders, including the Mental Health Commission (MHC), for the development and implementation of evidence-based and evidence-informed strategies to promote mental health and prevent mental health, alcohol and other drug-related issues amongst the Western Australian community.

The MHC has led the development of the Prevention Plan to provide a provider and funder neutralⁱⁱⁱ, evidence-informed guide for government agencies, non-government organisations and the community in the planning, implementation and evaluation of promotion and prevention programs and initiatives.

The goal of the Prevention Plan is to build upon and/or continue to implement a range of programs that will:

- increase optimal mental health and wellbeing;
- reduce the incidence of mental illness, suicide attempts and suicide; and
- prevent and reduce drug use and harmful alcohol use.

iii. The Prevention Plan recommends the mental health promotion and primary prevention strategies that may be implemented across the State, however it does not dictate who should fund and implement the recommended strategies. The responsibility to fund, implement and monitor the Prevention Plan strategies lies with all levels of Government (Local, State and Commonwealth), a variety of Government sectors (for example mental health, health, housing, education, employment), non government organisations and communities, as they deem appropriate within their respective areas of responsibility.

What is included in the Prevention Plan?

The Prevention Plan includes relevant background information and strategies organised by domains for action¹ across the life course. The Prevention Plan also provides information on priority populations and a summary of key prevention system support initiatives that will support the effective implementation of the Prevention Plan.

The majority of strategies provided throughout the Prevention Plan can be categorised as primary prevention as they are aimed at preventing illness by maintaining, protecting and/or enhancing the wellbeing of the general population and reducing risk of harm from alcohol and other drug use across the whole population. Whilst it is acknowledged that action is required across the continuum of prevention, including secondary and tertiary prevention; primary prevention remains the focus of this document. Where considered appropriate, secondary prevention strategies are mentioned, and the inclusion of health promoting activities in relevant services is encouraged. See page 10 for key prevention definitions.

It is acknowledged that many strategies and programs consistent with the Prevention Plan are already being implemented. In the future, it is anticipated that existing and new programs and services will be developed to align with and complement the Prevention Plan. It is also acknowledged that a number of strategies as recommended in the Prevention Plan may be implemented and occur outside of the Prevention Plan timeframe (2018-2025).

To implement the Prevention Plan, the MHC will aim to facilitate action with a variety of stakeholders including the broader community as well as the mental health, alcohol and other drug, health, education, housing, training and employment, local government, social services and finance sectors. The MHC is also a lead provider and funder of prevention programs and services, and will use the Prevention Plan to guide its own activities in this area where appropriate. Other key stakeholders may also utilise the Prevention Plan to identify prevention activities, programs and interventions that they can also develop, fund, implement and evaluate.

Suicide Prevention

Addressing and preventing suicide, suicide attempts and self-harm is a key priority area for improving the health and wellbeing of Western Australians. It is a complex issue, with a range of recommended strategies to be implemented. As such, the Western Australian approach to preventing suicide, suicide attempts and self-harm is addressed in its own strategy, namely, Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020)².

Suicide Prevention 2020 outlines six key action areas for suicide prevention:

1. Greater public awareness and united action across the community.
2. Local support and community prevention across the lifespan.
3. Coordinated and targeted responses for high-risk groups.
4. Shared responsibility across government, private and non-government sectors to build mentally healthy workplaces.
5. Increased suicide prevention training.
6. Timely data and evidence to improve responses and services.

A goal of the Prevention Plan to 'reduce the incidence of mental illness, suicide and suicide attempts' will be partially addressed through the implementation of Suicide Prevention 2020, specifically through strategies to reduce the incidence of suicide and suicide attempts. Further, a number of strategies within the Prevention Plan can have a positive impact on suicide, suicide attempts and self-harm.

Whilst suicide prevention is not specifically addressed in the Prevention Plan, it is acknowledged that the impacts of strategies for mental health promotion and the prevention of mental health, alcohol and other drug-related issues are likely to have a positive flow on effect in the prevention of suicide, suicide attempts and self-harm. For example, strategies to promote and strengthen resilience and coping skills amongst school aged children will have positive outcomes for preventing mental illness, alcohol and other drug harm; and subsequently suicide.

Tobacco

“Smoking is a leading cause of preventable death and disease in Australia. It is responsible for more drug-related hospitalisations and deaths than alcohol and illicit drugs combined”³.

It is acknowledged that there is also a high rate of tobacco use amongst people with a mental illness and conversely, it is also noted that quitting smoking is related to improved mental health.

Tackling smoking remains a key priority area for improving the health of Western Australians and as such necessitates a separate strategy in its own right. The Western Australian Health Promotion Strategic Framework 2017-2021⁴ outlines the following priorities for making smoking history in Western Australia:

- continue efforts to lower smoking rates;
- eliminate exposure to second hand smoke in places where the health of others can be affected;
- reduce smoking in groups with higher rates;
- improve regulation of contents, product disclosure and supply; and
- monitor emerging products and trends.

The National Tobacco Strategy 2012-2018⁵ sets out the national framework to reduce tobacco-related harm in Australia. The goal of the strategy is to improve the health of all Australians by reducing the prevalence of smoking and the inequalities it causes. It also details objectives and targets for tobacco control until 2018 and sets out priority areas for action.

Key Terminology in the Prevention Plan

There are a variety of terms and definitions used in the area of mental health and alcohol and other drugs. It is acknowledged that definitions and terminology preferences may vary within different agencies and organisations. Where possible, this document attempts to utilise the most appropriate and commonly used terms. The below preferred terms have been defined in the best way possible to ensure consistency and alignment with the promotion and prevention sector. Additional definitions are provided in the Glossary (see page 46).

Mental Health Commission Terminology Guide

In acknowledging the variety of terms and definitions used within the mental health and alcohol and other drug sectors, the MHC is currently developing a Commission-wide terminology guide based on relevant evidence, research and stakeholder input. The aim of this guide is to ensure consistent messaging is utilised in all strategic documents, publications and correspondence. Upon review of the Prevention Plan, as part of the Plan’s mid-term review in 2020, updated terminology will be considered for the Prevention Plan where appropriate.

Prevention Plan Terminology

Aboriginal social and emotional wellbeing:

Aboriginal peoples^{iv} have a holistic view of mental health and prefer to utilise the term social and emotional wellbeing. The domains of wellbeing that

typically characterise Aboriginal definitions of social and emotional wellbeing include connection to body, mind and emotions, family and kinship, community, culture, language, country, spirit, spirituality and ancestors.

Alcohol and other drug harm: Refers to the negative impact of alcohol and other drug use on communities, families and individuals. This includes health harms such as injury, cancers, cardiovascular disease, liver cirrhosis, mental health issues, road trauma, harm to the fetus and child, social harms including violence and other crime. It also includes economic harms from healthcare and law enforcement costs, decreased productivity, associated criminal activity, reinforcement of marginalisation and disadvantage, domestic and family violence and child protection issues such as abuse and neglect. Harmful alcohol and other drug use is also associated with social and health determinants such as discrimination, unemployment, homelessness, poverty and family breakdown.

Alcohol and other drug harm minimisation:

Aims to address alcohol and other drug-related issues by reducing the harmful effects of alcohol and other drug use on individuals and society. Harm minimisation considers the health, social and economic consequences of alcohol and other drug use on both the individual and the community as a whole. This approach is coordinated through multiple strategies focusing on demand reduction, supply reduction and harm reduction.

Mental health: The term mental health is a positive concept and has also been referred to as optimal mental health, good mental health, positive mental health, mental wellness and mental wellbeing.

iv. The reference to Aboriginal peoples within this document is inclusive of the Torres Strait Islander population. No disrespect is intended with the use of this terminology.

According to the World Health Organization (WHO) definition⁶ mental health involves a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. It is related to the promotion of wellbeing, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorder.

Mental health issues: A mental health issue can impact an individual's cognitive, emotional or social abilities, but may not meet the criteria for a diagnosable mental illness. Mental health issues are said to occur as a result of life stressors, and are usually less severe and of shorter duration than mental illnesses. These often resolve with time or when the individual's situation changes. However, if mental health issues persist or increase in severity, they may develop into a mental illness.

Please note that within this document, the term 'mental health issue' is used as an overarching term encompassing both diagnosed and undiagnosed mental illnesses and/or disorders as well as the issues that can develop into a mental illness.

Mental ill-health: The spectrum of problems that interfere with an individual's cognitive, social and emotional abilities including both mental health issues and mental illnesses.

Mental illness: A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. There are different types of mental illnesses, with varying levels of severity. Examples include mood disorders (such as depression, anxiety and bipolar disorder), psychotic

disorders (such as schizophrenia), eating disorders and personality disorders⁷.

Prevention Definitions

Alcohol and other drug prevention: Initiatives to prevent or delay the onset of alcohol and other drug use and to protect against risk and reduce harm associated with alcohol and other drug supply and use.

Mental health promotion: Involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles⁸.

Mental illness prevention: Initiatives which focus on reducing risk factors for mental ill-health and enhancing protective factors.

Primary Prevention: Strategies aimed at preventing illness by maintaining and/or enhancing the wellbeing of the general population. Includes the following categories of interventions:

- **Universal** – Interventions targeted at the whole population.
- **Selective** – Interventions targeting subgroups of the population who are at increased risk.
- **Indicated** – Interventions targeting high risk groups and those showing early signs/behaviours linked to mental health and/or alcohol and other drug-related issues.

Secondary Prevention: Seeks to lower the number of cases of a disorder or illness in the population through early detection and treatment.

Tertiary Prevention: Interventions that reduce disability, enhance rehabilitation and prevent reoccurrences of the illness.

Roles and Responsibilities

There are a range of agencies and organisations that play a role in, or have a responsibility to, implement promotion and prevention activities. A brief summary of some (not all) of the key agencies/organisations and their roles and responsibilities are provided below.

Mental Health Commission: The mission of the MHC is to commission, provide and partner in the delivery of:

- prevention, promotion and early intervention programs;
- treatment, services and supports; and
- research, policy and system improvements.

As such, the MHC plays a lead role in facilitating collaborative state-wide planning in regards to prevention, and also commissions and provides prevention services and programs. In addition, the MHC works with other key sectors, organisations and agencies to support the delivery of evidence-based prevention activity. The MHC monitors a range of key performance indicators through the MHC annual report, evaluates MHC commissioned and provided prevention activities, and provides guidance on how other agencies may wish to evaluate their own prevention activity.

Department of Health (DoH): The DoH, led by the Director General, provides leadership and management of the health system as a whole, ensuring the delivery of high quality, safe and timely health services. Under the *Health Services Act 2016*, the DoH is the 'System Manager' and Health Service Providers (HSPs) are established as statutory authorities.

The DoH includes an area focussing on prevention. Taking a population-wide perspective, the Chronic Disease Prevention area of DoH focusses on strategies to encourage healthy behaviours in the population.

Health Service Providers: Under the *Health Services Act 2016* a total of five HSPs were established. The HSPs are responsible for the delivery of health services to the population of Western Australia. In this way, the HSPs are involved in the delivery of services that can contribute to prevention. For example, the Child and Adolescent Health Service provide child health services that can include support to new parents and children, thereby contributing to improved health outcomes for families.

Government departments and agencies:

Government departments and agencies play a key role in the funding, planning, development and implementation of promotion and prevention activities and initiatives across Western Australia. For example:

- The Department of Education can implement a range of effective, age appropriate school-based programs for children and young people.
- The Department of Local Government, Sport and Cultural Industries have a role in liquor licensing decisions which have an impact on the health of the community. This Department also includes Local Governments which are discussed below.
- Healthway funds sport, arts, community activities, health promotion projects and research to promote the health of Western Australians. Healthway is an important stakeholder in the funding and implementation of activities and initiatives that promote mental health and prevent mental health, alcohol and other drug-related issues.

Local Government: Local Governments are responsible for developing and implementing local plans that can protect and improve the health and wellbeing of their community. As such, Local Governments may use the Prevention Plan to guide the development and implementation of strategies and programs that promote optimal mental health and reduce alcohol and other drug harm.

Peak bodies: Peak bodies, including the Western Australian Network of Alcohol and other Drug Agencies, and the Western Australian Association for Mental Health can be active in advocating for increases in prevention funding and activity across the State, promoting community awareness, reducing stigma and discrimination within the mental health and alcohol and other drug sectors and can be involved in workforce development and planning. Those experienced in prevention can also support the relevant agencies they represent to implement evidence-based prevention strategies.

Community organisations: Community organisations and groups (including, community alcohol and other drug services, suicide prevention coordinators and non-government organisations) are integral to the implementation of promotion and prevention activity. Organisations are aware of the key issues affecting their local community and can apply state-based programs at a local level. They can also play a key role in the development and implementation of community development initiatives and initiating and supporting community action within the metropolitan area and across the regions of Western Australia. Community organisations experienced in promotion and prevention may also wish to seek funding from a

range of sources to implement strategies discussed in the Prevention Plan.

Consumer, family and carer organisations: There are several consumer, family and carer organisations in Western Australia, including Carers WA, Consumers of Mental Health WA, Mental Health Matters 2 and Helping Minds. These organisations engage, consult with, represent and advocate for consumers, families and carers. They can assist agencies and organisations to progress consumers and carer partnership, co-design and co-production for the development and implementation of promotion and prevention initiatives.

Primary health care organisations: Primary health care has an important role in delivering services in the community that positively contribute to the health and wellbeing of Western Australians. Primary health care can include general practice, allied health services, community health and community pharmacy. Generally, it can be the first point of contact people have with the health system, and relates to the treatment of non-admitted patients in the community⁹ that can include identifying early signs of mental health, and/or alcohol and other drug-related issues. Primary care has an important role in providing brief intervention programs and implementing preventive health initiatives.

Other departments, agencies and stakeholders: Departments, agencies and stakeholders that also have an impact on prevention include (but are not limited to) those working in the areas of employment, housing, planning, and environmental health. The impact of these areas on prevention is discussed in greater detail in the Determinants of Health section of the Prevention Plan (see page 19).

Background

Development of the Prevention Plan

The development of the Prevention Plan was led by the MHC in partnership with a range of stakeholders, including key academic experts, senior representatives from a range of government departments, key non-government agencies, and the general public including consumers, families, carers and supporters of those with lived experience of mental health and/or alcohol and other drug-related issues. Prevention Plan contributors are outlined in **Appendix A**.

As a basis for the Prevention Plan, relevant national, state and local policies, strategies and literature were reviewed to ensure the Prevention Plan is reflective of the best available evidence regarding what works in promotion and prevention. Consultation with key stakeholders provided confirmation of strategies identified through the evidence, and the identification of other appropriate initiatives.

The Prevention Plan is aligned to, and/or complements, relevant national and state policies and strategies (see **Appendix B**). A number of key themes, principles and action areas emerged from the strategic documents reviewed. These include:

- Application of a systems approach, including implementing various actions at a national and state-wide level through to localised, community-driven responses.
- Improved collaboration, coordination and partnerships in order to implement effective prevention strategies.
- Utilisation of consistent models and frameworks, such as the harm minimisation approach to

prevent alcohol and other drug-related harm, and acknowledgement of the influence of both risk and protective factors.

- Identification of priority populations that will not only benefit from whole of population strategies, but may also require targeted approaches.

Ottawa Charter For Health Promotion

When reviewing the evidence regarding what works to promote optimal mental health, reduce the incidence of mental illness, suicide attempts and suicide, and prevent and reduce drug use and harmful alcohol use, recommended strategies generally fall into five domains for action, also known as the Ottawa Charter for Health Promotion action areas:

- Building healthy public policy.
- Creating supportive environments.
- Strengthening community action.
- Developing personal skills.
- Re-orienting health care services toward prevention of illness and promotion of health.

The Ottawa Charter was developed at the first International Conference on Health Promotion in 1986 and remains a seminal guiding framework for health promotion activity worldwide. The Prevention Plan has adapted the Ottawa Charter action areas, referring to them as “Domains for Action”. Across all domains for action, the building of protective factors and the early identification and mitigation of risk factors is a key priority.

Promotion and Prevention

What is Prevention?

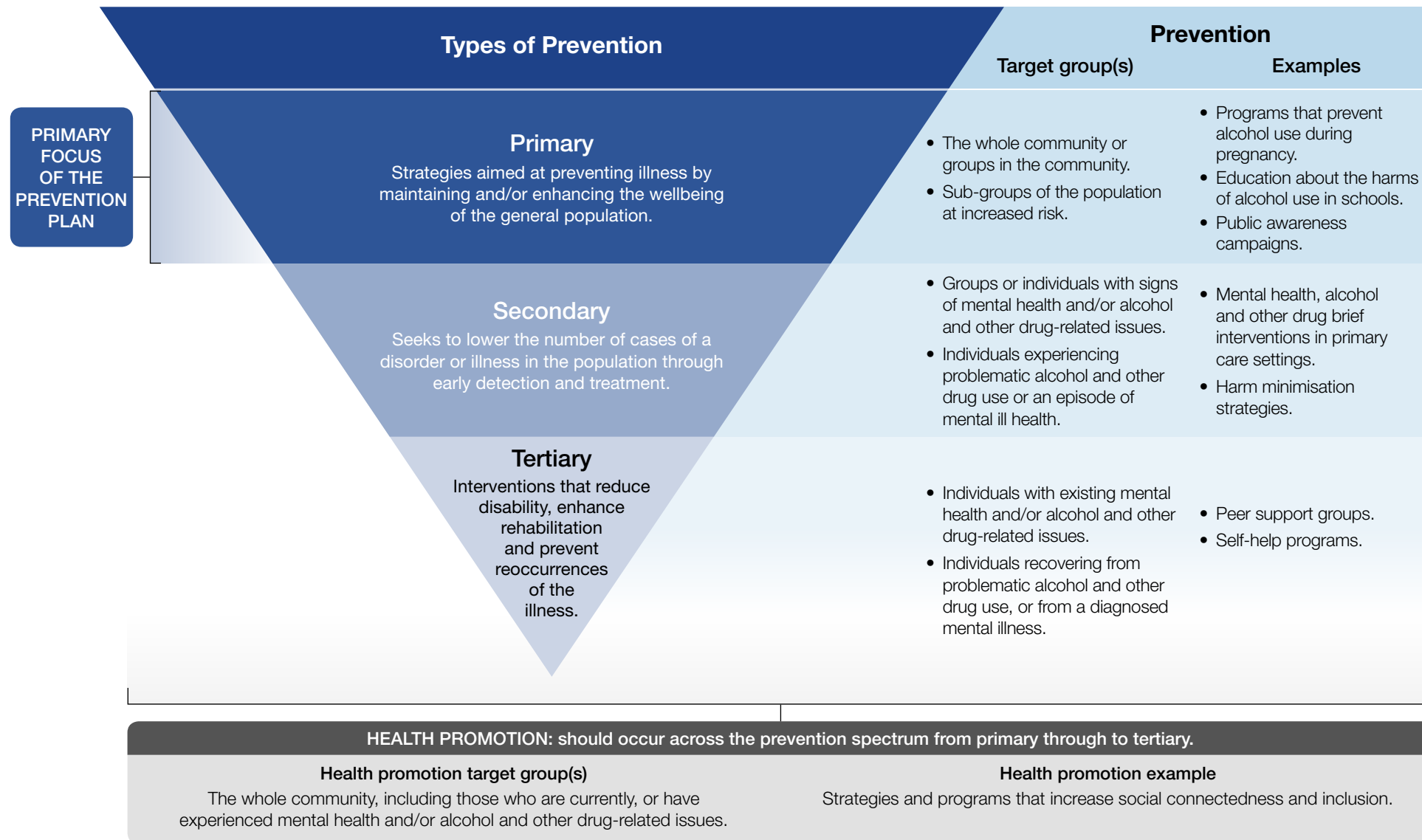
As demonstrated in **Figure 1**, prevention consists of three key components categorised as primary, secondary and tertiary prevention. Furthermore, health promotion activity can have a positive impact across the spectrum, from primary to tertiary prevention. Health promotion enables people to increase control over and improve their health, and addresses individual, social and environmental actions.

Figure 1 provides a pictorial representation of where this Prevention Plan fits within the prevention spectrum with its key focus being primary prevention and health promotion. Other health promotion and prevention models which separately address mental health and alcohol and other drugs are provided in **Appendix C**.

Depending on the prevention stage, different types of strategies can be implemented ranging from actions to promote health and prevent problems, through to actions to reduce the impact of already established problems. Target groups also differ based on the prevention stage. For example, actions can be targeted at the whole community, people at risk of experiencing problems and to groups or individuals who are already experiencing problems.

More information on health promotion and prevention can be found on the World Health Organization's website^{10, 11}.

Figure 1. Promotion and Prevention model



Why Prevention?

key facts



Alcohol is the most prevalent drug used in Western Australia and causes the most drug-related harm (excluding tobacco^v) in the community¹².



People in Western Australia were more likely to drink alcohol in quantities that placed them at risk of harm on a single occasion (at least monthly) than the national average in 2016 (27% in Western Australia compared to 25.5% in Australia)¹³.



In 2016, approximately one in 10 (11.6%) Western Australians had recently* used cannabis and approximately one in 40 (2.7%) had recently used amphetamines/methamphetamines¹⁴.



In 2016, people in Western Australia were more likely to use meth/amphetamines (2.7%) and ecstasy (3.2%) than other jurisdictions¹⁵.



Half of all mental illnesses emerge before the age of 14 years¹⁶.



One in five Australians aged 16 to 85 will be affected by a mental illness each year¹⁷.



Western Australia's suicide rate was approximately 20% higher than the national average in 2016 and has been consistently higher than the national average since 2007¹⁸.



In Western Australia, and nationally, suicide rates are consistently higher than motor vehicle deaths. Nationally, in 2016, 2,862 people died by suicide compared with 1,295 deaths by motor vehicle accidents. In Western Australia in 2016, 371 people died by way of suicide, almost twice the number of fatalities on Western Australian roads (196) for the same year^{19,20}.



Of all deaths from suicide globally, 22% can be attributed to the use of alcohol²¹.

Graphs 1, 2 and 3 provide data on the prevalence of mental illness by age group, alcohol use by age group and recent use of illicit drugs by age group respectively.

**Recent: used at least once in the previous 12 months.*

v. It is acknowledged tobacco causes the most drug related harm in the community, and is frequently used alongside alcohol and other drugs. There is also a high rate of tobacco use amongst people with a mental illness. Tobacco prevention activity occurs at the national and state level. State led activity is coordinated by the Western Australian Health Department and is addressed in the Western Australian Health Promotion Strategic Framework 2017 – 2021.

It is estimated mental health conditions cost Australian workplaces approximately \$11 billion per year through absenteeism, presenteeism (reduced productivity at work) and compensation claims²². Alcohol and other drug use costs the Australian community an estimated \$55.2 billion per year, of which 27.3% is attributed to alcohol and 14.6% is attributed to illicit drug use²³.

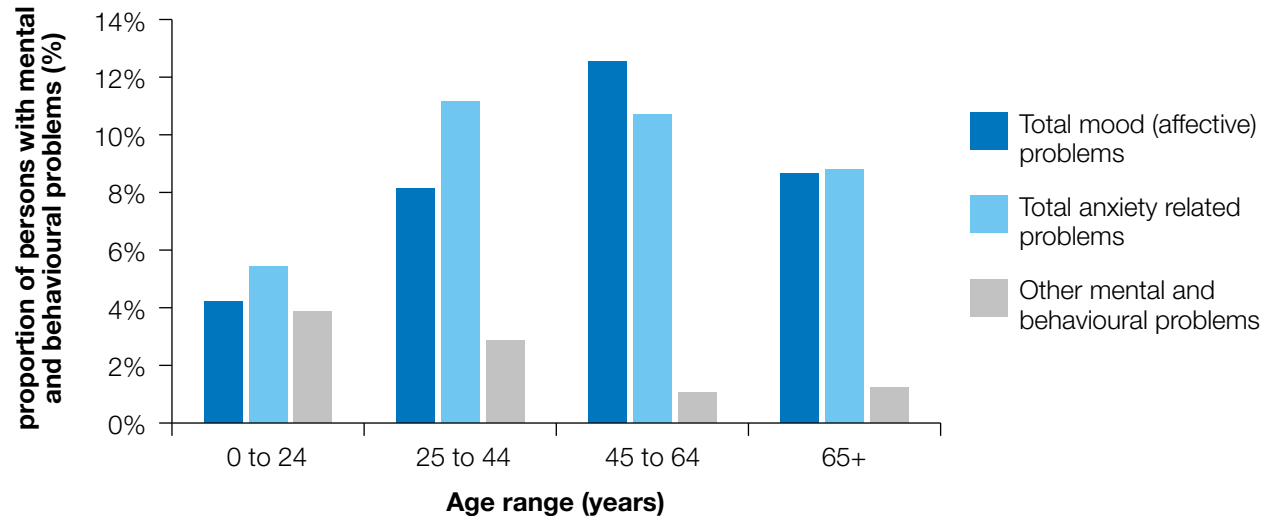
In Western Australia, it is estimated that the health, social and economic harms associated with alcohol use cost \$3.1 billion per year²⁴. In 2014, there were more than 19,400 hospitalisations in Western Australia attributable to alcohol, representing 113,549 bed days at a cost of over \$155 million²⁵.

Similarly, significant police resources are directed towards responding to mental health and/or alcohol and other drug-related issues such as anti-social behaviour, violence, child protection, drink driving, drug driving and other drug-related crime.

In 2006 it was established that 19.8% of the WA Police budget was spent responding to just alcohol-related matters²⁶. This equates to almost \$280 million in the 2017 financial year.

Investment in prevention not only improves an individual's and the population's quality of life, it also makes financial sense. According to a 2017 systematic review²⁷, assessing the return on investment across 52 public health interventions, for every \$1 spent on prevention there is a \$14 return on that investment. In other terms, for every \$1 invested in effective prevention initiatives, long-term financial savings of up to \$14 can be realised through reducing the need

Graph 1. Long-term^{vi} mental health or related conditions, Western Australia 2014-15³⁰



for treatment and other direct/indirect costs (for example, unemployment).

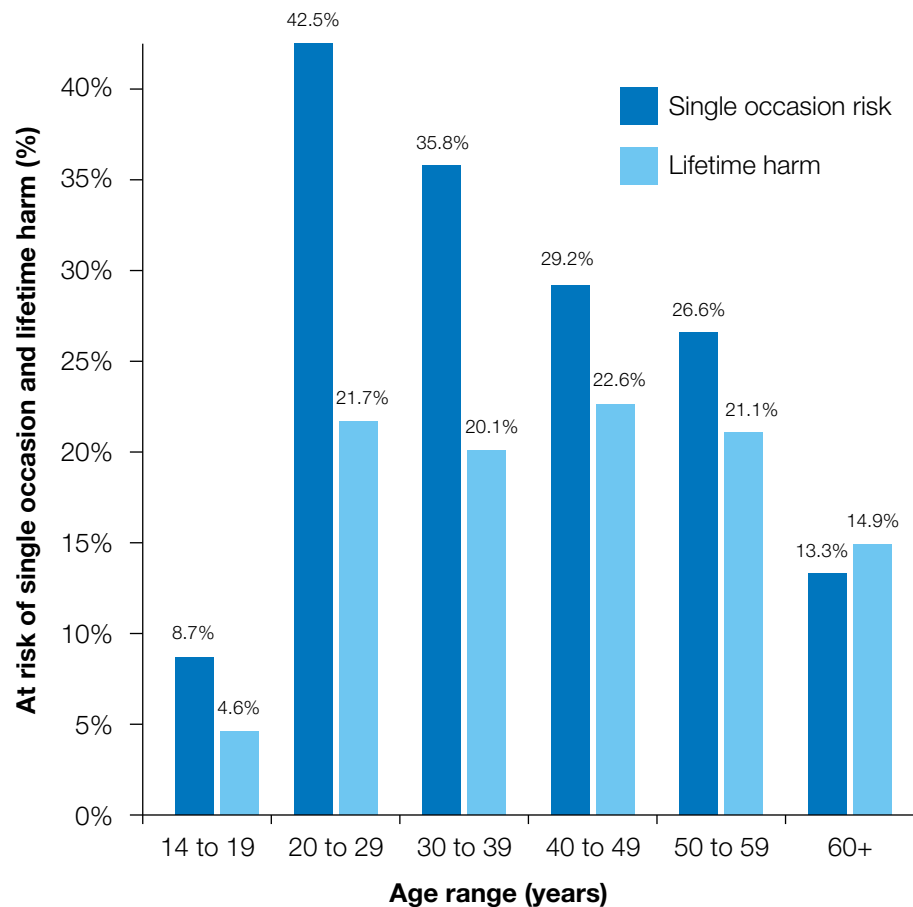
Currently the vast majority of funding is directed to costly services addressing the treatment of acute and chronic health problems. In 2016-17, approximately \$796.24 million was spent on mental health, alcohol and other drug treatment-related services (community treatment services, community bed-based services and hospital bed-based services) in Western Australia^{28, 29}. This equated to approximately 92% of the total 2016-2017 MHC budget.

As indicated in the Plan, approximately 2% of the MHC budget was allocated to prevention services dedicated to mental health in 2017, with an aim to increase this investment to 5% by the end of 2025. The Plan also indicates that for 2015, 108,000 hours were allocated to dedicated alcohol and other drug prevention activity with an aim to increase this to 208,000 hours by the end of 2025.

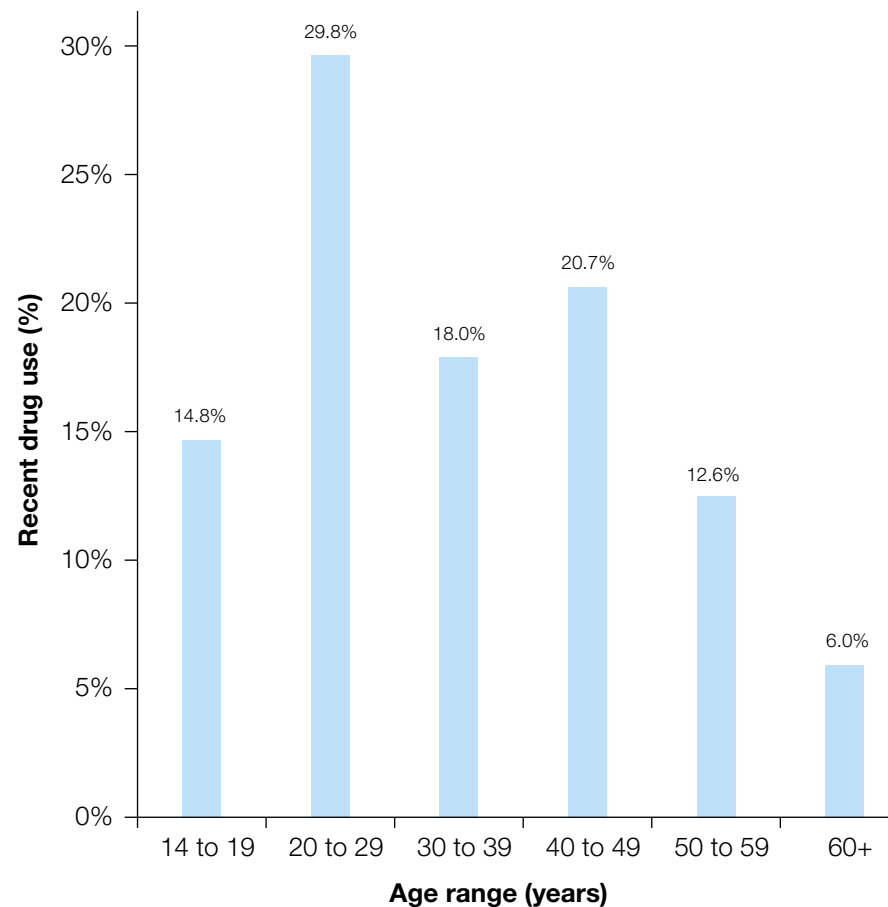
This Prevention Plan identifies a range of evidence-based prevention strategies that, when implemented, have the potential to improve lives and in the long-term, contribute to reducing direct and indirect costs to the economy.

vi. Persons who have a current mental health or related condition which has lasted, or is expected to last, for 6 months or more.

Graph 2. Western Australian alcohol drinking status and risk of harm by age group, 2016^{31, vii}



Graph 3. Recent use^{viii} in the last 12 months of any illicit^{ix} drug by age group, Western Australia, 2016³²



vii. Single occasion risk refers to having had more than 4 standard drinks on a single occasion at least once in the past year, and long-term risk of harm equates to having, on average, had more than 2 standard drinks per day in the last year.

viii. Recent use: used at least once in the previous 12 months.

ix. Illicit use of at least 1 of 17 drugs in the previous 12 months in 2013; the number and type of drug used varied between 2007 and 2013.

Examples of Current Promotion and Prevention Activity

Western Australia has a good track record with the prevention of alcohol and other drug-related harm. However, there is a need to build on coordinated mental health promotion and mental illness prevention programs whilst also maintaining effective prevention of alcohol and other drug-related issues.

Many of the prevention initiatives described in the Prevention Plan are already being implemented across Western Australia. In some cases, current programs could benefit from being refined or expanded. In other cases, identified gaps may highlight the need for new strategies and programs to be developed.

Examples of current initiatives include population-wide mental health promotion campaigns; mentally healthy workplace initiatives; alcohol and other drug public education campaigns; community action to prevent and reduce suicide attempts and suicide; community action and community development to prevent and reduce alcohol and other drug-related harm; and school health promotion programs.

In some cases, programs and initiatives may not be identified specifically as direct mental health promotion or alcohol and other drug prevention programs, but nevertheless are included as they can have a positive impact on mental health and can prevent mental health, alcohol and other drug-related issues. For example, home visiting programs for new families which aim to build protective factors and improve child and parent attachment can have a positive impact on the mental health of mothers and the future mental health of their children³³.

Prevention Challenges

The implementation of prevention is not without challenges. Below are some examples:

Financial pressures and long-term outcomes

Prevention activity, especially in difficult financial circumstances can receive less funding compared to other essential (and often costly) healthcare services. Prevention requires long-term, coordinated and sustained investment in order to see positive outcomes. Outcomes may also only be seen over the long-term. This can be less attractive to funding bodies, who may wish to see immediate or short-term outcomes.

Prevention not based on evidence

Uncoordinated, piecemeal or tokenistic prevention that is not informed by evidence can be ineffective. For example, raising awareness about a psychoactive substance that has recently entered the market can inadvertently attract people who may have otherwise not known about the substance.

Factors that Impact Mental Health and Alcohol and other Drug-related Harm

Determinants of Health

Our health is determined by a number of factors outside the health system, including our environment, the choices we make and broader social factors.

Social determinants of health can be defined as, *'the circumstances in which people grow, live, work, and age. The social determinants of health are mostly responsible for health inequities'*³⁴. Social determinants of health include socio-economic position, foundations built in early life, social exclusion, social capital, employment and work, housing and residential environment.

The physical environment also has the potential to influence our health. *'Safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions'*³⁵.

The strategies as identified in the Prevention Plan, whilst ultimately aiming to promote optimal health, and prevent mental illness and alcohol and other drug harms also have the potential to have a positive impact on a range of social and health issues. Conversely, it is acknowledged that social determinants and the physical environment have a significant impact on the occurrence of mental health, alcohol and other drug-related issues.

Although the Prevention Plan does include some strategies to address relevant social determinants and to improve the physical environment, a comprehensive list of strategies that positively impact social determinants of health and the physical environment is beyond the scope of the Prevention Plan.

Risk and Protective Factors

Risk and protective factors are factors that influence the likelihood of someone experiencing mental health and/or alcohol and other drug-related issues. The accumulation of risk factors can increase risk, while the presence of protective factors helps to reduce the impact of risk factors. However, it is important to acknowledge that if risk factors are present, it does not necessarily mean a person will experience mental health and/or alcohol and other drug-related issues. Similarly, a person may still experience mental health and/or alcohol and other drug-related issues, even if there are multiple protective factors present in the person's life. Risk and protective factors are not simply opposites of each other. The factors can operate at the individual, community and/or structural level and can also interact.

Figure 2 and **Figure 3** provide examples (not an exhaustive list) of key risk and protective factors for mental health and/or alcohol and other drug-related issues, as reported in literature^{36, 37, 38, 39}.

Figure 2. Examples of risk factors for mental health and/or alcohol and other drug-related issues

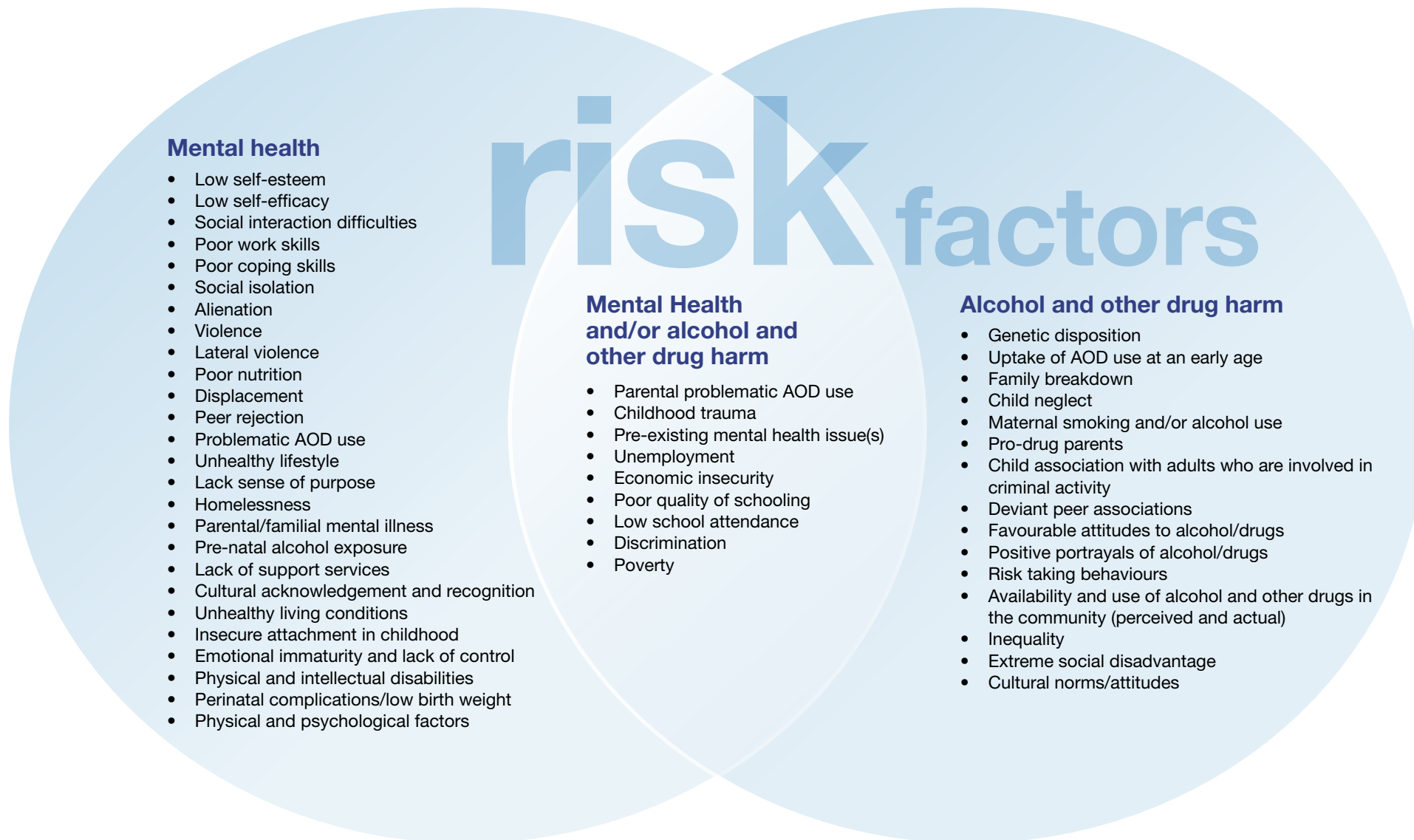


Figure 3. Examples of protective factors for mental health and/or alcohol and other drug-related issues



The Prevention Plan

Goals

The Prevention Plan aims to provide an evidence-based and evidence-informed guide for Commonwealth and State government agencies, Local Governments, non-government organisations and communities to guide investment, development, implementation and evaluation of promotion and prevention activities.

The goal of the Prevention Plan is to build upon and/or continue to implement a range of programs that will:

- increase optimal mental health and wellbeing;
- reduce the incidence of mental illness, suicide attempts and suicide; and
- prevent and reduce drug use and harmful alcohol use.

Principles

The following principles underpin the content and strategies contained within the Prevention Plan. Where appropriate, these principles are complementary and/or aligned to the principles identified in the Plan. Principles that relate more specifically to prevention are also included^x.

Principle 1: Mental health promotion and the primary prevention of mental illness and alcohol and other drug use/harm are the principal focus

Promotion and primary prevention actions target the whole community and groups at high-risk. Where relevant, reference is made to the importance of secondary prevention and tertiary prevention, but these are not the main focus of the Prevention Plan. Secondary and tertiary prevention strategies predominantly occur in primary care and other treatment services. It is, however, important that relevant health promoting initiatives are incorporated in treatment settings where possible.

Principle 2: Programs and initiatives are essential across the life course

Effective prevention starts at pre-conception and continues throughout life. Investing in promotion and prevention activities targeting the pre-conception, infancy, childhood and adolescent life are particularly important to improve health outcomes in later life as many mental health issues begin before the age of 14 years. The Prevention Plan includes strategies targeting specific life stages as well as strategies that have an impact across all life stages.

x. The Perth Charter for the Promotion of Mental Health and Wellbeing also includes important information regarding key principles for promoting mental health and wellbeing, with a focus on integrating physical and mental health promotion. The Perth Charter can be accessed here: https://espace.curtin.edu.au/bitstream/handle/20.500.11937/22737/196524_196524.pdf?sequence=2

Principle 3: A combination of whole-of-population, localised and targeted programs and initiatives are necessary

Whole-of-population prevention approaches, such as public education and awareness raising campaigns or policies to support the creation of healthy environments, have the greatest impact broadly upon the population's mental health and/or alcohol and other drug-related harm⁴⁰.

Localised and targeted initiatives have the greatest potential for positive impact when they are

The Strategy Of Preventive Medicine

Originally identified by Geoffrey Rose⁴¹, the "prevention paradox" refers to the observation that a large number of people at a small risk may give rise to more cases of a disease than the small number who are at a high risk.

Whole-of-population level interventions aim to reduce the exposure of risk factors across the population and therefore have the potential to prevent a larger number of cases than interventions targeted at high-risk populations. However, prevention programs targeting people at high-risk aim to protect susceptible individuals or groups of individuals and are also needed⁴².

The Prevention Plan prioritises whole-of-population level interventions, and encourages targeted interventions where there is evidence to support effectiveness.

co-produced with the targeted communities and are supported by a whole-of-population approach. It is important that co-production with communities focus on implementing evidence-based and evidence-informed action that can make a positive and sustainable improvement to the identified issues/priority groups.

To strengthen the potential impact of localised and targeted initiatives, messaging should be consistent with existing evidence-based state-wide public education campaigns (for example through the provision of community toolkits and resources) whilst promoting relevant existing local services and supports, and is an example of how state-based programs can be implemented and promoted at a local level.

An example of a tailored program for a specific priority group/population can include working with Aboriginal peoples to develop a social and emotional wellbeing program that addresses the specific needs of individuals in the community, including promoting connection to body, mind and emotions, family and kinship, community, culture, language, country, spirit, spirituality and ancestors.

Principle 4: Programs and initiatives are evidence-based (or evidence-informed)

Programs and initiatives are designed and produced on the basis of evidence of what does and does not work. This will ensure resources are allocated efficiently and effectively. Where evidence is not directly available, programs are informed by evidence and best practice methods in similar fields and their effectiveness should

be evaluated. To build the evidence base for effective promotion and prevention, continual development, implementation and evaluation of existing and future initiatives is important.

Principle 5: Programs and initiatives involve multiple strategies at local, state and national levels

In prevention, single isolated strategies are not as effective as implementing multiple complementary strategies. Implementing multiple strategies can also assist in mitigating any risks or unintended consequences of single isolated strategies. Complementary strategies can include education strategies, community action and legislative changes that when implemented together can make a substantial difference. It is also important that strategies are implemented across sectors, and at multiple levels, including nationally and at the state and/or local level. For example, effectively reducing harmful alcohol consumption can be impacted by a range of initiatives such as legislation (for example, drink driving limit of 0.05), regulation (for example, Commonwealth excise; opening hours), education campaigns to raise community awareness and prompt behaviour change (for example, public health campaigns promoting the risks and harms associated with alcohol consumption) and local community action mobilising communities to implement locally relevant initiatives⁴³.

Principle 6: Innovation supported by robust evaluation is strongly supported

There are some areas where the research evidence is scarce or still developing (for example, initiatives utilising online tools and resources). Promoting evidence-informed innovation and robust evaluation assists building evidence, which in turn enables new approaches to be implemented. Staying abreast of new and emerging evidence by collecting and analysing data, keeping up with technological changes and adapting programs where relevant will enable innovation.

Principle 7: Partnerships, collaboration, co-design and stakeholder participation are essential

Promotion and prevention activities often occur in non-health settings. Therefore, close working relationships are essential between government, private and non-government sectors, research institutions, communities and identified target groups.

Accessibility and inclusivity of prevention plan strategies

It is important that the implementation of whole-of-population and universal strategies, prevention programs and initiatives as recommended in the Prevention Plan are inclusive and accessible to diverse and priority population groups. Inclusive whole-of-population programs, as well as targeted programs are important in achieving health equity for at-risk groups and priority populations within the Western Australian community.

Effective prevention requires establishing consensus between key groups regarding their common goal(s). Forming a coalition of supportive individuals and agencies is essential and can assist with coordinating activities to reach the common goal(s). Facilitating co-production and co-design with the community can ultimately lead to increased relevance of prevention activities and greater community ownership.

Principle 8: Valuing diversity, equity, cultural inclusivity and human rights is a priority

The Western Australian population is diverse, and prevalence of mental health, alcohol and other drug-related issues is skewed. Certain groups in the community (for example, Aboriginal peoples and LGBTIQ+ communities) are disproportionately impacted by mental illness and alcohol and other drug-related harm. Consideration of diversity, equity, cultural inclusivity and cultural security is therefore paramount. Development of, and adaptations to, programs co-produced with community members may be required in some circumstances, to ensure all community groups feel included and can attain intended benefits.

Important cultural concepts

Acknowledging and understanding the historical impact of colonisation upon Aboriginal peoples' physical, spiritual, and social and emotional wellbeing is vital⁴⁴. To build on Aboriginal people's strength and resilience, projects include connection to land, culture, spirituality, ancestry, family and community, self-determination and community governance.

Cultural competence: Development of knowledge, skills and awareness that will enable healthcare providers to work competently in culturally diverse situations, including being aware of one's own world view, developing positive attitudes towards cultural differences and gaining knowledge of different cultural practices and world views.

Cultural security: Cultural security is a guiding principle to ensure the respect of the cultural rights, values, beliefs, and expectations of the variety of cultural groups in Australia and Aboriginal peoples in particular. A culturally secure approach is essential when developing programs, services, policies and strategies to ensure programs are accessible and effective⁴⁵.

An example of a culturally secure project includes the Strong Spirit Strong Future campaign⁴⁶ which aims to improve awareness among Aboriginal people, families and communities in metropolitan, regional and remote Western Australia of the harms associated with alcohol use in pregnancy to prevent the occurrence of Fetal Alcohol Spectrum Disorder.

The WA Aboriginal Health and Wellbeing Framework 2015-2030⁴⁷ is also a valuable guiding tool for the improvement of health and wellbeing for Aboriginal peoples in Western Australia.

Life Stages and Domains for Action

The strategies contained within the Prevention Plan fall broadly under the five domains below, which are based on the Ottawa Charter for Health Promotion⁴⁸. Action is required across these domains and the relevant life stages to achieve significant and sustained change. A key factor in the success of implementing strategies under each of these domains is establishing community and key stakeholder support for the need for change.

Whilst some strategies are appropriate across all life stages, others are best targeted at specific life stages. Strategies for each life stage are not necessarily identified for all five domains, but rather focus on the key strategies that evidence suggests will have an impact. This should not deter agencies, organisations and/or communities from developing their own strategies for domains not addressed in the Prevention Plan, and evaluating their effectiveness to build the evidence base.

It is acknowledged that there are many promotion and prevention initiatives being implemented in the community that may not have an evidence-base, but have a positive impact in promoting mental health and preventing mental health and/or alcohol and other drug-related issues. Continual development, implementation and evaluation of these initiatives is very much encouraged and supported.

xi. This life stage is included, as opposed to a "youth" category, due to the tendency for many primary prevention programs to be implemented in school-based settings, or to be targeted at school-aged children. In addition, alcohol and other drug prevention programs differ depending on whether they target the under 18 age group, or the over 18 age group, due to the legal drinking age of 18 years.

Life Stages

Across the life course

A range of programs and strategies can have a positive impact across all life stages. Many of the strategies described can influence the health of the whole population and/or local communities. Collaboration and partnership across a range of sectors is required to successfully implement these strategies.

Perinatal and early years

The perinatal and early years life stage encompasses the period from conception to prior to a child starting formal schooling (approximately three or four years-of-age). This is a critical stage which can influence future mental health and wellbeing. It is also a stage where future alcohol and other drug-related issues can be minimised. Dedicated programs for this life stage are essential to prevention and focus on:

- supporting mothers to cease alcohol and other drug use during pregnancy;
- achieve good health and wellbeing during pregnancy and post-natally;
- promote a secure attachment between the primary care giver and child;
- support effective parenting;
- reduce social isolation; and
- increase protective factors such as education, employment, safe and secure housing and help-seeking.

Children and young people^{xi}

This life stage encompasses the period when a child starts formal schooling (approximately three or four years-of-age), through to 18 years-of-age. These foundational years provide an opportunity to build key social and emotional competencies which promote optimal mental health and prevent alcohol and other drug use. Effective programs that are implemented at this life stage have the potential to set a child or young person up for a fulfilling, satisfying and contributing life.

Promoting positive environments and developing appropriate skills through evidence-based social and emotional learning programs is especially important during this life stage. For example, environments that minimise alcohol availability and alcohol promotion are important in framing the young person's expectations of alcohol use especially given that navigation of risky alcohol use begins in this life stage.

Specific strategies relevant to this life stage include whole of school programs that develop skills in key protective social and emotional competencies. This can include promoting resilience, coping strategies, positive body image, effective problem solving, help-seeking behaviour, and increasing age appropriate knowledge and skills in managing issues related to mental health, alcohol and other drug use. These skills can act as strong protective factors for children and young people when body image concerns, sexual orientation, relationship issues, bullying and social media use can have a significant impact on mental health and present and future alcohol and other drug use, including the potential for self-medication with alcohol and other drugs.

Adults

A range of life changes and challenges can occur during adulthood, such as raising children, caring for older parents, employment and/or unemployment problems and financial difficulties. It is also a time when a person is at greatest risk of being impacted by alcohol and other drug-related issues. For example, recent data suggests the prevalence of adults in the 50-59 year age group consuming more than 11 standard drinks in a single drinking occasion in the past 12 months has significantly increased from 9.1% in 2013 to 11.9% in 2016⁴⁹.

Many of the programs and strategies discussed in the 'Across the Life Course' section are likely to have positive impacts on the adult population's health and wellbeing. Programs that are particularly relevant to the adult population include those targeting workplaces, parents, online programs and programs to support people to return to work or gain employment.

Older adults

The proportion of the population aged over 65 years is increasing, and will continue to increase into the future. Supporting the attainment of optimal mental health and wellbeing and preventing alcohol and other drug harm is important to ensure older adults are able to continue to live a satisfying and contributing life. Many of the programs and strategies that target other life stages will have a positive impact on older adults. In addition, evidence suggests targeted programs for older adults at risk are also important. While older adults generally have better mental health than the general population, older people in residential care settings experience

mental illness at a significantly greater rate than the general population^{50,51}. There is also an increasing prevalence of harmful drinking among people aged 65 and over⁵². Older people may have a lower physical tolerance for alcohol, and alcohol may exacerbate other health conditions or interact with prescription medications⁵³.

Domains for Action

Domain 1: Building healthy public policy

There is a role for policy makers from all sectors to consider how decision making can impact mental health and alcohol and other drug-related harm. This can include identifying obstacles to optimal mental health and reducing alcohol and other drug related harm in non-health sectors. For example, the introduction of mental health and wellbeing policies and practices into occupational health and safety requirements, and the introduction of legislation and policy to reduce harmful alcohol consumption including the introduction of policies that can influence alcohol pricing, availability and promotion⁵⁴.

Domain 2: Creating and maintaining supportive environments

The interaction between people and their environment can have a significant impact on mental health and alcohol and other drug-related harm^{55,56,57}. All environments, including homes, communities, schools, workplaces, and social and cultural networks and settings provide opportunities to promote optimal mental health and reduce alcohol and other drug use and related harm. For example, prevention initiatives

can be focussed on creating supportive workplaces that promote optimal mental health and reduce alcohol and other drug use and related harm. Schools, sporting clubs and prisons are also settings where mentally healthy initiatives and alcohol and other drug prevention activities can be implemented.

Domain 3: Strengthening communities to take action

Increasing a community's capacity and involving them in decisions that impact them will increase the likelihood of ownership, empowerment and project sustainability. Development of localised approaches to implementing state-based plans can also enable more effective implementation of prevention strategies. To strengthen communities to take action there is a need to understand the key issues impacting the community, establish consensus with community members regarding the priority issues that need to be addressed, raising awareness and increasing support for effective evidence-based strategies, and working with the community to implement effective action. Examples can include working with local governments and communities to develop and implement prevention plans that reduce community risk of experiencing mental health and/or alcohol and other drug-related issues.

Domain 4: Developing personal skills, public awareness and engagement

Providing people with knowledge and tailored skills is a key step in enabling increased personal control over health. Challenging attitudes, beliefs and misconceptions as well as increasing awareness and support for healthy public policy are also key elements of this domain. Strategies include (but are not limited to) public health awareness raising campaigns, education strategies to increase support for effective policy, parenting programs and school-based health promotion.

Domain 5: Reorienting and maintaining relevant programs and services

The responsibility to provide high quality mental health promotion, mental illness, alcohol and other drug prevention is shared across a number of sectors including health professionals, community groups, government and non-government agencies. It is important that all these sectors work in collaboration and towards a common goal. In order to re-orient a program or service to be proactive in the prevention area, a thorough understanding of key research and evidence is necessary, as is an understanding of gaps and duplication in service delivery. Once baseline information is well understood by key stakeholders, an agreed strategic approach to effecting change and re-orienting the service(s) is required. This may involve initiatives such as (but not limited to) the development of policies, guidelines, referral pathways and staff training.

An example includes working with primary care and frontline health workers to promote early identification, intervention and screening programs to prevent and reduce alcohol use during pregnancy.

Strategies

Promotion and prevention initiatives are important in addressing mental health, alcohol and other drug-related issues which frequently co-occur and are often associated with other health and social issues. The strategies provided are intended to promote mental health and prevent mental health, alcohol and other drug-related issues, including at times when they co-occur. Various case studies are provided in **Appendix D**.

The Prevention Plan strategies are grouped by the life stage in which they are implemented, and are further categorised based on the relevant domain of action being addressed. Strategies are not identified under all domains for action for each life stage, but rather focus on the key domains and strategies that evidence suggests will have an impact. This is not to say that these strategies will not have an impact on other domain areas or that additional strategies could be developed and evaluated for their effectiveness in different domains.

It is also acknowledged that whilst the following strategies have been grouped by the identified life stages, there may be strategies that overlap across age groups. For example, the youth cohort may benefit from strategies within both the 'Children and Young People' and 'Adult' life stages.

Across the Life Course

Action Domain	Strategies
<p>Building healthy public policy</p>	<ul style="list-style-type: none"> • Support the implementation and enforcement of relevant legislative and control measures to reduce the harms associated with alcohol and other drug use such as, through regulatory initiatives targeting price, availability (including opening hours), promotion and products. • Introduce new evidence-based policies and legislation that can reduce alcohol-related harm, including (but not limited to) a national approach to alcohol taxation and minimum alcohol pricing; alcohol advertising controls and/or bans; and outlet density restrictions. • Incorporate the promotion of optimal mental health and prevention of alcohol and other drug related harm in health promotion programs targeting other health issues, such as physical health and nutrition. Health promotion programs that target high-risk groups such as those with chronic pain and physical ill-health should also be a key focus for the promotion of optimal mental health and reducing alcohol and other drug-related harm. • Build upon the achievements made in suicide prevention (including through Suicide Prevention 2020), through: <ul style="list-style-type: none"> – evaluating the effectiveness of existing strategies and the achievement of outcomes; – re-visiting the evidence-base to identify new strategies; and – aligning suicide prevention activities with general prevention strategies, where relevant. • Continue to implement, monitor and evaluate national and state government initiatives regarding meth/amphetamine demand, supply and harm. • Collaborate with, and promote communication and partnership between, relevant government and non-government agencies to ensure social determinants of health (including mental health) are adequately addressed, such as safe and secure housing; accessible education and training; employment; financial security; and safe and healthy environments that promote connection with nature. • Examine the need for legislation to declare management areas^{xii} to prevent and reduce harm resulting from volatile substance use (VSU). • Seek to form responses to new psychoactive substances including but not limited to, initiatives to improve: <ul style="list-style-type: none"> – detection and identification of psychoactive substances; – monitoring and associated data collection systems; – standardised harm assessment processes; – rapid responses to new psychoactive substances entering the market; – the standard approach to equivalent psychoactive substances; and – control approaches, such as including a reverse onus of proof for manufacturers to prove that substances are not harmful. • Monitor emerging evidence, for example, new and emerging psychoactive substances, research on nutritional medicine and neuroscience, and consider its potential to influence prevention.

xii. A management area refers to a local geographical area which communities can apply to gain legal recognition of locally-specific laws relating to the possession, supply and use of volatile substances.

Continued next page

Across the Life Course *(continued)*

Action Domain	Strategies
<p>Creating and maintaining supportive environments</p>	<ul style="list-style-type: none"> • Develop and/or implement whole-of-population prevention initiatives that: promote participation in local community activities; increase the sense of belonging within a community; provide appropriate mental health and alcohol and other drug information; encourage commitment by community organisations to participate in prevention activities; and build capacity of organisations to plan and implement their own prevention activities. The programs should aim to achieve key outcomes such as: <ul style="list-style-type: none"> – increased social connectedness and inclusion; – increased community networks; – increased mental health and alcohol and other drug literacy; – increased connection to the natural environment; – increased help-seeking behaviours; – improved nutrition and physical activity; – reduced harmful alcohol use; – delayed early uptake of alcohol and other drug use amongst young people; and – reduced mental health, alcohol and other drug-related issues. • Expand existing and develop new interventions that promote social inclusion and reduce the stigma associated with mental and/or alcohol and other drug-related issues. This can involve: <ul style="list-style-type: none"> – education, mass communication and sponsorship initiatives utilising effective, market tested key messages and/or branding. Priority target groups can include young males, health professionals, Aboriginal peoples, family and friends, employers, politicians, media, carers and community groups (for, example schools); – community engagement and partnership initiatives that promote social inclusion, shift stigmatising attitudes and beliefs, and dispel myths and misconceptions; and – advocacy targeting the media to encourage appropriate reporting. • Create a culture and related environment that supports low-risk drinking, discourages short-term and long-term harmful drinking, and reduces harm related to other drugs for example, through continuing or expanding: <ul style="list-style-type: none"> – legislation and regulation; – safer event initiatives (for example, providing chill out spaces, food and free water); – Local Government alcohol management support; – programs to reduce harmful alcohol use and exposure in various settings (for example, sporting clubs, schools and workplaces); – co-ordination of Leavers WA initiatives; – alcohol and other drug workplace policies; and – initiatives that promote the separation of alcohol sales, consumption and promotion from child focussed activities.

Continued next page

Across the Life Course *(continued)*

Action Domain	Strategies
<p>Creating and maintaining supportive environments <i>(continued)</i></p>	<ul style="list-style-type: none"> • Continue to support state-wide VSU prevention strategies such as: <ul style="list-style-type: none"> – education for families, community members, service providers and retailers in affected communities; – outreach visits or night patrols targeting identified hot spots; – developing protocols to improve communication between local service providers; and – providing alternative activities for young people (for example, recreation, school, employment).
<p>Strengthening communities to take action</p>	<ul style="list-style-type: none"> • Develop localised prevention plans in metropolitan and regional Western Australia that include a range of effective strategies, such as: <ul style="list-style-type: none"> – community mobilisation and community development actions; – activities to support and increase social connectedness, social inclusion and resilience; – suicide prevention actions; – local support for enforcement of relevant laws (for example, secondary supply laws); – harm reduction strategies; – programs targeting harmful alcohol and other drug use (including underage alcohol use); – responsible service of alcohol (RSA) initiatives (for example, RSA training and refresher courses); – mechanisms to promote state-wide education messaging and increase support for effective alcohol control measures; and – industry and retail supply programs to prevent VSU (in high risk/prevalence communities). • Support organisations and communities to initiate and be involved in effective localised community action to promote mental health and prevent mental health, alcohol and other drug-related issues. • Involve consumers, families, carers and supporters of those with lived experience of mental health and/or alcohol and other drug-related issues in the development and implementation of prevention activities. • Support and promote liaison between consumer, family and carer organisations with mental health and alcohol and other drug service providers for the provision of promotion and prevention initiatives.

Continued next page

Across the Life Course *(continued)*

Action Domain	Strategies
<p>Developing personal skills, public awareness and engagement</p>	<ul style="list-style-type: none"> • Support and expand the scope of whole-of-population (including public education campaigns) and targeted education strategies, including sponsorship where relevant, to: <ul style="list-style-type: none"> – increase mental health literacy; – increase help-seeking behaviour; – increase understanding and action relating to attaining and maintaining optimal mental health; – promote resilience; – increase community awareness of the impacts of harmful alcohol use (see breakout box, page 32), use of licit and illicit drugs; and – increase individual and community support for evidence-based policy. • Support and continue to develop advocacy groups to raise community and key stakeholder awareness of, and support for, evidence-based prevention policies and strategies, including (but not limited to): <ul style="list-style-type: none"> – mandatory school curriculum-based mental health promotion and alcohol and other drug prevention programs; – mentally healthy workplace policies, standards and assessments; – policies that reduce stigma and promote social inclusion; – alcohol advertising regulation; – reducing alcohol availability that has the potential to contribute to harm, for example, through control of outlet density; – volumetric alcohol taxation and a minimum floor pricing per unit of alcohol; and – measures that delay uptake and reduce harmful alcohol consumption amongst young people. • Deliver education to respond to emerging drugs of concern. • Deliver targeted education to increase the reach of key messages to specific population groups including but not limited to Aboriginal peoples, culturally and linguistically diverse groups, youth and pregnant women. • Through the media, and broader stakeholder communications, support the communication of appropriate and supportive alcohol and other drug, mental illness and suicide reporting to reduce stigma, promote social inclusion and reduce community misconceptions. • Advocate for the national development and implementation of a real time online tool for prescribing and dispensing data^{xiii}.

xiii. Information sharing sensitivities need to be taken into account when educating relevant staff, and requires input across all levels of government.

Continued next page

Across the Life Course *(continued)*

Action Domain	Strategies
<p>Developing personal skills, public awareness and engagement <i>(continued)</i></p>	<ul style="list-style-type: none"> • Educate prescribers, dispensers and other relevant staff and stakeholders about responsible dispensing practices in relation to potentially harmful medications. • Further investigate effective and innovative new and emerging methods of delivering whole-of-population and targeted evidence based prevention programs (for example, online initiatives). • Improve community access to reliable mental health, alcohol and other drug information and support services (for example, through phone-based and online interaction).
<p>Reorienting and maintaining relevant services</p>	<ul style="list-style-type: none"> • Ensure workforces are knowledgeable about promotion and prevention models, and take action to support and/or deliver promotion and prevention initiatives where appropriate. • Establish evidence-based brief intervention programs in primary care settings targeting mental health and/or alcohol and other drug-related issues. Brief interventions can include: <ul style="list-style-type: none"> – assessment of the client’s mental health and/or alcohol and other drug use; – feedback from the assessment; – advice or information about how to reduce alcohol and other drug related harms and/or improve mental health; – assessment of, and feedback about the client’s readiness to change; – problem solving; – goal setting; – alcohol and other drug relapse prevention; and – follow up. • Support relevant agencies to collect, monitor and share reliable data, to underpin prevention activity, policy and workforce development. • Encourage treatment services to incorporate relevant prevention messages wherever possible.

Australian Guidelines to reduce health risks from drinking alcohol

“Alcohol is responsible for a considerable burden of death, disease and injury”⁵⁸. Many Australians drink alcohol at levels that increase their risk of alcohol-related harm.

The National Health and Medical Research Council’s (NHMRC) Australian Guidelines to Reduce Health Risks from Drinking Alcohol (NHMRC Guidelines) provide evidence-based advice for health professionals, policy makers and the Australian community on the health effects of alcohol consumption.

The NHMRC Guidelines provide four guidelines for reducing the risk of alcohol-related harm:

1. For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.
2. For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.
3. a) Parents and carers should be advised that children under 15 years-of-age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important.
b) For young people aged 15–17 years, the safest option is to delay the initiation of drinking for as long as possible.
4. a) For women who are pregnant or planning a pregnancy, not drinking is the safest option.
b) For women who are breastfeeding, not drinking is the safest option.

Perinatal and the Early Years (0-3 years old)

Action Domain	Strategies
<p>Building healthy public policy</p>	<ul style="list-style-type: none"> • Collaborate with, and promote communication and partnership between, relevant government and non-government agencies to ensure factors impacting the health of young families, infants and children are adequately addressed.
<p>Developing personal skills, public awareness and engagement</p>	<ul style="list-style-type: none"> • Provide a comprehensive perinatal program (or suite of programs) for at-risk families, that target areas such as (but not limited to): <ul style="list-style-type: none"> – effective family planning; – participation in employment and/or education; – good nutrition; and – no alcohol use in pregnancy. • Deliver interventions that promote secure parent and child attachment and encourage positive parenting, particularly for families at high risk. Interventions should: <ul style="list-style-type: none"> – increase parents’ mental health, wellbeing and protective factors; – build strong, healthy relationships; – increase parents’ confidence in positively managing child behaviour; – include information and initiatives relating to good nutrition and physical health; – target a variety of settings, such as community centres and in the home; and – involve professionals, peer workers and volunteers where appropriate. • Deliver multi-faceted programs (or suite of programs) that promote optimal mental health, wellbeing and resilience of young children. Programs should: <ul style="list-style-type: none"> – target a variety of settings, such as day care centres and kindergartens; – work with families to support the development of young children’s social and emotional skills; and – include staff where appropriate (for example, day care staff, early childhood teachers) to develop strategies that promote and support young children’s mental health and wellbeing.

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Perinatal and the Early Years (0-3 years old) *(continued)*

Action Domain	Strategies
<p>Developing personal skills, public awareness and engagement <i>(continued)</i></p>	<ul style="list-style-type: none"> • Implement effective alcohol and other drug prevention interventions targeting women of child-bearing age (particularly pregnant and breastfeeding women) through a range of broad-based and targeted activities, such as: <ul style="list-style-type: none"> – education and awareness raising school-based programs and campaigns to increase knowledge of risks associated with alcohol and other drug use during child-bearing age, particularly pregnancy and breastfeeding; – increasing support for broad based alcohol control measures in the community; – education and training for key professional groups to increase their knowledge of the impact of alcohol and other drug use during pregnancy; – promotion of routine identification and intervention with women of child-bearing age (particularly pregnant women) who are using alcohol and other drugs; and – brief interventions in primary care settings.
<p>Reorienting and maintaining relevant services</p>	<ul style="list-style-type: none"> • Through relevant education agencies and organisations, such as the Department of Education, advocate for the implementation of effective, targeted educational support programs for at-risk young children (prior to commencing formal schooling).

Children and Young People (4-17 years old)

Action Domain	Strategies
<p>Building healthy public policy</p>	<ul style="list-style-type: none"> • Support key supply, demand and harm reduction policies and regulations to reduce alcohol and other drug-related harm, such as: <ul style="list-style-type: none"> – reducing alcohol advertising in places frequently seen by children and young people, such as public transport, sporting events and in social media; – implementing strategies to reduce or delay uptake of alcohol and other drugs, including limiting the secondary supply of alcohol to young people and implementing public education campaigns; – developing comprehensive VSU plans in regions prone to use; and – providing peer education. • Continued support by evidence-based organisations for whole-of-school approaches to mental health, wellbeing, alcohol and other drug education that promotes meaningful student involvement and include programs and strategies to address issues such as bullying, discrimination and risks associated with suicide and/or self-harm and which prevent, reduce and manage alcohol and other drug use.
<p>Creating and maintaining supportive environments</p>	<ul style="list-style-type: none"> • Provide whole-of-school plans that include measures to address harmful alcohol and other drug use by students, including provision of evidence-based alcohol and other drug education. • Advocate for all school-related events where school-aged children and young people are present to be alcohol-free. • Encourage organisations and services to become child safe and child friendly^{xiv}. • Encourage local communities to provide appropriate community initiatives that support mental health and wellbeing, and prevent alcohol and other drug-related issues amongst children and young people (for example, alcohol-free community events, sporting and cultural programs).

xiv. For example, see the Commissioner for Children and Young People WA Guidelines for Child Safe Organisations: <https://www.ccp.wa.gov.au/media/2154/child-safe-organsiations-wa-guidelines.pdf>

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Children and Young People (4-17 years old) *(continued)*

Action Domain	Strategies
<p>Developing personal skills, public awareness and engagement</p>	<ul style="list-style-type: none"> • Deliver whole-of-school and community-based multi-faceted programs that promote optimal mental health, wellbeing and resilience of young people and provide age appropriate alcohol and other drug education and practical skill development. School-based programs should link to the Western Australian Curriculum, be mandatory and provide appropriate training and support for teaching staff. Programs should reflect evidence-based best practice and include content to: <ul style="list-style-type: none"> – increase protective factors through the development of key skills and knowledge; – promote meaningful involvement of children and young people in decisions that affect them; – address the safe use of social media; – appropriately utilise a variety of platforms (for example, social media) to promote optimal mental health, and prevent early uptake and harm associated with alcohol and other drug use; – provide stress reduction initiatives; – promote family harmony and conflict management; – involve parents and staff; and – engage hard to reach groups. • Incorporate evidence-based training in positive behaviour support for relevant staff development activities (for example, for teachers, child and health staff) to provide for students with anxiety, trauma and/or attention-based needs. • Develop targeted evidence-based online prevention programs that can increase protective factors and decrease risk factors for at-risk groups (for example, youth programs focusing on increasing protective factors such as employment and coping skills).
<p>Reorienting and maintaining relevant services</p>	<ul style="list-style-type: none"> • Ensure early intervention services are provided for children and young people showing early signs of mental health issues and experiencing alcohol and other drug-related harm. This may include: <ul style="list-style-type: none"> – early psychosis interventions; – brief interventions for young people using alcohol and other drugs; – early identification of children whose parents have mental health and/or alcohol and other drug-related issues; and – collaboration with school-based services to promote and improve help seeking and referrals.

Adults (18 – 65 years old)

Action Domain	Strategies
<p>Building healthy public policy</p>	<ul style="list-style-type: none"> • Develop tailored workplace prevention activities that include: <ul style="list-style-type: none"> – genuine staff involvement; – employee assistance programs and other support programs (for example, Mental Health First Aid); – modification of stressful occupational environments through enhancing job control and conditions, job design, encouraging workload management, clarifying roles and implementing policies to tackle bullying, harassment and discrimination; – policies to enhance employment such as paid parental leave; – policies and resources that promote employee engagement through good work design, thereby optimising the wellbeing and performance of employees; and – policies that address alcohol and other drug use in the workplace. • Support key harm reduction strategies to reduce alcohol and other drug-related harm, such as: <ul style="list-style-type: none"> – initiatives to reduce VSU; – overdose prevention programs (for example, naloxone^{xv} programs); – peer education initiatives; and – needle and syringe programs to prevent blood borne viruses.
<p>Creating and maintaining supportive environments</p>	<ul style="list-style-type: none"> • Work with relevant agencies to support the enforcement of key legislation and policy, including RSA programs and supply reduction activities. • Increase understanding regarding the importance of education, training and employment in supporting individual mental health and wellbeing and collaborate with relevant agencies to ensure effective education, training and employment support programs for unemployed adults are provided. • Work with relevant agencies, including Local Governments to develop alcohol management and planning policies and practices that make for lower risk alcohol and other drug use and greater social connectedness in their communities.
<p>Developing personal skills, public awareness and engagement</p>	<ul style="list-style-type: none"> • Develop and implement evidence-based strategies (including public education campaigns) to: <ul style="list-style-type: none"> – increase awareness of the risks associated with harmful alcohol and other drug use; – promote mental health and wellbeing; and – increase help-seeking behaviours and access to appropriate services.

xv. Naloxone is a fast acting medication that reverses the respiratory depressant effects of opioids.

Older Adults

Action Domain	Strategies
<p>Developing personal skills, public awareness and engagement</p>	<ul style="list-style-type: none"> • Deliver comprehensive programs (or a suite of programs) that promote optimal mental health and wellbeing and reduce alcohol and other drug-related harm in at-risk older adults, including residential aged-care settings. Where relevant, programs should: <ul style="list-style-type: none"> – focus on older adults with ill-health, socially isolated older adults and those experiencing discrimination; – reduce stigma; – increase social inclusion and connectedness; – increase mental health literacy; – include strategies to minimise or reduce risk of depression and alcohol and other drug-related harm; – increase help seeking; – use peers, professionals and volunteers where appropriate; – encourage the uptake and maintenance of physical activity; and – encourage community involvement (for example, through volunteering).

Priority Populations

Whilst recognising that the Prevention Plan targets the Western Australian community as a whole, it is important to note there are a number of groups at greater risk of preventable mental health and/or alcohol and other drug-related issues, with research suggesting that almost all population groups could be considered at-risk at one point or another in their lifetime. Furthermore, the Prevention Plan includes broad strategies that can have a positive impact on a large number of people, as opposed to including a comprehensive list of strategies targeting particular mental health illnesses.

In the majority of cases, actions that aim to improve optimal mental health and reduce alcohol and other drug-related harm across the whole community will also have a beneficial impact on those at high risk. Broad strategies can be adapted and tailored to suit particular populations and groups and some programs can have a positive impact on more than one priority group. It is acknowledged, however, that there is a requirement to implement targeted programs for specific population groups and strategies that target particular illnesses.

People can be disadvantaged through economic, cultural, social, geographical and/or educational factors. The following groups have been identified as having greater risk of mental health, alcohol and other drug-related issues and can benefit from targeted promotion and prevention initiatives. Groups include (but are not limited to):

- Aboriginal peoples and communities;
- LGBTIQ+ individuals and communities;
- youth;
- victims of trauma;
- children affected by parental mental illness and/or harmful alcohol and other drug use;
- people at-risk of experiencing homelessness;
- military veterans;
- people within the criminal justice system;
- people with an existing mental illness;
- regional, remote and rural populations;
- Fly-In-Fly-Out workers and families;
- carers, families and supporters of consumers of mental health, alcohol and other drug services (in particular, children); and
- people with lived experience of mental health and/or alcohol and other drug-related issues.

Additionally, there are a number of strategies and initiatives that could be used to prevent specific mental illnesses (for example, eating disorders, dementia, conduct disorder). The strategies in the Prevention Plan would have a positive impact on the prevention of these as well as other mental health problems. However, as the Prevention Plan is a guiding document and given the vast range of mental illnesses, detailed and comprehensive strategies for individual illnesses have not specifically been included.

When developing and implementing prevention strategies with priority populations and for specific mental health illnesses, a number of principles should be considered. Importantly, co-production methods should be utilised to ensure programs and initiatives are appropriate, effective and sensitive to the needs of the identified priority population groups. Where available, evidence and research around what is effective should be referred to, and where there is a limited evidence base, comprehensive evaluation of programs and initiatives should be undertaken. Other things to consider when working with priority population groups should include (but are not limited to):

- what the evidence recommends is effective;
- cultural, social and economic factors;
- risk and protective factors (see **Figure 2** and **Figure 3**);
- a requirement for systemic advocacy;
- a need to create community empowerment, leadership and ownership;
- stigma and discrimination; and
- resource availability.

Further information on priority populations can be found in the *Western Australian Alcohol and Drug Interagency Strategy 2018-2022* and *Mental Health 2020: Making it Personal and Everybody's Business* accessible via the MHC website: www.mhc.wa.gov.au

Priority Populations

key facts



Youth aged 16-24 years old are the age group most likely to develop a mental health problem⁵⁹. Youth are also more vulnerable than adults to the effects of alcohol and consumption in this age group can increase injury⁶⁰ and mental health issues such as depression, self-harm and suicide⁶¹.



In Western Australia, compared to non-Aboriginal people, Aboriginal peoples are more likely to be hospitalised for alcohol-related causes⁶², have higher levels of illicit drug use⁶³ and are more likely to have experienced high/very high levels of psychological distress⁶⁴.



The mental health of LGBTIQ+ people is among the poorest in Australia, with more than twice as many homosexual/bisexual Australians experiencing anxiety disorders compared to heterosexual people (31% and 14% respectively)⁶⁵.



People living in remote and very remote areas are reported to be twice as likely as people in major cities to drink alcohol in risky quantities⁶⁶.



People living in rural and remote areas of Australia access health services at a lower rate than other Australians and are disproportionately impacted by suicide compared with the population living in urban areas⁶⁷.



In general, in Australia, Culturally and Linguistically Diverse (CaLD) groups and Australians born overseas report less mental health issues than Australian born individuals⁶⁸; however, people from CaLD groups, refugees and asylum seekers often face barriers to accessing mental health services⁶⁹.

The breakout box at right provides an example of prevention of mental health, alcohol and other drug-related issues in Aboriginal communities. Whilst it is acknowledged that this is only one priority population and this example may not be suitable for other priority populations, it is anticipated that this can act as a guide and an example of what works.

A selection of example strategies for specific population groups are provided in **Appendix E**.

Example – Strategies for priority populations: Aboriginal peoples and communities

Aboriginal peoples experience disproportionate rates of mental health, alcohol and other drug-related issues. In 2015, Aboriginal peoples were five times more likely to be hospitalised due to alcohol than non-Aboriginal people⁷⁰. Aboriginal peoples also have a higher proportion of drug use compared to non-Indigenous people⁷¹. Those aged 18 years and over were more than two times more likely than non-Indigenous people to have experienced high/very high-levels of psychological distress⁷².

The following strategies are examples of what can be considered when implementing prevention programs in Aboriginal communities:

- Ensure all programs are culturally secure for the diverse population of Western Australia, and meet the specific needs of Aboriginal peoples and communities.
- Ensure programs recognise the importance of the cultural determinants of health⁷³. Cultural determinants include, but are not limited to:
 - self-determination;
 - freedom from discrimination;
 - individual and collective rights;
 - importance and value of Aboriginal culture;
 - protection from removal/relocation;

- connection to, custodianship, and utilisation of country and traditional lands;
- reclamation, revitalisation, preservation and promotion of language and cultural practices;
- protection and promotion of traditional knowledge and Aboriginal intellectual property; and
- understanding of lore, law and traditional roles and responsibilities.
- Develop holistic programs that promote social and emotional wellbeing, and align with existing policies and programs. Where relevant, programs will:
 - be community-based and community-led;
 - provide opportunities to develop community leadership and skills;
 - be tailored to specific communities;
 - focus on building protective factors and reducing risk factors;
 - focus on improving health literacy; and
 - where possible, improve access to education, information, testing, care and support services.

For more information on effective strategies to promote health and wellbeing in Aboriginal communities, please see the *WA Aboriginal Health and Wellbeing Framework 2015 – 2030*.

Prevention System Supports

As indicated in the Prevention Plan, in order for the various strategies to have the greatest impact, a range of prevention system support initiatives are required. For example, in order to deliver upon programs and services, collaboration and coordination between key government and non-government agencies is essential and a significant increase in prevention investment and a skilled prevention workforce is necessary. Prevention system supports are outlined below according to themes and their corresponding strategies.

Theme	Strategies
Coordination	<ul style="list-style-type: none"> • Consider establishing dedicated multi-agency groups to lead the coordination of key prevention strategies as well as collaborate across agencies to clarify roles and responsibilities, reduce gaps and overlaps. • Ensure co-design and co-production principles are at the forefront when developing, coordinating and implementing promotion and prevention strategies and initiatives.
Cultural security	<ul style="list-style-type: none"> • Ensure all new and existing programs and initiatives are culturally secure. • Identify and respond to the cultural needs of Aboriginal peoples. • Recognise the importance of connection to country, culture, spirituality, family and community and reflect on how these factors affect health and wellbeing.
Workforce	<ul style="list-style-type: none"> • Increase the number and the equitable distribution of qualified, competent prevention professionals across the State and equip other relevant workers to undertake appropriate prevention activity where relevant, for example Emergency Department staff. • In alignment with other relevant state and national policies, build upon mental health, alcohol and other drug workforce development initiatives that increase the capability and capacity of the sectors to implement evidence based prevention. Suggested initiatives include (but are not limited to): <ul style="list-style-type: none"> – agreement on core competencies for prevention officers; – employing prevention specialists in prevention roles; – mentoring of prevention officers to increase their knowledge, competence and confidence in mental health promotion and prevention; – ensuring prevention officers have appropriate supports in place to carry out their role effectively, for example creating a network of prevention officers to share learnings and provide support; – including appropriate prevention curriculum in existing relevant undergraduate and post graduate courses and training (for example, health promotion, nursing, psychology and medicine courses); – expansion of the workforce skilled in prevention (including the Aboriginal workforce); and – inclusion of relevant training supporting workers to address issues relating to priority populations (for example, cultural competence training). • Continue to develop local and cultural expertise in mental health promotion and mental illness, alcohol and other drug prevention.

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Prevention system supports *(continued)*

Theme	Strategies
Funding	<ul style="list-style-type: none"> • Achieve the optimal level of resource (including human resources) to ensure the consistent and equitable delivery of prevention strategies to the community (including remote and very remote communities) through sustained universal and targeted programs. • Explore a range of funding opportunities for prevention strategies. • Improve the balance of funding between prevention and treatment services through increasing investment in prevention initiatives. • Ensure equity of funding for prevention programs across the geographical regions of the State. • Realign current funding and program development with the Prevention Plan.
Research and evaluation	<ul style="list-style-type: none"> • Continue to support independent research on what works in the area of mental health promotion, mental illness, suicide and alcohol and other drug-related harm prevention. • Consider prioritising research investment in the areas where little evidence exists, such as the prevention of severe mental illness (for example, psychosis, personality disorders). • Improve evaluation of individual prevention programs/strategies, including through formal partnerships with universities.
Data	<ul style="list-style-type: none"> • Improve the quality and collection of relevant data which can inform evidence-based prevention activity. For example, alcohol use in pregnancy notifications, Aboriginal specific data collection and data relating to priority populations. • Collect real time suicide attempt and death by suicide data. • Where appropriate, collect, monitor and report on relevant data and demographic information relating to priority population groups.

Monitoring and Reporting

The implementation of the Prevention Plan requires a collaborative approach between a variety of key agencies, sectors, levels of government and the community. The MHC will use existing mechanisms to facilitate across government coordination of activities aligned to the Prevention Plan and aid in monitoring its implementation, for example through the Drug and Alcohol Senior Officer's Group (DASSOG) who are responsible for implementing the Western Australian Alcohol and Drug Interagency Strategy 2018-2022 (AOD Strategy). Additional groups may be formed for the development of specific initiatives where required.

Other stakeholders including local government and local communities may review the Prevention Plan for application within their own services and programs.

Where appropriate, agencies may seek to reorient their prevention activities to align with the strategies outlined in the Prevention Plan.

Information on how the MHC intends to progress implementation and examples of how other stakeholders can progress implementation of the Prevention Plan is provided in **Appendix F**.

The Prevention Plan goals and strategies can guide the work of government and non-government agencies. However, it is important that organisations and agencies implementing prevention activities ensure they measure short and medium-term outcomes to determine whether the implemented prevention related activity is effective in ultimately achieving longer-term goals.

A Program Logic Model is a useful tool that may be applied when planning prevention activities. The MHC has developed a Prevention Plan Program Logic model as a guide for stakeholders to assist in their development, implementation and evaluation of promotion and prevention activity. The model (**Table 2**) includes examples of inputs and activities as well as short, medium and long-term outcomes. It includes examples of the types of activities/outputs and output indicators that could be used by stakeholders in relation to their organisation's relevant business activity.

The Prevention Plan will be reviewed as part of the evaluation of the Plan which is due to be comprehensively reviewed after five years of operation (2020). The MHC will monitor and evaluate its own promotion and prevention activities to assist in informing future promotion and prevention directions, and other stakeholders are encouraged to conduct their own evaluations guided by the Program Logic model in **Table 2**.

Program Logic Model

A Program Logic model provides a visual representation of the relationship among resources available, the activities planned and the results that are hoped to be achieved. The key elements of the Program Logic model developed for the Prevention Plan are outlined below.

Inputs: The resources available to implement a program. This can include financial, human, organisational and community resources.

Activities: What is done with the resources (inputs). They are the actions implemented to bring about the intended changes.

Outputs: Result from the activities that have been implemented.

Output Indicators: Quantify the activities/outputs implemented.

Outcomes: The change or expected improvement resulting from implemented activities.

More information on program logic models can be found here:

- **Western Australian Association for Mental Health:** www.waamh.org.au/assets/documents/projects/program-logic-model-resources.pdf
- **NSW Health:** www.health.nsw.gov.au/research/Publications/developing-program-logic.pdf

Table 2. Prevention Plan Program Logic Model

Inputs	Activities/Outputs	Output Indicators	Outcomes
<p>Funding</p> <p>Community involvement</p> <p>Human resources</p> <p>Workforce Development</p> <p>Research and data</p>	<p>Stakeholders to populate activities/outputs in relation to their organisation’s relevant business activity and the appropriate domains for action.</p> <p>Examples of the types of activities/outputs which could be implemented under each domain for action are provided below.</p> <p>Build healthy public policy</p> <ul style="list-style-type: none"> Support for whole school approaches to mental health, wellbeing, alcohol and other drug education that include strategies to delay, reduce and manage alcohol and other drug use. Support for whole school approaches to reduce the incidence and impact of bullying, discrimination and other risks associated with suicide and/or self-harm and alcohol and other drug use. <p>Create and maintain supportive environments</p> <ul style="list-style-type: none"> Work with relevant agencies to support the enforcement of key legislation and policy, including responsible service of alcohol programs and supply reduction activities. <p>Strengthen communities to take action</p> <ul style="list-style-type: none"> Develop local community action plans to address mental health, suicide prevention and alcohol and other drug prevention. Work with Aboriginal communities to empower them to develop culturally secure programs and services. <p>Developing personal skills, public awareness and engagement</p> <ul style="list-style-type: none"> Deliver a local community education and awareness raising campaign to reduce stigma associated with mental illness. <p>Reorient and maintain relevant programs and services</p> <ul style="list-style-type: none"> Establish an internal process to collect, monitor and share reliable data of prevention activities implemented. 	<p>Stakeholders to populate output indicators in relation to their organisation’s relevant business activity.</p> <p>Examples of the types of outputs which could be implemented are provided below.</p> <ul style="list-style-type: none"> Number of schools who are implementing a whole school approach to manage alcohol and other drug use and mental health issues. Number and type of strategies implemented to support legislative and control measures to reduce the harms associated with alcohol and other drug use. Number of local community action plans being implemented in local communities to address mental health, suicide prevention and alcohol and other drug prevention. Level of Aboriginal community engagement, consultation and leadership. Number and type of education and awareness raising campaigns implemented to reduce stigma associated with mental illness. Number of people who increased their knowledge about stigma associated with mental illness. A six-monthly report of prevention activity data is distributed to relevant stakeholders. Number of hospitals and emergency departments implementing prevention strategies and brief interventions for alcohol and other drug use. 	<p>Short-term</p> <ul style="list-style-type: none"> Increased mental health literacy surrounding mental health and suicide. Increased knowledge of activities to improve mental health. Increased knowledge of the National Health Medical Research Council alcohol drinking guidelines. Increased awareness of evidence-based strategies to reduce alcohol consumption. Increased understanding about the risks associated with licit and illicit drug use. <p>Medium-term</p> <ul style="list-style-type: none"> Increased number of people who have strategies to protect and build their mental health. Decreased social stigma towards people experiencing mental health issues. Increased capability to seek help for oneself or another person for mental health, alcohol and other drug-related issues. Increased support for evidence-based strategies to reduce alcohol consumption. Reduction in the number of people consuming alcohol at high risk levels. Reduction in the number of children less than 18 years of age consuming alcohol. Decrease in illicit drug use. Increased sense of belonging and community cohesion. <p>Long-term</p> <ul style="list-style-type: none"> Improved mental health and wellbeing. Reduction in the incidence of mental illness, suicide and suicide attempts. Reduction in the number of alcohol and other drug-related presentations to hospital and emergency departments. Positive changes in attitudes towards mental health.

Glossary

Aboriginal social and emotional wellbeing:

Aboriginal peoples have a holistic view of mental health and prefer a social and emotional wellbeing approach to mental health. The domains of wellbeing that typically characterise Aboriginal definitions of social and emotional wellbeing include connection to: body, mind and emotions, family and kinship, community, culture, language, country, spirit, spirituality and ancestors^{74, 75}.

Alcohol and other drug harm: Refers to the negative impact of alcohol and other drug use on communities, families and individuals. This includes health harms such as injury, lung and other cancers, cardiovascular disease, liver cirrhosis, mental health issues, road trauma, harm to the fetus and child and social harms including violence and other crime. It also includes economic harms from healthcare and law enforcement costs, decreased productivity, associated criminal activity, reinforcement of marginalisation and disadvantage, domestic and family violence and child protections issues. Harmful alcohol and other drug use is also associated with social and health determinants such as discrimination, unemployment, homelessness, poverty and family breakdown.

Alcohol and other drug harm minimisation:

Harm minimisation is an approach that considers the health, social and economic consequences of alcohol and other drug use on both the individual and the community as a whole. This approach is coordinated through multiple strategies focusing on demand reduction, supply reduction and harm reduction.

Alcohol and other drug prevention: Initiatives to prevent or delay the onset of alcohol and other drug use and protect against risk and reduce the harm associated with alcohol and other drug supply and use.

Community development: A process where members of a community take action to address common problems/issues within the community and collectively and collaboratively generate plans for actions to address the identified problem/issue. This could include advocating for reduced alcohol advertising near schools, and implementing sporting or cultural activities to provide entertainment and community connection for young people to promote mental health.

Co-design: Identifying and creating an entirely new plan, initiative or service, that is successful, sustainable and cost-effective, and reflects the needs, expectations and requirements of all those who participated in and will be affected by the plan⁷⁶.

Co-production: Implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in an equal and reciprocal relationship, with shared power and responsibilities, to achieve positive change and improved outcomes⁷⁷.

Cultural competence: Development of knowledge, skills and awareness that will enable healthcare providers to work competently in culturally diverse situations, including being aware of one's own world view, developing positive attitudes towards cultural differences and gaining knowledge of different cultural practices and world views.

Cultural security: Cultural security is a guiding principle to ensure the respect of the cultural rights, values, beliefs and expectations of Aboriginal peoples as well as the variety of other cultural groups in Australia. A culturally secure approach is essential when developing programs, services, policies and strategies. Culturally secure programs need to:

- identify and respond to the cultural needs of Aboriginal peoples and cultural groups;
- work within a holistic framework that recognises the importance of connection to country, culture, spirituality, family and community; and
- recognise and reflect on how these factors affect health and wellbeing⁷⁸.

Culturally and Linguistically Diverse:

Groups and individuals who differ according to religion, race, language and ethnicity, except those whose ancestry is Anglo Saxon, Anglo Celtic, Aboriginal or Torres Strait Islander.

Harmful alcohol use: Drinking alcohol at levels that are likely to cause significant injury or ill-health⁷⁹.

Lived experience: Any person who identifies as having a current or past lived experience of psychological or emotional issues, distress, mental health and/or alcohol other drug-related issues, irrespective of whether they have a diagnosed mental illness and/or alcohol and other drug-related issues and/or have received treatment.

Mental health: The term mental health has also been referred to as good mental health, positive mental health, optimal mental health, mental wellness and mental wellbeing.

Mental health involves a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. It is related to the promotion of wellbeing, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorder.

Mental health issues: A mental health issue can also impact an individual's cognitive, emotional or social abilities, but may not meet the criteria for a diagnosable mental illness. Mental health issues are said to occur as a result of life stressors, and are usually less severe and of shorter duration than mental illnesses. These often resolve with time or when the individual's situation changes. However, if mental health issues persist or increase in severity, they may develop into a mental illness.

Mental health promotion: Involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles⁸⁰.

Mental ill health: The spectrum of problems that interfere with an individual's cognitive, social and emotional abilities including both mental health issues and mental illnesses.

Mental illness: The term mental illness is sometimes referred to as mental health condition.

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. There are different types of mental illnesses, with varying levels of severity. Examples include mood disorders (such as depression, anxiety and bipolar disorder), psychotic disorders (such as schizophrenia), eating disorders and personality disorders.

Mental illness prevention: Initiatives which focus on reducing risk factors for mental ill health and enhancing protective factors.

New Psychoactive Substance: A range of drugs that have been designed to mimic established illicit drugs, such as cannabis, cocaine, ecstasy and LSD. A psychoactive substance means any substance that, when consumed by a person, has the capacity to induce a psychoactive effect on the person⁸¹.

Noongar^{xvi}: A person of the south-west of Western Australia, or the name for the 'original inhabitants of the south-west of Western Australia' and are one of the largest Aboriginal cultural blocks in Australia. Noongar country covers the whole south-western portion of Western Australia⁸².

Perinatal: The time of conception through to 12 months after a baby is born⁸³.

Volatile Substance Use: The deliberate inhalation of substances, which produce a vapour or gas at room temperature, for their intoxicating effects. It is commonly referred to as 'sniffing', 'solvent use', 'inhalant use' or 'chroming'⁸⁴.

xvi. It is acknowledged that there are several ways of pronouncing the word Noongar, as reflected in the spelling including: Noongar, Nyungar, Nyoongar, Nyoongah, Nyungah, Nyugah, Yungar and Noonga.

Appendices

Appendix A – Prevention Plan Contributors

The following organisations, agencies, groups and experts were represented on the Expert Advisory Group:

- Curtin University of Technology
- Department of Health (Chronic Disease Prevention and Aboriginal Health)
- Department of Education
- Healthway
- Mental Health Commission
- Prevention Academic Expert
- Telethon Kids Institute

As part of the consultation process a range of organisations, agencies and groups contributed to the development of the Prevention Plan, including (but not limited to):

- organisations that represent Aboriginal peoples and communities, consumers, families and carers of mental health, children and young people, and other key stakeholder groups;
- various government departments/agencies, non-government organisations and community organisations;
- peak bodies for the mental health and alcohol and other drug sectors; and
- primary care and clinical bodies.

In addition, the general public were invited to provide feedback on a consultative draft of the Prevention Plan during a period of community consultation, and a consumer, family and carer forum was held on 24 July 2017, to discuss and workshop ideas regarding the development of the Prevention Plan. The feedback received at this forum has also contributed to the development of the Prevention Plan.

Appendix B – Key Policies

The below documents are examples of some of the key policies to which the Prevention Plan is aligned and has been informed by. This list is not exhaustive and it is acknowledged that there may be other relevant policies and strategies that align with the Prevention Plan.

State-level policies and strategies

Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan) ^{xvii}

The Plan outlines the optimal mix and level of mental health, alcohol and other drug services required to meet the needs of Western Australians over the next ten years. The Plan identifies a range of actions relating to prevention, one of which includes the development of this Prevention Plan. The Plan also estimates the hours of service required to implement the alcohol and other drug prevention programs and the funding required for mental health promotion and mental illness prevention programs.

The Plan estimates by 2025, 5% of the total MHC budget should be dedicated to mental health promotion and mental illness prevention activity. In addition, the Plan estimates 208,000 hours of service should be dedicated to alcohol and other drug prevention, which does not include program costs (for example, for mass media campaigns).

xvii. Available at: www.mhc.wa.gov.au/media/1301/the-plan_final.pdf

xviii. Available at: www.mhc.wa.gov.au/about-us/strategic-direction/mental-health-2020-strategic-policy/

xix. Available at: www.mhc.wa.gov.au/about-us/strategic-direction/suicide-prevention-2020-together-we-can-save-lives/

xx. Available at: ww2.health.wa.gov.au/Improving-WA-Health/About-Aboriginal-Health/WA-Aboriginal-Health-and-Wellbeing-Framework-2015-2030

Mental Health 2020: Making it personal and everybody's business (Mental Health 2020) ^{xviii}

Mental Health 2020 outlines areas for reform and action in the mental health system. Many of the Mental Health 2020 action areas such as good planning, services working together, a good home, getting help early, a high quality system, a sustainable workforce, preventing suicide, justice and specific populations align with the action areas of the Prevention Plan. The key principles of respect and participation, engagement, diversity, quality of life and quality and best practice are also consistent with the Prevention Plan principles.

Suicide Prevention 2020: Together We Can Save Lives (Suicide Prevention 2020) ^{xix}

Suicide Prevention 2020 outlines Western Australia's approach to reducing suicides across the State.

The six areas for action in Suicide Prevention 2020 are:

1. Greater public awareness and united action.
2. Local support and community prevention across the life-span.
3. Coordinated and targeted services for high risk groups.
4. Shared responsibility across government, private, and non-government sectors to build mentally healthy workplaces.
5. Increased suicide prevention training.
6. Timely data and evidence to improve responses and services.

WA Aboriginal Health and Wellbeing Framework 2015-2030 (Aboriginal Framework) ^{xx}

The Aboriginal Framework aims to guide how WA Health and other agencies approach Aboriginal health from 2015 to 2030 and was developed in consultation with Aboriginal people and stakeholders.

Key guiding principles, strategic directions and priority areas are identified to improve the health and wellbeing of Aboriginal peoples in Western Australia.

Guiding principles include:

- cultural security;
- the health and wellbeing of Aboriginal people is everybody's business;
- partnerships;
- Aboriginal community control and engagement;
- access and equality; and
- accountability.

The Aboriginal Framework recognises the importance of culture, strength of community and encourages new ways of working to achieve the vision: Aboriginal people living long, well and healthy lives.

Western Australian Alcohol and Drug Interagency Strategy 2018-2022

The Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015 was a key across government policy document that outlined strategies to prevent and reduce the adverse impacts of alcohol and other drug use in Western Australia. This document has been updated, now titled the Western Australian Alcohol and Drug Interagency Strategy 2018-2022 (AOD Strategy). The AOD Strategy identifies prevention as a key strategic area and includes the following areas of focus associated with prevention:

- preventing and delaying the onset of alcohol and other drug use;
- supporting environments that discourage harmful alcohol use;
- enhancing community attitudes and skills to avoid harmful use;
- supporting and enhancing the community's capacity to address alcohol and other drug-related issues; and
- supporting initiatives that discourage the inappropriate supply of alcohol and other drugs.

Western Australian Health Promotion Strategic Framework 2017-2021 (Health Promotion Strategic Framework)^{xxi}

The Health Promotion Strategic Framework addresses the common risk factors that are responsible for a large proportion of preventable chronic disease and injury in Western Australia.

These risk factors include:

- being overweight or obese;
- poor diet;
- insufficient physical activity;
- smoking; and
- harmful levels of alcohol use.

The Health Promotion Strategic Framework notes the connection between chronic disease, injury and mental health, and is complementary to the MHC's plans for mental health promotion and mental illness and alcohol and other drug prevention.

Reducing harmful alcohol use is identified as a priority area in the Health Promotion Strategic Framework. Domains for action include: healthy policies, legislation and regulation, economic interventions, supportive environments, community development, targeted interventions, strategic coordination, building partnerships and workforce development. Many of the strategies in the Health Promotion Strategic Framework align to and complement the strategies contained in the Prevention Plan.

Methamphetamine Action Plan

In an effort to address the methamphetamine problem in Western Australia, the McGowan Government has committed to implementing the Methamphetamine Action Plan (MAP).

Initiatives of the MAP include:

- creation of a WA Police Meth Border Force;
- providing early intervention treatment facilities;
- expanding specialist drug services into rural and regional areas of need;
- improving drug and alcohol programs in schools;
- creating drug and alcohol rehabilitation facilities for prisoners, and
- increasing roadside drug and alcohol testing.

The MAP is focused on reducing methamphetamine demand, supply and harm, through coordinated implementation of initiatives across Government⁸⁵.

xxi. Available at: <http://ww2.health.wa.gov.au/Reports-and-publications/WA-Health-Promotion-Strategic-Framework>

National level policies and strategies

Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) ^{xxii}

The Fifth Plan seeks to establish a national approach for collaborative government effort from 2017-2022. It is underpinned by seven priority areas with supporting actions to enable change:

- integrated regional planning and service delivery;
- coordinated treatment and supports for people with severe and complex mental illness;
- suicide prevention;
- Aboriginal and Torres Strait Islander mental health and suicide prevention;
- physical health of people living with mental health issues;
- stigma and discrimination reduction; and
- safety and quality in mental health care.

The Fifth Plan recognises that consumers, families, carers and supporters with lived experience of mental illness and/or alcohol and other drug-related issues need to be at the centre of the way in which services are planned and delivered, and that a regional focus is a key platform of the change needed to address the shortcomings of the existing system.

National Drug Strategy 2017-2026 ^{xxiii}

The Draft National Drug Strategy 2017-2026 builds upon previous national drug strategies. The strategy aims to contribute to ensuring safe, healthy and resilient Australian communities through minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities. Based on the harm minimisation model, the strategy identifies priorities such as (but not limited to):

- increasing community engagement and involvement in responding to alcohol and other drug use issues;
- improving national coordination;
- developing and sharing data to support evidence-informed approaches; and
- developing responses that restrict or regulate the availability of alcohol and other drugs.

xxii. Available at: www.coaghealthcouncil.gov.au/Publications/Reports

xxiii. Available at: <https://campaigns.health.gov.au/drughelp/resources/publications/report/national-drug-strategy-2017-2026>

Appendix C – Promotion and Prevention Models

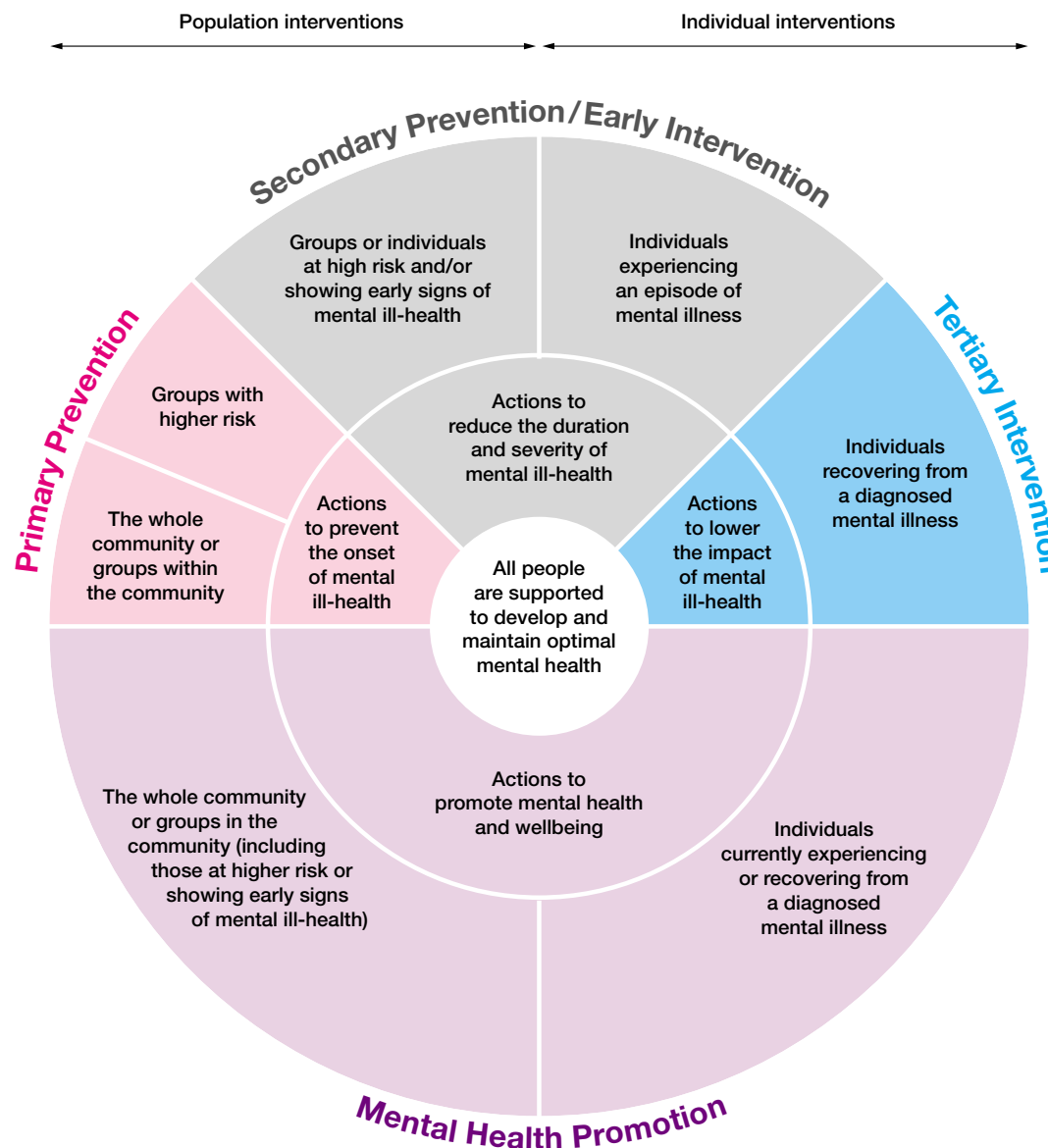
Below are alternative models that are used to guide the development and implementation of promotion and prevention initiatives.

Prevention First Framework – Mental Health⁹³

As explained by Everymind⁹⁴ (formally the Hunter Institute of Mental Health), the Prevention First framework takes a population health approach to prevention and promotion, and focusses on the health needs of the whole population, as well as for specific broad groups of people, including:

- groups at higher risk of mental ill-health;
- groups or individuals showing early signs of mental ill-health;
- individuals currently experiencing an episode of mental illness;
- individuals recovering from mental illness; and
- whole communities.

It includes focused prevention and promotion activity across the spectrum, and intervention at both a population and individual level. It also identifies seven key 'Action Areas' to further clarify the range of prevention and promotion activity that should occur.



Kantar Public Alcohol and Other Drug Behaviour Change Model

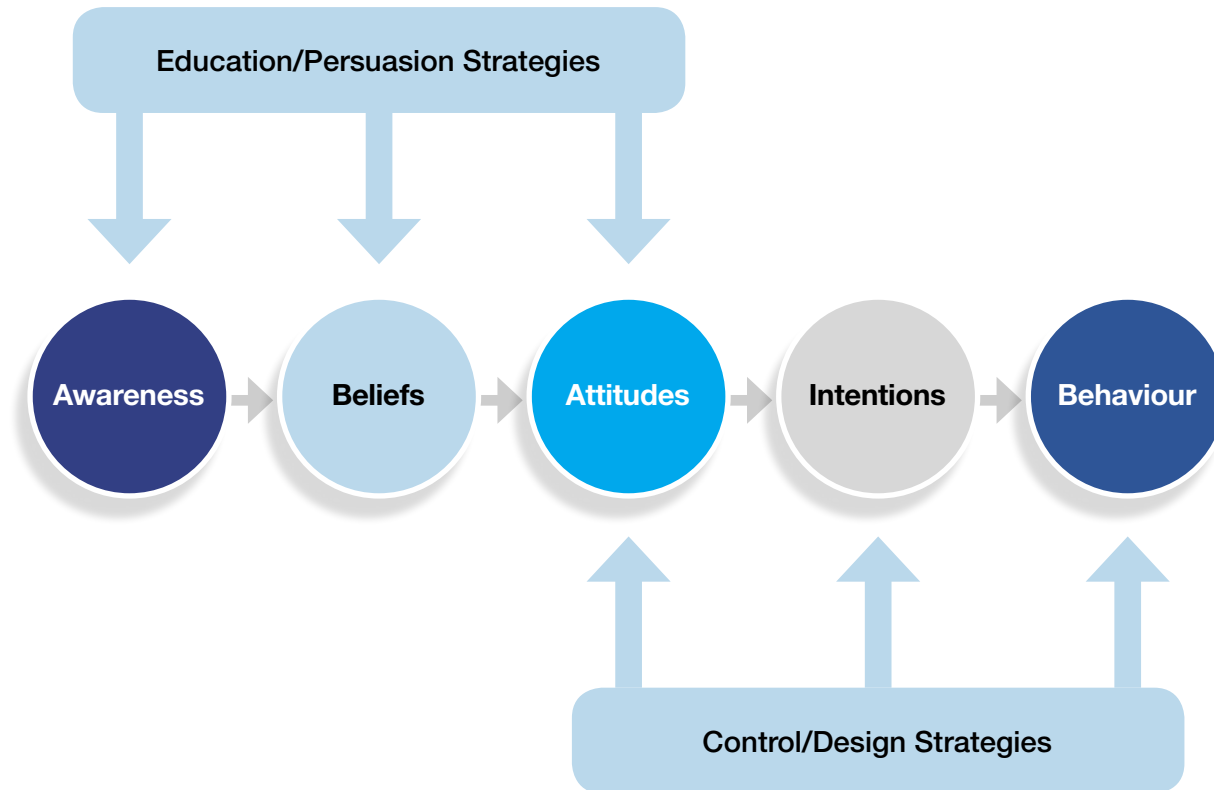
This model has been adapted from a Kantar Public framework⁹⁵ used to plan, implement and evaluate a wide range of behaviour change and social marketing programs.

This model identifies four primary tools to assist in changing peoples' behaviour towards alcohol and other drug use.

Education/Persuasion – inform, advise, build awareness, challenge norms, engage, motivate, build positive attitude, get on the social agenda.

Control/Design – legislate, regulate, enforcement, tax (incentives and penalties), re structure the physical environment, change the context, engineer new products.

The model acknowledges the key stages required to be addressed in the lead up to changing actual behaviour.



Appendix D – Case Studies

Alcohol.ThinkAgain – Young People Campaign

Alcohol consumption as an adolescent or young adult is associated with physical injury including unintentional and violent injury⁸⁶. Drinking alcohol also increases the risk of developing mental health and social issues, especially when a person starts drinking at a young age⁸⁷.

The Alcohol.Think Again (ATA) Program includes the Parents' Young People and Alcohol campaign (the Campaign) which aims to increase awareness of the National Health and Medical Research Council's guidelines⁸⁸ that state, for children and young people under 18 years of age, not drinking alcohol is the safest option.

The Campaign commenced in 2012 and campaign evaluation results show that since 2012 the proportion of parents who have never supplied alcohol to their child has increased each year from 56% in 2012 to 73% in 2016⁸⁹.

Independent national public health surveys have confirmed the Campaign's success against its objectives⁹⁰.

The current Campaign's phase, "I See", was launched in November 2014 and the primary target group is parents of young people aged 12 to 17 years-of-age. The key message of this phase is that "No one should provide alcohol to under 18s", with rationale provided by experts explaining the harm they see in young people from alcohol use (hospitalisations, damage to the developing brain and mental health issues).

The most recent (2014) Australian School Students Alcohol and Drug (ASSAD) survey found that fewer young people aged 12 to 17 years are consuming alcohol than at any time in the past three decades⁹¹. Not only were fewer young people drinking, of those who drank, fewer drank at risky levels compared to that of 2011⁹². This reflects the important contribution the ATA campaigns are making in targeting young people and parents with the message that drinking at a young age is a risk to their health and wellbeing.

Drug Aware – Methamphetamine Campaign

The Drug Aware Methamphetamine Prevention Campaign (the Campaign) was developed in 2008 in response to an increase in meth/amphetamine-related harm being experienced by people across Western Australia.

The Campaign is ongoing and aims to prevent and delay the uptake of methamphetamine use and stop use.

The current Campaign phase, titled: "Meth Can Take Control" was launched in December 2015. The primary target group for this phase is 17 to 25 year olds at risk of, or trialling, methamphetamine use. The Campaign portrays how methamphetamine use can impact your whole life by demonstrating the health, social and legal consequences of use. The Campaign is based on real experiences of people across Western Australia who shared their personal stories so they could help others stop meth taking control.

The second year evaluation, conducted in 2017, found that 77% of 17 to 25 year olds surveyed were aware of the campaign. This is the highest awareness rate achieved of any Drug Aware campaign since the program commenced in 1996.

In conjunction with increasing campaign awareness, campaign evaluations have found that the proportion of people not intending to use methamphetamine is consistently increasing over time (86% in 2014, 87% in 2016 and 91% in 2017).

Additionally, the most recent National Drug Strategy Household Survey found that fewer Western Australian people had used meth/amphetamine in the last 12 months than any time in the previous two decades, from 6% in 1998 to 2.7% in 2016.

Strong Spirit Strong Mind Metro Project

The Strong Spirit Strong Mind Metro Project was developed in 2012 with the aim to increase the awareness and knowledge of the harms associated with alcohol and other drug (AOD) issues among Aboriginal peoples, families and communities in the Perth metropolitan area.

The project focuses on young people aged 12 to 25 years and encourages Aboriginal young peoples to develop the knowledge, and attitudes to choose healthy lifestyles, promote healthy environments and create safer communities.

The key messages of the campaign are that alcohol and drugs can result in:

- you doing things you may regret; and
- you getting into trouble with the law.

The campaign consists of an ongoing prevention campaign; an Aboriginal Youth Network Group; and training and up skilling of AOD services working with Aboriginal young peoples.

An independent evaluation of the campaign was conducted in 2016 where 155 Aboriginal young peoples participated. Results included the following:

- eighty-three percent of respondents indicated they were more aware of the harms associated with alcohol and other drug use as a result of the Campaign;
- at least three quarters of all respondents recall being exposed to the Campaign, with half seeing or hearing it more than three times; and
- most respondents identified that all elements of the Campaign were appropriate for Aboriginal young peoples, and eighty-six percent of respondents would like to see the Campaign again.

The most recent evaluation of the campaign in September 2017 produced the following results:

- sixty-nine percent of respondents indicated they were more aware of where to get help;
- eighty-four percent of respondents indicated they had seen or heard the Campaign at least once;
- at least a quarter of respondents were aware of the Alcohol and Drug Support Line;
- sixty-five percent of respondents were more aware of the harms of alcohol and drug use; and
- the best known sources for help, as a result of the Campaign were friends/family and the Meth and Alcohol and Drug Support Lines.

Think Mental Health Campaign

The Think Mental Health Campaign is a key initiative of the state-wide suicide prevention strategy, Suicide Prevention 2020: Together we can save lives (the Strategy), under Action Area One – Greater public awareness and united action across the community. This strategy encompasses a comprehensive approach to mental health promotion and the prevention of suicide.

The Think Mental Health Campaign's focus is on building resilience and improving the mental health and wellbeing of the Western Australian community; de-stigmatising mental health issues; and assisting the Western Australian community to connect with the best information, support and services for their particular situation.

The first phase of the Think Mental Health Campaign targets men aged 25 to 54 years living in Western Australia, and family and friends of these men. Men have been chosen as the focus of this phase of the Campaign, as three out of four deaths by suicide in Western Australia are male. The Campaign will develop over time to address a range of issues for priority target groups.

The key messages for the Campaign include:

- check in on a mate, or someone you care about if they're not going so well;
- talking and listening are powerful; and
- mental health issues can affect anyone. It may be difficult at first but talking can help.

Feedback from the Think Mental Health Baseline Survey showed a high level of engagement among participants and there was a strong belief that research in the areas of mental health conditions and suicide is important and needed.

Results from the Think Mental Health Baseline Survey identified key considerations for future public education strategies including (but not limited to):

- providing ongoing education to encourage and normalise help-seeking behaviour;
- recognising signs and symptoms of mental health issues with the view to prevent suicide and related issues;
- increasing self-efficacy for maintaining one's own mental health;
- reducing the perceived stigma and discrimination following a mental health diagnosis; and
- providing messages relating to helping others, with a focus on proactive help.

Appendix E – Example Strategies for Population Groups

Whilst it is acknowledged that there are many other groups who can benefit from targeted promotion and prevention strategies, the following table identifies some examples of strategies which have been informed by evidence and best practice methods for specific population groups.

Strategies for population groups	
LGBTIQ+ people and communities	<p>Deliver targeted programs that promote good mental health and wellbeing and reduce the risk of mental illness for LGBTIQ+ people.</p> <p>This may include:</p> <ul style="list-style-type: none"> • promoting social connection and increasing a sense of belonging; • increasing self-esteem; • increasing mental health literacy and help seeking; and • promoting the use of self-help.
Culturally and Linguistically Diverse groups	<p>Develop holistic programs to promote mental health, and prevention mental health alcohol and other drug-related issues in Culturally and Linguistically Diverse groups, such as refugee communities.</p> <p>Programs should align with existing programs where relevant and may include:</p> <ul style="list-style-type: none"> • an advocacy component; • initiatives to decrease post-migration stress and increase social connectedness; • the creation of meaningful social roles; • increased access to education and support services; and • group style programs, peers and volunteers where possible.

Strategies for population groups	
People with disability	<p>Implement targeted programs for people with disability that promote good mental health and reduce the risk of mental health, alcohol and other drug-related issues.</p> <p>Programs should:</p> <ul style="list-style-type: none"> • target young people; • increase emotional literacy, emotional self-regulation, self-compassion and acceptance; • increase psychological flexibility and decrease unhelpful thoughts; and • support healthy lifestyle choices.
Children and/or young people who have a parent/s with a mental health, and/or alcohol and other drug-related issue	<p>Develop evidence-based programs to support mental health and wellbeing. This may involve online components where appropriate.</p> <p>Programs can aim to:</p> <ul style="list-style-type: none"> • increase mental health literacy; • build resilience; • establish effective thinking and coping styles; • increase social connection; • improve family dynamics where required; and • include age-appropriate alcohol and other drug education.

Appendix F – What Prevention Plan Stakeholders can do

Mental Health Commission

Although the implementation of the Prevention Plan requires the commitment of a range key stakeholders, an example of what the MHC intend to do in the early stages to implement the Prevention Plan is provided below.

As an early priority, the MHC will seek to mobilise their stakeholders to commence implementing the Prevention Plan through existing groups such as the DASSOG. MHC will also continue to seek additional investment for evidence-based and evidence informed prevention initiatives and direct resources to initiatives such as (but not limited to):

- Public awareness education.
- Supporting regional and remote areas across the State to develop, implement and evaluate local prevention plans.
- Building community capacity to develop, implement and evaluate mental health promotion, mental illness and suicide prevention activities.
- Monitoring liquor licensing applications to reduce alcohol-related harm to communities.
- Development and support of safe and healthy settings to reduce alcohol related harm to communities.

- Promotion of community connection and social inclusion; and pre-natal and early years resilience building.
- Future prevention investment and internal MHC prevention activity will also align with the recommendations of the Prevention Plan.

Other Key Stakeholders

The following are just some examples of what key stakeholders can do to contribute to the implementation of the Prevention Plan.

In the majority of cases, the Prevention Plan intentionally provides broad, high level guidance on the programs and strategies that can be implemented across the State. Based on the Prevention Plan recommendations, stakeholders can utilise the recommendations to guide their own detailed research and environmental analysis, applicability of programs and strategies to their own work and so on.

Further guidance and support in the development and implementation of effective, evidence-based promotion and prevention initiatives is available in the following resources.

- Mental Health Commission – ‘*Introduction to Alcohol and other Drug Prevention: Guidelines*’ available here: www.mhc.wa.gov.au
- Everymind (formally the Hunter Institute of Mental Health): www.everymind.org.au

Organisations and agencies funded to provide promotion and prevention programs:

- Implement evidence-based and evidence-informed promotion and prevention initiatives as recommended in the Prevention Plan.
- Monitor emerging evidence to inform promotion and prevention initiatives.
- Utilise program logic models to inform the evaluation of promotion and prevention activities.
- Consider how existing and future promotion and prevention activities can align with the Prevention Plan.
- Seek funding to implement appropriate promotion and prevention activities as outlined in the Prevention Plan.
- Where appropriate, collaborate and partner with external promotion and prevention organisations in developing and implementing programs.

Communities and individuals:

- Become involved in prevention planning locally.
- Participate in, and contribute to, local liquor licensing decisions wherever possible.
- Participate in activities that promote social inclusion and connectedness, and encourage neighbours and friends to do so too.
- Refrain from supplying alcohol to children under the age of 18 years.
- Work to make sure children feel comfortable talking about problems, such as bullying, and seek appropriate assistance as needed.

Continued next page

Other organisations and agencies (for example, WA Health, Department of Justice):

- Assess how organisational policies, practices and public policy decisions impact the health of the community.
- Review existing prevention related programs and where possible re orient relevant programs to align to the recommendations in the Prevention Plan.

Businesses and employers:

- Employ staff responsible for leading the development and implementation of workplace prevention plans and activities.
- Lead by example – promote social inclusion and connectedness.
- Provide family friendly workplaces.
- Donate to organisations that implement effective prevention activities.
- Provide safe team building activities that do not promote harmful alcohol and other drug use.

Institutions and stakeholders involved in education and training:

- Incorporate whole-of-school evidence-based prevention programs.
- Adopt policies and programs to decrease the use of alcohol and other drugs on school and campus grounds.
- Implement programs for reducing harmful alcohol and other drug use.

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