MENTAL HEALTH PROMOTION, MENTAL ILLNESS AND ALCOHOL AND OTHER DRUG PREVENTION PLAN 2018 - 2025

DRAFT

MHC17/19855

CONTENTS

FOREWORD

EXECUTIVE SUMMARY

The 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 (AOD) issues in the Western Australian community. The Mental Health Promotion, Mental Illness and Alcohol and Other Drug Prevention Plan (Prevention Plan) aims to provide an overview of the 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 Prevention Plan focuses primarily on activities relating to mental health promotion as well as the primary prevention of mental illness and AOD related harm. Primary prevention actions target the general population and groups at risk to promote optimal mental health and wellbeing, keep people well and to prevent and reduce AOD harm. Where considered appropriate, reference to secondary and/or tertiary prevention strategies are included in the Prevention Plan and involve actions targeting people showing early signs of mental health or AOD related problems and therefore often occur in treatment services.

The Prevention Plan includes contextual background information, strategies categorised into domains across the life course from pre-conception to older adulthood, reference to priority populations, and a summary of initiatives that will support the implementation of the Prevention Plan.

The Prevention Plan development 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 and the general public, including consumers, carers and families of those with a lived experience of mental health and AOD problems.

The Prevention Plan provides a guide for all stakeholders, including the MHC, in the development and implementation of effective, evidence-based prevention activity. Whilst the MHC provides high level oversight for the Prevention Plan's implementation, its implementation resides with a range of stakeholders responsible for mental health promotion and mental illness and AOD prevention.

An overview of the Prevention Plan is provided in Table 1 and a summary of key strategies is provided in Table 2.

Table 1. – Overview of the Mental Health Promotion, Mental Illness and Alcohol and Other Drug Prevention Plan

<table>
<tr><th colspan="6">GOALS</th></tr>
<tr><td colspan="6">1. Increase optimal mental health and wellbeing.
2. Reduce the incidence of mental illness, suicide and suicide attempts.
3. Prevent and reduce drug use and harmful alcohol use.</td></tr>
<tr><th colspan="6">TARGET POPULATION</th></tr>
<tr><td colspan="6">The Western Australian community and groups at high risk.</td></tr>
<tr><th colspan="6">PRINCIPLES</th></tr>
<tr><td colspan="6">1. Mental health promotion and primary prevention are the principal focus.
2. Programs and initiatives are essential across the life course from pre-conception to older adulthood.
3. Whole-of-population, localised, and targeted programs and initiatives are necessary.
4. Programs and initiatives are evidence-based (or evidence-informed), involving multiple strategies at local, state and national levels.
5. Promotion of innovation underpinned by robust evaluation is strongly supported.
6. Partnerships, collaboration and stakeholder participation are essential.
7. Valuing diversity, equity and cultural inclusivity are a priority.</td></tr>
<tr><th colspan="6">DOMAINS FOR ACTION</th></tr>
<tr><td colspan="6">• Building healthy public policy – Policy development across all sectors can positively or negatively impact mental health and AOD harm.
• Creating and maintaining supportive environments – A range of environments and settings provide opportunities to promote optimal mental health and reduce AOD harm.
• Strengthening communities to take action – Empowering a community to become involved in decisions that impact them, addresses local needs and increases project ownership and sustainability.
• Developing personal skills, public awareness and engagement – Increasing knowledge and skills is essential to enable personal control and the opportunity to choose options for better health.
• Reorienting and maintaining relevant programs and services[1] – The responsibility to implement prevention is shared across a number of sectors and services.</td></tr>
<tr><th colspan="6">PRIORITY AREAS FOR ACTION</th></tr>
<tr><td>Across the life course</td><td>Perinatal and early years</td><td>Children and young people</td><td>Adults</td><td>Older adults</td><td>Priority populations</td></tr>
<tr><td colspan="6">PREVENTION SYSTEMS SUPPORTS – To enable effective implementation a range of prevention system support initiatives need to be progressed focussing on strategic coordination, funding, workforce growth and development, cultural security, research and data.</td></tr>
<tr><td colspan="6">MONITORING AND REPORTING – Measurement of relevant short, medium and long-term outcomes. Programs, strategies and contracts reflect agreed outcomes to enable measurement of progress towards the Prevention Plan goals.</td></tr>
</table>

Table 2. Summary of key strategies

Priority Area	Summary of key strategies
Across the Life Course	• In partnership with key sectors, address social determinants. • Incorporate mental health promotion and prevention in other health promoting programs. • Use control and regulation initiatives where necessary. • Promote social inclusion, community connectedness and reduce stigma.
Peri-natal and early years	• Deliver comprehensive pre-natal support. • Promote secure parent and child attachment and encourage positive parenting. • Promote optimal mental health, wellbeing and resilience of young children. • Implement AOD prevention interventions targeting women of child-bearing age.
Children and young people	• Integrate whole of school approaches to bullying and discrimination. • Mandate age appropriate AOD, mental health and resilience education. • Provide relevant teaching staff development opportunities. • Develop online prevention programs. • Ensure early intervention services are available.
Adults	• Implement supply, demand and harm reduction strategies. • Integrate workplace mental health promotion and AOD prevention activities. • Enforce key legislation and policy. • Promote the importance of education, training and employment.
Older adults	• Promote optimal mental health and wellbeing and reduce AOD harm in older adults at risk.
Priority populations	• Implement targeted programs for at risk groups, including sexuality and gender diverse people. • Empower Aboriginal communities to develop holistic programs. • Support children who have a parent/s with an AOD problem and/or mental illness.

IMPORTANT NOTE

The Western Australian Mental Health Promotion, Mental Illness and Alcohol and Other Drug Prevention Plan (Prevention Plan) is an evidence-based 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 prevention activity. Where appropriate, the Mental Health Commission will collaborate with stakeholders and facilitate their mobilisation and engagement in the development and implementation of the Prevention Plan.

The strategies contained within this document and subsequent investment required is 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.

INTRODUCTION

The Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025 (the Plan) identified the requirement to develop a prevention plan for mental health and alcohol and other drugs (AOD). The Mental Health Promotion, Mental Illness and AOD Prevention Plan (Prevention Plan) includes evidence-based or 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 drug use and harmful alcohol use in the Western Australian community.

Optimising mental health and wellbeing, and preventing and reducing AOD harm is important for all Western Australians. Individuals that experience optimal mental health and wellbeing, and minimal AOD related harms, are able to fully participate in community and family life, contribute socially and economically, and live a longer, happier and meaningful life.

Comprehensive strategies are required 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 illness and AOD harm can be achieved.

The Prevention Plan primarily focusses on increasing optimal mental health and wellbeing and the primary prevention of mental illness and AOD related harm. That is, the actions aim to keep people well and prevent AOD related harms. It is acknowledged that action is required across the continuum of prevention, including secondary and tertiary prevention however is generally beyond the scope of this Prevention Plan. See page 9 for the prevention definitions breakout box, also see the **Glossary**.

BREAKOUT BOX – MENTAL HEALTH AND AOD DEFINITIONS

(PLEASE REFER TO THE GLOSSARY FOR OTHER KEY TERMS)

There are varying terms and definitions used in the area of mental health and AOD. Below are the preferred terms used in the Prevention Plan.

Mental health: *The term mental health has also been referred to as optimal mental health, good mental health, positive mental health, mental wellness and mental wellbeing.* According to the World Health Organisation definition,[2] 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.

Aboriginal social and emotional wellbeing: Aboriginal people[i] have a holistic view of mental health and prefer to utilise the term social and emotional wellbeing. As described in the Social and Emotional Wellbeing Framework[3], the domains of wellbeing that typically characterise Aboriginal definitions of social and emotional

[i] The use of the term "Aboriginal" within this document refers to both Aboriginal and Torres Strait Islander peoples and communities.

wellbeing include connection to body, mind and emotions, family and kinship, community, culture, language, country, spirit, spirituality and ancestors.

The Prevention First Framework[4] provides some useful definitions of common terms such as mental illness, mental ill health and mental health problems:

Mental illness: A clinically diagnosable medical condition 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 health problems: A mental health problem can also impact an individual's cognitive, emotional or social abilities, but may not meet the criteria for a diagnosable mental illness. Mental health problems 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 problems persist or increase in severity, they may 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 problems and mental illnesses'.

AOD harm: Refers to the negative impact of AOD use on communities, families and individuals. This includes health harms such as injury; cancers; cardiovascular disease; liver cirrhosis; mental health problems; 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 protections issues such as abuse and neglect. Harmful AOD use is also associated with social and health determinants such as discrimination, unemployment, homelessness, poverty and family breakdown[5].

AOD harm minimisation: Aims to address AOD issues by reducing the harmful effects of AOD on individuals and society. Harm minimisation considers the health, social and economic consequences of AOD 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[6].

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 effective[7].

PREVENTION DEFINITIONS - BREAKOUT BOX

Some key terms and definitions relating to prevention are provided below

Mental health promotion: As defined by the World Health Organisation[8], mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles.

Mental illness prevention: Prevention initiatives which focus on reducing risk factors for mental ill-health and enhancing protective factors[9]. **Alcohol and other drug prevention:** Measures that prevent or delay the onset of AOD use as well as measures that protect against risk and reduce harm associated with AOD supply and use[10].	
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 AOD and/or mental health problems[11].
Secondary Prevention	Seeks to lower the number of cases of a disorder or illness in the population through early detection and treatment[12].
Tertiary Prevention	Interventions that reduce disability, enhance rehabilitation and prevent reoccurrences of the illness[13].

PURPOSE OF THIS DOCUMENT

The Mental Health Commission (MHC) has led the development of the Prevention Plan to provide a funder and provider neutral[ii] evidence-informed guide for government agencies, non-government organisations and the community in the promotion of optimal mental health, prevention of mental illness, suicide and suicide attempts, and prevention of harms of AOD use.

The Prevention Plan includes relevant background information, domains for action across the life course from pre-conception to older adulthood, the identification of priority groups, and a summary of key prevention system support initiatives that will enable the effective implementation of the Prevention Plan.

To implement the Prevention Plan, the MHC will aim to facilitate and mobilise action with a variety of stakeholders including the broader community as well as the mental health, AOD, 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 can also utilise the Prevention Plan to identify prevention activities, programs and interventions that they can also develop, fund, implement and evaluate.

[ii] Provider and funder neutral refers to the fact that the Prevention Plan recommends the mental health promotion and primary prevention strategies that should 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.

THE GOAL OF THE PREVENTION PLAN

The Prevention Plan aims to provide an evidence-based and informed guide for government, non-government and community groups to assist with the planning of their promotion and prevention activities.

Specifically the goals of the Prevention Plan are to build upon and/or continue to implement a range of mental health promotion, mental illness and AOD prevention 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.

HOW WAS THE PREVENTION PLAN DEVELOPED?

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 consumer, carers, and families with a lived experience of mental illness and/or AOD problems.

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 prevention and mental health promotion. Consultation with key stakeholders provided confirmation of strategies identified through the evidence, or the identification of other initiatives based on their own personal and professional experiences.

CONTEXT

Key policies

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

- Working in a systematic way, including implementing various actions at a national level through to localised, community-driven responses.
- Improved collaboration, coordination and partnerships in order to implement effective prevention strategies.
- Consistent models and frameworks, such as the harm minimisation approach to prevent AOD related harm, and acknowledgement of the influence of both risk and protective factors.
- Identification of priority groups that will not only benefit from whole of population strategies, but may also require targeted approaches.

A summary of the key policies and strategies can be found in Appendix A.

BREAKOUT BOX – 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 categories, 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 early identification and mitigation of risk factors and the building of protective factors is a key priority.

Current prevention activity

The Prevention Plan provides an overview of recommended initiatives in the area of mental health promotion, mental illness and AOD prevention. Many of the recommended prevention initiatives are already being implemented across Western Australia. In some cases, current programs could benefit from being refined to ensure they align with the Prevention Plan. In other cases, identified gaps may highlight the need for new strategies and programs to be developed.

Current initiatives incorporate broad health promotion strategies for example, general mental health promotion programs; mentally healthy workplace initiatives; AOD mass reach campaigns; community action to prevent and reduce suicide attempts and suicide; community action to prevent and reduce AOD related harm; and school health promotion programs.

In some cases, programs and initiatives may not be named or identified specifically as direct mental health promotion or AOD prevention programs, but nevertheless can have a positive impact on mental health and reduce AOD harm. 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 children[14]. Furthermore, paid parental leave for parents, which prolongs breastfeeding, enhances parent child connectedness and reduces financial pressure, can have a positive impact on the future mental health of the child[15, 16]. Additionally, programs that provide safe and secure housing and prevent homelessness can have a positive impact on mental health and reduce risk of AOD harm[17].

PREVENTION

What is Prevention?

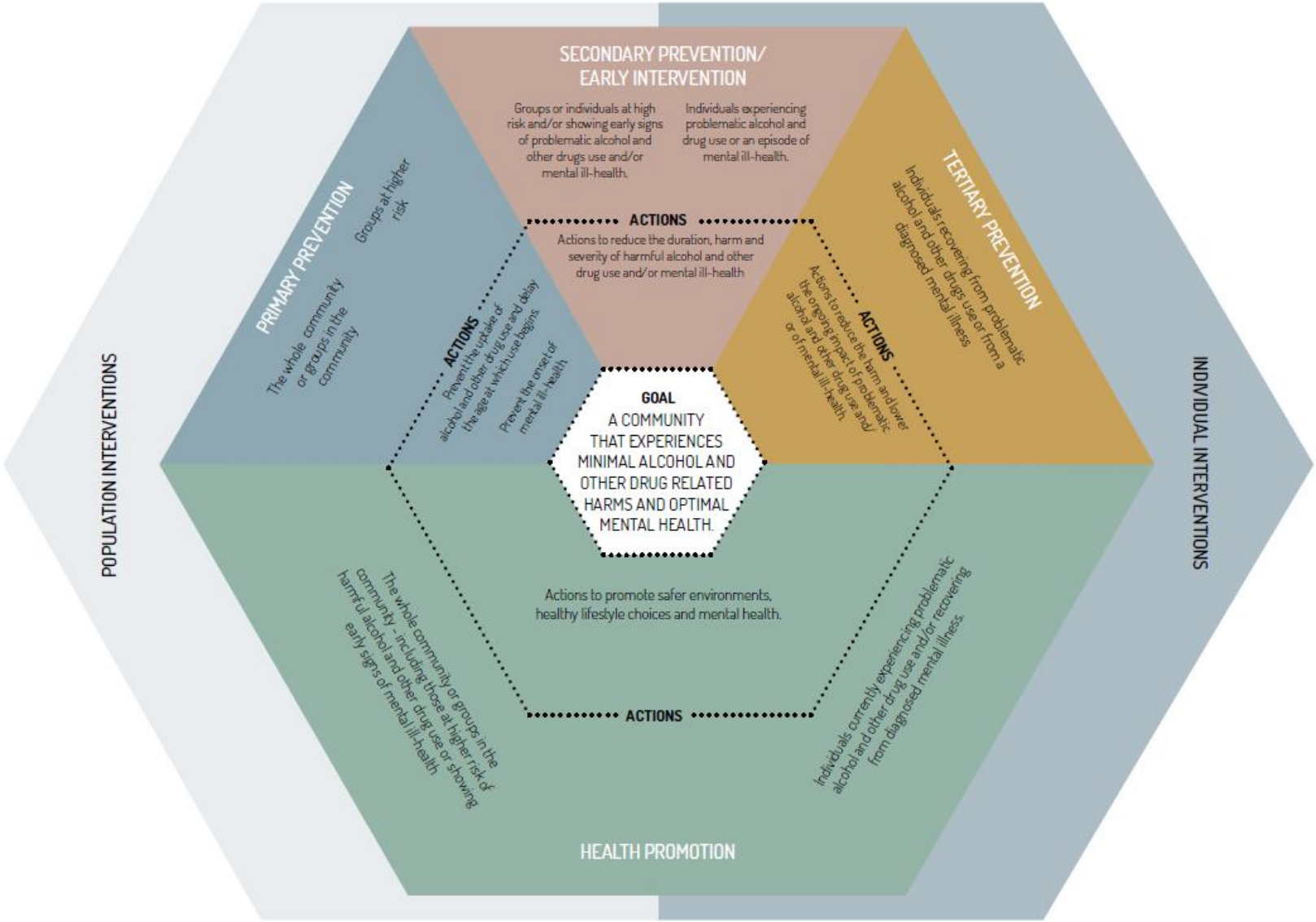
The MHC Prevention Model (Diagram 1) is an adaption of the Hunter Institute's Prevention First Framework[18] and provides a pictorial representation of what constitutes mental health promotion, mental illness and AOD prevention. The MHC Prevention Model is premised by the fundamental difference between AOD and mental health. That is, alcohol and/or other drugs are commodities that may or may not be consumed by an individual, whilst mental health is an inherent part of being human.

The model is underpinned by a centralised goal, "A community that experiences minimal AOD related harms and optimal mental health".

As shown in the diagram, prevention occurs along a continuum, from health promotion through to tertiary prevention. 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 (inner oval). Target groups also differ based on the prevention stage (outer oval). For example, actions can be targeted at the whole community, people at risk of experiencing problems, through to groups or individuals who are already experiencing problems. The accompanying table (Table 3) further expands on the approach of the MHC Prevention Model.

This Prevention Plan focuses primarily on activities relating to mental health promotion and the primary prevention of mental illness and AOD related harm. Where considered appropriate, reference to secondary and/or tertiary prevention strategies are included. However, most actions in the secondary and tertiary prevention stages of the continuum occur in the treatment services setting.

Diagram 1: The MHC Prevention Model



Adaptation of The Hunter Institute Prevention First Framework.

Table 3. The MHC Prevention Model

Focus	Target Group		Actions	Approaches/Models *May be implemented at any stage across the prevention continuum and could be primarily specific to AOD, Mental Health or a combination of both.*
	Population	**Individual**		
Health Promotion	The whole community or groups in the community - including those at higher risk of harmful AOD use or showing early signs of mental ill-health.	Individuals currently experiencing or recovering from problematic AOD use and/or a diagnosed mental illness.	To promote safer environments, healthy lifestyle choices and mental health.	**AOD AND MENTAL HEALTH SPECIFIC** Interventions focused on reducing the risk factors and enhancing protective factors regardless of their level of risk to: • Enhance social, emotional and spiritual wellbeing and quality of life. • Prevent the onset of harmful AOD use or mental ill-health in groups known to be at risk. • Reduce the impact of mental and AOD related ill-heath through rehabilitation and relapse prevention. **AOD SPECIFIC** AOD Three Pillars of Harm Minimisation: • *Demand reduction* - Preventing the uptake and/or delaying the onset of use of alcohol, tobacco and other drugs; reducing the misuse of alcohol, tobacco and other drugs in the community; and supporting people to recover from dependence through evidence-informed treatment. • *Supply reduction* - Preventing, stopping, disrupting or otherwise reducing the production and supply of illegal drugs; and controlling, managing and/or regulating the availability of legal drugs. • *Harm reduction* - Reducing the adverse health, social and economic consequences of the use of alcohol and other drugs, for the user, their families and the wider community. AOD Behaviour Change: • *Education/Persuasion* – inform, advise, build awareness, debunk myths and misconceptions/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. **MENTAL HEALTH SPECIFIC** • Early identification of individuals showing signs of mental health problems or illnesses and clear pathways to appropriate services. • Interventions focused on reducing risk factors and enhancing protective factors to lower the severity and duration of an illness through early evidence-based treatment.
Primary Prevention	The whole community or groups in the community. Groups at higher risk.		To: • prevent the uptake of AOD use; • delay the age at which use begins; • prevent harmful alcohol use; and/or • prevent the onset of mental ill-health.	
Secondary Prevention/ Early Intervention	Groups or individuals at high risk and/or showing early signs of problematic AOD use and/or mental ill-health.	Individuals experiencing problematic AOD use or an episode of mental illness.	To reduce the duration and severity of harmful AOD use and/or mental ill-health.	
Tertiary Prevention		Individuals receiving treatment to assist them to recover from problematic AOD use and/or from a diagnosed mental illness.	To lower the ongoing impact of problematic AOD use and/or of mental ill-health.	

Why Prevention?

KEY FACTS – BREAKOUT BOX

- Half of all mental illnesses emerge before the age of 14 years[19].
- One in five Australians aged 16 to 85 will be affected by a mental illness each year[20].
- Western Australia's suicide rate was 19 per cent higher than the national average in 2015 and has been consistently higher than the national average since 2006[21].
- Of all deaths from suicide globally, 22% can be attributed to the use of alcohol[26].
- Alcohol is the most prevalent drug used in Western Australia and causes the most drug-related harm (excluding tobacco[iii]) in the community[22].
- In 2016, approximately one in 10 (11.3 per cent) Western Australians had recently used cannabis and approximately one in 40 (2.7 per cent) had recently used amphetamines/methamphetamines[23].
- 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 2013, 332 people died by way of suicide and 152 people died as a result of a motor vehicle accident[24,25].

Graphs 1, 2 and 3 provide data on the prevalence of alcohol use by age group, recent use of illicit drugs by age group and mental illness by age group, respectively. This information supports the position that significant effort needs to be directed to implementing evidence based prevention activity in the pre-conception/peri-natal period, early years and childhood, to prevent AOD related harm and mental illness occurring in adolescence and later life.

It is estimated mental illness and mental health problems cost Australian workplaces approximately $11 billion per year through absenteeism, presenteeism (reduced productivity at work) and compensation claims[26]. AOD use costs the Australian community an estimated $55.2 billion per year, of which 27.3% is attributed to alcohol, 14.6% is attributed to illicit drug use and the remainder attributed to tobacco use[27].

In Western Australia, it is estimated that the health, social and economic harms associated with alcohol use cost $3.1 billion per year.[28,29] In 2014, there were more than 19,400 hospitalisations in WA attributable to alcohol, representing 113,549 bed-days at a cost of over $155 million[30].

Investment in prevention not only improves an individual's and the population's quality and length of life, it also makes financial sense. According to a 2017

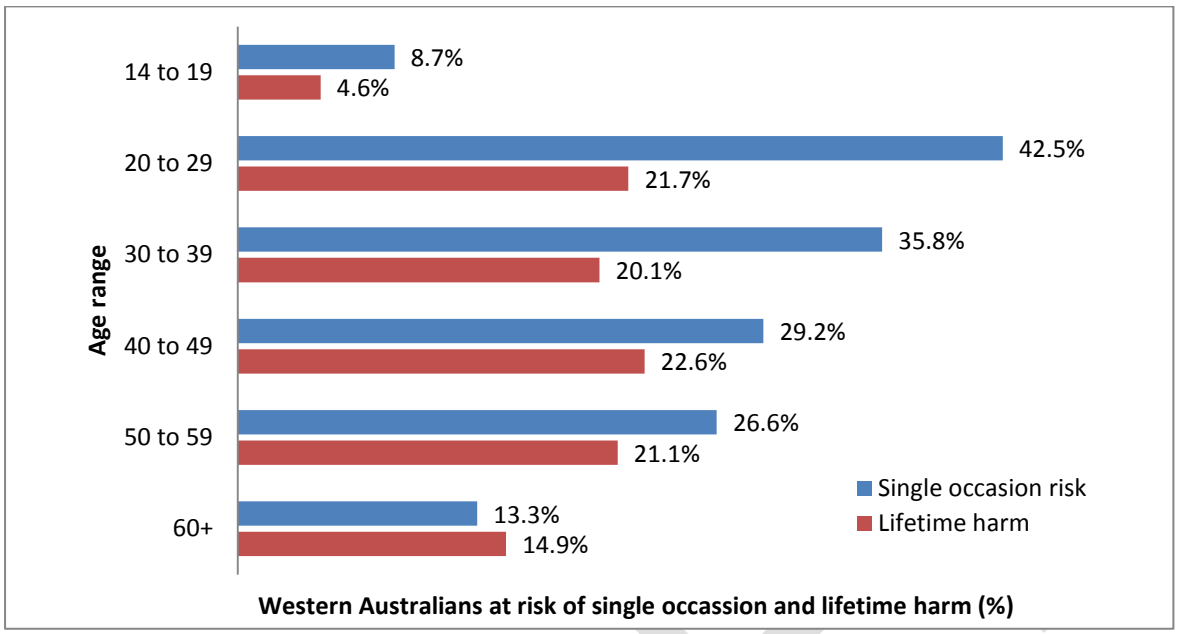
[iii] It is acknowledged tobacco causes the most drug related harm in the community, and is frequently used alongside alcohol and other drugs. There is also a high rate of tobacco use amongst people with a mental illness. Tobacco prevention activity occurs at the national and state level. State led activity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

systematic review[31] 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, it can be expected long term financial savings of up to $14 can be realised through reducing the need for treatment and other direct/indirect costs (for example, unemployment).

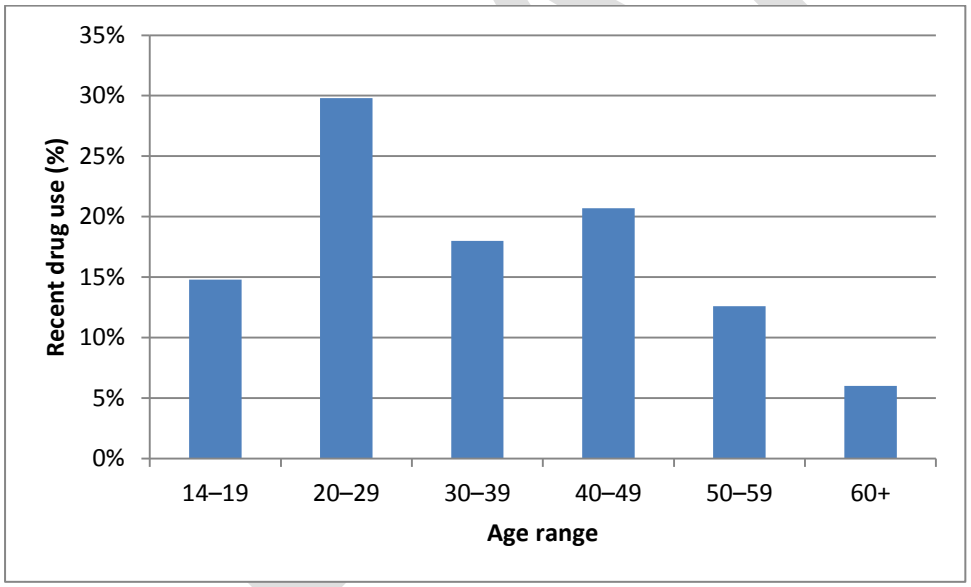
Currently the vast majority of funding is directed to costly services addressing the treatment of acute and chronic health problems. In 2016-17, approximately $842.55 million was spent on mental health and AOD treatment related services in Western Australia[32]. This equates to over 97% of the total MHC budget. Just over 2% of the MHC budget was spent on prevention. The Mental Health, Alcohol and Other Drug Plan 2015 – 2025 includes an action to increase prevention investment to 5% 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.

Graph 1. Western Australian alcohol drinking status and risk of harm by age group, 2016[33,iv].

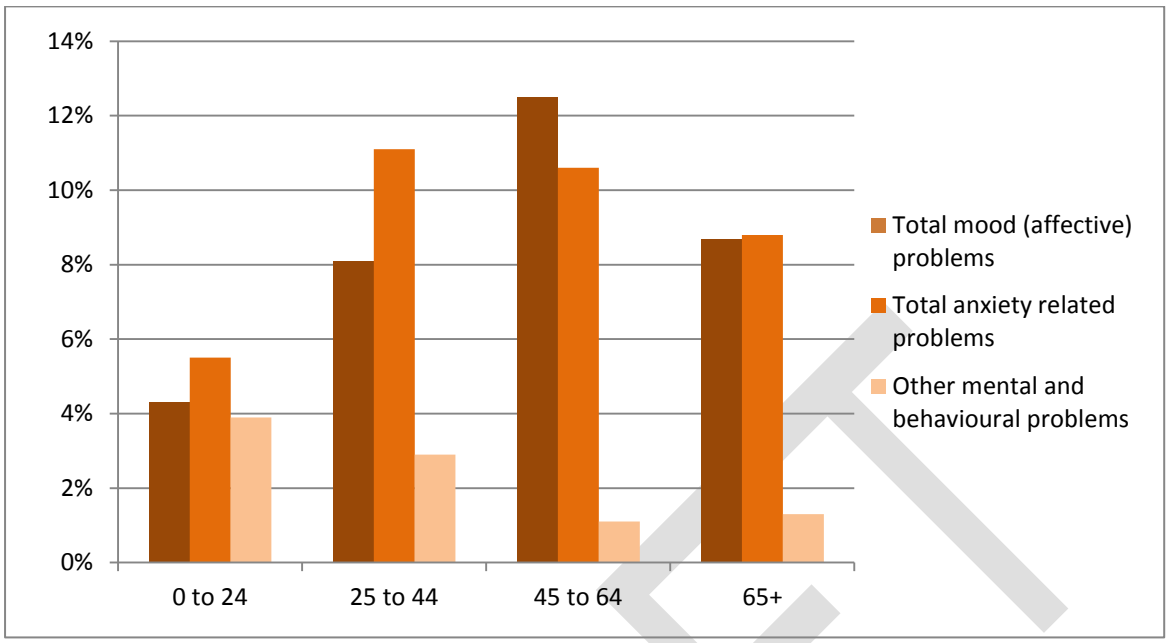


Graph 2. Recent use (in the last 12 months) of any illicit[v] drug by age group, Western Australia, 2016[34].



[iv] Single occasion risk refers to having had more than 4 standard drinks 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.
[v] 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.

Graph 3. Long-term[vi] health conditions (proportion of persons with mental and behavioural problems), Western Australia 2014-15[35].



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 Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025. Principles that relate more specifically to prevention are also included.

Principle 1: Mental health promotion and primary prevention 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 prevention and tertiary prevention strategies predominantly occur in primary care and other treatment services.

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

Effective mental health promotion and mental illness and AOD prevention starts at pre-conception and continues throughout life. Investing in prevention activities targeting the pre-conception, infancy, childhood and adolescent life are particularly important to improve health outcomes in later life. The Prevention Plan includes actions targeting specific life stages as well as actions that have an impact across all life stages.

[vi] Persons who have a current medical condition which has lasted, or is expected to last, for 6 months or more.

Principle 3: Whole-of-population, localised and targeted programs and initiatives are necessary.

Whole-of-population prevention approaches, such as public health 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 AOD harm[36].

Implementing a local education campaign targeting parents and young people on new laws regarding the supply of alcohol to minors is an example of how state based legislation can be implemented and promoted at a local level.

An example of a tailored program for a priority group 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.

Localised and targeted initiatives have the greatest potential to positively impact communities when they are co-produced with the targeted communities and are underpinned by a whole-of-population approach.

BREAKOUT BOX – THE STRATEGY OF PREVENTIVE MEDICINE

Originally identified by Geoffrey Rose[37], 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 needed[38].

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

Principle 4: Programs and initiatives are evidence-based (or evidence-informed), involving multiple strategies at local, state and national levels.

Strategies and programs are designed and produced on the basis of evidence of what works and what doesn't. This will ensure resources are allocated efficiently. Where evidence isn't directly available, programs are informed by evidence in similar fields and their effectiveness evaluated.

In prevention, single isolated strategies are not as effective as implementing multiple complimentary strategies. This 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 mass media campaigns to address drinking during pregnancy) and local community action (for example limiting access through becoming a "dry community")[39].

Principle 5: Promotion of innovation underpinned by robust evaluation is strongly supported.

There are some areas where the research evidence around strategies that work is scarce (for example initiatives effective in preventing mental illnesses such as personality disorders). 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 6: Partnerships, collaboration and stakeholder participation is essential.

Prevention activities often occur in non-health settings. Therefore close working relationships are essential between government, the private and non-government sectors, research institutions, communities and the identified target group(s). 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 greater community ownership.

Principle 7: Valuing diversity, equity and cultural inclusivity is a priority.

The Western Australian population is diverse, and prevalence of mental health and AOD problems is skewed. Certain groups in the community, such as Aboriginal peoples, are disproportionately impacted by mental illness and AOD related harm. Consideration of 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.

BREAKOUT BOX – GOOD PRACTICE CASE STUDY

ALCOHOL.THINK AGAIN – YOUNG PEOPLE CAMPAIGN

Alcohol consumption as an adolescent or young adult is associated with physical injury including accidental and violent injury[40]. Drinking alcohol also increases the risk of developing mental health and social problems, especially when a person starts drinking at a young age[41].

The Alcohol.Think Again (ATA) Program; Parents' Young People and Alcohol campaign (the Campaign) aims to increase awareness of the National Health and Medical Research Council's guidelines[42] 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 has been highly successful, continuously achieving high performance in evaluations. 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 2016[43]. Independent national public health surveys have confirmed the Campaign's success against its objectives[44].

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 decade45. Not only were fewer young people drinking, of those who drank, fewer drank at risky levels46. 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.

BREAKOUT BOX – DRUG AWARE CASE STUDY

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 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 Campaign has been highly successful, achieving high performance in evaluations. 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. This reflects the importance of the Campaign as part of a comprehensive approach to preventing and delaying methamphetamine-related harm in Western Australia.

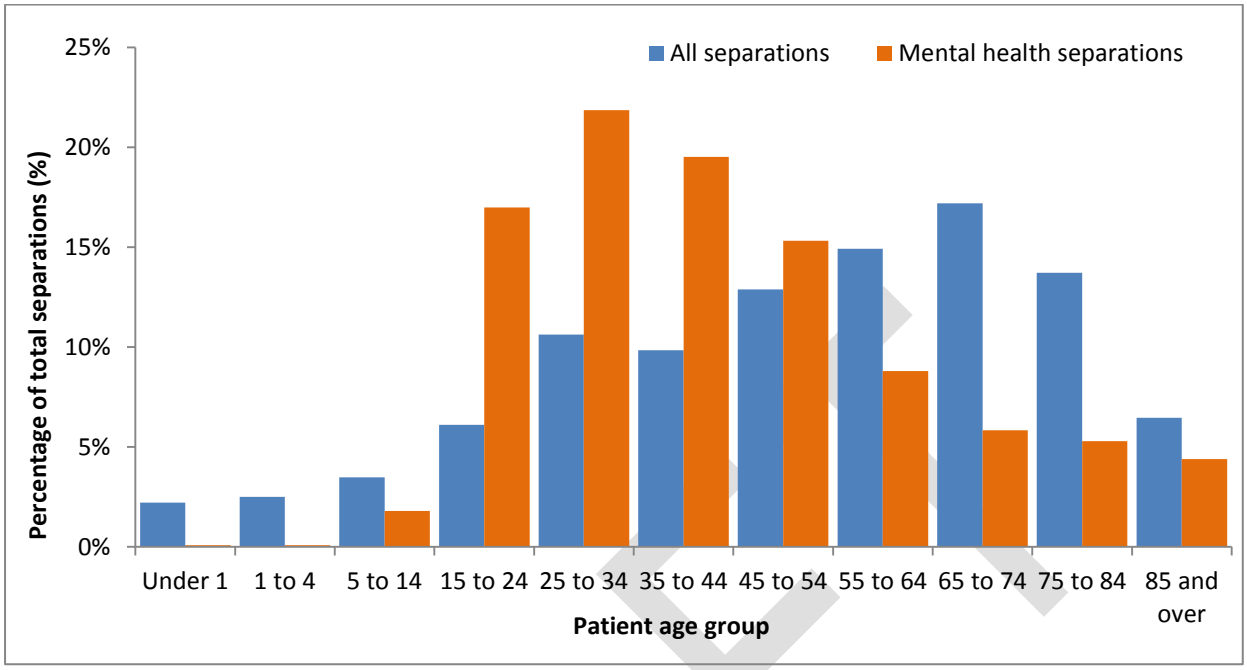
PRIORITY GROUPS

While recognising that the Prevention Plan targets the Western Australian community as a whole, it is important to note there are some groups at greater risk of preventable AOD harm and mental illness. People can be disadvantaged through economic, cultural, social, geographical location and/or educational factors.

Half of all mental illnesses emerge before the age of 14 years[47]. Investing in prevention activities targeting the pre-conception, childhood and adolescent life stages can have positive impacts across the life course therefore this life stage is a priority.

Graph 4 illustrates the percentage of inpatient separations in WA public hospitals by age group. Mental health related separations peak within the 25 – 34 year old age range, whereas all inpatient separations (inclusive of mental health separations) peak in the 65 – 74 year old age range. This indicates that in comparison with all separations, mental health problems being addressed within WA public hospitals are most common for younger age groups and highlights the importance of prevention initiatives targeting early childhood and adolescence.

Graph 4. All separations vs mental health separations in WA public hospitals by ages group, 2015/16[vii,viii]



In the majority of cases, actions that aim to improve optimal mental health and reduce AOD related harm across the whole community will also have a beneficial impact on those at high risk. Where evidence supports that particular interventions are available and effective, these can be implemented.

The Western Australian Alcohol and Drug Interagency Strategy 2017-2021 and the Mental Health 2020: Making it Personal and Everybody's Business include further information on priority groups.

FACTORS THAT IMPACT MENTAL HEALTH AND AOD HARM

Risk and protective factors are factors that influence harmful AOD use and/or the likelihood of developing a mental illness.

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 if risk factors are present, it does not necessarily mean a person will develop a mental illness or AOD problem. Similarly, a person may still develop a mental illness or AOD problem, 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.

[vii] The process by which an episode of care for an admitted patient ceases.
[viii] Data notes: All separation counts were sourced from "Admitted patient care 2015–16: Australian hospital statistics", page 51. These include non-mental health and mental health separations combined. Separations without sex or a date of birth recorded were not counted. Mental health separations were sourced from the Mental Health Data Collections at the WA Department of Health. These include all separations from mental health wards plus separations with a mental health related principal diagnosis from general wards.

Table 4 provides examples of key risk and protective factors for mental health promotion and mental illness and AOD prevention, as reported in literature[48,49].

Table 4. Examples of protective and risk factors.

	Protective factors	**Risk factors**
Mental Health	*Internal/individual level includes biological, emotional, cognitive, behavioural and interpersonal variables.*	
	• Positive sense of self • Pro-social behaviour • Problem solving skills • Adaptability • Stress management and effective coping skills • Literacy • Good parenting • Autonomy • Healthy lifestyle and good physical health • Individual mental health literacy	• Low self-esteem • Low self-efficacy • Emotional immaturity and lack of control • Social interaction difficulties • Poor work skills • Poor coping skills • Insecure attachment in childhood • Parental/Familial mental illness • Parental problematic AOD use • Pre-natal alcohol exposure • Childhood trauma • Physical and intellectual disabilities for example Attention Deficit Hyperactivity Disorder, chronic pain • Perinatal complications/low birth weight • Problematic AOD use • Unhealthy lifestyle
	Social/structural level includes social, environmental or economic variables.	
	• Good communication skills • Employment/ economic security • Positive educational experiences • Access to social services • Sense of social belonging • Community participation • Social inclusivity and tolerance • Safe and secure living environment • Community mental health literacy • Healthy living conditions	• Homelessness • Unemployment/economic insecurity • Poor quality of schooling and low school attendance • Lack of support services • Social isolation • Peer rejection • Discrimination • Poverty • Physical and Psychological factors • Violence • Displacement • Poor nutrition • Unhealthy living conditions

	Protective factors	Risk factors
AOD Harm/Problems	• Being born outside of Australia • An easy temperament • Social and emotional competence • Shy and cautious temperament • Family attachment • Parental harmony • Religious/spirituality involvement • Marriage	• Uptake of AOD use at an early age • Extreme social disadvantage • Family breakdown • Child neglect • Maternal smoking and/or alcohol use • Parental alcohol/drug problems • Pro-drug parents • School failure • Availability and use of alcohol and other drugs in the community (perceived and actual) • Child association with adults who are involved in criminal activity • Deviant peer associations • Favourable attitudes to drugs • Positive portrayals of drugs • Adult unemployment • Mental health problems • Risk taking behaviours

DOMAINS FOR ACTION

The strategies contained within the Prevention Plan fall broadly under the five domains discussed below and based on the Ottawa Charter for Health Promotion[50]. Action is required across all of these domains and the relevant life course/s 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.

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 AOD harm. This can include identifying obstacles to optimal mental health and reduced AOD harm in non-health sectors. For example, there is strong evidence to support the introduction of legislation and policy to reduce harmful alcohol consumption including the introduction of policies that can influence alcohol pricing, availability and promotion[51].

Domain 2: Creating and maintaining supportive environments.

The interaction between people and their environment can have a significant impact on mental health and AOD related harm[52,53,54]. All environments, including homes, communities, schools, workplaces, and social and cultural networks and settings provide opportunities to promote optimal mental health and reduce AOD harm. For

example, prevention initiatives can be focussed on creating supportive workplaces that promote optimal mental health and reduce harmful AOD use. Schools, sporting clubs and prisons are also settings where mentally healthy initiatives and AOD 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 requirement 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 a community that has a high suicide rate to determine a community based approach to suicide prevention. The development and implementation of AOD management plans that include a range of effective AOD prevention activities is another example.

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 and the opportunity for individuals to choose options for better 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 and AOD prevention is shared across a number of sectors including health professionals, community groups, and 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, 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.

SUICIDE PREVENTION

Suicide Prevention 2020: Together We Can Save Lives[55] (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.

The Prevention Plan is not intended to duplicate Suicide Prevention 2020, but rather provides an overarching framework for all mental health promotion and AOD prevention related activity across the State, of which suicide prevention is one important element.

An evolving evidence base has helped to inform the implementation of the projects funded under Suicide Prevention 2020. Two models have emerged in the suicide prevention space and have informed the implementation of Suicide Prevention 2020 projects. The LifeSpan multi-level systems approach to suicide prevention, currently being implemented in four pilot sites in New South Wales by the Black Dog Institute, involves nine individual strategies that aim to collectively contribute to a reduction in suicide deaths by approximately 20 per cent[56](see Diagram 2).

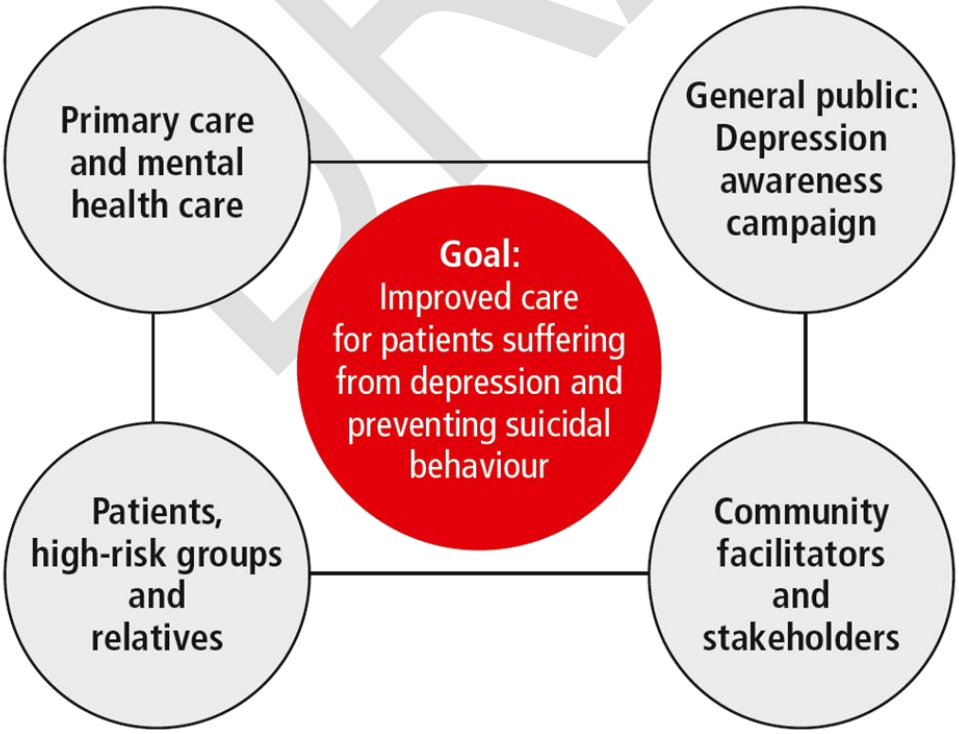
Similarly, a four-level systems approach, initiated by the European Alliance Against Depression (EEAD) saw nearly 20 per cent fewer suicidal acts in an intervention region (Nuremburg) compared with a control region (Wuerzburg) when trialled in Germany[57]. The EAAD intervention includes four areas for action, including training support for primary care physicians, awareness raising activities, training for community facilitators who serve as gatekeepers for at risk people in the community outreach and support for high risk and self-help groups (e.g. helplines). The EEAD model is currently being used by the Western Australian Primary Health Alliance as the framework for the three Commonwealth suicide prevention trial sites in Western Australia (see Diagram 3).

Although suicide prevention research is limited, what is currently available indicates that a multi-level systems approach may be the most productive way to address suicide prevention[58]. Suicide Prevention 2020 acknowledges the importance of a lifespan approach to suicide prevention, and aims to deliver activities across multiple priority populations at different stages of the life course. Several elements of a multi-level systems model are in place as a result of Suicide Prevention 2020 and these may be further improved, expanded, and consolidated as further evidence becomes available to support suicide prevention activities.

Current and future suicide prevention activity will aim to align with the systems approaches discussed above and will also take into consideration the continuously improving evidence base as new research emerges.

Diagram 2. The Black Dog Institute: LifeSpan Integrated Suicide Prevention.

Diagram 3. The EEAD: 4-Level Approach to Suicide Prevention.



STRATEGIES

The Prevention Plan strategies are categorised according to the life stage in which they are implemented and according to the relevant action domain. Strategies are not identified under all action domains for each life course, but rather focus on the key action domains and strategies that evidence suggests will have an impact.

Priority populations have also been identified, highlighting targeted prevention strategies that can have an impact on populations at higher risk of mental illness and/or AOD related harm.

Across the life course

A range of programs and strategies can have a positive impact across all life stages. Many of the strategies described below 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.

Action Domain	Strategies

Building healthy public policy	• Collaborate with 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; and financial security.
	• Support the enforcement and implementation of relevant legislative and control measures to reduce the harms associated with AOD use. This can be through initiatives targeting price, availability, promotion and products.
	• Incorporate the promotion of optimal mental health and reduction of AOD harm in health promotion programs targeting other health issues, such as physical health, nutrition and tobacco use. 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 AOD related harm.
	• Examine the need for legislation to declare management areas[ix] to prevent and reduce harm resulting from volatile substance use (VSU).
	• Seek to form responses to Emerging Psychoactive Substances including but not limited to, initiatives to improve:
	  ○ detection and identification of psychoactive substances;
	  ○ monitoring and associated data collection systems;
	  ○ standardised harm assessment processes;
	  ○ rapid responses to new psychoactive substances

[ix] 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.

	entering the market; ○ the standard treatment of 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, including that relating to nutritional medicine and neuroscience, and consider its potential to influence mental health promotion and mental illness prevention. • Introduce evidence-based policies and legislation that can reduce alcohol related harm, including (but not limited to) a national approach to alcohol taxation and/or minimum alcohol pricing; alcohol advertising controls and/or bans; and outlet density restrictions.
Action Domain	**Strategies**
Creating and maintaining supportive environments	• Develop a whole-of-population mental health promotion initiative that: promotes participation in local community activities; increases the sense of belonging within a community; provides appropriate mental health and AOD information; encourages commitment by community organisations to participate in promoting optimal mental health and reducing AOD harm; and builds capacity of organisations to plan and implement their own activities to promote optimal mental health and reduce AOD harm. The programs should aim to achieve key outcomes such as: ○ increased social connectedness and inclusion; ○ increased community networks, social connectedness, mental health literacy, connection to the natural environment, help seeking; ○ improved nutrition and physical activity; ○ reduced harmful alcohol use; and ○ delayed early uptake of AOD use amongst young people. • Expand existing interventions that promote social inclusion and reduce the stigma associated with mental illness and/or AOD use problems. This should involve: ○ Education, mass communication and sponsorship initiatives utilising effective, market tested key messages and/or branding. Priority target groups include young males, health professionals, 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.

Action Domains	Strategies

Creating and maintaining supportive environments	• 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:
	  ○ Liquor licensing programs;
	  ○ Safer events project;
	  ○ Local Government alcohol management support;
	  ○ Programs to reduce harmful alcohol use and exposure in sporting clubs;
	  ○ Leavers week co-ordination;
	  ○ AOD workplace policies; and
	• State-wide VSU co-ordination.

Strengthening communities to take action	• Develop localised prevention plans in metropolitan and regional Western Australia covering mental health promotion, mental illness and suicide prevention, and AOD prevention. Localised plans need to include a range of effective strategies, such as:
	  ○ community mobilisation actions;
	  ○ local support for enforcement of relevant laws (for example Secondary Supply laws);
	  ○ harm reduction strategies;
	  ○ programs targeting underage drinking and other drug use;
	  ○ responsible service of alcohol initiatives;
	  ○ mechanisms to promote state-wide education messaging and increase support for effective alcohol control measures;
	  ○ industry and retail supply programs to prevent VSU (in high risk/prevalence communities); and
	  ○ activities to increase community connectedness and social inclusion.
	• Build upon the achievements made in suicide prevention, through:
	  ○ 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 mental health promotion, mental illness and AOD prevention strategies, where relevant.
	• Support organisations that can foster effective localised community action.
	• Involve consumers, families, carers and community members in the development and implementation of prevention activities.

Action Domain	Strategies

Developing personal skills, public awareness and engagement	• Continue to support and expand the scope of whole-of-population (including mass reach campaigns) and targeted education strategies, including sponsorship where relevant, to:
	  ○ increase mental health literacy and help-seeking behaviour;
	  ○ increase understanding and action relating to maintaining optimal mental health;
	  ○ increase community awareness of the impacts of harmful alcohol use, use of licit and illicit drug use; 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 mental health promotion, mental illness and AOD prevention policies and strategies, such as (but not limited to):
	  ○ mandatory school curriculum-based AOD and mental health promotion programs;
	  ○ mentally healthy workplace policies, standards and assessments;
	  ○ policies that reduce stigma and promote social inclusion;
	  ○ alcohol advertising regulation;
	  ○ reducing alcohol availability, 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 priority population groups including but not limited to Aboriginal people, culturally and linguistically diverse groups, youth and pregnant women.
	• Through the media, and broader stakeholder communications, support the communication of appropriate and supportive AOD, mental illness and suicide reporting. Reporting in the media and other mass communications can have an impact on reducing stigma, promoting social inclusion and reducing community misconceptions.
	• Educate prescribers and dispensers about responsible dispensing practices in relation to potentially harmful medications.

Action Domain	Strategies
Developing personal skills, public awareness and engagement	• Further investigate effective and innovative new and emerging methods of delivering whole of population and targeted evidence-based prevention programs (for example, online).

Reorienting and maintaining relevant services	• Ensure workforces are knowledgeable about, and act on, mental health promotion and prevention.
	• Establish an evidence-based mental health and AOD brief intervention program in primary care settings. Brief interventions can include:
	  ○ assessment of the client's AOD use and/or mental health;
	  ○ feedback from the assessment;
	  ○ advice or information about how to reduce AOD-related harms and/or improve mental health;
	  ○ assessment of and feedback about the client's readiness to change;
	  ○ problem solving;
	  ○ goal setting
	  ○ AOD relapse prevention; and
	  ○ follow up.
	• Support relevant agencies to collect, monitor and share reliable data, to underpin prevention activity, policy and workforce development.
	• Improve community access to reliable AOD and mental health information and support services. Access to accurate information, such as easily accessible phone-based or online interaction (for example chat) and information, provides an avenue for individuals to seek further information and access relevant support if needed.

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

The perinatal and early years life stage encompasses the period before conception through to prior to a child starting formal schooling (approximately age 3 or 4 years). This is a critical stage which can influence future mental health and wellbeing. It is also a stage where future AOD harms can be minimised. Dedicated programs for this life stage are essential to prevention and focus on:

- supporting mothers to cease AOD 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.

Action Domain	Strategies

Developing personal skills, public awareness and engagement	• Provide a comprehensive prenatal program (or suite of programs) for at risk families. Programs should target areas such as (but not limited to):
	  ○ 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:
	  ○ increase parents' mental health, wellbeing and protective factors;
	  ○ build strong, healthy relationships;
	  ○ promote positive parenting;
	  ○ 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, and 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:
	  ○ 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.
	• Implement effective AOD prevention interventions targeting women of child-bearing age (particularly pregnant and breastfeeding women) through a range of broad-based and targeted activities, such as:
	  ○ education and awareness raising campaigns to increase knowledge of risks associated with AOD 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 AOD use during pregnancy and

Action Domain	Strategies
Developing personal skills, public awareness and engagement	○ promotion of routine identification and intervention with women of child-bearing age (particularly pregnant women) who are using AOD; and ○ brief interventions in primary care settings.
Reorienting and maintaining relevant services	• Through relevant education agencies, such as the Department of Education, ensure effective, targeted educational support programs are available for at-risk young children (prior to commencing formal schooling).

Children and young people (4-18 years old)

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 resilience, promote optimal mental health and reduce AOD harm. 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. Specific strategies relevant to this life stage can include school based programs that support resilience and coping, and increase age-appropriate knowledge regarding AOD. This is also an age where body image concerns, sexual orientation, relationship issues, bullying and social media use can have a significant impact on the mental health of young people and both present and future AOD use, including the potential for self-medication with AOD.

Action Domain	Strategies
Building healthy public policy	• Continue to support key supply, demand and harm reduction strategies to reduce AOD harm, such as: ○ 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 AOD, including limiting the secondary supply of alcohol to young people; ○ developing comprehensive VSU plans in regions prone to use; and ○ providing peer education. • Continued support for whole school approaches to manage AOD use and mental health issues such as bullying, discrimination and risks associated with suicide and/or self-harm.

Action Domain	Strategies
Developing personal skills, public awareness and engagement	• Deliver multi-faceted programs that include age appropriate AOD education and promote optimal mental health, wellbeing and resilience of young people. Programs should link the National Curriculum, be mandatory, reflect evidence-based best practice and include content to: ○ increase protective factors; ○ address the safe use of social media; ○ appropriately utilise social media to promote optimal mental health, and prevent early uptake and harm associated with AOD 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 behaviour modification for relevant staff development activities (for example for teachers, child and health staff) to enhance children's attention skills and improve management of challenging behaviours, such as those associated with Anxiety Disorders and Attention Deficit Hyperactivity Disorder. • Develop targeted evidence-based online prevention programs that can increase protective factors and decrease risk factors for at risk groups.
Reorienting and maintaining relevant services	• Ensure early intervention services are provided for children and young people showing early signs of mental health problems and experiencing AOD harm. This may include: ○ early psychosis interventions; ○ brief interventions for young people using AOD; ○ early identification of children whose parents have a mental illness and/or use AOD; and ○ collaboration with school-based services to promote and improve help seeking and referrals.

Adults (18 – 65 years old)

A range of life changes and challenges can occur during adulthood, such as raising children, caring for older parents, unemployment, employment, and managing financial difficulties. It is also a time when a person is at greatest risk of being impacted by AOD harm. Recent data suggest the prevalence of adults in the 50-59 year age group consuming more than 11 standard drinks over a month has increased from 4.1% in 2013, to 5.8% in 2016[59].

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.

Action Domain	Strategies

Building healthy public policy	• Develop tailored workplace mental health promotion and AOD prevention activities that include:
	  ○ genuine staff involvement;
	  ○ employee assistance programs;
	  ○ 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; and
	  ○ policies to enhance employment such as paid parental leave.
	• Continue to support key harm reduction strategies to reduce AOD harm, such as:
	  ○ initiatives to reduce VSU;
	  ○ overdose prevention programs (for example naloxone[x] programs);
	  ○ peer education initiatives; and
	  ○ needle and syringe programs to prevent blood borne viruses.

Creating and maintaining supportive environments	• Work with relevant agencies to support the enforcement of key legislation and policy, including responsible service of alcohol 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.

[x] Naloxone blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness.

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 AOD 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[60]. There is also an increasing prevalence of harmful drinking among people aged 65 and over[61]. Older people may have a lower physical tolerance for alcohol, and alcohol may exacerbate other health conditions or interact with prescription medications[62].

Action Domain	Strategies
Developing personal skills, public awareness and engagement	• Deliver comprehensive programs (or a suite of programs) that promote optimal mental health and wellbeing and reduce AOD harm in older adults at risk. Where relevant, programs should: ○ focus on older adults with ill-health, veterans, socially isolated older adults and those experiencing discrimination; ○ reduce stigma; ○ increase mental health literacy; ○ include strategies to minimise or reduce risk of depression and AOD harm; ○ increase help seeking; ○ use peers, professionals and volunteers where appropriate; and ○ encourage the uptake and maintenance of physical activity.

Priority Populations

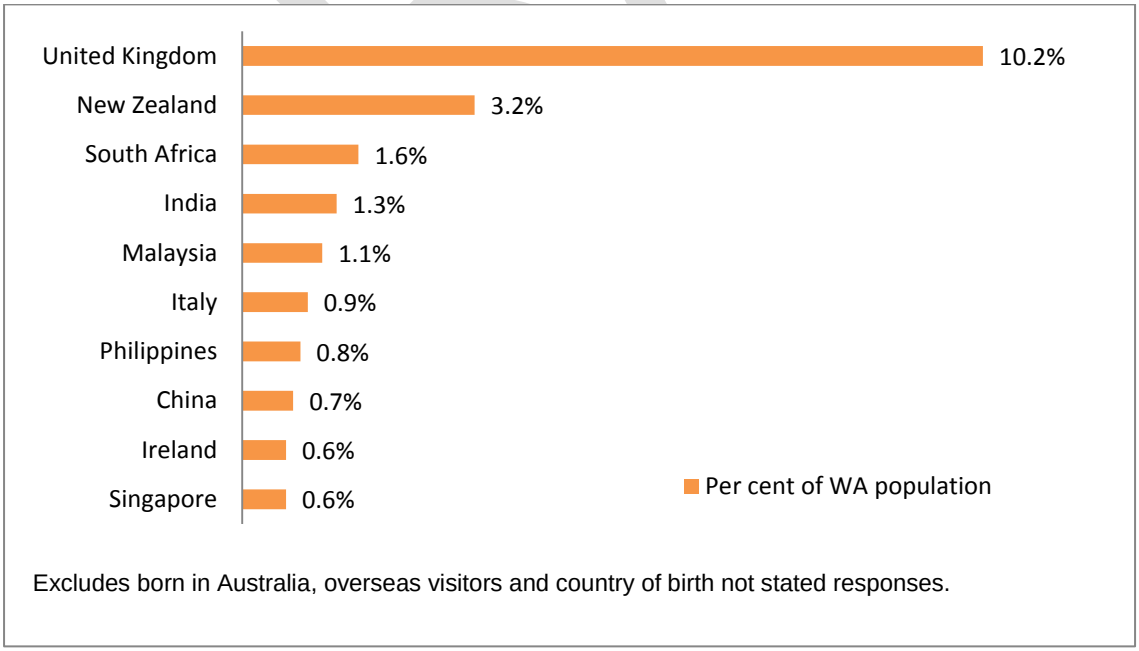
Particular groups in the population are at an increased risk of developing a mental illness or being impacted by AOD harm. The whole-of-population and age-specific programs and strategies described above can have a positive impact on people at greater risk. In addition, there is also a requirement to implement targeted programs for population groups at higher risk to further support population based approaches to mental health promotion and prevention. Targeted programs for priority populations are detailed below.

BREAKOUT BOX - Aboriginal Social and Emotional Wellbeing

Acknowledging and understanding the historical impact of colonisation upon Aboriginal peoples physical, spiritual, and social and emotional wellbeing is vital to reduce self-harm and suicide[63]. 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.

Examples of culturally secure projects are the *Looking Forward: Aboriginal Mental Health Project* which aims to improve the effectiveness of AOD services and public mental health services for Nyoongar families affected by serious mental health issues; and, the Family Wellbeing (FWB) package, an accredited course with the Australian Skills Quality Authority, which addresses the physical, mental, emotional and spiritual issues relevant to an individual's wellbeing, family and community harmony.

Graph 5. Proportion of Western Australians born overseas, top 10 countries of birth, 2011[64].



Excludes born in Australia, overseas visitors and country of birth not stated responses.

Strategies for priority populations

- Deliver targeted programs that promote good mental health and wellbeing and reduce the risk of mental illness for people with **diverse sexuality and gender**. This may include:
    - 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.
- Ensure all programs are culturally secure for the diverse population of Western Australia, and meet the specific needs of **Aboriginal people and communities**.
- Develop holistic programs that promote social and emotional wellbeing and prevent and reduce AOD harm in **Aboriginal communities**. Programs will align with existing policies and programs where relevant. Programs :
    - will be community based and community led;
    - provide opportunities to develop community leadership and skills;
    - will be tailored to specific communities; and
    - focus on building protective factors and reducing risk factors.
- Develop holistic programs to promote mental health, reduce mental illness and AOD harm in **Culturally and Linguistically Diverse** groups, such as refugee communities. Programs align with existing programs where relevant and may include:
    - an advocacy component;
    - initiatives to decrease post-migration stress and increase social connectedness;
    - the creation of meaningful social roles;
    - increased access to support services; and
    - group style programs, peers and volunteers where possible.
- Implement targeted programs for **people with disability** that promote good mental health and reduce the risk of mental illness and AOD harm. Programs should:
    - 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.
- Develop an evidence-based program to support the mental health and wellbeing of **children who have a parent/s with an AOD problem and/or parent/s with a mental illness**. This may involve online components where appropriate. Programs aim to:
    - increase mental health literacy;
    - build resilience;
    - establish effective thinking and coping styles;
    - increase social connection;
    - improve family dynamics where required; and
    - include age-appropriate AOD education.
- Develop targeted programs to treat trauma and reduce the risk of mental illness amongst people who have been **victims of trauma and/or sexual assault**.

PREVENTION SYSTEM SUPPORTS

Although there are a variety of strategies and programs described in the Prevention Plan, in order for these 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 skilled prevention workforce is necessary. Prevention system supports are outlined below according to themes and their corresponding strategies.

Theme	Strategies
Coordination	• 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.
Cultural security	• Ensure all new and existing programs and initiatives are culturally secure.
Workforce	• Increase the number and 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 AOD and mental health 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): o agreement on core competencies for prevention officers; o employing prevention specialists in prevention roles; o mentoring of prevention officers to increase their knowledge, competence and confidence in mental health promotion and prevention; o inclusion of appropriate prevention curriculum in existing relevant undergraduate and post graduate courses and training (for example health promotion courses); and o expansion of the workforce skilled in prevention. • Continue to develop local expertise in mental health promotion and mental illness and AOD prevention.

Theme	Strategies
Funding	• Achieve the optimal level of resource (including human resources) to ensure the consistent delivery of prevention strategies to the community 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	• Continue to support independent research on what works in the area of mental health promotion, AOD and mental illness 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	• Improve the quality and collection of relevant data which can inform evidence-based prevention activity, such as alcohol use in pregnancy notifications in appropriate data collection systems. • Real time suicide attempt and death by suicide data.

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. Additional groups may be formed for the development of specific initiatives where required.

Other stakeholders including local government and local communities can 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.

The Prevention Plan goals will guide the work of government and non-government agencies. However, it is also important to measure short and medium term outcomes

to determine whether the prevention-related activity implemented is effective to ultimately achieving longer-term goals.

A Program Logic Model is a useful tool to be applied when planning prevention activities. The MHC has developed a Prevention Plan Program Logic Model as a guide for all stakeholders to assist in their development, implementation and evaluation of prevention activity. The model (**Flow Chart 1**) includes inputs and activities as well as short, medium and long-term outcomes. The model 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 MHC will evaluate its own prevention activities, aligned to the Prevention Plan Logic Model, to determine the effectiveness of the initiatives and aid in informing future program development to achieve longer term goals.

BREAKOUT BOX – DEFINITIONS PROGRAM LOGIC[65]

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.

Flow Chart 1 Prevention Plan Program Logic Model

Inputs →	Activities/Outputs →	Output Indicators →	Outcomes
Funding **Human resources** **Workforce Development** **Research and Data**	Stakeholders to populate activities/outputs in relation to their organisation's relevant business activity and the appropriate domains for action. Examples of the types of activities/outputs which could be implemented under each domain for action are provided below. **Build healthy public policy.** • *Support for whole school approaches to manage AOD use and mental health issues such as bullying, discrimination and risks associated with suicide and/or self-harm.* **Create and maintain supportive environments** • *Work with relevant agencies to support the enforcement of key legislation and policy, including responsible service of alcohol programs and supply reduction activities.* **Strengthen communities to take action** • *Develop local community action plans to address mental health, suicide prevention and AOD prevention.* **Developing personal skills, public awareness and engagement** • *Deliver a local community education and awareness raising campaign to reduce stigma associated with mental illness.* **Reorient and maintain relevant programs and services** • *Establish an internal process to collect, monitor and share reliable data of prevention activities implemented.*	Stakeholders to populate output indicators in relation to their organisation's relevant business activity. Examples of the types of outputs which could be implemented are provided below. • *Number of schools who are implementing a whole school approach to manage AOD use and mental health issues.* • *Number and type of strategies implemented to support legislative and control measures to reduce the harms associated with AOD use.* • *Number of local community action plans being implemented in local communities to address mental health, suicide prevention and AOD prevention.* • *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 AOD.*	**Short-term** • 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 (NHMRC) 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. **Medium-term** • 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 AOD and/or mental health 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. **Long-term** • Increase mental health and wellbeing. • Reduction in the incidence of mental illness, suicide and suicide attempts. • Reduction in the number of AOD related presentations to hospital and emergency departments.

GLOSSARY

Alcohol and other drug harm: Refers to the negative impact of AOD use on communities, families and individuals. This includes health harms such as injury; lung and other cancers; cardiovascular disease; liver cirrhosis; mental health problems; 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 protections issues. Harmful AOD 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 AOD issues by reducing the harmful effects of AOD on individuals and society. Harm minimisation considers the health, social and economic consequences of AOD 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
Measures that prevent or delay the onset of AOD use as well as measures that protect against risk and reduce harm associated with AOD supply and use.

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. A culturally secure approach is essential when developing programs, services, policies and strategies.

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 problems: A disruption to our usual level of social and emotional wellbeing.

Mental health promotion
Mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles.

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

Mental illness: A clinically diagnosable medical condition that significantly interferes with an individual's cognitive, emotional or social abilities.

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

Social and emotional wellbeing: Aboriginal people 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.

APPENDIX A

Key policies

State-level policies and strategies

Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025 (the Plan)

The Plan outlines the optimal mix and level of mental health, AOD 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 level of FTE required to implement the AOD 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 AOD prevention, which does not include program costs (for example for mass media campaigns).

The Draft Western Australian Alcohol and Drug Interagency Strategy (the Draft IS)

The Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015 is the State's key policy document that outlines strategies to prevent and reduce the adverse impacts of AOD in Western Australia. The document has been updated and is expected to be finalised in 2017. The Draft IS identifies prevention as a key strategic area and includes the following areas of focus associated with prevention:

- preventing and delaying the onset of AOD 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 AOD problems; and
- supporting initiatives that discourage the inappropriate supply of AOD.

Mental Health 2020: Making it personal and everybody's business
(Mental Health 2020)

Mental Health 2020 is a pivotal document outlining 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.

Western Australian Health Promotion Strategic Framework 2017 – 2021 (the Health Promotion Framework)

The Health Promotion Framework acknowledges the link between mental health problems and a range of risk factors such as tobacco use, poor physical health, chronic disease and harmful alcohol use. Reducing harmful alcohol use is identified as a priority area in the Health Promotion Framework. Domains for action include: healthy policies; legislation and regulation; economic interventions; supportive environments; community development; targeted interventions; and strategic coordination, building partnerships and workforce development. Many of the strategies in the Health Promotion Framework align to, and complement the strategies contained in the Prevention Plan.

Suicide Prevention 2020: Together We Can Save Lives (Suicide Prevention 2020)

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 nongovernment sectors to build mentally healthy workplaces.
5. Increased suicide prevention training.
6. Timely data and evidence to improve responses and services.

National level policies and strategies

Draft National Drug Strategy 2016-2025

The Draft National Drug Strategy 2016-2025 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 AOD use issues;
- improving national coordination;
- developing and sharing data to support evidence-informed approaches; and
- developing responses that restrict or regulate the availability of AOD.

The Fifth National Mental Health Plan (Fifth Plan)

The Fifth National Health Mental Health 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 and carers 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.

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