

# People's beliefs about factors contributing to mental health: implications for mental health promotion

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## Introduction

Governments in developed countries around the world are being confronted with increasing rates of mental health problems and complex psychosocial disorders such as substance misuse, violence and crime. These outcomes are associated with significant personal, social and economic costs. Many of these problems are not new but what is new is their increasing prevalence and burden, their occurrence earlier in life, their increased visibility and their persistence. Within Australia, the point prevalence of mental health disorders in children and young people is in the order of 16-20% between the ages of 4-

11, rising to 20-25% between ages 12-17 and peaking at 25-40% between ages 18-24.<sup>1-5</sup>

In 1990, of the 10 worldwide leading causes of disability measured in years lived with a disability, five were mental health conditions. Using measures of disability adjusted life years, Murray and Lopez have shown that mental health disorders emerge as a highly significant component of global disease burden when disability, as well as death, is taken into account.<sup>6</sup> Their projections show that mental health could increase its share of the total global burden by almost half, from 10.5% of the total burden to almost 15%, by 2020. It is now widely

## Abstract

**Issue addressed:** To quantify people's perceptions of mental health identified in qualitative research and to inform mental health promotion communication strategies.

**Methods:** A statewide telephone survey of 1,500 adults was conducted in Western Australia using a structured questionnaire containing both open and closed-ended questions.

**Results:** The vast majority of people had negative (or illness) connotations to the words 'mental health', but had positive connotations to the term 'mentally healthy person'. The three factors perceived to contribute most to being mentally healthy were: having good friends to talk problems over with; keeping one's mind active; and the opportunity to have control over one's life. The three factors perceived to contribute most to being mentally unhealthy were: excessive use of alcohol or drugs; having no friends or support network; and life crises or traumas. The phrase 'being content with who you are' best summed up good mental health. Older people generally placed greater emphasis than younger people on cognitive functioning and keeping physically healthy for good mental health.

**Conclusions:** People's beliefs about factors influencing mental health are consistent with much of the literature. Communication components of mental health promotion interventions based on the data reported here would be viewed as credible and relevant by most people.

**Key words:** Mental health promotion, beliefs about mental health.

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## So what?

The first stage in promoting mental health should be to raise the salience of positive connotations to the term 'mental health'. To achieve this, it is recommended that the term 'mentally healthy' be used as widely as possible in all mental health promotion communications, both in produced materials and in spontaneous situations such as talk-back radio, television magazine shows or press interviews. It should not replace 'mental health', but rather be used concurrently. The communication strategy should create and reinforce the beliefs that there are things that people can and should do to maintain or enhance their mental health. Being active – cognitively, socially and physically – is a possible umbrella theme that would be easily understood and accepted as important for one's mental health by all demographic groups.

acknowledged that the growth of mental health problems is outstripping the capacity of mental health services to meet the demand for conventional, individually based treatment services.

It is against this background of increasing service demand and unmet need that there has been growing international interest in promotion, prevention and early intervention for mental health. The United States (US) Institute of Medicine produced a definitive review of the evidence for prevention in mental health,<sup>7</sup> and specific prevention programs have now been established in the US by government mandate.<sup>8</sup> The World Health Organization has taken a leadership role in assisting governments to recognise the economic benefits of promoting better mental health.<sup>9</sup> These initiatives have been developed within the framework of the Ottawa Charter for Health Promotion.<sup>10</sup> Key components of the charter are: building healthy public policy and emphasising the role of all sectors in health outcomes; creating supportive environments in all settings; strengthening community action; developing personal skills, including mental health literacy; and increasing the focus on prevention and early intervention. This has been further endorsed in a report of the US Surgeon-General that emphasises the role of promotion and prevention, particularly in relation to a growing understanding of the factors that are risks to or protective of mental health.<sup>8</sup>

Promotion, prevention and early intervention activities in Australia are taking place in the context of a major expansion of activity in the area of mental health. In 1992, all State and Territory health ministers agreed on a National Mental Health Strategy to take forward a nationally agreed agenda for mental health reforms in Australia.<sup>11</sup> This first National Mental Health Plan (1992) concluded in June 1998.

The second National Mental Health Plan for the period 1998 to 2003 provided a five-year framework to advance mental health reform, identifying three priority areas for future activity: promotion and prevention; partnerships in service reform; and quality and effectiveness of service delivery.<sup>12</sup> The third National Mental Health Plan for the period 2003 to 2008 has reframed these priorities as: promotion and prevention; increasing service responsiveness; improving quality; and fostering research, innovation and sustainability.<sup>13</sup>

However, many population-wide examples of promotion and prevention are concerned with encouraging early intervention or destigmatisation rather than the promotion of good mental health.<sup>14,15</sup> One recent exception is the VicHealth 'Together We Do Better' campaign, which sought to promote community understanding of the importance of behavioural and social factors to mental health outcomes, with an emphasis on connectedness as important for good mental health.<sup>16</sup>

To develop strategies to promote mental health and increase mental health literacy, we first need to identify and understand

people's beliefs about and understanding of mental health. Although communication strategies are only one component of mental health promotion interventions, they are a vital component as their objective is to sensitise the target audience to respond positively to other intervention components. However, although there have been studies in Australia and overseas of people's attitudes towards the mentally ill and people's perceptions of the causes of chronic mental illnesses,<sup>17,18</sup> little is known about people's beliefs about factors contributing to or hindering good mental health.<sup>19</sup> Donovan et al. developed a grounded theory model of people's understanding of mental health.<sup>20</sup> In their focus groups they found that the term 'mental health' had connotations primarily of 'mental illness', but that the term 'mentally healthy' had primarily positive (or 'good health') connotations. Their qualitative research also identified several factors people believed to contribute to good mental health, and, conversely, several

**Table 1: Sample demographics.**

	<b>Metro n=1,000 %</b>	<b>Country n=500 %</b>
<b>Sex</b>		
Male	50	50
Female	50	50
Total	100	100
<b>Age (years)</b>		
18-29	16	12
30-39	20	21
40-49	21	25
50-59	20	21
60-69	11	14
70+	12	7
Total	100	100
<b>Household composition</b>		
Live alone/group of unrelated people	20	15
Live with friend(s)	6	5
Live with a related person	28	36
Live with several related people	45	43
Live with friends and relatives	2	2
Total	100	100
<b>Employment status</b>		
Working full time	43	48
Working part time	19	20
Studying	9	4
Home duties	13	18
Retired/pensioner	22	18
Unemployed	2	3
Total <sup>a</sup>	—	—
<b>Household income</b>		
Less than \$25,000	23	29
\$25,000–\$50,000	26	29
\$50,000–\$75,000	20	16
More than \$75,000	20	19
Refused/Don't know	10	8
Total	100	100

(a) Total may exceed 100% as multiple responses were permitted.

factors believed to contribute to being mentally unhealthy or vulnerable to mental health problems. This study reports on the quantification of the perceived relative importance of the factors identified in the qualitative research via a statewide telephone sample and considers the implications for public health education campaigns designed to promote mental health.

**Methods**

**Sample**

A computer-assisted telephone interview (CATI) survey methodology was used. The interviews were conducted on weekends and weekday evenings between 4.30pm and 9pm to maximise the availability of household members aged 18 years plus. Random digit dialling was used to select households for inclusion in the survey. Quotas were used to recruit 1,000 metro and 500 country respondents and to ensure an approximately equal representation of males and females in each location. The interviewing was conducted by the Survey Research Centre at the University of Western Australia. For the metro sample, 7,959 calls in total were made. Of these, 5,550 were unobtainable or business numbers. Of 2,409 calls to home residences, 1,058 refused, 141 did not meet the screening criteria, 210 were unable to complete (for example, because the quota was full), leaving 1,000 completed questionnaires, a response rate of 41.5%. For the country sample, 4,006 calls in total were made. Of these, 2,733 were unobtainable or business numbers. Of 1,273 calls to home residences, 544 refused, 95 did not meet the screening criteria, 134 were unable to complete, leaving 500 completed questionnaires, a response rate of 39%.

**Questionnaire construction**

The questionnaire contained a number of open-ended and closed-ended questions related to people’s perceptions of mental health derived from the qualitative phase of the study.

This paper presents the results from two of the open-ended and three of the closed-ended questions described below. The complete questionnaire can be found in Donovan et al.<sup>20</sup>

One of the main findings from the qualitative phase was that the words ‘mental health’ had primarily negative associations for most people (i.e., connotations of mental illness). That is, when people were asked ‘what sorts of things might happen in a ‘mental health’ week’, most responded with connotations of mental illnesses (e.g. schizophrenia, psychiatry, institutions, depression).<sup>20</sup> Hence the questionnaire included the following question to quantify the extent to which these connotations existed in the population at large: Thinking about mental health, what thoughts, words or images come to mind when I say the words “mental health”?

The qualitative research<sup>20</sup> suggested that one strategy to achieve more positive connotations was to use the term ‘mentally healthy’ in place of or in conjunction with the term ‘mental health’ in public discourse. One objective of the quantitative phase was to confirm that the words ‘mentally healthy’ did in fact have positive connotations. Hence we asked the question: Now imagine a person who is “mentally healthy”. What words would you use to describe such a person?

Donovan et al. identified eight factors that people considered contributed to a person being ‘mentally healthy’.<sup>20</sup> These eight factors are shown in Table 2. The questionnaire asked respondents to select the factor they considered most contributed to good mental health. To reduce the cognitive effort required in a telephone interview to consider all eight at the same time, respondents were first presented with four of these statements and asked ‘which of these was the most important contributor to a person being mentally healthy’. They were then presented with the remaining four and asked which of those they thought most contributed to a person being mentally healthy. Respondents were then presented with their selection from each subset of four and asked which of those two they

**Table 2: Factor that most contributes to a person being mentally healthy.**

	% (n=1,500)
Having good friends to talk problems over with	28
Opportunity to have control over your life	22
Keeping their mind active	21
Being physically healthy	10
Having a job – whether it is paid or unpaid	6
Having the opportunity to achieve small successes every day	6
Belonging to a community group, club, church or some other group of like-minded people	4
Being recognised by others when they do something good	3
<b>Total</b>	<b>100</b>

**Table 3: Factor that most contributes to a person being mentally unhealthy or vulnerable to mental health problems.**

	% (n=1,500)
Excessive use of drugs or alcohol	32
Having no friends, no support network (friends/family) or being socially isolated	24
Life crises or trauma	15
Being too harshly criticised no matter what they do	10
Being discriminated against or rejected for whatever reason	8
Not having a job or role in life	7
Few opportunities to achieve any successes in everyday life	3
Having no time to themselves	1
<b>Total</b>	<b>100</b>

thought most contributed to a person being mentally healthy. The selection of subsets of four was randomised for each respondent by the CATI system.

Donovan et al. also identified eight factors that people considered contributed to a person being 'mentally unhealthy'.<sup>20</sup> These are listed in Table 3. Using the same split-half procedure as above, respondents selected the factor they considered most contributed to a person being mentally unhealthy.

Finally, Donovan et al. identified eight statements that people used in the group discussions to summarise what they felt 'good mental health' meant overall to them.<sup>20</sup> These statements are listed in Table 4. Using the procedure as above, respondents nominated which of these statements 'best summed up' what good mental health meant to them.

## Results

### Sample characteristics

As per the quota, equal proportions of males and females were obtained. The age, employment status, income distribution and household composition are shown in Table 1. The sample demographic composition is generally consistent with Census data.

Two coders worked together in conjunction with the first author to develop the content codes for all open-ended questions and then to classify all 1,500 respondents' responses into these categories. Where the two coders differed on a classification, the first author made the final decision. The individual comments classified under the various content codes are shown in full in Donovan et al.<sup>20</sup> for the questions of interest in this report. Chi square was used to test for significance of differences.

### Connotations to the term 'mental health'

Associations to the words 'mental health' were content analysed

**Table 4: Factor that most sums up what good mental health means.**

	% (n=1,500)
Being content with who you are	40
Being able to cope with everyday problems	11
Being active, living life and participating in things going on around them	11
Being able to control one's emotions, especially ones like anger, hate and jealousy	9
Being mentally alert, knowing what's going on around you	7
Able to openly talk to others easily both socially and about problems	9
Being able to cope with major crises that occur in life	7
Being cheerful and happy	6
<b>Total</b>	<b>100</b>

for themes indicating an illness or negative association and those indicating a healthy or positive association. As most respondents gave more than one response (36% gave only one; 32% gave three or more; the average was two), and some gave both positive and negative associations, each response was coded separately. Those who had only negative associations or who had more negative than positive associations were classified as 'negative'. Those who had only positive associations or who had more positive than negative associations were classified as 'positive'. Those who had an equal number of positive and negative associations were classified as 'mixed'.

As anticipated, the majority of associations to the words 'mental health' for the vast majority of respondents related to mental illness. In terms of individual respondents, the overall classification yielded:

- 68% with only or primarily negative associations.
- 11% with mixed associations.
- 21% with only or primarily positive associations.

In fact, considering first responses only, a 'negative' association was first to mind for 72% of respondents.

Females were more likely than males to have primarily or only negative associations, although the difference was not large (71% vs. 64%;  $p=0.00$ ); higher educated respondents were more likely to have positive associations than lower educated (24% vs. 15%;  $p=0.00$ ); and over 70s were more likely to have positive associations than under 70s: 31% vs. 20% ( $p=0.00$ ).

### Connotations to the term 'mentally healthy'

None of the associations to a 'mentally healthy' person was negative, confirming the qualitative research finding that the term 'mentally healthy' when used to describe a person generates generally positive connotations. The responses were content analysed for overall themes with the results showing themes of positive affect associations (e.g. happy/contented, positive, optimistic), emotional stability (e.g. calm), cognitive capability (e.g. mental alertness), coping capacity (e.g. ability to cope, in control) and being socially able (e.g. ability to communicate, good relationships, engaging). One in four respondents considered a 'mentally healthy' person was simply 'normal' (i.e. able to carry on a normal life) and one in five referred to having control over one's life.

The response categories mentioned by 20% or more of respondents were:

- Happy/content 38%.
- Emotional stability 35%.
- Mentally alert 31%.
- Normal 25%.
- In control of one's life 20%.

- Good coping capacity 20%.
- Physically healthy 12%.

There were no metro-rural differences, but several differences by age and gender:

- Mentions of 'mentally alert' increased with age (e.g. 22% of 18-29s vs. 46% of over 70s;  $p=0.00$ ).
- Mentions of 'in control', 'emotional stability', 'normal' and 'calm' decreased with age.
- Females were far more likely than males to mention 'happy/content' (46% vs. 31%;  $p=0.00$ ).

### What people think most contributes to a person being mentally healthy

When interpreting the following results, it should be kept in mind that all of these factors were considered relevant in the qualitative research. This quantitative analysis reports their perceived relative impact, not whether they have any impact.

The top three factors perceived to contribute to being mentally healthy were (see Table 2):

- Having good friends to talk problems over with (28% of 'most' mentions).
- Opportunity to have control over one's life (22%).
- Keeping one's mind active (21%).

Being physically healthy was the next most frequently mentioned with 10% of first mentions respectively. Overall, the top contributors are a mix of factors primarily perceived to be under the individual's control (or responsibility) (i.e. keep mind active, physically healthy), and external factors (i.e. good friends, opportunity for control).

There were no significant or substantial differences by gender or between metro and country respondents. The importance of having good friends to talk problems over with decreased systematically with age as did opportunity to have control over one's life ( $p=0.00$  and  $p=0.02$ , respectively). On the other hand, the relative importance of being physically healthy and keeping one's mind active increased with age ( $p=0.00$  for both factors). These data suggest a shift in relative importance of self-reliance or internal factors over external factors with age, perhaps reflecting an increasing sense of personal responsibility for health as one faces the results of the ageing process.

### What people think most contributes to a person being mentally unhealthy or vulnerable to mental health problems

Again, when interpreting these results, it should be kept in mind that all of these factors were considered relevant in the qualitative research, and that this study reports their perceived relative impact.

The top three factors perceived to contribute to being mentally

unhealthy or vulnerable to mental health problems were (see Table 3):

- Excessive use of alcohol or drugs (32% of 'most' mentions).
- Having no friends or support network (24%).
- Life crises or traumas (15%).

Being too harshly criticised no matter what they do and being discriminated against or rejected for whatever reason were nominated by 10% and 8% respectively.

Overall, the top contributors are a mix of agents (i.e. alcohol, drugs), social factors (i.e. friends, criticism, discrimination) and events (life crises).

There were no significant or substantial differences by gender or between metro and country respondents. The importance of life crises and traumas decreased after 50 years of age while that of excessive use of alcohol or drugs increased ( $p=0.00$  for both factors).

### What people think most sums up what good mental health means

Whereas the previous closed-ended questions elicited considerable diversity in what respondents viewed as the most relevant factors, one factor dominated people's response to this question (see Table 4): being content with who you are (40% of 'most' mentions).

The next most frequently mentioned factors perceived to sum up what constitutes good mental health were:

- Being able to cope with everyday problems (11% of 'most' mentions).
- Being active, participating (11%).
- Able to talk openly to others (9%).
- Able to control one's emotions (9%).

There were no significant or substantial differences between metro and country respondents. Being content with who you are was significantly more likely to be mentioned by females than males (45% vs. 36%,  $p=0.00$ ), and this factor appeared to peak in the 30-49 year age group, and then decreased after 50 years. Able to control one's emotions increased somewhat with age, and being mentally alert increased substantially for over 70s (19% vs. 6% for all under 70,  $p=0.00$ ).

## Discussion

Mental health in the sense of good mental health is rarely thought about and talked about in the population at large. When 'mental health' is talked about or encountered (either in the media or among friends, relatives or acquaintances), it is mainly considered in the context of chronic mental illnesses (e.g. schizophrenia, bipolar disorder, depression). The results presented here confirm that the overwhelming majority of

people have primarily illness connotations to the words 'mental health'. Hence there is a clear need to replace these illness connotations with more positive connotations so as to facilitate communications about improving mental health. There is both an opportunity and a need to create a salience for good mental health in the same way that one exists for physical health.

Achieving this objective is a realistic and feasible task in that a substantial minority already has primarily positive connotations, and the words 'mentally healthy', when applied to an individual, have largely positive connotations. Hence, it is recommended that the term 'mentally healthy' be used as widely as possible in all mental health promotion communications, both in produced materials and in spontaneous situations such as talk-back radio, television magazine shows or press interviews. It should not replace 'mental health', but rather be used concurrently.

With respect to the factors that most contribute to good mental health, mental health promotion campaigns should begin by reinforcing those beliefs most widespread, such as the importance of friendships and other social connections, keeping one's mind active, seeking opportunities for control over one's life and being physically healthy – all of which contribute to good mental health.<sup>15</sup> These can then be linked with the perceived lesser impact factors such as having a job or role in life and the opportunity for small successes. They can also be linked with factors that have a negative impact on mental health. In this sense we would hope to increase the relative importance of factors such as discrimination, coercive practices and lack of a job or role in life – all of which contribute substantially to mental ill-health<sup>21,22</sup> and often via the pathway of alcohol and drug abuse. The latter are often an outcome rather than a cause of mental illness. Substance use may exacerbate mental illness,<sup>23</sup> but is often a more complex relationship.<sup>24</sup>

When asked what statement best sums up 'what good mental health means', being content with who you are dominated the 'most' mentions. The qualitative research suggested this contentment linked to self-esteem in the sense of being satisfied with one's self- and other-images.<sup>20</sup> However, the statement is not readily operationalised or articulated in concrete actions. Hence in campaign messages it could be used to communicate with, in the sense of showing empathy with, the target audience, but cannot be promoted in the same sense that mental alertness can be promoted.

Another statement summing up what good mental health means, being active, living life and participating in things going on around them, received 11% of top mentions and was strongly endorsed in the group discussions.<sup>20</sup> This concept is more easily operationalised in terms of being socially, mentally and physically active. Although the phrase 'be active' is already associated with physical activity, there is potential to use an overall umbrella theme of activity, with specific executions relating to the different

types of activity. There are a number of advantages of 'activity' as an umbrella concept: the word has inherently positive connotations of 'energy' and 'healthiness'; activities can be modelled (i.e. there are concrete behavioural recommendations); and activities can be indoors and outdoors, vigorous or mild, and can be tailored to various groups (e.g. people with disabilities). Promoting the message that cognitive, social and physical activities strengthen mental health is both consistent with what people believe<sup>20</sup> and with the literature.<sup>25-27</sup> By way of example, the Western Australian Act-Belong-Commit Campaign aims to increase people's beliefs that they can and should do things to maintain and enhance their mental health by keeping mentally, physically and socially active (Act), by participating in community activities and being a member of formal or informal groups in the community (Belong), and by getting involved in causes, taking up realistic challenges or volunteering (Commit). At the same time, community organisations that offer opportunities to 'Act-Belong-Commit' are encouraged to promote these opportunities under the campaign banner, and particularly in co-operation with complementary organisations.<sup>28</sup>

## Conclusions

While there have been calls for greater collaboration between mental health and public health for mental health promotion and illness prevention,<sup>29</sup> there have been little data on which to base public education campaigns and interventions. The data presented here with respect to people's illness connotations to the words 'mental health', their perceptions of the dimensions of mental health, the factors influencing good mental health, and the factors leading to vulnerability to mental ill health, are a step towards informing such campaigns.

With respect to differences between subgroups in the population, there were no major metro-country differences that would warrant different campaign messages to these two populations. Nor were there substantial differences by gender. However, there were several age differences that should be taken into account when communicating with these groups. For example, older people's greater concerns with cognitive functioning should be acknowledged in communications with this group. Similarly, stress reduction factors were of more concern to younger age groups.

Being active – cognitively, socially and physically – is a possible umbrella theme that would be understood and accepted as important for one's mental healthiness by all demographic groups.

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