



## The role of the family therapist and health professional in mental health promotion and youth suicide prevention

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### Abstract

Youth suicide is complex and remains an issue of concern to all of us who work with families, including family therapists and health professionals. Having worked within a child, adolescent and family mental health service as a family therapist, psychiatric nurse and Mental Health Promotion Officer in Gippsland, Victoria, the author is in an interesting position to reflect upon and integrate each of these approaches into a whole population health approach to youth suicide prevention. These views are presented in three parts, beginning with an overview of youth suicide, depression and the current suicide prevention strategy. Then, the role and effectiveness of family therapy in working with these issues is presented. Finally, integration of mental health promotion with family therapy is reviewed. The challenges and opportunities for family therapists and other health professionals in striving to achieve integration in mental health promotion and youth suicide prevention are discussed. Practice examples from the author's rural region are included to demonstrate the fit of this approach with current youth suicide prevention strategies and research.

### Keywords

*youth suicide, suicide prevention, adolescents, depression, family therapy, mental health promotion, health professionals*

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### Introduction

#### *Suicide rates and risk factors*

While there is a continuing shift to older male age groups in Australia having the highest suicide rates, disturbingly, suicide rates for young males in low socioeconomic groups also continue to rise, and living rurally seems to be an added risk for young males (Australian Bureau of Statistics: ABS, 2005; Judd, Cooper, Caitlin & Davis, 2006; Page, Morrell, Taylor et al., 2006, 2007). Indigenous people have a much higher suicide rate with 12-36 deaths per 100,000 compared to 11-16 deaths per 100,000 for non Indigenous people (Steering Committee for the Review of Government Service

Provision, SCRGSP, 2005). Nationally there are differences in suicide rates. The Northern Territory has the highest rate followed by Tasmania, Queensland and South Australia, all of whom have above national rates (ABS, 2005). Young people themselves have identified mental health issues of suicide, self harm and depression as priority issues (Mission Australia, 2006).

Factors which increase the risk of youth suicide include having a significant psychiatric problem, with depression the most prevalent (Beautrais, Mulder & Mulder, 2000; Fergusson, Beautrais & Horwood, 2003; Gould & Kramer, 2001). Prior suicidal behaviour and substance abuse is linked with suicide attempts (Gould & Kramer 2001),

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and a family history of suicidal behaviour increases the suicide risk in young people (Beautrais et al., 2000; Goodwin, Beautrais & Fergusson, 2004; Gould, Greenberg, Velting & Shaffer, 2003; Gould & Kramer 2001). Completed adolescent suicide is associated with psychopathology in parents, particularly depression and substance abuse (Beautrais et al., 2000; Gould & Kramer 2001; Gould et al., 2003).

Depression is a common disorder in young people and children, with rates of 2% for children rising to 6% for adolescents in the whole population (Cheung, Emslie & Mayes, 2005). Females most commonly suffer depression in the 18-24 year age group (Andrews, Hall, Teesson & Henderson, 1999) and are more likely than males to be depressed (Gould & Kramer, 2001). Sawyer, Arney, Baghurst et al. (2000) found one in twenty adolescents aged 13-17 years had a depressive disorder. A Victorian survey found that the incidence of depression increased across the age groups, with year 7 students at 13%, year 9 students 20% and year 11 students 22% in one year (Bond, Thomas, Toumbourou et al., 2000). The National Health and Medical Research Council (NHMRC) give rates of 1-3% of 13-20 year olds who have had a depressive disorder. By the time they are 18 years old, 24% of young people will have been depressed at least once (NHMRC, 1997). Lifetime prevalence rates of depression in adolescents are between 15 and 20%. These are similar to adult rates, and suggest depression often starts in adolescence (Kessler, McGonagle & Zhao, 1994).

Depression is clearly a significant risk factor for suicide and is also a particularly significant disorder for young people because of the impact it can have on their own lives, their families and their communities.

### ***A public health approach to suicide prevention***

Cantor and Baume (1999) identified that the federal government rated youth suicide as a priority and called for a comprehensive effort in suicide prevention, recognising the complex issues involved and that no one strategy would reach all. They suggested that a public health, whole population approach to addressing youth suicide would be a comprehensive strategy that included health and non health workers, working together with primary, secondary and tertiary levels of prevention. This approach has been

endorsed and continues currently (Beautrais, 2006; Cantor, Neulinger, Roth & Spinks 2000; Commonwealth Department of Health and Aged Care, 2000a, 2000b). The LIFE framework (Living is for Everyone: Commonwealth Department of Health and Aged Care, 2000a) outlines a range of areas for action based upon Mrazek and Haggerty's (1994) spectrum of interventions for mental health. This model views prevention, early intervention and continuing care on a spectrum, with the targets ranging from whole communities to groups at risk to individuals experiencing mental health problems. Mental health promotion is conceptualised as occurring across the entire spectrum of interventions. The model provides a framework for guiding suicide prevention interventions at both an individual *and* community level, for those of us working with people with depression, young people and communities. So how might we, as family therapists and health professionals, go about addressing suicide prevention in communities as well as for individuals? A brief look at the literature related to family therapy, adolescent depression and suicide provides guidance.

## **Family therapy**

### ***Effectiveness***

For those readers not familiar with family therapy the following definition by the Victorian Association of Family Therapists Inc. (VAFT) provides an overview of the principles involved.

*[Family therapy is] engaging with the whole family system as a functioning unit. While the individuals in the family are as important in family therapy as in individual therapy, family therapists also deal with the personal relations and interactions of the family members, both inside the family and in the therapeutic system which comprises the family, the therapist or therapists, and their broader community. (VAFT, 2007a)*

Family therapy is as effective as other psychotherapies (Estrada & Pinosof, 1995; Hazelrigg, Cooper & Borduin, 1987; Markus, Lange & Pettigrew et al., 1990; Pinosof & Wynne, 1995; Shadish, Montgomery, Wilson et al., 1993; Shadish, Ragsdale, Glaser & Montgomery, 1995). It is also effective for depression in adolescents (Kaslow & Thompson, 1998), but it may be too early to say if family therapy works in childhood depression. Brent, Holder, Kolko et

al. (1997) compared systemic behavioural family therapy, individual nondirective, and cognitive behavioural therapies for depressed adolescents and found no differences in reducing suicidality and improving functioning between each group. A later study from this research group found no significant differences in long-term outcomes for depressed adolescents (Birmaher, Brent & Kolko, 2000). Diamond, Reiss, Diamond et al. (2002) developed and used attachment-based family therapy for depressed adolescents. Results were promising and included reduced conflict, anxiety and hopelessness, and improvements in adolescent attachment. Family therapy is recommended in practice parameters for suicidal children/adolescents (Shaffer & Pfeiffer, 2001) and is an effective treatment on its own or as part of a wider multiple system approach (Carr, 2000; Cottrell & Boston, 2002). Evidence is growing in support of family based treatments and these have also been identified as best models of practice in several national departments of the United States (Diamond & Josephson, 2005).

### *An integrated approach*

An integrated approach, combining family therapy with other treatment and therapeutic approaches, is advocated by some. Diamond, Serrano, Dickey and Sonis (1996) describe therapists working with individuals using behavioural and teaching skills with their family therapy. Birmaher et al. (2000) suggest integrating family therapy with pharmacotherapy for working with persistently depressed adolescents. Pinosof and Wynne (1995) suggest that disciplines such as child psychology and psychiatry should be more widely accepted by family therapists in the area of childhood disorders.

Cantor and Baume (1997) believe therapists should be familiar with mental illnesses and suicide risk assessment. Lerner (2003) suggests that family therapists offer 'an ethic of hospitality' to all other therapies (including psychiatry and cognitive therapy) while working within a mental health system. This allows clinicians/teams to use a range of skills, roles, frameworks and perspectives when working within a child and family mental health service. Diamond and Josephson (2005) state that research is needed on how to integrate family based and other treatments, and that a systemic

view could be helpful in the development of services for families that would make them more family sensitive.

### *Citizen-therapists?*

Pulleybank Coffey (2004) suggest that family therapists go public and integrate their therapy practice with the child and family mental health systems within which they work; that is, to advocate on behalf of their clients to achieve political and social change. She suggests that therapists follow in the family therapy tradition of 'going beyond the treatment room and applying systemic ideas to larger systems' (p. 171).

These ideas are echoed by family therapist Calvert (2005), Australian commissioner for children and young people, who advocates that therapists work at the individual, family and societal level with communities and that this may be the most 'desirable mix' to achieve sustainable change in young peoples' lives (pp. 1-9).

This idea of focussing on being a citizen *and* a therapist and thinking about how we can make a difference in the wider world has been labelled as a 'citizen-therapist' by William Doherty (2004). Waters (2004), in a special edition of the *Psychotherapy Networker*, reminds us of the work of Virginia Satir and Salvador Minuchin in which they looked beyond what was happening at an individual level to the wider societal context, focussing on society's influence on the presenting issues. Current practice examples are also given (Hardy, 2004; Lee, 2004; Rojano, 2004; Sollee, 2004).

This points to family therapy as being one of a number of strategies that is effective in working with adolescent depression and related issues of suicide, on its own or when integrated with other approaches. There is a need for family therapists and others to also consider integrating mental health promotion (population based approaches to youth suicide prevention) into our work with families. We have been challenged by some to integrate with other approaches, as cited previously (Birmaher et al., 2000; Pinosof & Wynne, 1995) and to consider wider society issues when dealing with youth (Calvert, 2005; Pulleybank Coffey, 2004). Youth suicide prevention is complex and requires multiple perspectives (Cantor & Baume, 1999). Family therapists should feel comfortable working with

multiple perspectives as we are systemic thinkers. If we accept the challenge of integrating other views and skills it would allow us to work at individual, family and community levels with clients to address priority areas in youth suicide, such as education and training of communities around recognition and treatment of depression and suicidal behaviours. This would also fit with being a citizen-therapist (Doherty, 2004) and therapy within wider systems (Calvert, 2005).

### **Bringing it all together: A role in mental health promotion and youth suicide prevention for family therapists and health professionals?**

#### *The Victorian MHPO role*

Mental health promotion officers (MHPO) working within Victorian child, adolescent and family mental health services are ideally placed to facilitate a public health, whole of population approach to youth suicide because of their regional and state liaison and consultation roles. Historically the MHPO positions were created specifically as part of the Victorian suicide prevention strategy for the age group 15-24 years in the face of rising suicide rates. The MHPO role is based on a population based approach to health, with primary roles of education and training across communities around young peoples' mental health issues (Mental Health Promotion Officers, 2004).

Indeed, much of the author's previous role as an MHPO in Gippsland was to deliver training in suicide intervention skills, mental health literacy, and early recognition and referral of mental health issues. Many current MHPOs continue this work. Examples include the Commonwealth initiative, MindMatters (2006). This population based approach to mental health and wellbeing for children in secondary schools has been coordinated across Victoria by MHPOs in each region. Another example is Mental Health First Aid (MHFA), an Australian research-based training program to promote community mental health literacy ([www.mhfa.com.au](http://www.mhfa.com.au)). Those targeted for training include teachers, youth workers, health, welfare, police and community members. The MHFA approach fits with strategies proposed in the literature (Beautrais et al., 2000; Birmaher, Ryan, Williamson et al., 1996; Cantor & Baume, 1999; Gould & Kramer, 2001;) and suggested in national strategies

(Commonwealth Department of Health and Aged Care, 2000a, 2000b, 2004).

These two examples show the value of working not only at the individual family and local community level as an MHPO, but of the potential to improve mental health and wellbeing (including depression) across whole populations and communities. This has been achieved locally by working with other systems such as education, welfare, health, justice, and local Indigenous networks, and by liaising with local government and other agencies across the 44,000 sq km Gippsland rural region. This practice example fits with whole population based approaches to youth suicide prevention called for in current national strategies. It is also an opportunity for individual family therapists and health professionals to consider incorporating this mental health promotion role within their practice. This would address issues of mental health literacy, stigma, education and training in the context of suicide prevention (Commonwealth Department of Health and Aged Care, 2000a, pp. 36-51).

#### *Opportunities for integration*

##### *Mental health literacy, stigma, education*

Communities generally have a poor understanding of mental health issues and low levels of mental health literacy (Jorm, 2000; Jorm, Blewitt, Griffiths et al., 2005). When this is combined with the issue of suicide, which can be emotionally confronting and stigmatising for some, there is the potential for misunderstanding what population based suicide prevention is and what it is trying to achieve. Clear, accessible, evidence-based information, such as that included in national strategies (Commonwealth Department of Health and Aged Care, 2000a; 2000b), needs to be provided to communities to increase their understanding of suicide prevention.

There is a potential role for family therapists and others in health and family services to explain and disseminate research around suicide prevention, such as the link between depression and suicide, and the need for early recognition and treatment.

Information about mental health promotion and wellbeing also needs to be disseminated, such as the importance of feeling included, knowing how to cope with relationship issues, being free from

violence, bullying, and discrimination (Mind Matters, 2007) and why young people do not seek help for mental health issues. This last point is significant as young people will often turn first to family, friends and local professionals such as school counsellors for help (Commonwealth Department of Health and Aged Care, 2000a, pp. 36-37). These groups need to be educated about what to do in this instance. This could occur as part of a community education or consultation role where practitioners are involved in their wider communities, such as schools, community agencies, and employment services. Practitioners could play a valuable part in education and mental health literacy by taking up this mental health promotion role as part of their practice. This whole population approach to youth suicide prevention could have a greater impact on larger numbers of people within our communities than working with individuals or families only.

#### *Community involvement*

Other roles for family therapists and health professionals could include participating in community health planning, professional groups and local youth networks to raise issues related to young people, their families, mental health and wellbeing. For example, issues such as the impact of high school leaving rates, high sexual abuse rates, recent bushfires and low employment opportunities for young people and families in the Gippsland rural region, were highlighted by the Gippsland MHPO and other health workers at local government planning meetings. These issues were subsequently addressed in community health planning, and the need for more youth specific MHFA training and support programs was identified. Community participation also raised the profile of family therapists and health professionals, and raised awareness of how to access them and other local services for mental health issues.

#### *Shared systemic framework*

Being able to work across agencies, disciplines and communities, using a systemic framework to understand different perspectives on the complexity of risk and protective factors in youth suicide, combined with knowing how to work with families, has been a useful stance for this author. A systemic framework could be a useful way for agencies with differing viewpoints to work together across agencies and agendas. This

shared understanding could be expanded to include mental health promotion and youth suicide prevention. For example, the number of MHFA trainers has increased in Gippsland as the importance of early recognition of mental health issues was identified. Funding has recently been gained by Lifeline Gippsland to network the MHFA trainers, with the goal of a regional mental health approach that crosses the boundaries of organisations and professional groups (J. Cockwill, personal communication, November, 2007). This fits with a whole population approach to addressing suicide prevention; local health professionals, MHPOs and a regional community agency worked together to achieve an integrated approach to mental health promotion to deliver and coordinate the MHFA training, for the entire community.

It was as an MHPO that the author networked with these colleagues, but it was the systemic thinking from family therapy that allowed the bringing together of those interested in developing the strategy. The rural nature of our services also meant many of us knew each other and worked together with the limited resources available in our region. We had to work in a strategic and systemic way to achieve the change we wanted. This is another useful component of systemic family therapy, applied at a community level, which has relevance to practitioners wanting to develop similar strategies.

#### *Challenges to integration*

There are, however, challenges in taking up the roles proposed here. These include family therapists and health professionals needing to have adequate mental health skills, and having limited resources in the rural context.

#### *Mental health skills*

For family therapists to work with mental health issues they require skills in assessment and treatment, as well as therapy (Cantor & Baume, 1997). Mental health skills need to be included in family therapy training. Currently family therapy training is under the umbrella of individual state professional bodies such as the Victorian Association of Family Therapists (VAFT, 2007b). Each state sets its own standards of practice. This allows differences across states and a subsequent lack of national consistency in the training of family therapists. The recently formed

national body, Psychotherapy and Counselling Federation of Australia, has established standards of practice (PACFA, 2006) and has the potential to address issues such as appropriate mental health content in therapy and counselling at a national level. MHFA is currently being included in the undergraduate nursing curriculum after discussions with the co-developer of MHFA (Betty Kitchener, personal communication, May 2007). There is potential to include it in family therapy training also, ensuring baseline mental health literacy and providing opportunities for research into the outcomes of such training.

#### *Limited rural resources*

The limited numbers of trained family therapists might be another barrier for family therapists and others in taking up the challenge of mental health promotion roles in rural regions. Rural health issues of social disadvantage, isolation, and limited access to services (Smith, 2007) are further barriers. These issues, combined with large geographical distances and travelling times, mean practitioners would need to give careful consideration not only to access and equity issues for their clients but also to how to sustain their own practice and clinical skills.

#### **Conclusion**

Youth suicide remains a concern and prevention is complex. While a number of risk factors have been identified, as well as the effectiveness of family therapy in working specifically with depression, there is still much work to be done. A comprehensive strategy at several levels within communities is required. As part of a community wide strategy the author has reviewed her work as a Victorian MHPO and suggested that family therapists and health professionals embrace and integrate mental health promotion roles within their practice and act as 'citizen-therapists' working also with communities, rather than just families. While there are challenges in taking up these roles, there are also opportunities for expanded practice and some of these have been suggested to stimulate discussion. We face a challenging future working with families around issues of suicide in our communities. At the very least, adopting mental health promotion roles would be advocating for the wellbeing of our young people, who are dying in significant numbers from suicide.

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#### **References**

- Australian Bureau of Statistics (ABS) (2005). *Suicides, Australia. Cat No. 3309.0*. Canberra: Australian Bureau of Statistics.
- Andrews, A., Hall, W., Teesson, M., & Henderson, S. (1999). *The Mental Health of Australians*. Canberra: Mental Health Branch, Commonwealth Department of Health and Aged Care.
- Beautrais, A., Mulder, J., & Mulder, R. (2000). Unmet need following serious suicide attempt: follow-up of 302 individuals for 30 months. In G. Andrews & S. Henderson (Eds.). *Unmet Need in Psychiatry: Problems, Resources, Responses*. Cambridge: Cambridge University Press.
- Beautrais, A. (2006). *Suicide prevention: What we know and do not know*. Keynote presentation, Canadian Association for Suicide Prevention (CASP) Complexity of Suicide Conference, Toronto, Canada.
- Birmaher, B., Brent, D., & Kolko, D. (2000). Clinical outcome after short-term psychotherapy for adolescents with major depressive disorder. *Archives of General Psychiatry*, 57, 29-36.
- Birmaher, B., Ryan, N., Williamson, D., Brent, D., & Kaufman, J. (1996). Childhood and adolescent depression: A review of the past 10 years. Part II. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(12), 1575-1583.
- Bond, L., Thomas, L., Toumbourou, J., Patton, G., & Catalano, R. (2000). *Improving the Lives of Young Victorians in our Community: A Survey of Risk and Protective Factors*. Melbourne: Centre Adolescent Health.
- Brent, D., Holder, D., Kolko, D., Birmaher, B., Roth, C., Iyengar, S., & Johnson, B. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry*, 54(9), 877-885.
- Calvert, S. (2005). Relationships, reconciliation and children: Giving young people a say. *Australian and New Zealand Journal of Family Therapy*, 26(1), 1-9.
- Cantor, C. & Baume, P. (1997). The psychotherapy of suicide prevention. *Psychotherapy in Australia*, 3(4), 8-15.

- Cantor, C. & Baume, P. (1999). Suicide prevention: A public health approach. *Australian and New Zealand Journal of Mental Health Nursing*, 8(2), 45-50.
- Cantor, C., Neulinger, K., Roth, J., & Spinks, D. (2000). The epidemiology of suicide and attempted suicide among young Australians. In Commonwealth Department of Health and Aged Care, *National Youth Suicide Prevention Strategy - Setting the Evidence-based Research Agenda for Australia (A literature review)*. Canberra: Commonwealth of Australia.
- Carr, A. (2000). Evidence-based practice in family therapy and systemic consultation. I. Child-focussed problems. Research update. *Journal of Family Therapy*, 22, 29-60.
- Cheung, A., Emslie, G., & Mayes, T. (2005). Review of the efficacy and safety of antidepressants in youth depression. *Journal of Child Psychology and Psychiatry*, 46(7), 735-754.
- Commonwealth Department of Health and Aged Care (2000a). *Life is for Everyone (LIFE). A Framework for Prevention of Suicide and Self-harm in Australia*. Canberra: Mental Health and Special Programs Branch.
- Commonwealth Department of Health and Aged Care (2000b). *Promotion, Prevention and Early Intervention for Mental Health - A Monograph*. Canberra: Mental Health and Special Programs Branch.
- Commonwealth Department of Health and Aged Care (2004). *Responding to the Needs of Young People in Australia. Discussion Paper: Principles and Strategies*. Canberra: Commonwealth of Australia. Available online at [www.mentalhealth.gov.au](http://www.mentalhealth.gov.au)
- Cottrell, D. & Boston, P. (2002). Practitioner review: The effectiveness of systemic family therapy for children and adolescents. *Journal of Child Psychology and Psychiatry*, 43(5), 573-586.
- Diamond, G. & Josephson, A. (2005). Family-based treatment research: A 10-year update. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(9), 872-887.
- Diamond, G., Reis, B., Diamond, G., Siqueland, L., & Isaacs, L. (2002). Attachment-based family therapy for depressed adolescents: A treatment development study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(10), 1190-1196.
- Diamond, G., Serrano, A., Dickey, M., & Sonis, W. (1996). Current status of family-based outcome and process research. *Journal of American Academy of Child and Adolescent Psychiatry*, 35(1), 6-16.
- Doherty, W. (2004). The citizen therapist: Finding the right lever. *Psychotherapy Networker*, 28(6), 44, passim.
- Estrada, A. & Pinsof, W. (1995). The effectiveness of family therapies for selected behavioural disorders of childhood. *Journal of Marital and Family Therapy*, 21(4), 403-440.
- Fergusson, D., Beautrais, A., & Horwood, L. (2003). Vulnerability and resilience to suicidal behaviours in young people. *Psychological Medicine*, 33, 61-73.
- Goodwin, R.D., Beautrais, A.L. & Fergusson, D.M. (2004). Familial transmission of suicidal ideation and suicide attempts: evidence from a general population sample. *Psychiatric Research*, 126(2), 159-65.
- Gould, M., Greenberg, M., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(4), 386-405.
- Gould, M. & Kramer, R. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior*, 31, 7-31.
- Hardy, K. (2004). Social healing high-wire act for racial tensions. *Psychotherapy Networker*, 28(6), 38-39.
- Hazelrigg, M., Cooper, H., & Borduin, C. (1987). Evaluating the effectiveness of family therapies: An integrative review and analysis. *Psychological Bulletin*, 101(3), 428-442.
- Jorm, A. (2000). Mental health literacy: public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*, 177, 396-401.
- Jorm, A., Blewitt, K., Griffiths, K., Kitchener, B., & Parslow, R. (2005). Mental health first aid responses of the public: Results from an Australian survey. *BMC Psychiatry*, 5(9), [www.biomedcentral.com/content/pdf/1471-244X-5-9.pdf](http://www.biomedcentral.com/content/pdf/1471-244X-5-9.pdf)
- Judd, F., Cooper, A., Caitlin, F., & Davis, J. (2006). Rural suicide - people or place effects? *Australian and New Zealand Journal of Psychiatry*, 40(3), 208-216.
- Kaslow, N. & Thompson, M. (1998). Applying the criteria for empirically supported treatments to studies of psychosocial interventions for child and adolescent depression. *Journal of Clinical Child Psychology*, 27(2), 146-155.
- Kessler R., McGonagle, K., & Zhao, S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry*, 51, 8-19.
- Larner, G. (2003). Integrating family therapy in child and adolescent mental health practice: an ethic of hospitality. *Australian and New Zealand Journal of Family Therapy*, 24, 211-219.
- Lee, B. (2004). Therapist on the hill. Clinicians' perspective to congress. *Psychotherapy Networker*, 28(6), 42-43.

- Markus, E., Lange, A., & Pettigrew, T. (1990). Effectiveness of family therapy: A meta analysis. *Journal of Family Therapy*, 12, 205-221.
- Mental Health Promotion Officers (2004). Developing partnerships: Mental Health Promotion Officers in Victorian CAMHS, *Auseinetter*, 20(1), 32-34.
- MindMatters (2006). Website (accessed 16 June 2006) <http://cms.curriculum.edu.au/mindmatters>.
- MindMatters (2007). Resources: MindMatters Booklets (accessed 12 November 2007). <http://cms.curriculum.edu.au/mindmatters/resources/mbook.htm>.
- Mission Australia (2006). *National Survey of Young Australians. Key and Emerging Issues*. Sydney: Mission Australia.
- Mrazek, P. & Haggerty, R. (1994). *Reducing the Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington DC: National Academy Press.
- National Health and Medical Research Council (NHMRC) (1997). *Depression in Young People: Clinical Practice Guidelines*, Canberra: NHMRC.
- Page, A., Morrell, S., Taylor, R., Carter, G., & Dudley, M. (2006). Divergent trends in youth suicide by socio-economic status in Australia. *Social Psychiatry and Psychiatric Epidemiology*, 41, 911-917
- Page, A., Morrell, S., Taylor, R., Dudley, M., & Carter, G. (2007). Further increases in rural suicide in young Australian adults: Secular trends, 1979-2003. *Social Science & Medicine*, 65(3), 442-453.
- Pinsof, W. & Wynne, L. (1995). The efficacy of marital and family therapy: An empirical overview, conclusions and recommendations. *Journal of Marital and Family Therapy*, 21(4), 586-613.
- Psychotherapy & Counselling Federation of Australia (PACFA) (2006). What is PACFA? [www.pacfa.org.au/pacfa\\_about\\_us.html](http://www.pacfa.org.au/pacfa_about_us.html) (accessed 7 June 2007).
- Pulleybank Coffey, E. (2004). The heart of the matter 2: Ecosystem family therapy practices with system of care mental health services for children and families. *Family Process*, 43, 161-173.
- Rojano, R. (2004). The middle-class express: mental health system for the poor. *Psychotherapy Networker*, 28(6), 34-35.
- Sawyer, M., Arney, F., Baghurst, P., Clark, J., Graetz, B., Kosky, R., Nurcombe, B., Patton, G., Prior, M., Raphael, B., Rey, J., Whaites, L., & Zubrick, S. (2000). *Mental Health of Young People in Australia: Child and Adolescent Component of the National Survey of Mental Health and Wellbeing*. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.
- Shadish, W., Montgomery, L., Wilson, P., Bright, I., & Okwumabua, T. (1993). Effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 61(6), 992-1002.
- Shadish, W., Ragsdale, K., Glaser, R., & Montgomery, L. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of Marital and Family Therapy*, 21, 345-360.
- Shaffer, D. & Pfeiffer, C. (2001). Practice parameter for the assessment and treatment of adolescents with suicidal behaviour. *Journal of the American Academy of Child and Adolescent Psychiatry, Supplement*, 40(7), 24S-51S.
- Smith, J. (2007). Rural people's health. In J. Smith (Ed.), *Australia's Rural and Remote Health* (pp. 121-133). Croydon, Victoria: Tertiary Press.
- Sollee, D. (2004). A born networker: putting marriage education on the map. *Psychotherapy Networker*, 28(6), 36-37.
- Steering Committee for the Review of Government Service Provision (SCRGSP) (2005). *Overcoming Indigenous Disadvantage: Key Indicators 2005*. Canberra: Productivity Commission. [www.pc.gov.au/gsp/reports/indigenous/keyindicators2005/overview/suicide\\_and\\_self-harm.html](http://www.pc.gov.au/gsp/reports/indigenous/keyindicators2005/overview/suicide_and_self-harm.html) (accessed 27 March 2007).
- Victorian Association of Family Therapy Inc. (VAFT, 2007a). *Family Therapy* (accessed 7 November 2007) [www.vaft.asn.au/about.html](http://www.vaft.asn.au/about.html).
- Victorian Association of Family Therapy Inc. (VAFT, 2007b). *About VAFT* (accessed 11 June 2007) <http://www.vaft.asn.au/about.html>.
- Waters, R. (2004). Making a difference. Five therapists who've taken on the wider world. *Psychotherapy Networker*, 28(6), 32-43.