A Healthy Start: Mental health promotion in early childhood settings
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Abstract
Childcare services are an important part of life for many families. Childcare workers have a vital role in the development of a child’s mental health, and yet are often under-trained in this area. This paper describes the implementation, evaluation and sustainability of the Healthy Start program in regional Western Australia, with particular attention to outcomes for childcare workers. Healthy Start aimed to build the capacity of the childcare workforce to promote the mental health of children attending childcare, their families and those working in the childcare sector. A range of strategies was developed and implemented, including mental health literacy training and communication skills training which were delivered to over thirty-five childcare workers. Pre and post-training questionnaires showed that awareness of risk factors, protective factors and referral sources, as well as levels of confidence in discussing mental health issues with parents, increased immediately after training. Baseline and follow-up telephone surveys showed however that the childcare workers’ awareness of risk and protective factors was not sustained over a twelve month period. The findings suggested that messages need to be reinforced post-training to retain new knowledge and confidence. As a result, agency partnerships have grown to include a range of early childhood professionals and provide annual training.

Keywords
child care, settings approach, mental health literacy, mental health promotion, evaluation

Introduction
The early years are recognised as a significant period for prevention programs to change the course of early mental health problems and to minimise the effect of risk factors in a child’s life (Commonwealth Department of Health and Aged Care, 2000a). Childcare services are an important part of life for many families with young children. Children attending childcare services are a ‘captive’ group whose mental and social development is affected by the environment, and the interaction and nurturing they receive whilst in care. Of significance are children who attend childcare full time (i.e. regularly attend for eight or more hours per day, for four or more days per week) as they rely on the childcare service for a large part of their mental and social development. Some children may spend up to 12,500 hours in childcare before starting school (50 weeks x 50 hours x 5 years). This is only 500 hours less than a child spends in class during thirteen years of primary and secondary education (40 weeks x 25 hours x
13 years) (National Childcare Accreditation Council, 2004). As well as being significant figures in the lives of the children in their care, childcare workers provide advice, support and interaction to families.

**Settings approaches to health promotion**

Settings approaches to health promotion identify ways to increase the extent to which the particular setting, be it school, workplace or childcare centre, can enhance health. By forming partnerships and building the capacity of community groups and services who are undertaking incidental, yet significant, health promoting roles, key health agencies can encourage a systems based approach to the promotion of mental health and wellbeing (Baum, 1998).

The childcare setting has been used to promote nutrition messages and organisational change has seen the adoption of healthy menus for children attending long day care (Lewis & Pollard, 1999). There has been a call for national action to provide quality childcare which promotes social and emotional wellbeing and to develop mental health promoting learning environments in early childhood settings in order to prevent later mental health problems (Commonwealth Department of Health and Aged Care, 2000a).

**Mental health problems in early childhood**

The need to prevent or intervene early in mental health problems was highlighted in the Western Australian Child Health Survey (Zubrick, Silburn, Garton et al., 1995). Approximately one in five children were identified as having a mental health problem in the six months prior to the survey and only 22% of children identified as having a mental health problem have a single mental health syndrome. Up to 10% of children were reported as having thought problems, 6% attentional problems, and 6% social problems. There were increased rates of mental health morbidity among those children whose parents were considered to use coercive or inconsistent disciplinary styles (29% and 24% respectively).

Mental health difficulties in childhood also have been linked to more severe mental health problems later in life (Marshall & Watt, 1999; World Health Organization, 2003). Younger children, aged under seven years, are less likely to exhibit measurable signs of mental illness, however their level of exposure to risk factors, such as harsh, punishment-driven discipline and high levels of family stress can be easily identified (Commonwealth Department of Health and Aged Care, 2000a).

Prevention programs that develop protective factors have greater likelihood for long-term success. Effective, evidence-based early childhood programs have targeted: the childcare environment (e.g. the High/Scope Perry Preschool curriculum comparison program, Schweinhart & Weikart, 1988); group education of parents (e.g. the Positive Parenting Program, Sanders & Markie-Dadds 1995); and home visiting programs (e.g. the Community Mothers Program and Best Beginnings: Office of Mental Health, 2002).

These programs included strategies such as enhancing social competence and cognitive development in children, providing a variety of support and educational services, and teaching caregivers skills in effective behaviour management (Commonwealth Department of Health and Aged Care, 2000b). The effects of high quality early childhood settings have been shown to continue into adulthood (Schweinhart & Weikart, 1988).

In responding to the need for quality childcare that promotes social and emotional wellbeing, and to develop mental health promoting learning environments in early childhood settings, it is important to look at the childcare environment as a whole, as well as identifying evidence-based interventions such as those listed above.

**Capacity building in childcare settings**

Using a capacity building model (Hawe, King, Noort et al., 2000), an initial step may be through workforce development to increase the mental health literacy of childcare workers, and organisational development to review workplace practice and plan for mental health promotion activity. Further steps may be the building of partnerships with a range of mental health and human service agencies and the allocation of specific resources for mental health promotion interventions.

Techniques developed for other settings may be adapted for use in childcare services. Of particular relevance is the Health Promoting
A ‘Health Promoting Childcare Service’ might aim to:

- actively promote the self-esteem of children by demonstrating that everyone can make a contribution to the life of the childcare service;
- develop staff/children and staff/staff relations in the daily life of the childcare service;
- make clear to staff, parents and children, the social aims of the service;
- provide stimulating challenges for children through a wide range of activities;
- develop childcare service/home/community links;
- promote staff wellbeing; and
- utilise the potential of specialist services in the community for advice and support (adapted from Kickbusch, 1992).

It is potentially easier for childcare services to promote mental health than it is for schools. Children’s services (such as childcare centres, child health clinics, playgroups) focus on human development, education for life, learning how to learn and catering for individual differences. Children’s services are not restricted by curriculum and can enhance community development (Cummings, 1991).

Childcare workers can promote or enhance the mental health of at least three different groups: children, parents and guardians, and colleagues. Opportunities for mental health promotion exist in the physical and social care environment of infants and children, interactions with children, parents and guardians and relationships between colleagues. The organisational environment of the childcare service, including accreditation requirements, policy and governance, formal communication with stakeholders and relationships with other agencies also provide opportunities for mental health promotion.

**The Healthy Start program**

Australian childcare service providers (long day care centres, occasional day care centres and family day care) have previously received no specific training in mental health promotion or early intervention yet many have contact with children with emerging mental health problems or families in distress. At a local level, childcare service providers in the Lower Great Southern region of Western Australia had recognised a need for professional development and support in the area of mental health through their regional childcare network (Cannon, 2000).

**Healthy Start** aimed to build the capacity of the childcare workforce to promote the mental health of children attending childcare, their families and those working in the childcare sector. It began as a pilot project, funded by Healthway, Western Australia’s health promotion foundation, and developed by the Great Southern Public Health Service. The pilot sought to equip childcare service providers with the knowledge and skills to promote positive mental health and an awareness of early intervention to families who use their services and reside in the local government areas of Albany, Plantagenet (Mt Barker) and Denmark. There were ten childcare service providers in the region at the time, offering up to 960 childcare places.

The objectives of **Healthy Start** were:

- To measure and increase levels of awareness of mental health risk and protective factors in children among childcare workers and parents.
- To measure and increase levels of awareness of the signs of postnatal depression and conduct disorder among childcare workers.
- To measure and increase levels of confidence in dealing with parents presenting with mental health issues among childcare workers, including the ability to refer to appropriate agencies.

The **Healthy Start** program used two types of health promotion action. The personal skills of childcare workers were developed and mechanisms for creating supportive childcare environments for children, parents and childcare workers were produced. This paper describes the implementation, evaluation and sustainability of the **Healthy Start** program, with particular attention to outcomes for childcare workers.

**Method**

**Telephone survey**

A literature review identified specific knowledge and skills for mental health literacy in issues
applicable for early childhood, as shown in Table 1. These components were used to generate questions for the structured telephone interviews. Childcare workers gave passive consent for their details to be sourced from childcare service databases and were contacted at work to complete the 20-25 minute interview. Eighty childcare workers were interviewed. Results from the telephone survey informed the content and activities of the subsequent information training and communication skills training and formed a baseline comparison for a follow-up survey.

The structured telephone interviews were repeated twelve months after the commencement of the program with 35 of the 80 childcare workers. Reasons for attrition included: had moved into other types of work, had left the area, or did not want to participate in the follow-up survey.

Table 1. Mental health literacy components applicable for early childhood

Knowledge of mental illness risk factors
(0-5 year olds) Lack of warm relationship with caregivers; low birth weight; genetic makeup; harsh or inconsistent punishment.
(Adults) relationship difficulties, lack of a personal support network.

Mental health protective factors
(0-5 year olds) Warm, secure attachment with caregivers with skills/resources to stimulate intellectual and emotional development; good infant health; genetic makeup; quality care in safe environments; consistent, fair behaviour management practices; low family stress; social and language skills.
(Adults) Social support, positive coping styles to deal with challenges and alleviate stress, family resilience; flexible, supportive workplaces.

Awareness of signs and signals of mental health problems
Awareness of the spectrum of mental health, of symptoms of conduct disorder and postnatal depression (as per DSM IV), personal and professional limitations and the need for professional diagnosis.

Self efficacy: Confidence in dealing with parents presenting with mental health issues
Active listening skills, clear understanding of personal and professional limitations, duty of care.

Referral to appropriate agencies
Ability to list three or more avenues for referral.

(Mrazek & Haggerty, 1994; Hawkins et al., 1992; Commonwealth Department of Health and Aged Care, 2000a; Davis et al., 1999)

Focus groups
Five groups of five childcare workers participated in focus groups. Questions related to concerning behaviours, methods of dealing with problem behaviour, interactions with parents and use of agencies. Results of the focus groups informed the content and activities in the training sessions. Focus group themes:

• Workers identified a range of sources for more information and referral, but expressed a need for information about behaviour management for children with specific health issues and about approaching parents and dealing with emotional parents.
• Parents approached childcare workers for advice on behaviour management or developmental issues and some turned to workers in times of crisis. Many workers would encourage discussion, but were not able to respond effectively due to work demands or lack of knowledge.
• Attitudes towards parents were varied: some workers felt that children’s behaviour was related solely to parenting and that parents alone were responsible for behaviour change. Workers felt that family factors and a mother’s emotional state could impact negatively on the child. Some workers had felt used by ‘emotionally demanding parents’.

Mental health information training
Two sessions, each of two hours duration, were developed for childcare workers and dealt with risk and protective factors that impact on the mental health of children, conduct disorder, postnatal depression and referral options. The project officer and a social worker delivered the mental health information training to 35 childcare workers in four series. All had participated in the baseline telephone survey. Pre and post-training questionnaires were completed by 35 and 26 childcare workers respectively.

Communication skills training
Six sessions, each of ninety minutes duration, were developed for workers and dealt with communication principles, active listening, recognising and responding to emotional crisis, discussing sensitive issues with parents, referral services and self care. The project officer and a mental health nurse delivered the series once to
22 childcare workers. Pre and post-training questionnaires were completed by 22 and 18 childcare workers respectively.

Evaluation

An extensive evaluation of the Healthy Start program was conducted in collaboration with the Survey Research Centre at the University of Western Australia. Evaluations assessed the effect of individual strategies, as well as the effect of the overall program over a twelve-month period. This paper focuses on the results applicable to the childcare worker training strategies. (Resources for parents and a mental health promotion action plan were also developed and evaluated, but are not explored in this paper.)

Results

Mental health information training

Thirty-five childcare workers completed the pre-training and 26 completed the post-training questionnaire. Workers rated their confidence in their ability to recognise the signs of postnatal depression and conduct disorder (see Table 2). At the conclusion of training, the proportion of workers expressing confidence (fairly confident or very confident) in their ability to recognise the signs of postnatal depression had increased by 43.8%, and confidence in recognising the signs of conduct disorder had increased by 40.7%.

Table 2. Confidence in recognising postnatal depression and conduct disorder

<table>
<thead>
<tr>
<th>Rating of confidence</th>
<th>Pre Post</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very</td>
<td>8.6 46.2</td>
<td>8.7</td>
<td>30.8</td>
</tr>
<tr>
<td>Fairly</td>
<td>40.0 46.2</td>
<td>42.9</td>
<td>61.5</td>
</tr>
<tr>
<td>Not very</td>
<td>31.4 7.7</td>
<td>25.7</td>
<td>7.7</td>
</tr>
<tr>
<td>Not at all</td>
<td>8.6 0.0</td>
<td>11.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Not sure</td>
<td>11.4 0.0</td>
<td>11.4</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Childcare workers listed factors that they thought put children at risk of developing mental health problems (Table 3). The proportion of childcare workers able to list two or more recognised risk factors for postnatal depression increased by 57%. Childcare workers listed factors that could prevent mental health problems in childhood. At the end of training, the proportion of childcare workers able to list two or more recognised protective factors for mental health increased by 64.6%.

Childcare workers listed which professionals or services they were most likely to refer a parent with possible postnatal depression. Table 3 shows that at post-training, the proportion of childcare workers able to list three or more referral options for parents with potential postnatal depression increased by 41.4%.

Table 3. Number of risk and protective factors listed for children’s mental health problems, and number of risk factors and referral options listed for postnatal depression.

<table>
<thead>
<tr>
<th>n listed</th>
<th>Children’s mental health problems</th>
<th>Postnatal depression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre %</td>
<td>Post%</td>
</tr>
<tr>
<td>Risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>25.7</td>
<td>0.0</td>
</tr>
<tr>
<td>2</td>
<td>42.9</td>
<td>23.1</td>
</tr>
<tr>
<td>3</td>
<td>25.7</td>
<td>38.4</td>
</tr>
<tr>
<td>4</td>
<td>2.9</td>
<td>7.7</td>
</tr>
<tr>
<td>5+</td>
<td>2.8</td>
<td>30.8</td>
</tr>
<tr>
<td>Protective factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>40.0</td>
<td>7.7</td>
</tr>
<tr>
<td>1</td>
<td>40.0</td>
<td>7.7</td>
</tr>
<tr>
<td>2</td>
<td>17.1</td>
<td>53.9</td>
</tr>
<tr>
<td>3</td>
<td>2.9</td>
<td>19.2</td>
</tr>
<tr>
<td>4</td>
<td>0.0</td>
<td>11.5</td>
</tr>
</tbody>
</table>

Communication skills training

Twenty-two childcare workers completed the pre-training questionnaire and 18 completed the post-training questionnaire. Workers rated their confidence in their ability to discuss the emotional problems of a child in their care, as well as adult emotional problems, with the child’s parents or guardians (see Table 4). By post-training the proportion expressing confidence (fairly confident or very confident) in their ability to discuss a child’s emotional problems with parents had increased by 34.4%. By the end of training, the proportion expressing confidence in their ability to discuss the emotional problems of adults with parents had increased by 40.4%.
Telephone survey follow-up
The childcare workers recalled risk factors for mental health problems in children. The comparison between baseline and 12 month follow-up survey (see Table 5) shows that childcare workers increased their ability to recall only one of four specific risk factors for mental health problems in children (‘lack of warm relationship with caregivers’). The ability to recall specific risk factors for postnatal depression had generally decreased between the baseline and follow-up surveys, except for ‘genetic makeup’. The proportion of workers recalling recognised protective factors for mental health problems had generally decreased at follow-up (however recall of ‘warm relationships’ and ‘positive parenting’ remained high).

Table 5: Recalled factors for children’s mental health problems and postnatal depression

<table>
<thead>
<tr>
<th>Factors</th>
<th>Base line %</th>
<th>Follow up %</th>
<th>Diff %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk factors for children’s mental health problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of warm relationship with caregivers</td>
<td>56.2</td>
<td>84.6</td>
<td>+28.4</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>29.9</td>
<td>5.1</td>
<td>-24.8</td>
</tr>
<tr>
<td>Genetic makeup</td>
<td>26.3</td>
<td>21.5</td>
<td>-4.8</td>
</tr>
<tr>
<td>Harsh or inconsistent punishment</td>
<td>21.2</td>
<td>23.0</td>
<td>+1.8</td>
</tr>
<tr>
<td>Risk factors for postnatal depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship difficulties</td>
<td>31.2</td>
<td>21.0</td>
<td>-10.2</td>
</tr>
<tr>
<td>Lack of a personal support network</td>
<td>67.5</td>
<td>56.4</td>
<td>-11.1</td>
</tr>
<tr>
<td>Genetic makeup</td>
<td>8.7</td>
<td>12.8</td>
<td>+4.1</td>
</tr>
<tr>
<td>Existing mental health problem</td>
<td>44.9</td>
<td>10.2</td>
<td>-34.7</td>
</tr>
<tr>
<td>Protective factors for children’s mental health problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warm relationship with caregivers</td>
<td>100</td>
<td>92.3</td>
<td>-7.7</td>
</tr>
<tr>
<td>Good infant health</td>
<td>100</td>
<td>92.3</td>
<td>-7.7</td>
</tr>
</tbody>
</table>

The childcare workers listed which services they would refer families to for emotional or mental health problems. At follow-up, they were more likely to refer postnatal depression issues to a general practitioner or child health nurse and more likely to refer conduct disorder issues to a child health nurse (see Table 7). The average...
number of referral sources recalled decreased between the baseline and follow-up survey for postnatal depression (from 2.5 to 1.7 options) and for conduct disorder (from 2.5 to 1.5 options).

Table 7. Referral services for postnatal depression and conduct disorder

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Postnatal depression</th>
<th>Conduct disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Base Follow up</td>
<td>Base Follow up</td>
</tr>
<tr>
<td>General practitioner</td>
<td>61.2 % 74.3 %</td>
<td>53.7 % 56.4 %</td>
</tr>
<tr>
<td>Child health nurse</td>
<td>27.5 % 56.4 %</td>
<td>22.5 % 53.8 %</td>
</tr>
<tr>
<td>Childcare supervisor</td>
<td>18.7 %</td>
<td>- 22.5 %</td>
</tr>
<tr>
<td>Family &amp; Children’s Services</td>
<td>20.0 % 12.8 %</td>
<td>35.0 % 17.9 %</td>
</tr>
</tbody>
</table>

Discussion

In the short term, the training strategies were successful in awareness raising and developing confidence amongst workers. Childcare workers reported greater confidence in discussing mental health issues with parents. The mental health literacy of childcare workers was enhanced, as they were better able to answer questions about postnatal depression, conduct disorder and mental health in general. Knowledge of local services and programs for families with children under five increased, as workers could list a greater number of alternatives for families needing specialist assistance.

Overall, the telephone interview results showed decreases in recall of mental health risk and protective factors over a twelve month period. For postnatal depression, but not conduct disorder, confidence in identifying signs and discussing with parents increased. Confidence in ability to recognise the need for referral actually decreased over the 12 month period.

There are a number of issues that should be considered when interpreting the results. During the baseline telephone interviews, respondents were encouraged to offer as many responses as possible. At follow-up, the number of responses was limited to three. The coding of these open-ended responses was potentially inconsistent between baseline and follow-up analysis as no inter-rater reliability tests had been undertaken. In assessing knowledge of risk and protective factors, workers were asked to recall factors without prompting. Another technique would have been to identify factors from a list.

The small sample size of the follow-up survey may also have an impact on the ability to make comparisons between baseline and follow-up results. Feedback indicated that the baseline survey was too long to be completed during work hours (20-25 minutes), and that workers did not want to be contacted out of hours for telephone surveys.

At the time of the pilot, there was a lack of standardised evaluation tools for assessing changes in mental health literacy (particularly knowledge and skills) as a result of small group education strategies (as explained by Francis, Pirkis, Dunt et al.’s 2002 review). As attitudinal information was collected during the focus groups, it would have been useful to revisit the attitudes of workers post-training.

The data assessing knowledge of referral agencies could be interpreted in a number of ways. Child health nurses in the region delivered the Triple P program, and referrals to child and adolescent mental health services were only accepted from general practitioners. General practitioners also made referrals to the postnatal depression intervention program. The data could reflect a better understanding of how the mental health system in the region operated, and a more targeted referral process by childcare workers. Application of this knowledge would only be effective if general practitioners and child health nurses were aware of the likelihood for more contact from childcare workers, so that requests for information or referrals would be handled appropriately.

It is difficult to assess how increased mental health literacy would change workplace practice. There is a need to follow up the implementation of other program strategies, and to identify how training sessions could have explored the use of these.

There was much interest in mental health amongst childcare workers; however, it was necessary to explain mental health promotion carefully and to move early discussions away from behaviour management. Anecdotally, skill development enabled workers to enhance their role, decrease work related stress and feel more comfortable discussing issues with parents.
Conclusions
This paper described the outcomes of two strategies of a mental health promotion program for the childcare setting. Education and skills training sessions were effective in the short term in increasing knowledge of mental health risk and protective factors and individual confidence in recognising and discussing mental health and emotional issues. Gains in skill and confidence generally were not retained at twelve-month follow-up and it is unclear what impact the training had on changing workplace practice. The training strategies appear to be a useful first step in building workforce capacity for mental health promotion. Further intervention would be necessary to ensure that the issues remained on the agenda for childcare service providers. Follow up of other program strategies would be useful to assess how much support childcare centre coordinators require to become advocates for mental health promotion in the workplace.

Lessons learnt
At the end of the pilot, the Steering Committee recommended that the health, welfare and education sectors raise awareness of mental health promotion amongst early childhood professionals to maintain a level of information and support for families from birth into the school system (0-6 years). Other settings and workforces for mental health promotion for young families were identified including maternity wards, child health clinics, child development centres, general practitioner clinics, parent information centres, kindergartens and preschools, playgroups, toy libraries, local libraries, neighbourhood centres, privately owned child recreation centres, and pharmacies.

The Steering Committee found that developing rapport with childcare services was dependent on linking training clearly to the early childhood role to improve work practices. Organisational change could be encouraged by centre based visits, specific action plans, resources and information in a range of formats. Elements that could hinder rapport with childcare services included:

Assuming sector-wide and workforce-wide motivations. At the time, family day care workers were more likely to attend training for networking and professional development. Long day care workers were more likely to attend for accreditation purposes. Occasional care workers were more difficult to attract, as they did not have as rigorous an accreditation process at the time. Specialised in-house training was more likely to appeal to this group.

Lack of understanding of service priorities. Incentives must be offered for childcare services to undertake health promotion activities, such as meeting accreditation requirements, state or national certification, grants, sponsorship for equipment or maintenance, or promotion of the service.

Sustainability
Since the completion of the pilot in July 2001, the program has been recognised in the Western Australian Mental Health Promotion and Illness Prevention Policy (2002) as a best practice program. The audience for training now includes child health nurses, physiotherapists, occupational therapists, childcare students, and preschool and kindergarten staff. The training has been condensed into a comprehensive four-session package, which combines communication skills development and mental health information. This package has been delivered to over 70 professionals. The Coordinator of Mental Health Promotion, Great Southern Public Health Service, oversees coordination of training delivery, which is co-facilitated by Great Southern Child and Adolescent Mental Health Service staff.

The Steering Committee has disbanded, however members are represented on interagency committees and help to sustain the concepts and strategies of the program. The Coordinator of Mental Health Promotion liaises with the Lower Great Southern Childcare Network and the Albany and Narrogin Mental Health Promotion in Schools committees, to ensure coordinated annual delivery of training. In particular, the Lower Great Southern Childcare Network provides an opportunity to build capacity of childcare administrators and to link mental health promotion strategies to Australian childcare accreditation requirements.

Negotiations are underway to deliver the training package in the Central and Upper Great Southern Health regions of Western Australia. There has also been interest from interstate health services in adapting the package to suit their needs.
Note

1. Other strategies which formed part of the Healthy Start program include:

A parent information module. A one-hour information module and facilitator’s guide, which dealt with mental health issues affecting families with young children, risk and protective factors and agencies for support, was delivered eight times to thirty parents.

A parent resource kit. A resource kit for parents included seven fact sheets that could be tailored to the ages of children in each family. The fact sheets dealt with risk and protective factors, prevalence of postnatal depression and conduct disorder, as well as referral options. Eight hundred copies of the kit were disseminated through childcare services.

Mental Health Promotion Action Plan. A twelve-month mental health promotion action plan template was developed with reference to the quality areas of the Quality Improvement and Accreditation System (QIAS) for Long Day Care Centres (NCAC, 2001). The action plan was trialed by five childcare service providers and was distributed to all ten services.

Acknowledgements

The Healthy Start Steering Committee members, the Lower Great Southern Child Care Network, WA Country Health Services - Great Southern Public Health Service, Marcelle Cannon, Tony Evers, Brett Kipling, Maree Dawes and Healthway.

References


