Evidence-based mental health promotion resource—Executive Summary

The Victorian Health Promotion Foundation (VicHealth) and the Victorian Department of Human Services (DHS) commissioned Deakin University to develop this *Evidence-based Mental Health Promotion Resource* (Keleher, H and Armstrong, R 2005). The purpose of this resource is to bridge a gap in available materials to advance and inform policy, research and practice responses to the promotion of mental health and well being. The resource provides background to mental health promotion as a field of inquiry; identifies the key determinants of mental health; presents current available evidence for mental health promotion interventions and finally provides a guide to planning and evaluating mental health promotion activities.

The resource will be of great relevance to health practitioners, policy makers and community workers in the wider community, arts, sports, justice, education, transport, local government, academic and housing sectors.

The full Resource provides practitioners with an **intervention description**; the **population groups and settings** studied; an assessment of the promotion's **effectiveness** as it is known; a discussion of **implementation issues**; and additional **comments** and **case studies**. A program planning tool to assist in the development of evidence-based mental health promotion activity with helpful check-lists and program approaches is also supplied.

Mental health promotion—a compelling case for action

Mental health disorders constitute 10 per cent of the global burden of disease. In Australia, one in five will experience a mental health disorder at some stage in their lifetime. The human, social and economic consequences of mental health disorders and illness are increasingly being recognized, as are the limitations of spending more resources on treatment and medical services only.

Evidence based practice

The resource takes account of the fact that evidence is not an unproblematic term and proposes that it is used in terms of 'weighing up' the strength of the evidence before deciding on a course of action. It argues that evidence of success may be sufficient to show that action should be taken when 100% proof is not available. Strength of evidence is linked to quality; it refers to methods used to minimize bias in the design and conduct of the study.

Determinants of Mental Health

Three key determinants found in the literature are indisputably linked to mental health and well being are **Social inclusion** (supportive relationships, involvement in community and group activity; and Civic engagement); **Freedom from discrimination and violence** (valuing diversity, physical security, Self determination and control of one's life); **Access to economic resources** (work, education, housing, money).

There is strong evidence supporting the effectiveness of interventions and activities in a wide range of areas which can be successful in the promotion of mental health. The Resource offers detailed accounts of this evidence and the most effective interventions are summarized below.

Interventions to increase social connectedness—the Evidence

Nine interventions have been shown to increase social connectedness. They build social capital, promote community well-being, overcome social isolation, increase social connectedness and address social exclusion.

1. *Community building and regeneration programs*—local neighborhood renewal programs; community building programs. Community-wide programs should be considered at individual, community and organizational levels if they are to be effective. However, effectiveness can be reduced if programs are too general and non-specific with ill defined areas of activity. Multi-agency partnerships, local government, skill enhancement, sustainability are each best practice approaches that improve effectiveness. Programs should explicitly address social capital and social connectedness, diversity and equal citizenship in their implementation (p. 28).

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2. *School based programs for mental health and well-being*—whole-of school programs that create a supportive environment, rather than topic-specific approaches to issues such as self-esteem or coping skills are found to be more effective. Programs are best implemented at the school level to engage with students, teachers, parents and the curriculum, and to connect with school policy (p. 31).
3. *Structured opportunities for participation*—civic structures that encourage engagement via local governance, community participation and other forms of social contribution. Engaging people to encourage their participation is a form of social validation. Reviews have tended to focus on 'high risk' individuals rather than populations or communities, therefore programs need to clearly identify the population groups (immigrant groups in particular women benefit from these programs), while work with leaders and all stakeholders is essential (p. 33).
4. *Workplace mental health promotion*—employee participation programs that involve all levels of workers and may also increase involvement in decision-making; modification of stressful occupational environments also reduces mental health problems among employees. Organization-wide and system approaches to employee participation (rather than those with individuals) are most effective when they support staff involvement, enhance workload management, clarify roles and involve policies to tackle bullying and harassment (p. 34).
5. *Social Support*—individual support which might modify behavior and create supportive environments, such as home-visiting programs by nurses and midwives or parent training programs. Such programs targeting mothers of young children, young mothers and early parenthood generally and vulnerable families in particular are found to be most effective (p. 36).
6. *Volunteering*—such as structured opportunities for people to do voluntary work for their community as part of civic engagement. Sustainability of volunteering programs is improved by ensuring processes for skill development; setting up avenues for ongoing support mechanisms; bringing about shifts in community attitudes; and creating connections that did not previously exist (p. 40).
7. *Community Arts Programs*—may involve community participation, social inclusion, capacity building and regeneration. A wide variety of social groups (including at-risk groups) are suitable for community-based arts projects. Factors thought to underpin success include creative passion, dynamic relationships, experimentation and innovative problem solving. Programs must be connected with local needs; democratic relationships are essential; developing good practice frameworks to allow for planning and evaluation and quality and striving for excellence to create pride in achievement are each essential factors in implementation. Activities may include the creation of an arts studio, dance, a circus performance, theatre and visual arts exhibitions (p. 40).
8. *Physical activity/exercise*—has a positive effect on mental health outcomes for adults and children, but emotional benefits and feelings of wellbeing are likely from increased social interaction as solitary exercise does not improve depression Implementation issues include the need for access to public space, for exercise to be tailored to suit people's preferences and needs. Enjoyment is essential for both adherence and benefits and programs must create welcoming environments. Local and State governments have responsibilities to ensure place-based strategies include physical activity policies (such as safety policies) and program goals and objectives for walking paths and bicycle paths. Greater intersectoral cooperation between health and recreational and leisure sectors is recommended (p. 45).
9. *Media campaigns for mental health promotion*—social marketing campaigns that challenge stigma and raise awareness of attitudes towards mental health. The principles of effective health promotion media campaigns apply to campaigns seeking to promote mental health. These interventions include approaches such as ensuring that media campaigns have a mix of interventions; that they reach into segmented groups or communities; and that there are culturally competent materials developed (p. 47).

Interventions to address violence and discrimination

Nine broad interventions have been shown to reduce or challenge violence and discrimination and are linked to the need to strengthen community action, re-orient health systems and build healthy public policy.

1. *Community-wide interventions*—activities that focus on community education, media, schools and policing. Community-wide interventions could be at a local neighborhood level, segmented to particular populations such as parents or youth, or more broadly intended for whole population groups. However, the evidence is equivocal about the effectiveness of public education campaigns and evaluation methods are still in development (p. 54).

2. *Community education campaigns*—increasing broad community awareness and educating against violence through campaigns (usually in the media). There is limited evaluation of the effectiveness of community-wide education campaigns although this is explained by a lack of planning to evaluate such campaigns to contribute to the evidence base (p. 57).
3. *Programs developed for at-risk populations*—children at risk and parenting programs such as early childhood education programs and behavioral and skill development programs. The most successful interventions appear to be those developed for population groups who are at a particular risk, or have a history of perpetrating violence against others. Programs or interventions with preschool children appear to be more effective than those for older youth (15–17) while short-term interventions appear less effective in adolescents than those with a long term focus. Sports participation has been found to be effective in reducing offending behavior (including violence) in youth aged over 16 years who are not participating in employment (p. 58).
4. *Programs for young people*—to break the cycle of violence, raise awareness of assist young people to deal with violence. Programs particularly for young people have been set in community-based organizations including women's health services, community health centers and welfare agencies. Evidence points to the following four approaches being those where most effective programs can be implemented: community development, peer education, programs provided at a school setting and community arts programs (p. 61)
5. *Programs for at-risk men*—targeting potential perpetrators: interventions focused on individuals primarily directed to preventing further occurrence of domestic violence. The most common interventions are counseling or education groups and strategies range from cognitive-behavioral groups, couple counseling, anger re-direction, trauma therapy and programs that use a mental health and/or substance abuse focus. (p. 62).
6. *Legislative and sentencing reform*—policy development, victim-centered care aimed at reducing further harm. These interventions target women who have been victims of some form of intimate partner violence. The evidence is conflicting about arresting perpetrators to reduce violence; however this seems to depend on the subsequent judicial process adopted. Civil remedies such as civil protection (intervention) orders and legal counseling and advocacy have been found to be effective (p. 63).
7. *School based bullying*—programs to prevent or reduce further bullying such as curricula, school, classroom and individual programs. Well-planned interventions can reduce bullying behavior; however, interventions with younger children are more effective than with older children. A range of other variables significantly affect these interventions but those that involve schools, parents and the community are effective and have long-term benefits (p. 64).
8. *Workplace bullying*—development of workplace bullying prevention policies are considered to be both important and effective. Australian interventions have focused on workplace education and mass media campaigns which have not yet been evaluated (p. 65).
9. *Discrimination prevention*—school based programs aimed at reducing racism in schools, such as racially integrated schooling, bilingual education, training in social-cognitive skills and role playing and empathy. The known effectiveness of interventions in reducing prejudice towards Aboriginal Australians is limited, given the lack of formal evaluation of such programs (p. 66).

Interventions to increase economic participation

Interventions that reduce income inequality have been found to be effective even recognizing that they are rarely explicit in their intention to address mental health and well-being yet have been found to have this effect.

1. *Adult literacy programs*—programs that improve language acquisition, health, computer, cultural, media and scientific literacy are effective because the relationship between literacy, life opportunities, employment and mental health and wellbeing is proven to be strong. These programs target adults of all ages in a range of community-based settings, particularly those people with low general primary or secondary education and non-English speaking new arrivals. Literacy programs are rarely evaluated in terms of mental health promotion but adult literacy programs do have an effect on self-concept, self-esteem and self-image (p. 73).
2. *Child care programs*—high quality child care programs, publicly funded or subsidized have been found to increase employment of women on low incomes. Quality child care meets the needs of a range of population groups of interest, including children, women, families and employers. Such child care programs promote women's economic and social equality by ensuring that child care is affordable; they ensure that families can meet their child care responsibilities and reduce poverty. Government

regulation, high quality, public funding and affordability of services are each relevant factors (p. 77).

3. *Work programs*—job readiness programs that focus on young people with high levels of risk factors and low levels of protective factors; or return to work' or 'welfare to work' programs are seen to be effective. A number of important variables affect implementation: education and training needs to include literacy and numeracy skill building; and the involvement of young people in the planning, decision making and evaluation. Approaches that recognize diversity and inclusion must also be included as outcomes (p. 80).
4. *Housing*—refurbishment of public housing: housing repairs, energy efficiency improvements and creation of safer and more secure areas for public housing tenants as part of neighborhood renewal programs (p. 83).

Program Planning for mental health promotion

Because mental health promotion practices are not the sole responsibility of health agencies, there is a need for planning methods that engage a wider range of practitioners in the mental health promotion effort. To this end, a program planning method is outlined in the resource.

A scheme for planning mental health promotion interventions is produced in the table on the right.

The Full Resource is available from the following link http://www.health.vic.gov.au/healthpromotion/quality/evidence_index.htm

Program Planning Schema

<table>
<tr><td rowspan="5">1. Planning stage (could be six months)</td><td>Rationale and vision setting</td><td colspan="2" rowspan="4">3. Impact evaluation (for intermediate outcomes, see 3(b); for long term benefits, see 3(c))</td></tr>
<tr><td>Priority setting and problem definition</td></tr>
<tr><td>Partnership development</td></tr>
<tr><td>Generation of plan, including interventions and evaluation plan</td></tr>
<tr><td>Program implementation</td><td colspan="2" rowspan="3">3(a). Process evaluation (of activities/projects within the overall program)</td></tr>
<tr><td>Evaluation and dissemination</td></tr>
<tr><td>2. Implementation stage (could be 18 months or much longer)</td><td>Implementation of a mix of health promotion interventions and capacity building strategies to achieve the program goal and objectives</td></tr>
<tr><td colspan="4">3(b). Intermediate outcomes (impact evaluation), including:</td></tr>
<tr><td>Individual
Projects and programs that increase:
• involvement in group activities
• access to supportive relationships
• self-esteem and self-efficacy
• access to education and employment
• self-determination and control
• mental health literacy</td><td>Organisational
Organisations that are:
• inclusive
• responsive
• safe, supportive and sustainable
• working in partnerships across sectors
• implementing evidence-based approaches to their work
Positive working environments improve the mental health and wellbeing of staff.</td><td>Community
Environments that are safe, supportive, sustainable and inclusive
Enhanced community cohesion
Enhanced civic engagement
Increased awareness and recognition of mental health and wellbeing issues</td><td>Societal
Integrated, sustained and supportive policy and programs
Strong legislative platform
Resource allocation
Governance structures</td></tr>
<tr><td colspan="4">3(c). Long term benefits (outcome evaluation), including:</td></tr>
<tr><td>Individual level
Increased sense of belonging
Improved physical health
Less stress, anxiety and depression.
Less substance misuse
Enhanced skill levels</td><td>Organisational level
Integrated, intersectoral resources and activities</td><td>Community level
Community valuing of diversity and active disowning of discrimination
Less violence and crime
Improved productivity</td><td>Societal level
Reduced social and health inequalities
Improved quality of life and life expectancy</td></tr>
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