

# Promoting social inclusion and connectednes 3

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**Useful resources**

*Agenda 21 is a comprehensive plan of action of the United Nations, to be taken globally, nationally and locally, wherever there are human impacts on the environment ([www.un.org/esa/sustdev/documents/agenda21/index.htm](http://www.un.org/esa/sustdev/documents/agenda21/index.htm)).*

*Local Agenda 21 in Australia is available through the Australian Department of Environment and Heritage ([www.deh.gov.au/esd/la21/](http://www.deh.gov.au/esd/la21/)).*

**Country-wide strategies for social inclusion**

- *The European Union has funded social exclusion via the European Social Fund and a range of anti-poverty programs.*
- *The Social Exclusion Unit of the UK Cabinet Office ensures whole-of-government commitment to social exclusion and its anti-poverty strategy.*
- *The Centre for Analysis of Social Exclusion, London School of Economics, receives substantial funding from the Economic and Social Research Council.*
- *UNESCO identifies social exclusion as a priority area for research and policy through Management of Social Transformations (MOST).*
- *The World Health Organisation promotes interest in social exclusion through its Healthy Cities program and its Disability and the European Social Exclusion Strategy (European Disability Forum, 1/02). The European Social Exclusion Strategy 2001–2005 contains objectives for employment participation, poverty, access to resources, disability and discrimination.*

## 3 Promoting social inclusion and connectedness

### 3.1 Overview of social inclusion

Social inclusion is a determinant of mental health and wellbeing that is integrally linked to the Ottawa Charter for Health Promotion, particularly through the action areas of building healthy public policy, creating supportive environments and strengthening community action. At one level, it represents the degree to which individuals feel connected with their communities; more broadly, it is about the strength within communities and organisations that sustains positive mental health. Social inclusion is thus a broad notion that incorporates concepts of social capital, social networks, social connectedness, social trust, reciprocity, local democracy and group solidarity (Jermyn 2001).

Social inclusion has dimensions of both content and structure. In terms of content, it is about supportive relationships, involvement in group activities and civic engagement. Its structural dimensions are about a socially inclusive society 'where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity' (VicHealth 2005a, 1). Mental health is thus a key outcome of social inclusion.

Notions of social inclusion and connectedness have origins in European strategies to address poverty, particularly the Healthy Cities initiatives. Healthy Cities advocated advanced ideas about the structural connections among elements of urban life and the promotion and maintenance of health, pioneering a range of community interventions. Since its implementation, a range of country-level strategies have explicitly linked social inclusion and exclusion to policy decisions, which also are understood to be determinants of health and social outcomes. Strategies for social inclusion are concerned with citizenship, the genuine participation of communities in decision making that affects them, and the creation of supportive built and natural environments and policy environments.

Some university affiliated programs in the United States have social exclusion and inclusion as a major focus of their disability studies applied research agenda.

### 3.2 Overview of social exclusion

Social inclusion can be understood only in relation to social exclusion. The ways in which governments and organisations have taken up social exclusion in forming social policy demonstrate a growing awareness of the global implications, both political and environmental, of increases in social exclusion. This agenda concerns the nonmaterial dimensions of poverty because they have enormous economic and social consequences for people who may already be living on the margins of communities and society more widely. Social exclusion is felt through the effects of marginality and inequity on people's opportunities to contribute and to participate economically and socially.

Poverty essentially refers to economic deprivation, which also carries notions of social deprivation and marginality. But poverty is not a proxy for social exclusion. Rather, social exclusion refers to deprivations that arise from economic deprivation and subsequent lack of material necessities, but also deprivation of opportunity. Sen (1999) interpreted social exclusion as the deprivation of capability when a person loses substantive freedoms that lead to the kind of life that he or she has reason to value. Similarly, the Joseph Rowntree Foundation (2000) identified four dimensions of social exclusion:

1. impoverishment, or exclusion from adequate income or resources
2. labour market exclusion
3. service exclusion
4. exclusion from social relations.

Populations most commonly identified as vulnerable to, or most at risk of, social exclusion include those with limited employment opportunities, particularly women, racial and ethnic minority groups, refugees, female and male prostitutes, people living with disabilities, people living with drug addiction, people living with chronic illness (including mental ill health), the long term unemployed/underemployed, people who are homeless, people living in temporary accommodation, young people (especially early school leavers) and older people (especially those living on pensions). For immigrant groups, language barriers, lack of employment opportunities, and non-recognition of foreign education and work experience reinforce their isolation in a strange culture. The evidence suggests that the prevalence of illness and mortality increases in individuals who do not feel connected and who feel socially excluded (Kawachi & Berkman 2000; Bunker et al 2003).

### 3.3 Overview of social capital and social support

Social capital is defined variously, but in general terms is meant to describe the resources available to individuals and to society which are provided by social relationships (Kawachi et al. 2002), or as networks that have shared norms, values and understandings that facilitate cooperation within or among the network members. Social capital has several key elements (Health Education Authority 2001):

- social resources – for example, informal arrangements between neighbours and members of clubs or churches
- collective resources – for example, self-help groups, community banks
- economic resources – for example, levels of unemployment, access to green spaces, community gardens
- cultural resources – for example, libraries, art centres, neighbourhood houses, local schools.

The synergy model of social capital identified by Woolcock (2001) has value for mental health promotion work, although stronger research evidence is needed of how the components of social capital can be created and sustained. Intra-community capital, or bonding capital, refers to the intimate relationships and connections among family members, close friends and neighbours. Intercommunity capital, or bridging capital, refers to the ties across communities and groups (non-local), but can also refer to local ties formed among work colleagues and associates, acquaintances and distant friends. Linking capital refers to the connections among organisations, services and members of a community, or among groups even if they have differing levels of social status and power (Putnam 2001). While much scholarship has developed knowledge about how to develop local communities, less is known about how to create networks across and between communities, or across difference, in ways that benefit vulnerable people.

Social capital and social networks are seen as a resonant measure of community strength (Johnson, Headey & Jensen 2003) and as vehicles for turning the tide of community decline. Changes occur through the regeneration of social and economic benefits from relationships among neighbours, citizens and governments, which in turn are relationships based on strong norms of trust and reciprocity. Important distinctions, however, are made between theorised and empirical understandings of social capital (Johnson, Headey & Jensen 2003; Stone 2001), and the definitions are much debated for their ideological implications.

Social capital has societal and structural dimensions. There is wide agreement that strong communities and levels of social capital are associated with civic engagement and stronger democracy, improved early childhood outcomes, improved mental and physical health, and improved local economic performance (Johnson, Headey and Jensen 2003). There is continuing interest in the concept of social capital, although intervention researchers of social capital tend to accord greater significance to psychosocial factors than material deprivation. Yet, income inequality, for example, is critical for understanding social capital because it creates stress and damages social capital.

Social connectedness and social capital are key determinants of mental and physical health and inequity. People are most commonly connected to family, schools, work and different types of community group, club and organisation. But social connectedness and social capital are not necessarily present in every community, with resulting social isolation. As determinants, they indicate the need for a progressive agenda from governments to make strategic investments in social and economic development. The strength of the relationships between social and structural conditions and mental health has been understood for some years, with strong associations made between poor mental health and unemployment, poverty, discrimination, social exclusion, violence and lack of social connectedness. It is not common, however, to see sufficient political will for tackling those social–structural issues to support the promotion of mental health or prevent mental ill health.

When developing measures of social capital, structure and content need to be distinguished. The specific activity to which measures are applied needs to be understood, as does the level of aggregation to which they are applied; further, the net benefits of observed social capital need to be assessed (Johnson, Headey and Jensen 2003). Social capital is measured at individual and collective/ecological levels (Rychetnik & Todd 2004). At individual levels, it is measured by the number and nature of social networks and social ties (Berkman and Glass 2000). At the collective/ecological level, measures of social capital and social cohesion are used to measure social connectedness, social ties and social networks (Berkman & Kawachi 2000). Social connections that matter are considered to be those with family, friends, schools, work, sporting clubs, religious organisations, youth organisations and arts organisations, and in various forms of civic engagement (VicHealth 2005a). When the distinct levels of social capital are understood and interventions to build or enhance social capital are targeted appropriately, those interventions are much more likely to be effective.

Social support and social isolation are independently associated with mental health status. An independent causal association exists between depression, social isolation and a lack of quality social support, as well as between the causes and prognosis of cardiovascular disease (Bunker et al. 2003). Berkman and Glass (2000) conceptualised social support mechanisms as:

- instrumental and financial, informational, appraisal and emotional
- person-to-person contact, close personal contact, intimate contact
- access to resources and material goods, including jobs/economic opportunity
- access to health care, access to housing, referrals and institutional contacts.

Social support can have constraining as well as enabling influences on health behaviours, and it is affected by: norms in help seeking and peer pressure; social engagement; the reinforcement of meaningful social roles; bonding/interpersonal attachment; 'handling' effects on children; and 'grooming' effects for adults. Along with emotional support, it is regarded as an adjunct to material support, particularly to reduce poverty in families with children and to help parents protect their children from the effects of disadvantage. It does so by removing barriers to work for parents who wish to combine work with parenting (including child care barriers) and by enabling those who wish to parent full time to do so (Acheson 1998).

### 3.4 Overview of interventions to increase social inclusion

The literature on mental health promotion to promote social inclusion focuses on interventions designed to build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion. The following list summarises the nine interventions reviewed in this section:

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|--|-------|
| 1. Community building and regeneration programs          | p. 28 |
| 2. School-based programs for mental health and wellbeing | p. 31 |
| 3. Structured opportunities for participation            | p. 33 |
| 4. Workplace mental health promotion                     | p. 34 |
| 5. Social support  | p. 36 |
| 6. Volunteering  | p. 40 |
| 7. Community arts programs                               | p. 40 |
| 8. Physical activity                                     | p. 45 |
| 9. Media campaigns for mental health promotion           | p. 47 |

Intervention categories (DHS 2003) used to increase social inclusion include one or more of the following:

- settings and supportive environments
- community action
- social marketing
- health information
- health education and skill development.

#### **Intervention – Community building and regeneration programs**

Community building and regeneration programs aim to increase social inclusion and tackle social exclusion. In doing so, they aim to enhance mental health and wellbeing. Both place policies and people policies are used. Many governments are developing place management programs, or local area regeneration/neighbourhood renewal programs, to address social and economic alienation of people, particularly of those living in urban areas of high unemployment and poor health. People policies focus on benefits, employment programs, community pride, crime and safety, employment, health and wellbeing, housing and initiatives focused on social exclusion in particular population groups. People and place policies supplement each other in ways considered to be important but only recently beginning to be understood. Community building policies and programs seek to combine people and place initiatives.

### *Population group/setting*

Settings include local, geographically defined communities as the focus of urban regeneration or neighbourhood renewal programs. Population groups of interest include youth, single parents, elderly citizens and people with disabilities within deprived communities. Community building policies and programs are developing and refining different approaches needed for rural townships and remote settlements, particularly those that depend on seasonal incomes or declining industries.

### *Effectiveness*

Effectiveness is affected if programs are too general and non-specific with ill defined areas of activity. The arguments for and against place-based initiatives should be reviewed before planning commences (Johnson, Headey & Jensen 2003). Planning also needs to incorporate a review of social benchmarks and indicators (see, for example, Frankish, Kwan & Flores 2002; Salvaris et al. 2000).

There is good evidence of the effectiveness of developing local interventions for specific needs and groups within community building and regeneration programs, such as those for youth, single parents, the elderly and people with a disability (Carley 2002). There are gaps in the evidence, however, on the effectiveness of neighbourhood interventions designed to affect social exclusion; models for effective partnerships to improve the delivery of mainstream services to deprived areas; and effective links between policy levels and programs delivered by various levels of government. In particular, poverty is difficult to overcome at the local level without effective national policies, and key institutional links.

Community-wide interventions should be considered at individual, community and organisation levels (section 2) if they are to be effective. They are broadly cast as public health approaches and are best undertaken by partnerships of community organisations, government and non-government agencies. In other words, intersectoral and multi-level actions are essential for community building and regeneration programs. These programs are most effective when using a wide range of strategic approaches and drawing on multidisciplinary paradigms (for example, public and environmental health, crime prevention and safety, education and economic development). Strategies at the community level should be designed to influence one or more determinants of mental health to reduce unhealthy influences, change unhealthy or harmful events or activities, or modify social mores at community and structural levels.

Building of social inclusion takes many years. The following are best practice principles and guidelines for area regeneration to build social inclusion:

- Multi-agency partnerships are the primary mechanism for area regeneration strategies – for example, partnerships involving the public sector, private sector and community sector.
- Local government is vital and should play a lead role in facilitating and supporting partnerships, given its political commitment and service infrastructure (Carley 2002). Private sector partners, however, rarely make an effective lead partner in neighbourhood regeneration.

**Example of good practice**

*The Beacon Project, a regeneration project conducted in the United Kingdom, has identified impressive health improvements. These have included an 80 per cent decrease in post-natal depression, a 60 per cent reduction in child protection notifications, a 50 per cent reduction in child accident rates and a 50 per cent decrease in the crime rate. There is anecdotal evidence to suggest this approach has benefited people who are socially excluded (Duggan & Cooper nd).*

- Capacity building through skill enhancement is needed to enable effective partnerships, and secretariats are required to assist with effective working together.
- Programs should pay particular attention to sustainability through the building of communities, so benefits and activities continue after specific program funding has ceased.
- Start-up, targeted funding should be used to leverage additional funding from other levels and departments of government.
- Strategies focused on improving physical capital (housing, open space, transport) are rarely successful if building of human capital through people focused programs is absent (Carley 2002).
- In social capital programs, resident involvement in decision making increases effectiveness, but effectiveness is reduced if regenerated neighbourhoods experience a high turnover of residents.

*Implementation issues*

- Programs should explicitly address social capital and social connectedness. The UK regeneration initiatives have provided useful learnings and highlighted the need to tackle the erosion of social capital.
- Measures of social capital should distinguish between the structure of networks (size, internal and external organisational linkages) and their content (trust, reciprocity). Each measure of structure should be matched to one or more appropriate measures of content (see Johnson et al 2001: 63) in order to specify the area of activity for interventions;
- Programs concerned with rebuilding communities will be more effective if they specifically address issues of diversity and equal citizenship.
- Programs that identify socio-environmental factors which residents associate with poor mental health, will enable them to feel some control over decision-making including their influence over neighbourhood decisions, and to identify levels of neighbourhood social capital in order to address social support and community action required.
- Mental health outcomes need to be evaluated in order to understand the effect of the program. See the VicHealth framework (2005a) and the Catholic Education case study (p. 42 below) for ideas.

*Comment*

The Health Education Authority (2001, p. viii–ix) published key recommendations to continue developing the knowledge base about effectiveness and to close inequity gaps through community/neighbourhood rebuilding and urban regeneration. Rychetnik and Todd (2004) noted that community interventions for neighbourhood or urban renewal undertaken in the United Kingdom and the United States need to be assessed for their applicability in the Australian context.

### Promising practices

Victoria is in the early stages of developing evaluation evidence for its Neighbourhood Renewal program ([www.dhs.vic.gov.au/neighbourhoodrenewal/](http://www.dhs.vic.gov.au/neighbourhoodrenewal/)). Neighbourhood renewal/urban regeneration programs are a relatively recent initiative and therefore evaluation is (at this stage), limited. They also vary in their focus. For example, Victoria's Neighbourhood Renewal program (Office of Housing 2005) is focused on social and economic exclusion rather than social capital, while other regeneration interventions are focused on strengthening the resilience and capacity of communities and/or population groups.

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### Intervention – School-based programs for mental health and wellbeing

In Australia, programs have been encouraged to adopt a whole-of-school approach to mental health and wellbeing. Outcomes are sought through resiliency training and by addressing the issues affecting young people within schools and the broader school communities (Wyn et al. 2000). Much of this work is based on the concept of health promoting schools: 'strengthening life skills and resilience, fostering a supportive school environment and a school culture which encourages partnerships between school and community within a comprehensive program is one pathway to promoting mental health and wellbeing among young people' (Commonwealth of Australia 1996 as cited in Wyn et al. 2000, p. 595). The World Health Organisation highlighted the importance of creating an environment conducive to promoting psychosocial competence and wellbeing across the whole school environment (Wyn et al. 2000). This approach seeks to benefit all members of the school community.

*Population group/setting*

Programs or interventions are conducted in the school environment with school age children and, by extension, the whole school community (including families).

*Effectiveness*

Evidence suggests that a schools approach to promoting mental health is likely to be more effective than focusing on topic-specific approaches (Lister-Sharp et al. 1999), particularly in relation to self-esteem, self-concept and coping skills (Tilford, Delaney & Vogels 1997). Several evaluation studies have identified a decrease in completed and attempted suicide and improvements in attitudes, emotions and coping skills, but the results about what worked are inconclusive (Gould et al. 2003), so links between health promotion programs and mental health improvement require further investment.

*Implementation issues*

Programs are best implemented at the school community level to engage with students, teachers, parents and the curriculum, and to connect with school policy. Promoting school change at all these levels is a recommended vehicle for mental health improvement (Lister-Sharp et al. 1999). Where multiple strategies are employed, each needs to be evaluated so as to establish the evidence base for which aspects of mental health promotion programs in schools are most effective and why.

**Promising practices**

*Progress in the Australian MindMatters project suggests this is a promising approach to mental health promotion and, therefore, the prevention of youth suicide* (Waring & Hazell 2002).

*References*

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### **Intervention – Structured opportunities for participation**

Participation provides opportunities for citizens to engage with others and become partners in building social life.

#### *Population group/setting*

Programs target all ages from school aged children to older people, in any community-based projects, including sport or cultural projects (HEA 2001; VicHealth 2003). In particular, communities with immigrant groups and cultural diversity benefit from projects that focus on participation. Women immigrants are particularly vulnerable to social isolation when they experience barriers to classes in the English language, underemployment, lack of family support, a decrease in social status, and family conflict, as well as gender issues related to the labour market (Mulvihill, Mailloux & Atkin 2001). Interventions are also developed for men who feel they do not have personal support and lack social connections.

Program settings include civic structures that encourage engagement via local governance, community participation and other forms of social contribution.

#### *Effectiveness*

People gain multiple health benefits from opportunities to participate and become involved. Genuine participation builds local democracy and neighbourhood social capital through social connections, as well as feelings of control over decision making about local issues. Engaging people to encourage their participation is a form of social validation (HEA 2001; VicHealth 2003).

Connectedness can be enhanced by ensuring access to familiar language and culture, connection to social support services and recreational activities, and appropriate organisation of neighbourhoods and shopping precincts (Mulvihill et al. 2001). Interventions to establish social connectedness of immigrants are usually local and conducted on a relatively small scale without strong evaluation. Reviews have tended to focus on 'high risk' individuals rather than populations or communities (Rychetnik & Todd 2004).

#### *Implementation issues*

These programs need to:

- identify population groups of interest who experience vulnerability or disadvantage, or social isolation
- work with migrant centres and community leaders
- ensure high levels of community engagement with all stakeholders
- establish social arenas that build connection and trust in multicultural contexts
- advance sustainability by:
  - ensuring processes for skills development
  - setting up avenues for ongoing support mechanisms
  - bringing about shifts in community attitudes
  - creating connections that did not previously exist.

**Example of good practice**

The Ambassador newspaper, a collaboration of the Horn of African Communities Network, Adult Multicultural Educations Services and VicHealth, is a self-managed enterprise producing a regular newspaper in eight of the languages spoken in the Horn-of-Africa. Produced for and by African communities, it provides information to assist new arrivals to settle in Australia. Those involved reap the mental health benefits of the natural social connections occurring through enterprise building and newspaper production. The skills that participants learn will contribute to the long term sustainability of the enterprise, as well as improving their prospects of gaining future employment. By contributing to a positive African Australian identity, the newspaper will also help to build self-determination and self-esteem in African communities.

**Comment**

The growing literature on partnerships and participation is testimony to the increasing value placed on these approaches, but program evaluations need to better identify mental health promotion outcomes (Kawachi & Berkman 2001).

**References**

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**Intervention – Workplace mental health promotion**

Job or occupational stress is a major public health problem that is increasing in prevalence but is largely preventable (LaMontagne et al. 2005). It is defined as the combination of high job demands and low job control, and it predicts physical and mental health problems and mental illness, particularly depression in women, cardiovascular disease, increased absenteeism, employee turnover and worker's compensation costs. Poor mental health in the workplace is connected to aggression, bullying and workplace violence, precarious work circumstances and job insecurity, and long working hours (LaMontagne et al. 2005).

Systems approaches (rather than those focused on individuals) that integrate public health/health promotion and prevention approaches (from primary level responses through to organisational change) are indicated as having the most effect in improving job stress. Organisations may have emerging capacity to deal with the mental health problems of staff, but leadership and guidance on the implementation of integrated systems strategies are needed (LaMontagne et al. 2005).

Employee participation is a key mechanism for mental health promotion in the workplace. Employee participation programs can involve all level of workers (particularly those in the lower hierarchy), and they aim to increase involvement in decision making that affects the health and wellbeing of workers, provide onsite, peer led training, teach new skills and strengthen networks (Heaney et al. 1995 cited in Jane-Llopis et al. 2005).

*Population group/setting*

Program can be implemented in workplaces of all types, particularly for female workers, workers aged less than 30 years who are working long hours (36–49 hour per week), and those employed to use low to middle occupational skill (LaMontagne et al. 2005).

*Effectiveness*

Organisation-wide approaches to employee participation are most effective when they support staff involvement, enhance job control, encourage workload management, clarify roles and involve policies to tackle bullying and harassment. Modification of stressful occupational environments reduces mental health problems among employees (Health Education Authority 2001). A large scale, randomised trial of the Caregiver Support Program was designed to measure support for caregiver teams in health and mental health facilities. Results included enhanced mental health and job satisfaction, and positive effects on retention (Heaney et al. 1995 cited in Jane-Llopis et al. 2005).

*Implementation issues*

- Interventions must be made relevant for the particular setting and must include genuine participation of staff to ensure empowerment is an outcome. Needs assessment and/or risk assessment is thus strongly recommended to tailor interventions to the context.
- The development of an evidence base on economic outcomes (such as absenteeism rates, costs and benefits) will encourage policy in, and the practice of, systems approaches. Job stress intervention research from public health approaches will help to guide policy and practice in this area (LaMontagne et al. 2005).

*Comment*

This intervention description links with the determinant of economic participation (section 5).

*References*

Health Education Authority 2001, *Making it happen: a guide to delivering mental health promotion*, UK Department of Health, London. Available at [www.nelf.nhs.uk/nsf/mentalhealth/makeithappen/ch3/3\\_0.htm](http://www.nelf.nhs.uk/nsf/mentalhealth/makeithappen/ch3/3_0.htm).

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### **Intervention – Social support**

Social support is regarded as a ‘psychosocial intervention’, which is a general term for interventions designed to modify behaviour and create supportive environments. These interventions encompass every level, from individuals, the family, social network, the workplace and the community, through to the population level (Glass 2000). Effective social support interventions include parent training programs for improving maternal mental health (Barlow & Coren 2002) and home-based social support for socially disadvantaged mothers (Hodnett & Roberts 2004). Programs such as the multi-country Home-Start program (Jane-Llopis et al. 2005) aim to increase family confidence and independence, empower parents, and offer social support through time, friendship and practical help by volunteers. The multi-country Community Mothers program (Jane-Llopis et al. 2005) focuses on health care, nutritional improvement and child development.

#### *Population group/setting*

These programs target mothers of young children, young mothers and early parenthood generally and vulnerable families in particular.

#### *Effectiveness*

- Home visiting by public health nurses or midwives, whether a stand-alone intervention or part of a multiple intervention, reduces the risk of postnatal depression, improves parenting skills and mother–child interactions, and has an impact on child health priorities such as child abuse, child behaviour, oral health, infant mortality and injury, language and literacy, and parent mental health (Eagar et al. 2005).
- Parent training programs are effective in promoting short term psychosocial health outcomes for mothers. Evaluations are not at the level of randomised controlled trials, although long term follow-up of Home-Start families noted self-reported parent satisfaction that the program made a positive difference to their lives. Significant differences between Home-Start families and comparison groups have not yet been found.
- Randomised controlled evaluation of the Jamaican adaptation of the home visiting program showed a dose–response relationship between frequency of visits and cognitive development of the children (Jane-Llopis et al. 2005).
- Peer or professional support programs for parents with mental illness have shown encouraging results in reducing stigma and assisting parent–child communication about mental illness. Depressive symptoms were reduced and family functioning was improved (Eagar et al. 2005).

*Implementation issues*

Programs from one country need to be examined for their applicability in the contexts and settings of another country. The replication of the Community Mothers Program demonstrates its ability to be adapted for various contexts, and evaluation demonstrates its potential to be delivered by lay persons.

**Promising practices**

*Community-wide interventions (such as Victoria's Best Start program) offering layers or 'tiers' of support to parents are promising, although evaluation data are not yet definitive (Eagar et al. 2005: ix)*

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**Useful resource**

*Home-Start International is an early childhood program with country programs across the world. Home-Start (Australia) Inc. ([www.home-start-int.org/Australia.asp](http://www.home-start-int.org/Australia.asp)) is an independent, non-government organisation that provides training and support for the establishment of local Home-Start programs, either auspiced by a community organisation or managed by a local committee of management. Trained volunteers reach out to provide social support to families who are struggling to cope with ill health, disability, poverty and other adversities.*

## Case study: the Schools as Core Social Centres initiative

A partnership between the Catholic Education Office Melbourne (CEOM) and VicHealth resulted in the Schools as Core Social Centres (SACSC) initiative, which was conducted across clusters of schools in Melbourne. This initiative aimed to strengthen evidence of the links between student wellbeing and learning outcomes. A School Improvement Agenda was developed and measured through accountability and measurement tools. The tools support a strategic approach to developing the link between social capital, school/community partnerships and student learning outcomes.

The Mental Health Promotion Framework below was developed from the results of the research conducted during the SACSC initiative, and then modelled into a conceptual framework based on the VicHealth Framework for the Promotion of Mental Health and Wellbeing. The conceptual framework was developed to inform strategic implementation in relation to:

- the role of schools in developing school–community partnerships and social capital
- the relationship between the growth of social capital, improved learning student wellbeing and outcomes.

### SACSC Mental Health Promotion Framework 2005–07

Key social and economic determinants of mental health and themes for action		
<i>School connectedness</i>	<i>Social connectedness</i>	<i>Community connectedness</i>
<ul style="list-style-type: none"> <li>• Involvement in school activities</li> <li>• Sense of belonging</li> </ul>	<ul style="list-style-type: none"> <li>• Supporting relationships</li> <li>• Emotional wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement in community activities</li> <li>• Access to local resources</li> </ul>

  

Population groups and action areas	
<i>Population groups</i>	<i>SACSC action plan</i>
<ul style="list-style-type: none"> <li>• Students</li> <li>• School staff/personnel</li> <li>• Parish priests</li> <li>• Families</li> <li>• Broader community</li> <li>• Partnerships</li> </ul>	<ul style="list-style-type: none"> <li>• Development of audit tools</li> <li>• Development of conceptual framework</li> <li>• Ongoing evaluation</li> <li>• External funding sources</li> </ul>

  

Settings for action		
<ul style="list-style-type: none"> <li>• Schools</li> <li>• Local government</li> <li>• VicHealth</li> </ul>	<ul style="list-style-type: none"> <li>• Community agencies</li> <li>• Catholic Education Office Melbourne</li> <li>• Sport and recreation</li> </ul>	<ul style="list-style-type: none"> <li>• Local government</li> <li>• Housing commission estates</li> <li>• Local church/parish</li> </ul>

  

Areas for action		
<ul style="list-style-type: none"> <li>• School ethos, culture and environment</li> <li>• Organisational structures</li> <li>• Policies</li> <li>• Decision-making processes and procedures</li> <li>• Diversity</li> </ul>	<ul style="list-style-type: none"> <li>• Leadership and governance</li> <li>• Curriculum teaching and learning</li> <li>• Research initiatives</li> <li>• Professional learning teams</li> <li>• Learning styles</li> </ul>	<ul style="list-style-type: none"> <li>• School/community partnerships</li> <li>• Professional development</li> <li>• Parent/community participation</li> </ul>

Intermediate outcomes			
<i>Individual</i>	<i>Organisational</i>	<i>Community</i>	<i>Schools</i>
<ul style="list-style-type: none"> <li>• Social emotional health</li> <li>• Supportive and caring relationships</li> <li>• Involvement in school and community activities</li> <li>• Resiliency</li> <li>• Protective factors</li> <li>• Learning outcomes</li> <li>• Student/school connectedness</li> <li>• Positive relationships</li> <li>• Student background and experience</li> <li>• Student engagement</li> </ul>	<ul style="list-style-type: none"> <li>• Research circle</li> <li>• Partnership across sectors (Victorian Department of Education and Training and Melbourne University)</li> <li>• School clusters developed</li> <li>• Professional development and learning</li> <li>• Collegiate support</li> <li>• Promotion of best practice</li> </ul>	<ul style="list-style-type: none"> <li>• Participation in SACSC activities</li> <li>• Connectedness</li> <li>• Community projects/activities</li> <li>• Social/cultural inclusivity</li> <li>• Involvement of families</li> <li>• Linking with agencies</li> <li>• Working with the community</li> <li>• Self-determination</li> <li>• Welcoming environment</li> <li>• Community/school collaboration and participation</li> <li>• Family/school support to students</li> </ul>	<ul style="list-style-type: none"> <li>• Core leadership teams</li> <li>• Whole school approach</li> <li>• School development plan</li> <li>• Audit tools</li> <li>• Professional learning teams</li> <li>• Access and equity</li> <li>• School-based action research Initiatives</li> <li>• Safe and supportive environment</li> <li>• Participation of school community</li> <li>• Partnerships</li> <li>• Relevant and meaningful curriculum</li> <li>• Democratic schooling</li> <li>• Warm classroom climate</li> <li>• Physically welcoming</li> <li>• School budget allocation</li> <li>• School/community collaboration and participation</li> </ul>

Population groups and action areas	
<i>Population groups</i>	<i>SACSC action plan</i>
<ul style="list-style-type: none"> <li>• Students</li> <li>• School staff/personnel</li> <li>• Parish priests</li> <li>• Families</li> <li>• Broader community</li> <li>• Partnerships</li> </ul>	<ul style="list-style-type: none"> <li>• Development of audit tools</li> <li>• Development of conceptual framework</li> <li>• Ongoing evaluation</li> <li>• External funding sources</li> </ul>

Long term benefits	
<ul style="list-style-type: none"> <li>• Improved student wellbeing</li> <li>• Increased community participation</li> <li>• Development and growth of partnerships</li> <li>• Placement of social capital and student wellbeing at the core of school life</li> <li>• Increased access to community groups, agencies and services</li> <li>• Improved learning outcomes for all</li> </ul>	<ul style="list-style-type: none"> <li>• Embedding the SACSC initiative across schools in the Archdiocese of Melbourne</li> <li>• Ongoing professional learning and professional development</li> <li>• Development and growth of research initiatives</li> <li>• Evidence-based research to inform systemic school improvement</li> </ul>

*Volunteering Australia (2001) defined formal volunteering as an activity that takes place in not-for-profit organisations or projects and is undertaken:*

- to benefit to the community and the volunteer
- of the volunteer's free will and without coercion
- for no financial payment
- in designated volunteer positions only.

*It noted the following principles of volunteering:*

- Volunteering benefits the community and the volunteer.
- Volunteer work is unpaid.
- Volunteering is always a matter of choice.
- Volunteering is not compulsorily undertaken to receive pensions or government allowances.
- Volunteering is a legitimate way in which citizens can participate in the activities of their community.
- Volunteering is a vehicle for individuals or groups to address human, environmental and social needs.
- Volunteering is an activity performed in the not-for-profit sector only.
- Volunteering is not a substitute for paid work.
- Volunteers do not replace paid workers or constitute a threat to the job security of paid workers.
- Volunteering respects the rights, dignity and culture of others.
- Volunteering promotes human rights and equality.

### **Intervention – Volunteering**

Volunteering provides structured opportunities for people to do voluntary work in their community, which is one aspect of civic participation and engagement.

#### *Population group/setting*

Volunteer programs target adolescents and adults of all ages.

#### *Effectiveness*

There is good evidence that engagement in meaningful volunteer activities increases feelings of wellbeing and quality of life and enhances social connectedness, especially among older adults (Wheeler, Gorey & Greenblatt 1998). The training of retired adult volunteers to deliver pre-retirement programs produced measurable change in self-efficacy, knowledge about retirement and morale (Wheeler, Gorey & Greenblatt 1998).

#### *Implementation issues*

Volunteers need support to ensure they feel able to sustain their involvement. Sustainability can be advanced by:

- ensuring processes for skills development
- setting up avenues for ongoing support mechanisms
- bringing about shifts in community attitudes
- creating connections that did not previously exist.

#### *References*

Volunteering Australia 2001, Home page at <http://volunteersearch.gov.au/>.

Wheeler, J, Gorey, K & Greenblatt, B 1998, 'The beneficial effects of volunteering for older volunteers and the people they serve: a meta-analysis', *International Journal of Ageing and Human Development*, vol. 47, no. 1, pp. 69–79.

### **Intervention – Community arts programs**

Community-based arts projects and initiatives are concerned with community participation, social inclusion, capacity building and regeneration, the building of social capital through participation and social connectedness, and health generally. They are also an expression of civic participation. Arts projects aimed at community participation, capacity building and regeneration are sometimes designed to have health outcomes with health promotion objectives, but they are more likely to be designed around arts

#### *Population group/setting*

A wide variety of social groups (including at-risk groups) are suitable for community-based arts projects in diverse settings.

### *Effectiveness*

While mental health is often an outcome of arts projects, objectives are not usually structured around mental health outcomes, so the evidence is more in terms of outcomes relating to pleasure and quality of life, and health and wellbeing outcomes such as 'feeling better' or 'happier'. In urban regeneration programs, arts programs have had a range of community development outcomes, including increased community identity, reduced social isolation, improved recreational options, the development of local enterprise and improved public facilities (Jermyn 2001). The Arts Council of England (Jermyn 2001) developed systematic evaluations to measure health and wellbeing outcomes from arts projects in settings such as hospitals, neighbourhoods and prisons. But there is little rigorous evaluation of social capital as an outcome of community arts programs. Outcomes related to trust and collaboration include group cooperation, effective communication of complex ideas, and the identification of common goals.

Much of the evidence is subjective – for example, appreciation of the value of community arts, the development of community identity/confidence, and the development of community networks

### *Implementation issues*

Health and social outcomes of community-based arts programs may seem difficult to measure, but the use of a framework such as the VicHealth framework (2005) can assist with planning. Factors thought to underpin success include creative passion, dynamic relationships, experimentation and innovative problem solving. Other success factors include:

- connection with local needs
- democratic relationships, which are critical to successful outcomes and include sharing control and adopting flexible and adaptable working methods
- good practice frameworks that allow sufficient time for planning, building successful participatory methods and creating robust models for working in partnership
- an emphasis on quality and striving for excellence, which creates pride in achievement. An 'anything goes' attitude can be detrimental to success.

### *Comment*

Rigorous analysis and long term evaluation of the impact of community arts programs on mental health and wellbeing need to be undertaken. The incorporation of short or intermediate term mental health outcomes into community arts projects or programs would be relatively easy to achieve. Evaluations of mental health outcomes from such programs would make valuable contributions to evidence about what works.

**Useful resources**

Flowers, R & McEwen, C 2003, The impact of re-igniting community and 'The Torch' on community capacity building, *Centre for Population Education, University of Technology, Sydney*.

Mills, D & Brown, P 2004, Art and wellbeing, *Commonwealth of Australia, Canberra*.

The evidence review undertaken by The Globalism Institute (McQueen-Thomson and Ziguras 2002) identified that a substantial body of research identifies the positive health impacts of community arts practice, but that much of the literature is anecdotal. To address these issues, the review report recommended that projects focus on known determinants of health rather than broad social indicators, focus on participants and audiences rather than organisers, increase sample size and use longitudinal dimensions. Another recent evidence-based review (Scottish Executive Education Department 2004) also called for longitudinal research.

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Jermyn, H 2001, *The Arts and social exclusion*, Review prepared for the Arts Council of England, London. Available at [www.artscouncil.org.uk/documents/publications/298.doc](http://www.artscouncil.org.uk/documents/publications/298.doc).

McQueen-Thomson, D & Ziguras, C 2002, *Review of the health benefits of community arts practice*, The Globalism Institute, School of International and Community Studies, RMIT University, Melbourne.

Scottish Executive Education Department 2004, *A literature review of the evidence base for culture, the arts and sport policy*, Research and Economic Unit, Scottish Executive Education Department, Scotland. Available at [www.scotland.gov.uk/library5/education/lrcas-00.asp](http://www.scotland.gov.uk/library5/education/lrcas-00.asp).

VicHealth 2002, *Creative connections: promoting mental health and wellbeing through community arts participation*, Victorian Health Promotion Foundation, Melbourne.

Williams, D 1996, *The social impact of arts programs: how the arts measure up: Australian research into social impact*. Community Arts and Adult Education Centre of Newcastle, Working paper 8, Available at [www.artshaus.com.au/communityarts/papers/Commedia.htm](http://www.artshaus.com.au/communityarts/papers/Commedia.htm).

## Promising Projects: promoting mental health and wellbeing through community arts participation

VicHealth acknowledge that community arts projects allow people to creatively express ideas about themselves and their communities in ways that celebrate and reflect their experience and identity. The Community Arts Participation Scheme provides funding to approximately 40 community arts projects each year. Activities have included:

- the creation of an arts studio
- dance
- a circus performance
- theatre (ranging from Shakespeare to puppetry)
- a visual arts exhibition.

### Good practice examples

#### *Shimmer*

This project involved the performance of a play exploring the themes of fame and local women's desires for relationships and children. Rehearsals were conducted on weekends, and a director and musical director supported the project. The project resulted in seven sell-out performances and critical acclaim from the media. The women involved felt valued and a sense of pride, and many discovered talents in singing, acting and movement. As a result, Platform Theatre, the auspicing organisation, benefited from an enhanced reputation.

*I feel like I can do anything after this.* (participant, Shimmer)

#### *High Rise*

High Rise was a puppetry and performance project based in the Carlton high rise housing estate and the onsite Carlton South Primary School. The project resulted in a large scale performance using the estate grounds as the theatre and the 12-storey building as a prop for projection and display. Partnerships among a range of agencies were developed. Those involved felt the project included all children, enhanced the children's pride in their school and produced positive behavioural changes in the children.

#### *A(Maze)*

Participants in this project were invited to participate in regular workshops with an artist. Together, they worked on the production of folio and exhibition pieces. Participants explored the theme of navigating the service system, using the maze to symbolise this them. Being based at the Bentleigh Bayside Community Health Service, the project (which received considerable media coverage) brought together the arts and health. Partnerships between a range of organisations have developed as a result. Some participants have continued their art work and enrolled in arts-related further education. Many also reported making major changes at a personal level and highlighted the importance of the building of friendships.

#### *The Torch*

The Torch project is an extensive program of community cultural development work in regional and metropolitan Victoria. Its evaluation indicates promising outcomes in relation effective engagement strategies, the strengthening of capacities among those who are most disadvantaged, and the impact on social capital indicators. Further information can be found at [www.thetorch.asn.au/current\\_project.html](http://www.thetorch.asn.au/current_project.html).

### **Success factors**

Evaluation has developed a list of ‘success factors’ from the projects’ experiences. These include having:

- project research and planning to identify community interest and engagement
- achievable project goals
- an environment supportive of participants and the creative process
- appropriate skills/experience in the project team.

### **Outcomes for individuals**

In general, evaluation has revealed that the projects assisted individuals to:

- develop positive relationships
- gain public recognition
- consider identity
- enhance skills
- participate economically.

Some individuals have used their participation in these projects as a springboard to career opportunities. The value of participation and belonging was identified as an important mental health outcome.

### **Outcomes for organisations**

Many agencies involved in these projects had never previously worked together. As a result, relationships were tested at times. But the benefits of project participation are clearly articulated:

- Many organisations’ involvement resulted in enhanced reputation and strong community support. The future viability of these organisations is thus likely to be improved.
- Relationships between the health and arts sector were strengthened through the funding of these projects.
- An appreciation of the link between health and arts participation has been a positive outcome.
- Short term funding for community arts projects is likely to have an impact on project sustainability.

### **Outcomes for communities**

These projects have worked hard to connect diverse communities through the arts. The benefits are an increased understanding of culture and the importance of the arts as a vehicle for improving mental health and wellbeing.

### **The value of partnerships**

As part of the funding agreement, projects were required to demonstrate a link between agencies or individuals to enable ongoing development. The strength of the partnership approach is thus evident in each of the projects. Evaluation highlighted the importance of resourcing the partnerships. Other partnership-related problems encountered during the projects’ implementation related to untested relationships, loose agreements and the recruitment of participants.

### **Intervention – Physical activity/exercise**

There is growing evidence that a physically active lifestyle has a positive impact on mental health outcomes in adults and children (Ekelane et al. 2004; Strawbridge et al. 2002). ‘Physical exercise’ implies regular, structured, leisure-time pursuits, while ‘physical activity’ arises in everyday domestic or occupational tasks (Salmon 2001).

#### *Population group/setting*

These program can target all population groups, from children to older age adults. For the elderly, activity and exercise sessions can be built into day and residential care programs, and in appropriate community based settings. For children, adolescents and adults, both activity and exercise settings are diverse.

#### *Effectiveness*

Research into effectiveness has focused on physical exercise rather than everyday physical activity. Until recently, little research had been conducted to determine the effects of physical activity on mental or social wellbeing (US Department of Health and Human Services 2002). But there is considered to be good reason to promote physical activity in the general public both to prevent physical and mental disorders and to promote health and wellbeing (Health Education Authority 2001). Physical activity interventions affect healthy people as well as those with co-morbidities, but prospective epidemiological studies are needed to determine the extent to which physical activity may be effective for long term positive mental health.

Physical activity has been perceived as likely to have a protective effect on mental health, but evidence of self-concept and self-esteem benefits from increased activity in children and adolescents (3–20 years of age) is also gathering. There is good evidence that physical activity reduces the risk of subsequent depression for older adults (Strawbridge et al. 2002). The World Health Organisation (2005) suggested that physical activity promotes psychological wellbeing, reduces stress, anxiety and feelings of depression and loneliness, and helps prevent or control risky behaviours (especially among children and young people) such as tobacco, alcohol or other substance use, unhealthy diet and violence.

Much of the evidence on physical exercise is self-reported as subjective wellbeing and feelings of improved mood following exercise, happiness, feeling better about oneself, feeling better about body image, and perceived fitness and health generally (Health Education Authority 2001; Salmon 2001). A limitation to the research is that it has been conducted in controlled environments that often assume people find exercise to be enjoyable. For habitual exercisers, a lack of exercise is likely affect mood change (Salmon 2001). Comparability across different forms of exercise cannot be assumed (Salmon 2001).

The emotional benefits of exercise (as opposed to the physiological stimulus) are likely to be due to environmental stimuli and social interaction. Emotional benefits and feelings of wellbeing from increased social interaction are important outcomes of exercise/activity, because solitary exercise does not improve depression. Mental health benefits can be measured in terms of social interaction, but the evidence for exercise as a stand-alone intervention is not straightforward and can be applied to only segmented population groups.

Ekeland et al. (2004) found moderate improvements in self-esteem from exercise. The analysis did not provide information on the most effective settings or specific exercise programs. Organised sporting clubs and bodies consistently report that participation in exercise increases social cohesion, a sense of belonging and thus social inclusion, but more rigorous evaluations need to be conducted. Confounding factors in some studies make it difficult to conclude whether exercise alone produced the measurable gains (Health Education Authority 2001).

#### *Implementation issues*

- Exercise must be appropriate and tailored to suit people's preferences, with participants' needs and characteristics understood to determine the amount and type of physical activity needed to promote optimal mental health.
- Enjoyment is necessary for both adherence and benefits (Salmon 2001).
- Brisk walking is considered a good starting point for people who are looking to increase levels of physical activity.
- Exercise frequency and sustainability of exercise are more important than format and intensity in older adults, so low intensity exercise, for example, is recommended for older adults.
- Access to public spaces suitable for physical activity cannot be taken for granted. Interventions need to identify mechanisms for enhancing the access of non-traditional service users to mainstream recreational and leisure activities.
- Programs must create welcoming and supportive 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, bicycle paths etc.
- Community and school-based physical activity schemes would benefit from the inclusion of mental health promotion aims and objectives to ensure mental health benefits and outcomes are openly identified and measured.

### Comment

Intersectoral cooperation between the health and recreation/leisure sectors could be strengthened to implement, maintain and sustain physical activity and physical exercise programs, including walking groups. Evaluations are needed of the health sector's appropriate role in providing physical activity and exercise programs, and of the costs and benefits of transferring programs from the health sector to the recreation/leisure sectors.

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### Intervention – Media campaigns for mental health promotion

Media campaigns are a social marketing intervention at the level of communities or populations. They are used to promote community awareness of mental health issues, challenge stigma and raise awareness of attitudes towards mental health issues. Campaign messages encourage people to understand good mental health and recognise mental health problems and when to seek help and talk about feelings and emotions. The media is a tool for advocacy and for strengthening community capacity to take action, make decisions and feel empowered. Media methods include television, radio and newspaper advertisements, printed material through various outlets (including mail-outs), information to professionals, open days and publicity.

**Good practice**

*Social marketing and media advocacy are more effective when part of a mix with other interventions, particularly local community action.*

**Population group/setting**

Media campaigns can target community settings, local populations and segmented population groups.

**Effectiveness**

Significant positive changes in knowledge of and attitudes towards mental health (particularly reducing stigma) have been found in UK, US and Norwegian evaluations of media campaigns (Jane-Llopis et al. 2005). The development of personal skills through changes in behavioural intentions was found in the United Kingdom (Barker 1993). The effectiveness of media-based campaigns for mental health promotion is increased when a campaign is complemented by a mix of focused community activities and used over time rather than as a brief intervention.

**Implementation issues**

The principles for effective health promotion media campaigns apply to campaigns seeking to promote mental health:

- Use media campaigns with a mix of interventions where possible.
- Reaching into segmented population groups or communities requires the development of culturally competent materials and practices.
- Well designed evaluations (including cost-effectiveness measures) are needed to strengthen the evidence on the use of media interventions for mental health promotion.

**Comment**

A small scale evaluation of the VicHealth 'Together we do better' campaign found media advocacy can have an impact on knowledge and attitudes in relation to mental health promotion literacy.

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