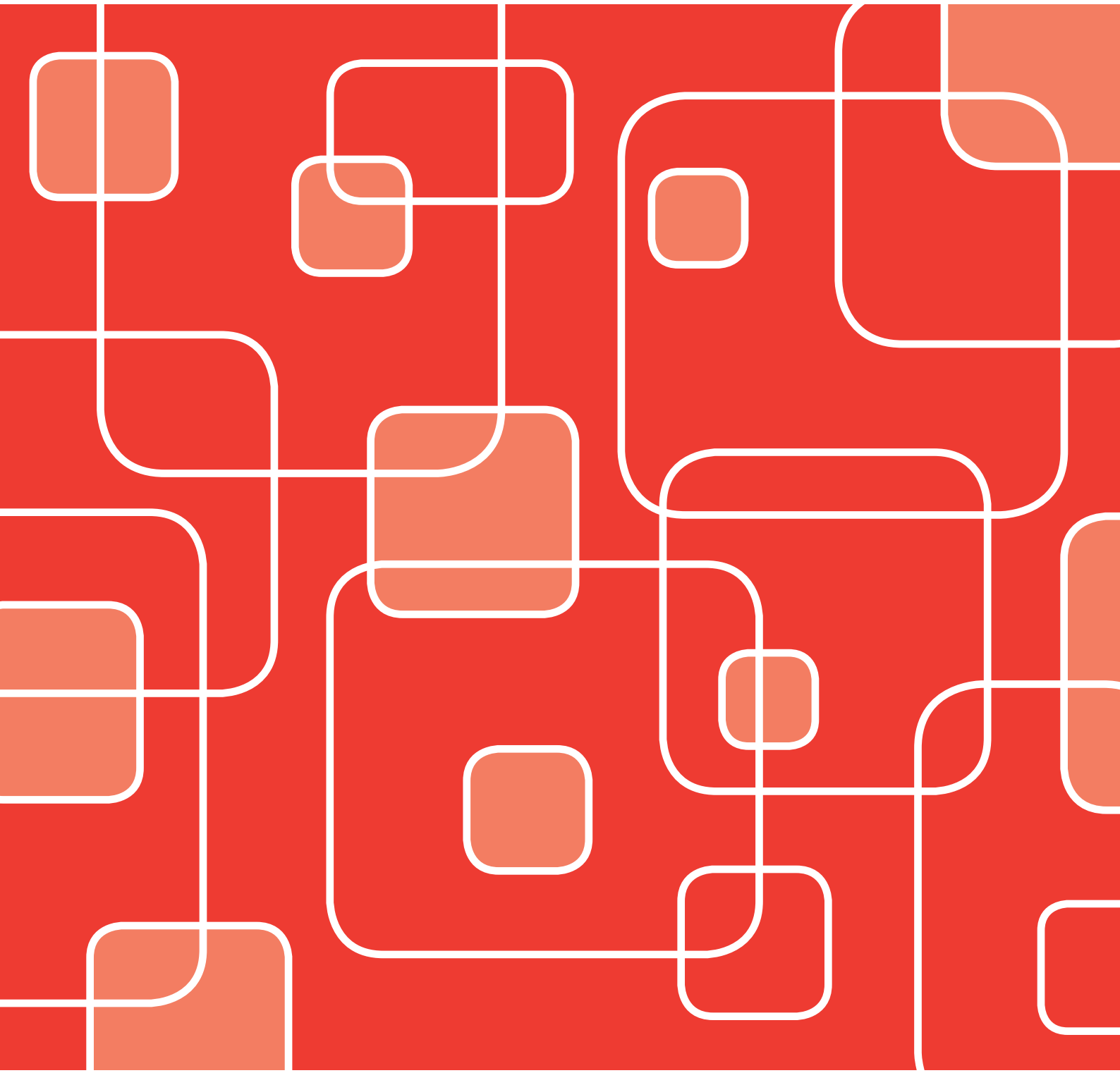
Evidence-based mental health promotion resource



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VicHealth

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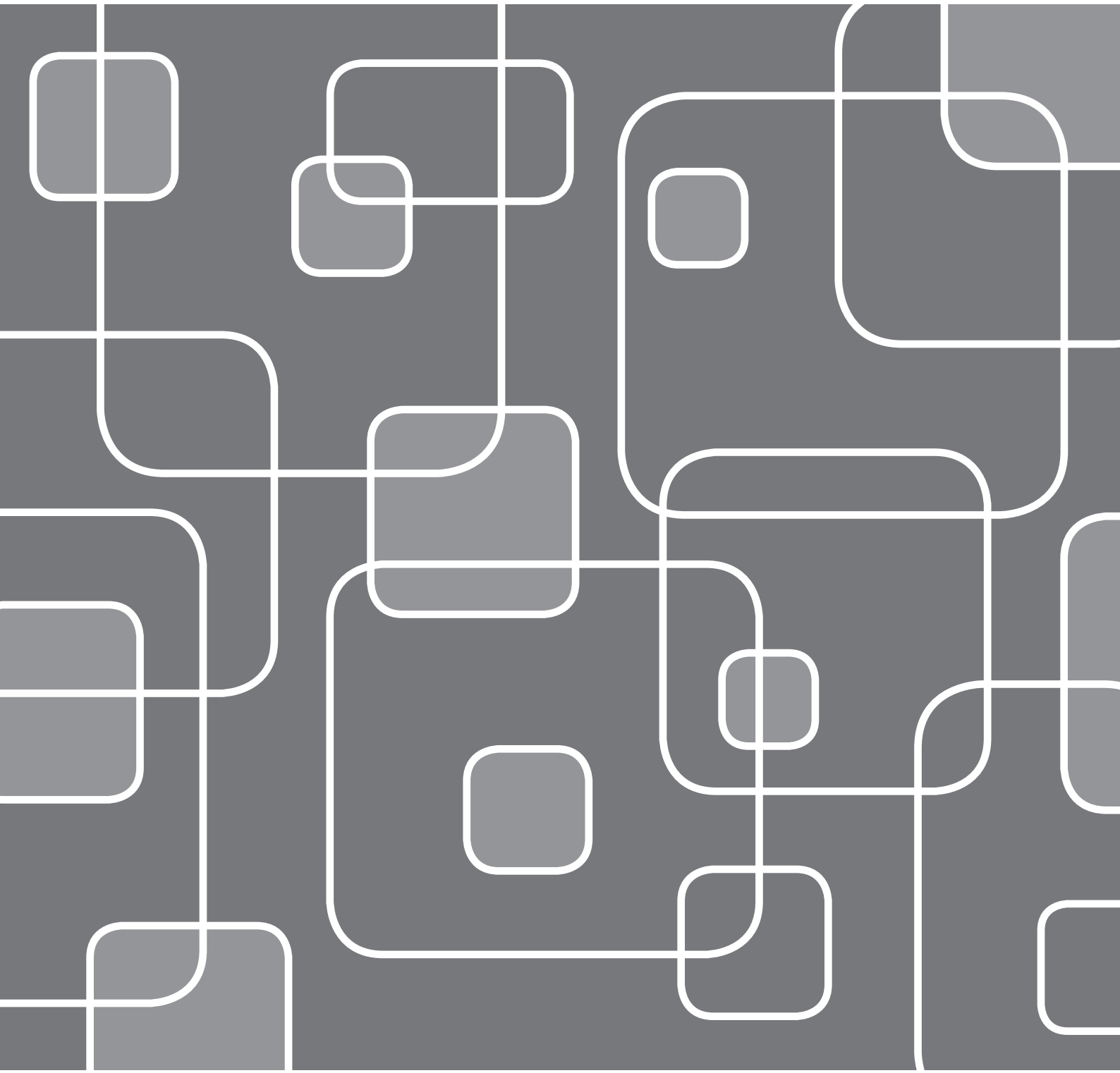

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Contents

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Foreword

We are pleased to provide the foreword to this wonderful resource, which will assist practitioners as they plan, implement and evaluate mental health promotion programs across Victoria.

Mental health disorders constitute 10 per cent of the global burden of disease. One in five Australians will experience a mental disorder at some stage in their lifetime. As the human, social and economic consequences of mental health disorders and illness are great, there is also a growing realisation of the serious limitations of focusing solely on treatment and rehabilitation. Our challenge is to identify ways of promoting mental health and wellbeing and preventing problems before they occur.

As mental health promotion is an emerging discipline, the continued development of evidence to enhance policy and practice, across diverse sectors, is fundamental. Whilst historically, health improvements have been attributed only to treatments and medical services, there is now indisputable recognition that some of the major determinants of our mental health and wellbeing lie within the social and economic domains of our lives, and include social inclusion, having a valued social position, physical and psychological security, opportunity for self determination and control over one's life and access to meaningful employment, education, income and housing.

Addressing these determinants to improve mental health requires that many organisations from diverse sectors within the community recognise how they can and do contribute to the promotion of mental health and wellbeing. It also requires a broadening of our collective understanding about the range of evaluation methodologies required to measure change in mental health and wellbeing across sectors. It is furthermore about providing resources and building the skills of practitioners in how best to monitor and measure interventions in mental health promotion. All of these actions will contribute to a more robust evidence base, which in turn, will assist with policy development and moving the research into practice.

The timing of this resource coincides with the government's renewed focus on a determinants approach to health. The recently released social policy statement, *A Fairer Victoria, creating opportunity and addressing disadvantage*, strengthens the current *Growing Victoria Together – a vision for Victoria to 2010 and beyond* policy platform and signals to the field that initiatives targeting mental health promotion are examples of good social policy. The recent Victorian Government budget announcements of $124.8 million over four years for expansion of mental health programs signals that the new policy framework will focus on good mental health and wellbeing for years to come.

VicHealth's *Mental Health Promotion Plan 2005–2007* provides a framework for mental health and wellbeing and is intended to serve as an information resource for practitioners from diverse sectors who are seeking to maximise opportunities to promote mental health and wellbeing through their research, policies and programs. This prioritisation on the determinants of health recognises the changing environment in which we live and reflects the fact that mental health is everybody's business and that all sectors, including the health sector, have a role to play in addressing those factors that enhance or obstruct mental health and wellbeing.

Practitioners are constantly being confronted with more complex issues, which require sophisticated and multidimensional solutions. We hope that this resource contributes to the solutions and we welcome your feedback and suggestions. We wish you good mental health as you read it.

Dr Robert Hall
Director Public Health &
Chief Health Officer
Public Health Group
Victorian Department of Human Services

Dr Rob Moodie
Chief Executive Officer
Victorian Health Promotion Foundation

Abstract

Objectives

To review the evidence on mental health promotion from determinants of health approaches, and to highlight strategies for policy and practice that will strengthen mental health among populations.

Design

The evidence on interventions to promote mental health and wellbeing was reviewed for effective practice developments.

Setting

The resource was compiled for VicHealth and the Victorian Department of Human Services in 2005 to support the VicHealth Framework for the Promotion of Mental Health and Wellbeing and the Department of Human Services Common Planning Framework for Health Promotion.

Results

Finding evidence of what works in mental health promotion is a vast undertaking because such a range of evidence can be considered. Given the relative recency of mental health promotion as a field of endeavour, the extent of programs with strong evidence is perhaps surprising. Many emergent programs would benefit from a strengthening of research design to enable the measurement of more robust outcomes. More established mental health promotion areas can be adapted or replicated locally, either integrated into existing programs or run as stand-alone programs. There is much scope for health promotion practitioners to include mental health promotion outcomes in a range of programs, and to develop skills and knowledge in thinking about the mental health benefits of programs in many sectors and settings.

Conclusions

Ensuring communities and populations have the opportunity for good mental health and wellbeing requires work across individual, community, organisational and societal and levels. Mental health promotion is certainly about predicting the possible effects of government policy in promoting or demoting mental health, as well as the ability of government to provide leadership for public and private sector activity. At individual, community and organisational levels, the evidence reviewed in this resource demonstrates that there is much that policy makers and program staff can do to actively promote mental health.

Margin notes throughout the resource are designed to provide easy access to key terms and links to supporting documents and websites.

How to use this resource

This resource assembles an overview of national and international evidence on the promotion of mental health and wellbeing. Evidence on each topic is presented as follows:

- a short **intervention description**
- the **population groups and settings** studied
- an assessment of the promotion's **effectiveness** as it is known
- a discussion of **implementation issues**
- additional **comments** (for some topics).

  New learnings and promising practices are included as an extra field. They are included to account for new information that has accumulated through efforts to build up knowledge about what works in mental health promotion but that might not have been evaluated to the level of criteria for this resource.
- Case studies are located in each section.

Interventions reviewed in this resource

Interventions to increase social connectedness

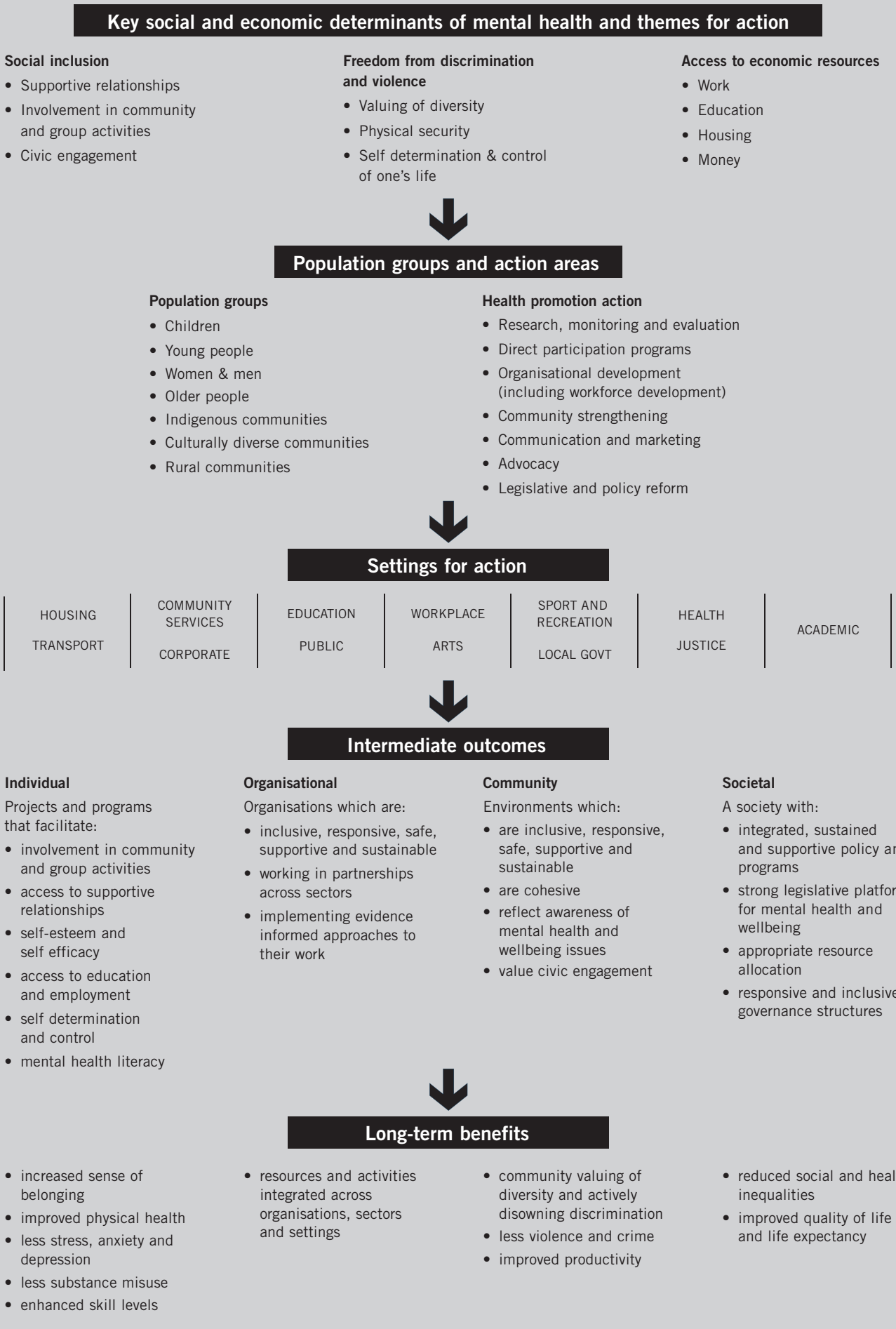
Interventions to address violence and discrimination

Interventions to increase economic participation

Many of these interventions have convincing evidence, while others, on the evidence available, are only promising at this stage. This resource considers existing evidence, but not the many gaps in the evidence base for successful interventions to enhance mental health and wellbeing.

The VicHealth Framework for the Promotion of Mental Health and Wellbeing is reproduced here for ready reference. Explanations of framework concepts are provided through the resource.

Figure 1: VicHealth 2005 Framework for the Promotion of Mental Health and Wellbeing



1 Introduction

Useful resources

For further information on health promotion policy in Victoria, refer to the Department of Human Services Integrated health promotion resource kit *(DHS 2003) and the website www.health.vic.gov.au/healthpromotion.*

To access the other evidence reviews and resources in this series, refer to www.health.vic.gov.au/healthpromotion/quality/evidence_index.htm.

1 Introduction

The drivers for health lie outside the health sector.

The Victorian Health Promotion Foundation (VicHealth) and the Victorian Department of Human Services (DHS) commissioned Deakin University to develop this mental health promotion evidence resource, to fill a gap in available resources to advance policy, research and practice responses to the promotion of mental health and wellbeing. The resource builds on the VicHealth Framework for the Promotion of Mental Health and Wellbeing (figure 1). Mental health promotion is an emerging sphere that includes research, policy development, community action and program activity. This resource is intended to develop understanding of mental health promotion and to assist policy makers and practitioners to develop and implement effective interventions in mental health promotion, which is emerging as a thought provoking field of endeavour. By drawing together the evidence literature, the resource aims to provide a practical summary not available elsewhere, to assist both the integration of mental health outcomes into existing program work and the development of programs focused on the promotion of mental health and wellbeing.

Since 2000, DHS has initiated wide ranging reforms in policy and practice to develop health promotion. Initiatives have been undertaken to develop and implement statewide policy to support both quality and effectiveness in health promotion, to therefore build on the capacity of the service system to plan and deliver effective high quality integrated health promotion programs. This resource is number 8 in the series of evidence-based health promotion practitioner resources supported by DHS. The full series is designed to help practitioners expand the range of their interventions with greater confidence and with a stronger rationale (based on evidence) than might have been available in the past.

1.1 Rationale for this resource

Good mental health is a prerequisite for good physical health.

Increasing attention is being given to the benefits of promoting mental health and wellbeing for populations and communities. The actions taken increasingly rely on a public health approach that emphasises the importance of the quality of societal and community life. This approach aims to support people to achieve and maintain good mental health, as well as improve the wellbeing of communities.

Mental and physical health are deeply intertwined and interdependent (World Health Organisation 2001). While the need for evidence-based actions to tackle mental health problems is acknowledged, there is growing recognition of the need to better understand and conceptualise how to actively engage in mental health promotion as an integral part of public health. Further, mental health promotion is often thought to be the responsibility of those working in the health field, but the determinants of mental health extend well beyond the health sector. The ability of the health sector to influence mental health and wellbeing is thus unlikely to be significant without support from other sectors (Walker et al. 2005). For this reason, greater investment is needed in resources that will assist practitioners and policy makers to develop their skills and knowledge of mental health promotion.

This context of mental health promotion accounts for the mental health of populations (not just individuals) and thus of values, systems, structures and processes that operate at all levels of society to promote mental health and wellbeing. Racism, sexism and other discrimination, homophobia, violence and lack of safety, poverty and unemployment, poor employment conditions, lack of access to education and needed health services, and lack of support for parents and carers, therefore, are identified as determinants of mental health and wellbeing.

Good mental health is a prerequisite for good physical health. The uptake of behaviours to improve physical health, including effective self-management of acute or chronic disease, is intimately connected to an individual's mental health and wellbeing. This resource is built on broad notions of health that recognise the range of social, economic and environmental factors that contribute to health. Health is understood not in terms of illness and disease but in terms of people's capacity to define, assess and analyse the determinants that influence their health (Labonte 2003), and to access the resources they need to act on those determinants. When these conditions are met, people are enabled to adapt, respond to or control the challenges and changes in the environments that surround them (Keleher & Murphy 2004).

Useful resources

Promotion and Education: International Journal of Health Promotion and Education *2005, 'The evidence of mental health promotion effectiveness: strategies for action', Supplement special edition 2, www.iuhpe.org.au.*

Mittelmark, MB 2003, 'Five strategies for workforce development for mental health promotion', IUHPE – Promotion and Education*, vol. 1, pp. 20–2.*

Further, mental health promotion can be intensely political, given the effects of society-wide values, systems and structures on people's mental health, and the implications of understanding that governments have ultimate stewardship for the mental health of populations (WHO 2001). Organisations too, have a critical role in supporting mental health and wellbeing. Mental health promotion work may thus include challenges to norms deeply held within social, cultural and political systems. But not just departments of health should be held accountable for mental health and wellbeing:

> *Because many of the macro-determinants of mental health cut across almost all government departments, the extent of improvement in mental health of a population is also in part determined by the policies of other government departments...and [those departments] should take responsibility for some of the solutions.* (World Health 2001, p. 101)

This emergent, but still new, paradigm of mental health promotion is moving onto political agendas (Jane-Llopis & Mittelmark 2005) as an increasing evidence base demonstrates its place in contemporary health promotion theory and practice.

Nonetheless, there is a continuing need for capacity building, particularly in methodological expertise in mental health promotion to strengthen the evidence base. Mental health promotion methods need to be strengthened through multi-level, intersectoral, well designed programs that are carefully evaluated for mental health promotion outcomes, including organisational change where efforts have been made to embed mental health and wellbeing outcomes in the work of the organisation. This process requires a common language about mental health promotion outcomes and an accessible evidence base, both of which this resource seeks to address.

1.1.1 Public health significance of mental health

Poor mental health is recognised as a growing cause of morbidity in Australia and a significant co-morbidity of many of the major disease conditions. Mental health disorders (excluding dementia) affect more than 25 per cent of the population in any given year (AIHW 2002), causing significant costs to health and economic systems, with often profound loss of capacity and productivity for those affected. People disadvantaged by chronic illness, low income, unemployment and violence are more likely to experience mental disorders. In turn, depression is a risk factor for cardiovascular disease, diabetes and cancer, significantly affecting people's quality of life (VicHealth 2005a). Women experience higher rates of depression and anxiety disorders than men do, but men experience higher rates of psychiatric conditions such as bipolar disorder and schizophrenia (AIHW 2002). Mental disorders account for about 9.6 per cent of total direct health systems costs and rate about third of the six illnesses or diseases that account for most of the health expenditure in Australia (AIHW 2002). Social factors related to urbanisation, unemployment, poverty, violence, conflict, war and strife, and technological change have had significant mental health consequences for populations, with differential effects based on economic status, sex, race and

society. Social isolation, rurality, limited economic and educational opportunities, the absence of supportive networks and environments, and limited access to needed health services are compounding problems for people with mental disorders (World Health Organisation 2001).

These data demand responses, in terms of not just treatments and service systems but also the prevention and promotion of mental health and wellbeing. In other words, while the prevalence of mental disorders is compelling in making demands of resource allocation, mental health promotion interventions occupy an additional space. In addition to developing effective multi-level, longer term strategies, mental health promotion interventions affect the prevalence and incidence of mental disorders.

Mental health promotion also involves setting the agenda for the governmental and societal responsibilities held by all of us. This requires more than just being aware of the mental health outcomes of policies, social change and our actions; it means, most significantly, actively promoting policies, social change and actions that will enhance mental health and wellbeing. For this reason, this is a public health agenda that is wide ranging.

The mental health plans of both VicHealth and the Australian Department of Health and Ageing highlight the need for cross-sectoral action in promoting mental health (Commonwealth of Australia 2003; VicHealth 2005a). The creation of good mental health for populations and the promotion of mental health will be more effective if integrated closely with all public health strategies and across all sectors around which social life is organised. The involvement of many different sectors, agendas, and policies is necessary to strengthen mental health promotion.

1.2 The focus and purpose of this resource

This resource focuses on intervention (or strategy) evaluation of population-based approaches to influencing factors that promote or demote mental health and wellbeing. The intention is to assist practitioners to develop effective interventions focused on mental health outcomes, and to emphasise that multi-level and intersectoral actions are critical for effective program development, implementation and evaluation.

The resource identifies and considers key reviews, research and other literature that document programs proven to be effective in promoting mental health, and it provides a guide on how to develop and implement mental health promotion programs. The literature reviewed in the resource has been selected for its relevance to the determinants identified in the VicHealth Framework for the Promotion of Mental Health and Wellbeing, and is informed by a Sydney Health Projects Group literature review (Rychetnik & Todd 2004) that VicHealth commissioned to support the framework's development.

Useful resource

For information about the burden of mental health disorders and approaches to build mental health and wellbeing, see the following VicHealth (2005a) mental health and wellbeing research summary sheets at www.vichealth.vic.gov.au:

1. *'Burden of disease due to mental illness and mental health problems'*
2. *'Social inclusion as a determinant of mental health and wellbeing'*
3. *'Discrimination and violence as determinants of mental health and wellbeing'*
4. *'Access to economic resources as a determinant of mental health and wellbeing'.*

Health promotion: a definition

Health promotion represents a comprehensive social and political process, not only embracing actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Community participation is essential to sustain health promotion action.
(World Health Organisation 1998)

Useful resources

The Ottawa Charter for Health Promotion *(www.who.int/hpr/archive/docs/ottawa.html), written in 1986 at the first international conference on health promotion, outlines a broad definition of health promotion, the prerequisites for health, and three foundation practices (advocacy, enabling and mediating differing interests). It perceives health promotion action as necessary in five areas: policy, supportive environments, community action, personal skills and the re-orienting of health services.*

The Jakarta Declaration on Health Promotion into the 21st Century *(www.who.int/hpr/archive/docs/jakarta/english.html) was made at the Fourth International Conference on Health Promotion in Jakarta. The conference was the first to be held in a developing country and the first to involve the private sector in supporting health promotion. The declaration provides an opportunity to reflect on what has been learned about effective health promotion, to re-examine determinants of health and to identify the directions and strategies required to address the challenges of promoting health in the 21st century.*

The Health promotion glossary of the **World Health Organisation (1998)** *(www.who.int/hpr/backgroundhp/glossary/glossary.pdf) is a substantial (and useful) document.*

This resource is intended to strengthen efforts to: promote mental health and wellbeing among populations, communities and individuals; raise awareness among practitioners, managers and policy makers about the importance of working across sectors; embed mental health into existing and future programs; and build new programs that have a primary focus on mental health and wellbeing. The following review questions guided the development of the resource:

- Based on current evidence, what strategies for the prevention of illness and promotion of mental health have been found to be most effective?
- What key implementation issues with mental health promotion interventions has the evaluation literature identified?
- What innovative strategies currently being implemented and evaluated show promise of success or are likely to be effective?
- What information and research gaps exist in the area of mental health promotion?

The action areas of the Ottawa Charter for Health Promotion (World Health Organisation 1986) (appendix B) are commonly used as a conceptual framework in health promotion program development. This resource uses the VicHealth framework instead to organise the evidence because it is a more explicit model for mental health promotion than are the broad action areas of the Ottawa Charter, but connections are made between the two. The resource also connects the VicHealth framework with the Department of Human Services (DHS 2003) Common Planning Framework for Health Promotion by using consistent terminology and identifying its fit with levels of mental health promotion interventions.

Health Promotion Interventions Framework

Health promotion interventions and capacity building strategies				
Individual focus ← → *Popultation focus*				
Screening, individual risk assessment immunisation	Health education and skill development	Social marketing Health information	Community action	Setting and supportive environments
Ensuring the capacity to deliver quality programs through capacity building strategies including: Organisational Development Workforce Development Resources				

Electronic databases, reference lists and the advice of an expert panel were also used to identify relevant reviews. This process highlighted that understandings of the determinants of mental health, policies and programs for mental health promotion, and methods of evaluation are broad and diverse but yet to be suitably indexed. In other words, databases are not sensitive to health promotion terms, the determinants of health or mental health promotion. Nonetheless, our search strategy revealed a wide ranging evidence base. Given the breadth of the evidence on a determinants of health approach to mental health and wellbeing, this resource is not a systematic review of all relevant studies.

1.3 Health promotion context

Health promotion is often said to be everybody's business. In other words, the promotion of people's health is a universal concern, understood and supported as requiring multi-level, multi-sector spheres of action. This resource is consistent with health promotion's universal principles, policies and practices, and its principle framework, the Ottawa Charter for Health Promotion (Appendix B), which takes a determinants approach to health promotion.

1.4 Understanding mental health promotion

Mental health promotion is underpinned by understandings of what constitutes mental health, but it is often defined at the level of individuals rather than community or population levels. Mental health promotion is frequently located in broad health and social development work, and distinguishes population-wide mental health promotion from the early intervention and prevention strategies of the mental illness movement. If a determinants approach is taken to defining mental health promotion, then it is necessary to recognise the importance to mental health of ensuring people can develop the capacity to adapt to, respond to and/or control life's challenges and changes, and have the necessary resources to act on the circumstances that determine their mental health and wellbeing.

Consistent with health promotion generally, mental health promotion actions need to be multi-level and intersectoral, and concerned with systems change, policy and the development of evidence about what population-based programs work. A key message for practitioners is that the inclusion in general health promotion programs, of mental health promotion outcomes, will enhance their ability to achieve equity and tackle inequities (Mittelmark 2003; Tilford, Delaney & Vogels 1997). Equity-related outcomes are central to the Ottawa Charter for Health Promotion.

Definitions of mental health

Mental health is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001,p 1).

Mental health is the embodiment of social, emotional and spiritual wellbeing. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just (VicHealth 2005b, p 7).

Definition of mental illness and mental disorders

In this resource, the term 'mental disorders' is used rather than 'mental illness'. But as this VicHealth (2005a, p. 1) definition makes clear, the two terms refer to different spectrums:

> *Mental illness is a diagnosable disorder that significantly interferes with an individual's cognitive, emotional and/or social abilities. Mental disorders are of different types and different degrees of severity.*

Definition of mental health promotion

Mental health promotion contributes to general health promotion by taking action to ensure social conditions and factors create positive environments for the good mental health and wellbeing of populations, communities and individuals. Mental health promotion requires action to influence determinants of mental health and address inequities through the implementation of effective multi-level interventions across a wide number of sectors, policies, programs, settings and environments.

1.5 Health promotion evidence

There is considerable debate about what constitutes health promotion evidence. This debate follows the wide acceptance in the evidence-based medicine and epidemiological fields of a hierarchy of 'rules of evidence', which are derived from positivist notions and developed from proof of causation and effect (McQueen 2001). Australia's National Health and Medical Research Council (1998), for example, identified levels of evidence that particularly apply to medical treatment and interventions, for which randomised controlled trials and quasi-experimental trials are the highest standards. Rules of evidence designed for the medical sciences, however, have little fit with the action oriented fields of health promotion, which cut across sectors and disciplines (McQueen 2001; Petticrew & Roberts 2002).

There is no consensus on what constitutes 'evidence' in the broad field of health promotion, or on the methods of evaluation that provide the strongest evidence base. Typologies of evidence are thus proposed, rather than hierarchies, to indicate the relative contributions that different types of evidence can make to evaluation research questions (Petticrew & Roberts 2002). The use of a range of methods, therefore, is advocated to evaluate critical success factors and outcomes.

Evidence is not a stark term; rather, it should be used in terms of 'weighing up' the strength of evidence before deciding on a course of action. Evidence of success could thus be sufficient to show that action should be taken even when 100 per cent proof is not available (Tones 1997). In decision making about what works, local knowledge and evidence on applied community-based programs, for example, may be more important than evidence that fits with prescribed levels of evidence in the medical–scientific or public health literature. Certainly, there are wide debates about different types of knowledge, what constitutes evidence, the strengths and weaknesses of different research methods, and thus what comprises robust evidence (Nutley, Walter & Davies 2002). These are debates that cannot be explored here.

The task for this resource is to assess the quality of evidence for mental health promotion. Given the determinants approach we have taken, that task requires the development of criteria suitable for multidisciplinary and multi-sectoral health promotion fields of action. Because there is not yet a clear consensus on what evidence to include/exclude for reviews of health promotion interventions, and on what basis, each review needs to establish its own criteria, drawing on accepted wisdom.

1.6 Structure of the resource

The resource is organised into six sections:

- Section 1 provides background and introduces mental health promotion as a field of endeavour.
- Section 2 establishes the determinants of the mental health promotion context that guided the conceptual development of this resource.
- Sections 3–5 present the evidence on mental health promotion interventions, organised under the three themes from the VicHealth Framework for the Promotion of Mental Health and Wellbeing: social inclusion and connectedness; freedom from discrimination and violence; and economic and social participation. Each of the framework themes is subdivided conceptually to account for the range of determinants for which intervention evidence was located. Promising interventions not yet included in systematic reviews were sought through similar sources, to inform the identification of promising directions for health promotion.
- Section 6 provides a guide for program planning and evaluating mental health promotion projects. This section links the VicHealth framework with the Department of Human Services Common Planning Framework for Health Promotion. As a result, a range of organisations and sectors should be able to translate the resource easily into their practice.

A consolidated reference list is provided at the end of the resource. Appendix A describes the methods used to develop this resource. And Appendix B outlines the Ottawa Charter and the Jakarta Declaration for Health Promotion.

Useful resource

Rychetnik, L & Todd, A 2004, Literature review to follow on from VicHealth's 1999–2002 mental health promotion framework: final report, *Sydney Health Projects Group, School of Public Health, Sydney University, New South Wales. Available from VicHealth.*

1.7 Inclusion criteria

Inclusion criteria for this resource were developed on the basis of 'best available evidence'. They needed to account for the guideline variations across evidence reviews, particularly to balance differences between guidelines for evidence-based medicine and the emerging criteria for health promotion evidence. While randomised control trials in health promotion or public health intervention evaluations are difficult to achieve (National Health and Medical Research Council 1998), criteria are still necessary to provide a framework of 'best available evidence' to support the recommendations.

Strength of evidence is linked to quality; it refers to methods used to minimise bias in the design and conduct of a study. Evidence 'relevance' refers to the extent to which study findings can be applied or transferred to other settings, while evidence 'strength' relates to the magnitude and reliability of the effect of the intervention (National Health and Medical Research Council 1998). Evaluations that met the following criteria were thus included if they:

- were at the level of systematic review
- demonstrated clearly defined outcomes in terms of promoting mental health
- were published in English between 1998 and 2004
- were guided by determinants of mental health promotion.

Appendix A contains the search strategy used for this resource, along with the processes used for data abstraction.

1.8 Limitations

The complexity of searching for evidence, the need to search multiple databases, the resources available (budget and time), and the emergent nature of mental health promotion were key constraints. A further limitation is that evaluations of mental health promotion work tend to be of small projects, predominantly using qualitative methods and focusing on subjective impacts. Assigning quality ratings to evaluations that rely on subjective impacts is exceedingly difficult, and interventions of this nature were only included if considered to be promising interventions and worthy of wider testing. More conclusive evidence is required to make higher level claims about the effectiveness of such interventions. Nonetheless, practitioners are encouraged to use or adapt these interventions and conduct careful, thorough evaluations that will contribute to the evidence on effectiveness and impact.

The accessibility of health promotion evidence is also challenged by the degree to which evidence of effectiveness is published and by the ease with which it can be sourced. As noted, this resource could not cover the breadth of the topics related to the determinants of mental health and wellbeing, given cost and time limitations and practical concerns with having an accessible, usable resource rather than a large, impractical volume. The literature review (Rychetnik & Todd 2004) commissioned by VicHealth was thus intended to provide a framework for the review of intervention evaluations.

2 Determinants approaches to mental health promotion

Useful resources

Australian Department of Health and Aged Care 2000b, Promotion, prevention and early intervention for mental health: a monograph*, Mental Health and Special Programs Branch, Canberra.*

Commonwealth of Australia 2003, National mental health plan 2003–2008*, Canberra.*

2 Determinants approaches to mental health promotion

There is no health without mental health!

This section outlines and explains the key elements of a determinants approach to mental health promotion, provides key literature that supports this approach, and continues to establish the resource framework outlined in the previous section.

2.1 Mental health promotion policy

Governments are the ultimate stewards of mental health, responsible for ensuring responsible policies, social environments and structures to support the mental health of populations (World Health Organisation 2001). Both government agencies and non-government organisations have responsibilities for the development and implementation of policies at appropriate levels. The critical roles of government stewardship of mental health include the development of policy, the identification of major issues affecting the wellbeing of populations, and the defining of public and private sector roles in developing, funding and implementing policy instruments and organisational arrangements that meet mental health objectives (World Health Organisation 2001).

Policies for mental health and wellbeing can be developed in any organisation, association, club or workplace, and at any level of government. Policy is part of the necessary infrastructure to support health promotion. Its development involves key health promotion personnel, the development of shared understandings and identifies the organisation's commitment to, and vision for, health promotion. Having policies in place demonstrates an organisation's commitment to mental health promotion, while the identification of support and resources is motivating for staff.

The evidence on the effectiveness of policy for mental health promotion is not yet strong, because few evaluations of mental health policy are available. This is not surprising given the difficulties of defining the field, along with the field's relative recency. The evaluation of the National Mental Health Strategy in Australia identified that the strategy's aims have not yet been translated into the benefits expected for the general population (Steering Committee for the Evaluation of the Second National Mental Health Plan 1998–2003 2003). Mental health policies should be evaluated against best practice criteria for health promotion generally, and with a clear definition of what mental health promotion means in the policy being developed.

Australia's goals and targets of the mid-1990s positioned mental health as a new strategic direction, with a focus on reducing suicide rates and the effects of mental illness on people's lives (Australian Health Ministers 1998). Australia's first National Mental Health Strategy was developed in 1992, with both a policy framework and an implementation plan. It was followed by a national community awareness program in 1994 to reduce stigma and discrimination. The second National Mental Health Plan was launched in 1998 and followed by the *National Mental Health Promotion, Prevention and Early Intervention action plan* (Commonwealth of Australia 2000). The primary objectives of the 2000 plan were to:

- enhance social and emotional wellbeing among populations and individuals
- reduce the incidence, prevalence and effects of mental health problems and mental disorders
- improve the range, quality and effectiveness of population health strategies to promote mental health
- prevent and reduce the impact of mental health problems and mental disorders among the Australian population.

The *National Mental Health Plan 2003–2008* (Commonwealth of Australia 2003) builds on the previous two national plans, to support mental health promotion at a national policy level. Priority themes for this most recent plan include:

- promoting mental health and preventing mental health problems and mental illness
- increasing service responsiveness
- strengthening quality
- fostering research, innovation and sustainability.

In Victoria, government is driving a strong agenda to address disadvantage. Its 2005 policy statement, *A Fairer Victoria*, sets out an action plan to improve services and environments to strengthen and support communities and their citizens. It takes up themes from policy statements and research from the Jesuit Social Services (www.jss.org.au) and the Brotherhood of St Laurence (www.bsl.org.au).

VicHealth is driving a strong policy agenda for mental health promotion in Victoria. This interest in mental health promotion has developed from an emergent evidence base about mental health and its relationship to the overall functioning of society (Moodie & Verins 2002). The first VicHealth *Mental health promotion plan 1999–2002* (VicHealth 1999) established a framework for research and program activity to guide understanding of mental health promotion from conceptualisation of the determinants of mental health, through settings and population groups, to expected intermediate and longer term outcomes.

Useful resources

A Fairer Victoria *is the Victorian Government's 2005 social policy statement on addressing disadvantage and inequity. It is available at www.vic.gov.au.*

T Vinson's Unequal in life *(1999, 2004) is a study of disadvantage in Victoria and New South Wales by postcode. It is available at www.jss.org.au.*

Definition

A determinant of health is a factor or characteristic that brings about a change in health, either for the better or for the worse (Reidpath 2004).

Useful resources

Health Canada has good information about the social determinants of health. Its website (www.hc-sc.gc.ca/hppb/phdd/determinants/e_determinants.html#income) introduces the social determinants of health, as well as the 'made in Canada' principles of health promotion.

Marmot, M & Wilkinson, R 2002, Social determinants of health: the solid facts, 2nd edn, Geneva, World Health Organization. Available at www.who.dk/healthy-cities.

VicHealth commissioned a literature review (Rychetnik & Todd 2004) to follow the 1999–2002 Framework for the Promotion of Mental Health and Wellbeing. The review identified three categories of mental health determinants to guide the literature review: social connectedness, freedom from discrimination and violence, and economic participation. and the review addressed two broad questions:

1. What published information is available about the identified determinants of mental health and the relationships between the determinants and mental health?
2. What is the evidence for potential interventions to address these determinants and promote mental health?

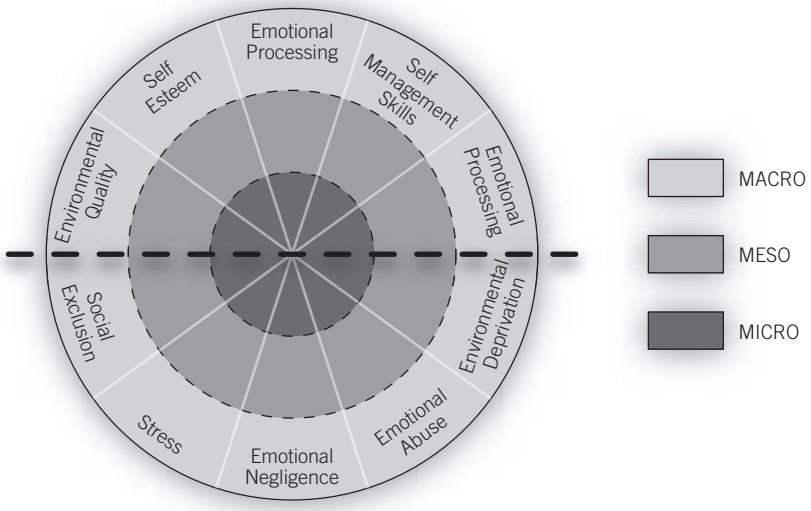
Building on this body of work, the second VicHealth plan, *A Plan for Action 2005–2007: Promoting Mental Health and Wellbeing* (VicHealth 2005b), was launched in March 2005.

2.2 Determinants of mental health and areas for action

A determinants approach incorporates understanding how behaviour affects both social processes and disease risk, and how social and structural conditions enhance or diminish opportunities for communities and populations to be healthy. Such approaches highlight the importance of cross-sectoral interventions that are planned and implemented at multi-levels, with the emphasis on influencing one or more determinants of health, rather than a disease. The considerable literature on the determinants of health identifies the complex interactions among determinants and across social, environmental, economic and biological dimensions (Keleher & Murphy 2004; World Health Organisation 2003).

The 10 element map of McDonald and O'Hara (1998 in HEA 2001) identified positive and negative influences on mental health – those that both promote and demote mental health and wellbeing.

Figure 2: 10 elements of mental health – positive and negative influences



(Source: McDonald & O'Hara 1998 in HEA 2001.)

To address both positive and negative influences on mental health and wellbeing, four intermediate outcome levels needing action have been identified (Health Education Authority 2001; Health Education Board for Scotland 2001; VicHealth 2005b):

1. **strengthening individuals:** that is, increasing social connection through sustained involvement in group activities, access to supportive relationships, mental health literacy (including emotional literacy) and resilience, including interventions designed to promote self-esteem and self-efficacy, self-determination and control, and life skills such as communicating, negotiating, and relationship and parenting skills
2. **strengthening organisations:** that is, bringing about change within organisations to ensure that they are inclusive and responsive, that they provide safe, supportive and sustainable environments for health, and that they can work in partnerships and across sectors, and implement evidence-based approaches to their work
3. **strengthening communities:** that is, providing environments that are safe, supportive and sustainable. Communities also need to be able to increase social inclusion and participation; improve neighbourhood environments; enhance social cohesion; develop health and social services that support mental health, anti-bullying strategies at school, workplace health, community safety, child care and self-help networks; increase citizenship and civic engagement (which affects how people relate to, and deal with, their social world); and increase awareness across sectors and communities of mental health and wellbeing issues.
4. **strengthening whole societies, including reducing structural barriers to good mental health:** that is, undertaking integrated, sustained and supported initiatives to build the healthy structures and social environments needed to address structural barriers to good mental health. This work must occur across sectors, including education, employment, housing, environment and justice. It must have a strong legislative platform and adequate resource allocation to reduce racism, discrimination and violence, to address inequities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

Even with these levels of action identified, specific sectors need to clearly understand their role in the promotion of mental health. Key sectors that need to act to promote mental health and wellbeing include:

- **employment and workplace.** The availability of work and the conditions of work, unemployment and underemployment are considerable influences on mental health.
- **education.** Basic and lifelong educational opportunities are prerequisites for good mental and physical health, and key to people's capacity to find satisfying work, participate in other aspects of social life and undertake social roles.
- **housing.** Adequate shelter is a prerequisite for health. Poor and insecure housing is associated with poor mental health.
- **local government.** The built, social, economic and natural environments have strong impacts on mental and physical health and wellbeing. The creation of healthy environments to promote good mental health is considered an ongoing challenge.

Key documents for health promotion (also see Appendix B).

The Ottawa Charter for Health Promotion (World Health Organisation 1986) outlines the prerequisites for health, along with three foundation practices: advocacy, enabling and mediating, particularly between competing interests. It perceives health promotion action as necessary in five areas:

1. *healthy public policy*
2. *supportive environments*
3. *community action*
4. *personal skills*
5. *the re-orienting of health services.*

The Jakarta Declaration on Health Promotion (World Health Organisation 1997) added five more levels at which action should be taken to strengthen health:

1. *promoting social responsibility for health*
2. *increasing investments for health development to address health and social inequities*
3. *consolidating and expanding partnerships for health*
4. *strengthening communities and increasing community capacity to empower the individual*
5. *securing an infrastructure for health promotion.*

- **justice.** Statutory regulations and policy are necessary to prohibit and reduce discrimination based on sex, race, colour, ethnic or social origin, language, religion or belief, or genetic features. Equality and nondiscrimination are critical for mental health.
- **transport.** Lack of affordable transport is related to social isolation and diminished opportunity for employment, education and access to health services.
- **the arts.** Community arts practices have positive mental health impacts through their impact on social factors.
- **sport and recreation.** Physical activity improves health. Emphasis is placed on participation in sport and recreation, not just competition, and on increasing access.

While overlapping, all of these sectors are outside the health sector. In other words, these sectors generate drivers for mental health and wellbeing, so they should be where program activity is focused.

The VicHealth framework identified three overarching social and economic determinants of mental health:

1. **social inclusion,** including:
- social and community connections
- stable and supportive environments
- a variety of social and physical activities
- access to networks and supportive relationships
- a valued social position

2. **freedom from violence and discrimination,** including:
- the valuing of diversity
- physical security
- opportunity for self-determination and control of one's life

3. **access to economic resources and participation,** including:
- access to work and meaningful engagement
- access to education
- access to adequate housing
- access to money.

These three determinants are used as key organising themes for this Resource, and guided the collection of reviews of key bodies of evidence in mental health promotion. The determinants and their sub-categories illustrate concept development of interest to this emergent field of endeavour, and their consistency with the Ottawa Charter is evident.

3 Promoting social inclusion and connectednes

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).

Local Agenda 21 in Australia is available through the Australian Department of Environment and Heritage (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:

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/). 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.

References

Carley, M 2002, *Community regeneration and neighbourhood renewal: a review of the evidence*, Report to Communities Scotland, Edinburgh Research Department, Edinburgh.

Duggan, M & Cooper, A (nd), *Modernising the social model in mental health: a discussion paper*, TOPSS, London. Available at www.critpsynet.freeuk.com/duggan.htm.

Frankish, J, Kwan, B & Flores, J 2002, *Assessing the health of communities: indicator projects and their impacts*, Institute of Health Promotion Research, University of British Columbia, Canada. Available at http://ihpr.ubc.ca.

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.

Johnson, D, Headey, B & Jensen, B 2003, *Communities, social capital and public policy: literature review*, Melbourne Institute working paper no. 26/03, University of Melbourne, Melbourne.

Salvaris, M, Burke, T, Pidgeon, J & Kelman, S 2000, *Social benchmarks and indicators for Victoria*, Report for the Victorian Department of Premier and Cabinet by the Institute for Social Research, Swinburne University of Technology, Melbourne.

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

Gould, MS, Greenberg, T, Velting, D & Shaffer, D 2003, 'Youth suicide risk and preventive interventions: a review of the past 10 years', *Journal of the Academy of Child and Adolescent Psychiatry*, vol. 42. no. 4, pp. 386–405.

Lister-Sharp, D, Chapman, S, Stewart-Brown, S & Sowden, A 1999, 'Health promoting schools and health promotion in schools: two systematic reviews', *Health Technology Assessment*, vol. 3, p. 22.

Tilford, S, Delaney, F & Vogels, M 1997, *Effectiveness of mental health promotion interventions: a review*, Health Education Authority, UK Department of Health, London.

Waring, T & Hazell, T 2002, *Evaluation of MindMatters: third interim report*, Hunter Institute of Mental Health, New South Wales.

Wyn, J, Cahill, H, Holdsworth, R, Rowling, L & Carson, S 2000, 'MindMatters: a whole-school approach promoting mental health and wellbeing', *Australian and New Zealand Journal of Psychiatry*, vol. 34, pp. 594–601.

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

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.

Kawachi, I & Berkman, LF 2001, 'Social ties and mental health', *Journal of Urban Health*, vol. 78, no. 3, pp. 458–67.

Mulvihill, M, Mailloux, L & Atkin, W 2001, *Advancing policy and research responses to immigrant and refugee women's health in Canada*, Canadian Women's Health Network, Manitoba.

VicHealth 2003, *Promoting young people's mental health and wellbeing through participation in economic activities – key learnings and promising practices*, Victorian Health Promotion Foundation, Melbourne.

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.

Jane-Llopis, E, Barry, M, Hosman, C & Patel, V 2005, 'Mental health promotion works: a review', *IUHPE – Promotion and Education*, vol. 2, pp. 9–25.

LaMontagne, AD, Louie, A, Keegal, T, Ostry, A, Shaw, A 2005, *Workplace stress in Victoria: developing a systems approach*, Report to the Victorian Health Promotion Foundation, Melbourne.

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)

References

Barlow, J & Coren, E 2002, 'Parent training programmes for improving maternal psychosocial health', *Cochrane Database of Systematic Reviews*, 2003, no. 4.

Barlow, J, Coren, E & Stewart-Brown, S 2001, *Systematic review of the effectiveness of parenting programmes in improving maternal psychosocial health*, Health Services Research Unit, University of Oxford, Oxford.

Eagar, K, Brewer, C, Collins, J et al 2005, *Strategies for gain – the evidence on strategies to improve the health and wellbeing of Victorian children*, Centre for Health Service Development, University of Wollongong, New South Wales.

Hodnett, ED & Roberts, I 2004, 'Home-based social support for socially disadvantaged mothers', *Cochrane Database of Systematic Reviews*, 2004, no. 4.

Jane-Llopis, E, Barry, M, Hosman, C & Patel, V 2005, 'Mental health promotion works: a review', *IUHPE – Promotion and Education*, vol. 2, pp. 9–25.

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) 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		
School connectedness	*Social connectedness*	*Community connectedness*
• Involvement in school activities • Sense of belonging	• Supporting relationships • Emotional wellbeing	• Involvement in community activities • Access to local resources

Population groups and action areas	
Population groups	*SACSC action plan*
• Students • School staff/personnel • Parish priests • Families • Broader community • Partnerships	• Development of audit tools • Development of conceptual framework • Ongoing evaluation • External funding sources

Settings for action		
• Schools • Local government • VicHealth	• Community agencies • Catholic Education Office Melbourne • Sport and recreation	• Local government • Housing commission estates • Local church/parish

Areas for action		
• School ethos, culture and environment • Organisational structures • Policies • Decision-making processes and procedures • Diversity	• Leadership and governance • Curriculum teaching and learning • Research initiatives • Professional learning teams • Learning styles	• School/community partnerships • Professional development • Parent/community participation

Intermediate outcomes			
Individual	*Organisational*	*Community*	*Schools*
• Social emotional health • Supportive and caring relationships • Involvement in school and community activities • Resiliency • Protective factors • Learning outcomes • Student/school connectedness • Positive relationships • Student background and experience • Student engagement	• Research circle • Partnership across sectors (Victorian Department of Education and Training and Melbourne University) • School clusters developed • Professional development and learning • Collegiate support • Promotion of best practice	• Participation in SACSC activities • Connectedness • Community projects/activities • Social/cultural inclusivity • Involvement of families • Linking with agencies • Working with the community • Self-determination • Welcoming environment • Community/school collaboration and participation • Family/school support to students	• Core leadership teams • Whole school approach • School development plan • Audit tools • Professional learning teams • Access and equity • School-based action research Initiatives • Safe and supportive environment • Participation of school community • Partnerships • Relevant and meaningful curriculum • Democratic schooling • Warm classroom climate • Physically welcoming • School budget allocation • School/community collaboration and participation

Population groups and action areas	
Population groups	*SACSC action plan*
• Students • School staff/personnel • Parish priests • Families • Broader community • Partnerships	• Development of audit tools • Development of conceptual framework • Ongoing evaluation • External funding sources

Long term benefits	
• Improved student wellbeing • Increased community participation • Development and growth of partnerships • Placement of social capital and student wellbeing at the core of school life • Increased access to community groups, agencies and services • Improved learning outcomes for all	• Embedding the SACSC initiative across schools in the Archdiocese of Melbourne • Ongoing professional learning and professional development • Development and growth of research initiatives • Evidence-based research to inform systemic school improvement

Volunteering Australia (2001) defined formal volunteering is 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.

References

Campbell, C, Wood, R & Kelly, M 1999, 'Social capital and health', Health Education Authority, London. Available at www.hda-online.org.uk/downloads/pdfs/socialcapital_health.pdf.

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.

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.

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.

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.

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.

References

Ekeland, E, Heian, F, Hagen, KB, Abbott, J & Nordheim, L 2004, 'Exercise to improve self-esteem in children and young people', *Cochrane Database of Systematic Reviews*, 2004, no. 1.

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.

Salmon, P 2001, 'Effects of physical exercise on anxiety, depression, and sensitivity to stress: a unifying theory', *Clinical Psychology Review*, vol. 21, no. 1, pp. 33–61.

Strawbridge, W, Deleger, S, Roberts, R & Kaplan, G 2002, 'Physical activity reduces the risk of subsequent depression for older adults', *American Journal of Epidemiology*, vol. 156, no. 4, pp. 328–34.

Tilford, S, Delaney, F & Vogels, M 1997, *Effectiveness of mental health promotion interventions: a review*, Health Education Authority, UK Department of Health, London.

US Department of Health and Human Services 2002, *Physical activity fundamental to preventing disease*, Office of the Assistant Secretary for Planning and Evaluation. Washington DC.

World Health Organisation 2005, 'Benefits of physical activity' information sheet'. WHO, Geneva. Available at www.who.int/moveforhealth/advocacy/information_sheets/benefits/en/index.html

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.

References

Barker, C, Pistrang, N, Shapiro, DA, Davies, S & Shaw, I 1993, '"You in mind": a preventive mental health television series', *British Journal of Clinical Psychology*, vol. 32, pp. 281–93.

Health Education Board for Scotland 1997, *Mental health promotion: strategic statement*, Edinburgh. Available at www.hebs.scot.nhs.uk/info/strategy.

Jane-Llopis, E, Barry, M, Hosman, C & Patel, V 2005, 'Mental health promotion works: a review', *IUHPE – Promotion and Education,* vol. 2, pp. 9–25.

Tilford, S, Delaney, F & Vogels, M 1997, *Effectiveness of mental health promotion interventions: a review*, Health Education Authority, UK Department of Health, London.

4 Addressing violence and discrimination

4 Addressing violence and discrimination

4.1 Overview of violence and discrimination

Violence and discrimination are determinants of mental health and wellbeing that are linked to the need to strengthen community action, re-orient health systems and build healthy public policy.

4.1 Discrimination

Discrimination is defined as 'the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group...this unfair treatment arises from socially derived beliefs each group holds about the other, and patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege' (Krieger 2001 cited in VicHealth 2005a, p 38. The links between discrimination and mental health are generally segregated according to the type of discrimination (that is, gender, race, age, culture or sexuality). Higher levels of discrimination are associated with poorer mental health (Krieger 2000 cited in Rychetnik & Todd 2004). More specifically, the link between racial discrimination and mental health has been well documented. Research has found an association between racial discrimination and anxiety disorder, and other mental health conditions (Rychetnik & Todd 2004).

Forms of discrimination exist in all societies. Depending on the taxonomy of prevalent types of discrimination, race, ethnicity, sexuality and gender are all classified as factors in discrimination, and they are all related to social exclusion because people or populations are often excluded on the basis of their difference. The major types of discrimination are based on race and ethnicity, gender, sexual preference and disability. All discrimination types are embodied in inequalities of health (Krieger 2000).

Racism in Australia is based on the dominance of white Anglo-Australians, who discriminate against subordinate groups, particularly Indigenous Australians, other people of colour and/or different religious and linguistic groups. Racism is embedded in the dominant culture and is manifest among Indigenous Australians in lower rates of educational attainment, lower incomes, higher rates of unemployment, reduced access to goods and services, political disempowerment and below average health status.

4.1.2 Violence

Violence is not a clearly definable term and is often used interchangeably with 'abuse', 'battering' and 'physical force'. The recent World report on violence and health (World Health Organisation 2002) identified several forms of violence, including youth violence, bullying, child abuse and neglect by parents and other caregivers, violence by intimate partners (domestic violence), abuse of the elderly, sexual violence, self-directed violence and collective violence.

VicHealth (citing World Health Organisation 2002) divides violence into three broad categories:

1. **self-directed violence**, which includes suicidal behaviour, self-abuse and self-mutilation
2. **interpersonal violence**, which is divided into:
    - family and intimate partner violence
    - bullying
    - community violence
3. **collective violence:** 'the instrumental use of violence by people who identify themselves as members of a group against another group or set of individuals, in order to achieve political, economic or social objectives' (World Health Organisation 2002, p. 6). The consequences of collective violence on mental health include depression and anxiety, psychosomatic ailments, suicidal behaviour, intra-familial conflict and anti-social behaviour (World Health Organisation 2002).

Data on the incidence and prevalence of violence are limited. Its availability depends on the type of violence. Verbal and psychological violence is unlikely to be reported, whereas physical violence is more visible and thus data are more readily available. Even so, only about 31 per cent of victims of assault are reported. In 2002, approximately 2 534 500 incidents of assault were reported in Australia. Of these victims, 51 per cent reported that they had experienced more than one assault in the previous 12 months (ABS 2003). The Australian Bureau of Statistics estimated that 2.6 million women in 1996 had experienced at least one incident of physical or sexual violence since the age of 15 years (ABS 1996).

Discrimination and violence are often linked and are similar in their associations with inequalities and social exclusion. Violence is frequently the vehicle through which discrimination is played out – for example, homophobia can lead to gay bashing, sexism can lead to gendered violence, and racism can lead to violence (as in the activities in the United States of the Klu Klux Clan) and situations of genocide. Social exclusion, isolation and discrimination can thus lead to violence.

The burden of disease apportioned to discrimination and violence is relatively unclear and often underestimated. National surveys have found that women are more likely to experience violence from a partner (either previous or current) than a stranger (ABS 1996) VicHealth (2004a) estimated that intimate partner violence is responsible for 9 per cent of the total disease burden in women aged 15–45 years. The greatest proportion (60 per cent) of this burden is associated with mental health problems. The results of this study indicate that intimate partner violence is the highest modifiable risk factor for the health of women aged 15–45 years, outstripping the effects of tobacco, drugs and alcohol (VicHealth 2004a).

Useful resources

The Women's Safety Strategy is available at www.women.vic.gov.au/owa/owaimages.nsf Images/wssframework/$File/wssframework. pdf. Details of funded projects can be found on the Office of Women's Policy website: (www.women.vic.gov.au/).

Victorian Government policies that support violence prevention include:

- Crime prevention Victoria – safer streets and homes: Victoria's crime and prevention strategy 2002–2005 *(www. justice.vic.gov.au/legalchannel/dojsite.nsf/)*
- *the Victorian Community Council against Violence, which provides a link between government and the community to help prevent violence www.justice.vic.gov. au/CA2569020010922A/OrigDoc/*
- *the Women's Health and Wellbeing Strategy of the Victorian Department of Human Services.*

References

Australian Bureau of Statistics 1996, *Woman's safety survey*, cat. no. 4128.0, Canberra.

Australian Bureau of Statistics 2003, *Crime and safety, Australia,* cat. no. 4509.0, Canberra.

Krieger, N 2000, 'Discrimination and health', in Berkman, LF & Kawachi, I (eds), *Social epidemiology.* Oxford University Press, New York.

Rychetnik, L & Todd, A 2004, *Literature review to follow on from VicHealth's 1999–2002 mental health promotion framework: final report*, Sydney Health Projects Group, School of Public Health, Sydney University, Sydney.

VicHealth 2004a, *The health costs of violence: measuring the burden of disease caused by intimate partner violence*, Melbourne.

World Health Organisation 2002, *World report on violence and health*, Geneva. Available at www.who.int/violence_injury_prevention.

4.2 Government policy supporting violence prevention

The nature and extent of violence against women in Australia are increasingly a matter for public policy. The 1997 Commonwealth initiative, Partnerships against Domestic Violence, aimed to work with both governments and communities to prevent domestic violence, and conducted projects at federal and state levels. Reports are available at www.padv.dpmc.gov.au/projects/projects.htm.

The National Crime Prevention Program was established in 1997 to identify and promote innovative ways of reducing and preventing crime and the fear of crime (National Crime Prevention Council 2004). Its priorities include:

- an early intervention, youth crime and families strategy
- Indigenous and family violence
- private sector (including fraud and small business crime)
- property crime
- public safety.

In Victoria, much of the violence-related work has focused on protection and justice. The Office of Women's Policy (2002) has released the Women's safety strategy: a policy approach. A coordinated approach to reducing violence against women, to address issues associated with violence against women.

Reference

National Crime Prevention Council 2004, The National Crime Prevention Program. Available at www.crimeprevention.gov.au/agd/WWW/ncphome.nsf/Page/National_Crime_Prevention_Program.

Office of Women's Policy 2002, Women's safety strategy: a policy approach. A coordinated approach to reducing violence against women. Victorian Government, Melbourne.

4.3 Overview of interventions to prevent violence

The VicHealth Framework for the Promotion of Mental Health and Wellbeing identified key themes for freedom from discrimination and violence as the valuing of diversity, physical security, and self-determination and control of one's life. Consistent with the population approach of this review, the interventions reviewed focus on interpersonal violence rather than violence that is self-directed (suicidal behaviour, self-abuse or self-mutilation).

The Rychetnik and Todd (2004) review of interventions focused on victims of collective trauma and violence (including refugees, asylum seekers and Indigenous people) revealed a limited literature base. Evaluation of interventions with these population groups appears to have been difficult, however. No systematic reviews or evaluations were identified for interventions conducted with refugees or asylum seekers. Further research and investment in evaluation is thus required.

The following list summarises the nine interventions reviewed in this section:

Intervention categories (DHS 2003) used to prevent violence include one or more of the following:

- education and social marketing
- settings and supportive environments
- community action.

Intervention – Community-wide interventions

Community-wide interventions have used a variety of strategies, including education, media, schools and policing, but have been less used than those interventions developed for specific population groups.

Specific population group/setting

Community-wide interventions could be at a local neighbourhood level, segmented to particular populations such as parents or youth, or more broadly intended for whole populations.

Effectiveness

A range of strategies have been used, including public education and 'neighbourhood organising' in the United States. The evidence is equivocal about the effectiveness of public education campaigns. While a review of American studies (Kellerman et al. 1998) suggested that public education is largely untested, an Australian review identified several studies with promising effects on perceptions about the acceptability of violence (Homel 1999). But the evidence, in terms of violence prevention, is not strong for supervised after-school recreation, juvenile curfews and proactive policing (Kellermann et al. 1998).

The Communities that Care program conducted in the United States focuses on activating communities to implement community violence and aggression prevention systems (Hawkins, Catalano & Arthur 2002). Outcomes have included a 30 per cent decrease in school problems, a 45 per cent decrease in burglary, a 29 per cent decrease in drug offences and a 27 per cent decrease in assault charges. These results have emerged through pre–post test research and need to be supported by other trial data. This support may result where the program is being replicated in The Netherlands, the United Kingdom and Australia (see the case study below) (Jane-Llopis et al. 2005).

Implementation issues

Evaluation of community-based interventions is complex, with methods still in development. Most studies have been conducted in other countries, so their applicability to the Australian context may be limited.

Comment

Crime Prevention Victoria funded 10 place-based community building projects in 2002, to encourage communities, government and business to work together to achieve agreed social, economic and environmental outcomes that were intended to affect crime levels in those communities. The projects are due to be completed in 2005. The evaluation will inform future crime prevention initiatives for Australian contexts.

References

Hawkins, JD, Catalano, RF & Arthur, MW 2002, 'Promoting science-based prevention in communities', *Addictive Behaviour*, vol. 27, no. 6, pp. 951–76.

Homel, R 1999, *Preventing violence - a review of the literature on violence and violence prevention*, Report for the Crime Prevention Division of the NSW Attorney-General's Department, Sydney.

Kellerman, AL, Fuqua-Whitley, DS, Rivara, FP & Mercy, J 1998, 'Preventing youth violence: what works?', *Annual Review of Public Health*, vol. 19, pp. 271–92.

Jane-Llopis, E, Barry, M, Hosman, C & Patel, V 2005, 'Mental health promotion works: a review', *IUHPE – Promotion and Education*, vol. 2, pp. 9–25.

Rychetnik, L & Todd, A 2004, *Literature review to follow on from VicHealth's 1999–2002 mental health promotion framework: final report*, Sydney Health Projects Group, School of Public Health, Sydney University, Sydney.

Case study: Communities that Care (CTC)

What is it?

CTC is a program that aims to activate communities to implement strategies to reduce community violence and aggression (Hawkins, Catalano & Arthur 2002). Developed by Professors Hawkins and Catalano from the University of Washington, CTC was designed to provide a framework to modify factors that undermine healthy youth development (Hawkins, & Catalano 1992 cited in Toumbourou 1999). It combines substance abuse approaches with approaches that aim to address crime prevention.

How does it work?

Key leaders who have influence over organisational collaborations and resources in a specified community are firstly identified. After being provided with training about CTC, these leaders help to build community capacity for crime prevention. Community prevention boards are established, consisting of community leaders and intervention personnel who also undergo relevant training. Data are then gathered, including school surveys, local community knowledge and demographic data. This information is used to identify community needs and to prioritise areas requiring intervention. Each community prevention board is provided with evaluated interventions from which to select those appropriate to its areas of priority. This ensures the adoption of an evidence-based approach to crime prevention. This is an important component of the program because the community is mobilised to make key decisions about implementation. CTC takes a long term approach.

Where has it been conducted?

CTC has been implemented across several hundred communities in the United States. It is also being replicated in The Netherlands, England, Scotland, Wales and Australia. In Australia, CTC research is being undertaken by the Centre for Adolescent Health. Initial plans referred to the conduct of a randomised control trial of CTC across six local government sites. Additional information about the trial is not yet available. The evaluation plan is available at www.aic.gov.au/publications/tandi/ti122.pdf.

Has it worked?

Reported outcomes using pre–post test designs of 40 communities have included a 30 per cent decrease in school problems, a 45 per cent decrease in burglary, a 29 per cent decrease in drug offences and a 27 per cent decrease in assault charges (

Want to read more?

- Crow, I, France, A, Hacking, S & Hart, M 2004 *Does Communities that Care work? An evaluation of a community-based risk prevention programme in three neighbourhoods*, Joseph Rowntree Foundation, York. Available at www.jrf.org.uk/bookshop/eBooks/1859351840.pdf.
- Centre for Adolescent Health, Australia (www.rch.org.au/cah/research/index.cfm?doc_id=1011).
- Hawkins, JD, Catalano RF and Arthur MW 2002, Promoting science-based prevention in communities. Addictive Behaviours, Vol 27, pp 951-976.
- Toumbourou, JW 1999 Implementing Communities That Care in Australia: A community mobilisation approach to crime prevention. Trends & Issues in Crime and Criminal Justice. No. 122, July, pp1-6.
- UK CTC program (www.communitiesthatcare.org.uk/index.html). Publications emerging from this program (including a guide to promising approaches) are available for purchase at www.communitiesthatcare.org.uk/publications.html.

Intervention – Community education campaigns

Community education campaigns are those implemented through media outlets. They are generally broad in scope and aim to increase knowledge and awareness.

Specific population group/setting

These interventions are intended for whole of a community, with the aim of increasing awareness and educating against violence.

Effectiveness

There appears to be limited evaluation of the effectiveness of community-wide education campaigns. No reviews of these types of intervention were identified.

The Western Australian Government has funded a long term media strategy, 'Freedom from Fear', to ensure the safety of women, children and other victims of intimate partner violence. The strategy is based on the premise that legal threats and sanctions, while important, do not remove the fear of recurring domestic violence (Donovan, Paterson & Francas 1999). Evaluation revealed improvements in men's awareness about where to seek assistance if they are, or could be, violent (Donovan et al. 2000; Gibbons & Paterson 2000). In addition, evaluation revealed a strong correlation between the number of calls to the men's domestic violence helpline and the advertising schedule. The strength of this correlation is not provided.

Implementation issues

Adequate planning to evaluate mass media interventions is required to contribute to the evidence base.

References

Donovan, RJ, Francas, M, Paterson, D & Zappelli, R 2000, 'Formative research for mass media based campaigns: Western Australia's freedom from fear campaign targeting male perpetrators of intimate partner violence', *Health Promotion Journal of Australia*, vol. 10, no. 2, pp. 78–83.

Donovan, RJ, Paterson, D & Francas, M 1999, 'Targeting male perpetrators of intimate violence: Western Australia's "Freedom from Fear" campaign', *Social Marketing Quarterly*, vol. 5, no. 3, pp. 128–44.

Gibbons, L & Paterson, D 2000, 'Freedom from fear campaign against domestic violence: an innovative approach to reducing crime', Paper presented at Reducing Criminality: Partnerships and Best Practice convened by the Australian Institute of Criminology in association with the Western Australian Ministry of Justice, the Department of Local Government, the Western Australian Police Service and Safer WA, Perth, 31 July – 1 August.

Intervention – Programs developed for at-risk populations

The most successful interventions appear to be those developed for population groups who are at particular risk, or have a history, of perpetrating violence against others. Empirical evidence suggests that poor parent–child relationships and marital conflict increase the risk that children will develop major behavioural and emotional problems, including juvenile crime and anti-social behaviour (Sanders 2003; Sanders, Markie & Turner 2003).

Specific population group/setting

Activity has focused on two population groups: children at risk of developing violent behaviour, and their parents. Settings have included home visitation, preschools and social support services. Justice-based programs are beyond the scope of this review.

Effectiveness

- Home visitation programs appear to be effective at preventing child abuse (Health Education Authority 2001; Kellermann et al. 1998). Further monitoring is needed to assess the effect on youth violence.
- Family therapy has had moderate to good effects in improving family functioning and reducing behavioural problems in children (Health Education Board for Scotland 2001; Kellermann et al. 1998). In Australia, the Positive Parenting program (Triple P) has been successful in improving parenting skills, reducing reported behavioural problems in children and improving parental wellbeing and relationship satisfaction (Sanders, Markie & Turner 2003).
- Early childhood education programs have had both long term and short term effects on reducing youth crime participation (Health Education Authority 2001; Kellermann et al. 1998). One such program, the Syracuse family development research project, combined early childhood education, parent education and links to social services. Long term follow-up revealed only 6 per cent of participants had a juvenile record by age 15 years, compared with 22 per cent of controls. The success of the Perry Preschool program is also well documented (Anderson et al. 2003). Participants were followed up to age 27 years. Significant improvements in high school graduation, employment status and home ownership were noted among participants compared with non-participants. In addition, significant reductions in teen pregnancies, delinquency, arrests and receipt of social services were identified among participants.
- Behavioural and skill development programs have been identified as effective in reducing or preventing youth violence. Individual therapy or casework is less effective or not effective, while cognitive behavioural therapy has had positive results in reducing violent crime (Health Education Board for Scotland 2001).

- Sports participation has been found to be effective in reducing offending behaviour (including violence) in youth aged over 16 years who are not at school or participating in employment (Health Education Board for Scotland 2001).
- School-based violence prevention programs intended for children who exhibit aggressive and/or violent behaviour have been effective in reducing this behaviour (Mytton et al. 2002). While individual components have not been assessed for effectiveness, training in non-response skills and relationship skills have both been shown to be effective.

Implementation issues

- Programs or interventions for preschool children appear to be more effective than those for older youth (15–19 years) (Kellermann et al. 1998).
- Short term interventions appear to be less effective in adolescents than are those with a long term focus.
- Much of the work has been conducted in the United States. Social circumstances may differ, so the generalisability of these results to the Australian context may be limited.

Comment

VicHealth acknowledges that interventions to address social inclusion also seek to address violence. This can occur through the creation of welcoming and inclusive organisational and community environments (VicHealth 2005b). Funded community arts programs are also a vehicle for raising awareness of the mental health impacts of violence and discrimination. It is difficult, however, to identify the impact of these programs on the reduction of violence.

Promising practices

Parenting programs have been identified as having a promising effect on reducing violent or aggressive behaviour in children and reducing persistent offenders' involvement in crime (Kellerman et al. 1998). A teen Triple P program conducted in Queensland showed promising outcomes for most participants (Ralph & Saunders 2004). Researchers identified significant reductions in targeted risk factors (harsh discipline, parent–teenager conflict, parental monitoring of teenager's activities, parental depression and marital conflict). Some improvements were still being made after six months.

References

Anderson, LM, Shinn, C, Fullilove, sMT, Scrimshaw, SC, Fielding, JE, Normand, J, Carande, VG & Task Force on Community Preventive Services 2003, 'The effectiveness of early childhood development programs: a systematic review', *American Journal of Preventive Medicine*, vol. 24, no. 3S, pp. 32–46.

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.

Health Education Board for Scotland 2001, *Mental health improvement: what works?*, Briefing for the Scottish Executive, Edinburgh. Available at www.hebs.scot.nhs.uk/topics/.

Kellerman, AL, Fuqua-Whitley, DS, Rivara, FP & Mercy, J 1998, 'Preventing youth violence: what works?', *Annual Review of Public Health*, vol. 19, pp. 271–92.

Nicholas, B & Broadstock, M 1999, 'Effectiveness of early interventions for preventing mental illness in young people', *New Zealand Health Technology Assessment*, vol. 2, No 3 , pp. 1-127 . Available at http://nzhta.chmeds.ac.nz/ymh.htm.

Mytton, JA, DiGuiseppi, C, Gough, DA, Taylor, RS & Logan, S 2002, 'School-based violence prevention programs: systematic review of secondary prevention trials', *Archives of Paediatric Adolescent Medicine*, vol. 156, pp. 752–62.

Ralph A & Saunders MR 2004 *The 'Teen Triple P' Positive Parenting Program: a preliminary evaluation.* Trends in crime and Criminal Justice No 282, Australian Institute of Criminology, Canberra.

Sanders, MR 2003. 'Triple P Positive Parenting Program: a population approach to promoting competent parenting', *Australian e-Journal for the Advancement of Mental Health*, vol. 2, no. 3, pp. 1–17.

Sanders, MR, Markie, C & Turner, KMT 2003, *Theoretical scientific and clinical foundations of the Triple P Positive Parenting Program: a population approach to the promotion of parenting competence*, Parenting Research and Practice monograph no, 1, The Parenting and Family Support Centre, University of Queensland, Brisbane.

VicHealth 2005b, *A plan for action 2005–2007: promoting mental health and wellbeing,* Victorian Health Promotion Foundation, Melbourne.

Intervention – Programs for young people

Interventions developed for young people are often designed to break the cycle of violence, to raise awareness of the impacts of domestic violence, to help young people deal with violence, to increase community support for young people and to encourage creativity, interaction and artistic expression.

Population group/setting

Programs specifically for young people have been set in community-based organisations, including women's health services, community health centres and welfare agencies. Programs have been offered to various population groups, ranging from whole communities to young people who witnessed or perpetrated domestic violence.

Effectiveness

A resource guide developed for the Partnerships against Domestic Violence program suggests programs should be developed in four areas: community development, peer education, programs provided in a school setting and community arts programs. Each area is supported by innovative case studies. While evaluation of intimate partner violence prevention interventions aimed at young people has been encouraged, few controlled studies have been conducted (Strategic Partners 2000). Further, much of the evaluation has focused on knowledge and attitudes rather than changes in behaviour (Strategic Partners 2000).

Implementation issues

Successful implementation relies on the development of cross-sectoral partnerships. Evidence of the effectiveness of these interventions is limited. Evaluation should thus be a key component of any similar programs conducted.

Promising practices

The innovative nature of Partnerships against Domestic Violence programs and the programs' responsiveness to community data suggest a promising impact on the prevention of intimate partner violence.

References

National Crime Prevention Council 2004, The National Crime Prevention Program. Available at www.crimeprevention.gov.au/agd/WWW/ncphome.nsf/Page/National_Crime_Prevention_Program.

Strategic Partners Pty Ltd 2000, *Domestic violence prevention: strategies and resources for working with young people*, Partnerships against Domestic Violence, Commonwealth of Australia, Canberra.

Intervention – Programs for at-risk men

Programs that are designed to target men who are at risk of perpetrating violence. Interventions are often focused on individuals and include counselling and education components.

Specific population group/setting

These interventions are generally developed for men who are at risk of becoming violent towards their partners.

Effectiveness

A large scale literature review identified that counselling or education groups are most commonly used to prevent partner abuse by violent men (Homel 1999). Strategies range from cognitive–behavioural groups, couple counselling, anger re-direction, trauma therapy and programs that use a mental health and/or substance abuse focus. The reviewers identified that the literature provides only preliminary evidence on the most effective interventions. Evidence suggests, however, that an educational cognitive–behavioural approach is promising; such an approach has been effective in reducing or ceasing violence.

The National Crime Prevention Program has funded a number of projects, including domestic violence perpetrator programs and several projects focusing on the prevention of intimate partner violence in adolescents. Adolescent programs have included a focus on Indigenous adolescents. Evaluations of these programs have not identified a quantifiable reduction in intimate partner violence – a result of the lack of tool development to measure this change (Poelina & Perdrisat 2004).

Implementation issues

The literature provides limited evidence of effective primary prevention interventions (interventions or programs that seek to prevent the occurrence of domestic violence).

Comment

Refer also to the discussion of community education campaigns. The Freedom from Fear campaign conducted in Western Australia focused on at-risk men.

References

Homel, R 1999, *Preventing violence – a review of the literature on violence and violence prevention*, Report for the Crime Prevention Division of the NSW Attorney-General's Department, Sydney.

Poelina, A & Perdrisat, I 2004, *A report of the Derby/West Kimberly project: working with adults to prevent domestic violence*, Australian Attorney-General's Department, Canberra.

National Crime Prevention Council 2004, National Crime Prevention Program. Available at www.crimeprevention.gov.au/agd/www/ncphome.nsf/Page/National_Crime_Prevention_Program.

Intervention – Legislative and sentencing reform

Policy development to prevent domestic violence has focused on tertiary-level interventions. These interventions tend to ensure the provision of victim centred care, with the aim of reducing further harm. They include apprehended violence orders.

Specific population group/setting

These interventions target women who have been victims of some form of intimate partner violence.

Effectiveness

A systematic review of interventions for violence against women has identified conflicting evidence about the effectiveness of arresting the perpetrators to reduce violence (Wathen & MacMillan 2003). Other reviews have identified that arrest is effective when combined with an appropriate judicial process (Holder 2001). Promising results have been identified from the use of civil protection orders and the provision of legal advocacy and counselling. But more research is required before conclusive statements about effectiveness can be made (Wathen & MacMillan 2003).

Implementation issues

It is important to note that studies reviewed by Wathen and MacMillan (2003) were primarily conducted in the USA. Interventions will need to be adapted for the context of the Australian legal system.

Comment

The Australian Longitudinal Study on Women's Health is investigating the experiences of women who have sought legal protection. While a report suggests that legal options can provide effective protection, the sample size is relatively small and more follow-up data are required (Young, Byles & Dobson 2000).

References

Holder, R 2001, *Domestic and family violence: criminal justice interventions,* Australian Domestic and Family Violence Clearinghouse issues paper 3, University of NSW, Sydney.

Wathen, CN & MacMillan, HL 2003, 'Interventions for violence against women: scientific review', *Journal of the American Medical Association*, vol. 289, no. 5, pp. 589–600.

Young, M, Byles, J & Dobson, A 2000, 'The effectiveness of legal protection in the prevention of domestic violence in the lives of young Australian women', *Trends and Issues in Crime and Criminal Justice*, vol. 148, Australian Institute of Criminology, Canberra.

Useful resource

Women's Health Australia is conducting the Australian Longitudinal Study on Women's Health. Reports are available from the website www.sph.uq.edu.au/alswh.

Intervention – School-based bullying programs

A range of school-based programs have been designed to prevent or reduce bullying.

Specific population group/setting

These interventions target schools, classrooms, curriculum development, individual children and parents.

Effectiveness

Evidence is fairly consistent that well planned interventions can reduce bullying behaviour. Nonetheless, reductions in bullying have tended to be relatively small and more commonly found in the proportion of children being victimised than in the proportion engaging in bullying (Rigby 2002).

Many programs have multiple components and specific populations of interest. One review noted, where individual components had been compared, that curriculum content appeared to be effective. By comparison, the cooperative learning approach used by teachers was not shown to be effective in reducing bullying behaviour (Rychetnik & Todd 2004). School-based bullying interventions that also involve parents and the community have been effective long term in reducing criminal behaviour, alcohol abuse, depression and suicidal behaviour (Health Education Authority 2001).

Many school-based bullying prevention programs are based on the Bergen program (Rychetnik & Todd 2004; Stevens, DeBourdeadjuij & van Ooost 2001). This program was conducted initially in Norway but has been used as a model of good practice in several other countries, including the United Kingdom, Canada Germany, the United States and Belgium. Strategies included in this program include the development of school bullying policies, curriculum work, group and individual work, playground work and peer support schemes. Program outcomes have included a 50 per cent reduction in students' reporting bullying, a reduction in other 'antisocial' behaviour and an improvement in the overall 'school climate' (Rychetnik & Todd 2004).

Implementation issues

- Interventions with younger children (primary and pre-primary) are more effective than those conducted with older children (Rigby 2002).
- Often, multiple component interventions have been implemented, and one review indicated that it would be difficult to identify which components, or combinations of components, are most effective (Rigby 2002).
- All aspects of bullying are not always reduced in one single intervention.
- Autonomy is needed at the implementation site (Rigby 2002). In particular, school commitment is viewed as a possibly crucial factor in implementation success.
- Interventions that involve school, parents and the community are effective and have long term benefits (Health Education Authority 2001; Health Education Board for Scotland 2001).

Comment

The Gatehouse project conducted by the Centre for Adolescent Health in Australia assists schools to increase the social connectedness of students to school and to increase students' skills and knowledge for dealing with everyday life challenges. Outcome evaluation commenced with the initial cohort in 1997. Follow-up surveys were undertaken in 1999 and 2001. Evaluation findings are not yet available.

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.

Health Education Board for Scotland 2002, *Mental health improvement: what works?*, Briefing for the Scottish Executive. Available at www.hebs.scot.nhs.uk/topics/.

Rigby, K 2002, *A meta-evaluation of methods and approaches to reducing bullying in preschools and early primary school in Australia*. Report for the Australian Attorney-General's Department, Canberra.

Rychetnik, L & Todd, A 2004, *Literature review to follow on from VicHealth's 1999-2002 mental health promotion framework: final report*, Sydney Health Projects Group, School of Public Health, Sydney University, Sydney.

Stevens, V, DeBourdeadjuij, I & van Ooost, P 2001, 'Anti-bullying interventions at school: aspects of programme adaptation and critical issues for further programme development', *Health Promotion International*, vol. 16, pp. 155–7.

Intervention – Workplace bullying

There is an emerging evidence base about the prevalence of workplace violence, particularly workplace bullying. Such bullying can include 'offensive behaviour through vindictive, cruel, malicious or humiliating attempts to undermine an individual or groups of employees' (International Labour Organisation 2005). At an individual level, workplace violence can lead to a lack of motivation, anxiety and loss of confidence (International Labour Organisation 2005). Impacts can also be felt at organisational and community levels (International Labour Organisation 2005).

Specific population group/setting

Interventions can be conducted in workplaces to prevent workplace bullying.

Effectiveness

Peer reviewed journal publications have tended to focus on the incidence and prevalence of workplace violence, rather than describing preventative interventions. Much attention has been given to the importance of developing workplace bullying prevention policies (Health Education Authority 2001; Health Education Board for Scotland 2002; WorkSafe Victoria 2003). Two reviews have identified that organisation-wide approaches are most effective in dealing with workplace issues (Health Education Authority 2001; Health Education Board for Scotland 2002). In particular, it is suggested that interventions should include policies to tackle bullying and harassment (Health Education Authority 2001).

Implementation issues

Evidence-based options for the prevention of workplace bullying should be investigated for effectiveness.

Comment

While interventions in Australia have included mass media campaigns and WorkCover/ legislative reform, the effectiveness of these interventions in reducing workplace bullying has not been established.

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.

Health Education Board for Scotland 2002, *Mental health improvement: what works?*, Briefing for the Scottish Executive. Available at www.hebs.scot.nhs.uk/topics/.

International Labour Organisation 2005, *SafeWork: introduction to violence at work*, Available at www.ilo.org/public/english/protection/safework/violence/intro.htm.

WorkSafe Victoria 2003, *Prevention of bullying and violence at work: guidance note*, Available at www.workcover.vic.gov.au/vwa/publica.nsf/.

Intervention – Discrimination prevention

The evidence of effective strategies to prevent discrimination is limited. Much of the evidence documents the associations between discrimination and health (including mental health). Where interventions have been conducted, they have tended to focus on knowledge, attitudinal and behaviour change. Rychetinik and Todd (2004) suggested that interventions designed to prevent discrimination are generally not yet overtly linked to mental health outcomes.

Population group/setting

Programs have been developed for specific populations in schools and communities, particularly young people and Indigenous people.

Effectiveness

- Pettigrew and Tropp (2000) conducted a meta-analysis of prejudice reduction programs based on intergroup contact. The 'contact hypothesis' predicted reductions in discrimination under the following conditions: equal status between the groups in the situation; cooperative activity towards common goals; perception of common interests and common humanity; and support for the contact by authorities or local norms (Rychetnik & Todd 2004). Findings revealed that of the 203 studies included, 94 per cent identified an inverse relationship between contact and prejudice (Rychetnik & Todd 2004). Pettigrew and Tropp (2000) concluded that 'optimal intergroup contact' should be a critical component of interventions to reduce prejudice.
- A review investigating school-based interventions suggested the implementation of five types of intervention: racially integrated schooling, bilingual education, multicultural and anti-racist education, training in social–cognitive skills, and role playing and empathy (Aboud & Levey 2000 cited in Rychetnik & Todd 2004).
- The known effectiveness of interventions in reducing prejudice towards Aboriginal Australians is limited, given a lack of formal evaluation of such programs (Hill & Augoustinos 2001). Evaluation is thought to be particularly problematic as a result of the multi-strategic nature of the programs. A project conducted with employees of a large public health organisation in South Australia was found to be effective in the short term, but outcomes were not sustained. This program used Indigenous peer leaders (who also worked in the health organisation) to educate other staff members about Aboriginal history and culture, with the aim of reducing prejudice. Other programs conducted internationally have identified similar effects with some less significant results.
- Often, only short term outcomes have been assessed (Rychetnik & Todd 2004).

Implementation issues

There is limited empirical support that interventions have reduced discrimination.

Comment

Evidence links racial or ethnic discrimination with poorer physical and mental health. Research to date, however, does not adequately examine this association, so does not describe how exposure to discrimination can lead to increased risk of poor mental health. It is crucial that this link be more clearly established (Williams, Neighbors & Jackson 2003).

Useful resources for the prevention of violence and discrimination

Bullying

Various projects such as The Friendly Schools Project, MindMatters, Peer Support and Program Achieve (United States) are available at www.bullyingnoway.com.au.

Domestic violence

The Australian Domestic and Family Violence Clearinghouse (www.austdvclearinghouse.unsw.edu.au) has a wealth of information on domestic and family violence, including resources and publications, a library service, a good practice database, research, links and news.

Partnerships against Domestic Violence is the face of Australia's national action program. Reports are available at www.padv.dpmc.gov.au/.

Report from the Freedom from Fear campaign against domestic violence are available at www.freedomfromfear.wa.gov.au/default.htm.

General information

The Australian Institute of Criminology website (www.aic.gov.au/research/localgovt/cwlth.html#initiatives) outlines government responses to violence and provides case studies of violence prevention strategies.

References

Hill, ME & Augoustinos, M 2001, 'Stereotype change and prejudice reduction: short and long term evaluation of a cross-cultural awareness programme', *Journal of Community and Applied Social Psychology*, vol. 11, pp. 243–62.

Pettigrew, TF & Tropp, LR 2000, 'Does intergroup contact reduce prejudice? Recent meta-analytical findings', in Oskamp, S (ed), *Reducing prejudice and discrimination*, Lawrence Erlbaum Associates, Mahway, New Jersey.

Rychetnik, L & Todd, A 2004, *Literature review to follow on from VicHealth's 1999–2002 mental health promotion framework: final report*, Sydney Health Projects Group, School of Public Health, Sydney University, Sydney.

Williams, DR, Neighbors, HW & Jackson, JS 2003, 'Racial/ethnic discrimination and health: findings from community studies', *American Journal of Public Health*, vol. 93, no. 2, pp. 200–208.

5 Increasing access to economic resources

5 Increasing access to economic resources

5.1 Overview of economic participation

Economic participation is a determinant of mental health and wellbeing, inextricably linked to the Ottawa Charter for Health Promotion (World Health Organisation 1986) (appendix B) through the action areas of healthy public policy, supportive environments and the development of personal skills. The broad determinant of access to economic resources (and thus economic participation) is strongly correlated with mental health at all life stages. While access to economic resources is frequently conceived in terms of individuals, it has important social dimensions. Paid work is a highly valued activity that produces many more outcomes than those of financial reward, although fair financial reward is a highly valued outcome. Access to work, education, housing and money is about economic wellbeing, which is strongly connected to health status where improvements to people's economic situations have significant impacts on their health (Mulvihill, Mailoux & Atkin 2001). Work, education, appropriate housing and sufficient money to live both protect and promote mental health and wellbeing.

Economic wellbeing is a term that engages with concepts of equity, social inclusion/exclusion, socioeconomic status, inequalities, access to income and employment, and the economic integration of marginalised groups. VicHealth evaluations have identified outcomes of economic participation as including not just access to appropriate levels of income, but also the enhancement of life skills, the promotion of attachment and belonging, and increased opportunities for control (VicHealth 2003, p. 55).

Lack of access to economic resources results in income poverty and its sequelae, of which inequity is the most prominent. Income inequality is highly correlated with poorer health outcomes in specific diseases such as heart disease and diabetes (Garrard et al. 2004) or in patterns of mental disorders (Puska & Vartiainen 1999). People at the lower levels of the socioeconomic hierarchy have significantly worse health status because the effects of economic disadvantage and persistently low income are cumulative, so sustained hardship produces a greatest risk of poor mental and physical health (Marmot & Wilkinson 2002; Puska & Vartiainen 1999).

Cycles of disadvantage are complex and multidimensional, and include associations with low levels of economic participation, which include lack of money, lack of work and lack of opportunity to acquire education and skills. Changing education, training and labour markets, together with fractured levels of social cohesion and restructuring of social and economic institutions, have created challenging circumstances for many population groups (VicHealth 2003). A critical dimension of economic wellbeing is access to affordable, accessible and appropriate health services. Populations who do not have access to economic resources and health services suffer significant health inequities (Freudenberg 2000). The structural arrangements governing health insurance systems are thus a key determinant of health, because universal health insurance is regarded as a component of a social wage system. Greater equity of access has been equated with the provision of universally funded public health insurance systems to which everyone has equal access on the basis of need rather than ability to pay.

Access to economic resources is a determinant of health related to social inclusion and connectedness. Economic participation is a key dimension of social inclusion, so it follows that labour market exclusion is a key dimension of social exclusion (Joseph Rowntree Foundation 2000). People policies used by community/neighbourhood regeneration programs are often framed in terms of economic outcomes.

Case study: the Winning New Jobs Program – promoting re-employment and mental health

The Winning New Jobs Program was developed in the United States to help unemployed workers effectively seek re-employment and cope with the multiple challenges of unemployment and job search (Caplan et al. 1989; Price et al. 1992; Price & Vinokur 1995). The program is based on theories of active learning process, social modelling, gradual exposure to acquiring skills, practice through role playing, and inoculation against setbacks.

Over one week, five intensive half-day workshops are held. The workshops focus on identifying effective job search strategies, improving participants' job search skills, increasing self-esteem and confidence, and motivating participants to persist in job search activities. Two trainers deliver the program to groups of 12–20 people. The intervention is designed to achieve its goals by creating supportive environments and relationships between trainers and participants and among participants.

The program has been evaluated in replicated randomised trials involving thousands of unemployed workers and their partners in the
quality of re-employment, increased self-esteem and decreased psychological distress and depressive symptoms over two years, particularly among those with a higher risk for depression (Price et al. 1992). In addition, the program has been shown to inoculate workers against the adverse effects of subsequent job loss because workers gain an enhanced sense of mastery over the challenges of job search (Price 2003).

(Source: Based on Jane-Llopis, J, Barry, M, Hosman, C & Patel, V 2005, 'Mental health promotion works: a review', *IUHPE – Promotion and Education*, vol. 2, pp. 9–25.)

5.2 Overview of interventions to increase access to economic resources

Interventions have been developed to reduce income inequality, given links to poorer health outcomes among 'those most vulnerable to poverty, and diminished life chances' (CCSD 2001). But interventions to address access to economic resources are rarely explicit in their intention to address mental health and wellbeing. The VicHealth Framework for the Promotion of Mental Health and Wellbeing has identified key themes for access to economic resources and economic participation as being access to resources of work, education, housing and money.

The following list summarises the four interventions reviewed in this section:

Intervention categories (DHS 2003) used to increase access to economic resources include one or more of the following:

- skill development and education
- settings and supportive environments
- community action.

Intervention – Adult literacy programs

Language acquisition is an enabler of economic participation. Empowerment is thus an important principle of adult literacy programs. Everyone has the right to education that is available, accessible, acceptable and adaptable (ICESCR 1999), including intensified adult and further education programs for those who did not acquire functional general literacy skills in their primary education. General literacy refers to the degree to which individuals can read, write and compute, without regard to the context in which the reading and writing occur (Weiss 2005). It covers a range of skills, including reading and listening ability, numeracy, comprehension ability, the ability to communicate through writing and speaking, negotiation skills, critical thinking and judgement. Literacy and numeracy are important because they promote sustainability of employment and underpin good health outcomes. Interventions to increase adult literacy and numeracy programs are provided either as stand-alone programs or as part of employment programs.

Health literacy is one of the main forms of literacy. It is considered to include knowledge about health and health care; the ability to find, understand, interpret and communicate health information; and the ability to seek appropriate care and make critical health decisions, including the ability to comprehend and act on social and economic determinants of health. And it is believed to improve community empowerment. Other 'literacies' include computer literacy, cultural literacy, media literacy and scientific literacy (Rootman & Ronson 2002).

There are strong links among education, employment and health. The International Adult Literacy Survey (OECD & Statistics Canada 2000), a comparative study of 12 Organisation for Economic Cooperation and Development countries, found a direct association between literacy and labour market experience. People with low literacy competency receive lower levels of income and experience unemployment for longer periods, compared with people who have higher levels of literacy; further, they are less likely to secure stable and secure employment (Lamb & McKenzie 2001; Marks & Fleming 1998; Rahmani, Crosier & Pollack 2002). Illiteracy has a major negative impact on employment and health.

Help with literacy skills appears to be needed among immigrant groups, with the provision of language and literacy skills for new arrivals helping bridge social capital. Classes to assist immigrant people with language skills in the principle language of a country are an important factor in their economic and social integration (Rahmani, Crosier & Pollack 2002).

Population group/setting

These interventions 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. Programs have been specifically developed for immigrant women, who are likely to be isolated by housework and child care responsibilities. Because men from non-English speaking backgrounds are known to be disadvantaged in employment, it follows that both men and women are population groups of interest.

Effectiveness

The relationship between literacy, life opportunities, employment and mental health and wellbeing is proven to be strong (Rahmani, Crosier & Pollack 2002; Rootman & Ronson 2002). Locally delivered programs, funded in the not-for-profit sector, are cost-effective (Rahmani, Crosier & Pollack 2002). While literacy programs are rarely evaluated in terms of mental health promotion outcomes, participation in adult literacy programs has a positive effect on self-concept, self-esteem and self-image (Beder 1999). The direct and indirect effects of literacy on health suggest the importance of relationships between literacy and other determinants of health, including early childhood, ageing, personal skills and capacity, gender, age and culture (Rootman & Ronson 2002).

Implementation issues

- Settings must be natural to participants and integrate literacy with health promotion actions.
- Health promotion actions should be based on Ottawa Charter principles.
- Program designers must understand that 'literacy has a colourful spectrum of meanings related to self-expression, culture, equity, empowerment and marginalisation' (Rootman & Ronson 2002, p. 4).
- Social, economic and health service exclusion of low literate populations is common and serves to distinguish them as 'hard-to-reach' populations.
- Programs to avoid are those that are labelled 'literacy' or that reveal other deficiencies among potential participants.
- Integration of health into literacy programs is perceived as adding value for the development of 'hard skills' (reading and writing) with 'soft skills' (such as speaking, presenting and discussing).
- Program design should be based on the learner's needs, interests and motivations.
- Learners should be involved in program design.
- Participatory action research is needed to collect meaningful data.
- Settings approaches in health have promising parallels for programs in literacy, and literacy and health.
- Programs should be evaluated for their mental health outcomes as well other outcomes.

Comment

The development of outcome indicators related to mental health and wellbeing is likely to increase knowledge about the effect of literacy on mental health. Measures of literacy need to investigate a range of literacy components, not just reading and writing (although these two components remain the cornerstone of literacy for good health and access to economic resources).

Partnerships between the health sector and the education and training sectors will facilitate the integration of program intentions.

References

Beder, H 1999, *The outcomes and impacts of adult literacy education in the United States*, National Center for the Study of Adult Learning and Literacy, Harvard Graduate School of Education, Cambridge, Massachusetts. Available at www.gse.harvard.edu/ncsall/research/report6.pdf.

ICESCR (International Committee on Economic, Social and Cultural Rights) 1999, 'The right to education', General comment 13, para 14.

Lamb, S & McKenzie, P 2001, *Patterns of success and failure in the transition from school to work in Australia*, Longitudinal Surveys of Australian Youth research report no. 18, Australian Council for Educational Research Ltd, Melbourne.

Marks, GN & Fleming, N 1998, *Factors influencing youth unemployment in Australia 1980–1994*, Longitudinal Studies of Australian Youth, Australian Council of Educational Research, Melbourne, Available at www.acer.edu.au/research/LSAY/.

Mulvihill, M, Mailloux, L & Atkin, W 2001, *Advancing policy and research responses to immigrant and refugee women's health in Canada*, Canadian Women's Health Network, Manitoba.

OECD (Organisation for Economic Cooperation and Development) & Statistics Canada 2000, *Literacy in the information age: final report of the International Adult Literacy Survey*, Paris.

Rahmani, Z, Crosier, T & Pollack, S 2002, *Evaluating the impact of the literacy and numeracy training programme for job seekers,* Australian Department of Education, Science and Training, Canberra.

Rootman, I 2002, Literacy and health research workshop: setting priorities in Canada. Available at www.nlhp.cpha.ca/clhrp/wrkshp_e/wrkshpre.pdf.

Rootman, I & Ronson, B 2002, The National Literacy and Health Program (Canada). Available at www.nlhp.cpha.ca/.

Good practice

The United Wood Cooperative: turning the great Aussie tool shed into a multicultural health promoting enterprise

This innovative initiative has focused on older men from refugee backgrounds, in inner city Melbourne. The Adult Multicultural Education Service formed a partnership with the Moonee Valley Council to provide premises for an enterprise making boutique furniture items. A project worker supports the cooperative. Participants are involved with employment opportunities, provided with education and training, and build partnerships (and thus awareness) with the local community.

Intervention – Child care programs

Child care is defined as a continuum of care of preschool children and children under the age of 12 years outside regular school hours, by people who are not family members. High quality child care is carefully defined in the literature separately from low quality child care, which is more likely to occur when caregivers are untrained, caring for too many children at a time and dissatisfied with the job.

Publicly funded or subsidised child care programs:

- promote women's economic and social equality by ensuring child care is affordable (thus enabling increased access to employment)
- ensure families can meet workplace responsibilities, have an adequate income and become economically self-reliant
- reduce poverty.

Women carry a greater burden of familial obligation when they are required to act as carer or mother, and they have reduced opportunities to participate in the paid workforce (or train for participation) when they have no reliable or affordable child care available. Women who have extended periods of leave from the workforce forgo direct earnings and lose life earnings and superannuation, opportunities to accumulate work experience, seniority and career advancement. Benefits of child care accrue to children, women, families, employers, communities and society through the development of a healthy economy based on equity principles. Child care programs should thus be informed by gender equity principles. They are also related to other health determinants, including social connectedness, social inclusion and social support.

The Organisation for Economic Cooperation and Development (OECD and Statistics Canada 2004, pp. 76–7) argued that public money should be provided to only public and non-profit child care services, with financial transparency ensured through strong parent management boards, and that a public agency should oversee the mapping of services and their location.

Population group/setting

These interventions target workplaces, community support structures (such as those provided by local, state and federal governments), families (especially mothers, particularly single and low incomes mothers) and women from immigrant families.

Useful resources

The Canadian Childcare Resource and Research Unit (CRRU) at the University of Toronto has a mandate to advance the idea of a universal, high quality, publicly funded, not-for-profit, inclusive early childhood education and care. The website (www.childcarecanada/org) has a comprehensive range of research and commentary papers on child care issues, including data on early childhood care, affordability, access, public and private provision of child care, quality, and child development.

Effectiveness

In relation to economic participation, quality child care meets the needs of a range of population groups of interest, including children, women, families and employers (Australian Council of Trade Unions 2003; Doherty et al. 1995). Nationwide studies show that families with high quality child care services have reduced absenteeism rates and their organisations have increased productivity (Cleveland & Krashinsky 2003). For single or poor mothers, the availability of child care makes the difference between financial independence and subsistence on social security benefits.

Implementation issues

- Strong government regulation of all aspects of child care is necessary to ensure high quality child care is provided.
- High quality child care is enabled by adequate funding for sufficient staff with appropriate education and training, where government regulates licensing.
- Publicly funded child care and that operating on a not-for-profit basis are more likely to provide high quality, affordable, accessible child care (Doherty et al. 1995)
- Equity and access to affordable, accessible services rests with the public and not-for-profit sectors (OECD & Statistics Canada 2004).

References

Australian Council of Trade Unions 2003, Child care background paper, Carlton, Available at www.actu.asn.au/congress2003/draftpolicies/.

Doherty, G, Rose, R, Friendly, M, Lero, D & Hope-Irwin, S 1995, Child care: Canada can't work without it, Occasional paper no. 5, Childcare Resource and Research Unit, University of Toronto, Available at www.childcarecanada.org/resources/CRRU/pubs.

Cleveland, G & Krashinsky, M 2003, Financing early childhood education and care services in OECD countries, University of Toronto at Scarborough paper commissioned by the OECD for the Thematic Review of ECEC Policy, Toronto

McDonald, P 1998, Issues in child care policy in Australia, Australian National University submission to the Senate Community Affairs Committee into Child Care Funding, Canberra.

OECD (Organisation for Economic Cooperation and Development) 2004, *Canada: country note – early childhood education and care policy*, OECD Directorate for Education, Paris.

Intervention –Youth employment programs

Youth unemployment in Australia is consistently much higher than adult unemployment. Poor school performance in literacy and numeracy is the one consistent factor in youth unemployment. Patterns of unemployment and earnings over time reveal degrees of inequality across social groups. Low levels of employment and earnings are related to lower health status and health inequities. Job readiness programs focus on young people with high levels of risk factors and low levels of protective factors.

Population group/setting

These interventions target young people, especially early school leavers and those experiencing disconnection or marginalisation from social and economic life.

Effectiveness

Longitudinal Surveys of Australian Youth (LSAY) have shown that participation in youth employment programs that young participants consider worthwhile has positive mental health and wellbeing outcomes (Marks & Fleming 1998). Participation provides social connectedness, skills and knowledge development, attributes such as confidence, feelings of being valued, and a sense of meaning and purpose. Completion of year 12 schooling and post-school training seem to provide increased employability (Marks & Fleming 1998). Early school achievement and literacy and numeracy skills are also critical to overcoming unemployment, even when post-school qualifications and labour market experience are taken into account.

Implementation issues

- Education and training need to include literacy and numeracy skill building.
- Building partnerships to engage with youth at all stages of the project is essential, including the planning, decision making and evaluation stages.
- Interventions must work strategically to build the capacity of individuals and communities.
- Diversity and inclusion must be included as outcomes.
- Interventions should provide concrete and immediate benefits for youth, including income and public recognition of the value afforded their efforts.
- Interventions must be conscious of establishing sustainable social and economic security for youth (Jane-Llopis et al. 2005).

Comment

Moodie and Jenkins (2005) commented on the low levels of awareness among business and industry of their role in promoting mental health in the workplace. Rarely are employment programs promoted in terms of their effect on mental health. Good employers are health promoting!

References

Jane-Llopis, E, Barry, M, Hosman, C & Patel, V 2005, *Mental health promotion works: a review, IUHPE – Promotion and Education*, vol. 2, pp. 9–25.

Marks, GN & Fleming, N 1998, *Factors influencing youth unemployment in Australia 1980–1994*, Longitudinal Studies of Australian Youth, Australian Council of Educational Research, Melbourne Available at www.acer.edu.au/research/LSAY/.

Moodie, R & Jenkins, R 2005, 'I'm from the government and you want me to invest in mental health promotion. Well why should I?', *IUHPE – Promotion and Education*, vol. 2, pp. 27–41.

VicHealth 2003, Promoting young people's mental health and wellbeing through participation in economic activities – key learnings and promising practices, Victorian Health Promotion Foundation, Melbourne.

Intervention – Adult work programs

Work of different types is categorised by attributes across a continuum from 'high grade' employment to 'low grade' employment. High grade employment typically has attributes that are relatively good and a lower risk of unemployment. Low grade employment is distinguished by relatively poor job attributes and negative material effects, including health effects (Cave et al. 2001). Adult work programs are described in various terms, including 'return to work' or 'welfare to work' programs, and enhance personal job search skills such as self-esteem and inoculation against setbacks (Jane-Llopis et al. 2005).

Strategies used to increase income equity include investment in publicly funded child care places, investments in publicly funded education (including higher education, job training, and housing and health care), an increase in minimum wages, and the development of progressive tax policies.

Population group/setting

Adults experiencing unemployment or underemployment for various reasons include those with involuntary job loss and those who need to retrain and acquire new education and skills such as assertiveness (Health Education Authority 2001). Men from non-English speaking backgrounds are a priority group because they remain disadvantaged in employment, even when all other factors are taken into account (Rahmani, Crosier & Pollack 2002). Other relevant groups include low income groups and disadvantaged communities. Interventions settings include local employment programs.

Effectiveness

The effectiveness of adult work programs is context dependent, but common impacts measured include job satisfaction, motivation, self-esteem, job seeking confidence and reduced depression (Health Education Authority 2001). The Winning Jobs Program has been evaluated across the United States and Finland (the Työhön Job Search Program) with randomised control trials involving thousands of unemployed people and their partners. Short term results at a two-year follow-up showed improved re-employment prospects and engagement with the labour market, and lower levels of distress (Jane-Llopis et al. 2005).

Where people move from unemployment to low grade work, however, negative mental health effects have been shown (Cave et al. 2001). Studies are needed of employment strategies that aim to improve work attributes to enhance mental health, including sustained, long term changes to employment, especially in the jobs available to the most vulnerable groups of the population.

Implementation issues

- Program designers need to understand the local region/community and population groups of interest to effectively tailor programs.
- Confidence in interview and job search skills, along with ongoing work support, is just as important as literacy and numeracy skills.
- Just moving unemployed people into 'low grade' work may not have positive health impacts (Cave et al. 2001). Income equity issues can be addressed at the local level by working with local employment programs to ensure they are health promoting and not health damaging.
- Evaluations should measure impact and include a follow-up to assess outcomes over time, including outcomes in terms of public policy and organisational practices.

Comment

Evaluations of adult work programs in terms of (at least) intermediate mental health outcomes (see the VicHealth Framework for the Promotion of Mental Health and Wellbeing) would provide valuable complementary data to help build the case for health outcomes of employment. The appropriate role for measures to redress income inequality is contested, however, with public health benefits not always linked to income equity programs, and mental health outcomes almost never connected to equity measures. Income equity programs will remain a challenge for many years to come, but the inclusion of mental health outcomes in evaluations will help to build the evidence on the effects of income equity on health and wellbeing.

The VicHealth (2004b) refugee relocation project indicates what other social infrastructure is necessary to safely and productively relocate refugees to rural areas with employment vacancies.

References

Bosma, H & Marmot, M 1997, 'Low job control and risk of coronary heart disease in Whitehall (prospective cohort) study', *British Medical Journal*, vol. 312, pp. 558–65.

Cave, B, Curtis, S, Aviles, M & Coutts, A 2001, *Health impact assessment for regeneration projects. Volume 11: selected evidence base*, East London and the City Health Action Zone and Health Research Group, Queen Mary, University of London. Available at www.geog.qmul.ac.uk/health/.

Friedlander, D & Burtless, G 1995, *Five years after: the long-term effects of welfare-to-work programs*, Russell Sage Foundation, New York.

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.

Rahmani, Z, Crosier, T & Pollack, S 2002, *Evaluating the impact of the literacy and numeracy training programme for job seekers*, Australian Department of Education, Science and Training, Canberra.

VicHealth 2004b, Mental health promotion in new arrival communities: learnings and promising practices, Victorian Health Promotion Foundation, Melbourne.

Intervention – Housing programs

Adequate housing is a prerequisite for employment (VicHealth 2005a) and a strategy, in conjunction with employment programs, to overcome worklessness, especially in areas of social housing with concentrated disadvantage (Carley 2002). The vicious cycle of poor mental health and poverty needs well targeted, structured investment for poverty alleviation (World Health Organisation 2003), including housing programs. These programs can take many forms: they include the refurbishment of public housing stock conducted as stand-alone programs, but housing improvements are also a key component of area regeneration and neighbourhood renewal programs. Program types include housing repairs, energy efficiency improvements and the creation of safer and more secure areas for public housing tenants as part of neighbourhood renewal programs.

Specific population groups/settings

These interventions apply to public housing and low income communities.

Effectiveness

There are strong associations between poor housing and poor health (Thomson, Petticrew & Morrison 2001), and good evidence that adequate, safe and secure housing has an independent effect on physical and mental health and wellbeing (TIlford et al 1997). Mental health is likely to show improvements from housing interventions ahead of physical health effects in a dose–response relationship (Thomson, Petticrew & Douglas 2003). Improvements have been found in measures of self-reported mental and physical health, levels of service use, physical symptoms and the use of prescription drugs. But research is lacking on the health gains and costs/benefits of investment in public housing, even though the basic human need for shelter is self-evident and associations have been found between mental health and general wellbeing and housing refurbishment. The health effects of housing programs are methodologically difficult to measure, and establishing quality longitudinal studies in this area is difficult, given the multifactored context, confounding factors associated with deprivation and also, perhaps, political factors (Thomson, Petticrew & Morrison 2001).

Implementation issues

- Housing interventions need to be localised because they are context specific: different neighbourhoods need different approaches and packages of intervention (Carley 2002).
- Prospective collaborative studies are needed between housing and health agencies and academics.
- Thomson, Morrison and Douglas (2003) identified a range of housing factors associated with health improvement, along with questions to ask in establishing housing–health impact assessments. The impact of area-based initiatives requires longitudinal studies that track both individuals and areas, and that closely link evaluation and policy.
- Housing is often a vertical program that lacks links with programs from other sectors. The formation of cross-sectoral partnerships is thus crucial for housing–health programs, and these partnerships should be incorporated into well designed vertical and horizontal people and place programs.
- Setting up and evaluating indicators and outcome measures of social capital, social exclusion, local democracy and local economic regeneration in housing programs will contribute to the evidence base about the relationship between housing and mental health and wellbeing.

References

Carley, M 2002, *Community regeneration and neighbourhood renewal: a review of the evidence*, Report to Communities Scotland, Edinburgh Research Department, Edinburgh.

Macintyre, S & Ellaway, A 2000, 'Ecological approaches: rediscovering the role of the physical and social environment', in Berkman, L & Kawachi, I (eds), *Social epidemiology*, Oxford University Press, New York, pp. 332–48.

Task Force on Community Preventive Services 2003, 'Recommendations to promote healthy social environments', *American Journal of Preventive Medicine*, vol. 24, no. 3S, pp. 21–4.

Thomson, H, Petticrew, M & Morrison, D 2001, 'Health effects of housing improvement: systematic review of intervention studies', *British Medical Journal* , vol. 323, pp. 187–90.

Thomson, H, Petticrew, M & Douglas, M 2003, 'Impact assessment of housing improvements: incorporating evidence', *Journal of Epidemiology and Community Health*, vol. 57, pp. 11–16.

Tilford, S, Delaney, F & Vogels, M 1997, *Effectiveness of mental health promotion interventions: a review*, Health Education Authority, UK Department of Health, London.

World Health Organisation 2003, *Investing in mental health*, Geneva.

Promising projects: Promoting young people's mental health and wellbeing through participation in economic activities

It's not just having this job, but everything else that comes from it. (Jane, program participant)

To implement the VicHealth Mental Health Promotion Plan 1999–2002, a number of projects were funded to encourage and promote the participation of young people in economic activities. These projects were intended to provide young people with 'a ran
enhancement of life skills, the promotion of attachment and belonging, and opportunities for control' (VicHealth 2003, p. 55). In general, projects covered a range of activities, including:

- employment placements
- unpaid work
- opportunities for income generation
- education and training
- interventions aimed at developing personal job search and small business skills, and providing information about options for education, training and employment.

Good practice examples

Kulcha Shift: the Brophy Family and Youth Services

This project combined economic participation with social welfare and community development approaches. It incorporated f
manual, technical training, personal development opportunities and employment preparation supported each 'activity centre'.

Changing Lanes: Nagle College, Bairnsdale

Changing Lanes was a diversion project based around a workshop specialising in basic fabrication, engineering and mechanical repair. It aimed to stimulate young people's interest in economic participation and to provide genuine life skill learning opportunities. Participants undertook a training program and four-week work placement.

Whitelion Juvenile Justice Employment Project

Participants in this program were undertaking a sentence at the Parkville Youth Residential Centre. The program used community and business partnerships to provide opportunities for employment skills training of young people in the centre.

Key lessons

- Promote activities that are purposeful to young people and communities.
- Work in partnership with young people.
- Involve young people in decision making.

Outcomes for individuals

The evaluation revealed that the projects had successfully provided young people with opportunities for economic participation. In particular, funded projects had the potential to:

- enhance skills
- enhance knowledge about work and work options
- foster positive changes in individual attitudes to employment and
- support participants to gain and maintain employment.

Outcomes for organisations

Building organisational capacity for economic participation was the most successful outcome of the projects evaluated. The projects demonstrated potential to integrate concern for young people's mental health and wellbeing into the core business of agencies, so as to:

- increase organisational capacity to assist young people
- build referral networks among organisations
- enhance understanding of mental health issues.

Outcomes for communities

The impact of the projects on the communities involved was less clear or consistent. Some projects, however, reported evidence of change in their community. As a result, the projects demonstrated potential to:

- enhance understanding of mental health and wellbeing
- enhance understanding of the links between economic participation and mental health
- foster awareness of the strengths of young people
- improve/sustain positive attitudes to the employment of young people.

The value of partnerships

Partnerships were an invaluable tool in contributing to project sustainability. In doing so, they were able to:

- broaden the expertise and resource base available to projects
- foster intersectoral action in mental health promotion
- enhance project impact by bringing together a broader range of agencies
- provide a forum for resolving differences.

VicHealth supported this partnership approach through its commissioning of the partnership analysis tool. This tool highlights the importance of planning for partnerships to maximise their potential contribution.

Making the link between economic participation and mental health

Participants symbolically viewed money as an indicator that their work was valued. Projects recognised that unless they dealt with issues of confidence, self-worth and resilience, mental health issues would remain as barriers to successful economic participation.

6 Program planning for mental health promotion

Good practice

Mental health promotion program work will be more sustainable and effective when it is supported by organisational policies that acknowledge mental health as an explicit goal, alongside the promotion of physical health and wellbeing.

6 Program planning for mental health promotion

6.1 Introduction

So far, this document has provided considerable information about the effectiveness of mental health promotion programs. Because mental health is a National Health Priority and because mental health figures so prominently in population health and burden of disease studies, catchment-level and local health organisations (including local government) are likely to have identified mental health as a priority area for action. To work effectively in the area of mental health promotion, where should planning begin? In this section, we set out practical steps in decision making for the planning, implementation and evaluation of mental health promotion programs.

The terms 'project' and 'program' are often used interchangeably. Here, we distinguish between the two. We refer to a project as a smaller and more discrete activity than a program, which is a set of activities or projects, usually at multi-levels and across two or more organisations. A program may have a series of projects within it, and each project may need to have its own set of objectives and activities to ensure it is planned well and implemented effectively. Each project can be evaluated; alternatively, a team may decide to evaluate only some projects within the overall program evaluation. Mental health promotion is likely to need a multi-level program approach (figure 4) conducted across two or more sectors and over time, keeping in mind that program effects may take two years of activity to become evident.

As discussed throughout this resource, program planning and evaluation processes for mental health promotion should be have a determinants perspective to maximise opportunities for effectiveness. This perspective involves understanding and selecting those determinants that the program aims to influence, based on the *evidence* about those determinants. The explicit inclusion of mental health promotion *impacts* and *outcomes* asks that initiatives are explicitly and specifically directed towards promoting good mental health (Health Education Board for Scotland 2001).

Mental health and wellbeing and their determinants are not the territory only of health departments and programs. They need to be interwoven across all sectors of society. Mental health thus needs more than a single project, agency or sector involved to make a difference. Work based on partnerships and multiple approaches has a multiplier effect towards larger goals (Labonte 2003). This is sometimes referred to as integrated health promotion because it involves agencies and organisations from a wide range of sectors and communities in a geographic catchment working in a collaborative manner, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues (DHS 2003). Or to put it another way, integrated health promotion refers to 'organisations from a range of sectors working in collaboration with local communities, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues' (DHS 2003, p. 3).

This section shows that program planning and evaluation are inextricably linked through 'program logic'. Logical program plans include a plan for evaluation; in turn, a plan for evaluation is useless without a good quality program plan to guide the measurement of program effects. These principles apply to both large scale and small scale programs and evaluations.

By adopting principles of program planning logic, the program is more to have a positive effect, and opportunities are created to provide evidence of that effectiveness. The field of mental health promotion evidence requires (a) thoroughness (or rigour) in program design and (b) evaluations that demonstrate effectiveness both in the program outcomes for people and in the measurements that can contribute to the mental health promotion evidence base.

Useful resources

Australian Department of Health and Aged Care 2000b, Promotion, prevention and early intervention for mental health: a monograph*, Mental Health and Special Programs Branch, Canberra.*

Commonwealth of Australia 2003, National mental health plan 2003–2008*, Canberra.*

VicHealth 2005a, Mental health and wellbeing research summaries 1–4*, Victorian Health Promotion Foundation, Melbourne.*

6.2 Steps in program planning for mental health promotion

Step 1: Work out the program rationale and set priorities

At the outset, it is essential to develop evidence about the *population group(s)* of interest[1] who are experiencing disadvantaged health or social status, about the *problem(s)* you want to address, and about the *determinants* that are your priorities for action. Identify key areas that are affecting mental health and that should be included in the program. This information provides a rationale for the program work. Many key documents summarise this information, including this resource. (The margin note lists three additional documents that provide rationale for mental health promotion work.)

Checklist 1: Rationale	Check
Build up evidence about the problem. Use local knowledge, experience and expert data from the most recent population health data sources. Now, draw the links between the determinants and the health issues (that is, unemployment and low socioeconomic status are determinants of chronic diseases, depression and anxiety, while discrimination, racism and sexism are determinants of depression, anxiety and stress, and may contribute to unemployment, low education levels). Ensure issues that the community has identified as important have been combined with population health data sources to add strength to the program.	
Identify those populations of interest experiencing disadvantaged health or social status.	
Identify state and federal government policies about mental health. Using these policies to inform planning increases the likelihood that the program will garner political support and funding.	

[1] We prefer not to use the language of target groups, with its top-down connotations (not to mention military overtones). Working with populations in whom we have an interest is preferable to taking aim at them or letting them know that they are in our sights.

Checklist 1: Rationale *continued*	**Check**
Identify who else is doing something about these issues. Examine the policy and socioenvironmental context that may affect the project. With what other agencies and community members could you be working? How could a combined effort enhance work on this issue?	
Work out whom in the community these issues would most affect, and ensure the needs of all groups have been considered. How strong is these groups' engagement with the issues and with your agency? What are the project implications of their degree of engagement or disengagement?	
Write an inventory of the resources available to the partnership (human, financial, information, technology) and from where you can obtain additional resources.	
Determine whether your agency would have to drop other work to be involved in this partnership for mental health promotion and to what degree the promotion effort can be incorporated into the agency's other work.	

Checklist 2: Priority setting	**Check**
Identify state and federal government policies about mental health, and use them to inform planning to increase the likelihood that the program will garner political support and funding.	
Ensure the partnership has information about the determinants of health and use a consensus process to prioritise which determinants will be the priority for action.	
Gather the most recent population health data sources and draw the links between the determinants and the health issues (that is, unemployment and low socioeconomic status are determinants of chronic diseases, depression and anxiety, while discrimination, racism and sexism are determinants of depression, anxiety and stress) to ensure issues identified as important by the community are combined with population health data sources to add strength to the program.	
Keep on asking what the partnership can influence.	

Step 2: Develop a basic program outline

The Department of Human Services Common Planning Framework refers to this stage as problem definition.

Based on your rationale and priorities, develop a basic program outline that you can take to potential stakeholders and partners to enlist their support. Use the VicHealth Framework for the Promotion of Mental Health and Wellbeing to develop a basic program outline that includes your proposals for:

- population groups of interest
- health promotion action areas
- settings
- levels at which intermediate outcomes are focused (individual, organisational, community, societal).

If you develop goals and objectives at this stage, be prepared for them revised and reworked by your partners as they engage with the project and you negotiate the program to be developed.

Step 3: Develop partnerships

The establishment of partnerships is critical to the effectiveness of mental health promotion programs, so knowing how to establish, maintain and sustain wider networks of community groups, agencies and organisations, and other practitioners and community folk is a necessary skill for effective mental health promotion practice.

Planning processes of other agencies in your area may have identified priority issues (although they are likely to be health issues rather than determinants), so links could be made to those agencies. It may also be useful to link with statewide programs working on mental health promotion. The key for success is to choose where and how your program will make a 'conscious, deliberate and substantial effort to influence change' (Labonte 2003, p. 15) in one or more determinants of mental health and wellbeing.

With your basic program outline, you are in a position to 'sell' the proposed program to potential partners, but your content and methods should remain fluid to ensure ownership by all partners. The evidence tells us that a program, to effect change, must 'unpack' the underlying determinants of any health issue in terms of mental health promotion outcomes, and you need to do this with your partners (even if you have already worked it through). For this reason, when developing integrated health promotion programs, you should involve partner agencies in brainstorming potential activities that may be required to achieve the objectives. Sitting around the table to unpack the determinants may turn up new information that you had not thought about.

Useful resources

A useful chapter on partnerships is available in Carley, M 2002, Community regeneration and neighbourhood renewal: a review of the evidence, Report to Communities Scotland, Edinburgh.

VicHealth has a partnership evaluation tool available at www.vichealth.vic.gov.au/, which would be a useful addition to resources on partnerships for mental health promotion. Many new partnerships have used this tool as a pre-test before their partnership and program development and then as a post-test to evaluate their success and point to areas in which the partnership could be strengthened.

To increase mental health and wellbeing at the level of communities (for example, schools, neighbourhoods, recreational environments, workplaces) and populations (for example, youth, new mothers, single parents, middle aged people out of work, people with a disability, the elderly) (Health Education Authority 1997; Labonte 2003), partnerships should aim to:

- identify common goals and agree on the determinants of interest to the partnership
- share intentions
- work together on strategies to reach out and increase knowledge
- intervene more than once
- use a combination of intervention methods
- pool and share resources.

Checklist 3: Partnerships	Check
Know whom you need to work with (the types of organisation and group).	
Identify whether you have worked with them in the past.	
Determine how you can best work with them (cooperation, coordination, collaboration).	
Find any evidence of the processes and outcomes that demonstrate a maturing of the partnership.	
Identify any new actions that the partnership has generated.	
Work out whether the partnership is maturing through the planning process. How do you know?	

Working upstream

We can gain a great deal of understanding about how to respond to the determinants of mental health by identifying 'levels' that relate to the targeting of interventions. Turrell, Oldenburg and McGoffin (1999) identified three broad levels of factors affecting health:

1. Downstream factors are those at the micro level, including treatment systems, disease management and investment in clinical research.
2. Midstream factors are those at the intermediate level, including lifestyle, behavioural and individual prevention programs.
3. Upstream factors are those at the macro level, including government policies, global trade agreements and investment in population health research.

A multi-level integrated program refers to a mix of interventions across two or more of these levels, which are expanded in the Department of Human Services Common Planning Framework and figure 3. General principles have been established for developing integrated health promotion programs:

- Select and implement a mix of approaches and interventions using the Common Planning Framework.
- Ensure a mix of upstream and downstream approaches to maximise effectiveness.
- Include a mix of strategies that address the broad determinants of mental health promotion (a population focused approach) and that focus on identified target group(s) (a high risk approach).
- Select strategies that evidence based.
- Link your interventions into broader priorities and health development plans for your community/area.
- Identify financial and human resources required to successfully implement the interventions.
- Consider opportunities for working cooperatively with other agencies to either build on or enhance investments already being made to achieve the program goal.

Quality integrated mental health promotion involves implementing a mix of interventions that always include some activity at upstream levels. Sections 3–5 provide extensive information about the broad range of interventions available for each risk factor for mental health. The following checklist provides a guide for selecting intervention strategies.

Checklist 4: Intervention selection and design	**Check**
Check that the proposed interventions will address specific determinants, as reflected in the program goal and objectives.	
Check that the selected mix of interventions (balancing individual focused and population-wide interventions) has proved to be effective elsewhere in achieving the desired outcomes in terms of the program goal and objectives.	
Set a strategy for involving community members in selecting intervention strategies and then planning, implementing and evaluating those interventions.	
Identify factors that will help or hinder people becoming involved, and strategies to address those barriers.	
Identify which groups are most vulnerable and talk with them about how the proposed program can meet their needs.	
Identify how other key agencies can be involved in the process, and understand how your work will complement the work being undertaken by other agencies.	

Capacity building: support and resources

Failure to give sufficient time and attention to the capacity building phase is the most frequent reason for an intervention's failure to achieve or maintain health and wellbeing improvements. Capacity building creates optimal conditions for success. It is concerned with obtaining the resources (such as funds, materials and people) and organisational support required to implement and sustain an intervention. Key actions areas for building capacity include:

- organisational development
- partnerships
- workforce development
- leadership
- resources.

Work with partner agencies to brainstorm potential capacity building strategies for creating the optimal conditions to achieve program sustainability and the program goal. Where there are limited resources or limited community and political support, it may be necessary to change the program objectives to better fit the available resources. It is also useful to clarify the types of action required to secure greater community and political support. Section 5.3 of the *Integrated health promotion resource Kit* (Department of Human Services 2003a) provides further information about capacity building strategies.

Checklist 5: Capacity building	**Check**
Identify the individual and collective skills and knowledge of the key partners in the program and which staff need further skill development.	
Check that the agencies involved have the necessary resources, including time, infrastructure, personnel and community participation for the program. Or be aware of how you can adapt different interventions, objectives and even program goals to suit the available resources.	
In relation to the budget, check that financial resources been transparently allocated to the program.	
Clearly define the roles and responsibilities of the key partner agencies.	
Ensure all key partners have agreed and signed off on the integrated health promotion strategy or organisational plan.	
Ensure the involved agencies have support and leadership from senior managers, boards and governance committees for the delivery of quality integrated health promotion services.	

Step 4: Generate a program plan

In this stage, your partnership will need to affirm its priorities and develop a more structured program plan. This plan is absolutely necessary to ensure everyone is 'on the same page' about what will be done and with what intentions. Briefly, your plan needs to be based on program logic to link theory with practice through a series of steps. Program logic is an accepted approach to health promotion program planning that helps practitioners to increase the effectiveness of their programs, and it is easier than it sounds!

The Department of Human Services Common Planning Framework refers to this stage as solution generation.

Before embarking on the design of a new program, consider transferring or adapting a program already implemented and evaluated elsewhere.

Basically, a program plan based on the logic model needs to include several fundamental components:

- goals (or aims)
- objectives
- interventions/actions
- an evaluation plan.

Goals for mental health promotion programs are best established at two levels – goals for the *partnership* as well as goals for *each individual agency* involved in the partnership – because the goals for each agency will differ from those shared by the partnership. Keep in mind the need to incorporate local perspectives and priorities.

The main difference between goals and objectives is their focus. Program goals are statements about long term outcomes and should articulate what change to a determinant(s) is the aim of the health promotion program. They are broad statements that relate to improving health and wellbeing status, through changes to determinants of health and wellbeing, to quality of life and to inequities. Program goals are measured by *outcome* evaluation. Program objectives, however, elaborate on and restate the goals in operational terms – that is, what the program is meant to achieve immediately after its completion. They are measured by *impact* evaluation.

Checklist 6: Goal and objective setting	**Check**
Identify the partnership's and each agency's overall beliefs in relation to their responsibilities for the promotion of mental health and wellbeing.	
Determine whether there is a clear link between the program goals and a determinant for mental health and wellbeing.	
Determine whether there is a clear link between the program goals and objectives for integrated mental health and promotion and the overall organisational/strategic/corporate plan.	
Check that the objectives reflect the guiding principles for integrated health promotion.	

*For effectiveness, program objectives should be **SMART**:*

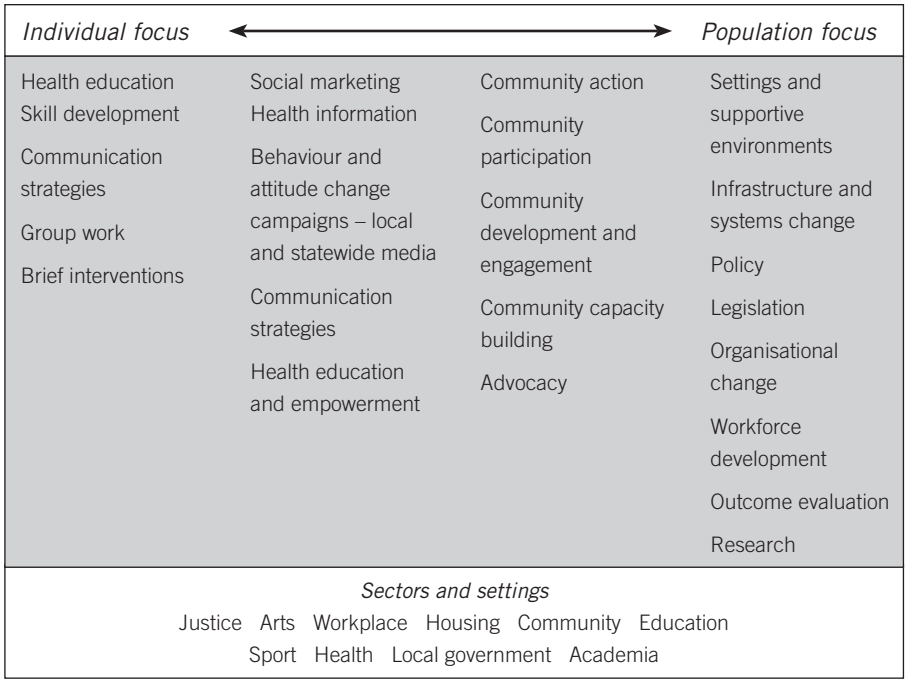
- ***S**pecific to a health determinant, population group or setting*
- ***M**easurable in evaluation terms*
- ***A**chievable given the resources and capacities*
- ***R**ealistic (that is, sensible and practical)*
- ***T**ime limited, showing a set period for the intervention/program, allowing sufficient time for planned changes to occur.*

Figure 3 provides a mental health promotion program planning template, to illustrate how to connect program goals, objectives and interventions/actions to evaluation processes. When developing the template, keep in mind the following principles to underpin your mental health promotion program plan:

- Ensure there is a shared understanding about the downstream–midstream–upstream determinants of mental health in the community.
- Ensure priority setting involves all key stakeholders for whom those determinants are a priority.
- Ensure processes are in place for the genuine engagement and participation of all key stakeholders through all processes, from priority setting to implementation and evaluation.

The fun part of planning is deciding on the interventions/actions that the partners will develop and put into action. Try not to rush into this part of your planning: ensure your goals and objectives are settled and agreed before proceeding to the planning of interventions, and then make sure you have a mix of interventions (because a mix is more effective than a single intervention). This is why cooperation with other agencies is so important, because a partnership can bring complementary approaches and skills to your community. Figure 3 is a model for understanding this necessary mix of upstream and downstream approaches to health promotion, and it overviews the range of approaches available to practitioners.

Figure 3: Mental health promotion interventions continuum



(Source: Based on Department of Human Services interventions continuum and the VicHealth Framework for the Promotion of Mental Health and Wellbeing.)

Use the language of 'intermediate outcomes' and 'long term benefits' from this resource and the VicHealth Framework for the Promotion of Mental Health and Wellbeing to guide your program and evaluation plans. This language will help you to describe what you are seeking to achieve and to set up the success criteria to guide your program.

Step 5: Develop an evaluation plan

Evaluation enables us to learn about the effectiveness of activities, as well as the reasons that programs achieve or fail to achieve their objectives. Practitioner wisdom and more formal measures are combined in evaluation to develop the knowledge base necessary for planning and implementing future activities. In addition, evaluation enables practitioners to meet accountability requirements and to more systematically document, disseminate and promote effective practice.

Mental health promotion or improvement programs necessarily account for a wide range of social, economic, political and environmental factors. Such complexity requires many types of evidence for effective evaluation. As described in this resource, the evidence base for health promotion interventions to reduce mental health problems is dominated by relatively large intervention trials conducted by universities and other research organisations. Smaller, community-based initiatives can be effective, but are rarely included in the published evaluation literature. Evaluation and documentation of these interventions will help to provide a more balanced evidence base for improving efforts to reduce the incidence of mental health problems.

Evaluating a health promotion program or intervention involves considering different aspects of that program/intervention. These aspects are generally referred to as process, impact and outcome evaluation. As discussed, goals, objectives and interventions are measured by different types of evaluation (DHS 2003 adapted from Hawe et al. 1990), as shown in figure 4.

Figure 4: Schema of program logic between program planning components and evaluation categories

Goal/aims	*measured by*	Outcome evaluation
Objectives and sub-objectives	*measured by*	Impact evaluation
Interventions/strategies	*measured by*	Process evaluation

- **Process evaluation** involves examining the implementation of the program. What elements worked? What elements were less successful? Who attended the program? Who was affected by the program (that is, what was the program reach? Who was not reached by the program?). Process evaluations are conducted early to midway through program implementation.
- **Impact evaluation** involves examining the intermediate outcomes you wish to achieve, which steers you to consider whether, and to what extent, the program or intervention has had an impact on people's health. It assists in examining whether the set objectives and sub-objectives have been achieved. Impact evaluation for intermediate outcomes is conducted at the end of the program or a program stage. In a mental health promotion, one or two years may be a relatively short period for intermediate outcomes.
- **Outcome evaluation** (that is, whether the program goal was achieved) is about long term benefits (see the VicHealth Framework for the Promotion of Mental Health and Wellbeing). It directs your partnership and your organisation to measure the long term changes related to program goals. Local level programs are not expected to invest in outcome evaluations, which are more likely to be commissioned for a cluster of similar programs or for a statewide funded program.

As discussed, it is important to begin planning evaluation, dissemination and sustainability strategies early in the program management cycle and not at the end of implementation, because evaluation works best when planned and then put into action over the life of the project. Program management of effective mental health promotion thus involves managing the total set of actions. Your schema will be improved if it has congruence with the VicHealth Framework for the Promotion of Mental Health and Wellbeing to identify the levels, action areas, population groups and intermediate outcomes.

Figure 5 illustrates program planning steps alongside the steps in the Department of Human Services Common Planning Framework. Added to this is a worked example of intermediate and long term outcomes, modelled on the VicHealth Framework for the Promotion of Mental Health and Wellbeing. Such a scheme can be easily adapted to illustrate the logic between a program's steps and desired outcomes.

Figure 5: 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 lesilative platform
Resource allocation
Government 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
Reduced social and health inequalities
Improved quality of life and life expectancy</td></tr>
</table>

Step 6: Implement the program

With all the details of your program plan in place, you are ready to start putting the plan into action. Your plan should give the both 'the big picture' (rationale, vision, aims) and specific directions for the program (objectives and actions). Ideally, it is sufficiently detailed to take to a management committee for approval or to use in a funding submission.

Planning for task organisation presupposes that you know what major activities are going to happen and in what order. For this reason, the time frame is often constructed first: do you run the media campaign, then start some of the education sessions and, lastly, lobby for improved council policies? Or is there a better order? Or are all tasks to be done at once? This ordering of activities (and often the tasks required to accomplish them) requires a timeline. A two or three stage process of development is usual: a program establishment stage, an operational stage and the final impact (or outcome) evaluation stage. Timelines include start and end dates for all stages, activities and tasks. Working out this timeline can be a complicated business, and getting the order right can mean the difference between success and failure, and between meeting the budget or making a loss (particularly on large financially sensitive projects such as community intervention projects).

In addition to the timeline, you need a plan for the organisation of tasks. This plan covers which organisations in the partnership and which staff will do what, what role they will play and at what point. Implementation can be straightforward or complex, and may require a number of different skills, depending on the approaches you are taking.

So how do you match people to tasks? A couple of main roles and two broad skill sets correspond to program implementation. The two skills sets required are:

1. *the skills to implement the strategies/interventions in the program plan* – that is, skills in health education and communication, group facilitation and leadership, media and policy development
2. *the skills to manage the program* – that is, skill at ensuring the whole program is implemented; staff are well briefed, trained for specific competencies, and supported; relationships with stakeholders are maintained; and evaluation is conducted effectively.

The management role is most important to understand, given its strategic nature. Many resources are available to review management skills. Figure 6 provides some key implementation questions to ask throughout the program.

Figure 6: Key implementation questions

Communication	Are you communicating well enough internally? Are you communicating well enough externally?
Project monitoring	Are you collecting enough good quality information about what is happening in the project? Are you analysing the information enough?
Sustaining the partnership	Are decision-making structures clear and functioning well? Are you addressing and solving the emerging problems? Are you recognising and celebrating progress sufficiently?
Managing contingencies	Are you looking for new opportunities and taking them? Are you monitoring resources regularly? Are you looking out for unforeseen circumstances or less than hoped for reactions to the program?
Leadership and innovation	Are you providing enough appropriate (and shared) leadership? What capacity do you need to develop? Are you making similar decisions over and over again? Do you have the political antennae working?

(Source: Based on DHS 2003.)

Specialist implementation skills

One person rarely, if ever, holds all the necessary skills for a mental health promotion program. In a smaller project, you might be left to do all the activities yourself (although you will be surprised how many skills you pick up over time), but a team approach is necessary in larger projects. Specialist skills are critical for multi-level, multi-sector programs. How do you obtain them for your program?

First, if you are taking a collaborative approach, the existence of a partnership among agencies increases the chance of one partner having the necessary skills and experience required for each strategy. You thus need to need to choose your partners with such an eventuality in mind – for example, if you know low English literacy is an issue, then it might be wise to recruit local adult educators to your team.

The second path is to develop training so the relevant staff or partners gain the necessary skills. This is easier in some instances than in others – for example, staff might obtain newsletter production skills more readily than, say, community development skills.

The other most common way of obtaining particular specialist skills is to buy them. This may mean employing temporary staff, such as someone with outdoor education skills to conduct an activity camp with young asthmatic teenagers. Or, it often means contracting another organisation to undertake the work – for example, an advertising agency to run a media campaign.

These three options bypass the need for you to have all necessary expertise, but they do point to the need for management skills.

Step 7: Write up evaluation reports

Finally, your mental health promotion work will be of wider benefit if you can write up your practices and what you and the partnership learned from the program and its processes. Remember, practitioner wisdom comes from people just like you; by sharing your experience, you will be contributing to the growing body of knowledge about the promotion of mental health and wellbeing.

The following are three key elements to consider in your evaluation report:

1. Evidence

Identify the evidence you used to develop your program:

(a) population health data that justified your intervention

(b) program evidence – was it based on evaluations of other programs or practitioner wisdom, or a combination of both?

(c) evaluation evidence – did it work and at what outcome levels?

2. Effectiveness

(a) What key factors and conditions facilitated high quality implementation?

(b) What adaptations did you make in adopting an existing program?

(c) What made your program work?

(d) With whom did you/your organisation work best? Under what circumstances?

3. Dissemination plan

Dissemination of your program findings is one of the most important ways of building the evidence base of which interventions are most effective, for which groups and under which conditions. Dissemination enables the key lessons learned from the program to be shared with other practitioners.

Contingency planning

Program progress may be slower than envisaged, the intended program impact may be less than hoped for, unforeseen circumstances and reactions to the program may occur, and unexpected opportunities may arise. All these contingencies need to be regularly addressed. This monitoring and reacting is sometimes called 'contingency planning', which is a key management skill.

6.3 Useful websites with program planning and evaluation resources

The following resources may provide additional guidance on completing an evaluation plan:

- The Quality Improvement Program Planning System (QIPPS), developed by the Victorian Community Health Association, is software that will assist subscribing organisations to plan and evaluate health promotion programs. Further information can be found at www.qipps.com.
- The Planning and Evaluation Wizard, developed by the South Australian Community Health Research Unit (SACHRU), is available at www.sachru.gov.au/pew/index.htm. This resource assists the user to develop a case for projects, construct project and evaluation plans and write project reports.
- The Northern Territory Government has developed a guide for planning and evaluating health promotion projects. While the guide is aimed at practitioners who work with remote Aboriginal communities, many of its elements apply to other contexts. The guide is available at www.nt.gov.au/health/healthdev/health_promotion/bushbook/volume1/ch4.html. It discusses evaluation planning processes and provides tools for planning and evaluation. Information on the analysis of quantitative and qualitative data is available at www.nt.gov.au/health/healthdev/health_promotion/bushbook/volume1/analyse.html#howto.
- Step-by-step manuals for program evaluation are available at the US Center for Disease Control website (www.cdc.gov/eval/resources.htm).
- The Victorian Department of Human Services Common Planning Framework and evaluation resources are available at www.health.vic.gov.au/healthpromotion/.
- The Health Communications Unit of the Center for Health Promotion at the University of Toronto has developed an excellent guide to evaluating health promotion programs. The guide includes examples and pro formas. In addition, it provides a comprehensive list of evaluation references. This guide is available at www.thcu.ca/infoandresources/

7 References

7 References

Acheson, D 1998, *Independent inquiry into inequalities in health. Report*. The Stationary Office, Great Britain.

Anderson, LM, Shinn, C, Fullilove, MT, Scrimshaw, SC, Fielding, JE, Normand, J, Carande, VG & Task Force on Community Preventive Services 2003, 'The effectiveness of early childhood development programs: a systematic review', *American Journal of Preventive Medicine*, vol. 24, no. 3S, pp. 32–46.

Australian Council of Trade Unions 2003, *Child care background paper*, Melbourne, Available at www.actu.asn.au/congress2003/draftpolicies/.

Australian Department of Health and Aged Care 2000a, *A framework for prevention of suicide and self-harm in Australia: areas for action*, Canberra.

Australian Department of Health and Aged Care 2000b, *Promotion, prevention and early intervention for mental health: a monograph*, Mental Health and Special Programs Branch, Canberra.

Australian Health Ministers (1998). *Second national mental health plan*. Canberra, Australian Government Publishing Service

AIHW (Australian Institute of Health and Welfare) 2002, *Australia's health*, Canberra.

Barker, C, Pistrang, N, Shapiro, DA, Davies, S & Shaw, I 1993, '"You in mind": a preventive mental health television series', *British Journal of Clinical Psychology*, vol. 32, pp. 281–93.

Barlow, J & Coren, E 2002, 'Parent training programmes for improving maternal psychosocial health', *Cochrane Database of Systematic Reviews*, 2003, no. 4.

Barlow, J, Coren, E & Stewart-Brown, S 2001, *Systematic review of the effectiveness of parenting programmes in improving maternal psychosocial health*, Health Services Research Unit, University of Oxford, Oxford.

Beder, H 1999, *The outcomes and impacts of adult literacy education in the United States*, National Center for the Study of Adult Learning and Literacy, Harvard University, Cambridge, Massachusetts. Available at www.gse.harvard.edu/ncsall/research/report6.pdf.

Berkman, LF & Glass, T 2000, 'Social integration, social networks, social support, and health', in Berkman, LF & Kawachi, I (eds), *Social epidemiology*, Oxford University Press, New York, pp. 137–73.

Berkman, LF & Kawachi, I (eds) 2000, *Social epidemiology*, Oxford University Press, New York.

Bosma, H & Marmot, M 1997, 'Low job control and risk of coronary heart disease in Whitehall (prospective cohort) study', *British Medical Journal*, vol. 312, pp. 558–65.

Bunker, S, Colquhoun, DM, Esler, MD, Hickie, I, Hunt, D, Jelineck, VM et al. 2003, 'Stress and coronary heart disease, psychosocial risk factors: National Heart Foundation of Australia: position statement update', *Medical Journal of Australia*, vol. 178, no. 6, pp. 272–6.

Campbell, C, Wood, R & Kelly, M 1999, 'Social capital and health', Health Education Authority, London. Available at www.hda-online.org.uk/downloads/pdfs/socialcapital_health.pdf.

Caplan, RD, Vinokur, AD, Price, RH & Van Ryn, M 1989, Job seeking, reemployment, and mental health: a randomized field experiment in coping with job loss, *Journal of Applied Psychology*, 74, 5, pp 759-769.

Carley, M 2002, *Community regeneration and neighbourhood renewal: a review of the evidence*, Report to Communities Scotland, Edinburgh.

Cave, B, Curtis, S, Aviles, M & Coutts, A 2001, *Health impact assessment for regeneration projects. Volume 11: selected evidence base*, East London and the City Health Action Zone and Health Research Group, Queen Mary, University of London. Available at www.geog.qmul.ac.uk/health/guide.html.

Cleveland, G & Krashinsky, M 2003, *Financing early childhood education and care services in OECD countries*, University of Toronto at Scarborough paper commissioned by the Organisation for Economic Cooperation and Development for the Thematic Review of ECEC Policy, Toronto.

Commonwealth Department of Health and Ageing, 2000, *National Mental Health Report 2000: Sixth Annual Report: Changes in Australia's Mental Health Services under the First National Mental Health Plan of the National Mental Health Strategy 1993–98*, Canberra: Mental Health and Special Programs Branch, Department of Health and Ageing.

Commonwealth of Australia 2003, *National mental health plan 2003–2008*, Canberra, Mental Health and Special Programs Branch, Department of Health and Ageing.

CommunityLIFE 2004, 'About CommunityLIFE', website of resources available at www.community-life.org.au/about.php (accessed 25 March 2004).

Crow, I, France, A, Hacking, S & Hart, M 2004, *Does Communities that Care work? An evaluation of a community-based risk prevention programme in three neighbourhoods*, Joseph Rowntree Foundation, UK. Available at www.jrf.org.uk/bookshop/eBooks/1859351840.pdf.

DHS (Department of Human Services) 2003, *Integrated health promotion resource kit*, Melbourne.

Doherty, G, Rose, R, Friendly, M, Lero, D & Hope-Irwin, S 1995, *Child care: Canada can't work without it*, Occasional paper no. 5, Childcare Resource and Research Unit, available at www.childcarecanada.org/resources/CRRU/pubs.

Donovan, RJ, Francas, M, Paterson, D & Zappelli, R 2000, 'Formative research for mass media based campaigns: Western Australia's freedom from fear campaign targeting male perpetrators of intimate partner violence', *Health Promotion Journal of Australia*, vol. 10, no. 2, pp. 78–83.

Donovan, RJ, Paterson, D & Francas, M 1999, 'Targeting male perpetrators of intimate violence: Western Australia's "Freedom from Fear" campaign', *Social Marketing Quarterly*, vol. 5, no. 3, pp. 128–44.

Duggan, M & Cooper, A (nd), *Modernising the social model in mental health: a discussion paper*, TOPSS, London. Available at www.critpsynet.freeuk.com/duggan.htm.

Eagar, K, Brewer, C, Collins, J et al. 2005, *Strategies for gain – the evidence on strategies to improve the health and wellbeing of Victorian children*, Centre for Health Service Development, University of Wollongong, New South Wales.

Ekeland, E, Heian, F, Hagen, KB, Abbott, J & Nordheim, L 2004, *Exercise to improve self-esteem in children and young people, Cochrane Database of Systematic Reviews*, 2004, no. 1.

Frankish, J, Kwan, B & Flores, J 2002, *Assessing the health of communities: indicator projects and their impacts*, Institute of Health Promotion Research, University of British Columbia, Canada. Available at http://ihpr.ubc.ca.

Freudenberg, N 2000, 'Health promotion in the city: a review of current practice and future prospects in the United States', *Annual Review of Public Health 2000*, vol. 21, pp. 473–503.

Friedlander, D & Burtless, G 1995, *Five years after: the long-term effects of welfare-to-work programs*, Russell Sage Foundation, New York.

Fullager, S & Gattuso, S 2002, 'Rethinking gender, risk and depression in Australian mental health policy', *Australian e-Journal for the Advancement of Mental Health*, vol. 1, no. 3, pp. 2–13.

Garrard, J, Lewis, B, Keleher, H, Tunny, N, Burke, L, Harper, S & Round, R 2004, *Planning for healthy communities: reducing the risk of carviovascular disease and type 2 diabetes through healthier environments and lifestyles*, Victorian Department of Human Services, Melbourne.

Gibbons, L & Paterson, D 2000, 'Freedom from fear campaign against domestic violence: an innovative approach to reducing crime', Paper presented at Reducing Criminality: Partnerships and Best Practice convened by the Australian Institute of Criminology in association with the Western Australian Ministry of Justice, the Department of Local Government, the Western Australian Police Service and Safer WA, Perth, 31 July – 1 August.

Glass, T 2000, 'Psychosocial interventions', in Berkman, LF & Kawachi, I 2000, *Social epidemiology*, Oxford University Press, New York, pp. 137–73.

Gould, MS, Greenberg, T, Velting, D & Shaffer, D 2003, 'Youth suicide risk and preventive interventions: a review of the past 10 years', *Journal of the Academy of Child and Adolescent Psychiatry*, vol. 42, no. 4, pp. 386–405.

Hawkins, JD, Catalano, RF & Arthur, MW 2002, 'Promoting science-based prevention in communities', *Addictive Behaviour*, vol. 27, no. 6, pp. 951–76.

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.

Health Education Board for Scotland 2001, *Mental health improvement: what works?*, Briefing for the Scottish Executive, Edinburgh. Available at www.hebs.scot.nhs.uk/topics/top.

Hill, ME & Augoustinos, M 2001, 'Stereotype change and prejudice reduction: short and long term evaluation of a cross-cultural awareness programme', *Journal of Community and Applied Social Psychology*, vol. 11, pp. 243–62.

Hodnett, ED & Roberts, I 2004, 'Home-based social support for socially disadvantaged mothers', *Cochrane Database of Systematic Reviews*, 2004, no. 4.

Holder, R 2001, *Domestic and family violence: criminal justice interventions*, Australian Domestic and Family Violence Clearinghouse issues paper 3, University of NSW, Sydney.

Homel, R 1999, *Preventing violence – a review of the literature on violence and violence prevention*, Report for the Crime Prevention Division of the NSW Attorney-General's Department, Sydney.

ICESCR (International Committee on Economic, Social and Cultural Rights) 1999, 'The right to education', General comment 13, Geneva. Available online http://www.unhchr.ch/html/menu6/2/fs16.htm

International Labour Organisation 2005, *SafeWork: introduction to violence at work*, Available at www.ilo.org/public/english/protection/safework/violence/intro.htm.

Jane-Llopis, E, Barry, M, Hosman, C & Patel, V 2005, 'Mental health promotion works: a review', *IUHPE – Promotion and Education*, vol. 2, pp. 9–25.

Jane-Llopis, E, Mittelmark, M 2005, Editorial: No health with mental health, *IUHPE – Promotion and Education*, vol. 2, pp. 4-5.

Jermyn, H 2001, *The arts and social exclusion: a review prepared for the Arts Council of England*, Available at www.artscouncil.org.uk/documents/publications/298.doc.

Johnson, D, Headey, B & Jensen, B 2003, *Communities, social capital and public policy: literature review*, Melbourne Institute working paper no. 26/03, University of Melbourne, Melbourne.

Joseph Rowntree Foundation 2000, *Poverty and social exclusion in Britain*, UK. Available at www.jrf.org.uk/knowledge/findings/socialpolicy/930.asp.

Kawachi, I & Berkman, LF 2001, 'Social ties and mental health', *Journal of Urban Health*, vol. 78, no. 3, pp. 458–67.

Kawachi, I, Subramanian, SV, & Almeida-Filho, K 2002, A glossary for health inequalities. *Journal of Epidemiology and Community Health*, 56, pp 647-652.

Keleher, H & Murphy, B 2004, (eds), *Understanding health: a determinants approach*, Melbourne, Oxford University Press.

Kellerman, AL, Fuqua-Whitley, DS, Rivara, FP & Mercy, J 1998, 'Preventing youth violence: what works?', *Annual Review of Public Health*, vol. 19, pp. 271–92.

Krieger, N 2000, 'Discrimination and health', in Berkman, LF & Kawachi, I (eds), *Social epidemiology*, Oxford University Press, New York.

Labonte R 2003, *How our programs affect population health determinants: a workbook for better planning and accountability*, Health Canada, Ottawa.

Lamb, S & McKenzie, P 2001, *Patterns of success and failure in the transition from school to work in Australia*, Longitudinal Surveys of Australian Youth research report no. 18, Australian Council for Educational Research Ltd, Melbourne. Available at www.acer.edu.au/research/projects/lsay/reports/lsay18.pdf.

LaMontagne, AD, Louie, A, Keegal, T, Ostry, A, Shaw, A 2005, *Workplace stress in Victoria: developing a systems approach*, Report to the Victorian Health Promotion Foundation, Melbourne.

Lister-Sharp, D, Chapman, S, Stewart-Brown, S & Sowden, A 1999, 'Health promoting schools and health promotion in schools: two systematic reviews', *Health Technology Assessment*, vol. 3, p. 22.

Macintyre, S & Ellaway, A 2000, 'Ecological approaches: rediscovering the role of the physical and social environment', in Berkman, L & Kawachi, I (eds), *Social epidemiology*, Oxford University Press, New York, pp. 332–48.

Marmot, M & Wilkinson, R 2002, *Social determinants of health: the solid facts*, 2nd edn, World Health Organization, Geneva. Available at www.who.dk/healthy-cities.

Marks, GN & Fleming, N 1998, *Factors influencing youth unemployment in Australia 1980–1994*, Longitudinal Studies of Australian Youth, Australian Council of Educational Research, Melbourne. Available at www.acer.edu.au/research/LSAY/.

McDonald, & O'Hara 1998, cited in 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.

McDonald, P 1998, *Issues in child care policy in Australia*, Australian National University submission to the Senate Community Affairs Committee into Child Care Funding, Canberra.

McQueen, D 2001, 'Strengthening the evidence base for health promotion', *Health Promotion International*, vol. 16, no. 3, pp. 261–8.

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.

Mittelmark, MB 2003, 'Five strategies for workforce development for mental health promotion', *IUHPE – Promotion and Education*, vol. 1, pp. 20–2.

Moodie, R & Jenkins, R 2005, 'I'm from the government and you want me to invest in mental health promotion. Well why should I?', *IUHPE – Promotion and Education*, vol. 2, pp. 27–41.

Mulvihill, M, Mailloux, L & Atkin, W 2001, *Advancing policy and research responses to immigrant and refugee women's health in Canada*, Canadian Women's Health Network, Manitoba.

Mytton, JA, DiGuiseppi, C, Gough, DA, Taylor, RS & Logan, S 2002, 'School-based violence prevention programs: systematic review of secondary prevention trials', *Archives of Paediatric Adolescent Medicine*, vol. 156, pp. 752–62.

National Crime Prevention Council 2004, *The National Crime Prevention Program*, Canberra, Available at www.crimeprevention.gov.au/agd/WWW/ncphome.nsf/Page/National_Crime_Prevention_Program.

National Health and Medical Research Council 1998, *Guidelines for the development, implementation and evaluation of clinical practice guidelines*, Canberra.

Nicholas, B & Broadstock, M 1999, 'Effectiveness of early interventions for preventing mental illness in young people', *New Zealand Health Technology Assessment*, vol. 2, No 3 , pp. 1-127 . Available at http://nzhta.chmeds.ac.nz/ymh.htm.

Nutley, S, Walter, I & Davies, H 2002, *From knowing to doing: a framework for understanding the evidence-into-practice agenda*, Research Unit for Research Utilisation, University of St Andrews, St Andrews, Scotland.

OECD (Organisation for Economic Cooperation and Development) 2004, *Canada: country note – early childhood education and care policy*, OECD Directorate for Education, Paris.

OECD (Organisation for Economic Cooperation and Development) & Statistics Canada 2000, *Literacy in the information age: final report of the International Adult Literacy Survey,* Paris.

Office of Women's Policy 2002, Women's safety strategy: a policy approach. A coordinated approach to reducing violence against women. Victorian Government, Melbourne.

Petticrew, M & Roberts, H 2003, 'Evidence, hierarchies, and typologies: horses for courses', *Journal of Epidemiology and Community Health*, vol. 57, pp. 527–9.

Pettigrew, TF & Tropp, LR 2000, 'Does intergroup contact reduce prejudice? Recent meta-analytical findings', in Oskamp, S (ed.), *Reducing prejudice and discrimination*, Lawrence Erlbaum Associates, Mahway, New Jersey.

Ploeg, J, Ciliska, D, Brunton, G, MacDonnell, J & O'Brien, MA 1999, *The effectiveness of school-based curriculum suicide prevention programs for adolescents*, Ontario.

Poelina, A & Perdrisat, I 2004, *A report of the Derby/West Kimberly project: working with adults to prevent domestic violence*, Australian Attorney-General's Department, Canberra.

Price, R, Van Ryn, M & Vinokur, A 1992, Impact of a preventive job search interventionon the likelihood of depression among the unemployed, *Journal of Health and Social Behaviour*, 33, pp 158-167.

Price, RH & Vinokur, AD 1995, Supporting career transitions in a time of organizational downsizing: The Michigan JOBS Program. In M. London (ed), *Employees, careers, and job creation: developing growth-oriented human resource strategies and programs*, San Francisco, CA, Jossey-Bass, pp 191-209.

Price, RH 2003, Understanding and improving the mental health of populations, In House, JS, Kahn, RL, Juster, FT, Schuman, H & Singer, E, (eds), *Telescope on society: survey research and social science at the University of Michigan and beyond*. Ann Arbor, Michigan, The University of Michigan Press.

Puska, P & Vartiainen, E 1999, Health Challenges 1: health disease, the lifestyle killer. *The Evidence of health promotion effectiveness: shaping public health in a new Europe, Part Two, Evidence Book*. A Report for the European Commission by the International Union for Health Promotion and Education. Luxembourg, pp 55-68

Putnam, R 2001, 'Social Capital; measurement and consequences', *Canadian Journal of Policy Research*, vol. 1, no. 2, pp. 41-51.

Rahmani, Z, Crosier, T & Pollack, S 2002, *Evaluating the impact of the Literacy and Numeracy training programme for job seekers*, Australian Department of Education, Science and Training, Canberra.

Ralph A & Saunders MR 2004 The *'Teen Triple P' Positive Parenting Program: a preliminary evaluation.* Trends in crime and Criminal Justice No 282, Australian Institute of Criminology, Canberra.

Reidpath, D 2004, 'Social determinants of health', in Keleher, H & Murphy, B (eds), *Understanding health: a determinants approach*, Oxford University Press, Melbourne.

Rigby, K 2002, *A meta-evaluation of methods and approaches to reducing bullying in pre-schools and early primary school in Australia*, Report for the Australian Attorney-General's Department, Canberra.

Rootman, I 2002, *Literacy and health research workshop: setting priorities in Canada.* Available at www.nlhp.cpha.ca/clhrp/wrkshp_e wrkshpre.pdf.

Rootman, I & Ronson, B 2002, *The National Literacy and Health Program (Canada).* Available at www.nlhp.cpha.ca/.

Rychetnik, L & Todd, A 2004, *Literature review to follow on from VicHealth's 1999-2002 mental health promotion framework: final report*, Sydney Health Projects Group, School of Public Health, Sydney University, Sydney.

Salmon, P 2001, 'Effects of physical exercise on anxiety, depression, and sensitivity to stress: a unifying theory', *Clinical Psychology Review*, vol. 21, no.1. pp. 33–61.

Salvaris, M, Burke, T, Pidgeon, J & Kelman, S 2000, *Social benchmarks and indicators for Victoria*. Consultants report for the Victorian Department of Premier and Cabinet by the Institute for Social Research, Swinburne University of Technology, Melbourne.

Sanders, MR 2003. 'Triple P Positive Parenting Program: a population approach to promoting competent parenting', *Australian e-Journal for the Advancement of Mental Health*, vol. 2, no. 3, pp. 1–17.

Sanders, MR, Markie, C & Turner, KMT 2003, *Theoretical scientific and clinical foundations of the Triple P Positive Parenting Program: a population approach to the promotion of parenting competence*, Parenting Research and Practice monograph no, 1, The Parenting and Family Support Centre, University of Queensland, Brisbane.

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.

Sen, A 1999, *Development as freedom*, Oxford University Press New York, pp. 87–110.

Steering Committee for the Evaluation of the Second National Mental Health Plan 1998–2003 2003, *Evaluation of the second national mental health plan*, Prepared for the Australian Health Ministers' Advisory Council, Commonwealth of Australia, Canberra.

Stevens, V, DeBourdeadjuij, I & van Ooost, P 2001, 'Anti-bullying interventions at school: aspects of programme adaption and critical issues for further programme development', *Health Promotion International*, vol. 16, pp. 155–7.

Stone, W 2001, *Measuring social capacity: towards a theoretically informed measurement framework for researching social capital in family and community life*, Research paper no. 24, Australian Institute of Family Studies, Melbourne.

Strategic Partners Pty Ltd 2000, *Domestic violence prevention: strategies and resources for working with young people*, Partnerships against Domestic Violence, Commonwealth of Australia, Canberra.

Strawbridge, W, Deleger, S, Roberts, R & Kaplan, G 2002, 'Physical activity reduces the risk of subsequent depression for older adults', *American Journal of Epidemiology*, vol. 156, no. 4, pp. 328–34.

Taft, A. (2003) Promoting Women's Mental Health: The Challenges of Intimate/Domestic Violence Against Women, Issues Paper No. 8, Australian Domestic and Family Violence Clearinghouse, Sydney, University of NSW.

Task Force on Community Preventive Services 2003, 'Recommendations to promote healthy social environments', *American Journal of Preventive Medicine*, vol. 24, no. 3S, pp. 21–4.

Taub, A 2001, 'Reviewing evidence on the effectiveness of health education: methodological considerations', Paper presented at the Second International Symposium on the Effectiveness of Health Promotion, Toronto, Canada, May.

Thomson, H, Petticrew, M & Douglas, M 2003, 'Impact assessment of housing improvements: incorporating evidence', *Journal of Epidemiology and Community*, vol. 57, pp. 11-16.

Thomson, H, Petticrew, M & Morrison, D 2001, 'Health effects of housing improvement: systematic review of intervention studies', *British Medical Journal*, vol. 323, pp. 187–90.

Tilford, S, Delaney, F & Vogels, M 1997, *Effectiveness of mental health promotion interventions: a review*, Health Education Authority, UK Department of Health, London.

Tones, K 1997, 'Beyond the randomized controlled trial: a case for a judicial review', *Health Education Research*, vol. 12, pp. 1–4.

Toumbourou, JW 1999 'Implementing Communities That Care in Australia: A community mobilisation approach to crime prevention', *Trends & Issues in Crime and Criminal Justice.* No. 122, July, pp1-6.

Turrell, G, Oldernburg, B, McGuffog, I & Dent, R 1999, *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda*, Brisbane, School of Public Health, Queensland University of Technology.

US Department of Health and Human Services 2002, *Physical activity fundamental to preventing disease*, Office of the Assistant Secretary for Planning and Evaluation. Washington DC.

VicHealth 1999, *Mental health promotion plan 1999–2002*, Victorian Health Promotion Foundation, Carlton South.

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

VicHealth 2003, *Promoting young people's mental health and wellbeing through participation in economic activities – key learnings and promising practices*, Victorian Health Promotion Foundation, Carlton South.

VicHealth 2004a, *The health costs of violence: measuring the burden of disease caused by intimate partner violence*, Victorian Health Promotion Foundation, Carlton South.

VicHealth 2004b, *Mental health promotion in new arrival communities: learnings and promising practices*, Victorian Health Promotion Foundation, Carlton South.

VicHealth 2005a, *Mental health and wellbeing research summaries 1–4*, Victorian Health Promotion Foundation, Carlton South.

VicHealth 2005b, *A plan for action 2005–2007: promoting mental health and wellbeing*, Victorian Health Promotion Foundation, Carlton South.

Vinokur, A, Van Ryn, M, Gramlich, E & Price, R 1991, long-term follow-up and benefit-cost analysis of the Jobs Program: a preventive intervention for the unemployed, *Journal of Applied Psychology*, 76 (2), pp 213-219.

Vinson, T. (1999). *Unequal in Life*. Ignatius Centre, Jesuit Social Services, Melbourne Available at www.jss.org.au.

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

Young, M, Byles, J & Dobson, A 2000, 'The effectiveness of legal protection in the prevention of domestic violence in the lives of young Australian women', *Trends and Issues in Crime and Criminal Justice*, no. 148, Australian Institute of Criminology, Canberra.

Walker, L, Verins, I, Moodie, R & Webster, K 2005, Responding to the social and economic determinants of mental health: a conceptual framework for action, In Herrman, H, Saxena, S & Moodie, R (eds). *Promoting Mental Health Concepts, Emerging Evidence, Practice: a report of the World Health Organisation*, Geneva, World Health Organisation.

Waring, T & Hazell, T 2002, *Evaluation of MindMatters: third interim report*, Hunter Institute of Mental Health, New South Wales.

Wathen, CN & MacMillan, HL 2003, 'Interventions for violence against women: scientific review', *Journal of the American Medical Association*, vol. 289, no. 5, pp. 589–600.

Weiss, B 2005, Epidemiology of low health literacy, In Schwartzberg, JG, VanGeest, JB & Wang, CC, Understanding health literacy: implications for medicine and public health, American Medical Association, AMA Press.

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.

Williams, DR, Neighbors, HW & Jackson, JS 2003, 'Racial/ethnic discrimination and health: findings from community studies', *American Journal of Public Health*, vol. 93, no. 2, pp. 300–308.

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.

Woolcock, M 2001, 'The place of social capital in understanding social and economic outcomes', *Canadian Journal of Policy Research*, vol. 2, no 2, pp. 11-17.

WorkSafe Victoria 2003, *Prevention of bullying and violence at work: guidance note*, Melbourne. Available at www.workcover.vic.gov.au/vwa/publica.nsf/.

World Health Organisation 1986, *Ottawa Charter for health promotion*. World Health Organisation, Geneva.

World Health Organisation 1998, *Health promotion glossary of the World Health Organisation*, Geneva. Available at www.who.int/hpr/backgroundhp/glossary/glossary.pdf.

World Health Organisation 2001, *World health report: mental health: new understanding, new hope*, Geneva.

World Health Organisation 2002, *World report on violence and health*, Geneva. Available at www.who.int/violence_injury_prevention.

World Health Organisation 2003, *Investing in mental health*, Geneva

World Health Organisation 2005, 'Benefits of physical activity' information sheet, Geneva, Available at www.who.int/moveforhealth/advocacy/information_sheets/benefits/en/index.html (accessed 31 March 2005).

Wyn, J, Cahill, H, Holdsworth, R, Rowling, L & Carson, S 2000, 'MindMatters, a whole-school approach promoting mental health and wellbeing', Australian and New Zealand Journal of Psychiatry, vol. 34, pp. 594–601.

Appendices

Appendix A: Review methods

Introduction

The preparation and publication of research and development reviews is commonly undertaken to develop knowledge and improve practice. Systematic reviews are reviews that are conducted with particular approaches that seek to minimise bias and error in the synthesis of a body of literature to draw conclusions and make recommendations. They are characterised by methods of systematic appraisal and summary according to an explicit and reproducible method, and may have narrow or broad criteria for the inclusion of interventions. Study designs may be based on decisions that quasi-experimental studies are the minimum acceptable standard of evidence but, as discussed in this section, such studies may not be available in the field of health promotion or may not be ethically or technically feasible.

The reviews of evidence here are informed by systematic review methods, but our aim has been to collate relevant studies that have used a broad range of methods, so as to develop a practitioner friendly resource. For this reason, we have made a considerable effort to track down published and unpublished studies. The resource is intended to be accessible in style, to make research available to practitioners, service users and policy makers.

Reviews of any form of health promotion evidence are complex. The search terms used in search engines are not necessarily compatible with health promotion language. This problem is illustrated by Taub's (2001) attempt to conduct a systematic review of health education literature, which was thwarted by the breadth of the topic and search limitations, and because health promotion is a poorly indexed concept. Reviews of mental health promotion interventions are thus also likely to be problematic, necessitating resourceful search strategies to overcome the limitations of search indexes.

In response to these limitations, we employed a range of strategies, including:

- focusing initially on three specific areas of mental health promotion: social isolation, freedom from discrimination and violence, and access to economic resources
- identifying systematic reviews of particular significance to the mental health promotion workforce
- using an international expert committee to inform the review
- actively exploring fields of relevance to mental health promotion as the evidence based emerged.

The following section outlines the method used to search for mental health promotion interventions. Some material included in this section is relatively technical but necessary to explain the approaches used to develop the resource and to describe some of the difficulties encountered.

Selecting reviews for this resource

Study selection

Initially, the search focused on systematic reviews of evidence. Where possible, searches were limited to 'reviews'. While this approach may include narrative reviews, it is an effective search strategy. We also used a systematic review filter (see 'Search strategy') where relevant and where databases would allow this function.

We included reviews if they:

- contained primary research or were reviews of primary research
- were published after 1998
- focused on one or more of the review foci (social isolation, freedom from discrimination and violence, and access to economic resources).

We excluded reviews if they:

- included poorly evaluated evidence
- focused on treatment rather than prevention.

We aimed to include the best available evidence. That is, we searched for systematic reviews that summarised good quality interventions. While randomised controlled trials are the most rigorously evaluated interventions, they are not always the most appropriate study design for health promotion. In some cases, it may be unethical to randomise a study; in other cases, the cost of a randomised controlled study may be prohibitive. Observational studies have thus been more commonly conducted to address mental health promotion. It is important to note that some systematic reviews do not include these types of intervention. We were committed, therefore, to a multi-strategic searching process that would identify the best available, most appropriate evidence.

Internal study selection process

A range of research groups have developed approaches to assess the quality of qualitative systematic reviews. Elements of the work conducted by the Centers for Disease Control and Prevention, Rychetnik and Frommer (the National Public Health Partnership) and Guyatt (the National Heart Foundation) were used to assess the quality of reviews included in this resource. This process was based on the criteria developed by the Deakin University team who worked on a review of cardiovascular disease and diabetes for the Department of Human Services (Garrard et al. 2004). The following three selection procedures were applied:

1. Selection criteria were applied by two reviewers to reviews identified in the final search.
2. Any discrepancies were discussed. Both criteria for inclusion/exclusion and quality were considered.
3. Additional studies and reviews identified through grey literature or expert committee were then considered as described above.

Expert review panel

A panel of experts was appointed to provide advice, identify published and unpublished literature and review a full draft of the resource. Each expert was consulted individually in late 2003 and asked to provide feedback on the following questions:

- What body of evidence are you most familiar with?
- Have you been involved in any systematic reviews?
- What systematic reviews are you familiar with?
- What grey literature sources are you familiar with?
- What promising strategies not yet evaluated are you aware of?
- Are you aware of any other innovative, successful interventions?

Once we developed a final draft of the resource, we sent it to the experts and representatives from VicHealth and the Department of Human Services to consider the evidence included and highlight gaps, based on their professional expertise.

Data sources

A critique of methods of systematic reviewing health education literature identified Medline, PsychInfo and EMBASE as the most appropriate data sources. These sources' level of indexing is more sophisticated than that of others, so more likely to identify the appropriate literature (Taub 2001). We searched using Medline and PsychInfo (because Deakin University has access to these databases) but also:

- the Cochrane Library (including the Database of Abstracts of Reviews of Effectiveness)
- CINAHL
- APAIS-Health
- AMI on Nursing and Allied Health.

Interestingly, few of the included reviews were identified through the electronic databases. The Internet (and grey literature sources) were thus an invaluable tool. We relied heavily on Google, a well respected Internet search engine (www.google.com). We also accessed websites and databases to identify unpublished literature. These sources included:

- the Centers for Disease Control and Prevention – www.thecommunityguide.org
- the City of Hamilton's Effective Public Health Practice Project – www.city.hamilton.on.ca
- the Karolinska Institute – www.phs.ki.se/hprin/evidence
- VicHealth – www.vichealth.vic.gov.au
- the Australian Department of Health and Ageing – www.health.gov.au
- the Victorian Department of Human Services – www.dhs.vic.gov.au
- the Campbell Collaboration – www.campbellcollaboration.org/

Search strategy

We conducted a separate search for each determinant of mental health, then added these terms to the health promotion/prevention terms and the study descriptor terms. This search strategy was an iterative process: several term categories were added as the review process developed. This approach was necessary due to the limitations of the electronic databases and indexing.

The terms listed in the following table are a combination of MeSH terms and text words used in the range of databases. Both truncation and boolean operators were applied where relevant.

Category	Search terms
Social connectedness/social isolation	Social inclusion
	Social isolation
	Social justice
	Social alienation
	Social environment
	Social involvement
	Social perception
	Social identification
	Social adjustment
	Social cohesion
	Social capital
	Social distance
	Civic engagement
	Self determination
	Personal autonomy
	Self-concept (includes self-efficacy)
	Hopelessness
	Self-esteem
	Self-control
	Inequalities
	Socioeconomic factors

Discrimination and violence	Violence (domestic violence, collective violence)
	Torture
	Trauma (and traumatic)
	Abuse
	Discrimination
	Prejudice
	Gender bias (bias, gender)
	Racism
	Sex bias
	Sexism
	Social discrimination
	Sex discrimination
Economic participation	Work
	Workplace
	Employment/unemployment
	Career mobility
	Occupation
	Education
	Educational status
	Housing
	Economic
	Economic participation
	Income

Following this initial search, it became clear that we needed to address other issues, including suicide prevention and literacy (both mental health and educational literacy). As a result, the following additional search terms were included.

Category	Search terms
Mental health literacy	Mental health literacy
Literacy (educational)	Literacy Adult education Adult literacy
Suicide prevention	Suicide Prevention

Additional search terms were used to identify reviews of effective mental health promotion interventions. They included 'effective(ness)', 'success(ful)', 'mental health promotion', 'intervention(s)', 'implementation' and 'evaluation'. These were then entered into Internet search engines.

Data extraction

Tables were designed to extract the most relevant data. They were used to identify key emerging themes and to highlight study foci. Key headings included 'Study', 'Interventions', 'Outcome effects', 'Comments' (related to quality/methodology, generalisability) and 'Author recommendations'.

Limitations

As outlined, searching for evidence of intervention effectiveness is less well understood in health promotion than in areas of clinical medicine. As a result, electronic databases are not yet designed to search for this literature in an effective manner. The primary issue is that subject headings for the social sciences are limited. While a subject heading for 'mental health' is present in Medline, all subheadings relate to clinical psychology and psychiatry. As such, this is a large subject heading and may not assist in narrowing a search. At the time of writing even 'health promotion' has only one subheading: 'healthy people programs'. That is, the subject headings do little to adequately describe the complexity of subjects in which we were most interested. From an indexing point of view, the breadth and depth of the social sciences make it difficult to categorise material into index areas. Further, some databases do not provide an indexing facility, so a reliance on text words is necessary. This process is time consuming and much more difficult to ensure a comprehensive review of the literature is conducted. There is thus potential for systematic reviews to have been missed. Given the breadth and depth of the search, however, and the involvement of mental health promotion experts, we assume that the key reviews and promising interventions have been identified.

This resource discusses important limitations related to the interventions described. Further details about the limitations of individual studies should be sought from the original source.

Appendix B: 10 health promotion action areas

The Ottawa Charter for Health Promotion (World Health Organisation 1986) and the Jakarta Declaration for Health Promotion (World Health Organisation 1997) have provided 10 areas in which action should be taken to promote health.

The Ottawa charter set out the first five action areas:

1. Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches, including legislation, fiscal measures, taxation and organisational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing those obstacles. The aim must be to make the healthier choice the easier choice for policy makers as well.

2. Create supportive environments

Our societies are complex and interrelated, so health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance – that is, to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasised as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. And the way in which society organises work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanisation – is essential and must be followed by action to ensure a positive benefit to public health. Any health promotion strategy must address the protection of the natural and built environments and the conservation of natural resources.

3. Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, whereby they own and control their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This process requires full and continual access to information, learning opportunities for health, and funding support.

4. Develop personal skills

Health promotion supports personal and social development by providing information, educating about health and enhancing life skills. By doing so, it increases the options available to people to exercise more control over their own health and environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This enablement has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

5. Re-orient health services towards primary health care

Individuals, community groups, health professionals, health service institutions and governments share the responsibility for health promotion in health services. They must work together towards a health care system that contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services also need to embrace an expanded mandate that is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environments.

The Jakarta declaration added the following action areas:

6. Promote social responsibility for health

Policies and practices should be pursued that: avoid harming the health of other individuals; protect the environment and ensure sustainable use of resources; restrict production and trade in inherently harmful goods and substances; safeguard both the citizen in the marketplace and the individual in the workplace; and include equity focused health impact assessments as an integral part of policy development

7. Increase investments for health development to address health and social inequities

Increasing investment for health development requires a truly multi-sectoral approach, including additional resources to education and housing as well as the health sector. Investments for health should reflect the need to address health and social inequities, focusing on groups such as women, children, older people, Indigenous people, those in poverty and marginalised populations.

8. Consolidate and expand partnerships for health

Health promotion requires health and social development partnerships among the different sectors at all levels of governance and society. Existing partnerships need to be strengthened and the potential for new partnerships must be explored. Partnerships offer mutual benefit for health through the sharing of expertise, skills and resources.

9. Strengthen communities and increase community capacity to empower the individual

Key strategies at a community level are:

- strengthening advocacy through community action, particularly through groups organised by women
- enabling communities and individuals to take control over their health and environment through education and empowerment
- building alliances for health and supportive environments to strengthen the cooperation between health and environmental campaigns and strategies
- mediating between conflicting interests in society to ensure equitable access to supportive environments for health
- improving the capacity of communities for health promotion, which requires practical education, leadership training, and access to resources
- empowering individuals, which demands more consistent, reliable access to the decision-making process and the skills and knowledge essential to effect change
- re-orienting health services, which requires stronger attention to health research and changes in professional education and training. This must lead to a change of attitude and organisation of health services, refocusing on the total needs of the individual as a whole person.

10. Secure an infrastructure for health promotion

Governments are the stewards of the health of populations. They have a responsibility to establish a strong infrastructure for public health that includes a funded commitment to health promotion. 'Settings for health' represent the organisational base of the infrastructure required for health promotion. New health challenges mean that health and non-health organisations need to be able to respond effectively, so new and diverse networks need to be created to achieve intersectoral collaboration. Training in, and practice of, local leadership skills should be encouraged to support health promotion activities.

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