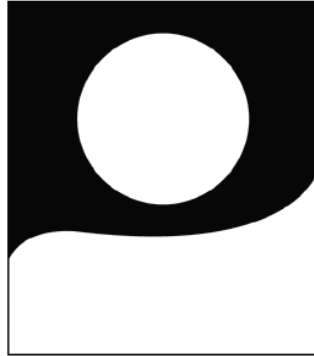


Mental Health Promotion Feasibility Study

for



**mental health
association
nsw inc**

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Members of the Feasibility Study Reference Group provided valuable feedback at key stages of the study.

While the views of all those consulted and the feedback from the Feasibility Study Reference Group was carefully considered the authors take responsibility for the final report.

Abbreviations

A3	Aspire Achieve Affect program
AOD	Alcohol and Other Drugs
ABS	Australian Bureau of Statistics
AMS	Aboriginal Medical Service
ANOP	Australian National Opinion Poll
ARAFMI	Association of Relatives and friends of the Mentally Ill
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse
CAP	Community Awareness Program
CDHAC	Commonwealth Department of Health and Aged Care
CAMHS	Child and Adolescent Mental Health Service
CEO	Chief Executive Officer
COPMI	Children of Parents with Mental Illness
CRS	Commonwealth Rehabilitation Service
CWA	Country Women's Association
DV	Domestic Violence
EIP	Early Intervention Program
FTE	Full Time Equivalent
GP	General Practitioner
IUHPE	International Union of Health Promotion and Education
MMEC	Mind Matters Evaluation Consortium
NAIDOC	National Aboriginal and Islander Day of Celebration
NESB	Non-English Speaking Background
NGO	Non-government organisation
NHMRC	National Health and Medical Research Council
PADV	Partnerships Against Domestic Violence
PCYC	Police Citizens Youth Club
PPEI	Promotion, Prevention and Early Intervention
RORRT	Reach Out! Rural and Regional Australia Tour
SBS	Special Broadcasting Service
SES	Socio-economic status
SF-36	Short Form 36
TWDB	Together we do better

1 Executive summary

This report details the findings of a feasibility study to determine if a state-wide mental health promotion campaign in NSW could be an effective and efficient strategy towards improving mental health and wellbeing.

Mental health promotion encompasses a broad range of activities that aim to influence the social, physical, economic, educational and cultural environments that underpin wellbeing and enhance the knowledge, skills and efficacy of individuals and communities. Mental health promotion activities or interventions may also reduce the risk of developing mental illness or disorders, through increasing emotional and social wellbeing. Addressing health inequalities is an integral part of effective health promotion. Health promotion campaigns that do not consider equity issues may exacerbate the gap between those with relatively good health and those most disadvantaged with worst health outcomes.

The feasibility study consisted of a review of the Australian and international literature on population based mental health promotion campaigns, general health promotion campaigns in Australia to assess the evidence base for health promotion campaigns, and interviews with key informants.

Literature review

Campaigns and programs considered in the review reflect a diversity of approaches. They range from social marketing mass media campaigns, community development initiatives, regional, and settings-based campaigns, campaigns and programs directed towards specific Indigenous, ethnic and geographic communities, and multi-strategic approaches. Systemic reviews of mental health and other health promotion campaigns were also included in the literature review.

Mental health population-based campaigns / programs broadly focussed on de-stigmatising mental illness; addressing discrimination against people with mental illness; promoting wellbeing and resilience, and developing coping skills; addressing specific mental health problems such as depression, schizophrenia, self harm and suicide; and addressing the social determinants of health.

General health promotion campaigns broadly focused on promoting healthy lifestyles; promoting healthy environments and improving safety; reorienting health and community services; disease prevention; and preventing violence.

Where possible the review examined the type of campaign, campaign message, target group, campaign duration, types of media used and other strategies to support the campaign, methodology used to evaluate the campaign, evaluation results and lessons learned.

Overall, there is a paucity of evidence from well-conducted randomised controlled trials, the “gold standard” of evidence-based interventions. Nevertheless there is evidence of the effectiveness of health promotion campaigns / programs, such as media campaigns in conjunction with appropriate community activities around mental health literacy, and strategies that strengthen social supports and community resiliency.

Interviews with key informants

Interviews with key informants were conducted in order to assess the perceived need for a campaign, identify the priority issues that could be addressed, and the contextual issues and resource capacity in NSW that may influence the effectiveness of a state-wide campaign.

Nearly all key informants expressed strong support for a state-wide strategy for mental health promotion and in particular for a multidimensional, carefully targeted, approach to promoting social and emotional wellbeing. Such a strategy would need to be inclusive and involve people from a range of sectors in its development eg, rural, remote and urban areas, Aboriginal and Torres Strait Islanders, CALD groups, consumers and carers. There was support for a broad based umbrella campaign but with an emphasis on the needs of different groups and communities and flexibility about how differing needs could be addressed.

The priority issues for a campaign or program as identified by the key informants included:

- Strengthening social supports/social capital
- Addressing social determinants
- Reducing stigma / normalising mental health and increasing mental health / drug / alcohol literacy
- Promoting wellbeing and coping skills
- Addressing specific mental health and associated problems such as stress, substance abuse.

Characteristics of effective health promotion campaigns

The literature and key informants identified the following characteristics of effective health promotion campaigns:

- Multi-strategic and multi-level campaigns
- Well-designed and thorough formative research
 - Culturally, geographically, and age appropriate messages
 - Strong, simple, memorable messages
- Specificity of program design and strategies for target audiences
- Adequate investment and commitment
 - Funding
 - Infrastructure
 - Time
- Consultation and partnerships at all levels
- Well-designed evaluation - process, impact and outcome
- A strengths based approach
- Focus on communities at risk rather than individuals at risk
- Community ownership of issue and interventions
- Adequate time for preparation, consultation, trust building, implementation and evaluation
- Supported by legislation, environmental changes
- Long-term investment is required especially when the focus is addressing inequities in health and the effects of social disadvantage.

Social disadvantage

A study mapping social disadvantage to specific geographic areas shows that a disproportionate amount of long term and inter-generational social disadvantage is concentrated in a relatively small number of postcode areas in rural and urban regions (Vinson 2004). This study provides critical information for the development of a controlled trial of a health promotion campaign to improve mental health and wellbeing by strengthening social capital and community resilience in socially disadvantaged areas. This approach would directly address health and social inequalities and also strengthen the evidence base for mental health promotion.

Proposed mental health promotion strategy

It is envisaged that a multi-strategic mental health promotion campaign / initiative would be implemented over a five-year period and would include specific strategies focusing on culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander communities, and other groups that experience discrimination or social disadvantage eg, gay and lesbian youth, people with disabilities, refugees and unemployed people. It would necessitate the formation of broad partnerships and involve meaningful community consultation, participation and ownership. It would be modelled on past campaigns and community development approaches that have been shown to be effective. It would have a strong research and evaluation base and its two main components would be community development initiatives in socially disadvantaged communities supported by a social marketing mass media campaign.

Community development component: A five-year controlled trial of a community development initiative to increase social capital and community resilience and improve emotional and mental wellbeing in two urban and two rural areas identified to be significantly disadvantaged. One or two urban and rural communities, that have also been identified as significantly disadvantaged, would be used as controls. The intention would be to expand the strategy after three years if it is shown to be initially successful. It would include:

- A baseline household survey in the intervention and control communities to assess emotional and mental wellbeing (eg, SF-36 or other validated mental health survey instrument), social capital,

social cohesion, community connectedness, safety and capacity to participate, and access to services

- Formation of strong partnerships across community organisations and with residents building a broad-based coalition consisting of community leaders, professionals and citizens to support the change process
- Consultation with the community about the results of the baseline research and follow-up surveys and the most appropriate community development initiatives to be implemented over the life of the project
- Flexibility to change, adapt and add to the initial community development initiatives as required
- Follow-up household surveys at three and five years.

Social marketing component: A state-wide social marketing campaign, that will provide an umbrella mass media campaign in support of the community development component to:

- Increase social capital and community resilience
- Increase community participation especially for disadvantaged or marginalized groups
- Improve mental and emotional wellbeing, and
- Promote practices opposing discrimination and violence.

It is envisaged that there would be four to five advertising phases, addressing different aspects of the campaign, over a five-year period. It would include:

- Baseline and follow-up telephone population surveys monitoring emotional and mental wellbeing, social capital, social cohesion, community connectedness, safety and capacity to participate
- Formative research and design of campaign materials for each phase of the campaign
- Two follow-up telephone surveys per phase of the advertising campaign. One mid advertising phase to check reach, direction and impact, and one post advertising phase to assess outcomes.

The social marketing campaign would be coupled with the community development component and provide a supportive context for it. This approach would increase the campaign reach to the whole of NSW and allow a comparison of the relative effectiveness of the stand alone social marketing strategy compared to the combined approach in the community development intervention communities.

Costs

It is estimated that a regional community development strategy along the lines of the *Villawood Icebreaker* program would cost approximately \$60,000 per year for each intervention community. This would provide sufficient funds of \$40,000 per year to employ a part time community development project worker and approximately \$20,000 per year for community development activities. In addition funding of \$45,000 for the baseline and two follow-up community surveys in each intervention and control community would be required.

A print, radio, cinema and website mass media campaign along the lines of the *Together we do better* campaign would additionally cost approximately \$1.32 million per year. This comprises approximately \$200,000 for research and evaluation, \$220,000 for strategy development and campaign materials \$900,000 advertising costs. The cost would be significantly higher if TV advertising was used.

If there are not sufficient funds for both components then it is recommended that the community development component should be implemented alone. The social marketing component should only be implemented in conjunction with the community development component, as there is little evidence for the effectiveness of social marketing campaigns alone.

Conclusion

The proposed mental health promotion strategy, incorporating both community development and social marketing components, is recommended because it has a number of advantages:

- There is already significant evidence of the effectiveness of a social marketing campaign along the lines of the *Together we do better* campaign and of a community development strategy modelled on the *Villawood Icebreaker* project
- There are possible cost savings to be made as much of the formative research and development of campaign materials has been done
- A state-wide social marketing campaign would increase the campaign reach to the whole of NSW and allow a comparison of the relative effectiveness of the stand alone social marketing strategy compared to the combined approach in the community development intervention communities
- The community development component has the advantage that it is cost effective and focuses on the most disadvantaged areas. If it is proven to be effective it will significantly strengthen the evidence base for mental health promotion and can be extended to other communities across NSW
- The social marketing component both provides a campaign context within which the specific community development projects can operate and also connects to other state-wide approaches such as the Premier's Department *Strengthening Communities* initiatives, *Families First*, etc.

2 Background

The Ottawa Charter for Health Promotion (WHO 1986) and the Jakarta Declaration (WHO 1997) outlined the key principles for health promotion. These are:

- Building healthy public policy (emphasising the role of all sectors in health outcomes)
- Creating supportive environments in all settings
- Strengthening community action
- Developing personal skills
- Reorientating services towards promotion, prevention and early intervention
- The need for evidence-based approaches to mental health promotion.

2.1 Mental Health Promotion in NSW

Mental Health promotion has been on the agenda in NSW since the release of *Mental health promotion in NSW: Conceptual framework for developing initiatives* (1997). This document drew on work undertaken in the United Kingdom, United States and Canada and the National Health and Medical Research Council's report *Scope for Prevention in Mental Health* (Raphael 1993). The conceptual framework provided a planning tool to assist with the identification of issues, risk and protective factors and the development of interventions.

NSW Health's policy framework for mental health *Caring for Mental Health: a Framework for Mental Health Care in NSW* (1998) outlines six key strategic directions for mental health in NSW. Strategic direction No. 3 - Mental health promotion, prevention and early intervention - includes the following strategies.

- Mental health promotion and prevention programs
- Prevention of depression and related disorders
- Suicide prevention
- Prevention of conduct disorders, aggressive and anti-social disorders and consequences of violence
- Early intervention.

A number of policies and strategic frameworks supporting Caring for Mental Health were developed for specific target groups or mental health issues. The following documents include a focus on mental health promotion and prevention strategies.

- Caring for Older People's Mental Health (1998)
- Suicide: We can all make a difference. NSW Suicide Prevention Strategy – Whole of Government Approach (1999)

- NSW Strategy: Making Mental Health Better for Children and Adolescents (1999)
- Getting in early: A Framework for Early Intervention and Prevention in Mental Health for Young People in New South Wales (2000)
- Prevention Initiatives for Child and Adolescent Mental Health, NSW Resource document (2000)
- Family Help Kit (2002).

In 2003 NSW Health published a series of brochures packaged as *Improving Mental Health and Well-Being in NSW* about the promotion, prevention and early intervention initiatives that have taken place in NSW. The titles in the series include:

- Improving mental health and well-being in NSW
- Integrated Perinatal and Infant Care (IPC)
- NSW Parenting Program for Mental Health
- NSW School-Link Initiative
- Children of parents with mental illness
- NSW Early Psychosis Program
- Suicide Prevention in NSW.

The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)¹ has recently been funded the Centre for Mental Health to develop a Promotion, Prevention and Early Intervention (PPEI) Strategic Plan for NSW. An Advisory Committee will be established to steer the development of the Plan and members of the committee will consult with key partners and stakeholders. The Plan will continue with the Centre for Mental Health's Population Health approach to PPEI and build on existing key initiatives across NSW (Auseinet, 2004).

¹Auseinet is a national project funded by the Australian Department of Health and Ageing under the Mental Health Strategy and the National Suicide Prevention Strategy.

2.2 National Mental Health Promotion Framework

The *Second National Mental Health Plan* (1998) focussed on three key priority areas, the first of which was mental health promotion and illness prevention. The framework used to guide illness prevention was a modified form of the threefold typology of universal, selective and indicated preventive measures as proposed by Mrazek and Haggerty (1994). **Universal preventive measures** refer to strategies targeting the whole population or population groups, whereas **selective preventive measures** are those aimed at groups or individuals identified as being asymptomatic but at risk of developing mental illness.

Indicated preventive measures are those targeted at people with early symptoms and defined as high risk in terms of developing more severe mental illnesses. The Plan proposes the development of strategies aimed at building resilience and enhancing coping mechanisms for dealing with stresses across the lifespan, especially at points of transition. This included projects in educational settings, anti-bullying and protective behaviours campaigns and life stage programs aimed at improving parenting skills, promoting healthy workplaces, preparing for retirement, and healthy ageing.

The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* (known as *Action Plan 2000*) outlines a strategic framework and plan for action to address the promotion, prevention and early intervention priorities and outcomes outlined in the Second National Mental Health Plan. It contains strategies to promote mental health, to reduce mental health problems and mental disorders through enhancing protective factors and reducing risk factors, and to intervene as early as possible to minimise the impact of the symptoms of mental health problems. There are specific strategies for the whole of community, groups across the lifespan, cultural groups, rural and remote communities, consumers, carers and health professionals. A companion document *Promotion, Prevention and Early Intervention for Mental Health: A Monograph 2000* provides the theoretical and conceptual framework and background for *Action Plan 2000*.

3 Purpose of project

This Mental Health Association NSW Inc. commissioned this project. The purpose of the project was to undertake a feasibility study to determine if a state-wide campaign in NSW could be effective and efficient in achieving mental health promotion outcomes.

The objectives of the project were to:

- Conduct a literature review of mental health and other health promotion campaigns in Australia and overseas
- Assess the strengths and weaknesses of state-wide health promotion campaigns
- Identify contextual issues in NSW that may influence the effectiveness of a state-wide campaign
- Assess the usefulness of a state-wide campaign
- Identify the approximate costs of a state-wide mental health promotion campaign
- Propose possible health promotion models for implementation in NSW
- Outline the development and implementation steps of a mental health promotion campaign or strategy.

The Mental Health Association NSW Inc established the Feasibility Study Reference Group to oversee the project. A list of members of the Reference Group is attached (Appendix 1). The Reference Group, chaired by Ms Gillian Church, CEO of the Mental Health Association NSW Inc., provided feedback to the consultants at key stages of the project.

4 Introduction

Mental health is a positive concept. It stresses the capacity of people and communities to relate to each other and the environment in ways that “promote subjective wellbeing, optimal development and use of

mental abilities... and achievement of individual and collective goals consistent with justice” (Australian Health Ministers 1991, quoted in CDHAC 2000a). This concept of mental health is much wider than simply the absence of mental illness or disorders. Mental health promotion, or “the promotion of emotional and social wellbeing”, is any action taken to maximise mental health and wellbeing among populations and individuals. It is not focussed on mental illness but rather encompasses a broad range of activities that aim to influence the social, physical, economic, educational and cultural environments that underpin wellbeing and enhance the knowledge, skills and efficacy of individuals and communities.

The National Mental Health Strategy (CDHAC 2000a) makes a distinction between mental health promotion activities that are aimed at improving mental health and wellbeing, and prevention activities that aim to prevent the development of mental health problems and disorders. Together, mental health promotion and prevention interventions aim to promote wellbeing and prevent mental illness. Prevention activities or interventions focus on the social, cultural, economic and personal determinants of health and aim both to reduce risk factors, and enhance protective factors, that impact on the lives of individuals and communities. They may be targeted towards the whole population or specific groups that are at increased risk. Mental health promotion activities or interventions may also reduce the risk of developing mental illness or disorders, through increasing emotional and social wellbeing.

The complex nature of mental health means that programs and campaigns targeting multiple risk factors with a multi-strategic approach have better outcomes than a single issue / strategy approach. The formation of broad partnerships, consultation and community commitment, and a multi-dimensional approach that addresses the complex interconnections of health determinants, is required for effective prevention and mental health promotion (CDHAC 2000b).

The factors influencing health differentials and inequities have been described extensively in the international literature (Davey-Smith et al.1998; Feinstein 1993; Mackenbach et al.1994) and Australian literature (Mathers et al.1999; National Health Strategy 1992; Turrell & Mathers 2000; CDHAC 2000b). Whitehead (1990) and, more recently, Turrell and Mathers (2000) have proposed comprehensive classifications of socioeconomic determinants of health.

Turrell et al (1999) discussed the evidence on socioeconomic status and health in Australia and concluded that it was unequivocal that:

- Those who occupy positions at lower levels of the socioeconomic hierarchy fare significantly worse in terms of their health
- Persons variously classified as “low” socioeconomic status have higher mortality rates for most major causes of death, their morbidity profile indicates that they experience more ill-health (both physiological and psychosocial), and their use of health care services suggests that they are less likely to act to prevent disease or detect it at an asymptomatic or early symptom stage
- Socioeconomic differences in health are evident for both females and males at every stage of the life-course (birth, infancy, childhood, adolescence and adulthood).

Addressing health inequalities is an integral part of effective health promotion. Health promotion campaigns that do not consider equity issues may exacerbate the gap between those with relatively good health and those most disadvantaged with the worst health outcomes. For example, faster uptake of healthy lifestyle behaviours, by more affluent and better educated groups within the community may lead to a net increase in disparities in health status. “Health promotion should take steps to play an active role in addressing [health inequities]. It is necessary for health promotion to take action to improve the health of all people, particularly the disadvantaged, to reduce the increasing gap in health status” (NSW Health 2004, p3)

Butterworth (2003) emphasises the growing recognition in international research and policy, that psychological and personal characteristics such as poor mental health, substance use disorders, physical health problems and domestic violence are more prevalent among welfare recipients and that these characteristics represent a substantial barrier to community connectedness and participation. Stressors, related to gender roles that may contribute to the risk of depression, include physical and sexual assault, sexual harassment and discrimination, unwanted pregnancy, divorce, poverty and powerlessness. There are differences between men and women in terms of mental health and it appears likely that this may reflect the different patterns of risk taking and protective behaviours as well as the effects of gender roles.

Increasingly, evidence suggests that psychosocial and environmental factors can result in poor mental health (CDHAC 2000b).

The Aboriginal and Torres Strait Islander population remains the most disadvantaged in Australia and has the worst health status. The effects of racism, colonisation and dispossession continue to be reflected in data on the levels of disadvantage affecting Aboriginal and Torres Strait Islander people and the discrimination faced by them. Discrimination also has severe psychological and socio-economic consequences for other marginalized groups such as refugees, people who are gay or lesbian, those who have disabilities or can be stereotyped as different from mainstream society. “Repeated rejection and hostility and feelings of shame can undermine self-worth and self-efficacy and contribute to psychological distress” (CDHAC 2000b, p12).

Social disadvantage can be concentrated in specific geographic localities. Vinson (2004) mapped the distribution of social disadvantage by postcode areas across NSW and Victoria. He found that disadvantage is strongly concentrated in a relatively small number of postcode areas. For example, 5.9% or less of NSW postcodes in every instance accounted for 25% of the total for each indicator of disadvantage. For three indicators – imprisonment (3.2%), child abuse (3.4%) and long-term unemployment (4.1%) it required only 4% or less of postcodes to account for a quarter of the cases.

The impact of social networks on health has been comprehensively described. For example, McClelland (2000) analyses the impact of lack of social support on health inequalities from both Australian and international literature and cites an Australian study which reports that people with low incomes often have less access to informal social supports, which in turn impacts on their capacity to combat stress, leading to increased risk of illness (Gilley and Taylor 1995).

Social support levels constitute an independent risk factor for disease and death (National Health Strategy 1992), with some groups being more vulnerable to the consequences of social isolation and inequity. Conversely, lack of social support is associated with social disadvantage and communities that have the highest levels of poverty and unemployment tend to have the lowest levels of social cohesion. This adversely affects the health of such communities (NSW Health 2002). Marmot and Wilkinson (2000) report that high participation in social networks and good social support leads to lower risk of death and mental illness.

Social capital is associated with improved health, greater self-reported wellbeing, and better care for children, lower crime and better government. It involves people participating in networks and strengthening social cohesion through activities based on principles of trust, mutual reciprocity and common purpose (Putnam 1993, Bullen & Onyx 1998; Vinson 2004). Putnam (2001) distinguishes between *bonding* social capital, which is bonding within peer or cultural groups, and *bridging* social capital which comprises relations of respect and mutuality between people or groups who are different from each other (for example, in age, ethnicity, sex, class). More recently, Szreter and Woolcock (2002, and Szreter 2002) have emphasised the importance of *linking* social capital. This is a refinement of the concept of bridging social capital between those horizontal relationships that “bridge” individuals who are relatively equal in terms of their status and power and those vertical social relations that connect people across power differentials.

A comprehensive guide to evaluating health promotion projects and strategies is provided by Hawe et al (1990) in evaluating *Health Promotion: A Health Workers Guide*. The authors provide a range of examples of population based health promotion strategies such as community development, community action to lobby for better resources, mechanisms to promote community involvement in planning and decision making and legislative change to reduce health risks. They propose three suitable types of evaluation for health promotion projects. These are:

Process evaluation – measures the activities of the program, program quality and who it is reaching.
Impact evaluation - measures the immediate effect of the program (does it meet its objectives?)
Outcome evaluation – measures the long term effects of the program (does it meet its goals?)

5 Methodology

5.1 Literature review

A search of the Australian and International literature was conducted for evidence-based articles and reports on evaluations of mental health promotion and other health promotion campaigns. Data bases searched include Medline, Cochrane Collaboration, Auseinet (www.auseinet.flinders.edu.au), Google, NSW Health (www.health.nsw.gov.au), beyondblue (www.beyondblue.org.au), Commonwealth Department of Health and Ageing (www.health.gov.au and www.mentalhealth.gov.au), Vic Health (www.vichealth.gov.au), Health Development Agency (www.hda-online.org.uk), Mentality (www.mentality.org.uk), Australian Indigenous HealthinfoNet at Edith Cowan University, (www.healthinfo.net.ecu.edu.au), and Health *Insite* (www.healthinsite.gov.au). Members of the Feasibility Study Reference Group supplied additional material.

The review identified a mix of reports of individual campaigns / programs and systemic reviews of mental health and other health promotion campaigns. Campaigns and programs considered in the review reflect a diversity of approaches. They range from social marketing mass media campaigns, community development initiatives, regional, and settings-based campaigns, campaigns and programs directed towards specific Indigenous, ethnic and geographic communities, and multi-strategic approaches.

Where possible the review examined the:

- type of campaign
- message
- target group
- campaign duration
- types of media used (paid advertising and community service announcements)
- other strategies to support the campaign
- methodology used to evaluate the campaign
- evaluation results.

5.2 Consultations with key informants

An interview schedule was developed in consultation with the Feasibility Study Reference Group. A copy of the interview schedule is attached (Appendix 2).

A total of eleven structured interviews were conducted with key informants from a range of backgrounds including Aboriginal Health, Multicultural Health, Population Health, Mental Health Promotion and Health Promotion.

Eight members of the New England Area Mental Health Promotion Network provided written responses to the interview questions.

A focus group with five mental health consumers was also conducted. It was organised by the NSW Consumer Advisory Group. A list of all key informants is attached (Appendix 3)

Data from the interviews, written responses and focus group were transcribed and analysed to identify main issues and themes arising from responses to the questions. A copy of the raw data is attached (Appendix 4).

The Directors of Mental Health in each AHS were contacted and asked to identify the composition and extent of the mental health promotion workforce.

6 Literature Review

Mental health population-based campaigns / programs broadly focussed on de-stigmatising mental illness; addressing discrimination against people with mental illness; promoting wellbeing and resilience and developing coping skills; addressing specific mental health problems such as depression, schizophrenia, self harm and suicide; and addressing the social determinants of health.

General health promotion campaigns broadly focused on promoting healthy lifestyles; promoting healthy environments and improving safety; reorienting health and community services; disease prevention; and preventing violence.

As reported in the literature (CDHAC 2000b) there is a paucity of randomised controlled trials, the “gold standard” of evidence-based health care, from population health promotion campaigns. However, findings from systemic reviews that include at least one randomised controlled trial, show that population based interventions that have been shown to promote mental health and wellbeing include:

- Pre-school day care and education
- Parenting skills training
- Health promoting schools promoting self-concept, self-esteem and coping skills
- Social support
- Anti-bullying policies
- Development of social competencies
- Supported employment in the workplace
- Regular exercise
- Volunteering
- Media campaigns in conjunction with appropriate community activities around mental health literacy, (www.mentality.org.uk; CDHAC 2000b; IUHPE 2000; www.hda-online.org.uk; Cochrane Library).

6.1 Mental Health Promotion Campaigns / Programs

6.1.1 De-stigmatising mental illness and addressing discrimination

Six population mental health promotion campaigns addressing de-stigmatising mental illness, and one addressing coping skills and help seeking behaviour were examined by Day et al (2001). The campaigns examined were population, rather than settings based, and had a media component. They included the \$8 million Australian Community Awareness Program (CAP) to increase community awareness about mental illness, reduce stigma and discrimination, and provide information about mental illness (www.mentalhealth.gov.au/info/cap/stigma/htm).

None of the campaigns / programs examined by Day et al (2001) was randomised controlled trials and none of them had a control group. Some had no baseline data (eg, the *Clip et Vous* program) or were inadequately funded for evaluation. The small sample size in some of the surveys (eg, the *Community Awareness Program*) also meant that meaningful statistical comparisons could not be made. There were minimal attempts to target campaigns to the cultural and linguistic diversity that characterises western societies such as Australia or the UK and, with the exception of the *Like Minds – Like Mine* Campaign, no analysis of how outcomes differ in culturally and linguistically diverse communities. The majority were evaluated (or intend to be evaluated) using a baseline and follow up survey.

Day et al (2001) concludes that the evidence demonstrates that large population based anti stigma campaigns do not work. This is because:

- The concept of mental health is too broad to address within a single advertising campaign
- Messages need to be harder hitting with campaigns moving beyond stating that discrimination is a problem to recognising practises that are unacceptable

- A whole population approach does not work across diverse cultures.

Community Awareness Program (CAP)

Type of campaign: Mass media advertising campaign supported by fliers, information kits and information booklets

Message: De-stigmatise mental illness, challenge myths about people with mental illness, and encourage people to take care of their mental health

Target group: General Australian population

Campaign duration: 4 years, 1994-97

Types of media used: Radio, television, cinema, billboards

Other strategies to support the campaign: Information kits, pamphlets, posters, videos, Rock Eisteddfod

Methodology used to evaluate the campaign: Oral consultations (20), written submissions (22), benchmark and follow-up structured surveys (66) with a range of stakeholders, consumers, carers and workers

Evaluation results:

- Poster and billboard advertising was probably a “waste of time”
- TV advertising “probably had small effects”
- Strong demand for information brochures
- Better evaluation emphasised as future priority
- Need for strategic regional public relations strategy to support a national campaign
- No change in the mainly tolerant attitudes found at start of campaign, and slight increase in awareness of support services
- No clear evidence of behaviour change towards people with mental illness in relation to level of stigma and discrimination experienced by people with mental illness (Day et al 2001; CAP 1998).

Like Minds – Like Mine

Type of campaign: New Zealand mass media advertising campaign supported by TV documentary, multi lingual facts sheets, celebrities used to normalise mental illness

Message: De-stigmatise mental illness and challenge discrimination

Target group: Whole population, New Zealand

Campaign duration: Not stated

Types of media used: Radio, television, cinema, a play “Show us your nuts”, TV documentary “Sticks and stones”

Other strategies to support the campaign: Regional workshops on discrimination for mental health staff

Development of policy guidelines on discrimination in the public sector merchandising with campaign message

Methodology used to evaluate the campaign: Pre and post telephone survey on awareness and attitudes, campaign reach, and message recall and acceptability (n=1207 including 375 Maori and 72 Pacific Islanders)

Evaluation results:

- Small effects of advertising campaign for whole population
- Some decrease in awareness following campaign
- Whole population approach does not work across cultures
- Need regional evaluations for regional components
- Need to develop policy with regional providers across cultures (Day et al 2001).

Defeat Depression Campaign

Type of campaign: UK mass media campaign, multi lingual facts sheets, leaflets, self-help video and two books

Message: De-stigmatise depression, educating public about depression, treatment for depression and importance in seeking treatment early

Target group: Whole population, UK

Campaign duration: 5 years, 1991-96

Types of media used: Radio, television, newspaper and magazines

Other strategies to support the campaign: Audiocassettes, self-help video, books

Methodology used to evaluate the campaign: Pre and post surveys of approximately 2000 people, conducted in 1991, 1995 and 1997, on awareness and attitudes and campaign reach, message recall and acceptability

No analysis of cultural or linguistic difference

Evaluation results:

- Limited reach / recall of campaign (5% in 1995, and 2% in 1997)
- Small, significant positive effects regarding: attitudes to depression, experience of depression, and attitudes towards anti-depressants (Day et al 2001).

Clip et Vous

Type of campaign: Canadian campaign around managing stress positively and increasing social support

Message: Young people self identify strengths and positive mental health images

Target group: Quebec youth

Campaign duration: Not stated (probably one year)

Types of media used: Video clips

Other strategies to support the campaign: Script competition, launch of video clips and distribution of video package for use in schools and colleges

Methodology used to evaluate the campaign: Post campaign survey of 403 students to assess short-term impact

Evaluation results:

- 53% of students aware of the program
- No significant differences in attitudes to mental health between groups with differing levels of program awareness
- Significantly greater number of students with no awareness of the campaign refused to express an opinion on mental health issues (Day et al 2001).

Open the Doors

Type of campaign: Austrian component of a worldwide campaign against stigma and discrimination related to schizophrenia

Message: De-stigmatise schizophrenia and challenge discrimination

Target group: Whole population, Austria

Campaign duration: 2 years, 1999-2001

Types of media used: Posters, billboards, video clips on cinemas, mental health related film festivals

Other strategies to support the campaign: National survey on attitudes and knowledge relating to schizophrenia

Local and regional action groups

Educational programs in schools

Methodology used to evaluate the campaign: Baseline survey of general population (1047) relatives of people with schizophrenia (137) and health professionals (214)

Evaluation results:

- Majority (80%) already familiar with the term “schizophrenia” and 84% were not keen to learn more about it
- Follow up evaluation not yet reported (Day et al 2001).

Changing Minds

Type of campaign: Irish campaign aimed at reducing the stigma of mental illness

Message: Multi-strategic program to increase knowledge and awareness relating to mental illness and media portrayals

Target group: Whole population, Ireland

Campaign duration: 4 years, 1998-2002

Types of media used: Cinema advertisements, information booklets; mental health media watch program

Other strategies to support the campaign: Primary school education package

Methodology used to evaluate the campaign: Baseline survey of general population (1,400)

Evaluation results: Baseline survey showed:

- Poor general knowledge of mental illness
- 15 – 24 year olds have poorest level of knowledge except in regard to eating disorders and drug abuse
- Negative attitudes about schizophrenia most common in young people
- General optimism about the benefits of treatment
- Follow up evaluation not yet reported (Day et al, 2001).

6.1.2 Promoting wellbeing, resilience and coping skills

MindMatters is an Australia-wide mental health promotion program for secondary schools (www.mentalhealth.gov.au; MMEC 2000). It aims to enhance the school environment so that young people feel safe, valued, engaged and purposeful, through a whole school approach to mental health promotion and suicide prevention. A *MindMatters* Resources Kit and a two-day professional development program are available for all government and non-government schools. The resources kit includes two whole of school resources:

- SchoolMatters: mapping and managing mental health in secondary schools
- Educating for Life: a guide for school based responses to preventing self-harm and suicide.

There is also a video *Understanding Mental Illnesses* and five sets of curriculum materials on: Enhancing Resilience 1 and 2, Dealing with Bullying and Harassment, Understanding Mental Illness, and Loss and Grief. The *MindMatters* project was an outcome of the 1996 audit of mental health education in Australian secondary schools that identified a number of barriers for teachers in implementing effective mental health promotion in schools. These included: a lack of confidence / comfort in teaching about mental health and sensitive issues, poor availability of classroom resources for teaching about mental health, and difficulty in fitting mental health promotion issues into an already crowded curriculum.

A pilot was conducted in 24 schools across Australia during 1998 and 1999. The *MindMatters* Evaluation Consortium (MMEC 2000) from the Hunter Institute for Mental Health conducted the evaluation. A number of factors, including insufficient funds, lack of time, problems with available measures, sampling and compliance with the evaluation protocol, and the late start of the evaluation, meant that true baseline data could not be obtained and that data could not be collected from control schools.

MindMatters

Type of campaign: Multi-strategic school based education and resources addressing priorities identified in the baseline “audit”

Message: Whole school approach to enhancing resilience and mental wellbeing, preventing self harm and suicide, changing school ethos and forming new partnerships around mental health promotion

Target group: Secondary school students and teachers, Australia wide

Campaign duration: Two year pilot 1998-99

Types of media used: Video

Other strategies to support the campaign: Professional development for staff. Establishment of a “core team” in each school with responsibility for planning and implementing the pilot

Development of “strategic plans” by the schools involved in the pilot

Curriculum materials on specific mental health promotion issues

Methodology used to evaluate the campaign: Baseline “audit” of activities, policies and curriculum relevant to mental health

Process evaluation of how *MindMatters* was actually implemented

Case study approach that collected qualitative (two telephone interviews and one field visit to 23 of the 24 pilot schools) and quantitative data (where possible) consisting of student questionnaires to assess changes in knowledge and attitudes about mental health, quality of school life, and coping style

Evaluation results:

- Biased selection of pilot schools on the basis of having a history of prior orientation towards health promotion and student welfare
- Inconsistent combination of approaches (no two schools adopted the same combination of approaches) and inconsistent implementation of quantitative student surveys (eg, no questionnaire data from some schools and incomplete data sets from other schools) meant that a standardised evaluation was not possible
- The curriculum components of the program (especially “Dealing with Bullying and Harassment”, “Understanding Mental Illness” and “Enhancing Resilience”) were the aspects most comprehensively implemented by the pilot schools
- Overall trend towards decrease in proportion of students who could define mental health in health-related / wellness terms and decrease in students able to correctly name one mental illness
- No significant difference in proportion of students who nominated “School” as source of information about mental illness
- Statistically significant increase in proportion of students who were willing to have “someone with a mental illness marry into their family” (MMEC 2000).

Valuing Young Lives - Youth Suicide Prevention Strategy

The National Youth Suicide Prevention Strategy, which ran from 1995-1999, took a number of approaches to primary prevention and cultural change. These included:

- Parenting education and support
- School based programs
- Media education, and
- Community development.

Seven parenting education and support programs were funded with the aim of preventing the development of emotional and behavioural problems in children and adolescents, such as conduct disorder and depression, that have been linked to self harm and suicide. The Strategy also funded the *MindMatters* school-based program (see above). A media kit was developed and approximately 1,400 kits were distributed. The kit focussed on educating the media on safe ways to report on and discuss youth suicide issues. Community development activities with a focus on primary prevention emphasised community-wide responsibility for the care and nurture of children and young people and changes to the quality of the community environment. They included *Project X* based at Kyogle Youth Action and projects, such as those based at the *Cellblock Youth Service* and at *High Street Youth Health Service*, that involved young people in producing artistic resources for mental health promotion for young people (Mitchell 2000a).

The strategy funded a study of an Aboriginal community in North Queensland (Yarrabah) that had developed its own responses to suicide and other health problems over a ten-year period. Yarrabah experienced a number of clusters of suicides in 1986-87 (3 deaths), in 1991-93 (9 deaths) and in 1995-96 (8 deaths). Whilst the community development activities were not funded by the Strategy, it was considered that the Yarrabah community had a great deal to offer in the analysis of effective community development approaches.

Yarrabah Study

Type of campaign: Multi- strategic community development program to respond to and prevent suicide, and to promote “Family Life Promotion”

Message: Not applicable

Target group: Aboriginal community in North Queensland

Campaign duration: 1988 and ongoing

Types of media used: Not applicable

Other strategies to support the campaign: 1998 Establishment of the Yarrabah Health Council

A community controlled Primary Health Care Service established

Emphasis placed on community level risk factors rather than individual risk factors Community driven responses eg, training in “suicide prevention” and counselling focussed on historical traumatisation and “cultural healing”

Whole of community meetings

Formation of a Crisis Intervention Group

Development of networks across family and clan groups

Formation of a base of local voluntary workers

Development of the “Yarrabah Family Life Promotion Program”

Employment of “Family Life Promotion Officers”

Commissioning of a 1997 Action Research study on the feasibility of establishing a multi-purpose health care service

Specific strategies implemented under the *Yarrabah Family Life Promotion* program include:

- Education and training for individuals and families to empower them with the knowledge, skills and understanding to deal with suicide from a holistic healing perspective
- Crisis intervention including a Safe Place and Telephone Crisis line
- One-on-one counselling: grief and loss counselling and family support groups
- Information and self awareness programs for survivors of suicide and those who are at risk
- Promotion of healthy family life through workshops on parenting and personal relationship development
- Networking and coordination with community agencies to encourage and support all people in the community, especially youth at risk, to be involved and participate in sporting, recreational and cultural activities, to promote unity amongst families and the community” (Mitchell 2000b, p 159)

Methodology used to evaluate the campaign: Analysis of suicide statistics, literature review and a historical descriptive study of a community development process

Evaluation results:

- Baseline: 1986-87 (3 deaths), in 1991-93 (9 deaths) and in 1995-96 (8 deaths)
- 1997 and 1998: Decrease to: no suicides reported
- Baseline: In the three quarters, September 1995 – June 1996, there were between 45-50 incidents of self harm per quarter for males, and between 20-25 per quarter for females
- In July-December 1996 this decreased to 10-20 incidents of self harm per quarter for both men and women
- 1998: Decrease to below 5 incidents of self harm per quarter for both sexes
- 1998: Reduction in police interventions for alcohol related problems and hospital presentations for accidental trauma
- Additional funding to support the Yarrabah Family Life Promotion program secured
- 1997 Yarrabah Community Council closed the canteen that sold alcohol to the community
- “The Yarrabah community identified the reclamation of ‘spirit’ or responding to the experience of hopelessness, as fundamental to the achievement of health improvement. The community reported that what comes with ‘healing the spirit’ is self- determination, the opportunity to be the author of one’s own destiny and to take responsibility for one’s own life” (Mitchell 2000b p. 160).

You in mind

Type of campaign: UK mass media campaign to improve coping and help-seeking behaviours

Message: Series of seven 10-minute TV programs on mental health

Target group: Whole population, UK

Campaign duration: One year, early 1990s

Types of media used: Television

Other strategies to support the campaign: Information booklets on local agencies and self help groups

Methodology used to evaluate the campaign: Baseline and follow up survey of general population (544)

Evaluation results:

- No significant changes in coping or self help behaviours
- Increased understanding of mental health problems but not of what to do about them
- Slightly greater anxiety at one-year follow-up in viewers than non-viewers (Day et al 2001).

6.1.3 Addressing specific mental health problems

beyondblue

Depression is a leading cause of illness and disability in Australia and has been identified as a priority under the Second National Mental Health Plan (www.mentalhealth.gov.au/resources/reports/dap.htm). The Commonwealth and Victorian Governments have each committed \$17.5 million over 5 years to the *beyondblue* initiative and this is complemented by further State, business and community support, making it one of the biggest mental health promotion initiatives in Australia. The aims of *beyondblue* are to:

- Increase community awareness of depression and to reduce stigma and discrimination;
- Enhance professional training and development, and
- Support research into prevention, treatment and management approaches (*beyondblue*2004).

Initiatives of the *beyondblue* campaign / programs include:

- Reach Out! across rural and regional Australia
- Aspire Achieve Affect (A3) Program
- Education and training of cardiac rehabilitation workers
- Depression in the workplace program (to increase awareness and understanding about depressions and its appropriate management in the workplace)
- Every Family Initiative (Triple P - Positive Parenting Program to improve parenting and family relationships)
- Post-natal depression program (state based comparison of treatment approaches where women have been screened and shown to be at risk of post-natal depression)
- Schools research initiative (investigating how schools can best prevent depression and increase resilience in young people)
- Advertising campaign (National advertising campaign to increase community awareness about depression)
- Work Outcomes Research and Cost-benefit Project (National workplace-based screening for depression)
- Ngaripirliga'ajirri Program (Primary School early intervention program on Tiwi Island to prevent suicide and self harm) (*beyond blue* 2004).

Few of these initiatives have been evaluated as yet. The exceptions are the *Reach Out! Across Rural and Regional Australia* program, the *Aspire, Achieve, Affect (A3)* Program, and the *Education and Training of Cardiac Rehabilitation Workers* program.

Reach out! Across Rural and Regional Australia Tour (RORRT)

Type of campaign: Community and schools based campaign to promote positive profiles of young people, improve coping and help seeking behaviour, enhance capacity of communities to support young people, and promote use of the Internet as a resource for social service delivery

Message: Promoting the internet as a source of help and involving youth in internet design

Target group: Youth in rural and regional Victoria and South Australia

Campaign duration: 2001-2003 and ongoing

Types of media used: Internet

Other strategies to support the campaign: Victoria: 3-week consultative tour to: provide an overview of the Reach Out! Website, explore local youth issues, provide a networking opportunity, and update the local listings in the "Who Cares?" Referral Database

The twelve-week formal tour included workshops with 13,300 young people in schools and community settings. The focus of the workshop presentation was to introduce young people to the Reach Out! Website. Where possible, local service providers participated in presentations as a way of increasing their profile with young people

After each presentation the RORRT staff spent time with young people capturing stories, music and artwork using a digital camera and audio recorder. This content was then edited and uploaded into a town sub-site on the Reach Out website

South Australia: School based presentations; one-day youth leadership workshops; school based promotional campaigns

Methodology used to evaluate the campaign: Victoria campaign: Action Research Model based on the analysis of data from consultative tour questionnaires, pre (1,159) and post (243) formal tour questionnaires

A feedback form on the Reach Out! Website

Nine discussion forums with young people post RORRT

Key contact feedback, RORRT reporter interviews and sponsor interviews

Evaluation results:

- Consultative workshops not seen as a very useful forum for discussing local youth issues and networking
- Most young people access the internet on a daily basis either at school or at home
- A large number of young people had heard of the Reach Out! website prior to the tour commencing
- Although most young people indicated that they would turn to friends and family first during “tough times”, many would access resources, such as Reach Out! rather than other people in their communities
- Results indicated greater knowledge concerning Reach Out! and its goals and subsequent higher rates of access to the website, although feedback on the design of the website was equivocal
- South Australian campaign was still being implemented and there were no evaluation results (O’Brien 2002).

Aspire Achieve Affect (A3) Program

Type of campaign: National promotion of healthy youth skills through eight-session program teaching life skills and increasing community connectedness

Message: AFL footballers and elite athletes as role models in a leadership program

Target group: Youth in schools, rural communities and juvenile justice settings in Victoria

Campaign duration: Two years, 2001-2002

Types of media used: N/A

Other strategies to support the campaign: Training of athletes to deliver 8-week leadership program in schools and community settings

Following on from eight-week program there was community planning and implementation of leadership programs eg, primary to secondary schools transition programs, peer drug education, mental health awareness programs

Methodology used to evaluate the campaign: Three follow-up qualitative focus groups with teachers, students and athletes

Evaluation results:

- The athletes/elite role models were successful in engaging students
- 74 athletes trained and 32 x 8-week programs run. The evaluation does not state how many athletes actually ran the 32 programs
- Follow on projects were considered fundamental as they were student directed and gave a sense, for the students, of adding something to the school and, for the athletes, a sense of putting something back into the community (beyond blue 2004).

Education and training of cardiac rehabilitation workers

Type of campaign: Pilot of half-day workshops about depression to improve skills and confidence of cardiac rehabilitation workers to identify and respond to depression

Message: With skills, knowledge and confidence workers can identify and respond to symptoms of depression in their clients

Target group: Cardiac rehabilitation workers, Victoria

Campaign duration: One year, 2002

Types of media used: N/A

Other strategies to support the campaign: beyondblue pack, website and fact sheet

Methodology used to evaluate the campaign: Pre (77), post (62) and 3 month follow up (54) surveys of participants

Evaluation results:

- Objective knowledge, subjective knowledge and confidence significantly improved between pre and post, and pre and 3 month follow up
- Whilst the majority referred a patient for treatment for depression during the 3-month follow-up period, referral rates were not related to knowledge or confidence but were associated with community-based links and written resources (beyondblue 2004).

6.1.4 Addressing social determinants of health

Together we do better

The 2001 Victorian Population Health Survey found that people with few social networks were less likely to feel valued by society and more likely to report fair to poor health, and to be experiencing some level of psychological distress (www.togetherwedobetter.vic.gov.au). The *Together we do better* campaign seeks to increase community awareness of the benefits of strong, connected and supportive communities. It is linked to the three elements identified as being necessary for mental health and wellbeing in the 1999 Victorian Mental Health Plan:

- Social connection
- Freedom from discrimination, conflict and violence
- Economic participation.

A communications and marketing campaign was launched in June 2001 focusing on working together to manage crises and reduce intolerance, loneliness and bullying. The second stage of the campaign - linking social connectedness with encouraging greater opportunities for people to connect and participate - was launched in April 2003. In Phase one around \$845,000 was spent on buying advertising, \$180,000 on research and evaluation, and \$212,000 on strategy development and production of campaign materials. Phase two had a budget of \$1.2 million for one financial year (Davidson Consulting 2002; Communications and Marketing Team 2002). It should be noted that the first six months of the campaign coincided with the Tampa affair, the detention of asylum seekers, the Federal election, the September terrorist attacks in the US, and the commencement of the “war against terror”.

Type of campaign: Communication campaign raising awareness of the importance of community connections, tolerance and good social relationships in promoting mental health and well being, and support for individuals and organisations to engage in civic participation as well as sport and recreational activities

Message: Feeling that you belong, have a valued place in the community and knowing you have friendships and supportive social networks are important factors influencing mental health and wellbeing. Connected, supportive communities that value diversity, are open and inclusive, and provide opportunities for everyone to participate in community life, will have better mental and physical health outcomes.

Social isolation, discrimination and hostility can lead to serious physical and mental health ill effects.

Specific campaign messages under the umbrella of *Together we do better* include:

- With a shared purpose our differences shrink away. Taking part with others, or making someone else welcome, is the best medicine on earth
- Everyday kindness is such powerful medicine, it can help to protect us from depression and illness.
- A fast track to success: A bedtime story is good medicine
- Hostility can harm you
- Loneliness is a real danger
- Do we ever get over it? A bully does life long damage

Target group: Phase one: Whole population, opinion leaders and decision makers, and stakeholders. Victoria

Phase two: as for Phase one, but starting with a focus on youth and seniors

Campaign duration: Phase one: 2001-2002. Phase two: 2003 and ongoing

Types of media used: Website; print, cinema and radio advertisements

Other strategies to support the campaign: Resources available through the website eg, the “Partner Pack”, media kit, slides and workshop materials, posters and postcards

Methodology used to evaluate the campaign: Benchmark survey of 1497 Victorians May 2001

Phase one: Three surveys of 597 Victorians in July 2001, and 601 Victorians in November 2001 and March 2002

Qualitative interviews with key stakeholders and opinion leaders

Phase two: survey of 600 Victorians in June 2003. Post campaign survey and repeat survey of opinion leaders is planned.

Media monitoring, monitoring the dissemination of campaign resources, visits to the website and participation in the Mental Health Promotion Network

Evaluation results:

Baseline survey

- Those most likely to rate their emotional or physical or overall wellbeing as “poor” or “fair” were much less active than others and were most likely to:
 - Be aged 55 or over
 - Have not completed secondary school
 - Be unemployed, retired or otherwise out of the workforce
 - Have lower household income
- Most reported regular social activities with men more likely than women to be involved in sporting activities and work, and women more likely to participate in community based activities than men
- Almost one quarter did not belong to any clubs or formal associations
- When considering factors that contribute to emotional health:
 - Young people (aged less than 25) were more likely to mention friendships, personal relationships and social life
 - Those aged 25-54 were more likely to be concerned with employment and professional relationships
 - Those aged 55 or more mentioned money and financial security more often
- “Being able to make ends meet” and “Being safe from crime” were seen as the most important of a number of statements rated by respondents as contributing to health and wellbeing
- Feeling needed, being accepted by others, being active in the community and being positive towards different cultures and ideas were all rated more highly by women than men
- Those who rated their health highly were most likely to remember health-related advertising
- There were high levels of agreement with a number of statements reflective of the aims of the campaign indicating a high baseline measure and meaning that statistically significant shifts in attitudes and behaviours were unlikely to be achieved quickly (Wallis Consulting Group 2001a).

Phase one

- On prompting, 45% recalled seeing advertising carrying one or both of the campaign themes and one in three recalled the bullying theme
- 11% reported taking action as a result of seeing or hearing the campaign advertising
- The advertisements were recalled by all segments of the Victorian community with women and middle-aged Victorians having slightly greater recall
- Without prompting one in twenty described the advertisements correctly
- Spontaneous awareness of the *Together we do better* campaign slogan was non-existent but, on prompting, one in six Victorians had heard or seen advertisements referring to this slogan and half of these offered a meaning that indicated they had genuinely absorbed the campaign messages (Wallis Consulting Group 2001a, 2001b & 2002)

Opinion leaders:

- Generally were well aware of the campaign
- Liked the overall campaign and the direction VicHealth was moving in with the campaign
- VicHealth was seen to be taking an important leadership role in the area of the social determinants of mental health
- Overwhelmingly informants felt the campaign was “innovative”, “fresh” or “clever” (Ridge & Murphy 2002).

Phase two

- On prompting, 29% recalled one or both of the campaign themes
- Both themes had similar recall levels but while all types of people noticed “Friendliness”, “Loneliness” had a greater tendency to be noticed by younger people, especially younger men. This was a significant change from the first wave of advertising that appealed to all Victorians but especially middle-aged women.
- Significant increase of un-prompted recall of the campaign slogan *Together we do better* and a higher percentage of people giving an accurate interpretation of the campaign slogan
- Significant increase from 11% to 15% of people taking action (such as “striking up a conversation with someone you normally wouldn’t”, “thought about or taken up an activity where you could meet others”, or “thought about or made contact with friends and acquaintances more than usual”) as a result of hearing or seeing the campaign messages
- One in ten correctly described the campaign advertisements without prompting and a further 15% were able to talk generally about aspects of the campaign
- A higher proportion of Victorians reported being involved in social or work related activities compared to the benchmark survey

- A higher proportion claimed to be members of clubs, sporting organisations or professional bodies compared to the benchmark survey
- Victorians continue to believe that financial stability, safety from crime, and feeling needed and valued, are the most important key factors contributing to health and wellbeing

- The biggest positive shifts in the importance of key factors contributing to health and wellbeing relate to tolerance and inclusion, which are now rated next in order of importance. These are:
 - Making friends and acquaintances with people from all walks of life, from different backgrounds and different opinions (7.9 – 8.4)
 - Being interested in and positive towards different cultures and ideas (7.7 – 8.3)
 - Making an effort to include all types of people in the activities and pastimes you participate in (7.3 – 7.8)
- Compared to the benchmark survey there has been a positive increase in agreement with all attitude and belief statements with a significant shift for the statements:
 - We all have a responsibility for recognising and dealing with loneliness in society (6.9 – 8.2)
 - In this day and age we should be tolerant of all people no matter what their background, beliefs or lifestyle (8.1 – 8.5)
 - Intolerance is harmful to your health 7.3 – 7.7) (Wallis Consulting Group 2003).

Villawood Icebreaker Project

Villawood is a suburb in South Western Sydney that has very high levels of social disadvantage. Vinson (2004) placed Villawood in the top 5-10% (2nd quintile) of disadvantaged communities in NSW. Social disadvantage is strongly associated with poor mental and physical health and communities with poor social capital. The aim of the *Villawood Icebreaker Project* was to improve the mental health and wellbeing of women aged 18-39 living in Villawood, with a particular emphasis on young single parents (Moore et al 2004). This was done through a range of strategies to build social capital (bonding, bridging and linking social capital), strengthen friendship and support networks, increase community connectedness and participation, improve safety, and increase knowledge of and access to services.

Type of campaign: Multi-strategic community development campaign. Initiatives aimed at building social capital focused on partnership and community capacity building, community celebrations, public and private safety, education and employment opportunities, research, information dissemination and coordination. Funding was \$180,000 over 3 years (\$50,000 per year for campaign implementation and \$15,000 respectively for the pre and post campaign community surveys)

Message: We create social capital by being part of our community, knowing and caring about our neighbours, helping each other out, joining in community events, feeling comfortable with those who are different from us, having friends and family close by, feeling safe, being proud of where we live and helping to make it a better place to live

Target group: Women 18-39 in Villawood, with an emphasis on young single parents. “Whole of community” approach taken in implementation of many strategies, eg, community celebrations, safety, partnerships and community capacity building

Campaign duration: Three years 2001-2004

Types of media used: Local print media; quarterly Villawood Icebreaker Newsletter produced

Other strategies to support the campaign: Planning forum established

Community celebrations and Villawood festival

Safety audits and Domestic Violence taskforce

Introduction to computer courses

Employment of local women

Multicultural women's weekend gathering (conducted in 3 languages)

Methodology used to evaluate the campaign: Quantitative: Pre and post random household survey of 328 women 18-39 years focusing on mental health and social capital, comparison with Women's Health Australia Longitudinal study. The Survey included the Medical Outcome Study 36-item Short Form Survey (SF36), an internationally recognised tool for measuring self-reported health status

Qualitative: Interviews, focus groups

Evaluation results:

- Improvement in all components of the SF36 in comparison to baseline and statistically significant improvements in mental health component and perceptions of wellness in comparison to others
- 75% agreed that Villawood had improved in the last 2 years or remained much the same and non-Australian born women aged 25 and over were significantly more likely to think Villawood had improved
- Women who had experienced violence, and unemployed women, were significantly more likely to report that physical or emotional problems interfered in their lives over previous 4 weeks
- Significantly fewer women reported feeling disengaged from the community in the post survey compared to the baseline
- Results of the quantitative research were echoed in qualitative interviews (Moore et al 2004).

6.2 Lessons learned from mental health promotion campaigns

Community Awareness Program

- Funding did not allow for adequate evaluation
- Evaluating the extent that behaviour change can be attributed to public education programs is limited
- If campaign is unrealistically "nice" it can gloss over the problem
- If "celebrity" that is public face of campaign goes out of favour / gets associated with opposite message this can have a negative effect on campaign messages
- Success with message reach and recall does not equate to success in terms of stated aims (Day et al 2001).

Like Minds – Like Mine

- Whole population approach does not work across cultures
- Need specific images / messages that have relevance to diverse / indigenous communities
- Need regional evaluations for regional components; need to develop policy with regional providers across cultures
- Need symbol / branding to link national and regional aspects of the campaign (Day et al 2001).

Defeat Depression

- Lack of logo or branding symbol can confuse recall
- Campaigns that coincide with negative publicity about issue being promoted can be ineffective eg, murders by people with mental illness; sexual assault allegations relating to men who are meant to be promoting anti-violence (Day et al 2001).

Clip et Vous

- Poor evaluation if no baseline
- Programs limited if no active follow-up eg, video resources produced but no mechanism for ongoing distribution and utilisation in educational settings (Day et al 2001).

Open the Doors

- Purpose of conducting a campaign is questionable if awareness is already very high at baseline (Day et al 2001).

Changing minds

- Strategies need to be related to outcomes of baseline research (Day et al 2001).

MindMatters

- Implementation teams need organisational, policy and infrastructure support from senior management
- Broader based teams are more successful in establishing mass support for a project/campaign
- Examples of successful strategies can help in formulating local plans
- Direct support from the coordinating body to local planning and implementation committees is helpful
- Inclusion of community partners in core planning and implementation beneficial to formation of meaningful partnerships across agencies (MMEC 2000).

Yarrabah Study

- Community ownership of the problem and the program is essential
- Developing community ownership is a process that may go through a number of stages
- Community empowerment is associated with the growth of democratic, community controlled, decision-making structures
- A social-historical understanding of health is a necessary pre-cursor to the community taking responsibility for its own health problems
- A primary health care approach provides a valuable conceptual and practical framework for supporting community-initiated responses
- A focus on “community at risk” rather than “individual at risk” acknowledges the true underlying causes of ill health and provides a framework that encourages the involvement of the community in a way that a focus on individuals does not
- Development of knowledge and skills increases the capacity of the community to identify causes and develop and implement solutions
- Adequate time is needed to engage the community, especially when working with Aboriginal and Torres Strait Islander communities
- A variety of informal, as well as formal, culturally appropriate mechanisms encourages engagement and participation
- Ongoing allocation of resources and support is critical to the community development process (Mitchell 2000b).

Reach Out!

- Key objectives need to be clearly defined
- A suitable evaluation design needs to be implemented to measure outcomes. This may incorporate identical pre and post questionnaires and control groups
- A more intensive and extended period of consultation and implementation needs to take place to allow local service providers adequate discussion time and the opportunity to become familiar with and contribute to the campaign
- The goals and objectives of the websites should also be examined to determine whether too much is being incorporated into the sites and whether the content is appropriate for the target audience
- Follow up and advertising needs to be increased to reinforce messages (O’Brien 2002).

Together we do better

- Keep the messages simple – VicHealth rationalised the number of themes communicated and executions used and this seemed to aid awareness and recall
- Choose messages that resonate with the community. Tapping into issues already high on the public’s agenda eg, bullying, lends potency to the campaign
- Timing of the campaign can greatly assist in making it easy for the media to create additional stories around the campaign thus adding to its reach and impact
- Print and radio media is appropriate for a campaign of this sort
- Challenging images and ideas should be done cooperatively with stakeholders
- The process undertaken for research, consultation and development is fundamental to gaining acceptance and support for the campaign
- Where a benefit of adopting a particular attitude is clearly stated eg, “talking and meeting with other people is good for your health”, respondents are more likely to agree than when a concept is put to them without stating its consequences

- The general public and stakeholders are comfortable with positive modelling of connectedness and diversity
- Successful collaboration around campaign themes and activities requires shared objectives, careful management and clear communication and a willingness to compromise
- Creating new opportunities and building on available opportunities extends the reach of the campaign and provides potential for collaborations
- “On the ground” campaign materials are useful for stakeholders and help spread the campaign messages
- It is possible to talk about mental health in a positive and wellness sense (Davidson Consulting 2002; Wallis Consulting Group 2002 & 2003).

Villawood Icebreaker Project

- Strengths-based approaches are effective because they focus on building on community strengths, facilitating community participation, and building relationships of equality between services and residents
- Employing local residents, wherever possible, is a crucial factor in recognising and valuing community skills and strengthening community leadership
- The Project was extremely successful in building ongoing community partnerships and attracting organisations to put greater resources into working with the Villawood community
- In terms of building social capital, the strategies that concentrate on bridging and linking social capital are most likely to have long term benefits for the community. They involve building respect between people or groups who are different from each other, and building the capacity of residents from diverse backgrounds to take on leadership roles in the community
- Infrastructure, such as the development of the new shopping centre and places to meet, can play an important role in building social capital
- The Planning Forum proved successful in bringing residents and community members together to identify issues and give direction to ongoing community development (Moore et al 2004).

6.3 General Health Promotion Campaigns / Programs

The literature search also identified a number of evaluations of population based health promotion campaigns that were not focused on mental health. These include the NSW *Hot water burns like fire* anti-scalds campaign, the *Active Australia* public education campaign, the WA 2001 *Me no fry* skin cancer prevention campaign, *Pap Smear Recruitment* campaigns, Aboriginal and Torres Strait Islander campaigns and multicultural campaigns against *Domestic Violence*.

Hot water burns like fire

Type of campaign: Multi-strategic mass media, policy development, environmental modifications with the aim of reducing the number of scalds in young children by 28% from 1992-2001. Cost of Phase one social marketing campaign was \$586,000. The estimated overall cost for 5 years was \$2 million.

Message: Hot water scalds like fire

Target group: Parents and carers of young children 0-5 years; decision makers and product manufacturers. NSW

Campaign duration: 1992-1995 (Phase one agenda setting / awareness raising, and Phase two focus on tap water scalds)

Types of media used: TV commercial; eight-page newspaper supplement; Doctor’s TV Network advertisement and interview; current affairs TV and radio programs; TV segment in seven languages; multilingual information disseminated through the “Health Column”

Other strategies to support the campaign: Other strategies included:

- Multilingual poster and brochure in 14 languages
- Print resources for people with low literacy
- Campaign resource kits
- Partnerships with building companies and local councils
- Scald safety checklist and hot water testing card
- Safety seminars for kitchen / bathroom designers
- Development of NSW Health Domestic Hot Water Policy Statement

- Amendment of Plumbing Code of Australia Standard setting maximum temperature for new residential hot water supplies at 50 degrees
- Engaging local Councils to adopt the safety standard
- Advertisements and articles in trade journals
- Sponsorship of a scald safety product for the Standards Australia Design Mark Awards

Methodology used to evaluate the campaign: Qualitative and quantitative measures

Three random surveys of parents with young children - pre campaign 1992 (NSW n= 375, Victoria n=250), two months after Phase one advertising 1992 and 10 months after Phase two in 1995 (NSW n=800, Victoria n=400), with Victoria acting as the control. The evaluation included:

- Analysis of emergency and hospital admission data
- “Shadow shopping” to assess campaign impact on retailers
- Random sampling of actual hot water temperatures in homes
- Randomised controlled survey of people who did and did not request the temperature testing kit
- A consumer satisfaction survey of 100 homes that trialed lowering the household hot water temperature

Evaluation results:

- Significantly more parents in NSW in 1995 (37%) aware of products that reduce scalds than in 1992 (31%)
- Significant increase in parents aware that thermostatic mixing valves can prevent scalds (8% pre campaign to 24% in 1995)
- Significant increase in awareness of bathwater as a source of scalds (pre campaign 55% to 63% post campaign); significant decrease in awareness of kettles and saucepans as a source of scalds and that turning off taps tightly and mixing hot and cold water together can prevent scalds
- After adjusting for a secular trend that also occurred in Victoria, the control State, the main outcomes that remained significant were awareness of products that reduce the likelihood of scalds at home and recall of the campaign slogan
- Significantly higher proportion of people who obtained a temperature testing card reported taking action to prevent scalds
- Between 1988/99 and 1995/96 the rate of hospitalisations of young people with scalds fell by 13%
- Combining the reduction in the number of cases and the severity of cases there was a 27% reduction in the total number of bed days during this 7-year period and 21% of the 27% reduction was achieved during the period following the campaign that focused on hot tap water (NSW Health 1998).

Active Australia Public Education Campaign

Type of campaign: \$700,000 media campaign to (a) increase awareness of the benefits of regular, moderate physical activity among: General Practitioners and other health sport and fitness professionals; and men and women aged 25-60 who were motivated but insufficiently active; (b) maintain motivation among people who were already sufficiently active; and (c) increase target population awareness of the 30 minutes, moderate intensity accumulated message.

Message: Taking the stairs at work or generally being more active for at least 30 minutes each day is enough to improve your health

Half an hour of brisk walking on most days is enough to improve your health; and

Exercise doesn't have to be done all at one time - blocks of 10 minutes are okay.

Target group: NSW GPs and men and women 25-60 years who were motivated but insufficiently active

Campaign duration: six months, 1998

Types of media used: two x 15 second TV commercials; print advertisements in metropolitan and rural press; print and radio advertisements and interviews and PR in ethnic press; PR strategy to optimise unpaid media coverage

Other strategies to support the campaign: These included:

- Mail out to all GPs in NSW
- Printed resources in 30 languages
- 1300 phone number
- Campaign merchandise
- Support from Area Health Services and Sport and Recreation regional staff

Methodology used to evaluate the campaign: Controlled trial with states outside NSW acting as controls, pre and post survey (number not stated); process, impact and outcome measures

Evaluation results: Impact measures

- Statistically significant increase in NSW to unprompted exact recall of campaign messages

- Evidence of source of unprompted message strongest for TV, newspapers and magazines which reflected the media schedule
- Statistically significant increase in knowledge of appropriate physical activity

Outcome measures

- Categorical measures of sufficient physical activity showed increased participation rates in NSW but decreased participation rates in comparison region for the same time period
- In NSW total hours of activity, walking hours, moderate physical activity hours and vigorous activity hours, were significantly higher post campaign whilst the comparison state showed a decline
- The “motivated but insufficiently active” group were significantly more likely to show any increase in total time and significantly less likely to decrease total time. They were significantly more likely to increase their total activity by at least one hour per week and increase their walking by one hour per week compared to all others (Bellow et al 1998).

Me No Fry

Type of campaign: Mass media campaign to promote and reinforce the use of sun protective behaviours among young Western Australians

Message: Me No Fry

Target group: Youth 12-17 years. WA

Campaign duration: Summer 2001/2002

Types of media used: “Vultures” TV advertisement screened on metropolitan and country commercial stations

Other strategies to support the campaign: Nil reported

Methodology used to evaluate the campaign: Series of cross sectional telephone surveys of young people 14-17 years of age – 150 pre campaign (December 2001) and 6 post surveys of 75 youth at 2 weekly intervals (mid January to March 2002)

Evaluation results:

- Females were significantly more likely than males to rate the use of sunscreen and spending time in the shade as “very important”
- Perceived susceptibility to getting skin cancer was significantly higher for females who also were significantly more likely to report they like to get a suntan and made an attempt to do so
- Males were significantly more likely to report getting sunburnt on the weekend preceding the survey than were females
- There were considerable differences in the type of sun protective behaviours adopted by males and females eg, females were significantly more likely to “always/usually” wear sunscreen, wear sunglasses and stay mainly in the shade, whereas males were significantly more likely to report they “always/usually” wear a hat or wear protective clothing
- Overall 95% “always/usually” adopted one or more sun protection behaviours
- Cued recall of the “Vultures” advertisement was 43% averaged over all post surveys
- Compared to other youth orientated advertising campaigns the peak level of recall (53% in the fifth survey) falls into the “above average” range
- The evaluation does not report if there were significant differences between the pre and post surveys although behaviour appears to be related to daily temperatures and the UV index (Jalleh & Donovan 2002).

National Tobacco Campaign

Type of campaign: Mass media campaign to increase smokers’ knowledge of the harmful effects of tobacco smoking, promote intention to quit and availability of help from the Quit call line and reduce the prevalence of smoking. \$7 million approximately

Message: Every cigarette is doing you damage

Target group: Smokers 18 – 40 years. National Australian campaign

Campaign duration: 18 months, June 1997 to December 1998

Types of media used: “Artery”, “Lung” and “Tumour” TV advertisements in 1997 supplemented with “Brain” and “Call for Help” for Quit help line in 1998. Radio advertisements in eight community languages

Other strategies to support the campaign: Print advertisements and media coverage of campaign
Support for multi-lingual component by bilingual health staff

Methodology used to evaluate the campaign: Baseline (1192 smokers), first follow-up (2981 smokers), and second follow-up (1646 smokers) random telephone survey

Evaluation results:

- Increase of recall of advertisements amongst those who recalled seeing a health related advertisement: Baseline 34%, 1st follow-up 57%, 2nd follow-up 52%
- 87% continued recognition of campaign message at 2nd follow-up survey
- Increase in number who reported talking to family or friends about quitting: Baseline 36%, 1st follow-up 36%, 2nd follow-up 42%
- Increase in number who reported contacting the Quit help line: Baseline 2%, 1st follow-up 4%, 2nd follow-up 5%
- Increase in people reporting using gum or patches to help quitting: Baseline 7%, 1st follow-up 10%, 2nd follow-up 15%
- Increased number who read the “How to Quit” literature
- 1.9% decrease in smoking prevalence over the 18 month campaign (CDHAC 2000c).

Ngua Gundi – The Mother / Child Project

Type of campaign: Multi-strategic program to improve health care and health outcomes for Aboriginal women during pregnancy and following the birth of their babies

Message: Not applicable

Target group: Aboriginal women who were pregnant, with particular emphasis on young women

Campaign duration: 1993 ongoing

Types of media used: Not applicable

Other strategies to support the campaign: These included:

- Needs assessment
- Outreach midwife clinic in culturally appropriate setting
- Home visiting and support by Midwife and Aboriginal Health Worker
- Information and education in a self-help learning environment
- Pregnancy workbook and support networks (older and younger women) developed
- Re-orientation of health services
- Active attempts to engage women who appear to be at risk and historically have refused services

Methodology used to evaluate the campaign: Process evaluation 18 months after commencement of program. Comparison with previous hospital and antenatal records

Evaluation results:

- Program accessed by 300-400 women and a further 100-200 women have accessed the mothers' group
- Women who had used services reported high levels of satisfaction
- Women reported increase in confidence in communicating with health professionals and hospital staff
- Self reported increased knowledge of birth process, care in pregnancy, contraception and immunisation
- Increase in women seeking antenatal care earlier and attending antenatal classes than in previous years
- Rate of caesarean section in women attending the program 10% while rate for other Aboriginal and Torres Strait Islander women attending Rockhampton Hospital is 18%
- Substantial increase in calls to the health service pertaining to the health of children and a declining rate of admissions for Aboriginal children 0-5 years with severe health problems (Dorman & Perkins 1997).

Cervical Screening: North Coast Regional Campaign

Type of campaign: Multi-strategic regional campaign conducted on the NSW North Coast. It followed immediately after a NSW state-wide media campaign in February 1988 that consisted of TV advertisements and information distribution to all GPs and community health workers. Costs \$3,800 for resource production and supplementary clinics

Message: Regular Pap tests can save lives

Target group: Women over 55 years and women under 25 years. NSW North Coast

Campaign duration: Two months during 1988

Types of media used: Local TV, radio and print

Other strategies to support the campaign: These included:

- Three posters targeting different age groups Fact cards.
- Direct personal contact with 10,000 women at shopping centres
- Provision of supplementary clinics in isolated areas

Methodology used to evaluate the campaign: Analysis of Health Insurance Commission data for changes in Pap smear rates before, during and after the promotion campaign compared to the same period the previous (control) year

Australian rates treated as a control

Evaluation results:

- Increase of 119% for women over 55 and 44% for women 15-24 with overall increase of 68% compared to overall NSW increase of 31%
- Statistically significantly higher Pap smear rates for North Coast than for NSW for all ages during March and for women aged 55 and over for April
- Differences between NSW and Australia (no active promotion) were significant for women 55 and over for March and April (Young & Trevan 1990)

Strengthening attitudes opposing domestic violence in culturally diverse communities

Type of campaign: Multi-strategic mass media and community development campaign focussing on Arabic, Chinese, Vietnamese and Tongan speaking communities in South Western and Central Sydney Area Health Services (\$120,000). Previous campaigns against domestic violence had been targeted towards general community and research had shown that NESB populations were less aware of domestic violence and that it is a crime, and less likely to report DV or take out Apprehended Violence Orders. The campaign was conceived in the languages of the target groups, rather being conceived in English and translated into the relevant languages.

Message: English: Domestic Violence hurts everyone in the family and it's a crime **Arabic:** Domestic violence causes family destruction

Chinese: Build family respect and harmony – Speak out against domestic violence

Vietnamese: Love builds harmony in the family – Domestic violence destroys everything

Tongan: Auhulu a Toutapa

Target group: Arabic, Chinese, Vietnamese and Tongan-speaking men and women in South Western and Central Sydney Area Health Service catchment areas

Campaign duration: Fifteen months, 1997-98

Types of media used: Radio (specific advertisements directed towards men and women specific to each language), billboards, newspapers, three minute Vietnamese advertisement for community TV

Other strategies to support the campaign: These included:

- Ethno specific working parties directing the planning and implementation of the campaign in their specific communities
- Posters, bookmarks
- Vietnamese fridge magnets and pamphlet on DV
- Chinese “Where to get help” pamphlet, and community information day
- Tongan Song writing competition and community Song Festival
- Arabic DV Awareness Day and information and referral kits

Methodology used to evaluate the campaign: Pre (425) and post (425) campaign survey of men and women conducted in English or the four community languages and comparison with the 1995 Australian National Opinion Poll (ANOP) survey of attitudes towards domestic violence; Reach survey combined with post campaign survey

Qualitative focus group research for men and women conducted in the relevant community language for each of the four communities; Monitor impact on 1800 help line.

Evaluation results:

Pre campaign:

- Comparison between 1997 baseline survey and 1995 ANOP survey confirmed significantly less understanding that: DV is a crime, the different forms of DV and the seriousness of DV
- More likely to believe the DV is a private matter best dealt with in the family
- Differences between men and women, with men saying women are likely to go to the police and women saying there is reluctance to go to the police for assistance
- Significantly fewer new arrivals (in Australia for less than 5 years) thought that DV was an issue for women or knew it was a crime

Post campaign:

- Identification of all forms of DV and percentage of people viewing different forms of DV as “serious” or “very serious” now consistent with ANOP survey
- Significant increase in number recognising DV as the main form of violence against women (25% increase) and in number that recognise that DV is a crime (20% increase)
- Significant reduction in number who agree that DV is a private family matter
- During the life of the campaign 43% of calls to 1800 help line from NESB people were from members of the four target populations
- Unprompted recall of the campaign messages on radio was between 67%-88% (Lane & Cobb 1998).

6.4 Lessons learned from general health promotion campaigns

Hot water burns like fire

- No health service can improve people's health on their own – it takes interest, support and action by whole community
- Apparent obstacles to success were overcome by involving key stakeholder groups in the planning process
- The temperature testing card and associated brochure were highly effective
- The impact of the efforts to secure policy changes is much more widespread because of the interest, media coverage and debate generated among key influencers
- Working with Area Health Services made the campaign relevant at the local level and ensured much greater reach of campaign messages and strategies
- Delaying the hardest to win strategy until there was a sufficient ground-swell from the community was effective
- Engaging multi media strategies (particularly TV) was effective for setting the agenda and providing a context for the tools distributed and products and policies promoted, as well as providing a strong incentive for stakeholder groups to get involved because they knew consumers would be reached
- Involve industry early
- Produce resources and information kits for local health workers early to allow time for them to plan local activities
- Have more process evaluation measures and qualitative feedback
- Develop a standardised evaluation tool for activities at a local level and evaluate strategies specifically targeted to sub-populations eg, NESB (NSW Health 1998).

Active Australia Public Education Campaign

- Substantial lead-time is necessary for planning community level activities in support of media campaigns. Where lead-time is reduced, intensive efforts need to be undertaken for local briefing and planning
- Rigorous formative, monitoring and evaluation research using consistent measures needs to be maintained
- Seasonal issues can influence the effectiveness of the physical activity and other campaigns and should be considered in evaluation (Bellow et al 1998).

Ngua Gundi – The Mother / Child Project

- Strong partnership between Aboriginal and Torres Strait Island community and health services involves both a recognition of Australia's history and the impact of colonisation, and the development and acceptance of more holistic, coherent, culturally effective and cohesive health care services
- Clear goals and involvement of Aboriginal health workers at all stages of the project
- Good level of resources and well supported by management eg, staff time, transport, venues, refreshments
- Sharing and support networks have grown and partnerships have been created
- Respect for Indigenous and non-Indigenous workers and boost in self-esteem for participants
- Strong partnerships between Indigenous and non-Indigenous people have engendered great trust and support for each other (Dorman & Perkins 1997).

Cervical Screening: North Coast Regional Campaign

- An intensive low-cost public health campaign working in partnership with service providers (GPs) can be effective in maximising broader campaigns and in reaching high risk groups who under utilise services. The combined approach was significantly more effective than mass media campaign alone (Young & Trevan 1990).

Strengthening attitudes opposing domestic violence in culturally diverse communities

- Baseline and follow-up surveys are awareness raising in themselves
- Radio was the most effective media
- When working with large communities from diverse countries of origin, eg, Arabic, Chinese, need to spread advertising across media to maximise reach

- The culturally specific working parties and bilingual workers were crucial to planning, developing and implementing the campaign
- Community events were a major vehicle for reaching communities and publicising the campaign. They also brought together groups that had not previously worked with each other to work towards a common goal
- The cultural specificity of the campaign messages and images meant that there was high recall of the campaign (Lane & Cobb 1998).

6.5 Systematic Reviews

Systematic reviews and meta-analyses play an important role in identifying effective health promotion interventions. They indicate principal areas for which good quality evidence exists and also point to gaps in knowledge. The quality of evidence is of high standard because methods are used to minimise selection, inclusion and measurement bias and because reviewers are able to synthesise research results thus gaining greater power than that obtained from results of a single study (Morrison 2003). The conclusions from the following systematic reviews point to areas of effective and ineffective health promotion practice.

Improving population health through transport interventions

This systematic review of 28 systematic reviews of population-based interventions and their health impacts concludes that the most effective transport interventions to improve health are:

- Health promotion campaigns to prevent childhood injuries, to increase bicycle and motorcycle helmet use, and to promote children's car seat and seat belt use
- Traffic calming
- Legislation against drink driving.

Driver improvement and education courses are associated with increases in crash involvement and violations study (Morrison et al 2003).

Mass media interventions for preventing smoking in young people

This systematic review of randomised trials, controlled trials without randomisation, and time series studies that assessed the effectiveness of mass media campaigns in influencing smoking behaviours in young people, found six studies that met the inclusion criteria. All six studies used a controlled trial design.

- Two studies found that mass media campaigns were effective in influencing the smoking behaviour of young people. Both had a solid theoretical base, used formative research in designing the campaign messages and the message broadcast was of reasonable intensity and over extensive periods of time. The broadcasts included an average of 190 TV, 350 cable TV and 350 radio spots in each of the four years of the campaign
- One study found the mass media campaigns were effective compared to no intervention and the other found that the mass media campaign combined with a schools-based intervention were more effective than schools-based programs alone.

The authors conclude that though there is some evidence for the effectiveness of mass media in preventing uptake of smoking in young people, overall the evidence is not strong (Sowden & Arblaster 2004a).

Community interventions for preventing smoking in young people

This systematic review found some limited support for community interventions to prevent uptake of smoking in young people. Community interventions were defined as coordinated, widespread programs in a particular geographical area or in groups of people who share common interests or needs. Sixteen studies were included in the review. All were controlled trials with six studies using a random allocation of schools or communities.

- Of thirteen studies that compared community interventions to no intervention, two, which were part of cardio-vascular disease prevention programs, reported lower smoking prevalence in the community intervention group
- Of three studies comparing community interventions to school-based programs only, one reported differences in smoking prevalence
- One study reported lower prevalence in a community receiving a multi-strategic intervention compared to a community receiving a media campaign alone and another reported lower prevalence in a community receiving a media, school and homework intervention compared to a media campaign alone (Sowden et al 2004b).

Mass media interventions: Effects on Health Services Utilisation

This systematic review included 20 studies. All were interrupted time series designs. Fifteen evaluated the impact of formal mass media campaigns and five of media coverage of health-related issues.

- All the studies concluded that mass media was effective and this was confirmed by the reviewers' re-analysis of seven studies. However the reviewers point to the variable methodological quality of the study designs and analyses that make it impossible to draw any firm conclusions about the characteristics of successful campaigns (Grilli et al 2004).

Effectiveness of interventions to promote mammography screening

This systematic review of 38 experimental or quasi-experimental studies using a control group examined a range of strategies to increase recruitment of under screened women. Interventions that were found to be effective include:

- Access-enhancing interventions (18.9% increase) eg, transportation, mobile vans, vouchers
- Individual-directed strategies in health care or community settings (17.6% and 6.8% increase) eg, one-to-one counselling; tailored and untailored letters of invitation and reminders
- Community education (9.7% increase)
- Media campaigns (5.9% increase)
- Social networks (5.8% increase) and
- Multiple interventions (13.3% increase overall).

The strongest combination of strategies was access-enhancing and individual-directed strategies which resulted in a 26.9% increase in mammography use (Legler et al, 2002).

6.6 Western Australian feasibility study

In 2002 the Western Australian Healthway Board commissioned a scoping exercise to provide background information and directions for a proposed mental health promotion campaign similar to the VicHealth *Together we do better* campaign. The Centre for Developmental Health, Western Australia coordinated the feasibility study, which was conducted by the Curtin University and the Telethon Institute for Child Health Research (Donovan et al 2004).

The feasibility project was commissioned to ascertain current beliefs and concepts about mental health, social connection, valuing diversity, and physical and emotional health and wellbeing in the Western Australian community. The study involved focus testing the key messages, resources and concepts of the VicHealth *Together we do better* campaign and conducting a benchmark quantitative study of community attitudes towards mental health and wellbeing and the concepts and issues to be promoted in any future WA campaign.

Four focus groups / community forums with 40 participants were held to engage mental health stakeholder groups in the development of the WA campaign initiative and to review the VicHealth *Together we do better* campaign materials. Participants included health, education, and welfare professionals, consumers and carers. Feedback from the focus groups was supportive of the idea of conducting a campaign and demonstrated high acceptance of the tag line "*Together we do better*". However participants believed that overall the campaign messages were complex and confusing and there seemed to be little understanding of the theme of connectedness and how this could make you healthy. Responses to the advertising material varied.

Both qualitative and quantitative research was conducted with members of the general public. Eight focus groups were conducted stratified by age, SES, gender, and rural / metropolitan areas. An additional focus group was held with people from non-Caucasian background born in Australia, or born overseas and resident in Australia for five or more years.

The primary connotation of "mental health" for the participants of the focus groups was one of mild or chronic mental illness and men in general did not find it easy to talk about mental health and what influences mental health. Stress was considered a major influence on both physical and mental health. Good self-esteem was seen to be at the core of good mental health, which can be demonstrated by people's ability to handle problems and seek help when needed.

Factors identified as influencing mental health (wellbeing) included:

- Opportunities for control and skill use
- Financial security
- Interpersonal relations
- Having a job or recognised role
- Rewarding versus belittling behaviour
- Childhood experiences and resilience
- Support of family and friends
- Social connectedness
- Recognition of achievements and
- Being accepted as part of a group.

In general, rural participants, and rural women in particular, felt connected to their community. There were marked differences between men and women in how they coped if they were feeling stressed or having problems. Women were far more likely to seek social support and talk about their problems to others. They also stressed the need for time for themselves. In contrast men preferred "time out", distracting or withdrawal strategies. Opinions varied about the efficacy of a mental health promotion campaign but topics mentioned as appropriate for such a campaign included: coping skills; connectedness / social interaction; communication skills / opening up; and de-stigmatisation of mental illness.

A random telephone survey of 1,000 metropolitan and 500 rural households was conducted. The survey explored associations to the terms "mental health" and "mentally healthy"; perceptions about how to become mentally healthy; and the impact of positive training practices (for people in authority over

others) on mental health. The survey confirmed the generally negative connotations of the term “mental health” and that “mentally healthy” has more positive connotations in terms of mental and emotional wellbeing.

The most common responses about what people can do to remain or become mentally healthy were: active mind (66.7%); physical activity (41.7%); reduce stress (22.6%) take time out for yourself (18.7%); social life (16.5%); family life (8.6%); participate (8.5%). The factors seen to contribute most to a person being mentally healthy were: having good friends to talk problems over with; opportunity to have control over your life; keeping your mind active; being physically healthy; having a job - paid or unpaid; having opportunity to achieve small successes in everyday life; belonging to a group of like minded people; and recognition by others when he or she does something good.

The report does not discuss any evidence for a relationship between positive concepts of mental health and actual improvements in mental health and wellbeing. Nevertheless the report recommends that the primary objective of Phase one of any mental health promotion program would be: “to increase the proportion of people having positive connotations to the words ‘mental health’ and decrease the proportion with primary connotations of ‘mental illness’ ”. Similarly they recommend that the secondary objective of Phase one would be to: “increase the salience and strength of the connection between good mental health and rewarding behaviours, and the corresponding connection between belittling behaviours and mental ill-health vulnerability” (Donovan et al 2004).

6.7 Principles of good practice

Principles of good health promotion practice, based on the evidence, have been identified by a number of authors.

6.7.1 Characteristics of effective mental health promotion programs

Bakshi et al (1999) identifies seven essential characteristics of effective mental health programs:

- An adequate time frame of at least 3-5 years to allow for the diffusion of new ideas
- Coordination of a variety of consistent and coherent activities
- Use of a range of strategies
- A multi-level approach which targets primary group and opinion leaders
- The flexibility to change, adapt and add to the initial program as required
- Research-based problem definition
- Adequate and appropriate evaluation.

6.7.2 Social capital and social change

Social capital, in itself, does not guarantee improved social and health outcomes for all members of society. Ideology, politics and history have a major influence on whether social capital promotes or undermines social, political and health outcomes. Bonding social capital, for example, may be a feature of divisive or regressive social movements such as the Hitler Youth Movement or Pauline Hanson's One Nation. Strong bonding capital can be used to exclude others, enforce conformity and encourage intolerance (ABS, 2002). Szreter and Woolcock (2002) point to the possible adverse uses of social capital to support practices such as nepotism, corruption and suppression.

In conceptualising how social capital can contribute to improved health and social outcomes it is important to consider social relations within a broader context of social change. This can inform the nature of community development interventions to build positive social capital to improve health outcomes.

Feek (1999, 2003), in his analysis of short-term indicators of long-term social change, points to a number of features of successful social change movements such as the US Civil Rights Movement, Women's Movement and Anti-Apartheid Movement. These include:

- A strong and independent voice in public debate, private dialogue and decision making by the people most concerned
- Increased accuracy of the information that people share in the dialogue/debate
- The issue of concern resonates with people's everyday interests and priorities
- Leadership by people most affected by the issue of concern (ie, key strategic decisions relating to the program are taken by the concerned population)
- People and groups with similar interests who might otherwise not be in contact are linked (a coalition of agencies contributing to change, support for the linkages which are created).

6.7.3 Health promotion principles for ATSI communities

An NHMRC report (1996) on promoting the health of Aboriginal and Torres Strait Island communities draws on a number of case studies to recommend the following principles of good practice:

- Needs are identified by the communities
- Partnerships between Indigenous health workers, communities, and non-Indigenous health worker are developed
- Resources and organisational support sustain the program
- Implementation is in the control of communities and Indigenous health workers
- Outcomes are identified.

These principles of good practice could be equally applicable to working with other diverse communities. They also are congruent with Feek's (1999, 2003) short-term indicators of long-term social change.

The report highlights that intermediate outcomes must be achieved before it is possible to reduce mortality and morbidity and stresses that the outcomes achieved in the case studies of good practice include all the elements of the Ottawa Charter:

- Changes in the ways health (and community) services are organised and delivered (reoriented services)
- Improvements in people's knowledge, skills and changes in health behaviours (increased personal skills)
- Changes to people's living environments and in their collective self esteem (supportive environments)
- Increase in communities' involvement in action to improve their health (community action), and
- Changes in public policy (building healthy public policy).

6.7.4 Community based interventions

Community-based interventions, as opposed to community-wide interventions, are focused at specific areas, populations or groups. They are often initiated or supported by local community members who are involved in planning and implementation. Mittlemark (1996, quoted in PADV 2003) identifies five critical stages in a community-based planning and action model:

1. *Community analysis:* This stage defines the parameters of the project, analyses the behaviour patterns, attitudes and beliefs that the campaign is attempting to change and identifies the skills and available community assets
2. *Design initiation:* The collaborators work together to establish the project, setting achievable goals and timelines for the project
3. *Implementation:* This stage covers the program's operation
4. *Maintenance and consolidation:* Participants gain expertise and experience with the program / campaign, and integrate learnings into existing community structures and networks.
5. *Dissemination and Assessment:* A continuous process of updating the community analysis, evaluating the effectiveness of the program / campaign, disseminating the results and developing future directions.

A key feature underlying the success of community-based campaigns is the building of a broad-based coalition consisting of community leaders, professionals and citizens to support the change process.

6.7.5 Community-wide / social marketing campaigns

Social marketing forms the basis for many health promotion campaigns. It allows for a multi-dimensional approach to complex problems that require change on a number of levels eg, behaviour, lifestyle, organisational, policy and cultural. Community-wide programs / campaigns address common health / social concerns and operate at regional, state and national levels addressing groups or society as a whole. One concern about community-wide campaigns is that because they are focussed on the community as a whole they can fail to reach specific populations within the wider community. The Department of Prime Minister and Cabinet, Government Communications Unit, has designed a guide for developing community awareness campaigns that is available at <http://www.gcu.gov.au/code/infodept>.

Cheetham (2001, quoted in PADV 2003) describes six stages in developing community-wide campaigns based on social marketing theory.

1. *Planning and selecting a strategy:* Research and assessment of the issue, defining and segmenting the target audience, and geographic coverage, assessing the available resources and developing goals, objectives and strategies for implementing them
2. *Selecting channels and materials:* Deciding which avenues will be used to deliver the campaign messages and the type of campaign materials

3. *Development of campaign materials and pre-testing:* develop messages, campaign slogans and draft materials to be tested with sample target groups. Revise materials to reflect testing outcomes
4. *Program implementation:* Sufficient materials are produced and distributed, a monitoring and evaluation program is implemented and material is updated as required to reflect ongoing feedback
5. *Assessing effectiveness:* This stage may include four kinds of evaluation that may be implemented before commencing the campaign, during the campaign, and at the end of the campaign. These types of evaluation are:
 - Formative evaluation which informs the design
 - Process evaluation which assesses how the campaign was implemented
 - Impact evaluation which assesses changes in knowledge and attitudes as a result of the campaign, and
 - Outcome evaluation which assesses the longer term outcomes of the campaign
6. *Refining through feedback:* This stage reports on the learnings of the campaign and recommends changes for future campaigns

7 Interview responses

The respondents had various backgrounds, expertise, experiences and perspectives and naturally highlighted their own concerns and interests. The result is that, whilst common themes emerged, there were also diverse responses and varying priorities identified. Some of the interview responses are in the next section Mental Health Promotion Resources.

Key informants were aware of a wide variety of general and mental health promotion campaigns that have been run in the past or were currently running. These included national and state campaigns such as the *Community Awareness Program*, *beyondblue*, *National Suicide Prevention Program*, *Mind Matters*, *School Link*, *Triple P – Positive Parenting Program*, *Transcultural Mental Health Centre Wellness Booklets and NSW Mental Health Week*. Other campaigns frequently mentioned were campaigns such as *Quit Smoking*, *Slip Slap Slop*, *Physical Activity*, *Domestic Violence*, *Families First* and campaigns targeted towards specific communities such as the *Arrive Alive* road safety campaigns focused on the Aboriginal and Torres Strait Islander communities, or the *Multicultural Domestic Violence* campaign “the ‘Rolls Royce’ of doing multicultural health promotion!” Respondents also had experience of regional or locally based campaigns such as the Central Coast *Dumping Depression*, the New England *Depression: Spot, Seek, Solve* community development campaign, and the New England *SeeSaw* initiative aimed at balancing the portrayal of mental health, mental illness and suicide.

7.1 Support for a state-wide strategy

Overall there was strong support for a state-wide strategy for Mental Health Promotion and in particular for a multidimensional, carefully targeted, approach to promoting social and emotional wellbeing. It was acknowledged however, that the evidence base for the effectiveness of mental health promotion campaigns was generally poor. Particular concern was expressed about the effectiveness of stand-alone mass media campaigns targeted towards the whole community.

Some of the reasons for supporting a state-wide campaign included:

- A consistent message across the state will have a greater impact
- A media campaign can stimulate discussion and bring people together.
- It saves each local Area doing the planning and piloting
- You can use or adapt materials developed by others rather than re-inventing the wheel

The importance of developing a strong, strategic and coordinated approach that would raise the profile of Mental Health Promotion across NSW was stressed. Such a strategy would need to be inclusive and involve people from a range of sectors in its development eg, representatives from rural, remote and urban areas, Aboriginal and Torres Strait Islander communities, CALD groups, consumers and carers.

Examples of the range of comments from key informants included:

*I think the idea of a state-wide campaign is excellent – it can address many needs in the community provided effective messages go out... a focus on mental **health** is important too*

I can't see any benefit from doing a media campaign and distributing information state-wide...I think programs that engage people have more impact – more potential for increasing knowledge – changing attitudes – changing behaviour – building resilience. And these are changes that can be sustained – that can make a lasting difference to people's mental health

There are lots of untapped opportunities for the Centre for Mental Health to recognise the potential for working in partnership. Ownership issues can be a problem.

Always a problem with large-scale campaigns – marginal effect if at all. They set an agenda within which people can build. Need a wider framework but must be specifically focused for different communities

If there was a long-term plan then a campaign could move through specific communities / populations, build up services and do workforce development. Need to consider where to get the best results and where to start

different target group each year however maintain the same theme or key message.

The Victorian campaign *Together we do better*, which is aimed at strengthening communities, increasing community resilience and enhancing social networks, was seen as a possible model for a broad based umbrella campaign.

Opinions varied about who should be the focus for a state-wide campaign or strategy. A number of respondents commented that this would depend on what issues are being addressed and the type of activities envisaged for a campaign. There was also concern about any campaigns that raised unrealistic expectations about the availability of services.

There was support for a broad based umbrella campaign but with an emphasis on the needs of different groups and communities and flexibility about how differing needs could be addressed.

One key informant stated:

It may be possible to maintain the same message or key theme however the campaign may be adapted to suit particular groups eg, information resources may contain the same key message or theme but are designed to appeal to different groups in the community eg, youth, older people, Aboriginal & Torres Strait Islander. Another option would be to focus on a

7.2 Possible focus of strategy / campaign

Key informants made the following suggestions of issues that could be addressed in a mental health promotion campaign or program.

Strengthening social supports and community connectedness, building social capital

A focus on social connectedness would be really great. That's what you want to change – to increase. And it's the lifeblood of communities. So having a campaign based on the theme of communities would encourage that connectedness – identify it as something that does do wonders for your mental health – and identify ways to get better connected for those who're at risk of being isolated.

Addressing the social determinants of health

Potential for addressing social issues is essential eg, employment, unemployment, under-employment, violence... address the economic and social determinants of mental health.

Reducing stigma, normalising mental health issues and increasing mental health literacy

There definitely is a need in our rural communities for information about a whole range of mental health issues... Mental health literacy covers a lot of ground – in terms of catering to a range of target groups – and achieving a range of outcomes. For example resources for consumers and carers about mental illness that help ease the anxiety associated with diagnosis, resources that help build those personal skills and coping mechanisms, resources that inspire and provide hope, that counter the myths and stereotypes that feed stigma, that provide information about local services, organizations, support network.

Promoting wellbeing and coping skills

*Protective factors for mental health eg,
On a broad community level – social connectedness
Sectors of the community – protective factors for mental health in a workplace setting
On an individual level – what you can do to maintain and strengthen your mental health. Building resilience.*

Addressing specific mental health and associated problems such as stress, substance abuse

Look at mental health and mental illness as a continuum – it's not 'either / or' – people are consumers some of the time and non-consumers some of the time. Stress is in the continuum; everyone is touched by it. Unless people are aware, they can move along the continuum towards mental illness. Fear and anxiety – is the same thing. Many people have no diagnosis, but stress, fear, anxiety, etc have the potential for developing into mental illness in some people or physical illness in other people – it's all part of the continuum, but many people don't see it that way.

7.3 Local mental health promotion activities

Key informants identified a broad range of strategies and activities that could be implemented at a local level. These included:

- Door knock to discuss campaign
- Identify community leaders and local identities
- Organise local forums to identify the risk and protective factors for mental health in local area and develop strategies to build on/create protective factors to reduce risks.
- Bring together a critical mass of people to work on activities then others will join in
- Respond to issues of greatest interest to local communities and organise relevant activities with the community eg, “Oracles of the Bush” festival in Tenterfield
- Establish local support groups following consultation with existing groups
- Participate in existing community functions, activities and sporting events
- Help organise community activities that are cheap and fun and aimed at reducing isolation rather than a specific mental health focus
- Work with established services and groups to maximise the spread of the campaign messages eg, carer and consumer groups, sporting organisations, clubs, GPs, Community Development Employment Program (CDEP), neighbourhood centres
- Work with local media, including Aboriginal and ethnic media, to provide stories, interviews, information
- Organise launches of campaign material and invite local identities/community leaders as drawcards
- Provide community education to local groups (eg, Probus) and distribute campaign materials
- Organise displays at local events
- Provide training to community leaders and local organisations about the campaign to enable them to provide community talks
- Work with local libraries for the distribution of campaign information – brochures, posters, videos, CDs, biographies, service directories etc

7.4 Activities not suitable for implementation at local level

Key informants were asked to identify any health promotion activities that were not suitable for implementation at a local level. Activities identified included:

- Mass media campaigns although the ideas for campaigns may originate in a local area eg, the anti-smoking cinema advertisements aimed at youth were initiated on the Central Coast.

- Legislative change but again the idea for change may be initiated at a local level
- Distributing information materials or holding one off events that have no links to sustainable initiatives

8 Mental health promotion resources in NSW

The *Caring for Mental Health* (1998, p.18) framework for mental health care in NSW made a commitment that 'each Area Health Service will have at least one specific prevention program in mental health in 1999'. Each AHS was provided with funding to employ at least one specific mental health promotion officer. Many of these staff and other staff working in mental health promotion or a related area formed the NSW Network for Promotion and Prevention in Mental Health. The Terms of Reference state that "The purpose of the NSW Network for Promotion and Prevention in Mental Health is to facilitate and strengthen the quality and effectiveness of health promotion and prevention action for the improvement of mental health among the NSW Population".

Table 1 below shows the mental health promotion positions as identified by the Directors of Mental Health in each AHS.

Table 1 Mental health promotion positions in NSW[^]

Area Health Service	Mental Health Promotion Positions	SchoolLink positions	Other (eg Aboriginal Health, CALD etc.)	Total positions (FTE)
Central Coast	1 MH Promotion	1		2
Central Sydney	1 EIP	1	1 COPMI 0.6 GP Liaison 2 Aboriginal 0.6 Triple P	6.2
Greater Murray	1 Aged 1.5 EIP	1		3.5
Illawarra		1	0.5 Child early intervention, focus on parenting.	1.5
Macquarie	2 MH Promotion	1	1 Aboriginal AOD 2 AOD	6
Mid Western				3
New England	3 MH Promotion 1 CAMHS	1	1 Aboriginal 0.2 See Saw Project 0.4 Depression Project	6.6
Northern Rivers		1	(6 Aboriginal MH Workers)	1
South Eastern Sydney		1	9.2	10.2*
Western Sydney	1	0.9**	0.2 **Resilience Programs 0.1** Aboriginal 0.5** Suicide Prevention	2.7
Far West				n/a
Hunter				n/a
Mid North Coast	1 (Suicide & Depression) 0.7 MH Promotion 1 EI/Health Promo	1		3.7
North Sydney	1 MH Promotion 1 MH Promotion Manager	1	0.4 Multicultural Health Promotion 1 Parenting (part) 1 Youth	5.4 (+ 14 youth consultants 1-2 hrs pw)
South Western Sydney	3 MH Promo 1 MHP Program Manager 2 MHP Researchers	2	2 COPMI 1 Suicide prevention 1 Parenting 1 CALD 1 Aboriginal 1 Aboriginal Child & Family MH Worker 1 Consumer Coordinator	16
Southern		3 (SchoolLink and COPMI)	1 Rural	4
Wentworth	1 MH Promotion	1	1 Aboriginal 1 COPMI 1 Suicide prevention (older people) 0.6 Parenting	5.6
Justice Health				0

n/a=not available

[^] whilst every effort has been made to ensure the accuracy of this information, we cannot guarantee it is correct due to the variety and complexity of the data received from each Area.

COPMI=Children of Parents with Mental Illness EIP=Early Intervention Program
AOD=Alcohol and Other Drugs CAMHS=Child and Adolescent Mental Health Service

*The South East Sydney Area Mental Health Service has no dedicated health promotion/prevention positions. There are a number of positions that have a proportion of this work within their roles. Some of these positions are currently vacant.

**indicates a full-time position, with percentage of mental health promotion work shown.

Other mental health promotion positions in NSW include 1.5 FTE positions at the Mental Health Association NSW Inc and up to seven positions (three are currently filled) at the Centre for Mental Health. A Mental Health Promotion Officer from the ACT is also a Network member.

8.1 Existing local resources

Many of the risk and protective factors for mental health are social, economic or environmental in nature and lie outside the health care sector. Key informants identified a broad range of resources that could be developed or accessed at a local level.

Identified resources included:

- People – residents, consumers, carers, Aboriginal elders
- Groups – local consumer advisory groups and support groups (eg, GROW, ARAFMI, Al Anon – for families and friends of alcoholics)
- Government departments – Housing, Education (Health Promoting Schools), Centrelink, Community Services, Corrections, Commonwealth Rehabilitation Service (CRS), TAFE colleges
- Local government – environmental health officers, libraries, community services and resources
- Health services – mental health promotion staff, health promotion staff, Aboriginal health promotion staff, consumer consultants, community health staff, mental health staff, alcohol and other drugs staff, Aboriginal Medical Services (AMSs), AHS Chief Executive Officers and other senior managers, Divisions of General Practice, GPs, specialist medical staff, Public Health Officers
- NGOs – Aboriginal Land Councils, neighbourhood centres, youth centres, carer respite centres
- Local businesses – sponsorship, access to facilities (eg, gyms)
- Telstra Technology Centres
- Religious organisations
- Clubs – sporting clubs (eg, “Good Sports Club” funded by Alcohol Summit), Service Clubs, Laughing Clubs, Police Citizens Youth Clubs (PCYC)
- Community organisations/charities – Rotary (organises community mental health forums), Country Women’s Association (CWA)
- Workplaces
- Local media
- Local Members of Parliament

8.2 Existing state level resources

Key informants identified a range of state level resources that could be accessed for a mental health promotion campaign. These included:

- Peak Consumer/Carer Groups – NSW Consumer Advisory Groups, GROW, ARAFMI
- Head offices of Government departments – Health (Centre for Mental Health, Centre for Health Promotion, Better Health Care), Housing, Education, Community Services, Corrections
- Health services and networks - Transcultural Mental Health Service, Aboriginal Health and Medical Research Council, NSW Network for Promotion and Prevention in Mental Health, Mental Health Promotion Advisory Committee, Mental Health Association NSW Inc
- Special Broadcasting Service (SBS)
- Peak CALD organisations
- Rotary state office (funds mental health research)
- Government ministers and other political leaders

8.3 Strategic partnerships

Collaborative intersectoral partnerships are critical to mental health promotion campaigns. Many informal and formal (eg, Memorandums of Understanding) partnerships already exist in local areas and these can be built on.

Strategic partnerships could be developed between any of the local and state resources listed above. Some of the potential partnerships identified by key informants as useful for a mental health promotion campaign aimed at building social capital and community resilience included:

- Health promotion staff and community groups and organisations
- Local Aboriginal communities, AMSs, Aboriginal Health Workers, carers and consumers
- Transcultural Mental Health Service, CALD communities and AHSs
- Health services, NGOs and local government (especially libraries)
- Health services, CEOs, Government ministers and other political leaders
- Physical activity programs and mental health programs
- Mental Health and Alcohol and Other Drugs programs and activities
- Health services, Rotary, CWA, Sporting Clubs and Service Clubs
- Government departments including Health, Housing, Corrections, Community Services
- Public Health Officers and local government Environmental Health Officers
- GPs, specialist medical staff and health promotion staff

8.4 Additional mental health promotion resources needed

Key informants identified that funding would be required at a local level to trial health promotion strategies and build the case for greater investment. A state-wide media campaign would require both local and state level resources to support the campaign.

Funding and resources would be required for:

- State-wide brochures and posters with room for local details, or locally designed brochures and posters
- Brochures and posters for specific CALD groups and Aboriginal and Torres Strait Islander communities
- Consultation with consumers, carers and other relevant groups about brochures and posters
- A critical mass of health promotion staff including mental health promotion and Aboriginal health promotion staff to drive the campaign and get others involved eg, New England Area Mental Health Promotion Network

- Administrative support
- Implementation packs providing resources and guidelines for local implementation of the campaign and the evaluation (see VicHealth's *Promoting Mental Health and Well-Being – The Partner Pack*)
- Training in community development, presentation of educational talks, group facilitation and evaluation techniques for staff and support persons in the community
- Specific projects and activities
- Monitoring and evaluation
- A central coordinating group with broad based representation (eg, people from rural and remote areas, Aboriginal and Torres Strait Islanders, CALD groups, young people, consumers, carers) if state-wide campaign
- A dedicated state level health promotion position to support the campaign
- A local network and identified contact person to liase with the central coordination group
- Access to resources (eg, video-conferencing) needed to connect people isolated by distance
- Development of partnerships between government, corporate and non-government sectors
- Relevant policy/protocol development and legislative changes to help sustain the campaign

Key informants stressed the importance of a commitment to the campaign from Area Health Service CEOs, Directors of Mental Health, mental health managers and other senior health staff, to ensure local workers are supported to deliver the campaign. Managers would also need to assess if existing services were adequate to cope with additional demand generated by the campaign. As one informant stated:

Don't create a demand for services that don't exist.

9 Identified strengths and weaknesses

The literature review and interviews with key informants identified a number of factors that underpinned effective and ineffective health promotion initiatives.

9.1 Strengths

The identified strengths of campaigns included:

Multi-strategic and multi-level campaigns

Most effective are ones that operate on multiple levels eg, Random Breath testing (linked to media, legislation, environment etc)... Best campaigns are not just awareness raising, but are also about engaging / enabling people to take action.

Well-designed and thorough formative research

- **Culturally, geographically, and age appropriate messages**
- **Strong, simple, memorable messages**

- Clearly state the benefits of adopting a particular behaviour
- Keep messages simple and choose ones that resonate with the community
- Need branding / symbol to link national and regional aspects of a campaign

A good message, a good slogan, a good jingle are very important – they must be memorable - they have to stick. This leads to high levels of recognition, which in turn form the basis for the next step of getting the message to translate into changed behaviour.

Specificity of program designs and strategies for target audiences

- Need specific images / messages that have relevance to diverse / Indigenous communities
- Whole population approach does not work across cultures

“The campaign needs to be inclusive – not just white Anglo people. Need a broad cross-section of people from different ages, different backgrounds, city/country, NESB, ATSI”.

Adequate investment and commitment

- **Funding**
- **Infrastructure**
- **Time**
- Implementation teams need organisational, policy and infrastructure support from senior management
- Adequate time is needed to engage with the community, especially when working with Aboriginal and Torres Strait Islander communities
- Mass media campaigns that are effective in influencing behaviour and have a solid theoretical base, use formative research in designing the campaign messages and have a message broadcast of reasonable intensity over extensive periods.

If you want to have an effect you have to make an investment. A good program and a big commitment is needed.

Consultation and partnerships at all levels

- Inclusion of community partners in core planning and implementation is beneficial to the formation of meaningful partnerships across agencies
- An intensive and extended period of consultation and implementation needs to take place to allow local service providers adequate discussion time and the opportunity to become familiar with and contribute to the campaign
- Strengths-based approaches are effective because they focus on building on community strengths, facilitating community participation, and building relationships of equality between services and residents
- Employing local residents, wherever possible, is a crucial factor in recognising and valuing community skills and strengthening community leadership
- A variety of informal, as well as formal, culturally appropriate mechanisms encourages engagement and participation.

Well-designed evaluation - process, impact and outcome

- Funding for adequate evaluation is essential
- Evaluation frameworks need to be considered before commencing the program / campaign to allow for baseline data collection, process monitoring and impact and outcome measurement
- Aims and objectives must be clearly articulated to allow for impact and outcome evaluation
- Strategies need to be related to outcomes of baseline research
- Success with message reach and recall doesn't equate to success in terms of stated aims.

9.2 Weaknesses

Conversely, health promotion campaigns / initiatives, that were identified as weak or ineffective, were those that were not evidence based, lacked adequate evaluation, that were too prescriptive or too “nice” in glossing over problems, or that were seen to be “preaching to the converted”.

Messages too paternalistic, prescriptive. Messages need to be memorable, relevant and empowering.

Be sure the advertisements don't result in unreal expectations ie, with a little support, people with mental illness are just like you – but often they aren't for all sorts of reasons, eg, poor concentration, lack of mobility, etc.

The effectiveness of campaigns can be undermined if communication, coordination and consultation are lacking or inadequate or if there are not adequate services to meet the demands raised by campaigns.

If you were to run a campaign that increased referral to services you would have to make sure that rural areas had the capacity to deliver. No expectations about intensive follow up for instance...

Services must be capable of responding promptly following a campaign. If not, potential benefits will be lost.

9.3 Cultural and linguistic factors

Key informants were asked specifically about what cultural and linguistic factors needed to be considered in planning and implementing effective health promotion campaigns. Whilst their responses were directed towards issues affecting Indigenous and culturally and linguistically diverse communities the

ATSI communities talk about social and emotional wellbeing – don't have a culture of diagnosis. Have "life promotion" officers in some communities

Use arts as a medium to improve self esteem... incorporate art, meditation, Yoga, philosophy...

Do culturally specific campaigns starting from go with language, images, and ways of infiltrating the community tailored to the communities you are working with

Language used is a big deal – fraught with danger so need very good quality control every step of the way

Keep it simple – information needs to be understood by people with a range of literacy skills. The language needs to be kept to "everyday" terms wherever possible – not mental health jargon

factors identified, and those identified in the literature review, have application across all groups including Anglo-Australian communities.

Respondents were aware that it is important to be prepared to "go an extra mile" to achieve outcomes in a culturally and linguistically diverse community like Australia.

Respondents spoke about taking a holistic approach to health. A focus on a "community at risk" rather than individuals at risk acknowledges the underlying causes of ill health and provides a framework that encourages the involvement of the community in ways that a focus on individuals does not.

Being aware of the socio-historical context of people's lives, tailoring language, images and ways of working to the specific communities of concern, and using a range of resources appropriate to community literacy levels is important.

Once again the timing of campaigns was seen as very significant. This applies both to avoiding running campaigns at times that are inappropriate or when a community is under

specific stress, as well as linking campaigns to community celebrations, such as NAIDOC Week or multicultural festivals, in order to maximise reach.

In terms of building social capital, the strategies that concentrate on bridging and linking social capital are most likely to have long term benefits for the community – they involve building respect between people or groups who are different from each other, and building the capacity of residents from diverse backgrounds to take on leadership roles in the community

10 Proposed strategy

The results of the literature review and interviews with key informants indicate that multi-strategic approaches to population based health promotion are the most effective. Long-term investment is also required especially when the focus is addressing inequities in health and the effects of social disadvantage. Social capital and social support is clearly associated with better health and wellbeing and a lower risk of mental illness.

A study mapping social disadvantage to specific geographic areas shows that a disproportionate amount of long term and inter-generational social disadvantage is concentrated in a relatively small number of postcode areas in rural and urban regions (Vinson 2004). This study provides critical information for the development of a controlled trial of a health promotion campaign to improve mental health and wellbeing

by strengthening social capital and community resilience in socially disadvantaged areas. This approach would directly address health and social inequalities and also strengthen the evidence base for mental health promotion.

It is envisaged that a multi-strategic mental health promotion campaign / initiative would be implemented over a five-year period and would include specific strategies focusing on culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander communities, and other groups that experience discrimination or social disadvantage eg, gay and lesbian youth, people with disabilities, refugees and unemployed people. It would necessitate the formation of broad partnerships and involve meaningful community consultation, participation and ownership.

It would be modelled on past campaigns, community development approaches and social marketing strategies that have been shown to be effective. It would have a strong research and evaluation base and its two main components would be community development initiatives in socially disadvantaged communities supported by a social marketing campaign.

It is recommended that the proposed strategy incorporate both the community development and social marketing strategies described below. If there are not sufficient funds for both components (see estimated costs below) then it is recommended that the community development component should be implemented alone. The social marketing component should only be implemented in conjunction with the community development component, as there is little evidence for the effectiveness of social marketing campaigns alone.

10.1 Community development component

This would consist of a five-year controlled trial of a community development initiative to increase social capital and community resilience, and improve emotional and mental wellbeing, in two urban and two rural areas identified to be significantly disadvantaged. One or two urban and rural communities, that have also been identified as significantly disadvantaged, would be used as controls. The intention would be to expand the strategy after three years if it is shown to be initially successful. It could be modelled on the *Villawood Icebreaker* project and may include:

- A baseline household survey in the intervention and control communities to assess emotional and mental wellbeing (eg, SF-36 or other validated mental health survey instrument), social capital, social cohesion, community connectedness, safety and capacity to participate, and access to services
- Formation of strong partnerships across community organisations and with residents building a broad-based coalition consisting of community leaders, professionals and citizens to support the change process
- Consultation with the community about the results of the baseline research and follow-up surveys and the most appropriate community development initiatives to be implemented over the life of the project
- Flexibility to change, adapt and add to the initial community development initiatives as required
- Follow-up household surveys at three and five years.

10.2 Social marketing component

A state-wide social marketing campaign along the lines of the VicHealth *Together we do better* campaign will provide an umbrella mass media campaign in support of the community development component to:

- Increase social capital and community resilience
- Increase community participation especially for disadvantaged or marginalized groups
- Improve mental and emotional wellbeing, and
- Promote practices opposing discrimination and violence.

The advantage of adopting a social marketing strategy modelled on the *Together we do better* campaign is that there is already significant evidence of its effectiveness, much of the formative research and

development of campaign materials has been done so there are cost savings to be made, and it provides a good model for researching, implementing and evaluating a mass media campaign. A similar campaign in NSW could therefore value-add rather than having to start from scratch.

The social marketing campaign would be coupled with the community development component and provide a supportive context for it. This approach would increase the campaign reach to the whole of NSW and allow a comparison of the relative effectiveness of the stand alone social marketing strategy compared to the combined approach in the community development intervention communities.

It is envisaged that there would be four to five advertising phases, addressing different aspects of the campaign, over a five-year period. It would include:

- Baseline and follow-up telephone population surveys monitoring emotional and mental wellbeing, social capital, social cohesion, community connectedness, safety and capacity to participate
- Formative research and design of campaign materials for each phase of the campaign
- Two follow-up telephone surveys per phase of the advertising campaign. One mid advertising phase to check reach, direction and impact, and one post advertising phase to assess outcomes.

10.3 Costings

It is estimated that a regional community development strategy along the lines of the *Villawood Icebreaker* program would cost approximately \$60,000 per year for each intervention community. This would provide sufficient funds of \$40,000 per year to employ a part time community development project worker and approximately \$20,000 per year for community development activities. In addition funding of \$45,000 for the baseline and two follow-up community surveys in each intervention and control community would be required.

A print, radio, cinema and website mass media campaign along the lines of the *Together we do better* campaign would additionally cost approximately \$1.32 million per year. This comprises approximately \$200,000 for research and evaluation, \$220,000 for strategy development and campaign materials \$900,000 advertising costs. The cost would be significantly higher if TV advertising was used.

Tables 2 and 3 below provide approximate funding requirements for the community development strategy over three years and the social marketing component over five years. The funding requirements are based on the campaign costs provided in the literature review.

Table 2 Cost of community development component of strategy

	Cost items	Year 1 \$	Year 2 \$	Year 3 \$	Year 4 \$	Year 5 \$	Total for 1 community	Total for 4 communities
Intervention community	P/t CD worker	40,000	40,000	40,000	40,000	40,000	200,000	1,000,000
	CD activities	20,000	20,000	20,000	20,000	20,000	100,000	500,000
	Evaluation (baseline, FU1 & FU2)	15,000		15,000		15,000	45,000	180,000
Control community	Evaluation (baseline, FU1 & FU2)	15,000		15,000		15,000	45,000	180,000
Total costs		90,000	60,000	90,000	60,000	90,000	390,000	1,860,000

A saving of \$90,000 could be made by reducing the number of control communities to two communities instead of four.

P/t=Part-time

CD=Community Development

FU1=Follow Up Survey 1

FU2=Follow Up Survey 2

Table 3 Cost of social marketing component of strategy

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Research & evaluation	200,000	200,000	200,000	200,000	200,000	1,000,000
Resource development	220,000	220,000	220,000	220,000	220,000	1,100,000
Advertising	900,000	900,000	900,000	900,000	900,000	4,500,000
Total costs	1,320,000	1,320,000	1,320,000	1,320,000	1,320,000	6,600,000

10.4 Steps in development and implementation

Assuming that funding is available to support the proposed mental health promotion strategy, steps towards its development and implementation would include:

- Establish a state-wide steering committee with representation from a broad range of rural and metropolitan stakeholders including but not restricted to eg:
 - NSW Centre for Mental Health
 - Mental Health Association NSW
 - NSW Consumer Advisory Group
 - NSW Network for Promotion and Prevention in Mental Health
 - Aboriginal Health
 - Transcultural Mental Health
 - Premier’s Department “Strengthening Communities” program
 - Health Promotion
 - Sport and Recreation
 - Local Government Association
- Develop a five year plan with clearly articulated goals, objectives, and strategies that can be related to process, impact and outcome evaluation
- Consult with key stakeholders to determine workforce development skills and needs around the proposed strategy
- Select intervention and control communities and commission Expressions of Interest from Area Health Services and other organisations, including NGOs, working in partnership with the community and consumers, to manage the community development components of the strategy
- Ensure adequate consultation, and establish both formal and informal mechanisms for the engagement and participation of the intervention communities
- Commission the design and implementation of the social marketing campaign
- Commission research, evaluation and training:
 - It is envisaged that the initial research design and establishment phase of both the community development and social marketing components will take approximately six months
 - **Community development component:** Design baseline and follow-up household surveys for intervention and control communities for the community development component
 - Provide training, support and analysis for locally based research and evaluation in the intervention and control communities
 - **Social marketing component:** Develop and implement an evaluation plan including baseline and follow-up telephone population surveys to monitor emotional and mental wellbeing, the impact of any mass media campaigns, dissemination of campaign materials and use of campaign resources, website etc. and conduct qualitative research with key stakeholders
 - Conduct formative research on existing and new campaign materials for each phase of the social marketing component
 - Conduct two follow-up telephone surveys per phase of the advertising campaign. One mid campaign to check reach, direction and impact, and one post campaign to assess outcomes
- Publicise the strategy and promote opportunities to form partnerships, work collaboratively and access financial support eg, with:
 - Research and tertiary institutions
 - Premier’s Department

- Families First Community Development programs
 - Local Councils
 - Clubs and sporting organisations
 - National Mental Health Promotion initiatives eg, beyondblue
 - Health Promotion demonstration programs.
- Ongoing monitoring, reporting and modification to ensure the strategy is consistent with the principles of best practice in health promotion (see Section 6.7) and that it is meeting process, impact and outcome indicators.

11 Conclusion

A number of national and state mental health promotion initiatives are currently being implemented or have been implemented in the recent past. However, many of these focus on preventing mental illness or minimising its personal and social effects rather than on promoting mental and emotional wellbeing. There is an identified gap in terms of a state-wide approach to improving mental health and wellbeing and a clear opportunity to focus on areas of social disadvantage and reduce health inequalities. Principles of good practice have been identified that can guide the development of a state-wide mental health promotion strategy (see Section 6.7).

The proposed mental health promotion strategy incorporating both community development and social marketing components is recommended because it has a number of advantages:

- There is already significant evidence of the effectiveness of a social marketing campaign along the lines of the *Together we do better* campaign and of a community development strategy modelled on the *Villawood Icebreaker* project
- There are possible cost savings to be made as much of the formative research and development of campaign materials has been done
- A state-wide social marketing campaign would increase the campaign reach to the whole of NSW and allow a comparison of the relative effectiveness of the stand alone social marketing strategy compared to the combined approach in the community development intervention communities
- The community development component has the advantage that it is cost effective and focuses on the most disadvantaged areas. If it is proven to be effective it will significantly strengthen the evidence base for mental health promotion and can be extended to other communities across NSW
- The social marketing component both provides a campaign context within which the specific community development projects can operate and also connects to other state-wide approaches such as the Premier's Department *Strengthening Communities* initiatives, *Families First*, etc.

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Appendix 1 – Feasibility Study Reference Group

Ms Gillian Church (Chairperson)
Chief Executive Officer
Mental Health Association NSW Inc

Ms Mariella Attard (until August 2004)
Mental Health Promotion Officer
Mental Health Association NSW Inc

Ms Marietta Davis (from August 2004)
Mental Health Promotion Manager
Mental Health Association NSW Inc

Ms Amanda Shaw (via video-conference)
Acting Team Leader/Senior Mental Health Promotion Officer
Area Mental Health Promotion and Prevention Service
New England Area Health Service
Member of NSW Network for Promotion and Prevention
Member of Mental Health Promotion Advisory Committee

Ms Yvette Cotton
Communications Officer
NSW Consumer Advisory Group (NSW CAG)
NSW CAG delegate to Mental Health Promotion Advisory Committee

Mr Peter Trebilco AM
Vice President - Finance
Public Health Association of Australia Inc
Mental Health Association NSW Inc. Board Member
Board delegate to Mental Health Promotion Advisory Committee

Ms Mary-Kate Pickett
Senior Mental Health Promotion Officer
Western Sydney Area Health Service
Member of NSW Network for Promotion and Prevention
Member of Mental Health Promotion Advisory Committee

Dr Meg Smith OAM
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University of Western Sydney
President, Mental Health Association NSW Inc.

Ms Julie Edwards
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South Western Sydney Area Health Service
Member of NSW Network for Promotion and Prevention
Member of Mental Health Promotion Advisory Committee

Corresponding members

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Mental Health Promotion Officer
Member of NSW Network for Promotion and Prevention

Ms Margaret Thomas
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Ms Bernadette Dagg
Manager Prevention
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NSW Department of Health
Member of NSW Network for Promotion and Prevention

Appendix 2 – Interview schedule

Introduction statement

Mental health promotion is a positive concept about promoting mental health and wellbeing rather than focussing on mental illness. It is about looking at the links between the social, economic and cultural environment and physical and mental health ie, the whole person rather than physical or mental health separately.

1. What issues could be addressed by a mental health promotion campaign in NSW?

Prompts

Strengthening social support and networks
Healthy lifestyles focussing on whole person rather than mental or physical health
Resilience
Stress
Educational opportunities
Employment opportunities
Access to community resources
Poverty
Building friendships and trust
Strengthening community and personal safety

2. Who should be the target audience for a mental health promotion campaign in NSW?

Prompts

State-wide
Specific communities eg, long term disadvantaged, Aboriginal and Torres Strait Islander communities, NESB communities, refugee communities, or a number of communities?
State-wide with additional focus on specific communities

3. What current or past national, state or local health promotion campaigns have you been aware of?

Prompts

Together We Do Better (strengthening social networks)
Community Awareness Campaigns around issues like de stigmatising mental illness
Campaigns around risk factors like the Mind Matters school program
Anti bullying programs in schools
Home visiting and parenting programs.
Me No Fry
Domestic violence
Anti smoking

4. What would you say are the strengths and weakness of these campaigns?

Prompts

Strengths

Strong message
Good media coverage
Backed up with legislation at State or local Government level eg, Scalds campaign, drink driving, seat belts, tobacco advertising and sales, smoke free venues.
Significant infrastructure support in terms of funding and training eg, the Families First campaign
Good relationship between head office and local initiatives in terms of support and resources
Broad support across agencies eg, Physical activity

Weaknesses

Targeted to English speaking or Anglo slogan translated rather than developed for community
Not properly evaluated
Campaigns come out of head office and people on the ground not informed so get swamped eg, cervical screening, breast screening
Lack of services to pick up on responses to messages eg, DV campaigns
Message might blame the victim eg, DV campaigns.

5. What cultural and linguistic factors need to be considered in a mental health campaign?

Prompts

Aboriginal and Torres Strait Islander friendly messages and resources
NESB friendly messages and resources
Translation of material
Developing culturally specific campaign messages not just translating
What is going on in specific communities at the time may influence take up of campaign.
Youth culture

6. What resources are already available at the local level to support a mental health promotion campaign?

Prompts

Local residents (identify community leaders)
Consumers
Carers
Mental health promotion staff
Health promotion staff
Community organisations
Local councils

7. What additional resources would be needed at a local level to maximise the effectiveness of the campaign?

Prompts

Mental Health Promotion staff
Training in community development and evaluation
Funding for specific projects supporting the campaign and for evaluation
Information/resources based on the campaign messages

8. What types of activities could be undertaken at a local level to support a mental health promotion campaign?

Prompts

Increasing community participation
Establishing Local support groups
Working with consumers and carers
Improving access to information and services
Improving collaboration between services and the community
Building community leadership
Promoting opportunities for participation
Organising local media coverage eg, radio interviews, newspaper articles, newsletters

9. What health promotion activities are not suitable for implementation at a local level?

Prompts

Mass media campaigns
Legislative change

10. What state level resources are available to support a mental health promotion campaign?

Prompts

Expert research and evaluation design
Coordination
Training
Broad media and communication strategies
Partnerships across programs eg, Families First, Premier's Dept.

11. What partnerships could be formed if the approach was to do something along the lines of Together We Do Better ie, building social capital and community resilience?

Prompts

Consumers
Carers
Local residents
Local government (libraries, community services)
Community organisations
CWA
Rotary
Churches
Generalist health promotion
Schools and tertiary institutions
Employment and training agencies
Other Government agencies eg, Housing, Police, DoCS
Aboriginal and Torres Strait Islander communities
NESB organisations
Other Area health Service departments
NGOs
Other programs eg, Families First
Telstra (technology centres)

12. Do you have any other comments?

Appendix 3 - Key informants

Consumer Focus Group participants²

Yvette Cotton – Communications Officer, NSW Consumer Advisory Group

Nicole Emerson

Anna Saminsky

Paula Hanlon

Elizabeth Pemberton

Ms Jenice Craig

Mental Health Promotion Officer

Central Coast Area Health Service

Ms Mary-Kate Pickett

Senior Mental Health Promotion Officer

Western Sydney Area Health Service

Dr Meg Smith OAM

Associate Professor

Social Justice and Social Change Research Centre

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Emeritus Professor Ian Webster AO

University of NSW

Ms Anne Dadich

Registered psychologist and doctoral candidate

Mr Peter Trebilco AM

Vice President - Finance

Public Health Association of Australia Inc

Mental Health Association NSW – Board Member

Mr John Spiteri

Transcultural Mental Health Service

Barbara Caine

Aboriginal Mental Health Worker

South Eastern Sydney Area Health Service

Sharon Minnicon

Aboriginal Health Promotion Officer

Central Sydney Area Health Service

Paige Dowd

Aboriginal Health Promotion Officer

South Eastern Sydney Area Health Service

² Consumer Focus Group participants gave permission for their names to be included.

New England Area Mental Health Promotion Network

Amanda Shaw

Elisabeth Wakeford

Greg Strong

Warren Bartik

Warren Isaac

Kate Bowman

Yarif Freestone

Julie Kruss

Appendix 4 – Interviews with key informants

The information below is the raw data from the interviews with key informants.

1. What issues could be addressed by a mental health promotion campaign in NSW?

Strengthening social supports and community connectedness, building social capital

- A focus on social connectedness would be really great. That's what you want to change – to increase. And it's the lifeblood of communities. So having a campaign based on the theme of communities would encourage that connectedness – identify it as something that does do wonders for your mental health – and identify ways to get better connected for those who're at risk of being isolated
- Community capacity, empowerment, building strong communities
- If you can create a groundswell of community action they can address issues such as safety, social isolation, availability of healthy foods...
- Something like the Victorian campaign 'Together we do better', which is aimed at strengthening communities, increasing community resilience and enhancing social networks, could work
- Holistic health
- If you were thinking about doing a media campaign I'd say we've already reached saturation point – and it would have very little impact in terms of changing people's mental health. It may succeed in flagging mental health as an important issue for people to look at. But I think you're probably still taking the risk that the message will get drowned out by all the other community service messages on TV. For example the RTA – Drive Safe campaigns, QUIT, Domestic Violence. I think people get bombarded with that kind of stuff already and just tune out. The media is a very passive medium anyway – especially television. I think there would be far more value in engaging with people more – and developing something that is sustainable
- Mental health promotion for me is community oriented – it services the needs of local communities. So it's hard to identify a single issue that would affect all of those communities across the State – hard to find something that is relevant to everyone

Addressing social determinants of health

- Make the link between the socio-economic determinants and physical and mental health Potential for addressing social issues is essential eg, employment, unemployment, under-employment, violence... address the economic and social determinants of mental health Positive messages towards employment and education. If we want to engage communities, then we need to discuss other issues ie, causes of suicide like depression, homelessness, housing issues, disadvantage that underpins mental health. Should be engaging other parts of the system eg, the welfare system, how to deal with Centrelink and payments For rural areas: the effects of the drought – loss of income, loss of purpose. So far the State response and the media reports have focused on the lack of water – eg, local government changing areas according to water catchments. All these messages about how to conserve water. So there's a lot of State and Federal campaigns on the water shortage, but not much on the actual effects it has on the rural population. The social effects – that lack of water means much more. The real significance. That's something that's starting to apply to cities as well now isn't it?

Reducing stigma, normalising mental health issues and increasing mental health literacy

- There definitely is a need in our rural communities for information about a whole range of mental health issues... Mental health literacy covers a lot of ground – in terms of catering to a range of target groups – and achieving a range of outcomes. For example resources for consumers and carers about mental illness that help ease the anxiety associated with diagnosis, resources that help build those personal skills and coping mechanisms, resources that inspire and provide hope, that counter the myths and stereotypes that feed stigma, that provide information about local services, organizations, support networks
- Stigma affects everyone regardless of creed or colour. But how to change that in the community. The SeeSaw project developed by our Area Mental Health Promotion is a great example of what can be done to reduce stigma and increase the positive portrayal of mental health and mental illness and suicide, locally. The SeeSaw project's other significant program is the development of a Speakers Bureau so that there are trained speakers that provide a range of perspectives on mental health and help to dispel some of the myths about mental illness that create stigma in the first place.

The strongest part of this project is the involvement of consumer and carer speakers. They provide a really powerful message that counters stigma – just giving them a public profile does help to show that people with a mental illness recover and are no different from the rest of community – not knife wielding maniacs. The range of speakers could be extended to indigenous people – migrants – refugees.

- How to overcome stigma in Aboriginal communities
- Normalcy around mental health issues... everyone has the capacity for experiencing mental health problems but this is a normal part of life. Without help from family and friends the consequences can be dire
- The well group need education to be far less stigmatising. Many people have some personal experience of mental health problems - whether they acknowledge that or not is another matter
- For young people peer support is the most effective, need to teach young people about suicide and where to go for support and how to assist their friend
- Could also incorporate information about services and encourage help seeking – because often stigma stops that – people don't know who to call and they feel awkward or scared about getting help anyway
- Encourage early intervention without shame
- Another idea would be to focus on the recruitment of mental health workers – and address the shortage of workers – especially in rural areas. Have a recruitment drive that looks at the rewards in the community – the difference that one person can make out here. Just one person. Get the message across that a career in mental health is viable and rewarding
- Awareness and increased knowledge of resources available in areas.

Promoting wellbeing and coping skills

- Use the term “wellbeing” rather than “mental”
- Mental health – not illness. Consider the protective factors for mental health and perhaps choose one or some as the focus of a campaign
- What are positive steps to promote mental health for yourself and those around you
- Protective factors for mental health eg,
 - On a broad community level – social connectedness
 - Sectors of the community – protective factors for mental health in a workplace setting
 - On an individual level – what you can do to maintain and strengthen your mental health. Building resilience
- Focus on the positive benefits of looking after your mental health
- I would like to see an investment made in resilience... there is a catchy phrase that describes the building blocks of resilience, which might be useful to a campaign... “I am, I can, I have”. I AM speaks to the personal qualities you possess – personal strengths, self esteem, confidence etc. I CAN speaks to your abilities, what you can do, what you are capable of. I HAVE speaks to your social networks and supports – friends, mentors, community groups, organisations etc.
- Looking for positive coping strategies / healthy behaviours. Promote the “pros” of a healthy lifestyle. Promote mental health in a way that doesn’t disempower people
- People need to hook into hope ie, dealing with it leads to recovery and resilience. It’s not just about picking out positive examples or being positive. Remaining hopeful is more important

Addressing specific mental health and associated problems such as stress, substance abuse

- Look at mental health and mental illness as a continuum – it’s not ‘either/or’ – people are consumers some of the time and non-consumers some of the time. Stress is in the continuum; everyone is touched by it. Unless people are aware, they can move along the continuum towards mental illness. Fear and anxiety – is the same thing. Many people have no diagnosis, but stress, fear, anxiety, etc have the potential for developing into mental illness in some people or physical illness in other people – it’s all part of the continuum, but many people don’t see it that way
- Substance abuse problems...in between 15% - 20% of suicides people have been drinking heavily. There is a bit of a turf war... demarcation disputes about issues eg Suicide prevention – mental health almost never discusses suicide
- Stress and its relationship to physical and mental health problems
- Lots of words have taken on new meanings. Words like stress and self esteem have become part of common parlance, as though they aren’t mental health problems but just part of life problems
- Not sure how a campaign deals with social pressures, eg, higher mortgages and higher expectations, possibly resulting in stress, alcohol abuse, etc. It’s not about dealing with the pressures – it’s more about acknowledging their potential effects and supporting and strengthening people and communities to deal with those pressures better

2. Who should be the focus for a mental health promotion campaign in NSW?

- Target group needs to be broad – across communities and the lifespan. Can't focus too much on specific groups because you'll leave others out. One way that you could cover all these groups would be to show how mental health promotion – looking after your mental health – is something that's important for all of those diverse groups within the general community – across that diversity – something that they can all do
- Whole of community. It may be possible to maintain the same message or key theme however the campaign may be adapted to suit particular groups eg, information resources may contain the same key message or theme but are designed to appeal to different groups in the community eg, youth, older people, Aboriginal & Torres Strait Islander. Another option would be to focus on a different target group each year however maintain the same theme / key message
- State-wide campaign targeting everyone is a waste of money, it needs to be carefully targeted to particular groups eg adolescents, aged, rural communities
- Can't see any justification for a state-wide campaign – a carefully designed local campaign will work best
- Perhaps a staged campaign could work – I remember a series of TV ads about the effects of alcohol abuse where there was an ad run for a period of time targeting blue collar workers, then another ad ran for a period of time targeting white collar workers. Same message just a focus on different groups at different times during the campaign
- There may be some resistance from rural areas because a state campaign could build up an expectation of local resources – eg services – that don't exist, or are already overloaded. To make it effective need to have local initiatives and publicity at that local level as well
- General community is very broad - there are some universal concepts however re social connectedness and ways individuals can look after their mental health that is applicable across all groups
- Everyone has a community regardless of whether you're from the city or the country, have a Vietnamese background or have lived here all your life, whether you're young or old. Maybe that's a way of having a broad theme that can then be applied or adapted locally. And those issues – like the drought – those issues that are specific to particular communities can be included
- The target audience should be state-wide and should include all Aboriginal and Torres Strait Islander people. Not all Aboriginal communities have the same needs or resources so there would need to be different campaigns for different areas
- It is possible to develop campaign that is general and CALD specific. Strike a balance between new and emerging communities, communities with demonstrated need, larger communities, communities where you have an in or already existing links
- Local community campaigns can be effective. Some towns in NSW are running really good programs. Town campaigns in conjunction with or as part of a state-wide campaign would be good
- GPs are often the first port of call and need to know how to promote a holistic lifestyle and how to raise issues of mental health and wellbeing in an appropriate way. They are often reluctant to broach the issue with clients
- Each (ATSI) community has different language, traditions, lifestyles and belief systems
- General community, young people, people from CALD communities, ATSI communities, “disadvantaged” communities
- What changes do you really want to generate from the campaign. Increase in knowledge? About what? An increase in people's personal skills? Their coping abilities – being able to do the things that increase mental health and protects against illness. Decrease in stigma? Increase in social connectedness? An increase in resilience – which combines a whole range of elements - personal and social skills – self esteem, problem solving - and community involvement, support networks. What form will this campaign take? Are you looking at a media campaign, information distribution, and community development?
- Always a problem with large-scale campaigns – marginal effect if at all. They set an agenda within which people can build. Need a wider framework but must be specifically focused for different communities
- If there was a long-term plan then campaign could move through specific communities / populations, build up services and do workforce development. Need to consider where to get the best results and where to start
- Could target professional people who are in contact with mental illness but whose primary job is not focused on mental illness, e.g. police, ambulance officers, etc

- Target group needs to be broad – across communities and the lifespan. Can't focus too much on specific groups because you'll leave others out. Very difficult to be inclusive in this way – not workable to run a separate campaign for the city and the country for example. One way that you could cover all these groups would be to show how mental health promotion – looking after your mental health – is something that's important for all of those diverse groups within the general community – across that diversity – something that they can all do
- Caution – for example, don't rush to raise awareness of depression, because the system is not geared to handle raised caseloads and raised expectations; families would suffer as a consequence. You could put out a “be healthy, be happy” message
- In the past Mental Health Week has covered very broad issues. It's difficult to do something at a State level that's not too broad – so it's so general it doesn't really get to the issues. Doesn't cover them. And there are so many broad generalized campaigns – I think people get tired of them – just the same old thing with a different label. Like the ribbons – everyone has a ribbon for awareness – for AIDS, Cancer – even locally with the reaction against this merger – they had a green ribbon. There are so many out there already that they've lost their impact.

Support for a state-wide strategy for Mental Health Promotion

- I think the idea of a state-wide campaign is excellent – can address many needs in the community provided effective messages go out... a focus on mental health is important too
- Saves each local Area doing the planning and piloting.
- A consistent message across the state will have a greater impact
- Can use or adapt materials developed by others rather than re-inventing the wheel
- A media campaign can stimulate discussion and bring people together
- Having some sort of strategic and coordinated approach to Mental Health Promotion in NSW would be good
- I think it's a good idea – to have a state-wide campaign and get more mental health content out there in the media so that people take notice
- Generally think it is an excellent idea to have a Mental Health Promotion campaign. Very worthwhile
- I can't see any benefit from doing a media campaign and distributing information state-wide...I think programs that engage people have more impact – more potential for increasing knowledge – changing attitudes – changing behaviour – building resilience. And these are changes that can be sustained – that can make a lasting difference to people's mental health
- If a state-wide campaign approach is recommended it will be important to involve people from a range of sectors in the development of the campaign eg, rural and remote, Aboriginal, consumers and carers, metropolitan areas...
- An advantage of a state-wide campaign is - if it is planned / piloted by a coordinating body prior to resourcing other communities across the State to implement it – this saves local areas the planning / piloting time

3. What current or past national, state or local health promotion campaigns have you been aware of?

National and state campaigns

Community Awareness Program, beyondblue, Mental Health Week, and the National Youth Suicide Prevention campaign.

Other campaigns mentioned were Quit Smoking, Slip Slap Slop, Physical Activity, Domestic Violence, and campaigns targeted towards specific communities such as the Arrive Alive road safety campaigns focused on the Aboriginal and Torres Strait islander communities or the Multicultural Domestic Violence campaign “the ‘Rolls Royce’ of doing multicultural health promotion!”

Regional or locally based campaigns

Central Coast Dumping Depression, the New England Depression: Spot, Seek, Solve community development campaign and their SeeSaw initiative aimed at balancing the portrayal of mental health, mental illness and suicide.

4. What would you say are the strengths and weakness of these campaigns?

Strengths

Multi-strategic and multi-level

- Most effective are ones that operate on multiple levels eg Random Breath testing (linked to media, legislation, environment etc)
- Best campaigns are not just awareness raising, but also about engaging people to take action eg, physical activity
- Models that can be adapted / applied to suit the local context and encourage community involvement / a community development approach, support materials eg, printed information resources, web sites, pre-developed programs with 'how to' guides
- Policy and education together can have a profound effect
- Legislation, advocacy, building in a range of long term strategies

Formative research

- Culturally, geographically, and age appropriate messages
- Strong simple memorable messages
- Succinct, consistent and clear messages
- Consistent message and symbol
- The flannel flower – the significance of that – it has a soft appearance but it's hardy and resilient underneath. It's a survivor. And it's an Australian native. You could use that symbol to talk about what resilience really means. How you build it up
- A good message, a good slogan, a good jingle are very important. – they must be memorable - they have to stick. This leads to high levels of recognition, which in turn form the basis for the next step of getting the message to translate into changed behaviour
- A strong simple message works best eg, the domestic violence advertisements now being broadcast. People can relate to behaviours on screen eg, what men actually say to one another, bring that behaviour out of the closet and counter the myths
- Extensive formative development of program messages that are relevant to the target

Specificity of program designs and strategies for target audiences

- Strong messages and strong visuals would draw attention in Aboriginal and Torres Strait Islander communities
- Needs to be Koori specific. Needs humour in advertising. Sharing and caring messages
- Strength of local campaigns is that they can be targeted to the specific needs of the community
- The DV campaign considers both men and women's perspectives and people from different cultural backgrounds are represented in the media materials
- It comes back to being inclusive and having something broad that covers all those cultural and socio groups – including farmers and rural people
- Some of the 'soapies' have included good stories. Especially those aimed at younger people, eg, 'Home and Away'. Some have got it badly wrong eg, the occupational therapist character with bipolar disorder in 'All Saints'. In the past 'GP' did some good ones. It could be worth talking to the writers and/or directors

Adequate investment and commitment

- How well and how widely you can deliver the message depends on financial backing. Television is good, but it is expensive. It's good to combine television, radio and print, posters, etc. if possible
- Need adequate funding to work strategically, in flexible ways, and for evaluation
- Good amount of money put into media component so they got good recognition
- Health Department provided resources to be used at the local level and did all the formative development work for these. They pulled resources together and provided them at no cost
- If you want to have an effect you have to make an investment. A good program and a big commitment
- Money would be better spent funding small projects at a local level. Each Area Health Service could apply for funding for their local communities. You could organize it around a theme. If the State initiative had a theme – a broad theme that could apply to everyone – then it could be adapted to local communities, by local communities. So then the initiative would meet the diverse needs of those communities but still be at a State level

Consultation and partnerships at all levels

- Networking among people involved in delivering the campaign / program in different settings
- Consultation means that resources can be developed that address needs of diverse communities.
- It'd also help to ensure that there is rural representation on the working parties that develop the campaign
- There is no national mental health consumer group – so consumers have little input into national campaigns
- How will you include everyone and get to everyone? Will have to do a lot of consulting and have a broad inclusive approach to do this – gather a lot of local knowledge and do some solid preparation
- You identify your target group with local knowledge. Because it's more than a postcode – an area. I think it's important, for what makes the particular community, to be defined by the members of that community. At a State level you'd never know this information. You wouldn't be able to identify community for those areas across the State. You'd have to find the gatekeepers at a local level –

those people who everyone recognizes – GPs, ministers, teachers, council members, Aboriginal elders – and consult with them – get them to identify what makes up their own community.

- Then you could make sure the projects that are done are appropriate for the needs of that local community – as identified by them. That way you can have a community development focus.

Range of media coverage/range of people represented

- When running state campaign need to consider way that everyone can access information – use news media that is accessible to everyone – TV would be ideal, but a combination of media that incorporates TV would be the best
- Broad media coverage.
- The campaign needs to be inclusive – not just white Anglo people. Need a broad cross-section of people from different ages, different backgrounds, city/country, NESB, ATSI
- TV seems to be tremendously effective in terms of reach and getting message across but is very expensive
- Using celebrities
- Streetwise comics – recent one on bi-polar disorder, there is one on young women and depression in rural areas and one on young people, depression and suicide, one about kids with hassles but otherwise doing OK
- I'd like to see something like Andrew Denton when he interviews an audience member, or a couple of real people from the community, about a particular issue – and make it about a mental health issue. That kind of television coverage. Maybe something like Australian story. They do that kind of thing well. Or even on Australia Day – when an ambassador comes out to give a speech. Imagine if that was someone who had recovered from a mental illness. Someone with a high profile – a significant Australian figure

Well-designed evaluation - process, impact and outcome

- With good evaluation / evidence can get further funding
- Including an evaluation component – and a guide for how to do this when implementing the initiative on a local level
- You can count responses or enquiries following exposure, and this quantitative data is useful, particularly when arguing for resources. It's harder to isolate longer-term effects and outcomes and measure them. So the government do mailbox drops with booklets covered in plastic. There's been heaps of them lately – Domestic Violence, Medicare, Rural Information. You could look at the impact of these existing Federal campaigns. Look at the evaluation for those – what the campaign was like – did it work. Like the Domestic Violence stuff. Was there more awareness of DV, do more people feel comfortable about reporting it – has incidence reporting increased, have people been using services?
- Clear objectives that are measurable
- Give evaluation feedback to those involved as often as possible

Weaknesses

Not evaluated or poor evaluation

- Only process evaluation – not impact eg, may sound great that thousands of posters or postcards were circulated but did these make a difference in terms of requests for information, mental health literacy, for example
- Not properly evaluated
- Not properly evaluated, evaluation not funded or under funded
- Indistinct target group. Waffley objectives

Paternalistic, judgemental or prescriptive messages and strategies

- Message shouldn't be prescriptive in terms of behaviour as this could lead to the campaign being seen as only for people with a mental illness. The message is that mental health is just like physical health – same for everyone
- Messages too paternalistic, prescriptive. Messages need to be memorable, relevant and empowering

'Nice' messages can gloss over problems

- Be sure the advertisements don't result in unreal expectations ie, with a little support, people with mental illness are just like you – but often they can't for all sorts of reasons, e.g. poor concentration, lack of mobility, etc
- Campaigns that are too nice, sanitised
- Stress less days - Warm feelings don't have any real bite. The messages are too 'nice'

Preaching to the converted/already high level of awareness

- Often seem to be preaching to the converted. Wonder how far the messages permeate. Who comes apart from people who are in the sector?

Not evidence-based

- There's so much mental health promotion that's just short term. In your face - like an ad - like handouts. What kind of impact does sending out postcards and sunflower seeds have? I've got stacks of sunflower seeds, but they just sit in my office!
- Too many promotional materials eg, heaps of Active Australia pens – these simply get used up and thrown out – what do they really achieve?
- Weaknesses in campaigns include shock tactics, though they can forcefully deliver new information. Mental health messages must be punchy, not necessarily new ground breaking research, but evidence based information can be more convincing
- Most of the evaluations of MH Promotion show they don't work
- Youth suicide campaign didn't understand why people were committing suicide - they just picked vulnerable groups

Poor communication, coordination and consultation

- Sometimes coordination of media campaigns is done without consultation or sufficient notice to local workers.
- Poor lead time to develop local support and planning
- Delineation between Central Office and Area Health Services not good
- Communication, coordination and consultation needs improvement
- Needs to be more consultation with communities and organisations (ATSI)
- Not enough infrastructure support in terms of funding and training
- Once you've decided on what you want to achieve, how and with what medium – then the barriers will become clear... aside from funding, which always seems to be scarce, it will be the coordination of the campaign across the state that will be the most difficult. Making links, liaising, getting local people involved in the organization. That practical stuff. Do you have enough human resources to do that? Should you employ someone to do that? Should you get representatives from all over the state to organize in their own areas?

Limited engagement of diverse communities

- Limited engagement of CALD communities
- Some are too visual eg, Quit smoking
- Some cause grief (in ATSI communities where they may remind people of loss and grief associated with the issue) eg, drink driving deaths and injuries, smoke alarms
- Not many Aboriginal or Islander people used to promote anything
- Not too many NESB people either
- Current federal DV campaign does not address needs of other cultures/religious doctrines, young people, old people..

Creating a demand that can't be met by services

- So if you were to run a campaign that increased referral to services you would have to make sure that rural areas had the capacity to deliver. No expectations about intensive follow up for instance Services must be capable of responding promptly following a campaign; if not, potential benefits will be lost. Campaigns usually lead to increased demand across the state that need to be met by services across the state

5. What cultural and linguistic factors need to be considered in a mental health campaign?

Taking an holistic approach to health

- Aboriginal and Torres Strait Islander friendly messages and resources eg, posters that talk about social and emotional wellbeing rather than mental health
- ATSI communities talk about social and emotional wellbeing – don't have a culture of diagnosis. Have "life promotion" officers in some communities
- Using arts as a medium to improve self esteem... incorporate art, meditation, Yoga, philosophy into Wellness group activities
- ATSI need to take a holistic approach... maybe needs a special program on its own
- All mental health resources are focused on mental illness... need a wellness model to take non-English speaking background communities forward especially when working with other partners like AMESs

- Need a positive perspective acknowledging, respecting peoples' different experiences and looking at strategies for people to promote their own mental health (strengths approach)

Tailor language, images and ways of working to specific communities

- Translations from English won't do it
- Transcultural Mental Health does cultural adaptations taking the English language material to the communities and getting their input as much as possible.
- Would like to do culturally specific campaigns starting from go with language, images, ways of infiltrating the community tailored to the communities you are working with
- Best not to do straight translations but develop messages in first languages for specific groups
- Appropriate language, format, design
- Messages must be specifically targeted – NESB and Aboriginal groups do not listen to Anglo messages
- Culturally appropriate material for youth
- Aboriginal people in promotional materials
- Local (Aboriginal) languages
- Don't forget rural CALD communities – may need a different type of approach to urban CALD communities
- Perhaps resource materials could be printed in different languages – a colleague suggested linking up with multicultural mental health organisations eg, Transcultural Mental Health Network. Any images used on printed resource materials need to be representative of groups across the lifespan, different cultures, locations eg, rural & remote
- Aboriginal designs and colours
- Visual and colourful
- Set out in layman's terms
- Images used on any information materials need to be representative of people from different cultures / lifestyles eg, rural, coastal, metro
- SBS radio is very effective
- Any images associated with media or marketing materials need to represent people from a range of cultural backgrounds. In our Health Area for example we have a high population of Aboriginal people that we would like a campaign to include / be relevant to
- Proper terminology must be used, so no communities are offended. There should be an inclusive range of images
- If there are resources, it should include translation of written material and posters, tailored for particular groups. Translations should be appropriate, ie literal translations might not be easily understood by particular communities
- Youth culture – see 'Reachout' web site. Have developed a rationale, there has been some evaluation of who uses it. There are project officers to analyse data.

Community literacy levels

- Information materials need to use simple language – taking into account a range of literacy skills in the community
- Wording – appropriate language, simple language
- Informational materials produced in different languages – possible partnership with Multicultural Mental Health Australia or the Transcultural Mental Health Centre
- Keep it simple – information needs to be understood by people with a range of literacy skills. Average literacy level in Australia is about that of a 12 or 14 year old – this needs to be considered in the development of information resources. Plus the language needs to be kept to 'everyday' terms wherever possible – not mental health jargon.
- Transcultural Mental Health has done audio cassettes, CDs, web, print, radio and ethnic press

Social-historical understanding of health

- Respecting belief systems
- Need to consider how people doing the promotions relate to the community – do they go about it in the right way. Do they know who to work with eg, religious leaders, community leaders? The culture of the service provider eg, GPs and health workers, needs to be considered – Do they feel uneasy and does this in turn affect the client
- There are complexities in different cultures about how they view mental health
- Mental health is a taboo topic in some cultures

- Need sensitivity towards communities that are the focus eg, focus on Torture and Trauma and Stolen Generations is too confronting
- Also need to work with other services that work with NESB and ATSI communities to help make them more aware and sensitive eg provide outreach services where people are

Go an extra mile to achieve outcomes

- Every aspect needs to be checked
- Language used is a big deal – fraught with danger so need very good quality control every step of the way
- Need to go the extra mile to ensure production is accurate and appropriate. Good evaluation is essential

Formal and informal mechanisms to encourage participation

- Support ATSI (and other culturally diverse groups) to run them themselves but provide support and other expertise as they need
- Role is one of enabling, providing information and bridging cultures

Timing – NAIDOC celebrations, Knockout, Harmony Day

- Appropriate timing of mental health promotion campaigns
- Timing eg, NAIDOC Week celebrations, Knockout

6. What resources are already available at the local level to support a mental health promotion campaign?

- Aboriginal Medical Services
- Aboriginal Land Councils
- Aboriginal Mental Health promotion staff
- Aboriginal carers
- Elders
- Local residents – contacts and networks
- TAFE Colleges
- Outreach workers
- New England Area Mental Health Promotion Network
- New England Area Mental Health Promotion and Prevention Service – a critical mass of staff creates more potential
- Interested local community mental health workers
- Community health services should highlight that physical activity can promote mental health
- Existing partnerships and networks between services providers, and between service providers and communities
- Consumer and carers
- Support for mental health promotion from MH management in NEAHS
- Housing Department, Education Dept, Centrelink and other agencies that deal with people at risk. Important also that these agencies recognise their role in promoting mental health
- Parenting programs but they are under enormous pressure from demand
- Suicide prevention, School Link and resilience programs are in place in WSAHS but focus on kids with problems
- Health Promoting Schools, School Link
- Bi-lingual sessional workers have been skilled by TMHS – good at reviewing resources
- Social cohesion is seen as a strength in CALD communities
- NGOs including community centres, neighbourhood centres, youth centres, GROW, ARAFMI
- Existing relationships between government, corporate and third sectors – social entrepreneurial activities
- Carer respite Centre
- Al Anon
- Community venues eg neighbourhood centres rather than CHCs
- Local govt support
- Telstra technology centres in rural areas provide meeting places
- CWA have premises, good networks and a web site that could include MH information
- Libraries have books about mental health issues and internet access
- Divisions of General Practice
- Rotary

- Alcohol Summit is funding “Good Sports Clubs” – promote clubs as family friendly places rather than drinking/gambling places
- Community Life – a suicide prevention program is offering training in how to respond to suicide – can lead to forming of coalitions
- Laughing clubs
- Gyms, massage and natural therapies
- RSL clubs

7. What additional resources are needed at a local level to maximise the effectiveness of the campaign?

- If you want an effect you need to invest – a good program and a big commitment
- Funding to trial strategies and build case for greater investment
- If there is a media campaign you need resources to support it at a local level
- State-wide brochures and posters with room for local contact details
- Locally designed leaflets and posters
- More Aboriginal Mental Health Promotion staff
- More mental health promotion staff
- Staff and other support persons in the community trained in community development, presentation of educational talk, group facilitation and evaluation
- Funding for specific projects supporting the campaign and for evaluation eg small grants program
- Educational activities – face to face activities and printed information
- Information/resources based on the campaign messages
- Follow-up evaluation and statistics
- Local contact person/coordinator and local group to manage project across the Area and liase with central coordinating group
- Specifically designated marketing, communications, evaluation person to resource people at the local level
- Recruit support of managers of mental health and other health services.
- Support from Area CEOs and directors of MH - Area needs to have a shared vision to ensure local workers are supported to deliver campaign.
- Services must be available to pick up demand from campaign – don’t create a demand for services that don’t exist
- Celebrities to back campaign
- Funding could be contingent on partnerships bet govt, corporate and third sectors
- Resources to connect rural people with mental illness and their families isolated by distance
- Admin support
- Screening in pharmacies
- Political will – must have support of CEO, AHS board, Minister, Parliament – all must give the same message when approached by the media
- Need a critical mass of MH promotion staff to drive project and then they get others involved

8. What types of activities could be undertaken at a local level to support a mental health promotion campaign?

- Improving collaboration between services
- Working with consumers and carers
- Promoting opportunities for participation such as community functions, sporting events, consulting elders, engaging local identities, games: Koori Bingo and Play Your Cards Right
- Establishing local support groups but not before consultation with groups already established in the community
- Organising local media eg, Koori Radio, Koori Mail, Aboriginal and Islander Health Journal
- Link with existing initiatives and services eg Aboriginal men's groups, CDEP, Land Councils, AMSs.
- Door knocking to discuss campaign
- Identify the risk and protective factors for mental health in local area and work out how to build on/create protective factors to reduce risks
- Community education, distribution of campaign materials
- Training of other organisations
- Working in partnership maximises spread
- Where interest/need is felt communities will respond quickly at a local level and with sensitivity to needs
- Every community has a different language, a different way of relating eg public forums, newspapers, support groups, fairs, festivals, school programs, correctional centre programs, baby health centres, shopping centres.
- Rural communities respond better to face to face messages than email, text messages
- Tap into existing networks and services eg clubs, sporting organisations, GPs, child care, housing, leisure activities
- Working with CALD communities
- Working with service providers
- There is no 'one size fits all' activity in local areas eg in Tenterfield mental health worker links in with "Oracles of the bush" festival (writing and poetry)
- Identify the community 'gatekeepers' – they provide the local knowledge of what is important for a particular community
- Professional development about health promotion with GP, psychiatrists, psychologists, social workers, Drug and alcohol workers etc. Work with professional organisations.
- Shopping centre displays, displays at community events
- Work with local media – relate campaign to something local, publish a series of articles, broadcast a series of interviews etc
- Give talks to local organisations – Rotary, Probus etc
- Launches – invite key people – politicians, councillors, GPs, departmental and agency staff, AHS staff, health promotion officers
- Stories in local newspapers eg positive stories about group homes
- Local support groups – need 3 people to get started then they all asked someone else to join etc. A six session program has been developed and people can take it in turns to facilitate, make tea etc.
- Meditation groups
- Local forums linked to other local issues – need to create different auspices, not just Health
- Local forums can identify local needs and help services to adjust their services to accommodate community needs
- Need to train up local people to speak at local forums as people will relate better to locals. Could combine local speakers with a fly in high profile person.
- Ethnic and local media is hungry for stories, information
- Community activities that are cheap and fun – aimed at reducing isolation. Won't work if focussed on a health problem
- Need to bring together a critical mass of people then others will join in
- NDARC has a 'drug info at local libraries project', this could be extended to include MH info eg videos, CDs, brochures, posters, information about services, personal stories of recovery, biographies. Clinicians could refer clients to library for up to date info.

9. What health promotion activities are not suitable for implementation at a local level?

- Mass media campaigns (although ideas may develop in a local area, eg the anti-smoking advertisements in cinemas aimed at youth were developed on the Central Coast.
- Legislative change (but change can begin at a local level)
- Distributing information materials with no linked activities
- One off events that have no links to sustainable initiatives
- Shopping centre displays!
- Giving out pamphlets?
- One-off education talks?
- Activities that are not evidenced based
- Admin responsibilities that detract from health promotion activities eg submission writing, excessive documentation required by funding bodies, minute taking, photocopying resources

10. What state level resources are available to support a mental health promotion campaign?

- Partnerships across programs eg Aboriginal Medical Services and Area Health Services eg, SESAHS, CSAHS and NSAHS
- NSW Consumer Advisory Group, and carers groups
- Australian Centre for Agricultural Health and Safety (national)
- Centre for Mental Health, CMH distribution lists
- Centre for Health Promotion – interested in links between exercise and mental health
- Mental Health Association NSW Inc. – it would be good if they did more than Mental Health Week
- Aboriginal Health and Medical Research Council
- Broad media and communication strategies
- Marketing, communication and media monitoring
- Resources and assistance with evaluation
- Transcultural Mental Health Service
- NSW Network for Promotion and Prevention
- Good relationship with SBS, mutual skill development between TMHS and SBS
- Peak CALD organisations
- Better Health Centre for brochures etc
- Rotary has funding for 2-3 years from beyondblue to run community forums. Rotary also funds mental health research.
- Public Health Officers could mentor health promotion staff and provide advice to NGOs

State-level resources required

- Implementation kits providing resources and guidelines for local implementation and evaluation eg Vic Health *Promoting Mental Health and Well-Being – The Partner Pack*
- If state-wide campaign is recommended you need a central coordinating group with wide range of representatives eg rural, remote and metro reps, ATSI, consumers, carers etc
- A dedicated state level mental health promotion position to support a campaign or program is needed
- There is lots of untapped potential for Centre for Mental Health to recognise the potential of working in partnership. Ownership issues can be a problem
- Funding to pilot strategies and build case for greater investment
- Resources in as many languages as possible
- Funds for TV advertising – an expensive but powerful medium
- Management and admin support for a big campaign
- Policy development support
- Protocols to ensure sustainability
- Need enough resources so MH workers can spend 20% of time on health promotion and community development
- GPs need readily available resources that are culturally appropriate
- Links between MH and D&A
- There is more money for MH – need to lobby for MH promotion funds
- Consultation with consumers and carers about state wide resources eg poster design etc

11. What partnerships could be formed if the approach was to do something along the lines of Together We Do Better ie, building social capital and community resilience?

- Build on existing partnerships

- Don't need coordinators – need a genuine network of partners
- Partnerships between local communities, consumers, carers and the AMS
- Consumers, consumer consultants
- Community consultants
- Carers
- Local residents
- Community organisations and Health promotions
- Local PCYC, hospitals, schools, jails, sporting bodies (NRL / AFL)
- Aboriginal Health workers and NGO and different AHS eg, SESAHS and CSAHS
- Government agencies eg, Housing, Police, DoCS, Centrelink, CRS
- Aboriginal and Torres Strait Islander communities
- Using local libraries within communities. There are existing networks to link with – partnerships with librarians and local councils and the committees they have in place. This would also enable you to do needs assessments that were specific to the communities that used libraries – and covered those cultural differences – made the project more inclusive. For example – a library in Cabramatta would need resources in a couple of languages – that are culturally sensitive and address the issues of that population – immigration, refugee issues, drugs etc - as well as appropriate service information. Whilst Gulargambone library would be looking at aboriginal and farming issues and have resources that reflected the needs of that communities.
- Community service clubs
- Local government – link into events on the local govt calendar eg community festivals
- Health services
- Workplaces
- Schools
- Sporting bodies and physical activity campaigns
- Partnerships with peak CALD organisations and community leaders
- Religious organisations
- Government, corporate and third sector partnerships
- Need both formal and informal links eg, MOUs, social gatherings, training opportunities
- Community forums are a good example of successful partnerships eg, Rotary forums held 3 times per year (for youth, adults and older people). Youth forum attracted 200 people on central Coast. They include 15-20 display tables promoting local services
- NGOs eg PEP?
- Local businesses
- GPs
- Local media who may run free announcements and do stories
- CWA
- Religious organisations eg churches run sporting and fellowship activities - these could include information about MH
- Rotary
- Drug and Alcohol services
- Partnerships between TMHS and communities, and TMHS and AHSs
- Consumer consultancy services in each AHS
- Consumer advisory bodies
- Health Participation Council (22 members advising the Minister)
- Partnership Promotion Committee should be invited to participate with health promotion staff, Mental Health Association, NGOs, local govt
- Partnership between psychiatrists, GPs, Physicians and health promotion staff. Doctors are not trained in health promotion and need to learn about it
- Partnerships between Public Health Officers and local govt environmental health officers

12. Do you have any other comments?

- It could raise the profile of Mental Health
- To have a higher understanding and support for Mental Health Promotion at the Health Department level would also be good
- The term “campaign” is a bit misleading... it does not have to necessarily involve a media campaign. Maybe the term “initiative” would be better
- There are lots of untapped opportunities for the Centre for Mental Health to recognise the potential for working in partnership. Ownership issues can be a problem.

- What is possible really depends on what you want to achieve, how you're going to do it – what medium would provide the greatest impact, and the resources you have available. Also on what's already being done – you don't want to duplicate
- First you have to look at the current state-wide initiatives – like Mental Health Week. What's the purpose of it – the aim - and how well was it met? If it was to distribute 3,000 postcards – look at what that achieved. Look at the evaluations that have been done already eg, on Mental Health Week. Because it would be defeating the purpose to just repeat something that's already working. And if it isn't working then looking at that gives you directions towards changing it. That would be a good start for feasibility.
- Resources must be applicable to and appeal to rural people
- Have to make a campaign relevant to rural people and consider what is happening in their lives eg they may ask why all this stuff about MH when my stock are dying, nothing will grow and we have no money
- You will alienate rural people if they feel included in a tokenistic way
- Rural CALD communities need a different approach to urban CALD communities
- Mix of community development and social marketing would be good. Community development helps ensure sustainability
- If campaign is successful there may be an opportunity to lobby for mental health community development workers to continue the campaign cause
- The term campaign is a bit misleading as it does not necessarily have to involve a mass media campaign, maybe initiative is better
- Need to reduce gap between advantaged and disadvantaged
- Evaluation needs to be carefully considered –not just process measures but impact and outcomes measures are needed
- Evaluation must start at the beginning and be properly funded.
- Monitoring is important to see if participants have digested the essence of the activity.
- It is important to work out how people get information eg local paper, local church, networks of influential people in the community (this was the rationale for the Rotary forums)
- Peer support – target young impressionable people who want to do good and can support their peers
- Target people with skills, resources and enthusiasm – things can then snowball eg Ryan's Well
- Financial counsellors in rural areas during the drought – aimed to support/reduce suicides, ease the way, reduce discrimination and stigma
- GROW seems to work because everyone has a role, is made to feel useful with skills to contribute. Evaluated by Young in 1970 and recently by Cowan University.