

**Mental health improvement: evidence
based messages to promote mental
wellbeing**

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Summary

This report was commissioned by NHS Health Scotland to assess the strength of the evidence for mental health improvement messages and to establish the views of the public and professionals on what are sometimes referred to as 'positive steps' for mental health. These include: keeping physically active; eating well; drinking in moderation; learning new skills; creativity; spirituality; relaxing; valuing yourself and others; talking about your feelings; social networks; caring; making a contribution and asking for help.

The findings presented in this report are drawn from:

- a review of the literature on the effectiveness of mental health improvement messages
- qualitative research, including grey literature, from campaigns and other initiatives to promote mental health messages
- an online survey and telephone interviews with BT employees
- one to one telephone interviews with colleagues in Scotland and the rest of the UK with experience of mental health improvement in a range of settings
- feedback from practitioners at a consultation seminar held in Edinburgh to discuss emerging findings

Findings from the review show that, although the quality and quantity of studies vary, overall there is good evidence to support the effectiveness of positive steps messages for the promotion of positive mental health, the prevention of some mental health problems and for improving quality of life for people living with mental health problems.

The 'positive steps' approach may empower individuals to improve and protect their own and others' mental health. At the same time, actions that individuals have the resources or capacity to initiate are shaped by family, social, cultural, economic, environmental and political contexts. Messages focused on the individual may be interpreted as missing the causes of psychological distress and as therefore reinforcing disadvantage. Some of the positive steps may contribute to improved mental health but may also be a casualty of poor mental health. Mental health influences motivation, capacity and opportunity to adopt healthy lifestyles and socio-economic circumstances influence factors like social contact that protect individual mental health. For example, studies that address the 'ubiquitous loneliness' of elderly people often make no mention of the extent to which it is socially and economically constructed.

Nevertheless, if knowledge is indeed power, then evidence-based campaigns to promote mental health have considerable potential. Evidence for the effectiveness of exercise to promote well-being and to reduce reliance on medication for some people living with mental health problems, for example, should not be underestimated. Many of the 'positive steps' are consistent with a wide range of research on what people who experience mental health problems find helpful. Even where evidence of

mental health benefit is limited or equivocal, there are very few examples of positive steps producing negative side effects.

The strength of the evidence for individual positive steps is as outlined below. It is important to note that evidence from longitudinal and good quality experimental studies is very limited. Evidence from cross sectional and other studies shows the strength of the association between different activities or factors and mental health and/or mental illness, but does not demonstrate whether or not there is a causal link. In addition, absence of evidence and/or weak or limited evidence, (for example on *help seeking* or *diet*), does not necessarily indicate lack of effectiveness but rather that there are insufficient good quality studies to make a judgement.

Exercise

- There is good quality evidence for a positive association, but not necessarily a causal link, between physical activity, exercise and mental well-being.

Diet

- There is limited and weaker, but promising, evidence for the relationship between good nutrition and mental health.

Alcohol

- Evidence is mixed and equivocal on the relationship between alcohol use and poor mental health and it is unclear whether a reduction in alcohol consumption at a population level would reduce incidence of depression and anxiety. There is a clear relationship between alcohol abuse and social functioning and factors that influence mental health e.g. violence, intimate partner violence and sexual abuse of children.

Learning

- There is good evidence that participating in learning throughout life reduces risk of depression, is associated with a wide range of mental health benefits and contributes to the adoption of healthy behaviours.

Creativity

- There is promising and some good evidence that creative pursuits improve mental health, limited but promising evidence that participation in the arts can reduce offending and re-offending behaviour and weak/mixed evidence that creativity can contribute to community level benefits e.g. cohesion.

Spirituality

- There is good evidence that regular engagement in religious activities is positively related to happiness, life satisfaction, positive emotion and reduced risk of depressive symptoms.

Talking

- There is review-level evidence for the effectiveness of psychotherapeutic treatments for a wide range of mental health problems. Evidence that talking protects mental health in non clinical populations is limited.

Valuing yourself and others

- There is good evidence linking low self-esteem with depression, suicidal behaviour and eating disorders
- There is good evidence that social trust is associated with higher well-being and a lower probability of suicide and psychological problems but weak evidence on causality.

Social support

- There is good evidence, including some review level studies, that strong social networks and social support play a significant role both in preventing mental health problems and improving outcomes.
- There is mixed evidence that some types of social network have a negative impact on mental health, notably for women and marginalized groups
- Social support and social participation do not mediate the effects of material deprivation.

Asking for help

- There is weak and limited evidence on the benefits of help seeking, although it is important to note that this reflects lacks of research.

Getting involved and making a contribution

- Evidence for the impact of volunteering on well-being is mixed.
- On balance, informal care-giving has a negative impact on well-being.

Contact with nature

- There is promising but limited evidence that contact with nature produces mental health benefits.

Relaxing/taking a break

- There is good evidence that organizational and cultural factors in the workplace have a stronger impact on the mental health of employees than individual lifestyle behaviours but that exercise, socializing outside work, supportive colleagues, a healthy diet and achieving a work/life balance can improve mental health.

The review of qualitative research on attitudes to 'looking after' mental health in Scotland and elsewhere in the UK showed high levels of public interest in emotional and cognitive well-being, whether that is expressed in terms of concerns about stress, worries, low mood or the importance of a positive attitude, coping or not 'bottling things up'. There are sensitivities about language and many people prefer not to use, or do not recognise, terms like mental health. Nevertheless, members of the public across all age groups and backgrounds had sophisticated explanatory frameworks for what influences 'how people think and feel' and many people in all social groups are already doing a lot to promote their own mental health and to cope in the face of adversity. Older people in Scotland demonstrated the greatest recognition of the importance of mental health and an ease and familiarity with taking steps to look after their mental well-being.

An online survey of British Telecom (BT) employees provided a compelling snapshot of responses to a recent 'positive steps at work' campaign. More than half of respondents had tried some of the positive steps and continued to practice them; 34% tried and subsequently gave up and 10% either could not or did not want to try any of the steps. For those who did make changes, 51% noticed an improvement in mental well-being, 17% noticed an initial benefit which then faded and 31% noticed no change. Overall, the survey and follow up interviews suggest that 'positive steps' in the workplace were viewed very favourably by some employees and were acted upon, although time constraints and work pressure were mentioned as frequent barriers. Concerns about stress and depression in the workplace are common and widely understood to be influenced by working conditions, as well as by personal circumstances. Where employees feel working conditions or management practice are stressful or damaging well-being, mental health messages may be viewed negatively or with considerable scepticism.

The relevance of social marketing to mental health improvement is twofold: firstly, as an approach that may improve the effectiveness of mental health improvement messages and secondly, because social marketing views positive mental health as a key factor in achieving behavioural change. A number of systematic reviews of interventions using social marketing techniques show that social marketing approaches can significantly improve effectiveness and the achievement of behavioural change goals across a range of topics. The reviews found strong evidence for nutrition, reasonably strong evidence for physical activity and more modest, although significant effects for alcohol, tobacco and substance misuse. The extent to which effectiveness is influenced by socio economic status, ethnicity and context (most studies are from North America, New Zealand or Australia) is unclear and there are ongoing debates about whether social marketing in fact represents a unique departure from health promotion traditions like community development.

The response of health and other professionals to promoting mental health messages in Scotland was informed by people's experience of working to improve mental health in a range of challenging environments. Most colleagues consulted believed that mental health improvement messages have been seriously neglected, are likely to be well received by the public and are consistent with the recovery agenda. The potentially empowering nature of some of the messages was welcomed. At the same time, there were familiar concerns that lifestyle messages risk blaming people who have poor mental health or low levels of well-being and may reinforce inequalities. Many people felt that wider determinants and socio-economic context must be *'central to the approach'*.

Overall, the strength of the evidence and the views of the general public and of professionals across all sectors suggests a good case for informing and empowering people to take action to look after their own mental health. Once some of the taboos and language barriers around the term 'mental' have been addressed, it is clear that many people are aware of their own mental health (however that is described or conceptualised) and already have a wide range of strategies for coping with adversity, keeping their spirits up, dealing with low mood, stress and anxiety. At the same time, for some groups, the depth and complexity of the problems they face mean that 'positive steps' could seem trite or patronising. Individual action should not be seen as an alternative to addressing economic, fiscal, cultural and environmental factors that are toxic to mental well-being.

Taking all of these factors into account suggests that the development of positive steps campaigns has ethical, as well as strictly mental health-related dimensions. Evidence from the review, as well as interviews with key informants and the seminar for practitioners, indicate that:

- positive steps messages to promote mental health should form part of a wider strategy to tackle the social determinants of mental health problems
- local communities and groups should be supported to adapt positive steps messages to take into account their lived experience and thus to promote greater effectiveness and ownership of mental health campaigns

The evidence base for mental health improvement is still at a relatively early stage. The findings in this report should be seen as preliminary and as a contribution to ongoing debate about the key influences on mental health and wellbeing in Scotland. We welcome comment and feedback: please send these to:
joanna.teuton@health.scot.nhs.uk

1 Introduction

“Encouraging people to access mental health services or take steps to look after their mental health is a tougher challenge than enticing them to buy a new chocolate bar, but it can be done using the right techniques, the right communication routes and the right evidence.”

Ed Gyde, Social Marketing in Action, 2006

“The only way to understand the complexity of people’s choices is to see how they are rooted in and profoundly influenced by the social and physical environment in which they have to be made.”

Miranda Lewis, Institute for Public Policy Research, 2007

This report was commissioned by NHS Health Scotland to inform the development of evidence based mental health promotion messages: *what individuals can do to protect and improve their own and others’ mental health* – sometimes referred to as ‘positive steps’ for mental health. The research brief highlighted the need for:

- a review of the evidence for mental health promotion messages (e.g. what mental health gains are associated with exercise, diet, talking about problems, participating etc)
- a review of findings from social marketing, campaigns and other initiatives to promote mental health messages (e.g. response to messages among different target groups, evidence of acceptability, impact, behaviour change etc)

The research is intended to:

- inform future work relating to mental health improvement messages for the whole population, vulnerable/at risk groups and people with mental health problems
- inform practice among the mental health improvement workforce i.e. those working in a wide range of different settings, sectors and agencies to improve mental health
- inform the possible development of resources and campaigns aiming to increase mental health knowledge and awareness

The target audience for the messages is the whole population, including individuals, groups and communities at greater risk (taking account of, for example, age, geography, ethnicity, disability, socio-economic status and factors like isolation or social exclusion), and those who are currently experiencing mental health problems.

The research therefore covers:

- actions that promote mental health
- actions that prevent mental health problems and/or alleviate symptoms
- actions that contribute to improve quality of life for people living with mental health problems

The findings presented in this report are drawn from:

- a review of the literature on the effectiveness of mental health improvement messages
- qualitative research, including grey literature, from campaigns and other initiatives to promote mental health messages
- an email survey and telephone interviews with BT employees
- one to one telephone interviews (21) with colleagues in Scotland and the rest of the UK with experience of mental health improvement in a range of settings
- feedback from 40 practitioners at a consultation seminar held in Edinburgh to discuss emerging findings from the literature review, qualitative research and interviews

The report complements and forms part of a well-developed and extensive range of mental health improvement activities ongoing in Scotland as part of the Scottish Executive's *National Programme for Improving Mental Health and Well-being* (launched in 2001), as well as NHS Health Scotland's major portfolio of mental health improvement work.¹ It has also been informed by Scottish evidence and campaigns in other areas relevant to mental health e.g. physical activity, diet and alcohol² and programmes exploring well-being e.g. *Cultural influences on mental health and well-being in Scotland*.³

It is hoped that the research will contribute to one of the key challenges for public mental health: to move from general observations about the importance of mental health and well-being to specific recommendations for action, supported by the literature on evidence of effectiveness and the knowledge and expertise of practitioners.

1.1 Aims

The main aim of the research is to identify key evidence based promotion messages for individuals aimed at supporting mental health and well-being by:

- identifying and reviewing the existing evidence base for mental health promotion messages (promotion, prevention and support for those experiencing mental health problems)
- assessing the strength of the evidence for existing and emerging mental health promotion messages

¹ The development of 'positive steps' is consistent with the National Programme's goal to encourage activities that promote positive mental health and well-being and raise awareness, as well as the future focus of the programme on promotion, prevention, support and inequalities.

² For example the current alcohol online campaign:

http://www.infoscotland.com/alcohol/displayhome.jsp?pContentID=112&p_applic=CCC&p_service=Content.show&

³ A collaboration between the Scottish Executive's National Programme for Improving Mental Health and Well-being and the Glasgow Centre for Population Health:

<http://www.wellscotland.info/publications/consultations4.html>

- identifying and reviewing examples of social marketing campaigns and other initiatives to promote mental health promotion messages to assess audience responses, uptake, impact and/or outcomes.

The findings will form the basis for a range of future activities relating to increasing mental health literacy and the general public's knowledge and understanding about how to promote and protect their own and others' mental health.

1.2 Research methods

The research design has been developed with the intention of:

- ensuring that the search strategy yields relevant and manageable results
- building on existing knowledge and experience in delivering mental health and mental health promotion messages
- testing emerging findings with practitioners

A four-stage methodology was undertaken, including (i) a review of the available published and unpublished (or grey) literature, (ii) interviews with key informants from selected health, mental health and other agencies, and (iii) a briefing seminar for practitioners to explore their response to the emerging research findings. Additionally, (iv) data was obtained from a survey of BT employees concerning their views and opinions on the usefulness and relevance of positive steps messages.

(i) Review of the published literature

Methods

The research design was developed with the intention of ensuring that the search strategy yielded relevant and manageable results. The review is not a systematic review. A number of recent general and topic-based reviews on the effectiveness of mental health promotion were identified and interrogated for evidence relevant to 'positive steps' messages. These were supplemented by a partial search of Applied Social Sciences Index and Abstracts (ASSIA) database, a rapid review of the Centre for Reviews and Dissemination (CRD) database and a hard search of recent papers in the International Journal of Mental Health Promotion to address any gaps in the evidence base. These searches were made to develop a comprehensive, but targeted, list of references of potential relevance to a rapid review of the evidence base for positive steps messages.

The review included studies published in English in the UK, North America, New Zealand and Australia. Only studies targeted at adults were included.

Analysis

Some studies are conceptually or empirically cross-cutting and provide evidence for more than one 'positive step'. The evidence has been analysed thematically to identify what mental health gains were associated with each of the positive steps. The strength of the evidence base was also explored. As far as possible, issues of

social diversity (age, gender, ethnicity and socio-economic status) have been integrated into a discussion of the strengths and weakness of the evidence base.

(ii) *Grey literature and interviews with key informants*

The primary source of grey literature is an extensive series of reports prepared for World Mental Health Day (WMHD) 1996-1999 (see appendix three), supplemented by qualitative research on attitudes to mental health, mental illness and mental health campaign materials undertaken for NHS Health Scotland and Health Promotion Agency Northern Ireland. Key informants were identified in consultation with NHS Health Scotland (see appendix one); Twenty one interviews were conducted, plus one face to face group interview with senior staff from the Mental Health Foundation.

(iii) *Seminar*

The purpose of the seminar was to present emerging findings from our research and to invite comment and debate from colleagues across Scotland about barriers, facilitators and issues to consider in promoting mental health improvement messages in Scotland. Participants were identified in partnership with NHS Health Scotland and forty people attended (see appendix five).

(iv) *BT survey*

Permission was obtained from BT to conduct a short online survey to investigate employee attitudes to 'positive mentality', a BT mental health promotion initiative. A total of 374 surveys were completed and fifteen follow up telephone interviews (see appendix four).

2 Background

Mental health improvement can be seen as any action to increase mental health and includes action aimed at promoting mental health, preventing mental health problems and improving the quality of life of people experiencing mental health problems.⁴ Although it is widely recognised that individual behavior and lifestyle factors (as well as wider socio-economic and environmental determinants) influence physical health, the relationship between mental health and lifestyle has been largely neglected in public health campaigns (Mental Health Foundation, 2005a). The need to address this by increasing knowledge and awareness of what individuals can do to look after their mental health is now a policy commitment in England (Department of Health, 2006; NIMHE, 2005) and will form part of emerging work on social marketing (French and Blair-Stevens, 2006; National Consumer Council, 2006). For example, *marketing mental health* is one of nine priority actions in *Making it possible: a guide to improving mental health and well-being in England* (NIMHE, 2005). Mental health promotion messages are also central to the current media campaign in Northern Ireland, *Minding your head*.⁵

To date, the mental health improvement messages or 'positive steps' that have been most commonly recommended (for example by the Health Education Authority (HEA), the Mental Health Foundation (MHF) and the National Institute for Mental Health England (NIMHE) include variations of the following:

Lifestyle/activities

- keeping physically active
- eating well
- drinking in moderation/avoiding drugs
- learning new skills
- doing something creative
- exploring your spiritual side
- taking a break/relaxing

Emotional/cognitive

- valuing yourself and others
- talking about your feelings

Social

- keeping in touch with friends and loved ones
- caring for others
- getting involved and making a contribution
- asking for help

⁴ Some definitions and concepts that have informed mental health improvement work in Scotland are included in a briefing paper for the National Programme: Scottish Executive (2004): www.wellscotland.info/information-resources.html

⁵ <http://www.mindingyourhead.info/template.asp?g=6>

Messages promoting mental health have appeared in a number of previous local and national mental health campaigns, although the predominant focus has generally been on reducing the stigma surrounding mental illness, rather than on taking steps to improve mental health. The former Health Education Authority developed a series of positive steps messages from 1996-2000, based on the emerging evidence base (see appendix two). These were subsequently further developed by Mentality and most recently by the Mental Health Foundation.⁶ The HEA's positive steps materials were extensively pre-tested and the research on how different audience segments responded to the messages forms an important part of the grey literature (see appendix three).

The research literature is broadly divided into three areas:

- lifestyle/behaviours that promote mental well-being (e.g. diet, exercise, sleep, help-seeking)
- emotional and cognitive skills and attributes associated with mental well-being (e.g. positive thinking, problem solving, communication)
- the relationship between social functioning and mental well-being

Previous research has demonstrated that a number of 'positive steps' activities, (notably exercise, diet, creativity, challenging negative thoughts, learning new skills and getting involved) show some effectiveness for promotion, prevention and symptom relief (Friedli and Watson, 2004; Scottish Development Centre for Mental Health, in press). This is consistent with a growing body of evidence that activities supporting recovery for those with mental health problems are consistent with activities that promote mental health for everyone. NIMHE (2005) states:

These 'positive steps' for mental health are familiar themes in a wide range of research on what people who experience mental health problems find helpful. They provide a foundation for everyone's mental health and now need to be much more widely disseminated to the general public

(p.16)

However both the Royal College of Psychiatrists and the Sainsbury Centre for Mental Health (SCMH) have challenged a focus on individual lifestyle choices, arguing that lifestyle has little or no impact on risk of mental illness.

"Nobody chooses to have a mental health problem. Mental illness cannot be prevented by promoting healthy lifestyles. Promoting mental wellbeing is about tackling the things that put people at risk of mental ill health and taking action to offer fair chances in life to those with mental health problems."

(SCMH press release, quoted in Mental Health Foundation 2005a)

"While it can be argued that an individual's risk of heart disease is, in part, a culmination of lifestyle and dietary choices, it is difficult to make the same argument for depression, schizophrenia, agoraphobia and most other mental health problems. The emphasis of the white paper is that individuals are

⁶ MHF also include messages to actively discourage people from putting their mental health at risk e.g. through work related stress and recreational drugs.

responsible for their own health. The balance between individual and societal responsibility for people with mental health problems may be significantly different to that for preventable physical problems.”

(RCPsych press release www.rcpsych.ac.uk, quoted in Mental Health Foundation 2005a)

Nevertheless, overall, the idea of taking positive steps to improve mental health is gaining currency and ‘top tips’ for looking after mental health are appearing more regularly in the media and on websites.⁷ Notwithstanding this, there is no single source of information on the strength of the evidence on positive steps. This report is intended to increase awareness of the evidence base on key mental health promotion messages and to contribute to a wider debate about the determinants of mental health and the relationship between mental health improvement and lifestyle.

2.1 Signposts through the report

- Section 3 gives details of our findings on the strength of the evidence for ‘positive steps’ messages.
- Section 4 covers the lessons learned from qualitative evidence from other initiatives on how people view their own mental health, public attitudes to the idea of ‘looking after your mental health’ and what action, if any, people take to protect or promote their mental health
- Section 5 outlines key findings from the survey of BT employees on their views and opinions about positive steps messages
- Section 6 provides an overview on insights from social marketing and other initiatives/campaigns relevant to mental health improvement messages
- Section 7/8 include findings from telephone interviews and seminar feedback from mental health promotion, public health and other practitioners
- Section 9 provides a summary of conclusions and recommendations

⁷ Recent examples in Scotland include Well on the Web and NHS Fife Staff newsletter.

3 Evidence of effectiveness: key findings from a review of the literature on positive steps for mental health

3.1 Introduction

This section of the report presents key findings on the strength of the evidence for 'positive steps' messages that represent the staple elements of mental health campaigns targeted at the individual. Data has been distilled from an extensive trawl of the literature with the objective of identifying evidence of greatest potential use to practitioners, policy makers and the general population. As far as possible, the data is presented with a view to achieving clarity while not losing sight of the complexity of the topic.

While the findings focus on evidence to support individual action to protect and promote mental health, it is clear that social, economic, cultural and environmental factors interact in complex ways to produce mental well-being or ill health. Individual capacity to act on any of the positive steps discussed here is also a product of societal influences. Evidence on the impact of social diversity and inequality on outcomes for mental health has been integrated into a discussion of the findings. A common criticism of mental health campaigns targeted at the individual is that, unless due attention is given to the social determinants of mental health, they risk 'blaming the victim' for whatever distress they may experience. There is therefore a strong argument in favour of integrating an equalities perspective into mental health promotion campaigns.

Mental health status (levels of well-being) is both a cause and a consequence of individual behaviour and lifestyle. Many health-damaging behaviours may be survival strategies in the face of multiple problems and despair related to occupational insecurity, poverty and exclusion. These problems impact on intimate relationships, the care of children and care of the self. The 20% - 25% of people who are obese and continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities (Gordon et al, 2000). This is also the population with the highest prevalence of anxiety and depression (Melzer et al, 2004). Capacity, capability and motivation to choose health are strongly influenced by mental health and well-being.

To some extent, 'positive steps' messages for mental health are a combination of lifestyle messages and self help, which has been defined as involving little or no input by a professional and oriented towards enabling individuals to develop and use skills to cope and manage their difficulties more effectively (Lewis, 2004). Historically, the notion of 'self-help' is associated with Victorian values of self-reliance and uncomplaining endurance in the face of adversity. Yet, self-help and self-efficacy are closely related concepts and might therefore be interpreted as empowering, since the choice to explore the effectiveness of a particular coping strategy rests with the

individual.⁸ Indeed, it has been argued that previous generations have coped with difficult life events without the help of counsellors or mental health professionals, using a range of alternative self-help approaches. These have commonly included eating, drinking, smoking, denial and talking to friends (Warr and Payne, 1982) – approaches that are still widely used, as is clear from the findings discussed in Section 4.

Further, it may be argued that individuals are also social actors, with a capacity to resist negative social messages and overcome life circumstances. To deny the agency of the individual is itself a form of oppression. These complex questions underline the importance of context and value-base for the practice of mental health promotion. When reflecting on the evidence for the effectiveness of positive steps messages for mental health promotion, it may be useful therefore to bear in mind some key questions: what is the social and political context in which they are delivered? what are the values that underpin their use in mental health campaigns? how might such campaigns fit within broader strategies to promote mental health and reduce health inequalities?

3.2 Evidence base: some provisos

In assessing the strength of the evidence for positive steps messages, a number of provisos concerning the relative strengths and weaknesses of different research methodologies require careful attention. Different studies use different definitions of mental health, measure different attributes of mental health and use different scales. The well-being literature, for example, investigates dimensions of subjective well-being, life satisfaction, happiness, and measures of flourishing or positive mental health (Carlisle, 2007; Dolan, 2006), while other studies focus on measures of mental illness. The relationship between mental health, mental illness and different skills, attributes or behaviours (social functioning, talking about problems, eating a healthy diet) depends to some extent on which aspect of mental health and well-being is being measured and which scales are used.⁹ Therefore the evidence must be viewed with caution, although for positive mental health, there tends to be a reasonably good correlation between different aspects of positive mental health e.g. life satisfaction, positive affect, optimism, psychological well-being, quality of life and 'happiness' (Blanchflower and Oswald, 2004).

There are also wider considerations of cultural specificity and cultural bias, as well as the fact that a high proportion of 'mental well-being' studies are based on relatively privileged cohorts e.g. students, white collar workers. Positive affect, for example, may have a greater influence on outcomes for people who are relatively well-resourced.¹⁰

⁸ It is also potentially highly cost effective; A review by NICE (2007) reported that computerised cognitive behaviour therapy could produce an estimated saving of £1,260,000 per 250,000 population over 2 years compared with face-to-face therapy.

⁹ For a review of a wide range of well-being scales validated for use in the UK see Speight et al, 2007 (in press).

¹⁰ Diener found that among affluent students, positive affect was a significant determinant of improved educational and employment outcomes, whereas for less affluent students, parental income was a more significant determinant (Diener cited in Lyubomirsky et al, 2005).

Some 'positive steps' have received considerably more attention from researchers than others. The evidence base is therefore uneven; the mental health benefits of exercise, for example, has been the subject of experimental study whereas evaluations of creative activities for mental health focus more on post hoc opinion surveys of participants. These methodological differences do not necessarily reflect the relative importance attached to various positive steps (although this might be the case) but rather that some benefits or practices are harder to measure than others. However, even where the quality and quantity of studies is high, most evidence highlights associations between different variables rather than a causal chain. Nevertheless, many of the associations between positive mental health and positive outcomes are increasingly being confirmed in longitudinal and experimental studies.

3.3 The strength of the evidence

The strength of the evidence presented in the report has been assessed according to the following general criteria:

- Limited: there are not enough studies to draw firm conclusions – more research needed
- Weak: methodological flaws means the findings should be viewed with caution
- Mixed: some findings support the claim, others do not support it
- Good: high quality and quantity of studies, including longitudinal studies
- Review level syntheses of high quality studies, including systematic and meta-analytic reviews
- On balance the weight of the evidence appears to support the claim

3.4 Positive steps

3.4.1 Lifestyle: exercise, diet, substance abuse

'keep physically active; eat well/healthily; drink in moderation/avoid drugs'

Summary

Exercise

- There is good (review level) evidence for a positive association, but not necessarily a causal link, between physical activity/exercise and mental well-being. There is good evidence that physical activity has some level of benefit for a) emotion and mood, b) self-perception and self-esteem, c) ageing and psychological well-being d) stress e) sleep, f) preventing or alleviating symptoms of depression and anxiety, and g) treating mental illness. In some studies, it is difficult to identify whether the benefits are a result of physical activity or the associated social contact.

Diet

- There is limited and weaker, but promising, evidence for the relationship between diet and mental health.

Alcohol

- Evidence is mixed and equivocal on the relationship between alcohol use and poor mental health. There is limited agreement on direction of causality and it is unclear whether a reduction in alcohol consumption at a population level would reduce incidence of depression and anxiety. There is a clear relationship between alcohol abuse, social functioning and factors that influence mental health e.g. violence, intimate partner violence and sexual abuse of children.

Exercise: emotion and mood

A review of 5 experimental and controlled trials conducted in the UK identified a positive association between physical activity and emotion or mood (Biddle, 2000 quoted in NICE, 2007). However, *intensity* of physical activity emerged as a key variable. In two trials, low intensity exercise had a positive effect whereas moderate intensity exercise had a more negative impact on mood. A further trial found that only the group engaged in moderate-intensity exercise reported an improvement in mood, suggesting level of intensity should be matched to the needs of the target population. For example, a further study found that high intensity exercise had a negative effect on the moods of those with a history of low activity.

Exercise: self-perception and self-esteem

Fox (2000, quoted in NICE, 2007) suggests that improvements in self-perception and self-esteem may be a result of participants' feeling better about their body image, level of fitness and physical strength. His review of different populations taking part in a wide range of exercise (including aerobic exercise, weight training, jogging, walking, yoga, and tai chi) found participants reported feeling better about their body, but were less certain about the impact of exercise on their self-esteem. Only five out of 21 trials reported a positive association between physical exercise and self-esteem. Improvements in self-esteem may be greater in people with initially low self-esteem, such as adults with learning difficulties, obese men and people with alcohol problems (Fox, 2000.)

Exercise: ageing and psychological well-being

The intervention group began to socialise together outside of the exercise class, and this unanticipated development may have influenced the findings.
(Moore and Bracegirdle, 1994)

A review of the effects of exercise on the psychological well-being of older adults (aged 45 years and over) identified a positive association in the majority of studies but not a causal link (McAuley and Rudolph, 1995 quoted in NICE, 2007). A key variable for level of impact was the *length* of the programme. Shorter programmes (less than 10 weeks) tended to demonstrate a less positive effect than programmes of 10-20 weeks duration, or compared with programmes of more than 20 weeks.

A small RCT conducted in the UK (Moore and Bracegirdle, 1994 cited in Tilford and Delaney, 1997) found that an exercise to music programme, involving 12 elderly women in a day centre over a six week period, had a positive impact on self-reported levels of psychological well-being. The extent to which reported benefits may be attributable to the exercise programme or to other factors, such as increased sociability, is less clear.

Exercise: stress

An RCT investigating the impact of three different exercise formats on a sample of middle aged white participants (aged 50-64 years) found a significant and positive impact in reducing stress levels in all three intervention groups. Whereas Biddle (2000) and McAuley and Rudolph (1995) highlighted intensity of exercise and length of exercise respectively as key variables, this study identified *frequency and sustainability* of exercise over a 12 month period as more important factors (King, Taylor and Haskell, 1993 cited in Tilford et al., 1997).

Exercise: sleep

Regular exercise, such as brisk walking, may reduce sleep disorders (Sherrill et al, 1998). Findings of an RCT showed that walking briskly for 30-40 minutes four times a week had a positive impact on older people with sleep problems (King et al, 1997).

Exercise: cognitive functioning

There is review level evidence (meta-analysis) that regular exercise can have a positive effect on cognitive functioning and general psychological well-being of older people (Etnier et al, 1997).

Exercise: depression

“patients of all ages with mild depression should be advised of the benefits of following a structured and supervised exercise programme”

(NICE 2004b, p15)

Exercise can contribute to the prevention as well as the amelioration of depression. Physical inactivity increases the risk of depression (Farmer et al, 1988; Paffenbarger et al, 1994) and physical exercise can reduce the symptoms of mild, moderate and severe depression (Craft and Landers, 1998; Mutrie, 2000; Lawlor and Hopker, 2001). An investigation of a GP-prescribed exercise programme for clinically depressed patients found that after three months a majority of participants (68%) had reached non-clinical status (Darbishire and Glenister, 1998). A supervised programme of exercise can be as effective as antidepressants or psychotherapy in treating mild or moderate depression, notably in the long term (Blumenthal et al, 1999; Grant, 2000), and may be particularly helpful as the most recent guidelines do not recommend antidepressants as a first line response to mild/moderate depression (NICE 2004b).

Exercise: other mental health problems

Physical exercise can also have a positive impact on a range of other mental health problems, such as anxiety, phobia, panic attacks, stress (O'Connor et al., 2000) and as an adjunct to treatment in the management of symptoms of schizophrenia (Faulkner and Biddle, 1999). Review level evidence suggests that physical activity has a weak to moderate impact, with those who experience high levels of anxiety and the physically unfit gaining most benefit (Taylor, 2000; NICE, 2004b).

Physical exercise may contribute to a weight control and obesity-related diseases in people with schizophrenia (Brown et al., 1999; Faulkner et al., 2003) and therefore indirectly increase positive mental well-being.

Diet

The link between diet and mental health is an emerging field with a lack of experimental trials (Mental Health Foundation, 2006; Van de Weyer, 2006). Although the results are not conclusive, one view is that as a dietary approach (for example to reducing depression) has no negative side effects, it is worthy of serious consideration (Holford, 1998).

Emerging hypotheses supported by limited evidence suggest:

- poor diet may contribute to biochemical imbalances that contribute to depression and supplements or a diet high in certain nutrients or foodstuffs

can be an effective form of treatment (Holford,1998; Suboticanec, 1990; Rybakowski and Weterle, 1991; Smith et al., 1997; Hibbeln, 1998).

- international variations in levels of schizophrenia and depression are linked to national patterns in food consumption (Peet, 2004) and dietary risk factors for depression and schizophrenia are similar to those for coronary heart disease and diabetes. Therefore a similar dietary treatment programme (particularly the enhanced intake of omega-3 fatty acids) can produce positive outcomes in mental as well as physical health (Peet and Horrobin, 2002; Nemets et al., 2002).
- vitamin deficiencies are associated with cognitive impairment in older people (Fillett et al., 2002; Mattson, Chan and Duan, 2002). Improvements in diet, particularly the consumption of adequate fruit and fibre, have also been associated with optimal cognitive and physical health for older people (McReynolds and Rossen, 2004).
- Diet influences behaviour through its impact on emotion and cognition. A randomised double blind placebo trial in a prison found a significant reduction in violent behaviour following food supplements (Gesch et al., 2002).

Having a good diet is protective of health, but is also related to socio-economic factors. Evidence points to an association between obesity and stress: people who are experiencing stress are less likely to have a good diet or to exercise thereby establishing a circle of negative effects between mental and physical health (Cabinet Office, 2004).

Diet: eating disorders

Body dissatisfaction and weight controlling behaviour are risk factors for eating disorders and a meta-analytic review found that these can be reduced. However, these factors are so prevalent among young women that the connection may be an artefact (Stice and Shaw, 2004).

Substance misuse: alcohol and illegal drugs

Alcohol

Poor mental health and social problems are associated with a) binge drinking and b) prolonged and excessive drinking. Both forms of alcohol misuse are associated with enhanced risk of physical harm (alcohol poisoning, liver disease, cancer, stroke, premature mortality, accidental injury) which may impact on mental health, social harm (physical and sexual assault, including intimate partner violence, and anti-social behaviour) and mental health problems (Cabinet Office, 2004). A key debate concerns the extent to which alcohol misuse precedes, or is a consequence of, mental health problems such as anxiety and depression (Kessler et al., 1996; Merikangas et al., 1998; Rehm et al., 2003).

Drugs

The risks associated with illicit drug use, such as heroin, crack cocaine, and cannabis are similar to those of alcohol misuse, and comprise the risk of physical harm (including physiological damage, dependency, and risks associated with intravenous use), and social harm (drug-related crime and family breakdown). Evidence indicates an increased risk of contracting HIV or hepatitis among users of mental health services who also engage in drug misuse (Cohen and Phelan, 2001).

A recent study devised a new 'matrix of harm' which assessed a range of substances (including illicit drugs, alcohol and tobacco) according to the risks they pose to a) physical harm, b) dependency and c) social harms. According to this system of classification, alcohol and tobacco would occupy positions comparable to class A and B drugs respectively (Nutt et al., 2007).

Alcohol: depression and anxiety – direction of causality

Rehm et al (2003) argues that epidemiological evidence demonstrates a strong relationship between alcohol dependence and depression (Swendsen et al., 1998) as depressive symptoms tend to improve rapidly once users abstain from alcohol use (Penick et al., 1988; Davidson, 1995). Others argue that alcohol misuse is a consequence, rather than a cause, of mental health problems (Allan, 1995) and recommend that a period of abstinence is the only way to determine whether an underlying psychological problem underpins alcohol misuse.

In clinical populations, the level of alcohol consumed by people who experience anxiety tends to be no more than that of the general population (Tilley, 1987). Singleton and Lewis (2003) in a follow-up of the Office of National Statistics (ONS) Survey of Psychiatric Morbidity found that heavy drinking was not associated with the onset of anxiety or depression at an 18-month follow-up, but that people who did not drink alcohol were less likely to experience a new onset at follow-up. Abstinence protects against depression and anxiety and, in terms of mental health, the current guidelines (maximum of 3-4 units per day for men and 2-3 units for women) may need to be lowered to reduce the risk of anxiety and depression (Haynes et al., 2005).

More recently, a number of studies have refuted the existence of an association between alcohol consumption and incidence of depressive illness (Moscato et al., 1997, Wang and Patten, 2001).

3.4.2 Activities: learning, creativity, spirituality

'Learn new skills, do something creative, explore your spiritual side'

Summary

Learning

- There is good evidence that participating in learning throughout life reduces risk of depression and is associated with a wide range of mental health

benefits including confidence, self-esteem, self-efficacy, coping, life satisfaction and social functioning

- There is good evidence that learning contributes to the adoption of healthy behaviours

Creativity

- There is promising/good evidence from survey data that creative pursuits improve confidence, self-esteem, motivation, happiness and reduce stress and enhance control
- Opportunities for increased social contact is an important factor in explaining positive mental health outcomes for creativity, but there is some evidence of independent benefits
- There is limited but promising evidence that participation in the arts can reduce offending and re-offending behaviour and increase engagement among young people
- There is weak, limited and mixed evidence that creativity can contribute to community level benefits e.g. cohesion, regeneration

Spirituality

- There is good evidence that regular engagement in religious activities is positively related to happiness, life satisfaction, positive emotion and reduced risk of depressive symptoms

Learning

Studies on the mental health benefits of learning generally focus on adult and continuing education (vocational and non vocational), including adult literacy and numeracy.

Education protects mental health and low educational attainment is a risk factor for common mental health problems (Melzer et al., 2004). It has been suggested that learning impacts on health (including mental health) through increasing four types of capital: economic capital (e.g. employment opportunities), human capital (knowledge and skills), social capital (e.g. levels of civic engagement and social cohesion) and identity capital (confidence and self-esteem) (Feinstein et al., 2003).

Learning: on prescription

Limited evidence that prescription for learning schemes increase confidence, self-esteem, mood, sleeping, activity and result in wider social networks, greater sense of control, hope and optimism and improved health behaviours (James, 2001a, James, 2001b, James, 2001c; Scottish Development Centre for Mental Health, in press).

Learning: depression and malaise

In a longitudinal econometric study, Chevalier and Feinstein (2006) found that education reduces the risk of poor mental health, with the largest impact for gaining low level qualifications. Education at all ages reduced the risk of transition to depression and improved mental health even at a low level of malaise score. The effect is significantly stronger for women.¹¹

Learning: attitudes

A study on the health impact of participation in learning in a sample of 10,000 adults, found that learning contributes to the small shifts in attitudes and behaviours that take place during mid adulthood. Positive changes relevant to mental health included levels of exercise taken, life satisfaction, race tolerance and participation/engagement (Feinstein et al., 2003).

Learning: emotion, cognition, social functioning

Qualitative research on self-reported health outcomes among people aged 50-71 found that participation in learning had a positive impact on self confidence, self-esteem, satisfaction with life and ability to cope (Dench and Regan, 2000). Aldridge and Lavender (postal questionnaire n = 2000) found that participants identified greater confidence, new social contacts and more opportunities for paid or voluntary work as the most important benefits gained from learning. Reduced stress and anxiety and a greater sense of achievement and satisfaction were also reported. 89% reported 'feeling mentally better' and that involvement in learning helped them to avoid dwelling on difficult problems and feelings. It was perhaps surprising that involvement in learning also had wider benefits for family life, including improvements to family health and psychological well-being (Aldridge and Lavender, 2000). A Scottish study of basic skills participants (including interviews with tutors) had similar findings, plus reduced unemployment (7%) and improved job prospects (28%) at 12 month follow up (Tett et al., 2006).

Creativity

"participation in culture adds enjoyment to life, increases self-belief, equips people with important life skills and improves well-being and health"
(Scottish Executive, 2003d)

Definitions of creative activities are broad and sometimes overlap with learning, but may include: arts and performance (including writing, painting, sculpture, photography, music, poetry, drama, dance and film); libraries; museums; heritage; and, cultural tourism.

¹¹ They estimate that a policy increasing the education of females from no to basic qualification will reduce the total cost of depression for the population by £230 million a year or £4.9 billion over the working life of these women (see also Friedli and Parsonage forthcoming)

Creativity: emotion, cognition and social functioning

A range of studies, suggest that creativity improves self-expression and self-esteem, opportunities for social contact and participation, and/or provides a sense of purpose, meaning and improved quality of life (Oliver et al., 1996; Callard and Friedli, 2005; Tyldesley and Rigby, 2003; Huxley 1997). These studies have, however, been criticised for being generally methodologically weak small scale and relying on self assessment (Evans and Shaw, 2004; Ruiz, 2004).

Creativity: youth offending

Hughes (2004) found limited but promising evidence that arts programmes can reduce offending behaviour and incidents of disruption, help disaffected young people re-engage with education, and sponsor personal and social development. Arts interventions were associated with reductions in re-offending, reducing rule-breaking and improving relationships in prison, changing attitudes to offending, building up human and social capital and enhancing the effectiveness of offending behaviour programmes.

Creativity: educational benefits

Cultural activities may provide a context for learning new social skills, creative capacities and language competences (HDA 2000). Longitudinal evidence from the British Cohort Study shows that involvement in cultural activities during childhood and adolescence has statistically significant and positive effect on economic capital at age 29 years (Ruiz, 2004). Four cultural activities were shown to produce the most benefit: participation in the arts or music, theatre, reading and writing for pleasure (Ruiz, 2004). These findings support Coulter's argument that personal development derived from involvement in arts activities is one of many 'intermediate' outcomes that lead to increased employability, social integration and improved psychological health (Coulter, 2001).

Creativity: positive mental health

Surveys of adult participants in arts projects reported increased self-confidence (Matarasso, 1997; Matarasso, 1998). By reducing social isolation, stress and boredom, as well as enhancing self-confidence, cultural activities are attributed with promoting positive mental health for unemployed people (Shaw, 1995) and for mental health service users (Matarasso, 1997). Involvement in cultural activities was reported as empowering former hospital patients to develop the confidence necessary to live independently in the community (Landry and Matarasso, 1996). A further case study on people referred to arts activities by health and social services found that participants used in-patient and other hospital services less often and that the risk of relapse was reduced (Department for Culture, Media and Sport, 1999).

Arts activities have the potential to improve many of the standard measures of mental health, such as: a) enhanced personal motivation; b) improved social networks; c) greater optimism; d) lower levels of anxiety, and e) increased self esteem (HEA, 1999a; HDA, 2000). Although the health benefits of arts activity are sometimes difficult to assess, survey data shows that 66% of arts projects report increased

happiness and 53% report lower levels of stress among participants. 78% said participants felt more creative and confident, 59% said that participants made new friends, and 64% reported that participants demonstrated enhanced control over their lives (HDA, 2000).

Religion and spirituality

There are considerable problems with defining religion and spirituality. One distinction is between a) religion as a formalized, shared system of beliefs and practices designed to bring people closer to God (or other divine power) and b) spirituality as a personal quest and relationship with the sacred (Koenig et al., 2001). Central features of religion and spirituality include the influence of concepts of the divine and the non-material on relationship with the self, with others and with nature and on the sense of purpose and meaning in life.

Key hypotheses for the mental health benefits of religious and spiritual practice include:

- perceived support received from God or other spiritual sources
- participation in social networks associated with religious groupings
- beliefs in love, forgiveness, hope and optimism having positive effects on endocrine and immune systems

Other explanatory mechanisms concern the possibility that 'religious coping' helps individuals to adjust to the effects of traumatic events (Shaw et al., 2005). Coyle (2002) suggests that, contrary to the prevailing faith in the power of self-efficacy and mastery, religious or spiritual belief may produce positive benefits by shifting the locus of control from the individual to the divine. Mental health benefits are connected to a greater capacity for gratitude and forgiveness (Vaillant, 2002).

Spirituality: recovery

User led research has widely seen spirituality, religion and membership of faith communities as an aid to recovery from mental illness among survivors (Faulkner, 1997; Faulkner and Layzell, 2000; Fallot, 2001; Mental Health Foundation, 2006c). However, religious beliefs and practices can damage mental health, (Trenholm, Trent and Compton, 1998; Foskett, Marriott and Wilson-Rudd, 2004) particularly for people who have been rejected by fellow believers.

Spirituality: positive mental health

There is review level evidence for a relationship between religion and mental health, notably a positive association between religious involvement and enhanced well-being on measures of life satisfaction, happiness and self-esteem (Keonig et al., 2001). Lower levels of anxiety, schizophrenia and divorce were also reported. Dolan found consistent evidence in 10 studies that regular engagement in religious activities is positively related to happiness (e.g. Cohen, 2002; Ferris, 2000), life satisfaction (e.g. Clark & Lelkes, 2005; Hayo, 2004) and positive emotions (Kahneman et al., 2004) and negatively associated with depressive symptoms (e.g. Lee et al., 2001) (all cited in Dolan, 2006).

Spirituality: anxiety, depression

Although direction of causality is unproven, spirituality is associated with reduced levels of depression, particularly among older people with chronic physical illness (Koenig et al., 1992; Koenig et al., 1995; Koenig, Larson and Larson, 2001). Religion and spirituality may also have a positive effect on depression in the wider population, as well as reducing the risk of substance abuse and suicide (Fenwick, 2003). In a study of the relationships between religion, spirituality and mental health outcomes of individuals recovering from substance abuse, it was found that higher levels of religious or spiritual belief were associated with greater optimism, higher perceived social support, enhanced resilience to stress and lower levels of anxiety (Pardini et al., 2000).

Religious faith or spirituality generally has a positive effect in helping people to recover from traumatic experiences, although it also appears that spirituality may also develop as a result of such trauma (Shaw, Joseph and Linley, 2005).

Spirituality: ageing

One longitudinal study found that, in late adulthood, religiosity was positively associated with good inter-personal relationships, involvement in the local community and a sense of altruism. People who were described as more spiritual in their orientation derived their well-being from personal growth, creativity and from insight into the human predicament. Compared with spiritually-oriented individuals, religiosity was associated with greater involvement in communal activities. However, both groups were involved in social and community 'life tasks' (Dillon and Wink, 2003).

Spirituality: meditation and praying

Meditation has been linked to improved learning ability, memory, emotional stability and vitality and decreased anxiety, depression and irritability (Lee and Newberg 2005). A review of 36 articles on the relationship between meditation, spirituality and the health of elderly people identified reductions in stress and anxiety and higher levels of self-esteem regardless of age, level of education, occupation or cultural background (Lindberg, 2005).

Kahneman et al. (2004) found that praying is also associated with high levels of positive emotion.

3.4.3 Emotional/cognitive: talking about your feelings; valuing yourself and others

'talking things over; accepting ourselves, accepting others'

Summary

Talking

- There is review-level evidence for the effectiveness of psychotherapeutic treatments for depression, anxiety disorders, obsessive compulsive disorder.

Studies on other mental health problems also found strong evidence for their effectiveness. Evidence that talking protects mental health in non clinical populations is limited.

- Evidence for the effectiveness of written self-help materials for treating mental health problems is mixed.

Valuing yourself and others

- There is good evidence linking low self-esteem with depression, suicidal behaviour and eating disorders
- There is good evidence that social trust is associated with higher life satisfaction, happiness, and a lower probability of suicide and psychological problems but weak evidence on causality.

Counselling and other psychotherapies

The evidence for the mental health benefits of talking about feelings derives from evidence that confiding relationships are protective and the wider literature on social support (see 3.4.4). There is also an extensive literature on the impact of counselling and other structured talking therapies. The psychotherapeutic benefit gained from the use of written materials designed to treat mental health problem has received less attention.

Talking therapies and treatment

Counselling and psychotherapy can be effective in treating a wide range of mental health problems and helping people to cope with difficult life events. Effectiveness is influenced by the therapeutic relationship (who you talk to matters more than the model), matching the interventions to the type of psychological distress and adequate duration of treatment (Department of Health, 2001c; NICE, 2004a; 2004b; 2006b).

Cognitive behaviour therapies have been shown to be most effective for anxiety disorders (panic, agoraphobia, social phobia, obsessive compulsive disorder and generalised anxiety (NICE, 2004a). CBT is also recommended for eating disorders, although, family therapy and general individual therapy appears to be most effective for anorexia nervosa (Crisp et al., 1991; Anthony and O'Brien, 1997 quoted in Department of Health, 2001c).

Review level evidence from Scotland on CBT for anxiety disorders and psychosis found short term benefits but limited long term gains, notably for psychosis (Durham et al., 2005).

Review level evidence from primary care suggests that talking therapies are more popular with patients but no more effective or cost effective in the long term than usual GP care (Bower et al., 2000; Bower, Rowland and Hardy, 2003).

Self help

The self-help approaches discussed here focus on the use of written materials for the treatment of mental health problems, on writing as a form of therapy, and on the benefits of brief instruction to enhance coping skills.

Self help: written materials

A review by Emler (2001) noted that the production of self-help materials is now 'big business' but that insufficient attention has been paid to their evaluation, particularly the long term effects. Lewis (2004) concluded that CBT based self-help materials produced positive outcomes for people experiencing depression, anxiety, bulimia nervosa and eating disorders following a clinical assessment and supervision. However, serious methodological weaknesses in the evidence base were also identified, including a lack of independent valuations and of randomised controlled studies. A systematic review of the effectiveness of written materials for use in self-help approaches to reduce depression and anxiety found no evidence for long term benefits and concluded that there was only modest evidence for their clinical effectiveness overall (Bower, Richard and Lovall, 2001).

Other reviews have argued that self-help treatments are more beneficial than no treatment and that outcomes are comparable to those of standard psychotherapeutic approaches (Scogin et al., 1990; Cuijpers, 1997). Review level evidence indicates that writing about past traumatic or stressful events can be as effective as psychotherapy for minor mental health problems (Esterling et al., 1999). Like bibliotherapy, it is argued that writing therapy may be cost effective and have universal appeal. However, others (Karel and Hinrichson, 2000) warn that 'life review' may not be appropriate for people with severe depression.

Self help: coping skills

Several studies examining the effectiveness of brief instruction to enhance coping skills are targeted at carers – a group whose sources of stress are often enduring and difficult to influence. Other populations may respond more or less positively to such interventions.

Controlled trials designed to strengthen coping skills have shown reductions in depression among carers (Dellasega, 1990; Barush and Spaid, 1991; Lovett and Gallagher, 1988) and, in combination with relaxation skills, equivocal evidence of reduced anxiety (Greene and Monahan, 1989). However other studies with carers (of people with dementia) have reported no or limited effectiveness (Haley, 1989).

Valuing yourself and others

Valuing yourself: self-esteem

There is some evidence that self-esteem is negatively associated with depressive symptoms and that people higher in self-esteem are less likely to suffer from

depression (Dolan et al., 2006). Emler found that low self-esteem is a risk factor for depression, suicidal behaviour, eating disorders and being bullied (Emler, 2002).

Valuing others: trust

Trust might be considered a fair proxy indicator of valuing others. Dolan et al (2006) found that from the few studies that have looked at trust, the effects are relatively large although 'establishing causality is a real problem': low levels of mental health also influence capacity to trust.

Social trust is associated with higher life satisfaction and happiness, and a lower probability of suicide (Dolan et al., 2006). Stafford *et al* found that in neighbourhoods characterised by low levels of trust/tolerance for others, people living there were nearly 1.5 times as likely to rate their health poor (Stafford et al 2004). Lack of trust in unfamiliar others is a risk factor for psychological problems (Berry and Rickwood, 2000).

3.4.4 Social: social support, getting involved, caring for others, asking for help

'keeping in touch with friends and loved ones; getting involved and making a contribution; asking for help'

'it is easy to forget that life is lived in relationships, and the quality of those relationships has much to do with how life turns out'

(Lewis, 1998)

Summary

Social support

- There is good quality longitudinal and cross sectional evidence, including some review level studies, that strong social networks and social support play a significant role both in preventing mental health problems and improving outcomes.
- The level of *perceived* support is the key factor in influencing mental health
- There is mixed evidence on the relative importance of quantity and quality of social support and the extent to which limited social networks are a cause or consequence of poor mental health.
- There is mixed evidence that some types and levels of social network have a negative impact on mental health, notably for women and marginalized groups
- Social support and social participation do not mediate the effects of material deprivation
- There is weak and very limited evidence on the benefits of help seeking
-

Getting involved and making a contribution

- Evidence for the impact of volunteering on well-being is mixed.
- On balance, informal care-giving has a negative impact on well-being.

Social support

Social support generally refers to the quality and type (instrumental, informational, emotional) of support and perceived support, as well as the size and nature of social networks (Stewart Brown, 2005). Social support is associated with both negative and positive impact on mental health.

Social support: onset and recovery from mental health problems

A small social network may be a cause or consequence of mental ill-health (Brugha, 1993). A prospective investigation at the onset of mental illness found that individuals with a small social network (friends and relatives) of three or less were at greater risk of mental disorder at 18 month follow-up (Brugha et al, 2005).

A lack of social support is a contributory factor in the onset and poor recovery from mental health problems: low contact with friends and low social support decreases the likelihood of a recovery by up to 25% (Pevalin and Goldberg, 2003). In a large-scale survey of the general population over an eight-year period (British Household Panel Survey 1991-98) low social support, separation or divorce, unemployment and caring for a sick relative were all associated with differential rates of onset and recovery (Pevalin and Rose, 2003).

User-led research consistently cites maintaining relationships with family, friends, professionals and other mental health service users, notably during 'difficult times' as 'most helpful' in achieving recovery. (Faulkner & Layzell, 2000; Faulkner, 1997; Faulkner, 2002). The benefits of such support are described as enhancing self-acceptance and, in the case of peer support, of solidarity gained from shared experience.

Social support: risk and protective factors

The level of *perceived* support, rather than actual support, is the key factor in influencing mental health (Dunkel-Schetter and Bennett, 1990; Wethington and Kessler, 1986) although Brand et al. (1995) found that improving perceived social support from family members (through CBT) had no effect on levels of anxiety or depression.

Social participation and social support are associated with reduced risk of common mental health problems and social isolation is an important risk factor for both deteriorating mental health and suicide (Pevalin and Goldberg, 2003). Social isolation and low levels of perceived social support are associated with an increase in stress (HEA, 1999b)

A lack of supportive relationships is an independent factor in the development of mental health problems (Melzer et al., 2004). A lack of confiding relationships is a risk factor for mental health problems in working adults and elderly people (Melzer et al., 2004; Whelan, 1993; Brown and Harris, 1978).

It is unclear whether it is more important to have one confiding relationship than a large number of unsupportive relationships (Madge and Marmot, 1987; Thoits, 1995). One view is that the larger and more diverse an individual's social network, the more likely s/he is to find supportive social relationships (HEA, 1999b).

Social support: treatment of depression

A support programme that aimed to reduce depression among carers of partners with Alzheimer's disease found that carers who received support were less depressed than those in the control group at 8-month follow-up (Mittelman et al., 1995). However, due to the multi-component nature of the intervention, researchers were unable to identify with certainty which aspect of the support programme had been effective in reducing depression.

A review by Tilford and Delaney (1997) suggests that; increasing support for carers had variable results, benefits were often short-term and carers may need both social support *and* training to improve coping skills and reduce depression.

An RCT to improve the mental health of women with chronic depression using volunteer befriending reported a statistically significant reduction in depression after twelve months (Harris, Brown and Robinson, 1999).

Social support: bereavement

Increasing levels of peer and group support for widows and widowers can improve mental health, assist more rapid adaptation to bereavement and lower distress scores (Vacheron et al., 1980). An evaluation of the impact of support groups for widows and widowers also reported lower levels of depression and psychotropic drug use after 12 months (Lieberman and Videka-Sherman, 1986).

Social support: cognitive function

A longitudinal cohort study conducted in Sweden found that single people and individuals with few social ties were more likely to develop dementia than married people. The quality of social support was a more important factor than the frequency of contact. An inadequate social network increased the risk of dementia by 60% (Fratiglioni et al., 2000).

Social support: communities

A focus on the degree of social support or isolation of individuals may fail to take the wider social context into account. Kawachi and Kennedy (1997) claim that social deprivation should not be ignored and that entire communities or societies may lack sufficient social connections (Kawachi, Kennedy and Lochner, 1997). Three national datasets investigating the relationship between social support and social capital on health found that material living conditions and socio-economic status were stronger predictors of ill health than measures of social support or social capital (HEA, 1999b).

Social support: costs and benefits

Thoits (1995) found that the costs of social support can sometimes be greater than its benefits and it has been argued that the negative aspects of social networks have a greater impact on women's mental health (Belle, 1982). Support that is prompted by a sense of obligation and duty rather than from love and affection, particularly on the part of family members or partners, can be a cause of stress for both supporter and recipient, as can support that is perceived as 'interfering' or inadequate (Thoits, 1992; Thoits 1995). Ginn, Arber and Cooper (1997) draw a distinction between the support offered by friends compared with that of family member, and found that friendships are more reciprocal in nature and are therefore more likely to have a positive impact on self-worth and self-identity.

Attempts have been made to explain why, if women's social networks are generally larger than that of men, they experience higher levels of psychological ill health (Kawachi and Berkman, 2001). It has been suggested that women's social connections may make them more vulnerable to demands from others and consequent 'role strain'. This may be of particular relevance to women experiencing social deprivation, since women in these circumstances are more likely to need support, are least likely to receive it, and are more likely to be called upon to provide it (Belle, 1983).

Confiding relationships may also make women more susceptible to 'contagion of stress' as women share feelings around difficult life events with others. It has also been claimed that in dyadic relationships – particularly intimate heterosexual relationships – there is a lack of reciprocity which can result in higher levels of depression among women (Barnett and Gotlieb, 1988).

A study of depression among women in two rural Gaelic speaking communities in the Outer Hebrides showed that, while traditional aspects of life in the community (such as church attendance and participation in crafts) resulted in lower levels of depression, they also produced higher levels of anxiety resulting from the pressures of social conformity (Brown and Harris, 1978). Minority groups may also experience particular pressures to conform in both small communities (Kawachi and Berkman, 2001) and in the wider society (Meyer, 1995). Social norms may reinforce racism (Rogers and Pilgrim, 2003) but social support may also offer an important resource for coping with the impact of racism.

Asking for help

Help-seeking behaviour appears to be strongly influenced by gender: men are less likely than women to approach health services and other agencies for help in dealing with mental health problems. This pattern is attributed to norms of masculinity which discourage the open expression of feeling (Moller-Leimkuhler, 2002).

Evidence from a survey of 300 university undergraduates found that, regardless of gender, individuals who were more likely to need help (defined as those who were poor at managing their emotions) were the least likely to seek it out and that, even if they did so, they were the least likely to benefit (Carrochi and Frank, 2001).

Getting involved/making a contribution

“while some observers have claimed that greater community involvement is a win-win situation, providing better outcomes for the community at large and making those involved feel better about themselves, the evidence we review here suggests more caution is needed”

(Dolan et al., 2006)

Dolan found a positive correlation between subjective well-being and participation in the community but not in all studies. For volunteering, Hadler and Haller (2006 cited in Dolan et al 2006) found no relationship between volunteering and happiness or life satisfaction across 34 countries. Thoits and Hewitt (2001) found a positive relationship with well-being but also that people with high levels of well-being tend to do more voluntary work. In a classic study by Halpern (1995) residents who were more involved in their local community tended to be happier, regardless of the physical quality of their homes (Halpern (1995) cited in Stansfeld, 2006).

Other evidence is also mixed, with much of the data coming from studies on older volunteers (Wheeler et al. (1998) cited in Department of Health, 2001; Morrow-Howell et al., 2003; Greenfield & Marks, 2004). Some studies show volunteering benefits volunteers in addition to the receiver/community (Wilson, 2000), enhances positive mental health and reduces depression and depressive symptoms in the presence of stressors (Rietschlin, 1998; Van Willigen, 2000; Thoits & Hewitt, 2001). Some studies suggest that older volunteers are more likely to gain psychological benefits from volunteering than younger people (Van Willigen, 2000; Musick, & Wilson, 2003; Lum, & Lightfoot, 2005). Volunteering also benefits those experiencing mental health problems who self report that voluntary activity can improve their mental health (Ellis & Davis Smith, 2004).

A review of 37 studies by Wheeler, Gore and Greenblatt (1998) found that 70% of older volunteers scored higher on quality of life measures compared with peers who did not volunteer. Additionally, the quality of life for 85% of the volunteers' clients also improved as a result of becoming less isolated and depressed. Greenfield & Marks (2004) found that among a sub-set of older people, volunteering was associated with more positive, but not less negative affect

Caring for others

Dolan et al found that the evidence from the few studies that examined the effects of informal care-giving suggests that more care is associated with worse GHQ scores, lower happiness and more depressive symptoms. The effects are especially strong for close kin. The same review also found that transition into care-giving is associated with a range of negative well-being outcomes (Dolan et al., 2006).

3.4.5 Contact with Nature

Summary

- there is promising but limited evidence that contact with nature produces mental health benefits.

- urban parks and the countryside may function as antidotes to the stresses of urban and everyday life, offering opportunities for relaxation, sporting activities, and 'peace and quiet', as well as contributing to social cohesion and a sense of local identity

Contact with nature: urban and rural

Contact with nature includes the countryside and various types of open space in urban areas, such as parks, playing fields, playgrounds or commons (Atkins, 1999; Morphet, 1994).

Two key mechanisms have been suggested to explain the mental health benefits of contact with nature:

- 'stress recovery' (Ulrich et al., 1991); and
- 'attention restoration' (Kaplan and Kaplan, 1989; Kaplan, 1995).

Both models suggest that the peace, quiet and attractiveness of the countryside and urban parks have restorative effects.

Contact with nature: positive mental health

Evidence for the positive impact of urban parks and the countryside on mental health is generally output (e.g. the number of visits made to parks or the countryside) rather than outcome-based (i.e. based on measures of psychological well-being) (Local Government Association, 2001). More systematic investigation and precise measurement is required of the role and potential mental health benefits of urban parks, open spaces and the countryside (Walker and Duffield, 1983). Much of the available evidence derives from opinion surveys of users of parks and visitors to the countryside.

A wide range of psychological benefits are ascribed to the peace and quiet, relaxation, fresh air and physical exercise gained from outdoor pursuits in urban parks and the countryside (Countryside Recreation Network, 2005). Surveys of visitors to national parks indicate that enjoyment of the natural environment is the main motive for visiting and enjoying the countryside. 93% of respondents report that the 'peace and quiet' of the countryside was important to them (Coalter et al., 1996). A further survey found that nine out of ten respondents valued the sense of relaxation and well-being they obtained from visiting the countryside (Countryside Commission, 1997). In urban settings, parks are attributed with offering an antidote to the stresses of urban life and contributing to psychological well-being (Plummer and Shewan, 1992).

Contact with nature: physical exercise

Urban parks and the countryside provide opportunities for promoting physical fitness (and thus, arguably, mental well-being). Plummer and Shewan (1992), for example, suggest that 'green trails' in towns and cities encourage people to walk further. Survey evidence indicates that the countryside functions as a recreational resource for a substantial proportion of the population; 7.5million adults and 2.1million children participate in formal and informal sports each year in urban parks (Coalter, 1996; Collins, 1994).

Evaluation of programmes to encourage walking show a positive mental and physical health impact and good involvement from older people and women (Countryside Recreation Network; Countryside Agency, 2000).¹² Mental health benefits from 'green exercise' (physical exercise in a natural environment) is associated with increases in self esteem, positive mood and self efficacy (Pretty et al., 2003; Countryside Recreation Network, 2005). Findings from evaluations of 'Green Gyms', (volunteer conservation activities such as planting, hedge-laying, and repairing fences, gateways and stiles), found that participants felt fitter and more energetic, with reductions in symptoms on the Hospital Anxiety and Depression Scale and improvements in quality of life in some cases (British Trust for Conservation Volunteers, 1999).¹³

Contact with nature: urban parks

There is weak and limited, but promising evidence that urban parks influence mental health through strengthening social cohesion, local identity and continuity. Parks are described as one of the few contexts in which individuals from different backgrounds share 'social space' (Greenhalgh and Worpole, 1995). Researchers in Germany have suggested that urban parks can be designed to promote health through, for example, the construction of perfumed gardens, herb gardens and meditation spaces. Such spaces may offer 'sensual experiences' and a context for the activities of self-help groups and individuals wishing to promote their own health (Ebert, 1995).

3.4.6 Workplace

'finding a work-life balance'

Summary

- There is good evidence that people in lower grade jobs experience higher levels of stress related ill-health than people in higher grade job. Key determinants are lack of job control, poor supervisory support, effort and reward imbalance and job insecurity.
- There is good evidence that structural factors (organizational and cultural factors in the workplace) have a stronger impact on the mental health of employees than individual lifestyle behaviours but that exercise, socializing outside work, supportive colleagues, a healthy diet and achieving a work/life balance can promote mental health
- There is review level evidence for the effectiveness of stress-management techniques in the workplace, involving some experimental trials and controlled studies

¹² However a systematic review of organized walks found insufficient evidence to recommend them as an intervention to increase physical activity (NICE 2006).

¹³ There are currently green gym programmes across Scotland, including Aberdeen, Fife and Inverness (http://www.btcv.org.uk/cgi-bin/office_opps.cgi?region=sc). Scotland's strategy for conservation and the enhancement of biodiversity includes an objective to: improve opportunities for people to enjoy and care for biodiversity through increased awareness, volunteering, local action and lifestyle, with a specific commitment to increase the number of and participation in, green gyms (Scottish Executive, 2004).

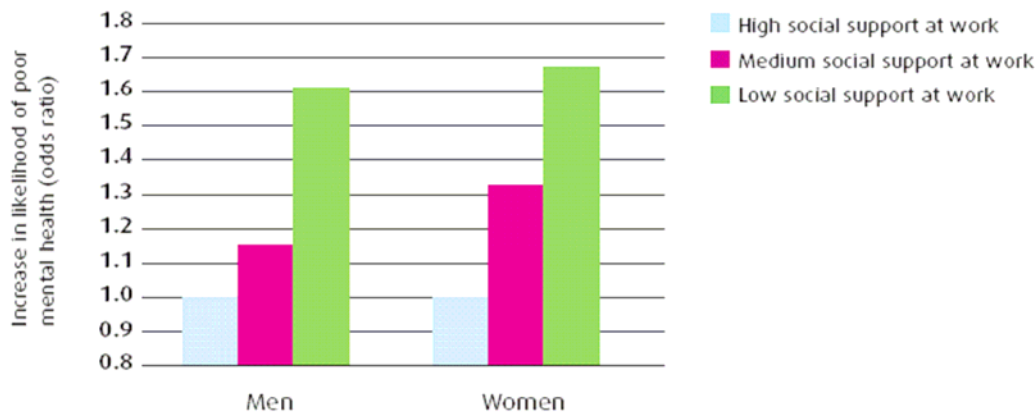
Workplace: risk and protective factors

There is a significant body of evidence, including studies in the Whitehall II series, that the way in which work is organised and the work climate have a strong influence on health and also contribute to the social gradient in health (Ferrie, 2007). Poor communication, a lack of job control, poor social support at work, how work is organised, and the balance between effort and reward, all have a major role to play in determining mental and physical health outcomes, regardless of the characteristics of the individual. A poor work environment, including poor social support at work, was one of the main factors explaining the higher prevalence of depressive symptoms among participants in lower employment grades (Stansfeld et al., 1999). Low control was independently associated with higher rates of mental and physical illness. People in lower grade jobs are disproportionately affected by these factors and this explains their poorer mental and physical health compared with people in higher-grade jobs.

Key determinants of mental health in the workplace are:

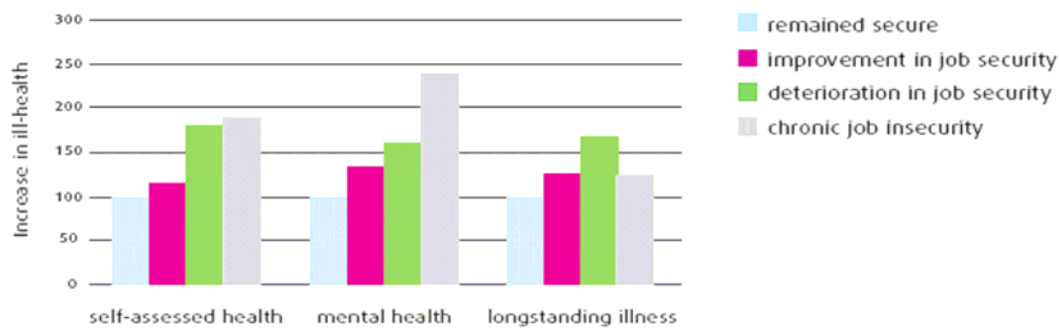
- high demands and low control (although high demand is independently associated with poor health);
- lack of support from supervisors and unclear or inconsistent information from supervisors (two-fold increased risk of poor general mental health) (figure 1);
- job insecurity (also increase use of health services) (figure 2);
- effort-reward imbalance (although most strongly associated with increased risk of Coronary Heart Disease) (Kuper et al., 2002).

Figure 1: Social support at work as a risk factor for subsequent poor mental health (from Ferrie 2007 p.11)



Adjusted for age and employment grade.

Figure 2: Effects of loss or gain of job security and of chronic job insecurity in women (from Ferrie 2007 p.15)



Lifestyle behaviours (such as smoking, lack of exercise and obesity) were more common among people in lower grade jobs and were associated with work-related stress (Ferrie 2007). A healthy diet, exercise and giving up smoking reduced the risk for ill health and increased well-being. Low levels of alcohol consumption reduced levels of sickness due to alcohol dependency. Participation in moderate exercise, such as gardening and walking, was associated with improved physical health and therefore, indirectly, of mental health.

Supportive relationships with colleagues and good social networks outside work were protective of health, particularly mental health. Demands made by work commitments could have a negative impact on family life and relationships, and vice versa. Therefore, arguably, achieving a work-life balance can be protective of mental health.

Workplace: stress management

Although management styles and practices and workplace cultures are likely to yield greatest benefit in reducing mental health problems (Lowe et al., 2003), review-level evidence indicates that the individual can reduce their stress and that cognitive behavioural methods are the most effective ways of achieving this (Van der Klink, et al., 2001). One review found that stress reducing interventions resulted in larger effect sizes for employees with 'high-control' jobs. The only cognitive behavioural study involving employees with low-control jobs found no significant effect on their levels of occupational stress (Taylor et al., 2007).

3.5 Conclusions and recommendations

Findings of the review show that, although the quality and quantity of studies vary, overall there is good evidence to support the effectiveness of 'positive steps' messages for the promotion of positive mental health, the prevention of mental health problems and for the improving the quality of life for people living with mental health problems. A lack or absence of evidence in relation to some aspects of 'positive steps' messages does not necessarily imply a lack of effectiveness – merely that sufficient research has not yet been conducted.

In addition to identifying evidence for those 'positive steps' that have become a traditional feature of mental health campaigns targeted at the individual, recent

research has highlighted evidence for new or emerging messages, such as 'contact with nature' and 'finding a work/life balance' as beneficial for mental health.

The 'positive steps' approach attempts to strengthen the agency of the individual to improve their own mental health. Nevertheless, actions that individuals have the resources or capacity to initiate, are shaped by social and cultural factors, and by what Rutter (1974) has termed the 'permitting circumstances', of familial, social, economic, environmental and political contexts.

During the course of this review, a number of key themes have emerged concerning the social and political implications of their application. These may be summarized as follows:

- Some of the 'positive steps' may contribute to mental health but may also function as a consequence of mental health. For example, having a wide circle of friends may be the result of high self-esteem and good relationship and communication skills. People living with mental health problems may lack confidence to make social contacts, and therefore a message that exhorts them to do so risks reinforcing, rather than alleviating, social exclusion.
- Some studies highlight the tendency for social deprivation and discrimination to produce a clustering of risk factors that accumulate over time. Thus, messages focused on the individual may be interpreted as missing the causes of psychological distress, and as focusing only on the symptoms of inequality and as therefore reinforcing disadvantage. For women with low resources, for example, social networks may account for, rather than protect them from, their higher levels of mental illness (Kawachi and Berkman, 2001). Likewise, individuals whose childhood was affected by serious parental conflict, child abuse or neglect are much more likely to experience low self-esteem in adulthood (Emler, 2001).
- Positive steps messages may inadvertently reinforce inequalities by overlooking the greater personal and social resources (social and individual capital) that enable individuals to make active choices and exercise more control over their lives. For example, employees in higher status jobs have a higher degree of control over their jobs and therefore have greater scope to take advantage of stress management techniques or other strategies to reduce work-related stress.
- Discrimination and inequality produce social exclusion. Elderly people, for example, are routinely excluded from many potential sources of social support, and may be thus less able to participate in local community networks. Personal action to reduce the impact of loneliness therefore needs to take into account 'permitting circumstances' for involvement in community activities. Studies that address the 'ubiquitous loneliness' of elderly people often make no mention of the extent to which it is socially constructed.

Nevertheless, the value of 'positive steps' messages is that they help individuals to make informed choices about how to protect their own and others' mental health. If knowledge is indeed power, then the potential benefits of evidence-based campaigns to promote mental health may contribute to, if not provide the complete answer for,

raising awareness of how mental health can be promoted and protected. Evidence for the effectiveness of exercise to promote well-being and to reduce reliance on medication for people living with mental health problems, for example, should not be underestimated. Similar arguments may be made in favour of participation in social networks and the development of supportive relationships with friends, family and partners.

Taking all of these factors into account suggests that the development of 'positive steps' campaigns has ethical, as well as strictly mental health-related dimensions. Evidence from the review, as well as interviews with key informants and the seminar for practitioners, indicate that:

- 'positive steps' messages to promote mental health should form part of a wider strategy to tackle the social determinants of mental health problems;
- local communities and groups should be supported to adapt 'positive steps' messages to take into account the lived experience of their members, and thus to promote their ownership of mental health campaigns.

4 Learning from other initiatives: qualitative research

There is now extensive data, from Scotland and across the UK and Europe, on public attitudes to mental illness and to people experiencing mental health problems (Braunholtz et al., 2004; Gale et al., 2004; Crisp, 2001). Data on how people view their own mental health, public attitudes to the idea of 'looking after your mental health' and what action, if any, people take to protect or promote their mental health is more limited.¹⁴ Much of what is available comes from research designed to test responses to campaign materials e.g. for World Mental Health Day or Scottish Mental Health Week. Box 4.1 below lists sources of qualitative data from the UK used in this section, mostly unpublished.

Box 4.1: Sources of qualitative data

Qualitative research: Scotland

- Breathing Space evaluation (Sheehy et al., 2006) and online poll
- Views of young Scottish men (MacDonald and Soloman, 2002)
- Young men: pre-test of SMHW materials (Scott Porter, 2002)
- Caledonian Omnibus Survey – Scottish adults (McCall, 2004)
- Mental health in later life – older people's perceptions (NHS Health Scotland, 2004)
- Dundee Healthy Living Initiative (Lewis et al., 2006)
- Mosaics of meaning – ethnic minority perspectives (Glasgow Anti Stigma Partnership, 2007)

Qualitative research: Northern Ireland

- Mental health advertising pre-testing (Health Promotion Agency Northern Ireland (HPANI), 2007)

Qualitative research: England

- HEA World Mental Health Day 1996-1999 pre-testing and evaluation (appendix three; Tidyman, 2007)

Box 4.2: Well, what do you think?

'Well, what do you think?' (Third National Scottish Survey of Public Attitudes to Mental Health, Mental Well Being and Mental Health Problems) includes questions on people's perceptions of factors that have a positive or negative effect on mental health, as well as how much control people believe they have over these. Also included are questions on volunteering and social networks and a range of questions on what helps recovery from mental health problems. Those most relevant to 'positive steps' include: coping strategies, support from others, meaningful activity, and having a chance to contribute.

¹⁴ However the Third National Scottish Survey includes a range of relevant questions – see Box 4.2 and (<http://www.scotland.gov.uk/Publications/2007/09/11092351/0>)

This section summarises key themes from the qualitative research, looking at public perceptions of mental health in Scotland and elsewhere in the UK, lay explanations for low mood and related feelings, coping strategies and responses to positive steps messages.

4.1 Perceptions of mental health

Some qualitative research appears to show “widespread misunderstanding of the terminology associated with *mental health improvement* amongst the adult population” (Box 4.3 McCall, 2004). McCall states that Scottish adults interviewed for the Caledonian Consumer Omnibus Survey “did not understand the terminology associated with mental health improvement, in particular the difference between mental wellbeing and mental illness”.

Box 4.3 Caledonian Consumer Omnibus Survey

Research with Scottish adults suggests that any new tool or resource should:

- define what is meant by mental wellbeing and why it is important
- illustrate the implications of poor mental wellbeing and how they can be avoided
- explain what the individual can do to maintain or achieve good mental wellbeing
- signpost people to additional information and support
- define mental wellbeing positively, avoiding the terms “mental” or “emotional”.

(McCall 2004)

MacDonald and Soloman (2002), looking at perceptions of ‘what affects your mental health’, found that among Scottish young men aged 18-30, very few associated the term ‘mental health’ with any of the problems with which they were dealing. Similarly, commenting on focus groups looking at materials for Northern Ireland’s recently launched mental health campaign¹⁵, researchers from HPANI said:

“We then realised that very few people understood the concept of mental health, always interpreting it as mental illness or even mental disability/learning disability; so we felt the concept of mental health as a positive concept should be introduced to people first to allow people to talk about the issue openly.”

(Health Promotion Agency Northern Ireland, personal communication)

However, closer analysis of the grey literature suggests that the problem may be the term ‘mental health’, rather than the underlying concepts of how people think and feel and the importance attached to this. In fact, the grey literature we examined (Box 4.1, page 43) appears to show high levels of public interest in emotional and cognitive well-being, whether that is expressed in terms of concerns about stress, worries, low mood or the importance of a positive attitude, coping or not ‘bottling

¹⁵ The broad campaign message is to “treat your mental health in the same way as your physical health- as with physical health it is possible to protect and improve mental health/wellbeing.” So far, however, the main focus of the campaign is on what to do when things go wrong and early identification of problems.

things up'. Although the term mental health is often interpreted as meaning mental illness (among both professionals and lay audiences), people in focus groups drew on an extensive vocabulary for expressing the nuances of psychological and emotional states. In qualitative research for Breathing Space, participants felt that suicide and mental health, particularly depression, were important societal issues. They were issues *that had touched everybody's lives to some extent*. All groups expressed strongly the view that these were problems that should be addressed (Sheehy et al., 2006).

Focus group responses to publicity for Breathing Space illustrate ongoing sensitivities about language rather than lack of understanding. Participants suggested: 'instead of using the word 'depressed', softer language such as: 'feeling down', or 'feeling low' could be used, as reflected in the strap line '**open up when you're feeling down**'. These terms were felt to be more universal and would encourage more people to call the phone line because they could relate to 'feeling down' more so than feeling 'depressed':

"I think if you say everybody feels low sometimes, it makes it more universal that everyone ... anyone can call. You don't have to have depression to call. And although depressed isn't a bad thing and it isn't a bad word and all this kind of thing, a lot of people who have depression are in denial and won't go for help until it gets to the extent that it is an extreme. Whereas if it says everybody feels low they're more likely to phone if you're just feeling like you can't cope." (FG6, female)

(Sheehy et al 2006)

Although holistic views of health are particularly strongly held among many Black and Minority Ethnic communities, the view that health includes both mental and physical health appears to be widely shared across all communities (HPANI 2007; Glasgow Anti Stigma Partnership 2007; HEA, see appendix three).

"mental health related belief systems are based on holistic view of emotional, physical, and spiritual aspects of living"

(Glasgow Anti Stigma Partnership 2007)

"Participants were asked in the first instance to highlight what constitutes good health. It was interesting to note that although issues such as eating healthily/having a good diet, not smoking, reducing alcohol intake and taking regular exercise were all mentioned so too was not getting stressed out, socialising/feeling part of society, getting enough sleep, positive attitude, good mental health and peace of mind."

(HPANI 2007)

Among the focus groups in Northern Ireland, in response to the statement 'mental health is just as important to your general health as your physical well-being', the majority of participants not only agreed with this statement but went further by saying that mental health is more important than physical health:

“If you don’t feel right in your mind you just don’t feel right”
(Female 35-49 C2DE)

“It’s your ability to cope with things” Male
(35-49 ABC1)

“You don’t care about yourself when you’re not right mentally. You don’t give a damn”
(Female 50-64 ABC1) (HPANI 2007)

In the HEA research for WMHD, the general public widely regarded the slogan ‘positive steps’ as applicable to them and had little difficulty applying the messages to their own situations, and making the link to mental health.

‘We could get people to identify what strategies or steps they take when feeling down or under pressure and then discuss how they help them.’
(NHS Trust Employee, Scotland)

4.2 Explaining ‘feeling low’

Where people are asked questions about what factors impact on their mental health, a wide range of sophisticated explanatory frameworks are provided:

“the general public in urban areas (especially Glasgow) was more likely to appreciate a range of different circumstances, situations and pressures which could influence mental health (life events). Respondents of all ages in these areas felt that issues such as drugs, homelessness, unemployment, violence, crime, lack of money and racism were real and potentially relevant to them. Those in suburban or rural areas tended to feel more distant and removed from many of these issues.”

(HEA, see appendix three)

Among Scottish young men, MacDonald and Soloman found that life stage and socio-economic group had the greatest impact on what respondents saw as key influences.

“Issues facing young males in Scotland today are complex and varied. They tend to differ depending on employment status, socio-economic grouping, level of parental responsibility and age of children”

(MacDonald and Soloman 2002)

Younger respondents were heavily influenced by peer pressure relating to clothes and girlfriends and being able to balance their lifestyle with a job. Those at the top end of the social scale were more concerned with careers issues while those at the lower end were dealing with poverty, and in the case of young fathers, pressure of commitment and a pessimistic view of the future.

Participants in the HPANI focus groups listed a very extensive range of influences:

financial worries; work stress or unemployment; family relationships /health of family; relationship breakdown; lifestyle too busy; no free time; loneliness; medication; not being helped; bullying; alcoholism/drug abuse (HPANI 2007)

For older people in Scotland, asked in a series of workshops and focus groups to prioritise the issues that affect mental health and well-being in later years, the key issues were:

- family and friends
 - positive attitudes
 - keeping active
 - maintaining capability and independence
 - negotiating transitions (e.g. retirement, redundancy, bereavement)
- (NHS Health Scotland 2004)

The HEA research found that of all the target groups, older people showed the most understanding of the interface between physical and mental health, had a sophisticated understanding of mental health and, an overall awareness of mental wellbeing as a state that needed to be maintained (HEA Appendix Three- Target group research Scotland 1998; Target group research 1999).

4.3 Coping strategies

What is also clear from the qualitative research cited is that many people are already taking a wide range of coping action, either as an antidote to feelings of stress, anxiety or low mood and/or to 'feel good' or 'make yourself happy'. The pre-testing of Health Education Board for Scotland (HEBS) Scottish Mental Health Week materials, for example, 21st century manual, which covered issues like stress, healthy eating, alcohol, drew very positive reactions to the idea of doing things to '*learn to cope with life's challenges*' (Scott Porter 2002). In the Northern Ireland focus groups, many participants stated that they would do things to keep themselves happy, but that they do not interpret this as a conscious effort to improve their mental health. Participants who had personally experienced mental health problems were more consciously aware of their own mental health and what actions improve their mental health (HPANI 2007).

Exercise; hobbies; DIY; gardening; being creative; socialising; time with family; music; diet; talking to people

(HPANI 2007)

An online poll on the Breathing Space website elicited a wide range of activities that people across Scotland use to 'get a breathing space'. For men, the most popular included walking, reading, sport, socialising, film and music. The results for women were similar, although having a bath also scored very highly. Keeping active, support from family and friends and maintaining a positive attitude were consistently mentioned by older people in the HEA focus groups for World Mental Health Day (HEA, see appendix three)

"It's common sense"

(HEA older people)

'I've been through a lot, we all have. As you get older you begin to see that you have to look after yourself and your mind'

(HEA Male 60+)

Action listed by young Scottish men included: exercise, music, sleeping, talking; alcohol, cannabis, violence. In relation to these, McDonald and Soloman (2002) observed that the young men seemed to passively accept many of the issues that they had to deal with in everyday life.

"There is also evidence that they feel as if they have no ability to take ownership of many of the problems they face. Issues such as unemployment, marital problems, work pressures and family problems were commonly mentioned. Current coping strategies appear to be relatively short term and evasive or escapist in nature."

However, these young men had clear views about what kind of messages would be helpful, stating that they must include: 'you are not alone', 'having problems such as depression does not mean you aren't normal', and 'talking really does help'. Breathing Space is attracting an increasing number of calls, suggesting that 'talking about your feelings' and 'asking for help' are acceptable messages for men in the target group (men 16-40) (Sheehy et al., 2006).

The HPANI focus groups provide a particularly rich source of recent data on perceptions of 'positive influences on mental health', which include exercise, walking, gym, family, socialising with friends, money, listening to music, reminiscing about childhood, weather and food. The most popular suggestions for action were exercising, keeping active (reading, hobbies, DIY, creativity, trying to expand your mind, work/life balance and having a job) and walking. Talking and sharing your problems were also mentioned frequently across all groups. Amongst some groups, keeping positive, having something to look forward to and setting goals was important. Other insights included being aware of your limitations and not expecting what you cannot achieve.

In the face of specific problems such as depression, people in the HPANI focus groups suggested talking, socialising, listening to music, getting exercise and walking. Some were unsure how they would go about looking after their mental health, in comparison with their knowledge about physical health:

"you're always being told what to eat and what not to do, nobody tells you how to exercise your brain"

(Male 25-34 C2DE, HPANI 2007)

The Scottish Association for Mental Health used the popularity of music as a source of wellbeing in the 'One In Four' music campaign. The aim of this campaign was to raise awareness in younger adults, with a series of messages that focused on promotion, prevention and recovery, as well as stigma reduction.

4.4 Response to 'positive steps' messages

The most comprehensive source of data on public responses to 'positive steps' messages in the UK comes from research commissioned by the Health Education Authority (1997-1999).¹⁶ This was designed to test reactions to a wide range of materials for a series of World Mental Health Day campaigns from 1996-1999 which focussed specifically on 'looking after your own mental health'. In addition to generic 'positive steps' resources, both messages and design were tailored to appeal to different audiences, with specific materials for different ethnic minority groups (Irish, African-Caribbean, Chinese, Vietnamese, South Asian), as well as for different age groups. The research also includes an extensive series of surveys and interviews with local organisers, inviting their views on the effectiveness of the campaign and campaign materials. Although the research is now some ten years old and cannot be taken as a reliable indicator of current public attitudes, it does provide a rare source of information on how a very wide range of different groups, (taking account of age, ethnicity, sexuality, disability and specific circumstances e.g. young offenders) responded to mental health improvement messages. The following section is based on focus group responses from the public and local organisers to individual 'positive steps' messages. Where focus groups were held in Scotland, this is indicated.

Box 4.4: WMHD Campaigns

"WMHD campaigns between 1996-99 both influenced, and responded to, the growing awareness of mental health as a general issue – and the general public became more receptive to the campaign messages. The notion of positive steps was readily accepted by the general public as a 'good thing'. It offered practical advice which seems 'common-sense' and sensible. Positive steps proved very important in creating a link between the concept of mental health and its relevance for everyone. With the introduction of positive steps, WMHD was perceived as more of a call to action – similar to No Smoking Day. It helped the general public to understand how mental health issues apply to themselves and offered some practical methods for approaching this issue in the future."

(Tidyman 2007)

Overall, the positive steps messages were well received across all groups, although some groups, notably lesbians and gays and mental health service users, were more likely to express concerns about messages being patronising, blaming, or implying that mental health is a consequence of lifestyle.

Box 4.5: WMHD Campaigns

Those who had experienced mental health problems in the past often felt that the messages were unsympathetic and even patronising. The (exercise) message was widely felt to undermine the significance and the seriousness of mental health issues - by suggesting that the solution could simply be sought in fitness and activity. A significant number felt that it "blamed" the lifestyle of the individual for their state of

¹⁶ This was undertaken by Research Works Ltd. See appendix three for further details.

mind. The exercise focus gave many a chance to distance themselves from the execution - because they did not enjoy sport.

(Tidyman 2007)

Interestingly, older people in both England and Scotland were most receptive to the steps. As a group this sector had experienced a broad range of distressing events and readily recognised the need to be aware of mental health.

Some steps were much more popular with certain groups e.g. 'explore your spiritual side' was most relevant to African Caribbean and South Asian groups. 'Get involved', 'ask for help' and 'accept yourself' were more problematic, less well recognised, and some respondents found them harder to consider carrying out. It was also sometimes difficult to maintain the focus on mental, as opposed to physical health: in both Scotland and England words such as 'relax' could be seen as related to looking after your body rather than your mind.

Exercise

Of all the 'positive steps', exercise is perhaps the most readily accepted as helpful to mental health:

'Healthy mind in a healthy body'

(African Caribbean)

'Keeping active' was strongly supported by older people as excellent advice. There was a subtle understanding of mental health and the mind/body relationship. Most respondents believed in a 'use it or you'll lose it' philosophy, and were 'naturally' already keeping active (Target group research 1999). In Scotland, older people viewed group activities such as a swimming class as positive and something many older people do. Dancing was a much enjoyed activity (Target Group Research Scotland 1998, see appendix three).

At the same time, for many respondents in both England and Scotland, words such as 'exercise', 'dance', 'cycle' were perceived to be related to looking after your body rather than your mind.

Basketball or working out were activities undertaken by high proportions of young offenders, since they were recognised as effective ways of relieving stress (Young offenders 1998).

"Exercise can help - even if you don't feel like it"

(Young Offender)

There was a high level of awareness of the need to keep active, with many Irish respondents already making an effort to keep active. It was felt by some that men may require more motivation than women to begin regularly exercising (BME Research 1999; Appendix Three)

Valuing yourself and others

Older people in Scotland felt respected and valued as part of their communities and readily recognised the importance of this (Target Groups Scotland 1998, see appendix three).

'I want to be seen as still having a role in the world.... I might be old but I'm certainly not stupid'.

(Male, 66+ years)

Strong relations with older role models such as grandparents heightened the sense of value and respect attributed to this group (Target Group Research Scotland 1998, see appendix three). Acknowledging the skills of older people, and their potential to be applied throughout life, was genuinely considered to be a relevant and positive message, with older people taking pride in the achievements of their working lives. The campaign resource design was successful in reaffirming older people's belief in themselves.

Most young offenders who had been in prison for a while had come to terms with the position they were in and had developed their own methods of coping. They recognised that staying positive was vital, since they had seen others struggle and "go under" after letting prison get to them.

'Stand up for yourself - for who you are'

(Young Offender)

For African Caribbeans, the use of one phrase, "the power to be what I am", proved evocative and its positive tone appealed to male African-Caribbeans. It was seen as raising the issue of self awareness, pride and self image.

'Accept who you are' was found particularly useful by people with physical disability since it accentuates the positive (Target Group Research 1999, see appendix three)

Self-acceptance was interpreted as a cultural comment that was already followed by Irish people (BME Research 1999, see appendix three).

'That's why we don't change our accents.'

(Irish Male, 40-50 years)

Talking about your feelings

The general public recognised the value of support systems and communication in Scotland, where a higher proportion had experienced 'life events'. Among the Irish groups, the importance of talking about your feelings was widely accepted.

"There's nothing like a good natter with an Irish person"

(Irish Male)

'You do feel better, regardless of what's wrong.'

(Irish Male, 40-50 years)

'Share your worries was also felt to be very positive, helpful message among young people: "I know I should do these things more. I don't talk to my friends enough. When I've got problems I bottle things up."

(Female, 18 years)

Younger African Caribbean men felt that when talking to others trust was a crucial issue. Although they felt they would discuss issues such as relationships, work and issues surrounding racism with friends, they felt it was important to recognize those who did not feel they could. Maintaining an image was important for this group and many indicated they would need re-assuring before discussing any concerns with peers in case it was interpreted as weakness.

'I wouldn't talk to strangers.'

(Afro-Caribbean Male, 35+ years)

'Sharing your troubles is good advice. It's common sense.'

'(Afro-Caribbean Female, 35 + years)

For South Asians, being encouraged to speak out and open up was regarded as empowering. The emphasis on sharing and the community was felt to potentially reduce feelings of isolation, since it conveyed a sense that others were experiencing similar difficulties

It's empowering people to do something about their problems

(Asian group)

For mental health service users, talking about mental health problems openly to friends and relatives was acknowledged as a problem (Target Group Research England 1998, see appendix three). Many users were unsure of how to broach the subject, how much to tell other people and indeed how much other people could cope with knowing

All respondents with learning disabilities related strongly to the message 'Talk to people' and saw it as something everyone should do (Target Group Research 1999, see appendix three)

'It's good advice to tell your problems and get them out in the open.'

'(Male, 23 years)

Keeping in touch with friends

Messages offering broad, general avenues of support, such as family and friends were the most widely applicable and useful across the whole target audience.

"I'm on my own now and I sometimes think 'where can I go for help', where can I go to make friends and have a chat?"

(Female, Bereavement)

'I've been widowed, which was hard, but I go clubbing regularly. You have to keep going.'

(Female, 66 years)

However, for those with more severe problems, family and friends had often proved inadequate at providing support.

Most older people in Scotland did not perceive exclusion or 'losing touch' as an issue until a life event triggered feelings of vulnerability or isolation – declining physical and/or mental health, death of a partner (Target Group Research Scotland 1998, see appendix three).

Many young offenders recognized the importance of maintaining contact with their support system, i.e. their family and friends, outside of the prison (Young Offenders 1998, see appendix three). They felt it was crucial to keep in touch since it helped them remain positive. They stressed how important it was to have people you trusted and loved in an environment where these qualities were scarce. This had particular relevance for new arrivals.

"Keep in touch - this can be difficult but everyone needs support/friends"
(Young Offender)

Whilst the younger Irish generation often refused to acknowledge that Irish people could have social problems, many of the older generations valued the advice to keep in touch (BME Research 1999, see appendix three).

'You need someone to phone - someone with a similar background who's been there in your situation.'
(Irish Male, 40-50 years)

'I didn't know anyone, no friends, no family.'
(Irish Female, 40-50 years)

Getting involved/making a contribution

In Scotland, older people's close involvement with children and grandchildren enhanced a sense of participation and diminished feelings of separation or alienation from modern life (Target Group Research Scotland 1998, see appendix three). The benefits of getting involved, particularly joining a club and having a pet, were valued by most (Target Group Research 1999, see appendix three).

"Time flies – just get involved"
(Male 60+)

'Getting involved' was viewed as sound common sense advice by older people. The dangers of isolation and boredom were fully understood, especially for those living on their own (Target Group Research England 1998, see appendix three).

"I've been widowed twice. I go to a club which is my life saver. I go fishing - me and all the men!"
(Female, 55-65 years)

'It pays to have something to do otherwise it's very boring.'
(Male, 60+)

One design provided a strong sense of older people doing what they wanted and enjoyed. Older people also felt that it communicated confidence, showing people that older people were out and about and actively taking part in the world (Target Group Research England 1998, see appendix three).

Taking a break/relaxing

"I'm really busy trying to hold down two jobs - when I get stressed I recognise the value of "peace and quiet", being on my own for while"

(Female, 18 years, Scotland)

The concept of listening to music to relax was in keeping with the strategies employed on a daily basis by boys aged 15 – 19. A significant number explained that music helped them to get into a certain mood - for example it could be energising when they were getting ready to go out, or calming when they were trying to rest. Most had songs that they could relate to good times they remembered in the past. The majority felt that they would listen to this music alone, to unwind. Music helped to promote a positive frame of mind and sense of mental well being.

"I put a CD on really loud when I come home from school and I've had a bad day - it makes me feel better"

(Male, 18 years)

"My good memories are always associated with various bits of music"

(Male, 16 years)

Asking for help

'Accept offers of help and support' was felt to be a very positive message in Scotland and England. Many people indicated they would be encouraged to use helplines, given the supportive and understanding tone of the message. There was a feeling, however, that more could be done to encourage people to ask for help - either from their family and friends or professionals. Many people saw the idea of seeking support as a sign of weakness and it was, therefore, important that the wording assured its audience that this was not the case.

"It's what my doctor says to me, I should take "steps" to improve my mental health, rather than expect drastic improvements. You have to recognise the value of the people around you and aim to take advantage of offers of support."

(Male, 47, Scotland).

For some groups, notably South Asian and Chinese communities, help outside close family and friends was considered crucial, e.g. expert help in tackling what were seen as insurmountable problems - particularly within the family (Asian, Chinese focus groups). Many in the community would not know where to go, since there was generally low awareness of where confidential help was available. Young Asian females, in particular, felt it essential to discuss issues in confidence. A significant number of African Caribbean participants expressed a low acceptance of seeking external professional help.

For Chinese people, the inclusion of a specialist number, rather than referral to a GP could encourage them to seek support. This was particularly important where loneliness was a real concern and there was no obvious avenue for support in the local community.

Sensitivities

The response to taking action to look after your mental health was largely positive across all social groups. Once some of the taboos and language barriers around the term 'mental' had been addressed, it was clear that many people are aware of their own mental health (however that is described or conceptualised) and already have a wide range of strategies for coping with adversity, keeping their spirits up, dealing with low mood, stress and anxiety. At the same time, some groups were less positive about some messages, as in the examples below. For some groups, the depth and complexity of the problems they faced meant that 'positive steps' could seem trite or patronising.

'Following such advice is not enough to keep you mentally healthy'
(HEA service users)

'Try something new. Ok tell me what I can try. Tell me what is available for me. It doesn't mean anything.'
(Male Wheel -chair User)

'Emphasizing that gay men and lesbians can "contribute" to society is patronizing'
(Gay man)

- **Doing something creative**

One resource included suggestions around drama, yoga, poetry, painting, reading and these were widely perceived as 'middle class' – increasing the sense of alienation among lower socio economic groups.

- **Learning new skills**

This was associated with professional occupations and training courses - daunting for people who had lost their jobs.

- **Sensible drinking**

'why assume the Irish don't drink in moderation?'
(Irish focus group)

The reference to moderation was found slightly curious. 'Having a good drink', was suggested to be a realistic way to unwind (African-Caribbean BME Research 1999, see appendix three).

5 British Telecom research: Positive Mentality

Stress, anxiety and depression are the most common forms of mental health problems among the workforce. It is estimated that 91 million working days are lost each year due to mental ill-health (Department of Health, 1995). Evidence from the British Household Panel Study showed that job satisfaction declined between 1991-2002 – a trend that is likely to contribute to increasing levels of work-related stress. Findings from cohort studies also suggest that the mental health of young employees has declined and that this cannot be explained by poor mental health before they entered the workforce (Bartley et al., 2005). The Health and Safety Executive (HSE) has made a series of recommendations for improving mental health at work (HSE, 2004) and a growing number of major employers have invested in initiatives to reduce stress related sickness absence and improve wellbeing. This section describes a programme recently implemented by British Telecom (BT).

Positive Mentality was the fourth health promotion campaign run by BT under their health promotion vehicle 'Work Fit'.¹⁷ Sited on the intranet delivered newspaper 'BT Today', Positive Mentality was a 16 week programme which ran between October 2006 and February 2007. It was designed to raise awareness of mental health issues, tackle stigma, and promote mental wellbeing, and dealt with the link between physical and mental health, lifestyle issues, support and relationships. The aim was to strengthen mental resilience rather than simply focus on mental ill health, although some material was included on how to deal with problems if they arose. Quizzes were used to test participant understanding of the material.

The module content, based on the ten 'positive steps' from World Mental Health Day, was as follows:

- Module 1: Keeping active
- Module 2: Eat well and drink sensibly
- Module 3: Relax
- Module 4: Keep in touch with friends
- Module 5: Talk about it
- Module 6: Maintain close relationships
- Module 7: Ask for help
- Module 8: Accept who you are

A total of 28,932 hits to the site were received, the most (21%) for the first module 'Keeping active' followed by the second module 'Eat well and drink sensibly'. 'Ask for help' received the lowest number of hits (6%) followed by 'Keep in touch with friends'. There was a drop-off in site hits mid-campaign but there was an upturn towards the end.

¹⁷ See appendix four

5.1 Follow up survey and interviews

Following the campaign, in partnership with BT, we carried out a short online survey (15 questions) to find out about BT staff views on Positive Mentality, and whether the campaign influenced knowledge, attitudes or behaviour (Appendix Four). A total of 374 surveys were completed in the 2-week period from 5th June to 15th June 2007.

“For BT to put together such a campaign on such a topic is amazing”

“I think that it was excellent that BT is promoting good mental health. It can only be a good thing for the workforce & BT as a whole. It's a positive step that what was once a bit of a taboo subject is out in the open.”

“Very well intentioned programme. Reality on the ground is that BT people face ever increasing pressures from top to bottom. This is hard to square with mental well being, but is a wider problem than just BT.”

The survey gender breakdown was 63% male and 34% female. Ninety-two percent (N=355) were based in the UK, 3% in the rest of Europe, 2% in the US and 1% in Asia-Pacific. We were not able to identify what percentage of the UK sample was based in Scotland. Forty-one percent (N=158) were in the 46-55 age bracket, 38% in the 36-45 range and 10% were aged 26-35. 48% of respondents to the survey had accessed some of the Positive Mentality programme, and of these 70% looked at all eight modules during the campaign.

- 56% tried some of the positive steps and continued to practice them
- 34% tried but didn't continue
- 10% either could not or did not want to try any of the steps

For those who did make changes in their lifestyles as a consequence of the programme:

- 51% noticed some positive changes to their mental well-being
- 17% noticed an initial benefit which then faded
- 31% noticed no change

Following the online survey, 97 individuals volunteered to take part in a telephone interview and a total of 15 interviews were carried out (7 men and 8 women, all from England with the exception of one woman from Scotland).¹⁸ The data, although limited, provides an interesting insight into current responses to mental health promotion messages within a workplace setting

5.2 Telephone interviews: results

Overall impressions of the programme were largely favourable. Many respondents (80%, N=12) commented that it was “good” or “very good”, that it helped reinforce what they already knew, served as a reminder, and also gave them new ideas and strategies to help themselves. Also mentioned by several respondents was the positive effect it could have on work colleagues – reducing stigma and raising

¹⁸ See appendix four. A full report on the findings is available on request (Tidyman and Kilfedder 2007)

awareness. Several respondents liked the way it was broken into bite size chunks and the fact that people could take away what they wanted, and disregard those elements that were not relevant. Overall it was welcomed as a brave initiative by BT, some said long overdue.

It should be noted that the majority of those interviewed said they were interested in the programme because of personal experience of mental health problems themselves or friends, family, colleagues. Nine respondents said they knew some or a lot of the information beforehand, while 6 respondents felt they knew nothing or very little.

'No, I knew nothing at all. That's probably why I ended up so ill. I didn't recognise I had a problem, didn't realise that mental health problems have physical symptoms – no energy, not sleeping, not eating properly, feeling very lethargic.'

(Female, 46 -55, Scotland)

'I already knew the statistic about 1 in 4. That's about it. I didn't know the link between exercise and mental health or any of the other messages.'

(Female, 46 -55)

A few respondents (N=3) had some reservations or felt it was of more limited value, and some raised doubts about BT's commitment to mental health or felt they were not practicing what they preach.

'The content was very, very good and a lot of it made a lot of sense. I was favourably impressed. Positive Mentality dealt with things at many levels – from a lack of confidence to quite serious issues... There are some things I struggle with and it is good to be reminded that you can do something to help yourself. It helps to be aware of other people's fragility, what other things are going on in their life, and what you can do as a colleague, manager or friend.'

(Female, 36 – 45)

'My initial reaction was that some of it was patronising. Some of the things that affect your mental health at work were not addressed – things that BT could and should address. So I had some reservations about it.'

(Male, 56+)

'I feel it was a good initiative for BT to run, and the content was largely good. It was actually quite compelling to read. I copied it and put in a ring binder for future reference. A good idea, well presented, and the content was beneficial.'

(Male, 46 – 55)

'...some applied to me, some didn't, but I know friends and family who it did apply to, so it was all useful and relevant in one way or another. I do feel that what BT are doing with this recognition is all to the good.'

(Female, 46 – 55)

Almost everyone agreed that the workplace is a good place to discuss mental health.

'Yes, I think it's appropriate. It's one area of life where we've all been... at least some element of stress, and it's certainly right for BT to take responsibility and address that area.'

(Male, 26 -35)

'Personally, I actively try to read books, take an active interest in dealing with stress and things like that so it wasn't completely new to me but it's useful to have a refresher in things like techniques for dealing with stress and I think the advice was very practical. So I would say it was very useful for me.'

(Male)

'It was really good. There is a stigma about it and when you suffer from different sorts of problems it helps to know about it... It is still helping me now and has made me think of different ways of doing things, sorting problems out, developing life skills and making a difference to me.'

(Male, 46 -55, Anglo-Indian)

'It was only marginally useful for me. There were some fairly interesting bits. But things about diet and about exercise were not relevant- I have a huge allotment so get exercise and healthy food from that.'

(Female)

'It was potentially very useful. I probably haven't used it as much as I could have yet. It was of some benefit.'

(Female)

What was not useful?

Ten respondents also identified areas that were not useful. Five felt that the modules about diet, alcohol and exercise were not useful, because *'most of us know these things.'*

'Eat well – that is common sense really and we all know that one.'

(Female 46-55)

'Alcohol is not an issue for me because I very rarely drink, so that was not relevant – probably the least useful part.'

(Male)

'Ask for help -I'm struggling to reconcile how I am meant to ask for help from the very people who have triggered the illness in the first place.'

(Male)

Which messages did you find most easy to accept and apply to yourself?

The messages most easily accepted and applied were 'keep in touch with friends', 'eat well' and 'keep active'. This was followed by 'talk about it' and 'accept who you are'. 'Ask for help' was not named by anyone as the most easy or relevant to them.

Are there any key mental health messages that everyone needs to know?

Everyone interviewed believed that there are some key mental health messages that everyone needs to know. One respondent felt that although there are some key messages, there is probably no one message for everyone:

'Yes, I think there are some key messages, but then I do feel we are all rather bombarded with things that you should and shouldn't do – it's becoming a bit like the nanny state. So I don't think there is a particular mental health message for everyone.'

(Female, 36 -45)

Another was concerned about how people are helped to put messages into practice:

'You as a person are what goes on in your head and your body – it's not one or the other. I think people should definitely be aware of all the messages, but how do they put them into practice?'

(Female, 36 – 45)

What changes did you make?

Ten respondents had made one or more changes to their day to day life as a result of the programme. These varied from getting active (N=5), getting in touch with friends (N=5), talking about things (N=3), eating well and drinking sensibly (N=3), thinking more positively (N=2), trying to get into better sleep patterns (N=2), relaxing more (N=1) and asking for help (N=1). One respondent found that the programme reinforced the steps she was already taking, but that if she had been experiencing depression or stress for the first time, the programme would have been reassuring. Four respondents had not made any changes to date. None of the respondents experienced any negative impact from any changes they made to improve their mental health.

For those who had made some changes, they had all noticed some improvement and had benefited from it. The majority (8) were managing to maintain some of the changes.

'I joined the gym at work and am now in a new routine of working out 3 x per week which is good. Talking about things as and when issues come up – making sure I speak to my line manager, a colleague or a friend when things come up

This has all had a big impact on both physical and mental health... I have a more positive outlook in general, more energy, better overall health'.

(Male, 26 – 35)

'I'm fairly new to BT and virtual working is quite a culture shock. I have tried to make an effort to call some of my graduate friends and use the instant messenger facility to make contact with people, because it's very easy just to sit all day and perhaps not talk to anyone unless it's a business related call. I think virtual working - that social environment is going to have an impact on mental health.'

(Female, 26 - 36)

'I made a conscious effort to get out of the house at least once every week, to go out for a walk. I felt calmer. After a couple of hours of walking everything comes back into perspective. I am still doing the exercise and it still helps.'

(Female, 26 – 35)

'I've tried exercise and it doesn't actually work. For example, I've got a dog and I go for walks – I know it's good for me but it doesn't help. I've tried both of those (acupuncture and reflexology) and I don't find they work.'

(Female, 36 – 45)

'Yes, having got in touch with some old friends, we actually ended up going on holiday with them and had a really lovely time. It was a lovely boost when they wrote to us to say how much they enjoyed it.'

(Female, 36 – 45)

'I have printed some tips and put them in my bring-up system so they reappear every few months as a reminder.'

(Female, 36 – 45)

In addition to the telephone interviews, people who completed the online survey also provided a very wide range of comments on the idea of positive steps at work and looking after your mental health (Tidyman and Kilfedder 2007). Overall the data suggests:

- 'positive steps' in the workplace were viewed very favourably by some employees and were acted upon, although time constraints and work pressure were mentioned as frequent barriers
- concerns about stress and depression in the workplace are common and widely understood to be influenced by working conditions, as well as by personal circumstances
- where employees feel working conditions, or management practice are stressful or damaging well-being, mental health messages are viewed negatively or with considerable scepticism
- levels of awareness vary considerably: for some people the messages are 'common sense' and for others completely new
- people with existing mental health problems felt reassured by the existence of a mental health campaign, which was seen as reducing stigma and taboos
- great care needs to be taken to avoid mental health messages sounding simplistic or patronizing

"Frankly anything with a name like "Positive Mentality" which implies that you can make it all alright by taking a positive attitude (typically the "glass is half full" mentality) is going to be so simplistic and patronising that I would only be annoyed by it. There - I've proved your point....all I have to do is get my mind right and display a positive attitude and all will be fine for me...."

(Male)

A number of developments suggest a ground swell of support for fundamental changes in working life in the interests of reducing stress and promoting well-being. These include the campaign for work/life balance, launched by the Prime Minister, the 'heartbeat economy' which addresses the impact of working practice on the well-being of employees and customers, the 'well-being manifesto', launched by the New Economics Foundation, and calls from a number of prominent economists for alternatives to Gross Domestic Product (GDP) as the measure of economic success

6 Learning from other initiatives: social marketing and mental health campaigns

Social marketing is a relatively new approach to promoting public health messages and there are few examples of the structured use of these techniques in mental health promotion in the UK (see box 6.1).

Box 6.1: What is social marketing?

“Social marketing provides a framework for behaviour change and borrows techniques from the commercial sector to apply to the resolution of health and social problems. Recent thinking also emphasises the potential of branding in public health, the need for long-term strategic thinking, and the importance of moving from one-off transactions to ongoing relationships both with the target audience and other key stakeholders” (Stead et al., 2007)

The majority of the literature on the use of social marketing approaches to mental health concerns challenging stigma: i.e. changing attitudes and behaviour towards people with mental health problems, rather than promoting ‘positive steps’ (see for example the review by Gale et al., 2004). Behaviour change, consumer research, segmentation, marketing mix, exchange and competition are the benchmark criteria for this approach identified by Andreason in 2001 (see box 6.2) and now generally used to determine whether an intervention can be called ‘social marketing’ (Stead et al., 2006a). Some key features said to distinguish social marketing from other approaches to achieving health behaviour change are:

- start with where people are
- focus on building emotional connections with the target audience
- positive, upbeat and aspirational – selling healthy, satisfied lives rather than ‘don’t do’ messages
- exchange – there must be a clear benefit for the ‘customer’ (intended recipient of the message) if change is to occur

“Identify any competition to behaviour change that exists (e.g. apathy, effort, time) and consider how to best remove or minimise its influence. It is critical to make it easy for people to adopt new behaviours, especially in the case of vulnerable groups (e.g. children, low-income) who face extra difficulties. An insider perspective on these difficulties can be especially insightful and can highlight problems that may be otherwise difficult to detect”

(Stead et al 2006a)

The extent to which social marketing approaches differ significantly from the principles of health promotion¹⁹ is the subject of debate in Scotland and elsewhere. This was expressed by one interviewee as “it sounds like community development with an advertising budget”. Nevertheless, the case for applying social marketing principles to public health has been strongly made (National Consumer Council,

¹⁹ Set out in the Alma Ata (1978) and defined in the Ottawa Charter 1986 (WHO 1986) as building healthy public policy, creating supportive environments, community empowerment, personal skills development and reorientation of health services (http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf)

2006). As the National Social Marketing Centre²⁰, (funded by the Department of Health), states: “*social marketing has been recognised by the UK Government as an important and currently under-utilised approach to tackling behavioural issues linked to smoking, obesity, and lack of exercise*”.

The Scottish Executive has recently commissioned a scoping or social marketing audit, undertaken by Gillian Govan, on secondment from Union Advertising, with a view to developing an *Integrated Social Marketing Strategic and Evaluation framework*. Research to inform the development of a social marketing strategy for health improvement in Scotland has been carried out by the Institute of Social Marketing (Stead et al., 2007).²¹

Box 6.2: Defining characteristics of social marketing approaches

- **Customer or consumer orientation** A strong ‘customer’ orientation with importance attached to understanding where the customer is starting from, their knowledge, attitudes and beliefs, along with the social context in which they live and work.
- **Behaviour and behavioural goals** Clear focus on understanding existing behaviour and key influences on it, alongside developing clear behavioural goals, which can be divided into actionable and measurable steps or stages, phased over time.
- **'Intervention mix' and 'marketing mix'** Using a range (or 'mix') of different interventions or methods to achieve a particular behavioural goal. When used at the strategic level this is referred to as the 'intervention mix', and when used operationally it is described as the 'marketing mix' or 'social marketing mix'
- **Audience segmentation** Clarity of audience focus using ‘audience segmentation’ to target effectively
- **'Exchange'** Use and application of the ‘exchange’ concept – understanding what is being expected of ‘the customer’, the ‘real cost to them’.
- **'Competition'** Use and application of the ‘competition’ concept – understanding factors that impact on the customer and that compete for their attention and time.

(NSMS, adapted from Andreason, 2001)

The relevance of social marketing to mental health improvement is twofold: firstly, as an approach that may improve the effectiveness of mental health improvement messages (French and Blair Stevens, 2006) and secondly, because social marketing views positive mental health as a key factor in achieving behavioural change:

“Positive mental health leads to positive behaviour change; how our target audience processes change/motivation will be very dependent upon their

²⁰ <http://www.nsms.org.uk/public/default.aspx>

²¹ The campaigns reviewed include West of Scotland Cancer Awareness Project (WoSCAP), See Me, Alcohol and Binge Drinking, Think About It, Healthyliving, McDonald’s, Smokefree Scotland and Smokefree Ireland. They were not evaluated in terms of their outcomes but instead examined from a social marketing perspective to assess the extent to which campaigns had utilised different social marketing principles.

positive mental health profile e.g. beliefs about ability/likely success, optimism versus hopelessness, resilience to keep trying. We should therefore embed in all of our strategies the psychological strands of empower and enable”

(Govan, 2007)

From a social marketing perspective, positive mental health offers expansion from topic related messages that are often negative (nutrition, alcohol, exercise) to messages that enhance the development of attitudes and skills to increase resilience and well-being: valuing yourself and others, talking about your feelings, keeping in touch with friends and loved ones, caring for others, getting involved and making a contribution, learning new skills, doing something creative, exploring your spiritual side, taking a break/relaxing, asking for help. In this respect, social marketing is consistent with the salutogenic approach of mental health improvement: health not illness, an asset rather than a deficit model, a greater focus on protective factors.

Stead et al., in their review for the Scottish Executive, concluded:

Health improvement needs to move away from unexciting piecemeal propositions – eat less fat, walk more – to an aspirational vision selling satisfied and healthy lives, integrating physical health with mental and emotional wellbeing. Health improvement can also not be imposed; the public have to get enthusiastically involved for efforts to be not only effective but sustainable.

(Stead et al., 2007 p.4)

Key aspects of current thinking about social marketing, for example ‘relationship building that requires an ever more intimate knowledge of the customer’, also draw strongly on positive psychology and other cognitive approaches:

“In public health, positive emotion and branding are potentially useful but typically underused (in huge contrast to commercial marketing)”

(Stead et al., 2006a)

In a review of eleven health related campaigns (including Mind Out, the English anti stigma initiative) commissioned by the National Social Marketing Centre (NSMC), Wellings et al. (2006) found the following:

- whilst direct application of social marketing is rarely explicit, many campaigns adopted some of its components, notably where a PR agency with experience of using social marketing techniques has been involved
- exchange is a more challenging issue in the context of health-related action, which often involves forfeiting a tempting or pleasurable behaviour for little obvious gain
- the evidence for the link between specific behaviours and health outcomes is often equivocal and the cost of such behaviour distant .
- advertising response and tracking surveys are often used to assess impact, and consequently short term gains in awareness, attitude change and brand recognition are given disproportion weight as success criteria for campaign effectiveness

A range of topic based systematic reviews of social marketing approaches have been undertaken by the Institute of Social Marketing (University of Stirling), some of which include topics relevant to mental health, notably nutrition, exercise and alcohol (Gordon et al., 2006; McDermott et al., 2006; Stead et al., 2006a; 2006b).²² The results suggest that social marketing approaches can significantly improve effectiveness and the achievement of behavioural change goals across a range of topics (National Consumer Council, 2006) The extent to which effectiveness is influenced by socio economic status, ethnicity and context (most studies are from North America, New Zealand or Australia) is unclear.²³ The reviews found strong evidence for nutrition, reasonably strong evidence for physical activity and more modest, although significant effects, for alcohol, tobacco and substance misuse:

- nutrition - main outcomes examined were fruit and vegetable consumption, fat intake – plus knowledge, self efficacy and view on perceived benefits; fruit and vegetables intake increased by between half and one portion per day, with most of the evidence coming from school or workplace settings
- physical activity (22 studies) main outcome examined: level of physical activity 8 out of 21 influenced physical behaviour activity
- short term impact on reducing alcohol consumption in majority of studies (8 out of 13)

A key message to emerge from Stead et al., (2007) is the importance of specific behavioural objectives, with calls to action requiring more clarity around what constitutes a positive shift in behaviour.

The National Institute of Health and Clinical Excellence will shortly publish guidance on the ‘most appropriate generic and specific interventions to support attitude and behaviour change at population and community levels’, based on a wide range of reviews, including one on social marketing approaches (Stead et al., 2006a).²⁴ This should provide clearer evidence of the effectiveness of social marketing approaches in comparison with other types of intervention.

Box 6.3: Inequalities

“In the past marketers viewed the low-income market as problematic, alienated and difficult to reach. However, they soon realised that this was because they were not communicating with low-income consumers in the right way and were offering them products and services not suited to their needs. Following a change in mindset – and by listening to their needs – marketers discovered that they could engage with low income consumers and successfully influence their behaviour. The public health community should adopt a similar mindset when trying to influence this group.”
(Stead et al 2007)

²² To our knowledge, all the UK systematic reviews on the effectiveness of social marketing have been carried out by the Institute for Social Marketing

²³ According to NICE, no systematic reviews on behaviour change included sufficient data about health inequalities to inform evidence regarding health inequalities within population sub-groups

²⁴ <http://guidance.nice.org.uk/page.aspx?o=395474>

6.1 Other campaigns

Most mental health campaigns, both in the UK and globally, focus on raising awareness of mental illness and reducing stigma and discrimination. A number also incorporate attempts to influence social support and social norms for recognition of mental health problems, to increase help seeking or to encourage early intervention among groups identified as at risk.²⁵ It is therefore difficult to draw any definitive conclusions about the impact of mental health improvement messages on behaviour or to identify whether messages about physical activity or nutrition, for example, have a different impact when included in the context of mental health (rather than physical health) improvement.

Two notable exceptions include the Public Health Institute of Iceland's '*commandments of mental health*'²⁶ and Mental Health America's '*top tips*' for *improving mental health*.²⁷ Unfortunately, no information is available on whether these initiatives have been evaluated. The American top tips are consistent with the 'positive steps' messages familiar in the UK, with a focus on exercise, good nutrition, spending time with friends and family and getting involved. Getting sufficient sleep is also mentioned. Within these themes, messages are tailored for older people, families and people worried about their mental health or feeling stressed.

The Western Australia **Act-Belong-Commit** (A-B-C) mental health campaign is an example of a population-wide approach. The campaign aims to improve mental health in six demonstration sites by encouraging the whole population of these towns to: Act-Belong-Commit to improve individual resilience and community cohesion. The Mentally Healthy Western Australia (WA) campaign is ongoing and is being implemented and evaluated by The Centre for Behavioural Research in Cancer Control.²⁸ The key message of the campaign is: *Being active, having a sense of belonging, and having a purpose in life all contribute to happiness and good mental health. Act-Belong-Commit*

Box 6.4: Act-Belong-Commit

Campaign messages are targeted for specific audiences, including building awareness for, and increasing behavioural adoption of, three major ways in which people in authority can enhance the mental health of those for whom they are responsible (e.g. as supervisors, employers etc): providing opportunities for all to actively participate in activities and decision making; providing challenges that increase skills and self-efficacy; and publicly recognizing individuals' achievements.

(Donovan et al 2006a)

²⁵ The Compass campaign in Australia, for example, used increasing mental health literacy as a route to reducing barriers to help seeking for young people at risk of depression (Wright et al 2006). There are also a number of school based campaigns aiming to improve emotional well-being, often within a health promoting schools framework, but these are outside the scope of this report. (see for example the Australian MindMatters <http://cms.curriculum.edu.au/mindmatters/resources/resources.htm>)

²⁶ http://www.lydheilsustod.is/media/gedraekt/efni/gedrakt_enska.PDF

²⁷ <http://www.mentalhealthamerica.net/go/information/get-info/healthy-living>

²⁸ <http://actbelongcommit.org.au/>. It is worth noting that it appears from the literature that the team involved in implementation are also conducting the evaluation of the campaign, although we have not been able to verify this.

Objectives of the campaign are to:

- Implement a range of interventions in six regional centres in WA to influence people's; understanding of mental health, awareness of their own mental health, and the desirability of being proactive about one's own and others' mental health.
- Increase individual's participation in individual and community activities to increase mental health and reduce vulnerability to mental health problems. The interventions will be related to the theme: 'Act-Belong-Commit'.
- Increase the understanding of employers, and other persons in authority, of the importance of how they deal with those in their care, and increase the use of positive rather than coercive practices amongst parents, teachers, supervisors/managers, coaches, etc.
- Build cohesion in communities by fostering links between organisations around a unifying theme promoting positive mental health.
- Build links between those in the community dealing with mental health problems and those in the community with the capacity to strengthen positive mental health.
- Study and document how best to develop and implement partnerships related to mental health promotion across government departments and local organisations.
- Help communities reduce the incidence of mental health problems such as depression, alcohol and drug abuse, juvenile and adolescent delinquency, and suicide.

An evaluation at 24 months (James et al., 2007), including a community survey, found that overall awareness of the *Act-Belong-Commit* Campaign was 26% in the intervention towns and less than 2% in both the metro and rural comparison towns.

In the intervention towns, respondents who were aware of the campaign were significantly more likely than those unaware of the campaign to:

- do more exercise (78% vs 60%)
- socialise more (51% vs 44%)
- volunteer or take up a good cause (50% vs 32%)
- mention doing these activities for their mental health (20% vs 12%)

Among respondents who were aware of the campaign, 26% reported that they have changed the way they think about mental health as a result of the messages in the campaign's advertising and publicity. The campaign increased awareness of mental health in general, increased belief that people can do things to keep mentally health and reduced the stigma surrounding mental health problems and people with mental illness. Eleven percent of respondents reported behaviour change as a result of the campaign. Respondents mentioned participating in activities related to the A-B-C message, being more accepting of people with mental health problems and having a more positive outlook on life in general.

The data is of special interest because it indicates that a mental health promotion campaign can encourage people to do things to improve their own mental health and

simultaneously reduce the stigma associated with mental health problems. The final Community Survey will be conducted in October 2007 (Donavan et al., 2006; 2007b).

A further development in the UK is the number of campaigns that are beginning to include evidence of mental health benefits to strengthen their case. Examples include access to nature (Natural England's Health Campaign), which promotes the health benefits of access to the natural environment. This aims to provide accessible natural space within 300 metres (5 minutes walk) of every home in England²⁹, and is supported by MIND. MIND has launched its own ecotherapy campaign, highlighting the green agenda for mental health, notably in a small piece of qualitative research comparing the mental health benefits of a walk in the country with a walk in an indoor shopping centre.³⁰

The Mental Health Foundation has launched a series of media initiatives aiming to highlight the relationship between lifestyle and mental health with a focus on:

- preventing mental illness and encouraging mental health and wellbeing through the provision of information and advice. The proven mental health benefits of a healthy diet, regular exercise and moderate alcohol consumption should be actively promoted,
- actively discouraging people from putting their mental health at risk. Lack of exercise, over-consumption of alcohol and work-related stress must be tackled, and steps need to be taken to warn people of the mental health dangers associated with recreational drugs

Topics have included nutrition (*Feeding Minds*), exercise (*Up and running*), alcohol (*Cheers*), spirituality and friendship and are part of an ongoing programme of work aimed at increasing general understanding of the value of non-medical interventions in mental health (Mental Health Foundation, 2006a; 2006b; 2006c).

²⁹ <http://www.naturalengland.org.uk/campaigns/health/default.htm>

³⁰ *Ecotherapy: the green agenda for mental health* <http://www.mind.org.uk/mindweek/report/>

7 Learning from practice: interviews with key informants and agencies

Statutory bodies, the voluntary and community sector, specialist mental health services, public relations and other agencies across the UK have developed a substantial body of experience and knowledge on developing and communicating mental health messages. In some cases, this includes messages to promote mental health, or messages that are relevant to mental health (e.g. physical activity and diet). As part of the HEA's WMHD research, colleagues from a range of different agencies involved in mental health improvement were interviewed (see appendix three).

In summary, local organisers in Scotland responded well to messages around positive support and preventative measures in relation to service users and the public. There was broad support for the 'positive steps' messages and the overall theme of mental health improvement:

'We'd like messages covering looking after your general mental health, a bit more in-depth on prevention. Most think mental health happens to someone else, it is very extreme.'

(Local Organiser, Scotland)

A key area for mental health promotion was seen to be the promotion of positive mental health amongst the general public, moving away from perceptions of mental health denoted as mental illness (Qualitative research 1998, see appendix three). Those working in mental health promotion wanted the campaign to promote long term strategies for promoting mental health, both for those with mental health problems and those without

For this report, we also conducted a series of twenty one telephone interviews and one group interview (during June and July 2007) to draw on the expertise of colleagues with experience of delivering mental health improvement. We also sought to gain an up to date practitioner perspective on promoting mental health improvement messages (see appendix one – although no comments are attributed to individuals, four people preferred to remain anonymous). Interviews were open ended and all interviewees had previously been sent a summary of the proposal for the research. Respondents were asked:

- overall, what is your response to promoting positive steps messages to promote mental health in Scotland? (prompt: benefits, challenges, potential problems)
- what is your own view on the strength of the evidence for steps like exercise, talking things over etc.? (prompt: is it similar to stopping smoking for example?)
- how relevant are the messages to people with mental health problems? (or other groups relevant to role of interviewee)
- Any other views you have?

Key responses are summarized below:

Mental health improvement messages have been seriously neglected

“People had no idea of the links between exercise and emotion/cognition or of the impact of diet on mood”

“mental health is fundamental to health improvement and this simply hasn’t been recognised”

“organisations whose job is around mhi need guidance – what are the messages? because people do want to know, especially about stress”

The strength of the evidence varies but most of the positive steps

“definitely contribute to improved mental health”

“wherever you are mentally, there are things you can do; most GPs would be quite happy to suggest these steps”

“there’s an established relationship with physical health, so you are looking at a double benefit”

“building confidence, self esteem and self worth through creating opportunities for social networking is a key factor in affecting change - physically, mentally and emotionally”

The time is right: mental health messages are likely to be well received by the public and are consistent with the recovery agenda

“there’s this well-spring; the whole issue is coming out of the closet; I see small signs, men are better able to use a feeling vocabulary”

*“as long as we recognise conceptual, cultural and linguistic differences”
“we’ve been saying all this helps recovery for years”*

“it’s about moving away from an illness identity to wellness; it’s saying here are some things that might help – take what you will”

Lifestyle messages may reinforce inequalities

“they don’t address the key causes of either mental health problems or psychological pain and distress in deprived areas”

“how could we build in an equalities perspective from the start?”

“no matter how deprived you are, there are simple things you can do: walk; bath; take time out...”

“there’s a danger that well-being will become just another commodity for the ‘haves’”

“there are equalities issues, but it’s about enabling people to take control – directing your own recovery - that is central and is there in the Nursing Review and Delivering for Mental Health”

Wider determinants and socio-economic context must be ‘central to the approach’

“I do worry about this emphasis on individual psychology; you can’t separate thoughts, feelings, self esteem, motivation etc from the material circumstances of people’s lives. Is it great to be positive? Maybe people are right to be pissed off..”

“of course it’s more difficult for some people to act on these messages than others; you need supportive measures in place – not everyone can just ‘go out for a walk’. So care needs to be taken; a community development approach for example, that builds people’s ability to take action”

It risks blaming people who have poor mental health or low levels of well-being

“it’s that old ‘pull yesel thegither’ message; if you’re sad, or depressed or unhappy, just go for a long walk or help out in a charity shop”

“I’d be cautious about a lifestyle approach to a complex problem; will these steps reduce prevalence? I doubt it. It is not like the smoking message”

“personally I find it patronising; I did all those things but I still had a breakdown”

A number of interviewees had considerable experience of working with mental health issues in deprived or fragmented communities and of attempting to integrate individual approaches with a wider recognition of and action to address the material and economic circumstances of people’s lives.

Dundee Healthy Living Initiative is an example of a long standing local programme centrally informed by awareness of the mental health benefits of activities like community walking groups, and that health improving behaviour change is often a bye product of increasing well-being.

“networks can provide social support, self-esteem, identity and perceptions of control. Renewed social connections are the most apparent benefit of respondents’ involvement with the DHLI. There is a high level of awareness from participants that the DHLI is a health project but during interviews and focus groups the majority prioritised the biggest impact as no longer feeling isolated.”

(Lewis et al 2006 p34)

Box 7.1: Dundee Healthy Living Initiative (DHLI)

“engaging people in groups and activities opens new social networks and ends social isolation. The resulting supportive learning environment enables the participants to build self-confidence, or what Bandura terms ‘self-efficacy’: a general belief that one does have the ability to make changes. People are ‘empowered’ to make changes. Health benefits arise either from the group activity itself (for example, ‘exercise to music’), or from putting into (often tacit) practice the information received. They also have a ‘ripple-effect’, impacting also on families. Some participants then express a desire to engage others – a move from self- to collective-efficacy. Of this latter group, some express a desire to ‘work with’ the Project” (Lewis et al., 2006)

Box 7.2: Views from DHLI participants

Well, I find the exercise is fine. Whereas at first I used to get out of breath, just walking a wee distance, I find that I can walk for quite a bit now...but you're socialising as you go along and I find that helps. If I feel good inside me, I can feel good on the outside. Before, I wasn't feeling good inside. I've got my self-confidence, I've got me, I'm happy.

It's not like maybe it's an instant thing. It's not like you go to a motivational class, and you suddenly get a better life or whatever. It's like when you study. I mean, you study for the job you're going to do, but you have to be in the job a while before you feel comfortable with it an everything else.

you're (I'm) part of the community...you interact more...you're less isolated... it's (the DHLI) bringing back community spirit in a way.

8 Learning from practice: seminar for practitioners

The emerging findings (from the literature review, interviews with key informants and analysis of the grey literature) were presented at a seminar attended by around 40 colleagues from across Scotland (in addition to two colleagues working on the Northern Ireland ‘Mind your Head’ campaign).³¹ The purpose of the seminar was to test the validity and reliability of the research messages and to identify potential barriers and opportunities for delivery, using a simple framework developed by the Health Development Agency (Kelly et al., 2004; Thomas et al., 2004). The seminar was well attended, well received and generated considerable debate. Key issues emerging in the seminar are of special value because they highlight, from a practitioner perspective, some of the factors that would need to be taken into consideration in promoting ‘positive steps’ in Scotland.

Most seminar participants expressed support for increasing public awareness of the link between lifestyle and mental well-being. For many however, it was also crucial to:

Recognize the complexity of mental health and the complexity of the evidence for ‘positive steps’

“Life is complex, so positive steps shouldn’t be simplistic”.

“Unremitting positive messages urging people to ‘be happy’ are not helpful. Individuals may feel responsible if they’re not happy, when it’s more complex than that. The findings so far are helpful and positive, they seem to acknowledge the complexity of mental health issues.”

“What is the greater change that it’s trying to achieve. Smoking is straightforward – mental health is more complex.”

Avoid what has happened in the case of other lifestyle health improvement initiatives, which have largely served to increase inequalities

“ The difficulty is how to capture the complexity without reducing it to sound bites. There is a danger of only adding to inequalities. Future mental health campaigns should take this into account.”

“There are equalities issues – that isn’t a reason not to do it, but there’s a danger of reinforcing a sense of failure”

“The whole history of health improvement demonstrates the likely results of this kind of individual approach”.

³¹ See appendix five for a copy of the programme

Integrate action on the broader determinants of mental health

“We have to remember the broader determinants of someone’s health. If someone is experiencing racism, it’s unlikely that the positive steps will have an impact until the racism is stopped. Influencing the policy makers and getting structural change is vital.”

“We need to link the individual and society - the impact of the environment on mental health; of discrimination for older people, or prejudice.”

“But improving people’s material circumstances won’t necessarily improve their lives – it may, or it may not.”

Ensure that information is evidence based

“We need the evidence to support messages that are already out there. We don’t have any plans for a campaign, but if we produce resources for mental well being/media interviews/training then we need the evidence base. We often get requests for resources from practitioners, so these have to be right.”

“Mental health and physical health messages are very similar and it’s good to have evidence of that.”

Work with local communities on mental health improvement messages

“We can’t promote messages like these unless we’ve had some initial engagement with the individuals and communities we’re targeting. We need to find a way of having a dialogue with people first. This has to be bottom up.”

“With mental health, we may need different messages depending on age, race, sex, place, social status, etc, so the audience does need to be broken down. If explored fully, this would entail an enormous volume of work.”

“At Breathing Space, the experience is that people find it difficult to form mutually sustaining relationships.”

Identify potential change agents and delivery mechanisms for mental health improvement

“It’s important to think about where people are and agents of change – these change agents are often from the voluntary sector, but in Scotland they’re under resourced and struggling for survival.”

“Use of the internet, anonymity, online communities etc bring new challenges for health promotion.”

9 Conclusions

Findings from the review show that, although the quality and quantity of studies vary, overall there is good evidence to support the effectiveness of 'positive steps' messages for the promotion of positive mental health, the prevention of mental health problems and for the improving the quality of life for people living with mental health problems.

The 'positive steps' approach may empower individuals to improve and protect their own and others' mental health. At the same time, it is crucial to recognise the wider contexts that influence both the mental health of individuals and their capacity to adopt 'positive steps'. Mental health influences motivation, capacity and opportunity to adopt healthy lifestyles and socio-economic circumstances influence factors that protect individual mental health e.g. social contact.

The review of qualitative research showed high levels of public interest in emotional and cognitive well-being, whether that is expressed in terms of concerns about stress, worries, low mood or the importance of a positive attitude, coping or not 'bottling things up'. Members of the public across all age groups and backgrounds had sophisticated explanatory frameworks for what influences 'how people think and feel' and many people in all social groups are already doing a lot to promote their own mental health and to cope in the face of adversity. This interest in looking after mental health is also evident in findings from the BT online survey and interviews, with many employees expressing both considerable support for action on mental health and concerns about stress and depression in the workplace. At the same time, where employees feel working conditions or management practice are stressful or damaging to well-being, mental health messages may be viewed negatively or with considerable scepticism.

The response of health and other professionals to promoting mental health messages in Scotland was also largely positive and again informed by a concern to empower individuals to take action to improve their own mental well-being, in the context of tackling the wider determinants of mental health and Scotland's ongoing commitment to social justice and reducing inequalities.

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