Review of Evidence about the
Effectiveness of Mental Health Promotion
Programmes Targeting Youth/Rangatahi

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1. Introduction

The Mental Health Foundation of New Zealand (MHF) has been delivering youth/rangatahi mental health promotion (MHP), as per the service objectives identified in its Ministry of Health contract, for a number of years. Since the service objectives and outcome measures were originally defined, the youth/rangatahi mental health promotion area has moved on. New research, and new ways of thinking and describing youth/rangatahi mental health have developed during the intervening years.

The MHF is proposing to refocus its work on the provision of mental health promotion for youth/rangatahi. To inform the development of its youth/rangatahi mental health promotion programme, The Mental Health Foundation has commissioned a review of evidence about the effectiveness of mental health promotion programmes targeting youth/rangatahi. This report presents the findings of that review.

1.1 Purpose and objectives of the evidence review

The overall purpose of the review is to inform and provide context for the design of the Mental Health Foundation's youth/rangatahi mental health promotion programme. The objectives are to:

- Identify, review and summarise international and local literature and evidence-based best-practice approaches on the design and implementation of mental health promotion programmes that target youth/rangatahi aged 12-24
- Provide an analysis and summary of key programme elements that will enhance the effectiveness and efficiency of mental health promotion programmes targeting youth/rangatahi.
- Provide an analysis about the implications of the current policy context on the delivery of mental health promotion, and highlight how mental health should be positioned within the current policy context.
- Draw conclusions about the core components and key principles for effective delivery of a youth rangatahi health promotion programmes(s) in the New Zealand context.

The review draws together established knowledge about successful mental health promotion, and focuses on robust and well documented empirical findings. It is intended as a high level review providing a snapshot of the current evidence base in order to inform further work.

1.2 Methods

The search strategy involved a search of key academic databases (Medline, PsychInfo and Embase); searching the internet using Google and Google Scholar; and hand-searching known websites listed below.

International: Cochrane Library

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1 Throughout the report 'rangatahi' refers to young people aged 12-24 who identify as Maori.
1.3 Limitations

A mental health promotion evidence review would ideally take a ‘determinants’ approach, and examine all known determinants of mental wellbeing (e.g. employment, exposure to violence etc) and interventions to address them e.g. youth employment programmes, family violence prevention programmes, literacy programmes, and policy interventions to reduce poverty, improve housing etc. Such a broad approach was well beyond the scope of the current review. However, the Foresight Project (Jenkins et al, 2008) recently undertaken in the UK is just such a wide ranging review. The youth-specific results of the Foresight Project are included in the current review.

The review focuses on evidence of the effectiveness of strengths-based mental health promotion and youth development interventions. Suicide prevention interventions and mental illness prevention interventions were specifically excluded from the review. The review did not specifically seek out findings
on anti-discrimination programmes, but where such findings were covered in broader reports, these were included. The aims of the review did not include identifying and summarising the risk and protective factors for youth mental wellbeing.

This review is primarily based on high level review findings. Knowledge about ‘what works’, although increasing, remains limited. Where evaluation has been undertaken, the focus is generally on the extent to which outcomes were achieved, not on the active ingredients for success. It should also be noted that there is very little literature, on effect sizes associated with different mental health promotion actions, so it is not possible to compare the effectiveness of different actions.

Within the included literature, there is almost no empirical research on the effectiveness of interventions that focus on environmental or structural risk and protective factors. Empirical research on effectiveness of interventions for Māori youth and for older youth (i.e. post-secondary school) is also extremely limited.

Most reviews included cover children and young people of all ages, and it is often difficult to separate out findings specifically for youth aged 12-24. It is possible that some of the aggregate findings reported here are not relevant for the 12-24 age group. In some instances where there are evidence gaps, findings from all-age reviews have been included. These inclusions are clearly noted in the text, but the reader is cautioned that all-age findings may not hold for the 12-24 age group.

The majority of research findings are from US school-based interventions and longitudinal studies. The applicability of these and other international findings to the New Zealand context is not well established.

The time frame and budget for the review was modest and demanded a rapid approach to identifying and summarising key findings from the literature.
2. Context for the evidence review

2.1 What is mental health promotion?

There is no universally agreed definition of mental health promotion, but the definition currently used in New Zealand by the Ministry of Health and the Mental Health Foundation is:

*Mental Health Promotion is the process of enhancing the capacity of individuals and communities to take control of their lives and improve their mental health.* (Mental Health Foundation, 2004: 18)

Implicit in this definition is the concept of positive mental health, or mental wellbeing. There is a growing literature on positive mental health and a general agreement that mental health is more than the absence of mental illness (Friedli, 2005). Working definitions of mental wellbeing have been developed by policy makers and practitioners, but finding a universally agreed definition remains elusive due to differing values, cultures and professional backgrounds.

Also implicit in the definition above is the idea that mental health is not immutable: there is a range of factors that influence mental health positively and negatively (often called ‘protective factors’ and ‘risk factors’), and there are actions that can enhance the capacity of individuals and communities to improve their mental health.

Mental health promotion considers the mental health needs of the population as a whole, not only people who experience mental illness, and addresses the underlying determinants of mental wellbeing. Mental health promotion action encompasses a wide range of activities at a number of different levels and in a range of sectors and settings. For example, mental health promotion action includes:

1. **Strengthening individuals** - or increasing emotional resilience through interventions to promote self-esteem, life and coping skills, negotiating relationships and parenting skills
2. **Strengthening communities** - this involves increasing social inclusion and participation, improving environments, developing health and social services which support mental health, workplace health, school-based initiatives, community safety and self help networks
3. **Reducing structural barriers to mental health** - through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, and support for those who are vulnerable. (ProMenPol, 2009)

Mental Health Promotion draws heavily on health promotion, social change, community development, youth development and personal development theory and practice.

**Health Promotion Framework**

It may be helpful to consider mental health promotion within a wider health promotion framework. Health promotion services are offered to populations rather than individuals. Health promotion is based on the assumption that a healthy population requires not only curative services to heal people who are sick, but also a physical, social and economic environment that supports the health and wellbeing of the whole population. For example, a healthy population requires clean air and water, freedom from violence and discrimination, and access to enough income to support a reasonable quality of life (Ball, 2006). The following diagram illustrates these and other health determinants:
Health promotion in New Zealand is guided by the Ottawa Charter (WHO, 1986) as well as key Ministry of Health documents such as Achieving Health for All People (Ministry of Health, 2003). The adoption of the Ottawa Charter in 1986 marked a dramatic shift from a ‘health education’ approach (“give them the information and people can make their own decisions”) to an environmental approach that recognizes that people’s decisions are affected by many factors, and that many determinants of health are out of the control of the individual. Part of the role of health promotion is informing and influencing key decision makers in health and other sectors and advocating for health policy that is more preventive and non-health policies that are more conducive to wellbeing. The five strands of the Ottawa Charter are:

- Building healthy public policy
- Reorienting health services
- Creating supportive environments
- Strengthening community action
- Developing personal skills

The definition and three levels of mental health promotion action outlined above reflect a health promotion approach underpinned by the strands of the Ottawa Charter.
Misunderstandings about mental health promotion

Despite the concept of positive mental health described above, the term ‘mental health’ is often equated with mental illness, sometimes leading to misunderstandings about the purpose of mental health promotion. It is sometimes mistakenly believed, for example, that mental health promotion is primarily aimed at people with mental health problems, or that its main purpose is to educate the public about mental illness. This is not the case.

Defining mental health promotion for the purposes of this review

In line with leading mental health promotion researchers and practitioners, this review defines mental health as a positive state of mental wellbeing. For the purposes of this review mental health promotion excludes suicide prevention and mental illness prevention, and includes findings on youth development interventions. The focus is on strengths-based initiatives designed to promote mental health and wellbeing at the population level.

2.2 What constitutes “effectiveness”?

Outcomes

The aim of this review is to summarise the evidence on ‘what works’ to promote mental health in young people/rangatahi aged 12-24. ‘What works?’ can’t be answered without first having a clear idea of the desired outcome(s). In other words, what exactly is mental health, and how is it manifested? Is positive mental health the same as, for example, ‘happiness’, ‘flourishing’, ‘subjective wellbeing’, ‘life satisfaction’, ‘resilience’, ‘mental capital’, or ‘positive youth development’?

Each of these terms is backed by a growing body of literature and a variety of models and measurement tools (see for example: Harvey et al (n.d.), Huppert & So (2009), Thomas et al (2010) and Thompson & Aked (2009)). From a research and evaluation point of view, the overlaps and distinctions between these different concepts are crucial, and there is much debate in the literature about how each should be defined, operationalised and measured. For example a recent European study found that a third of flourishing people did not obtain a high score on life satisfaction and half of those with high life satisfaction did not meet criteria for flourishing (Huppert, 2009), proving that these are quite different concepts. However, to avoid the risk of becoming bogged down in academic debate, the various positive mental wellbeing concepts listed above have been treated as equivalent for the purposes of this review. Despite differences, they have much in common. Principally, they focus on achievement of positive outcomes for young people rather than prevention of negative outcomes (e.g. suicide, mental illness).

According to Aked et al (2008) "The concept of well-being comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity and engagement are characteristic of someone who has a positive experience of their life. Equally important for well-being is our functioning in the world. Experiencing positive relationships, having some control over one’s life and having a sense of purpose are all important attributes of wellbeing."
Risk and protective factors

Ideally, “effectiveness” of interventions is based on outcome measures, but in mental health promotion the ultimate outcomes may not manifest for many years and may be difficult to define or measure directly. However the evidence about which factors are associated with positive youth outcomes is fairly well developed, and these risk and protective factors are often used as a basis for guiding and evaluating interventions.

As stated above, there is general agreement that mental wellbeing is more than the absence of mental illness and that “becoming a competent and successful adult requires skills and competencies above and beyond being free of problems” (Hilkene Bernat & Resnick, 2006: S14). Based on longitudinal research and developmental theory, there is now a strong evidence base about the skills, competencies, assets, behaviours and environmental factors that are associated with positive outcomes for young people. These include positive pro-social relationships, connectedness/engagement, self esteem/confidence in one’s own self worth, coping skills, efficacy, and contribution to one’s community. For further detail see Browne et al, 2004; Guerra & Bradshaw, 2008; Hilkene Bernat & Resnick, 2006; and Ministry of Youth Development, 2009 which provide comprehensive reviews of the youth development and resilience literature. Longitudinal results demonstrate that protective factors can buffer the effects of risk factors. In other words hardship and disadvantage (e.g. poor parenting, family instability) can be ‘neutralised’ by factors such as strong relationships with other adults, school connectedness, and having friends and interests (Hilkene Bernat & Resnick, 2006).

These findings provide solid grounding for what should work to promote mental wellbeing, and most of the evidence based youth development programmes designed in recent years aim to enhance the protective factors/assets/competencies outlined above, and reduce known risk factors such as drug and alcohol abuse. The science on what actually works in practice (i.e. the programme elements associated with successful youth outcomes) is far less developed.

In the mental health promotion field there is growing evidence that mental health and mental illness are not ‘opposites’; the two dimensions may be independent rather than opposite ends of a single dimension (Aked et al, 2008). A recent UK review explored this relationship in more detail, concluding that ‘while some factors affect both well-being and ill-being [e.g. physical activity, positive relationships], there are other drivers which influence well-being alone’ (Aked et al, 2008: 2). For example, mindfulness (taking notice and being aware of the present moment) and giving (being actively and generously involved in social and community life) specifically influence wellbeing in a positive way (Aked et al, 2008). This research suggests that reducing risk factors for mental illness/suicide will not necessarily lead to optimum positive mental wellbeing. While ‘prevention’ and ‘promotion’ may use some similar methods, their goals and objectives are different, and some methods are unique to promotion.

Critics of the ‘prevention paradigm’ have pointed out other disadvantages of a problem-focused approach. Guerra & Bradshaw, for example argue that “from a pragmatic perspective, one of the principal challenges of a risk-focused approach is that it resulted in a proliferation of separate problem-specific-programs […]. Rather than emphasising the identification of shared risk, protective and promotive factors, both research and practice generally have treated adolescent risk behaviours [e.g. youth crime, teenage pregnancy, drug and alcohol problems] as separate and independent, with little consideration of their interconnectedness and common causal pathways” (Guerra & Bradshaw, 2008, p2-3). This issue has also been recently highlighted in New Zealand by the Whānau Ora Taskforce in its initial discussion paper (Whānau ora taskforce, 2009).
and by Mason Durie (2009b). Both highlight the way a problem-focused approach and siloed funding streams and services can create barriers to positive development and whānau ora. For example:

Services to whānau members are provided by a number of sectors, often resulting in inconsistencies, fragmentation, overlaps in service delivery, duplication of effort, and frequently confusion and frustration for those seeking assistance. Moreover, because each agency usually focuses on a particular problem experienced by an individual whānau member (such as truancy or chronic illness) an opportunity for a sustainable whānau-wide approach to resolve problems is lost. (Whānau Ora Taskforce, 2009: 1)

According to Hilkene Bernat and Resnick (2006, p813) “the resilience literature provides a compelling rationale for redirecting interventions from the traditional emphasis on the prevention and treatment of problem behaviours to capacity building in youth”.

Young people’s perspectives

Another way of exploring what should work to promote mental wellbeing and positive youth development is to find out what young people themselves consider to be important. In New Zealand qualitative research by SHORE as part of the Health Research Council-funded project Theorising Youth Mental Health Promotion (Edwards et al, 2003) gave insight into Māori, Samoan and Pakeha young people’s perception of “wellbeing” and the things that impact on wellbeing.

The findings align with international research and show that wellbeing is heavily influenced by a wide variety of environmental domains:
• Social domains: culture, family, peer group, school, sport, work, church.
• Physical domains: place, public space, transport, accommodation, venue.
In addition the research identified a range of generic issues that young people talked about as important in their lives within these environments: identity, health, emotions, drugs, sexuality, death, spirituality, risk, bodies, bullying, and coping (Edwards et al, 2003).

UK research found that young people consistently see material and physical resources (e.g. having a stable home, financial security, having the means to participate in leisure activities, employment prospects) as major influences on their mental health, but noted that few evaluated interventions targeted these factors (Oliver et al, 2008). This research also explored young people’s conceptualisations of mental wellbeing, and concluded that “young people described their mental health in functional rather than symptomatic terms “(Oliver et al, p 786).

Māori /Indigenous Perspectives

What does ‘effective’ mental health promotion mean from a Māori perspective? Mason Durie has argued that Māori-specific health promotion approaches are necessary because Māori and non-Māori do not necessarily share the same values and aspirations. Durie pointed out that "the indicators of ‘good’ mental health are not universal and indigenous peoples place particular emphasis on the quality of relationships with family, tribe, community, the land, sites of heritage, and traditional knowledge” (Durie, 2004: 7). He says promotion of good health will be ineffective if it is based on an assumption that all New Zealanders subscribe to the same views of health and aspire to similar goals (Durie, 2004). Judgements about
“effectiveness” of mental health promotion initiatives for rangatahi must be grounded in the Māori values and aspirations, and take into account what Māori consider to be important.

Others (e.g. Ministry of Youth Development, 2009) agree that culture has a significant impact on human development and aspirations, and argue that while high level assets or indicators (e.g. competence, self worth) are universal, their meanings at the community level are culturally specific, and the means of achieving them are also culturally specific. For example, strengthening self worth for rangatahi may involve strengthening their identity as Māori.

Māori have disproportionately high rates of universal risk factors e.g. poor housing, low educational achievement, unemployment, and inadequate income (Durie, 2004), and may have poorer access to universal protective factors e.g. stable family life, school connectedness. There are also Māori specific risk and protective factors that affect mental wellbeing at the population level e.g. societal prejudice and discrimination, loss of sovereignty, dispossession, alienation from the land and from intellectual and cultural resources (Durie, 2004). Durie argued that “deculturation contributes to poor mental health and [lack of] a positive personal identity” (Durie, 2004 p3) and Keri Lawson stated “there can be no doubt that cultural alienation, identity and role confusion and loss of cultural systems of meaning and practice are directly relevant to indigenous youth suicide” (Lawson, 1998 p10). International research points to the benefits of a strong cultural identity for the individual wellbeing of indigenous youth (Lawson, 1998). In a recent lecture Durie (2009b) outlined positive attributes on which future Māori wellbeing will be built e.g. youthful vitality of the Māori population, engagement in te ao Māori.

In summary, the literature suggests “effectiveness” in a Māori context means setting goals and objectives that reflect Māori values and aspirations, using culturally appropriate methods, and addressing Māori-specific as well as generic risk and protective factors.

2.3 Policy environment

In Europe and the UK, the policy environment has shifted dramatically away from a focus on mental illness prevention, towards a whole of government approach to enhancing the mental wellbeing of the entire population. Although New Zealand has been a leader in some aspects of mental health promotion, the idea that mental health is a national asset for cross-government investment has yet to gain traction here in the political arena.

2.3.1 New Zealand

In New Zealand mental health promotion services are purchased by the Ministry of Health under the public health budget. Public health gets about 2% of Vote: Health funding. Of that, approximately 3% is spent on mental health promotion services, primarily delivered by Public Health Units and NGO providers (Ball, 2006). Note that the Ministry of Health also funds family violence, alcohol and drug, gambling prevention, social environments and other health promotion services that are likely to impact on the mental health of the population, but these initiatives are not included in the Mental Health Promotion spend.

It is also important to note that the policies and operations of departments across government have a huge impact on the determinants of mental health for young people e.g. they can influence youth unemployment rates, educational outcomes, the incidence and impact of family violence, how young people are dealt with in the justice system, the quality of care and support for wards of the state.
With regard to policy, youth mental health promotion is positioned at the intersection of four key policy spheres: public health, Māori health, youth health and mental health. There is no one strategy or action plan to guide youth mental health promotion specifically, but a number of documents contain elements that directly relate to youth mental health promotion. These are outlined below:

**Building on Strengths: a new approach to promoting mental health in Aotearoa/New Zealand.**  
(Ministry of Health, 2002) was the first (and remains the only) policy to provide an overarching framework for mental health promotion action in this country. The framework is attached in Appendix A. It clearly defines ‘mental health’ in positive terms and uses a determinants of health and strengths-based approach, rather than a risk-prevention or medical model approach. It lays out three broad goals: reduce inequalities; create environments supportive of positive mental health; and improve individual and community resiliency skills. The document also proposes action streams, priority populations, settings and approaches to achieve these goals, and identifies three key determinants of mental health: participation in society; valuing diversity; and safe, cohesive communities. Although Building on Strengths is now eight years old, the overall framework remains relevant and is supported by the latest evidence summarised in this review. However its vision is extremely broad, which is challenging for a small and modestly funded sector such as mental health promotion struggling to make a positive difference with limited resources.

More recently, the Ministry of Health has updated the New Zealand Suicide Prevention Strategy (Ministry of Health, 2006) and associated Suicide Prevention Action Plan (Ministry of Health 2008). Whereas the previous strategy was specifically focused on youth suicide, the current documents address suicide in all age groups. The strategy outlines a multisectoral approach to addressing inequalities, promoting supportive environments and reducing risk factors for suicide. Although suicide prevention has been excluded from the current review, this policy is relevant as it identifies mental health promotion as an important element in suicide prevention. The strategy takes a combined promotion-prevention approach and the first of seven goals in the strategy is to promote mental health and wellbeing, and prevent mental health problems. More specifically, the goal is “to develop policies, services and strategies that: a) reduce population exposure to the range of social, familial, and individual risk factors that contribute to mental health problems and suicidal behaviour; and b) promote resilience following exposure to adversity” (MoH, 2003, p23). The strategy outlines broad areas for action under this first goal, including:

- promoting initiatives to support the mental health, wellbeing and resilience of families/whānau and individuals
- promoting initiatives to encourage people to be more responsive to emotional distress and the early symptoms of mental health problems
- supporting initiatives to reduce the stigma of mental illness
- supporting initiatives that address social inequality, violence, discrimination and abuse
- promoting polices and practices in a range of settings to promote mental health and wellbeing, including: schools, universities, marae, churches and other faith-based organisations, prisons and workplaces
- increasing, where appropriate, the role of cultural development as a protective factor for Māori.

To support the national suicide prevention strategy, the Ministry of Health released Te Whakauruora: Restoring Health. Māori Suicide Prevention Resource last year. Te Whakauruora is a community development and community action-focused resource primarily to assist hapū, iwi, hapori Māori and community groups. It provides an insight into the importance of Māori tikanga (cultural) frameworks in suicide prevention initiatives, outlines risk and protective factors for Māori, corrects myths about suicide,
and suggests promotion, prevention and early intervention to enhance protective factors and reduce risk factors.

He Korowai Oranga: Māori Health Strategy (Ministry of Health, 2002) promotes whānau ora recognizing that healthy whānau is the foundation for Māori well-being. It is a holistic strategy that recognises the importance of self-determination and the significance of environmental factors for wellbeing. The strategy focuses on reducing inequalities and achieving whānau ora via four action areas: working across sectors to address determinants of health; supporting whānau, hapu and iwi development; ensuring Māori participation in the health and disability sector, and enhancing effective service delivery. Whakatātaka Tuarua: Māori Health Action Plan 2006-2011 (Ministry of Health, 2006) provides further guidance in each action area.

In 2002 the Ministry of Health also launched Youth Health: A Guide to Action. This action plan proposes a shift in the way the health sector has traditionally seen young people: from being “at risk” and as “a problem to be solved,” to being valued participants in the community’s efforts to create a healthier environment. The action plan takes its cue from the Government’s Youth Development Strategy Aotearoa in recognising that the wellbeing of young people is dependent on healthy connections with whānau, schools, peers, work and training, culture and environment. The broad definition of health explicit in the action plan is consistent with Māori and Pacific models of health. The first four of the ten goals outlined are particularly relevant to mental health promotion.

1. A safer, more supportive environment for New Zealand’s young people
   Young people’s health is affected by what is happening in their families and whānau, with friends and in school. Families, schools, communities, and local and central government agencies all have a role to play in improving young people’s health and keeping them well.

2. A measurable improvement in young people’s mental health
   New Zealand has high rates of youth suicide, particularly among rangatahi, and high rates of mental illness and drug and alcohol abuse. Devising effective ways of keeping young people mentally healthy is a priority.

3. A measurable improvement in young people’s physical health
   Taking risks and trying new things are integral to young people’s lifestyles. Finding ways of reducing the negative outcomes is part of the action plan.

4. Young people influencing health policy and programme development
   Young people want to be actively involved in decisions that affect them and in decisions about their own health care. Programmes and services work better when young people participate in their design and/or delivery.

In 2005, The Ministry of Health launched Te Tahuhu Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan. The strategy outlines desired outcomes for the sector, and a set of ten leading challenges along with priorities for immediate action. Promoting mental health and wellbeing, and preventing mental illness and addiction is presented as the first of the 10 key challenges. Of the five priority actions to overcome this challenge, only two are relevant to mental health promotion as defined in this review: (1) increasing people’s awareness of how to maintain mental health and wellbeing,
and (2) implementing the Government’s strategy to reduce suicide and suicide attempts\(^2\). The strategy states “Looking at risk factors and promoting protective factors that strengthen communities – such as enhanced cultural awareness, sensitivity and competence, affirmation, and promoting access to the resources of mainstream society to encourage full participation in society – are important for the mental health of disadvantaged groups” (MoH, 2005 p8). *Te Kokiri The Mental Health and Addiction Action Plan 2006-2015.* (Ministry of Health, 2005) proposes specific actions under each of the 10 challenges.

*Te Raukura Mental Health and Alcohol and Other Drugs - Improving Outcomes for Children and Youth. Ministry of Health (2007).* The strategy has a clinical rather than a population health promotion focus but does recognise the need for “an increasing role for PHOs in mental health promotion, working to reduce risk factors, and supporting and strengthening protective factors to build resiliency” (p21). The primary focus of this strategy is on continuing to build and broaden the range and choice of services and support for children and youth severely affected by mental illness. Reducing inequalities and improving access to services for Māori and Pacific peoples across the primary to tertiary continuum is also a key aim.

In summary, there is a strong policy mandate in New Zealand for strengths-based mental health promotion. This approach is particularly supported by the *New Zealand Suicide Prevention Strategy (2008), Building on Strengths (2002)* and the *Youth Health Plan (2002)* which all take a holistic and strengths based approach, and are consistent with Māori models of health and international best practice in health promotion. The current mental health policy *Te Tahuhu (2005)* also focuses on the importance of promoting mental health and wellbeing at the population level, and highlights a number of priority actions e.g. increasing awareness of how to maintain mental health, and implementing the suicide prevention strategy for example. High level health policy focuses on the importance of reducing inequalities, addressing the determinants of health and strengthening whānau ora as key strands of any health promotion activity.

2.3.2 International

The World Health Organization (WHO) argues that national mental health policies should not be solely concerned with mental disorders but also recognise and address the broader issues that promote mental health (WHO, 2007). In Europe at least, this message has been heeded.

Positive mental health is increasingly being seen internationally as a valuable asset and resource for long term social and economic prosperity (Barry, 2009, Jenkins et al, 2008). This view is particularly apparent in the UK, where *New Horizons*, a whole-of-government approach to protecting and promoting mental health, was launched in 2009. The vision of New Horizons is “flourishing people and connected communities through the promotion of wellbeing and resilience and the reduction in inequalities”. The new policy is partially based on the outcomes of the Foresight Project (Jenkins et al, 2008) which concluded:

> A key message is that if we are to prosper and thrive in our changing society and in an increasingly interconnected and competitive world, both our mental and material resources will be vital. Encouraging and enabling everyone to realise their potential throughout their lives will be crucial for our future prosperity and wellbeing. (Foresight Project, 2008)

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\(^2\) Although suicide prevention is specifically excluded from the scope of this review, the NZ Suicide Prevention strategy includes mental health promotion as a primary prevention approach.
Scotland has had a national mental health improvement policy and programme in place since 2003, and in 2009 a new policy and action plan was published: *Towards a mentally flourishing Scotland: Policy and Action Plan 2009-2011*. The logic model underpinning this policy is attached in Appendix B. The sits within the health sector, but aims to influence physical, social and economic environments in order to promote good mental wellbeing, reduce the occurrence of mental illness, and improve the quality of life of those who experience mental illness.

Within the EU there is a strong research and policy emphasis on identifying and addressing the determinants of mental wellbeing across sectors. For example, key points from a 2009 conference on promoting child and youth mental health included a focus on adequate paid parental leave, urban planning to ensure good access to leisure activities for young people, and empowering young people to participate in community decision making (*Promotion of mental health and wellbeing of children and young people – making it happen*, Stockholm, Sept 2009). Strengthening child and youth mental health is seen as an investment for the future. ‘Mental health protection and promotion should not be regarded solely as enhancement of wellbeing in children and youth. It is also embracing the future wellbeing of these individuals as adults’ (ProMenPol, 2009)

Australia has placed emphasis on prevention and promotion within mental health policy since the late 1990s (Parham, 2007), and at the national level the model used has been a spectrum of intervention from promotion, to prevention and early intervention, targeted according to needs (see Appendix C). In contrast, VicHealth has been a world leader in adopting a 'determinants of health' approach to promoting mental wellbeing, and locating mental health promotion within the public health rather than the mental health sector. Its mental health promotion framework launched in 2005 (see Appendix D) focused action on addressing three key determinants: social inclusion, freedom from discrimination and violence, and access to economic resources. The latest overarching VicHealth strategic framework, published in 2009, maintains a focus on these three determinants, but no longer under the 'mental health promotion' banner. Presumably it has been recognised that these factors underlie overall wellbeing and are as relevant to physical health as they are to mental health.

In the USA the late 1990s and early 2000s have been described as a time of ‘focus and ferment in regard to youth mental health in America’ (Weisz et al, 2005). The US leads the world in large scale high quality research on effective interventions to reduce risk and promote child and youth wellbeing, however such research largely focuses on individual level assets/risks rather than social determinants of health. In contrast to the US, a 'wider determinants of health' approach is dominant in Canada.

**Cost effectiveness of mental health promotion**

Looking to the future, experts agree that more work on cost effectiveness of interventions is required (Browne, 2004, Zechmeister et al, 2008). Barry (2007) argues that programmes that address clusters of risk and protective factors for a range of health and social behaviours represent sound economic investment, as they are capable of producing wide social and economic gain. This view is supported by economic modelling which predicts that effective mental health promotion will result in enormous economic benefits (Aked et al, 2009). However high quality cost benefit analysis of actual interventions is sorely lacking. What little evidence is available suggests the most favourable results are related to early childhood development programmes (Zechmeister et al, 2008). Focus on shared risk/protective factors across sectors (e.g. education, justice, health, social welfare) and embedding of mental health promotion elements within other programmes (e.g. education sector, physical health promotion) has been suggested as a way of gaining efficiencies (Jane Llopis & Barry, 2005).
3. Key findings from the evidence review

3.1 Is mental health promotion in young people aged 12-24 effective?

Reviews of programme evaluations show that interventions designed to promote young people’s social, emotional, behavioural and cognitive development can successfully enhance skills and assets associated with mental wellbeing (Browne, 2004; Keleher & Armstrong, 2005). The UK Foresight project proposes that “achieving a small change in the average level of wellbeing across the population would produce a large decrease in the percentage with mental disorder, and also in the percentage who have a sub-clinical disorder” (Jenkins et al, 2008, p24). Evidence indicates that such programmes can indeed contribute towards the prevention of mental health problems (Casswell et al, 2007b; Weisz et al, 2005) and suicide (Keleher & Armstrong 2005). Furthermore, strengths-based interventions that aim to build core competencies in youth can be successful in preventing specific risk behaviours such as high risk sexual behaviour, school failure and early school leaving, youth violence, and substance use (Casswell et al, 2007c; Guerra and Bradshaw, 2008; Hilkene Bernat & Resnick, 2006; Weisz et al, 2005). These risk behaviours may be both a cause and a consequence of poor mental health (Pollett, 2007).

Programme effectiveness varies by age. Younger children (pre-school or early primary school) generally benefit more than older children, but some programmes for older children are also effective (Browne et al, 2004; Pollett, 2007). A recent New Zealand review of youth development programmes concluded that “when done well, the impact of youth development programmes appears positive but modest” (Ministry of Youth Development, 2009). Research on child development shows that by 12 years of age identity and behaviour patterns are strongly established and resistant to change. There is wide agreement in the literature that earlier intervention (even from birth) is recommended to set children up for lifelong mental wellbeing (Jenkins et al, 2008; ProMenPol, 2009).

Programmes to develop protective factors (generally by increasing competence and skills) produce better results than programs to reduce existing negative behaviours (Browne et al, 2004; Jane Llopis & Barry, 2005), though it is not clear whether this finding is independent of participant characteristics. Participants of universal strengths-based programmes are likely to be younger and have higher average functioning than participants of programmes targeted at those with already established problem behaviours, and this could partly explain the results.

3.2 What outcomes should youth MHP programmes focus on?

This section relates to the aims and objectives of a youth mental health promotion programme.

Enhance the positive, reduce the negative. Evidence suggests a dual approach of promoting protective factors (e.g. enhancing skills and supportive environments) while also reducing risk factors (e.g. alcohol and drug abuse, family violence) is likely to be the most effective in the long term (Hilkene Bernat and Resnick, 2006; Ministry of Youth Development, 2009).

Address both individual and environmental factors. It is widely agreed that wellbeing is influenced both by skills and attributes of the individual, and by environmental factors such as the support of caring adults, opportunities for skill development, a stable and non-violent home environment, and employment.
opportunities for example. One review found programmes that solely focus on individual behaviour are
less likely to be effective than those that also address environmental factors (Casswell et al, 200?b). Progrmames that fail to address structural barriers to wellbeing (e.g. poverty, unemployment) are likely to
increase inequalities, since such barriers to wellbeing disproportionately affect disadvantaged youth
(Oliver et al, 2008).

Use both universal and targeted interventions. The evidence calls for universal interventions to bolster
protective factors and for tailored, long term, timely interventions for high risk young people (Browne et al,
2004; Casswell et al, 200?b).

*Individual assets and competencies*

Various mental health promotion and youth development reviews have produced sets of individual-level
assets and/or attributes that are associated with positive youth development and mental wellbeing. Most
of these findings are based primarily on US research. These lists have much in common, although each
is worded and framed slightly differently.

For example the Canadian Centre for Addiction and Mental Health recommends a focus on skill building,
empowerment, self efficacy, individual resilience, and respect (CAMH, 2007).

A recent New Zealand review concluded that for positive youth development to occur young people need
opportunities to: 1) experience supportive adult relationships; 2) learn how to form close durable
relationships with peers that support healthy behaviours; 3) feel a sense of belonging and being valued;
4) develop positive social values and norms; 5) build and master skills; 6) develop confidence in abilities
to master one’s environment (efficacy); and 7) make a contribution to one’s community. In this review,
personal planning, incorporating meaningful goal setting activities, was seen as a critical element of
successful structured youth development programmes (MYD, 2009).

Based on an extensive review of the youth development literature, Guerra & Bradshaw (2008, p1) argue
healthy adjustment in youth is linked to five core competencies: (1) positive sense of self, (2) self control,
(3) decision making skills (4) a moral system of belief and (5) pro-social connectedness. They point out
that these skills and competencies may have distinctive meanings in specific cultural contexts. For
example, good decision making skills in a Māori context may mean an emphasis on collectivity and group
values whereas Pakeha may value independent thinking and logic to a greater extent.

After reviewing the evidence, Hilkene Bernat & Resnick conclude that attachment and connectedness to
family, other adults, school and community are robust, recurring protective factors across a variety of
studies and youth sub-groups (Hilkene Bernat & Resnick, 2006).

Browne et al (2004) argue the key mediators of positive youth development are: engagement, support,
identity, competence, and efficacy. The foundations of resilience are described as the three Cs: caring
people, confidence in self worth, and good coping skills.

In their review of reviews, Casswell et al (200?b) found that successful outcomes for young people were
associated with programmes that aimed to strengthen social, emotional, behavioural, cognitive, and moral
competencies; build self-efficacy; and increase bonding with adults, peers, and younger children. Positive
changes in self esteem, social skills, coping abilities, and interpersonal problem solving were associated
with positive mental health outcomes.
**Behavioural outcomes**

Modifying and measuring behavioural outcomes (e.g. alcohol use, academic achievement, contribution to the community, and physical activity) that are correlated with mental wellbeing may help to promote current and future mental wellbeing.

Alcohol and drug abuse is identified as a key risk factor for young people in the 12-24 age group (Mental Health Foundation, 2004; Jenkins et al, 2008). Mental health problems and problems with living (e.g. criminal justice sector involvement, school failure) may be both a cause and/or a consequence of drug and alcohol use in young people (Jenkins et al, 2008). Evidence suggests that focusing on generic skill development and enhancing other protective factors is more effective than traditional ‘health education’ approaches to addressing drug and alcohol use.

Academic success is associated with positive outcomes in the short and long term, whereas school failure is associated with long term social exclusion and poor mental health outcomes. Like drug and alcohol abuse, academic failure may be a cause and/or a consequence of poor mental health. Comprehensive support systems that focus on peer and parent-child relations and academic performance are seen as important mental health promotion elements (CAMH, 2007; Jenkins et al, 2008). The UK Foresight study recommends identification and early treatment of learning difficulties as part of a national approach to improving mental wellbeing through the life course (Jenkins et al, 2008).

There is emerging evidence that physical activity may have self-esteem and self-concept benefits for children and adolescents, as well as other well known benefits for mental, social and physical health (Keleher & Armstrong, 2005). There is some evidence that involvement in sport is associated with reduced risk of substance abuse and other risky behaviours in young people (Keleher & Armstrong, 2005).

**Environmental level outcomes**

While there is wide agreement that interventions should address both individual and environmental factors, there is little empirical evidence about the effectiveness of environmental level interventions. However research into the determinants of wellbeing suggests the following environmental factors may be important:

Supportive home, school, workplace and community environments. There is consistent evidence that positive and enduring relationships with adults enhance young people’s mental wellbeing and support resilience. Based on this evidence, the Canadian Centre for Addiction and Mental Health recommends training non-professionals to establish caring and trusting relationships with young people (CAMH, 2007). Parenting programmes have been shown to be effective in promoting young people’s wellbeing, though evidence is strongest in relation to antenatal and preschool programmes (Jenkins et al, 2008). Training for teachers and front line professionals in adolescent learning and development has also been suggested as a key strategy to promote supportive environments (Jenkins et al, 2008). Strengthening community networks and support has also been suggested (Mental Health Foundation, 2004).

Prevention of violence. Reducing exposure to violence is an important aspect of creating supportive environments. Violence prevention is a recommended component of a comprehensive mental health promotion approach (Mental Health Foundation, 2004; Oliver et al, 2008; Keleher & Armstrong, 2005).
There is consistent international evidence that whole-of-school bullying programmes can be effective (Weisz et al, 2005).

**Housing quality.** The relationship may not be causal, but poor housing is associated with poor mental development in children. Housing quality may be a proxy for a range of other factors (family stability, poverty, stress) that impact on development (Jenkins et al, 2008; Mental Health Foundation, 2004).

**Youth employment.** The health benefits of employment and health risks of unemployment are well established in the literature. Young people consistently identify lack of employment opportunities and lack of money as barriers to mental wellbeing (Oliver et al, 2008; Edwards et al, 2003).

**Debt.** Recent UK research shows that debt is a much stronger overall risk factor for mental disorder than low income (Jenkins et al, 2008). Young people in the 18-24 age group may experience credit card debt or student loans as a barrier to wellbeing, however there is no evidence currently available specifically focused on debt and young people.

**Inequalities.** The social gradient associated with mental illness is well documented, and it is likely that mental wellbeing is also unevenly distributed in the population, with those who are materially well off enjoying better mental health on average than socioeconomically disadvantaged groups. Increased access to resources/services, environmental modification, and legislation/ regulation may be important strategies for reducing inequalities, since socially excluded young people identify more barriers to wellbeing in these areas than other young people (Oliver et al, 2008).

### 3.3 What are the characteristics of successful interventions?

Not all interventions are successful, but current empirical evidence about the particular components and characteristics associated with success is limited. According to Weisz et al, “At present we know much more about what outcomes are produced by our interventions than about what actually causes those outcomes” (Weisz et al, 2005: 641). One UK systematic review found no clear pattern of effectiveness in terms of mental health promotion focus or intervention type (Oliver et al, 2008).

Although hard evidence is limited, a number of reviews and guidelines highlight factors believed to be associated with success. These findings are generally based on qualitative evidence (e.g. opinions of professionals and young people about what made the intervention successful), theoretical models, and expert opinion. Key success factors are summarised below.

**1. Holistic approach, addressing both the environment and the individual**

Interventions should be holistic, addressing the whole person, rather than focussing on a single problem behaviour (CAMH, 2007; Browne et al, 2004). Evidence indicates that supporting positive youth development using a strengths-based approach may be more effective for achieving behavioural outcomes than interventions specifically designed to target alcohol and drug use or sexual health behaviour for example.

A holistic approach also means awareness of the contexts in which young people live – at home, at school and tertiary institutions, workplaces, the community and amongst peers. This approach is consistent with Māori models of health, e.g. Te Whare Tapa Wha. Research shows that interventions that address ecological/ external influences are more likely to promote positive adjustment in young people (Guerra & Bradshaw, 2008). The well-researched ‘resiliency’ construct emphasises the importance of
factors extrinsic to the individual e.g. connectedness to family, school, and community (Hilkene Bernat & Resnick, 2006).

Success of mental health promotion interventions is likely to be limited if underlying socio-political issues that lead to poor health and inequalities (poverty, unemployment, poor housing etc) are not addressed (Browne et al, 2004; Casswell et al, 2007; Mental Health Foundation, 2004, Oliver et al, 2008). Examples of effective interventions at policy level include measures to reduce poverty, improving high-quality affordable housing, access to high quality education, improving nutrition, taxation of addictive substances, and regulatory policy in workplaces (Pollet, 2007).

Collaboration across health, social services, child care, recreation, education, labour, corrections, and social housing sectors would increase efficiency and coherence of mental health promotion interventions for children and young people (Browne et al, 2004).

2. Culturally appropriate, and tailored to age level and gender

Developmentally appropriate interventions that build on current skills are crucial (MYD, 2009). The values, priorities, experiences and needs of young people vary according to gender and culture as well as age. Research indicates programs that are sensitive to gender (Browne et al, 2004) and cultural differences are more effective than ‘one size fits all’ approaches (Browne et al, 2004; CAMH, 2007; Guerra & Bradshaw, 2008; MYD, 2009; Pollett, 2007; Weisz et al, 2009).

An important aspect of tailored programmes is the use of language that is meaningful and acceptable to the target audience. For example a UK review found that young people equate the term ‘mental health’ with ‘mental illness’ and do not see it as relevant to their own lives (Oliver et al, 2008).

Another aspect of a tailored approach is to design engaging activities to capture the attention of young people. Research shows that interactive activities that stimulate discussion and action are more effective than direct instruction (Browne et al, 2004; Guerra & Bradshaw, 2008).

3. Comprehensive approach: Multiple interventions in multiple settings and domains

There is generally agreement in the literature that effective interventions for school aged children should address their needs and involve the multiple domains and support systems in their lives. Programmes with multiple, integrated elements across more than one domain (family, school, community) are more likely to be successful than single focus, single domain interventions (Browne, 2004; Casswell, 2007; CAMH, 2007). The most effective programmes are often those which build and maintain strong links between families, schools and broader community resources (MYD, 2009).

4. Long term

According to Canadian guidelines, the best programmes demonstrate a long-term commitment to programme planning, development and evaluation (CAMH, 2007). Long term interventions (from several months to years) are more likely to be effective than one-off or short intensive interventions (Browne et al, 2004; Casswell et al, 2007b, Jane Llopis & Barry, 2005). Post-intervention effect sizes decrease over time, suggesting the need for periodic reinforcement (Browne et al, 2004).

Consistent adult staffing or a stable relationship with a mentor were found to be important aspects of effective programme delivery in one review (Browne, 2004). Another review also identified empathetic staff who stay long enough to build and maintain trusting relationships with young people as a key success factor (MYD, 2009).
Although in general longer interventions are more successful than short term ones, one review notes that the intensity of the intervention should match the intensity of the need (Hilkene Bernat & Resnick, 2006). This is an important principle to bear in mind in terms of programme efficiency. Young people who have the benefit of supportive environments may need little or no structured intervention in order to flourish, whereas those experiencing multiple challenges and disadvantages are likely to require sustained and intensive intervention to counteract adversity.

5. Informed by theory and research

The content, structure and implementation of successful implementations should be grounded in sound theory and research (Browne et al, 2004; Hilkene Bernat & Resnick, 2006; Jane Llopis & Barry, 2005; Barry 2007).

6. Youth participation and leadership

A strong theme in the literature is the importance of youth involvement in the design and delivery of programmes. One review concluded successful programmes meaningfully involve young people in choosing and designing activities (MYD, 2009). Age appropriateness of youth participation is key, with increasing opportunities for young people to make decisions and to take on leadership roles as they mature and gain more expertise (MYD, 2009). A detailed description of a youth participation model used successfully in Australia is provided in Biedrzycki & Lawless (2008).

Research shows peer mentoring can effectively promote favourable academic and social behaviour and social skills in early intervention programmes. However peer mentoring is less reliable for general competencies and skill maintenance (Browne et al, 2004).

7. Skilled and competent workforce

A recent New Zealand youth development review highlighted the importance of having a skilled and competent workforce and staff that interact with young people in a way that optimises learning and growth (MYD, 2009). More specifically, the literature highlights the importance of programme staff having high aspirations for, and expectations of, young people (MYD, 2009).

Training and support for staff delivering mental health promotion initiatives has been identified as a key success factor in programme implementation (ProMenPol, 2009).

3.3.1 School specific success factors

The majority of intervention research is on school based interventions. Key findings specific to schools are summarised below.

According to a Canadian literature review, “The most successful school based interventions target many risk factors and health outcomes and take a long term, whole of school approach to mental health promotion [...] By building coping and social skills, and by creating a positive safe environment that fosters a sense of inclusion, identity and connectedness amongst students, interventions result in improved adjustment to school, enhanced competence, self-esteem, increased control and problem solving skills, improved school achievement, and decreases in loneliness, learning problems, bullying and aggression and depression and anxiety” (Pollett, 2007 p4).
Research shows a whole school approach - particularly where families and community are involved – is more effective than topic based interventions with a sole focus within a school’s curriculum (Casswell et al, 2007b; Casswell et al, 2007c; Jane Llopis & Barry, 2005; ProMenPol, 2009; Keleher & Armstrong, 2005). A whole school approach means a comprehensive and integrated set of strategies to create change, including school-wide environmental change, parental involvement and community-wide interventions. This approach ensures that the Health and Physical Activity Curriculum is reinforced by school policies, procedures and practices (Casswell et al, 2007c).

Bullying prevention provides one example of a whole school approach. Best practice in this area involves establishment of school policies and classroom rules against bullying, improving supervision during breaks, curriculum work, peer support schemes, and direct intervention with bullies and victims involving parents of both. Such an approach has been consistently successful in reducing bullying and improving the overall school climate in Norway, the USA, UK, Canada and Australia, although it should be noted interventions at primary school level are more successful than those with adolescents (Weisz et al, 2005; Keleher & Armstrong, 2005).

Evidence suggests the ethos and climate of school is integral to the success of school-based mental health promotion initiatives (Casswell, 2007b). Another review noted the level of support from the principal and administrators can have a critical impact on success or failure (Jane Llopis, 2005).

One set of guidelines developed in Europe makes the following suggestions for successful mental health promotion in the school setting: integrate MHP into the curriculum; begin interventions early; employ age appropriate interventions; promote self esteem, self confidence and life skills; provide personal support, guidance and counselling; build warm relationships; set clear rules and boundaries; encourage youth participation and autonomy; involve peers and parents in the process; create a positive climate or school ethos; take a long term, developmental approach; avoid language that is stigmatising and use age-appropriate and meaningful language (ProMenPol, 2009).

### 3.3.2 Community setting success factors

Participation and collaboration is a key principle in community based health promotion. Jane-Llopis and Barry argue that change is more likely to come about when the people and organisations it effects are involved in the change process (Jane-Llopis & Barry, 2005). Therefore community mental health promotion practice should be shaped by evidence and the opinions of individuals and communities most affected.

Jane Llopis & Barry (2005) identified a number of key elements of effective community partnerships including shared goals, clear roles, and clear lines of communication. Building core competencies and capacities in partnership organisations was also seen as critical, e.g. skills in communication, management, facilitation and evaluation.

Addressing wider determinants of health, Barry (2007) outlines a number of development projects that resulted in mental wellbeing gains, along with a range of other positive health and development outcomes including better nutrition, higher educational achievement and reduced domestic violence. These include development of community banks in low income countries and community development programmes targeting poverty, inequality and gender discrimination. These successful programmes suggest that empowerment of disadvantaged groups through greater economic and social participation can lead to
positive mental health outcomes, either directly or via determinants such as domestic violence, and educational achievement.

Community Arts. The following key success factors for community arts projects in Victoria (Aust) have been identified through evaluations: (1) project research and planning to identify community interest and engagement; (2) achievable project goals; (3) an environment supportive of participants and the creative process; and (4) appropriate skills/experience in the project team. Outcomes for individuals included: development of positive relationships; gaining of public recognition; gained sense of identity; enhanced skills; enhanced career opportunities. Benefits of participation for organisations included: enhanced reputation and community support; enhanced intersectoral relationships particularly between health and arts sectors; greater appreciation of the links between health and arts (Keleher & Armstrong, 2005).

3.3.3 Workplace setting success factors

A high proportion of 12-24 year olds are employed either part time or full time, therefore the workplace may be an appropriate setting for mental health promotion interventions with this age group. Having said that, the literature did not include any examples of or evidence relating to youth-specific workplace mental health promotion programmes.

Overarching principles for successful all-age programmes in this setting are a dual focus on individual and organisational level interventions (Jane Llopis & Barry, 2005) and a participatory approach that engages employees, employers and management structures (Jane Llopis & Barry, 2005; Keleher & Armstrong, 2005). Organisation wide approaches that enhance job control, encourage workload management, clarify roles and involve policies to tackle bullying and harassment have been demonstrated to be effective (Keleher & Armstrong, 2005).

Youth employment programmes. In many countries including the UK, Australia and New Zealand, youth unemployment is consistently higher than unemployment for those aged 24-65. Youth employment programs target young people, particularly early school leavers and marginalised youth, and may focus on building numeracy and literacy as well as confidence, goal setting, job search skills and relationship skills. Some programmes may include work experience and/or job placement. There is some evidence that participation can lead to positive mental health and wellbeing outcomes, however employment outcomes are not reported (Keleher & Armstrong, 2005). Success factors include: (1) youth participation in planning and decision making; (2) strengths based approach; (3) interventions provide concrete and immediate benefits for participants e.g. income and public recognition of the value of their efforts; (4) interventions must be conscious of establishing sustainable social and economic security for youth (5) activities should be purposeful for both youth and communities (Keleher & Armstrong, 2005).

3.3.4 Media Campaign success factors

None of the reports in the current view covered the effectiveness of mental health promotion media campaigns targeting young people.

One review identified two overarching principles applicable regardless of age of target audience: (1) Media campaigns to influence knowledge and attitudes about mental health are more effective when complemented by a mix of long term community based interventions; and (2) effective audience
segmentation is crucial and requires the development of culturally competent and age-appropriate materials and practices (Keleher & Armstrong, 2005).

Another report examined the evidence base for the use of ‘positive steps’ messages to promote mental wellbeing amongst adults (Friedli et al, 2007). Aked et al (2008) also reviewed the evidence to identify five everyday actions people can take to improve their mental wellbeing: connect, be active, take notice, keep learning, give. Their applicability to all age groups (including youth) was one of the criteria for selection.

A recently completed New Zealand review, *What works in social marketing to young people?* (Thornley & Marsh, forthcoming), may provide further evidence-based guidelines for youth-specific media campaigns.

### 3.4 What doesn’t work?

Certain methods of programme delivery are associated with lower effectiveness and/or poor outcomes for young people.

Programs that only deliver information tend to be ineffective (Brown et al, 2004) and traditional topic-based classroom learning approaches to health promotion are of limited value (Jane Llopis & Barry, 2005). For example, one review found short term knowledge building sessions did not improve long term depressive symptoms, risk factors, knowledge, attitudes or intentions (Oliver et al, 2008). Similarly curriculum teaching about suicide and depression was not effective for knowledge, stress, anxiety or hopelessness (Oliver et al, 2008).

Individual behavioural approaches have been found to be less effective than interventions that address both the individual and the environment and/or focus on generic skills (Casswell, 2007b). Focusing on generic coping and competence skills using interactive and participatory methods has been shown to be more effective than focusing on problem behaviours (Jane Llopis & Barry, 2005).

Fear inducing interventions (e.g. ‘shock incarceration’ programmes) seem to be ineffective (Brown et al, 2004).

Unstructured youth activities (e.g. youth clubs with no particular aim or focus) are associated with poor immediate and long-term outcomes for the young people involved (Ministry of Youth Development, 2009).

### 3.5 Effective mental health promotion for rangatahi

As noted above, cultural appropriateness is an important feature of successful mental health promotion interventions. This section explores the evidence for effective mental health promotion for rangatahi. Because the evidence specifically relating to Māori is limited, this section of the review is at a more detailed level, and includes less recent and less robust research methods than the previous section which was based on review-level findings.

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3 Robustness is defined according to the internationally recognised “hierarchy of evidence” which considers cross-sectional studies and qualitative findings as relatively weak forms of evidence compared with randomised controlled trials, and systematic reviews. It should be noted that this hierarchy of evidence has been strongly
3.5.1 Evidence about resilience and wellbeing contexts for rangatahi

Kiri Merritt (2003) undertook empirical research and identified a number of individual, familial, and external factors that contributed to the educational success and resilience of young Māori girls.

In line with international research, Merritt found strong positive relationships with adults other than parents (particularly extend whānau) was a significant protective factor for Māori girls. Even where the nuclear family situation was not optimal, connections with other adults had a strong buffering effect against adversity. Merritt states “The most striking finding from this research was the impact a significant female family member had on enabling the girls to become resilient despite their adverse background” (2003, p109). The type of support that these adults (often an aunty, nan or older sister) provided was their ability to make the girls feel comfortable in their presence, as well as the unconditional love and nurturance they gave them. The participants rarely mentioned supports outside the whānau, but in the few cases where external support systems were identified in the girls’ narratives, they ranged from school and friends, to counseling and spiritual support.

The study also showed there are individual attributes characteristic of resilient Māori girls. According to Merritt “These include a communication style that is open and honest, a caring and helpful nature, the ability to be self-reflective, a positive approach to life, and a maturity beyond their years. In addition to these attributes, the psychosocial competence results showed the girls to have an active orientation towards engaging in life events” (Merritt, 2003:109).

Merritt concludes:

In summary, the results of this research show a promising path for enabling Māori girls to succeed despite backgrounds of hardship and adversity. This research shows the need to emphasise that adverse environments do not have to determine the path in life one is going to take. In stating this, communities and wider society need to offer these girls opportunities for extra support, so that they do believe they are capable of success, in whatever manner each individual defines this (2003, p109).

Qualitative research by SHORE as part of the Health Research Council-funded project Theorising Youth Mental Health Promotion (Edwards et al, 2003) gives insight into Māori, Samoan and Pakeha young people’s perceptions of wellbeing and the social context within which wellbeing is achieved (or not). A total of 27 interviews were conducted with Māori aged 10-24 living in Counties Manukau. At the time of the interview, about half of the participants were attending school or a tertiary institution. Nine participants reported that they were in full time employment and two participants reported being unemployed. Three females reported being at-home mothers.

Māori Identity. Findings support Durie’s assertions about deculturation: participants felt they had been disadvantaged by not having access to things that they identified as part of their culture; they felt that they lacked knowledge, which led to self-doubt. All the participants said that images including media representations meant that Māori were viewed by society, and by many Māori themselves, as an inferior people. They felt that in many instances it was embarrassing to be Māori but they still wanted to identify as Māori. One of the positive cultural traits identified by participants was collectivism. Being part of such a group was identified as a very fulfilling intergenerational experience. For many of the Māori youth there critiqued by indigenous and feminist researchers and epistemologists who question the validity of its underpinning assumptions.
was little contact with their marae due to travel distance and it was often the death of grandparents that brought them into contact with their ancestral roots. For many this required a return to their marae to bury their elders. This also meant that the limited experience they had of their marae was surrounded in grief. As a result many still held a myriad of thoughts and feelings towards their marae that affected their sense of connection with it and their identity as Māori. Many of the participants felt that although these times of grief were difficult, their families bonded together strongly to fulfill their requirements in meeting the duties to their elders. A large number of youth also enjoyed the ability to openly grieve and shed tears. For males this provided an experience where they would not be judged or labeled if they openly cried.

**Connectedness.** International literature on resilience emphasises the importance of youth connectedness to family, peers, school and community. The role of connectedness in subjective wellbeing is also supported by this New Zealand study. Māori participants were all in agreement that the most traumatic experience of their youth was moving house or location and relocating somewhere else. The major disadvantage of this was leaving behind friends they felt they would never see again due to physical distance. The young people talked of sadness at having to leave friends they had bonded with. Many said they were never consulted on the move and felt they were not given enough time to prepare. Other memories of growing up for many Māori youth centred round parents splitting up. This caused major turmoil in the lives of the participants as they were made to choose between parents, had no one they could talk to about the situation, and felt insecure and uncertain. The participants talked of growing up as a time when they felt connected with a large variety of people, places (where they lived, friends’ houses, parks) and things as they formed meaningful relationships. They talked of their feelings of anger, pain and frustration as the connectedness was removed and usually they were powerless to prevent it.

**School.** Memories of school, particularly secondary school, tended not to be happy amongst Māori participants. Name-calling, embarrassment, failure and pressure associated with school featured heavily as the participants grew up. Participants could all identify what a good teacher was; someone who cared, showed an interest and who could relate with them at their level. This was described as coming across to the students rather than the students having to come across to the teacher. It was also seen as important that teachers knew the latest language, looks, phrases, music and things that are integral parts of Māori youth culture.

**Work aspirations.** Regarding work, the majority of participants wanted to go further than their parents had in employment. None wanted to be employed in manual labour. Participants had many ideas about what they wanted to do or be but were largely unsure how they might achieve this. Their aim was to ensure a well paying job that carried with it status that identified them as successful rather than poor. The participants wanted to experience something different from what their parents’ status offered them. Those who were working were not in the professions they had envisaged or were not happy with their current jobs. The choice to stay in these jobs was driven by the shortage of opportunity, lack of required skills and their current need for money. Many at this stage felt life offered them little. However, they had become resigned to the situation and were not taking action to bring about changes.

**Money.** Economic power was of huge importance to the Māori youth and was perceived as directly related to personal power through enabling choices, for example to work or not, where or where not to live, and where to shop and what to buy. Many saw money as a means of escape from their monotonous and mundane existence, so that for a period they could ‘enjoy’ life and achieve status amongst their peers.
Violence. The Māori participants who had experienced physical violence said this usually happened within the family. Many said that they themselves had been victims at a young age. Many of the males said they were violent themselves and one of the more commonly recalled memories was of reacting to an older sibling or father’s dominant role by reacting physically to break this role. Most of the violence the participants experienced occurred when alcohol was present. Violence among siblings and cousins was seen as a natural and normal part of family behaviour. This was often of a physical nature and centred round disputes of property, space and rights. Many felt powerless when they were victims of abuse and vented their anger by withdrawing, destroying property or getting drunk and fighting. Violence among peers often involved issues of image and group respect.

Coping. Māori participants saw being able to handle anger as a key life skill. Participants said anger was a short-term thing and sadness was longer term and had the ability to make them weak. When relationships with partners ended this was hard to deal with emotionally, especially for males, and spending time with same-sex friends was a key coping strategy. Very few talked to their parents about these emotions or saw parents as a source of support in this area, mainly due to fear and embarrassment. The youth did not believe they had been prepared appropriately enough for the many of the challenges they faced. They felt they were prepared for things other people prioritised, but not for failure, disappointment, rejection, anger and other emotions. They felt if they had had these skills a lot of things would have been different for them.

Recreation. At the school level, sport was played for fun and as a way of being with friends. Sport was also a way for families to interact through supporting each other. Māori male participants recognized that sport was a vehicle for being accepted and popular and for achieving success, by being acknowledged and held in high esteem by others. With this came pressure to continually perform well to maintain this level of popularity.

3.5.2 Evidence of ‘what works’ for rangatahi in practice

The current review identified two relevant New Zealand reviews (a background paper to the Kia Piki Te Ora Suicide Prevention Strategy, and a literature review for ACC on indigenous injury prevention and health promotion interventions) and three evaluation studies of New Zealand health promotion programmes aimed at Māori youth. Findings from each of these five studies are presented below, along with international findings about ‘what works’ for indigenous youth.

Review Level Findings

International research shows that programs for indigenous children have more positive results when they use traditional knowledge and modes, are based on community initiatives, and involve both family and community (Browne, 2004).

In the New Zealand context, one review (Cherrington & Masters, 2005) identified three overarching themes contributing to the success of indigenous health promotion interventions: (1) the need for consultation and community-driven programmes; (2) holistic frameworks and (3) coordinators building strong community networks. These findings were based on both New Zealand evaluation studies and international research on indigenous health promotion, and are general rather than specific to youth programmes or mental health promotion programmes.
Lawson (1998) draws on both theory and international empirical research in her background paper to Kia Piki Te Ora, New Zealand’s Māori Youth Suicide Prevention Strategy published in 1998 (which has now been superseded). Although suicide prevention is outside the scope of the current review, this paper has been included because of its strong focus on health promotion principles (i.e. positive youth development and positive Māori development). Lawson summarises principles and lessons learned internationally including:

- Each community has the potential capacity to build on its strengths. Healthier communities that have identified their own strengths and built on them have less destructive behaviour.

- Māori health development should be led by Māori, and address Māori priorities, with an emphasis on whānau, hapu and iwi development.

- Rangatahi should be central to the design of interventions, and interventions should recognise the diversity amongst Māori youth.

- Address the whole community, not just ‘problem’ youth. Attention given at time of crisis is too late.

- Successful indigenous programmes internationally have focused on skill-building e.g. communication skills; personal and community goal setting; community development; use of indigenous cultural knowledge and practices e.g. involving elders in programme delivery; and integration of traditional elements with contemporary realities.

- Evaluation tools should be established which measure behaviour changes in individuals as well as communities.

**Review of Manawa ora o nga taiohi. Canterbury Region.**
This Mental Health Foundation sponsored programme consists of a marae-based kaupapa Māori wananga for rangatahi aged 13-18 aimed at strengthening Māori identity, strengthening confidence and esteem, promoting whānau wellbeing, leadership, and encouraging rangatahi to access services and iwi networks that support resilience. The service was reviewed by Te Rau Matatini (Te Rau Matatini, 2009). Based on self-report by participants, the researchers found that the outcomes for taiohi (youth) contributed positively to wellbeing, cultural identity, and self-esteem. According to the review, this can be largely credited to the style of delivery of this programme which consisted of kaupapa Māori style wānanga that engaged learners in a way they found to be applicable to their everyday lives. The programme was developed to support local level community needs, and the review states it has clearly achieved this goal. Programme leaders acknowledge extrinsic challenges like high rates of youth unemployment in the region continue to have a detrimental effect on wellbeing. Limitations of the review – it is based on qualitative self-report which is considered a relatively weak form of evidence. Long term outcomes of participation in the wananga are not known.

**Evaluation of Stand Up! South Auckland.**
Stand Up! is a school based initiative aimed at improving resilience, health and social wellbeing of young people whose lives are adversely influenced by alcohol and/or other drug use. The programme is a partnership between Counties Manukau DHB, Odyssey House and six decile one and two schools in South Auckland, and was evaluated by Resonance Research (JakobHoff et al, 2008). Stand Up! was developed as a mainstream rather than culturally specific programme, though it delivers services to predominantly Māori and Pacific Island young people. Over 40% of participants identified as Māori. The initial design and development of the Stand Up! Pilot programme had limited inclusion or participation by Māori, whānau, hapu, iwi or other Māori organisations. As a result Māori concepts did not inform the initial
design of Stand Up! The programme as a whole, and its organisational structure, policies, procedures, staff recruitment and training are yet to be developed to reflect and embed cultural responsiveness. The evaluation used robust qualitative and quantitative methods and found young people and school staff were universally positive about the programme which was being delivered according to its values and principles. Based on scores on the SCS (Substances Choice Scale) and SDQ (Strengths and Difficulties Questionnaire) and self report, there were no negative outcomes associated with the programme. Positive outcomes included: staff and young people reported confidence and skills had been gained as a result of participation; young people felt happier and calmer; staff reported transference of new skills to other parts of their lives; alcohol/other drug use decreased or stayed the same in 80% and 96% of cases respectively; staff reported that participants’ engagement with school had improved, along with academic achievement and classroom behaviour. Based on staff survey, 70-90% of participants made positive changes on each of 12 measures included in the survey. Limitations of the evaluation: frequency but not quantity of alcohol/drug use was measured so reductions in the amount young people were drinking/using would not have been picked up. Results by ethnicity are not provided. Long term outcomes are unknown. It is also important to note that in this evaluation “effectiveness” is measured using mainstream instruments and perspectives that do not necessarily reflect Māori values, aspirations or priorities. As noted in section 2.2 above, the effectiveness of mental health promotion for Māori should be judged according to Māori values and aspirations, not solely on universal measures. The results of this evaluation should therefore be treated with caution when considering ‘what works?’ for rangatahi.

**Evaluation of Te Ahurei a Rangatahi Sexual Health Programme. Hamilton**

Te Ahurei a Rangatahi is a peer education programme in which education sessions on sexual health issues are led by peer facilitators. The programme targets rangatahi and employs a Māori cultural framework to facilitate and convey information. The evaluation found that the agency overall appears to have a good reputation amongst community stakeholders and the programme is meeting a need within the community. The rangatahi found the education sessions informative and found the peer educators approachable, empathetic, close in age, and able to "still see life as we see it". The use of games and activities made rangatahi feel included in the session and grabbed the participants’ attention. The impact of the programme on rangatahi was evaluated via a pre- and post- participation surveys on sexual health knowledge and attitudes. Overall, rangatahi perceived themselves to be less informed about sexual health matters after participation in the programme. This suggests that in the Te Ahurei a Rangatahi programme has the effect of reducing what was possibly an inflated view of what rangatahi felt they knew about sexual health and wellbeing. After participating, rangatahi felt more confident about talking with their partner or their parents about sexual matters. Sexual health behaviour (e.g. condom use) was not measured. It should be noted that this review was undertaken nearly a decade ago, and findings may be less relevant in the current environment.

It is difficult to draw firm conclusions based on the five studies included in this review, since each has a very different focus and methodology and there is no obvious pattern in the results. A strong theme in the literature on indigenous health promotion is the importance of self determination, Māori participation, and a kaupapa Māori approach to programme activities. In line with this, the kaupapa Māori approach was deemed to be an important success factor in the Manawa ora o nga taiohi and Te Ahurei a Rangatahi programmes. There is also evidence that generic programmes such as Stand Up! can effectively achieve the programme aims they set out to achieve, however unless Māori values and aspirations are incorporated into the programme aims, “effectiveness” from a Māori perspective remains questionable.

The evidence suggests that there is a range of quality factors and success factors that need to be considered when designing programmes targeting Māori youth, including - but not limited to - Māori
participation and cultural responsiveness. The generic characteristics of successful programmes outlined in 3.3 are also likely to be important.

3.6 Best practice in programme design, implementation and evaluation

In designing and implementing a mental health promotion strategy it is crucial to take into account those principles of programme design, implementation and evaluation that are more likely to lead to programme efficacy (Jane Llopis & Barry, 2005). Various sets of guidelines are available, for example:

- Best practice guidelines for directing interventions for children and youth (CAMH, 2007)
- Manual for promoting mental health and wellbeing: The educational setting (ProMenPol, 2009)
- Planning, monitoring and evaluating mental health promotion (VicHealth, 2005)
- Generic principles of effective mental health promotion (Barry, 2007)
- Guide to Developing Public Health Programmes (Ministry of Health, 2006)

These guides identify a number of programme design and implementation characteristics associated with successful interventions, including:

- Programme development based on underpinning theory, research, and needs assessment of the target population and setting
- Clear goals and objectives that are outcomes-focused
- A focused and targeted approach to programme planning, implementation and evaluation
- An implementation approach that is empowering, collaborative and participatory
- Inclusion of training and support mechanisms to ensure high quality implementation and sustainability

At the more detailed level, step by step programme planning is required in order to gain clarity about exactly what the programme should involve and why.

Clarifying the issues

It is crucial to have a clear understanding of why an intervention is needed. In other words, the population health problem must be clearly defined, along with the target population(s) (Ministry of Health, 2006). The unique characteristics of the population or local context also need to be understood, for example, community strengths, concerns and the political context (Barry, 2007). The following questions may help to clarify some of these issues:

- Who has identified the need for a youth mental health promotion programme, and what information was this based on? (Ewels & Simnett, 2003)
• What are the determinants (individual, environmental, structural) that affect mental wellbeing for 12-24 year olds in New Zealand? What are the Māori-specific determinants? (Ministry of Health, 2006)

• What are the links between the determinants, the health problem and the population(s) of interest? (Ministry of Health, 2006)

• How do inequalities affect this age group? Who is most advantaged and most disadvantaged? (Ministry of Health, 2006)

The VicHealth guide to planning, monitoring and evaluating mental health promotion (2005) recommends drawing a causal mind-map as a group exercise to clarify the often complex and multi-directional relationships between various risk and protective factors and outcomes of interest.

Hilkene Bernat & Resnick (2006) note that differences exist as to how different risk and protective factors work for different ages, genders, and ethnic groups in different contexts, so research should be used to guide the selection of applicable risk and protective factors.

As well as drawing on robust research evidence, analysis should also incorporate the knowledge and aspirations of the young people and communities who will be affected by the programme, and other relevant stakeholders and experts.

Barry (2007) highlights the Communities that Care (CTC) initiative, which aims to provide communities with a framework for planning, based on their own assessment of risk and protective factors and choosing interventions that address the unique strengths and needs of each community. According to Barry, “The CTC system has been applied in more than 500 communities in organising promotion of positive social development for young people and prevention of problems such as youth crime and substance abuse” (Barry, 2007:10).

**Goal setting**

Clear goals, objectives and sub-objectives, with logical links between them are essential (Ministry of Health, 2006). Long term, intermediate and short term goals should be based on sound research and analysis. Goals should be specific, measurable, achievable, relevant and agreed by all stakeholders (Barry, 2007; Ewels & Simnet, 2003). Where possible, outcome measures should be identified and assessed for their validity and reliability (Ministry of Health, 2006).

**Evaluation**

Evaluation means looking critically at what worked, what didn’t, and how a programme could be improved (Ewels & Simnet, 2003). Ideally, evaluation should be built in from the beginning. Outcome evaluation focuses on whether the goals and objectives of the programme have been achieved, while process evaluation looks at whether the most appropriate methods have been used, and whether they have been implemented effectively and efficiently. Programmes should be evaluated using the most robust research designs possible (within budgetary and methodological limitations), and focus on both process and outcomes (Barry, 2007).

A programme logic model provides a systematic framework for guiding both implementation and evaluation and is recommended by the Ministry of Health (2006) and Barry (2007).
Methods

What are the best and most efficient ways to achieve the goals and objectives that have been set? There will likely be a wide range of options to choose from (e.g. mass media, posters/leaflets, whole-school approach, workshops, peer-led activities, advocacy, lobbying, community development, organisational development, health impact assessment etc) and normally a range of aligned methods would be used. Decisions should consider:

- Which methods will be most effective for achieving the goals and objectives?
- Which methods will be easiest and cheapest?
- Which methods will be most acceptable to the target audience?

The Ministry of Health guide (2006, p6) states the chosen intervention should:

- Target the key determinants of health for the defined health problem and population(s)
- Reduce health inequalities in the target population(s)
- Be consistent with the aim of whānau ora and aligned with the four pathways described in He Korowai Oranga
- Reflect the current state of knowledge and best practice.

Internationally, there are now a number of model programmes that have been proven to be effective in a wide range of settings. It may be possible to choose an approach ‘off the shelf’ and adapt it rather than designing and intervention from scratch.

Infrastructure

As Barry (2007) points out, adopting a proven programme is not in itself a guarantee of success. “There is a need for attention to good implementation, including adequate resources such as funding, staff skills, training, supervision and the organisational support needed to implement the programme to a high quality in the local setting” (Barry, 2007:12). The importance of training and support is also highlighted in other reports and guides (ProMenPol, 2009; Jane Llopis & Barry, 2005).

Partnership working is widely recommended, but often “research overlooks organisational and financial governance and policy mechanisms needed to foster integration within and across differently financed services” (Browne et al, 2004, p 1375).
4. Discussion

The evidence gives a good sense of what a comprehensive cross government multi-million dollar youth mental health promotion programme might look like. However it is abundantly clear such a programme is beyond the scope of a small NGO like the Mental Health Foundation. There are two challenges here: one is that the objectives of mental health promotion are very broad and multi-level, reflecting the multitude of influences on young people’s mental wellbeing. The other is that a certain level of intensity and comprehensiveness seems to be a prerequisite for effectiveness – addressing just one or two determinants, addressing determinants at only one level, and/or engaging in one-off rather than sustained interventions may not be enough to make a long term difference to young people’s wellbeing.

One of the comments in the recent New Zealand youth development review is equally applicable to mental health promotion. “The current conceptualisation of what constitutes appropriate youth development activity is so broad that very few things could actually be considered inconsistent or out of scope […] Having such broad programme aims and outcomes potentially encourages programmes to ‘do everything’ and ‘be everyone’ with young people. The risk, when this happens, is that very little is achieved because efforts are too dispersed and lack the intensity and/or the focus needed to facilitate specific outcomes “(MYD, 2009).

So on one hand, interventions are unlikely to make a difference unless they are comprehensive and multi-level, but on the other hand an overly-broad focus can lead to a scatter-gun approach where much is attempted but little achieved.

Unfortunately there are no easy answers to these challenges. One point worth noting is that New Zealand has a wide array of government and non-government agencies with goals to improve youth wellbeing in one way or another. Although none of them individually has the scope to address all the determinants of mental wellbeing, collectively they may be able to provide a comprehensive, multi-level and long term approach to enhancing mental health in New Zealand’s young people.

The Mental Health Foundation may be guided, then, by consideration of the current needs and gaps with regard to enhancing protective factors and reducing risk factors for young people. What is already being done well by other agencies? Which issues/determinants are not being addressed? Which determinants are best addressed by other sectors and organisations, and which of the determinants is the Mental Health Foundation in a unique position to influence?

There is increasing discussion internationally about the need to jointly address shared risk and protective factors across a number of sectors, and this discussion is also reflected in the findings of the Whānau Ora Taskforce in New Zealand. Part of the Mental Health Foundation’s role in coming years may be to advocate for the kind of cross-government approach to mental health promotion that is being developed elsewhere. As Barry (2007) argues “Mental health promotion needs to be incorporated into the wider health development and social inclusion agenda, in order that the broader determinants of poor mental health, such as poverty, social exclusion, exploitation and discrimination can be successfully addressed” (Barry, 2007 p 7).
5. Conclusions and recommendations

There is a strong policy mandate in New Zealand for strengths-based mental health promotion. This approach is particularly supported by the *New Zealand Suicide Prevention Strategy* (2008), *Building on Strengths* (2002) and the *Youth Health Plan* (2002). The current mental health policy *Te Tahuhu* (2005) also focuses on the importance of promoting mental health and wellbeing at the population level, and highlights a number of priority actions e.g. increasing awareness of how to maintain mental health, and implementing the suicide prevention strategy for example. High level health policy focuses on the importance of reducing inequalities, addressing the determinants of health and strengthening whānau ora as key strands of any health promotion activity.

Evidence shows strengths-based programmes can successfully a) build skills and assets that are associated with mental wellbeing and resilience; b) reduce ‘problem’ behaviours in young people; and c) reduce mental health problems in young people. However research suggests interventions are more likely to be effective and have a greater impact in pre-school and primary age children than in youth aged 12-24. Influencing the mental wellbeing of young people in this age group may require earlier intervention.

Successful programmes are those that focus on achieving a range of outcomes known to influence wellbeing. These include:

<table>
<thead>
<tr>
<th>Skills</th>
<th>Goal setting, communication, decision making and coping skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assets</td>
<td>Confidence, identity, sense of self worth, sense of meaning/purpose, efficacy, pro-social values, supportive adult relationships, and connectedness to peers, parents, other adults and school</td>
</tr>
<tr>
<td>Behaviours</td>
<td>Academic achievement, low/no drug and alcohol use, healthy levels of physical activity, contribution to the community</td>
</tr>
<tr>
<td>Environmental</td>
<td>Supportive and violence-free home and school environments; opportunities for skill development; opportunities for development of enduring pro-social relationships with adults and peers</td>
</tr>
<tr>
<td>Structural</td>
<td>Youth employment, access to quality housing</td>
</tr>
</tbody>
</table>

Mental health promotion programmes are more likely to make a difference if they have the following characteristics:

- A holistic approach addressing both the environment and the individual
- A comprehensive approach with multiple interventions in multiple settings addressing multiple determinants
- A long term approach, preferably over several years
- Interventions informed by theory and evidence
- Culturally appropriate interventions, with input from the relevant communities at each stage of the programme
Interventions appropriately targeted to the age and gender of the target audience

Youth participation, and a philosophy of youth empowerment

A skilled workforce

New Zealand research with Māori youth broadly supports some key overseas findings, for example positive relationships with adults other than parents can help young people overcome adversity, and young people value connectedness to friends, whānau and community. Both New Zealand and overseas findings suggest that for disadvantaged young people, material and structural barriers (e.g. unemployment) are perceived as significant barriers to wellbeing. There is also empirical support for the theory that cultural identity is linked with mental wellbeing for Māori. The literature suggests effective mental health promotion for Māori involves setting goals and objectives that reflect Māori values and aspirations, using culturally appropriate methods, and addressing Māori-specific as well as generic risk and protective factors. Attention to generic success factors and quality issues is also likely to be important.

Research indicates the risk and protective factors for positive youth outcomes across health, education, justice and social welfare sectors are very similar, and the seeds for youth wellbeing are planted very early in life. This suggests that efficiencies may be gained by joint intersectoral approaches that address common determinants early in the life course, rather than separate approaches to ‘treat’ youth problems such as youth crime, or teenage pregnancy when they occur.

Best practice programme design involves developing a clear rationale for intervention; setting short, medium and long term goals that are specific, measurable, achievable and relevant; building in evaluation from the beginning; and employing a collaborative and consultative approach to programme design. Chosen interventions should target key determinants, reduce inequalities, support whanau ora and reflect the current state of knowledge and best practice. Effective implementation requires adequate funding, staff skills, training, supervision, communication with stakeholders and, often, partnership development.

Recommendations

In order to align with all of the relevant policies and evidence outlined in this review, the Mental Health Foundation’s youth mental health promotion policy should focus on:

- **Reducing inequalities** by ensuring initiatives reach and are effective for those in greatest need. Application of the HEAT tool⁴ may assist planning in this regard. Where possible, structural and material barriers to wellbeing (e.g. youth unemployment, family violence, poverty, drug and alcohol abuse) should be addressed since these disproportionately affect disadvantaged young people.

- **Building resilience** in young people, whānau and communities by enhancing protective factors such as cultural identity, communication skills, goal setting, connectedness, & healthy lifestyles.

- **Creating safer, more supportive environments** particularly at home, at school, in tertiary institutions, and in community settings (e.g. marae, sports clubs).

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• **Taking a long term approach** so effective partnerships can be developed with stakeholders, and so, where applicable, young people benefit from consistent ongoing support and connections with programme delivery staff.

• **Youth participation** in the design and governance of mental health promotion initiatives.

• **Māori participation** in the design and governance of mental health promotion initiatives.

• **Building on existing initiatives**, partnerships, and successful programmes where possible, rather than starting from scratch.

• **Partnership and collaboration** across health, youth development, education, justice and community sectors. Efficiencies may be gained by working across sectors on shared risk and protective factors, and/or ‘building in’ mental health promotion elements to existing programmes.

• **Best practice programme design and implementation** with clear and logical links between aims, objectives and actions.

The youth mental health promotion programme should avoid:

• One-off events or workshops, *unless* delivered as a component of a broader ongoing programme, in partnership with other organisations.

• A sole focus on individual level interventions (as opposed to interventions that also address environmental and/or structural factors). This approach is likely to increase inequalities.

• A major focus on mental illness education. Skill building has been shown to be more effective for promoting flourishing and resilience.

• Duplication of work already being done by other agencies.

• Spreading resources too thinly, or using a ‘scatter-gun’ approach. It is better to do a few things well than a lot of things poorly.

It is recognised that the Mental Health Foundation is a small organisation with limited resources, and that a comprehensive and far reaching programme that meets all of the recommendations above may be unrealistic. In order to be effective, the Mental Health Foundation will need to set clear priorities and focus resources on specific objectives and activities where it can work in partnership with other agencies to make the most difference.
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Appendix A: Building on Strengths Mental Health Promotion Framework, NZ 2002.

Appendix B: Illustrative logic model for mental health and wellbeing, Scotland 2009

Appendix C: Conceptual Framework for Mental Health Promotion, Australia 2000

The diagram below is from *Promotion, Prevention and Early Intervention for Mental Health* published by the Australian Commonwealth in 2000.

*Figure 1: The spectrum of interventions for mental health problems and mental disorders*
Appendix D : VicHealth Mental Health Promotion Framework, Australia 2005

Mental Health Promotion Framework 2005 – 2007

Key Social & Economic Determinants of Mental Health & Themes for Action

- Social inclusion
  - Supportive relationships
  - Involvement in community & group activities
  - Civic engagement
- Freedom from discrimination & violence
  - Valuing of diversity
  - Physical security
  - Self determination & control of one’s life
- Access to economic resources
  - Work
  - Education
  - Housing
  - Money

Population Groups & Action Areas

- Population groups
  - Children
  - Young people
  - Women & men
  - Older people
  - Indigenous communities
  - Culturally diverse communities
  - Rural communities

- Health promotion action
  - Research, monitoring & evaluation
  - Direct participation programs
  - Organisational development (including workforce development)
  - Community strengthening
  - Communication & social marketing
  - Advocacy
  - Legislative & policy reform

Settings for Action

- HOUSING
- TRANSPORT
- COMMUNITY SERVICES
- CORPORATE
- EDUCATION
- PUBLIC
- WORKPLACE ARTS
- SPORT & RECREATION
- LOCAL GOVT
- HEALTH
- JUSTICE
- ACADEMIC

Intermediate Outcomes

- Individual
  - Projects & programs which facilitate:
    - Involvement in community & group activities
    - Access to supportive relationships
    - Self esteem & self efficacy
    - Access to education & employment
    - Self determination & control
    - Mental health literacy
- Organisational
  - Organisations which are:
    - Inclusive, responsive, safe, supportive & sustainable
    - Working in partnerships across sectors
    - Implementing evidence-informed approaches to their work
- Community
  - Environments which:
    - Are inclusive, responsive, safe, supportive & sustainable
    - Value civic engagement
    - Are cohesive
    - Reflect awareness of mental health & wellbeing issues
- Societal
  - A society with:
    - Integrated, sustained & supportive policy & programs
    - Strong legislative platforms for mental health & wellbeing
    - Appropriate resource allocation
    - Responsive & inclusive governance structures

Long-term Benefits

- Increased sense of belonging
- Improved physical health
- Less stress, anxiety & depression
- Less substance misuse
- Enhanced skill levels
- Resources & activities integrated across organisations, sectors & settings
- Community valuing of diversity & actively disowning discrimination
- Less violence & crime
- Improved productivity
- Reduced social & health inequalities
- Improved quality of life & life expectancy