Care Services Improvement Partnership CSIP

West Midlands
Development Centre

North West
Development Centre

Social Marketing and Mental Health Briefing

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Cover awtwork: Untitled, by Janis Noble

Introduction

This paper provides a summary of key themes and debates from a seminar on social marketing and mental health hosted by CSIP North West and West Midlands Regions (see appendix one for programme and seminar outcomes).
The aim of the event was to explore:

- the principles of social marketing and its application to mental health improvement,
- evidence on 'positive steps' for mental health
- what works in marketing mental health messages, and
- opportunities for development of practice.

The focus of the event was on the relationship between behaviour/lifestyle and mental health and on the potential for identifying specific behavioural goals to improve mental health. This was set firmly in the context of the importance of wider determinants and socio-economic position, which not only influence opportunities and motivation for adopting health behaviour, but also provide a context for interpreting individual choices:

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

(NIMHE/CSIP 2005 p.17)

"the evidence shows that different patterns of behaviour are deeply embedded in people's social and material circumstances, and their cultural context."

(NICE 2007 p.7)

"Some damaging and, therefore, apparently negative health behaviours may provide positive psychological, social or physical benefits for individuals in certain social and cultural contexts. For example, smoking cigarettes may provide 'time out' for people in difficult circumstances."

(NICE 2007 p.15)

The importance of promoting 'positive steps for mental health' messages is highlighted in Making it possible: improving mental health and well-being in England (NIMHE 2005) and in Our health, our care, our say (Department of Health 2006). A number of mental health organisations, notably the Mental Health Foundation, have also produced resources or published research emphasising the link between lifestyle factors (e.g. alcohol, diet, exercise) and mental health (Mental Health Foundation 2005; 2006a; 2006b). In Scotland, NHS Health Scotland has recently published an overview of the literature in an attempt to highlight the strengths, weaknesses and gaps in the evidence on the influence of different health behaviours on mental health (Friedli et al in press). This briefing paper includes a summary of some of the findings from that report, as well as a synopsis of the potential contribution of social marketing to improving mental health and well-being.

Social marketing

Social marketing is a relatively new approach to promoting public health in the UK and there are few examples of the structured use of these techniques in mental health promotion. The National Social Marketing Centre describes social marketing as "the systematic application of marketing concepts and techniques, to achieve specific behavioural goals, to improve health and reduce inequalities" (NSMC, 2006).

What is social marketing?

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

(Stead et al., 2007)

Behaviour change, consumer research, segmentation, marketing mix, exchange and competition are the benchmark criteria for this approach (see box below) and are generally used to determine whether an intervention can be described as 'social marketing' (Stead et al., 2006a). Some key features said to distinguish social marketing from other approaches to achieving health behaviour change are:

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

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

(Stead et al 2006a)

The case for applying social marketing principles to public health has been strongly made (NCC 2006). As the NSMC[1] states: "social marketing has been recognised by the UK Government as an important and currently under-utilised approach to tackling behavioural issues linked to smoking, obesity, and lack of exercise".

A partnership between Knowsley Primary Care Trust, Knowsley Council and the Roy Castle FagEnds service in Knowsley provides an example of the successful application of social marketing principles at a local level, using detailed segmentation and a highly tailored, customer focussed approach to supporting smoking cessation.[2]

Defining characteristics of social marketing approaches

Customer or consumer orientation:
A strong 'customer' orientation with importance attached to understanding where the customer is starting from, their knowledge, attitudes and beliefs, along with the social context in which they live and work.

Behaviour and behavioural goals:
Clear focus on understanding existing behaviour and key influences on it, alongside developing clear behavioural goals, which can be divided into actionable and measurable steps or stages, phased over time.

'Intervention mix' and 'marketing mix':
Using a range (or 'mix') of different interventions or methods to achieve a particular behavioural goal. When used at the strategic level this is referred to as the 'intervention mix', and when used operationally it is described as the 'marketing mix' or 'social marketing mix'

Audience segmentation:
Clarity of audience focus using 'audience segmentation' to target effectively

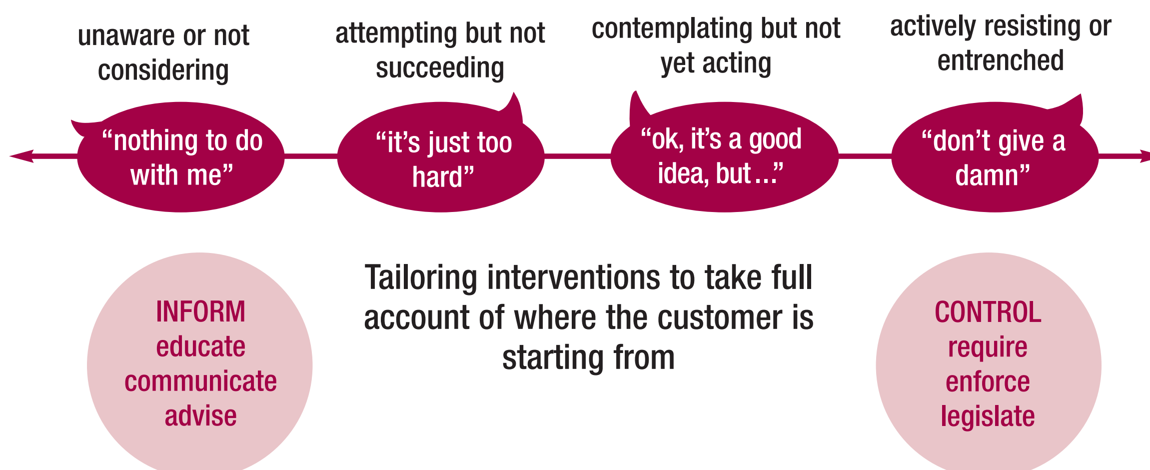
'Exchange':
Use and application of the 'exchange' concept – understanding what is being expected of 'the customer', the 'real cost to them'.

'Competition':
Use and application of the 'competition' concept – understanding factors that impact on the customer and that compete for their attention and time.

(NSMS, adapted from Andreason, 2001)

1 *www.nsms.org.uk/images/CoreFiles/NSMC-R3_alcohol_tobacco_substance.pdf*

2 *Knowsley achieved the highest rate of smoking cessation (560 per 100,000) out of England's 152 Primary Care Trusts with Liverpool seventh (387) in Department of Health figures published in September 2007.*



Social marketing and mental health

The majority of the literature on the use of social marketing approaches to mental health concerns challenging stigma: i.e. changing attitudes and behaviour towards people with mental health problems, rather than promoting ‘positive steps’ (see for example the review by Gale et al., 2004). More broadly, the relevance of social marketing to mental health improvement is twofold:

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

“Positive mental health leads to positive behaviour change; how our target audience processes change/motivation will be very dependent upon their positive mental health profile e.g. beliefs about ability/likely success, optimism versus hopelessness, resilience to keep trying. We should therefore embed in all of our strategies the psychological strands of empower and enable”.

(Govan, 2007)

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

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

(Stead et al., 2007 p.4)

A range of topic based systematic reviews of social marketing approaches has been undertaken by the Institute of Social Marketing (University of Stirling), some of which include topics relevant to mental health, notably nutrition, exercise and alcohol (Gordon et al., 2006; McDermott et al., 2006; Stead et al., 2006a; 2006b).[3] The results suggest that social marketing approaches can significantly improve effectiveness and the achievement of behavioural change goals across a range of topics (National Consumer Council, 2006) The extent to which effectiveness is influenced by socio economic status, ethnicity and context (most studies are from North America, New Zealand or Australia) is unclear.[4] The reviews found strong evidence for nutrition, reasonably strong evidence for physical activity and more modest, although significant effects, for alcohol, tobacco and substance misuse:

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

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

Social marketing and inequalities

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

(Stead et al 2007)

The National Institute of Health and Clinical Excellence's recent guidance on supporting behaviour change is based on a wide range of reviews, including one on social marketing approaches (Stead et al., 2006a; NICE 2007).[5]

Positive steps for mental health

A recent review on the strength of the evidence for the relationship between lifestyle and mental health concluded that there is good evidence to support the effectiveness of 'positive steps', although the quality and quantity of studies varies considerably (Friedli et al in press)[6]. The review suggests that the 'positive steps' approach may empower individuals to improve and protect their own and others' mental health, while recognising the importance of wider determinants.

"Mental health influences motivation, capacity and opportunity to adopt healthy lifestyles and socio-economic circumstances influence factors like social contact that protect individual mental health."

(Friedli et al in press)

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

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

5 guidance.nice.org.uk/page.aspx?o=395474

6 Commissioned by NHS Health Scotland; this is not a systematic review but an initial scoping exercise, exploring a wide range of studies on the influence of lifestyle factors on mental well-being.

The strength of the evidence for individual positive steps is as outlined below: [7]

Exercise

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

Diet

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

Alcohol

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

Learning

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

Creativity

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

Spirituality

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

Talking

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

Valuing yourself and others

There is good evidence linking low self-esteem with depression, suicidal behaviour and eating disorders

There is good evidence that social trust is associated with higher well-being and a lower probability of suicide and psychological problems but weak evidence on causality.

Social support

There is good evidence, including some review level studies, that strong social networks and social support play a significant role both in preventing mental health problems and improving outcomes.

There is mixed evidence that some types of social network have a negative impact on mental health, notably for women and marginalized groups.

Social support and social participation do not mediate the effects of material deprivation.

Asking for help

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

Getting involved and making a contribution

Evidence for the impact of volunteering on well-being is mixed.

On balance, informal care-giving has a negative impact on well-being.

Contact with nature

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

Relaxing/taking a break

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

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

Public attitudes to looking after your mental health

Qualitative research on attitudes to 'looking after' mental health in Scotland and elsewhere in the UK show high levels of public interest in emotional and cognitive well-being, whether that is expressed in terms of concerns about stress, worries, low mood or the importance of a positive attitude, coping or not 'bottling things up'. There are sensitivities about language and many people prefer not to use, or do not recognise, terms like mental health. Nevertheless, members of the public across all age groups and backgrounds had sophisticated explanatory frameworks for what influences 'how people think and feel' and many people in all social groups are already doing a lot to promote their own mental health and to cope in the face of adversity (Friedli et al in press; Tidyman 2007).

An online survey of British Telecom (BT) employees provides an example of employee responses to a recent 'positive steps at work' campaign. Overall, 'positive steps' in the workplace were viewed very favourably by some employees and were acted upon, although time constraints and work pressure were mentioned as frequent barriers. Concerns about stress and depression in the workplace are common and widely understood to be influenced by working conditions, as well as by personal circumstances. Where employees feel working conditions or management practice are stressful or damaging well-being, mental health messages may be viewed negatively or with considerable scepticism (Tidyman and Kilfedder 2007).

Recent qualitative research in Scotland on the response of health and other professionals to promoting mental health messages reflects people's experience of working to improve mental health in a range of challenging environments (Friedli et al in press). Most colleagues consulted believed that mental health improvement messages have been seriously neglected, are likely to be well received by the public and are consistent with the recovery agenda. The potentially empowering nature of some of the messages was welcomed.

At the same time, there were familiar concerns that lifestyle messages risk blaming people who have poor mental health or low levels of well-being and may reinforce inequalities. Many people felt that wider determinants and socio-economic context must be 'central to the approach'.

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

(Friedli et al in press)

Case study:
Act-Belong-Commit

The Western Australia **Act-Belong-Commit** (A-B-C) mental health campaign is an example of a population-wide approach to improving mental health that adopts a range of social marketing techniques. The campaign aims to improve mental health in six demonstration sites by encouraging the whole population of these towns to: **Act-Belong-Commit** to improve individual resilience and community cohesion. The Mentally Healthy Western Australia (WA) campaign is ongoing and is being implemented and evaluated by The Centre for Behavioural Research in Cancer Control.[8] The key message of the campaign is:

Being active, having a sense of belonging, and having a purpose in life all contribute to happiness and good mental health. **Act-Belong-Commit.**

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

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

(Donovan et al 2006a)

Objectives of the campaign are to:

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

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

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

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

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

The data is of special interest because it indicates that a mental health promotion campaign can encourage people to do things to improve their own mental health and simultaneously reduce the stigma associated with mental health problems. The final Community Survey will be conducted in October 2007 (Donavan et al., 2006; 2007b).

Conclusions

A partnership between social marketing and mental health promotion has the potential to contribute to regional strategies for improving mental health in the North West and West Midlands. The strength of the evidence for the relationship between improved mental health and improved outcomes across a wide range of health and social domains also suggests a strong case for the value of integrating mental health within all initiatives aiming to deliver healthy behaviours (Friedli and Parsonage in press; NIMHE 2005). The future development of social marketing approaches to promoting mental health will need to take account of and build on:

- emerging evidence on behaviour that improves mental well-being e.g. physical activity, diet, learning new skills and the importance of social contact e.g. friends, family relationships, networks
- the social, material and cultural context for different attitudes to mental health and different strategies for 'looking after mental well-being' and coping with life's challenges
- NICE guidelines on behaviour change
- different communities and target groups' own views on what helps and hinders their mental health and well-being

For further information on how this work is being taken forward in the North West and West Midlands please contact:

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Appendix One:
Programme, Context and Seminar Outcomes

1.0 Programme

Social Marketing and Mental Health

25th October 2007, 10.00am-4.00pm, Holiday Inn, Runcorn

The aim of this event is to explore:
- the principles of social marketing and its application to mental health improvement
- the evidence base of what works in marketing mental health messages
- opportunities for development of practice

Time	Session	Speaker
10 00	Arrival and Refreshments	
10 .30	Welcome and introduction	**Kate O'Hara and Jude Stansfield,** WM and NW CSIP
10.40	Principles of Social Marketing Social Marketing emergence, key concepts, techniques, and a practical example	**Ben O'Brien,** Head of Marketing & Communications, Knowsley Health & Social Care & Associate, National Social Marketing Centre
11.40	Discussion – Social Marketing applied to mental health	
12.30	Lunch	
1.15	Marketing Mental health improvement – will it work and is it ethical? Lessons from the Evidence base	**Dr Lynne Friedli,** Mental Health Promotion Specialist
2.00	Discussion – Implications for practice	
2.45	Refreshment break	
3.00	Up-date on NW Regional Health Improvement Campaign	**Dr Alison Giles,** Director NW Our Life NHS North West
3.15	Next Steps – plans for regional action	**Kate O'Hara and Jude Stansfield**
3.45	Plenary	
4.00	Close	

2.0 Local context: risk and protective factors in the North West and West Midlands

Inequalities in risk factors: West Midlands

Higher or significantly higher than average for England:

- Proportion of SOAs (26%)
- Unemployment
- Unemployment of people with mental health problems
- People on incapacity benefit
- Limiting long term illness
- Physical inactivity
- Low educational attainment
- Violent crime (slightly higher)
- Self harm (HAR)

Inequalities in risk factors: North West

Highest or significantly higher than average for England:

- Proportion of SOAs (33%)
- MI/MH Needs Indices
- Unemployment
- Unemployment of people with mental health problems
- People on incapacity benefit
- Limiting long term illness (one fifth of population in NW)
- Alcohol consumption
- Physical inactivity
- Low educational attainment/studying for qualification
- Fear of crime and violent crime rates
- Suicide rates (men)
- Self harm (HAR)

Protective factors: West Midlands

Above average:

- not drinking about recommended levels
- Having a religious affiliation

Average:

- Healthy eating
- Participation
- Social support
- Learning and development (job training and studying)

Protective factors: North West

Above average:

- Having a religious affiliation
- Social support
- Neighbourliness

Average:

- Healthy eating
- Participation
- Learning and development (job training)

(source: APHO Indications of Public Health in the England Regions: Mental Health *http://www.apho.org.uk/apho/indications.htm*)

3.0 Outcomes and next steps

The seminar considered the following questions:

- What are the benefits of incorporating social marketing into the way we approach mental health promotion?
- What exactly is it that we are asking people to do/ change when we promote mental health?
- What are the challenges and opportunities of promoting individual mental health messages - what will it look like in practice?
- What else needs to happen at the same time e.g. the equivalent of nicotine patches, smoking legislation etc.?
- What are the potential pitfalls in the context of inequalities, people with severe and enduring mental health problems, deprivation etc.?

Social Marketing: Joint Action

Participants recognised the need to focus on a narrow range of interventions, targeting a small number of communities. Noting that, not all the positive steps will be positive for everyone, as the qualitative research from Scotland showed. The aim will be to focus down on what we can realistically achieve, find out more about the suggested options below (as well as using segmented insights in whatever we do), explore how we will facilitate this process and ensure best use of funding.

Whatever we decide we must not forget to address the context and to tackle structural barriers as well as tackling the barriers to the positive steps.

It was agreed to commission the production of a business case/briefing report for marketing mental health, that will inform local and regional developments in specific marketing of mental health and in integrating mental health into other marketing themes.

Social Marketing: Next steps in the West Midlands

Option 1

Explore the potential for a social marketing capacity building and skills development programme.

Option 2

Prioritise (focus on) the positive steps with good evidence, referenced against the inequality risk factors in the West Midlands e.g. keeping physically active and physical inactivity.

A second area to explore (find out about – we must not over-simplify) was low educational attainment and learning new skills, with a specific focus on women.

Social Marketing: Next steps in the North West

- To prioritise the five steps with good evidence.
- To integrate the evidence based steps into the social prescribing patients briefing.
- To integrate mental health into the Our Life themes of alcohol and obesity.
- Localities developing mental health social marketing work in the region (Liverpool, Cumbria & Lancs) will continue to share approaches and integrate and build evidence based practice

We help to improve services and achieve better outcomes for children and families, adults and older people including those with mental health problems, physical or learning disabilities or people in the criminal justice system. We work with and are funded by