

From rhetoric to action: Adapting the Act-Belong-Commit Mental Health Promotion Programme to a Danish context

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In response to recent calls for implementing mental health promotion (MHP) in Denmark, the Danish National Institute of Public Health undertook a perusal of existing MHP frameworks. While a small number of such frameworks exist, the Act-Belong-Commit campaign that originated in Western Australia, was the only comprehensive, population-wide program identified that had a strong evidence base, demonstrated success in implementation and universal principles of well-being. Following a successful funding application to the Ministry of Health, the National Institute for Public Health, is leading a partnership to implement the Act-Belong-Commit campaign in Denmark in 2015–2017. This article describes the Act-Belong-Commit campaign and its implementation in Australia and how the National Institute of Public Health plans to introduce the campaign into Denmark. It is hoped that our planning for Denmark will be helpful to other countries planning to adopt the Act-Belong-Commit campaign.

Keywords: Mental health promotion, well-being, Act-Belong-Commit, social franchising.

Introduction: the need for mental health promotion

An individual's mental health, like physical health, is fundamental to short and long-term thriving, the ability to work and the ability to contribute positively to society (Chida & Steptoe, 2008; Kirkwood, May, Mckeith, & Teh 2008; Lehtinen, Ozamiz, Underwood, & Weiss, 2005; World Health Organization [WHO], 2005). Over the life course, approximately 50% of the population will experience mental health problems (OECD), with half of all mental health disorders having their onset before the age of 14 (WHO, 2014). Studies show that mental health in childhood affects general well-being (Holstein et al., 2011; Viner et al., 2012), is related to mental health later in life (Fergusson, Horwood, & Ridder, 2005; Richards & Huppert, 2011) and affects cognition and ability to learn, which in turn affects educational attainment and employment in later life (Stewart-Brown, 2005). Mental health and health-risk behaviors are strongly correlated (Colby, Linsky, & Straus, 1994; Hamer, Stamatakis, & Steptoe, 2009; Hoyt, Chase-Lansdale, Mcdade, & Adam, 2012; Kwag, Martin, Russell, Franke, & Kohut, 2011; Royal College of Physicians, 2013; Whiteford et al., 2013). Mental health problems are also important risk factors for unintentional and intentional injury (WHO), and the risk of marginalization (WHO, 2009).

Mental health problems do not only have vast implications for the individual and their families; in the upcoming decade, mental health problems are estimated to constitute one of the major global burdens of disease (Whiteford et al., 2013; WHO, 2003). This has wide

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ranging social and financial implications for society (WHO, 2005). In the Member States of the European Union (including Denmark), the cost of mental health problems is estimated to be between 3% and 4% of GNP due to loss of productivity and increased expenses for social services and the healthcare system (OECD, 2013b; WHO, 2003). Further substantial economic consequences of mental health problems may be overlooked due to lack of knowledge of a multitude of indirect expenses outside these systems (Knapp, 2003).

Given the increasing burden of disease, and monetary costs in particular related to mental illness, in recent years there has been an increased focus on population mental health and recognition that treatment alone is unlikely to make a significant difference to the escalating rates of mental illness being experienced worldwide (Anwar McHenry & Donovan, 2013; The European Commission, 2005, 2008; WHO, 2005). It has been recognized that interventions focusing on prevention and promotion are critical in enabling individuals to protect their mental health (Anwar McHenry & Donovan, 2013; Centre for Mental Health et al., 2012; The European Commission, 2005, 2008; WHO, 2004b, 2005); with recent health economic evaluations suggesting that investing in mental health promotion (MHP) is cost-effective in the short-term as well as in the long-term (Knapp, Mcdaid, & Parsonage, 2011; Mcdaid & Park, 2011; Zechmeister et al., 2008).

The situation in Denmark

As in most countries, over the past decade mental health has been declining in Denmark, with marked increases in levels of stress, depression and anxiety (Christensen, Davidsen, Ekholm, Pedersen, & Juel, 2014). Nevertheless, again as in most countries, the primary focus in Denmark has been on treatment. For example, Denmark is the European OECD country with the highest use of antidepressants (OECD, 2013a). Recent reference to promotion and prevention has mainly been rhetorical with a scarcity of political action (Epløv & Lauridsen, 2008). However, in the national goals for health put forward by the Danish Government's Ministry of Health 2014, mental health goals feature for the first time (The Danish Government, 2014). Also the National Board of Health recommended that Danish municipalities include MHP in their work (The Danish National Board of Health, 2012).

In Denmark, the five overall regions are responsible for the hospitals and treatment that requires hospitalization. Promotion, prevention and community care however is the responsibility of the municipalities. Many service-providers in the municipalities are uncertain as to how to implement MHP, resulting in little action (Friis-Holmberg, Illemann Christensen, Zinckernagel, Skytte Petersen, & Hulvej Rod, 2013). Reasons for this uncertainty include the complexity associated with mental health, but primarily that service-providers have not had an easily understood and practical framework for the implementation of MHP. It can be noted here, that the Act-Belong-Commit MHP campaign was designed to not only reduce the complexity surrounding mental health for the population at large, but also to provide service-providers, health professionals and clinicians with a practical framework for doing MHP.

Defining mental health and MHP

Mental Health has been defined by the WHO as: '... a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (Herrman, Saxena, & Moodie, 2004). That is, mental health is more than the absence of mental illness; it comprises subjective well-being, being fully functional (i.e.

realizing or developing one's potential), having the ability to handle the stressors of daily life, and the ability to form positive relationships with others, and able to contribute positively to one's community or society (Chida & Steptoe, 2008; Huppert, 2005; Keyes, 2002; Kirkwood et al., 2008).

MHP can be defined as interventions designed to maximize mental health and well-being by increasing coping capacity of communities and individuals and by improving environments that affect mental health. MHP aims to improve the well-being of all people regardless of whether or not they have a mental illness (Donovan & Anwar-McHenry, 2014).

Frameworks for MHP

In spite of the many recent and past commendable documents presenting frameworks for MHP over the past decades and recently (Centre for Mental Health et al., 2012; WHO, 2004b), Act-Belong-Commit appears to be the world's first and only attempt to develop and implement a population-wide MHP program, as distinct from mental illness prevention or early intervention initiatives (Donovan & Anwar-McHenry, 2014).

There are a number of school and worksite interventions aimed at increasing positive mental health (Durlak & Wells, 1997; Morrow, Verins, & Willis, 2002; Nielsen, Meilstrup, Kubstrup Nelausen, Koushede, & Holstein, *in press*), various organizations provide tips on maintaining or building mental health [e.g., Iceland's *Ten Commandments on Mental Health* (WHO, 2004a), and the UK's *Five Ways to Well-being* (The New Economics Foundation, 2011)], and a number of community-wide interventions focus on increasing awareness of specific mental illnesses, education about stress reduction and coping strategies, encourage help-seeking, promote early detection and treatment of mental health problems, and the de-stigmatization of mental illness (Barry, Domitrovich, & Lara, 2005; Patterson, 2009; Saxena, Funk, & Chisholm, 2013; Saxena & Garrison, 2004) [e.g., 'Time to change' in England (www.time-to-change-org.uk, 2014), 'Beyond blue' in Australia (www.beyondblue.org.au, 2014) and 'It's up to us' in San Diego, California (www.up2sd.org, 2014)]. However, other than Act-Belong-Commit, we could find no comprehensive programs explicitly related to the promotion of mental health and well-being.

The Act-Belong-Commit campaign

In line with the principles of the Ottawa Charter for Health Promotion (WHO, 1986) and the seventh principle of the Perth Charter for the Promotion of Mental Health and Wellbeing (Anwar McHenry & Donovan, 2013) (i.e. 'mental health promotion must take place at the individual and societal levels'), Act-Belong-Commit utilizes a community development approach through social franchising, to influence individual behavior and to create supportive environments for fostering and maintaining mental health and well-being (Donovan & Carroll, 2008; Donovan, James, & Jalleh, 2007; Pettigrew & Donovan, 2009). That is, the campaign targets individuals to engage in mentally healthy activities while at the same time supporting and encouraging organizations that offer mentally healthy activities to promote, and increase participation in, their activities (Donovan, James, Jalleh, & Sidebottom, 2006).

The campaign messages are derived from primary research undertaken by Curtin University with members of the general population into their perceptions of mental health and the behaviors they believed promoted and protected positive mental health (Donovan, Henley, et al., 2007; Pettigrew & Donovan, 2009), and confirmed by reviewing the

scientific literature. The origins of and rationale for the campaign have been described in more detail previously in this *Journal* (Donovan et al., 2006).

Act-Belong-Commit denotes the three behavioral domains that contribute to positive mental health:

Act: Individuals that keep physically, mentally, spiritually and socially active have higher levels of physical and mental health (Buchman et al., 2009; Hamer et al., 2009; Hsee, Yang, & Wang, 2010; Kwag et al., 2011) and better cognitive functioning (Buchman et al., 2009; Crooks, Lubben, Petitti, Little, & Chiu, 2008; Ybarra et al., 2008).

Belong: The feeling of belonging is fundamental to mental health (Gailliot & Baumeister, 2007). Mental health and the ability to cope with the stressors of daily life, increase with increasing social interactions (Cohen & Janicki-Deverts, 2009; Crooks et al., 2008; Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009).

Commit: Engaging in activities that are meaningful and provide a purpose in life affects mental health positively. Setting and achieving small and large goals and challenges provides feelings of self-worth and well-being (Lyubomirsky, Sheldon, & Schkade, 2005; Noels, Pelletier, Clement, & Vallerand, 2000; Taylor, 2011). Volunteering contributes to a feeling of purpose and increases quality of life, well-being and self-rated health (Meier & Stutzer, 2008; Piliavin & Siegl, 2007; Waddell & Jacobs-Lawson, 2010).

Overall, the Act-Belong-Commit message encourages people to be physically, spiritually, socially and mentally *active*, in ways that increase their sense of *belonging* to the communities in which they live, work, play and recover, and that involve *commitments* to causes or challenges that provide meaning and purpose in their lives.

Results from Australia (Anwar-McHenry, Donovan, Jalleh, & Laws, 2012; Jalleh, Anwar-McHenry, Donovan, & Laws, 2013) show Act-Belong-Commit has been effective in:

- (1) increasing awareness that there are things people can and should do to protect their mental health;
- (2) changing beliefs about mental health and mental illness;
- (3) reducing stigma related to mental illness;
- (4) increasing openness to talking about mental health issues;
- (5) encouraging people to engage in activities to promote their mental health;
- (6) achieving a variety of local mental health-promoting initiatives and activities;
- (7) establishing effective and sustainable partnerships;
- (8) introducing systemic change within the health system.

The Act-Belong-Commit framework is also considered to have far broader implications for society, in particular for suicide prevention and civic-mindedness. For example, with respect to suicide prevention, according to Joiner (2005) the desire or motivation to suicide is driven by two factors: low or 'thwarted' belongingness and perceived burdensomeness. Given that *Belong* is about building and maintaining connections with others, including community and civic organizations and institutions, and that *Commit* involves doing things that provide meaning and purpose in life, including taking up causes and volunteering that helps society and other individuals, the Act-Belong-Commit campaign can be viewed as strengthening two major protective factors for suicide. Furthermore, by encouraging participation in public events by people with different demographic and ethnic backgrounds, the campaign also contributes to greater understanding between groups and to what Aristotle called 'civic virtue'; that is, greater feelings of obligation and responsibilities towards communities to which people have a greater sense of belonging (Sandel, 2012).

Implementing Act-Belong-Commit in Western Australia

After a two-year pilot of the campaign in six regional towns throughout the state in 2005–2007, the campaign was launched statewide in 2008. The ongoing development and implementation of the Act-Belong-Commit campaign is coordinated by Mentally Healthy WA (MHWA), a small team (equivalent 6 full-time employees) based at Curtin University in Perth, the state's capital, with funding from the Western Australian Health Promotion Foundation (Healthway) and the Mental Health Commission of Western Australia (WA). Funding is sufficient to allow limited media advertising and publicity, merchandise for distribution to partners, evaluation, ongoing resource development and website maintenance. MHWA is considered a 'hub' and partners with a diverse range of community groups, local governments and statewide organizations (e.g., theatre groups; women's health groups; sporting groups; recreational and hobby groups, etc.; see under 'Partners' at actbelongcommit.org.au). Franchises/partners sign a Memorandum of Understanding (MOU) to ensure message integrity and activities consistent with scientific evidence, branding consistency with permitted variations, sharing of activities and learning between partners, and regular submission of process evaluation data. These collaborative community partnerships/social franchises involve local people in implementation, thus ensuring both local commitment and relevance, which are considered essential for the success of health-promoting campaigns (Annor & Allen, 2008; Barnett & Kendall, 2011). Partnerships with sectors other than health (i.e., sport, recreation, the arts, education, charities, etc.) make mental health 'everybody's business' and are necessary in attempts to address the social determinants of mental health and well-being (Quinn & Biggs, 2010).

MHWA provides franchises with initial and ongoing training, overall strategic direction, scientific resources, merchandising, mass media advertising, publicity and event sponsorship. MHWA also conducts population impact surveys and surveys of partners/franchisees (Anwar-McHenry et al., 2012; Jalleh et al., 2013). Importantly, in an area where funding is not readily available, the social franchise model enables the Act-Belong-Commit campaign to grow and expand its impact and geographical reach without necessarily increasing the size of the franchiser 'hub' (Beckmann & Zeyen, 2013).

The campaign has a number of resources, including a self-help guide ('A Great Way to Live Life: the Act-Belong-Commit Guide to Keeping Mentally Healthy'), which not only provides individuals with a tool for enhancing their mental health, but also provides the clinician with a helpful tool in the clinical setting. The Guide is downloadable from the website or can be completed online. Other resources include a mobile phone app, a search tool to find clubs and organizations in one's areas of interest, various fact sheets, curriculum materials for schools and worksites, and print and video advertisements (visit actbelongcommit.org.au).

Furthermore, although different groups may articulate the domains differently and place different emphases on each, these three domains appear universal across different cultures. Various ethnicity-based groups have participated in Act-Belong-Commit activities in Australia, organizations in the UK and Japan (Takenaka, Bao, Shimazaki, Lee, & Konuma, 2012) have used the campaign materials and organizations in Northern Ireland, the USA and Fiji have shown interest in utilizing the campaign in their activities.

Implementing Act-Belong-Commit in Denmark

In April 2014, Denmark became the first country outside Australia to sign an MOU to implement Act-Belong-Commit (Koushede, 2014). The following is a description of

actions taken so far and actions planned in order to adapt and implement the campaign in a Danish context.

In January 2014, a small group of researchers from the Danish NIPH traveled to Perth to meet up with the Act-Belong-Commit team at Curtin University. The aim was to learn more about the campaign and examine possibilities for an international partnership around the campaign. In April, the Danish NIPH became the first international Act-Belong-Commit hub. Professor Robert Donovan founder of Act-Belong-Commit in Australia visited Denmark to help support the initiative. Key researchers at the NIPH were then formally trained in the Act-Belong-Commit concept via skype facilities.

Initial relevant organizational stakeholders were identified and meetings held in order to examine possibilities for entering Act-Belong-Commit partnerships with a multi-disciplinary team of private and public institutions. As a result of these meetings, on 1 June, a funding application to adapt and pilot Act-Belong-Commit in a Danish context was sent to the Danish Ministry of Health by NIPH and the following partners: The Danish Healthy Cities Network (HCN), The Danish School of Media and Journalism (DSMJ), Public Health Copenhagen (PHC), and Red Cross Copenhagen (RCC). In October 2014, the partnership was granted 5,000,000 DDK (~ 530,100 £ or 671,475 €) from the Ministry of Health.

Meetings with additional relevant stakeholders (e.g., the Danish National Board of Health) will be held to examine further opportunities for funding and/or partnerships.

The Danish model mirrors the beginning of the Act-Belong-Commit campaign in Australia where an initial partnership with a state health authority was vital to the campaign's success. However, it differs somewhat from the Australian model in that various components of the campaign will be implemented through one or other of these partners rather than only through the 'hub' (see Figure 1).

Partner roles and responsibilities

The NIPH will act as a hub for the campaign throughout Denmark. Hence, as in WA, the hub will have overall leadership of the campaign. The hub will also be responsible for

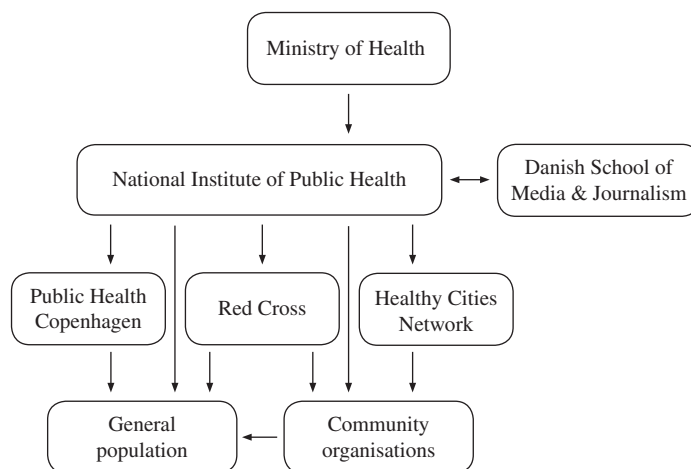


Figure 1. Danish partnerships for the implementation of Act-Belong-Commit.

adapting existing fact sheets and other resources to the Danish context; advising and supporting interested organizations and agencies who wish to promote mental health initiatives under the Act-Belong-Commit framework; training official local Act-Belong-Commit coordinators and Act-Belong-Commit ambassadors from the community; creating and maintaining an Act-Belong-Commit website; monitoring the overall campaign and selected local initiatives; conducting process evaluation; and disseminating results to stakeholders, policy-makers and in scientific journals.

The DSMJ will act as a resource partner for the hub in terms of developing communication materials for Act-Belong-Commit via digital and social media platforms. This will happen on an annual basis and will be part of students' assignments. These assignments will include tailoring the communication to specific target groups (e.g., young people, the elderly, individuals living in deprived areas etc.) based on research carried out by the NIPH.

Given current structures in Denmark (i.e. health promotion and prevention interventions are delivered via municipalities), PHC will be responsible for delivering the adapted Act-Belong-Commit messages to the general public via billboards, distribution of information leaflets, advertising and coverage of Act-Belong-Commit activities in the local media. PHC will also work to bring local actors together to work under the Act-Belong-Commit framework via local coordinators trained by the NIPH. PHC have also committed to hosting a minimum of one large public Act-Belong-Commit event annually.

The HCN will also host an annual Act-Belong-Commit theme day. More importantly, the HCN will create a platform for disseminating knowledge and experiences about the adapted Act-Belong-Commit to other Danish Healthy Cities in the network and share their knowledge on national mental health-promoting activities from the Theme Group on Mental Health and Well-being.

The RCC will act a social franchise, disseminating knowledge about Act-Belong-Commit both internally to its staff and volunteers, and externally to the population at large and the communities within which it operates. RCC will also specifically encourage people to become Act-Belong-Commit ambassadors and will help gather volunteers for Act-Belong-Commit events.

Overview of initial activities

Our next step will be to establish a steering group and an expert advisory board. MHWA has a steering committee containing a variety of expertise across community organizations, mental health and mental illness, behavioral science, government and a mental health consumer representative. Their steering committee also includes representatives of major funders. It was felt that at least in the beginning stages, NIPH would benefit from additional experts via an expert advisory board.

By the end of 2014, the following activities will have commenced: a decision as to whether there is a need for a Mental Well-being Impact Assessment (Public Health England, 2013); a documentation and evaluation plan; adaptation of the overall information material; training of Act-Belong-Commit coordinators and a website plan.

It is anticipated that in 2015 the campaign will commence with launching of the website, the finalizing of information material and fact-sheets and distribution to relevant agencies, and the beginning of the Act-Belong-Commit public information component via mass and limited reach media. It is anticipated that the first PHC annual event will be held by August and the HCN theme day will be held in December.

The campaign is so far planned to continue throughout 2016 and 2017. Additional funding will be sought in order to disseminate the campaign further after this period.

Adapting the main messages to the Danish context

As noted earlier, the three behavioral domains of keeping active, participating with others to provide a sense of belonging and engaging in activities that provide meaning and purpose in life, are universal fundamentals of building and maintaining mental health and well-being. These campaign messages have been accepted by a variety of ethnic groups in Australia, including Indigenous Australians, as relevant to them.

Given Denmark's and Australia's shared European heritage and societal orientation, members of the NIPH and the Danish partners consider that these three behavioral domains are consistent with their own beliefs and constructs around mental health and well-being. Hence, the initial focus of the adaptation will be to confirm that members of the Danish general population also accept that these three domains build mental health and well-being. This process has already begun with students from the Danish School of Media & Journalism embracing the messages and anecdotally reporting that working on communication of the messages has reinforced or further informed their views on how to keep mentally healthy.

Considering these, the main initial formative research focus will be on: (i) how to translate the messages within each of the domains into Danish; (ii) developing an overall Danish language term or slogan that encompasses 'mental health and well-being' for the general population and (iii) deciding whether to substitute three Danish words for 'Act', 'Belong' and 'Commit' in the logo and overall branding, or whether to retain the English branding – but with the overall slogan in Danish as in (ii).

A series of focus groups will be held to provide information on these specific questions as well as simply exploring people's concepts around mental health and well-being. The qualitative research methods used by the Australian researchers will be used to guide the group discussion topic outlines (Donovan et al., 2003). With respect to aim (iii), it is noted that there appear to be no direct single word translations in Danish that have the same meaning as do 'Act', 'Belong' and 'Commit'. Hence it may well be that the advertising practice of English-spelling international consumer brands in Denmark will be acceptable; that is, the spoken or written words are in Danish, but the brand and its slogan are in the original English (e.g., as is the case with 'Burger King' and 'Taste is King').

Evaluation

Because of the pilot nature of the project, evaluation will be centered around the formative research underpinning the campaign and process evaluation. The process evaluation will assess the extent to which Act-Belong-Commit was implemented as planned, and focus particularly on factors facilitating and inhibiting implementation in different settings. It will include: (i) interviews with the partnering coordinators, and pre and post interviews with local ambassadors involved in the program and (ii) feedback from different population sub-groups with respect to the relevance and usefulness of the adapted messages and material.

Perspectives

In future, the aim is to adjust the Danish Act-Belong-Commit in relation to findings from the pilot-study, to implement it nationally and to monitor the development. Using the National Health and Morbidity Surveys and national registers factors related to the campaign (e.g., population reach, knowledge, attitudes, behavior, well-being) (Stewart-Brown et al., 2009, 2011; Tennant et al., 2007) and mental health problems will be examined.

Conclusion

Results and experiences with adapting Act-Belong-Commit to a Danish setting will be published in future articles. In the meantime, we hope that this article may be of inspiration and help to others looking for a comprehensive population-wide framework to promote mental health.

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