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Older Audiences' Responses to Mental Health Promotion Messages

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Introduction

In their framework of how advertising works, Vakratsas and Ambler (1999) listed motivation and ability as among the variables that mediate the impact of advertising on audiences. In a health promotion context, Moonman and Matulich (1993) demonstrated the role of motivation and ability in influencing individuals' health-related

behaviours, and noted that the importance of this role varies according to age. The present study focused on the role of motivation and ability in older audiences' interpretations of mental health promotion messages. A combination of individual and focus group interviews provided access to the experiences of older people as they were exposed to a series of mental health promotion messages. The findings provide insight into how such messages may be interpreted by older people, and the implications for the development of effective mental health promotion communications.

A B S T R A C T

This study focused on the role of motivation and ability in older audiences' interpretations of mental health promotion messages. The aim was to generate insights into the ways in which older people respond to such messages, to inform the development of mental health promotion communications. Twenty individual interviews and 12 focus groups were conducted with a total of 111 Western Australians aged 40 years and older. Interviewees were exposed to a series of mental health messages and asked to share their thoughts

and feelings about the message content and style. Data analysis focused on the barriers and facilitators that influenced interviewees' acceptance of the mental health recommendations contained in the messages. The major themes evident in the data were a desire to exhibit compliance, the importance of perceived personal relevance, sensitivity to the tone of the message, literal interpretations of message content and impediments to adoption. Implications for mental health promotion are discussed.

Communicating with older audiences

It has been suggested that older people process information in somewhat different ways from those in younger age groups (Yoon *et al*, 2005). These differences are likely to have implications for health-related motivations and abilities (Moorman & Matulich, 1993), and thus it is critical to understand these differences when developing health promotion messages targeted at older people. As a segment, older people typically constitute a more heterogeneous group than other age segments, because they have experienced a greater variety of circumstances and situations during their lives (Davis & French, 1989). This greater experience makes them more sceptical of advertising, and has been postulated to result in a preference for advertisements that are more affective than cognitive in approach (Yoon *et al*, 2005). More varied life experiences could also be expected to result in different perspectives on health-related issues such as mental health.

In addition to attitudinal differences, the physical effects of the ageing process introduce sensory and cognitive processing complications for older people. The ability to perceive stimuli is influenced by the reductions in sight and hearing that accompany older age (Wahl & Heyl, 2003). The neural pathways in the brain also deteriorate with age, requiring the older person to use both hemispheres of the brain to a greater extent when processing information, thus incurring longer processing times (Li, 2002). These age-related changes have implications for the development of messages for older audiences, including consideration of appropriate message content and media selection (Pettigrew, 2004). For example, a growing need to self-pace information flows to allow for slowing cognitive processing can result in a preference for media such as newspapers that allow the reader to determine the speed of information exposure (Moschis, 1992). The greater difficulties faced by older people in processing new information results in their being less able to recall the source of new information (Yoon *et al*, 2005) and less likely to change their beliefs in the face of new information (Rice & Okun, 1994). These outcomes suggest that it may be more difficult to achieve attitudinal change among older audiences.

As well as influencing the ability to process health promotion messages, age-related changes can affect the individual's ability to perform recommended behaviours. For example, exercise is now understood to be an important protective and treatment factor for mental illness (Wattles, 2001). However, older people with chronic physical health conditions, such as arthritis, may find it very difficult to comply with recommendations to increase their physical

activity to protect their mental health (Chad *et al*, 2005). Increasing frailty can also lead to safety and security concerns when leaving the house to engage in physical activity (Booth *et al*, 2000).

In terms of motivation, as people age they increase their likelihood of experiencing a range of physical and mental problems (Ball *et al*, 2002; World Health Organisation (WHO), 2001). This higher incidence may serve to increase involvement relating to health, as the personal and/or vicarious experience of illness may motivate individuals to pay more attention to health promotion messages and to engage in any recommended preventative behaviours (Moorman & Matulich, 1993; Resnick, 2001). To date, however, there is little research that specifically examines motivation among older people, as most theory development and testing relating to health behaviour models has focused on younger adults (Burton *et al*, 1999). There is thus a need to investigate in more detail how older audiences process health-related information, as one step towards understanding how members of this group can effectively be encouraged to engage in behaviours that will prevent age-related illnesses.

Mental health promotion

Older Australians have been identified as a group that is currently receiving less mental health assistance than is warranted by their level of need (Raphael, 2000; Steering Committee, 2003). Approximately 18% of Australian adults reported experiencing a mental disorder in the 12 months prior to the Mental Health and Wellbeing survey conducted in 1997, although this figure did not include those suffering from dementia (Australian Bureau of Statistics (ABS), 2000). Mental illness accounted for around \$4.8 billion of public health expenditure in 2000–01, excluding costs relating to dementia (Department of Health, 2004). Australians over the age of 65 exhibit the highest per capita rates of use of medications for mental health (Ball *et al*, 2002), indicating that their mental health is poorer than that of younger age groups. The World Health Organisation (2001) has noted that mental illness associated with ageing is an increasingly large expense item for national economies, and this burden is likely to increase, along with the significant social costs, as the world's population ages (Chernoff, 2003).

It is now recognized that treatment alone is unlikely to make a significant difference to the escalating rates of mental illness being experienced in Australia and elsewhere (Commonwealth Department of Health and Aged Care (CDHAC), 2000a; WHO, 2001), and that interventions that focus on prevention are critical in enabling individuals to

protect their mental health (Jorm *et al*, 2002; Keyes, 2002; Raphael, 2000). However, despite growing awareness that informing people of the behaviours that can protect and promote their mental health should be an intervention priority, such efforts are commencing from a low knowledge base about which forms of mental health promotion are likely to be most effective (CDHAC, 2000b). One area that has been noted as especially worthy of attention is investigation of how target audiences' specific characteristics influence their reactions to mental health promotion messages (Francis *et al*, 2002). Information pertaining to barriers affecting the positive perception of messages and adoption of recommended behaviours is critical, because advertisements promoting prevention have a more difficult task to achieve than those that are able to deliver immediate outcomes (Francis *et al*, 2002). The task is also more difficult because of the tendency for individuals to show a particular dislike for messages relating to adverse health conditions (Diehl *et al*, 2008).

Given the tendency for older people to differ in their health information processing styles (Rice & Okun, 1994), the particular needs of this group should be considered, to allow development of effective mental illness prevention programs (CDHAC, 2000a, 2000b). Such programs would increase older people's independence and dignity while helping to contain health care costs (Ball *et al*, 2002).

Method

A series of mental health promotion messages was tested on older adults. The primary emphasis of the messages was the prevention of mental illness through the ABC program, an acronym that stands for Act-Belong-Commit (Donovan *et al*, 2006). The idea behind the program is that, in order to strengthen and maintain good mental health, individuals should aim (A) to be more physically, socially and mentally active, (B) to join groups and participate in community activities and (C) to take up causes or challenges, including leadership or administrative roles within groups, to encourage long-term commitment and greater engagement. The program was developed on the basis of the mental health literature and findings from a scoping project that investigated Australians' mental health literacy (Donovan *et al*, 2003). The ABC program was developed for all ages, but of interest was whether a change in approach was required for older audiences, given likely differences in motivation and ability.

Of the five messages tested, one was presented as a television advertisement and four were presented in print form. Each of the messages stated the ABC message, but had a different focus. The television advertisement provided

a broad description of the ABC program (explaining what each of the letters stands for) while showing cartoon visuals of an androgynous person engaging in various protective behaviours (such as exercising, playing chess or interacting with friends). The first press advertisement (titled 'Feeling Blue? Act Green') discussed the importance of connecting with nature for mental health. The second press advertisement (titled 'What makes you happy?') noted the failure of possessions to bring lasting happiness, and recommended engaging in personally meaningful pastimes. The third press advertisement (titled 'What does it mean to be mentally healthy?') gave a more detailed account of mental health, and emphasized the need to be proactive in the prevention of mental illness. The fourth press advertisement was a combination of four panels, the first three of which defined 'Act', 'Belong' and 'Commit' separately and comprised vignettes about a grandmother, grandfather and aunt respectively and their intuitive preventative health actions (such as talking to the neighbours, joining clubs or keeping active). The fourth panel provided general information about the ABC program.

Of the five advertisements, the content of 'What does it mean to be mentally healthy?' was more informational (cognitive) in approach, while the other messages were more affective and motivational. Each press advertisement was designed to be approximately a magazine page in size, and all included contact information for ABC program representatives who could provide further assistance if required. The 'Feeling Blue? Act Green' message is contained in the Appendix to illustrate the format of the messages.

The test advertisements were shown to a sample of older Australians to gauge their reactions to the content and style of the messages. Interviewees were asked to read through the messages and discuss their resulting thoughts and feelings. The aim was to explore the messages through the audience's eyes, to identify varying reactions (Mick & Buhl, 1992). Because of the prevention (rather than treatment) focus of the messages, the sample was made up of individuals aged 40 years and older. The selection of 40 as the minimum age reflects the need for consideration of the ageing process to commence by around this time, to allow individuals to establish health-promoting behaviours that have the potential to influence their mental health positively in later life. For example, very high levels of psychological distress among both men and women are more common in the 45–54 age group than in any other (ABS, 2003), resulting in the need to commence prevention behaviours before this age.

Twenty individual interviews and 12 focus groups were conducted with 40+ Australians exhibiting a range of

sociodemographic profiles. On average, seven participants attended each focus group, which when combined with the individual interviews resulted in a total sample size of 111. Age (40–54, 55–64, 65–79) and gender groupings were represented in equal numbers across the interviews, and variation was also obtained in perceived physical health (poor/fair, good/excellent), location (city, country) and working status (working, semi-retired, retired). Perceived physical health was used as a recruitment variable because, as noted earlier, physical health may influence the ability of individuals to follow any physical activity recommendations provided in mental health promotion messages. The close association between mental and physical health is evident in the fact that 44% of those experiencing mental disorders also suffer from a mild to severe physical disability (ABS, 1998), indicating that a comprehensive health program should include both physical and mental health components. While emphasizing mental health, the ABC messages also included many physical activity recommendations that are conducive to good mental and physical health.

The majority of the focus groups were held in metropolitan Perth, the capital of the state of Western Australia (WA). Four groups were held in two regional WA cities (Kalgoorlie and Albany) to ensure representation of non-metro individuals. The country groups were segmented only by gender (one male and one female group in each location) because the small number of groups prevented more comprehensive segmentation. Only community-dwelling (non-institutionalized) individuals were included in the study, as those who are free-living have more control over their adoption of the behaviours recommended in the messages.

The individual interviews ran for between 20 and 45 minutes and the focus group interviews between 60 and 90 minutes. All interviews were audio-taped and the digital recordings were subsequently transcribed. The transcriptions were imported into NVivo7 (a qualitative data analysis software program) for coding and analysis. Theoretical nodes were created prior to coding, based on the extant literature, and inductive nodes were introduced throughout the coding process to allow emergent concepts to be incorporated. Reiteration between individual content nodes, node intersections and the full transcripts facilitated identification of themes relevant to motivation and ability in interviewees' reactions to the messages.

Findings

The interviewees were generally very positive about the messages, although the women tended to show greater

interest than the men. This positive reaction mirrored an acceptance among almost all interviewees that mental health is an important issue that is worthy of their attention. Interviewees were asked to nominate the advertisement they liked the most. The 'Feeling Blue? Act Green' advertisement was the favourite overall, followed by the television advertisement. The 'What does it mean to be mentally healthy?' advertisement was mentioned least frequently as a favourite.

The small number of interviewees who expressed very little interest in the messages were adamant that they were in excellent mental health and therefore had no need to attend to messages on the topic. Some also had a difficult time in coming to terms with the need for preventive behaviours, as they viewed mental illness as something to react to rather than prevent. This appeared to reflect a less informed and more fatalistic approach to mental health compared to physical health.

'I just don't believe in any of it... I can understand lots of people wanting to do this sort of thing but maybe it's just my lifestyle, I feel I don't need it... Mental health sort of strikes you down. You're smitten without cause or effect, it's not like smoking 50 a day.' (M, 40–54, metro focus group (FG))

In terms of interviewees' motivation and ability to process the messages and accept the provided recommendations, the major themes evident in the data were a desire to exhibit compliance, perceived personal relevance, sensitivity to the tone of the message, literal interpretations of message content and impediments to adoption. Each theme is discussed below.

Ticking the boxes

The immediate reaction of many interviewees, especially the women, was to move down the list of recommended behaviours and comment on their current level of compliance. It seemed important to them that they demonstrate that they are already 'doing the right thing', and many expressed pride in the extent to which they were already engaging in the recommended behaviours. Reflecting this, numerous interviewees explicitly noted that one of the most positive aspects of the messages was the reinforcement of existing protective behaviours.

'I would read it because I would be interested to see if there was anything that I wasn't doing, but it would reinforce that I'm doing everything I can to keep myself mentally active.' (F, 65–79, metro FG)

'It reinforces, and you do need to be reminded all the time.' (F, 55-64, metro FG)

Some of those who noted that they do not engage in many of the behaviours were somewhat defensive, and explained why a particular recommendation was not suitable for them. These explanations included dislike of the pastime, physical limitations or numerous current commitments that prevent them from taking on new activities. However, even among these people there was general acceptance that they could do more for their mental health and, now that they had been sensitized to the need for prevention, they would try to do more. The messages thus seemed to have a motivational effect on both those who were and those who were not engaging in the recommended behaviours.

'Um, I haven't [been engaging in the recommended behaviours] because of what I've been doing. I have two daughters with kids and they say, 'Are you doing anything today?', and I say, 'No', and they say, 'Can you come and babysit?'. There's a certain time of the week taken up with family things, but I have been wondering whether I should take up something. But I haven't worked out what yet.' (M, 64-79, individual interview (II))

It could happen to me

Perceived personal relevance of mental illness appeared to influence interviewees' interest in the content of the messages. Those who reported suffering from depression or anxiety in the past or had vicariously experienced mental illness through the afflictions of friends and families were particularly keen to learn as much as possible about protective behaviours. Experience thus appeared particularly important in determining whether the messages were perceived as personally relevant. As explained by one woman who had nursed her husband through a mental illness:

'I find that I read this because I've had dealings with mental illness. But it's like anything that you see, if it doesn't relate to you, you don't read it. But if it is something that relates to you or a friend or something, you think 'Oh yeah, there might be something new in it'. So you read it' (F, country FG).

For those who were convinced that they are of sound mental health and unlikely to experience mental illness, the motivation to act on the message was low.

'That's just telling you how to prevent yourself from being mentally unhealthy and having a problem. So that would say to me that unless I thought I had a problem, I wouldn't pursue it.' (M, 55-64, II)

Perceived relevance also related to whether the interviewees had personally or vicariously experienced the recommended behaviours. Once they had decided on the veracity of the information by comparing it to these experiences, they were better able to accept the message content. For example:

'Meals on wheels – Dad did that, he loved that. Mmm, okay.' (M, 40-55, II)

Related to this assessment of experience of the behaviours was a tendency for interviewees to present evidence of the effectiveness of the recommended behaviours as they contemplated the content of the messages. Sometimes this evidence was presented in the context that they were already aware of the mental health implications of the behaviours, and that this was a significant motivator of their participation. At other times interviewees appeared to be pleasantly surprised that some of their favourite pastimes are protective of their mental health. Either way, they derived pleasure from being able to provide tangible examples of the benefits to be derived from engaging in the behaviours. For example, one woman made this comment while reading the 'Feeling Blue? Act Green' message.

'That one makes me smile because I usually walk around the lake and I am usually power walking because I think that will do me good, but today I stopped because there were some long-neck tortoises that were in the lake that were trying to climb up a log. I was watching them and as one got up one had to fall off and it was so funny watching these tortoises all trying to get up on this skinny log. I stood there for ages and I was just laughing to myself at these little things that were trying so hard and it was all just so useless for them because as soon as one got there the other one fell off and it was just so lovely. It made me feel great.' (F, 65-79, metro FG)

Showing respect

A small number of interviewees noted the importance of the tone of the messages. They expressed dislike of being talked down to, and used terms such as 'goody goody', 'folksy' and 'schmaltzy' to describe those messages, or parts of messages, that they felt were condescending. For

these interviewees, their motivation to read the messages and abide by the recommendations appeared to be reduced by their sensitivity to the tone of the text. One interviewee made the following comment while reading the ‘What does it mean to be mentally healthy?’ message.

‘I sort of started to get a bit turned off at the beginning by the judgmental tone of it. I find it is a bit preachy, and, you know, I’m sort of one of those people who don’t like being preached at. Then when I got down further I thought, “Well, that’s starting to be positive”.’ (M, 55–65, II)

Communications targeting older people may therefore need to engage in adequate message testing to ensure that the information is being conveyed in a manner that is considered respectful.

Literal interpretations

There was a tendency for some interviewees to focus on the specific examples of protective behaviours provided in the messages, rather than appreciate them as activities that are exemplars of the kinds of behaviour that are protective of mental health. Although this may result from the demand characteristics of the test situation, it is possible that where specific examples are provided the audience may not move beyond them to other similar behaviours that are also beneficial, unless explicitly directed to do so. In addition, inability to relate to the specific examples provided may result in counter-arguments that prevent the individual from accepting the remaining content of the message. For example, one man explained to his fellow focus group participants that the recommendation to get closer to nature didn’t suit him, and as a result he would continue with his current favourite pastime, which might or might not be conducive to positive mental health.

‘Don’t get me wrong, I think it’s probably all right for people like yourself, but it does nothing for me. I don’t have a green thumb, I don’t have any plants. What I have got is the pub.’ (M, 65–79, metro FG)

For such individuals, listing of a wide variety of possible activities and provision of details of sources for further information may serve to increase their perceived ability to engage in protective behaviours.

I would if I could

Physical health limitations were noted by some interviewees

to constitute barriers to compliance with the recommended behaviours. This raises the possibility that sensitizing individuals to the need to engage in specific kinds of behaviour to protect their mental health may cause those who are physically incapacitated to feel more vulnerable. The comment below demonstrates the frustration that can be experienced by those who want to stay more active but are not able to do so.

‘I’ve been retired now and I try to fill my day. I have rheumatoid arthritis and I’ve got some damage there. With exercise I have to kind of pace myself; I’m very limited in what I can do, or the amounts that I can do. Physical exercise, the enjoyment of feeling physically fit, is something that I just don’t get much of these days because I am not physically fit with arthritis.’ (M, 65–79, II)

Inability stemmed from social as well as physical limitations. Some of the recommendations provided in the messages involved becoming more socially active, but those interviewees who were single reported finding it difficult to instigate social interaction. Attending group functions was described as overwhelming and embarrassing for those who had to enter a gathering on their own and attempt to break into existing friendship groups. Responses to the exercise recommendations also included comments about the desire for companionship while exercising, and that the lack of a partner was a major barrier to this activity. Comments relating to social concerns were more common among women.

‘I find it very hard to talk to strangers but I’ve made myself speak to people, unless if I speak to somebody and they don’t speak, I just go away. But I’m learning that I’ve got to speak and speak to different people.’ (F, country FG)

While inabilities relating to adopting the recommended behaviours were readily apparent in the data, inabilities relating to processing the content of the messages were almost non-existent. A partial exception was in a focus group of 65–79-year-old males, who reported difficulty in distinguishing the words of the spoken message over the background music featured in the television advertisement. This low incidence of perceptual difficulties may have been at least partly attributable to the request made during recruitment for interviewees to bring reading glasses to the interviews, effectively preventing problems associated with deteriorating vision.

Discussion

The findings provide support for previous work relating to advertising effects in general and health promotion communications in particular. As expected from Vakratsas & Ambler's (1999) model of advertising effects and Moorman & Matulich's (1993) health promotion results, both motivation and ability were key elements of interviewees' reactions to the messages to which they were exposed during interviews. In addition, the study yielded detailed information about the specific ways in which motivation and ability were manifest in interviewees' reactions to the messages. This information can inform communications, to maximize their ability to influence the attitudes and behaviours of the target segment.

Motivation to act on the recommendations provided in the messages appeared to be influenced by a desire to 'do the right thing', possibly reflecting a tendency among older people to prioritize personal responsibility and independence (Quine & Carter, 2006). Motivation also appeared to be heavily influenced by the perceived relevance of mental health to the individual, as determined by personal and vicarious exposure to mental illness sufferers. This experience effect is in line with the proposed role of experience in Vakratsas & Ambler's model.

The findings also suggest that motivation to process information contained in health promotion messages can be influenced by the tone used, and that messages targeted at older audiences should be carefully created and pre-tested to reduce the likelihood of causing offence by 'teaching grandma to suck eggs'. The tendency for female interviewees to appear more concerned and proactive about mental health issues may be related to their heightened predisposition to age-related mental decline as a result of their greater longevity (Watari & Gatz, 2002). Their dominance in caring roles also increases the likelihood that women will be vicariously exposed to mental illness more often than men, and hence may provide women with greater motivation to notice and heed mental health messages.

The contention that older people are likely to prefer affect-laden advertisements over more cognitive advertisements (Yoon *et al.*, 2005) was supported by the fact that the most preferred message ('Feeling Blue? Act Green') adopted a primarily affective or transformational approach. By comparison, the least preferred message ('What does it mean to be mentally healthy?') was the most informational. The tendency for some interviewees to note with pride the congruence between their current behaviours and those recommended in the messages is in line with the hypothesis that the experience of 'warm' feelings such as pride may

increase liking for an advertisement and favourably influence behavioural intentions (Aaker *et al.*, 1986).

The perceived ability of the sample members to comply with the recommendations was found to be related to their physical limitations, their social skills and their interpretation of the specific behaviours in the messages as indicative of a wide range of activities that are protective of mental health. This suggests that message developers should ensure that recommendations reflect the physical and social situations of older people and create awareness of the diverse range of possible actions that can be taken to promote health. Stating that listed examples are representative of a wide range of possible protective behaviours may assist in preventing formation of counter-arguments among those who do not consider the listed examples to be personally relevant.

Finally, the findings indicate that sensitizing individuals with poor physical health to the importance of physical activity for prevention of mental illness may be a source of anxiety, because it may suggest to them that they have increased susceptibility to mental illness. This can be minimized by ensuring that adequate examples of other kinds of protective behaviour (cognitive and social behaviours) are included in the messages. On a positive note, any negative outcomes of the effect of sensitization may be ameliorated by the tendency for those in poorer health to be more motivated to engage in health-promoting behaviours (Moorman & Matulich, 1993).

To conclude, the study has identified issues relating to motivation and ability that are particularly relevant to older audiences in the context of mental health promotion. The findings provide insights for the development of communications that seek to encourage older people to engage in behaviours that are protective of their mental health.

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Appendix – Press advertisement example

Feeling blue? Act green!

It seems that watching tv wildlife shows, exploring parks and gardens, looking at fabulous mountain and ocean views, and getting away from it all to the bush and Pacific island beaches are not only pleasurable, but are actually good for us!

Eminent biologists, psychologists, and health professionals are showing that contact with nature – whether through parks, natural bush, pets or farm animals – helps us recover from stress and mental fatigue, helps us relax and puts us in a good frame of mind.

Of course, most of us know this intuitively and it's probably why we are drawn to nature instinctively. We all know that a walk on the beach, down a bush track or in a park is good to clear the head when we feel a little tired or stressed.

So, next time you are feeling like a lift, 'act green': do some gardening, pet the cat or dog, take a walk around the park or head down to the water for some time out.

Better still, don't wait until you're tired or feeling flat. Act green more often. Being in touch with nature makes us feel good, builds good mental health and helps beat the blues. And it's as easy as A-B-C

Act – do some gardening; take a walk around the local park; watch a wildlife documentary; take time to watch the sun set; spend time with pets ...

Belong – get a group together for a picnic in a natural setting; visit a wildlife sanctuary with friends; join a hiking group ...

Commit – become a 'civic environmentalist'; join a tree planting group; volunteer to keep your local parks & gardens clean; take up orienteering; learn more about ecology; offer to take a home-bound person out to a park ...

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

**If you want to know more, visit www.mentallyhealthywa.org.au
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