Implementing a Mentally Healthy Schools Framework based on the population wide Act-Belong-Commit mental health promotion campaign

A process evaluation

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Abstract

Purpose – Mentally Healthy WA developed and implemented the Mentally Healthy Schools Framework in 2010 in response to demand from schools wanting to promote the community-based Act-Belong-Commit mental health promotion message within a school setting. Schools are an important setting for mental health promotion, therefore, the Framework encourages schools to adopt a whole-of-school approach to mental health promotion based on the World Health Organisation's Health Promoting Schools framework. The paper aims to discuss these issues.

Design/methodology/approach – A process evaluation was conducted consisting of six-monthly activity reports from 13 participating Western Australian schools. Semi-structured interviews were also conducted with key school contacts in November 2011 with nine schools who had signed partner agreements prior to July 2011.

Findings – The schools valued promoting the mentally healthy message and the majority felt the programme was implemented successfully. More intensive implementation was facilitated by a proactive and enthusiastic school "champion" who had influence over other staff, and who did not have too many competing priorities. Factors inhibiting implementation included a lack of effective time management, lack of whole school commitment, and evaluation demands.

Originality/value – Act-Belong-Commit is a positive, proactive message making it easier for teachers to talk about mental health with their students. For schools reporting implementation success, the Mentally Healthy Schools Framework raised the profile of mental health in the school setting and fostered a sense of belonging among students.

Keywords Health promoting schools, Implementation, School health promotion, Mental health promotion, School mental health, Project evaluation

Paper type Research paper

Introduction

Schools are an important setting for mental health promotion to prevent mental health problems (Power *et al.*, 2008), enhance quality of life, and contribute to the social and economic development of individuals, communities, and nations (WHO, 2000). Many

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mental health problems and disorders have a peak age onset in childhood or adolescence (McGorry *et al.*, 2007). Thus mental illness prevention and mental health promotion interventions targeting young people (including school-based health promotion) can reduce socio-economic differences in mental health among adolescents (Nielsen, 2015) and are critical for improving adolescent mental health overall. Young people spend almost half their waking lives at school and their experiences and relationships at school can have a substantial impact on their wellbeing, influencing both behaviour and academic performance (Bourke, 2003). Furthermore, the second principle of the 2012 Perth Charter for the Promotion of Mental Health and Wellbeing states that, "the foundations of social and emotional wellbeing develop in early childhood and must be sustained throughout the lifespan" (Anwar McHenry and Donovan, 2013, p. 63).

This paper describes the development and implementation of the Mentally Healthy Schools Framework developed in 2010 by Mentally Healthy WA (Western Australia) in response to demand from schools to promote the community-based Act-Belong-Commit mental health promotion message within a school setting. The Mentally Healthy Schools Framework is based on the World Health Organisation's Health Promoting Schools framework and encourages schools to adopt a whole-of-school approach to mental health promotion.

School mental health promotion

In recognition that schools are an ideal setting for promoting health to children and young people, Australia was one of the first countries to adopt the World Health Organisation guidelines for Health Promoting Schools. With a positive approach to wellbeing, the Health Promoting Schools model enables the development of targeted interventions and prevention within a universal approach to health promotion (Quirke, 2015). The Health Promoting Schools approach places mental health promotion within the context of a general education mandate, with all aspects of the school ethos, organisation, and environment placing an emphasis on how mental health promotion can contribute to the core business of the school (Paulus, 2009).

While the quality of evidence supporting the effectiveness of the Health Promoting Schools model is variable, it has been associated with reductions in students' BMI, cigarette use, and reports of being bullied, and increases in physical activity and fitness levels, and improved fruit and vegetable consumption (Langford *et al.*, 2014). Using the Health Promoting Schools approach in both development and implementation, school-based mental health promotion programmes have been associated with increased levels of resilience, social inclusion, and greater mean positive wellbeing among students (Levin *et al.*, 2012; Stewart, 2014). Health Promoting Schools can be transformative for individuals, reduce burden of disease, and support the wellbeing of the broader community, even with limited resources (Macnab *et al.*, 2014).

The effectiveness of the Health Promoting Schools model is dependent on a number of factors, that is school-based initiatives require both a whole-of-school and a school-led approach to intervention development and implementation (Quirke, 2015; Morrison and Kirby, 2010). Effective change achieved through the Health Promoting Schools framework is attributable to the empowerment of staff (including teachers) through "shared ownership" (Macnab *et al.*, 2014). Therefore, securing "buy-in" from school staff is essential for successful implementation, especially when they are expected to commit extra time and effort to the cause (Mũkoma and Flisher, 2004). Adequate and timely training, when accompanied by a healthy schools manual, can

provide a useful framework to ensure fidelity with respect to consistent and quality implementation through the provision of a clear structure or guidelines for implementation (Quirke, 2015). School-based mental health interventions should incorporate a number of key strategic actions including the introduction of supportive school policies, changes to the school environment, the development of students' problem solving skills and coping strategies, and participation of parents and the broader community (Morrison and Kirby, 2010).

Mentally Healthy WA's Act-Belong-Commit campaign

Mentally Healthy WA's Act-Belong-Commit campaign is an evidence-based, comprehensive, population wide mental health promotion framework that utilises universal principles of wellbeing (Donovan *et al.*, 2006b) with documented implementation success (Anwar McHenry *et al.*, 2012). The campaign targets individuals to increase their mental health literacy and engage in mentally healthy activities, while at the same time supporting and encouraging organisations that offer mentally healthy activities to promote and increase participation in these activities.

The goal of the campaign is to encourage people to become more proactive about their mental health in the three behavioural domains: Act, Belong, Commit. Specific aims are to: increase awareness that, as for physical health, there are actions one can take to strengthen and retain mental health; that increase knowledge of activities that strengthen mental health and wellbeing, and that increase participation in activities that yield mental health benefits. Thus, people can build positive mental health by keeping physically, mentally, spiritually and socially active (Act); by keeping involved in family and club or team activities and participating in community events (Belong); and by taking on challenges or causes that provide meaning and purpose in their lives (Commit).

There is substantial evidence that these three domains contribute to increasing levels of positive mental health and physical health (Donovan and Anwar McHenry, 2014; Donovan *et al.*, 2006a). The campaign is guided by the Ottawa Charter principles and is implemented via a community-based social marketing strategy. Since its establishment state-wide in Western Australia (WA) in 2008, Mentally Healthy WA has achieved ongoing partnerships with over 140 organisations, including health services, local governments, schools, workplaces, sports and recreation clubs, arts groups, and volunteering organisations. The campaign has diffused across Australia and, more recently internationally, with the first international hub at Denmark's National Institute for Public Health (Koushede *et al.*, 2015).

The literature supports targeting the Act-Belong-Commit framework to adolescents and children to improve mental health and wellbeing. For example, young people who are mentally, physically, and socially active (Act) report greater physical fitness (Blair *et al.*, 2001), psychological wellbeing (Biddle *et al.*, 2001; Clough and Sewell, 2000), and positive self-esteem (Daley and Buchanan, 1999). Positive socialisation among young people (Belong) protects against delinquent behaviour (Hawkins and Weis, 1985). When coupled with a sense of belonging to school, young people are more likely to be productive, report a greater sense of psychological wellbeing, feel happier, and demonstrate a greater coping repertoire (O'Brien and Bowles, 2013; Willms, 2003). Committing to a cause or contributing towards something with greater meaning or purpose (Commit) provides adolescents with greater life satisfaction and happiness (Magen and Aharoni, 1991; Magen, 1996), reduces stress, and increases immune functioning and life expectancy (McKnight and Kashdan, 2009; Cruess *et al.*, 2000).

The Act-Belong-Commit Mentally Healthy Schools Framework

The Mentally Healthy Schools Framework was developed to promote positive mental health using the Act-Belong-Commit message in a school setting. Based on learning from the evaluation of school mental health promotion interventions available at the time, the Mentally Healthy Schools Framework sought to increase knowledge and skills of school staff to create mentally healthy school environments, change student/staff behaviour and attitudes with respect to mental health and mental illness, strengthen community links with the school, enhance meaning and purpose of activities and events in which the students already participate, and increase student connectedness to, and teacher morale within, the school.

The Mentally Healthy Schools Framework encourages a whole-of-school approach to mental health promotion through each of the three domains of the Health Promoting Schools framework (Figure 1): Curriculum, Teaching, and Learning encompasses the incorporation of Act-Belong-Commit in all areas of the school curriculum through classroom resources developed by Mentally Healthy WA; School Environment, Ethos, and Organisation involves incorporating Act-Belong-Commit in the social and physical environment of the school through school policies and guidelines, school governance, and marketing (including event branding and publicity); and partnerships and services refers to schools being encouraged to partner with local clubs, groups, and organisations that offer opportunities for mentally healthy activities, or who share a vision for a more cohesive and mentally healthy community.

Implementation of the Mentally Healthy Schools Framework

With the support of an Australian Health Promotion Association (WA Branch) Graduate Scholarship (six months full time), a schools project officer was appointed full time for 12 months and part-time for the final six months of the pilot period (December 2010-June 2012). Following the promotion of the Framework through education and health promotion organisations, schools were invited to an information session at the Mentally Healthy WA hub in Perth, WA on Tuesday 16 November 2010, which included an overview of the Framework, how to apply for funding through the Healthway "Health Promoting Schools" scheme, and case study examples from two Australian schools who had adopted Act-Belong-Commit in their school community. Over 50 principals, teachers, school psychologists, nurses, and pastoral care advisors

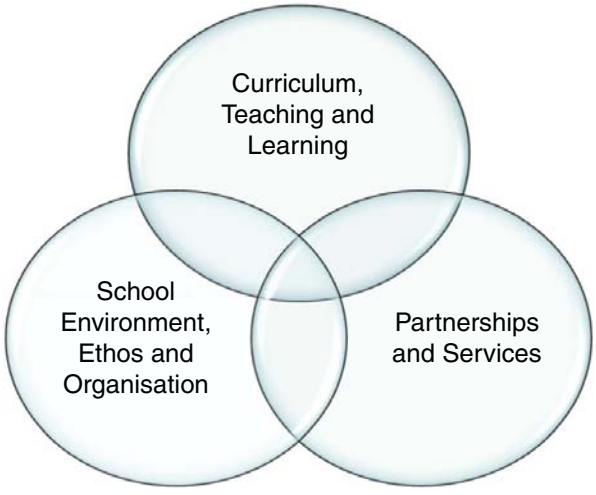

Figure 1.
The Health Promoting Schools framework

from various schools who attended the launch were invited to submit an expression of interest to take part in the pilot. Thus, the selection of schools for the pilot was based on convenience sampling, as individual schools approached Mentally Healthy WA directly to be involved in implementing the Mentally Healthy Schools Framework.

Schools who adopted the Act-Belong-Commit Mentally Healthy Schools Framework signed a School Partner Agreement with Mentally Healthy WA and nominated a key school contact for training and ongoing liaison. The agreement details mutually agreed obligations between Mentally Healthy WA and the school with respect to what it means to be a mentally healthy school and the expectations of the partnership, including acknowledgements, the provision of resources and promotional materials, and evaluation requirements. Schools were provided with strategies and resources to promote the campaign messages to students, staff, parents, and the wider community. As the framework complemented areas of the Australian school curriculum, it was not considered to be an additional burden on teacher workloads. The programme was also designed to be self-sustaining, that is, once the resources had been developed and the staff were trained, it provided a simple and ready-to-use framework for continued mental health promotion in the school setting.

A total of 13 WA schools participated in the pilot with key school contacts ranging from school psychologists, nurses, student services staff, principals, and teachers. The pilot schools included 11 public schools (eight secondary and three primary) and two private secondary schools (see Table I). One public secondary school was based in a regional town, the remaining schools were from diverse locations largely in the outer metropolitan area of the state's capital city, Perth. All of the pilot schools were mixed gender and ranged in size from 155 to 1,120 students (mean 639 students).

Code	Signed Partner Agreement	School type (i.e. primary/ secondary and public/ private)	Years	No. of students	Index of relative socio-economic advantage and disadvantage by suburb (percentile of WA, 2011)	Other
HS1	December 2010	Secondary/public	11-12	450	79	[a]
HS2	January 2011	Secondary/public	8-12	480	43	[a]
HS3	January 2011	Secondary/private (uniting church)	8-12	850	94	
PS1	March 2011	Primary/public	K-7	158	13	[a]
PS2	March 2011	Primary/public	K-7	155	29	[a]
HS4	March 2011	Secondary/public	8-12	937	80	
PS3	March 2011	Primary/public	K-7	430	89	
HS5	March 2011	Secondary/Public (independent)	11-12	500	33	
HS6	June 2011	Secondary/public	8-12	1,120	94	[b]
HS7	July 2011	Secondary/public	8-12	475	55	[c]
HS8	September 2011	Secondary/public	8-12	800	96	
HS9	October 2011	Secondary/public (independent)	8-10	500	93	
HS10	October 2011	Secondary/private (catholic)	7-12	1,450	24	

Notes: HS, high school; PS, primary school. [a]Students from diverse ethnic/multicultural backgrounds (e.g. indigenous/refugees, etc.); [b]Accredited Mindmatters School prior to signing of School Partner Agreement; [c]regional location

Table I. Participating pilot schools

The socio-economic indexes for areas (SEIFA) by suburb varied with pilot schools ranging from the 13th to 94th percentile on the 2011 index of relative socio-economic advantage and disadvantage for WA (ABS, 2013). School Partner Agreements were signed from December 2010 through to October 2011. Hence, there was considerable variation in the length of time schools had been implementing the programme. Nine schools were involved in the pilot phase for at least 12 months and the remaining four for at least eight months (average 13 months, ranging from eight to 18 months).

Following the signing of a School Partner Agreement, Mentally Healthy WA conducted a one-hour formal training session with the school on the Act-Belong-Commit campaign and the Mentally Healthy Schools Framework, followed by an action planning session. Schools were free to determine their own strategies and priorities for implementing the framework. Schools received a copy of the Mentally Healthy Schools Handbook and a CD containing resources to assist with the successful integration of the campaign into the school setting, including a "How-to Guide on Creating a Mentally Healthy School", ideas for activities and events, a "Speaker's Kit", interactive classroom resources, and a suite of brand logos. Schools received $150 worth of Act-Belong-Commit merchandise per year and an A-frame sign for the duration of their agreement. Schools also received ongoing support from Mentally Healthy WA's Schools Project Officer.

It was recommended that schools form Act-Belong-Committees, with student representation, to ensure continual implementation and shared workload. Schools were also encouraged to host an Act-Belong-Commit launch announcing their commitment to mental health and to brand their events and activities with the Act-Belong-Commit message. Resources were supplied to assist the embedding of Act-Belong-Commit into the curriculum and to integrate Act-Belong-Commit into school policies and guidelines, such as a student wellbeing policy, health and physical education policy, or health promoting school policy. Finally, schools were supported in their efforts to form mutually beneficial and supportive partnerships with organisations, groups, and services within the local community to strengthen community cohesion around a unifying theme of positive mental health.

Partnerships were formed with MindMatters and KidsMatter Primary to ensure the complementary integration of the framework with both of these initiatives. The Hon. Ken Wyatt, a Federal Member of Parliament, became the official ambassador for the framework. As ambassador, the Hon. Mr Wyatt assisted in the recruitment of schools to the pilot project and supported the Mentally Healthy Schools Framework by endorsing the handbook and speaking at launches and other official functions.

Evaluation of the Mentally Healthy Schools Framework

All schools were required to provide regular process data (every six months) to Mentally Healthy WA as a condition of the School Partner Agreement. As schools were free to determine which elements of the framework to implement, and how this would take place, a process evaluation was considered essential for determining how the intervention was being delivered (i.e. dose delivered/received), to whom (i.e. reach), and how often (Mũkoma and Flisher, 2004). The evaluation tools were adapted for the school setting from Mentally Healthy WA's existing evaluation tools used in ongoing campaign evaluation of Act-Belong-Commit partner organisations (Jalleh *et al.*, 2007; Donovan *et al.*, 2006b). Using the process evaluation spreadsheet provided in the Mentally Healthy Schools Framework Handbook (Appendix), key school contacts provided information on: Act-Belong-Commit events and activities held within the school, including numbers of participants, spectators, and volunteers; on-going school

projects; published news items and radio interviews; newsletter articles; presentations to students, staff, and parents; new resources developed as result of the Framework; and school policy changes that included mental health and/or Act-Belong-Commit. This simple process of observing and recording activities aims to ensure programme integrity by demonstrating whether it was implemented as planned (Nutbeam, 1998). Reminder e-mails were sent by the schools project officer four and two weeks prior to the due date.

Semi-structured interviews were conducted in November 2011 with key school contacts whose schools had singed the partner agreement prior to July 2011 (i.e. nine of the 13 participating schools) to assess the process of adopting the framework and identify barriers and facilitators to implementation. Post-implementation interviews were favoured over other forms of data collection, such as objective observation, for their low cost and fewer resource requirements (McGraw *et al.*, 2000). The interviews ranged from 15 to 45 minutes in duration. In two of the interviews, the key school contact invited other staff members who had been closely involved in the programme delivery to participate in the interview. This enabled an assessment of stakeholder "buy-in" by staff members who were responsible for the delivery and implementation of the intervention (Bracht *et al.*, 1994 as cited by Nutbeam, 1998). Both individual and small group interviews were conducted at nine schools with a total of 12 participants (three males and nine females) who ranged in age from 25 to 60 years. All interviews were conducted by the first author. The interviews were audio recorded, transcribed, and analysed thematically.

Results

Six-monthly reports

Table II summarises the schools' six-monthly reports. The most frequently reported implementation strategy was the branding of events or activities with the Act-Belong-Commit message ($n = 163$). This typically involved displaying signage and announcements explaining the mental health benefits of participating in the event or activity to the participants. Examples of some of the events and activities that were branded by the partner schools include an Act-Belong-Commit launch or expo,

Code	Events and activities	Ongoing projects	MH policy	Grants/ sponsorship	Media publicity	School newsletter	Presentations/ workshops
HS1	6	3	–	–	–	2	2
HS2	23	5	✓	2	3	20	6
HS3	34	12	✓	–	–	3	7
PS1	35	6	✓	–	–	–	2
PS2	21	17	–	–	–	1	–
HS4	15	–	–	–	3	1	–
PS3	3	13	–	–	–	–	1
HS5	6	1	–	–	–	6	–
HS6	2	2	–	1	–	–	1
HS7	3	3	✓	–	2	7	1
HS8	3	2	–	–	–	2	7
HS9	10	2	–	–	–	1	–
HS10	2	2	–	–	3	5	6
Total	163	68	4	3	11	48	33

Notes: $n = 13$ schools. ✓, mental health policy

Table II. Summary of achievements and activities undertaken under the Act-Belong-Commit banner: February 2011-June 2012

fundraising events (e.g. pancake breakfast, walkathon, HBF Run for a Reason, Australia's Biggest Morning Tea, 40 Hour Famine, etc.), athletics carnival, health promotion forums, careers expo, harmony week, staff wellness activities, whole-of-school sporting events, and performing arts incursions. The second most frequently reported activity was delivering the message through on-going projects ($n = 68$). Some of these projects included a wellness, resilience, or other similarly-named committee, and other ongoing workshops and activities, such as the Shine Program, Glee Club, an Act-Belong-Commit Circus Troupe, and Zumba classes. Whilst these events and projects primarily served to increase familiarity with the brand and associate the activity with positive mental health, school "champions" also delivered more intensive instruction on mental health via 33 presentations and workshops.

Schools reported 48 instances where their activities attracted publicity in school-based newsletters and 11 articles were published in local newspapers and other external publications, thus indicating some penetration of their local communities. Three schools received sponsorship funding from Healthway to support these activities and four of the 13 schools incorporated mental health into their school policies. A number of schools reported being in the beginning stages of forming community partnerships, but none of these were formalised when the final evaluation took place.

Key contact interviews

The semi-structured interviews probed why the key school contacts adopted the Mentally Healthy Schools Framework, what they thought would be the benefits of implementing the Framework, and what were the key facilitators of, and barriers to, implementation. Of the nine key contacts interviewed, five stated that they felt the implementation had been a "success", with the remaining four suggesting that the programme had not been implemented to the extent they desired due to a number of barriers. These subjective determinations of success were reflective of the data from the six-monthly reports (see Tables III and IV). For example, those who believed that

Table III.
Self-reported successful implementation by key school contact

Code	Partner agreement signed	Events and activities/ ongoing projects	Mental health policy	Publicity/ newsletter	Presentations/ workshops
HS2	January 2011	28	✓	23	6
HS3	January 2011	46	✓	3	7
PS1	March 2011	41	✓	–	2
PS2	March 2011	38	–	1	–
HS4	March 2011	15	–	4	–

Note: $n = 5$

Table IV.
Self-reported unsuccessful implementation by key school contact

Code	Partner agreement signed	Events and activities/ ongoing projects	Mental health policy	Publicity/ newsletter	Presentations/ workshops
HS1	December 2010	9	–	2	2
PS3	March 2011	16	–	–	1
HS5	March 2011	7	–	6	–
HS6	June 2011	4	–	–	1

Note: $n = 4$

implementation of the Mentally Healthy Schools Framework had been successful hosted an average of 34 activities and on-going projects during the pilot phase, whereas those who considered implementation was unsuccessful hosted an average of nine activities and ongoing projects .

Reasons for and benefits of adopting the Mentally Healthy Schools Framework. Overall, the most common themes expressed by key contacts related to the following: that their school participated in the project to raise the profile of mental health in a school setting; to make students and staff more open about mental health, thereby reducing stigma surrounding mental health problems; to increase attachment to the school by strengthening a sense of belonging and cohesion within the school; and to improve behaviour and academic achievement in the classroom. Each of these and related topics are elaborated further below. These schools recognised the importance of good mental health for their students, identifying it as a priority issue that didn't always get the profile that it deserved:

> Mental health is obviously a big priority in a high school situation (HS6).
>
> We know mental health in this area is a huge issue (HS5).
>
> It's about raising the profile of mental health and for kids to be mentally healthy (HS4).

The key contacts felt that the campaign facilitated open discussion about mental health amongst both staff and students. By enabling students to be more open about mental health, it was felt that the Act-Belong-Commit campaign had a de-stigmatising effect on mental health problems within the school setting. A noticeable change in students' attitudes towards mental illness had been observed in some schools:

> We always talk about the physical side […] this message has allowed us to talk about being mentally healthy and what you can do for that […]. It's made it easier for the kids to talk about it because it's out there and it's not […] seen as bad now (HS4).

A number of schools suggested that the positive and proactive approach to mental health allowed students to become comfortable with the topics of mental health and mental illness, and feel confident enough to broach the topic in certain circumstances. In fact, several key contacts identified the most rewarding part of implementing the Framework was the students' reaction to the message, in that it has given students a greater understanding of the difference between mental health and mental illness:

> It's changing the terminology. It's not talking about mental [ill] health it's talking about being mentally healthy. That's the big difference because it takes away that stigma (HS4).

The campaign was reported by some key contacts to also be successful in changing attitudes towards and reducing the incidence of bullying of students with mental health problems. It was further reported that the campaign has strengthened school cohesion and helped foster a sense of belonging amongst some of the students:

> You see kids that don't usually mix, actually mixing and working well together […]. Everyone's making more of an effort in the school to do more, to include kids more, to get more groups happening (HS2).

Some schools chose to adopt the Mentally Healthy Schools Framework because they recognised that mentally healthy children were more likely to concentrate better and have overall improved behaviour and academic achievements in the classroom:

> Mentally healthy children are happy, they are engaged and they are striving for improvement and in some cases excellence (PS2).

> At the end of the day […] happy healthy kids, happy school - and they learn more and they're more prepared to stay at school. Anything like that is a great benefit to the kids I work with (HS2).

Perceived facilitators of successful implementation. Consistent with their overall qualitative assessment, those respondents who felt the programme was implemented successfully in their school cited an average of five facilitators, whereas those who felt implementation was not as successful as desired cited an average of 1.5 facilitators.

The most commonly mentioned facilitator of successful implementation was the presence of a school "champion" who was enthusiastic, proactive, passionate, and deeply interested in the message. The role of school champion was often filled by the key school contacts responsible for implementation of the Mentally Healthy Schools Framework. Being in a position with influence over other staff and having fewer competing priorities facilitated the impact of these school champions.

The simplicity of the Act-Belong-Commit message was also cited frequently as a success facilitator. It was felt that the simple language allowed students to easily grasp what it means to be mentally healthy and understand the things they can and should do to promote and protect their own mental health and wellbeing. In this regard, schools felt the Mentally Healthy Schools Framework was a relatively straightforward programme to implement:

> It's very easy because it is terminology the children understand […] in that way it's very powerful (PS2).

> The beauty of it, it's just so simple […]. Because of that simplicity, it means that it can be incorporated across the school rather than necessarily being a whole bunch of crappy health jargon terms that most people look at you and go "you're talking a whole load of rubbish here" (HS4).

A majority of key contact interviewees mentioned that the complementary nature of the Mentally Healthy Schools Framework to the WA health curriculum facilitated implementation success. This was highlighted to schools during their training as it was important that they did not feel that adopting the campaign would be an additional burden. Indeed, all schools liked the ease with which the campaign fitted with what they were already doing:

> It actually fits very easily as we already do a lot of things that encourage kids to Act-Belong-Commit (PS3).

> It complements our other health programs and physical education programs (PS1).

The key contacts also noted that students made the connection between the Act-Belong-Commit message and other subject areas, not just the health curriculum, which was one of the many benefits of the Framework's complementary nature. Another benefit was the ease with which the Framework complemented and integrated into the MindMatters and KidsMatter Frameworks.

Adopting the Mentally Healthy Schools Framework allowed schools to link existing activities to the Act-Belong-Commit message which raised awareness of the added mental health benefits of participating, and thus promoted another reason to get involved:

> That's the really good thing. That's the message we want to get to other school staff is that it doesn't necessarily mean a lot of work […] it's doing things we're already doing but putting the Act-Belong-Commit message with it (HS2).

> Schools are already doing the Act-Belong-Commit message […] We wanted to implement a program that could get that [mental health] message out to the kids and also tie it in with everything else that you normally do with your whole school events (HS4).

The flexibility of the Mentally Healthy Schools Framework and the autonomy to choose how they delivered the Framework were also mentioned as facilitators to success. As each school has different priorities and needs, the flexibility to tailor their implementation was beneficial for them – especially in the case of minimising the burden on school staff. This need for autonomy was evident during the action planning section of the training sessions as different schools devised significantly different objectives and strategies to achieve the same overall goal of improving mental health and wellbeing.

This flexibility in the adoption and delivery of the campaign fostered a sense of ownership of the campaign within schools and hence supportive environment for implementation. A few schools mentioned how well the Act-Belong-Commit campaign was adopted compared to other programmes, due to the overwhelming support staff provided:

> The ease and how well it's been accepted across the school. Not having any resistance with something you bring into a school is remarkable really when you look at just about anything else that tries to get changed in the school (HS4).

Having an "Act-Belong-Committee" or equivalently named support team that met on a regular basis to discuss strategies for implementing the Mentally Healthy Schools Framework was a strong driver of success. More was achieved when a team was involved than when implementation was solely the responsibility of the key contact. Schools that had team members from a diverse range of subject areas, not just health, and with an interest in the message implemented the Framework more successfully. A few schools noted the value of including students as members of the Act-Belong-Committee and having a student group responsible for promoting the message. The schools that involved students in campaign planning, implementation, and decision making found they achieved more and that a greater number of students joined in events and activities.

A supportive school principal was another facilitator identified by some schools. As the ultimate decision maker, it was considered important to have the principal's support and approval for proposed activities to demonstrate to the whole school community that the school sees mental health as a priority:

> If the leaders are passionate about the campaign, and they model, and they provide support for teachers and networks and collaborative meetings that all just sets the tone very positively. If you don't have that, it's an uphill battle (PS2).

Those schools that hosted an official Act-Belong-Commit launch event reported it as a strong driver for successful implementation. The launch helped to spread the message to the entire school community whilst publicly asserting that their school was now an Act-Belong-Commit Mentally Healthy School. Some schools chose to launch the campaign during a school assembly whilst others elected to host an event with interactive activities and merchandise giveaways. When the key school contacts were asked what part of the Mentally Healthy Schools Framework implementation they liked best, the launch was a popular favourite.

The Act-Belong-Commit logo, merchandise and signage provided branding opportunities for the campaign message. The merchandise was offered to schools as

giveaways and prizes at Act-Belong-Commit activities. The logo and signage were identified as facilitating elements of the implementation because they were simple, easy to use, and served as a regular reminder about behaviours that keep you mentally healthy. The promotional materials "branded" school activities as mentally healthy activities and provided a "subliminal message for the kids" (PS3).

The majority of staff who attended the training session ran by the Mentally Healthy Schools project officer noted the case study section was the most useful to them as it provided tangible examples of what other schools had done. Finally, the help and support the Mentally Healthy Schools project officer provided to the schools was another facilitator of success of the pilot project.

Barriers to the Mentally Healthy Schools Framework implementation. The most commonly cited barriers, amongst both the schools that felt implementation was successful and those that thought it was less successful, were competing priorities and inadequate resources. Although the Mentally Healthy Schools Framework was developed in conjunction with the Australian School Curriculum to ensure it complemented the syllabus, some additional planning was required by school staff organising Act-Belong-Commit activities or projects and developing partnerships:

> The main barrier is time because you've got to compete with everything else in the school. And this is not something that all teachers see as a priority because their priority is to get through their curriculum, meet all the deadlines from the Curriculum Council and all these other pressures (HS1).

Despite acknowledgement by the broader school community of the value of the Act-Belong-Commit programme and the importance of positive mental health, several key school contacts were often confronted by resistance from school staff who considered that they did not have time to focus on the Mentally Healthy Schools Framework. In other cases, it was simply a matter of staff not being supportive because they did not see mental health as a priority or concern for them.

Competing time pressures also impacted on the regularity of Act-Belong-Committee (or equivalent) meetings. Due to the tight schedules of teachers, the time between meetings was often very long for some schools, which meant planning and implementation of agreed strategies was suboptimal. The lack of mental health/student wellbeing policies or guidelines also was considered a barrier to successful implementation by some key school contacts.

Several schools indicated they were dissatisfied with the curriculum resources, stating they were limited and sometimes inappropriate for certain age groups. Some secondary schools in particular reported that resources were insufficient for upper year levels, resulting in an additional burden on the teachers to produce their own material:

> Teaching resources are not appropriate for secondary schools. It's very primary focused […]. I couldn't use the resources at all (HS5).

> I think the resources provided are very minimal […]. You really do need to provide a lot more teaching resources, lessons and more class-based activities (PS1).

> There's not a lot in there (PS3).

When asked how the current resources could be improved, the following suggestions were made: include more lesson plans in general; include more practical, interactive class-based activities; link activities to other curriculum topics, e.g., personal development;

ensure the activities are able to be easily photocopied for ease of distribution; and, for the upper grade levels, activities need to be more information-based, assignment-based, and include more extended response type of materials. Some schools also requested permanent signage, which they felt would keep the campaign message salient. Additionally, a resource such as a factsheet or brochure for parents outlining the benefits of their child attending a Mentally Healthy School was also suggested by the key contacts.

Discussion

These results, while qualitative in nature, indicate that for those schools reporting implementation success, the Mentally Healthy Schools Framework was considered to have raised the profile of mental health in the school setting, reduced stigma surrounding mental illness, strengthened school cohesion, fostered a sense of belonging among students, and improved behaviour and academic achievements in the classroom. Schools generally valued promoting the mentally healthy message and enjoyed promoting it, indicating that as a positive and proactive message, Act-Belong-Commit made it easier and more comfortable for teachers to talk about mental health with their students. A facilitator for successful implementation is the programme's flexibility and the freedom schools have to devise their own objectives and strategies, tailoring the framework to their own school's priorities and needs, thus minimising additional burden on school resources and staff time.

The timing of implementation is important with an ideal planning phase of at least six months, including training, before commencing implementation early in the school year. As with other successful interventions, the schools that achieved the most during the initial implementation period were those with a proactive and enthusiastic school champion who could act as a "driver for change", were already well integrated into the life of the school, and did not have too many competing priorities (Wyn *et al.*, 2000; Stolp *et al.*, 2014; Nielsen *et al.*, 2015). The school champion is an invaluable resource for securing "buy-in" from stakeholders through a number of engagement strategies (Stolp *et al.*, 2014). Another strategy that secured "buy-in" from stakeholders was the formation of an "Act-Belong-Committee". As the local context in which implementation occurs is important for considering school staff and teacher readiness to deliver the programme, a supportive school culture, organisational structure, and policies are essential for programme sustainability (Clarke *et al.*, 2010; Barry *et al.*, 2005). The Act-Belong-Committee ensures participation by representatives of the whole school community in both the development and implementation phases, enabling the delegation of tasks among the team, and thus reducing the workload of the school champion (Stolp *et al.*, 2014; Rowling and Jeffreys, 2000).

Knowledge of mental health promotion and training of school staff are pivotal for successful implementation and school change for better mental health (Nielsen *et al.*, 2015; Rowling, 2009; Khan *et al.*, 2011). As such, the dedication of sufficient time to work through the Mentally Healthy Schools Framework Handbook with the key school contact is required, including clarification of important evaluation requirements and an emphasis on planning and brainstorming to support the development of ideas for implementing the Mentally Healthy Schools Framework. Staff changes can also impact on the nature and extent of organisational support (Quirke, 2015), therefore, to secure "buy-in" from school staff, ongoing training and regular forums for the discussion of wellness, as well as increase awareness of the positive correlation between school-based health promotion and student academic and behavioural outcomes, are recommended (Stolp *et al.*, 2014).

Limitations and future directions

The purpose of health promotion is to support individuals and communities to take action and control over the determinants of health, thus interventions typically differ in both the nature of implementation and delivery intensity (Nutbeam, 1998) making both the implementation and evaluation equally complex (Mũkoma and Flisher, 2004). When compared to other forms of interventions, Health Promoting Schools are considered to be less tangible and predictable, take longer to develop, and are not as easy to measure or control (Baum and Brown, 1989 as cited by Nutbeam, 1998). Likewise, the measurement of health promotion impact from action to outcome is difficult to trace in any single study (Nutbeam, 1998).

The limitations in the evaluation of mental health promotion interventions in the school setting is well documented. As with other interventions, schools participating in the Mentally Healthy Schools Framework were self-selecting, and therefore, the selection and randomisation of representative schools was not possible (Quirke, 2015). The burden placed on the project officer and school staff to both develop and implement the intervention, while also collecting and managing data for the evaluation, proved to be a strain on already stretched resources, thus impact evaluation data was unable to be collected and the collection of comprehensive process evaluation data was limited (Linnan and Steckler, 2002). The time required to formalise the partnership by way of the School Partner Agreement took longer than expected, and, for some schools, several months elapsed from the time the school made initial contact with the schools project officer to the time the School Partner Agreement was finalised. This resulted in less time for planning the implementation and official launch of the framework as teachers had to work around competing priorities, such as exams and school holidays. These delays had flow-on effects for the schools project officer's capacity to collect data for the impact evaluation of the project, including obtaining parental consent to collect data from the students themselves. In addition, the reliability of some elements of the process evaluation were questionable, for example, data concerning the reach of the activities (i.e. numbers of student attendance) was incomplete in several schools process evaluation spreadsheets, and the fidelity or quality of the implementation was not able to be captured with the evaluation tools used for data collection. The methodology for this evaluation was further limited with the source of the data solely from the key school contact, and not the students, parents, or other staff members, and the absence of any objective observation.

The lack of randomised control trials (RCTs) is often listed as a methodological limitation in the evaluation of school mental health promotion interventions (Simovska, 2012). As a setting for mental health promotion interventions, however, schools are dynamic, relational, and not easily controlled, provoking much debate on the most appropriate evaluation methods and outcome measures needed to ensure useable and actionable evidence (Simovska, 2012; Hawe *et al.*, 2004). Studies using RCTs have failed to demonstrate observable differences between intervention vs control schools attributed to extraneous variables impacting the control schools and the dilution of positive impacts within intervention schools (Quirke, 2015). Furthermore, school mental health promotion is often under resourced, therefore, evaluation of the effectiveness of school-based mental health interventions is highly variable in quality with many interventions of insufficient duration to produce lasting change, small sample sizes and high student drop-out rates, lack of objective measurement, and inconsistent implementation (Sawyer *et al.*, 2010; Langford *et al.*, 2014). As such, despite evidence supporting the use of the Health Promoting Schools approach to promote positive

mental health in schools, findings have been criticised for being inconsistent and difficult to compare across studies (Nielsen *et al.*, 2015).

The way in which key facilitators and barriers are addressed as they arise will determine implementation success (Quirke, 2015). In particular, challenges concerning time management, whole-of-school commitment to the project, and evaluation demands need to be considered when delivering interventions in schools. Thus, school staff need support from health promotion professionals in the development of resources and delivery of these interventions (Turunen *et al.*, 2006), while health promotion professionals, in turn, need to focus on how the intervention will assist schools in achieving their educational priorities (Rowling and Jeffreys, 2000). Many of the learnings from this pilot project have since been incorporated into the Mentally Healthy Schools Framework, including allowing greater time for planning and negotiating the School Partner Agreement, and the allocation of funds for both process and impact evaluation that draws on the methodological approaches of more recent school health promotion evaluation studies (e.g. Nielsen *et al.*, 2015; Macnab *et al.*, 2014).

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Act-Belong-Commit Event and Activity Register				
Date	**Event Title**	**Partners** (list key organisations)	**Target Group**	**Overall Attendance** (n)
e.g. 19-Mar-10	Act-Belong-Commit Sports Carnival	Sunsmart, local grocery store	Students	65

Act-Belong-Commit On-going Projects				
Timeframe	**Project**	**Partners**	**Target Group**	**Participants** (n)
e.g. Mar - May 2010	ABC Photography Project	Local community groups	Students, wider community	50

Published Newspaper Items Containing Act-Belong-Commit or Mentally Healthy WA			
Date	**Article**	**Newspaper**	**page**
e.g. 12-Jun-10	Launch of Act-Belong-Commit partnership	Subiaco Post	3

Newsletter Articles Containing Act-Belong-Commit or Mentally Healthy WA				
Date	**Article**	**Newsletter**	**Organisation**	**page**
e.g. 31-Mar-10	Act-Belong-Commit Community Walk	Govo News	Governor Stirling Senior High School	6

Act-Belong-Commit education sessions presented								
Date	**Presenter**	**Event**	**Audience**	**Presentation** (title)	**Workshop** (title)	**Conference Presentation** (name)	**Duration** (mins)	**Attendance (n)**
e.g. 2-Feb-10	School Psychologist	Partnership announcement	Staff		Building Resilience		30	15
e.g. 3-Mar-10	Head of H&PE	School Assembly	Students	Act-Belong-Commit			20	20

Miscellaneous additions to process data		
Date	**Additonal Item**	**Description**
e.g. 1-Jun-10	Wellbeing Policy	School wellbeing policy changed to include Act-Belong-Commit
e.g. 12-Jul-10	Successful grant application	$2,500 Healthway grant received for 'Health Day' launching Act-Belong-Commit