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Evaluation of the "PsychoŻak" mental health promotion programme for university students. Report of a pilot study

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Summary

Aim. This article presents the results of the evaluation of the pilot of the "PsychoŻak" mental health promotion programme for university students. The main aim of the "PsychoŻak" programme is to enhance students' wellbeing in the mental (including emotional and cognitive), physical/somatic and social spheres, which is in line with the previously researched expectations of young adults towards mental health promotion.

Method. A comparison was made between selected mental health indicators and the mental health knowledge and competences of participants before and after taking part in the mental health promotion programme. An evaluation questionnaire on the content presented in the programme and the General Health Questionnaire (GHQ-28) were used.

Results. The analysis of the collected data indicates an increase in mental health knowledge and competences after participation in the mental health promotion programme. Most of the observed differences were statistically significant. Participants in the mental health promotion programme were also characterised by better mental health indicators, as measured by the GHQ-28, after completing the programme.

Conclusions. The evaluation of the pilot implementation of the "PsychoŻak" mental health promotion programme for university students confirms that the intended effects have been achieved and supports the programme's relevance for universities.

Key words: mental health promotion, university students, evaluation

Introduction

Epidemiological data from Poland and around the world indicate that an increasing number of people are experiencing a wide range of mental health problems, including serious mental disorders, which are related to successive crises such as the COVID-19 pandemic, war, the climate crisis, and economic crises [1, 2]. Mental disorders affect

people of all ages, including children, youth, and young adults [3-6]. Recommendations from the WHO and expert networks of both researchers and clinical practitioners point to the need for the prevention of mental disorders and the strengthening of mental health, including through its promotion [7-10].

Mental health promotion is a process of enabling everyone to improve and maintain their own mental health [11]. It not only seeks to prevent mental health problems (prevention) but also shapes and strengthens health (promoting positive mental health and wellbeing) [12, 13]. Promoting mental health in educational institutions is regarded as a priority [2, 7]. The development of mental health promotion programmes is seen as a way forward [14]. The effectiveness of these programmes depends on a few factors, including whether they were developed based on up-to-date research and empirical evidence, the degree to which programmes are focused on the needs of the individual, and testing and evaluation [15-18]. The evaluation of mental health promotion activities is particularly important for monitoring the effectiveness and efficiency of the activities undertaken. The results of these evaluations form the basis for recommending the implementation of a mental health promotion programme or the need to make changes prior to their use [15].

This article presents the results of a pilot mental health promotion programme, 'PsychoŻak', developed for Polish university students, which was conducted at one of the universities in Warsaw.

The 'PsychoŻak' mental health promotion programme

The aim of mental health promotion is to create appropriate conditions for an individual to develop strategies which will enable them to meet their mental health needs and contribute to their personal development [19]. The academic environment is where young adults spend several years, developing not just their cognitive and professional skills but also their social competence. During this time, young people face new challenges, including educational development, acquiring professional qualifications, increasing independence, and taking responsibility for their own decisions [13, 20]. It is important for the university environment to provide students with opportunities to accomplish these tasks and to support them when they encounter challenges in doing so [21-24]. This is especially important in early adulthood, which can be challenging for some individuals. This is often the time when serious mental health problems can appear, i.e. the onset of symptoms of a first episode of psychosis [25-27]. Therefore, the university plays a key role in providing mental health promotion programmes to support students in this time [4, 8, 9, 28, 29]. 'PsychoŻak' is a mental health promotion programme developed by a team from the Institute of Psychology at the Maria Grzegorzewska University in Warsaw, as a response to this need.

The main objective of the 'PsychoŻak' programme is to strengthen students' wellbeing in the psychological (including emotional and cognitive), physical/somatic,

and social domains [13], which is in line with the previously assessed expectations of young adults regarding mental health promotion [30]. The principles of the programme have been described (including the stages of programme development and its content and implementation rules) in separate publications [13, 31]. The meetings focus on enhancing the mental and social wellbeing of students by, among other things, transferring knowledge about mental disorders, mental health, the factors that determine it, and strengthening the competence for taking care of it, such as effective coping with stress. The programme content includes training in recognising and expressing feelings, training in coping with stress, a workshop on how to establish and maintain meaningful relationships and how to take care of one's physical condition; information regarding mental health and ways to take care of it, as well as on mental disorders (their recognition and forms of support for people suffering from mental health disorders), provided in the form of a mini-lecture. The classes emphasise the multidimensionality of mental health and the role of the individual in building and maintaining mental health [13, 31].

Students of the Maria Grzegorzewska University of Special Education in Warsaw (APS) took part in a pilot of the 'PsychoŻak' mental health promotion programme. The entire programme consisted of eight three-hour meetings held once a week, face-to-face. The workshops were conducted by trained psychologists, employees of the Institute of Psychology of APS. Participation in the workshops was voluntary and free of charge. It was neither group psychotherapy nor a support group. The workshops were aimed at all students, which is in line with mental health promotion activities. Through its group character, it provided an opportunity to develop interpersonal skills in a peer group under the guidance of a specialist.

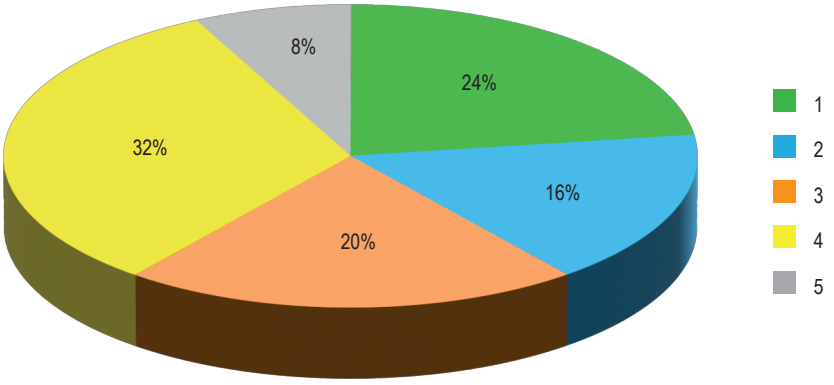
Information about the programme and enrolment was available on posters distributed at the academy and on its website. The programme was evaluated formatively to check whether the proposed content and the form of its presentation met the objectives of the programme [15] and whether the programme in this form can be recommended to university students. The implementation of the evaluation took place within the framework of the statutory project entitled: 'Piloting study of the mental health promotion programme "PsychoŻak" for university students' No. BSTP 35/15-I. The project was positively reviewed by the University Ethics Committee.

Material and method

The aim of the study was to answer the following questions:

1. Did knowledge of mental health and ways to strengthen one's own mental health increase among the group of people who completed the 'PsychoŻak' mental health promotion programme?
2. How, and to what extent, did participation in 'PsychoŻak' contribute to changes in the level of selected mental health indicators of the respondents?

The pilot of the 'PsychoŻak' programme was started by 59 people and completed by 25, whose data were taken for analysis. These were female students of psychology (11 people, 44%) and pedagogy (14 people, 56%). The average age of the workshop participants was 23.9 ± 5.4. Two students declared that they were receiving psychological support, and one was under the care of a psychiatrist. Figure 1 shows the characteristics of the group by year of study.



1 – 1st year students, 2 – 2nd year, 3 – 3rd year, 4 – 4th year, 5 – no data

Figure 1. **Percentage comparison by year of study of participants in the 'PsychoŻak' mental health promotion programme**

Three research tools were used in the study, in sequence:

1. A sociodemographic questionnaire, in which respondents provided their age, gender, field of study, and a code to pair the data received.
2. The General Health Questionnaire (GHQ-28) by David Goldberg, adapted by Zofia Makowska and Dorota Merecz, which is used to assess the mental health status of adults. It is a screening tool that identifies individuals whose mental state has broken down (temporarily or long-term) because of experienced problems, difficulties, or mental illness. The GHQ-28 consists of four scales: somatic symptoms (scale A); anxiety and insomnia (scale B); dysfunction (scale C); and depressive symptoms (scale D), each of which contains seven questions. The respondent refers to each statement on a four-point scale, which includes responses such as 'better than usual'/ 'not at all', 'same as usual'/ 'no more than usual', 'rather more than usual'/ 'rather worse than usual', and 'much more than usual'/ 'much slower than usual'.
3. An evaluation questionnaire with 16 statements and open-ended questions relating to the content of the programme. It was prepared with the programme [13] and was designed to assess the knowledge that participants in the mental health promotion programme already have and are expected

> to acquire in subsequent meetings. Students respond to the statements on a scale of 1-5, where 1 means 'completely no' and 5 means 'completely yes'. The statements include knowledge of how to deal with stress, factors affecting mental health, and taking care of mental and physical health. The open-ended question, 'How do you take care of your mental health?', was designed to test the knowledge that participants gain by taking part in the 'PsychoŻak' programme [13, p. 70].

The sociodemographic questionnaire was filled out by the participants once, at the beginning of the first workshop. The GHQ-28 and the evaluation questionnaire were completed by participants twice – at the beginning of the first workshop as a pre-test and at the beginning of the last workshop (the eighth) as a post-test.

Results

Quantitative data analysis

Data analysis was performed using IBM SPSS Statistics software, version 26. The Student's *t*-test was used for variables with a normal distribution, while the Wilcoxon signed-rank test was used for variables whose distribution deviated from normal.

First, the results of the evaluation questionnaire, which was completed at the beginning and the end of the programme ($N = 25$) were analysed. Cross-analysis of the data obtained from the evaluation questionnaire shows higher scores in all 16 statements of the 'PsychoŻak' programme, and in the following 11 statements the increase is statistically significant:

- I know how to take care of my mental health: $Z = -3.274$, $p = 0.001$;
- I take care of my mental health on a day-to-day basis: $t = -4.342$, $p < 0.001$;
- I have my own effective ways of learning: $t = -5.335$, $p < 0.001$;
- I know effective learning techniques: $t = 4.843$, $p < 0.001$;
- I understand what a balanced diet is: $Z = -3.274$, $p = 0.001$;
- I can distinguish between mental health problems and temporary unwellness: $Z = -3.213$, $p = 0.001$;
- I have strengths: $t = -3.381$, $p = 0.002$;
- I am aware of the relationship between my feelings and my behaviour: $Z = -2.000$, $p = 0.046$;
- I can provide some examples of how mental health difficulties can affect daily life: $Z = -2.066$, $p = 0.039$;
- I know a minimum of three ways to effectively cope with stress: $Z = -3.497$, $p < 0.001$;
- I use effective ways to cope with stress: $t = -3.273$, $p = 0.003$.

No statistically significant differences were found; however, higher response rates after participation in the entire programme were noted for the following questions:

- I eat a balanced diet daily: $t = -1.886$, $p = 0.073$;
- I regularly participate in sports: $Z = -1.956$, $p = 0.051$;
- I would seek advice from a psychologist/psychiatrist if needed: $Z = -1.249$, $p = 0.212$.

Second, the scores obtained on the GHQ-28 were analysed. Analysis with the Wilcoxon test showed that the scores on the overall GHQ-28 and on the two subscales were statistically significantly different between the pre- and post-programme measurements. Table 1 shows the results obtained.

Table 1. **Results of comparative analysis of data obtained with the GHQ-28 before and after the programme**

Score: overall and GHQ-28 scales	**Measurement before training**			**Measurement after training**				
	N	*M*	*SD*	*N*	*M*	*SD*	*Z*	Wilcoxon test – *p*
Overall GHQ-28 score	**18**	**56.7**	**14.6**	**24**	**48.6**	**12.8**	**2.332**	**0.020**
Scale A	**19**	**15.4**	**4.5**	**25**	**13.5**	3.5	**2.179**	**0.029**
Scale B	18	14.6	4.7	25	13.2	4.6	1.508	0.132
Scale C	**20**	**16.0**	**3.8**	**24**	**12.4**	2.7	**-2.507**	**0.012**
Scale D	20	10.9	4.3	25	9.4	4.1	1.725	0.084

'Before' refers to data collected in the pre-test, i.e. in the first classes of the programme; 'after' refers to data collected in the post-test, i.e. in the last, eighth classes of the programme. *N*-number, *M*-mean, *SD*-standard deviation, *Z*-statistic value, *p*-statistical significance level

At the end of the programme, participants' scores were significantly lower compared to the pre-programme measurements on two GHQ-28 scales: the somatic symptoms scale (scale A) and the dysfunction scale (scale C), indicating that their overall physical wellbeing had improved and their perceived difficulties had decreased. On the other two GHQ-28 scales – anxiety and insomnia (scale B) and the depressive symptoms scale (scale D) – scores were also lower, but the differences were not statistically significant.

Qualitative data analysis

To gain a deeper understanding of the changes that have taken place in knowledge regarding mental health and ways of taking care of mental health, the responses to the open question 'How do you take care of your mental health?' were analysed. This question was asked because mental health literacy was a key tenet of the programme. Twenty-four evaluation questionnaires were analysed (one person completed only

the quantitative evaluation). A competent judge procedure was used to analyse the responses from the evaluation questionnaires. It included references to the criteria of the Functional Model of Mental Health [13, p. 32-33], i.e. consideration was given to: (A) the state of wellbeing, (B) individual resources, and existing (C) social resources to benefit from individual and institutional support. Mental health was thus linked to physical wellbeing, individual emotional, cognitive and social competencies, and existing environmental resources [13, p. 63-64] – which dimensions were previously used to construct the 'PsychoŻak' programme.

The procedure for analysing statements

Expert judges analysed the statements of female participants before and after the programme. By coding the responses, it was determined whether:

1. Does the participant formulate a positive answer to the question: 'How should mental health be taken care of?' (code 1). It was assumed that a lack of positive actions means the participant either does not mention any ways to take care of one's mental health or expresses the belief that there are no ways to support one's mental health (code 0).
2. Does the content indicated – as important for mental health enhancement – refer to somatic health, linking care for a state of wellbeing to physical health (code A) and/or refer to care for individual resources that support mental health, e.g. caring for one's own wellbeing, looking for ways to cope with stress, training memory and learning strategies, etc. (code B) and/or refer to environmental resources, indicating taking care of one's health using support from peers or specialists, etc. (code C).
3. Whether the ways of caring for mental health – understood as caring for individual resources (code B) – can be further characterised and specified: (I) whether they take into account emotional aspects, e.g. personal coping with emotions, caring to enjoy life and appreciate oneself, problem-solving, coping with stress in daily life, etc. (in which case, next to code B, its specificity, i.e. code BI, was to be entered); (II) whether they include cognitive aspects, e.g. care for cognitive health and cognitive strengths, involving the acquisition and use of knowledge, to work effectively on learning strategies, memory, and attention (code BII); and (III) whether they include caring for social health, e.g. ensuring one's own social wellbeing, emphasising contribution to building constructive relationships with others, and personal/individual effort to build and maintain relationships (code BIII).

Results of qualitative data analysis

The coding levels – from A to C – completely exhausted the possibilities; there were no uncoded statements left by participants before and after the programme.

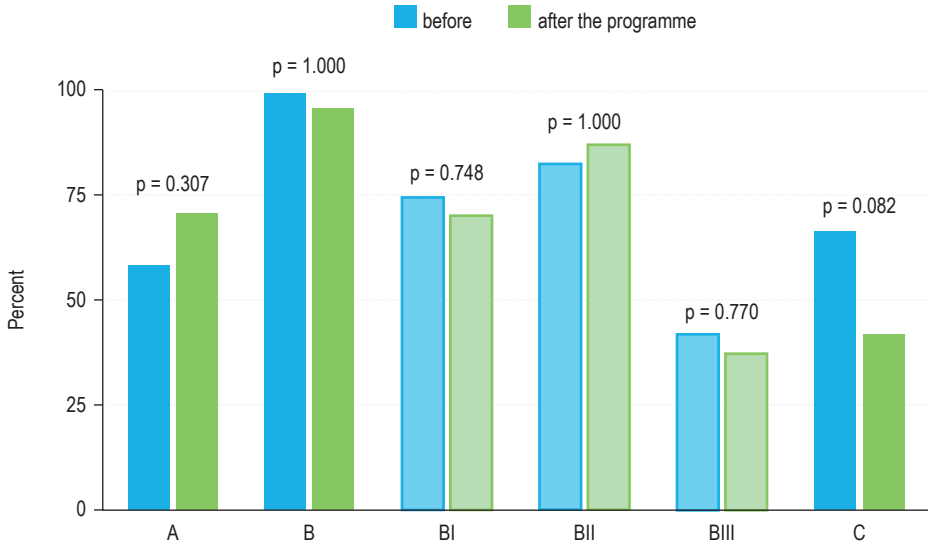
However, individuals did not always use all possibilities coded by the expert judges (from A to C, with detailing at B from BI to BIII) when describing ways to take care of their mental health. Table 2 shows the numerical and percentage description of the prevalence of the six categories of ways of taking care of one's mental health, before and after the 'PsychoŻak' programme. All respondents reported ways of caring for their individual mental health resources before the programme (category B), while 95.8% reported them after the programme. An example of taking care of the emotional and cognitive dimensions of health is provided by a participant after the training: [I take care of my mental health] *By naming emotions and feelings. By looking for the sources of problems, bad feelings, events, facts, or situations that cause (not necessarily in a way I am aware of – hence looking for) discomfort and feelings of dissatisfaction*). This is similar to the statement of another participant, who also emphasises the emotional and cognitive dimensions of mental health, but does so before the training: [To take care of my mental health] *I reduce tension, I try to cope with stress well, I find time for pleasure, I live in harmony with myself.*

Table 2. **Numerical and percentage description of the prevalence of the six categories of mental health care modalities before and after the PsychoŻak programme**

Description	*N* before	% before	*N* after	% after
A attention to physical condition, which can be linked to mental health	14	58.3	17	70.8
B attention to individual resources related to mental health	24	100.0	23	95.8
BI caring for individual resources related to the emotional dimension of mental health	18	75.0	17	70.8
BII attention to individual resources related to the cognitive dimension of mental health	20	83.3	21	87.5
BIII caring for individual resources related to the social dimension of mental health	10	41.7	9	37.5
C caring for community resources that provide support to others	16	66.7	10	41.7

Note: the BI, BII AND BIII categories do not add up to 100%, as attention to individual resources may have simultaneously addressed two or even three dimensions of mental health, i.e. the emotional dimension of BI and/or the cognitive dimension of BII, and/or the social dimension of BIII.

Figure 2 shows that the pre – and post-programme scores are very similar in each of the six coded categories, and no statistically significant differences were observed.



Comparisons described as A refer to physical health care activities considered important in the context of mental health (described 'before' in blue, 'after' in green). Comparisons described as B refer to care activities for individual resources important for mental health. In addition, category B is subdivided into BI, which denotes care for individual resources concerning the emotional dimension of mental health; BII, which denotes care for individual resources concerning the cognitive dimension of mental health; and BIII, which denotes care for individual resources concerning social health. Category C describes social/environmental resources (described 'before' in blue, 'after' in green) (statistical significance *p* was analysed using the $\chi 2$ test with appropriate Yates or V-square corrections).

Figure 2. **Percentage comparison of the prevalence of each of the six codes before and after the 'PsychoŻak' programme**

The qualitative categories received before and after the programme were retained in 52.8% of participants – more than half of the trainees mentioned a particular way of taking care of their health both before and after the programme. This was most often in relation to individual resources (code B), particularly taking care of one's emotional (code BI) and cognitive (code BII) competencies. An example of this comparative emphasis on caring for physical health, individual resources, and social resources can be seen in two statements made by participants. One statement written before the training reads: *I try to get negative emotions and experiences out of me, although I usually only use two methods: talking, crying, sometimes I also pour my thoughts into text (blog, loose papers). For some time now I have been trying to worry less about things I don't need to worry about (e.g. concerning others). I am aware that my mental health is also affected by my physical functioning; in moments of high stress, I go out for some fresh air*. The statement written after the training included similar categories, i.e. care for physical health, individual resources, and social resources: *I play sport regularly.*

I take on fewer responsibilities. I try not to worry about what I don't need to worry about. I speak up when something doesn't suit me. I am surrounded by inspiring and positive people. I look for myself; *I don't force myself to do anything. I try not to blindly follow patterns. I 'let go' when I don't have to do something 100%.*

A total of 14.6% of participants did not mention certain dimensions of caring for mental health either before or after the workshop. Most often, when some dimensions were omitted, they concerned ways of taking care of social resources (code C) and caring for individual resources related to social health, i.e. individual abilities to sustain these social relationships (code BIII). These can be seen as two sides of the same coin. On the one hand, one needs objectively existing environmental resources, an opportunity for meaningful social relations, provided by the presence of people and the real possibility of using these resources within specific institutions or groups. And on the other hand, one needs to be able to recognise the emotional value of relationships with others, put personal effort into establishing and maintaining satisfying social interactions, to nurture bonds. A person must take care to develop her interpersonal competencies and strengths, which include caring for others. An example of such a comparable 'abandonment' is provided by one participant, who stated before the training: *Seldom staying up at night – doing activities during the day and not carrying them over into the night*. After the training, the same participant provided a statement that also does not mention social resources or building one's own interpersonal competencies: *Relaxation. Doing something for pleasure*.

A total of 13.9% of participants mentioned a way of taking care of their mental health after the programme – including a new dimension. Codes that were absent before the training (0) appeared after the inclusion of the new strategy (1). An example of this, although not very elaborated, covers multiple aspects of mental health care. One participant stated before the training: *Sleep, diet, relaxation, sport, interpersonal contacts, hobbies, self-development.* After the training, the same participant retained these elements and appropriately expanded them, adding attention to the cognitive dimension of mental health*: Self-awareness, analysis of the day, issues, difficulties (reflections, thoughts, solutions); sleep, diet; talking to loved ones about difficulties; movement (walking); greenery and surrounding oneself with nature; realising dreams and plans in harmony with oneself.*

At the same time, 18.8% of respondents did not return to the previously described dimensions of mental health care after the programme. Codes that were present before the training (1) were not reported later (0) when no new strategies were adopted. An example is a statement before the training about taking care of healthy sleep, the cognitive dimension, and the social dimension of mental health*: I sleep as much as I need. I solve difficult feedback*. The post-training statement omits these issues*: I go to a psychologist; I talk about emotions.*

Discussion of the results

One of the principles of good practice in mental health promotion is evaluation, i.e. checking whether the objectives of the health promotion programme are being implemented and having the desired effect, or whether they need to be changed [15, 16]. When the results of the formative evaluation of a programme are negative, it is necessary to look for other solutions and to change the activities [32]. All of this is done to shape and strengthen mental health. In the process of preparation of the 'PsychoŻak' mental health promotion programme, formative evaluation was also considered. A questionnaire was prepared concerning the expected effects of the programme, a method of evaluation was described (pre- and post-test) [13], and evaluation was used during the pilot implementation of the programme.

The analysis of the data obtained from the evaluation questionnaire of the 'PsychoŻak' mental health promotion programme shows higher scores in all responses of the questionnaire completed at the end of the workshop compared to the pre-test data received. Most of the observed differences are statistically significant. This means that participation in the 'PsychoŻak' mental health promotion programme has significantly, in the opinion of the participants, increased their awareness and knowledge of what mental health is, how to take care of it, what ways of coping with stress they can use, where to seek help in mental health crises, what symptoms may indicate a crisis – both experienced by themselves and others – and how to react appropriately in such situations. The observed significant changes in respondents' answers before and after participation in the mental health promotion programme indicate the validity of the methods used and the content of the programme. Through the content and the way of working, programme participants increased their awareness of mental health and mental health care, which was a key objective of the 'PsychoŻak' programme. Psychoeducation, including information on mental health, its dimensions, and the factors affecting it, is a recommended way to promote mental health among students [21, 29]. Equally important is shaping and strengthening coping with stress through, for example, presentations and practice of relaxation techniques [24], which is the subject of the programme.

Interesting data were obtained from the qualitative analysis of the responses. It turns out that the female participants had a high awareness of mental health from the very beginning of the programme. Comparing their answers to the open-ended question: 'How to take care of mental health?', no significant differences were noticed before and after the workshop. At the same time, it can be confirmed that the programme's enrollees have a lot to say about ways of taking care of their health – and that these ways are varied and adequate. It is likely that the programme attracted such knowledgeable people and that participation in the programme did not diminish this knowledge, but – most likely – simply consolidated it. Three statements can be quoted to document the above claim, the first two of which were entered in the questionnaire before the training: (1) *I try to listen to myself. I allow myself to experience emotions and situa-*

tions from my life, I analyse them and try to draw conclusions. I try to act according to my views/feelings in a conscious way. In addition, I try to maintain a balance between being alone and being with people. I try to calm and soothe myself by giving my 'head' a rest. Moreover, I see a psychotherapist; (2) *I rest, I don't overload myself cognitively. I find time to think about myself, I try to be attentive to my body's signals and my emotions and to the here and now, I take care of my physical health – a healthy diet and physical activity, I maintain healthy interpersonal relationships, I become more aware of my emotions and my health; (*3) *I do sports regularly (3-4 times a week), follow a balanced diet, try to get enough sleep, relax when I can't manage, I don't hold negative emotions in but try to express them and have an optimistic attitude towards the world. I deal with stress by going to fitness classes or by talking to loved ones*. All three statements are multidimensional, taking into account personal as well as social resources, which underlines the participants' awareness.

Another interesting example of respondents' awareness of mental health and taking care of it is the previously mentioned statement from before the workshop: *I sleep as much as I need. I solve difficult situations as they arise, I go to a psychotherapist if I need to. I learn to give constructive feedback.* This contrasts with the omission of these issues in a statement after the programme: *I go to a psychologist; I talk about emotions.* Changing forms of mental health support does not mean worsening or lowering self-care. Awareness of one's own needs makes it possible to choose adequate forms of shaping and strengthening one's own mental health, and this is how the participant's statement can be understood. Awareness is shaped, among other things, through the dissemination of knowledge and education in mental health, which was the working method of the 'PsychoŻak programme. It is possible that the field of study attended by the programme participants was relevant to the data obtained. The pilot 'PsychoŻak' programme was implemented at a pedagogical university, and the participants were students of psychology and pedagogy. Both fields of study prepare students to work with people, including individuals with different needs, and include content on mental health and caring for it in the study programmes. The mode of studying is also adapted to the special needs of students, which should be the current standard [33]. It would be important to further implement the programme and its evaluation in other fields of study, e.g. technical studies.

The aim of mental health promotion and the programme presented here is to impact mental health in the sense of shaping and enhancing it [34]; hence, as part of the evaluation, participants were asked to complete the screening General Health Questionnaire (GHQ-28). A comparative analysis of the data obtained at the beginning and at the end of the programme also shows differences, with the data from the second measurement being lower. Participants in the study, after the implementation of the 'PsychoŻak' health promotion programme, were characterised by significantly lower scores on the somatic symptoms scale (scale A) and the dysfunction scale (scale C).

The referenced programme presents the previously mentioned stress-coping techniques and the importance of applying them and taking care of somatic health, which

can have a significant impact on reducing the severity of somatic symptoms in participants (scale A). Physical activity, a proper diet, adequate sleep, and effective methods of managing stress are very important for the body. People who accumulate tension in the body often experience chronic headaches, abdominal pain, reduced physical condition, sleep difficulties, and chronic fatigue. Somatic symptoms typically reduce quality of life, can increase sensitivity to stress, and reduce coping effectiveness [35]. Worse somatic functioning can impair the quality and quantity of relationships that are built and nurtured. Sometimes somatic difficulties contribute to withdrawal from relationships or cause conflict. Somatic difficulties and perceived pain increase anxiety and irritability, which are felt by those around them [36]. Reducing somatic symptoms can be important in building and maintaining relationships, which is particularly important in early adulthood. Due to the severe stress experienced by young people in recent times, e.g. related to the COVID-19 pandemic and the war in Ukraine, it seems crucial to shape adequate ways of coping with stress, e.g. by increasing knowledge about reducing stress symptoms, building resilience, and increasing awareness of somatic health [2].

Participants in the 'PsychoŻak' mental health programme also received significantly lower scores on scale C of the GHQ – 28, relating to functional impairment. This result is promising and may indicate the validity of the content and format of the programme implementation. During the workshops, information is provided and and exercises are carried out on contact with other people, building relationships, effective communication, as well as on self-awareness regarding one's own feelings, experienced emotions and coping with them, and self-esteem. Appropriate behaviour is the basis not only for building lasting and close interpersonal relationships but also for functioning well in places of learning and work, fulfilling daily responsibilities, and coping with them, which is also an important developmental task for young adults. In contrast, the effective fulfilment of developmental tasks is an important indicator of mental health [37, 38]. There is a growing number of young people complaining of loneliness, withdrawing from relationships, or having difficulty building relationships [3, 5, 39]. This makes the opportunity to develop and strengthen social skills even more important. Such an opportunity during university studies is provided by the implementation of a mental health promotion programme. The workshops are delivered in person, in small groups. This provides an opportunity to build intimacy and to share one's thoughts and experiences, which is a kind of exercise in experiencing the presence of others, presenting oneself, and building relationships in a safe environment. An important task of young adults is to learn a profession and to educate themselves, which is an obvious student task. Mental health promotion programmes also have an impact on academic performance. People who manage stress effectively are calmer, more concentrated, and remember and reproduce studied material more easily. Success in the educational field, such as passing examinations, influences self-esteem and enhances the sense of empowerment, which is an indicator of mental health [40].

The data obtained suggest the validity of the use of the 'PsychoŻak' mental health promotion programme among university students and the need to continue research on its effectiveness. This not only aligns with current WHO recommendations, but may also fill a specific gap in the area of proposals for a comprehensive mental health promotion programme for university students [29]. In Poland, there is a lack of such a programme, while at the same time there is high demand for its introduction [8, 9, 23, 28, 39]. On the other hand, the pilot implementation of the programme indicates a worrying phenomenon, namely a very high drop-out rate. In addition to relevant content of the mental health promotion programme, communication and implementation are very important [16]. The pilot programme was completed by just over 40% of those who started the workshop. Participation in the programme was voluntary, free of charge, and delivered outside of academic classes. It should be noted that those who completed the programme confirmed their satisfaction with it.

When seeking reasons for the high drop-out rate during the programme, it would have been necessary to monitor the causes of drop-out, which was not done during the pilot stage. It is possible that a mindset remains among young people that, if someone has no difficulties with mental health, there is no need to address it, to increase knowledge about it, or to develop new skills for coping with stress. This could explain why some participants dropped out of the programme. This aligns with research on students' expectations of mental health promotion. When asked about mental health promotion, students often understood it as a supportive method for people already experiencing a mental health crisis [30]. It therefore seems important to educate young people that mental health promotion is a form of psychological support aimed at the entire population, designed to shape and strengthen mental health [41]. It is not an intervention or support solely for those already experiencing a mental health crisis, although this is one of the priorities of mental health promotion [7]. Drop-out, lack of awareness about the possibility of participation, and misunderstanding of the programme are risks associated with the implementation process, and these should be considered in the design and delivery of mental health promotion programmes to counteract them effectively [16].

Conclusions

1. The outcomes of the 'PsychoŻak' mental health promotion programme have been achieved. Participants who completed the mental health promotion programme reported significantly greater knowledge and competence regarding mental health, the factors that influence it, and skills for maintaining and enhancing mental health, e.g. effective ways of coping with stress. The mental wellbeing of the participants also increased, as indicated by the GHQ-28 scores at the end of the programme. It is therefore reasonable to assume that the 'PsychoŻak' mental health promotion programme for university students, in this form, may achieve its intended effects. Further

efforts should be made to monitor the programme's effectiveness over thelong term, to include more objective evaluation methods (as the current study relies on self-assessment), and to assess its suitability for wider implementation at universities. It is also important to apply and evaluate the programme among students from other faculties, e.g. technical or medical studies.

2. Research on the effectiveness of the programme should be continued (evaluation of effectiveness – including a control group) and the number of participants completing the entire 'PsychoŻak' mental health promotion workshop should be monitored, in order to achieve the objectives of mental health protection. At the same time, it is important to monitor the reasons for dropping out of the programme, as this can help to introduce necessary updates to ensure that the programme is as effective as possible.
3. It is important to continue education in the field of mental health promotion and to raise awareness among young adults about taking care of their health, not only reacting to difficulties that arise in mental health. The high proportion of participants who did not complete the programme may be related to low awareness of the need to maintain mental health even when difficulties have not yet arisen. Ensuring the availability of information materials aimed at shaping and/or strengthening awareness of mental healthis crucial. In this context, the 'PsychoŻak' mental health promotion programme, information about it, and free access for interested individuals could serve as an effective tool.

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