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Health Santé Salud

## The evidence of mental health promotion effectiveness: strategies for action

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# & Promotion & Education

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# No health without mental health

■ Mental health is moving onto the political agenda. And the promotion of mental health, which has been generally neglected by policy makers, has gained prominence over the last few years. The IUHPE has contributed largely to this change. Only one example is the influence on policy making of the mental health promotion chapter (Hosman & Jané-Llopis, 1999) published under the European initiative “The Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe”. This publication, which was translated into several languages, has been a source of evidence worldwide.

Five years on, the collection of papers in this volume adds to the ongoing, and ever more comprehensive, IUHPE initiative to emphasise mental health promotion as a vital aspect of health promotion. A prime example of this commitment is the inclusion of mental health promotion as a top priority subject in the IUHPE Global Programme on Health Promotion Effectiveness (GPHPE), now launched on all continents with the WHO and the CDC, among other partners<sup>1</sup>. Also of considerable significance, mental health promotion was included as a major stream at the 18th World Conference on Health Promotion and Health Education in Melbourne (April 2004). Continuing this emphasis, we anticipate a strong mental health promotion element on the programmes of the upcoming 19th and 20th World Conferences, in Vancouver in 2007, and in Hong Kong in 2010.

The main purpose of this special issue is to review the state of the art in the promotion of mental health and the prevention of mental health problems with due consideration to high, middle and low-income countries. Because of the global scope of the challenge to promote mental health, the evidence and recommendations included herein, have been collected from different sources and have been selected to emphasise diverse cultural contexts. In the volume, Marshall Williams, Saxena and McQueen reflect on the reasons for the momentum of mental health. They make the case that more applied research is needed in order to provide public health practitioners with the evidence

they need to advance mental health promotion on their local agendas. Jané-Llopis, Barry, Hosman and Patel provide the ‘heart’ of the collection, a review, drawing on different research sources, of the international evidence base for mental health promotion. Patel’s contribution on poverty and gender as determinants of mental health remind us that real progress for human development is a prerequisite for improved mental health, and that structural solutions are as vital to mental health promotion as to health promotion in general. Barry, Domitrovich and Lara further our understanding of key success factors in implementing mental health promotion on the ground. Moodie and Jenkins take us up several levels, with lessons from experiences about how to get mental health promotion on national agendas. Herrman and Jané-Llopis call for mental health to be better integrated with health promotion in general, making the case at the same time for targeted and distinct efforts in mental health promotion advocacy. This is also true for many, if not all, advocacy arenas that health promotion is involved with. Jané-Llopis and Barry provide an overview of the key success factors in mental health promotion interventions and underline the needs for continuously evaluating initiatives across countries and ensuring sustainability through the creation of partnerships. Mittelmark rounds out the collection emphasising why we need this mental health promotion constellation as a specific part of health promotion, why we should refer to the term mental health promotion, and why information and advocacy efforts for mental health promotion are crucial.

This issue has left out the arena of building capacity in mental health promotion. Without an adequate workforce in this field, no amount of advocacy, policy-making and planning will move us from words to sufficient action. The Guest

## Key words

- mental health promotion
- advocacy
- state of the art

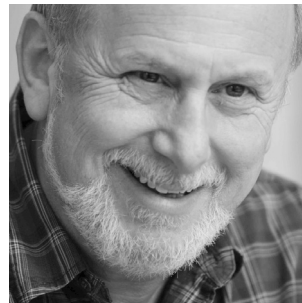
Editors of this volume wish to include as a part of this collection in spirit, if not in fact, the recently published paper in *Promotion & Education* on the topic (Mittelmark, 2003).

This publication is intended for a broad range of readers, including policy makers, practitioners and researchers working in mental health, health promotion and public health, worldwide. We hope and expect that the publication will be a useful tool for mental health advocates to make the case that mental health promotion works and can bring about health, social and economic development to societies. Our wish is that policy makers will use the publication as a resource that documents the need for strategies to effectively reduce the burden of mental illness. Practitioners, too, should be able to use this volume as a stimulus for dialogue with old and new partners in the arenas of practice, policy and research.

The authors of the different papers in this issue deserve our congratulations and gratitude for bringing this volume together, providing yet more evidence of the IUHPE's dedication to keeping mental health promotion high on our agenda. We hope and look forward to hear from readers who wish to offer their experiences, ideas and suggestions for further strengthening this initiative.



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1. African Medical and Research Foundation; Health Promotion Switzerland; National Institute for Health and Clinical Excellence, England; The Netherlands Institute for Health Promotion and Disease Prevention; Pan-American Health Organization; Public Health Agency of Canada; Victorian Health Promotion Foundation; Voluntary Health Association of India.

# The momentum for mental health promotion

■ The greater awareness and better understanding of mental health and its importance to overall health, social and economic development, has led to a momentum for mental health promotion. In recent years, mental health finally seems to be coming out of the shadows.

There are several possible reasons for this increasing interest in the population's mental health. First, the awareness of mental disorders being common and disabling is increasing. These problems are no more being regarded as affecting a small segment of the population and it is becoming common knowledge that as many as one in four of us may experience mental health problems during our life time. The Global Burden of Disease study by the WHO and the World Bank (Murray & Lopez, 1996) did an enormous service by demonstrating the massive death and disability burdens due to neuropsychiatric disorders.

Second, the economic consequences of mental health problems are becoming clearer (WHO, 2003). The aggregate cost of mental disorders is estimated to be between 2.5 to 4.0% of global GNP (WHO, 2003). In addition, increasing attention is paid to the costs that are not easily assessed, such as those associated with mental health problems not amounting to disorders, and their related impaired social functioning.

Third, the links between physical and mental health are better understood and

appreciated. Physical and mental health are closely associated through a variety of mechanisms. These include comorbidity, behavioural and lifestyle factors playing a role in health and illness and also in treatment seeking and adherence. Mind-body relationship continues to be an area of intense research and might in time break the remaining artificial boundaries between physical and mental health.

Fourth, another important factor is the linkage of mental health with human rights issues. The stigma and discrimination as well as deprivation of basic human rights faced by those with mental disorders has attracted attention all over the world and is becoming a serious issue for debate and concern.

Finally, all of these reasons effectively conveyed in high level publications with a policy purpose, their wide dissemination, and the continuous advocacy efforts for mental health during last few years, have put this topic on the political and public agenda. Prominent among these reports are the World Health Report 2001 (WHO, 2001a), some high level reports from the U.S. (United States Department of Health and Human Services 1999; Center for Mental Health Services, 2001; New Freedom Commission on Mental Health, 2003), the publication «Mental health promotion and mental disorder prevention: A Policy for Europe» supported by the European Commission (Jané-Llopis & Anderson, 2005), and the recent WHO Declaration and Action Plan for Mental Health, endorsed at the European WHO Ministerial Conference, held in Helsinki in 2005 (WHO, 2005).

## Burden of mental and behavioural disorders

According to the WHO's World Health Report, more than 450 million people suffer from mental disorders worldwide, and one in four persons will develop a mental or behavioural disorder

throughout their lifetime, including unipolar depression, bipolar affective disorder, schizophrenia, epilepsy, alcohol and other drug disorders, dementias such as Alzheimer's, post-traumatic stress disorder and compulsive disorder, panic disorder and primary insomnia (WHO, 2001a). The prevalence of mental and behavioural disorders is about 10% for the adult population worldwide (WHO, 2004). Twenty percent of the adolescents under the age of 18 suffer from developmental, emotional or behavioural problems, and one in eight has a mental disorder (WHO, 2004b). Among adolescents and children from poor communities, the rate is about one in five. Mental disorders are expected to be second only to heart disease as a leading source of the global burden of disease by the year 2020 (Murray & Lopez, 1996). Unipolar major depression is the number one cause of disability-adjusted life years (DALYs) lost for developing countries, accounting for 9.9% of the DALYs lost at ages 15-44 (WHO, 2004a).

The economic cost of mental disorders is substantial. Mental disorders are costly to the individual, families and communities. In 1996, the direct costs of mental health services in the United States of America were estimated to be more than \$99 billion (Rice & Miller, 1996). Indirect costs of mental illness totalled approximately \$79 billion in 1990 (the most recent estimate available). Many other costs associated with mental illness are indirect and not readily measurable. While the burden of mental and behaviour disorders has typically been discussed with respect to the economic costs associated with mental illness, the WHO strategy for improving mental health particularly for underserved communities

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## Key words

- burden
- mental health
- mental disorders

is one that includes acknowledging the *undefined* and the *hidden* burden of mental disorders. Conceptualizing burden in this manner reveals that the defined burden has implications for the effect on individuals; however, the undefined and hidden costs often have implications on the emotional and socioeconomic impact on the family and community. Indirect costs measure loss of productivity attributable to the illness and include costs related to morbidity, premature mortality, incarceration and caregiver time. The hidden costs refer to those that are a consequence of social isolation, humiliation, stigma and other human violations (Weiss, Cohen & Eisenberg, 2001).

## Adopting a mental health promotion approach

During the latter part of the twentieth century, public health went through many changes such that some referred to a «new» public health that incorporated health promotion, chronic diseases and an understanding of social epidemiology. The 1990's witnessed the rise of chronic diseases into the mainstream of public health thinking and the recognition of the need for good epidemiological surveillance as an essential function of public health. The 1990's also raised awareness on the tremendous burden of mental disorders worldwide and recognized the need for evidence-based practice.

As the scientific field continues to develop new ideas and research evidence, more researchers are acknowledging that mental health is not simply the absence of mental disorders. Mental health is largely seen as a state of well being that allows each individual to recognise his or her own abilities, to cope with the normal stresses of life, while working productively and fruitfully to contribute to his or her community (WHO, 2004c).

While mental ill-health must be treated when it occurs, increasingly international attention is being devoted to actively creating social and physical environments that contribute to and promote positive mental health (New Zealand Ministry of Health, 2002). Mental health and well-being are not only vital to the functioning of the individual, but is also vital to the functioning of societies

### Box 1

#### Social, environmental and economic determinants of mental health

##### Risk factors

Access to drugs and alcohol  
Displacement  
Isolation and alienation  
Lack of education, transport, housing  
Neighborhood disorganisation  
Peer rejection  
Poor social circumstances  
Poor nutrition  
Poverty  
Racial injustice and discrimination  
Social disadvantage urbanisation  
Violence and delinquency  
War  
Work stress  
Unemployment

##### Protective factors

Empowerment  
Ethnic minorities integration  
Positive interpersonal interactions  
Social participation  
Social responsibility and tolerance  
Social services  
Social support and community network

Hosman, Jané-Llopis & Saxena, in press

and populations. To this end, it is important that mental health promotion be applied equally to people with undiagnosed mental or social distress as well as to those identified as having mental health problems.

## Social and contextual determinants of mental health

Social determinants underlie and are related to mental well-being. Social and environmental factors such as poverty, industrialisation, discrimination, war and violence all play a key role in all aspects of public health, and are risk factors for mental health problems (WHO, 2004b). Because mental health and ill-health are intertwined with historical and contextual factors, it is important that they be considered in understanding the mental health of populations (Weiss, Cohen, Eisenberg, 2002). When communities lack social and physical infrastructures that support and affirm their members, people often do not develop to their fullest individual potential (Baum, 1999). The confluence of risk factors, including psychological problems, and social factors coupled with environmental influences has been shown to lead to mental health problems (WHO, 2004b).

Socio-environmental risk factors are also particularly common in low and middle income countries. For example, people in deprived areas or low socio-economic groups may typically not have adequate access to healthcare, education, or to as basic resources as food or shelter. In addition, low income countries often do

not provide the conditions that are necessary to promote positive mental health such as suitable housing, adequate income, and opportunities for developing social coping skills. Such conditions prevent poor individuals from leading the kind of healthy life that populations in more affluent conditions enjoy (WHO, 2004c). Emphasis should be placed on encouraging positive mental health by eliminating individual, socio-economic and environmental risk factors (e.g., stigma, discrimination, unemployment and social isolation) and by promoting protective factors (e.g., community and family cohesion). Box 1 presents some examples of socio-economic and environmental risk and protective factors for mental health.

## Population-based mental health interventions

Consistent with this focus, current research and practice in the field is now moving towards the active promotion of mental health and identifying successful population-based public health interventions. The most successful mental health interventions are those programmes that focus on evidence based risk and protective factors. To date systematic reviews and meta-analyses on specific mental health topics have demonstrated that promotion of mental health and the prevention of mental disorders can bring about health, social and economic benefits to society. The evidence on their efficacy is reviewed and referenced by Jané-Llopis and colleagues in this volume (Jané-Llopis *et al.*, 2005). For example, there is ample

evidence of the positive effects on mental health of home visiting interventions for pregnant mothers, or school-based programmes to promote mental health (WHO, 2004b). Evaluations of home visiting programmes have found that such programmes can for example, reduce risk factors for child maltreatment such as physical and emotional abuse, improve parent-child interaction or can reduce violence and crime over time (WHO, 2004b). These interventions are particularly successful for those at highest risk such as unmarried, teen mothers or children of parents with mental disorders. On the other hand, ecologic multi-component interventions, such as school programmes that take a whole school approach and target generic risk and protective factors, have

shown to be more successful in improving mental health and reducing externalising and internalising problems such as depressive symptoms, than programmes that have an individual base (WHO, 2004b; WHO 2004c).

Even with the promulgation of efforts promoting mental health and the development of ecologic and individual-level interventions, there remain relatively few examples of evaluated population-based, public health approaches that address mental health comprehensively. There is an urgency to undertake effectiveness and cost-effectiveness evaluations that can provide practitioners and policy makers with considerations about feasibility and cost of promotion programmes in the

diversity of global settings, especially in low- and middle- income countries. When this evidence can be delivered, it has a good chance of being used.

## Mental health surveillance

The underlying theoretical base for a socio-behavioural monitoring system has many underpinnings that are crucial to understanding mental health at a population level. Behavioural risk factors, lifestyle patterns, personal behaviours and social determinants all need to be monitored to understand their relationship to mental health and how changing patterns in these entities affect changes in reported mental health status. Surveillance encompassing mental health is no different from other forms of health surveillance in that the issues relate to technical and structural concerns. The technical concerns are the usual: questionnaire design, sampling, data collection methods, analysis and dissemination of information. The structural concerns relate to community/government buy-in, relationship to the public health infrastructure and the development of sustainable resources to maintain surveillance over time. While clinical, diagnostic measures used in the assessment of mental disorders have been developed for quite some time, there is still a paucity of international databases to assess the extent of mental health burden and disorder in the general population. Further, tracking systems oriented towards assessing positive mental health from a population health approach are particularly lacking.

A population health approach is one where the physical and mental health of large numbers of people is addressed; there is a careful delineation of the population; and societal and individual-level determinants of health are considered (Moriarty *et al.*, 2003). Tracking systems that are designed from a population health approach are particularly needed in low- and middle-income countries such as Asia, Africa, South America and the Western Pacific (Weiss *et al.*, 2001). A few examples of population-based, survey and surveillance systems that contain some mental health component exist in the United States. For instance, the National Center for Chronic Disease Prevention and Health Promotion at the Centers for

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Disease Control and Prevention (CDC) has developed the Health-related Quality of Life (HRQOL) set of questions and incorporated it into the nationwide Behavioural Risk Factor Surveillance System. The purpose of the HRQOL is to assess and track «perceived physical and mental health over time» with the inclusion of the concept of perceived mental health (Henessy, Moriarty, *et al.*, 1994). Such measures track whole populations over time, and provide a summary score for positive mental health as well as poor mental health. Despite the considerable success of this single measure, there is a need for more measures similar to the HRQOL that are able to determine the number of individuals in the population who may have elevated levels of depressive symptoms but no depressive disorder;

thereby determining the need for promotion and prevention interventions capable of reducing the number of people who go on to experience depressive episodes.

## The way forward

In recent years the field of mental health promotion and prevention of mental disorders has acquired world-wide recognition. New initiatives are being undertaken and new research is emerging, however, there are many areas that need to be further developed. First, there is a need for greater investment in mental health policies and interventions that are evidence-based and incorporate social and contextual determinants of mental health. Second, it is crucial to ensure that opportunities for addressing mental

health issues and developing effective interventions are equally targeted and supported across low-, medium- and high-income countries. Currently available effective programmes need to be brought to scale, and whenever possible, disseminated, adopted and implemented across countries tailoring to the cultural variation in different social contexts and being adopted according to available resources. These efforts will move the field towards fully achieving the definition of health expressed by the World Health Organization: *A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* (WHO, 2001b p.1).

*Eva Jané-Llopis, Margaret Barry, Clemens Hosman and Vikram Patel*

# Mental health promotion works: a review

Positive mental health is a value in its own right; it contributes to the individual's well-being and quality of life; and also contributes to society and the economy by increasing social functioning and social capital. Positive mental health refers to human qualities and life skills such as cognitive functioning, positive self-esteem, social and problem solving skills, the ability to manage major changes and stresses in life and to influence the social environment, the ability to work productively and fruitfully and to make contributions to the community, and a

state of emotional, spiritual and mental well-being (Hosman, 1997; WHO, 2001). Mental health is an integral part of overall health and well-being and in a broad sense, reflects the equilibrium between the individual and the environment (Lethinen *et al.*, in press).

Lack of positive mental health, mental health problems, and mental disorders are not exclusive to any special group, and are found in people of all regions, countries and societies (WHO, 2001). The lack of access to education, health care or environmental resources, or even at a more basic level, the lack of food, water or shelter contribute to mental health strain in populations around the world. Not only individuals suffering from mental health problems but also their families, have to bear the negative impact of stigma, discrimination and social exclusion.

Mental health promotion targets the whole population and focuses on enabling and achieving positive mental health. This multidisciplinary area of practice aims to

enhance well-being and quality of life for individuals, communities and society in general. Mental health promotion conceptualises mental health in positive rather than in negative terms and delivers effective programmes designed to reduce health inequalities in an empowering, collaborative and participatory manner. Mental health promotion endorses a competence enhancement perspective and seeks to address the broader determinants of mental health. This is in keeping with the fundamental principles of health promotion as articulated in the Ottawa Charter (WHO, 1986).

There is a growing theoretical base and accumulating body of evidence to inform

## Key words

- mental health promotion
- prevention
- evidence
- review

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the development of mental health promotion practice (Barry, 2001, 2002; WHO 2004a; WHO 2004b; Jané-Llopis and Anderson, in press). Evidence from systematic reviews of mental health promotion and preventive interventions shows long-lasting positive effects on multiple areas of functioning, leading to outcomes such as improving mental health (Durlak and Wells, 1997; WHO, 2004a), reducing risks of mental disorders (Mrazek and Haggerty, 1994; Jané-Llopis *et al.*, 2003; WHO 2004b) and producing social and economic benefits (Hosman and Jané-Llopis, 1999).

The Ottawa Charter for health promotion (WHO, 1986) provides a framework for improving the populations' health in a holistic manner tackling health determinants at different levels. Mental health promotion is based on the fundamental principles of the Ottawa Charter, and this paper aims to review and present some of the evidence of mental health promotion under the five headings of the Charter. This is not a systematic review but an overview presenting some examples that illustrate the efficacy of mental health promotion. The paper draws on different sources of evidence from across a number of levels i.e. from systematic reviews, randomised controlled trials (RCTs), quasi-experimental and process evaluations. Specific efforts have been undertaken to include initiatives or programmes from middle and low-income countries by inviting practitioners to submit descriptions of their work. To continue gathering and disseminating practices from all over the world, professionals in this field are encouraged to contact the first author of this paper if any of their work could be included in a worldwide database of programmes for mental health promotion ([www.imhpa.net](http://www.imhpa.net)).

### **Effective interventions: The Ottawa Charter and mental health promotion**

The evidence of the efficacy of interventions for mental health promotion is presented under the five headings of the Ottawa Charter. In presenting the evidence in the framework of the Ottawa Charter, the authors propose to consider the inclusion of mental health promotion as an integral part of health promotion interventions and policies.

## **1. Building healthy public policy**

Building healthy public policies puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept responsibilities for health. Such policies include legislation, fiscal measures, taxation, and organisational change. Existing public policies in some health and social domains have also proven to promote mental health, such as policies aiming to increase access to education, housing, nutrition or health care. These are particularly relevant in low income settings, where conditions for health are compromised, as further described by Patel (2005) in this volume.

### **1.1. Nutrition**

Improving nutrition in socio-economically disadvantaged children can lead to healthy cognitive development and improved educational outcomes, especially for those at risk or living in impoverished communities. Effective nutrition intervention models include complementary feeding and growth monitoring (WHO, 2004a; WHO, 2004b). These have combined nutritional interventions (such as food supplementation) with counselling on psychosocial care (e.g. warmth, attentive listening) (WHO, 1999) indicating cost-effective outcomes (WHO, 2002). Iodine, which can be supplemented through iodination of salt or water, is central to preventing mental and physical developmental delay and impairment in learning ability (WHO, 2002). Global efforts supported by UNICEF have led to 70% of the world's households using iodized salt, which protects 91 million newborns from iodine deficiency (UNICEF, 2002 report).

### **1.2. Housing**

Poor housing has been used as an indicator of poverty and as a target to improve public health and reduce inequalities in health. Results from a systematic review indicate that improvement of housing conditions has led to positive impacts on individual health and mental health outcomes. These include improvements in self-reported physical and mental health, perceptions of safety, crime reduction and social and community participation (Thomson, Petticrew and Morrisson, 2001; WHO, 2004a; WHO, 2004b). In this

volume, Moodie and Jenkins (2005) expand on the effects of urban planning for positive mental health.

### **1.3. Access to education**

Low levels of literacy and education are a major social problem in many countries, particularly in South Asia and sub-Saharan Africa, and tend to be more common among women (Patel and Jané-Llopis, in press). Lack of education limits the ability of individuals to reach their full potential in terms of life opportunities, access to work and economic entitlements. While there are impressive gains in improving literacy levels in most countries through better educational programmes targeting children, there is much less effort directed to illiteracy among adults. Ethnographic research in India (Cohen, 2002) suggests that programmes aimed at improving literacy in adults may have tangible benefits in promoting mental health. This research has noted that 'literacy programmes have significant consequences beyond the acquisition of specific skills. By bringing women together in new social forms that provide them with information about and ideas from wider worlds, the classes were potential catalysts for social change...by participating in the campaigns as volunteer teachers, impoverished literate women and girls gained a sense of pride, self-worth and purpose' (Cohen, 2002).

### **1.4. Taxation of addictive substances**

Effective regulatory interventions for addictive substances include taxation, restrictions on availability and total bans on all forms of direct and indirect advertising (Anderson, 1999). One of the most effective interventions has proven to be the taxation of tobacco and alcohol products. Price is one of the largest determinants of alcohol and tobacco use. A tax increase that raises prices by 10% reduces both the prevalence and consumption of tobacco products by about 5% in high income countries and 8% in low-income and middle-income countries (Chaloupka *et al.*, 2000). Similarly for the case of alcohol, although the impact of price varies across countries and beverage categories, a 10% increase in price can reduce the long term consumption of alcohol by about 7% in high income countries, and, although there are very limited data, by about 10% in low income countries (Anderson *et al.*, in press). Direct health

and social outcomes of taxation policies include the reduction of traffic accidents, other intentional and unintentional injuries, such as suicide, family violence, and the associated negative mental health impacts of the consequences attributed to alcohol consumption (Anderson *et al.*, in press).

## 1.5. Regulatory policy at the workplace

Similarly workplace policies have been shown to have positive impacts on mental health. Interventions at the organisational level tend to include legal policies associated with improving job security and job conditions. Effective meso strategies to improve mental health and to prevent the risk of mental disorders include: (1) task and technical interventions (e.g., job enrichment, ergonomic improvements, reduction of noise, lowering the workload); (2) improving role clarity and social relationships (e.g. communication, conflict resolution); and (3) interventions addressing multiple changes directed both at work and employees (Price and Kompier, in press). Notwithstanding the existence of legislation with respect to the psychosocial work environment, these interventions still remain underused (Schaufeli and Kompier, 2001). Policy initiatives such as the EU Framework Directive (89/391/EEC) (1989) recommend a holistic approach towards employees' well-being at work, taking into account psychological well-being and physical health in occupational safety and health policy. The 2001 European Council conclusions on combating stress and depression-related problems (Official Journal of the European Community, 2002/C 6/01) and the Communication on Health and Safety at Work (COM 2002, 118 final, 11 March 2002) emphasise the importance of good working conditions, social relations and the promotion of well-being at work.

## 2. Creating supportive environments

The Ottawa Charter advocates for the creation of supportive environments which puts the emphasis on a socio-ecological approach to health, promoting the change of home, work and community environments with the aims of improving control over the determinants of health. The creation of supportive environments has received increasing attention in mental health

promotion as mental health is mediated by the interaction between the individual, the environment and wider social forces. This perspective moves mental health beyond an individualistic focus to consider the influence of broader social, cultural and economic factors. The socio-ecological perspective underscores the importance of mediating structures such as home, schools, workplaces and community settings as providing key contexts for mental health promotion interventions operating from the micro to the macro levels.

### 2.1. Creating supportive home environments for early development

Intervention research in early life has focused on intervening through home-based strategies focusing on the family environment, as mental health is shown to be strongly linked to a healthy and supportive family life. Most home-based interventions are particularly directed to vulnerable children and families for example, those with socio-cultural, health, psychological and psychosocial vulnerabilities. These types of interventions aim to support parenthood through education on the health and development of the newborns, to enhance responsible and sensitive parenting styles and to facilitate the development of healthy parent/child relationships. Some successful interventions are described below. Tables 1-3 present a sample of other examples of existing programmes across settings.

#### **Home visiting for families at risk**

A classic example of an effective home-based intervention is the Prenatal/Early Infancy Project (Olds *et al.*, 1998, 2002), a two-year home visiting programme designed to serve low-income, at-risk pregnant women bearing their first child. Several evaluations, using a randomised controlled trial design, showed that the programme had health benefits for the newborns including an increase of up to 400 grams in birth weight, a 75% reduction in preterm delivery, more than a two-fold reduction in emergency visits, a lessening of severity for hospitalisations when they occurred and less reports of child maltreatment. The programme showed improved health and social outcomes for the mothers as well, such as an 82% increase in employment rates. Health and social outcomes extended up to age 15, when their

children were 56% less likely to have problems with alcohol or drugs, reported 56% fewer arrests and 81% fewer convictions. Olds and colleagues have argued that home-based programmes are cost-effective because a 'major portion of the cost for home visitation can be offset by avoided foster care placements, hospitalizations, emergency room visits, and child protection service worker time. Even the most expensive programmes pay for themselves by the time the children are 4 years old' (Olds, 2002).

Similarly Home-Start is a family support programme that aims to help families under stress and prevent family crisis and breakdown. The programme aims to increase the confidence and independence of the family and to prevent family crisis and breakdown through supporting and empowering parents and assisting children in their development (McAuley, Knapp, Curry & Slead, 2004). The project approach is to support the mental health of parents and their children by offering time, friendship and practical help by volunteers. The volunteers visit the families for over one year (Hermanns *et al.* 1997). A large number of countries worldwide have started working with the Home-Start method including Greece, Norway, Hungary, the United Kingdom, Ireland, Canada, Australia, the Netherlands, the Czech Republic, Israel, Russia, Uganda, Kenya, Sri Lanka and South Africa. Each local Home-Start project is grounded within the community it serves and is therefore, focused on meeting identified needs. Local projects base their work on information about the needs of local children, parents, referrers, volunteers and staff. There have been some evaluation studies on Home-Start in the UK, Ireland and the Netherlands although no randomised controlled studies have been undertaken. Evaluation studies have found high levels of reported parent satisfaction with the Home-Start programme and they considered it had made a positive difference to their lives (Van der Eyken, 1982; Gibbons and Thorpe, 1989; Frost *et al.*, 1996, Rajan *et al.*, 1996; Shinman, 1994). However significant long term differences between the group of families who received the Home-Start programme and the comparison group have not yet been clearly identified (Reading, 2005; Hermanns *et al.*, 1997).

### Home visiting support for mothers with depression

Interventions targeting the early years of life have also provided outcomes on parental mental health such as reductions in maternal anxiety and depression symptoms and more positive attitudes towards children, both in healthy mothers (Erickson, 1989) and in mothers with depression (Gelfand, 1996; Van Doesum, Hosman and Riksen Walraven, 2005). Especially mothers experiencing depression tend to be less engaged in their interactions with their babies than non-depressed mothers. A pilot study conducted in a deprived peri-urban settlement in South Africa, where the prevalence of postpartum depression is reported to be three times higher than that of developed countries (Cooper *et al.*, 1999), showed preliminary evidence that the quality of mother-infant engagement was significantly more

#### Box 1

##### A Jamaican home visiting programme

The Jamaican primary health care services provide health and nutritional advice to parents through home-visiting. To improve the development of children and the mother-child interaction, a psychological stimulation component was added to the home visits. The home-visitors received 8 weeks of nutrition and health care training and a further 8 weeks training in child development, teaching techniques and toy making.

The weekly, biweekly or monthly home visits lasted approximately one hour. Home-visitors would play with the children to illustrate positive techniques and encourage mothers to use praise and positive feedback with their children. Each visit included combinations of games, songs, language, and crayon and paper activities. Toys would be left at the home until the next visit.

Every effort was made to ensure that the curriculum was culturally appropriate, including indigenous songs and games, pictures and books depicting local scenes and people.

The results of a randomised controlled evaluation study showed that the benefits to the mental/cognitive development of the children increased as the frequency of visiting increased, both in the degree of improvement and in the number of different areas of development affected. Results showed that children visited weekly scored higher on the developmental quotient, performance, and hearing and speech, compared to the control groups. It showed that at least weekly visiting is necessary to make a substantial impact on child development.

Box 1. A Jamaican Home-Visiting programme (Powell and Grantham-McGregor, 1989)

positive for those mothers who received a mother-infant intervention delivered by unqualified, but trained, community workers (Cooper *et al.*, 2002).

##### Communities supporting early parenthood

Another example of an effective programme in creating supportive environments is the Community Mothers Programme. This intervention recruits and trains volunteer mothers in disadvantaged areas to give support and encouragement to first-time parents in child-rearing (Johnson, Howell and Molloy, 1993). The programme focuses on health care, nutritional improvement and overall child development. Evaluation showed increased maternal self-esteem, parent-child interaction and improved dietary intake. A 7-year follow-up (Johnson *et al.*, 2000) indicated that benefits had been sustained and extended to subsequent children. Many of the Community Mothers had also become involved in adult education programmes such as literacy, counselling and personal development as a result of their contact with the programme, demonstrating a spin-off from the process of empowerment. This programme has been widely replicated and various models are in operation across Ireland, the Netherlands (Mothers Inform Mothers, Hanrahan, Prinsen and De Graaf, 1997) the UK (The child development programme, Barker, Anderson and Chalmers, 1992), Australia and the USA. Replications include an initiative with the Irish Traveller Community, an indigenous ethnic minority group whose health status is significantly lower than the national average (Fitzpatrick, Molloy and Johnson, 1997). The success of this initiative suggests that the programme has potential for adoption by other low-income communities across the globe.

Similarly, it has been stated that home-visiting programs might be especially useful in low-income countries, because of constraints in access to health care, education on parenting, access to information or illiteracy. In addition, these types of interventions can be delivered by lay persons in the community when resources are scarce for health care providers. An example of such intervention delivered by lay personnel in Jamaica is described in Box 1. The results of the evaluation of the

#### Box 2

##### Videotape modelling

One approach to parent training is the use of videotape modelling programmes. These programmes have proven to be efficacious on the short and the long-term in changing a broad range of parent-child interactions. The programme is aimed at teaching parents how to reduce their children's behaviour problems, especially aggression and non-compliance, and how to increase their children's prosocial behaviours.

To evaluate the effect of videotape modelling four different interventions were compared: a group discussion videotape modelling training, an individually administered videotape modelling training, a group discussion training (10-12 sessions), and a waiting-list control group.

Results of a randomised controlled evaluation study showed that all three parent training programmes led to reliable and sustained improvements at least up to one year for approximately two thirds of the sample. The group discussion video modelling training was somewhat superior to the other two training groups and was the only intervention that showed sustained and stable improvements over three years.

Box 2. Videotape modelling training (Webster-Stratton, 1982; Webster-Stratton, Kolpacoff and Hollinsworth, 1988; Webster-Stratton, 1990)

Jamaican Home-Visiting Programme show that it is feasible to integrate psychosocial stimulation into primary health care services.

##### 2.2. Parenting interventions

Group-based parent-training programmes can have a positive impact on the behaviour of children between the ages of 3 and 10 years, and are more cost-effective and successful in the long-term than methods that involve working with parents on an individual basis (Barlow, 1999). A range of different group-based formats and techniques have proven effective. For example, Webster-Stratton (Box 2) has pioneered the use of videotape modelling in which parents watch numerous examples of interactions between parents and children, followed by discussion and modelling activities (Webster-Stratton, 1982).

Parenting programmes are also effective in promoting the short-term psychosocial health of mothers (Barlow, Coren and Stewart-Brown, 2001). Depression, anxiety/stress, self-esteem and relationship with spouse/marital adjustment were all significantly improved in a meta-analysis of the results

of 17 parenting programmes, compared with control groups (Barlow and Coren, 2004). Moodie and Jenkins in this volume (Moodie and Jenkins, 2005) provide some case studies on parenting programmes in the UK. The role of parents and family in the early years of life is crucial. Programmes supporting parents contribute to their welfare, which in turn contributes to the quality of raising children, and consequently can lead to improved well-being of their children.

### 2.3. Pre-school interventions

Preparing children for school is a great challenge for families and educators. Children from low socio-economic backgrounds are less likely than their middle or higher socio-economic class peers to enter school ready to learn and to achieve academic success. One of the most convincing controlled studies of the long-term benefits of preschool intervention for children living in poverty is the High/Scope Perry Preschool Project (Schweinhart and Weikart, 1998; Schweinhart, 2000). Targeting at risk 3 to 4 year old African-American children from impoverished backgrounds, the programme combines half a day preschool intervention using a developmentally appropriate curriculum with weekly home visits. On the short term children in the intervention groups showed improved cognitive development, lower levels of learning disability, improved academic achievement, better social adjustment and increased high school completion. When followed up through to age 27, young adults showed increased social competence, a 40% reduction in lifetime arrests, a 40% increase in literacy and employment rates, fewer welfare dependence and improved social responsibility (Schweinhart and Weikart, 1998). The costs of US\$1000 per child were returned by the benefit produced by the programme, which was estimated to be over US\$7000 - US\$8000 per child (Barnett, 1993), due to decreased schooling costs, increased taxes paid on higher earnings, reduced welfare costs, decreased justice system costs, and decreased crime victim costs (Schweinhart and Weikart, 1998). Unfortunately, there are very few cost-effectiveness studies on mental health promotion programmes and although, trials like this one make a strong case for investing in promotion, more efforts

should go to undertaking cost-effectiveness studies in this field.

### 2.4. Schools as a supportive environment to learn and grow

The school setting is central in influencing the behaviour and development of children. Evidence from systematic reviews and intervention trials on mental health promotion in schools highlights that comprehensive programmes that target multiple health outcomes in the context of a co-ordinated whole-school approach are the most consistently effective approach (Durlak and Wells, 1997; Tilford, Delaney and Vogels, 1997; Lister-Sharp *et al.*, 1999; Weare, 2000; Greenberg, Domitrovich and Bumbarger, 2001; Harden *et al.*, 2001; Wells, Barlow and Stewart-Brown, 2001; Patton, Olsson and Toumbourou, 2002; Mental Health, 2003). Interventions have successfully led to increases, for example, in mental well being, competence and social skills as well as decreases in anxiety and depressive symptomatology. Social outcomes have included, among many, reductions in aggression and bullying and increases in school achievement (Greenberg *et al.*, 2001).

Several programmes have successfully targeted students' transition to a new educational environment, by promoting competence, decision-making, participation and social awareness (e.g. Snow *et al.*, 1986; Elias *et al.*, 1991). The School Transitional Environment Project (Felner and Adan, 1988) goes beyond the curriculum by redefining the role of teachers and restructuring schools' physical settings, successfully reducing absenteeism, drop-out rates and internalising symptoms, while improving self-concept and academic performance (Felner *et al.*, 1993).

Other ecological approaches include whole-school programmes which seek to provide a positive school climate, fostering a sense of identity and connectedness for pupils by altering the school environment. The Australian Mind Matters project promotes connectedness recognising the importance of the organisational structures, the social environment, and the individual within this context (Wynn *et al.*, 1999). Many school-based programmes are also supported by involving parents to some degree. For example, the programme

Linking the Interests of Families and Teachers (LIFT) (Reid *et al.*, 1999) offers six sessions for parents on how to create a home environment conducive to the ongoing practice of discipline and supervision. In Project PATHE, Promoting Action Through Holistic Education (Gottfredson, 1990), parents, staff, students and community members work together to design and implement improvement programmes. Fast Track also includes the home environment (Conduct Problems Prevention Research Group, 1992), and is composed by elements such as parent training, home visitation, academic tutoring, social skills training, and the classroom-based PATHS curriculum (Greenberg, Kusché and Mihalic, 1998). Olweus' Bullying Prevention Programme applies this whole-school approach to the reduction and prevention of bully/victim problems. Evaluation has shown significant reductions in reports of bullying and victimization, anti-social behaviour, vandalism, fighting, theft and truancy as

### Box 3

#### The Caregiver Support Program

The Caregiver Support Program was designed to increase social support and participation in work related decision making for caregiver teams in health and mental health care facilities. The programme involved six training sessions of four to five hours long. With groups of approximately ten home managers and ten direct care staff, sessions were focused on: (1) understanding and strengthening existing helping networks within the organizations; (2) increasing worker participation in decision-making and using participatory decision-making; (3) teaching supervisors and direct care workers to develop and lead training activities in their home site; and finally, (4) teaching techniques for maintaining these new skills over the long-term. To ensure effective delivery, social learning principles were employed to engender a strong sense of mastery and to inoculate workers against setbacks.

Results of a large-scale randomised trial indicated that the programme increased the amount of supportive feedback on the job, strengthened participant perceptions of their abilities to handle disagreements and overload at work, and enhanced the work team climate in the group homes. The programme also enhanced mental health and job satisfaction of those who attended at least five of the six training sessions. The Caregiver Support Program also had positive effects on the mental health of those employees most at risk of leaving their jobs.

Box 3. The Caregiver Support Programme (Heaney *et al.*, 1995a; Heaney 1995b)

well as an improved social climate (Olweus, 1989).

### **2.5. Supportive environments in the workplace**

Similarly, interventions at the workplace have been developed to reduce the negative mental health impacts of stressful work. An example of an intervention at the workplace is the Caregiver Support Programme (CSP) a work stress intervention to increase employee coping resources and enhance mental health. The programme led to increases in social support and improved the work team climate (Box 3).

## **3. Strengthening community action**

Based on empowerment principles, strengthening community action emphasizes enabling local communities to actively participate in setting priorities, making decisions, planning strategies and implementing them in order to achieve better health. Effective community interventions focus on the development of building a sense of ownership and social responsibility through the empowerment of community members, and have led to health and social outcomes around the world.

### **3.1. Strengthening community networks**

The Maryborough Mental Health Promotion Project in Australia (VicHealth, 2002) and the Rural Mental Health Project in Ireland (Barry, 2003) are two examples of projects which employ community models in strengthening community capacity through partnerships for mental health promotion. For example, in both cases, membership of the project planning group was drawn from a wide range of community members who were engaged through a process of participation to effect community change through implementing a range of local initiatives.

An efficacious USA community intervention for at-risk youth is the Midwestern Prevention Project (MPP). This comprehensive, multi-faceted community-based programme is designed to prevent adolescent drug abuse (Pentz, Mihalic and Grotz, 1998). The programme is implemented through well-coordinated, community-wide strategies introduced in sequence a

school programme with school boosters, a parent education programme, community organisation and training, mass media programming and local policy change regarding tobacco, alcohol, and other drugs. Evaluation showed reductions in gateway drug use, increased parent-child communications about drug use, decreased self-reported prevalence of monthly drinking up to one year after the intervention (although did not differ after 3 years) and effects on monthly intoxication through the end of high school (Pentz *et al.*, 1998).

Another example is the Communities that Care Program, CTC (Hawkins, Catalano and Arthur, 2002). CTC has been implemented across several hundred communities in the USA and is currently being adopted and replicated in the Netherlands, England, Scotland, Wales and Australia. CTC is a strategy to activate communities to implement community violence and aggression prevention systems (Hawkins *et al.*, 2002). Using local data on risk and protective factors, communities develop action, including interventions operating at multiple ecological levels: the community (e.g., mobilisation, media, policy change), the school (e.g., changing school management or teaching practices), the family (e.g., parent training) and the individual (e.g., social competence) (Hawkins, 1997). CTC supports communities in selecting and implementing existing evidence-based programmes that fit the needs of their community. To date CTC has been evaluated in the USA with pre-post designs and comparisons with baseline data involving about 40 communities in each field-test. Outcomes have indicated improvements in, for example, youth cognitive skills, parental skills, community relations, 30% decrease in school problems, 45% decrease in burglary, 29% decrease in drug offences and 27% decrease in assault charges.

### **3.2. Community action against substance dependence**

A community approach to combating alcoholism and promoting mental health in rural India started with participatory research on the burden of alcohol problems and led to the development of promotion actions including education and awareness building, advocacy to politicians to limit the sale and distribution of alcohol in bars and shops,

and mass oaths for abstinence. The programme was implemented through a community movement led by young people and women and village groups for the liberation from liquor. The programme has led to a marked reduction in the number of alcohol outlets in the area and a 60% reduction in alcohol consumption. Social outcomes include larger availability of money for food, clothing, and welfare, and a reduction of domestic violence (Bang and Bang, 1991). A similar multi-faceted intervention in Yunnan, China, to prevent drug abuse among youths, involved multiple sectors and leaders in the community. The programme emphasised community participation and action, education in schools, literacy improvement, and employment opportunities. It led to a reduction in the incidence of drug abuse, and a marked improvement in knowledge and attitudes towards HIV/AIDS and drug use (Wu *et al.*, 2002).

### **3.3. Schools as a gateway for the community**

In Pakistan, a school-based programme succeeded in reducing the stigma surrounding mental ill-health in a rural community (Rahman *et al.*, 1998). School-going children acted as a source of information for their families, friends and neighbours in a cascade approach. The evaluation found that the school mental health programme improved school children's awareness of and attitudes towards mental health problems. There were also positive changes in the attitudes and knowledge of community members. This study has positive implications for adapting such a programme in other communities where levels of formal education and literacy may be low.

### **3.4. Media campaigns**

Challenging stigma and promoting increased awareness of, and positive attitudes towards, mental health issues have been addressed through media campaigns like, You in Mind (Hersey *et al.*, 1984; Barker *et al.*, 1993); the Norwegian Mental Health Campaign (Sogaard and Fonnebo, 1995); "Changing minds" by the Royal College of Psychiatrists in the UK; and the World Psychiatric Association's campaign "Open Doors" (Sartorius, 1997). For example, in Europe, the Norwegian Mental Health Campaign (Sogaard and

Fonnebo, 1995) was a nationwide mass media-based publicity and information strategy over a 6-month period, culminating in a 6-hour television broadcast. The campaign achieved wide penetration, putting mental health issues on the cultural agenda in Norway and changing the knowledge of and attitudes towards mental health problems. In the UK, the 'You In Mind' television series had a positive impact on mental-health-related understanding and behavioural intentions of a large and diverse national audience (Barker *et al.*, 1993).

In the USA, the media-based San Francisco Mood Survey Project, aimed to target depression and depressive symptoms in the population (Muñoz *et al.*, 1982). The intervention was delivered through television being available to all individuals in the community. The programme led to a significant reduction in depressive symptoms in those individuals who initially scored at high levels of depressive symptoms and watched the segments during the intervention's broadcast.

Mass media interventions particularly if they are supported by local community action can have a significant impact on increasing understanding, reducing stigma and increasing knowledge, as well as impacting positively on mental health literacy at the community level. More efforts need to be undertaken to evaluate these types of interventions as they can be highly cost-effective because of their potential reach to large numbers of people.

## 4. Developing personal skills

Developing personal skills supports personal and social development through providing information, education for health and enhancing life skills. This increases the options available to people to exercise more control over their own health and over their environment to make choices conducive to health.

### 4.1. Enhancing resilience and promoting social competence

Cognitive restructuring techniques have been used successfully with a range of age groups. For elementary schools, the projects PATHS – Promoting Alternative Thinking Strategies (Greenberg *et al.*, 1998), and ICPS – I Can Problem Solve / Interpersonal Cognitive Problem Solving

(Shure and Healey, 1993) have proven efficacious in promoting emotional and social competencies in children.

In the Philippines, the Youth Life Enrichment Programme, although not formally evaluated through a controlled trial, has influenced the lives of thousands of teenagers, their families and friends since 1975. Organised by the Philippine Mental Health Association and implemented through student mental health clubs in public schools, the programme has focused on youth as a 'family facilitator' (de Jesus, 2003). Themes include self-awareness, positive relationships with others, leadership skills and effective communication as well as fostering positive attitudes towards mental health and people suffering from mental disorder. The materials have been revised three times during the last decade to meet the changing needs of youth and the general community, and now include modules promoting awareness of social issues pertinent to mental health, commitment to social responsibility, spirituality as a way of life, and prevention of drug abuse. Efforts should be placed in evaluating these types of comprehensive interventions where they are implemented.

### 4.2. Targeting the prevention of depression

The Penn Resiliency Program (PRP) aims to change cognitive distortions and to improve coping skills in children with depressive symptoms (Jaycox, Reivich, Gillham, and Seligman, 1994; Gillham, Reivich, Jaycox, and Seligman, 1995; Gillham and Reivich, 1999; Reivich, Shatté, and Seligman 2000). The programme evaluation has shown reductions in depressive symptoms by half (22% in experimental group versus 44% in controls) at post-treatment, 6-month and 2-year follow-up. Recently, a randomised controlled study of the PRP with Latino and African-American children from low-income families (Cardemil, Reivich and Seligman, 2002), has indicated a sustained effect over six months on the reduction of depressive symptoms for those who were initially symptomatic (Cardemil *et al.*, 2002). The PRP (also called the Pen Optimistic Programme) has been adapted and implemented with success in China (Lei Yu and Seligman, 2002). It reduced levels of depressive symptomatology for up to

six months in children and adolescents at risk. This provides evidence of the programme's effectiveness in diverse cultural settings. Similarly, the Australian Resourceful Adolescent Program, which uses a cognitive approach, successfully reduced depressive symptoms in 12-15 year olds (Shochet *et al.*, 2001).

The targeted 'Coping with Stress Course', a cognitive oriented group programme, has shown to reduce the incidence of depression in adolescents at high risk (Clarke *et al.*, 1995). Participants attend fifteen group sessions, during which they are taught cognitive techniques to identify and challenge negative or irrational thoughts. Outcomes of a randomised controlled trial indicated that programme participants experienced a total incidence of depressive disorder over one year period approaching half that of the control group (14.5% vs. 25.7%). A randomised controlled trial of a similar intervention for children with parents suffering from a mental disorder, also showed a decrease in new and recurrent depressive episodes from 25% in the control group to 8% in the prevention condition over the first year after the intervention, and from 31% to 21% respectively over the second follow-up year (Clarke *et al.*, 2001). The «Coping with Depression Course» for adults has been adopted and implemented to scale in the Netherlands, showing reductions in depressive symptomatology, especially for those who had lower levels of symptoms at the beginning of the intervention (Allart-van Dam *et al.*, 2003).

### 4.3. Addressing the negative impact of unemployment

An example of a work related intervention to develop personal skills is the JOBS programme for the unemployed, firstly developed in the USA (Price, Van Ryn and Vinokur, 1992), successfully disseminated in the USA, China, Korea and Finland (Vuori *et al.*, 2002) and currently being implemented in the Netherlands and Ireland. This programme aims to enhance job search skills, self-esteem and sense of control, self-efficacy and inoculation against setbacks. The intervention was particularly beneficial to participants at high risk of depression. Other benefits included improved confidence, self-efficacy and re-employment (Vinokur, Price and Schul, 1995). In Box 4, the original Winning New Jobs Program

## Box 4

### The Winning New Jobs Program: Promoting Reemployment and Mental Health

The Winning New Jobs Program was developed in the United States to aid unemployed workers to effectively seek reemployment and cope with the multiple challenges of unemployment and job-search (Caplan, Vinokur, Price, & van Ryn, 1989; Price *et al.*, 1992; Price and Vinokur, 1995). The programme is based on theories of active learning process, social modelling, gradual exposure to acquiring skills, practice through role playing, and inoculation against setbacks.

Over a one week period five intensive half-day workshops are held. The workshops focus on identifying effective job-search strategies, improving participant job-search skills, increasing self-esteem, confidence, and the motivation of participants to persist in job-search activities. Two trainers deliver the programme to groups of 12 to 20 people. The intervention is designed to achieve its goals through the creation of supportive environments and relationships between trainers and participants and among participants themselves.

The Winning New Jobs programme has been evaluated in replicated randomised trials involving thousands of unemployed workers and their partners in the USA. Results indicate that this type of intervention is cost-effective (Vinokur *et al.*, 1991) and has shown increased quality of re-employment, increased self-esteem and decreased psychological distress and depressive symptoms, over 2 years, particularly among those with higher risk for depression (Price *et al.*, 1992). In addition, the programme has been shown to inoculate workers against the adverse effects of subsequent job-loss because they gain an enhanced sense of mastery over the challenges of job-search (Price, 2003).

Box 4. The Winning New Jobs Program (Price *et al.*, 1992)

## Box 5

### The Työhön Job Search Program

In Finland, the Winning New Jobs Program, originally developed in the United States, has been adapted, implemented and evaluated nationwide. The Finnish version, called Työhön Job Search Program, is guided by the same principles as the USA programme, which is strongly theory-driven and documented in detail (Curran, 1999). However, the Finnish programme has been adopted to meet cultural differences in unemployment, duration of social and economic security and labour policies regarding the use of labour market programmes. For example, because of longer periods of financial security for unemployed, the Finnish programme does not only aim at those who have been recently unemployed, like in the USA version, but targets also those who have been unemployed for long periods.

Similar intervention methods as in the USA trials have been used in the Finnish evaluation study, including more than one thousand unemployed job seekers. Short-term results after 6-months showed increases in quality of reemployment, strongest for those who were unemployed for a moderate long period and at risk of becoming long-term unemployed, and reductions in levels of distress, strongest for those who were at high risk for depression. It was not until the long-term follow-up, two years after the programme, that decreases in depression symptoms and increases in self-esteem were found. Beneficial effects on the re-employment of participants in the intervention groups were indicated by higher engagement in the labour market, either employed or participating in vocational training. These long-term results are comparable with the results from studies in the USA.

Box 5. The Työhön Job Search Program (Vuori *et al.*, 2002; Vuori and Silvenon, in press)

(Price *et al.*, 1992), and the Finnish adaptation, the Työhön Job Search Program (Vuori, *et al.*, 2002), are described.

## 5. Reorienting health services

Reorienting health services emphasises that health is a shared responsibility among individuals, community groups, health professionals, health service institutions and governments. The reorientation of health services includes attention to health research, changes in professional education and training and a change in the organisation of health services including the needs of the individual as a whole person.

### 5.1. Including brief interventions in primary health care

Harmful substance use during pregnancy has important negative impacts on the mental health and development of the foetus, increasing the likelihood of premature deliveries, low birth weight, long-term neurological and cognitive-emotional development of children, and perinatal mortality (e.g. Brown and Sturgeon, in press; Tuthill *et al.* 1999). Being born prematurely, and low birth weight have led to adverse mental health outcomes and psychiatric disorders (Elgen, Sommerfelt and Markestad, 2002). Educational programmes to enable pregnant women to abstain from tobacco, alcohol and other drugs can have long-

term mental health benefits on their children. For instance, Windsor *et al.* (1993) evaluated a 15 minute behavioural intervention for pregnant smokers, showing a 6% increase in smoking cessation. Among those who quit, their babies were 200 grams heavier at birth; cutting down smoking increased birth weight half this amount.

To date there have been relatively few efforts to integrate mental health promotion strategies in primary health care. One example is a collaborative European project that has developed a training manual for health care professionals in primary care to work with families to promote the psychological well being of children and to prevent the development of psychological and social problems (Puura, *et al.*, 2002; Tsiantis *et al.*, 2000). Primary health care providers have been trained in five European countries to conduct health promotion interviews with all mothers one month before and after birth. A counselling model is used with mothers identified at risk to promote children's mental health and try to prevent the onset of child mental health difficulties (Puura *et al.*, 2002). Currently, another European project (Implementing Mental Health Promotion Action, IMPHA), has developed and pilot-tested the first training manual for primary health care professionals on mental health promotion for adults using problem solving skills training ([www.imhpa.net](http://www.imhpa.net)).

### 5.2. Interventions for new mothers

The postpartum period can be a stressful time for new mothers. Recent epidemiological studies in low-income countries have noted increased prevalence of postnatal depression, reduced mental health and a strong relationship between poverty, gender, marital violence and postnatal depression (Patel, Rodrigues and DeSouza, 2002). In India, for example, more than one third of mothers report to be beaten by their husbands (Jejeebhoy, 1998). Although there is contradictory evidence of the effectiveness of antenatal programmes to prevent postpartum depression alone (Brugha *et al.*, 2000; Morrell *et al.*, 2000; Hayes, Muller and Bradley, 2001; Cooper *et al.*, 2002), brief and long antenatal education programmes have led to reductions in depressive symptoms (Elliott *et al.*, 2000;

Zlotnick *et al.*, 2001) and lead to other health outcomes related to the child and the mothers, including, mother-infant engagement, mother sensitivity, and increased birth weight (Olds *et al.*, 1998; Cooper *et al.*, 2002; Olds *et al.*, 1998). This suggests the possible effectiveness of antenatal interventions especially in low-income countries where maternal and infant health policies should be comprehensive and include multiple measures, throughout long term follow ups, of mental, physical health and social outcomes for mothers and neonates.

### 5.3. Hearing aids

An example wherein physical and mental health are closely related, is a study set in primary care clinics to assess whether hearing aids would improve the quality of life of elderly persons with hearing loss (Mulrow *et al.*, 1990). A randomised control study was undertaken with 194 elderly veterans with impaired hearing. At baseline, 82% of the veterans reported adverse effects on quality of life due to hearing impairment, and 24% were depressed. After the intervention those in the intervention group as compared to the control group, showed significant improvements for social, emotional, communication and cognitive functions and depression scores. In this volume, Herrman and Jané-Llopis (2005) explore the implications of the links between mental and physical health and expand on the added value to assess mental health outcomes in existing health promotion initiatives with the aim to increase efficiency.

### 5.4. Early intervention for people with mental disorders

Mental health promotion within the mental health services adopts a more holistic approach towards mental health, taking into account people's mental, physical, spiritual and emotional needs and draws on people's own expertise in living and coping with mental distress. Programmes that promote supported employment strengthen opportunities for creativity and social support and reduce the stigma and discrimination associated with mental health problems have all

shown to be effective in promoting mental health (Friedli, 2000). An example of a specific early intervention programme in first-episode psychosis is the Early Psychosis Prevention and Intervention Centre programme (EPPIC). Edwards and McGorry (2002) highlight some of the potential benefits of this early intervention which include: reduced morbidity; more rapid recovery; better prognosis; preservation of psychosocial skills; preservation of family and social supports and the decreased need for hospitalisation.

### Conclusions

This overview of programmes, although not a systematic review aims to illustrate that, to date, there is a large range of initiatives that can be efficacious in promoting mental health. However, it is crucial to highlight, that there are also non-effective programmes, and meta-analyses have shown a large variation in outcomes of existing mental health promotion and prevention programmes (Durlak and Wells, 1997; Brown *et al.*, 2000; Jané-Llopis *et al.*, 2003; WHO, 2004b). In addition, the evidence for many programmes is still lacking robustness through confirmation by the outcomes of replication studies. This large variation in outcome and in quality of evidence urgently calls for formal evaluations (including cost-effectiveness studies) of existing programmes across countries, including low- and middle-income countries. In spite of the low resources in those countries, individual studies, partnerships between research institutes and practitioners, and seeking the support of international organisations and researchers in high-income countries, have proven to facilitate the so needed evaluations, as Patel (2005) further describes in this volume. When considering adoption and implementation of programmes across cultures, it is essential to have evidence-based knowledge and information on what programmes have proven to be efficacious and why. In this volume, Jané-Llopis and Barry (2005) expand on what ingredients make programmes effective,

and what principles should be taken into account when deciding to adopt a given programme. Barry and colleagues (2005), present in this issue a discussion of the implementation conditions and principles that should be taken into account to ensure improved quality implementation. Patel (2005) underlines some key determinants of mental health in low income countries, identifying key areas for implementation. Moodie and Jenkins (2005) illustrate how the choices for implementation should be relevant for policy making, and Herrman and Jané-Llopis (2005) present the relationship between mental and physical health and suggest strategies for increasing intervention efficiency.

There is enough mental health promotion knowledge to move evidence into practice. However, this translation should be based on what works and should stimulate continuous evaluation and improvement of existing practices. Although the promotion of evidence-based practice and policy is needed worldwide, special attention and support should be provided to those countries where these types of strategies are less developed and needed most.

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**Table 1****Settings : Home****Examples of home based interventions**

Country	Programme name	Target group	Aims and objectives	Risk and protective factors	Type of research	Health impact	Social and economic impact
South Africa	Mother-Infant Intervention Project (Cooper, Landman <i>et al.</i> , 2002)	At risk mothers and their newborn infants, particularly in deprived areas	Promote health, secure attachments between parents/ caregivers and their infants in order to develop healthy emotional cognitive and physical development of children	Secure parent-infant attachment; Parental emotional resources; Social support and information; Parent education and empowerment	Quasi-experimental design (pilot study)	Positive attitudes towards children; Positive mother-infant engagement	Reducing child abuse; Reducing child abuse; In the long run children have less problems later in life
Poland	Program Domowych Detektywów (Ostaszewski <i>et al.</i> , 2000)	Children (pre-adolescents)	Prevent under-age drinking; Facilitate parent-child communication about alcohol and other substance use; Establishing effective family rules regarding under-age drinking	Under-age alcohol use; Intention to use substances; Being informed about alcohol; Parent-child communication; Peer support; Resistance skills	Quasi-experimental design	Reduction in alcohol use and intention to use; Increased knowledge about consequences of alcohol; Increased parent-child communication	Reported lower alcohol consumption
United Kingdom	Child Development Programme (Barker <i>et al.</i> , 1992)	First time parents; Parenting problems	Empower parents	Parenting; Self-esteem; Self-control; Social support	Quasi-experimental design; Experimental matched community	50% lower child abuse rates	41% lower rate in the Child Protection Register
United Kingdom	Home start (Frost, <i>et al.</i> , 1996; McAuley <i>et al.</i> , 2004)	Families with children under five years old	Empower parents; Increase confidence and independence of the family; Promote mental health of children	Social support; Self-esteem; Stress	Quasi-experimental design	Increase in parental self-esteem; Increase in coping ability; Decrease in family dysfunction	Reported positive benefits in parents' lives and family functioning
Finland	An early home-based intervention (Aronen and Kurkela, 1996)	Families with newborns	Improve family interaction; Prevent psychiatric problems on the long term	Family interaction	Quasi-experimental design	Decrease in internalising and externalising problems at adolescent age	Long-term benefits in development of positive mental health; Less use of mental health services

**Table 2**  
**Setting : School**  
**Examples of school based interventions**

Country	Programme	Target Group	Aims and objectives	Risk and Protective Factors	Type of Research	Health Impact	Social and Economic Impact
Philippines	Youth Life Enrichment Programme (de Jesus, 2003)	Youth (12-17 years old)	Promote awareness of social issues related to mental health, commitment to social responsibility, spirituality, and prevention of drug abuse	Coping skills; Self-awareness; Communication skills	Post-intervention survey	Increase in self-reported understanding/knowledge of a range of personal development topics	Nationwide implementation; Government support; Student endorsement
Pakistan	School mental health programme (Rahman <i>et al.</i> , 1998)	Students (12-16 years old)	Reduce the stigma surrounding mental ill-health and improving the understanding of disorders of mental health in the rural community	Knowledge of mental health issues in rural areas	Quasi-experimental controlled design		Improved awareness of mental health issues amongst schoolchildren, their parents, friends, and neighbours
Norway	Bullying Prevention Programme (Olweus <i>et al.</i> , 1989)	Students (6-15 years old)	Reduce existing bully/victim problems inside and outside the school setting; Prevent development of new bully/victim problems; Improve peer relations; Reduce opportunities and rewards for bullying	School climate; Self-esteem; Adult-student-peer interaction; Attitudes towards bullying; Anxiety; Permissive parenting	Experimental design (RCT); experimental/control group	Reduction (by 50% or more in most comparisons) in reports of bullying and victimization	Reduced antisocial behaviour e.g. vandalism, fighting, theft and truancy; Improved social climate
USA	PATHS - Promoting Alternative Thinking Strategies (Greenberg <i>et al.</i> , 1998)	Students (6-11 years old); including all children, but also specific groups like deaf children or behaviourally at-risk children	Promote social/emotional competence	Self-control; Social competence; Peer relationships; Interpersonal problem-solving skills; Emotional literacy	Experimental design (RCT); experimental/control group	Decreased symptoms of anxiety and depression; Increased understanding and recognition of emotions; Improvements in social problem solving	Reduction in conduct problems and aggression
Australia	Queensland Early Intervention and Prevention of Anxiety Project (Dadds <i>et al.</i> , 1997; Dadds <i>et al.</i> , 1999)	Children (7-14 years old) at risk for anxiety disorders	Prevention of anxiety symptoms and anxiety disorders	Coping skills; Emotional resilience; Parental coping skills	Experimental design (RCT); experimental/control group	Reduction in anxiety symptoms; Prevention of onset of new anxiety disorders	
USA	SCPP-YA - Social Competence Promotion Program for Young Adolescents (Weissberg <i>et al.</i> , 1997)	Adolescents (in 5 to 8th grade)	Promote social and emotional competence in order to prevent high risk behaviours such as substance use, high-risk sexual behaviour and delinquency	Social competencies; Self-control; Communication skills; Problem solving skills; Stress management skills; Substance use; Antisocial and aggressive behaviour	Experimental design (RCT); experimental/control group	More adaptive stress management strategies; Improved alternative solutions to problems	Less self-reported antisocial and delinquent behaviour; Improved pro-social values; Improved teacher-rated peer relations and behaviour

**Table 3****Setting: Workplace****Examples of interventions at the workplace or for the unemployed**

Country	Programme name	Target group	Aims and objectives	Risk and protective factors	Type of research	Health impact	Social and economic impact
USA	JOBS programme (Price <i>et al.</i> , 1992)	Involuntary recently unemployed adults	Seek effectively reemployment; Cope with the multiple challenges of unemployment and job-search	Coping skills; Job-seeking skills; Self-esteem; Sense of control; Self-efficacy; Helplessness; Social support	Experimental design (RCT); Experimental/control group	More job satisfaction and motivation; Higher self and job seeking confidence; Decreases in depressive symptoms (39%-25%)	Finding jobs more quickly; Better jobs and income; Cost: \$286 per person, Benefits: \$720 per person after 32 months, \$1,649 for the government per person
Finland	The Työhön Job Search Program (Vuori <i>et al.</i> , 2002; Vuori <i>et al.</i> , in press)	Long-term unemployed adults	Seek effectively reemployment; Cope with the multiple challenges of unemployment and job-search	Coping skills; Job-seeking skills; Self-esteem; Sense of control; Self-efficacy; Helplessness; Social support	Experimental design (RCT); Experimental/control group	Higher and better quality of reemployment; Decrease in psychological distress and depressive symptoms; Increase in self self-esteem	Socio-economic benefits from improved employment outcomes
The Netherlands	Stress prevention training (Bekker <i>et al.</i> , 2001)	Recently ill or working employees with work related stress complaints, without any other psychological problems	Improve coping skills in order to build resistance against work stress	Coping skills/capability; Social support	Quasi experimental design	Less psychological and somatic complaints; Less stress; Use of more active coping; Higher capability for managing new situations	Increase social support seeking

**Table 4**  
**Setting : Community**  
**Examples of interventions in the community**

Country	Programme	Target Group	Aims and objectives	Risk and Protective Factors	Type of Research	Health Impact	Social and Economic Impact
United Kingdom	You in Mind (Barker <i>et al.</i> , 1993)	National media audience (adults)	Promote greater understanding of mental health problems; Change coping or help-seeking behaviour	Knowledge about psychological problems; Behavioural intentions towards mental health problems	Pre-post stratified random sample		Improved mental-health-related understanding and behavioural intentions
Norway	Norwegian Mental Health Campaign (Sogaard and Fonnebo, 1995)	National media audience age 14+	Changing knowledge and attitudes about mental health, and willingness to communicate about it	Knowledge about psychological problems; Behaviour towards mental health problems	Pre-post stratified random sample with post-control group		Wide penetration; Improved knowledge about and attitudes towards mental health problems
Ireland United Kingdom	Community Mothers Programme (Johnson <i>et al.</i> , 2000)	Socially disadvantaged first-time mothers	Provide support to first-time parents in rearing their children up to 1 year of age	Mutual support; Empowerment; Social deprivation; Parenting skills; Maternal self-esteem	Experimental design (RCT); experimental/control group	Increased immunisation rates; Better dietary intake; Improved maternal psychological health	Increased rates of mothers reading to their children; More positive maternal feelings; Increased maternal involvement in personal development programmes
Ireland	Rural Mental Health Project (Barry, 2003)	Community members of two rural communities on the border region of the Republic and Northern Ireland		Community engagement and participation Community awareness of depression and suicide; Help-seeking attitudes and supports; Skill development Re-orientation of services	Quasi-experimental design	Improved community awareness concerning suicide and depression; Improved attitudes towards help-seeking; Improved job search skills; Improved awareness of supports, services and help-seeking among young people	Enhanced capacity to engage with local services; Sustainable school-based and employment programmes put in place; Inter-agency and cross-sectoral collaboration established; Cross border collaboration and co-operation in implementing local programmes

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# Poverty, gender and mental health promotion in a global society

■ The powerful influence of a range of social and economic factors on mental health has been documented in virtually all epidemiological investigations of mental disorders. These risk factors are similar to the various indicators used to measure 'human development'. This concept was first operationalised by the United Nations Development Program in its first 'Human Development Report' released in 1990. That report opened with the lines:

"The real wealth of nation is its people. And the purpose of development is to create an enabling environment for people to enjoy long, healthy and creative lives. This simple but powerful truth is too often forgotten in the pursuit of material and financial wealth".

Mental health is an implicit component of this concept, for there is good evidence that poor mental health will compromise longevity, general health, and creativity. Thus, the factors which influence human development will be those which also influence mental health; causality is not likely to be simple or unidirectional for both human development and mental health are broad constructs. It is likely that a dynamic relationship exists between specific aspects of human development, such as poverty, and specific aspects of mental health, such as self-esteem (Patel, 2001). The indicators used to measure human development are varied, and show great variation between countries. In the Human Development Reports, countries are ranked according to an overall Human Development Index (HDI)

which is computed on the basis of a number of variables. Another measure, which is of relevance to this paper, is the Gender-related Development Index (GDI), which is a composite measure reflecting gender inequalities in human development. Of the 173 countries for whom HDI were computed in the 2002 report, 53 were ranked as being in the high HDI category, 84 in the middle HDI category, and 36 in the low HDI category. A scan of the list of countries shows that all the countries of Western Europe, North America and Australia/New Zealand are in the high HDI category, whereas most of the rest of the world falls in the middle and low categories.

The use of HDI shows that there is a huge diversity between countries which have traditionally been lumped together as 'developing'. These diversities are further reflected in the frequency of a range of adverse social and economic factors which influence mental health, such as crime rates, physical health indicators, political commitment to public health and social welfare, and the experience of severe civil disturbances such as those caused by conflict and disasters. Disparities are evident both between major geographical regions, and within geographical regions; indeed, human development reports for specific countries reveal enormous disparities even within the same country. Political commitment to public health and social welfare also show a similar pattern of disparity; sadly, some of the poorest countries in the world continue to spend more on the military than they do on education and health. The number of internally displaced peoples and refugees are alarming; again, the numbers are consistently higher in countries with low HDI, demonstrating that poor countries bear the lion's share of the burden of war and displacement. However, it is reassuring that for the vast majority of countries, including those in the low HDI category, there has been a steady, if slow, improvement in HDI over the past two decades.

In this paper, I will focus on two key macro-issues which profoundly influence all aspects of human development, viz., poverty and gender, with the aim to demonstrate how these elements are related to mental health and mental disorders. The paper will also consider the impact of globalisation on poverty and gender in the context of their influence on mental health, and the strategies for action for mental health promotion.

## Poverty and mental health

There are no unitary or cross-culturally valid indicators to measure poverty. Instead, definitions vary depending on the social, cultural and political system in a particular region and country, and according to who might be the user of the data on poverty. Poor people's definitions of poverty, as described on the basis of interviews in a number of developing countries, reveals that poverty is a 'multidimensional social phenomenon' (Narayan, Patel, Schafft, Rademacher and Koch-Schulte, 2000). Thus, lack of what is perceived to be necessary for material well-being, particularly food but also housing and land is a key defining feature. Exclusion from social and political forums, absence of basic infrastructure in their communities, literacy and lack of assets (as opposed to income) are also viewed as important. Poverty, from an epidemiological perspective, means low socio-economic status (measured by social or income class), unemployment and low levels of education. As might be expected, poverty is much more common in developing countries; in

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## Key words

- developing countries
- mental health promotion
- poverty
- gender
- depression

addition to absolute poverty, relative poverty or inequality also tends to be more common in developing countries.

A recent review of community studies from low and middle income countries found that most studies showed an association between low education and the risk for depression; many studies also showed a relationship between other indicators of low socio-economic status such as poor housing or low income with the risk for depression (Patel and Kleinman, 2003). Persons who are depressed often cite economic difficulties as the cause of their ill-health. The relationship between poverty and poor mental health may be mediated by a number of factors including the humiliation and insecurity of living in poverty (Narayan, Chambers, Shah and Petesch, 2000), the greater burden of physical health problems in the poor, and poor access to appropriate health care. Irrespective of the average per capita income of a society, persons who are at the bottom end of the social hierarchy are at a greater risk to suffer these disorders than those who are at the upper end, an effect which seems to be more pronounced in more unequal as well as poorer societies. Thus overcoming poverty might contribute to the promotion of mental health but it is unlikely to be enough; a more equitable distribution of resources remains important.

A variety of social phenomena associated with rapid urbanisation by globalisation may be detrimental to mental health through increasing stress or reducing natural protective factors. Examples of such phenomena include squalid living conditions in urban areas for migrants, and the breakdown of families as sources of social support. The suicide of farmers in parts of India since the mid-1990s, provides another illustration of the impact of globalisation and ensuing financial insecurity on mental health. The seasonal monsoon has consistently failed in some regions of India leading to low harvests and lower incomes for farmers. The ones who have suffered the most have been the poorest subsistence farmers who were not credit-worthy enough to get bank loans and had to borrow money from loan-sharks. With their crops failing year after year, the farmers were faced with the stark choice of selling whatever few assets they still

had or become bonded labour to the moneylender until the debt was repaid. Globalisation and the inroads of multinational companies has led to new competition for small-scale farmers whose goods are no longer competitively priced. This adds, directly or indirectly, to numerous other problems such as sub-standard quality of seeds and the lack of cooperative supports from banks. The result of this stress has been more than 1000 suicides in recent years (Sundar, 1999).

Depressive and anxiety disorders are disabling and can prevent sufferers from carrying out their tasks at home and in employment. Depressive and anxiety disorders have adverse economic implications for the individual, their families and society. Thus, it is likely that poverty and poor mental health interact with one another, setting up in vulnerable individuals, a vicious cycle of poverty and mental illness. Socio-economic determinants play an important influence on other mental disorders, such as the economic burden placed by alcohol and substance abuse and severe mental disorders; almost always, the poor face a disproportionately higher fraction of the burden.

## Gender and mental health

Whereas sex is a term used to distinguish men and women on the basis of their biological characteristics, gender refers to the distinguishing features which are socially constructed. Gender influences the control men and women have over the determinants of their health, including their economic position and social status, access to resources and treatment in society. Gender can be conceptualised as a powerful social determinant of health which interacts with other determinants such as age, family structure, income, education and social support and with a variety of behavioural determinants (WHO, 2000). The role of gender in public health in developing countries has been acknowledged and 'mainstreamed'; gender is a core component of major health programmes targeted at child and adolescent health, reproductive health and primary health care. The promotion of gender equality and the empowerment of women is the third of the Millenium Development Goals (MDG) formulated at

the Millenium Summit of 2000 which set the strategic direction for the World Bank, UN institutions, and development and donor agencies. The role of gender in mental health is universal, but as with poverty, its impact is likely to be significantly greater in developing countries because gender is a much less recognised determinant in these countries; indeed, the Human Development Report's Gender Development Index league tables show that low and middle income countries tend to have lower GDI than high income countries (United Nations Development Programme, 2002).

One method of examining the role of gender on mental disorders is to consider those disorders with significant, cross-cultural sex differences, for example, Depression, Alcohol Use Disorders (AUD) and Eating Disorders. The female excess for Depression has been demonstrated in most community based studies in all the regions of the world (WHO, 2000). Stresses in life are known to make a person more likely to become depressed and the greater exposure to stressors may partly explain the female excess in the risk for Depression. The social gradient in health is heavily gendered and women are disproportionately affected by the burden of poverty which, in turn, may influence their vulnerability for Depression. Women are far more likely to be victims of violence in their homes; women who experienced physical violence by an intimate partner are significantly more likely to suffer Depression, abuse drugs or attempt suicide (Astbury, 2001; WHO, 2002). Gender based factors such as heavy workloads, humiliating and entrapping life events related to marital relationships and the preference for boy children in some cultures have all been shown to be associated with a higher risk for depression (Broadhead and Abas, 1998; Patel, Rodrigues and De Souza, 2002). The male excess for AUD has been demonstrated in every community study from every region, although the gaps are the greatest in developing countries. The wide sex differences in alcohol abuse in Latin American countries and the Caribbean has been attributed to a number of gender factors (Pyne, Claeson and Correia, 2002). Drinking and drunkenness are more often perceived to be consistent with gendered notions of

masculinity and thus, men who conform more closely to cultural norms are more likely to drink. In many cultures (but perhaps most well recognised in Latin American cultures), the role of *machismo*, i.e. the importance of male sexuality, is central in shaping alcohol consumption.

The evidence that gender may play a role in eating disorders stems from the fact that there are enormous sex differences (females outnumbering men) and that cultures which have been relatively immune to the media-driven creation of the ideal body image for women have very low rates of these disorders. Recently, a study from Fiji has demonstrated that the introduction of television in a media-naïve non-Westernised population is associated with a rise in attitudes favouring thinner body image and self-induced vomiting in girls (Becker, Burwell, Gilman, Herzog and Hamburg, 2002), adding weight to the theory that the emphasis on women's thinness by the media and fashion industries is now leading to a rise in disordered eating in non-Western cultures as globalisation leads to increasing homogenisation of media imagery across the world with Western imagery being the predominant force.

Gender also influences other aspects of mental disorders, such as impact, burden and stigma, and this is evident for those disorders which do not have significant sex differences such as schizophrenia and bipolar disorder. Social responses to mental illness more clearly show a gendered difference, with greater stigma and rejection being evident in the event of a woman suffering from mental illness. Because of the different expectations and evaluations of men's and women's behaviour, mental illness in women may attract a greater amount of shame and dishonour and has a greater impact on family life due to the woman's role in running the domestic activities of the household. These differences may lead to a suppression of the acknowledgement of the experience of mental disorders in women and men. Whereas a mentally ill man may get married, mentally ill women are often left alone. Married mentally ill women are more likely to be sent back to their parental homes, deserted or divorced (Davar, 1999). Gender also influences suicidal behaviour; the higher rates of male suicide in some countries is

partly due to the acceptability for men to carry guns and gendered differences in social roles and expectations when faced with adversity. On the other hand, rapid social change with its impact on interpersonal networks and social identity, has been attributed as one the major causes for the rise in suicide rates, especially in rural women in China (Phillips, Liu and Zhang, 1999).

### Implications for mental health promotion

One of the central challenges faced by mental health promotion in contexts where infrastructure is poorly developed, where human and material resources are scarce, and where human rights practices cannot be taken for granted is that many of the social changes necessary for improved mental health are far more wide-reaching than generally considered within the ambit of mental health promotion practice. The impact of the changes in terms of narrow and proximate mental health gains is also hard to measure, especially in the short term. In addition, for a range of reasons, some of which have to do with a lack of resources and capacity in developing countries, far less research has been conducted in these contexts than in wealthier countries. It is likely, therefore, that there will be little specific evidence, in particular based on controlled trials, which demonstrates the impact of social and economic development policies and programmes on the promotion of mental health. The evidence that does exist includes narrative and case study material of specific programmes and evidence from the domain of physical health promotion which may be extrapolated to mental health. These programmes focus on three major areas of action: advocacy, empowerment and social support. Empowerment is the process by which groups of persons in the community who have been traditionally disadvantaged in ways which compromise their health, can overcome these barriers and can exercise all the rights that are due to them, with a view to leading a full, equal life in the best of health. In the context of poverty and gender, empowerment can be conceptualised as a core mental health promotion activity in developing countries. Examples of such empowerment activities are considered below.

### Economic empowerment

In many developing countries, indebtedness to loan-sharks is a consistent source of stress and worry. These vulnerabilities arise because of the failure of the formal banking sector to extend short term loans to the poorest in the community, who often lack the literacy or 'credit-worthiness' which are essential for accessing loans. Radical community banks and loan facilities such as those run by SEWA in India and the Grameen Bank in Bangladesh have been involved in setting up such loan facilities in areas where they do not exist. Provision of such loans may reduce mental illness by removing the key cause of stress: the threat posed by the informal moneylender. Some evidence of the ability of such banks to promote mental health is available. The Bangladesh Rural Advancement Committee (BRAC) is the world's largest NGO in terms of the scale and diversity of its interventions. Its activities span health care provision, education and rural development programmes. The latter programmes are implemented at the level of individual villages, through Village Organizations (VO) comprising of the poorest members of the community. The primary activities are raising

**Figure 1**

#### Recommendations

- Raise awareness about the association of poverty and gender with mental health amongst public health policy makers, donors and mental health workers.
- Advocate for sustainable and equitable economic development to ensure that economic policies do not inadvertently lead to greater inequalities and marginalisation of people.
- Advocate for eliminating gender discrimination and violence in society.
- Improve access for health care and social welfare of persons living in poverty.
- Enable community programmes which aim to empower women and the poor.
- Evaluate the impact of globalisation on mental health, in particular, where globalisation influences the livelihood or lifestyles of people.

consciousness and awareness and compulsory savings. Once established, VO members can access credit for income generation schemes. BRAC has carried out evaluations of its programmes in a number of different settings. Data used for evaluation include baseline surveys, seasonal surveys, ethnographic surveys and demographic surveillance. These data show that BRAC members have better nutritional status, better child survival, higher educational achievement, lower rates of domestic violence and improved 'well-being' and psychological health (Chowdhury and Bhuiya, 2001).

## Equitable economic development

The epidemiological evidence clearly demonstrates the greater risk for common mental disorders for persons living in socio-economically disadvantaged situations. These findings suggest that economic development, which improved the lives of the poor, would lead to an improvement in mental health. A study on the impact of economic development on mental health was conducted in a rapidly industrialising region of Sumatra, Indonesia (Bahar, Henderson and Mackinnon, 1992). The study was able to access data on the change in development levels of each village; the rates of mental disorder were lowest in persons living in those villages which had shown the greatest improvements in living standards and socio-economic development in the previous three years. Community development programmes which include health sector reforms such as decentralisation, participation of local community leaders and empowerment of the marginalised, are being implemented across the developing world as a way of promoting health and preventing disease amongst the poor. Many of these programmes are being led by social 'entrepreneurs' and community based non-governmental organisations. In all these models, health is seen as a fundamental part of development and vice versa, i.e. health cannot be assured unless overall development is achieved.

## Empowerment of women

Although the link between domestic violence and mental health problems has been firmly established in numerous

studies, there have been no systematic evaluations of the mental health impact of violence reduction programmes being implemented in many developing countries. Such programmes work at several different levels, including sensitisation of health workers so that they are confident and comfortable when asking about abuse, integration of education about violence into existing health programmes and communication strategies (such as TV soap operas), enabling legal reforms to ensure the rights of abused women, raising the cost to abusers by imposing a range of legal penalties, provision for the needs of victims and reaching out to male perpetrators (Heise, Ellsberg and Gottemoeller, 1999). Approaches which focus on strengthening intimate relationships, one of the most common contexts for violence, include parenting training, mentoring and marriage counselling; some of these, such as the Stepping Stones programme have been

shown to help men to communicate and gave them new respect for women, in qualitative evaluations in African and Asian settings (cited in Heise *et al.*, 1999). Many programmes have been demonstrated to be effective in the reduction of the primary outcomes of reduction in violence and, given the linkages between domestic violence and common mental disorders in women, it is likely that such programmes will have a powerful impact on mental health promotion as well.

In conclusion, although there is considerable variation between, and within, countries in indicators of poverty and gender, there is a clear association between these macro-social factors and mental health. Programmes aimed at empowering women and the poor, and policies which ensure gender equality and equity in economic development are likely to play the greatest role in promoting mental health.

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# The implementation of mental health promotion programmes

■ The evaluation of programme implementation has a critical role to play in advancing knowledge and practice in mental health promotion. While much progress has made in recent years in establishing a sound evidence base for mental health promotion (Hosman and Jané-Llopis, 1999; Friedli, 2003), research on programme implementation has been relatively neglected. The published research studies and systematic reviews are mainly concerned with programme outcomes and provide little or no data on implementation or the quality of programme delivery necessary for positive outcomes to be produced (Durlak, 1998; Dane and Schneider, 1998; Domitrovich and Greenberg, 2000). As a result there is a dearth of published information to guide practitioners and decision-makers regarding the practical aspects of programme adoption and replication. From those studies that have monitored implementation, it is clear that implementation is often variable and imperfect in field settings. Durlak (1998) cautions that programmes may not be implemented with a high degree of fidelity and that between 23% to 81% of programme activities may be omitted. When implementation is documented it is clear that the level and quality of implementation influences programme effectiveness and that higher quality implementation is associated with stronger, more positive outcomes (Dane and Schneider, 1998; Durlak, 1998; Domitrovich and Greenberg, 2000; Mihalic, Fagan, Irwin, Ballard and Elliott, 2002).

Expanding the evidence base in order to inform the implementation of effective, feasible and sustainable programmes across diverse cultural contexts and settings is a key challenge in the mental health promotion area (WHO, 2002). This calls for a focus on researching the process of implementing programmes in naturalistic settings, i.e., outside of controlled research conditions, and identifying the key factors and conditions which can facilitate high quality implementation. This is essential if the area is to move to a new level of understanding and sophistication beyond the question of whether programmes work (efficacy), to also consider what makes them work, with whom and under what circumstances (effectiveness). An increasing body of research has been devoted to establishing the efficacy and effectiveness of interventions through trials, mainly in high-income countries, and it is now timely to invest in community-based dissemination research in order to examine how evidence can be used effectively to guide the adoption and adaptation of interventions when applied across different cultural settings or used with different populations (Barry and McQueen, 2005, in press). In particular, there is an urgent need to identify how effective programmes derived from efficacy and effectiveness studies can be translated and sustained in low-income countries and in various settings such as schools and communities.

## The importance of programme implementation

The most common definition of programme implementation is, “how well a proposed program or intervention is put into practice” (Durlak, 1998), i.e., what the programme consists of in practice and how it is delivered. This is often referred to as “fidelity” but other definitions or indicators of quality have also been used (Box 1). As Mihalic *et al.* (2002) point out, the identification of programmes with a strong evidence-base

regarding their efficacy is only the first step in ensuring best practice, as the decision to adopt a best practice or model programme does not in and of itself guarantee successful implementation. Although details of programme implementation are typically under-reported in the published literature, there is a wealth of information based on practitioner experience. This is what Domitrovich and Greenberg (2000) refer to as the ‘wisdom literature’, a body of knowledge based on practical experience of programme delivery on the ground. There is a need for greater attention to documenting and accessing this body of knowledge in order to become better informed about the circumstances and practices that enhance programme implementation.

Durlak (1998) identifies four major steps in studying implementation; 1) defining active programme ingredients; 2) developing an accurate and valid assessment system; 3) monitoring implementation during programme execution; and 4) relating implementation levels to outcomes. Both the quantity and quality of the implementation should be assessed in order to establish how much of the programme was delivered and how well each part was conducted (Durlak, 1998). In general, high quality implementation is more likely when core programme components are defined in advance, either through the use of structured manuals or detailed intervention protocols, and then systematically monitored to ensure compliance.

Implementation information has a critical role to play in the accurate interpretation of evaluation outcomes. Undocumented

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## Key words

- mental health promotion
- programme implementation
- quality of implementation
- process of implementation

## Box 1

**Aspects of implementation** (adapted from Dane and Schneider, 1998)

- Programme adherence or fidelity - the degree to which core programme components were delivered as planned
- Exposure - the frequency and duration of the programme
- Quality of programme delivery - the skill and style of delivery
- Participant responsiveness - engagement with and reaction to the programme
- Programme differentiation - verifying the conditions of the study design.

variations in programme delivery create difficulties in interpreting the findings from outcome studies. It may be incorrectly concluded from evaluation studies that specific programmes do not work when positive outcomes are not found. However, negative findings may be due to poor quality implementation rather than poor quality programmes per se. In the absence of data on programme implementation, a programme may therefore, be incorrectly judged as ineffective when in fact negative outcomes are due to poor quality of implementation. This leads to a Type III error, i.e., the programme as delivered is of such poor quality as to invalidate the outcomes. If programme implementation is not monitored and assessed, an outcome evaluation may be assessing a programme, which differs greatly from that originally designed and planned. Likewise concerning programme differentiation, if a comparison or control group is included as part of the evaluation, it is important to ensure that there is no contamination and that a similar intervention is not actually being conducted. As Gresham, Cohen, Rosenblum, Gansle and Noell (1993)

## Box 2

### Implementation barriers

(adapted from Mihalic *et al.*, 2002)

Implementation barriers:

- failure to commit time and resources;
- hiring implementers who lack the appropriate skills to deliver the programme;
- insufficient organisational and key leader support;
- poor motivation and buy-in of implementing staff;
- failure to provide ongoing support and technical assistance;
- lack of programme monitoring.

point out, continuing to ignore implementation compromises knowledge of the relationship between process and outcomes, it makes replication of effective programmes difficult and leads to an inability to clearly distinguish between ineffective programmes and effective programmes that are poorly implemented.

The collection of systematic data on programme implementation plays an essential role in advancing knowledge on best practice for replication in 'real world' settings. It is also critical to the effective dissemination of programmes, particularly when they are exchanged between different countries or settings and facilitates the translation of research evidence into best practice. Process evaluation techniques based on careful project description, documentation and monitoring are required to assess both the quantity and quality of programme implementation. Implementation information is necessary for understanding programme strengths and weaknesses, determining how and why programmes work, documenting what actually takes place when a programme or strategy is conducted, and providing feedback for continuous quality improvement in programme delivery (Domitrovich and Greenberg, 2000).

Programme implementation occupies an especially important place in mental health promotion as this multidisciplinary area of practice is concerned with the process, as well as the outcomes, of enabling positive mental health (Barry, 2002). As such, there are core principles which underpin mental health promotion practice which need to be taken into account. In keeping with the fundamental principles of health promotion, as articulated in the Ottawa Charter (WHO, 1986), the delivery of mental health promotion programmes in an empowering, collaborative and participatory manner is central to mental health promotion activity. Programme evaluation methods are needed that will focus on documenting the process of implementation, identifying both the key predictors of change and the necessary conditions for bringing about such change. Jané-Llopis and Barry (2005) in this volume discuss further the elements that are likely to improve success of mental health promotion interventions.

## A conceptual model for implementing schools-based programmes

Although programme implementation has been examined in several fields, there are very few comprehensive models that define the domain or provide guidance for understanding how it relates to outcomes or the factors that facilitate or undermine the process in specific contexts. Greenberg and colleagues were commissioned by the Center for Mental Health Services in the United States to create a comprehensive model of implementation specifically for school-based mental health promotion and prevention programmes (Greenberg, Domitrovich, Graczyk and Zins, 2001). Schools are excellent settings for conducting health promotion and prevention activities but they are complex, multi-level systems (i.e., building, classroom, individual) with numerous factors that have the potential to influence implementation (Durlak, 1998; Elias, 1997; Elias, Bruene-Butler, Blum and Schuyler, 2000; Gottfredson, Fink, Skroban and Gottfredson, 1997; Hoagwood and Johnson, 2003; Mihalic *et al.*, 2002; Weissberg and Greenberg, 1998).

The authors based their model on the theory-driven evaluation work of Chen. According to Chen (1990; 1998), a comprehensive programme theory includes a "causative" theory of how the program or intervention achieves its targeted outcomes and a "prescriptive" theory to guide the process. The prescriptive theory dictates how the strategy is implemented including the nature of the programme delivery and the context (e.g., training, supervision, organizational characteristics) that is necessary to support successful implementation. This includes the process and structure of the planning, implementation and training; the characteristics of programme implementers and participants and the nature of their relationship; facilitatory and inhibitory factors in the local context including readiness, mobilisation of support, ecological fit of the programme, cultural sensitivity and the extent of participation and collaboration with key stakeholders. Chen (1990) argues that although an intervention is the major change agent in a programme, the 'implementation system' is likely to make

an important contribution to programme outcomes as it provides the means and the context for the intervention.

Figure 1 provides an overview of the school-based model. First, implementation has the potential to be affected by aspects of the programme itself. That is, the programme model, quality of delivery, target audience, and participant responsiveness. For example, if a programme requires more time than the typical educator can devote in a day or week to non-academic activities, then it is more likely to be diluted when it is implemented. Similarly, quality of delivery is critical for any prevention or health promotion programme. If an implementer merely reads out of a manual as opposed to injecting their own energy into the delivery of the material they will be less likely to engage the students. If students are not engaged (i.e., low participant responsiveness) with an intervention they will not remember what is presented to them or make the connection between what they are learning and its relevance to their own lives.

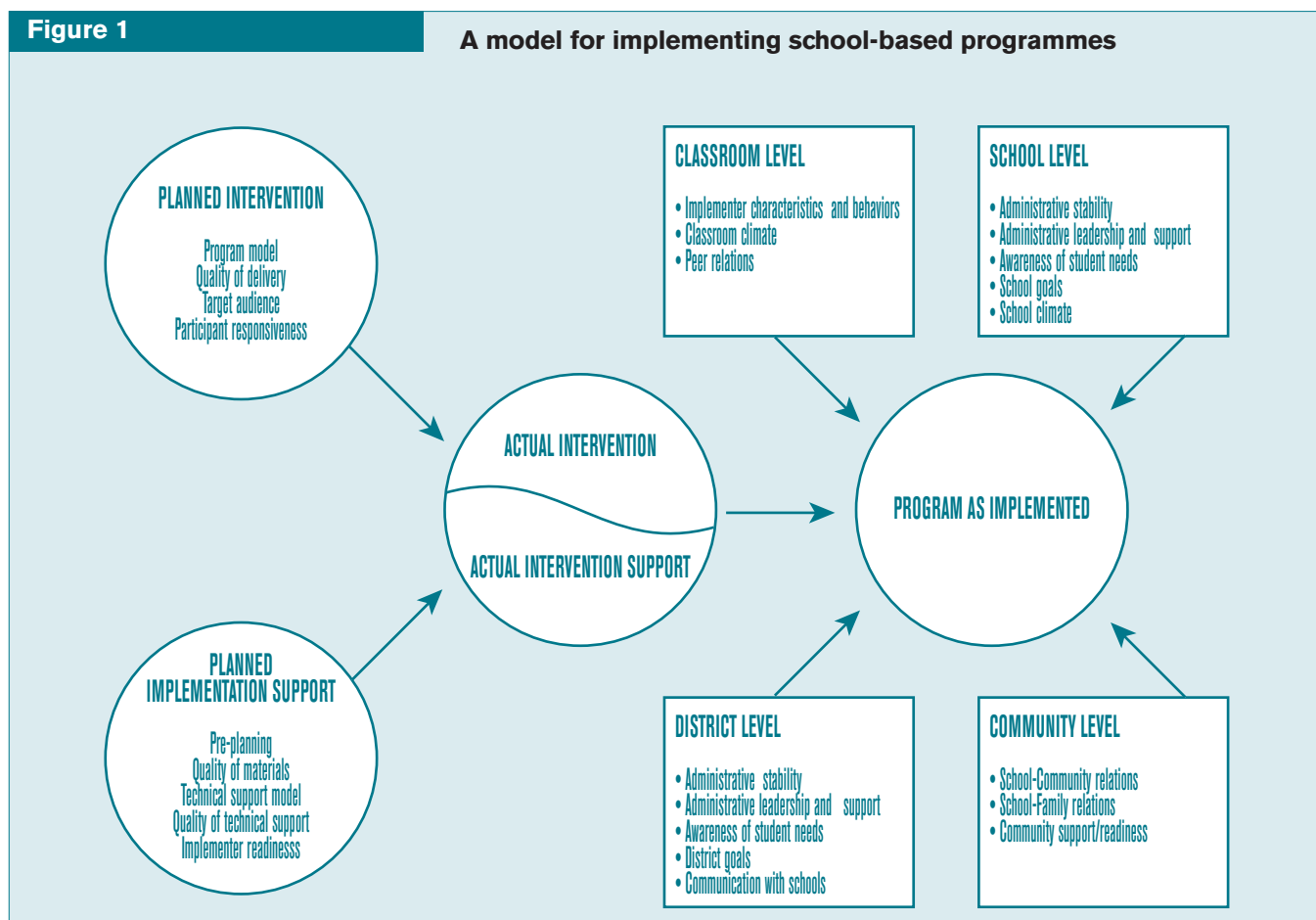
Implementation quality is greatly affected by the support that is provided with a programme. In the Greenberg model, the implementation support system includes pre-planning, the quality of materials, the quality and structure of the technical support model, and implementer readiness. The success of any school-based initiative begins with the pre-planning that is conducted. It is important to know the interventions that a school or teacher has implemented because the history of that experience (positive or negative) will influence how they approach subsequent programmes and their beliefs about effectiveness. Beliefs are one aspect of implementer readiness that can influence the likelihood of programme success but first, implementers must be convinced of the value of the intervention and then feel prepared to conduct the programme. Included in the technical support system is the content and quality of the intervention training and the on-going support that is provided. Similar to quality of deliver of an intervention, the training that prepares implementers to

use a programme can vary in terms of quality. If it is poorly organised or boring, the participants will more than likely walk away from the session disinterested and unprepared. Under these circumstances even the highest quality programme is doomed to fail.

It is important to recognise that in any system, particularly schools, there are influences external to the actual programme that may greatly impact on the quality of programme implementation. In other words, the environment or context in which a programme is implemented has its own ability to support or undermine the success of a promotion or prevention initiative. It is important to identify those factors specific to educational settings when conducting programmes in schools. These include the school ethos, policies and management structure. The administration and teaching staff must be aware of the importance of mental health and feel that the intervention being proposed is an appropriate one for the school and the students. This type of

**Figure 1**

**A model for implementing school-based programmes**



institutional “buy-in” is critical for successful implementation.

The implementation principles highlighted in this conceptual model for schools are also applicable to other mental health promotion interventions and settings.

## Evaluation of programme implementation in community settings

In evaluating the implementation of mental health promotion programmes, some interventions, such as community-based programmes, may not be easily standardised. Community programmes typically involve multi-faceted interventions and overlapping strategies such as capacity-building, skill development, social action etc. However, given the multiplicity of activities that may be involved, programme documentation becomes even more critical. Cunningham, Michielutte, Dignan, Sharp and Boxley (2000) point out that community-based programmes require especially comprehensive process evaluation systems to track implementation and ensure adequate documentation of the range of activities involved. These interventions are guided by the principles of collaborative practice, partnerships, and active participation by community members. There is therefore, a need to use multiple methods to capture the range of programme activities and assess the dynamics of the programme in action (Barry, 2003). Documenting the programme in action permits an accurate account of the programme as it unfolds and informs the detection of intermediate level changes leading to ultimate programme outcomes.

Dynamic community programmes need to respond and adapt to changing local circumstances and as such will require a continual flow of information from process evaluation in order to be able to fine-tune the programme interventions. Dane and Schneider (1998) highlight that even though a programme may be planned and fine-tuned in active collaboration with the adopting site, it is still possible to document and specify the procedures that were jointly planned, and through comprehensive process evaluation to verify that they were implemented. The process evaluation therefore needs to document the

actuality of programme implementation and to capture the individuality of the local community contexts.

Recommendations for improving programme implementation, based on these principles, are outlined in Box 3.

## Strategies for ensuring high quality programme implementation

There are a variety of strategies that can be used to improve the overall delivery and effectiveness of mental health promotion programmes (Domitrovich, Weare, Greenberg, Elias and Weissberg, 2005, in press; Durlak, 1998; Greenberg *et al.*, 2001; Mihalic *et al.*, 2002). It is important to note that these phases begin as early as when a programme is being considered and planned (pre-adoption).

The most complicated phase is when a programme is being conducted (delivery) but there are important steps to take even after a programme is in place and while it is being maintained (sustainability). Recommendations for practitioners and developers to support effective monitoring and use of implementation information across these three phases are outlined in Box 3.

In many countries, implementing programmes entails working with minimal resources and programmes may need to be adapted or modified to meet the needs and conditions of the local setting. This presents the challenge of conducting programme evaluation, which will document programme replication and innovative forms of practice, in the absence of large research grants. The

### Box 3

#### Recommendations for improving programme implementation

##### Programme implementers/developers

##### Pre-adoption phase

- Assess the characteristics and resources available in the local community
- Identify the problem and associated risk and protective factors for that community
- Verify that the programme model is appropriate for implementation in the target community
- Involve key stakeholders in the decision-making process, including implementing staff, management and potential programme recipients
- Ensure buy-in of all parties by providing documentation that supports the need for the programme (e.g. the evidence-base for the programme and the match between the approach adopted and the needs in the community)
- Identify the key components of the intervention based on underlying programme theory
- Identify and communicate programme objectives, principles and the mechanisms that will be used to achieve them, to all relevant players at the planning stage.
- Provide decision-makers and stakeholders with the necessary information to secure adequate resources to implement the programme
- Lay the foundation for successful co-operation and collaboration by clearly defining the roles of all parties involved and establish a system for discussing and resolving problems
- Plan for the long-term sustainability of the programme

##### Delivery phase

- Assess readiness to implement the programme
- Make modifications or adaptations in delivering the programme, balancing programme fidelity with the needs of the local site
- Draw on the ‘wisdom knowledge’ of those with experience of the programme
- Develop a structured manual or detailed programme description to facilitate programme implementation
- Train programme staff to conduct the programme effectively
- Provide ongoing support and supervision once the programme has begun
- Partner with an evaluator to develop an implementation monitoring system that includes assessment of the programme (i.e. programme fidelity, exposure, quality of delivery, participant responsive and programme differentiation), support system, and key system factors.

##### Sustainability phase

- Develop a plan for the sustainability of the programme based on existing funding, long-term priorities and resources
- Use implementation information and process evaluation data to fine-tune and improve programme delivery
- Provide regular updates and evaluation information to key stakeholders
- Document the provision of feedback and any subsequent changes that are made to the programme

## Box 4

### Case study of programme implementation in low-income settings

#### A psycho-educational intervention for women with depressive symptoms

This case study reports on a psycho-educational intervention that was developed and evaluated for low-income women displaying both depressive symptoms and clinical depression (with no suicidal ideation, suicide attempts or psychiatric co-morbidity). This intervention targeted women aged between 25 and 45 years of age and was carried out at primary health and mental health settings in Mexico City. The intervention is structured around the educational material: *Is it Difficult to Be a Woman? A Guide to Depression* (Lara *et al.*, 1997), which is based on psychological and cognitive-behavioural treatments and includes a gender perspective. The educational material is written in a comic strip format to describe depression: symptoms, causes, and ways of coping with it and targets women with low levels of literacy. It considers a multi-factorial model of depression that takes into account biological, child development, life events, gender condition, and social factors. The intervention programme relies on local research findings on women's mental health and on clinical practice as much as experience elsewhere. Muñoz and Ying's (1993) prevention of depression programme provided a framework to guide the development of the intervention programme. However, the specific strategy and materials used were developed to meet the needs of the local context. There are various hypothesised mechanisms of change (e.g. allows a better understanding of depressive symptoms and current problems; increases positive thinking and reinforcing activities; widens the behavioural repertoire, increases self-esteem, improves problem solving, facilitates the expression of emotions, and challenges beliefs about traditional female roles).

To ensure delivery of the program according to specifications, an Intervention Guideline was developed (Lara, Acevedo and Weckmann, 2001). The programme was delivered in two modalities: six two-hour weekly sessions or a single twenty-minute to one-hour orientation session. Post-intervention and follow-up assessments showed that both were equally effective in reducing depressive symptoms (Lara, Navarro, Rubí and Mondragón (2003a) and that the former was slightly better in leading to participants' satisfaction (Lara, Navarro, Rubí and Mondragón, 2003b; Lara, Navarro, Navarrete, Mondragón and Rubí, 2003).

practical challenges of evaluating programme implementation in low-income settings will now be explored by illustrating the strategies outlined above with a case study of depression prevention in Mexico (Box 4).

#### Pre-Adoption:

Creating partnership is crucial to securing support for programme delivery. There are wide cultural differences regarding how to go about locating and motivating suitable partners. There can be agreements at the top levels which do not ensure that the operative level staff be willing to collaborate, or conversely, staff on the ground may be highly motivated because they can more directly perceive the benefits of programme but such programmes may not be supported by, or form part of, the organisation's goals. Too many administrative procedures may lead to long delays while too little formality may mean starting negotiations all over again every time there is a change in personnel at the decision-making level, a problem often encountered. Creating partnership may entail showing potential benefits to recipient agencies as well as ensuring

that the staff concerned (GPs, psychiatrists, psychologists, nurses and social workers) are involved as much as possible. In this programme this involved providing information on the programme and requesting staff to participate by referring potential candidates. Other benefits of achieving a good alliance with agencies was the support received in appointing their social workers or psychiatric nurses to promote the programme in the community, where they are known and are trusted, and in conducting follow-up interviews in the participants' homes.

Investing effort in pilot studies is worthwhile, especially when previous experience is scarce. This is particularly important in low-income countries where there tends to be less local knowledge on almost any research topic, and since available knowledge comes from the more affluent countries, it applies mostly to the latter's problems and resources. A great deal of adaptation and translation is often necessary. In this case study programme, the feasibility study helped to explore potential partners, to decide on an appropriate recruitment strategy, to gain knowledge about the target

population, the general functioning of the programme and the length of follow-up required (Lara, Mondragón and Rubí, 1999).

#### Delivery:

*Programme Model:* The educational material was the corner stone in the planning and delivery of the intervention. The appropriateness of the material in terms of culture, gender and social issues was a key consideration. Evidence had previously been gathered that the material was easy to read and was appealing to women. The structured material helped set out the aims of the programme and to structure the sessions around key programme components and activities, thereby increasing programme adherence. Purposively investigating the degree of fidelity with which the intervention was delivered by a qualitative analysis of transcripts from the audiotaped sessions (Lara *et al.*, 2004), as well as assessing the subjective evaluation of the participants, contributed to identifying implementation weaknesses and strengths (Lara *et al.*, 2003b).

*Implementation Support System:* The inclusion of a clinical psychologist on the team together with the high standard of training of the research interviewers and facilitators, and the commitment and high morale that prevailed despite the difficulties involved, contributed to the success of the programme. Developing an intervention manual ensured quality of programme delivery. The fact that the manual included guidelines for the proper functioning of the group, and that these were explained to the participants, led to respectful exchanges that enabled the intervention to develop within a conflict-free atmosphere (Lara *et al.*, 2004). Selection of suitable programme participants was also a crucial issue, since women displaying more severe conditions might not have benefited from the intervention.

#### Sustainability:

In terms of programme sustainability, this programme has already been replicated in various health and social institutions in Mexico and a distance course for facilitators using electronic media has been developed. The programme is now at the stage of dissemination and in a process of being adapted to a new population – prevention of postpartum

## Box 5

### Recommendations for improving programme implementation

#### Policymakers

- The decision to adopt a best practice programme does not guarantee success without attention to good quality implementation.
- Provide adequate resources for programme development and replication including the necessary staff skills, training, supervision and organisational support needed to implement the programme to a high level of quality.
- Invest in process evaluation in order to facilitate and enhance knowledge and best practice in programme implementation.

#### Researchers

- Systematically monitor and assess programme implementation as a core part of programme evaluation
- Collect qualitative data on the barriers, obstacles and facilitating factors encountered in the course of programme delivery
- Gather information from multiple sources, including programme recipients, implementers and researcher observation, in order to reduce bias in assessing the quality of implementation
- Identify key mediating variables that are theorised to be responsible for the programme outcomes
- Relate variability in implementation to short-term and long-term programme outcomes
- Work in partnership with practitioners, employing collaborative evaluation methods, in order to feed back implementation findings and to ensure continuous improvement of programme quality.

depression – where it will be assessed.

The following factors have been identified as contributing to the successful implementation and dissemination of the programme:

- a. Developing and adapting the programme materials for the local setting

- b. Developing an intervention manual to ensure quality of programme delivery
- c. Obtaining additional resources for:
  - developing a training programme for facilitators
  - offering training on a regular basis for participating agencies
  - follow-up institutions that have adopted the intervention
- d. Making the educational materials available in bookshops has meant that many people contact us seeking more information or advice on how to use it.
  - Participating in interviews on local TV and radio programmes.

Intervention projects, like the one reported here, are long-term multistage programmes and thus require large amounts of material and human resources for implementation and evaluation, which is a challenge in less developed countries where fewer resources are allocated to research and health care. However, it is clear that evaluation findings, especially those that are sensitive to the importance of implementation, play a critical role in demonstrating the potential of a programme and may therefore be vital in securing funding for sustaining an initiative in the longer-term.

### Conclusions

There is a need for practice and policy guidelines based on best available evidence concerning the critical factors needed to ensure the implementation of successful programmes across a range of cultural and economic settings. As well as identifying programme-specific outcomes, this includes identifying the generic processes that underpin effective programme planning and delivery. Implementation is important at each stage of programme development, from

initial pilot studies, to efficacy and effectiveness trials and more widespread dissemination in 'real world' settings. As a programme moves to more widespread implementation, practitioners in collaboration with programme evaluators will need to identify key programme elements needed for a high probability of success and identify factors that increase the potential for sustainability of effective programmes. In addition to programme content, there is a need to consider the organisational structures and policies that are necessary to support long-term maintenance and sustainability of quality programmes. Recommendations for policymakers and researchers in supporting and evaluating the quality of programme implementation are outlined in Box 5.

The generation of practice-based evidence and theory is an important challenge in mental health promotion and requires that researchers and practitioners work in partnership in documenting and analysing the implementation of mental health promotion programmes. Through the development of more collaborative and participatory evaluation methods, there will be an opportunity to include the knowledge base of programme implementers and participants into the evaluation process, thereby incorporating the 'wisdom literature' into the evidence base. There is a need for analytic frameworks that integrate process and outcome data in a meaningful way so that clear statements can be made about how and why programme changes have come about. Contrasting and complementary perspectives and methods are needed to fill out the larger picture and to tap previously undocumented areas of knowledge and practice.

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## I'm from the government and you want me to invest in mental health promotion. Well why should I?

■ This paper presents the rationale for governments to promote mental health: *Mental health is not only fundamental to the health of a population, but is also fundamental to its human, social and economic development.*

The paper discusses the responsibility for promoting mental health, by expanding the traditional view about who 'owns' mental health promotion, and who actually does, or can, promote mental health in most populations. It presents strategies for action largely drawn from the authors' experience in the UK and Australia. The paper finishes with some ideas about how to get mental health promotion on the national agenda, and what might be included.

Using a broad understanding of mental health<sup>1</sup> we argue that every government, at local, provincial/state or national level, whether in developing, transitional or developed countries would benefit from the inclusion of mental health promotion as a integral part of overall health, social and economic policies.

Mental health promotion not only enhances positive mental health, but also contributes to the reduction of risk behaviours such as tobacco, alcohol, and drug misuse, unsafe sex; the reduction of social and economic problems such as drop out from school, crime, absenteeism from work and intimate partner violence; and the reduction of rates, severity of, and mortality from,

physical and mental illness.

### Time to make a stand: why governments should promote mental health

At a societal level, good mental health is an important resource for individuals, families and communities. Mental health is an indivisible part of public health, contributes to the functions of society and has an effect on overall productivity. Mental health contributes to human, social and economic capital.

As introduced by Williams and colleagues in this volume (Marshall Williams, Saxena and McQueen, 2005), neuropsychiatric disorders account for 13% of the Global Burden of Disease, with depression alone currently accounting for 6.1% (Ustun, Ayuso-Mateos, Chatterji, Mathers and Murray, 2004). Predictions estimate that, by 2020, depression will be the second leading cause of disability in the world (Murray and Lopez, 1996).

Poor mental health unequally affects those who are socially and economically disadvantaged while also contributing directly to poverty (Fryers, Meltzer and Jenkins, 2004).

Poor mental health also contributes to poor physical health (Herrman and Jané-Llopis, 2005). For example, depression, social isolation and lack of social support are significant risk factors for Coronary Heart Disease that are independent of conventional risk factors such as smoking, high cholesterol and hypertension and are of similar magnitude to these conventional risk factors (Bunker *et al.*, 2003).

Promoting mental health has the potential to reduce a whole range of risk behaviours and their consequences such

as loss of productivity, crime, drop-out from school, and disrupted family relationships.

Increasingly we are seeing similarities appear in the antecedents of a number of different health and social outcomes. For example, the presence of the same risk factors (eg., low attachment to one's community, school, family and workplace; parental alcohol and drug use, family conflict, inconsistent parenting, marital instability and friends engaging in problem behaviours), and the absence of protective factors (a culture of cooperation and tolerance between individuals and between institutions and diverse groups in society, a sense of belonging to family, to school, to one's workplace and to one's community, good relationships within and outside the family, positive achievements, stability and security) can result in increased crime, drop out from school, increased risk of alcohol abuse, sexual activity, depression and suicide, drug addiction (Homel *et al.*, 1999; Bond, Thomas, Toumbourou, Paton and Catalano, 2000).

Workplace studies are revealing the costs of poor mental health such as lost productivity and lost creativity. It has been estimated that 30-40% of sickness

1. Mental health includes a sense of well-being, self-esteem, optimism, sense of mastery, ability to initiate, develop and sustain mutually satisfying relationships and the ability to cope with adversity (resilience). Together, these will enhance the individual's capacity to contribute to family and other social networks, the local community and society at large. Good mental health is fundamental in avoiding risk taking behaviours.

### Key words

- mental health
- health promotion
- social cohesion
- discrimination
- participation

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absence is attributable to mental disorders (e.g. Jenkins, 1985). Workplace claims resulting from stress related causes are reported to be on the rise in Australia (Pelly, 2004).

School studies show us the importance of mental health for learning. We know that anxious children, and children that are depressed, perform less well academically at school. And a major study in schools has shown that up to 30% of depressive symptoms in high school students can be attributed to harassment or bullying at school (Bond *et al.*, 2000).

A largely untapped area is the associations between poor mental health and disrupted family and personal relationships, and the social, health, economic and intergenerational costs that arise from breakdown of these relationships (Quinton and Rutter, 1998).

Research in the field of mental health promotion has generally been stronger about the association (and to a lesser extent the causality) of certain risk and protective factors listed above and poor mental health, than it is in showing how interventions can work. Nonetheless, there is now a rapidly growing body of evidence on the effectiveness of intervention (Mrazek and Haggerty, 1994; Jané-Llopis, Hosman, Jenkins and Anderson, 2003).

The combination of knowledge about risk factors, and social economic consequences of poor mental health, together with knowledge of effective interventions, makes a persuasive case that the less governments pay attention to the promotion of mental health, the more they will have to pay in a whole range of ways such as crime, drug abuse, poor educational performance, poor productivity, and poor physical health. Some may even pay the costs at the ballot box!

### Whose responsibility is it to promote mental health?

In the light of the determinants of mental health such as the risk and protective factors listed above, then it makes great sense for governments at all levels:

- To focus on mental health promotion as a means of developing a physically and emotionally healthier, safer, better educated and more productive community.

- To bring the relevant parts of the community, public and private sectors together to work on the upstream determinants of mental health such as social cohesion, community building, urban renewal, participation in the economy, parenting and reduction of discrimination.

Traditionally mental health promotion has been seen as the responsibility of the health sector, and the mental illness services in particular. But when we look at the determinants of mental health, two issues become obvious.

Firstly, that while the health sector has to pick up the pieces resulting from poor mental health, it has little effect on these determinants. Secondly, individuals and organisations in business and industry, housing, local government, sports, recreation, arts and popular culture, primary, secondary and tertiary education, and justice already are promoting or in some cases, demoting, mental health. Often however, they are not aware of the effect they have on mental health and can be further encouraged to either expand their health promoting work, or reduce the health damaging effects of their work. An example of the former is supporting and encouraging the role of good sports coaches or drama teachers in promoting the mental health of adolescents, and an example of the latter is changing work practices that actively encourage bullying in the workplace.

The challenge is to work out how to create effective partnerships with these individuals and organisations. The first step is to understand what is in their interest that aligns with ours in promoting mental health. For example, participation in sports and the arts has positive associations with social inclusion and reducing risk factors for poor mental health (Harrison and Narayan, 2003). Sports, recreation and arts organisations are generally very interested in reaching higher levels of participation (including active participants as well as coaches, leaders, teachers, managers and other volunteers) and so are those interested in mental health promotion. But in this case it is not enough to promote any form of sport, recreation or arts. It has to be inclusive sport, arts and recreation where a welcoming environment, that

promotes health and respectful relationships, is as important as performance and the results on the field or on the stage.

### Strategies for action

In addition to the evidence presented in this volume (Jané-Llopis *et al.*, 2005), in this section we present a number of ideas, projects and programmes that governments can use at all levels. They are presented to stimulate thinking rather than suggest they either have ironclad evidence for their success, or that they should be copied, without local adaptation. These projects and ideas are not representative but have been selected on the basis of the authors' experience and contacts, so are based in the UK and Australia.

A larger review of the evidence can also be found in the reviews on mental health promotion and mental disorder prevention or the world health organization (WHO, 2004a; WHO, 2004b). Further examples of mental health promotion initiatives from a number of different countries can be found in a series of case studies published by the World Federation for Mental Health and World Health Organization (Saxena and Garrison, 2004).

It is our view that the way the programmes are developed and implemented, and the relationships developed among organisations, and between participants and these organisations are crucial to the long term results. As a study of housing in the UK shows, the context in which the programme is implemented is crucial to the promotion of mental health – see below (Thompson, Petticrew and Douglas, 2003).

### Early childhood development and parenting

Group-based parenting training programmes improve the mental health of both parents and children (Barlow, 1999; Barlow, Coren and Stewart-Brown, 2001) and may be more acceptable to parents than clinic-based programmes for individual parents. A Primary Care Health Improvement Programme for mental health in Suffolk has established a partnership involving health, education and social services. They have set up a Healthy Schools Programme involving two primary schools and one upper school.

The Primary Care Trust is covering the cost of six 90-minute parenting classes for parents of children between five and 15 years of age. A nursery is also provided. The classes are facilitated by school nurses and health visitors and promote positive parenting messages in a relaxed atmosphere. The aim of the classes is to increase parents' self-esteem and confidence about parenting.

Two major national initiatives aim to improve emotional development of young children within comprehensive child development programmes. Sure Start is a large national initiative in the UK, begun in 2001, currently running in 524 local programmes involving up to 400,000 children in less advantaged areas. It aims to increase the life chances of children living in disadvantaged neighbourhoods by increasing the availability, affordability and quality of child care, improving their health, education and emotional development, as well as supporting their parents as parents and in their aspirations for employment (NESS, 2004; Sure Start, 2004). Predating Sure Start is the US government's Head Start programme, begun in 1965. The programs, for children, pregnant women and families aim to improve school readiness of young children in low income families. The programmes are run by local organisations and in 2003 they reached over 900,000 children, employing 206,000 staff, supported by 1,372,000 volunteers (Head Start, 2004).

### Teenage development

As reviewed in this volume, there are different approaches that can be used to promote the mental health of young people (Jané-Llopis, *et al.*, 2005). They might include school based programs (e.g., Gatehouse project, Patton *et al.*, 2003), including those that limit victimisation, discrimination and bullying (Kallestad and Olweus, 2003), and programmes to enhance young people's participation in the economy (VicHealth, 2004a).

Other approaches include direct youth services such as the "331 Young People's Centre" in London, funded by Barnet Local Authority, Barnet Primary Care Trust and the local Connexions service. It is a multi-disciplinary service providing advice, information, support and counselling to young people from 12 – 21 years. It is a general service, also providing information on sexual health

needs. Young people were involved in the Centre's development and young volunteers working in the Centre continue to input ideas. The main aim is to provide a high quality service that will inform, empower and respect young people so they are able to access the appropriate specialist local statutory and voluntary services. The project runs part time and has had over 12,000 contacts in its first three years. A second 331 centre has opened in West Hendon in January 2004 (331 Young People's Centre, 2004).

### Promoting mental health and active ageing

Similarly with older people there is a great range of possible approaches to improve mental health. Most of them represent the fundamental importance of valued participation, including paid and unpaid employment, connectedness, support, and encouragement.

The "Ageing Well UK Network", facilitated by *Age Concern England*, is a national health promotion programme with and for older people. The projects recruit and train volunteers aged 55 or older, known as Peer Mentors to provide support, encouragement, advice and information to their peers in order to promote positive physical and mental health. One of the projects in the Network, the Positive Mental Health Project in Warrington, is developing some groundbreaking work using trained volunteer peer mentors to help older people improve their mental health and outlook on life. They also offer support for people to access social and health activities in their local community. (Further information about this and other schemes can be found on <http://www.ageconcern.org.uk/AgeConcern/staying.htm>).

### Sports and recreation

VicHealth was established in 1987 by using a dedicated tax on tobacco to buy out and replace tobacco company sponsorship in sports and the arts with health promotion. The buy out was completed and now VicHealth's *Sport and Active recreation programme*, representing an annual AU\$8million investment in sports, and active recreation is focussed on increasing participation levels – for two reasons – for the physical health benefits of good sport, but also to promote mental health through improving capacity to welcome, encourage and maintain

active participants, coaches, managers and volunteers (VicHealth, 2004b).

### Arts and culture

The Women's circus, started in 1991, is a project of the Footscray Community Arts Centre in Melbourne, and is an initiative to empower women through the development of circus skills. It welcomes all women but gives priority to women who have been victims of physical and sexual abuse, women over 40 and women from diverse cultural and linguistic backgrounds (Women's Circus, 2004).

Somebody's Daughter Theatre Company was started in a women's prison in 1980. The company works in art, drama and music with women and now young people who have been excluded from the cultural and social life of the community (Somebody's Daughter, 2004).

Vocal Nosh is a programme to teach singing and develop local community choirs based on the notion of eating and singing together. It is based along principles of creative participation, cooperation and celebration, respect and inclusiveness. It now is expanding through teaching leaders skills to scale up the programme across the state of Victoria (Community Music Victoria, 2004).

### Urban planning

In the UK a large prospective controlled trial has shown that housing improvements can reduce anxiety, depression, and self reported mental health problems (Thompson, Petticrew and Douglas, 2003). And, like the example of sport above it is not simply the provision of housing that influences mental health, it is also the context in which it is provided. For example the tenure and ownership, housing design and moving needed, as well as the relationships and negotiations between provider and tenant, have to be taken into consideration, so that it becomes "mental health promoting" housing, not just the provision of bricks and mortar.

The Planning Institute of Australia has been providing professional development and training for its members, underpinned by the understanding that good [mental] health can be planned into a community, as can poor mental health. This project includes focus on the physical design and layout of new and old communities, traffic management,

provision of public transport, walking and bicycle paths, the resiting of shopping precincts and community amenities (Planning Institute of Australia, 2004).

### Local government

In many countries, local governments have been the core promoters of mental health in their communities, through the provision of services such as maternal and child care, early learning programs, sports and cultural amenities for all ages, local employment, democratic local decision making, local traffic management, urban design and walking and bicycle paths.

The Walking school bus has begun in many countries including the UK, New Zealand, USA and Australia. In Victoria, Australia the programme has been introduced under the auspices of local councils. The evaluation of the first four projects in Victoria has shown that although this has been fundamentally introduced as an initiative to promote physical activity it has considerable reported positive effects on mental health for students (inclusiveness, prevention of bullying while walking to school) and for parents and volunteers involved (VicHealth, 2003).

### Business, industry and employment

Business and industry can promote mental health in two major ways. Firstly, employment compared to unemployment is inherently better for mental health, and secondly workplaces can become ideal places for promoting mental health, rather than actively harming mental health, as many currently do.

England's Department of Health has worked with key agencies including the Confederation of British Industry, the Trade Union Congress, the Health and Safety Executive and others to promote mental health in the workplace (Department of Health, 1995; Jenkins and Warman, 1993; Jenkins and Coney, 1992).

The (negative) evidence suggests that one of the best things you can do for someone's physical or mental health is to assure them a satisfying and secure job. So good employers have been health promoters for years, yet how many are really aware of this role? *Whitelion* and *Connectus* are relatively new initiatives that bring together unions, employers, health and welfare agencies, sports and popular culture identities and local

governments to provide training, mentoring and employment opportunities young people in the juvenile justice system (Whitelion, 2004) and others in communities with high levels of risk factors and low levels of protective factors (Connectus, 2004). They not only provide support for the young people at risk but also provide support for the employers who need to be "young people ready" just as much as the young people need to be "job ready".

And there is another reason why business and industry might be interested in investing in mental health promotion. A recent study claims that the quality of workplace relationships is the most important driver of excellence in Australian workplaces (Hull and Read, 2003). Similarly emotional intelligence (in other words 'good mental health') is increasingly being understood as the hallmark of effective leaders (Goleman, 2000). Governments might even want to use the public service departments both to promote the mental health of its own public servants, and to increase their collective productivity.

### Getting mental health promotion in the agenda

Each country is different, with different contexts, cultures, and existing service structures, and even different interpretations of mental health. But, nonetheless it would seem, as suggested in the discussion above, we face some very similar issues for which we need locally tailored solutions.

Research is obviously a key part of any national strategy, all the more so, because we are collectively building the (evidence) boat as we are sailing it. A good national example is in the impact of urban design on health. Because of their conviction that the design of a community's built environment influences the physical and mental health of its citizens, the U.S. Centres for Disease Control has developed a research agenda for further understanding the relationship between community design and health – not only physical health but mental health, social capital and crime (Dannenberg *et al.*, 2003).

In order to get mental health promotion into national policy it is important to: 1) have a good understanding of the current

situation (context, needs, demands, existing policies); 2) then develop an overall mission statement, national goals and targets, strategic plans and comprehensible and comprehensive explanatory frameworks. Such frameworks should be addressed to decision makers and to those not in the health sector, but who are major or potentially major promoters of mental health.

It is crucial, in particular, to look for partners outside the mental health sector that may become allies, such as those working in HIV/AIDS, tobacco, alcohol and other drugs. The available evidence and strong rationale that improved mental health will decrease these other health risks, provides an argument that partnership will increase health and efficiency for all. Similarly, it is important to look for allies outside the health sector such as in urban renewal, arts, sports, employment as they will add to the chances of mental health getting on the political agenda, just as the [mental] health rationale can help them in their case for added financial and political support.

### I'm from the government, am I convinced?

Well I have just read this paper by Moodie and Jenkins, and to be honest I admire their enthusiasm and their approaches, and I think it would be a good idea for us to start mental health promotion programmes. I am concerned, however, that the Departmental Secretary, my boss, won't support this, as it is so hard to prove or show some quick outcomes that he can show to the Minister. I think we'll need to get some key community and business leaders to convince the secretary and the Minister.

#### Box 1

##### Sustainability of programmes

- Build an evidence base, monitor programmes, evaluate and reflect, focussing on economic arguments as well as health arguments.
- Work with mental illness professionals – if they do not adequately understand and support mental health promotion, they can block investments in mental health promotion.
- Find key influential supporters within and outside government.
- Build a coalition among the participating agencies, organisations, government departments, professional associations and individuals across a number of relevant sectors.

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# Mental health promotion in public health

■ Mental health has been defined recently as “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2001a). In this positive sense mental health is a foundation for well-being and effective functioning for an individual, and for a community, and is created and compromised in everyday life, in families and schools, on streets and in workplaces (Lahtinen, Lehtinen, Riikonen and Ahonen, 1999). This definition clearly expands the boundaries of the concept of mental health which should not be defined in a restrictive way as the absence of disease. Mental health is better understood as a state of balance between physical, mental, cultural, spiritual and other personal factors, and between the self, others and the environment (Sartorius, 1990).

Moreover, mental health is intimately connected with physical health and with behaviour, as implicit in the WHO’s famous definition of health as “not merely the absence of disease or infirmity”, but rather, “a state of complete physical, mental and social well-being”. Mental health is then an essential component of general health. Similarly, mental and physical illnesses are closely associated, and may accompany, follow, or precede one another.

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## The lack of positive mental health and yet the lack of action

As it is for physical disorders, mental health problems and disorders are universal and are more common among people with relative social disadvantage in any community (Desjarlais, Eisenberg, Good and Kleinman, 1995). The absence of positive mental health and the presence of mental health problems and mental disorders cause death, suffering, disability, and exclusion (WHO, 2001a). Yet mental health and mental disorders are neglected topics for most governments and societies.

The main reasons for this neglect and the consequent low priority and lack of governmental interest in investing in mental health relate to widespread confusion about how to understand and define mental health (Sartorius, 1990). The understanding that mental health is integral to health is far from universal, even though implicit in many cultures’ views of health and explicit in the WHO definition of health. The belief that mental health and mental illness are mutually exclusive leaves the focus for intervention on treatment. In addition, information on effective public health actions for mental health is not readily available to decision-makers or to communities, making it difficult to engage those concerned with an overall strategy for health. The lack of strategies to make efficient use of available resources and the difficulty of working in partnership across sectors, represent a missed opportunity for identifying and introducing mental health promoting interventions. Otherwise this work could proceed even while governments at first had little interest.

This paper presents mental health promotion as integral to public health, reflects on the relations between mental and physical health within a health promotion framework and presents opportunities to overcome some of the barriers to mental health promotion.

The case is made to mainstream mental health promotion activities with health promotion, while keeping the advocacy for mental health as a distinct strategy.

## Mental health promotion as part of public health

The activities that can improve health include the prevention of disease, impairment and disability, the treatment of diseases, and the promotion of health. These are all required, are complementary, and one is no substitute for the other (Sartorius, 1990). In some of these activities the actions and outcomes overlap with one another.

The promotion of health requires changing the place which health has on the scale of values of individuals, families and societies (Sartorius, 1998). The World Health Organization (1998) defines health promotion as action and advocacy to address the full range of potentially modifiable determinants of health. These determinants include not only those related to the action of individuals, such as behaviours and ways of life, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environment.

Mental health promotion aims to raise the position of mental health in the scale of values of individuals, families and societies, so that decisions taken by government and business improve rather than compromise the population’s mental health, and people can make informed choices about their behaviour. In addition to its specific interventions, mental health promotion can be

### Key words

- physical health
- public health
- comorbidity
- mental health
- efficiency

completely achieved when policy-makers in different sectors, such as education, welfare, housing, employment and health sectors make decisions resulting for example in improved social connection; reductions in discrimination on grounds of race, age, gender or health; and improved economic participation (VicHealth, 1999).

In this context, mental health promotion is more than the prevention of mental disorders although these are necessarily related and overlapping activities. Because the former is concerned with the determinants of health and the latter focuses on the causes of disease, promotion is sometimes used as an umbrella concept covering also the more specific activities of prevention (Lehtinen, Riiikonen and Lahtinen, 1997). The aims of improving mental health and lowering the personal and social costs of mental ill health require a comprehensive public health approach that encompasses the promotion of health, the prevention of illnesses and disability, and the treatment and rehabilitation of those already suffering (WHO, 2004a; WHO, 2004b). Therefore just as mental health is part of health, so the promotion of mental health is integral to health promotion and public health.

## Tackling the determinants of mental health

Mental health and mental disorders are determined by multiple and interacting social, psychological, biological and environmental factors, just as health and illness in general (Mrazek and Haggerty, 1994; Desjarlais *et al.*, 1995; Marmot and Wilkinson, 1999; Hosman and Jané-Llopis, 1999; WHO, 2001b; Patel and Kleinman, 2003; WHO, 2004b). There are also complex interactions between these determinants, behaviour and mental health. For example, a lack of meaningful employment may be associated with depression and alcohol and drug use, which in turn may result in road trauma, loss of employment and physical disability (Walker, Moodie and Herrman, 2004).

The personal, social and environmental factors promoting mental health and protecting against ill health may be clustered conceptually around three themes (Health Education Authority, 1997; Lehtinen *et al.*, 1997; Lahtinen *et al.*, 1999) for intervention:

- 1) The development and maintenance of healthy communities: which then provide a safe and secure environment, good housing, positive educational experiences, employment and good working conditions, a supportive political infrastructure, minimise conflict and violence, allow self-determination and control of one's life; and provide community validation, social support, positive role models, and the basic needs of food, warmth and shelter;
- 2) Each person's ability to deal with the social world through skills like participating, tolerating diversity and mutual responsibility: associated with positive experiences of early bonding, attachment, relationships, communication and feelings of acceptance;
- 3) Each person's ability to deal with thoughts and feelings, the management of life and emotional resilience: associated with physical health, self esteem, ability to manage conflict and the ability to learn.

## Intervening to foster positive mental health

Programmes and policies for mental health promotion aim, in various ways, to foster these individual, social and environmental qualities, and to avoid the converse.

The classification for prevention and promotion according to the levels of risk proposed by Mrazek and Haggerty (1994) (Box 1), is useful to define the scope for intervention by identifying what type of collective action is required (Eaton and Harrison, 1998).

As in other fields of health promotion, action will often be possible without, and will necessarily precede, a clear understanding of mediating factors and pathways. The evidence for direct causal pathways is generally strongest for the most immediate influences. Most illnesses have multiple causes interacting in a 'vicious spiral' over time (Desjarlais *et al.*, 1995), and important factors such as child abuse and neglect may influence the later occurrence of several types of illness, and the level of wellbeing in later life. Other life events and circumstances will interact favourably or unfavourably

to contribute to health or the development of illness. The categories of universal, selective and indicated interventions for population groups can be identified both in the socio-political approach to mental health promotion and in the five domains of the Ottawa Charter for health promotion.

It is widely understood that anyone can experience physical ill-health and while not all physical illness can be prevented, people can take steps to improve their health. This is reinforced by a wide range of policies to promote physical well-being and reduce the risk of physical health problems. Achieving the same policies in relation to mental health is part of the underlying rationale for mental health promotion (The Sainsbury Centre for Mental Health/mentality, 2003). The ultimate expected outcomes are improved quality of life, improved circumstances for child development according to cultural norms, better educational performance and work productivity, and the prevention of health damaging and anti-social behaviours as well as the prevention of suicide and mental disorders.

An example of a comprehensive strategy for mental health promotion is the one developed by the Victorian Health Promotion Foundation (VicHealth, 1999). It is based on expert opinion and the evidence linking mental and physical health to other aspects such as *social inclusion, discrimination and violence, and economic participation*. The strategy

### Box 1

#### Universal, selective and indicated preventive interventions (Based on Mrazek and Haggerty, 1994)

*Universal* interventions are directed to the whole population, and include, for example, school based interventions or policy actions like taxation of harmful addictive substances, at the population level.

*Selective* interventions are targeted to vulnerable groups or sub-groups of the population with risks significantly above average, including for example interventions to provide family support for young, poor, single, first time pregnant women.

*Indicated* interventions are targeted at high-risk individuals who already experience minimal but detectable symptoms of a mental disorder, including for example, interventions to promote the coping strategies and support of individuals with symptoms of depression or anxiety.

defines three broad *themes for action* for a programme of mental health promotion, with the activities being mainly *socio-political*. These include reducing unemployment, improving schooling and housing, working to reduce stigma and discrimination of various types, and wearing seat belts to avoid head injury. The key agents are politicians, educators, and members of non-government organisations. Mental health professionals are engaged in reminding these key agents about the evidence for the impact of the key variables on mental health (Goldberg, 1998). Some of these effective public policy options are reviewed in this volume (Jané-Llopis *et al.*, 2005). The publication: «Mental Health Promotion and Mental Disorder Prevention: A Policy for Europe» (Jané-Llopis and Anderson, 2005) provides a policy framework for action in mental health promotion across mental health, public health and public policy, providing the evidence and case for action in these different sectors.

### Relationships between mental and physical health

Mental health status is associated with «risk behaviours» at all stages of the life cycle. For instance, in young people depression and low self-esteem are linked with smoking, binge drinking, eating disorders and unsafe sex (Patton *et al.*, 1998). Depression in other age groups is linked with social isolation, alcohol and drug abuse and smoking (Hemenway, Solnick and Colditz, 1993). Similarly, mental health is linked closely to other aspects of wellbeing, including physical health, employment and academic success. The links between physical health and mental health are bi-directional. Physical ill health is detrimental to mental health as much as poor mental health contributes to poor physical health. For example, malnourishment in infants can increase the risks of cognitive and motor deficits; heart disease and cancer can increase the risk of depression (Marmot and Wilkinson, 1999; Blane *et al.*, 1996); mood disorders can lead to an increased risk of accidents, injuries and poor physical and role function (Wells *et al.*, 1989); learned helplessness, hopelessness and depression are associated with decreased immunological activity and an increased risk of tumour growth and infections (Kopp, Skrabski and Szedmák,

2000). Low control at work and poor social support are important predictors of morbidity and could be considered generic factors since they can influence both physical health (e.g., cardiovascular morbidity) and psychological health (e.g., depression) (Kopp, *et al.*, 2000). Another example is that of individuals infected with HIV/AIDS and their families, who suffer substantial psychological disorders. Apart from stigma and discrimination, depression, anxiety, and adjustment disorders have been associated with HIV/AIDS. The long-term consequences for the families have not been studied in detail but are likely to be significant (WHO, 2001a).

Tackling the determinants of health and providing people with a healthy environment will improve physical and mental health and will contribute to the prevention of some mental illnesses (WHO, 2004a; WHO, 2004b; Jané-Llopis, Saxena and Hosman, 2004). Attention needs to be paid to the relationships between the social determinants of physical health and their impact on mental health. Effective social and public health programmes and policies that tackle the social determinants of health have been shown to have broad impacts on more than one health outcome simultaneously, including mental health outcomes. For example, increasing the price of alcohol through taxation reduces the risk of liver cirrhosis, alcoholic psychosis and suicide (Edwards *et al.*, 1994). However, there is still a lack of research and evidence on the relationship between the social determinants of health and their impact on mental health. Disadvantages like poverty, lack of social support, unemployment or an unhealthy start to life are clearly linked to poor mental health outcomes and to an increased risk of mental disorders. Where the direct relationship between health determinants and mental health is not strong, there is sufficient evidence of precipitating chains of events where a health determinant such as poverty leads to specific and generic factors such as low socio economic status, low education, stress, perinatal complications, premature deliveries and low birth weight that in turn will lead to health and mental health problems such as depressive symptoms, school drop out and unemployment (WHO, 2001a; WHO, 2001 b; Patel and Kleinman, 2003).

### ‘Mainstreaming’ mental health promotion

The activities of mental health promotion may usefully be ‘mainstreamed’ with health promotion, although the advocacy needs to remain distinct (Herrman, 2001). Bearing in mind the intimate connection between physical and mental health, many of the interventions designed to improve mental health will also promote physical health, and *vice versa*. Mental health promotion in this sense is broader than currently understood as it can be effective in the prevention of mental disorders as well as in the prevention of a whole range of behaviour-related diseases and risks such as smoking, unprotected sex, AIDS or teenage pregnancy (Orley and Weisen, 1998).

Especially in those cases where resources are scarce for mental health promotion, multi-component interventions that tackle generic determinants of mental and physical health can lead to multiple outcomes including the reduction of negative consequences such as unemployment and the increase of mental well-being and quality of life. An efficient strategy is to embed mental health promotion components in existing health promotion programmes, such as already implemented in the community (Jané-Llopis *et al.*, 2004). Combining mental and physical health strategies potentially can lead to positive health, social and economic outcomes and large savings on resources (WHO, 2004b).

Addressing the needs of vulnerable populations can make a significant contribution to mental health promotion in addition to improving physical health, especially in those situations where resources are not available for mental health promotion in the general population. Governments, in consultation with other partners and organisations, can consider investing in multi-component programmes for vulnerable groups (e.g. young people, elderly people, rural populations, indigenous populations, and displaced or immigrant communities). Such groups may often be identified with defined settings (such as schools and workplaces) and sectors (such as transport and environment). A settings approach, coordinating activities between several sectors over a sustained period, may contribute to changes in a

broad range of areas such as improved social connection and reduced discrimination and violence and increased social capital. Specific examples include: providing support to families to improve nurturing of children and to reduce the chances of child neglect and abuse; addressing physical health, bullying and aggression in schools; improving the conditions of labour; and supporting care of older persons.

The unused opportunities for mental health promotion in any community remain largely unexamined. In addition, the burden of mental disorders will not be reduced by individual treatment alone. Improving health, as well as reducing the social and economic costs of mental ill health, require a comprehensive public health approach, together with better treatment services for people with mental disorders (Sartorius, 1998; VicHealth, 1999; Jenkins, 2001; Hosman, 2001; Herrman, 2001; Walker *et al.*, 2004; WHO, 2004b).

## Increasing the evidence base: programme evaluation and aetiological research

Mental health promotion has been seen to ask for peace, social justice, decent housing, education, and employment. The call for inter-sectoral action has sometimes been diffuse (Kreitman, 1990). Specific evidence-based proposals with measurable outcomes are required. However, asking individual health promotion projects to demonstrate long-term changes in ill health or death from suicide or quality of life is often unrealistic and unnecessary. What is required instead is a marshalling of the evidence linking mental health with its critical determinants (aetiological research), and programme design and evaluation to demonstrate changes in the same determining or mediating variables. Programmes and policies can aspire, in other words, to produce changes in indicators of economic participation, levels of discrimination, or social connectedness. Identifying and documenting the mental health benefits of these changes, and developing indicators of these determinants, are complementary areas of work needing further support. An evidence base for mental health promotion does exist but it needs boosting with aetiological research and programme and policy evaluation

(WHO, 2004a; WHO, 2004b). Projects assessing the utility and cost effectiveness of specific programmes for families or schools or workplaces are urgently needed and require support over a long lead-time. A project determining the staff and training requirements of successful community care (Bowis, 1998) will require information gathering and cooperation across several areas and service sectors. The Victorian Health Promotion Foundation sponsored an example of an integrated programme of research and health promotion concerning family caregivers. The results suggest a number of ways to support caregivers with the aim of improving well-being and preventing ill health (Schofield *et al.*, 1998).

One important challenge is thus to strengthen the evidence base in order to inform practice and policy globally. Another major task is to promote the application of existing evidence into good practice on the ground, particularly in disadvantaged and low-income countries and settings. This entails identifying programmes that are effective, feasible and sustainable in various cultural settings, and adapting programmes and policies to suit local conditions (Barry and McQueen, 2005).

## Most players are necessary and not sufficient

In some countries it is mental health practitioners who are leading the advocacy and action in mental health promotion and prevention of mental disorders. In other countries, however, mental health professionals will often underestimate the scope of mental health promotion or prevention of mental illness because of their clinical focus. Those who see the importance of these activities feel daunted by the task, or threatened by a perception of competing for resources. Given the scarcity of resources for treatment, it is critical that any perception of competing is recognised and averted, and replaced with the idea that resources from other sectors can be harnessed. Politicians and educators may not understand the effects of their work on mental health, nor have access to relevant information, or equally likely, have to set priorities excluding health-promoting measures. The community understanding the importance and the relationship between social conditions and mental

health will encourage politicians and educators to act.

## Conclusion

The impact of social and economic conditions on mental health is evident in a broad sense. Understanding the mediating pathways and causal links, and the extent to which the impact can be altered, require more study. However it is clear that governments and others in the community can influence the effect of social and economic conditions on mental health. For instance, decisions in the education, welfare, housing, employment and health sectors influence mental health (WHO, 2004a; WHO, 2004b). At the same time, on an individual level, mental health is influenced by circumstances and decisions about behaviour, and by the behaviour of others (Lahtinen *et al.*, 1999).

### Box 2

#### Recommendations for action to strengthen the evidence base and to stimulate work on mental health promotion in a country it is proposed:

- To develop programmes showing that mental health can be promoted through social interventions. To support this, the evidence linking mental health with its critical determinants, including social support, educational experiences, employment and working conditions, and freedom from violence, abuse and discrimination will be collated with particular regard to the local situation
- To develop and use appropriate indicators of mental health (and associated aspects of function and quality of life), its determinants where needed, and the multiple outcomes of mental health promotion interventions including cost-effectiveness analyses
- To develop specific guidelines concerning the promotion of mental health in different socio-cultural settings and to develop strategies to integrate mental health components in already existing health promotion programmes such as health promoting schools or community interventions
- To develop partnerships with people, governments and organisations in the public, private and nongovernmental sectors, leading to an integrated health promotion approach that includes horizontal action through different sectors in society, such as the environment, housing, social welfare, labour and employment, education, criminal justice, transport and human rights.

The need to give appropriate attention to promoting mental health in global, national, state and regional policy and practice has become evident. The spur for this is twofold: the recognition that the social and economic costs of mental ill health are increasing, and will not be

reduced by individual treatment alone; and second, the growing realisation that the unused opportunities for improving mental health are also costly. Improving mental health, as well as reducing the social and economic costs of mental ill health, require a comprehensive public

health approach, together with better treatment services for people with mental disorders.

Promoting mental health is relatively new as a recognised area of health promotion activity. However it is an integral part of

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health promotion, and innovations in health promotion theory and practice are needed. Advice and advocacy are also needed from public health and mental health experts. Because of the range of social and economic circumstances affecting mental health status, and the behaviours and outcomes influenced by the individual's mental health, mental health promotion is the role and

responsibility of people working across a range of sectors (Friedli, 2002). Thus, the effective promotion of mental health requires a comprehensive health promotion-public health approach that encompasses action through different sectors in society such as the environment, social welfare, labour and employment, education, transport, the criminal justice system and housing as

well as health care. Interventions across sectors should be designed and implemented with an understanding of the different factors that have an immediate and longer-term influence on an individual's health and wellbeing. The challenge remains for effective public health policy to establish an inter-sectoral strategy where an awareness of mental health is included.

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## What makes mental health promotion effective?

### A framework for intervention: settings for mental health promotion

When designing a comprehensive strategy for mental health promotion, as that called for in the European WHO Action Plan for Mental Health (WHO, 2005), one possible effective framework for such a strategy is to take a settings approach. The Ottawa Charter (WHO, 1986) for health promotion emphasises a settings-based approach in creating supportive environments for health, as reflected in the statement that "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love..". An overview of effective mental health promotion programmes across different settings has been presented by Jané-Llopis and colleagues (Jané-Llopis, Barry, Hosman and Patel, 2005) in this volume, and in other recent reviews (WHO, 2004a; WHO, 2004b). The following

section describes why the home, the school, the workplace and the community are four crucial settings for intervention, and describes a set of health and mental health determinants that are addressed through interventions in these settings.

#### Home-based interventions

The time from conception through childhood is crucial in determining the development of each individual and each future generation. During this first period of life there is more development in mental, social and physical functioning than in any other period across the lifespan (UNICEF, 2002). Because of the crucial role of this period, special attention is given in national and international government statements and policies, to promoting quality interventions for early years. For example, in the Universal Declaration of Human Rights, the United Nations proclaimed that "childhood is entitled to special care and assistance" (UN, 1989). Article 19 of the UN Convention of the Rights of the Child states that "parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s), or any other person who has the care of the child" (UN, 1989).

Brown and Strugeon (WHO 2004b; Brown and Strugeon, in press) have reviewed the different determinants of a healthy start in life, which include physical, psychological and socio-environmental dimensions. Freedom from poor nutrition, infirmities, injuries, abuse and neglect or exposure to drugs prior to birth, are conducive to children's positive development and their future mental well-being (Brown and Strugeon, in press). The development of a healthy attachment with their parents from the first months of life, positive interaction with parents, and a stimulating pre-school environment are conducive to psychological and cognitive development and social skills. Exposure during the early start of life to socio-environmental risk factors such as poverty, violence, armed conflict or HIV-AIDS in the family, have a negative impact on the newborns' future mental health (UNICEF, 2002). In general a healthy start in life free from most determinants of poor mental health greatly enhances the child's functioning in schools, with peers, in later intimate relations, and with broader connections with society, leading to improved health and well-being across the lifespan.

#### Key words

- effect predictors
- evidence-based interventions
- implementation principles
- adoption

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Interventions to promote a healthy early start in life have been implemented by health care professionals and by trained lay persons in the community with success. The use of available community resources is particularly relevant in low and middle-income countries and provides a framework for intervention that can be adopted and implemented across cultures and countries.

### **The school setting**

The enormous potential of the school as a setting for mental health promotion has been endorsed in a number of major policy documents in recent years. In 2001 the World Health Report stated that schools can, and should, help to prevent suicide and enable children and adolescents to develop 'sound and positive mental health' (WHO 2001). The school has also been advocated as a 'major setting' for promotion and prevention interventions for young people by the US Surgeon General in his 1999 report, which was devoted to the topic of mental health (USDHHS, 1999).

The school setting provides an efficient and systematic means of promoting the health and positive development of young people. Most children and adolescents spend a large proportion of their time in school and there is no other setting where such a large proportion of children can be reached. As well as providing a ready audience, school is known to have a significant influence on the behaviour and development of children (Rutter *et al.*, 1979). A positive school experience can strengthen the ability of young people to cope successfully with transition and change. A sense of school connectedness is a key protective factor for positive mental health and health promoting behaviours (Anteghini *et al.*, 2001; Resnick *et al.*, 1997). School is also an important source of friends and social networks. Academic achievement is closely linked to positive social and emotional development. If schools are to achieve their primary function of positive educational outcomes, the promotion of positive mental health must also be an integral part of the school ethos.

The health promoting school concept, as promoted by the WHO and the European Network of Health Promoting Schools (ENHPS), provides an organising framework for a comprehensive

approach to health promotion in the school setting which can be adopted in low, middle and high income countries (Flisher and Reddy, 1995). This is a multi-faceted approach which integrates working with pupils through the school curriculum, developing a school ethos and environment that supports health and involving families and the local community.

### **Intervening at the work place**

Although work should be experienced as a contribution to health and well-being and as a source of satisfaction and pleasure, it has become for many a source of psychological distress and ill health (Price and Kompier, in press). Both the quantity and quality of work have strong influences on mental health and many related factors, including income, social networks and self-esteem. Also the lack of work leads to poor health as well as to labour market disadvantage. Unemployment puts mental health at risk, and the risk is higher in regions where unemployment is widespread (Bethune, 1997). The health effects of unemployment are linked to both its psychological consequences and the financial problems it brings – especially debt. In a number of countries, the labour market has shifted away from secure unskilled or semi-skilled work, with on-the-job training, to work that requires a high level of pre-employment education and training, a development which has exacerbated youth unemployment, in particular.

Certain occupations are more sensitive to work stress than others. In the workplace, stressors such as noise, work overload, time pressure, repetitive tasks, interpersonal conflict and job insecurity, low sense control can put employees at risk for poor mental health (Price and Kompier, in press). The consequences of living under stressful working conditions are huge and extend to the family and the society. Anxiety, depression, sleeplessness, headache, alcohol abuse, child maltreatment and marital disruption are some examples (Price, 2003). In addition to the individual and family distress, work stress and the lack of work also create social and economic burdens on health and human services. Social burden includes increases in crime rate, traffic accidents, divorce and a variety of other social consequences

(Vinokur *et al.*, 1991). Economic burden includes loss of productivity, increases in health care costs and increases in the welfare system costs (Vinokur *et al.*, 1991).

Improved conditions of work can lead to a physically and mentally healthier work force, which will lead to improved productivity. Interventions at the workplace such as the implementation of organisational measures for job security that reach all employees can create more stimulating, enjoyable and healthy working conditions, increased participation in decision making and reduce mental health problems (including reduced stress) in a large proportion of the adult population. A comprehensive and integrated health promotion approach within the work environment, which combines both individual and organisational level interventions, will be more likely to be efficacious in improving and maintaining health through the workplace environment.

### **Community interventions**

The community setting provides an important opportunity to engage community members in the process of addressing positive mental health in their local settings such as schools, workplaces, youth and community centres. The principle of participation, central to community-based approaches to health, is based on the premise that change is more likely to come about when the people it affects are involved in the change process. Participation by local people is recognised as having the greatest and most sustainable impact when solving local problems and setting local norms (Thompson and Kinne, 1999).

A community perspective to promoting positive mental health calls for appropriate models and implementation strategies to ensure that the desired process of implementation and programme outcomes are achieved. Partnership working and inter-sectoral collaboration are very much at the core of modern health promotion practice in which citizens, community groups, health professionals, governmental and non-governmental agencies work together to achieve agreed goals and objectives in promoting health and well-being. As such, collaborative community

partnerships based on existing strengths and resources are recognised as a key strategy for developing community mental health promotion.

## What makes interventions work?

When adopting and implementing interventions across diverse cultural settings and resource situations, it is crucial to pay attention to the underlying principles that will increase the likelihood of their success. This section reviews some of the key working principles underpinning successful programmes and their implementation, including both generic principles and those that are specific to a given setting. Barry and colleagues in this volume (Barry, Domitrovich and Lara, 2005) develop further the essential principles for improved quality implementation. The evidence base for these effect principles has been generated from review studies and meta-analyses, both in the fields of mental health and health promotion. It is important to note that this is not a systematic review of all working mechanisms that have been studied in the literature, but an overview of some of the crucial factors identified in determining programme success based on the review paper presented by Jané-Llopis and colleagues (2005) in this volume.

## Some generic evidence-based principles

### *Theoretical basis*

The content, structure and implementation of successful interventions is founded on sound scientific theory and research (Bond and Hauf, in press). Theories are essential to the design of programmes because they facilitate understanding and describe the mediating processes that might operate in interventions (Lochman, 2001). Rigorous theory is crucial also in supporting the flexibility of implementation, so that, programmes can be adapted to the needs of particular settings and populations without necessarily compromising their integrity (Dadds, 2001). A theoretical basis should be used in the design and implementation of any intervention. Evidence based information should be available on the underlying determinants including risk and protective factors (for content), pedagogical practices (or

process) and organisational capacity (for implementation).

### *Clarifying goals and objectives*

The development of a shared mission and clear goals and objectives for a given intervention are critical to its success. The goals of a given initiative need to be concrete, attainable, measurable and agreed by all members. An early assessment of participation readiness, such as community readiness, is crucial in determining the nature and timescale of a new programme. This is also important for the implementation process. Most successful implementation partnerships take time to establish relationships, and to build strong links with key players locally in order to effectively engage with and mobilise key players in supporting the programme. Goals and objectives need to be transparent for the partners to engage in this process.

### *Programme provider training and support*

Effective programmes build capacity through adequate resources and comprehensive professional development for programme providers, such as teachers, nurses, lay personnel or community members, providing also support for implementation (e.g., clear guidelines in structured manuals). Ineffective programmes have been characterised by little or no investment in training and provision of support resources. A focus on the quality of programme implementation is also critical in determining the degree of programme success, as Barry and colleagues (2005) describe further in this issue. Results of a meta-analysis on mental health promotion and mental disorder prevention interventions found that high quality implementation, including training and supervision of programme providers and high participation in the programme sessions predicted higher programme efficacy (Jané-Llopis, 2002).

### *Evaluation and high quality research methods*

High quality, systematic rigorous evaluation and ongoing monitoring procedures are essential to successful intervention programming (Bond and Hauf, in press). The quality of the research designs should be ensured in single trial evaluations at the early design

stages of the programmes and trials. Especial attention needs to be paid to evaluation of programmes using the best research designs available. Results from a meta-analysis on primary prevention programmes to prevent depression (Jané-Llopis, *et al.*, 2003) and a meta-analysis on the prevention of substance abuse amongst children and adolescents (Tobler and Stratton, 1997) found that programmes rating higher in the quality of the research design were significantly more effective than programmes that rated lower in quality.

There is a need for a focus on research methods which will document the process, as well as the outcomes, of enabling positive mental health and identify the necessary conditions for successful implementation in real world settings. The systematic study of programme implementation is highlighted as an area that has been relatively neglected and has a critical role in advancing the generation of practice-based evidence and theory. This is essential if the area is to move onto a new level of understanding and sophistication beyond the question of whether programmes work to now also consider what makes them work, with whom and under what circumstances. The evidence and knowledge base needs to be expanded to embrace the process of programme implementation and delivery as well as outcomes. This applies also to complex cases such as the challenge of evaluating multi-faceted community programmes. The disadvantages of low quality research designs should provide a warning to policy makers and practitioners and should reinforce the need for well designed studies to improve the validity of promotion and prevention effects (Lochman, 2001). The future development of mental health promotion needs to be based on a sound knowledge and evidence base and this demands that appropriate evaluation frameworks and research methods are applied which are capable of reflecting the complexities and creativity of contemporary practice (Barry, 2003).

### *Infrastructural support from management*

The degree of administrative or infrastructural support for a programme can have a critical influence on its success or failure. Because prevention

and promotion programmes can involve new intervention approaches, it is often necessary to make structural changes such as reducing class sizes in schools or reorganising the workplace ecology. A supportive organisation head such as the school principal or a workplace director is also an encouraging force in promoting the programme, in keeping teachers' or employees' motivation and interest, and in facilitating their attendance at training sessions.

### **Programme fidelity versus reinvention**

Programmes should be implemented with high quality which includes, among others, the fidelity of the programme implementation. As Barry and colleagues (2005) also stress in this volume, implementation is an area where there is a need for increased theory development and systematic research. The tension between programme fidelity and local adaptation creates numerous challenges for prevention and promotion research (Koretz and Moscicki, 1997). Although, at present, the evidence points to the need for high quality implementation with fidelity, it is important to note that proven efficacy or effectiveness is no guarantee that programmes or policies will work similarly in different cultural or economic environments (Hosman and Engels, 1999). New studies should focus on identifying the mechanisms and processes of adaptation and reinvention without losing initial efficacy.

### **Transferability to different countries and cultures**

It is essential to explore transferability of promotion and preventive practices to different cultural situations. Especially in low-income countries, there is an increased need for cost-effective strategies, which might need to be adapted to specific situations. More insight on the processes of transferability, adaptation, and reinvention, along with evaluation efforts of adapted practices should be identified as priorities in different countries and regions. Successful adoption and replication of programmes calls for what Price (2004) terms good 'procedural knowledge'. This essentially refers to the art of getting things done in the context of the local setting based on political and culturally specific knowledge. This means understanding the needs and culture of the local setting and ways of relating to the local population.

There is an urgent need to expand the evidence base to be more relevant to the realities of those working and living in low-income countries and settings. More active strategies are required for disseminating the evidence base and providing technical assistance and capacity-building resources for mental health promotion in low-income countries. Clear messages and guidelines, based on best available evidence, need to be communicated to practitioners and policymakers in order to inform best practice and policy globally.

### **Setting specific evidence-based principles**

This section outlines working principles that relate to specific settings, although, in some cases, these are also applicable across settings.

#### **a) School interventions**

##### *Adopting a whole school approach*

There is widespread support in the literature for whole-school approaches that aim to influence multiple domains using multiple strategies for mental health promotion. Greenberg and colleagues (2001) recommend 'a package of co-ordinated, collaborative strategies and programmes' (p.31), changing institutions and environments as well as individuals. This includes integrating prevention and promotion programmes with secondary prevention and treatment systems, linking with existing local community services for sustainability. In their systematic reviews of school-based health promotion, Lister-Sharp and colleagues (1999) found that while most studies used classroom-based curriculum approaches only; interventions that included changes to the school ethos and environment and promoted the involvement of families and the local community are more likely to be effective. The health promoting school framework has emerged in recent years as a mechanism to successfully combine these different elements (Weare, 2000).

##### *Social competence approach*

Traditional, topic-based approaches to health promotion are of limited value (Mentality, 2003; Lister-Sharp *et al.*, 1999). The focus of school interventions should be on the promotion of resourcefulness and generic coping and competence skills rather than interventions focusing

on specific problem behaviours. This approach embraces methodologies that are interactive and participatory which have proven to lead to better outcomes (Tobler *et al.*, 2000). There is also some evidence for the effectiveness of peer-led approaches (Lister-Sharp *et al.* 1999; Durlak and Wells, 1997) which suggests that these approaches are worthy of further investigation.

##### *Interventions over multiple years*

Another factor critical to programme success is sustained intervention for more than one year, and ideally over multiple years. Results of a meta-analysis revealed that interventions for children that span longer than three months are more effective than those that were shorter (Jané-Llopis, 2002). Reviews have also suggested that one-off sessions or short-term interventions seem to have short-term results, for which, long-term follow ups of school-based interventions over years are urgently needed (Greenberg *et al.*, 2001).

#### **b) Workplace interventions**

##### *Participatory*

A participative approach, that engages employees, employers and management structures in communication and joint participation, appears to be an important success factor for the development and implementation of interventions for mental health promotion in the workplace.

##### *Advocacy*

There is an especially strong case for demonstrating the cost-benefit of implementing mental health promotion programmes in the workplace. Work stress interventions that actually reduce health care costs for employers or visibly improve productivity are much more likely to be adopted and implemented (Briner and Reynolds, 1999). Advocacy efforts, underlying the costs and benefits of intervening at the workplace, including social and other welfare benefits, will enhance the likelihood of management support for intervention implementation and ownership.

##### *Engage key partners in the dissemination across countries*

Workplace programmes are most effectively disseminated by persons skilled in its delivery (Price, 2003) because they have developed knowledge

of the key factors and benefits of the programme and are aware of the possible resistance that can arise both at the management and the employee levels. During the dissemination of workplace mental health promotion programmes, partnership with persons skilled in programme delivery is necessary for the implementation and adoption of the programme across different sites and countries.

## c) Community interventions

### *Creating clear structures*

One of the key features of effective community-based programmes is successful collaborative working (Foster-Fishman *et al.*, 2001). An agreed organisational structure is critical to the efficacy of community-based projects. Clear lines of communication are important and can be enhanced for example, by clearly defined roles and expectations, detailed minutes of planning and review meetings, and a good flow of information. Successful community coalitions are characterised by a collaborative style of leadership, expanding leadership among members and delegating responsibility rather than relying on a single charismatic person.

### *Generating participation*

Obtaining meaningful participation of community members is a major challenge. Involvement of community representatives allows the project to be more responsive to and understanding of local needs (Hawkins *et al.*, 1997). New members may need to be recruited as the project develops and there is an ongoing need to build trust and positive relationships between diverse groups of people around a shared goal. Participation is crucial to achieve sustainable outcomes and written action plans, task forces, and measurable indicators of success can all foster the translation of plans into action.

### *Building core competencies and capacities*

Ongoing training and support in developing a range of skills is critical to the functioning of working partnerships. Skills in communication, management, facilitation and evaluation are all examples of core capacities from which coalitions can benefit. In this way programme sustainability will be ensured in terms of strengthening resources from within the project.

### *Comprehensive evaluation*

Community-based interventions require especially comprehensive process evaluation systems to track implementation and ensure adequate documentation of a wide range of activities and procedures. The use of evaluation logic models provides a useful opportunity for evaluators and practitioners to collaborate in formulating project design and sequential planning and evaluation as the project unfolds (Barry, 2003). The detailing and evaluation of the project in action permits an accurate assessment of quality of implementation and plays a crucial role in informing the detection of intermediate level changes leading to ultimate programme outcomes.

## **Towards increasing efficiency: the promotion of mental and physical health**

The relationships between physical and mental health have important implications for public health. Herrman and Jané-Llopis expand on these relationships in this volume (Herrman and Jané-Llopis, 2005). Different sectors such as education, physical health services, labour, and mental health services are not separable.

Improvements in one area can affect other areas. For example, as illustrated in this volume (Jané-Llopis *et al.*, 2005), interventions promoting a healthy start of life have led over time to reductions in crime, violence, harmful substance use, birth weight, child abuse, psychological distress, and increased employment (Olds, 1997; Schweinhart and Weikart, 1998). Current interventions that aim broadly to change the life chances of individuals and to increase their health and/or mental health, are likely to lead to improved physical and mental health and to reduce vulnerability to mental disorders.

This interplay between mental and physical health is crucial, particularly in low-income countries with fewer resources. Existing interventions to promote physical health might already be promoting mental health and vice-versa. One example is the promotion of exercise in older populations. While physical activity is advised to deal with age-related physical disabilities, some recent controlled studies suggest that exercise, such as tai chi, can provide

psychological benefits such as reductions in depressive symptomatology and increased mental well-being in clinical (e.g., Mather *et al.*, 2002; Singh, Clements and Fiatarone-Singh, 2001) and nonclinical (Deuster, 1996; Fletcher, Breeze and Walters, 1999) older populations (Chen, Snyder and Krichbaum, 2001). Because of this interplay, it is important that health promotion programmes take into account the possible mental health outcomes of their interventions and vice versa.

Similarly to increase efficiency, mental health promotion components could be embedded in already existing health promotion programmes, such as those implemented in schools, hospitals, or communities. The potential of the combination of mental and physical health strategies can lead to increased health and social outcomes and larger savings on resources (Herrman and Jané-Llopis, 2005). Therefore, the promotion of mental health requires a comprehensive approach that encompasses action through different sectors in society (Jané-Llopis and Anderson, in press). Interventions across sectors should be designed, implemented and evaluated employing a more horizontal approach, taking into account the broader socio-environmental influences on individual and community health and well-being.

## **Where do we still need more efforts? Recommendations for research and practice**

### **Increase replication and effectiveness studies across countries and cultures**

Most of the effects in the presented interventions in this volume (Jané-Llopis *et al.*, 2005) and other available reviews (WHO 2004a; WHO, 2004b) have only been studied in efficacy trials, mainly in experimental settings, which do not reflect the real world situation. If we want to rely on the conclusions of single trial evaluations and meta-analyses, high priorities for future research are effectiveness and replication of efficacy studies by independent investigators in different settings that reflect real life situations. One of the limitations of the current knowledge on the effects of prevention and promotion programmes in the field of mental health is that most intervention trials are from western cultures, mostly from the United States, Canada, Australia and some north-

European countries. Barry and McQueen (2005) highlight the need to identify mental health promotion initiatives that are effective, feasible, low-cost and sustainable across diverse cultural contexts and settings. More efficacy and effectiveness research should be supported across countries, continuously reported and prioritized by publishing agencies.

#### **Stimulate evaluation through creating partnerships with other organisations**

In establishing a credible evidence base from low-income countries, there is a need for internationally supported dissemination research which will examine the documentation, replication and adaptation of effective programmes across diverse low-income country settings. More active strategies are required for disseminating the evidence base and providing technical assistance and capacity-building resources for mental health promotion in low-income countries. The creation of partnerships for implementation and evaluation of new or existing interventions for mental health promotion and prevention between practice and research teams should be stimulated. The promotion of such collaborative alliances would result in science and practice working together in designing, implementing and evaluating mental health promotion programmes and increased knowledge of their effects in less controlled settings. These symbiotic relationships are likely to lead to an increase in the availability of information of effective programmes across the world, in the quality of implemented interventions, and in the population-based outcomes.

#### **Include long term follow-ups in evaluations**

Programme evaluations should include long-term follow-ups to give sufficient time for interventions to show effect and to provide an accurate estimation of the duration of effects. Knowledge of the duration of effects should lead to improved efficacy by guiding decisions about when and for how long interventions should take place (Greenberg *et al.*, 2001). Long-term follow-ups will also reflect the reality of the reach of programme effects and will lead to clearer and more convincing advocacy messages to influence the support for prevention and promotion interventions.

#### **Undertake cost-effectiveness research**

Jané-Llopis and colleagues (2005) note in

this volume the lack of cost-effectiveness studies in prevention and promotion trials. There is evidence that primary prevention works in the field of mental health but policymakers and society need to be convinced that it is cost effective, similar to the past experience with certain physical illnesses (Kiselica, 2001). More precise cost-benefit models need to be developed and more cost-effectiveness research undertaken to provide the arguments that governments need in making spending decisions on mental health promotion and prevention, and to give the information on the likely pay offs in terms of reduced health care costs and improved social and economic development.

#### **Stimulate research on cross-fertilisation**

Research on the assessment of mental health impact and outcomes of existing health promotion programmes should be promoted, along with designing promising new strategies that include mental health components into existing programmes, to increase the reach and efficiency of prevention and promotion interventions. For example, research efforts should stimulate the evaluation of the mental health impacts of community-integrated initiatives such as the World Health Organization's Healthy Cities Project (Manson, 1997). As Manson notes, the interventions embodied in these efforts employ a wide range of community mobilization and development strategies intended to recalibrate social attitudes toward various behaviours, to engineer critical changes in decision-making processes, and to extend responsibility. Research on mental health in such initiatives should be stimulated to make conclusions on the reach and impact of comprehensive strategies. This should also take into account more upstream interventions on the social determinants of health, such as improved housing, education, etc. and their impact of mental health as discussed by Patel in this volume (Patel, 2005).

#### **Support multi-outcome interventions for mental and physical health**

There is a need to support research on the impact of more generic programmes that address several mental and physical health determinants simultaneously. The accumulation of multiple proximal outcomes across different domains of

functioning, including health behaviour, social skills and adjustment, emotional competence and mental well-being can simultaneously bring about more efficient strategies than those collections of programmes with more fragmented outcomes. One of the remaining problems in promotion and prevention is the categorical approach to mental, social, educational, behavioural and legal problems. Many of these problems have commonalities that can be addressed simultaneously and that impact on many areas of functioning (Herrman and Jané-Llopis, 2005). It is the accumulation of multiple proximal outcomes across various mental and physical health domains that will form the most convincing arguments for the effectiveness and efficiency of interventions (Mrazek and Hall, 1997).

#### **The importance of sustainability**

In general, follow-ups for prevention and promotion trials in mental health are on average no longer than one or two years. To be able to provide follow-ups over a longer period of time, it is crucial that interventions can promote and build on indigenous resources in order to maximize their local impact over time, after efficacy trials have been undertaken (Trickett, 1997). It is crucial to develop communities' accountability and to support sustainability strategies within health agencies. Therefore there is a need to bridge the mismatch that exists between the funding available for short-term interventions and the funding for long-term programmes within communities where resources should be sustained for prevention and promotion practices.

As a programme progresses to more widespread implementation, another critical step involves identifying what factors increase the potential for sustainability of effective interventions. There is a need to consider the organisational structures and policies that are necessary to support long-term maintenance and sustainability of quality programmes. To effectively maintain quality programmes, practitioners in collaboration with programme evaluators, will need to identify key programme elements needed for a high probability of success such as organisational capacity, quality training, funding, stability, commitment and resources. Some programmes may need new sponsors, other programmes may

need to be significantly changed. Developing a strategy or plan for continued collaboration and partnerships is critical to the continued sustainability of the programme. Disseminating information on project activities and evaluation results increases the project's visibility, acceptance and level of interest among potential support sources. Maintaining high visibility and ensuring that key decision-makers learn about the project or programme may also be critical in determining whether resources will be made available for the project's continuance. A combination of good quality relationships, a high standard of implementation, rigorous evaluation, together with widespread programme acceptance and support provides the basis for effective and long-lasting mental health promotion practice.

### **Make use of tools that enhance efficacy and effectiveness**

Programme efficacy and effectiveness could still be strengthened if tools to disseminate knowledge, support programme development and their implementation were developed. Such tools could include for example, registries of effective programmes or interventions, validated instruments to assess implementation quality, improved tools to measure quality of research designs, and checklists pinpointing what should be reported in research evaluations. Knowledge about available tools to improve efficacy of interventions should be made available and stimulate their use by researchers, practitioners and policy makers.

It is important that the evidence-base should serve the needs of practitioners and policy-makers concerned with the practicality of implementing successful programmes that are relevant to the needs of the populations they serve. This calls for the active dissemination of

validated programmes and guidelines on best practices based on efficacy, effectiveness and dissemination studies. There is a need for international co-operation in assisting low-income countries with technical support and other capacity-building resources; in designing dissemination strategies, publishing guidelines for effective implementation of low-cost sustainable programmes and providing training in programme planning and evaluation.

### **From evidence to practice: strategies for action**

If the mental health of the population is to be promoted, there is a need to develop a systematic and comprehensive approach including strategic policy and action plans for mental health promotion that include evidence based interventions covering different target groups and settings. In designing and implementing a mental health promotion strategy it is crucial to take into account those principles of programme design, adoption, implementation, and evaluation that are more likely lead to intervention efficacy. This includes a needs assessment of the population, an analysis of the determinants of mental health, the demonstrated effectiveness of the programme, a systematic implementation and evaluation plan, and an efficiency strategy that includes reach by cost. It is important to note that in some cases, expensive interventions or strategies can be still more cost effective than others that seem relatively more economic. That is why when taking into account their reach and the associated outcomes, it is essential to include the broader health, social and economic outcomes.

Box 1 outlines recommendations to take into account when designing a mental health promotion programme.

## **Box 1**

### **Recommendations for the development of a mental health promotion programme**

1. Base the development and implementation of mental health promotion programmes on the principles of efficacy and a process that is empowering, collaborative, participatory and that includes partnerships with key stakeholders;
2. Clarify key goals and objectives of the action plan and its programmes and specify the key resources required for effective implementation including training and support mechanisms
3. Take into account all key factors that will enhance intervention efficacy when designing and implementing a mental health promotion strategy; for example, undertake a needs assessment of the population, and an analysis of the determinants of mental health.
4. Support capacity building and training in mental health promotion for effective action across a range of settings
5. Develop and sustain a system of monitoring and evaluation of process, impact and outcome evaluations of mental health indicators
6. Build on existing health promotion programmes and integrate a mental health promotion component in programmes already being implemented such as health promoting schools, home based educational interventions, health promotion in the workplace and in the community.
7. In the adoption and adaptation of a given programme or strategy across diverse cultural and economic settings (e.g., low-income countries), take into account their feasibility, efficacy and sustainability in settings with low levels of infrastructure.

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■ At the time I drafted this commentary, I was in attendance at the WHO European Ministerial Conference on Mental Health, in Helsinki, Finland (12-15 January 2005). The conference is the first of its kind in Europe, and very welcome indeed. The conference culminated with a Mental Health Declaration for Europe and an Action Plan that will undoubtedly be useful tools to European mental health advocates. Virtually all who are informed and concerned about mental health are in agreement about one objective at least: we seek to influence political processes to replace rhetoric with action, and not surprisingly, the lack of funding to back up ambitious mental health policy was a recurring theme at the Conference.

I came away from the conference more convinced than ever of the importance of health promotion's involvement in mental health, and of the need for information and advocacy for effective mental health promotion, such as this special issue of *Promotion & Education*. The Conference reminded me forcefully that different constellations of mental health advocates are circling about in Europe, usually not colliding and blissfully unaware of one another. They do collide occasionally at the edges, but the collisions are glancing – the constellations do not otherwise meet, and quickly regain their insularity.

The much larger of these constellations is medically-oriented and treatment-focussed, concerned with the primary, secondary and tertiary prevention of mental disorders. Its conversational agenda tends to be dominated by mortality, morbidity and disability related to mental illness, alcohol and substance abuse, health budgets and mental health's too small piece of the pie, psychiatry's need for expansion and its responsibility to train other health professionals in screening, early detection and referral to appropriate care, numbers and types of facilities and beds, and policy and legislation related to the prevention and treatment of mental disorder.

The much smaller of these constellations is community health-oriented, and focussed on mental health promotion for the entire population. It is deeply concerned with tackling mental disorder, too, but its perspective is that of the patient, the family, the informal carer, and the community. This constellation's conversational agenda is dominated by talk of empowerment through participation and rights to health, the need to break health professionals' stranglehold over policy-making and resource allocation, primordial prevention (prevention of the conditions that give rise to risk factors for mental disorder) and mental health as a resource for robust living for all people in the community, not just vulnerable sub-groups.

As heavenly constellations more in different orbits, but nevertheless influence one another despite great

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### Key words

- mental disorder prevention
- mental health promotion

distances, these earth-bound constellations stay mostly in their own orbits, and have rather weak magnetic attractions for one another. Strengthening that magnetism has been an obsession of Professor Clemens Hosman, Head of the Prevention Research Centre at University of Nijmegen, The Netherlands. His advocacy to stimulate and connect mental disorder prevention and mental health promotion has had a profound effect on the International Union for Health Promotion and Education. Mental health promotion has become a priority of the organisation, it is a featured theme at our conferences, it is among the priorities of the Global Programme on Health Promotion Effectiveness, the International Journal of Mental Health Promotion has become a partner in the Health Promotion Journals' Equity Project... and it has resulted in this special issue of *Promotion & Education* on mental health promotion.

There are other promising developments for mental health promotion. The WHO will soon release an authoritative text on mental health promotion, and the influence of adherents of both constellations on its contents is clearly evident. Textbooks on mental health promotion are multiplying. Seminars, conferences and symposia on mental health promotion are on offer almost continuously. University's offer courses and specialities in mental health promotion. A new and rapidly growing academic field called positive psychology is quickly advancing the knowledge base for mental health promotion. Public health surveillance systems in Europe will soon include health promotion and mental health promotion indicators, alongside the sickness indicators that have long been tracked.

My assessment is that the two constellations' attraction for each other is strengthening, but from a very weak level to only to a slightly stronger level. This is understandable; there exist natural forces that oppose the attraction – professional competitiveness, differences in understanding of what health means, competition for political attention and for funding. At the Helsinki conference, one vocal mental health advocate called for a stop to professional jealousy, unfathomable bickering and territory defending, loosening one of the

Conference's few spontaneous bursts of enthusiastic applause. But as applause does, it quickly exhausted itself. At this conference, dominated by the larger constellation, the term 'mental health promotion' was used mostly as a euphemism for mental disorder prevention. And the conversational agenda of the mental disorder constellation was stoutly defended and clearly dominant.

Assuming I have got all this right, what is a small constellation to do? We now have quite a few Clemens Hosman clones running about (including me), thanks to his legendary perseverance – he once drove me to an airport several hours distant, knowing a good opportunity to capture one's undivided attention when he saw one! I think we just have to carry on, and that is what this collection of papers does, most effectively in my opinion. Mental health promotion, as all health promotion, is effective when done with seriousness of purpose and in a sustained way. And today, there is considerable momentum for mental health promotion. This is taken up in the paper by Marshall Williams, Saxena, and McQueen. Particularly important is emerging emphasis on protective as well as risk factors as determinants of mental health, on the need for including mental health indicators in health surveillance systems, and the proof that this is feasible. The US' nationwide Behavioral Risk Factor Surveillance system demonstrates how measures such as the Health-related Quality of Life indicators can be introduced into existing surveillance efforts and provide for the simultaneous tracking of positive as well as poor mental health.

On the intervention side, Jané-Llopis, Barry, Hosman and Patel's contribution is a most welcome update of what works for mental health promotion, must reading for anyone wishing to know the state-of-art in this rapidly advancing arena. I think it particularly fortunate that they chose to organise the material using the Ottawa Charter action areas as the framework. They illustrate convincingly that each of the five action areas provides opportunity for effective mental health promotion, reaching all population segments in a wide range of settings. I am struck particularly by the evidence on effective action to reorient health services, thought by many to be the

Ottawa Charter action area in which least progress has been made. However true that may or may not be, this paper shows that brief (read feasible) interventions in primary care can pay large dividends. If only more primary care providers were aware that their interventions need not necessarily be costly and time consuming, their inclination to try such interventions would undoubtedly be strengthened.

Patel's contribution addresses the influences on health of two intertwined macro factors: gender and poverty. Biological differences between men and women play a certain role in defining distinct health and illness experiences, but Patel focuses rightly on gender as socially constructed, not biologically constructed reality. The significance of this for mental health promotion is illustrated by evidence cited by Patel. A particularly instructive example is that of the economic and social interventions carried out by the Bangladesh Rural Advancement Committee, resulting in demonstrable improvements in nutritional status, child survival, educational attainment, and reduce domestic violence. This and other examples of successful intervention discussed by Patel show how women and the poor, too often mutually inclusive groups, may be empowered to take increased control of their own mental health, however deprived of resources they may be.

Barry, Domitrovich and Lara take on a critical issue – how can mental health promotion programmes that are proven in research be disseminated with high quality and effectiveness? There is often scholarly discussion of this issue, but this paper adds a new level of rigour, by systematically addressing and integrating literature on factors that both assist and retard quality dissemination of programmes. Most usefully, they propose a checklist that can be used by funders, programme managers and quality monitors to determine if appropriate steps are taken before, during and after implementation of a programme, to ensure the highest possible quality and effectiveness, when programmes are disseminated beyond their point of origin. Of special value are the paper's admonitions to policy makers and researchers, nicely presented as recommendations, to use energy, time

and resources to produce knowledge, not just about programme effectiveness, but also about critical programme processes. If a fine, research-tested community-based mental health intervention has certain magic ingredients and/or Achilles' tendons, it is vital to illuminate them for the benefit of those who will disseminate the programme.

Moodie and Jenkins signal something different right from the start, with their provocative title 'I'm from the government and you want me to invest in mental health promotion. Well, why should I?' The message of this paper is of special importance to the researchers among the readership, who have well-honed expertise in telling audiences what we don't know, and why yet more research is needed on virtually all aspects of mental health promotion. That is appropriate in scholarly discourse, but the kiss of death in dialogues with policy-makers, who recognise an opportunity to say 'no' the instant they see it. There are times and places where one puts one's best foot forward, and this paper provides a blueprint of just how to do that. It makes a factual and a persuasive case for investment in mental health promotion, with example after example that shows how virtually every sector of society can promote mental health. Perhaps most importantly, the paper illustrates that one does not need necessarily to launch formal mental health promotion programmes to obtain good results. As stimulating examples, the authors cite the Women's Circus, the Somebody's Daughter Theatre Company, and Vocal Nosh – arts and culture projects not launched with mental health promotion explicitly in mind, but with major health promotion impact nonetheless.

Herrman and Jané-Llopis' contribution is to secure in readers' minds connections that are sometimes lost by mental health promoters – the reciprocal connection between mental and physical health, and the professional and research connections between mental health promotion, mainstream health promotion and public health. The similarity of discourses in all three arenas is solid evidence that the underlying values of empowerment and participation, and concern with structural determinants of health, closely unite these arenas, despite any surface differences. At the

same time, the authors add important nuance to their argument, maintaining, for example, that in advocacy, the activities of mental health promotion should remain distinct. The same is true for many aspects of health promotion, because of the way that society chooses to govern itself. As long as funding streams, professional education programmes, and services delivery systems are defined by disease, by risk factor, by target group, we will need to show that our work is relevant to various actors' vested interests. Advocating for health promotion in general cannot be near as effective as focussed advocacy for patients' rights, for tobacco control, for safe streets, for inclusive schools, among many other specialised interests that all fall somewhere under an umbrella we call health promotion.

The final paper in this issue by Jané-Llopis and Barry makes a strong case for using the concept of health promotion settings to establish a framework for a comprehensive European strategy for mental health promotion. This idea makes great sense. Regardless of cultural and other differences, informal and formal social institutions are remarkably similar across Europe, enough so that national and international networks devoted to setting-based health promotion flourish (e.g., health promoting schools, work places, hospitals). Without necessarily claiming to promote mental health per se, better mental health is a sure outcome in community settings where participation and empowerment processes are set into motion to improve social, psychological and physical functioning. To be explicit about the positive mental health outcomes of health promotion is to strengthen the argument that all settings need to be health promoting settings. Also worthy of note is the section of the paper that relates to quality. There, the authors elucidate principles of practice, which when adhered to, increase the likelihood that interventions will work like they are supposed to work.

That is why we need the label 'mental health promotion', even though just under the skin, virtually all health promotion in Europe today shares the same touchstone of the Ottawa Charter and the developments it stimulated. This brings me back to the Helsinki Conference, and to the constellations of

mental disorder prevention and mental health promotion with which this commentary opened. For many – too many – in the constellation of mental disorder prevention, the term mental health promotion is but a euphemism for mental disorder prevention. The terms are frequently used interchangeably and without thought, and this is indeed unfortunate. The vulnerable population sub-groups with which the mental disorder constellation is occupied require all the attention and care that can be mustered. But we need also a mental health promotion for the entire community, and a vision of mental health as a resource for robust living, not merely the absence of mental disorder.

That explains the need for the mental health promotion constellation, for the term mental health promotion, and for information and advocacy efforts of which this special issue of *Promotion & Education* is a fine example.

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## The Fourth Biennial World Conference

### The Promotion of Mental Health and Prevention of Mental and Behavioural Disorders

11-13 October 2006 – Oslo, Norway

The Conference is organized by The World Federation for Mental Health, The Clifford Beers Foundation, The Carter Center and Voksne for Barn.

In 1997, following progress made through the Annual European Mental Health Promotion Conferences, the Clifford Beers Foundation and the World Federation for Mental Health agreed on a joint venture to secure recognition of promotion and prevention as an essential part of the global mental health agenda. With the support of the Carter Center and WHO a series of biennial conferences was initiated to pursue this agenda. The Inaugural World Conference, held in Atlanta, Georgia in 2000, was followed by the London and Auckland Conferences in 2002 and 2004 respectively.

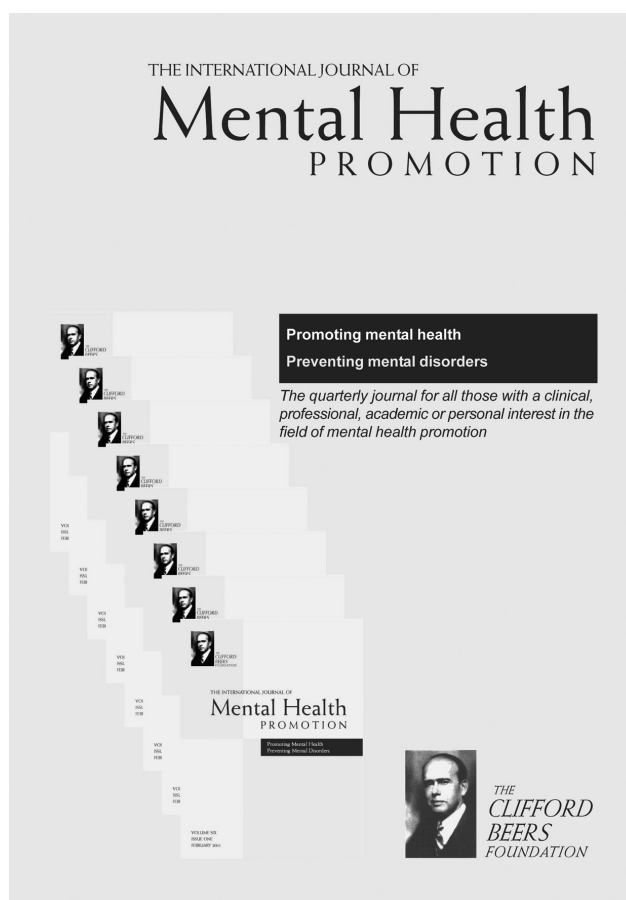
From the earliest stages of planning it has always been envisaged that the biennial conferences would form a focus for this development. The vision has generated significant interest from government agencies, NGOs and academic institutions which have stressed the need to strengthen ties and expand collaborative actions internationally. As a result of expanding enthusiasm, a world consortium of international organisations, the Global Consortium for the Advancement of Promotion and Prevention in Mental Health, was formed at a meeting in Dublin in 2005 to seek opportunities for joint activities and mutual support.

For the 2004 Conference, the Mental Health Foundation of New Zealand agreed to act as a partner and host and Voksne for Barn, Norway will fulfill this role for the Oslo Conference.

For further details about the Oslo Conference please contact:

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## The International Journal of Mental Health Promotion



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## Pas de santé sans santé mentale

■ La santé mentale commence à faire partie de l'agenda politique. Et la promotion de la santé mentale qui a généralement été négligée par les décideurs a gagné de l'importance et de la visibilité au cours des dernières années. L'UIPES a contribué de manière significative à ce changement. On pourrait citer comme exemple l'influence au niveau de l'élaboration des politiques qu'a eu le chapitre sur la santé mentale (Hosman & Jané-Llopis, 1999), publié dans le cadre de l'initiative européenne « *The Evidence of Health Promotion Effectiveness – Shaping Public Health in a New Europe* ». Cette publication traduite en plusieurs langues a apporté un ensemble de preuves de l'efficacité de la santé mentale partout dans le monde. Le recueil d'articles dans ce numéro est un ajout à l'initiative encore plus large que mène actuellement l'UIPES pour que la promotion de la santé mentale soit considérée comme un élément essentiel de la promotion de la santé en général. Un exemple primordial de cet engagement est l'inclusion de la promotion de la santé mentale comme sujet prioritaire dans le programme mondial sur l'efficacité de la promotion de la santé, coordonné par l'UIPES. Ce Programme est désormais développé sur tous les continents et mis en œuvre avec ses partenaires principaux que sont l'OMS et les CDC américains, entre autres.<sup>1</sup>

Autre événement tout aussi important, la promotion de la santé mentale était l'une des principales thématiques de la 18<sup>e</sup> conférence mondiale de promotion de la santé et d'éducation pour la santé qui s'est déroulée à Melbourne en avril 2004. Dans cette continuité, il est prévu d'inclure aux programmes des prochaines 19<sup>e</sup> et 20<sup>e</sup> conférences mondiales, à Vancouver en 2007 et à Hong Kong en 2010, un important élément de promotion de la santé mentale.

Le principal objet de ce numéro hors-série est de faire un tour d'horizon de la promotion de la santé mentale et de la prévention des problèmes de santé mentale en prenant en considération les pays à revenu élevé, moyen et faible. Comme la

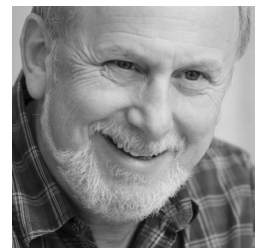
promotion de la santé mentale est un défi de dimension mondiale, les données probantes et les recommandations présentées dans ce numéro ont été recueillies de sources variées et ont été choisies pour faire ressortir la diversité des contextes culturels.

Marshall Williams, Saxena and McQueen réfléchissent sur les raisons de l'élan actuel pour la santé mentale et soulignent ses dimensions positives. Ils font valoir qu'il faut faire davantage de recherche appliquée si l'on souhaite doter les professionnels de santé publique des preuves dont ils ont besoin pour faire progresser la promotion de la santé mentale dans leurs programmes locaux. Jané-Llopis, Barry, Hosman et Patel fournissent le « cœur » du recueil ; ils passent en revue les données probantes internationales de l'efficacité de la promotion de la santé mentale, recueillies à partir de différentes sources de recherches. La contribution de Patel sur la pauvreté et le sexisme en tant que déterminants de la santé mentale nous rappelle que le véritable progrès du développement humain est un préalable à l'amélioration de la santé mentale, et que les solutions structurelles sont tout aussi importantes pour la promotion de la santé mentale que pour la promotion de la santé en général. Barry, Domitrovich et Lara nous aident à mieux comprendre les principaux facteurs qui déterminent la réussite de la mise en œuvre de la promotion de la santé mentale sur le terrain.

Moodie et Jenkins entraînent le débat sur plusieurs niveaux en présentant des leçons recueillies de l'expérience sur la façon d'inscrire



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### Mots clés

- santé mentale
- promotion de la santé mentale

la santé mentale à l'ordre du jour des programmes nationaux. Herman et Jané-Llopis se font les avocats d'une meilleure intégration de la santé mentale à la promotion de la santé en général. Ils font valoir, par la même occasion, qu'il faut encore déployer des efforts ciblés pour plaider en faveur de la promotion de la santé mentale. Cela vaut également pour bon nombre, sinon tous les terrains de bataille sur lesquels la promotion de la santé est impliquée (la lutte contre le tabac n'en est qu'un exemple). Jané-Llopis et Barry fournissent une vue d'ensemble des facteurs principaux de succès des interventions en promotion de la santé mentale et soulignent les besoins de continuer à évaluer les initiatives entre pays et d'en assurer la viabilité au travers de partenariats. Mittelmark complète la collection en soulignant les raisons pour lesquelles la promotion de la santé mentale est tellement nécessaire et lance un appel. Un élément de la promotion de la santé mentale a été laissé de côté dans ce recueil : le développement des compétences et performances professionnelles. Faute de professionnels convenablement formés pour assurer la promotion de la santé mentale, nous aurons beau plaider, élaborer des politiques et plans autant que faire se peut, nous ne parviendrons jamais à traduire les paroles en actions. Les rédacteurs de ce numéro ont donc souhaité inclure dans ce recueil l'article

récemment publié dans *Promotion & Education* sur le sujet (Mittelmark, 2003), en esprit sinon dans les faits.

Cette publication est destinée à un large éventail de lecteurs, notamment les décideurs, les professionnels et les chercheurs qui travaillent dans les domaines de la santé mentale, de la promotion de la santé et de la santé publique dans le monde entier. Nous espérons qu'elle sera un outil utile à ceux qui militent en faveur de la santé mentale et s'efforcent de démontrer que la promotion de la santé mentale est efficace. Notre souhait est que les décideurs utilisent cette publication comme ouvrage de référence qui documente le besoin de disposer de stratégies qui permettent de réduire efficacement le fardeau de la maladie mentale. Les professionnels devraient également pouvoir trouver dans cet ouvrage l'inspiration pour dialoguer avec d'anciens et de nouveaux partenaires dans les domaines de la pratique, des politiques et de la recherche.

Enfin les auteurs des différents articles méritent nos félicitations et notre gratitude pour avoir réalisé cette publication, qui apporte s'il en était besoin, les preuves de l'attachement de l'UIPES à maintenir la promotion de la santé mentale comme priorité de son programme. Nous espérons recevoir les idées et suggestions des lecteurs pour renforcer davantage encore cette initiative.

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1. L'Agence de santé publique du Canada ; l'Association indienne des bénévoles en santé (VHAI) ; le Centre néerlandais de promotion de la santé et de prévention des maladies (NIGZ) ; la Fondation africaine de recherche médicale (AMREF), la Fondation pour la promotion de la santé de l'état de Victoria (VicHealth) ; la Fondation suisse de promotion de la santé ; l'Institut national de santé et d'excellence clinique (NICE), Angleterre ; l'Organisation panaméricaine de la santé.

## L'élan en faveur de la promotion de la santé mentale

■ Il n'y a pas de santé sans santé mentale. Ce message simple oriente tous les efforts vers la promotion de la santé mentale. Les faits corroborent qu'il faut intensifier les efforts consentis au niveau mondial pour améliorer la santé mentale. On estime que près de cinq cents millions de personnes dans le monde souffrent de troubles mentaux, neurologiques ou liés à la consommation de substances psychoactives. Les calculs montrent que le poids de ces troubles représente près de 13 pour cent du fardeau mondial de la maladie. Un tiers de toutes les incapacités résultent de ces désordres. Près d'un million de personnes se suicident chaque année. Une famille sur quatre est touchée par des troubles mentaux. On estime que le coût total des troubles mentaux se situe entre 2,5 et 4 pour cent du PNB mondial. Cependant, ces statistiques n'ont pas même commencé à prendre en compte l'impact concevable d'une santé mentale moins qu'optimale sur d'autres

maladies, états pathologiques et conditions de vie.

La santé mentale a également des dimensions positives. Il s'agit d'un état de bien-être dans lequel la personne peut se réaliser, faire face aux tensions normales de la vie, accomplir un travail productif et fructueux et apporter sa contribution à la vie de sa communauté. L'élan en faveur de la promotion de la santé mentale s'est amplifié au cours des quelques dernières années par une plus grande prise de conscience et une meilleure compréhension de la santé mentale et de son importance pour la santé dans son ensemble. Cependant, alors même que des efforts de promotion de la santé mentale se répandent un peu partout, on a toujours relativement peu d'exemples d'approches de santé publique qui s'appuient sur la population pour aborder ce fardeau conséquent. On constate un manque, à l'échelle mondiale, d'études systématiques et de

travail sur les données de surveillance en matière de santé mentale.

Comme la littérature sur la façon de mettre en œuvre des interventions stratégiques axées sur la population pour améliorer la santé mentale sont rares, les auteurs concluent leur introduction par un bref tour d'horizon des efforts et des suggestions émanant d'organismes scientifiques et de plaidoyer en faveur de la santé mentale pour relever le défi d'aborder enfin la question des interventions fondées sur la population. Il est urgent de fournir aux professionnels de la santé publique des preuves de l'efficacité des interventions de promotion de la santé mentale, notamment des éléments de réflexion sur la faisabilité et le coût des programmes de promotion dans la diversité des contextes dans le monde. Si l'on peut apporter ces preuves, il y a de bonnes chances que la promotion de la santé mentale soit utilisée.

E. Jané-Llopis et al., p. 9

## La promotion de la santé mentale est efficace : examen des résultats probants

■ Dans cet article, les auteurs examinent les preuves de l'efficacité de la promotion de la santé mentale récoltées partout dans le monde, pour guider l'élaboration des politiques et la pratique dans ce domaine. La santé mentale est une valeur en soi, une composante intrinsèque et intégrale de la santé et un droit humain fondamental. La masse des données probantes concernant la mise en œuvre de programmes efficaces de promotion de la santé mentale parmi divers groupes de population et dans des lieux de vie différents, ne cesse de croître. Cependant, il est également admis que ces données probantes font souvent le plus défaut là où on en a le plus besoin, c'est-à-dire dans les pays et lieux à faibles revenus ou à revenus moyens.

Cet article résume différents types de preuves allant des analyses systématiques jusqu'aux évaluations de processus et inclut des exemples de programmes publiés dans des revues scientifiques internationales de même que des études de cas de pays ayant des ressources économiques différentes. En s'appuyant sur le cadre de la Charte d'Ottawa pour la promotion de la santé (OMS, 1986), cet article examine les preuves de l'efficacité des interventions de promotion de la santé mentale en termes d'impact social, économique, politique et sanitaire. Les interventions à domicile, à l'école, au travail et dans les collectivités ont montré qu'elles augmentaient les facteurs protecteurs de la santé mentale, réduisaient les facteurs de risque de mal-être mental et

produisaient des résultats positifs manifestes dans de nombreux domaines de la santé et du fonctionnement social. Parmi ces résultats, les auteurs citent par exemple l'augmentation du bien-être mental et de la qualité de la vie, la diminution de l'agressivité, des symptômes dépressifs, de la toxicomanie de même que des résultats sociaux positifs tels que le développement des compétences au sein d'une communauté, la baisse du décrochage scolaire et de la criminalité, l'amélioration de la qualité du travail et de l'emploi qui ont conduit à une augmentation du capital social. Quelques interventions ont également produit des données probantes, bien que moins disponibles, sur le rapport coût-efficacité de la promotion de la santé mentale ; ainsi, un programme

d'éducation préscolaire a produit un rendement sept fois plus important que l'investissement du gouvernement dans cette intervention. Toutefois, la grande majorité des preuves sur l'efficacité de

ces interventions provient de pays relativement aisés.

Les auteurs insistent particulièrement sur l'adoption et la mise en œuvre

d'interventions fondées sur les preuves pour la promotion de la santé mentale dans des contextes culturels et des situations de disponibilité de ressources divers.

*V. Patel, p. 26*

## Pauvreté, sexisme et promotion de la santé mentale dans une société mondiale

■ L'influence des facteurs sociaux et économiques sur la santé mentale a été documentée dans pratiquement toutes les études de recherche épidémiologiques des troubles mentaux. La santé mentale est une composante implicite du concept de développement humain énoncé par les Nations Unies, car il existe de sérieux indices que la mauvaise santé mentale compromet la longévité, la santé en général et la créativité. Les facteurs qui influent sur le développement humain et ceux qui influent sur la santé mentale sont donc les mêmes ; il est peu probable que la causalité soit simple ou unidirectionnelle, car le développement humain et la santé mentale sont tous deux des concepts larges. Il est vraisemblable qu'une relation dynamique existe entre des aspects spécifiques du

développement humain, tels que la pauvreté, et des aspects spécifiques de la santé mentale, tels que l'estime de soi. Le classement des indices du développement humain montrent qu'il existe une très grande diversité entre les pays qui ont traditionnellement été regroupés comme étant « en développement ». Ces différences se retrouvent également dans la fréquence d'un ensemble de facteurs sociaux et économiques défavorables qui influent sur la santé mentale, tels que le taux de criminalité, les indicateurs de santé physique, l'engagement politique en faveur de la santé publique et du bien-être social et l'expérience de troubles civils graves tels que ceux provoqués par des conflits et des désastres naturels. Dans cet article, l'auteur se concentre sur deux macro-problèmes très importants qui

influencent profondément tous les aspects du développement humain, à savoir la pauvreté et la discrimination sexuelle ; il compte montrer de quelle façon ces éléments sont liés à la santé mentale et aux troubles mentaux. Il examine également l'impact de la mondialisation sur la pauvreté et le statut social des hommes et des femmes dans le contexte de leur influence sur la santé mentale, et les stratégies d'action pour la promotion de la santé mentale. L'article aborde en particulier le rôle du pouvoir économique, du développement économique équitable et de l'autonomisation des femmes, en tant qu'initiatives de politique publique importantes qui pourraient exercer un effet significatif sur la promotion de la santé mentale.

*M. M. Barry, C. Domitrovich et Ma. A. Lara, p. 30*

## La mise en œuvre des programmes de promotion de la santé mentale

■ Dans cet article, les auteurs examinent l'importance de la mise en œuvre des programmes pour faire avancer la recherche, les pratiques et les politiques dans le domaine de la promotion de la santé mentale. L'attention est mise en particulier sur l'évaluation des différentes dimensions de la mise en œuvre des programmes et les facteurs clé qui influent sur la qualité sont examinés. Un modèle conceptuel de mise en œuvre de programmes en milieu scolaire est présenté comme un guide pouvant servir à faire progresser la

recherche et favoriser la compréhension dans ce domaine particulier ; des suggestions pour une application à d'autres lieux de vie sont apportées. Les auteurs abordent également les difficultés pratiques que pose la mise en œuvre de programmes de promotion de la santé mentale et les défis qu'elle présente sur le plan de la recherche, notamment pour ce qui est de l'élaboration et de l'adaptation d'interventions pour être réalisées dans des contextes culturels différents. Un programme de prévention de la dépression mené auprès de femmes

mexicaines ayant de faibles revenus est présenté comme une étude de cas qui montre comment garantir une mise en œuvre de qualité grâce à une intervention fondée sur la théorie et culturellement adaptée. Les auteurs font référence à la documentation et à la recherche existantes pour faire ressortir ces éléments et d'autres facteurs clé qui peuvent améliorer la qualité des programmes et formulent des recommandations à l'intention des décideurs, des professionnels et des chercheurs.

R. Moodie et R. Jenkins, p. 37

## J'appartiens au gouvernement et vous voudriez que j'investisse dans la promotion de la santé mentale. Pourquoi ?

■ La santé mentale est non seulement essentielle à la santé d'une population ; elle est également essentielle à son développement économique, social et humain.

Nous adoptons une acception large de la santé mentale pour faire valoir que les pouvoirs publics à tous les niveaux – local, province/État ou national – des pays en développement, en transition ou industrialisés, doivent faire de la promotion de la santé mentale un élément central des politiques globales sociales, économiques et de santé. Dans cet article, les auteurs expliquent

pour quelles raisons les gouvernements doivent favoriser la santé mentale, qui peut avoir comme résultat de réduire la morbidité et la mortalité imputables à la fois aux maladies physiques et mentales, de réduire également la prévalence et la gravité d'un ensemble de comportements à risque (par exemple le tabac, l'alcool, les drogues, les troubles de l'alimentation) et de problèmes sociaux et économiques tels que l'abandon scolaire, la criminalité, l'absentéisme au travail et la violence dans les couples. Ils examinent à qui incombe la

responsabilité de promouvoir la santé mentale en poussant plus loin l'idée traditionnelle de qui « a la charge » de la promotion de la santé mentale et qui l'assume effectivement ou peut l'assumer dans la majorité des populations. Ils présentent des stratégies d'action et des exemples pratiques tirés largement de leur expérience au Royaume-Uni et en Australie. Ils concluent en exposant quelques idées sur la façon d'inscrire la promotion de la santé mentale à l'ordre du jour des pays et sur ce qui devrait y être inclus.

H. Herrman et E. Jané-Llopis, p. 42

## La place de la promotion de la santé mentale dans la promotion de la santé et la santé publique

■ La santé mentale est un état de bien-être dans lequel la personne peut se réaliser, faire face aux tensions normales de la vie, accomplir un travail productif et fructueux et contribuer à la vie de sa communauté (OMS, 2001a). Tout comme la santé, la santé mentale est déterminée par des facteurs et des expériences individuels, l'interaction sociale, les structures et les ressources de la société et des valeurs culturelles. Des déterminants importants de la santé tels que la pauvreté, le chômage ou l'exclusion sociale influent à la fois sur la santé physique et mentale. La santé mentale est donc intimement liée à la santé physique et aux comportements car la santé ne consiste pas seulement en une absence de maladie ou d'infirmité, mais plutôt en un état de complet bien-être physique, mental et social (OMS, 2001). Les liens entre la santé physique et la santé mentale vont dans les deux sens.

La mauvaise santé physique nuit à la santé mentale, tout comme la mauvaise santé mentale altère la santé physique d'un individu. Ainsi, la malnutrition des enfants en bas âge peut accroître les risques de déficiences cognitives et motrices. De même, on sait que la vulnérabilité et la dépression sont associées à la diminution de l'activité immunologique et à l'augmentation du risque de développer des tumeurs et infections.

Dans ce contexte, la promotion de la santé mentale fait partie intégrante de la promotion de la santé et de la santé publique. Les rapports entre santé physique et mentale signifient que l'élaboration et la mise en œuvre des politiques et interventions de promotion de la santé vont avoir des résultats multiples sur la santé. Ainsi, des interventions qui favorisent un début de vie sain et l'amélioration du poids à la

naissance ont apporté de multiples bienfaits, parmi lesquels une bonne santé physique et mentale et ses conséquences sociales et économiques. Il est suggéré dans l'article, qu'en général, les interventions qui visent à augmenter la résilience et encourage la participation communautaire chez ceux dont la santé est déterminée par des facteurs défavorables, vont souvent améliorer la santé physique et mentale et réduire la vulnérabilité aux troubles mentaux. Cet article présente une définition de la santé mentale et établit une distinction entre stratégies de prévention et de promotion, toutes étant décrites comme faisant partie intégrante de la santé publique. Les auteurs argumentent en faveur de l'intégration des activités de promotion de la santé mentale à celles de la promotion de la santé, mais préconisent une mobilisation distincte en faveur de la santé mentale.

## Qu'est-ce qui rend la promotion de la santé mentale efficace ?

■ Cet article aborde l'adoption et la mise en œuvre d'interventions promotrices de santé mentale basées sur des données probantes à travers divers contextes culturels et situations. Il présente une série de déterminants de la santé mentale qui sont abordés dans des interventions promotrices de santé mentale en milieu familial, scolaire, professionnel et communautaire. Faisant appel à l'évaluation des données probantes présentées dans ce numéro, les principes clés qui sous-tendent le succès de l'implémentation des programmes ainsi que les résultats sont considérés en

fonction d'implications pratiques et politiques. Certains de ces principes de travail sont spécifiques à un environnement particulier, comme le fait d'adopter une approche de santé à l'école dans sa globalité, tandis que d'autres sont génériques et par là même pertinents d'une intervention à l'autre, comme la qualité élevée du processus de mise en œuvre de l'intervention. Lorsqu'on élabore une stratégie de promotion de la santé mentale, il est capital de prendre en compte ces principes clés qui augmenteront la probabilité de réussite des interventions. Cependant, il subsiste

des manques au niveau des données probantes disponibles et de la traduction de ces données dans la pratique. C'est pourquoi il est essentiel de poursuivre les efforts, que ce soit pour accroître l'efficacité en mettant en place des interventions offrant des résultats variés ; pour multiplier les études sur l'efficacité et la reprise des modèles à travers les pays et les cultures, notamment des suivis à long terme et des analyses de coût-efficacité ; pour stimuler l'évaluation à travers les pays en créant des partenariats avec d'autres organisations ; enfin pour garantir la pérennité des interventions.

M. B. Mittelmark, p. 55

## Pourquoi la promotion de la santé « mentale » ?

■ Deux constellations de défenseurs de la promotion de la santé coexistent sans beaucoup interagir. La plus large est orientée vers la médecine et axée sur les traitements, et se préoccupe principalement de la prévention primaire, secondaire et tertiaire des troubles mentaux. La plus petite est orientée vers la santé communautaire, et axée sur la promotion de la santé mentale pour

l'ensemble de la population. Elle met l'accent sur l'*empowerment* du patient, de la famille, du soignant informel, et de la communauté. Mais ceux qui plaident pour une action qui réduise le fardeau des troubles mentaux tendent, eux aussi, à utiliser les termes 'promotion de la santé mentale' pour décrire leurs efforts. Ainsi, les deux constellations utilisent la même expression – promotion de la

santé mentale – pour désigner des concepts bien distincts quoique complémentaires. Il serait souhaitable de renforcer la connexion entre ces deux constellations afin que chacune connaisse mieux la perspective de l'autre, ce qui développerait leur motivation à travailler en synchronie pour réduire les troubles mentaux et améliorer la santé mentale.

Eva Jané-Llopis y Maurice B. Mittelmark

## Sin salud mental, no hay salud

■ La salud mental comienza a integrarse en las agendas políticas y la promoción de la salud mental, la cual ha sido generalmente desatendida por los responsables de elaborar políticas, ha ganado un puesto de privilegio en los últimos años. La UIPES ha contribuido de manera importante a este cambio. Un claro ejemplo es la influencia ejercida sobre la elaboración de políticas a través capítulo sobre la salud mental (Hosman & Jane-Llopis, 1999) publicado en la iniciativa europea *La evidencia de la eficacia de la promoción de la salud*. Esta publicación, traducida a diversos idiomas, es una referencia para la evidencia a nivel mundial.

El conjunto de artículos que integran el presente volumen se suman a la iniciativa, cada vez más amplia, de la UIPES de subrayar la importancia de la promoción de la salud mental como aspecto fundamental de la promoción de la salud en general. Perfecto ejemplo de este compromiso es la inclusión de la promoción de la salud mental como cuestión prioritaria en el Programa Mundial sobre Efectividad de la Promoción de la Salud (GPHPE en sus siglas en inglés) de la UIPES, que se ha lanzado en todos los continentes en colaboración con la OMS y los CDC, entre otros aliados<sup>1</sup>.

También es significativo que la salud mental figurase como una de las ramas principales de la XVIIIª Conferencia Mundial de Promoción de la Salud y de Educación para la Salud que se celebró en Melbourne en abril de 2004. En esta línea, prevemos que la promoción de la salud mental constituirá uno de los puntos fuertes de los programas de las futuras Conferencias Mundiales que se celebrarán respectivamente en Vancouver en 2007 (XIXª) y en Hong Kong en 2010 (XXª).

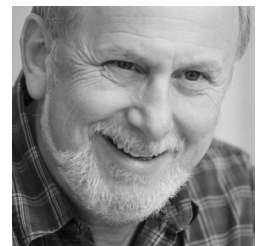
La finalidad primordial de esta edición especial de *Promotion & Education* es revisar la situación actual de la promoción de una salud mental y de la prevención de los problemas de salud mental, teniendo presentes a los países de renta alta, media y baja. Dado el alcance mundial del reto

de promover la salud mental, la evidencia y las recomendaciones recogidas en la selección de los artículos que integran este número provienen de diferentes fuentes y se han llevado a cabo con la idea de poner de relieve la existencia de diversos contextos culturales.

Marshall Williams, Saxena y McQueen reflejan las razones de la fuerza del momento que vive la salud mental y subrayan sus aspectos positivos. Defienden la necesidad de una mayor investigación aplicada si queremos dotar a los profesionales de salud pública con la evidencia que necesitan para promover la salud mental positiva en sus agendas locales. Jané-Llopis, Barry, Hosman y Patel aportan el “núcleo” del conjunto, con su análisis de la base de pruebas de la eficacia de la promoción de la salud mental a escala internacional. La aportación de Patel, que afirma que la pobreza y el género son determinantes de la salud mental nos recuerda que avanzar en desarrollo humano es un requisito indispensable para mejorar la salud mental y que las soluciones estructurales son tan decisivas para la promoción de la salud mental como para la promoción de la salud en general. Barry, Domitrovich y Lara hacen una valiosa aportación a nuestra idea de los factores clave para que la ejecución de la promoción de la salud sobre el terreno tenga éxito. Con Moodie y Jenkins subimos varios escalones y aprendemos cómo incluir la promoción de la salud mental en las agendas nacionales con lecciones aprendidas de la experiencia. Herrman y Jané-Llopis cierran la serie con una llamada a integrar mejor la salud mental dentro de la promoción de la salud en general. Al mismo tiempo, argumentan que se necesitan todavía iniciativas con destinatarios concretos que defiendan la promoción de la salud mental. Esto es aplicable a muchos



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### Palabras clave

- promoción de la salud mental
- abogacía

campos, si no a todos, de abogacía relacionados con la salud mental (un ejemplo de ello sería el control del consumo de tabaco). Jané-Llopis y Barry proporcionan una visión de conjunto de los factores para intervenciones exitosas de promoción de la salud mental y subrayan la necesidad de evaluar iniciativas continuamente en los países y asegurar sostenibilidad a través de la creación de alianzas. Mittelmark pone fin a esta colección de artículos enfatizando la necesidad de tener la constelación de la salud mental como una parte intrínseca y específica de la promoción de la salud, la necesidad de utilizar y referirse a la promoción de la salud mental y la importancia de informar y abogar por la promoción de la salud mental.

Merece explicación aparte la omisión en este número del desarrollo de capacidades en la promoción de la salud mental. Sin personal adecuado para la promoción de la salud mental, no habrá discursos, políticas ni planificaciones que nos hagan pasar de la teoría a la acción necesaria. Los editores de la presente edición desean incluir el artículo recientemente publicado en *Promotion & Education* sobre este tema (Mittelmark, 2003), si no de hecho, sí a nivel conceptual.

Este número está pensado para una amplia gama de lectores, entre ellos, los responsables de elaborar las políticas, los profesionales de salud y los investigadores que trabajan en el campo de la salud mental, de la promoción de la salud y de la salud pública en todo el mundo. Esperamos y confiamos que la publicación será una herramienta útil a los defensores de la salud mental en su esfuerzo por demostrar que la promoción de la misma es un instrumento eficaz. Deseamos que la revista sirva a los responsables de elaborar las políticas para confirmar la necesidad de elaborar estrategias que reduzcan de manera efectiva la carga que supone la enfermedad mental. También los profesionales de salud deberían ser capaces de utilizar esta publicación para estimular el diálogo con colaboradores antiguos y nuevos en los campos de la práctica, las políticas y la investigación.

Los autores de los artículos se merecen nuestra felicitación y agradecimiento por su contribución a la compilación de este ejemplar, el cual aporta una prueba más de la intención de la UIPES de mantener la promoción de la salud mental en los primeros puestos de nuestra agenda. Esperamos que los lectores nos envíen ideas y sugerencias para fortalecer esta iniciativa todavía más.

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Mittelmark M. B. (2003). Cinco estrategias para desarrollar personal apto para la promoción de la salud mental. *Promotion & Education*, X (1): 20-22.

1. Agencia de salud pública de Canadá; Asociación india de voluntarios de salud (VHA); Instituto holandés de promoción de la salud y de prevención (NIGZ); Fundación africana de investigación médica (AMREF); Fundación para la promoción de la salud del estado de Victoria (VicHealth); Fundación suiza de promoción de la salud; Instituto nacional de salud y de excelencia clínica (NICE), Inglaterra; Organización Panamericana de Salud (OPS).

## El impulso de la promoción de la salud mental

■ No hay salud sin salud mental. Este sencillo mensaje orienta todas las iniciativas encaminadas a la promoción de la salud mental. Los hechos confirman la necesidad de aumentar el esfuerzo mundial por mejorar la salud mental. Se calcula que casi 500.000 millones de personas padecen trastornos mentales, neurológicos o derivados del consumo de estupefacientes. Las cifras muestran que estos trastornos representan casi un 13% de todas las enfermedades a escala mundial. Una tercera parte de las discapacidades deriva de este tipo de trastornos. Cada año se suicidan casi un millón de personas. Una de cada 4 familias se ve afectada por algún trastorno mental. Se calcula que el coste total de los trastornos mentales se halla entre el 2,5% y el 4,0% del PIB mundial. No obstante, las estadísticas ni siquiera rozan las potenciales consecuencias que tiene una

salud mental deficiente en otras enfermedades y dolencias.

La salud mental también tiene dimensiones positivas. Es un estado de bienestar en el que la persona materializa sus capacidades, puede afrontar las tensiones de la vida cotidiana, trabajar de forma productiva y útil y contribuir a la buena marcha de la comunidad a la que pertenece. Durante los últimos años ha aumentado el impulso dado a la promoción de la salud mental, gracias a una mayor concienciación y comprensión de lo que es y de su importancia para la salud en general. Sin embargo, aunque se lleven a cabo iniciativas de promoción de la salud mental, siguen siendo relativamente escasos los ejemplos de intervenciones de salud pública basadas en la población que intenten abordar esta pesada carga. Contamos con

relativamente pocos trabajos de investigación y de inspección que aborden la salud mental a nivel mundial.

Dada la escasez de literatura sobre cómo llevar a cabo iniciativas basadas en la población para mejorar la salud mental, la introducción concluye con un breve resumen de las mismas y sugerencias formuladas por los organismos mundiales de tipo científico y de concienciación y movilización para asumir el reto de realizar intervenciones basadas en la población. Es urgente ofrecer a los profesionales de la salud pública pruebas de la eficacia de las iniciativas de promoción de la salud mental, en las que se incluyan consideraciones relativas a la viabilidad y al coste de los programas de promoción en la diversidad de entornos de este mundo. Si se les facilitan estos datos, no cabe duda que les resultarán de utilidad.

*E. Jané-Llopis et al., p. 9*

## La promoción de la salud mental funciona: pruebas que lo demuestran

■ Este artículo examina la base de pruebas de la eficacia de la promoción de la salud mental a escala internacional a fin de informar a los responsables de la elaboración de las políticas y de la práctica de esta materia a nivel mundial. Se reconoce que la promoción de la salud mental tiene un papel decisivo que desempeñar si queremos conseguir el objetivo mundial de mejorar la salud mental de la población. Desde el punto de vista positivo, la salud mental es un valor en sí, un componente intrínseco e integral de la salud y un derecho humano fundamental. Cada vez es mayor la base de pruebas de la eficacia de los programas de promoción de la salud realizados en una amplia gama de grupos de población y de entornos. No obstante, se reconoce

también que esta información es más difícil de encontrar donde más se necesita, es decir, en los países y entornos de ingresos medios y bajos.

Este artículo resume distintos tipos de evidencia, desde meta-análisis a evaluaciones de proceso, e incluye ejemplos de programas publicados en revistas científicas internacionales así como estudios de caso de países con distintos recursos económicos.

En aplicación del marco que establece la Carta de Ottawa para la promoción de la salud (OMS 1986), el artículo repasa las pruebas de la eficacia de las intervenciones de promoción de la salud mental en base a sus repercusiones

sanitarias, sociales, económicas y políticas. Se ha demostrado que las intervenciones realizadas en los hogares, en la escuela, en el lugar de trabajo y en la comunidad han aumentado los factores de protección de la salud mental, han reducido los factores de riesgo de enfermedad mental y han obtenido resultados positivos en diversas áreas del funcionamiento social y sanitario. Entre estos resultados podemos señalar, por ejemplo, el aumento del bienestar mental y de la calidad de vida, la disminución de las agresiones, de los síntomas depresivos, del consumo abusivo de estupefacientes y resultados en el campo social, a saber, la potenciación de las comunidades, la reducción del absentismo escolar y de las conductas

delictivas, la mejora de la calidad de los trabajos y del empleo, todo lo cual ha llevado a un aumento del capital social.

Aunque no es tan fácil acceder a ellas, algunas intervenciones también demuestran la rentabilidad de la

promoción de la salud. Un ejemplo sería un programa de educación preescolar cuyos resultados multiplicaron por siete la inversión realizada por el gobierno para llevar a cabo la intervención. Sin embargo, la mayor base de la evidencia todavía proviene de países con recursos

económicos elevados. Se insiste particularmente en que se aprueben y apliquen intervenciones de promoción de la salud basadas en hechos probados, en entornos culturales variados y en diversidad de situaciones en materia de recursos.

*V. Patel, p. 26*

## Pobreza, género y promoción de la salud mental en una sociedad global

■ La influencia de los factores sociales y económicos en la salud mental se ha documentado en prácticamente todos los estudios epidemiológicos de los trastornos mentales. La salud mental es un componente intrínseco del concepto de Desarrollo Humano formulado por las Naciones Unidas, puesto que está de sobras probado que una salud mental deficiente es una amenaza para la longevidad, para la salud en general y para la creatividad. Así pues, los factores que inciden en el desarrollo humano son los mismos que afectan a la salud mental; ahora bien, la causalidad entre unos y otros no será fácil de establecer, ni unidireccional, puesto que tanto el desarrollo humano como la salud mental son conceptos amplios. Sin embargo, es probable que exista una relación

dinámica entre determinados aspectos del desarrollo humano, como la pobreza, y otros aspectos de la salud mental, como la autoestima. La clasificación de los Índices de Desarrollo Humano muestra muchas diferencias entre países que se han agrupado tradicionalmente bajo el epígrafe “en vías de desarrollo”. Estas diferencias se reflejan todavía más en la frecuencia de una serie de factores sociales y económicos adversos que inciden en la salud mental, como los índices de delincuencia, los indicadores de salud física, el compromiso político con la salud mental y el bienestar social y la existencia de graves disturbios civiles causados por los conflictos y los desastres. Este artículo se centra en dos grandes temas clave que inciden profundamente en todos los aspectos del

desarrollo humano, como son la pobreza y la situación de la mujer, a fin de demostrar cómo se relacionan estos elementos con la salud mental y los trastornos de este tipo. El artículo aborda también las consecuencias de la globalización en la pobreza y la situación de la mujer en el contexto de su influencia sobre la salud mental y las estrategias de acción para la promoción de la salud mental. Concretamente, el artículo trata del papel que desempeñan la capacitación económica de las personas, el desarrollo económico equitativo y la potenciación de la mujer como iniciativas públicas prioritarias que probablemente tendrán importantes repercusiones en la promoción de la salud mental.

*M. M. Barry, C. Domitrovich y M<sup>a</sup>. A. Lara, p. 30*

## La ejecución de los programas de promoción de la salud mental

■ Este artículo analiza la importancia de la ejecución de los programas para que se avance en la investigación, en la práctica y en las políticas de promoción de la salud mental. En primer lugar, evalúa las diversas dimensiones de la ejecución de los programas y examina los principales factores que afectan a la calidad de dicha ejecución. Presenta un modelo conceptual de ejecución para los programas de base escolar, a modo de guía para ulteriores estudios en este

campo en particular y aporta sugerencias para su aplicación en otros entornos. Se contemplan los retos prácticos y teóricos que plantea la ejecución de los programas de promoción de la salud mental, lo que incluye el reto de desarrollar y adaptar intervenciones que puedan utilizarse en entornos culturales diferentes. Como caso práctico, se presenta un programa de prevención de la depresión que se llevó a cabo con mujeres mejicanas de ingresos bajos a modo de ejemplo de cómo

asegurar una ejecución de calidad gracias a una intervención bien fundamentada a nivel teórico y adecuada en su dimensión cultural. Tomando como referencia la literatura existente y los estudios realizados al respecto, se subrayan éstos y otros factores que pueden mejorar la calidad de la ejecución de los programas y se ofrecen recomendaciones a los responsables de elaborar las políticas, a los profesionales de salud y a los investigadores.

## Yo estoy en el gobierno y tú quieres que invierta en promoción de la salud mental. Convénceme

■ La salud mental es de vital importancia no sólo para la salud de la población, sino también para su desarrollo humano, social y económico.

Tomando la acepción más amplia de salud mental, defendemos que todo gobierno, local provincial, nacional o estatal, debería incluir la promoción de la salud mental como parte fundamental de su política general en materia sanitaria, social y económica, independientemente del grado de desarrollo de cada país.

El artículo presenta las razones por las

cuales los gobiernos deberían promover la salud mental, y sus consecuencias en la reducción de la morbilidad y de la mortalidad tanto en relación con las enfermedades físicas como mentales, en la reducción de la prevalencia y de la gravedad de toda una gama de comportamientos de riesgo (consumo de tabaco, alcohol, estupefacientes, trastornos de la alimentación) y de una serie de problemas sociales y económicos como el absentismo escolar o laboral, la delincuencia y la violencia en el seno de la pareja.

Aborda la cuestión de la responsabilidad de la promoción de la salud mental ampliando la perspectiva tradicional de a quién le corresponde y quién lo hace en la práctica o puede hacerlo en la mayor parte de las poblaciones. Presenta estrategias de acción y ejemplos prácticos tomados en gran medida de la experiencia de los propios autores en el Reino Unido y Australia. El artículo concluye con algunas ideas sobre cómo incluir la promoción de la salud mental en la agenda nacional y los temas que debería abordar.

H. Herrman y E. Jané-Llopis, p. 42

## La salud mental en el ámbito de la promoción de la salud y de la salud pública

■ La salud mental es “un estado de bienestar en el que la persona materializa sus capacidades, puede afrontar las tensiones de la vida cotidiana, trabajar de forma productiva y útil y contribuir a la buena marcha de la comunidad a la que pertenece” (OMS 2001a). Al igual que ocurre con la salud, la salud mental viene determinada por factores y experiencias personales, por la interacción social, por las estructuras y los recursos de cada sociedad y por los valores culturales. Los principales factores determinantes de la salud, como la pobreza, la falta de trabajo o la exclusión social tienen consecuencias en la salud física y mental. Por lo tanto, la salud mental se halla íntimamente relacionada con la física y con la conducta del individuo puesto que “la salud no es simplemente la ausencia de enfermedad o dolencia”, sino más bien, “un estado de bienestar físico, mental y social completo” (OMS, 2001). Los vínculos entre salud física y mental son

bidireccionales. Una mala salud física incide negativamente en la salud mental, de la misma manera que una salud mental deficiente reduce la salud física de la persona. Por ejemplo, la desnutrición en el lactante puede aumentar los riesgos de déficit en su sistema cognitivo y motor. Asimismo, la sensación de impotencia y la depresión se relacionan con una disminución de la actividad inmunológica y un aumento del riesgo de la aparición de tumores e infecciones.

En este contexto, la promoción de la salud mental es una parte integral de la promoción de la salud y de la salud pública. Las relaciones entre salud física y mental significan que el desarrollo y la ejecución de la promoción de la salud tienen resultados de salud múltiples. Por ejemplo, las intervenciones que promueven la salud en el inicio de la vida y la mejora del peso al nacer han conseguido múltiples beneficios en la

salud física y mental de dichos lactantes y efectos de tipo social y económico. Se señala que en general, las intervenciones que pretenden aumentar la resistencia (elasticidad) y promover la participación comunitaria entre las personas afectadas por los determinantes de la salud deficiente tienen muchas posibilidades de conseguir una mejora de la salud física y mental y reducir su vulnerabilidad a los trastornos mentales.

El artículo expone la definición de salud mental y hace la distinción entre estrategias de prevención y de promoción, todo ello dentro del marco más amplio de la salud pública. Se argumenta a favor de la integración de las actividades de promoción de la salud mental dentro de la promoción de la salud, al tiempo que se defiende que la defensa de los postulados de salud mental debería diferenciarse de las otras actividades de abogacía en materia de salud.

## ¿Que determina la eficacia en la promoción de la salud mental?

■ Este artículo examina la adopción e implementación de intervenciones eficaces para la promoción de la salud mental en distintos entornos y en países con situaciones económicas diversas. El artículo presenta una serie de determinantes de la salud mental que se abordan en intervenciones de promoción en distintos entornos, el hogar, la escuela, en el lugar de trabajo y en la comunidad. Basándose en el resumen de la evidencia presentada en este volumen, este artículo presenta los principios clave que determinan y sustentan el éxito en la implementación de programas y sus

resultados basándose en sus implicaciones para la práctica y diseño de políticas. Algunos de estos principios de funcionamiento son especialmente aplicables a un entorno concreto, como la adopción de un enfoque integral en una escuela, mientras otros son genéricos y relevantes para cualquier intervención, como la exigencia de calidad del proceso de ejecución. Al diseñar una estrategia de promoción de salud mental es indispensable tener en cuenta estos principios que incrementarán la posibilidad del éxito de las intervenciones. Aun así, todavía

existen vacíos en el conocimiento y existencia de evidencia así como en la traducción de la evidencia a la práctica. Por eso es esencial continuar aumentando la eficiencia de las intervenciones a través de la ejecución de intervenciones con múltiples resultados, incrementar la replicación y estudios de efectividad en países y culturas diversas, incluir análisis de coste-eficacia y evaluación de impacto a largo plazo, estimular evaluación en todos los países creando partenariados con otras organizaciones y asegurar la sostenibilidad de las intervenciones.

**M. B. Mittelmark, p. 55**

## ¿Por qué salud “mental”?

■ Dos constelaciones de profesionales que abogan por la promoción de la salud coexisten con escasa interacción entre ellos. La mayor de éstas la forman la orientación médica y el enfoque al tratamiento, que se concentran en la prevención primaria, secundaria y terciaria de los trastornos mentales. La menor de las constelaciones se orienta hacia la salud comunitaria con un

enfoque en la promoción de la salud mental de la población en general. El énfasis de esta última está en empoderar al paciente, la familia, el curador informal y la comunidad. Aquellos que abogan por reducir el peso de los trastornos mentales describen sus esfuerzos como “promoción de la salud mental”. Con lo cual, ambas constelaciones utilizan el mismo término, promoción de la salud

mental, para describir dos interpretaciones complementarias, pero distintas. Aumentar el vínculo entre ambas constelaciones es deseable, para que estén más al corriente de las perspectivas de cada una, con el fin de incrementar la motivación para trabajar sincronizadamente para reducir los trastornos mentales y mejorar la salud mental.



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The mission of the International Union for Health Promotion and Education (IUHPE) is to promote global health and contribute to the achievement of equity in health between and within countries of the world. The IUHPE fulfils its mission by building and operating an independent, global, professional network of people and institutions to encourage the free exchange of ideas, knowledge, know-how, experiences, and the development of relevant collaboration projects both at the global and regional levels. The work of the IUHPE includes: advocating for actions that promote health, improving and advancing the quality and effectiveness of practice, advancing knowledge, and developing capacity globally, regionally and locally to do health promotion and health education.

The IUHPE comprises the following membership categories: Trustee Members (organisations of national scope which are responsible for organising and/or supporting health promotion and health education in their country, state, province, region, or equivalent level), Institutional Members (organisations of international, national, or local scope, one of whose main purposes is to undertake, or promote one or more aspects of health promotion and health education, and/or which focus on specific themes, target groups, or settings), Individual Members (individuals who support the mission, goals, and objectives of the IUHPE), and Honorary Members (an individual or organisation who makes a special contribution to the mission of the IUHPE, or to the development of its goals and objectives may be invited to be an Honorary Member).

La mission de l'Union internationale de Promotion de la Santé et d'Éducation pour la Santé (UIPES) est de promouvoir la santé dans le monde, et de contribuer à la réduction des inégalités de santé, à l'intérieur des pays, et entre les pays. L'UIPES remplit sa mission en organisant et en animant un réseau mondial, professionnel et indépendant, de personnes et d'institutions, en vue de favoriser le partage des idées, des savoirs, des savoir-faire et des expériences, ainsi que le développement de projets coopératifs, au niveau mondial, ou entre les pays et les régions. L'activité de l'UIPES consiste à : plaider pour la mise en place d'actions de promotion de la santé, faire progresser la qualité et l'efficacité de la promotion de la santé et de l'éducation pour la santé à travers leur pratique et les connaissances acquises, et développer la capacité des pays à entreprendre des programmes de promotion de la santé et d'éducation pour la santé. L'UIPES se compose des catégories de membres suivantes : Membres Administrateurs (les organisations nationales qui ont la responsabilité d'organiser ou de renforcer la promotion de la santé et l'éducation pour la santé dans leur pays, état, province, région ou niveau équivalent), Membres Institutionnels (les organisations internationales, nationales ou locales dont l'un des buts principaux est de mettre en œuvre ou de promouvoir un ou plusieurs aspects de la promotion de la santé et de l'éducation pour la santé, et/ou qui concentrent leur activité sur des thèmes, des groupes cibles ou des lieux de vie spécifiques), Membres Individuels (les personnes qui soutiennent la mission, les buts et les objectifs de l'UIPES), et Membres d'Honneur (une personne ou une organisation contribuant d'une manière spéciale à la réalisation de la mission de l'UIPES peut être invitée à devenir Membre d'Honneur).

La misión de la Unión Internacional de Promoción de la Salud y Educación para la Salud (UIPES) es promover la salud mundial y contribuir a la consecución de la igualdad entre los países del mundo y en el seno de los mismos en materia de salud. La UIPES lleva a cabo su misión creando y gestionando una red independiente, mundial y profesional de personas e instituciones que fomenta el libre intercambio de ideas, de conocimientos, de experiencias y el desarrollo de proyectos de colaboración relevantes tanto a nivel mundial como regional. La actividad de la UIPES consiste en : explicar públicamente las actuaciones que promueven la salud de las poblaciones en todo el mundo ; mejorar y aumentar la calidad y la eficacia de la práctica y de la teoría de la promoción de la salud y de la educación para la salud ; y contribuir al desarrollo de las capacidades de los países que emprenden actividades de promoción de la salud y de educación para la salud. Los miembros de la UIPES se dividen en las siguientes categorías : Miembros Administradores (aquellas organizaciones de índole nacional responsables de la organización o apoyo de la promoción de la salud y de la educación para la salud en su país, estado, provincia, región o nivel equivalente), Miembros Institucionales (aquellas organizaciones de índole internacional, nacional o local, entre cuyas finalidades esenciales se encuentre la provisión o promoción de uno o más de los aspectos de la promoción de la salud y la educación para la salud (centrados en temas y/o grupos de población o lugares de vida específicos), Miembros Individuales (individuos que apoyan la misión, las metas y los objetivos de la UIPES), y Miembros de Honor (un individuo u organización que haga una aportación especial al cometido de la UIPES, o al desarrollo de sus fines y objetivos puede ser invitado a convertirse en un Miembro de Honor).

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