Promoting Mental Health

CONCEPTS ▪ EMERGING EVIDENCE ▪ PRACTICE

**A Report of the
World Health Organization,
Department of Mental Health and Substance Abuse
in collaboration with
the Victorian Health Promotion Foundation
and
The University of Melbourne**

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Editors:
Helen Herrman
Shekhar Saxena
Rob Moodie

World Health
Organization

Foreword

The World Health Organization (WHO) embraces a definition of health as "physical, mental, and social well-being". Of these elements, mental well-being historically has been misunderstood and often forgotten. WHO has spent the last five years actively addressing the barriers that prevent access to mental health care and campaigning for the full incorporation of mental health in world-wide public health. Thanks greatly to their hard work, mental health now ranks as a priority within the international health and development agenda. Governments across the world and health professionals across the disciplines are now more aware of the importance of mental health issues to the overall health of individuals, communities, cities, and even entire nations.

Promoting Mental Health: Concepts, Emerging Evidence, Practice clarifies the concept of mental health promotion and is a potent tool for guiding public officials and medical professionals in addressing the behavioural health needs of their societies. It presents striking evidence that there is a strong link between the protection of basic civil, political, economic, social, and cultural rights of people and their mental health. In these times, when conflicts between individuals and communities are on the increase and economic disparities are widening, this message is especially relevant. Good mental health goes hand in hand with peace, stability and success, and *Promoting Mental Health* presents a powerful case for including mental health promotion in the public health policies of all countries.

WHO recognizes that besides the vital need for expanding services to those who currently receive none, prevention of mental disorders and vigorous promotion of healthy behaviours are critical for decreasing the international burden of mental illnesses and for helping people to realize their full potential. WHO's efforts include international reviews of scientific evidence for interventions; wide dissemination of evidence, particularly in lower and middle income countries; and assisting governments and non-governmental organizations in using the evidence to develop actual programmes.

Promoting Mental Health: Concepts, Emerging Evidence, Practice emphasizes that everyone has a role and responsibility in mental health promotion and encourages integrated participation from a variety of sectors such as education, work, environment, urban planning and community development as the best way to make the most positive improvement in people's mental health. It appropriately focuses on resource-poor settings; however, money is not the key determinant to ensure good mental health. Awareness and active involvement by each member of the community often have the greatest impact.

I congratulate WHO on this excellent work and urge policy-makers the world over to use this important information to effect real improvement in the mental health and well-being for all their people.

Rosalynn Carter

Chair, Mental Health Task Force

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Foreword

 "… not merely the absence of disease or infirmity."

"… attainment by all people of the highest possible level of health."

"… to foster activities in the field of mental health, especially those affecting the harmony of human relations."

These objectives and functions of the World Health Organization (WHO) are at the core of our commitment to mental health promotion.

Unfortunately, health professionals and health planners are often too preoccupied with the imme- diate problems of those who have a disease to be able to pay attention to needs of those who are "well". They also find it difficult to ensure that the rapidly changing social and environmental conditions in countries around the world support rather than threaten mental health. This situa- tion is only partly based on the lack of clear concepts or of adequate evidence for effectiveness for health promoting interventions. This has much to do with how the professionals and planners are trained, what they see as their role in society and, in turn, what society expects them to do. In the case of mental health, this also has to do with our reluctance to discuss mental health issues openly.

Promoting Mental Health: Concepts, Emerging Evidence, Practice is WHO's latest initiative to over- come these barriers. It describes the concept of mental health and its promotion. It tries to arrive at a degree of consensus on common characteristics of mental health promotion as well as variations across cultures. It also positions mental health promotion within the broader context of health promotion and public health. The evidence provided for the health and non-health interventions for mental health benefits is likely to be useful to health policy planners and public health professionals. The emphasis, however, is on the urgent need for a more systematic genera- tion of evidence in the coming years, so that a stronger scientific base for further planning can be developed.

Prevention of mental disorders and promotion of mental health are distinct but overlapping aims. Many of the interventions discussed in this report are also relevant for prevention. However, the scope as well as the target audience is considered much wider for mental health promotion. For this reason, WHO is releasing this report on promotion separately from a forthcoming report on the evidence for prevention of mental disorders.

I trust that the present full report, along with the summary report released earlier, will create a more definite place for mental health promotion within the broader field of health promotion and will be useful for the countries that WHO serves.

Dr Catherine Le Galès-Camus

Assistant Director-General

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Preface

Promoting Mental Health: Concepts, Emerging Evidence, Practice aims to bring to life the mental health dimension of health promotion. The promotion of mental health is situated within the larger field of health promotion, and sits alongside the prevention of mental disorders and the treatment and rehabilitation of people with mental illnesses and disabilities. Like health promotion, mental health promotion involves actions that allow people to adopt and maintain healthy lifestyles and create living conditions and environments that support health. This book describes the concepts relating to promotion of mental health, the emerging evidence for effectiveness of interventions and the public health policy and practice implications. It complements the work of another major WHO project focusing on the evidence for prevention of mental illnesses.

Many within and outside the fields of mental health and health promotion recognize a need to assemble, review and generate evidence about the tangible benefits of mental health promotion. This includes evidence on the relationship between social and cultural factors and the mental health of individuals and communities. This book reviews the available evidence from a range of countries and cultures. It documents how actions such as advocacy, policy and project development, legislative and regulatory reform, communications, research and evaluation may be achieved and monitored in countries at all stages of economic development. It considers strategies for continued growth of the evidence base and approaches to determining cost-effectiveness of actions. International cooperation and alliances will play a critical role in generating and applying the evidence by encouraging the social action required and monitoring the impact on mental health of a range of policies and practices.

Promoting Mental Health: Concepts, Emerging Evidence, Practice has been written for people working in health and non-health sectors whose decisions affect mental health in ways that they may not realize. It is also a sympathetic account for people in the mental health professions who need to endorse and assist the promotion of mental health while continuing to deliver services for people living with mental illnesses. It is relevant to people working to develop policies and programmes in countries with low, medium and high levels of income and resources, as well as those concerned with guidelines for international action. It uses a public health framework to address the dilemma of competing priorities that concerns planners and practitioners in low income as well as affluent settings.

Promoting Mental Health: Concepts, Emerging Evidence, Practice is the result of collaboration with scientific contributors from sectors outside as well as within health. The editors consulted a group of senior project advisers and contacted a wide group of interested people and organizations: professional, government, nongovernment and others. The aims of the project were to facilitate a better understanding of the evidence and approaches to gathering local evidence, activation of the scientific community and growth in international cooperation and alliances.

The book is divided into three parts. Part One introduces the topic and describes a number of concepts associated with health, health promotion and mental health, as well as their use across different cultures, countries and subpopulations. In Chapter 1, the introduction, we identify a new enthusiasm for mental health as a public health priority, and describe how international collaboration is crucial to stimulate much needed interest in mental health promotion. Chapter 2 sketches the landscape of health promotion. Since we consider mental health promotion as a subset of health promotion, this information is likely to be useful in our examination of the concept of mental health promotion. Chapter 3 discusses the concept of positive mental health and how our understanding of it has changed over time. The intrinsic value of mental health to individuals, families, communities and nations is discussed in Chapter 4, which also includes a discussion on the spiritual dimensions of mental health. How the concepts of mental health and mental health promotion may differ

in different contexts across the world is taken up in Chapter 5, where the point is made that before engaging in mental health promotion in any community it is first necessary to understand that particular community's understanding of mental health. The concept of social capital has been of great interest to researchers across a number of disciplines in recent years, and the relationship between social capital and mental health is the focus of Chapter 6. Our view is that mental health is inextricably linked with human rights and these links are discussed in Chapter 7, which gives an overview of the international human rights framework and discusses some of the groups particularly vulnerable to human rights violations. Chapter 8 describes how a framework for mental health promotion can bring the concepts already discussed together to guide actions to address the determinants of mental health.

Part Two focuses on evidence for mental health promotion. It begins with examining the nature of evidence in mental health promotion (Chapter 9) and then considers the available evidence in two specific areas – social determinants (Chapter 10) and the interface with physical health and illness (Chapter 11). Chapter 12 reviews the literature on indicators for mental health promotion and identifies their strengths and weaknesses. The next chapter (13) reviews the evidence on effectiveness of interventions using available information from the published literature. Since this evidence most often comes from high income developed countries, a separate chapter (14) focuses on evidence accumulating in developing countries where interventions are most urgently needed. Since it is clearly recognized that the available evidence is limited in scope, even while sufficient to prompt national and international action, Chapter 15 describes the way forward for generating further evidence on determinants of mental health and the effectiveness and cost-effectiveness of interventions.

Part Three takes the concepts and evidence forward to examine and suggest actions for policy and practice that serve the needs of mental health promotion. Since national mental health policy often forms the blueprint for all actions in this area, Chapter 16 describes how mental health promotion can and should be an important component of policy. This is followed by a chapter (17) that traces the historical basis for mental health promotion within international charters and comments on the relevance and limitations of these approaches for policy and practice. Since community development can provide an important strategy for promoting mental health, Chapter 18 describes one such model being implemented in a low income country to illustrate a successful example. Sustainability of interventions is a serious issue in all health promotion programmes; it is examined with relevance to mental health promotion in Chapter 19 and some lessons drawn. Chapter 20 emphasizes the importance of intersectoral approaches in developing and implementing mental health promotion programmes by giving examples from several relevant sectors.

Finally, Chapter 21 draws conclusions and key messages from the material presented in the earlier chapters and proposes a way forward to make evidence-based mental health promotion a reality.

As we worked on this project, we became aware of the richness of information available about programmes of proven effectiveness in the area of mental health promotion, as well as the limitations and shortcomings of the evidence in areas of greatest need. We believe there is much that can be done by countries and communities within the available financial and human resources to advance mental health promotion. We will feel rewarded in our efforts if the information provided in the chapters that follow encourages action and programmes to enhance mental health across the world, as well as stimulates further research.

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Key messages

There is no health without mental health

The World Health Organization (WHO) defines health as:

> … *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*

Mental health is clearly an integral part of this definition. The goals and traditions of public health and health promotion can be applied just as usefully in the field of mental health as they have been in heart health, infectious diseases and tobacco control.

Mental health is more than the absence of mental illness: it is vital to individuals, families and societies

Mental health is described by WHO as:

> … *a state of well-being in which the individual realizes 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.*

In this positive sense mental health is the foundation for well-being and effective functioning for an individual and for a community. This core concept of mental heath is consistent with its wide and varied interpretation across cultures.

Mental health is determined by socioeconomic and environmental factors

Mental health and mental illnesses are determined by multiple and interacting social, psychological and biological factors, just as health and illness in general. The clearest evidence for this relates to the risk of mental illnesses, which in the developed and developing world is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and low income. The greater vulnerability of disadvantaged people in each community to mental illnesses may be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health.

Mental health is linked to behaviour

Mental, social and behavioural health problems may interact so as to intensify their effects on behaviour and well-being. Substance abuse, violence, and abuses of women and children on the one hand, and health problems such as heart disease, depression and anxiety on the other, are more prevalent and more difficult to cope with in conditions of high unemployment, low income, limited education, stressful work conditions, gender discrimination, unhealthy lifestyle and human rights violations.

Mental health can be enhanced by effective public health interventions

The improvement in heart health in several countries has had more to do with attention to environment, tobacco and nutrition policies than with specific medicines or treatment techniques. The malign effects of changing environmental conditions on heart health have been reversed to varying extents by actions at multiple levels.

Similarly, research has shown that mental health can be affected by non-health policies and practices, for example in housing, education and child care. This accentuates the need to assess the effectiveness of policy and practice interventions in diverse health and non-health areas. Despite

uncertainties and gaps in the evidence, we know enough about the links between social experience and mental health to make a compelling case to apply and evaluate locally appropriate policy and practice interventions to promote mental health.

Collective action depends on shared values as much as the quality of scientific evidence

In some communities, time-honoured practices and ways of life maintain mental health even though mental health may not be identified as the outcome, or identified by name. In other communities, people need to be convinced that making an effort to improve mental health is realistic and worthwhile.

A climate that respects and protects basic civil, political, economic, social and cultural rights is fundamental to the promotion of mental health

Without the security and freedom provided by these rights it is very difficult to maintain a high level of mental health.

Intersectoral linkage is the key for mental health promotion

Mental health can be improved through the collective action of society. Improving mental health requires policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing and welfare, as well as specific activities in the health field relating to the prevention and treatment of ill-health.

Mental health is everybody's business

Those who can do something to promote mental health, and who have something to gain, include individuals, families, communities, commercial organizations and health professionals. Particularly important are the decision-makers in governments at local and national levels whose actions affect mental health in ways that they may not realize. International bodies can ensure that countries at all stages of economic development are aware of the importance of mental health to community development. They can also encourage them to assess the possibilities and evidence for intervening to improve the mental health of their population.

Part I
Concepts

Chapter 1 • Introduction: Promoting Mental Health as a Public Health Priority

Helen Herrman, Shekhar Saxena, Rob Moodie, Lyn Walker

> *Public health is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society (WHO, 1998a, p. 3).*
>
> *Health polices in the 21st century will need to be constructed from the key question…"What makes people healthy?" (Kickbusch, 2003, p. 386).*

What is mental health?

Since its inception, WHO has included mental well-being in the definition of health. WHO famously defines health as:

> … a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2001b, p.1).

Three ideas central to the improvement of health follow from this definition: mental health is an integral part of health, mental health is more than the absence of mental illness, and mental health is intimately connected with physical health and behaviour.

Defining mental health is important, although not always necessary to achieving its improvement. Differences in values across countries, cultures, classes and genders can appear too great to allow a consensus on a definition (WHO, 2001c). However, just as age or wealth each have many different expressions across the world and yet have a core common-sense universal meaning, so too can mental health be understood without restricting its interpretation across cultures. WHO has recently proposed that mental health is:

> … a state of well-being in which the individual realizes 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, 2001d, p.1).

In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. It is more than the absence of mental illness, for the states and capacities noted in the definition have value in themselves. Despite this, mental health is still portrayed by some as a luxury. The misunderstandings on which this view is based are now clearer than they were in the past, and WHO and other international organizations identify the improvement of mental health as a priority concern for low and middle income countries as well as for wealthier nations and people (WHO, 2001b).

Neither mental nor physical health can exist alone. Mental, physical and social functioning are interdependent. Furthermore, health and illness may co-exist. They are mutually exclusive only if health is defined in a restrictive way as the absence of disease (Sartorius, 1990). Recognizing health as a state of balance including the self, others and the environment helps communities and individuals understand how to seek its improvement.

Towards a new public health

Public health in modern times has a broad scope as the organized global and local effort to promote and protect the health of populations and to reduce health inequalities. This ranges from the control of communicable diseases – the original impetus for public health work – to the leadership of intersectoral efforts to promote health (Beaglehole, 2003). The new public health is

a social and political concept, aimed at improving health, prolonging life and improving the quality of life among whole populations. It works through health promotion, disease prevention and other forms of health intervention (WHO, 1998a).

Health promotion has had new prominence in recent decades. Its strategies are based on the question of how health is created, and it aims to offer people more control over the determinants of their health. The priority this gives to investing in the determinants of health is matched by the increasing focus on health outcomes around the world. The concept of ecological public health has also emerged. It emphasizes the common ground between achieving health and sustainable development, focusing on the economic and environmental determinants of health (WHO, 1998a).

Several key thinkers in the last two decades have influenced public health practice. Marmot, in his work with Wilkinson on the social determinants of health, noted that it is possible to alter "the impact of the social environment on health, as represented by social inequalities in health" (Marmot & Wilkinson, 1999, p. 3). Specific social determinants of health can be characterized and their effects studied. It is then potentially possible to affect these determinants with a consequent impact on health. Syme (1996) noted the importance of distinguishing between individual risk factors and environmental causes of disease. Rose (1992) suggested that the causes of individual differences in disease may not be the same as the causes of differences between populations. These population determinants are the focus of much of the new public health and health promotion work.

The report of the Commission on Macroeconomics and Health, published by WHO in 2001, supports the economic as well as humanitarian value of improving the health of poor and disadvantaged populations in all countries. Since the determinants of health and the most powerful means for health improvement are located at the global and regional levels, and since most public health work lies outside the conventional market framework and remains the responsibility of government, its "public good" nature can be stressed and is gaining acceptance. Reducing health inequalities requires action on the underlying structural determinants of social and economic deprivation and serious intersectoral action is required (Beaglehole & Bonita, 2003). Beaglehole and Bonita call for better education of public health practitioners to give them the skills for this type of work.

A new enthusiasm for promoting mental health

Along with enthusiasm for the new public health, over the past 20 years the interest in promoting mental health has grown (Friedli, 2002; Secker, 1998; Trent & Reed, 1992–6; Tudor, 1996; WHO, 1981, 2002). The fields of mental health and public health have a long history of weak interactions, despite the possibilities for a stronger working relationship (Cooper 1990; Goldberg & Tantam, 1990; Goldstein, 1989). This relates mainly to the stigma of mental illness, and vagueness in the concepts of mental health and mental illness. The interest has grown recently for two main reasons. First, mental health is increasingly seen as fundamental to physical health and quality of life and thus needs to be addressed as an important component of improving overall health and well-being. The concept of health enunciated by WHO as encompassing physical, mental and social well-being is more and more seen as a practical issue for policy and practice. In particular, there is growing evidence to suggest interplay between mental and physical health and well-being and outcomes such as educational achievement, productivity at work, development

of positive personal relationships, reduction in crime rates and decreasing harms associated with use of alcohol and drugs. It follows that promoting mental health through a focus on key determinants should not only result in lower rates of some mental disorders and improved physical health but also better educational performance, greater productivity of workers, improved relationships within families and safer communities.

Second, there is wide acknowledgement of an increase in mental ill-health at a global level. The authoritative work undertaken by WHO and the World Bank indicates that by the year 2020 depression will constitute the second largest cause of disease burden worldwide (Murray & Lopez, 1996). The global burden of mental ill-health is well beyond the treatment capacities of developed and developing countries, and the social and economic costs associated with this growing burden will not be reduced by the treatment of mental disorders alone (WHO, 2001c). Evidence also indicates that mental ill-health is more common among people with relative social disadvantage (Desjarlais et al., 1995).

The global focus on mental ill-health has sparked interest in the possibilities for promoting mental health as well as preventing and treating illness. There is a need to ensure that appropriate care and treatment is in place for those experiencing mental ill-health while at the same time developing a greater focus on promotion of mental health and prevention of illness, and giving priority to each of these in global, national and local policy and practice. Many policy-makers, practitioners and academics working in public health are committed to addressing health inequalities resulting not only from biological and behavioural characteristics but also from a maldistribution of resources. Consequently, health promotion, including the promotion of mental health and well-being, is as much an emerging political and social project as a health project (Mittelmark, 2003).

Promoting mental health is an integral part of public health

Mental health and mental illness are determined by multiple and interacting social, psychological and biological factors, just as are health and illness in general. The clearest evidence relates to the risks of mental illness, which in the developed and developing world are associated with indicators of poverty, including low levels of education. The association between poverty and mental disorders appears to be universal, occurring in all societies irrespective of their levels of development. Factors such as insecurity and hopelessness, rapid social change and the risks of violence and physical ill-health may explain this greater vulnerability (Patel & Kleinman, 2003). Economic levels also have important implications for family functioning and child mental health (Costello et al., 2003; Rutter, 2003).

Mental, social and behavioural health problems may interact to intensify each other's effects on behaviour and well-being. Substance abuse, violence and abuses of women and children on the one hand, and health problems such as heart disease, depression and anxiety on the other, are more prevalent and more difficult to cope with in conditions of high unemployment, low income, limited education, stressful work conditions, gender discrimination, unhealthy lifestyle and human rights violations (Desjarlais et al., 1995, p. 6).

Mental health for each person is affected by individual factors and experiences, social interaction, societal structures and resources and cultural values. It is influenced by experiences in everyday life, in families and schools, on streets and at work (Lahtinen et al., 1999; Lehtinen, Riikonen & Lahtinen, 1997). The mental health of each person in turn affects life in each of these domains

and hence the health of a community or population. Some of the newest research across the disciplines of genetics, neuroscience, the social sciences and mental health involves elaborations of ideas about the impact societies have on human life over and above the sum of the impact of the individual members of the society (as discussed in Chapter 10).

Ethnographic studies show how people living in adverse environments and social settings such as the slums of Mumbai are faced with problems such as migration and displacement, poor conditions, unequal distribution of amenities, demolition of housing, homelessness and communal and ethnic disharmony. These in turn shape local experience and affect the mental health of the inhabitants and the community. Hopelessness, demoralization, addictions, distress, anger, depression, hostility and violence can all be linked back to these experiences and problems (Parkar, Fernandes & Weiss, 2003).

Despite this, mental health and mental illness are largely viewed as residing outside the public health tradition with its fundamental concepts of health and illness as multifactorial in origin (Cooper, 1993) and of there being a continuum between health and illness (Rose, 1992). The consequences are twofold. First, the opportunities for improving mental health in a community are not fully exploited. Second, organized efforts by countries to reduce the social and economic burden of mental illnesses tend to focus mostly on the treatment of ill individuals.

Mental illnesses are common and universal. Worldwide, mental and behavioural disorders represented 11% of the total disease burden in 1990, expressed in terms of disability-adjusted life years (DALYs). This is predicted to increase to 15% by 2020. Depression was the fourth largest contributor to the disease burden in 1990 and is expected to be the second largest after ischaemic heart disease by 2020 (WHO, 2001c). Mental health problems also result in a variety of other costs to the society (WHO, 2003). Yet mental illness and mental health have been neglected topics for most governments and societies. Recent data collected by WHO demonstrates the large gap that exists between the burden caused by mental health problems and the resources available in countries to prevent and treat them (WHO, 2001a). In contrast to the overall health gains of the world's populations in recent decades, the burden of mental illness has grown (Desjarlais et al., 1995; Eisenberg, 1998).

This neglect is based at least in part on confusion and false assumptions about the separate concepts of mental health and mental illness. Until now, the prevailing stigma surrounding mental illness has encouraged the euphemistic use of the term "mental health" to describe treatment and support services for people with mental illness. This usage adds to confusion about the concept of mental health as well as that of mental illness.

In most parts of the world the treatment of mental illness was alienated from the rest of medicine and health care at least until recently. In the isolated setting of asylums, practitioners saw many seemingly incurable patients. The supposed incurability of insanity and melancholy made practitioners believe the causes were entirely biological. The idea has since persisted that prevention of mental illness is "all or none" (Cooper, 1990). This concept of an irreversible process once a person becomes ill leads to a sense of therapeutic nihilism as well as a belief that prevention is either absolute and one-dimensional or unlikely to succeed at all. Furthermore, the promotion of mental health is sometimes seen as far removed from the problems of the "real world" and there are concerns it could shift resources away from the treatment and rehabilitation of people affected by mental illness.

The twin aims of improving mental health and lowering the personal and social costs of mental ill-health require a public health approach.[1] Within a public health framework, the activities that can improve health include the promotion of health, the prevention of illness and disability, and the treatment and rehabilitation of those affected. These are different from one another, even though the actions and outcomes overlap. They are all required, are complementary, and no one is a substitute for the other.

Mental health is more than the absence of mental illness

As already noted, mental health implies fitness rather than freedom from illness. In 2003, George Vaillant in the USA commented that mental health is too important to be ignored and needs to be defined. As Vaillant pointed out, this is a complex task. "Average mental health" is not the same as "healthy", for averaging always includes mixing in with the healthy the prevailing amount of psychopathology. What is healthy sometimes depends on geography, culture and the historical moment. Whether one is discussing state or trait also needs to be clear – is an athlete who is temporarily disabled with a fractured ankle healthy or unhealthy? Similarly, is an asymptomatic person with a history of bipolar affective disorder healthy or unhealthy? There is also "the two-fold danger of contamination by values" (Vaillant, 2003, p. 1374) – a given culture's definition of mental health can be parochial, and, even if mental health is "good", what is it good for? The self or the society? For fitting in or for creativity? For happiness or for survival? Even so, Vaillant advocates that common sense should prevail and that certain elements have a universal importance to mental health; just as despite every culture having its own diet, the importance of vitamins and the five basic food groups is universal.

No health without mental health: mental health and behaviour

Physical health and mental health are closely associated through various mechanisms, as studies of the links between depression and heart and vascular disease are demonstrating (see Chapter 11). Many studies since the 1950s support the idea that medically ill patients with negative attitudes have worse outcomes than those with more positive attitudes. Now studies demonstrate that healthy people who are optimistic have lower death rates from heart disease than those who are pessimistic, even taking other risk factors into account (Giltay et al., 2004). The relevance of emotional status to the maintenance of good physical health and recovery from physical illness is now well substantiated, as is the converse.

Physical ill-health is detrimental to mental health as much as poor mental health contributes to poor physical health (Herrman & Jané-Llopis, in press). For example, malnourishment in infants can increase the risks of cognitive and motor deficits, and heart disease and cancer can increase the risk of depression (Blane et al., 1996; Marmot & Wilkinson, 1999). Strong evidence establishes depression as a risk factor for heart disease, and some national health policies now assert that the causal link is undeniable. The importance of short-term mental stress as a trigger for the

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[1] A number of books and articles have discussed this point. For example: CDHAC, 2000; Christodoulou, Lecic-Tosevski & Kontaxakis, 1999; Goldberg & Tantam, 1990; HEA, 1997; Healthy Living, 2003; Herrman, 2001; Hosman, 2001; Jenkins, 2001; Jenkins & Ustun, 1998; Lehtinen, Riikonen & Lahtinen, 1997; Mrazek & Haggerty, 1994; Newton, 1988; Paykel & Jenkins, 1994; Rowling, Martin & Walker, 2002; Sartorius, 1998, 2002; Secker, 1998; VicHealth, 1999, 2005; Walker, Moodie & Herrman, 2004; and WHO, 1998b.

development of myocardial infarction and sudden death in people with heart disease is no longer questioned. The notion that hypertension may arise through psychological stress, in turn related to occupational and other adverse factors in the environment, remains contentious, but the idea is an old one (Esler & Parati, 2004). Low control at work and poor social support have important influences on both physical health (e.g. cardiovascular morbidity) and psychological health (e.g. depression) (Kopp, Skrabski & Szedmák, 2000). Many of the people living with HIV/AIDS and their families experience stigma and discrimination as well as depression and anxiety and other mental illnesses (WHO, 2001c). Persistent pain is linked with suffering and lost productivity around the world. A WHO study across 15 centres in Asia, Africa, Europe and the Americas examined the relationship between pain and well-being in over 5000 individuals. Those with persistent pain were over four times more likely to have an anxiety or depressive disorder than those without pain (Gureje et al., 1998).

Research has pointed to two main pathways through which a person's mental and physical health and functioning mutually influence each other over time (WHO, 2001c), interacting with social and environmental influences on health. The first pathway is directly through physiological systems, such as neuroendocrine and immune functioning. The second pathway is through health behaviour. The term health behaviour covers a range of activities, such as eating sensibly, getting regular exercise and adequate sleep, avoiding smoking, engaging in safe sexual practices, wearing safety belts in vehicles and adhering to medical therapies. The physiological and behavioural pathways are distinct yet interact with one another and the social environment: health behaviour can affect physiology (for example, smoking and sedentary lifestyle decrease immune functioning) and physiological functioning can influence health behaviour (for example, tiredness leads to accidents). In an integrated and evidence-based model of health, mental health (including emotions and thought patterns) emerges as a key determinant of overall health. Anxious and depressed moods, for example, initiate a cascade of adverse changes in endocrine and immune functioning and increase susceptibility to a range of physical illnesses. For instance, stress is related to the development of the common cold (Cohen, Tyrrell & Smith, 1991) and delays wound healing (Kielcot-Glaser et al., 1999).

While many questions remain concerning the specific mechanisms of these relationships, it is clear that poor mental health plays a significant role in diminished immune functioning, the development of certain illnesses and premature death. As WHO points out:

> Understanding the determinants of health behaviour is particularly important because of the role that health behaviour plays in shaping overall health status. Noncommunicable diseases such as cardiovascular disease and cancer … are strongly linked to unhealthy behaviour such as alcohol and tobacco use, poor diet and sedentary lifestyle. Health behaviour is also a prime determinant of the spread of communicable diseases such as AIDS, through unsafe sexual practices and needle sharing …
>
> The health behaviour of an individual is highly dependent on that person's mental health. Thus, for example, mental illness or psychological stress affect health behaviour (WHO, 2001c, p. 9).

In young people, depression and low self-esteem are linked with smoking, binge drinking, eating disorders and unsafe sex, putting them at risk of a range of diseases including sexually transmitted diseases such as AIDS (Patton et al., 1998; Ranrakha et al., 2000). Depression in other age groups is linked with social isolation, alcohol and drug abuse and smoking (Hemenway, Solnick

& Colditz, 1993). Mood disorders can lead to an increased risk of accidents and injuries and poor physical and role function (Wells et al., 1989). Other factors such as learning through experience or observation also have an effect on health behaviour. For example, it has been established that drug use before the age of 15 years is highly associated with the development of drug and alcohol abuse in adulthood (Jaffe, 1995). Environmental influences, such as poverty or societal and cultural norms, also affect health behaviour (WHO, 2001c).

There are complex interactions between the determinants of health, behaviours and mental health at all stages of life. A body of evidence indicates that the social factors associated with mental ill-health are also associated with alcohol and drug use, crime and dropout from school. An absence of the determinants of health and the presence of noxious factors also appears to have a major role in other risk behaviours, such as unsafe sexual behaviour, road trauma and physical inactivity. For example, a lack of meaningful employment may be associated with depression and alcohol and drug use. This may in turn result in road trauma, the consequences of which are physical disability and loss of employment (Walker, Moodie & Herrman, 2004). Kleinman (1999) describes the clustering of mental and social health problems in "broken communities" in shantytowns and slums and among vulnerable and marginal migrant populations: civil violence, domestic violence, suicide, substance abuse, depression and post-traumatic disorder cluster and coalesce. He calls for a research agenda and innovative policies and programmes "that can prevent the simply enormous burden that mental illness has on the health of societies resulting from the variety of forms of social violence in our era" (Kleinman, 1999, p. 979). The corollary is the need for the development and evaluation of programmes that on the one hand control and reduce such clusters and on the other hand assist people and families to cope in these circumstances.

A life-course approach helps in understanding social variations in health and mental health. Exposure to experiences and environments accumulate throughout life, increasing the risk of adult morbidity and premature death if they are disadvantageous. Exposure to health-damaging environments during adulthood may accumulate on top of health disadvantage during childhood (Holland et al., 2000). This approach takes into account the complex ways in which biological, economic, social and psychological factors interact in the development of health and disease. Such an approach reveals biological and social "critical periods" during which policies that will defend individuals against an accumulation of risk are particularly important. The policies of modern "welfare states" can be seen to contribute in many ways to present-day high standards of health overall in developed countries (Bartley, Blane & Montgomery, 1997).

The evidence is clear: mental health is fundamentally linked to physical health outcomes. Mental health status is a key consideration in changing the health status of a community. Health and behaviour are influenced by factors at multiple levels, including biological, psychological and social. Interventions that involve only the individual, such as training in social skills or self-control, are unlikely to change long-term behaviour unless family, work and broader social factors are aligned to support a change (Institute of Medicine, 2001).

Objectives and actions of mental health promotion

This [20th] century has seen greater gains in health for the populations of the world than at any other time in history. These gains have been made partly as a result of improvements in income and education, with accompanying improvements in nutrition, hygiene, housing, water supply and sanitation. They are also the result of new knowledge about the causes, prevention and

treatment of disease and the introduction of policies that have made intervention programmes more accessible. The greatest advances in health have been made through a combination of structural change and the actions of individuals (Nutbeam, 2000, p.1).

Effective health promotion leads to changes in the determinants of health (Nutbeam, 2000, p. 3).

Health promotion is an approach to improving public health that requires broad participation. It may be understood as actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain healthy lives and those that create living conditions and environments that support health (WHO, 1998a). Mental health promotion is an integral part of health promotion theory and practice. The interventions can be applied at population, subpopulation and individual levels, and across settings and sectors within and beyond the health field (Walker & Rowling, 2002).

The personal, social and environmental factors that determine mental health and mental illness may be clustered conceptually around three themes (HEA, 1997; Lahtinen et al., 1999; Lehtinen, Riikonen & Lahtinen, 1997):

■ *the development and maintenance of healthy communities*

  This provides a safe and secure environment, good housing, positive educational experiences, employment, good working conditions and a supportive political infrastructure; minimizes conflict and violence; allows self-determination and control of one's life; and provides community validation, social support, positive role models and the basic needs of food, warmth and shelter.

■ *each person's ability to deal with the social world through skills like participating, tolerating diversity and mutual responsibility*

  This is associated with positive experiences of early bonding, attachment, relationships, communication and feelings of acceptance.

■ *each person's ability to deal with thoughts and feelings, the management of life and emotional resilience*

  This is associated with self-esteem, the ability to manage conflict and the ability to learn.

The fostering of these environmental, social and individual qualities, and the avoidance of the converse, are the objectives of mental health promotion. In each nation or community, local opinion about the main problems and potential gains as well as evidence about the social and personal determinants of mental health will shape the activities of mental health promotion.

As noted earlier, health promotion and prevention are necessarily related and overlapping activities: the former is concerned with the determinants of health and the latter focuses on the causes of disease. The evidence for prevention of mental disorders (Hosman & Jané-Llopis, 2005; Jane-Llopis, in press) contributes to the evidence for the promotion of mental health. The evidence for effectiveness of mental health promotion is also being extended through evaluation of experience in different countries and settings. This gives growing confidence to develop and evaluate interventions, even while the principle of prudence (see Chapter 2) recognizes that we can never know enough to act with certainty.

The actions that promote mental health will often have as an important outcome the prevention of mental disorders. The evidence is that mental health promotion is also effective in the prevention of a whole range of behaviour-related diseases and risks. It can help, for instance, in the

prevention of smoking or of unprotected sex and hence of AIDS or teenage pregnancy. Indeed, the potential contribution of mental health promotion to the prevention of health-damaging and anti-social behaviours is probably greater than its potential to prevent mental disorders (Orley & Weisen, 1998).

As already discussed, many of the activities of mental health promotion are sociopolitical: reducing unemployment, improving schooling and housing and working to reduce stigma and discrimination of various types. Other policy initiatives such as wearing seat belts to avoid head injury are designed to prevent illness and injury. The key agents are politicians, educators and members of nongovernment organizations. The job of mental health practitioners is to remind these agents of the evidence showing the importance of these key variables (Goldberg, 1998) and to assist them in introducing policies that lead to better mental health. Health practitioners may be more directly involved in prevention of illness, devising and applying programmes in primary health care and other settings, as well as working with communities to promote awareness of mental health.

A combined approach to health promotion and prevention of illness categorizes interventions according to the levels of risk of illness (or scope for improving health) in various population groups and makes it clearer what type of collective action is required (Eaton & Harrison, 1996; Mrazek & Haggerty, 1994). Interventions are categorized as either *universal* (directed to whole populations, e.g. good prenatal care), *selected* (targeted to subgroups of the population with risks significantly above average, e.g. family support for young, poor, first pregnancy mothers) or *indicated* (targeted at high-risk individuals with minimal but detectable symptoms, e.g. screening and early treatment for symptoms of depression and dementia).

The approach to gathering evidence is influenced by recognizing that (1) the evidence for direct causal pathways is generally strongest for the most immediate influences on health or disease; (2) most health states have multiple causes interacting over time (Desjarlais et al., 1995); and (3) important factors such as family environment will influence the level of physical and mental health as well as the risk for several types of illness in later life. Other life events and circumstances will interact favourably or unfavourably to contribute to health and resilience or the development of illness.

Mental health promotion has been seen to ask for peace, social justice, decent housing, education and employment. The call for intersectoral action has sometimes been diffuse (Kreitman, 1990) or characterized as lacking an evidence base. Specific evidence-based proposals with measurable outcomes are required. However, asking individual health promotion projects to demonstrate long-term changes in ill-health, productivity 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 (etiological 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. Further work is required to identify and document the mental health benefits of these changes, especially in the face of the complex interactions, and to develop indicators of these determinants. As discussed throughout the following chapters, an evidence base for mental health promotion does exist but it needs boosting with etiological research and programme and policy evaluation of various types.

International collaboration and the role of WHO

International collaboration is crucial for vigorous and successful advocacy as well as for the actions that follow. WHO is the lead international agency responsible for health and is increasingly recognizing the value of mental health. Its activities emanate from the definition of health given earlier. The WHO Constitution stipulates a number of core functions that include:

- "To foster activities in the field of mental health, especially those affecting the harmony of human relations"; and

- "To assist in developing an informed public opinion among all peoples on matters of health".

Numerous World Health Assembly (WHA) Resolutions have urged Member States to take steps to prevent mental illness and to promote mental health, and have requested the Director-General to provide information and guidance regarding suitable strategies (WHO, 2002). A resolution adopted in 2002 urged WHO to "facilitate effective development of policies and programmes to strengthen and protect mental health" (WHA55.10). It called for "coalition building with civil society and key actions in order to enhance global awareness-raising and advocacy campaigns on mental health".

The role of WHO in mental health promotion can be briefly summarized as follows.

- *To generate, review, compile and update evidence on strategies for mental health promotion, especially from low and middle income countries*

  Although there are numerous published studies on mental health promotion and from time to time efforts have been made to assimilate them, a comprehensive review of the literature related to evidence-based research in this area has not been available. This volume and the accompanying work on prevention of mental disorders are an attempt to fill this gap. The evidence for the effectiveness of mental health promotion is least available in areas that have the maximum need, such as in low and middle income countries and conflict areas where mental health is especially compromised. More efforts are needed to generate evidence from these settings. Attention also needs to be paid to strategies that have been found to be ineffective or inappropriate on the basis of all kinds of evidence. Information on these is useful in order to prevent wastage of precious resources.

- *To develop appropriate strategies and programmes*

  WHO can assist countries to develop and introduce appropriate strategies and programmes. Some of the factors to be considered are:

  - evidence of effectiveness

  - the principle of prudence

  - cultural appropriateness and acceptability

  - financial and personnel requirements

  - level of technological sophistication and infrastructure requirements

  - overall yield and benefit

  - potential for large-scale application.

- *To facilitate partnerships and collaboration*

   Mental health promotion requires the collective efforts of all organizations and sectors that may have a direct or indirect impact on mental health. At the international level these include professional associations, international organizations, national governments, nongovernment organizations, the health industry and prospective donors. WHO is well positioned to forge strategic links with all these bodies and to develop effective programmes for mental health promotion. International organizations with which WHO regularly collaborates in this area are the International Labour Office (ILO), the United Nations Children's Fund (UNICEF), the Office of the United Nations High Commissioner for Refugees (UNHCR) and the World Bank.

Mental health is everybody's business

The scope and outcomes of mental health promotion activities are potentially wide and difficult to grasp. At the conceptual level, mental health can be and should be defined broadly. At a more practical level, however, it is useful to distinguish between interventions that have the primary goal of improving the mental health of individuals and communities and others that are mainly intended to achieve something else but which enhance mental health as a side-benefit. Examples of the former are policies and programmes that improve parenting skills and encourage schools to prevent bullying. Policies and resources that ensure girls in a developing country attend school and programmes to improve public housing could be considered examples of the latter. This distinction helps allocate responsibilities. Monitoring the effect on mental health of public policies relating to housing and education is, for instance, becoming feasible (see Chapter 15). The mental health promotion programme or interests in a country or locality would need to advocate for this, watch that it occurs and help use the findings. Other groups will need to do the work, however, and ensure that policies and practices are shaped by the findings.

The activities of mental health promotion can be usefully mainstreamed with health promotion, although the advocacy needs to remain distinct. 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. Health and mental health are affected by policies of many different kinds and by a range of community interventions.

Various types of evidence suggest that mental health and its determinants can be improved in association with planned or unplanned changes in the social and physical environment. As will be discussed in the chapters that follow, sufficient justification exists for the implementation of programme and policy interventions to promote mental health. These need to be accompanied by evaluations of process and outcomes in countries of varying income levels. It is also clear that there is a need to monitor the effects on mental health of social, economic and environmental changes in any country. These actions in turn will continue to expand the evidence base to encourage further prudent interventions designed to improve or maintain mental health that will be suited to each unique time, country, locality and population.

Countries now have the technical base on which to build the political commitment to promote mental health. This also has a strong ethical foundation, an important pre-requisite for health action (Lee, 2003) at global and other levels. The moral values of equity and human rights, as well as humanitarianism and utilitarianism, can guide the policy choices and shape the programmes (Alkire & Chen, 2004), as described in the chapters to follow.

Promoting Mental Health: Lessons from Social Brain Research

Thomas R Insel

Over the past two decades, neuroscience research has transformed our understanding of the brain. Three insights have been fundamental. First, we now recognize the brain as a dynamic organ, capable of remarkable changes in how cells are connected and even in the number of cells available throughout life. Second, we recognize considerable individual variation in the relationship between brain anatomy and function. Classic maps of the cortex with specific areas for motor and sensory fields are still useful but only as a broad generalization that varies greatly across individuals. And finally, we now appreciate a stunning level of modularity in the brain, with circuits dedicated to highly specific functions, such as verbs versus nouns or animate versus inanimate objects.

While all three aspects of brain function are pertinent to the promotion of mental health, I will focus on the high degree of modularity with specific reference to how the brain processes social information. We tend to consider social information among the most highly complex forms of knowledge, requiring visual, auditory and even somatosensory processing. In fact, recognizing friend from foe, kin from predator, and mate from stranger are among the most basic forms of information for survival in the animal kingdom. No wonder then that many species, including many mammals, have developed extraordinary abilities to detect social information, usually in the olfactory domain (Insel & Fernald, 2004).

Humans, like other primates, are primarily visual rather than olfactory creatures. One particular area of the visual cortex appears to be essential for face recognition. Most people activate the fusiform area when looking at pictures of faces, but those with autism do not and those with schizophrenia appear to have a reduced volume of this region. People with strokes infarcting this region develop prosopagnosia, an inability to recognize faces. Connections from this area to a subcortical nucleus, the amygdala, are believed to be important for higher order decoding of faces, including the reading of emotion, non-verbal expressions and gaze.

In the past couple of years, a surprising set of studies in mice suggest that there may be a specific molecular as well as anatomic basis for social information. Studies in mice lacking the gene for oxytocin show a specific loss of social memory apparently without loss of any other aspect of cognition (Ferguson et al., 2000). Mice lacking oxytocin cannot distinguish familiar from novel mice. This neuropeptide hormone has been implicated in social behaviour including maternal care and pair bonding or attachment. Replacing oxytocin into the amygdala completely restores social cognition in mice lacking the oxytocin gene.

Few would doubt the importance of social interaction and in particular maternal bonding for the development of the mental health of the newborn. There may be critical time periods for development of bonding or attachment. The Nobel Laureate ethologist Konrad Lorenz described a critical period for social attachment in Greylag geese. In the hours after hatching, goslings form a preference for the first object they follow, usually the mother but, as Lorenz demonstrated, they can imprint on a human almost as easily. Studies of human orphans raised with a variety of institutional caretakers have reported persistent social deficits, akin to autism (Rutter et al., 2004). If these children are provided with a consistent caring foster parent in the first two years, there is no evident long-term deficit. Children who remain institutionalized for

longer periods may fail to recover full social abilities, just as infants who do not have their cataracts repaired in their first six months may not develop normal vision.

We do not know the brain mechanisms for critical periods in either the visual domain or the circuits for social information. However, recent studies in infant rats have suggested a potential mechanism by which the quality of infant care influences the "mental health" of offspring. Studies by Michael Meaney and his students have linked high levels of licking and grooming given by mothers to their pups to less stress responsiveness when they become adults compared to pups receiving less licking and grooming after birth (Meaney, 2001). Of course, this difference could reflect a genetic difference in the rats. Perhaps mothers with more licking and grooming behaviour gave birth to pups genetically less responsive to stress. However, cross-fostering experiments showed that it was indeed the maternal behaviour and not the biological mother that determined adult behaviour (Francis et al., 1999).

This decrease in stress responses seems to be due to increased numbers of receptors for glucocorticoids in the hippocampus. These receptors, which sense the circulating stress hormone corticosterone, serve as a brake on the brain's stress circuit. Therefore, more receptors mean less stress responsiveness (higher tolerance to stress). Licking and grooming appears to cause an enduring change in the glucocorticoid receptor gene – an "epigenetic modification" of the gene. Amazingly, this state change appears to occur within a critical period. Licking and grooming in the first six days postnatal, in ways we still do not understand, remove the methylation tag from this region of the receptor gene and allow the induction of gene expression, with a resulting lifelong increase in receptors and decrease in stress responsiveness (Weaver et al., 2004).

In this case, we are beginning to understand the molecular mechanisms by which early experience confers lasting changes in behaviour. It is certainly possible that an opposing process occurs in children who have been physically or sexually abused. We know that these children have increased stress responsiveness and have high baseline levels of stress hormones, such as corticotrophin releasing hormone (CRH). It seems highly likely that the chronic elevation of stress hormones has deleterious effects on the central nervous system, and this includes increasing the risk for major depressive disorder. A recent comparison of the outcome of drug treatment and cognitive behaviour therapy in depression found no significant effect of medication in the subgroup with a history of abuse, although this subgroup responded to psychotherapy (Nemeroff et al., 2003).

In summary, social neuroscience is revealing the mechanisms by which social experience influences the developing brain and how the brain, in turn, can process social information. Although one is tempted to suspect that molecular and cellular studies will only prove reductionistic, failing to capture the richness of behaviour, our experience in the past decade suggests just the opposite. Studies of the molecular and cellular mechanisms of social information have begun to reveal previously unexpected, counter-intuitive insights, from unique molecules for social memory to molecular consequences of maternal care. We have unprecedented traction in modern neuroscience. The task for the next decade will be to translate this traction towards the study of the treatment and prevention of mental disorders as well as mental health and its promotion.

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Chapter 2
Health Promotion: A Sketch of the Landscape

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Concepts of health

Health promotion is an emerging field of action, often referred to as the "new" public health (Baum, 1998). However, the term health promotion can have many meanings, depending on one's perspective (Tones & Tilford, 2001). The term "health" is itself imprecise (Naidoo & Wills, 2000). Health can refer both to absent and present states. It is often used to mean the absence of disease or disability but, just as often, may refer to a state of fitness and ability or to a reservoir of personal resources that can be called on when needed (Naidoo & Wills, 2000). People with different backgrounds may hold different conceptions of health and an individual may have different ideas about the meaning of health depending on the circumstances under which the matter is raised. It is beyond the scope of this chapter to review the discourses on the meanings of health and in any case excellent discussions are readily available (Baum, 1998; Lupton, 1995; Seedhouse, 1986; Seedhouse, 1997; WHO, 1998b). Here some of the main viewpoints on general health are mentioned to establish the context for this chapter. The more specific concept of "mental health" is discussed in more detail in the chapters that follow.

In prestige and command of resources a medical model of health is dominant (Lupton, 1995; Naidoo & Wills, 2000). It assumes that health is a property of beings that can be reduced to the smallest components of the body. It approaches the body and its parts as a machine that in its healthy state functions as designed. When the body malfunctions the person is said to be ill, the reasons for the malfunction are investigated and treatment to restore functioning is undertaken. Internal processes that have gone awry are classified as diseases and the correction of these through medical treatment processes restores health. The prevention of diseases is valued because it maintains health. Public health is work to prevent the spread of diseases in the general population.

There are alternatives to the view that health is defined by the absence of disease and illness, however. Seedhouse (1986) illustrates this by describing hypothetical people who each have a different perspective on what it means to be healthy. The perspective of Seedhouse's Medic is reflected in the paragraph above. To his Social Scientist, by way of contrast, to be healthy means to function in normal social roles. The Medic might well examine a prisoner and find him to be healthy, while the Social Scientist surely would not. This is because the Social Scientist equates health with autonomy and role fulfilment. In this view, to be healthy is to live under conditions that permit a person or a group to achieve realistic ambitions. Thus, while our prisoner is unhealthy in the Social Scientist's eyes, a person living their chosen way of life and managing their responsibilities could be judged to be healthy, even while living with medical diagnoses and treatments.

The most stimulating and controversial efforts to define health are found in the work of WHO. The WHO Constitution of 1946 defines health in the most general terms as a state of well-being and not only the absence of disease and disability. Tones and Tilford (2001, p. 2) captured well the spirit in which this has been received:

> [It] has served both as an inspiration to those subscribing to a holistic philosophy of life and an irritant to those faced with the practical and pressing demands of managing and preventing disease on a day-to-day basis!

The WHO Ottawa Charter of Health Promotion provides the most widely cited definition of health promotion (WHO, 1986). It places emphasis on the idea that the promotion of health is a process that requires broad participation:

> Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

This definition covers wide territory indeed, including as it does environmental and well as individual factors in the range of resources that define health. The obvious implication is that the promotion of health must have foci on both the individual and the environment. This calls for the involvement of a much broader array of interventions and actors than does the traditional medical model. Indeed, many of the determinants of health are beyond the control of the health care system, as described next.

Determinants of health

An individual's health is affected in part by the person's way of living – for example, whether or not they smoke tobacco products, consume too much fatty, sugary and salty food, and so forth (WHO, 2002b). However, other key determinants of health are not a matter of choice, such as one's gender and ethnicity. The Health Survey of England 1993–1996, for example, observed substantially poorer health among all minority ethnic groups compared to whites of working age and higher morbidity for many minority ethnic women compared to men in the same ethnic group (Cooper, 2002). In Brazil, black infants experience much worse health than white infants (Barrosa, Victorab & Hortac, 2001). In Africa, women have higher mortality rates than men and women in the sub-Saharan region have higher maternal mortality rates than other women in both developed and developing countries outside the region (Harrison, 1997).

An individual's health is also influenced by their access to social and development resources, such as education. Both formal and informal education is a critical factor affecting health. People with better education in general have better health than those who are poorly educated. An increase in education level among women improves not only their own health but also the health of their children (Harrison, 1997).

Housing is also a factor affecting health, with homelessness and housing conditions such as poor sanitation, crowding and inadequate ventilation clearly associated with respiratory infections, asthma, lead poisoning, meningitis, injuries and poor mental health (Howden-Chapman, 2002).

Social relations between individuals are also factors that influence or determine their health. An individual may learn from others and consequently adopt healthy or unhealthy lifestyles. There is also abundant evidence that social connectedness affects people's health. Social isolation and social stress lead to poor health, while social participation enhances health (Eng et al., 2002; Mittelmark, 1999b; Seeman, 1996).

Health is influenced also by one's economic and employment status. In Australia, it has been observed that chronic disease risk factors such as tobacco use, overweight, obesity and excess

alcohol consumption are more prevalent in the lower socioeconomic status (SES) groups than in the highest SES group (Hayen et al., 2002). In the USA, income level predicts mortality and poor people are less healthy than those who are better off (Wagstaff & van Doorslaer, 2000).

Another consistent finding is that unemployed people are less healthy and have higher mortality rates than those that have employment (Morris, 1994). There are suggestions also that the health of individuals in occupations with higher prestige is better than that of people in lower prestige occupations (Marmot et al., 1997). These relationships are complex, and the associations between employment and health may be confounded by other factors such as income, education and social class (Morris, 1994).

Poverty is a key factor predicting poor health at the individual and population levels (Fiscella & Franks, 1997), and health improvement contributes to poverty reduction, economic growth and development. In recent reviews of the conceptual and empirical linkages between poverty and poor health in both developing and developed countries, the empirical evidence is convincing that poverty is causally related to poor health at both the individual and societal levels (Subramanian, Belli & Kawachi, 2002; WHO, 2002a).

Characteristics of the physical environment over which people have little control may also threaten health, including climate and climate change, air pollution, noise, the design of community infrastructures such as roads and buildings and the presence of hazardous substances. Especially important is ingestion of and contact with unsafe water as well as lack of access to water and sanitation. Water poverty is consistently associated with adverse health outcomes such as diarrhoea and parasitic diseases such as hookworms and schistosomiasis (WHO, 2002b).

Risky physical environments in workplaces produced by toxic substances, unsafe contact with machinery and poor ergonomic conditions are associated with a range of diseases and injuries including skin and respiratory disorders, injuries and work stress leading to psychological disorders (Driscoll et al., 2001; Jin et al., 2000; Leigh & Sheetz, 1989; Loewenson, 1999).

Health inequalities

The examples given above provide a greatly oversimplified, but illustrative, picture of the complex web of factors that influence people's health. Inequalities in health are related to a wide range of factors, including social class, gender, ethnic origin and place of living, among others. Inequalities in health are due in part to individual differences in genetics, health related behaviour and choices regarding education, work and play. Part of the work of public health is to inform people about health issues, to enable them to make healthy choices that raise the level of health for entire populations and hopefully reduce inequalities in health.

To the degree that inequalities are a consequence of social injustice, there exists not merely inequality but inequity as well (the contrast between equal shares versus fair shares). Virtually all health promoters, regardless of their professional area of interest, are united by their dedication to one overriding aim – improved equity in health. That is, they seek to reduce the "unjust" gap between those with the best and those with the worst health (Dahlgren & Whitehead, 1992; Whitehead, 1990; WHO, 1996; Wilkinson, 1996). Alarmingly, this gap seems to be widening (WHO, 2002b).

Health promoters believe the gap between those with the best and the worst health can be narrowed significantly if underlying injustice is corrected. The principal means to this end is to improve equality in opportunities for education and employment, access to a safe, nurturing physical and social environment, opportunity to participate in the governance of society and access

to high quality health care and social support services. This is in addition to the most fundamental determinants of health – access to food, water, shelter and freedom from violence – that are not yet realities for many people.

Perfect equality in life's chances is an idealized goal, but striving for better equity in health through improving equality in life's chances is feasible and socially responsible. Much of the scholastic effort in this arena has until now gone into descriptive research to document the course and causes of health inequality. This is vital to understand the relative roles of inevitable individual differences in health, compared to unjust social circumstances that propel people on poor health trajectories over which they have little or no control. The evidence on this matter is mixed and several competing explanations have been advanced.

There is much controversy about possible measurement problems. Trend analyses are quite difficult because of changes over time in the ways social factors and health are measured. Despite such measurement problems, so many indictors of social conditions show the same pattern of a widening health gap that measurement problems alone seem an inadequate explanation (Leon & Walt, 2001).

Other explanations of health inequality suggest that people with poor health are "selected" into socially disadvantageous situations, and that for others inequalities arise from individuals' free choices to engage in activities that carry the risk of damage to health. Both these explanations, to the degree they are true, might reduce concern about the possibility of inequity as a fundamental cause of health inequality. It can be argued, however, that a caring society will do its best to protect those with poor health from the risk of social disadvantage. In addition, individuals' choices of lifestyle are made in a social context that may truncate the range of realistic choices. The degree to which inequalities are inequities turns on these and similar differences in viewpoint about individuals' places in a society and the kinds of societies we create. This discourse in the health promotion arena is thus part of a much larger discourse, not the least important of which is taking place in political arenas.

Another explanation for health differences is that they are caused in part by unequal distributions of material resources in a society and between societies, including access to health and social services. Such inequality may or may not be stamped as being inequitable and depends on one's viewpoint about the kinds of interpersonal relationships members of a society should maintain with one another. One thing is clear, however: when poor health is seen as resulting from unfair distributions of resources, the territory of political philosophy has been entered, and that of practical politics too. This recurring theme is taken up in later in this chapter.

Though most of the research in this area is descriptive, there is mounting evidence that it is possible to intervene at several levels in pursuit of improved equality in health (Benzeval et al., 1995; Black & Mittelmark, 1999). Whitehead's review of the policy intervention arena reveals that at all levels, from local to national, examples can be found of policies that assist people living in social and economic disadvantage to enjoy better health (Benzeval et al., 1995). There is some evidence, also, that community development and regeneration approaches can be powerful tools for improving health equity in a variety of community settings (Black & Mittelmark, 1999). The assessment of WHO, for which improving equity in health is a high priority, is that health promoting policies are needed not only in the health care sector but also in the economic, environmental and social sectors for positive impact on the determinants of health and improved health equity (WHO, 1998c).

Health promotion responds to the challenge

By most accounts, the modern health promotion movement dates back only to the mid-1970s, to a Canadian government document titled *A New Perspective on the Health of Canadians* (Lalonde, 1974). Its fundamental message was that contemporary health problems of Canadians could not be solved by the health services and called for a health promotion strategy that aimed at improving, among other things, the health related lifestyles of all citizens. Canada began on a path of innovation in health thinking for which it has become famous.

There were, however, other forces critically significant in the emergence of health promotion as it is known today. As a result, concern with healthy lifestyle is balanced with regard for environmental factors that determine health status over which individuals have little or no control and that require the collective attention of a society. Among the earliest of these forces was the International Conference on Primary Health Care, held in Alma-Ata, USSR, in 1978. In the Declaration of Alma-Ata, health was reaffirmed as a human right, the role of the social and economic sectors in promoting health was illuminated and health inequalities were termed politically, socially and economically unacceptable (WHO, 1978). This introduced a social model of health promotion that was reinforced a little more than a decade later in the Ottawa Charter, inarguably the most significant single document in the health promotion movement (WHO, 1986). The Ottawa Charter resulted from a conference that was the first in a series of WHO sponsored conferences that have been "spark plugs" to the health promotion movement and about which more details are provided in the next section. The five action strategies of the Ottawa Charter outlined in box 2.1 remain today the basic blueprint for health promotion in many parts of the world.

Yet other forces responded to the need for holistic approaches. By the early 1990s, nongovernment organizations, which had long been focused on the development of health education as a public health tool, had fully incorporated a social model of health in which health education plays a balanced role with policy interventions and in which health equity is the central goal. Prime among these organizations is the International Union for Health Promotion and Education (IUHPE), which shares the mantle of responsibility, together with WHO and many other government organizations and NGOs, for the further global development of health promotion as an action arena for improved public health.[1]

Health promotion practice

Clearly, health promotion as characterized above is as much a political and social project as a health project, hence the reference, by both admirers and detractors, to health promotion as a new and radical public health. It is important, however, not to over-dramatize the matter. Practical work in policy and programme planning, implementation and evaluation dominates the day-to-day work of health promotion practitioners. They use professional tools and approaches that are science-based and there is a strong emphasis on the importance of quality, effectiveness and improvement. Most front-line health promoters work in organizations whose missions determine which health issues are the priorities: safety, food and water, infant care, drug use, exercise, mental health, community development and so on. Each area has unique features, yet experience shows

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[1] This brief historical sketch excludes many key developments in health promotion's evolution. Interested readers are referred to several texts that provide rich perspectives on health promotion's historical development: Baum, 1998; Bracht, 1999; Dines & Cribb, 1993; Downie et al., 1996; Katz & Peberdy, 1997; Kelly, 1988; Raeburn & Rootman, 1998; Tones & Tilford, 2001.

Box 2.1
Ottawa Charter of Health Promotion Action Strategies

■ **Build healthy public policy**

Health promotion goes beyond health care. It 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 their responsibilities for health.

■ **Create supportive environments**

The inextricable links between people and their environment constitute the basis for a socio-ecological approach to health. Systematic assessment of the health impact of a rapidly changing environment is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

■ **Strengthen community action**

Health promotion works through concrete and effective community action in setting priorities, making decisions and planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

■ **Develop personal skills**

Health promotion supports personal and social development through providing information and education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments and to make choices conducive to health.

■ **Reorient health services**

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system that contributes to the pursuit of health.

Source: WHO, 1986

that successful health promotion work exhibits certain commonalities that transcend almost any health topic. These commonalities have to do with the underlying philosophy of how to work with people and models of good professional practice.

Two models of how health promoters seek to work with people are Tones and Tilford's (2001) Empowerment Model of Health Promotion and Raeburn and Rootman's (1998) People-Centred Model of Health Promotion. Empowerment is at the heart of both, referring both to the intention to build people's capacity to manage and control their own health and to a professional style of working in which citizens are partners in change processes and senior partners as much as is feasible. Health promoters have the intention of working with people in a participatory way, with first-order goals set by the realities of the setting and task and second-order goals of building capacity and control that have transferability to a wide range of future challenges and opportunities.

Putting this intention into practice in an ethical and effective manner requires complex professional skills in conducting recurrent cycles of programme planning, implementation and evaluation through which the quality and effectiveness of health promotion are enhanced over time (Davies & Macdonald, 1998; Minkler, 1997). Many practice models are available to assist health promoters, such as Green and Kreuter's (1999) PRECEDE–PROCEED model, intended for use in community-wide applications and also within community settings such as workplaces and schools. A number of other models are also in wide use (Baum, 1998; Dines & Cribb, 1993; Katz & Peberdy, 1997; Kemm & Close, 1995; Naidoo & Wills, 2000).

There are a number of generic features common to virtually all health promotion practice models. First, action is preceded by a considerable period of careful study of a community's needs, resources, priorities, history and structure, and this study is done in collaboration with the community. This style represents an underlying philosophy of "doing with" rather than "doing to". Second, a plan of action is agreed, the required resources are gathered, implementation begins and monitoring of action and change processes is undertaken. Practice models emphasize the need for fluidity in planning and implementation to meet the demands of new or changing conditions and constant surveillance of and reflection over practice, change processes and outcomes to inform better quality of practice. Third, they stress the importance of evaluation and dissemination of best practices, with attention to maintaining and improving quality as dissemination unfolds.

Politics of health promotion

Public health and health promotion professionals are naturally inclined to view their chosen fields as being science-driven, with rational decision-making processes based on the best evidence available about how to improve health. However, the abstract ideals of positivist science, emphasizing a detached, cool and sceptical approach to knowledge development, do not match particularly well with reality. Science and public health and health promotion are essentially political activities because they are funded as work for the public good yet there is often visceral disagreement about what the public's "good" is and how it should be pursued.

Deeply held ideological positions about the individual's proper relationship to society lie at the heart of much of this political controversy. Specifically, the dialectic between individualism and collectivism is reflected in debates about how the helping arts such as health promotion should be practiced. How much risk, with what degree of certainty, for how many and for what kinds of people should be manifest before the rights of the few are abrogated for the protection of the many – and how few and how many? Individualists set high thresholds for mass intervention, while collectivists argue for prudence. Individualists tend to prefer educational interventions that permit individual citizens to "take it or leave it"; collectivists tend to prefer legislative or environmental interventions, which soften the landing for everyone.

Few health promoters are purely one type; many anxious discussions about what should be done turn on the nuances of particular situations in particular places at particular times. Under what conditions, for example, does a health risk warrant an information campaign, a stern advisory or a policy of forced containment? Scientific evidence can never provide a fully satisfactory answer and political considerations enter naturally into the decision-making process.

On these matters, health promotion practitioners tend to take a dual position, advocating both individualistic and collectivist interventions for social change, arguing that the two taken together

have synergistic effects. This is essentially the formula given by Tones and Tilford's (2001, p. 43) elegantly simple definition:

Health promotion = health education x healthy public policy

Health promotion successes

As you will read in later chapters, the generation of evidence of the effectiveness of health promotion is a hard undertaking. Health promotion is social action that takes place not in the clean laboratory, but out in the messy world. Controlled laboratory experiments, therefore, are never appropriate ways to generate evidence of health promotion's effectiveness. Instead, consensus about effectiveness is based on the principle of methodological triangulation that leads to a converging interpretation of evidence of different kinds, from different places, generated by different researchers. The "principle of prudence" recognises that all evidence has weaknesses, that we can never know enough to act with certainty, but that we can in many cases be reasonably sure enough of the quality of the existing evidence to make recommendations for action.

Of course, decisions to prioritize various policies and programmes are only partly influenced by "the facts" and a wide range of concerns and priorities may lead to decisions that are not in concert with the recommendations of professionals. Health promoters have learned that if evidence is to make a difference, policy-makers and the people that influence them need it to be "served" in a politically meaningful way (Mittelmark, in press). In recent years, written reviews of the evidence of health promotion's effectiveness have been produced as guides for policy-makers on topics as diverse as community heart health, health promotion in schools and workplaces, oral health, nutrition and community safety (IUHPE, 1999). Two major successes in health promotion have been in the arenas of tobacco control and heart health promotion.

Tobacco control

The great health hazards of tobacco began to be known over 50 years ago. Today, the evidence on a whole range of health hazards is extensive, and tobacco, as a single avoidable issue, presents the greatest global public health risk. It is therefore most alarming that tobacco use has increased dramatically in all parts of the world with devastating consequences for public health. The latest estimates are that annually some 4.9 million people die of tobacco use and this figure is expected to increase to 10 million per year within the next 20 years (WHO, 2002b).

Tobacco, despite its highly addictive properties and ubiquitous overt and subliminal marketing, can be defeated. Effective tobacco control strategies have been developed and are undergoing constant improvement. The challenge is to expand with efficiency and effectiveness the tobacco control campaign to all parts of the world, especially the markets in Asia, Africa and other regions that are so tempting to the tobacco industry.

Successful tobacco control has three main aims: prevention of onset (mainly children and youth), cessation of use (mainly adults) and protection from environmental tobacco smoke (especially indoors).

These different objectives call for somewhat different approaches. Preventing smoking among youth has had relative success, especially in school-based interventions that have been based on appropriate theoretical frameworks (RCP, 1992). Training in skills to resist the pressures to start smoking has been an important component.

Methods for smoking cessation have been based on breaking the strong dependence on nicotine as well as behavioural and social dependency. In this regard, pharmacological and behavioural interventions, and their combination, have shown a considerable degree of effectiveness (USDHHS, 2000). At the same time, issues of cost effectiveness for public health purposes have stimulated the development of low intensity population-wide interventions, such as education for physicians on tobacco control for patients and innovative public campaigns like "Quit&Win" (Korhonen et al., 1996).

Although both individual and community-based interventions have shown effectiveness, successful tobacco control requires national and international strategies (de Beyer and Brigden, 2003; USDHHS, 2000; WHO, 1998a). Effective measures for tobacco control, especially those that have cross-border and global dimensions, are outlined in the WHO Framework Convention on Tobacco Control that was approved by the World Health Assembly in 2003 (WHO, 2003). This text is a firm basis for countries to build effective tobacco control programmes, employing an array of effective measures in the best spirit of the Ottawa Charter.

Heart health

The epidemic of cardiovascular diseases (CVD) grew rapidly in most industrialized countries after World War II. Epidemiological studies soon identified a few strong, obviously causal, CVD risk factors: elevated blood cholesterol, elevated blood pressure and smoking. Over time, others, such as physical inactivity, have been added to the list. Because blood cholesterol and blood pressure are influenced by diet, preventive efforts have focused on promoting a healthy lifestyle among patients, people with elevated risk factors and society as a whole. This comprehensive approach is founded on a public health strategy that has six elements (Rose, 1992). Mittelmark's (1999a) summary of these elements is shown in box 2.2.

Box 2.2
Justifying a population approach to public health: Rose's six principles

- Risk factors for a large number of diseases and health problems are distributed in populations in a graded manner.

- There is often no obvious and clinically meaningful risk factor threshold that differentiates those at risk and those not at risk for a chronic disease.

- For many chronic diseases there are many more people in a population at a relatively moderate level of risk than at the highest levels of risk.

- Addressing only the very high risk (clinically recognized) segment of a population misses the opportunity to improve the risk profile of the entire population.

- Modest risk lowering among many people with moderate risk factor levels will shift the risk factor profile of the entire population in a favourable manner.

- A population-wide approach to intervention is thus called for, the objectives of which should be to reduce the average level of the population's risk through intervention for all and to intervene intensively for those few at the highest level of risk.

Source: Mittelmark, 1999a

It was clear that merely providing information on CVD risk factors is not enough to produce desired changes. Furthermore, it was realized that although individuals with high risk benefit from most of the risk reduction, from a public health point of view a population approach was needed. Since the vast majority of CVD cases come from the relatively large group of people with only modest risk factor elevations, the key to prevention is the shifting of the risk factor profile of the whole population to a lower level (Kottke, Puska & Salonen, 1985; Rose, 1981). This can be accomplished only via general lifestyle changes.

Based on these considerations, community-based preventive programmes were started. The first major one was in the Province of North Karelia in Eastern Finland (see box 2.3), where the heart disease rates were exceptionally high (Puska et al., 1995). Very soon several others were started – in the USA, in several European countries and elsewhere (Carleton et al., 1995; Fortmann et al., 1995; Luepker et al., 1994). These programmes were based on the notion that risk elevating behaviours are deeply rooted in the community and that a broad prevention approach is needed, consistent with the principles of health promotion outlined earlier.

> **Box 2.3**
> **Heart health promotion in North Karelia, Finland**
>
> The potential for health promotion as a tool for CVD prevention is illustrated well by a project undertaken over 25 years in the province of North Karelia in Finland.
>
> Over the life of this project, smoking has been greatly reduced and dietary habits changed in the male population. The dietary changes led to a 17% reduction in the mean population level of serum cholesterol between 1972 and 1997. Elevated blood pressures were brought well under control and leisure time physical activity increased. Among women, similar changes in dietary habits, cholesterol and blood pressure levels took place, although smoking increased somewhat from a low level. By 1995, the annual mortality rate of coronary heart disease in the middle-aged male population (below 65 years) had reduced by 73% from the pre-programme years (1967–71). During recent years, the decline in CVD mortality among men and women in North Karelia has been approximately 8% per year.
>
> From the 1980s, favourable changes began to develop also throughout Finland. By 1995, the annual CVD mortality among men in all of Finland had reduced by 65%. The lung cancer mortality had also reduced, by more than 70% in North Karelia and by nearly 60% in all Finland.

Source: Puska et al., 1995; Puska et al., 1998

Puska (2002) reviewed the experiences of the North Karelia and other CVD programmes and made a number of recommendations for successful heart health promotion which are outlined in box 2.4

Box 2.4
Recommendations for heart health promotion

- Preventive community programmes should pay attention to the well-established principles and rules of general programme planning, implementation and evaluation.
- Preventive community programmes should be concerned with both appropriate medical/epidemiological frameworks to select the intermediate objectives and with relevant behavioural/social theories in designing the intervention programme.
- Good understanding of the community ("community diagnosis"), close collaboration with various community organizations and full participation of the people are essential elements of successful community intervention programmes.
- Community intervention programmes should combine well-planned media and communication messages with broad-ranged community activities involving primary health care, voluntary organizations, food industry and supermarkets, worksites, schools, local media and so on.
- Community intervention programmes should seek collaboration and support from both formal community decision-makers and informal opinion leaders.
- Successful community intervention programmes need to combine sound theoretical frameworks with dedication, persistence and hard work.
- A major emphasis and strength of a community intervention programme should be attempts to change social and physical environments in the community to be more conductive to health and healthy lifestyles.
- Major community intervention programmes can be useful for a target community and can also have broader impact as a national demonstration programme. For this, proper evaluation should be carried out and results disseminated.
- For national implications, the project should work in close contact with national health policy-makers throughout the programme.

Source: Puska, 2002

Health promotion in low income countries

Stories of health promotion success are not isolated to regions with highly productive economies. Indeed, health promotion is suited to the widest imaginable array of social and economic situations. An excellent illustration of this is WHO's Healthy Cities project, which aims to disseminate best health promotion practices to all communities around the globe. As the WHO Regional Office for Europe describes it, the Healthy Cities approach has at its core the principle that modern public health must tackle basic health determinants through comprehensive multisector policy, planning and action:

> The health of people living in towns and cities is strongly determined by their living and working conditions, the quality of their physical and socio-economic environment and the quality and accessibility of care services.

Health is everybody's business and most statutory and non-statutory sectors have a role to play in health development.

Local governments are in a unique position to promote health and sustainable development because they have direct responsibility for sectors that have major impacts on health (such as environment, housing or social services and public health) and/or because they represent the natural conveners of locally based agencies and citizens' groups and community organizations.

Modern public health calls for comprehensive and systematic efforts that address health inequalities and urban poverty; the needs of vulnerable groups; the social, economic and environmental root causes of ill health and the positioning of health considerations in the centre of economic, regeneration and urban development efforts (WHO, 2004).

A large number of communities in Europe, Asia, Africa, the south-west Pacific and the Americas have successfully implemented the Healthy Cities model, as exemplified in Latin America:

Healthy municipalities in Mexico have carried out education campaigns to protect the environment and basic sanitation, projects to improve the quality of life and physical and social environment, and drug addiction prevention activities. They have also established investment policies designed to improve the quality of life of special groups affected by several types of inequities.

In Argentina, healthy municipalities have worked with NGOs, schools, governmental and educational institutions, ecological groups and the Red Cross to improve the health of children, adolescents and mothers. They are working to reduce malnutrition, create micro enterprises and community vegetable gardens, and to establish broadcasting networks to disseminate health promotion information.

Chile strengthened its health promotion efforts by creating committees for health promotion in 60 per cent of its municipalities. The mayors worked to ensure political support and mobilize resources.

The creation of healthy spaces in Jamaica was expanded to include an inter-ecclesiastical grouping, expanding health services of church groups to include health promotion (PAHO, 2004).

The global political achievement of health promotion, built on successes such as those described above, is incontestable. Among recent evidence of this is the World Trade Organization's (WTO) Doha Declaration on the TRIPS Agreement and Public Health (http://www.wto.org). Signers affirmed that the Agreement "can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health". Social clauses that include health protections are becoming commonplace in trade agreements whereas just a few years ago they were almost non-existent.

The nature of evidence of health promotion's effectiveness

From the examples given, it is obvious that evidence of health promotion's effectiveness must be derived from community-based research. Although such real world research is a very complex undertaking, it is possible to develop a body of dependable knowledge about what works and what does not. Signifying the importance of this, a resolution to employ an evidence-based approach to health promotion was adopted by the 1998 World Health Assembly.

There are two focal issues with regard to evidence of health promotion's effectiveness: the strength of evidence and its implications for research, practice and policy development.

The strength of evidence is influenced by the design of interventions and related methodological issues such as the validity of indicators, the efficacy of the interventions and the effectiveness of efforts to minimize biases arising from the context in which the interventions are implemented. Tang, Ehsani and McQueen (2003) provide a useful strength-of-evidence typology that has reference to three elements of scientific enquiry: falsifiability, predictability and repeatability. Four types of evidence are the result:

- Type A: What works is known, how it works is known and repeatability is universal.

- Type B: What works is known, how it works is known but repeatability is limited.

- Type C: What works is known, how it works is not known but repeatability is universal.

- Type D: What works is known, how it works is not known and repeatability is also limited.

Though Type A evidence is the most reliable, it is very difficult to develop in health promotion research, which operates in an environment where numerous cultural, social, economic and political factors interact. Moreover, behaviour and policy change are two concerns of much health promotion activity. When the behaviour of individuals, organizations and political processes are the focus, complexities are involved that rarely resolve sufficiently to produce Type A evidence. Also, the expertise of practitioners determines to a great extent the success of an intervention, regardless of its earlier successes.

Health promotion strives therefore for Type B evidence, which has important implications for practice. Because it is unlikely that the effectiveness of any health promotion intervention can be guaranteed beforehand, there is a strong need for evaluation research to be combined with health promotion practice. In this regard, the WHO European Working Group on Health Promotion Evaluation (1998) has published the seven recommendations for policy-makers outlined in box 2.5.

The nature of evidence in the health promotion arena also carries implications for formal research. The complexity of health promotion interventions precludes total reliance on traditional quantitative public health research methods and necessitates the use as well of research methods from social sciences. The use of qualitative methods to gain insight into the "anatomy and physiology" of complex interventions can pay dividends in efforts to achieve greater transferability of programmes from setting to setting.

Innovative funding strategies

Health promotion is a cost-effective way to improve public health and quality of life and reduce the economic costs of illness. Governments in general and health and welfare ministries may be aware of this but national health budgets are targeted inevitably for care and cure services. Thus, while health promotion is cost-effective, many countries are in need of new resources to promote health and tackle priority health problems. Secure and long-term funding for health promotion is essential and innovative funding solutions are urgently needed.

One such solution is the use of earmarked tax income to fund national health promotion foundations. The existence and growth of the International Network of Health Promotion Foundations demonstrates the viability of this innovative way of mobilizing resources for promoting health.

> **Box 2.5**
> **Health promotion evaluation: recommendations for policy-makers**
> - Encourage the adoption of participatory approaches to evaluation that provide meaningful opportunities for involvement by all of those with a direct interest in health promotion initiatives.
> - Require that a minimum of 10% of the total financial resources for a health promotion initiative be allocated to evaluation.
> - Ensure that a mixture of process and outcome information is used to evaluate all health promotion initiatives.
> - Support the use of multiple methods to evaluate health promotion initiatives.
> - Support further research into the development of appropriate approaches to evaluating health promotion initiatives.
> - Support the establishment of a training and education infrastructure to develop expertise in the evaluation of health promotion initiatives.
> - Create and support opportunities for sharing information on evaluation methods used in health promotion through conferences, workshops, networks and other means.

Source: WHO European Working Group on Health Promotion Evaluation, 1998

The founding members of the Network are Fonds Gesundes Österreich, Health Promotion Switzerland, Healthway, Hungarian 21 Foundation, Korea Health Promotion Fund, ThaiHealth and VicHealth of Australia. These foundations have the ability and the mission to support research and innovation and the strengthening of health promotion capacities in the health sector and beyond. They have already established a record of supporting health promotion in sectors such as education, sport, the arts, the environment and commerce in developed and developing countries.

A mechanism for financing such foundations is a dedicated tax (hypothecation) on tobacco. The adoption of the WHO's Framework Convention on Tobacco Control at the 56th World Health Assembly in May 2003 provides renewed impetus for examining innovative financing models for sustained health promotion actions. It reaffirms the advantages of imposing a levy on tobacco products, resulting not only in extra funds for health promotion actions but also lower tobacco consumption. There do not appear to be any documented cases of reduced revenues for government following tobacco taxes increases. There is therefore plenty of leeway for governments to increase taxes on tobacco – it is popular with the public and all of society benefits through financing the work of health promotion foundations.

In addition to the setting up of health promotion foundations, the involvement of public social insurance programmes and the private health insurance industry can have fortuitous financial outcomes for health promotion. Social insurance and health promotion share a common value base, with a strong commitment to protection, equity and solidarity. Over the years, the interdependence between health and social and economic development has been affirmed. The high and increasing cost of cure and care, and the increasing burden on social insurance provisions, contrasts with the lower costs of prevention and promotion.

In recent years, private health funds have been undertaking measures to encourage their members to maintain or promote health. For example, they offer financial incentives to members who take actions to stay healthy by providing rebates for health promoting activities such as t'ai chi classes or jogging shoes. They may also provide rebates for members to seek prompt and appropriate care when they feel unwell or charge non-smoking members a lower premium.

These examples of innovation show that financing models for health promotion can go well beyond traditional models that have depended on national, regional and local government spending. This is an underdeveloped area in health promotion and one that holds much promise for expanding the resource base so that health promotion's full potential might be realized.

Conclusion

It is clear that simply improving and extending formal health services cannot alone solve contemporary health challenges. A comprehensive approach to health promotion is needed. Action must take place in the health and social sectors; however, this is not sufficient. Real progress can be made only if action is broad-based. Society at all levels, including individual citizens, families and the institutions of education, government, business and law must contribute actively if health promotion action is to be truly effective.

That is why, ideally, health promotion takes place at many levels. Governments and businesses create policies and practices that support health, institutions from the local to the international levels create supportive environments, communities increase their capacity to support healthful living, individuals develop skills that promote their own health and the health services include health promotion among their priorities.

Perhaps no image has been called upon more often to provide a portrait of health promotion's aspirations than that of many people being swept downstream by a mighty river current, shouting for help and clearly near drowning. All rescue attempts must be made, of course, but people need to be kept safe from falling in the river in the first place, and need to learn self-rescue skills just in case. Similarly, health promotion calls for the orchestration of multiple strategies for health, including the assurance of equitable access to health care, the provision of a physical and social environment that supports health and the opportunity to have control over one's own health.

There is much that mental health promotion can learn from the experiences of health promotion. The key lessons are outlined in box 2.6. The following chapters describe the concepts, emerging evidence, practice and policy associated with the promotion of positive mental health.

Box 2.6
Key lessons from health promotion relevant to mental health

- Combine individual and structural strategies with advocacy.
- Work with an array of public and private sectors, not just the health sector.
- Emphasize positive mental health as well as prevention and treatment.
- Use professional tools for programme planning, implementation and evaluation.
- Strive to increase people's control over their own mental health.
- Avoid over-dependence on "expert-driven" approaches.
- Adopt a capacity building approach with individuals and communities.

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Chapter 3
Evolution of Our Understanding of Positive Mental Health

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Introduction

Over the past 30 years, research has contributed to an understanding of what is meant by the term "mental health" although this understanding has been constrained by the fact that much of the evidence that is accessible widely is recorded in the English language and obtained in developed countries. Mental health has been variously conceptualized as a positive emotion (affect), such as feelings of happiness; as a personality trait inclusive of the psychological resources of self-esteem and mastery; and as resilience, which is the capacity to cope with adversity. Various aspects and models of mental health contribute to our understanding of what is meant by positive mental health.

As discussed in Chapters 1 and 2, WHO defines health as being a complete state of physical, psychological and social well-being. Jahoda (1958) elaborated on this by separating mental health into three domains. First, mental health involves "self-realization" in that individuals are allowed to fully exploit their potential. Second, mental health includes "a sense of mastery" by the individual over their environment and, thirdly, positive mental health means "autonomy", as in individuals having the ability to identify, confront and solve problems. Others, like Murphy (1978), argued that these ideas were culturally based and influenced by the North American culture that favours individualism and so not reflective of many other cultures where the group may be as important as the individual. Murphy also warned that a high level of aspiration might even threaten the mental health of individuals. For example, he found that women living in an affluent suburb of Montreal were presenting with more negative symptoms than those who were living in the inner city, a rather deprived area. He concluded that suburban women had aspirations that they could not fulfil while inner city women were proud to contribute to the survival of their family members. The definition of mental health is therefore clearly influenced by the culture that defines it and has different meanings depending on setting, culture and socioeconomic and political influences.

This chapter gives an overview of the history of the development of these concepts of positive mental health and the closely related concept of "quality of life".

Concepts of mental health

Positive affect

In the 1960s, Bradburn, building on the earlier conceptual work of Gurin, viewed psychological well-being as the balance between two independent dimensions which he termed positive and negative affect. In his view, an individual will experience a high degree of psychological well-being if positive affect dominates. Likewise, a low degree of well-being is characterized by negative affect (Bradburn, 1969).

Bradburn proposed a scale to measure the positive and negative facets of psychological well-being in community surveys. This 10-item Bradburn Scale has been used in a number of large health surveys including the Alameda County Study and the Canadian Health Survey. Many questions have been raised concerning the scale, however. For example, some of the items have been criticized for being linked too strongly to specific situations or being difficult to respond to.

The meaning of the term "positive affect" was also disputed by Beiser (1974), who proposed it be renamed "pleasurable involvement". Nevertheless, according to McDowell and Praught (1982), Bradburn's detailed conceptual formulation of the construct of well-being represents a milestone in attempts to measure it.

A number of other instruments have been used to assess positive affect. One example is the General Well-Being Scale (GWBS), which was created by Dupuy for the USA National Center for Health and Statistics and used in major studies such as the Canadian Health Survey and the later Quebec Health Survey. The Quebec Health Survey found that 75% of the adult population had a high or very high score on the GWBS independently of their age. Scores were affected, however, by gender (78% of men scored high or very high compared with 70% of women), matrimonial state (married people scored higher than divorced, widowed or single people), income, life events and physical handicap. These findings were very similar to those obtained from the 1978 National Canadian Health Survey.

A personality trait

Psychological resources such as self-esteem, mastery and sense of coherence fall under this domain and a number of scales have been developed to assess each of these. The inclination to be optimistic or pessimistic is also included in this sphere and instruments specifically designed to measure these have also been constructed. Three views of mental health as a personality trait are discussed here.

Antonovsky: the salutogenic approach

Antonovsky (1979) proposed the "salutogenic approach", which focused on coping rather than stressors and "salutory" factors rather than risk factors. He hypothesized that a sense of coherence, which is the degree to which a person views their own experience as comprehensible, manageable and meaningful, is a major explanatory construct and contributes to health. He rejected the notion that stressors always have pathogenic consequences, since people have to survive transitions and stress in their daily lives. Rather, he viewed them as having the potential for positive, neutral or negative consequences. It then became important to understand what the characteristics of those people who cope successfully are and the conditions that facilitate such coping.

As outlined further in Chapter 4, Antonovsky did not think that sense of coherence was a "buffering" factor in the way that self-esteem, social support, high social class or cultural stability are sometimes thought to be. Rather, these buffering factors had an impact on health because of their influence on building a sense of coherence. According to his observations, the sense of coherence was rather stable, at least in adult life, but could change under some dramatic experiences. He proposed that sense of coherence should be considered as a dispositional orientation that should be distinguished from personality traits. In his view, the personality traits fixed a behavioural tendency whereas sense of coherence implied a varying capacity to respond to stressors flexibly. A person with a high sense of coherence will select the coping strategy most appropriate to the stressor they are being confronted with.

Antonovsky also considered that the sense of coherence was culture-free whereas sense of mastery, hardiness and locus of control were culture-bound since they are valued in societies that favour individual control over environment. He considered that these latter constructs were based on the assumption that these were the responses likely to lead to the resolution of problems that

confront individuals. Although this may be the case in middle-class America, it may be the reverse in other societies where different patterns are favoured.

The Canadian National Health Survey, which began in 1994–95, collects information about the health of the Canadian population every two years and uses sense of coherence as a positive mental health measure. At the first follow-up, men and women who scored low on the sense of coherence index in cycle 1 had twice the likelihood of experiencing a depressive episode prior to their cycle 2 interview. Decrease in emotional support and low sense of coherence were the two indicators associated with depression, the risk being about twice that of those without these characteristics. This was true for both men and women (Swain, Catlin & Beaudet, 1999).

Optimism/pessimism

In 1985, Scheier and Carver proposed the optimism/pessimism dimension, which they described as a tendency to believe that one will generally experience either good or bad outcomes in life. Working on the effect of expectations on actions and affects, they discovered that global expectancies were relatively stable across time and context and formed the basis of an important characteristic of personality. In order to measure this, they developed the Life Orientation Test (LOT). The LOT has been used in many studies to evaluate the influence of optimistic expectations on diverse outcomes, including those associated with health. Although some of these studies are controversial, most conclude that optimism is beneficial for psychological and physical health.

Better coping with the situation may be the mechanism that explains the benefit to the psychological and physical state of the optimists. Carver, Scheier and Weintraub (1989) examined this point in an undergraduate population and found that optimists were more active copers, less avoidant and more likely to engage in positive health practices.

Leighton and Murphy

Leighton and Murphy (1987) proposed that non-symptomatic individuals from general population surveys could be classified according their personality types and their coping strategies into three groups:

- "cabbage": individuals who have low aspiration and achievement;

- "Elizabethan": individuals who have an intense emotional life characterised by periods of intense happiness and unhappiness; and

- "hermit crab": individuals who have built up a shell that protects them against stress emanating from family, social network and professional life. People in this group have a high risk of breakdown when the protective barrier fails.

Their classification brought to light that individuals who do not exhibit symptoms of poor mental health might nevertheless be using coping strategies that are unhealthy and that could put them at risk for mental illness.

Resilience

Rutter's definition

The capacity to cope with adversity and to avoid breakdown or diverse health problems when confronted by important stressors differs tremendously among individuals. This phenomenon has been observed and studied by many researchers following quite diverse theories.

As Rutter (1985, p. 598) remarked: "Even with the most severe stressors and most glaring difficulties more than half of … children will not succumb". This view was supported by Paykel's work on life events, which found that most people did not become depressed in spite of stressful experiences (in Rutter, 1985). More recently, Cederblad et al. (1995) followed up 148 people selected from an earlier study (the Lundby study) as being at risk of developing mental disorders. They found that the great majority of them were doing well.

During the 1970s, some children had been described as "invulnerable", meaning that they were thought to be so constitutionally tough that they could not give way under the pressures of stress and adversity. Rutter considered that this notion was wrongheaded in at least three aspects: in his view, the resistance to stress is relative, not absolute; the basis of the resistance is both environmental and constitutional; and the degree of resistance is not a fixed quality. He proposed the concept of "resilience" instead of this absolute notion of invulnerability, defining resilience as the capacity to cope with adversity and to avoid breakdown or diverse health problems when confronted with stressors. A number of factors have been found to increase a person's resilience.

The role of protective factors and cognition

Influences that modify, ameliorate or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome are called protective factors. Rutter warned that protective factors do not always exist as a result of pleasurable happenings. There is evidence that acute stress in early life, for example, leads to changes that enhance an animal's resistance to later stress experiences; this effect – referred to as the "steeling effect" of stressors – has also been described in human parachute jumpers. Protective factors may have no detectable effect in the absence of stressors and may concern a quality of the individual rather than an experience (e.g. girls are less vulnerable than boys to many adversities). Possessing protective factors may also not always be a pleasant and desirable trait: people who appear the most immune to stress also appear to be more self-centred, shallow and labile in their relationships (Rutter, 1985).

Interactive processes can have an important impact on the development of resilience. For example, it seems that having a working mother is not a risk as such but rather that the perceived loss of the mother through her getting a job for the first time can become a stressor if it coincides with the loss of a father (e.g. through a divorce). Likewise, early parental loss predisposes to depression only if it leads to inadequate care and to lack of emotional stability in the family. This lack of care can be influential because it sets in motion a chain of events that in combination predispose to later disorder. Each of these links in the chain is subject to further influences at the time.

Parental mental health disorder is a particular stress that appears to predict child emotional disorders through associated family discord, especially if the child is involved in the conflict. The presence of a mentally healthy spouse, the maintenance of good relationships with one parent and restoration of harmony have been found to be protective factors. Some child characteristics, such as an easy temperament or being of the opposite sex to the ill parent also have protective effects. Some schizophrenic family studies suggest that if the stresses are manageable and of a kind that give rise to rewarding tasks, the health of the children is preserved and resistance to stress enhanced. Helping others may lead to heightened morale and the acquisition of problem-solving skills. However, some traits that are positive in one situation can be negative in another. For example, compliance that is adaptive in some settings would not be in a situation where child abuse is occurring.

Studies on the effects of multiple social adversities on children have established the value of parental supervision in preventing their children's involvement in activities and social groups likely to predispose to delinquency. In a longitudinal study, non-delinquent outcomes were also predicted by positive parent–child relationships and good support from relatives, especially grandparents (Werner & Smith, 1982, in Rutter, 1985). Resilience was associated with a good-natured disposition, a positive self-concept and taking responsibility for younger siblings. It seemed that coping successfully, accepting productive roles and having close family ties led to personality strengths in such circumstances (Elder 1974, 1979, in Rutter, 1985).

The importance of appraisal of life situation raises the issue of cognitive sets. A person's cognitive set (a sense of self-esteem, self-efficacy) can make successful coping more likely. Even though some coping mechanisms may be better than others, the existence of at least some coping processes is essential and their absence leads to helplessness. Helplessness in turn increases the likelihood that one adversity will lead to another. Longitudinal studies show that cognitive set is not a fixed personality trait but may change with altered circumstances. Resilience is characterised by some sort of action with a definite aim in mind and a strategy to achieve the chosen objective. It involves a sense of self-esteem and self-confidence, a belief in one's own self-efficacy, an ability to deal with change and to adapt, and a repertoire of social problem-solving skills. Two factors that appear to foster such a cognitive set are secure and stable relationships and experience of success and achievement. Neither needs to be generalized but they do have to happen in some aspect of the person's life. Distancing yourself from an unalterably bad situation is also a protective factor. These findings may be relevant to prevention promotion actions for children in difficult situations.

A psychoanalytic approach

Fajardo (1991) noted that many psychoanalysts have treated patients who have surprised or puzzled them in their response to treatment: some who in spite of favourable history and disposition have not made use of the treatment to change or improve and others who have unexpectedly done very well. It was generally concluded that there were dynamic factors that were not recognized or that there was something constitutional in the patient that was responsible. Fajardo felt that constitutional explanations tended to be discredited among psychoanalysts, however, mainly because there was a limited number of ways to think about constitution in psychoanalysis and because such an explanation seemed static and alien in light of the contemporary emphasis on psychoanalysis as process. Among psychoanalytic ideas about constitution is Sigmund Freud's original (1916) notion of the individual variability of drive strength. A second idea, also from Freud (*Totem and Taboo* and *Civilisation and Its Discontents*), is that constitution determines certain contents of the unconscious that are universal but which have some individual variation. This view was expanded by Jung and later by Melanie Klein. Constitutional influences have also been thought to operate in development through the biological unfolding and maturation of cognitive and motoric capacities, an idea held by Anna Freud, Hartmann and the ego psychologists.

Some psychoanalytic concepts can be used to explain resilience and adaptive mechanisms and bridge the various theories. For example, coping could be defined as "the adaptive application of defence mechanisms". This views coping as conscious while defence mechanisms are subconscious (Rutter, 1985). Psychoanalysis would suggest there are no good or bad coping mechanisms but rather distinguish between short and long-term coping mechanisms; the ultimate goal being a genuine integration of experiences which should make sense to the subject.

Psychoanalytic theory proposes positive mental health as the capacity for a subject to use their inside energy for realization in emotional, intellectual and sexual domains. The quality of resi-

lience resides in how people deal with life changes and what they do with situations. This implies a varying capacity to respond to stessors flexibly. All this is influenced by early life experiences, by what happens during childhood and adolescence and by circumstances in adult life. None of these is determinative in itself but each may serve to create a chain of indirect linkages that fosters escape from adversity. Effective prevention and therapeutic interventions could have an influence at all of these life stages.

A transcultural approach

The balance between internal and external resources for fostering resilience was also discussed from the transcultural angle by Rousseau et al. (1998) in their study of unaccompanied minors from Somalia. They agreed with Rutter's view that resilience is not a fixed attribute but a balance between the mechanisms and processes of protection and vulnerability. They also emphasized the cultural basis to the construction of resilience and protection. Unaccompanied refugee children are traditionally considered to have a high risk of mental ill-health. Using ethnographic data, Rousseau et al. showed how young Somali refugees are protected, however, by the meaning attributed to separation within their nomadic culture and by the establishment of continuity through lineage and age group structures.

This work, embedded in clinical experience, shows the importance of considering the cultural background of immigrant people in order to be able to respect their own resilience mechanisms which otherwise may be destroyed by applying rules of the dominant culture to protect them. This view has to be especially underlined in a worldwide review of mental health promotion.

Possible negative aspects

Wolff (1995) points out that there can be a price to be paid for negotiating salient developmental tasks in spite of major stressors. She refers to Luthar's work, which found social competence among highly stressed but resilient adolescents was accompanied by increased levels of depression, anxiety and self-criticism.

Although Wolff acknowledges that behavioural deviance and educational problems have more ominous consequences than internal suffering, she believes that we have to judge resilience in terms of both externalizing and internalizing difficulties. She proposes that resilience be defined as "the process of, capacity for or outcome of successful adaptation despite challenging or threatening circumstances".

Wolff also identifies the "St Matthew effect": children with the fewest assets are often those most likely to be challenged by adverse events. In other words, chronic adversity and stressful events in children's lives correlate with low social status and with inadequate parenting. She proposes that interventions should operate though proximal rather than distal variables. This means helping families and children to cope with their environments rather than relying on attempts to enhance protective factors or remove the risk factors themselves through, for example, global employment or housing policies. Nevertheless, Wolff does advocate well-designed social interventions as well as raising political awareness of the impact of housing and employment on childhood resilience. Citing Felsman and Vaillant's follow-up study of a delinquent boys cohort, she states that the political and socioeconomic climate of the era into which one is born can affect one's resilience to adversity. She also points to the long-lasting benefits of targeted preschool education and other educational provisions that are well established as fostering resilience.

Quality of life

Quality of life has to be added to any conceptual framework of positive mental health. Early attempts to bring "quality of life" and "social well-being" to a discussion about the value of population life were made not by health practitioners but by social scientists and philosophers in the 1960s and 1970s (Campbell, Converse & Rodgers, 1976; Erickson, 1974; Katschnig, 1997). Although the WHO 1948 definition of health was broad and foreshadowed a conceptualization of health that went beyond physiological, anatomical or chemical dimensions (WHO, 1948), measures of health at both population and individual levels remained relatively narrow until a few decades ago. Traditional statistics on births, deaths, life expectancy and survival periods, among others, remained the accepted indices of health and outcome until questions about their adequacy began to be raised by consumers and human rights advocates. Part of the motivation for this was the need to capture indices of social and economic well-being and to address the importance that consumers attach to things like autonomy, choice, life satisfaction and self-actualization. This was eloquently expressed by Elkinton when, drawing on Francis Bacon's view that "the office of medicine is but to tune this curious harp of man's body and reduce it to harmony", he asked: "What is the harmony within a man, and between a man and his world – quality of life – to which the patient, the physician and society aspires?" (Elkinton, 1966).

Given the broad nature of the construct of quality of life, a need soon arose to define a more specific range of issues relating directly to health that were distinct from those that were not perceived as being directly related to health. In defining health-related quality of life, therefore, issues such as housing, income, freedom and social support have traditionally been excluded (Patrick & Erickson, 1993). The concept of health-related quality of life found early application in physical medicine, in particular in areas such as oncology and arthritis. The concept had a late entry into psychiatry, however, even though the assessment of non-disease aspects of patients, such as impairments, disabilities, social functioning and satisfaction, has had a long tradition in the field (Katschnig, 1983, 1997).

For psychiatry in particular, and mental health in general, the concept of quality of life has generated controversy (Barry, Crosby & Bogg, 1993; Gill & Feinstein, 1994; Hunt, 1997). Part of this controversy relates to the overlap between a number of the dimensions included in quality of life assessment and traditional psychopathological domains that are generally regarded as indicators of mental illness. The measurement redundancy raises the question of whether assessing quality of life in people with mental disorders adds anything of value to the psychiatric evaluation. The conceptualization of health-related quality of life as excluding things such as housing, social support and autonomy is also contentious in psychiatry since those issues are of direct relevance to mental health (Oliver et al., 1996). Also, the emphasis placed on subjective reports of well-being in quality of life assessments seems tautological in mental health where subjective experience is a core feature of the exploration of health or ill-health. Indeed, reliance on subjective report as a way of evaluating quality of life has other important limitations in psychiatry where patients' reports of the quality of their lives may depart significantly from what may be predicted by objective or social norms (Atkinson, Zibin & Chuang, 1997). A discussion of what may produce this counterintuitive evaluation of one's quality of life has been offered by Katschnig (1997), who identified several components of what he termed "psychopathological fallacies" as possible causes.

In spite of these limitations, few will question the relevance of quality of life assessment to a discussion of mental health issues today. For example, the centrality of the need for autonomy,

human rights and freedom from the experience of stigma to an informed concept of mental health makes its consideration very relevant.

The importance attached to evaluating quality of life is reflected in the range and number of tools that have been developed to measure it within the mental health field in the past two decades (Lehman, 1996). Of particular importance is the focus of many tools not only on negative factors that may impair quality of life but also on positive factors that may enhance general well-being. The definition of quality of life provided by WHO (WHOQOL Group, 1995) as "an individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns" reflects a broad view of well-being encompassing social indicators, happiness and health status. It is a definition to which many in the field of mental health can relate as it gives voice to the hitherto voiceless mentally ill and emphasizes the interaction between personal and environmental factors in health. It also reflects the utility of the concept of quality of life for describing health, including mental health, in terms that go beyond the presence or absence of symptoms and signs of disorders and captures positive aspects of coping, resilience, satisfaction and autonomy, among others.

The mental hygiene movement

Early in the 20th century the mental hygiene movement was successful in putting mental health promotion on the international agenda. During the 1920s and 30s there was substantial activity to stimulate "the integration of mental health principles into the practices of social work, nursing, public health administration, education, industry and government" (Beers, 1935, p. 327), views that are still very prevalent today. Despite the efforts of the pioneers, the movement initially failed to attract sufficient interest from these wider groups. It was not until the 1970s that the first studies into the value of integrating mental health principles into practice in other fields were initiated. During the past 30 years, however, some 2000 outcome studies have been published on promotion, prevention and related fields (Hosman, 2000).

Mental health promotion and the prevention of mental disorders

Although mental health promotion and the prevention of mental disorders have overlapping and related properties, they are derived from different conceptual principles and frameworks. Mental health promotion focuses on positive mental health and, in the main, on the building of competences, resources and strengths, whereas the prevention of mental disorders concerns itself primarily with specific disorders and aims to reduce the incidence, prevalence or seriousness of targeted problems (Barry, 2001). Mental health promotion is not primarily about the prevention of mental disorders but is a desirable activity in itself and has a major contribution to make to promoting personal and social development (Orley & Birrell Weisen, 1998). It can also assist in the prevention of a whole range of behaviourally-related diseases, for example by preventing smoking and therefore lung cancer (Botvin, Eng & Williams, 1980; Errecart et al., 1991) or reducing unprotected sex and consequently teenage pregnancies and AIDS (McLean 1994; Gold & Kelly, 1991).

A competence enhancement approach to mental health promotion

The competence enhancement approach promotes the goal of enhancing potential rather than emphasizing the prevention of mental disorders. Mental health is conceptualized in positive terms and mental health promotion programmes build upon strengths, abilities and feelings of efficacy (Weissberg, Caplan & Harwood, 1991). The competency model builds on the lifespan developmental approach (Cowen, 1991) and the ecology perspective of community psychology, including the structure of social power and support (Orford, 1992). It assumes that the individual becomes more capable as their psychological well-being improves. Evidence supports the view that competence enhancement programmes have the potential to strongly influence multiple positive outcomes across personal and social health domains (Lazar et al., 1982; Price et al., 1988; Schweinhart & Weikart, 1988).

Conclusion

Positive mental health is a huge domain that has many aspects. Many theories and concepts are pertinent to it and consequently many indicators could and have been used to measure it. The public health consequences of positive mental health are many and nearly all public health measures have effects on mental health.

The various theories and concepts represented in the literature about positive mental health and quality of life add to the understanding of the ideas and how they may be used to promote mental health. Each of these perspectives can be used to derive approaches to promoting mental health in settings and populations around the world. Understanding the evolution of these approaches and their application to promoting mental health, at least in certain parts of the world, is an important prelude to taking the next steps. The international community is now encouraging each country to assess and consolidate the evidence for promoting mental health and to consider new or adapted ways of promoting mental health in policy and practice across many aspects of community life.

There is now compelling evidence for the need to promote positive mental health through interventions that promote competence and psychological strengths. Scientific methodologies in promotion are increasingly sophisticated and the results from high-quality research trials are as credible as those in other areas of biomedical and psychosocial science. There is a growing recognition that promotion does work. Although some interventions have been proven to be effective in some settings there is still much to do to gain a better understanding of the mechanisms that help people to develop positive mental health and to assess how these may vary across cultures. Among these, a better knowledge of ways to enhance individual capacities to cope with adversities appears promising. This should not conflict with the necessity of decreasing social stressors by raising political awareness of their consequences.

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Chapter 4
The Intrinsic Value of Mental Health

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Introduction

Mental health and well-being are issues of everyday life: in families, in schools, on streets and in workplaces. Therefore they should be of interest to every citizen, to every politician and to every employee as well as to all sectors of society. This includes sectors such as education, employment, environment, housing and transport as well as health and social welfare. Many civil society organizations have taken an active role in the field of mental health. Mental health, social integration and productivity are linked: well-functioning groups, societies, organizations and workplaces are not only healthier but also more effective and productive. However, the main reason for promoting good mental health is its great intrinsic value.

There exist many misconceptions among the general public, politicians and even professionals regarding the concept of mental health. This is due to the fact that mental health is in many ways undervalued in our societies. The concept is often confused with severe mental disorders and associated with societal stigma and negative attitudes. It is also often the case that curative medicine focusing on health problems attracts more attention than public health questions of prevention and, even more so, of promotion. The positive value of mental health, contributing to our well-being, quality of life and creativity as well as to social capital, is not always seen.

Mental health is an indivisible part of general health and well-being. In principle, mental health refers to the characteristics of individuals, but we can also speak about the mental health of families, groups, communities and even societies. Mental health as a concept reflects the equilibrium between the individual and the environment in a broad sense. This is reflected in figure 4.1 which shows the so-called "structural" model of mental health. Here the determinants are grouped into four categories: individual factors and experiences, social support and other social interactions, societal structures and resources, and cultural values (Lahtinen et al., 1999). As the arrows in the figure show, the influences between mental health and its determinants are reciprocal. Thus, one can also speak about a "systemic" model of mental health. Furthermore, physical and mental health are also tightly connected (as is discussed in detail in Chapter 11).

Spiritual or religious values also contribute to mental health. Although they can overlap with cultural values, religious or spiritual values are often not the same as those of the specific culture. They can have both positive and negative effects on mental health in the same way as other determinants. An example of a positive spiritual value might be the assumption that each individual is of great worth apart from their functional capacity.

Mental health can be described in two dimensions:

- Positive mental health considers mental health as a resource. It is essential to subjective well-being and to our ability to perceive, comprehend and interpret our surroundings, to adapt to them or to change them if necessary, and to communicate with each other and have successful social interactions. Healthy human abilities and functions enable us to experience life as meaningful; helping us to be, among other things, creative and productive members of the society.

- Mental ill-health is about mental disorders, symptoms and problems. Mental disorders are defined in the current diagnostic classifications mainly by the existence of symptoms. Mental symptoms and problems also exist without the criteria for clinical disorders being met. These

subclinical conditions are often a consequence of persistent or temporary distress. They, too, can be a marked burden to individuals, families and societies (Lavikainen et al., 2001).

In theory, the aim of mental health promotion is to increase and enhance positive mental health and that of mental ill-health prevention is to protect individuals from mental health problems. In practice, however, many activities have both promotive and preventive effects.

Conceptualization and measurement of values

As already stated, mental health is of intrinsic value. Intrinsic value can be attributed to various qualities in the abstract by the society, culture or philosophical or religious framework. This identification of values and acting on those values is influenced by the cultural setting and often reflects cultural norms. Philosophers and theologians have often stated that some values exist even apart from societal norms and need to be affirmed in the way we live our lives.

A value that most consider important is human life itself. But even something as basic as this has qualifiers. An example of this is the weighing of the value of many against the value of enhanced life quality for particular individuals. Having the assumption that a value is important to the society as a whole can influence legal and government structures and research and health care choices. Epidemiological studies have moved beyond mortality measures to assess broader outcomes, to look at quality of life and functional status as outcome measures. This reflects a judgement of what is of value. Statements of values by religious and philosophical leaders past and present are often taken as a guide to what is intended to be of value and can move people beyond merely the summation of collective contentment. One can often pragmatically assess what a society or culture finds of value by examining various actions, rewards and governmental-legal structures.

Intrinsic value can also be assessed in a personal way by each individual. Questions that address this are ones such as, "What is most important to me personally? What makes life worth living?" A variety of scales have been constructed in the social sciences and psychology to measure this concept. In behavioural economics, value is often measured in terms of what you would be willing to exchange for something, either imaginatively in a questionnaire or in an experimental setting.

The WHO Quality of Life Measurement Instrument (WHOQOL Group, 1998) is an excellent example of a cross-cultural assessment of what makes life worth living and therefore captures values. Whereas most instruments that assess quality of life used in the health care field measure purely physical and mental functioning, the WHOQOL instrument measures mental well-being, social well-being and spiritual well-being. By examining the contribution of the various dimensions to the overall ranking of quality of life we can analyse, for example, the valuable contribution of lack of mental distress, our relationships with others and various spiritual variables to overall happiness and well-being. These can be seen as outcomes to be pursued as we institute health care and prevention measures.

Mental health as an individual capacity and experience

As outlined in Chapter 1, WHO defines mental health as "a state of well-being in which the individual realizes 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, 2001).

Figure 4.1
The structural model of mental health
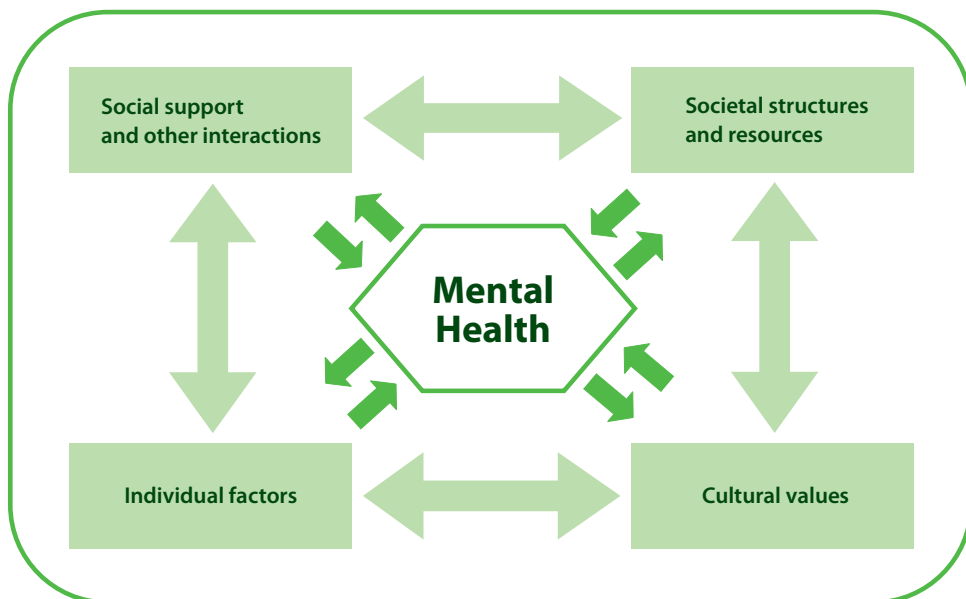
In lay language the concept of mental health is used in different ways, and rather often it has a negative connotation because it is connected with severe and chronic mental illnesses. However, the positive aspects of mental health have been more and more recognized by the general public and political decision-makers in recent years, partly due to the activities and reports of different international organizations, including WHO (2001) and the European Commission (Lahtinen et al., 1999). In the USA, the Office of the Surgeon General also published a comprehensive report on mental health in 1999 (USDHHS, 1999). Mental health is now seen as an essential element of our general health, well-being and quality of life.

It seems useful to regard mental health mainly as an individual resource contributing to different capacities and skills. Mental health has even been compared to natural, renewable resources (Lehtonen, 1978). Thus, mental health and its renewal must be understood as a continuous process which makes up the course of life, consisting of a sequence of phases in which the earlier always affect those that follow. In favourable circumstances mental health can increase, but mental health resources can also be exploited beyond their natural capacity for renewal or even be destroyed by inappropriate actions by the society.

The individual value of mental health is realized by positive feelings and different individual skills and capacities that can be seen as components or consequences of good mental health (Korkeila, 2000). Early research considered positive mental health largely from the viewpoint of life satisfaction. A low level of life satisfaction has been significantly associated with mental health problems. Life satisfaction refers generally to a personal assessment of one's condition compared to an external reference standard or to one's own aspirations. A second approach records affective reactions to daily experiences and a third screens for psychological distress. Numerous instruments

exist for measuring "psychological well-being", "subjective well-being" or "positive mental health" (McDowell & Newell, 1996; see also Chapter 3).

One aspect of mental health is a sense of personal control over the events of one's life. Rotter (1966) launched the concept "locus of control" to assess individuals on a presumed continuum of internality and externality of control. People who believe that they can themselves influence events in their lives (internal locus of control) cope better with challenging life events than those who explain events by such concepts as "luck" or "chance" or who attribute events to other people (external locus of control). Another relevant aspect of personal control is the concept of self-effi-cacy, which refers to the belief that one can succeed in what one desires to do. It has been shown that people with strong sense of self-efficacy show less psychological and physiological strain in stressful situations. Some authors use the term "sense of mastery" in the same meaning.

The concept of sense of coherence, developed by Antonovsky (1979), has been associated with mental health by many researchers and authors. Antonovsky's salutogenic model, which is discussed in more detail in box 4.1 and in Chapter 3, stresses positive aspects and resources of health rather than symptoms or disorders. The three components of a sense of coherence are comprehensibility (ability to find structure in events), manageability (control of environment) and meaningfulness (importance and value inherent in events and one's life). A person with a strong sense of coherence is able to choose between various potential resources available. A low level of sense of coherence has repeatedly been associated with mental ill-health, suicidal behaviour and psychosomatic conditions.

One feature of good mental health is resilience, by which is meant resistance towards mental disorders in the face of life adversities (Rutter 1985; also see Chapter 3). Resilience comes close to such concepts as hardiness and coping. Resilience may be seen as a dynamic process, greatly influenced by protective factors, which are the specific competencies necessary for the resilience process to occur. Competencies are healthy skills and abilities (e.g. problem-solving skills) that the individual can access. Their main function is resistance to stress, which can vary across time and circumstances and have both constitutional and environmental determinants. Coping with adver-sities plays a significant role in protecting from unfavourable health and mental health outcomes.

Mental health and social interaction

Another aspect of good mental health is the capacity for mutually satisfying and enduring rela-tionships. Social relationships and networks can also act as protective factors against the onset or recurrence of mental ill-health and enhance recovery from mental disorders. Interaction with other people is an inevitable prerequisite for human development. Without social interaction the whole potential for development of the infant remains totally unfulfilled, as has been shown by studies of children who have been left without any human contact, the so-called wolf children. Some authors regard the availability of social support as directly contributing to increased mental health whereas others see its role mainly as a buffering one in face of stressful adversities or life events.

For most people the childhood home is their most important developmental environment. Family is also for most adults the important core area of intimate relationships. Family researchers have developed the concept of "family homeostasis" (Jackson, 1957), by which they describe the fact that there usually exists a kind of dynamic equilibrium between the relationships of different

Box 4.1
The Salutogenic Perspective and Mental Health

Bengt Lindstrom, Monica Eriksson

The salutogenic framework

Promoting mental health as a positive concept belongs to the family of salutogenic concepts, that is, concepts that explore the origin of health not disease (Antonovsky, 1979, 1987). Prior to Antonovsky, stress had been seen as a negative event that increased the risk of people "breaking down". In contrast, Antonovsky stated that diseases and stress occur everywhere and all the time and that it was surprising that an organism is able to survive at all for such a long time. His conclusion was that chaos and stress are part of life and natural conditions. In his view, health is a relative concept on a continuum and the really important research question is what causes health (salutogenesis) not what are the reasons for disease (pathogenesis).

The fundamental concepts of salutogenesis are generalized resistance resources (GRRs) and sense of coherence (SOC). The GRRs are biological, material and psychosocial factors that make it easier for people to perceive their lives as consistent, structured and understandable. Typical GRRs are money, knowledge, experience, social support, culture, intelligence, traditions and ideologies. These are shaped by life experiences characterized by consistency, participation in shaping outcome and a balance between underload and overload. If a person has these kinds of resources available or in their immediate surroundings there is a better chance for them to deal with the challenges of life.

GRRs help the person to construct coherent life experiences. Even more important than the resources themselves is the ability to use them, the sense of coherence (SOC). The GRRs lead to life experiences that promote a strong sense of coherence – a way of perceiving life and an ability to successfully manage the infinite number of complex stressors encountered in the discourse of life. The salutogenic concept is a deep personal way of thinking, being and acting, a feeling of an inner trust that things will be in order independent of whatever happens. The inner trust developed by internalising the SOC concept leads us to identify, benefit, use and re-use the GRRs from our surroundings.

Three types of life experiences shape the SOC: consistency (comprehensibility), load balance (manageability) and participation in shaping outcomes (meaningfulness) (Antonovsky 1979, 1987). A fourth experience has been added to the SOC concept – emotional closeness – which refers to the extent to which a person feels emotional bonds and experiences social integration in different groups (Sagy & Antonovsky, 2000). SOC applies at the individual, group and societal level. Antonovsky postulated that it mainly is formed in the first three decades of life and that only very strong changes in life would upset and change the SOC thereafter.

Salutogenesis and mental well-being

The assessment of SOC has been translated into 33 languages in 32 countries (Eriksson & Lindstrom, 2004). The evidence shows that SOC is strongly and negatively related to

anxiety, burnout, demoralization, depression and hopelessness, and positively with hardiness, mastery, optimism, self-esteem, good perceived health, quality of life and well-being. SOC seems to be relatively stable over time, at least for people with a high initial SOC, but not as stable as Antonovsky assumed, with fluctuations of more than 10% (Lindstrom, 2004; Nilsson et al., 2003; Smith, Breslin & Beaton, 2003). SOC tends to increase with age and gender differences are found – men usually score higher on SOC than women (Eriksson & Lindstrom, 2004).

SOC seems to have a main, moderating or mediating role in the explanation of health, especially in relation to factors that measure mental health. There is a positive association with optimism, hope, learned resourcefulness and constructive thinking. One conclusion of this is that SOC is another expression for mental health. The higher the SOC the more satisfied people are with their lives and consequently they report a higher level of quality of life and general well-being (Eriksson & Lindstrom, 2004). Social networks and intimate relationships are GRRs, both factors enabling development and strengthening of the individual SOC and strongly and positively related to SOC. They are essential for all human beings and provide, if they are stable, deep and favourable social support and create a climate of social integration for the people involved. Giving support also has the effect of promoting health related to the meaningfulness component (Folkman, 1997).

Other related concepts which contribute to the understanding of the health process are hardiness (Kobasa), sense of permanence (Boyce), the social climate (Moos), resilience (Werner) and the family's construction of reality (Reiss), all mentioned by Antonovsky (1987). Additional concepts which he did not discuss and which resemble SOC's connection to health are learned resourcefulness (Rosenbaum, 1990), flow (Csikszentmihalyi & Csikszentmihali, 1998), life control (Soderqvist & Backman, 1988) and theories on welfare/well-being (Allardt, 1980) and quality of life (Lindstrom, 1994).

Conclusions

The salutogenic approach claims health is open-ended and dependent on the skills to organize the resources available in society, the social context and self. These skills enable people and populations to develop their health and deal with the fragmentation and chaos of reality through using cognitive and emotional perception, behavioural skills and motivation developed through meaningful frameworks based on culture, tradition and belief systems. The salutogenic framework could guide public health in a new direction. This framework suggests that what we perceive as being good for ourselves (subjective well-being) also predicts our outcome on objective health parameters. In other words, if we create salutogenic processes where people perceive they are able to live the life they want to live they not only will feel better but also lead better lives.

The full text of this paper and more references can be requested from the authors on bengt@nhv.se.

family members. This is related to the needs of the different family members and their mutual power positions. Homeostasis may not only be healthy and thus flexible and tolerate changes but may also be rigid and pathologizing. Family researchers have shown that the type of family homeostasis is clearly associated with the state of mental health of the family members, which again has an effect on the function of the whole family.

Mental health contributes to our social participation and vice versa. People suffering from mental disorders are easily marginalized and socially excluded. Starting from the work by Faris and Dunham (1939), it has also been repeatedly shown that social disintegration of a community is associated with an increased rate of mental disorders in that community. The disintegration of community is characterized by high rates of lonely people, divorces, abandoned children, lack of social support, violence, crime, drug and alcohol problems and anomie. Several community interventions exist in which the main goal is to provide opportunities for social support and mutual responsibility. One example is the "community diagnosis" approach to enhance social interaction in socially disintegrated urban environments (Dalgard & Tambs, 1997).

One of the most important areas of social participation through our adult years takes place within our work life. The relationship between mental health and work is very complex. First of all, to be able to fully participate in work a certain level of mental health and psychological capacity is needed. In this sense the value of an individual's mental health is shown in service to society as one of its productive members. Work is also a valuable supporter of our mental health. It gives structure and rhythm to our daily life, it gives the possibility for self-fulfilment, it strengthens our self-esteem and it provides security and an opportunity for satisfying relationships. On the other hand, work has become more and more a source of distress and even mental ill-health due to stressful work conditions, overload, increasing requirements and bad workplace relationships with bosses and co-workers. In many studies, unemployment has been shown to be associated with increased rate of mental health problems, although in some cases it can also be a relief from unbearable work conditions and so prevent mental ill-health.

Undoubtedly, a mentally healthy workforce is important for the present and future of organizations in the information and knowledge society. Assessment of the mental health of employees and the implementation of strategies for the promotion of mental health in enterprises should nowadays be at the core of a company's success.

Mental health contributes to social capital

One way of looking at the relationship between mental health and the society is through the concept of social capital (Putnam, 1993). This concept refers to features of social life such as institutions, networks, norms, reciprocity and social trust that shape the quality and quantity of social interactions and facilitate collective action, coordination and mutual benefit. Increasing evidence shows that social cohesion is critical for societies to prosper economically and for their development to be sustainable. Aspects of social capital, like trust, social support and social networks, are also important determinants of the mental health of individuals. Furthermore, it is evident that social capital can improve access to services for people with mental disorders and so shorten the duration of these disorders (Sartorius, 2003). The relationship between mental health, its consequences and organizations as part of social capital is demonstrated in figure 4.2.

Figure 4.2
Modelling the impact of mental health on social capital

Mental Health ⟷ **CONSEQUENCES**
- Level of well-being
- Physical health
- Reciprocity
- Knowledge and skills
- Quality of relationships
- Sexual satisfaction
- Use of services
- Productivity
- Trust
- Social cohesion
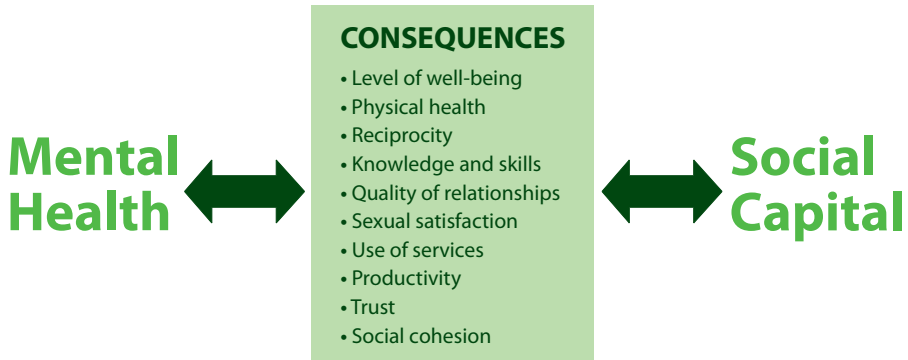
⟷ **Social Capital**

These relationships between social capital and mental health are more thoroughly discussed in Chapter 6.

The social capital–mental health relationship should be a key consideration in the promotion of mental health because mental health is a key input to human productivity. This knowledge should be used in the development of any social policy aiming to enhance social capital. There are experiences of the development of mental health service resources and systems that have had favourable impact in the restructuring of societies in crisis. We need more systematic research to deepen our knowledge on these associations, however, in order to be able to provide useful recommendations for planning and implementation of new service strategies.

Cultural values and mental health

The task of explaining the relevance of cultural values is complicated somewhat by the fact that in most of the world's cultures mental health is a foreign concept (see Chapter 5). Even so, it is often possible to identify cultural values directly concerned with the essential features of mental health. For example, cultural formulations of suffering as an essential feature of the human condition (e.g. Buddhist) may complement or displace notions of mental illness; positive subjective experience may refer to a sense of inner and interpersonal harmony (Wig, 1999) or be construed in religious terms. The interplay and relative priority of personal achievement and independence in Euro-American cultures may be contrasted with an emphasis on interdependence and family commitment in Asia, Africa and elsewhere. In a diverse world, many factors outside the individual produce stress or provide support that directly influence mental health. Cultural values, social organizations and socioeconomic conditions determine the nature and availability of opportunities for productive and fulfilling activity.

Like any cultural comparison, ideas about mental health that emerge as products of the world's cultures are notable both for shared common features and for striking differences in their emphasis and substance. The clinical formulation of health as the condition resulting from successful treatment that cures illness often proves to be unsatisfactory, especially outside of clinical settings

where the health of populations rather than individual patients is at stake. Thus, the well-known WHO definition of health aims to respect the interests of various cultures and avoids the kind of specificity that would exclude the endorsement or participation of people from any particular cultural group.

Earlier psychiatric concepts of mental health were mainly concerned with a working model for clinical practice rather than broader population-based interests of mental health; they were also less concerned with questions of culture. Among the few psychodynamically oriented clinical scholars and teachers who explicitly addressed a need to define mental health in the context of psychiatric assessment, Havens (1984) argued that human connectedness and self-protectiveness should be regarded as key features. On the other hand, Freud's relative inattention to the concept of mental health remains a persistent feature of mainstream psychiatry. Although his famous quip "to love and to work" seems benign and superficially appealing, Erikson's (1963, p. 264–5) elaboration of the remark – emphasizing genital sexuality, procreation and a capacity for recreation – specifies a cultural ideal that would be unacceptable, if not offensive, in many cultures as a working definition of mental health, and dated as well, even in Europe and America.

Writing from a feminist and mental health advocacy perspective in Pune, India, Bhargavi Davar analysed a variety of definitions of mental health (including Erikson's) formulated from the 1950s through to the 1970s. She dismissed them as essentially bourgeois, concerned primarily with promoting conformity and suppressing deviance (Davar, 1999). She argued that the unexamined effort to generalize local cultural ideals as expectations defining "healthy" works to the disadvantage of women and others who lack the entitlements and resources to achieve such ideals. Others have argued that multicultural populations in America and Europe are also poorly served because of too little attention being paid to social contexts and cultural values and by relative inattention to subjective well-being compared with the predominant interest in the field of psychopathology (Christopher, 1999).

Calling upon evidence from psychiatric epidemiology to make the case yields mixed results. As discussed in Chapter 12, findings from comparing rates of disorders and suicide rates turn out to be difficult to interpret, if not misleading (Weiss, 2001). These indicators are relatively blunt instruments that may obscure as much as they clarify the adverse impact of racism, poverty, urbanization and social change, victimization by violence and the displacement of populations. When rates of psychiatric disorders and suicides fail to show the special needs of disadvantaged groups, data are too often explained away as inconclusive findings from inadequate studies.

Although mental health problems (in contrast to psychiatric disorders) are regarded by some as signs and symptoms of "insufficient intensity or duration to meet the criteria for any mental disorders" (USDHHS, 2001a, box 1-2, p. 7), this formulation is incomplete and therefore flawed. Mental health problems that do not meet criteria for a psychiatric disorder may nevertheless be so troubling and persistent that they lead to suicidal behaviour and mortality from suicide. It is not just limited seriousness and duration but also specific cultural configurations of distress and suffering that may distinguish mental health problems from psychiatric disorders. Careful attention to locally significant mental health problems is especially important to guide population-based mental health policy. Lessons from a study of suicidal behaviour showing substantial self-harm without a psychiatric diagnosis clearly show that criterion-based disorders should not be regarded as the only valid outcome variables for mental health research, especially in community studies. Programmes concerned with social problems recognize this point. For example, mental

health priorities for addressing community violence (e.g. dowry deaths, marital rape, honour murders and youth violence) focus more appropriately on problem behaviours, their typical social and gender contexts and the cultural values that support them rather than the diagnosis of underlying disorders (Fishbach & Herbert, 1997; USDHHS, 2001b).

Some initial efforts in this regard have begun to consider the interests of children and families at risk in a study of urban and rural communities in and near Bangalore, Delhi, and Kanpur, India. An assessment of indicators of mental health was followed by an intervention and evaluation of impact with reference to controls (Channabasavanna, Varghese & Chandra, 1995). Additional community-based innovative studies are needed to develop a population-based mental health agenda to promote mental health. The potential gains from effective policy to develop a population perspective for mental health are vast. Culturally appropriate strategies to identify and assist families in need may ultimately provide mental health interventions targeting children with long-range, non-specific benefits comparable to the positive impact of vitamin A on general health status.

Spiritual dimensions of mental health

Many would agree that to be fully human includes the spiritual dimension of life (Smith, 2003). Spiritual well-being can be thought of as a component of mental health, but it also stretches beyond the comfort of the individual and his or her community to aspirations that transcend this. Spirituality makes an important contribution to quality of life for many people all over the world. This has been documented in a WHO study of over 4000 people at 18 sites worldwide. Qualities such as awe, meaning of life, faith and connection to a spiritual being make significant contribution to the overall rating of quality of life, above and beyond that of psychological well-being or social connection (Saxena, O'Connell & Underwood, 2002). In the development of a new WHO instrument to measure quality of life in people living with HIV and AIDS it was concluded that it was crucial to include measures of the contribution of spiritual factors to life. "Many PLWHA [people living with HIV/AIDS] reported experiencing a more intense spiritual life as a result of their HIV infections" (WHOQOL AIDS Group, 2003). In situations such as these, when the end of life is clearly in sight, particular elements of the spiritual can promote mental health.

Spirituality can exist independently of religious practice or affiliation, but in most people their spirituality is nested in a religious context. In an article summarizing the relevance of religion to public health research and practice, Chatters (2000) states:

> Religious doctrines may support positive views of human nature and the self that engender attitudes and emotional states that are associated with better physical and mental health outcomes. Belief in the intrinsic value and uniqueness of each individual may promote feelings of self-esteem. Religious injunctions may shape interpersonal behaviours and attitudes towards others in ways that emphasize a variety of positive and pro-social goals (e.g. interpersonal warmth and friendliness, love, compassion, harmony, tolerance and forgiveness) and that reduce the likelihood of noxious and stressful interpersonal interactions (p. 345).

Hope and hopelessness are important determinants of mental health. For example, in depression hopelessness is one of the key symptoms. A number of well-conducted clinical and epidemiological studies have shown that spirituality can under some circumstances help prevent depression (Koenig, McCullough & Larson, 2001). Spirituality can provide hope to people in despair, and

in that sense even prevent suicide which is often the result of a decision that life is not worth living. In interviews about the role spirituality played in their daily lives, people reported being able to experience deep peace even in the midst of mental distress (Underwood & Teresi, 2002). Spirituality can enable people to step outside or beyond the mental distress and experience comfort and calm. Especially in the midst of crisis, particular kinds of spirituality can prove to be a powerful resource which can be a real buffer against excessive mental distress and despair (Pargament, 1997).

A large number of studies have recently been completed looking at the role of spirituality/religiousness in preventing alcohol problems. One of the studies showed that in inner-city African-American adolescents, those who had a sense that they were "working cooperatively with God" had fewer alcohol problems than those who did not have such a belief or experience (Goggin et al., 2003). Pardini et al. (2000) found in a study of 237 recovering substance abusers that higher levels of religious faith and spirituality predicted a more optimistic life orientation, greater perceived social support, higher resilience to stress and lower levels of anxiety. In addition, in a study of over 2000 female-female twins, Kendler, Gardner and Prescott (1997) reported that current drinking and smoking as well as lifetime risk for alcoholism and nicotine dependence were inversely associated with personal devotion (such as frequency of praying and seeking spiritual comfort). Religiousness and spirituality can also improve overall health by encouraging healthy behaviours and practices (such as healthy dietary practices, sexual regulation and limitations on addictive substances) that can often improve physical health, and through that improve overall well-being, including mental health (Koenig, McCullough & Larson, 2001).

Maintaining mental health also has a positive effect on the development of a healthy spiritual life. It is more difficult to see the positive hopeful view, have faith or face the moral challenges and demands for ethical behaviours presented by the spiritual life if the mind is clouded by mental health problems. Religion can also contribute negative features to a person's spirituality, however, such as guilt and inappropriate revenge-motivated behaviours. In general, though, the positive contribution of religion to spirituality is the dominant effect.

One of the most important ways spirituality contributes to human value is that it tends to define the human being in a way that is beyond merely the ability to function:

> The functional world defines people in terms of how effectively they perform functions: in other words, as 'human doings' rather than human beings. The spiritual approach tends to view the functional aspect as just one part of life, with issues such as root motivations and attitudes such as appreciation, awe and compassion being ultimately more important (Underwood-Gordon, 1999, p. 60).

Conclusion

There is an urgent need to develop mental health policies and to enhance promotion of mental health at different levels because of the great value of mental health in different contexts. The information in this chapter has shown that:

- Mental health, to which much confusion and many misconceptions are attached, is essential for the well-being and functioning of individuals.

- Good mental health is also an important resource for families, communities and nations.

- Mental health, as an indivisible part of general health, is often undervalued, although it contributes to the functions of society and has an effect on overall productivity.

- Mental health can be approached both from professional and lay perspectives. It concerns everyone as it is generated in our everyday lives in homes, schools, workplaces and in leisure activities.

- Positive mental health contributes to the social, human and economic capital of societies.

- Because culture influences the way people understand mental health and their regard for it, cultural contexts should be evaluated and considered when designing interventions to promote mental health.

- Spirituality can make a significant contribution to mental health promotion, and mental health positively influences our spiritual life.

Without exaggeration, it is possible to say that mental health contributes to all aspects of human life. Mental health has both material or utilitarian and immaterial or intrinsic values. Material values are those that contribute to productivity and can, at least in principle, be measured in monetary terms. But one must not forget that mental health is also a great value in itself.

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Chapter 5
Concepts of Mental Health Across the World

Shona Sturgeon, John Orley

Introduction

The concept of positive mental health (discussed in detail in Chapter 3) is considered by mental health practitioners to refer to the individual having a positive sense of well-being, resources such as self-esteem, optimism, sense of mastery and coherence, satisfying personal relationships and resilience or the ability to cope with adversities. These qualities enhance the person's capacity to make a meaningful contribution to their family, community and society (Lavikainen, Lahtinen & Lehtinen, 2000). While these qualities of mental health may be universal, the form they take may well differ individually, culturally and in different contexts. Before engaging in mental health promotion in any community, therefore, it will be necessary to understand that particular community's concept of mental health, although it is unlikely that their ideas will be couched in mental health terms.

Who promotes mental health?

Given that mental health is broadly defined, it would be naïve to think that its enhancement should be the preserve of mental health professionals. Actions which potentially can promote mental health are usually undertaken by people other than mental health practitioners, whether through interacting directly with people in ways they consider to be positive, such as is done by parents and teachers, or indirectly, such as through creating environments which they consider positive, as do town planners.

It is unlikely, however, that these people will describe the impact of their activities in mental health terms, and they may not even be aware of such impact. They are more likely to describe the outcome of their activities in terms derived from their own background and world view.

Having made the point that most of what is done to enhance mental functioning and well-being falls within the scope of others, perhaps it is helpful to list some of the roles of the mental health specialist. These include to:

- identify and point out areas where mental health is not optimal;

- help develop measures of mental health to monitor the situation;

- help (if asked) to devise interventions;

- help with the training of those intervening; and

- help monitor the effectiveness of interventions.

It is important to note that the "cultural gap" can be just as great when one is engaging with someone from another discipline as it is when engaging with someone from another culture.

Who defines mental health?

Naturally, if the aim is to make some impact on the mental health of people, it is important for those involved to have some shared understanding of what is meant by mental health. A challenge posed in mental health promotion, and perhaps why it has been so difficult to get program-

mes adopted, is that people from different professions, not to mention the potential recipients of the programmes, may have difficulty in articulating what they mean by mental health or even widely disagree in what they conceive of as good mental health. This also refers to ways in which they conceive of circumstances that lead to good mental health. The possibility of widely differing ideas has increased as international partnerships are formed to address mental health promotion. The recognition of this diversity has led to the emphasis on community involvement in the development of programmes with the aim of developing respectful partnerships between communities and mental health professionals.

Mental health professionals have to reframe what they see as mental health issues in ways that engage those from other cultures or disciplines in useful dialogue. Similarly, it might be helpful to assist others to conceptualize certain actions or behaviours in mental health terms. Working towards this improved communication in itself constitutes a form of mental health promotion.

An understanding of people's conceptions is useful for those designing and implementing programmes to promote mental health so that programmes that are introduced are as far as possible compatible with the existing views of the people. In this way, you can build on what is already there, as well as understand what is happening that may not be optimal for the development and maintenance of good mental health.

Approach of this chapter

This chapter has attempted to address these issues by posing these challenges to practitioners working with different groups in different parts of the world and asking for their comment, rather than entering the debate on culture and mental health or attempting to provide a glossary of "interesting" cultural phenomena collected from around the world.

The latter would have constituted an emic approach to examining culture, in which the focus is on studying each cultural group as a separate entity. Although such a culture-specific approach may increase cultural sensitivity, it is unhelpful in that it assumes homogeneity within cultures and ignores individual differences. It also tends to feed into prejudice and stereotyping. With the impact of globalization there are few homogeneous cultures anywhere in the world and an approach that allows for cultural diversity and overlapping cultures within communities is possibly more helpful (Lee, 1996).

The practitioners selected include people working with different developmental stages in the lifecycle, such as infancy, the school context and the elderly, and practitioners working with groups that pose particular challenges, such as under-age soldiers, people with HIV/AIDS and the terminally ill. This was not intended to be an exhaustive or representative list, but was helpful in broadening the debate into seeing what is actually happening in the field. By selecting such diverse groups in terms of age and issues, the intention was to afford an opportunity for differences and similarities in relation to perspectives of mental health to emerge, whether or not originating from cultural beliefs.

The exercise has been both enlightening and frustrating to the authors and the contributors, which perhaps reflects the challenges encountered in working in this field. Contributors generally commented on how important it was to understand the concept of mental health held by the individuals they worked with. Such understanding, however, seems to be usually inferred by the professional from the behaviour of the group they are working with rather than from any attempt

to directly address this with the people concerned. The point was made several times of the danger of generalizing and stereotyping. It is also clear how difficult it is to address "mental health", and to recognize what is identified and valued by people in relation to their own mental health and to build on these strengths. It seems much easier to identify problems or "illness" and intervene accordingly.

Concepts of mental health in infancy and early childhood

The promotion of mental health in infancy and childhood understandably has received great attention and today much is known about what constitutes good childrearing practices. Studying the differences in childrearing beliefs and practices in diverse cultures has always been of great interest to practitioners. It is suggested that understanding the function of these practices in their context is essential before any intervention is planned within a particular community, even if ultimately the goal of the practitioner might be to encourage change.

In his paper examining cultural diversity and infant care, Tomlinson (2001, p. 4) strongly criticizes reports that encourage the "drawing of false dichotomies between methods of childcare in the developed world and the rest". He makes the point that when attempting to understand the conceptualizations of infancy and childhood in a particular culture it is essential to analyse them within their political, economic and social context in terms of their functional meaning and at a particular point in time. To illustrate this he describes how a Xhosa mother in the apartheid era in South Africa explained in an interview with him that she did not comfort her son when he cried, not for any cultural reasons, but because she felt he had to grow up strong enough to leave the country and join the armed struggle. However, it could be argued that to understand the political or social function of a behaviour does not necessarily mean to condone it.

Pedro Mendes (2003b) also makes the distinction between behaviours motivated by "external life conditions" as opposed to "culture". He illustrates how the political, economic and social conditions faced by those living in war-torn countries impact hugely on the population. He describes the situation in Angola, where 4 million (40%) of the population have been displaced as a result of the war and have moved from small towns or rural areas into slums on the outskirts of towns or into camps. He portrays the last decade as being violent and destructive in terms of people, the social fabric and means of production. He considers that these conditions have damaged cultures and their transmission processes. The inability to cope with urban life, loss of loved ones and property and current lack of work opportunity leads to an ingrained sense of hopelessness, dependency on external aid and resignation to an unpredictable future.

The resulting attitudes of apathy and passivity impact on all human relationships, but particularly on relationships with children. Although mothers try to feed and care for the basic needs of their children, even this is often not possible, and the mothers themselves are underfed and unable to breastfeed. It would seem that often they lack the impulse for bonding or interacting with their children. Mendes (2003b) describes how mothers can be seen sitting on the ground in front of their huts, gazing away and not responding to the crying of their babies.

Another reason given by Mendes for the restricted bonds of affection and interaction of mothers with their children relates to the high infant mortality rate in the camps and suburbs. He suggests that the pain of losing a child is the "ultimate blow in a meaningless life" and the function of this restriction of affection is to make the loss of the child more bearable, particularly during the first two years of life and until the child becomes more autonomous. This behaviour becomes entren-

ched culturally as new mothers brought up in this way repeat and perpetuate this pattern of childrearing.

Likewise, in a Brazilian community with a high infant mortality rate the tendency for new mothers to avoid bonding with their children may derive not from cultural beliefs but from a functional sense of keeping some emotional distance until the child is older and less likely to die (Scheper-Hughes, 1992). This same behaviour is being recorded in HIV-positive mothers in South Africa, but here the mothers state they are also trying to protect their children from the pain associated with the mother's potential death (Landman, 2002). Emotional distance, it would seem, is elected for as a way of dealing with a hostile environment and attempts to change this behaviour would need to take cognizance of its functional purpose.

Cultural beliefs may also play a part, however. Mendes (2003b) suggests that in many cultures children are not considered "people" with their own feelings, thoughts and wishes until they can communicate and engage in domestic tasks. He also describes how, despite the harsh conditions, mothers in Angola are more active towards their babies if they are the first-born. The first child in most Angolan cultures is both a personal and a social symbol. On a personal level it confirms to the mother that she is a healthy and complete woman; on a social level it proves that she is capable of "generational continuity". It establishes her place with her husband, his family and the community. First-born children are thus particularly meaningful and so receive more attention, tenderness and expressive care than children born later. Although loved and welcomed, subsequent children lack the symbolic meaning of the first-born, detrimental though this may be for them.

Tomlinson (2001, p. 3) cautions against producing cultural stereotypes which leave no room for changing beliefs and individual differences. He describes one of his interviews on the Thula Sana Mother Infant Project as follows:

> A commonly stated belief amongst many Xhosa people has to do with how parents are to understand the crying of their infant. Providing that the infant has been fed and does not need to be changed, then the crying is understood as a signal reassuring the parents that the infant is still alive. Furthermore it is seen as a device to ward off evil spirits.

Tomlinson (2003, p. 2) also reports that in one Xhosa community there is "an often repeated belief that infants cannot hear until they are a year or so old", although he has no independent data on this. He suggests, "the reality on the ground is however, that for every mother that believes infants cannot hear until they are one, there are two or three who believe that to be a ridiculous idea (even if they are not always immediately willing to share that belief)". While it is good to know that this deafness belief is not strongly held, there do seem to be mothers who have this idea and it is unlikely to be confined to the Xhosa. Certainly in the United Kingdom, as well as elsewhere, most mothers can be surprised at the extent to which their newborn baby has the capacity to be involved in quite complex social interactions. Once they come to understand that their (cultural) preconception of their baby's passivity is wrong they feel encouraged to make greater efforts at interaction, which is surely beneficial for their child's development.

On another issue, Tomlinson reports (2001, p. 3):

> In one of my interviews I asked an older mother (both her children were now adults) about whether the belief about why infants cried was in fact something that she subscribed to and had followed. She said yes and that in the case of both her children this was in fact the way that she had dealt with their crying. I asked her whether her children believed the same thing. She said no. She stated that she had informed them of these

beliefs but had also told them that infants might cry for a number of other reasons – illness, or the need for contact and comfort being just two of these alternative reasons. I then asked her how she had come to these alternative beliefs. She said that she had always believed that infants cry for various reasons. Why she had left her infants to cry was that she was living in the house of her mother-in-law. Her status within the house required her to respect the child care views of her mother-in-law – even if they contradicted her own.

Similar examples could be drawn from many countries which have a wide diversity of cultures undergoing rapid social change and where cultural groups themselves are not homogeneous.

The point has been made how important it is to recognize the complexity of all the factors that impact on childrearing behaviour. One wonders how often people are asked to speak for themselves and how often their beliefs are inferred by others from their behaviour, often interpreted from another cultural background. Asking parents what goals they strive for in relation to their children, in other words their concept of good mental health, and the role, if any, they believe they can play in reaching this, would provide answers that would be very helpful when designing promotion programmes.

Concepts of mental health and the school context

The teaching profession would assume that it has a positive role to play in the promotion of mental health. While teachers may agree that they are particularly concerned with "mastery and coherence" (Lavikainen, Lahtinen & Lehtinen, 2000), there are differences in opinion within and between countries as to how this should be attained and how the learner, and ultimately the adult, should demonstrate this mastery. For example, in the South African context some black school headmasters consider being "obedient and docile" as highly admirable qualities in applicants for tertiary education, an opinion not shared by a university selection board. In some parts of the world it is considered acceptable for learners to challenge their teachers, while elsewhere this is punished severely. These different perceptions of this aspect of mental health must be recognized, as there are reports of how school life skills programmes that teach assertive behaviour can create confusion in learners if such behaviour is not condoned by other teachers or by their parents and community.

Teachers are in a very powerful position. Their behaviour as a model and their opinions as to what constitutes good mental health impact very directly on the concepts of mental health adopted by their pupils. Sexual abuse of girls by male teachers, for example, is common in some countries and sends an unfortunate message about power and gender relationships to the pupils.

Teachers are also concerned, in varying degrees in different parts of the world, in promoting other aspects of mental health, such as improving the self-esteem of their learners, teaching acceptable ways of relating to others and managing stress and adversity. As such, their interpretation of what constitutes good mental health is significant. In deprived communities, and in communities undergoing rapid social change, teachers often have particular responsibilities as they are faced with youth needing guidance with many life skills, such as conflict resolution and problem-solving. For many of these young people little parental guidance is available at home.

Van der Merwe (2003) describes conditions in South Africa where many teachers feel the need to help pupils but feel helpless as they do not have these skills themselves. Others are anxious,

stressed and worried, and feel that caring for the mental well-being of learners should not be part of their job description. Some consider it their responsibility to talk to the learners and assist them with their problems but, with the diversity of cultures and rapid social change, feel unsure what constitutes acceptable behaviour. Discipline in schools is becoming increasingly problematic and norms of behaviour are changing. The HIV/AIDS pandemic has forced many other changes, particularly in relation to dealing with sexuality and sexual relationships. Economic conditions have also sometimes split rural families, with fathers having to obtain work in urban areas. This leads to boys receiving little guidance from their fathers and it is not considered appropriate for mothers to do so.

It is also essential to understand and respect the spiritual aspect of mental health as defined by both individuals and cultures. Mental well-being for many people is linked to their relationship with their concept of God. Problems are considered to be caused by a breakdown in this relationship or an oversight in the respect that should have been shown. Consequently, problem-solving requires some action that repairs this relationship. Undertaking this spiritual action may not necessarily preclude other, more secular, problem-solving activities. In traditional African cultures the relationship breakdown may be concerned with ancestors and healing this relationship may require a concrete atonement of some kind, while in other belief systems the breakdown may be couched in other terms and require other actions.

Concepts of mental health and under-age soldiers

The phenomenon of children and youths being forced into the role of soldiers is all too common today throughout the developing world. When hostilities cease they have to reintegrate into a society that, for them, appears alien. It is important to understand what they consider, or value, as good mental health in order to identify the circumstances that would help them attain it. The example related below refers to the situation in Angola, but the interruption of normal developmental experiences is common in any situation when children are forced into adult roles.

Mendes (2003a), working with men who had been under-aged soldiers involved in conflict for at least 10 years, found soldiers from opposing parties to share similarities in their past experiences and future aspirations; in other words, the aspects of mental health they most valued for the future. Regarding the past, they felt expendable or used, although some were more aware of this feeling than others. They felt they had lost their youth and the experience and richness of family life and the socialization experience that this would have provided. They felt clumsy in dealing with social situations and unsure of social norms. They felt "different" and had difficulties adapting to and finding a place in their families, although they had formed an "inner circle" of comradeship with each other. They tended to be aggressive and have difficulty controlling their aggression and instituted strict discipline in their homes. They had difficulties relating to children, including their own, and some reported that children were afraid of them.

Regarding the future, the aspect of mental health that seemed of particular importance to them was the "sense of coherence (life experienced as meaningful and manageable)" (Lavikainen, Lahtinen & Lehtinen, 2000, p. 56). Having spent a considerable part of their lives fighting for something, they were now "striving for a place in a society they had supposedly served" and they "wanted to build a new world of meaning and purpose, and this meant reframing and retouching what had happened" (Mendes, 2003a, p. 1). Helping them to re-experience their childhood was a very meaningful and emotional experience for them and important in helping them to relate to

their own children. Such interventions are essential, not only to facilitate the adjustment of these people back into a peacetime society but also to enable them to provide an environment conducive to the promotion of mental health in their children.

Young people in unstable societies, or societies characterized by political, racial or religious discrimination, sometimes are forced, or elect to join, activist movements that remove them from normal developmental life experiences, including education. Their concerns and aspirations are not unlike those of under-aged soldiers as they struggle to find a place in the society that they had hoped to change. Returning exiles also struggle with this task.

Concepts of mental health and HIV/AIDS

The HIV/AIDS pandemic impacts on all aspects of those societies in which the prevalence rates are high and there is limited access to drugs. Freeman (2003, p. 1) describes the complexity of the pandemic as follows:

> With HIV prevalence rates round 30% in some countries and dramatic increases in severe illness and deaths in communities, mental health problems are inevitably on a dramatic rise. While not universally true, and perhaps not yet evident in some situations where the epidemic is in its early stages, whole societies are and will increasingly experience the mental health impacts of the virus. Starting with the infected person him/herself the effects ripple in widening circles to the direct family and caregivers of the infected person, to other family and friends, to communities confronted with multiple deaths and large numbers of children orphaned by the disease.

He goes on to state that mental health problems peak at the time of hearing of the diagnosis, when the person becomes symptomatic and in the last stages of AIDS. People close to the infected person also experience depression and anxiety when they die.

The stigma associated with HIV/AIDS impacts hugely on all concerned:

> Given the stigma attached to HIV and the discrimination against infected people and their families, the psychological reactions often become more complex and difficult to deal with compared to other illness. For example, a family member may themselves hold stigmatized attitudes and values and be angry with the infected person for behaving "irresponsibly" and for bringing shame on the family, while at the same time feeling love and compassion and fear for the person dying. The situation is often exacerbated by the "clustering" of AIDS. Thus both partners in a relationship may be affected at the same time, a parent may find more than one (or all) their children infected. Children orphaned by AIDS have also been shown to experience depression, suicidal ideation and other psychological difficulties (Freeman 2003, p. 1).

The scale of the pandemic is such that the impact on the community as a whole must also be recognized:

> Moving on to a more community level some countries are reaching a situation where young people are being buried each week as a result of AIDS deaths. Two scenarios may develop, either communities may become overwhelmed by the deaths and the grieving and suffer deep ongoing emotional turmoil or they may deny their emotional reactions and cut off from them in order to protect themselves from their continual grief. Neither of these options is good for mental health. Orphaned children may find themselves out

on the streets and having to fend for themselves. Lack of early bonding and emotional abandonment may well lead to personality disorders and other mental health problems. This in turn will have negative impacts of crime, violence and social stability.

All the above points then need to be added together. In doing this it appears most probable that the whole impact will be far greater than the sum of the parts. In other words, the interactive effects are more than likely to result in mental health problems, the like of which may perhaps not have been previously seen … if mental health professionals wish to mitigate the mental health impacts of HIV/AIDS it is important to fully understand what is happening in each of the "layers" mentioned and design promotion programs to deal with or minimize the effects (Freeman, 2003, p. 1).

HIV/AIDS impacts on every aspect of a person's quality of life. The unique nature of the condition is the stigma associated with HIV infection that results in much of the distress and disability associated with the illness. Disclosure and failing health may lead to HIV-positive people losing their jobs. Families sometimes reject them. Communities struggle to accommodate them. The fear of disclosure prevents the infected person accessing help and programmes aimed specifically at HIV-positive people are often avoided. The "meaning" of HIV/AIDS in itself causes huge problems for the HIV-positive person and their social network.

It would be helpful to understand the aspects of quality of life of most concern to HIV-positive people as they may live with the illness for many years. Certainly, if the stigma were removed their personal relationships and social support systems would improve, enabling them to live more satisfying lives and possibly better able to take care of themselves financially. Likewise, if the stigma were removed the distress experienced by others in their social network would be lessened. However, the sheer enormity of the pandemic in some communities can lead to the whole community lacking the resources to respond helpfully.

Efforts to combat the spread of HIV/AIDS have continuously been frustrated by people continuing to engage in behaviour that places them at risk of contracting the virus, despite knowledge about its transmission. It seems that the behaviour change required conflicts with more strongly felt beliefs, personal or cultural, about acceptable or desired behaviour. In other words, the change in behaviour required may threaten the person's self-esteem, their sense of mastery or their personal relationships. For example, an adolescent equates risk behaviour or sexual conquest with a sense of mastery. In a patriarchal society, a woman places her relationships in jeopardy if she refuses sex or insists on condom use. In contrast, it seems that behaviour change has occurred in societies where norms of acceptable behaviour have been targeted. It would seem that it would be helpful to focus on the concepts of mental health held in order for intervention programmes to be pertinent to a particular community.

Concepts of mental health and palliative care

Dying is a normal part of life and the same qualities of positive mental health are important to the dying person as at any other time of their life. Advances in medicine have tended to over-focus on the person's illness to the detriment of these other qualities.

Palliative care aims to rectify this, and can be understood as:

… an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suf-

fering by means of early identification and impeccable assessment and treatment of pain
and other problems, physical, psychosocial and spiritual (Sepulveda et al., 2002, p. 91).

As such, the approach is grounded in promoting mental health rather than focusing on illness.

The philosophy of palliative care is simply that the individual's own concept of what is good mental health for them should direct all interventions of the palliative care team. Helping the person to identify these wishes and make these decisions is one of the tasks of the team:

> Palliative care encourages open communication and truth-telling and empowers the
> patient to take an active role in the management of his/her illness. This gives the patient
> a sense of control, which has often been lost in the turmoil of the diagnosis and treat-
> ment of the illness. Palliative care emphasises that one should not give the patient false
> hope (by colluding in denial of the seriousness of the illness) but that hope is still an
> important part of quality of life. Thus palliative care personnel foster hope in realistic
> terms e.g. to gain a full night's sleep by control of pain, to realise a life-long goal, to
> reconcile estranged family members and at the end for a dignified and peaceful death
> (Gwyther, 2003, p. 1).

This philosophy of aiming to understand what is important to the person underpins palliative care anywhere in the world. What people consider important will differ, and the philosophy allows for this. Similarly, the form that grief takes will vary. For example, the HIV/AIDS pandemic means that patients will be younger, with young children who will be bereaved. They may have suffered from stigma, have suffered multiple losses and come from deprived backgrounds. The course of the condition may be very uneven, with their health varying greatly as opportunistic infections occur and are treated. How these individuals wish these issues to be addressed should direct the intervention.

Concepts of mental health and older people

Throughout the world the proportion of old and very old people is growing, while at the same time the attitudes of families towards their care is changing. What were previously considered the normal results of ageing are being increasingly recognized as the result of illnesses, deprivation or externally or internally inflicted abuse, and therefore avoidable. Developed, unlike developing, countries have shown some success in reducing the level of incapacity in the elderly, with the exception of dementia, by improving their health when younger. Depression and dementia remain the two major mental illnesses affecting old people (Copeland, 2003).

What is becoming increasingly understood is that the concepts of mental health or ideas regarding quality of life held by older people do not differ substantially from those of younger people. Most differences in behaviour are the result of physical or mental disease or social disadvantage rather than the ageing process itself. For example, elderly people have to contend with real issues of lack of financial and social support, isolation or increased responsibilities in caring for grandchildren in the case of HIV/AIDS.

Other misconceptions include that the elderly choose to "disengage" socially, that depression is natural, that intellectual decline is a normal feature of ageing and that older people are not distressed by the death of contemporaries or their own disabilities. These attitudes, in fact, are either in response to disability or are simply not valid assumptions. Dementia has also been confused with the ageing process (Copeland, 2003).

As with the other stages of the life-cycle, the older person's values regarding their mental health should be respected and they should be encouraged to make their own decisions regarding their lifestyle rather than having others decide for them. There will be individual and cultural differences across the world but the principle remains the same. Efforts to maximize their options through improved physical health, supportive social conditions and opportunities for personal growth would promote their improved mental health (Copeland, 2003).

Conclusion

This chapter has attempted to examine concepts of mental health in selected, diverse groups in various countries through a process of engaging mental health practitioners currently concerned with different population groups and inviting them to comment.

A strong theme that has emerged is the centrality of mental health in enabling individuals to function constructively in their particular roles and therefore to contribute positively to their community. Communities in which individuals struggle to experience a positive sense of well-being and connectedness to others, to experience life as having meaning and being manageable, are largely dysfunctional. Far from mental health being a "luxury" as some might argue, it is recognized as fundamental to a healthy society.

The practitioners consulted for this chapter clearly articulate that beliefs and actions need to be understood within their political, economic and social contexts and that cultural beliefs are only one element to be considered. Today there are very few homogeneous cultural groups, and socioeconomic class and urban-rural differences impact greatly on lifestyle and beliefs. Many societies are also undergoing rapid social change.

There is also an appreciation that while the components of positive mental health are universal, their expression and interpretation will differ individually, culturally and in relation to the current context. Similarly, different aspects of mental health will take on particular importance and priority depending on the situation and context. However, while the mental health perspectives held by groups should always be acknowledged, it is clear that they are not always helpful.

A constructivist approach, which "recognizes the presence of diversity as normative" (Lee, 1996, p. 189) is advocated as a useful way forward. In this approach, no assumptions are made by the practitioner as to how individuals or groups might perceive a situation, its etiology and meaning, or how it might be addressed. Rather, the practitioner is charged with hearing the group's construction of their own reality, thus avoiding simplistic, often incorrect, "cultural" explanations.

This approach also allows for the process of "co-construction" between the practitioner and the target group or community in which, through a "recursive and educational process" (Lee, 1996, p. 199), the practitioner can assist the target group to consider new, more appropriate behaviours. This approach provides a framework for respecting people's conceptions of mental health while allowing for change.

The challenge posed to those involved in mental health promotion is to take cognizance of these differences in order that programmes are experienced by participants as meaningful and relevant. This is particularly important when attempting to introduce programmes that may run counter to locally held beliefs and perceptions. While the general goals of programmes may be similar across groups and cultures, the focus, form and intervention strategy will vary as they respond to the norms and priorities of the particular community.

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Chapter 6
Social Capital and Mental Health[1]

Harvey Whiteford, Michelle Cullen, Florence Baingana

Introduction

Research over the last two decades has demonstrated that social capital is linked with economic development, the effectiveness of human service systems and community development. Social capital has also been shown to decrease transaction costs in the production and delivery of goods and services, thereby improving productivity and efficiency. Political scientists have studied the contribution of social capital to the functioning of democracy, more efficient government, decreased corruption and the reduction of inequality within a society. Social scientists have investigated how higher social capital may protect individuals from social isolation, create social safety, lower crime levels, improve schooling and education, enhance community life and improve work outcomes (Woolcock, 1998).

This research has also demonstrated a downside of social capital. The same strong ties that are needed for people to act together can also exclude non-members, such as the poor or minority groups. Strong ties within the group may lead to less trust and reciprocity to those outside the group. For example, drug cartels and terrorist groups may have high levels of social capital among group members, with obvious detrimental effects for those outside the group. Social interactions can have negative as well as positive effects – as good behaviour spreads, so does bad (as shown by studies on education and crime). Networks can just as easily influence and reinforce bad choices as they can good.

Understanding the positive and negative effects on health of what is now called social capital has been an increasing focus of research in the last decade. At the same time authors have begun to speculate about and attempt to unravel possible relationships between social capital and mental health (Kawachi & Berkman, 2001; McKenzie, Whitley & Weich, 2002; Sartorius, 2003). This chapter explores the concept of social capital, outlines the understanding at present on the relationship between social capital and health and mental health and discusses the potential for mental health promotion to enhance social capital.

Conceptualizing social capital

There are four views of social capital. The narrowest conceptualization focuses on local, horizontal community associations and the underlying norms (trust, reciprocity) that facilitate coordination and cooperation for mutual benefit (Uphoff, 2000). This view primarily focuses on the positive aspects of social capital and does not necessarily include the detriments (such as exclusion and excessive demand on members).

A broader conceptualization of social capital, such as that employed by Coleman (1988), incorporates a wider spectrum of social dynamics. A definition based on function, this view includes vertical associations, characterized by both hierarchy and an unequal power distribution among members within a society.

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[1] This chapter draws heavily on a Discussion Paper by Michelle Cullen and Harvey Whiteford entitled *The Interrelationships of Social Capital with Health and Mental Health* released by the Australian Department of Health and Ageing in 2001.

A more macro view of social capital (Grootaert, 1998) focuses on the social and political environment that shapes social structures and enables norms to develop. This social and political environment includes formalized institutional relationships and structures within government and related agencies, the political regime and the legal and regulatory systems.

An integrative view of social capital recognizes that micro, meso and macro institutions co-exist and interact with each other:

> This view not only accounts for the virtues and vices of social capital, and the importance of forging ties within and across communities, but recognizes that the capacity of various social groups to act in their interest depends crucially on the support (or lack thereof) that they receive from the state as well as the private sector. Similarly, the state depends on social stability and widespread popular support (World Bank, 2004).

Given these varying conceptualizations of social capital, it is not surprising that it also has elastic definitions. In this chapter, social capital means "the features of social organization, such as civic participation, norms of reciprocity, and trust in others, that facilitate cooperation for mutual benefit" (Kawachi et al., 1997, p. 1491). Despite contention over definitional parameters, there is a growing consensus that social capital captures a concept that facilitates collective action and can promote social and economic growth and development by complementing other forms of capital (Grootaert, 1998).

Although the consensus is that social capital is "social" and collective, debate continues around whether it is a form of "capital". Capital is conceived of in two fundamentally different ways (Eatwell, Milgate & Newman, 1987). It may be thought of as a fund of resources that can be switched from one use to another. This has been called the "financial" concept of capital. It may also be conceived of as a set of productive factors that are embodied in the production process, the so-called "technical" concept of capital.

Using the technical concept, traditional capital theory arbitrarily divided productive factors (inputs) into three groups: natural resources, human labour and man-made goods (financial and physical capital). This last was called capital goods (or often just "capital") and was defined as produced goods that could be used as inputs for further production (Samuelson & Scott, 1975, p. 50; Dow & Hendon, 1991). Over time, the other inputs, natural resources and human labour, began to be referred to as capital as well. In the early 1960s economists such as Schultz and Becker reintroduced Adam Smith's term human capital to refer to how educated and healthy workers productively utilized other capital inputs (Schultz, 1963; Becker, 1962). Thus the literature now routinely recognizes natural capital (soil, atmosphere, forests and water), human capital (human productivity) and physical or financial capital (man-made goods, e.g. buildings, roads and technology). The concept of social capital, referred to as the missing link in economic development (Grootaert, 1998), has grown out of the belief that cohesive and productive groups of individuals are more than just the sum of their human capital.

Social capital emerges from interactions that are social and external to the individual, not lodged within individuals as human capital is. It is inherent in the structure of social relationships and therefore is an ecological characteristic (Henderson & Whiteford, 2003). Using the term to mean the assets of individuals or families (Portes, 1998; Walkup, 2003) introduces confusion.

Deconstructing social capital

To understand the relationships between social capital and mental health we need to understand its cognitive and structural components. Cognitive social capital is derived from "mental processes and resulting ideas, reinforced by culture and ideology, specifically norms, values, attitudes, and beliefs that contribute to cooperative behaviour" (Uphoff, 2000, p. 218). Cognitive social capital influences behaviour, including control of risk-taking behaviour, mutual support and informal means of information exchange.

Structural components of social capital are the "roles, rules, precedents and procedures as well as a wide variety of networks that contribute to cooperation" (Uphoff, 2000, p. 218). Structural social capital has two dimensions – *horizontal*, reflecting ties that exist among individuals or groups of equals or near-equals, and *vertical*, stemming from hierarchical or unequal relations due to differences in power or resource bases. Structural social capital is shaped by government policies and the formal service networks that result from their implementation.

Social capital, health and mental health

Considerable investments are made, nationally and internationally, to improve the health of people. However, as Lomas (1998, p. 1181) has noted:

> On the one hand, millions of dollars are committed to alleviating ill-health through individual intervention. Meanwhile we ignore what our everyday experience tells us, i.e. the way we organize our society, the extent to which we encourage interaction among the citizenry and the degree to which we trust and associate with each other in caring communities is probably the most important determinant of our health.

There is an extensive literature on health and social factors that is sometimes seen to come under the rubric of social capital. Indeed some commentators feel that the notion of introducing social capital to health is merely putting old wine into new bottles (Labonte, 1999, in Campbell, 2000). While the socioeconomic determinants of health have been well studied and there is good evidence that more socially isolated individuals have poorer health (House, Landis & Umberson, 1988), the notion of social capital is addressed in studies showing that more socially cohesive societies are healthier with lower mortality (Kawachi & Kennedy, 1997). Studies have shown that there is a correlation between poor health and lower levels of social capital, as evidenced by levels of interpersonal trust and norms of reciprocity.

Population health measures, whether morbidity or risk factors, are usually considered as the aggregate of the individual characteristics in the population. When considering the environmental contribution to, or protection against, disease, the conceptualization again is usually one of binary associations between one (or more) environmental factors and individual health (Marmot, 1998). The power of the concept of social capital lies in its potential to understand the environment in another way: the interaction between environmental (including social) factors and connected groups of individuals. The smallest of these groups is usually the family, with the size increasing up to entire nations. This perspective of networks of individuals interacting with environments has the power to explain an array of collective outcomes beyond that explained by aggregated individual health outcomes. Many studies have shown the powerful health effects of social connectedness (Putnam, 2001). The mechanisms by which this social capital is beneficial to health are not clearly delineated, but social networks are believed to promote better health education, improve access to health services and informal caring, and enforce or change societal norms that impact on

public health (e.g. smoking, sanitation and sexual practices) (Baum, 1999; Kawachi, Kennedy & Glass, 1999). Much work remains to be done in accounting for the mechanisms underlying the alleged health–community link (Gillies, 1997; Henderson & Whiteford, 2003) and the interrelations of social capital with mental health. It is also unclear if the relations between these two variables are multidirectional and of causality or correlation (Lochner, Kawachi & Kennedy, 1999). While quantitative data is lacking, the four areas discussed below – socialization, protection during crisis, income disparities and suicide and antisocial behaviour – suggest a theoretical basis for important relationships between health, mental health and social capital.

Socialization

The norms that govern interpersonal behaviour are transmitted through socialization within what can be considered social capital networks (e.g. the family and community). With this process comes the transmission of cultural norms and acceptable behaviour within society. Individual functioning, well-being (self-esteem, individual identity) and vulnerability are affected by diverse social experiences and conditions, which include an individual's social capital environment (OECD, 2001).

It is necessary to examine this social capital environment to understand the health of a population. Durkheim (1897) was among the first to note that a lack of social cohesion within a society had negative consequences on health and mental health. The benchmark Whitehall study demonstrated the link between social exclusion and ill-health (Marmot, Shipley & Rose, 1984) and social isolation has been linked to unhappiness, illness and shortened life (OECD, 2001). Veenstra (2000) specifically included what we now call social capital and demonstrated that socializing with colleagues from work, attending religious services and participating in clubs are related to positive health status. In fact, frequency of socializing with workmates and attendance at religious services had the strongest (most positive) relationships with health in his social engagement questions, even after controlling for human capital (K McKenzie, personal communication, 2000).

Kawachi et al. (1997) studied the relationship between health and social capital using the indicators of interpersonal trust, reciprocity norms and density of associational membership (a wide array of voluntary associations such as church groups, fraternal organizations and labour unions). The results suggested a breakdown in social trust is linked to higher mortality rates. They found that "per capita group membership was strongly inversely correlated with all-cause mortality … level of group membership was also a predictor of coronary heart disease, malignant neoplasms, and infant mortality" (Kawachi et al., 1997, p. 1494). Associational membership and civic trust were highly correlated. Conversely, levels of distrust were significantly correlated with age-adjusted mortality rates. In regression models, variations in the level of trust explained 58% of the variance in total mortality across states. Lower levels of social trust were associated with higher rates of most major causes of death (Berkman & Kawachi, 2000). Veenstra (2000), however, suggests that trust may not be significant once effects from human capital (socioeconomic status measured by income and education) are controlled.

The classic studies of Faris and Dunham (1939), Hollingshead and Redlick (1958), Leighton (1959) and Brown and Harris (1978) demonstrated relationships between mental illness and social structure, social isolation, poverty, life events and psychological stress. One explanation for the relationship is that at the individual level mental disorder impairs psychological and social functioning and this leads to downward "social drift" (Goldberg & Morris, 1963). There is some support for this as mental disorders such as schizophrenia interfere with the person's capacity to cope with the usual demands of interpersonal interaction and the decoding of social communication (Murphy,

1972). As a result, individuals lose social connectedness and end up more socially isolated. Adverse effects on socialization can also arise from the more common mental disorders, such as depression and anxiety. These mental disorders have adverse consequences that include breakdown in marital stability (Kessler, Walters & Forthofer, 1998), increased teenage parenthood (Kessler et al., 1997), more distant social relationships (Mickelson, Kessler & Shaver, 1997) and other factors associated with social deterioration. For individuals, early identification of, and intervention to remove, target symptoms associated with the social and vocational decline is possible (Hafner et al., 1999). The outcomes of these interventions have traditionally been measured in terms of clinical outcomes and/or "social reintegration". However, the implications of such outcomes include the enhancement of cognitive social capital with benefits accruing to the wider social group as well as the individual. At a population level, the challenge is to identify risk reduction (e.g. teaching cognitive-behavioural or parenting skills) and protective (e.g. increasing social connection) strategies that can be widely implemented (Rose, 1992).

Protection during crisis

A second explanation for the association between mental disorders and poor social circumstances (which would be considered environments with depleted social capital) is that individuals in these circumstances are exposed to more psychosocial stressors (adverse life events) than those in more advantaged environments. The impact of these stressors is modulated by the psychological, social and physical resources available in a person's environment (see figure 6.1). Interventions which augment these resources can protect against the adverse effects of psychosocial stressors (Marsella, 1995; Muntaner & Eaton, 1998). For example, vulnerability for depression includes a lack of confiding relationships, unemployment and low social status (Perry, 1996), all of which can derive from a breakdown in social cohesion. This relationship has been reported even in conditions where psychosocial factors are generally not considered to be pathological. For example, socially isolated elderly people have a relatively greater risk of developing Alzheimer disease, controlling for other risk factors (Fratiglioni et al., 2000).

Figure 6.1
Social capital and psychosocial processes
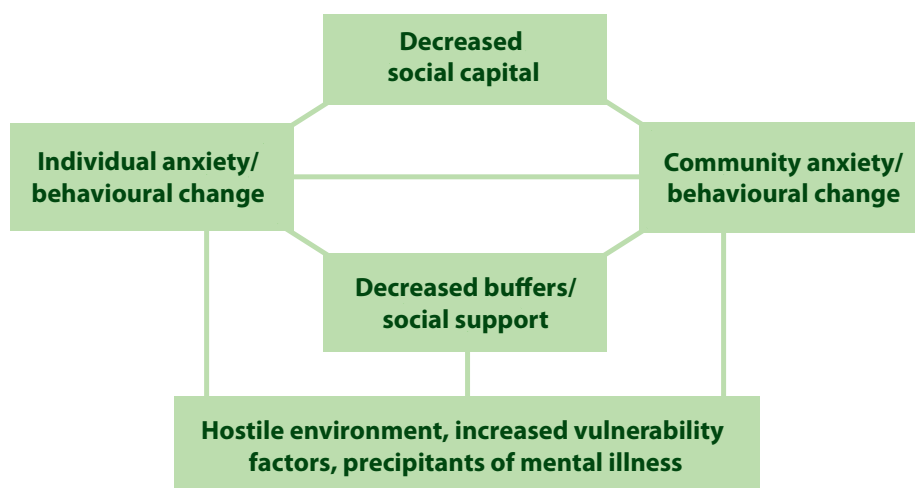
During crisis, assistance and support rely on the availability of social capital networks. These networks include nuclear and extended families (basic social units) as well as local religious institutions, political organizations and economic systems. During extreme strife, families first help themselves, then relatives, and then neighbours. During recovery, it is these basic social units that are most looked to for emotional recovery and thus influence mental health status (Cuny, 1994). Rose (2000), in his survey of how social capital networks in Russia contributed to basic welfare such as income security, health and food consumption, concluded that measures of social integration explained almost 10% of the variance in "emotional health".

Social capital adds another dimension to our understanding of mental health and mental disorder. It broadens the biopsychosocial determinants of mental disorder (genetics, neurobiology, psychological factors, social environment, etc.) and brings an understanding of population mental health beyond the aggregation of individual health characteristics or risk factors. One might postulate that the best ways to address mental health with social capital interventions would be to target those aspects closest to the psychosocial determinants of health, i.e. those closest to the cognitive aspects of social capital (T Harpham, personal communication, 2000). For example, following Durkheim, a lack of social norms (cognitive social capital) produces social disintegration which results in anomie, suicide and antisocial behaviour. A social capital intervention which addressed social norms could therefore have positive mental health outcomes.

Income disparities

According to Putnam (1993), a thriving civic community is typically characterized by strong horizontal, rather than vertical, relationships. This has ramifications for the relationship between social capital and inequality. According to Putnam (1993, p. 105), "equality is an essential feature of the civic community". Putnam's more recent work continues to reinforce findings that "economic inequality and civic inequality are less in states with higher "social capital" (Putnam, 2001, p. 50).

As Murray, Gakidou and Frenk (1999, p. 540) have noted:

> Both health inequalities and social group health differences are important aspects of measuring population health. In the face of enormous variation in health within populations, we cannot simply focus on average levels of health. There are convincing reasons to measure social group health differences: they are normatively important; they provide insights into causal pathways linking distal socioeconomic determinants and health; and they are relatively easy to measure.

While income disparity is associated with a decline in health status (e.g. Kaplan et al., 1990), social capital is also relevant. According to Kawachi and colleagues (1994), income inequality may be linked to ill-health through the frustration that results from increasing inequality, which may be catalyzed or perpetuated by underinvestment in human capital. This underinvestment can occur in areas with low social capital, which concurrently may be those more prone to allow large disparities to emerge (RG Wilkinson, personal communication, 2000). Putnam (2001) also found that in states with low social capital and high levels of perceived inequality, self-assessments of well-being and happiness were low.

Wilkinson (1996), when discussing the relationship between income inequality and a less cohesive social environment, suggested that there is a "culture of inequality" that is more aggressive and violent and less cohesive. By examining the relationships between income inequality, social capital and health, Wilkinson has emphasized the importance of psychosocial pathways in physical health. His work has shown that the social environment is more cohesive in more egalitarian places (less

violence, less homicide, less hostility and more trust). This has obvious ramifications for public health. From Wilkinson's work, and the findings of others such as Putnam and Kawachi, a likely way to build social capital would be through improving income equality.

Suicide and antisocial behaviour

Variations in antisocial and suicidal behaviour have been traced to strengths or absences of social cohesion (OECD, 2001). Weak social controls and the disruption of local community organization have long been hypothesized to be factors producing increased rates of suicide (Durkheim, 1897) and crime (Shaw & McKay, 1942). Social disorganization, defined as the "inability of a community structure to realize the common values of its residents and maintain effective social controls", correlates with rates of suicide and crime (Sampson & Groves, 1989). The social organizational approach views local communities and neighbourhoods as complex systems of friendship, kinship and acquaintanceship networks and formal and informal associational ties rooted in family life and ongoing socialization processes (Sampson, 1996). From the perspective of crime control, a major dimension of social disorganization is the inability of a community to supervise and control teenage peer groups, especially gangs. Shaw and McKay argue that residents of cohesive communities are better able to control the youth behaviours that set the context for gang violence (Berkman & Kawachi, 2000).

Social disorganization has been linked to social capital by Sampson, Raudenbush and Earls (1997), who surveyed neighbourhood residents on their perceptions of social cohesion and trust. They found a high rating of collective efficacy was significantly inversely related to neighborhood violence, violent victimization and homicide rates. The link between social capital and violent crime/homicide has been replicated at the state level (Kawachi, Kennedy & Glass, 1999). In an analysis of ecological factors, societies with low trust levels exhibited higher rates of violent and property crime, such as homicide, assault, robbery and burglary (Berkman & Kawachi, 2000).

Mental health promotion and social capital

Social capital can enhance mental health and reduce the impact of mental illness. Further, mental health promotion can potentially build social capital in various ways, with outcomes at both the societal and community levels. At the community level, mental health promotion can build pathways between health and social capital that can affect behaviour and service provision by promoting the psychological attributes of individuals and strengthening the relationships between individuals. While many mechanisms can be postulated, three are briefly discussed here: health-related behaviours, access to services and amenities, and psychosocial processes.

Health-related behaviours

Social capital can influence population health behaviours by promoting a more rapid diffusion of health information (mental health literacy), increasing the likelihood that healthy behaviour norms are adopted and by exerting social control over deviant health-related behaviour. The theory of diffusion of innovations (see Chapter 19) suggests that innovative behaviours (e.g. use of preventive services) diffuse much more rapidly in communities that are cohesive and that have higher levels of trust (Rogers, 1983). Some studies have suggested that the higher the degree of "collective efficacy" the more likely the community is to prevent antisocial behaviour (e.g. Sampson, Raudenbush & Earls, 1997). This process may be applied similarly to prevent deviant behaviour, such as adolescent drug abuse (Berkman & Kawachi, 2000).

Access to services and amenities

Community social capital can affect access to services and amenities. Cohesive communities are more able to unite to form appropriate social organizations which ensure access to services that are directly related to health, such as community health clinics. Decreased access to services and amenities is often a result of poverty, crisis or chronic illness. Social capital links in these situations become even more important; they can serve as a mechanism that helps improve social support, integration, rehabilitation and recovery. Long-term solutions to the problems of inadequate resources and social exclusion require connecting marginalized groups to mainstream resources and services through mechanisms of bridging social capital, which unites these excluded groups with the majority (Putnam, 1995; see also Chapter 10).

Psychosocial processes

High levels of social capital are conducive for the development of an individual's psychosocial processes that are needed to cope with life's stressors and protective against ill-health. These psychosocial processes in part arise from social interaction within an individual's community. Interaction with others is enhanced if it is based on trust and reciprocity, which provide protective factors against the initiation of any psychosocial processes that are known to be determinants of ill-health.

The developmental processes by which the moral values of trust and reciprocity become instilled in children occur more quickly in communities with higher social capital. Members of such communities have some sense of public responsibility for each other, even if they have no related ties. These norms of reciprocity or mutual respect can translate into easier childrearing, improved self-government and the maintenance of public life civility (Berkman & Kawachi, 2000).

Variations in the availability of psychosocial resources at the community level may help to explain the anomalous finding that socially isolated individuals residing in more cohesive communities do not appear to suffer the same ill-health consequences as those living in less cohesive communities (Berkman & Kawachi, 2000, p. 105).

Building social capital

Studies examining and projects incorporating social capital have revealed more about what destroys this phenomenon than what builds it. For instance, merely creating civil society groups does not automatically lead to the concurrent creation of social capital within and among these new groups. Instead, efforts to build social capital must consider the various sources of social capital that stem from these: "family, schools, local communities, firms, civil society, public sector, gender and ethnicity". From this, social capital can be built "at the 'level' of families, communities, firms, and national or sub-national administrative units and other institutions" (OECD, 2001, p. 45). Regardless of the level of intervention, the process of developing social capital takes a long time. Consequently, investing in social capital should be seen from a life-course approach, for investments now may not only benefit this generation but also the next. Similarly, current disinvestment may have parallel long-term effects. It has been posited that interventions that target various dimensions of social capital simultaneously may be more effective. This would entail intervening across multiple levels, including macro social policy reform while also increasing community access to external resources and power (Grant, 2000; also see figure 6.2).

It is accepted that improved health status enhances human capital (Bhargava et al., 2001; World Bank, 1993). Can the argument be made that improvements in health and mental health can build social capital? For those with mental illness, action to remove psychosocial stressors, provide social and psychological support and provide clinical treatments to reduce symptoms and disability can all lead to an enhancement of the individual attributes necessary for constructive social interaction and assuming a productive social role. Mental health promotion activities targeting "well" populations have aims of enhancing resilience and social competencies. These actions should have a pay-off in terms of building social capital as good mental health enhances the competencies necessary for more constructive participation in civil society. In this context, mental health may have specific importance in contributing to the cognitive and psychological attributes necessary for the interactions that underpin social capital. There is some evidence to support these hypotheses. Studies carried out by the World Bank in Rwanda and Cambodia demonstrated that individual attributes such as resilience contributed to the rebuilding of social capital in the post-conflict periods in both countries (Colletta & Cullen, 2000).

Conclusion

The level of social capital in a country or neighbourhood is an attribute of the social environment. Research to identify the relationships between social capital and mental health has relied largely on cross-sectional data, and has produced mixed results (McCulloch 2001; McKenzie 2000; Rose 2000; Rosencheck et al., 2001; Weitzman & Kawachi, 2000). Much of the work so far relates to mental ill-health, and the trend is towards an inverse relationship between social capital and mental illnesses of various kinds in a population. Overcoming the methodological challenges (Henderson & Whiteford, 2003) is necessary before social capital can become a tool to explain the epidemiology and outcomes of mental disorders. More work beyond that is required to understand the demonstrated links between social capital and positive mental health, and their relationships to economic development, the effectiveness of human service systems and community development. The links between social capital, population health and mental health, and the potential of mental health promotion to enhance social capital are current topics of research and debate with important implications for improving population mental health.

Figure 6.2
Interventions to build social capital at the community level

- *Strengthen social networks*
  e.g. Employ a community health worker to mobilize resources within social networks and bring resources into communities

- *Build social organizations*
  e.g. Facilitate the development of nongovernment organizations (NGOs)

- *Strengthen community ties*
  e.g. Bring together groups normally divided along class, caste, race/ethnicity or religious grounds

- *Strengthen civil society*
  e.g. Inform decision-makers about the social consequences of macroeconomic policies

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Chapter 7
Mental Health and Human Rights

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Introduction

The international human rights system offers a useful framework for the promotion of mental health. The international human rights discourse today widely recognizes mental health as a basic human right. The right to physical and mental health was first enunciated in the Constitution of the World Health Organization in 1946, which states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being". The United Nations International Covenant on Economic, Social and Cultural Rights (1966) also articulates this in Article 12, when it recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

Beyond merely acknowledging the right to mental health, the international human rights discourse recognizes that certain sociopolitical and economic conditions need to exist in order to promote the mental well-being of the population. Indeed, the right to mental health extends to the underlying determinants of mental health and is dependent upon the realization and enjoyment of a range of civil, political, economic, social and cultural rights.

Certain people and groups within society are particularly vulnerable to human rights violations. Factors such as discrimination and marginalization increase their propensity for developing mental health problems as well as acting as a barrier to accessing appropriate health care services. The human rights discourse recognizes the need for countries to pay particular attention to the needs and interests of such people, as well as the necessity to adopt specific measures in order to safeguard and realize their rights, including their right to mental health.

The international human rights framework thus offers useful guidance to governments in understanding the requirements for creating the necessary social, economic and political conditions to promote the mental health of the population.

The link between mental health and human rights

A fundamental link exists between mental health and human rights. Human rights violations within a country can have damaging and harmful repercussions on the mental health of the population. Conversely, people's mental health is dependent upon their ability to enjoy and exercise a range of human rights (Gostin, 2001).

It has long been acknowledged that extreme forms of abuse, human rights violations and crimes against humanity such as genocide and ethnic cleansing impact negatively on people's mental health. The loss of loved ones, the exposure to extreme forms of violence and the general disruption to people's lives not only result in dramatic increases in post-traumatic stress disorders but also in other more long-term and chronic mental health problems related to trauma, such as depression and anxiety (Rwema, 2003; Sotheara, 2003).

One of the fundamental purposes of torture and other forms of inhuman and degrading treatments and punishments is to inflict psychological as well as physical harm. This leads to poor mental health in victims as well as their families and the community. Similarly, rape, domestic violence and other physical and psychological abuses directed against women result in poor mental health outcomes (Gostin, 2001).

It is not only extreme forms of human rights violations that have a negative impact on the mental health of the population, however. Indeed, the link between poverty and increased risk of mental disorders has become increasingly apparent over the last decade (WHO, 2001). Unemployment, low levels of education and lack of food, shelter and access to health care (including health insurance coverage) limit people's ability to be active and productive members of society, to realize their potential and ultimately to be mentally as well as physically healthy. These negative social and economic factors associated with poverty furthermore act as a barrier to health and mental health care services.

Similarly, restrictions in civil liberties such as the right to vote; to take part in public affairs; to express one's opinion; to seek, receive and impart information; and to have freedom of association, assembly and movement can also adversely affect the mental health of a population. These limitations impede one's ability to participate fully and actively in the community, be part of the decision-making process on issues affecting one's life and have the opportunity to improve one's social and economic situation and status.

Discrimination can also impact negatively on mental health. Victims of discrimination are particularly vulnerable to limitations in civil, political, economic, social and cultural rights that make it difficult for them to integrate into society and lead well-balanced and productive lives. The negative repercussions of discrimination, along with the sense of alienation and discrimination itself, can deeply affect a person's dignity and self-esteem, which is detrimental to mental health and well-being (Gostin, 2001).

The international human rights framework

International human rights instruments provide a useful and comprehensive framework for mental health promotion. Key instruments within the UN system are known as the International Bill of Rights. These comprise the Universal Declaration of Human Rights (UDHR) adopted in 1948 and the International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR), both adopted in 1966.

The latter two Covenants impose legally binding obligations upon Member States to respect, protect and fulfill the human rights contained within them. Importantly, these instruments have been ratified by the vast majority of UN Member States. The UDHR, while not legally binding, represents a consensus among the international community as to the basic human rights that must be protected. The provisions within it are widely accepted as representing international customary law.

The focus of discussion in this chapter is on the UN human rights system, though it is important to note that there are also a number of other regional mechanisms and instruments protecting human rights. Key examples include the European Convention for Protection of Human Rights and Fundamental Freedoms (1950), the American Convention on Human Rights (1978) and the African Charter on Human and Peoples' Rights (1982; also known as the Banjul Charter).

As previously stated, the right to physical and mental health is recognized as a fundamental human right to be afforded to all people. The Committee on Economic, Social and Cultural Rights, which monitors the ICESCR, adopted a General Comment on the right to health at its twenty-second session in 2000 (General Comment 14) in order to provide guidance to countries on the meaning and requirements of implementing this right. In recognition that many people experience barriers to health and mental health services and care, the Committee states that health

care services require adequate funding to ensure that health facilities, goods, services and programmes as well as health care professionals and essential medication are available in sufficient quantity.

The Committee also underscores the importance of making health care services accessible. This means that facilities, goods and services must be physically accessible (that is, within safe physical reach for all sections of the population, including rural populations and vulnerable or marginalized groups), economically accessible (affordable to all based on the principle of equity) and accessible to everyone without discrimination. Information on health matters must also be accessible (that is, people have the right to seek, receive and impart information and ideas concerning health issues).

Finally, the Committee stresses that health facilities must be acceptable and of good quality. In other words, health facilities should be sanitary, respect medical ethics and the right to confidentiality, be culturally, medically and scientifically appropriate and have medical personnel that are adequately skilled.

These guiding principles are particularly pertinent to the mental health field if one considers the numerous barriers to mental health care. The low priority of mental health on the agenda of governments means that there is a paucity of mental health care services and essential medication in some countries. Mental health care facilities in many countries have poor standards of treatment and care and inadequate living conditions. In certain countries health insurance companies fail to provide people with adequate coverage for mental health treatment. The stigma and discrimination associated with mental health also means that many people fail to seek the treatment they require. These principles therefore represent important means for overcoming the different barriers to care and thus for promoting the mental health of the population.

The international human rights framework also provides an effective tool to identify, analyse and respond directly to the underlying determinants of mental health. Importantly, there is widespread recognition that all human rights are interrelated, indivisible and interdependent (Vienna Declaration and Programme of Action, 1993) and that the realization of the right to physical and mental health is therefore reliant upon the realization of a range of other basic human rights. This is reflected in Article 25 of the UDHR which states:

> Everyone has the right to a standard of living for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The Committee on Economic, Social and Cultural Rights reiterates the need for countries to consider the underlying determinants of health and to adopt measures to promote a range of civil, political, economic, social and cultural rights as contained in the International Bill of Rights. These include the right to life, food, housing, work, education, participation, the enjoyment of the benefits of scientific progress and its applications, non-discrimination, equality, prohibition against torture, privacy, access to information, and freedom of association, assembly and movement. Additionally, the Committee strongly emphasizes that the participation of the population in all health-related decision-making processes, both at community and national level, is an essential aspect of health and mental health promotion.

Freedom from discrimination is one of the fundamental principles of the international human rights discourse. In relation to the right to health, it proscribes:

> … any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health (General Comment 14).

Vulnerable groups

Certain groups within society, such as women, children and refugees, are at particularly high risk of suffering from mental disorders *and* having their human rights overlooked or violated due to marginalization and discrimination. The United Nations Special Rapporteur on the Right to Health notes that discrimination is a social determinant of health:

> Social inequalities fueled by discrimination and marginalization of particular groups, shape both the distribution of diseases and the course of health outcomes amongst those afflicted. As a result, the burden of ill-health is borne by vulnerable and marginalized groups in society. At the same time, discrimination and stigma associated with particular health conditions, such as mental disabilities and diseases like HIV/AIDS, tend to reinforce existing social divisions and inequalities (Hunt, 2003).

Although the ICCPR and the ICESCR are designed to protect the basic human rights of *all* people without exception, the international human rights discourse recognizes that particular attention, and in certain instances particular measures, need to be adopted in order to address the deep-rooted inequalities within society and to ensure that the rights of vulnerable groups are promoted and protected. Therefore, in addition to the International Bill of Rights, the UN human rights mechanism has a number of other legally binding instruments concerned with these groups, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC) and the Convention Relating to the Status of Refugees (CRSR).

Women around the world bear a disproportionate burden of poverty and human rights violations. The unequal position they hold within society means that they often experience discrimination in the fields of employment and education and in the exercise of their civil liberties. The unequal power relationship between men and women also means that women are exposed to domestic and sexual violence. These factors have been linked to a higher prevalence of certain mental disorders such as depression and anxiety among women. The 2001 World Health Report notes that "the traditional role of women in societies exposes them to greater stresses, as well as making them less able to change their stressful environment" (WHO, 2001, p. 42).

In recognition of the particular vulnerability of women within society, CEDAW requires that countries adopt appropriate legislative and other measures, including special measures if necessary, to eliminate discrimination and ensure the full participation of women in the political, social, economic and cultural life of their community on equal terms with men. The Convention also requires the enactment and effective enforcement of laws and the formulation of policies to address domestic and sexual violence against women. Article 12 of CEDAW focuses specifically on the right to health of women. General Recommendation 24 (adopted by the Committee on the Elimination of Violence Against Women at its twentieth session in 1999), which aims to provide

guidance to countries on the meaning and implementation of this article, emphasizes the need to address the barriers that women face in accessing health services. It also acknowledges the disproportionate susceptibility of women to mental health problems as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation, and indicates that countries need to take measures to ensure that health services are sensitive to the particular needs and human rights of these women.

Minors also represent a vulnerable group and often lack the cognitive abilities and legal status to make independent decisions concerning their own interests. Their emotional, social and economic environment can greatly influence their emotional and physical development. Minors in many parts of the world live in impoverished conditions and have to work in poor and often hazardous conditions in order to contribute to the income of the family, which may result in their being denied educational opportunities. Also, minors are often denied the opportunity to express their opinions on issues concerning them, including health-related matters. Contrary to popular belief, mental and behavioural problems are common among children (WHO, 2001) and result in significant harm and suffering to both children and families. Because many of the disorders are not detected, these problems remain and are often further exacerbated in adulthood.

The UN Convention on the Rights of the Child specifically acknowledges that an adequate standard of living is fundamental to promoting children's physical, mental, spiritual, moral and social development (Article 27), and sets out a range of rights that require particular attention and protection. These include the protection from all forms of physical and mental abuse; non-discrimination; the right to life, survival and development; consideration of the best interests of the child; and respect for the views of the child. The Convention stresses the need for children to be protected from any work that is likely to be hazardous or interfere with their education, in recognition of the particularly detrimental effects that this can have on their physical and mental health, well-being and development (Article 32). Finally, it makes specific reference to the right of children with mental disabilities to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community (Article 23).

People who have been exposed to genocide, ethnic cleansing, war-related violence, persecution, repression and other life-threatening situations, such as refugees, forced migrants or displaced people, represent a particularly vulnerable group. In addition to the trauma that they may have suffered in the past, other risk factors exacerbate or contribute to poor mental health among these people including chronic unemployment, poverty, starvation, racial discrimination, lack of access to medical care, poor physical health, lack of safe and affordable housing, marginalization, social isolation and absence of family and community networks and social support structures (Jablensky et al., 1994; Jaranson, Forbes Martin & Ekblad, 2000).

The UN Convention Relating to the Status of Refugees represents one of the key instruments protecting the rights of refugees and other stateless people. These people are not in their country of origin and are often not afforded the same rights as the nationals of the country they are in. The Convention therefore sets out a range of civil, political, economic, social and cultural entitlements. These include the rights to freedom from discrimination; freedom of religion, association and movement; and access to courts, gainful employment, housing and education as well as property rights. Refugees and other stateless people are also offered protection under humanitarian law (namely, the 1949 Geneva Conventions). Though humanitarian law has different origins and uses different mechanisms of implementation, it shares a fundamental common objective to that of

human rights law, that is, the respect for human dignity without any discrimination whatsoever as to race, colour, religion, sex, birth, wealth or any similar criteria (WHO, 2002).

Finally, people with mental disorders are also particularly vulnerable to human rights violations. Violations can often occur in psychiatric institutions through inadequate, degrading and harmful care and treatment practices as well as unhygienic and inhuman living conditions. Violations can also occur outside the institutional context. The stigma, myths and misconceptions associated with mental disorders negatively affect the day-to-day lives of people with mental disorders leading to discrimination and the denial of even the most basic rights. People all over the world experience limitation in the fields of employment, education and housing due to their mental disorder (WHO, in press). As we have seen, this stigma and discrimination can in turn impact on a person's ability to gain access to appropriate care, integrate into society and recover from illness.

Any effort towards the promotion of the mental health of the population as a whole necessarily entails the promotion and protection of the needs and interests of people with mental disorders. To date, however, the UN human rights framework does not comprise a legally binding international instrument dealing specifically with the rights of people with mental disorders. However, people with mental disorders are commonly considered as part of the larger group of people who are disabled for any reason, including physical, intellectual, sensory and psychiatric disability. The UN has a Global Programme on Disability. This stems from the World Programme of Action Concerning Disabled Persons, adopted by the UN in 1982, and the Standard Rules on Equalization of Opportunities for Persons with Disabilities, adopted in 1993. In 2001, a process was begun towards the development of a UN convention on the rights and dignity of people with disabilities; this process is ongoing at the time of writing. Key to the process is the emphasis on full participation by people with disabilities in all aspects of society.

It is important, though, not to consider people with mental disorders only under special categories. Indeed, by virtue of their humanity, people with mental disorders are entitled to all the same basic rights and protections found within the articles of different binding instruments such as the ICESCR and ICCPR as people without mental disorders. The adoption of the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles) in 1991 reflected a growing consensus that there are a number of issues and concerns in relation to the rights of people with mental disorders that require special consideration by governments, however. Important ethical standards underpinning the provisions of the MI Principles include the promotion of individual independence and social integration, the right to treatment that enhances individual autonomy, rights related to standards of care and treatment including involuntary admission and consent to treatment, the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment, the right to protection of confidentiality, the right to live and work in the community and the right to community care.

The question of how to implement the rights required to promote mental health remains an enormous challenge in the light of political instability and severe financial and human resource constraints faced by many countries. Undeniably, governments are often faced with hard choices in terms of prioritizing different health and development issues, and historically mental health has been a poor contender in such decisions. In addition, many countries use the lack of resources as an excuse to avoid taking responsibility for implementing human rights.

In recognition that the realization of the right to health is likely to require reform, restructuring, investment and planning on the part of governments, and consequently cannot be achieved

overnight, the Committee on Economic, Social and Cultural Rights provides for the progressive realization of the right to health (General Comment 14, adopted at the twenty-second session in 2000). This requires countries to take expeditious, deliberate, concrete and targeted steps towards the realization of this right, and to ensure that all available resources are used equitably and judiciously (General Comment 3, adopted at the fifth session in 1990). The Committee emphasizes that even in times of severe resource constraints vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes. The Committee also states that countries must adopt all appropriate means to put human rights into effect. This may include formulation and implementation of health and other relevant social policies and programmes, and in particular "the adoption of legislative measures".

As an example, a number of countries have used the UN Principles for the Protection of People with Mental Illness as a guide to promoting the rights of people with mental disorders. Mexico, Hungary, Costa Rica, Portugal and Australia, for example, have incorporated the Principles in whole or in part into their own domestic laws. Other countries, such as Nicaragua and Costa Rica, have used the Principles as a guide for the development of their mental health policies (WHO, 2003). The fact remains, however, that countries still need encouragement and assistance to adopt international standards that will lead to the promotion of mental health.

Conclusion

A climate that respects and protects basic civil, political, economic, social and cultural rights is fundamental to the promotion of the mental health of the population. Without the security and freedom provided by these rights it is very difficult to maintain a high level of mental health (Gostin, 2001).

A human rights framework offers a useful tool for identifying and addressing the underlying determinants of mental health. The instruments which make up the UN human rights mechanism represent a set of universally accepted values and principles which can serve to guide countries in the design, implementation, monitoring and evaluation of mental health policies, laws and programmes. As legal norms and standards ratified by governments, they generate accountability for mental health and thus also offer a useful standard against which government performance in the promotion of mental health can be assessed.

Human rights empower individuals and communities by granting them entitlements that give rise to legal obligations on governments. They can help to equalize the distribution and exercise of power within society, thus mitigating the powerlessness of the poor (WHO, 2002). The principles of equality and freedom from discrimination, which are integral elements of the international human rights framework, demand that particular attention be given to vulnerable groups. Furthermore, the right of all people to participate in decision-making processes, which is reflected in the International Bill of Rights and other UN instruments, can help to ensure that marginalized groups are able to influence health-related matters and strategies that affect them and ensure that their interests are considered and addressed.

Mental health promotion is not solely the domain of ministries of health. It requires the action and involvement of a wide range of sectors, actors and stakeholders. Human rights encompass civil, cultural, economic, political and social dimensions and thus provide an intersectoral framework to consider mental health across the wide range of mental health determinants.

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Chapter 8 • Responding to the Social and Economic Determinants of Mental Health: A Conceptual Framework for Action

Lyn Walker, Irene Verins, Rob Moodie, Kim Webster

Introduction

Global attention is now focused on the development of strategies to reduce mental ill-health and promote mental health and well-being. As indicated in Chapter 1, this phenomenon has occurred for a number of reasons. We now know that the global burden of mental ill-health is increasing, is well beyond the treatment capabilities of all countries and is linked to adverse social and economic changes that are enduring and unacceptable (VicHealth, 1999).

We also know that mental ill-health is more common among people with relative social disadvantage (Desjarlais & Kleinman, 1997). A focus on social and economic determinants of mental health in our health promotion efforts should not only result in lower rates of some mental disorders and improved mental health but also improved physical health, educational and work performance, relationships and community safety. Thus, as indicated in Chapter 2 in terms of health promotion overall, the promotion of mental health and well-being is as much an emerging political project as a health project (Mittelmark, 2003).

Conceptual and practice frameworks to progress work in the promotion of mental health and well-being have been developed over the last decade in a number of countries, including Finland, the United Kingdom and New Zealand. In this chapter we present a framework that has been developed by the Victorian Health Promotion Foundation (VicHealth) in Australia to address the key socioeconomic determinants of mental health. Through examining three of these determinants, we present concepts, emerging evidence and examples of practice which indicate the role that varying sectors can play and the partnerships that can be created to promote mental health. The process of developing and using the framework is similar to that found in other fields of public health and health promotion as outlined in Chapter 2.

The VicHealth framework to promote mental health and well-being

At the International Primary Health Care Conference held in Alma-Ata in 1978 a declaration was made in which health was reaffirmed as a human right, the role of social and economic sectors in promoting health was illuminated and health inequalities were termed politically, socially and economically unacceptable. The ensuing Alma-Ata Declaration and Ottawa Charter for Health Promotion introduced a social model of health promotion that is now a common feature of health promotion practice (see Chapters 1 and 2).

Robertson and Minkler (1994) suggest that some two decades since the development of the influential Ottawa Charter, prominent features of contemporary health promotion include:

- broadening the definition of health and its determinants to include the social and economic context in which health or ill-health is produced;

- going beyond the earlier emphasis on individual lifestyle strategies to achieve health to broader social and political strategies;

- embracing the concept of empowerment, individual and collective, as a key health promotion strategy; and advocating for the participation of the community in identifying health problems and strategies for addressing those problems.

Figure 8.1
VicHealth's framework for the promotion of mental health and well-being

Key Determinants of Mental Health & Themes For Action		
Social inclusion	**Freedom from discrimination & violence**	**Economic participation**
■ Supportive relationships ■ Involvement in group activities ■ Civic engagement	■ Valuing of diversity ■ Physical security ■ Self-determination and control of one's life	■ Work ■ Education ■ Housing ■ Money

↓

Population Groups & Action Areas	
Population groups	**Health promotion action**
■ Children ■ Young people ■ Women and men ■ Older people ■ Indigenous communities ■ Culturally diverse communities ■ People who live in rural communities	■ Research, monitoring & evaluation ■ Individual skill development ■ Organisational development ■ Community strengthening ■ Communication & marketing ■ Advocacy of legislative & policy reform

↓

Sectors & Settings for Action					
HOUSING	COMMUNITY	EDUCATION	WORKPLACE	SPORT, ARTS & RECREATION	HEALTH
TRANSPORT	CORPORATE	PUBLIC	ACADEMIC	LOCAL GOVT	JUSTICE

↓

Intermediate Outcomes		
Individual	**Organisational & Community**	**Societal**
Increased sense of: ■ belonging ■ self-esteem ■ self-determination & control	■ Accessible and responsive organisations ■ Safe, supportive & inclusive environments	■ Integrated & supportive public policy & programmes ■ Strong legislative platform ■ Resource allocation

↓

Improved Mental Health

↓

Long-term Benefits		
Less anxiety & depression Less substance misuse Improved physical health	Improved productivity at work, home & school Less violence & crime	Reduced health inequalities Improved quality of life & life expectancy

Source: VicHealth 1999.

It was in this context that VicHealth developed its framework for the promotion of mental health and well-being (VicHealth, 1999).

As shown in figure 8.1, the framework begins with acknowledgement of three key determinants of mental health: social inclusion, freedom from discrimination and violence, and access to economic resources. Health promotion actions that address these determinants can be carried out with different populations, through involvement with different sectors and in varying settings. Health promotion methodologies are used to secure intermediate outcomes (increased sense of belonging; safe, supportive and inclusive environments; accessible and responsive organizations; supportive and integrated public policy; and a strong legislative platform). These are expected to result in improved mental health as well as less substance misuse, improved physical health and productivity and other longer-term outcomes.

Key aspects of the framework

An intersectoral approach

> A central challenge for moving public mental health forward will be to shift the debate about mental health away from a singular focus on the health sector to a focus on areas such as employment, education, transport, housing, criminal justice, welfare and the built environment (Friedli, 2002, p. 1).

The contribution that health promotion can make in the area of mental health is currently misunderstood and sometimes contested. This is not a new phenomenon if we recall that some 30 years ago a medical model of health informed management of heart disease with little acknowledgement of the role that those working in areas such as physical activity, tobacco control and nutrition could play in promoting heart health and preventing heart problems. Some three decades later the contribution of these sectors in the promotion of heart health and the prevention of heart disease is well evidenced and acknowledged (see Chapter 2).

In the area of mental health we stand at a crossroad where medical concepts of health are the prevailing paradigm but emerging evidence is now indicating that, as in the case of heart heath, a major contribution to the promotion of mental health and the prevention of mental ill-health will be made by those working outside the health system.

Thus, given the relationship between social and economic factors and mental health, success in promoting mental health and well-being can only be achieved and sustained by the involvement and support of the whole community and the development of collaborative partnerships with a range of agencies throughout the public, private and nongovernment sectors. Mental health promotion needs to occur within the health sector and in all other sectors that influence the way in which people live, love, are educated and work (Walker & Rowling, 2002).

Use of multiple and mutually reinforcing health promotion methodologies

Health promotion has a strong history in the use of multiple and complementary methods. If we apply health promotion theory to mental health these methods are likely to include:

- research and evaluation to build the evidence for mental health promotion and assess the effectiveness of strategies;

- developing the capacity of communities and organizations to implement strategies that increase participation in a range of social, educational and economic activities and create safe and supportive environments;

- supporting community development approaches which increase levels of civic engagement and assist communities to articulate priority areas for action;

- developing education and training programmes to strengthen understanding of mental health promotion theory and practice across sectors and to ensure there is a trained and skilled workforce to promote mental health and well-being;

- communicating about mental health promotion issues through local, regional and national media and avenues such as community meetings, conferences and forums; and

- advocating for policy and programme development, resource allocation and legislative and regulatory reform.

A focus on social and economic determinants

It is predicted that the continuing decline of social cohesion over the next two decades will be reflected in high levels of structural unemployment, an increase in part-time, insecure and low paid employment, a widening gap between rich and poor, demographic shifts, technological progress, open trade and greater competition in less constrained market places (Murray, 2001; Zubrick et al., 2000). This rapid economic and social change could translate into relationship and family breakdown, child abuse, early school failure, depression, suicide, alcohol and drug misuse, teenage pregnancy and violence, with serious negative effects on the development of mental health and well-being of children and young people (Zubrick et al., 2000).

As many of the chapters in this book indicate, our knowledge of the determinants of mental health is growing. There is also consensus among authors that some of the major determinants of mental health are located within social and economic domains and include:

- social inclusion and access to supportive social networks;

- stable and supportive family, social and community environments;

- access to a variety of activities;

- having a valued social position;

- physical and psychological security;

- opportunity for self-determination and control of one's life; and

- access to meaningful employment, education, income and housing.

The evidence suggests that these determinants are also common to alcohol and drug use (Resnick et al., 1997), crime (Homel, 2001), dropout from school and reduced academic achievement (Zubrick et al., 2000). It is therefore reasonable to assume that the development of strategies designed to address the socioeconomic determinants of mental health could also have a positive impact in other domains.

The three major determinants of mental health that inform the VicHealth framework – social inclusion, freedom from discrimination and violence and economic participation – are discussed further below.

Increasing social inclusion

Concepts

A socially inclusive society is defined as one where "all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity". Social exclusion is the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of a person into the community (Cappo, 2002).

Social inclusion for an individual means access to supportive relationships, involvement in group activities and civic engagement. Social networks can provide social support, social influence and opportunities for social engagement and thus create meaningful roles, resources and opportunities for intimate one-on-one contact. The impact on mental health can occur through two mechanisms: either as a *main effect* influence in which social networks have a beneficial effect on mental health regardless of whether or not the individuals are under stress, or as a *stress buffer*, in which social networks improve the well-being of those under stress by acting as a buffer or moderator of that stress (Kawachi & Berkman, 2001).

Evidence

There is strong epidemiological evidence of significant and persistent correlations between poor social networks and mortality and ill-health from almost every cause of death (Berkman & Glass, 2000; Seeman, 2000). Social isolation and lack of social support are linked with increased likelihood of heart disease, complications in pregnancy and delivery and suicide (Syme, 1996).

In relation to heart health, an expert working group of the National Heart Foundation of Australia reviewed evidence relating to major psychological risk factors to assess whether there are independent associations between these and the development of coronary heart disease. They concluded that there is strong and consistent evidence of an independent causal association between depression, social isolation and lack of quality social support and the causes and prognosis of this disease (Bunker et al. 2003). The links between physical health and mental health are discussed further in Chapter 11.

A lack of social connections and networks is also associated with poor mental health. In a study conducted by the Centre For Adolescent Health in Australia, young people who reported having poor social connectedness (defined in this case as not having someone to talk to, someone to trust, someone to depend on and someone who knows you well) were two to three times more likely to experience depressive symptoms than peers who reported the availability of confiding relationships (Glover et al., 1998). Similarly, a meta-analysis of routinely collected data about USA college students from 1952 to 1993 found correlations between a rise in anxiety and reduced social connections (Twenge, 2000).

As indicated elsewhere in this volume, greater levels of community participation, social support and trust in others have been associated with lower crime figures, higher educational achievement, better economic growth and reduced experience of psychological distress (Berry & Rickwood, 2000; see also Chapter 10). Positive mental and physical health benefits of social interaction are also well-documented for specific population groups, such as older adults (Seeman, 2000).

Practice

While information about these global associations and impacts can be overwhelming and leave many of us wondering what can be done in our own sphere of influence, it is clear that we can

facilitate social inclusion at the local level. Evaluation of local interventions then leads to greater understanding about what works as well as growth of the evidence base for causal associations.

The overall aim of this practice is to build the capacity of organizations and communities to consciously and systematically increase opportunities for participation and belonging: to build a consciousness of health into planning, programmes and policy. This can involve, for example, working at the community level to ensure that the built environment does not isolate people from one another or conversely cause overcrowding. It can also involve strategies at the organizational level that increase access to participation in groups, associations and networks.

Because vulnerability to ill-health is not equally distributed in the population but rather moderated by gender, socioeconomic position and stage in life (Kawachi & Berkman, 2001), few reviews thus far have identified population-wide interventions that seek to promote mental health or prevent depression and anxiety by building social networks or enhancing existing social networks. Most social support interventions have rather focused on "at risk" populations (Rychetnik & Todd, 2004). A large body of work focuses on such targeted social inclusion activity which involves specific individuals, groups or neighbourhoods likely to be affected by multiple forms of economic, social or environmental deprivation; deals with the causes of deprivation rather than (or as well as) its symptoms; and works in partnership with local people or communities of interest. Examples of such evidence can be found at the website of the Centre for Economic and Social Inclusion (www.cesi.org.uk/_newsite2002).

The following are two examples of this approach.

Urban design in San Francisco – The tale of three streets

Three streets in San Francisco were studied, looking at the traffic passing and the level of connectedness and safety as perceived by the residents. One (heavy street) had approximately 16 000 cars per day, one 8000 per day and one (light street) 2000 per day. Those living on light street had three times as many friends among their neighbours as those on heavy street. The light street was perceived to be friendly and safe for kids, whereas the heavy street residents kept to themselves and there was little sense of community (Dora & Phillips, 2000).

This study shows how local government planning can create environments that increase access to social relationships.

The Walking School Bus

A study of more than 1000 children in Australia found that almost three out of every four children were driven to school, although a significant proportion preferred to walk (VicHealth, 2003b). Most children who did walk to school identified the social aspect of the activity as the most important, describing it as a fun activity which gave them a sense of freedom and independence and feelings of better health.

The Walking School Bus concept is a simple one: a group of children walk to and from school under the supervision of adult volunteers.

Through this process:

- children engage in regular physical activity;
- traffic congestion and pollution outside and around schools is reduced;
- children become more familiar with their community and are provided with the opportunity to develop and improve road safety and pedestrian skills; and
- cooperative relationships between local government, primary schools, families and the community are established that facilitate a positive sense of community and increase the opportunities for the children and project supporters to access social networks.

Reducing discrimination and violence

Concepts

Discrimination and violence perpetrated on the basis of gender, cultural or religious background, sexual identity, political beliefs, health status or level of ability is one of the most enduring characteristics of humanity. The health effects of discrimination resulting in extreme violence were obvious in Nazi Germany, in Aboriginal lands in Australia, in the killing fields of Cambodia and in the lives of women from across the globe (Walker, Moodie & Herrman, 2004).

Racial discrimination is present if there is:

- under-representation of minority group members in the media;
- reinforcement of negative stereotypes in the reporting of conflicts involving minority groups;
- continuing restrictive immigration policies;
- limitations in access to education and employment for minority group members; and
- limitations in access to adequate standards of health, housing and basic infrastructure (Sanson et al., 1998).

Violence is defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (WHO, 1996). The World Report on Violence and Health divides violence into three broad categories, according to who commits the violent act:

- self-directed violence, which encompasses suicide and self abuse;

- interpersonal violence, which is divided into two main categories: family or intimate partner violence and community violence which takes place in settings such as schools and workplaces, including sexual assault by strangers; and

- collective violence, which takes a variety of forms including armed conflict, repression and human rights abuses (WHO, 2002).

The report comprehensively maps the etiology of violence across all population groups and notes the dimension of the problem, referring to surveys from around the world indicating that 10–60% of women report being physically assaulted by an intimate partner at some point in their lives. In some countries, one in four women report sexual violence by an intimate partner and up to one third of girls report forced sexual initiation. Hundreds and thousands more are forced into prostitution or subjected to violence in other settings such as schools, workplaces and health care institutions (WHO, 2002).

Evidence

Community and population level studies focused on racial discrimination have consistently shown an association between higher rates of self-reported discrimination and poorer mental health (Krieger, 2000). For example, there are proven associations between racial discrimination and diminished sense of well-being, low self-esteem, lack of control or mastery, psychological distress, and depression, anxiety and other mental illnesses (Brown et al., 2000; Kessler, Mickelson & Williams, 1999; Williams & Williams-Morris, 2000; Williams, Neighbours & Jackson, 2003).

Evidence indicating a relationship between the experience of interpersonal victimization and adverse mental health outcomes is strong. For example, women who have experienced interpersonal violence have high rates of depression, anxiety, stress, pain syndromes, phobias and chemical dependency as well as poor subjective health (WHO, 2002).

A study into the burden of disease associated with violence perpetrated against women in intimate relationships found that intimate partner violence constituted the highest risk factor for poor health in Australian women aged between 15 and 45 years. Mental illnesses such as anxiety and depression were the most significant resulting health burden (VicHealth, 2004).

Research has also linked poor mental health with interpersonal victimization in the form of bullying. Trauma from bullying has been associated with depression, low self-esteem, poor self-concept, loneliness and anxiety (Hawker & Boulton, 2000). A Victorian study of 14–15 year olds found that students with a history of victimization were two to three times more likely to be depressed than other students (Bond et al., 2001).

Practice

Interventions at the societal level are the most effective mechanisms for reducing discriminating attitudes and behaviours (Rychetnik & Todd, 2004). Examples of this include racial vilification legislation designed to combat discrimination on the basis of race or ethnicity, sexual harassment complaint procedures designed to combat discrimination on the basis of gender and codes of conduct. While legislative reform alone will not make substantial changes where discrimination is rife, combined with widespread communication strategies its effects can be significant. The following practice example illustrates this point.

If racism wins, sport loses

To combat racism on sporting fields in Australia, government authorities have worked with peak sporting organizations to develop codes of conduct to indicate behaviours that are deemed unacceptable and the penalties that will be applied if these behaviours exist and resource material to assist sporting organizations to manage racism within their clubs. A widespread communication and marketing campaign designed to increase awareness of the damage caused by racism within the sporting environment was also developed. Due to the very visible and public nature of sport in Australia, in the longer-term it is likely that these developments will enhance notions of fair play and teamwork within sporting clubs and help to build positive attitudes and behaviours at the broader community level.

Such combined approaches to legislative reform and widespread communication can be implemented to address key determinants of mental health and well-being at the organizational and broader community level. (Further information is available at http://www.voma.vic.gov.au.)

While legislative reform and large-scale communication strategies are among the most powerful mechanisms for changing discriminatory attitudes and behaviours at a societal level, they are also the most costly. Consequently, in recent years other common approaches to discrimination reduction have targeted individuals and groups and have been based on the "contact hypothesis" (Oskamp, 2000). This hypothesis centres on the premise that prejudice is largely derived from ignorance and that one of the major means of reducing inter-group prejudice is through contact between groups under optimal conditions.

Pettigrew and Tropp (2000) conducted a review of prejudice reduction programmes based on inter-group contact. A meta-analysis was performed of 203 individual studies combining 90 000 subjects from 25 nations. An inverse relationship between contact and prejudice was found in 94% of these studies. They concluded that inter-group contact should be a critical component of any successful effort to reduce discrimination. They identified six issues relevant to achieving optimal contact. First, programmes to reduce prejudice should incorporate four elements: equal status between the groups in the situation; cooperative activity towards common goals; personalized acquaintance, that is, perception of common interests and common humanity; and support for the contact by authorities. Second, the perspectives of both in-group and out-group members must be considered. Third, the contact should be designed to improve several components of prejudice, such as beliefs, social distance and stereotypes. Fourth, contact in work and organizational settings has stronger effects than those typical of travel and tourism settings. Fifth, it is important to actively create situations that counter prevailing negative stereotypes. Finally, social-structural changes in institutional settings are necessary to provide opportunities for optimal inter-group contact on a scale sweeping enough to make a societal difference; although such changes are typically resisted by powerful minorities. The following intervention is an example of the contact hypothesis in practice.

Addressing discrimination through the Arts

The Torch Project is a community building initiative designed to address racial discrimination in rural and regional areas of Victoria. Artists working alongside young people from Indigenous and mainstream communities develop theatre pieces that explore issues of discrimination, violence and widespread oppression. The young people work together in development of the work which culminates in a performance attended by community members. Individual assessments indicate that through the contact facilitated by the Torch project understandings between participants are forged and friendships made. Issues around discrimination and violence are also communicated to the audience, which has prompted community dialogue at a broader level. (More information on the Torch project is available at http://thetorch.asn.au/.)

A vast literature also indicates the systematic changes – cultural, political and social – that are needed to alter well-entrenched patterns of violence, especially violence against women (Rychetnik & Todd, 2004). While prejudice is often closely tied to ignorance, evidence indicates that violence linked to discrimination has its roots in social-structural relationships with a power imbalance between groups being the dominant feature. This is often the case in relation to racial and gendered violence. Thus, a range of strategies designed to address institutionalized violence is required. An example of a community development approach to this issue is the Comprehensive Rural Health Project (CRHP) in India which is discussed in detail in Chapter 18 and outlined below.

Comprehensive Rural Health Project (CRHP), Jamkhed, Maharashta, India

In order to respond to the primary health care needs of rural Indian communities, local women were provided education, training and support to assist them to develop skills to respond to presenting health issues. The women were then able to make a significant contribution to the health of their families, neighbours and friends. Over time, the women developed the confidence to step outside the traditional confines of their roles as wives and mothers to explore economic development activities that would also benefit their communities. Their value at the community level increased and with this came a marked decrease in the level of domestic violence perpetrated against them.

Through such community development approaches power imbalances can be addressed with a resulting reduction in discrimination and consequent levels of violence.

Increasing economic participation

Concepts

Economic participation is not simply a question of full employment. It includes a continuum ranging from adequate employment (e.g. secure, appropriately paid, good job satisfaction) to inadequate employment, through to unemployment (Dooley, Prause & Ham-Rowbottom, 2000) as

well as access to the money and education necessary to feed, clothe and house one's self and to participate in community life.

Evidence

Research consistently finds that mental health is relatively poor among those with low education levels, low-status occupations and low incomes (Astbury, 2001, cited in VicHealth, 2004; Schwabe & Kodras, 2000; WHO, 2000) and among unemployed people and those with job insecurity (Creed, Machin & Hicks, 1999; Power et al., 2000).

Occupying a low social rank also limits access to material and psychosocial resources and affects individuals' autonomy and decision-making over severe life events. Both of these factors have consistently been associated with an increased risk of depression (WHO, 2000). These factors can also have a flow-on effect from one generation to another. For example, recent work by Zubrick and colleagues indicates that children of unemployed parents have higher incidences of mental health problems and lower academic competence than children with working parents (Zubrick et al., 2000 in Walker & Rowling, 2002; see also Chapter 12).

Children living in low socioeconomic status households and disadvantaged neighbourhoods suffer more anxiety, depression, substance abuse, delinquent behaviour and poor adaptive functioning. Children living in low socioeconomic status circumstances are also more likely to be exposed to multiple adverse events and experiences (acute and chronic) which can have a cumulative effect on their long-term mental health (Bradley & Corwyn, 2002; McMunn et al., 2001; Power et al, 2000).

The link between low socioeconomic status, unemployment, income insecurity and mental ill-health is well established. In an era characterized by downsizing, reductions in benefits, globalization, use of temporary workers and welfare reform there is a need to continue to document and understand the impact of economic and social policies on the mental health of populations and subpopulations (Kaplan & Lynch, 1997).

We need to ensure that fewer people fall and that they fall less far. Societies that enable all their citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation (Wilkinson & Marmot, 1998).

Practice

A comprehensive approach to promoting mental health would ideally address the socioeconomic conditions that exacerbate poor mental health such as low income, low literacy, limited education, insecure employment, stressful work conditions or unemployment, poor quality housing, violent and run-down neighbourhoods, and social and political disenfranchisement.

While stabilizing global economies and increasing national rates of employment is not within the scope of localized mental health promotion activity, it is possible to undertake research into the mental health impacts of government policies and programmes across jurisdictions. It is also possible to develop the skills required for employment and to create enterprise opportunities for people and communities at the local level. This can be achieved through a range of health promotion strategies including legislative control, advocacy and organizational and community capacity building.

The following examples show the role that intersectoral collaboration can play in this area.

Whitelion project

In this project, partnerships have been developed between juvenile youth correction facilities and private industry to secure supportive employment experiences for young people being released back into the community from detention. Through this process workplaces are provided with guidance to ensure optimal support for the young people employed, the skills of the young people are enhanced, contact with mainstream society is initiated, self-confidence develops and the likelihood of re-offending is lessened. (More information is available at http://www.whitelion.asn.au.)

This project shows how partnerships developed between public organizations and private industry can create opportunities where mental health and well-being can flourish.

Urban renewal programme

A 5.5 million pound, five-year housing renewal programme (1992–1998) in Newcastle upon Tyne in the UK was used as an opportunity to research the health effects of poor housing and to evaluate the effectiveness of housing improvement. The intervention comprised environmental improvements, external repairs, refurbishment, demolition of void dwellings, renovation grants for individual dwellings and improvements to security and road safety. Psychological distress showed significant decline (a fall of 10% in adults with one or more mental health problems in cross-sectional data and a 50% reduction in adults having "trouble with nerves" in longitudinal data). The prevalence of smoking was halved on both cross-sectional and longitudinal samples (Blackman et al., 2001).

The framework in action: mental health promotion in refugee communities

Over the past four years, the VicHealth framework has been applied to guide development of mental health promotion programmes at population and subpopulation levels. These programmes have been designed to respond to the socioeconomic determinants of mental health, use the full range of contemporary health promotion methods and be implemented by people working across sectors and disciplines. The following description of VicHealth's approach to mental health promotion in refugee communities shows how the framework operates in practice.

Reasons for focusing on refugee communities

There are currently over 17 million refugees and displaced persons globally, with forced human movement becoming a major issue for many countries, both developed and developing (UNHCR, 2004).

As indicated in Chapter 7, fundamental solutions to this problem lie in efforts to address the root causes of conflict, violence and human rights abuses. However, for the foreseeable future there will be a large number of people for whom repatriation is not a viable option and who will face the challenge of integration in their countries of asylum or resettlement in a third country (UNHCR, 2002).

While the countries receiving refugees and asylum seekers are diverse, a large body of evidence indicates that there are a number of common negative social and economic influences on mental health in the asylum and resettlement environments (Chung et al., 2001; Dyregrov, Gjesta & Raundelen, 2002; Gorst-Unsworth & Goldenberg, 1998; Hyman, Beiser & Vu, 2000; Silove et al., 1997). These include hostility and racism in the receiving community as well as limited access to basic economic resources such as housing and income, key cultural, legal and economic institutions, and family and community support (VicHealth, 2003a). These exposures can compound the existing vulnerability resulting from the exposure to deprivation, conflict and social and economic exclusion commonly preceding forced movement (Silove et al., 1997; Thomas & Lau, 2002).

As a signatory to the UN Convention, Australia, alongside many developed and developing countries, is a destination for asylum seekers and offers a formal resettlement programme in cooperation with the United Nations High Commissioner for Refugees (UNHCR). A large proportion of these entrants come to Victoria, where VicHealth has worked with government and nongovernment organizations and mainstream and refugee communities to promote mental health and well-being in the new arrival population.

Programmes developed under the framework

A number of programmes have been developed under the framework to promote the mental health and well-being of refugee communities in Victoria. A selection of these is described in the box below.

Research: involving the academic sector

The Centre For Refugee Health is conducting a longitudinal study into the settlement experience of young refugees. This research will investigate the settlement experiences that have positive and negative mental health impacts on young people and their families, and the policy, legislative and organizational reforms required to promote mental health and well-being among this population group.

Policy and programme reform: involving local government and communities

Australia has seen an increasing trend towards migrant and refugee settlement in rural areas where there are better employment opportunities, a trend supported by government. Keen to ensure that policy development in this area not only takes account of employment issues but also the need for an inclusive and supportive environment, VicHealth has commissioned research to assess the mental health impact of this emerging policy and to evaluate two rural refugee relocation programmes being conducted by local government authorities. The evaluation will identify good practices that can be used to inform future government policy development and implementation.

Community development: involving refugee communities and education and business sectors

Melbourne's African communities were supported by an adult migrant education service to develop a community newspaper. In addition to providing participants with tangible

skills to enhance their future employment prospects, the newspaper has strengthened the communities by improving access to information vital to positive resettlement and promoting communication both within the communities and between them and the mainstream community and business networks. It has also helped to build a positive African-Australian community identity. The newspaper is developed in six languages and is currently working towards sustainability through attracting advertising fees from small businesses.

Community enterprise: involving refugee and mainstream communities, education and business

Through onsite education and support, older African men opened their own carpentry business, the United Wood Cooperative. This has led to the development of supportive relationships and acquisition of English language, carpentry, marketing and business management skills. This has facilitated increased levels of self-esteem, mutual reliance, productivity and family and community pride in their achievement. Those providing mentoring assistance have also experienced a sense of purpose through their contribution. The cooperative now provides traineeships to young men and partnerships are being formed with the business sector. Thus, community and organizational capacity building is being achieved

Organizational development: involving the education sector

As well as an important context for the building of social connections, progress in the education system influences refugee young people's access to current and future economic resources. Partnerships have been developed with Victorian schools and technical colleges to enhance their responsiveness to the needs of refugee children and young people. Activities have included policy and curriculum development, group programmes and piloting of alternative approaches to education and training. The resulting changes to educational settings have been embedded in their ongoing practice.

Workforce development: involving the sports sector

Sports settings are important for the development of social connections between young people and between them and significant adults. They may also be sites for discrimination and exclusion. The Centre for Multicultural Youth Issues has been supported to undertake work with sporting organizations to build their capacity to engage refugee young people and address discrimination in sporting environments. Through this process, access to mainstream activity is created and enduring relationships between young people across cultures are formed.

Advocacy and legislative reform: involving faith organizations

The Justice for Asylum Seekers Project, a network of refugee, human rights and faith-based groups, was supported to develop an accessible publication, *The Better Way: Refugees, Detention and Australia*. As well as seeking to influence changes in government asylum policy, the resource provided information to counter common myths about asylum seekers, many of which underlie discriminatory practices toward this group. Through such advocacy, the Australian policy in relation to the detention of asylum seekers, particularly children, is in the process of reform.

Communication: working with the media

As a means of raising community awareness about the socioeconomic influences on mental health and well-being, the *Together We Do Better* campaign focused on the importance of creating opportunities for people to connect with each other and to build bridges within and across age and cultural groups. Print and radio advertisements described why connection and active social participation in community life are important and suggested ways in which this can be achieved.

Communication and marketing: involving artists, communities and community leaders

Work is currently taking place on the development of a publication designed to promote mental health and well-being through portrayal of the positive individual, family and community impacts of multiculturalism. The publication, *A Day in the Life of Multicultural Melbourne: Together We Do Better,* will be produced by over 300 community members working with photographic artists to capture images which celebrate and honour diversity. The publication will be supported by key political, community and faith leaders and will be produced and marketed through a mainstream publishing house. Images developed will then be used for ongoing communication activity by participating organizations.

Future challenges

Cross-sector engagement

In order to engage all sectors in mental health promotion activity, synergies across sectors must be identified and a common language which focuses on health as opposed to illness developed. Given the scarcity of resources and the global effort required for managing and reducing the mental health burden, it is also critical that any perceived or actual competition for resources with the health treatment sector is avoided.

Integrated long-term approaches

Government policy, research and practice often take place in systems or organizations that have little involvement with each other ("silos"). In order to develop effective mental health promotion activity at a population level, long-term and integrated planning, implementation and investment across these silos is essential. Evaluation needs to occur and progress will be slow. Long-term gains are not always the drivers attractive to governments in the short-term, so effective ways of managing political discourse must be developed for the promotion of mental health to be seen as a non-party-political public good.

Focusing upstream

Health promotion is an emerging field of activity with mental health promotion being one of the most recent areas of focus. While the rhetoric of health promotion includes multi-methodological approaches to combating structural determinants of health, as indicated in Chapter 15, practice in

this area has not moved far beyond the rhetoric. Challenges lie in the development of strategies to address health issues at their source.

To assist this process, it is critical that interdisciplinary collaborations are forged between those working in health and sociopolitical domains. This will require a melding of varying ideological perspectives as well as a cultural shift in the competitive academic and practice environments.

Skilling multisector workforces

In order to develop and implement evidence-based mental health promotion practice, a skilled intersectoral workforce is required. To facilitate this process, practitioners require training and tools to assist the conceptual development and planning, implementation and evaluation of project and programme activity. Efforts in this regard are emerging in a number of countries; however, a challenge lies in ensuring that these efforts are coordinated and that the training and tools developed have relevance for workers in both developed and developing countries.

Working in partnership

Finally, competition across sectors, disciplines, states and nations will keep us divided and obstruct our progress. The development of international collaborative arrangements is fundamental to ensuring that mental health promotion activity takes place in developed and developing countries and is informed by the shared wisdom and expertise of all.

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Part II

The Emerging Evidence

Margaret M Barry, David V McQueen

Introduction

There have been important advances in establishing a sound evidence base for mental health promotion in recent years. There is consensus that there are clusters of known risk and protective factors for mental health and there is evidence that interventions can reduce identified risk factors and enhance known protective factors (Mrazek & Haggerty, 1994). An International Union for Health Promotion and Education (IUHPE) report for the European Commission in 2000 clearly endorsed that mental health promotion programmes work and that there are a number of evidence-based programmes that inform mental health promotion practice (IUHPE, 2000). This accumulating evidence demonstrates the feasibility of implementing effective mental health promotion programmes across a range of diverse population groups and settings.

An important challenge is strengthening the evidence base in order to inform best practice and policy globally. There is a need to identify gaps in, and expand, existing knowledge in order that the complexities and creativity of contemporary practice can be captured and disseminated widely. While researchers are more likely to be concerned with the quality of the evidence, its methodological rigour and contribution to the knowledge base, different stakeholders in the area may have different perspectives on the types of evidence needed. As described by Nutbeam (2000), policy-makers are likely to be concerned with the need to justify the allocation of resources and demonstrate added-value, practitioners need to be able to have confidence in the likely success of implementing interventions, and the potential users or the people who are to benefit need to see that both the programme and the process of implementation are participatory and relevant to their needs. Another major task is to promote the application of existing evidence to good practice on the ground, particularly in disadvantaged and low income countries and settings. This entails identifying programmes that are effective, feasible and sustainable across diverse cultural contexts and settings. The challenge is therefore twofold: translating research evidence into effective practice and translating effective practice into research so that currently undocumented evidence can make its way into the published literature and thus build on and expand the existing evidence base (see figure 9.1). This calls for critical consideration of how best to assemble and apply evidence which is congruent with the principles of mental health promotion practice and which is inclusive of the realities of programme implementation across diverse cultural settings.

Evaluating the promotion of positive mental health

As discussed in earlier chapters, mental health promotion reconceptualizes mental health in positive rather than negative terms and is concerned with the delivery of effective programmes designed to reduce health inequalities in an empowering, collaborative and participatory manner. This shift in focus from negative to positive indicators of well-being calls for methodological refinement in establishing sound measures of protective factors and positive indicators of mental health outcomes. Chapter 12 of this volume provides a useful discussion of this issue and outlines a socioecological framework for developing indicators of positive mental health. A focus on positive mental health also calls for more attention to the process and principles of programme delivery. Evaluation methods are needed that focus on documenting the process, as well as the

Figure 9.1
Bridging the gap between evidence and practice
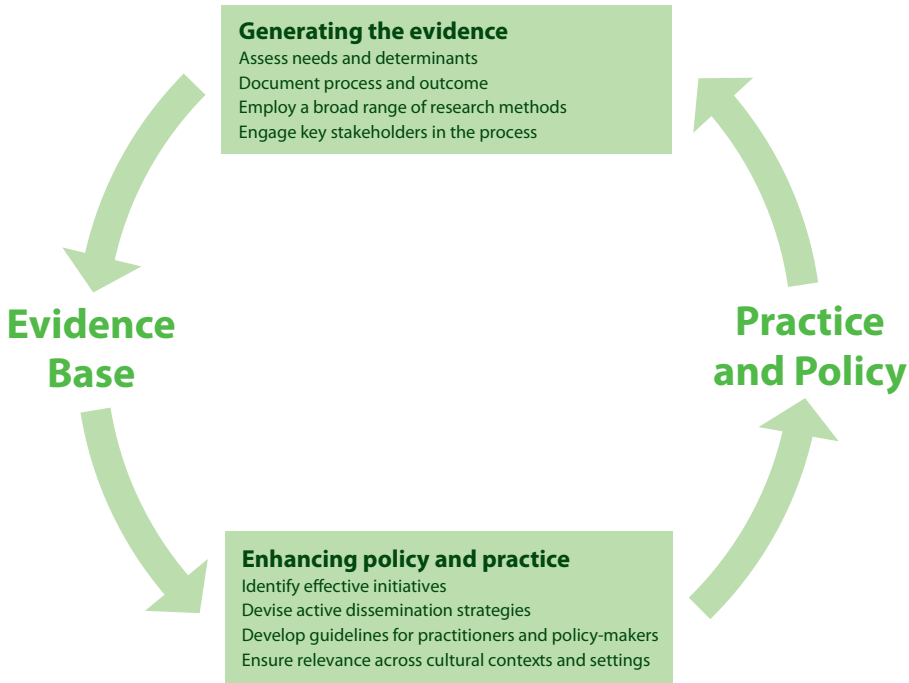
outcomes, of enabling positive mental health and identifying the intervening or mediating varia-bles which act as key predictors of change. This leads to a focus on evaluation methods aimed at capturing the dynamics of programmes in action and identifying the critical ingredients for suc-cessful programme development, planning and implementation.

The available evidence supports the view that competence-enhancing programmes carried out in collaboration with families, schools and wider communities have the potential to produce mul-tiple positive outcomes across social and personal health domains (Barry, 2001; Durlak & Wells, 1997; Friedli, 2003; Hosman & Jané-Llopis, 2000; Tilford, Delaney & Vogels, 1997). Most interven-tions have been found to have the dual effect of reducing problems and increasing competencies. However, much of the existing evidence has focused on individual-level interventions and, as highlighted in Chapter 15, there is a paucity of evidence on the effectiveness of upstream policy interventions such as improved housing, welfare, education and employment in improving men-tal health. There is a need to generate evidence of the effectiveness of interventions operating at different levels – individual, community and macro-level policy – in promoting positive mental health.

The evidence-based practice of health promotion is a relatively recent phenomenon, therefore strengthening the evidence base in order to inform best practice and policy is an important challenge. There is considerable debate, however, as to how this is best approached. This chapter takes a critical look at some of the key issues, challenges and opportunities in strengthening the mental health promotion evidence base.

Adopting an evidence-based approach: issues and challenges

There has been much discussion about what constitutes legitimate evidence in health promotion evaluation and how best to assemble the evidence in ways which are relevant to the complexities of contemporary practice (McQueen, 2001; Nutbeam, 1999; Tones, 1997; see also Chapter 2). As health promotion is an interdisciplinary area of practice, the challenge is to use evaluation methods and approaches that are congruent with the principles of health promotion practice (Labonté & Robertson, 1996), that cross methodological boundaries and that seek to evaluate initiatives in terms of their process as well as their outcomes. The WHO European Working Group on Health Promotion Evaluation (1998) set forth recommendations for policy-makers concerning the appropriate methods for evaluation in health promotion (see table 9.1). They point out that the use of randomized control trials (RCTs) to evaluate health promotion initiatives "is, in most cases, inappropriate, misleading and unnecessarily expensive". While RCTs and systematic reviews are regarded as the "gold standard" in the traditional hierarchy of research designs (WHO, 2002), their application to

The Cochrane Collaboration

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The Cochrane Collaboration, an international organization of health professionals, aims to promote the preparation and use of high quality, regularly updated, systematic reviews on the effectiveness of health interventions. Cochrane reviews begin life as a registered title of a Collaborative Review Group. A protocol (a blueprint for the review) is developed, peer reviewed and published electronically on the Cochrane Library. The review is then carried out, peer reviewed and published. The authors make a commitment to update the review at least every two years and Cochrane protocols and reviews are open throughout their lifespan to comments and criticism by readers. The Health Promotion and Public Health Field (the Field) of the Collaboration is aiming to improve the quality and quantity of systematic reviews in order to develop a solid foundation of evidence relevant to core public health questions, including reviews of mental health promotion interventions and interventions with mental health outcomes. The emergence of the Campbell Collaboration, which focuses on social, education and justice interventions, also has relevance for identifying interventions that have an impact on mental health.

In October 2003, the Field completed a collaborative initiative to develop a list of priority topics for future health promotion and public health Cochrane reviews. A global taskforce including representatives from the IUHPE, WHO, Global Health Council, Global Forum for Health Research, Centers for Disease Control and Prevention and MacFarlane Burnet Institute for Medical Research and Public Health identified a list of the top 15 topics for review. Six of these 15 are directly relevant to mental health promotion and are highlighted in bold below.

Further information can be found at:
Cochrane Collaboration: *www.cochrane.org*
Cochrane Health Promotion and Public Health Field: *www.vichealth.vic.gov.au/cochrane/*
Campbell Collaboration: *www.campbellcollaboration.org*

Health promotion and public health field topics for review

1. **Community-building interventions (designed to build a sense of community, connectedness, cultural revival, social capital) to improve social and mental health**

2. Healthy cities, municipalities or spaces projects in reducing cardiovascular disease risk factors [Could include mental health outcomes]

3. Interventions to build capacity among health care professionals to promote health and/or
   Interventions to build organizational capacity to promote health

4. **Physical exercise to improve mental health outcomes for adults** [specified to adults to avoid overlap with existing reviews focusing on children and young people]

5. Interventions utilizing marketing strategies to promote healthy behaviours in young people [focusing on tobacco, alcohol and food]

6. **Prenatal and early infancy interventions for prevention of mental disorder**

7. **Interventions using the WHO Health Promoting School framework in improving health and academic achievements among students in schools**

8. Interventions that employ a combination of environmental, social and educational strategies to prevent infectious diseases such as malaria, dengue and diarrhoea

9. Interventions addressing gender disparities in family food distribution to improve child nutrition

10. **Interventions to decrease/minimize adverse health effects of urban sprawl** and/or Interventions to increase the supply of sidewalks and walking trails for the public

11. Interventions for healthier food choices
    • Sales promotion strategies of supermarkets to increase healthier food purchases
    • Pricing policies to increase healthy food choices

12. Transport schemes to increase use of maternal and newborn health services (with a skilled attendant), increase community support and action for maternal and newborn health populations

13. Interventions to improve nutrition of refugee populations and displaced populations

14. **Interventions that aim to reduce health risk behaviours through enhancing protective environments for adolescents**

15. Interventions focusing on adolescent girls in order to improve nutritional status of women of child-bearing age prior to first pregnancy

the field of health promotion has generated considerable debate. Such approaches restrict the current body of evidence to published research carried out mainly in high income countries.

McQueen and Anderson (2001) discuss the complexity of the debate and call for a broadening of the base of appropriate research methods in keeping with the diversity of practice in the area. They point out that researchers and practitioners in health promotion have not reached consensus on any hierarchy of evidence and that international groups have asserted that it is premature to prioritize types of evidence in a linear hierarchy. They argue for the establishment of rules of evidence that take into account the diverse, multidisciplinary and contextualized nature of health promotion practice. Different methodological approaches are required to encompass the different elements of process, impact and outcome evaluation. While outcome-focused studies may lend themselves to more quantitative approaches, process-focused research requires more qualitative and naturalistic methods. Standards of rigour and quality can equally be applied to evidence derived from different methodological perspectives. The quality of the different types of evidence should be judged on criteria derived from their respective paradigms and ultimately on their appropriateness to the research questions being addressed. A useful generic framework for guiding the evaluation of health promotion initiatives has been proposed by Goodstadt and colleagues (2001). This model has its conceptual and operational roots in the Ottawa Charter (WHO, 1986) and describes a structure and logical sequence of steps that can be followed.

Flexible and creative approaches are required for mental health promotion evaluation ranging from RCTs to more qualitative process-oriented methods. This calls for an expansion of the current range of evaluation methodologies and analytical frameworks applied in mental health promotion and a widening of the evidence base to be more inclusive of the realities of practical applications from a more global perspective (Barry, 2002; Friedli, 2001; Jenkins, Lehtinen & Lahtinen, 2001). This includes the use of case studies, narrative analyses, correlational studies, quasi-experimental and experimental studies, interviews and surveys, epidemiological studies, ethnographic studies and others (McQueen & Anderson, 2001). Approaches covering action research and participatory research methods also have an important role to play in developing more collaborative forms of research inquiry. These approaches seek to actively engage those most involved in and affected by the research with the researcher and the process of evidence gathering.

There is also a need to agree on quality standards and rules of evidence at each stage of the evidence building process. In this manner, research methods can be tailored to the evaluation of programmes at different stages of development and levels of implementation. As mental health promotion draws on a diverse range of disciplines, different theoretical and methodological perspectives may also be brought to bear in establishing a sound evidence base. As McQueen (2001) suggests, we need to identify the rules of different disciplines and where they fit into the process of building the evidence base in order to capitalize on the multidisciplinary nature of the field. This broad approach is the one endorsed and taken up by the IUHPE Global Programme on Health Promotion Effectiveness (Jané-Llopis, in press).

Table 9.1
Conclusions and recommendations from WHO European Working Group on Health Promotion Evaluation

Conclusions	Recommendations to policy-makers
Those who have a direct interest in a health promotion initiative should have the opportunity to participate in all stages of its planning and evaluation.	Encourage the adoption of participatory approaches to evaluation that provide meaningful opportunities for involvement by all of those with a direct interest in health promotion initiatives.
Adequate resources should be devoted to the evaluation of health promotion initiatives.	Require that a minimum of 10% of the total financial resources for a health promotion initiative be allocated to evaluation.
Health promotion initiatives should be evaluated in terms of their processes as well as their outcomes.	Ensure that a mixture of process and outcome information is used to evaluate all health promotion initiatives.
The use of RCTs to evaluate health promotion initiatives is, in most cases, inappropriate, misleading and unnecessarily expensive.	Support the use of multiple methods to evaluate health promotion initiatives. Support further research into the development of appropriate approaches to evaluating health promotion initiatives.
Expertise in the evaluation of health promotion initiatives needs to be developed and sustained.	Support the establishment of a training and education infrastructure to develop expertise in the evaluation of health promotion initiatives. Create and support opportunities for sharing information on evaluation methods used in health promotion through conferences, workshops, networks and other means.

Adapted from: WHO European Working Group on Health Promotion Evaluation, 1998

Evaluating the process of programme implementation

As already discussed, there is a need for an approach that embraces the process of programme development and implementation as well as programme outcomes and how the two areas are linked. This is essential if the area is to move to a new level of understanding and sophistication beyond the question of whether programmes work to consider what makes them work, with whom and under what circumstances. The published research studies are largely restricted to research outcomes and typically little information is provided on the process and extent of programme delivery that must occur in order for those outcomes to be produced.

Programme implementation refers to the actuality of putting a programme or intervention into practice: what the programme consists of and how it is delivered (Durlak, 1998). Details of programme implementation are typically under-reported in the published literature. 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. In contrast to the absence of formal measurement there is, however, 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. 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. Process evaluation techniques based on careful project description, documentation and monitoring are required to assess both the quantity and quality of programme implementation.

Although the majority of evaluation studies provide little or no data on implementation (Dane & Schneider, 1998; Durlak, 1998), it is clear from those studies that have monitored it that it is often variable and imperfect in field settings and that the level of implementation influences outcomes (Durlak, 1998; Domitrovich & Greenberg, 2000; Mihalic et al., 2002). Monitoring and documenting the process of programme implementation is critical to highlighting programme strengths and weaknesses, determining how and why programmes work, enhancing the validity of outcome evaluation and providing feedback for continuous quality improvement in programme delivery (Domitrovich & Greenberg, 2000). If programme implementation is not monitored and assessed, an outcome evaluation may be assessing a programme that differs greatly from that originally designed and planned. The collection of systematic data on programme implementation plays an essential role in advancing knowledge on best practice for replication in real world settings.

Evaluating implementation is a complex process as it entails capturing the dynamics of programmes in action and monitoring the gaps between plans and delivery. Information is needed about the specific programme components, how they are delivered and the characteristics of the contexts or settings in which they are conducted (Dane & Schneider, 1998). In addition to identifying the core components of the intervention, information is also needed on what Chen (1995) refers to as "the implementation system". This includes the process and structure of the planning, implementation and training; the characteristics of programme implementers and participants and the nature of their relationships; and facilitating and inhibitory factors in the local context, including readiness, mobilization of support, ecological fit of the programme, cultural sensitivity and the extent of participation and collaboration with key stakeholders. Chen (1995) argues that although the intervention itself is the major change agent, the implementation system is likely to make an important contribution to programme outcomes as it provides the means and the context for the intervention. Comprehensive documentation of programme delivery provides data on the practical realities of implementation including programme modification and adaptation for the local setting.

Barry (2002) highlighted the need for a more explicit understanding of programme theory and a more systematic study of programme implementation in mental health promotion practice. Of interest is the growing emphasis on theory-driven evaluation (Chen, 1995; Goodstadt et al., 2001) and the use of evaluation logic models (Scheirer, Shediac & Cassady, 1995) in clarifying the connections between a programme's operations and its effects. While outcome-focused evaluation provides summary information on the total effects of a programme, it does not of necessity evaluate

the intervening mechanisms responsible for the intervention's success or failure. The usefulness of the theory-driven perspective is its focus on examining the causal mechanisms underlying the change process and the relationship between the programme's conceptual theory and action theory, i.e. its translation into practice. Evaluation logic models have been used to make explicit the logic of the change processes linking programme implementation with intermediate and early outcomes. Scheirer, Shediac & Cassady (1995) illustrate the use of a chain of events research paradigm to examine the detail of actual programme delivery by tracking prospectively the sequence of programme actions influencing intended outcomes. The detailing of the programme in action permits an accurate record to be kept as it unfolds and plays a crucial role in informing the detection of intermediate-level changes which lead to ultimate programme outcomes. This form of evaluation research gives equal emphasis to process and outcome data and attempts to link the two in a logical and systematic fashion, relating variability in programme implementation with variability in outcomes. This type of logic model approach has been adopted, developed further and consistently and effectively applied in the systematic reviews of evidence carried out by the USA Community Preventive Services Task Force over the past several years (Briss et al., 2000).

The systematic study of programme implementation calls for the use of a wide range of research methods and the collection of rigorous data drawn from multiple sources. The generation of practice-based evidence and theory is an important challenge in this area and will require researchers and practitioners to work in partnership to document and analyse 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 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.

Widening the evidence base: applying the evidence to low income countries

While good progress is being made on building the research base of mental health promotion, there is a need to extend the evidence debate beyond an academic elite concerned with the quality of research design to focus more directly on the quality of the intervention programmes and their wider practice and policy implications. As advocated by Mittelmark (2003), it is time to draw clear messages from the existing evidence and establish guidelines based on that evidence in order to inform best practice and policy on the ground. While addressing the complex methodological issues and specifics of the evidence debate, it is critical not to lose sight of the bigger picture, which is to apply what we do know in order to inform decision-making and bring about lasting change in the broader policy context. Speller, Learmonth & Harrison (1997) highlighted that there is a tendency for researchers reviewing the evidence to focus their energies on the research and methodological issues rather than on the quality of the actual programmes being evaluated. While continuing to build on systematic reviews of specific topic areas, it is important to identify crosscutting themes and generic processes that underpin the successful implementation of mental health promotion programmes. There is a need for practice and policy guidelines based on the

existing evidence to inform practitioners and decision-makers concerning effective programme planning, delivery and evaluation and the critical factors that are needed to ensure the implementation of successful programmes. This information is beginning to emerge, and there are some useful practitioner-oriented publications, such as Price et al. (1988), the Blueprints series by Elliott (1997) and Making it Happen (Department of Health, 2001), all concerned with providing practical guidance on programme implementation.

There is a particularly urgent need to expand the evidence base to be more relevant to the realities of those working and living in low income countries. McQueen (2001) points out the strong cultural and geographic bias in the manner in which evidence is currently articulated and represented in the health promotion literature. The evidence debate has been mainly conducted in the English language within a European-American context and is largely the preserve of an academic elite. As McQueen points out, much of the relevant material that could broaden the discussion on evidence is unpublished. Voices from developing countries are absent as indeed are the voices of practitioners and programme users/recipients. This view is echoed in a WHO 2002 report on prevention and promotion in mental health which highlights that evidence is "least available from areas that have the maximum need, i.e. developing countries and areas affected by conflicts" (WHO, 2002, p. 27).

In many countries implementing programmes usually entails working with minimal resources, few of which can be allocated to large research programmes. Because there may not be "evidence" as represented by sophisticated outcome measures, this doesn't mean that there is not good practice. There may indeed be many worthwhile and effective interventions taking place in developing countries; however, the documented evidence may lag behind the practice. In the absence of large grants, a key challenge is how to uncover and document good practice which is not yet disseminated in the literature. Traditional documentation is often lacking and even such rudimentary publications as newsletters and brochures may not exist. Nonetheless, intervention programmes may be known through word of mouth and other traditional ways of spreading the word about good practice in the field. The problem for those trying to assess these practices is how to bring them into view of the so-called scholarly world. That is a challenge that calls for innovative methods of discovery such as Delphi techniques among recognized health promoters who are in the field. Such a type of data gathering and the methodological rigour that it should pursue remain developmental and a task for programmes such as that of the IUHPE. In the mental health field the challenges may be even greater.

Much energy and many resources have been devoted to establishing efficacy and effectiveness trials in middle to high income countries; it is now timely to invest in dissemination research to examine how the existing evidence can be used effectively across diverse cultural settings. As discussed in Chapter 13, the development of user-friendly information systems and databases is required in order to make the evidence base accessible to practitioners and policy-makers. In particular, there is an urgent need to identify effective programmes that are transferable and sustainable in low income country settings such as schools and communities. In this respect it may be useful to explore the application of programmes based on community development and empowerment methods, such as the community mothers programme (Johnson, Howell & Molloy, 1993; Johnson et al., 2000) and the widow-to-widow peer support programme (Silverman, 1988) to name but two. These programmes, among others, have been shown to be highly effective, low-cost replicable programmes based on empowerment principles and successfully implemented

and sustained by non-professional community members in disadvantaged community settings. The implementation of school-based programmes for young people would also appear to be a key area for development in low income countries.

Mental health promotion needs to be incorporated into the wider health development agenda in order that the broader determinants of poor mental health such as poverty, social exclusion, exploitation and discrimination can be successfully addressed. The innovative Voices of the Poor study, carried out under the auspices of the Poverty Reduction Group of the World Bank (Narayan & Petesch, 2002), underscored the need to invest in poor people's assets and capabilities and to work in partnership with people living in poverty in order to develop strategies and solutions that can be locally owned and adapted.

In establishing a credible evidence base from low income countries there is a need for internationally supported dissemination research that 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 and providing technical assistance and capacity building resources for mental health promotion in low income countries. As Backer (2000) points out, dissemination entails not only distributing information about successful programmes and practices but also the provision of technical assistance and capacity building resources to enable practitioners to actually implement the programmes and the complex processes involved. This involves funding not only a particular programme but also the overall ability and resources of the organization or group needed to implement and sustain the programme in complex and challenging local contexts. Capacity building also entails increasing the organizations' ability to share new programmes and practices with others, including documenting innovative practice at the local level. Learning will then be a two-way process in terms of innovation, adaptation and dissemination of promising programmes and creative practice.

Conclusion

A key challenge in establishing the mental health promotion evidence base is how this evidence can be used to create change and bring about improved mental health for individuals, families and communities in most need. 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 cooperation in assisting low income countries with technical support and other capacity building resources, designing dissemination strategies, publishing guidelines for effective implementation of low-cost sustainable programmes and providing training in programme planning and evaluation. The ultimate test will be how the evidence base can be effectively used to inform practice and policy that reduces inequalities and brings about improved mental health, especially where it is needed most.

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Chapter 10
Social Determinants of Mental Health and Mental Disorders

James C (Jim) Anthony

Introduction

The famous astronomer Carl Sagan often used the crisply enunciated phrase "billions and billions" to convey our universe's vast macroscopic scale and the numerous celestial objects of study in astronomy. Over the course of the 20th century we have learned that this same phrase applies just as well to the vast microscopic scale of the human brain and central nervous system. With respect to mental health and mental disorders, the numbers of controlling neurons, synaptic connections and elements in pre-synaptic and post-synaptic signaling pathways readily match the numbers of the celestial objects Sagan had in mind.

Concurrent with advances in the brain sciences and neuroscience, there has been an evolution of ideas about the social determinants of mental health and mental disorders. For example, at the start of the 20th century, there was great enthusiasm for eugenics and accompanying ideas about the use of social institutions to breed humans selectively in order to cull defective germ lines and to enhance the successful adaptation of the most fit (see box 10.1). Eugenics lost favour, however, particularly after World War II. Towards the end of the 20th century we returned to a position of widespread enthusiasm about our genetic endowment and social shaping of its expression. At present, the predominant motif is not from "eugenics" as practiced at the population level via the now-rejected modes of ethnic cleansing and selective sterilization, but that gene expression can be shaped by exogenous agents and may be affected by social experience. Some of the newest transdisciplinary bridges between genetics, neuroscience, the social sciences, psychiatry and the other mental health disciplines involve elaborations of ideas about the use of social institutions to control exposure to exogenous agents and to influence social experience in order to promote mental health and prevent and control the occurrence of mental disorders.

It will be important for the lay public and for societal leaders to grasp these ideas as they emerge and are developed during the new decades of the 21st century. Perhaps the most important reason for science education on these topics is that social mobilization of resources depends more upon shared consensus about values than on the quality of scientific evidence. The mandate for mobilization of resources in order to prevent or control occurrence of mental disorders or other health problems depends upon our capacity to predict the occurrence of harm and upon

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Box 10.1
The discredited eugenics approach

In 1916–17, psychiatrist Aaron J Rosanoff designed and conducted a detailed house-to-house survey of the inhabitants of Nassau County, New York, in the USA. One of the focal points of inquiry was the intergenerational transmission of mental disorders. The survey aimed to identify households and families that were breeding mental disorders and associated socially maladaptive behaviour, including criminal acts. A prominent motif in Rosanoff's introduction and description of the study is eugenics (Rosanoff, 1917).

> **Box 10.2**
> **Making decisions to mobilize resources**
>
> The mandate for societal response and action is a function of two values: the accuracy of our scientific predictions of whether serious harm will occur, and an evaluation of the benefit-to-risk ratio of acting versus not acting to prevent or control the occurrence of the serious harm.
>
> For example, psychiatric epidemiologists now are improving the accuracy of our prediction of who will make repeat suicide attempts and who will complete suicide after one or more suicide attempts (e.g., Chitsabesan et al., 2003). Via RCTs, investigators are refining interventions that have clear benefit in reducing risk of completed suicide among suicide attempters. Some of these interventions have considerable costs (e.g. civil commitment and involuntary hospitalization after the suicide attempt). Other apparently effective interventions are less intrusive and cost very little to deploy once we identify individuals who have made a suicide attempt but who show no immediate threat of self-harm to complete the suicidal act (e.g. Motto & Bostrom, 2001). As our prediction of serious harm increases, and as the evaluation of the benefit–risk ratio becomes more favourable, there is an increasing mandate for societal response and action to prevent and control the occurrence of the harm.

our benefit–risk analysis with respect to deployment of individual or societal resources (box 10.2). Although the accuracy of our predictions is disclosed in the evidence and is more or less objective, the benefit–risk evaluation and the choice of interventions depend upon an expression of shared consensus about values.

During occasions of social response to prevent or control the occurrence of serious harm, we see manifestations of social interconnectedness between members of society and the expression of this shared consensus about values. Consider the tragic instance of a mother and father returning home from work to find their house on fire and progressively burning to the ground, surrounded by a fire brigade that is struggling to bring the fire under control. Under most circumstances, the fire brigade will restrain the parents and not allow them to enter the household – even if there is a chance that children, grandparents or other household members still are alive inside and might be rescued. Social interconnectedness between members of the society is manifest not only in the appearance of an organized fire brigade in response to the fire, but also in the fire brigade's actions to inhibit the parent's expression of an intent to act individually in order to control the harm to children or others still in the burning household.

For more than 150 years, social and behavioural scientists have speculated about this type of social interconnectedness, as well as other aspects of the importance of society and social institutions in the promotion of mental health and the prevention and control of mental disorders. For over a century there have been empirical investigations on these topics. A central theme in this research has been a belief that societies have an impact on human life over and above the sum of the impact of their individual members. From sociologist Emile Durkheim's work between 1893 and 1912 we have the idea that humans together direct their own fortunes through a spirit of

social collectivity and solidarity and must be studied at a level above the level of the individual (Durkheim 1895, 1897).

Durkheim described social structures and functions in organic terms, using concepts such as the "cerebrospinal system of the social organism" and the "social brain". He discouraged the idea that suicide and suicidal acts should be understood as the behaviour of disturbed individuals and was an especially strong advocate of a social interpretation for increasing suicide rates during the 19th century. According to this interpretation, the increasing numbers and rates of suicide should be understood as a manifestation of the weakening of social solidarity and the institutions that bind the individual within the social collective: family, religion and political states.

Consistent with his belief that the social sciences should offer remedies to promote health, Durkheim pointed towards the possibility that social solidarity might be found and cultivated within the occupational groups or corporations of society that were gaining increased prominence relative to family, church and state. A century later, one of the most promising recent suicide prevention programmes has been implemented within the US Air Force. Within this programme, which is intended to reverse an upward trend in suicide rates of pilots, mental health promotion and the prevention of suicide have been made an explicit social role expectation at multiple levels within the organization – from top-rank generals down to individual pilots and peers. The suicide prevention programme not only calls for individualized intervention services for individual pilots as needed, but also calls for interventions at the level of collectives within the Air Force (e.g. at the level of divisions and battalions). The upward trend in suicide rates for Air Force pilots has been reversed in the years since first implementation of this programme (Knox et al., 2003) and there is a widely held enthusiasm for the idea that this type of multilevel intervention can be deployed effectively in other occupational groups and corporations where suicide is of special concern (e.g. within school systems and schools or within colleges and college dormitories, where suicide rates of adolescents and young adults are of special concern).

Whereas Durkheim looked towards social collectivity and solidarity as he tried to understand and illuminate the functions of social institutions and structures of an "organic" society, social scientists and epidemiologists of the late 20th and early 21st century have introduced a new vocabulary and concepts in their own efforts to prescribe remedies that might promote health. In this renaissance of thinking about social collectivity and health promotion, the concept of social capital, which is discussed in detail in Chapter 6, has been prominent. At present, social capital is in a shake-down period, with theorists and empirical researchers seeking a general consensus about how it might be transformed from a somewhat metaphysical concept and made operational without reduction to the individual level.

Notwithstanding uncertainty about whether and how social capital might be conceptualized, measured and manipulated for lasting improvements in mental health or in health generally, there have been some remarkable research advances at the interface of genetics and the behavioural and social sciences. Some of the most noteworthy recent advances have come from genetic-epidemiological studies of twins. To the surprise of many observers, most twin studies of mental health and mental disorders indicate that the heritability of these conditions is in a range from 30% to 70% or lower (100% is the theoretical maximum level of heritability when genetic influence is at peak penetrance). This indicates an influence of social and other environmental conditions and processes. Twin studies also indicate that some of the similarities of monozygotic twins can be attributed to environmental conditions and processes that are present in utero, as disclosed in recent research

comparing monozygotic twins who had different embryonic sacs during gestation (dichorionic twins) with monozygotic twins who shared the same embryonic sac (monochorionic twins) (Jacobs et al., 2001). As such, the twin studies are teaching us that there is ample room to promote mental health and to prevent and control the occurrence of mental disorders once we develop more definitive evidence about these influential social environmental conditions and processes.

Laboratory experiments with non-human primates also have been illuminating the social determinants of mental health and the occurrence of mental disorders. The theoretical advances and evidence from these experiments have started to guide more probing research with humans in social environments (e.g. Caspi et al., 2003) and opened up some new lines of public health research to find out whether these discoveries can be applied in human mental health promotion and prevention activities.

In consideration of the above, this chapter on social determinants of mental health and mental morbidity has three themes. The first of these concerns social mobilization of resources to prevent, reduce and ameliorate the suffering associated with departures from mental health and to promote mental health. The second concerns the uncertainty of presently available evidence on social determinants of mental health and mental morbidity. The third theme involves next steps in research on this front, especially the bridging across scientific disciplines that can shed light on the uncertainties we see at present.

Social mobilization of resources to prevent, reduce and ameliorate suffering

As implied by the introduction, an immediate challenge for the public at large and society's leaders is to create or refine the social structures and processes we use to evaluate the available evidence and to mobilize resources that can prevent, reduce or ameliorate the suffering associated with departures from mental health and to promote mental health (Jenkins, 2001). Some critics of the available evidence may assert that we first need more research because we do not yet have enough knowledge about the social determinants of mental health to be able to do anything along these lines (e.g. Thisted, 2003). Psychiatrist and epidemiologist Benjamin Pasamanick was quick to contradict such critics. His reply was this: "Why do you want to do more research? We have not yet begun to apply what we already know about the prevention of mental disorders and the promotion of mental health!"

Pasamanick's remark was one that placed social mobilization of resources within the domain of social determinants of mental health, consistent with more general perspectives about collective "mental hygiene" activities in the community (Lemkau, 1949; box 10.3). According to this perspective, new discoveries and increasingly definitive evidence about the determinants of mental health are of limited value unless there are social structures and processes to put the new discoveries and evidence into action.

It follows that the first mental health promotion priority is to ensure that social structures and processes are in place for evaluation of available evidence and for social mobilization of resources once the predicted probability of serious harm and the evaluation of benefits and risks intersect to create a mandate for collective action. In the face of uncertainty, WHO and the public health authorities of individual nations (for example, the Medical Research Council in the UK and the National Institutes of Health in the USA) can create consensus conferences to weigh the evidence,

> **Box 10.3**
> **A mental hygiene approach**
>
> "[P]ublic health has developed until its field includes all ill-health in the population so severe or so widespread that management at other than governmental level is economically and sociologically unsound or impossible. Mental hygiene has grown so that its aims include the prevention of mental illness by a contribution to the mental health of the population and by the prevention of major illnesses through the early treatment of cases. It has developed technics that can be the basis for public health programmes. The opportunity for development of programmes would appear to be open, though there remains much experimental work to be done, both on the mental hygiene technics offered and in their administration. Some experiments already are underway, and more are being undertaken constantly. It is important to keep in mind, however, that all programmes are experimental, technics being tried out to see how they will work and what contribution they can make to the improvement of the health of the public (Lemkau,1949, p. 14)".

evaluate the benefit–risk ratios for each intervention and issue prescriptions for choosing among interventions in the face of uncertainty.

On this basis, there is a general recommendation for collective intervention actions and social mobilization of resources in relation to activities such as: prevention of mental retardation and developmental disabilities secondary to iodine deficiencies via iodinization of dietary sodium chloride (salt); vitamin A supplementation to ensure that newborn infants will not face increased risks of premature mortality, blindness and associated mental impairments and deficiencies; neonatal screening for phenylketonuria (PKU) and subsequent phenylalanine adjustments and changes in dietary practices whenever the PKU defect is identified; and programmes to encourage childbearing during the first 35 years of a woman's life, prior to the later years when there is increased risk of chromosomal anomalies such as a trisomy (e.g. Down Syndrome of trisomy 21).

These examples are focused upon actions that can be taken early in the lifespan. Readers of the other chapters in this volume will have learned a broad array of mental health promotion and preventive interventions appropriate to different developmental stages: gestation, infancy, childhood, adolescence, young adulthood, middle years and later life. It is well known also that the organization and timely delivery of treatment interventions to control and ameliorate the suffering of people affected by mental disorders can yield a lasting benefit in terms of promotion of mental health of these affected cases and can help prevent associated serious secondary harms and disabling conditions. The ultimate social determinant of mental health involves social mobilization of resources to evaluate evidence on these interventions as it is developed and refined and to apply interventions based on the evidence.

Uncertainty of presently available evidence

As the 20th century ended, there was an increasingly acidic critique of risk factor epidemiology, by which is meant a selectively narrow research focus on individual level characteristics and behaviours that signal increased risk of mental disorders or general medical conditions (e.g. Susser &

Susser, 1996). There developed a considerable pessimism about how little was being gained when prevention programmes were focused upon individual level behavioural change (e.g. Syme, 2003).

This type of critique was not new: it was voiced more than 25 years ago by Claus Bahne Bahnson and others:

> [In the past, psychosocial researchers] … often have introduced sociological data only for control purposes, rather than including them in an open system matrix which allows for *multilevel integration* of all relevant material [emphasis added].

> It is hoped that, in the future, more of us will be involved in research designs which accommodate … multidimensional theoretical models, brushing aside old controversies about the greater or lesser significance of given process levels (e.g., physiological, socio-logical), … [and] integrating these several levels in a larger matrix expressing the total process (Bahnson, 1974, p. 1038).

To the extent that disturbances in mental health such as suicide-related behaviour may be regar-ded as social phenomena, the critique is more than a century old: "Every time that a social pheno-menon is directly explained by an [individual level] psychic phenomenon, one may be sure that the explanation is false" (Durkheim, 1895, p.129).

Social capital is one of the most prominent concepts invoked to reframe previously individualized lines of research on the social determinants of health generally and mental health in particular. As discussed in Chapter 6, public policy analyst Robert Putnam of Harvard University is widely credited for stimulating a renaissance of interest in the social capital concept (Putnam, 1995, 2000), by which he means "the connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them" (p. 19). Extending beyond the tools and training that enhance individual productivity ("physical capital" and "human capital"), this type of social capital "refers to features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit" (Putnam, 1995, p. 67). A "bonding" form of social capital can be created when groups of similar people get together and create and sustain the social solidarity of the group, with social solidarity defined much as Durkheim envi-sioned it in 19th century sociology. A separable "bridging" form of social capital arises when there are between-group ties between dissimilar people (that is, bridges between people who do not belong to the same social groups).

Putnam asserts that social capital is manifest at the level of nations in the levels of social trust and the degree of civic engagement. Here, social trust is measured by surveying neighbourhood residents with questionnaire or interview items such as true/false evaluation of the statement, "most people can be trusted". Civic engagement is also measured by survey responses, with items about recency of attendance at a "public meeting on town or school affairs". According to this metric, social trust and civic engagement in the USA have declined markedly over the past several decades. Based upon results from the 35 countries surveyed in the 1991 World Values Survey, the social capital values of South Korea, Belgium, Estonia and the USA are roughly equivalent; Chile, Portugal and Slovenia have lower social capital values (Putnam, 1995).

Concurrent with the evolution of the concept of social capital and its importance for general health and the promotion of mental health, a concept of "natural capital" has emerged as part of the discussion of sustainable development. Elaborated in *Our Common Future*, the Brundtland Commission oriented itself to sustainable development that meets present needs without jeopar-dizing the future needs of humankind. In this sense, sustainable development uses bonding social capital as it exists in the "here and now" in order to create bridging social capital that might link

the present generation with future generations. In this context, the notion of natural capital can be extended to encompass social ties that will sustain transgenerational availability of fresh water, clean air, forests and other natural resources (Fenech et al., 2003).

Sampson (2003) has introduced the concept of "collective efficacy" into the discussion of social determinants of general medical conditions, mental health and behavioural acts, with a focus on violent events such as suicides and homicides. He conceptualizes and measures collective efficacy as a characteristic of neighbourhoods and social groups. He has measured neighbourhood levels of collective efficacy in various ways, including surveys of neighbours about a social control aspect and a separate social cohesion and trust aspect. The social control aspect is measured by asking whether neighbours would take action in response to specified stimulus conditions: if local children were observed spray-painting graffiti on a building, if the local fire station were to be closed due to budget cuts or if a fight broke out in front of the neighbour's home. The cohesion and trust dimension is measured by asking whether neighbours trust one another, have shared values and are willing to help one another. Aggregated across individuals within each neighbourhood, Sampson found the level of collective efficacy to be associated not only with occurrence of recent and past violent events but also with future occurrences of these events, even with statistical control for the past level of violence. This statistical control is important: without control, the prior violence might be the cause of low levels of collective efficacy rather than vice versa (Sampson, 2003).

Buoyed by supportive theory and empirical research results such as these, Sampson and others have raised the idea that it might be possible to prevent violence and violent events via community level efforts to change social environments. Shonkoff and Phillips (2000), Singer and Ryff (2001) and Kawachi and Berkman (2000), among others, have advanced the idea that there is much to be gained in the promotion of health, mental health and well-being by social mobilization of resources to increase social capital and related community level characteristics such as collective efficacy (see box 10.4).

Box 10.4
Changing places and social environments rather than people: optimism about promotion and prevention

Traditional thinking about health and disease has emphasized behavioural change among individuals as a means to reduce disease risk: for example, smoking interventions that have targeted smokers have included hypnosis, smoking cessation programmes and nicotine patches. Environmental approaches look instead to macro level factors such as taxation policies, regulation of smoking in public places and restriction of advertising in places frequented by adolescents.

In sum, community level efforts to change places and social environments rather than people may yield pay-offs that complement the traditional individual and disease-specific approaches typical of the National Institutes of Health. A recent report of the National Academy of Sciences recommends exactly this sort of community level augmentation (Singer & Ryff, 2001). Basic research in science also appears to be moving in a direction that integrates the rigorous study of community contexts with individual development (Shonkoff & Phillips, 2000). Such integrated study of health in the neighbourhood context promises a greater pay-off than the conceptual separation that has dominated past thinking on research and intervention.

Source: Sampson, 2003, p. S62.

In counterbalance, some observers judge the available evidence as premature and uncertain (e.g. Henderson & Whiteford, 2003). To some extent, the evaluation of uncertainty is based upon still unresolved questions about conceptualization and measurement of community level concepts such as social capital, with special concern when the measurement is based upon the neighbourhood residents' self-reports about community characteristics and well-being. To some extent, these uncertainties can be removed in the future by not resorting to such reports. For example, MacIntyre and Ellaway (2000) have described a programme of research in the west of Scotland that has a focus on five features of local areas that might be health promoting or health damaging and that can be measured without relying on self-reports. Information is collected on physical features shared by all residents in the locality, such as quality of air and water, latitude and climate; availability of health environments at home, work and play, including whether decent housing, safe playgrounds and non-hazardous work environments are available; availability of community services such as education, transport, street cleaning and policing; sociocultural aspects of the community, such as the occurrence of uncivil behaviour and being a victim of a crime; and each area's reputation as perceived by banks, investors, area planners and service providers who are not residents of the area. As noted by MacIntyre and Ellaway (2000, p. 343):

> These [five] categories are not mutually exclusive and may well interact with one another, and their health effects may vary by people's personal resources. More broadly, we conceptualize features such as these as opportunity structures, that is, socially constructed and socially patterned features of the physical and social environment which may promote or damage health either directly or indirectly through the possibilities they provide for people to live healthy lives.

The MacIntyre-Ellaway conceptualization represents the union of the concepts of social capital and natural capital as applied to local areas and communities, in that the natural resources such as fresh air and clean water are joined with the bonding and bridging forms of social capital outlined earlier. When there is reliance upon self-report methods to measure both the social determinants and the responses in terms of well-being or mental health, one may expect some degree of association in the resulting evidence. The situation is made even more complex in the context of longitudinal or other over-time studies. This is due to the impact of in-migration and out-migration patterns that can change the character of the neighbourhood and the observed linkages between prior social capital levels and subsequent occurrence of mentally healthy behaviour or rates of mental disorders. For example, a neighbourhood with declining social capital values might have subsequently higher levels of mental health disturbances, not because the declining social capital has caused decrements in mental health, but because the mentally healthier community residents have moved out to neighbourhoods with stable or increasing social capital values. In some sense, this selective out-migration actually would be an instance of social capital levels influencing later levels of mental health, but it is not clear that a quick infusion of social capital would alter trajectories of selective out-migration from the declining area. Instability in the social capital levels and the residents' uncertainty about future social capital levels in the neighbourhood might prove to be more powerful determinants of selective out-migration.

After learning of these reservations, some readers may wonder whether useful social capital building might occur in the process of creating a local area mental health planning council with a capacity for evaluation of evidence and for social mobilization of resources to promote mental health. Indeed, there are many open questions about how to build social capital to promote mental health

and to prevent and control the occurrence of mental disorders. To answer these questions, it is necessary to acknowledge the existing uncertainties in the evidence about the social determinants of mental health and to make deliberate investments in research that can constrain the uncertainties and yield more definitive evidence than presently exists.

Future directions in research

Some new directions for research on social determinants of mental health already have been mentioned earlier in this chapter and in the works just cited. For example, long ago, Bahnson (1974) called for multilevel thinking about the social and psychosocial processes and conditions that influence the occurrence of health conditions. More recently, Shonkoff and Phillips (2000), Singer and Ryff (2001), Sampson (2003) and others have amplified these calls for multilevel thinking and have sketched ideas for randomized preventive trials and community level systems research with interventions directed towards communities, neighbourhoods and individuals. Knox and colleagues (2003) have described the multilevel thinking that inspired the recent US Air Force initiative to reverse the upward trend in the suicide rates of pilots. Within the domain of research on prevention of problems due to consumption of alcoholic beverages, Holder (1999) has offered evidence from both systems research simulations and community interventions based on this type of multilevel mobilization of social resources for prevention.

Given global concern about suicide rates and heavy drinking by school-attending youths in the later years of adolescence and by young adults, one important future direction for research on social determinants is an application of these multilevel intervention models. This research could expand upon the promising non-experimental observational field studies conducted to date and could include the use of randomization designs and systems research methods used to increase the definitiveness of the resulting evidence. Large universities with many students living in dormitories may prove to be the most suitable environments for initial studies of this type, which could be conducted within this relatively privileged context to enable researchers to gain the experience needed for the more challenging context of community studies. Just as the Air Force suicide prevention programme made leaders responsible for reducing the suicide rates in the units under their command, the dormitory residence hall directors and in-residence floor directors could be helped to be responsible for the students in their charge, combined with dorm-level and floor-level interventions directed to the students in aggregate, with individualized interventions as needed. Students could log into websites with online surveys of suicide-related characteristics and conditions (e.g. depressed mood, heavy drinking, poor school performance, disruption in peer relations) and individualized interventions. Students could remain anonymous during their repeated log-ins, using screen names to provide longitudinal surveillance reports. The screen name could also be used by the programme organizers to deliver individualized interventions (e.g. video-streaming of "reasons for living" interventions, email communications or chat room interventions) within the protected environment of the Internet. With a suitable research design, this type of mental health promotion and prevention research could yield estimates of the multilevel intervention as a whole and, under some conditions, it should be possible to test combinations of different dorm, floor and individual level interventions.

Once experience along these lines has been gained in a specific domain of mental health and behavioural research (such as suicide-related behaviour, heavy drinking, tobacco smoking), the line of research could be elaborated in the direction of new responses (depressed mood, eating

disorders) and mass-scale intervention research. For example, one may envision recruitment of hundreds of thousands of school-attending youths or household residents for a one-time brief, anonymous epidemiological survey of general health, mental health and behaviour. At the conclusion of the survey assessment session, participants could be provided with a coupon that allowed free access to an online health consultation website (via a local cyber-café, library or other Internet access point), with each participant using a self-generated screen name that was recorded on the initial anonymous survey form. With a randomized incentive design used to gain experimental control over participation in the web-based follow-up survey and subsequent assessment sessions, the investigators would be able to use individualized trajectories of mental health and behaviour levels in order to guide delivery of individualized preventive or ameliorative interventions. Under most circumstances, the web-based longitudinal surveillance also would allow geo-coding of the responses so that a local community or neighbourhood could be identi-fied, even if the individual respondent could not. If observed community or neighbourhood level occurrence rates exceeded pre-specified levels, the individualized interventions could be comple-mented with community or neighbourhood level interventions.

To be sure, at present billions of the world's inhabitants do not have Internet access, and would not welcome it if it were available to them and their families. Similarly, in some parts of the world there is insufficient protection of the privacy and anonymity that would be required to complete this type of coordinated large-sample surveillance and intervention research. Under these cir-cumstances, research plans of this type are impertinent and new research on social determinants of mental health will have to take a different direction. Nonetheless, Internet access and usage patterns are expanding rapidly, with home-based Internet access becoming a reality for large proportions of household members in many parts of the world. Under these circumstances, the Internet provides a new medium for delivery and evaluation of mental health interventions, par-ticularly those interventions of a social and behavioural character. Pioneering work along these lines already has been completed by research teams under the aegis of the Australian National University and elsewhere around the globe (e.g. Griffiths et al., 2004). Research on the social determinants of mental health and the application of new research evidence for promotion of mental health almost certainly will benefit from these developments.

Thisted (2003) and others have pointed out the challenges of research on the social determinants of health and disease, with a particular focus on opportunities for fallacies of an ecological variety. An ecological fallacy is one that is based on observations made at an aggregate level of analysis, such as the neighborhood level, but the inference from these observations is erroneously taken to a disaggregated unit of analysis, such as the individual. For example, we might observe that neighborhood rates of heroin dependence are correlated with neighborhood rates of alcohol dependence, but it would be an ecological fallacy to think that this observed correlation supports the inference that alcohol users are more likely to be heroin users. The measurement of social con-text requires a consideration of aggregates of individuals, but the measurement of mental health and mental disorders almost always requires assessments at the individual level. The experimental paradigms of laboratory research on non-human primates permits some escape from the pos-sibilities of ecological fallacies, especially when the animals can be assigned at random to social conditions when it is not possible to make random assignments of humans.

An especially intriguing line of primate research has developed from Harlow's early experiments on separation of primate infants from their mothers, which helped to sharpen our focus on how

mother-infant separation can be a social determinant of poor mental health in the human condition. There is, for example, recent evidence of gene-environment interactions in relation to overly-aggressive behaviour of vulnerable male primate offspring and alcoholic beverage consumption (Suomi, 2002). This research has shown that male primate offspring show exacerbations of aggressive behaviour and drinking behaviour when they are assigned to conditions involving early disengagement and separation from the maternal environment and subsequent rearing solely with other maternally-separated peers, with even more aggressive behaviour and more alcohol consumption observed among males with a mutation involving the serotonin transporter. When the male offspring are kept with their mothers in the maternal-rearing environment, however, there are neither aggression nor drinking differences in association with the serotonin transporter. That is, the insalubrious activity of the serotonin transporter mutation is apparent only under the peer-rearing condition and not under the maternal-rearing condition.

Another important line of primate research on social determinants of mental health and behaviour has emerged in a set of elegant studies of social rank, dopamine neurotransmission and cocaine using behaviour. In brief, after ordinary intervals of maternal rearing, young monkeys were moved to individual cages and their dopamine neurotransmission parameters characterized. Monkeys with dopamine neurotransmission parameters that were not appreciably different were then moved to a group cage environment for a three-month interval, during which the ordinary course of social interaction was allowed to yield social ranking of the individual monkeys, with some monkeys sorting out into the top (alpha) rank and others into lower social ranks. The imaging studies were then repeated and followed by cocaine self-administration studies. These studies showed that the monkeys who became dominant showed greater dopamine receptor distribution volume ratios and did not self-administer as much cocaine as the monkeys who became subordinate in social rank. This longitudinal evidence suggests that dopamine transmission and the reinforcing functions of cocaine self-administration had changed in response to each monkey's position in the social hierarchy. This apparently was not a predisposition of initially dominant monkeys because social rank was indeterminate until after the monkeys were moved into a social environment that allowed it to emerge (via interactions such as fighting and grooming) and because the dopamine neurotransmission parameters were equivalent prior to the group cage condition (Morgan et al., 2002).

Primate experiments of this type cannot be readily replicated with humans. Nonetheless, "experiments of nature" sometimes create circumstances in which infants are separated from their families prematurely, with subsequent group housing (such as in areas where a high density of parental HIV/AIDS mortality has led to the creation of large orphanages). In addition, in many urban areas around the globe, youths leave their home environments, become street children and enter peer group contexts that necessary evoke social rank hierarchies. The findings from the primate laboratories point towards social determinants of mental health that might become disrupted under these conditions and make these orphanage and peer group settings an especially fruitful context for new research.

As noted in this chapter's introduction, there is much to be learned in future public health research that builds transdisciplinary bridges between genetics, neuroscience, the social sciences, psychiatry and the other mental health professions. Working across these bridges, investigators will add new and more definitive evidence on the social determinants of mental health, as well as the prevention and control of mental disorders in the population.

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Chapter 11
Links Between Mental and Physical Health and Illness

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Introduction

Positive mental health is a set of key domains encompassing well-being and positive states of mind. It is an integral part of health, including positive physical health. It can co-occur with and influence the onset, nature and outcomes of physical and mental illnesses. Similarly, positive physical health can influence the onset, nature and outcomes of mental and physical illnesses. These interrelationships are encompassed in holistic concepts of health, such as are held by many indigenous populations. Systematic studies are increasingly identifying these influences and cor-relations. This is exemplified in figure 11.1.

Figure 11.1
An holistic view of health
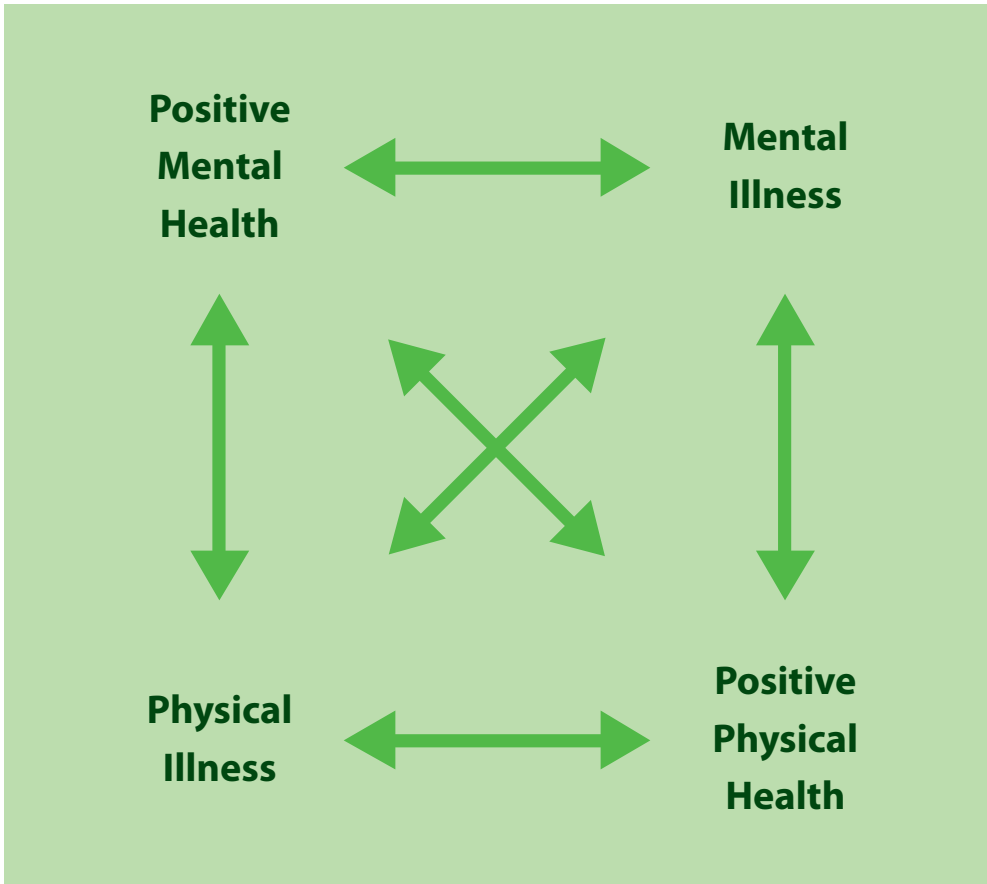
The relationship between physical and mental health and between the social, biological and psychological determinants of these positive states is complex. This is also true in relation to illness states. The co-occurrence of physical illness and mental illness is well established and the complex nature of their relationships is being increasingly explored. Processes involving interactive and multiple trajectories towards health or illness status provide one framework where promotion and preventive interventions may be targeted. A complex mix of psychological, social and physiological processes is involved in the onset and course of illness and disease, a course that may be altered by interventions designed to improve mental health. As discussed elsewhere in this volume, research defining positive states of health – mental and physical – is limited, however. Thus, the evidence for mental health promotion as promoting positive mental health and having an impact on physical and mental illnesses is emerging and often based on inference. That is, much of the existing evidence is based on studies of the relationships between illness states and their determinants.

Holistic concepts of health are basic to many indigenous beliefs on the nature of health and well-being. This is well exemplified by the definition of health accepted by Australia's ancient indigenous culture. In 1989, the National Aboriginal Health Strategy Working Party defined health as:

> … not just the physical health well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life (Swan & Raphael, 1995, p. 1).

Spiritual, environmental (e.g. land and place), physical, social (including community and culture) and emotional factors are seen as interacting with and influencing each other in complex ways. Recent research in developed countries has come to recognize similar influences, such as the effect of social determinants (Marmot & Wilkinson, 1999), including social advantage, and social connectedness (Turrell & Mathers, 2001; Williams et al., 1992) on health in general, and the influence of positive states of mind on physical health (see Kelly et al., 1998; Nordin & Glimelius, 1997). Such interactions are hypothesized to occur through psychological and psychophysiological mechanisms. Thus, there is a body of evidence highlighting the value of an holistic approach to health in terms of mental health and physical health and illness. The natural consequence of this is that promoting positive mental health may be seen as significant in terms of health globally, and as potentially improving outcomes of both physical and mental disorders.

This chapter discusses the nature of these complex interconnections as well as the implications of promoting mental health for various aspects of health, behaviour and illness. To begin this discussion, the distinction between health and illness is emphasized in line with the WHO statement that health is not simply the absence of disease.

Concepts

Positive mental health

Vaillant (2003) examined a number of models of positive mental health and the empirical evidence or conceptualization that supports them.

The first of these was the concept of mental health as being above normal in functioning. To be mentally healthy is to be particularly "fit" in this context. This encompasses characteristics equivalent to the highest score on the GAF (Global Assessment of Functioning) scale of DSM IV (APA, 1994), defined as a person having the following characteristics: "superior function in a wide range

of activities, life's problems never seem to get out of hand, is sought out by others for his or her many positive qualities". Interestingly, the words "no symptoms" have been added to the scoring of this, which is counter to the concept of mental health as distinct from, and not just the opposite of, mental illness.

Vaillant noted the similarities of this concept to the findings of a study of 130 jet pilots that aimed to select the first astronauts. Those selected had evidence that they were good at work and at loving intimate family relationships. They could be interdependent with others and trust them but could also deal with extreme isolation. They could deal with strongly experienced negative and positive emotions and were empathic with others. They avoided interpersonal difficulties and did not complain of discomforts. They had a very low level of accidents. Vaillant suggested that the domains of mental health described by Jahoda (1958) and supported by others are the key features in this conceptualization (see Chapter 3).

Positive psychology relates to concepts such as optimism and "authentic happiness", concepts well explored by Seligman (1991, 2002). Positive psychology is based on the idea that if people are taught to be resilient and optimistic they will be less likely to suffer from depression and will lead happier, more productive lives. In other words, building on human strengths can be seen as building psychological "muscles" before problems occur. Positive psychology also deals with personal hopefulness, one of the characteristics shown to be associated with better adjustment to mental and physical illnesses (Jacobson & Greenley, 2001) and to major life stressors, including disasters (e.g. the Newcastle earthquake; Lewin, Carr & Webster, 1998).

This concept of mental health encompasses love, intimacy and the capacity for reciprocal attachments; empathy, nurturance and social/emotional intelligence; temperance and self regulation; wisdom, curiosity and creativity; courage; fairness and sense of justice; hope and future-mindedness. Cognitive behaviour therapy (CBT) interventions may increase some of these attributes, such as optimism, self-efficacy and hopefulness (e.g. Seligman's "optimistic child": Seligman, 1991). Learned optimism and enhanced self-efficacy may not only improve overall mental health but also lessen risk of physical and psychiatric illness and contribute to better outcomes if they do occur.

The next model is mental health as maturity. Vaillant highlights the findings from longitudinal studies to demonstrate that the stages and phases of human development, building on the developmental tasks of identity, intimacy, generativity and integrity, may, if successfully negotiated, represent progressive attainments of mental health. To these stages of Erickson (1950), Vaillant has added career consolidation and becoming a "keeper of meaning". Again, there are themes of loving reciprocal relationships, empathy, emotional regulation and future and hopeful orientation.

Mental health as social and emotional intelligence is a concept that highlights the capacity to recognize and respond appropriately to the emotions of the self and others. Mental health as subjective well-being encompasses the concept of happiness as it relates to joy, love, self-efficacy, play and deep involvement rather than happiness as an illusionary high. Vaillant goes on to discuss research supporting the relationship between happiness and physical health. For instance, Ostir et al. (2000) found that even when age, income, education, weight, smoking and drinking were controlled for, happy people were half as likely to die early or become disabled as unhappy people. A longitudinal study of nuns showed that those who had expressed the most positive emotions in a description of themselves in their twenties were less likely to die by age 80 than those with the least positive emotion (24% compared to 54%: Danner, Snowdon & Friesen, 2001).

Mental health as resilience was the final conceptualization proposed. Here Vaillant drew on his own work with defence and coping patterns, which related to maturity, with the themes of denial of reality and poor problem solving capacity indicating poorer mental health. Mature defensive styles included the capacity to experience and modulate affects, capacity for rewarding relationships, flexible response styles, anticipation (future orientation) and humour.

These concepts have several common themes: themes that may be affected by interventions to promote more positive mental health, themes that may ultimately be able to be operationally measured and validated and themes that are known in many instances to affect the development and outcomes of mental and physical illnesses. Many may be amenable to interventions to improve mental health and thus to influence holistic health outcomes.

Positive physical health

Physical health is more readily defined and measured. Concepts such as "physical fitness" involve physical activity to achieve physical goals but may also require this to be achieved in complex and coordinated ways that inevitably involve higher mental functions. This may involve being "fit" in basic functioning and having the capacity to respond to extra functional demand in a range of physiological systems. Like positive mental health, positive physical health may encompass being better than normal, above average. Like positive mental health, those with positive physical health may have this even in the face of some functional loss: for instance, athletes in the paralympics. Physical health may also encompass developmental aspects: what is considered positive physical health in childhood, adolescence, adulthood and old age may vary. Positive physical health may also encompass the capacity for resilience when the person encounters threats, including those of injury, illness and disability, both physical and mental. Physical health encompasses, as does mental health, concepts of self-efficacy. A sense of well-being about one's body and its functioning is described by those who are physically fit. Like those of positive mental health, these concepts need to be better operationalized and measured so they are not just recognized by the absence of indicators of pathology. Positive concepts such as "vitality", reflecting perhaps a sense of life force as is in the SF36-12 (see Chapter 12), may better indicate positive mental and/or physical health.

Interrelationships

While common sense would suggest these domains interact and overlap, this has not been well tested empirically. However, as outlined earlier in the study of the jet pilots, positive mental health may be associated with positive physical fitness over and above the norm. The sense of well-being generated by physical exercise and the sense of achievement generated by physical actions to achieve certain goals are positive interactive processes between these two domains.

These interrelationships suggest that promoting mental health can potentially improve physical health and the outcomes of physical and mental illnesses.

Comorbidity: mental illness and physical illness

Comorbidity – the co-occurrence of physical and mental conditions – is common, with likely poorer outcomes for both. Although strong and complex relationships between physical illnesses and mental illnesses (such as anxiety and depression) have been found repeatedly, they are still poorly understood. Australian data indicate that 39% of people with depression and anxiety

have a physical illness and at least 14% of those with a physical illness have depression or anxiety (Andrews et al., 1999). A report on the health and well-being of people with psychotic illnesses has shown how poor that physical health typically is, with high rates of major physical disorders and increased premature mortality from these conditions (Coghlan et al., 2001; Lawrence, Holman & Jablensky, 2001).

The results of a recently released New York City Community Health Survey show that there is no health without mental health. The telephone survey of 10 000 New Yorkers, with representation from 33 communities, found that poor general health is three times more common among those who report significant emotional distress. These respondents reported high rates of many chronic conditions that put them at risk for early death. These included high cholesterol, high blood pressure, obesity, asthma and diabetes. Respondents also reported risk behaviours that potentially increase the incidence of poor health, such as lack of exercise, binge drinking, smoking and poor nutrition (NYC Department of Health and Mental Hygiene, 2003).

Physical diseases and mental disorders are relatively well-defined in the various classifications of disease (ICD 10, DSM IV). Diagnostic criteria provide the framework for clinicians to make judgements about the presence or absence of those conditions that are reflected in consistent and identifiable patterns of symptoms, signs and investigation results. The person who experiences such conditions may define themselves as ill, and illness is the personal experience and its functional and social concomitants and constructs. The causes of physical and psychiatric conditions are variously understood. The underlying pathology may be clear or obscure and the etiological processes multiple, complex, interacting (e.g. genes and environmental) and variable in course over time and outcomes. In many instances, the symptoms and signs may be on a continuum with average or normal experience. For example, depressive symptoms below the agreed categorical level have been referred to as "sub-syndromal" depression. Risk factors and protective factors for onset, course and outcome also operate in complex and interacting ways. This is exemplified by protective, safe and harmful levels of alcohol use.

These interactions have been the subject of a growing body of research in recent years and highlight the opportunities to improve health outcomes by enhancing the recognition and treatment of physical illnesses for those with mental illnesses and vice versa.

Mental health and mental illness

As noted earlier, current approaches to measurement of mental health in psychiatry have taken a disease/illness classification approach which has been the primary formulation in a range of countries (APA, 1994; Mezzich, 1995). That is, for the most part they have focused on mental health as on a continuum with or the opposite of mental illness. However, a salutodiagnostic approach (see Chapters 3 and 4) that includes assessment of the risk and protective factors that enhance and promote resilience has been advocated in a number of longitudinal, cross-sectional and retrospective studies (e.g. Werner & Smith, 1982). Definitions, and therefore assessments, of what constitutes resilience in such contexts vary. However, a number of standardized instruments for assessing health promotive factors and positive mental health aspects have been described (e.g. Friborg et al., 2003), with research particularly focusing on identifiable aspects of resilience in children. Resilience in the face of the adversities of mental illnesses and their consequences could be a significant indicator of mental health, particularly in adults with serious illnesses such as schi-

zophrenia. Peterson and Seligman (2004) have described a measure that takes a related strengths approach – the Values in Action (VIA) classification of strengths.

Other key elements of positive mental health might include those related to concepts of adjustment to physical illness. For instance, there is a need to explore concepts such as "fighting spirit" (personal psychological characteristics representing a form of resilience) and the role of hope in adjustments to mental illness. "Living well" with HIV/AIDS was a valuable and empowering concept that promoted physical health and well-being in response to an illness condition. It improved attitudes to illness, helped to lessen stigma and discrimination and gave a sense of self-efficiency and hope.

There are no standard or universal characteristics of positive mental health in people living with a mental illness. These characteristics need to be understood as unique features in each person and embedded in their specific social and cultural context. Qualitative autobiographical reports can provide researchers with a deeper understanding of the experience and overcoming of mental illness. There is the danger, however, that these accounts could be transformed by the particular viewpoints and conceptual frameworks about mental disorders that professionals harbour and convey to patients.

John Strauss (1989) challenged the field to discover and develop methods of inquiry that preserve subjectivity and protect rather than reduce experiential data. He asserts that many interactive processes (psychological, social and biological) are involved in a patient's healing and recovery. In a study of people with schizophrenia he reported that good rapport and an unstructured interviewing approach gleaned a greater amount of information on coping strategies and regulatory mechanisms. Examples of positive coping strategies (in this particular culture and setting) were behavioural comparison, relaxation, cognitive strategies such as self-talk and thought stopping, less stressful social interaction, pleasant events scheduling and reading the Bible. Strauss (1987) reported a number of important processes for rehabilitation of people coping with a mental illness, including self-determination in recovery, the role of meaning and a sense of identity.

Hatfield and Lefley (1993) also identified a number of important factors in recovery from mental illness: the acceptance of illness, a sense of control, hope, and personal support from family and professionals that includes respect for the individual and their personal growth.

Schmolke (2001, 2003) based her qualitative and quantitative studies with outpatients suffering from schizophrenia on the concepts of salutogenesis (Antonovsky, 1987) and health promotion (WHO, 1986). She found positive health outcomes for patients who developed an expert knowledge and experience of effective coping strategies. Family, peer and partner support were protective factors. Other protective factors included the desire and ability to work, the feeling of being important and useful to others, and religious beliefs and spirituality giving emotional support and meaning. The results of the quantitative study confirmed the possible co-existence of protective health resources and positive health with (sometimes severe) psychopathology.

These studies suggest the value of developing more comprehensive clinical approaches that focus on a person's positive health, strengths, capabilities and efforts towards recovery. This approach would prove valuable across the spectrum of prevention, diagnosis, treatment and rehabilitation. Implications for health professionals are significant. They include the need for an approach that considers and promotes recovery (hopefulness) and a willingness to collaborate with consumers in developing tools that promote functioning and meaning (Holsenbeck, in

Mulligan, 2003). These studies also suggest the importance of balance between empirically valid methodology and the recognition of consumers' desires to define and discuss their needs.

DeSisto and colleagues (1995) conducted an epidemiological study of a sample of seriously disabled persons in the USA who were consumers of mental health services. In line with other research (see Jacobson & Greenley, 2001), they reported that practices based on the principles of a "recovery model" (such as hope, social connection and self-determination) were important components in the high rate of recovery in this group compared with a comparison group in Maine, where treatment was based more on a medical model of maintenance and medication compliance.

A Mental Health Continuum

Corey LM Keyes

Keyes has characterized a mental health continuum in the USA population that may point the way to further investigation in other populations. The presence of mental health is called "flourishing", a condition characterized by the presence of high levels of emotional well-being and high levels of positive functioning. The absence of mental health is called "languishing", a condition characterized by low levels of emotional well-being and low levels of positive functioning (Keyes, 2002, 2004, in press).

This "diagnostic scheme" was used in the MacArthur Foundation Midlife in the United States (MIDUS) survey of a nationally representative sample of USA adults aged 25–74 that was conducted in 1995.

In this study individuals were assessed for mental health using structured scales of positive affect and life satisfaction, psychological well-being and social well-being. They were also assessed for mental illness (major depression episode) using the CIDI-Short Form (CIDI-SF) and according to the DSM-III-R criteria.

The two diagnostic approaches (i.e. mental illness or mental health) yielded a different prevalence estimate of mental health. Table 1 reveals that whereas 14.1% of adults reported a major depressive episode during the past 12 months, suggesting that at least 8 of every 10 adults should be viewed as mentally healthy, most adults were only moderately mentally healthy, while 12% were languishing and 17% were flourishing.

These results suggest mental illness (i.e. major depression) and mental health are correlated but independent dimensions. Nearly 5% of flourishing adults and 13% of moderately mentally healthy individuals had a depressive episode in the past year, compared with 28% of languishing adults. That is, mentally unhealthy, languishing adults are between 5 and 6 times more likely than mentally healthy, flourishing adults to have experienced a major depressive episode during the prior 12 months.

Table 1.
Cross-tabulation of the mental health diagnosis with the CIDI-SF DSM-III-R diagnosis of 12-month major depressive episode

Major depressive episode past 12 months	Mental health status			Total N %
	Languishing N %	Moderately Mentally Healthy N %	Flourishing N %	
No	368 12.1% Mentally unhealthy, *Languishing*	1715 56.6% Moderately mentally healthy	520 17.2% Mentally healthy, *Flourishing*	2603 85.9%
Yes	143 4.7% Complete mental illness, *Depressed and languishing*	259 8.5% Mentally ill, *Pure depressive episode*	27 0.9% Mentally ill, *Pure depressive episode*	429 14.1%
Total	511 16.8%	1,974 65.1%	547 18.1%	3032

Note: $\chi^2_2 = 120.5$, $p < 0.001$ (two-tailed).

The burden and benefits of mental health

Research has investigated the burden of mental health and mental illness by focusing on perceived mental health, limitations of activities of daily living, risk of cardiovascular disease and work productivity losses attributable to mental health (Keyes, 2002, 2004). Findings reveal that the absence of mental health (languishing) rivals and sometimes compounds the burden of major depression. Flourishing is the least burdensome mental health status.

That is, adults who were completely mentally ill (depressed and languishing) had a higher number of workdays lost or cutback, more limitations of activities of daily living and lower perceived mental health than adults who were languishing only or depressed only. Adults who were languishing only showed very similar burden profiles (sometimes worse profiles) than adults who were depressed only. It is important to note that languishing does not appear to be subclinical depression; languishing adults reported an average of 0.2 symptoms of depression. Adults who were moderately mentally healthy, in turn, showed markedly better profiles than languishing adults. Mentally healthy, flourishing adults exhibited the least burdensome profiles in the study.

Mental health, mental illness and physical illness

Several studies provide evidence linking mental health domains to physical conditions, particularly on the interactions between depression and related illnesses including anxiety, and major conditions such as heart disease (Kuper, Marmot & Hemingway, 2002), stroke (Carson et al., 2002), diabetes (Anderson et al., 2001), asthma (Goldney et al., 2003) and cancer (De Boer et al., 1999). The implications are that the treatment of depression and anxiety may mitigate negative physical health outcomes. More importantly, it is reasonable to surmise that positive mental health and the prevention of depression and related disorders may significantly improve physical health outcomes. While empirical studies are required, this suggests that the promotion of positive mental health should be evaluated and built into health care systems and the delivery of health care for physical and psychiatric conditions (as discussed later).

Cardiovascular disease

Depression occurs in 16–23% of patients with coronary artery disease and may precede myocardial infarction in 33–50% of cases. Depression and anxiety have also been found in patients following coronary artery bypass graft and in patients with congestive heart failure, while panic disorder has been linked to coronary artery disease. In these studies, directions of effect were sometimes uncertain. Some of the studies examined depression and related disorders as potential risk factors for heart disease. Depression and anxiety may play some role in increasing risk or in etiology, as may lack of social support and some work and personal characteristics (Kubzansky & Kawachi, 2000; Kuper, Marmot & Hemingway, 2002; Scheier & Bridges, 1995). A recent review by the National Heart Foundation in Australia concluded that "there is strong and consistent evidence that depression is an independent risk factor for clinical coronary heart disease and its prognosis" (Bunker et al., 2003, p. 273) and that the level of risk may also be related to the severity of depression with a dose-response effect. The overall relative risk was 1.64 and the risk related to both depression symptoms and clinical depression. Social isolation and lack of social support were also risk factors.

A range of individual interventions, such as psycho-education, counselling and behavioural strategies aimed at improving mental health and hence heart health outcomes, have improved well-being without lessening anxiety and depression. Exercise is another important area, both in terms of its role in improving a sense of well-being and potentially lessening depression and anxiety. While it is widely recommended for improved cardiac outcomes it has not consistently been shown to lessen depression-related risk in those with cardiac disease.

The complex interactions of mood, hope and self-efficacy with risk factors such as smoking, alcohol consumption and poor nutrition, and their relationship through this or other pathways to cardiac conditions and outcomes has not been adequately explored. This is an important area for further study, as is investigation of the relationship between well-being, self care, hope and other factors, and the prognosis of cardiac conditions.

Behaviours such as tobacco and alcohol use and other risk and protective factors such as exercise and overweight may influence onset, course and outcomes of cardiac pathology through complex causal and associative pathways. Opportunities for mental health promotion may thus exist at multiple levels.

Cerebrovascular disease

Depression and anxiety may worsen prognosis for stroke. Interventions such as education, follow-up home visiting, leisure therapy, support workers and counselling have been seen as potential support but there is inadequate high quality research to provide the basis for clear guidelines. Cognitive behaviour therapy (CBT) is identified as useful by some in this field (Anderson, Hackett & House, 2003). Again, these interventions may be seen as good clinical psychosocial care and potentially mental health promoting in terms of their enhancement of self-efficacy, knowledge, hopefulness and well-being.

Metabolic disease and diabetes

People with diabetes mellitus have high rates of depression and anxiety (Anderson et al., 2001, 2002). Depression and anxiety can influence the course of diabetes in complex and reciprocal ways and are associated with poor control of blood glucose levels and a range of complications. The complex interaction of risk factors is evidenced by the fact that diabetes complications are also risk factors for depression. Behavioural and psychological interventions lessen the symptoms of anxiety and depression for patients with diabetes and in children have been shown to improve illness management as well as emotional and behavioural problems (Kibby, Tyc & Mulhern, 1998). Other studies have shown that in some cases CBT can not only decrease depression and anxiety but also improve blood glucose levels and blood glucose control (Snoek & Skinner, 2002). These and other studies suggest that interventions that improve well-being and self-efficacy improve the handling of the stress of illness and can be seen as mental health promoting as well as enhancing physical health outcomes in the holistic sense.

Respiratory illness

Asthma has also been researched in terms of comorbidity and psychosocial risk factors that may influence course and outcome. Increased rates of depression have been found in people with asthma (Goldney et al., 2003). Relaxation based behavioural therapies and education have both been shown to improve well-being and functioning in terms of this illness in adults (Devine, 1996) and similar results have been found with children. Family therapy has also been found to be helpful with children with asthma (Panton & Barley, 2003). Pharmacotherapies for depression and anxiety for patients with physical illness have not been the focus or well studied, but psychosocial interventions, many of which may be considered as promoting components of mental health, have demonstrated benefits.

Cancer

The literature reports many studies of the comorbidity of depression or anxiety with various forms of cancer in men, women and children. Risks of depression or anxiety are greater in younger patients with more severe illnesses, illness recurrence, advanced stage of cancer, body image changes, previous personal or family mental health problems, poor social support and cancer treatment side-effects (Barsevick et al., 2002). Risks are also higher in certain family settings, for instance for women with young children.

A number of studies report the benefits of psychosocial interventions for altering depression and anxiety symptoms in cancer patients (Fawzy et al., 1990; Spiegel, 1999), particularly in children (Scott et al., 2003).

There is limited support for the popular view that psychological factors influence onset of cancer, but anxiety and depression have in some instances been associated with poorer patient survival

(De Boer et al., 1999). Studies that show that support groups and fighting spirit may improve survival rates for women with breast cancer highlight the broad and complex nature of psychosocial influence (Spiegel, 1999).

The treatment of co-existing illnesses in their own right, be they anxiety, depression or other major mental illnesses such as schizophrenia and bipolar disorder, is also relevant. It is also clear that the treatment of physical illnesses among those with severe and disabling mental illnesses is frequently neglected, either through isolation of service systems or stigma and neglect impacting on access to high quality medical care (Lawrence, Holman & Jablensky, 2001).

Obesity

Obesity is a major health risk and a common problem among people with mental health problems. According to Ekpe (2001), behaviour change, which is usually a valid strategy for health promotion, might not be sufficient to achieve the desired health objectives, such as weight loss. However, an empowered individual or community may be able to bring about positive and permanent health change by mobilizing necessary resources.

Addiction

Results of an empirical study based on the salutogenetic model investigating the consumption of alcohol and medicaments in women aged between 20 and 60 years identified the following factors as being protective against the development of an addiction: being married and living in a partnership, load balance of stress and resources (especially concerning social burdens), strong sense of coherence, positive attitude towards the pleasures of life, competent coping with emotions, low reliance on the capabilities of substances to influence emotions and/or feelings and subjective contentment with own mental health (Franke, 2002).

Health problems in the elderly

The interrelationship between physical and mental health is also evident in studies on the health of the elderly. For example, findings on daily living practice among Thai elderly suggest the importance to their physical and mental health of good food habits, regular exercise, seeking knowledge about health, religious activity involvement, good relationships with others and well-planned management of income and expenses (Othaganont, Sinthuvorakan & Jensupakam, 2002).

In Great Britain, the importance of these interrelationship to the health of older people is shown in the National Service Framework (NSF) for Older People. This framework sets out eight standards, which include strategies to reduce falls, strokes and poor mental health as well as to improve general and intermediate care. The final standard, "promoting health and active life in older age", is an overarching theme (Biley, 2002).

HIV/AIDS

Psychological beliefs such as optimism, sense of personal control and a sense of meaning are known to be protective of mental as well as physical health. An investigation by Taylor et al. (2000) on men infected with HIV has revealed that even unrealistically optimistic beliefs about the future may be health protective. The ability to find meaning in the experience was also associated with a less rapid course of illness. The authors of the study concluded that psychological beliefs such as meaning, control and optimism act as resources that may not only preserve mental health in the context of traumatic or life-threatening events but also be protective of physical health.

Stress and health and illness

A related area is the impact of life stress and stressors on physical and mental health and their potential contributions to etiology and to course and outcome of illness. There is a growing body of research in fields such as psychoneuroendocrinology and other psychophysiological fields concerning the potential influence of stressor environments on the biological reactions in brain and body. Those studies which now demonstrate, for instance, the impact of childhood abuse on brain functioning and development (DeBellis et al., 1999), the risk for the development of psychiatric disorders (Cicchetti, 1994) and re-exposure to further trauma all show that sophisticated understanding needs to come into play with any attempts at mitigation. Promoting mental health in the broad sense relates to creating social and physical environments that are nurturing, protective from violence and harm, enhance relating and empathic skills from early attachments and family life, enhance social and emotional as well as other intelligence, facilitate resilience in the face of adversity and facilitate development and progressive maturation. A range of effective promotion, prevention and early intervention strategies across the lifespan can address such issues (CDHAC, 2000a, 2000b).

Social programmes have been shown to be effective in some settings in improving mental health. Examples include early home visiting for those at high risk (Olds et al., 1997), positive parenting programmes to help emotional regulation and lessen risk of acting out disorders (Sanders & Markie-Dadds, 1996) and school based programmes to enhance self-efficacy, problem solving and positive and optimistic thinking (Dadds et al., 1997; Jaycox et al., 1994). Other strategies adopt a promotion and prevention approach with respect to major life stressors such as bereavement and trauma (Raphael & Wilson, 2000; Stroebe et al., 2001). The cross-cultural applicability of this work, and the way that mental health and mental illness relate to each other and to stressors generally, require more research and programme evaluation as discussed elsewhere in this volume. Other issues identified in this volume include human rights and their relation to mental health, for instance the place and rights of women and children and their relation to well-being (see Chapter 7).

Behaviour and mental health

Health behaviours seem an obvious pathway between those aspects of mental health detailed above and physical and possibly mental illnesses. There are limited studies but, as noted previously, these may only reflect a two-way interaction such as between exercise and depression or drug and alcohol use and depression or their relationship to stressful life experiences rather than the potential diversity and complexity of such interactions over time.

Social environments where there is support, cohesion and little isolation may also contribute to positive mental health, despite adversities such as poverty and social disadvantage or even the stress of physical illness or injury. Future considerations about environments and individual interactions are likely to require a better understanding of gene/environment interactions as a component of promoting mental health and how these complex processes may link to other interaction patterns of illness vulnerability.

Developing mental health promoting health care systems and environments

The evidence outlined suggests the development of mental health promoting systems and environments may have significant effects on mental and physical health and illness. In addition, enhancing psychosocial functioning of individuals and promoting support, education, resilience, relationships that are empathic and reciprocal and mature defenses in response to stress – and doing no harm – may all promote positive mental health even in the face of illness, physical or mental.

Programmes adopting the positive psychology approach can be delivered to school-aged children and via community education systems. Short-term benefits may lead to greater integration of children into the community, increased cohesiveness among children and their families, and the development of elements of resilience such as adaptive thoughts and behaviours and problem-solving. The long-term benefits could be the prevention of violence and antisocial behaviour, substance abuse and mental health problems. These positive components could also potentially promote mental health and lessen negative physical as well as mental health outcomes.

It has also been argued that mental health promotion and recovery movements may maximize systems of social support and community networks through programmes that engage consumers as peer counsellors in mental health services and, through self-efficacy and empowerment, contribute to better physical and mental health outcomes for them (e.g. Chinman et al., 2001; Felton et al., 1995; Peter, 2003; Simpson & House, 2002; Valentine et al., 2003).

Conclusion

Holistic approaches to mental and physical health and illness have been the central tenets of indigenous belief. Science is increasingly demonstrating the complex interrelationships between physical, psychological and social factors in health and illness. To promote mental health globally and in terms of physical and mental illnesses, such an holistic view is critical.

Research on the role of mental health and mental illness with respect to risk behaviours is a developing field. Behaviours related to nutrition, excessive alcohol, smoking and illicit drug use are common among people with mental illnesses and require active health promotion efforts, as they complicate treatment and recovery (Smith, 2004). However, more contentious is the question of whether mental ill-health leads to risk behaviours such as those listed and further work is needed to clarify directions of interaction and possible causation.

More sophisticated research is needed to address mental health and how it may be promoted, and how outcomes of interventions to do so can be measured in terms of both changes in mental health and physical and mental illnesses. The methodologies that can examine such complex biopsychosocial interventions and pathways and their multiple interconnections will need to be developed. Perhaps this science can also be improved by indigenous wisdom and "wisdom sciences" to deliver better mental health.

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Chapter 12
Indicators of Mental Health

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Introduction

Perhaps no other issue has a greater capacity to bring together concepts, evidence and practice in the field of mental health promotion than that of indicators. This chapter has a principal focus on indicators of positive mental health and associated indicators of capacity building as they apply to mental health promotion initiatives.

Previous chapters have detailed the evolution of our understanding of mental health (Chapter 3), the variation in these concepts across the world (Chapter 5), the conceptual basis of mental health in health promotion (Chapter 8) and what is known about the determinants of mental health (Chapter 10). In many regards this volume draws together a comprehensive overview of the field of mental health promotion and theoretical perspectives from which a considered approach to the development of indicators of positive mental health might logically commence. This makes what is offered here at best tentative and at worst premature.

Still, as will be shown, practitioners, policy-makers and researchers have simply had to proceed in the absence of integrated theory and in the face of need. As a result, there is a considerable body of practice that informs the development and use of indicators in mental health and mental health promotion. This includes epidemiological studies of mental health, cross-national studies of the quality of life, findings relating social determinants and inequalities to health and mental health, item development and psychometric studies of specific instruments, and observations from programmes of health surveillance and monitoring.

Positive mental health and the absence of disorder

Practitioners of mental health promotion face particular challenges in monitoring and surveillance. Worldwide awareness of the burden of mental health is a response to growing epidemiological evidence of disease burden – that is, a response to studies that have measured the presence of mental illness or disorder and its associated consequences (Murray & Lopez, 1996). In this way, the monitoring and surveillance of mental health through observations of the incidence and prevalence of mental illness reflects the wider tradition and history of public health with its focus on patterns of disease, morbidity and mortality rather than on the presence of health per se.

More specifically, surveillance in the delivery of public health and health care was historically based in the accurate detection and monitoring of infectious diseases, with the gradual extension of these techniques in modern times to address acute and chronic diseases, reproductive health, injuries, environmental and occupational hazards and behaviours (Thacker & Berkelman, 1992). Thus, health surveillance systems principally seek to monitor the health of populations, communities and individuals through the detection and description of the distribution of diseases, illnesses, hazards and risk exposures in people over time. By and large, the surveillance of general levels of positive (physical) health has had relatively little place in the delivery and evaluation of health and public health services. The absence of disease or infirmity has largely been taken as an indicator of the presence of health in individuals, communities and populations. While practical, this assumes that there is a dichotomy between illness and health, and that indicators of morbidity and mortality are sufficient to evaluate initiatives in health promotion and to monitor levels of positive health in the population.

Not surprisingly, mental health and mental health surveillance and monitoring have followed a similar trajectory, with population reporting being based on assessing patterns and distributions of mental illness, morbidity and mortality. Even so, the challenges in the monitoring and surveillance of mental illness have been substantial. Both quantitative and categorical methods have been developed, promoted and used. Categorical taxonomies in mental health such as those used in Europe and the USA, while working towards convergence, have undergone regular revision and many diagnostic categories remain volatile. As described in Chapter 5, cultural differences pose significant challenges in the establishment of uniform definitions and descriptions and threaten valid cross-national comparisons. Developmental variation in symptom and illness trajectories across the lifespan requires often radically different approaches when considering children, young people, adults and the elderly. Finally, health and mental health systems remain reluctant to commit to policy development and to expend resources on the promotion of positive mental health in the face of the documented increase in the burden of, and unmet need for, mental health care. Simply put, the vast proportion of health resources is aimed at detecting, curing, treating or managing illness and much of the surveillance that occurs aims to assess the impact of these activities and the delivery of health care. As a result, measuring positive health outcomes of health promotion programmes and preventive interventions holds little sway in mainstream health surveillance and monitoring.

There is, however, good reason to argue for the development and implementation of an array of indicators of positive mental health. As discussed in Chapter 1, the estimated worldwide population burden of mental health disorders is well beyond the treatment capacities of developed and developing countries – and the burden is growing. Authorities around the world are moving to initiate scientific trials and evaluations, assess evidence, develop policies and implement programmes of intervention to prevent mental disorders and maintain or improve levels of positive mental health (CDHAC, 2000). These approaches require measurements and indicator frameworks relevant and responsive to the interventions and methods of mental health promotion. There is certainly a place for epidemiological measurement of mental disorders and many well-developed instruments with which to do this. Such measures are essential where mental health promotion and prevention programmes seek to prevent or reduce illness or disorder. However, the absence of a mental illness or disorder does not necessarily result in a "state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and fruitfully, and makes a contribution to his or her community" (WHO, 2001, p. 1). Individuals without a mental illness or disorder have varying degrees of well-being and hence differing levels of abilities to cope with the normal stresses of daily living. These are the aspects of positive mental health for which indicators are sought.

A social-ecological framework for positive mental health

When proposing mental health indicators, the different perspectives of health promotion practitioners and mental health practitioners need to be appreciated.

For health promotion practitioners, health promotion is a process of development that addresses determinants, strategies and specific levels of action (Evans & Stoddart, 2003; Hamilton & Bhatti, 1996). These in turn should have a clear evidence base that draws upon research, experience and evaluation. Critically, the entire model rests upon stated values and assumptions (see figure 12.1; see also Chapter 16). As Lahtinen et al. (1999, p. 11) state:

> Promotion of mental health puts special emphasis on participation and empowerment
> and on intersectoral cooperation. It can work with whole societies, communities, social

groups, risk groups or individuals. Action aiming at promoting mental health underlines and highlights values supporting sustainable development.

The health promotion approach is particularly congruent with a population perspective.

For mental health practitioners, mental health is first and foremost an individual developmental process best understood over the lifecourse. As a developmental process the expression of individual positive mental health is nested within specific cultural, historical, sociopolitical and economic settings. Within these broad settings, positive mental health is conditioned by specific neighbourhood, school and community influences that intersect with families, peers and individuals. The individuals themselves bring their own developmental characteristics and capacities – genetic, behavioural and social – which interact with and within these larger systems. As a consequence, like other complex health outcomes, an individual's mental health is multiply determined, with causal pathways that more often than not lie outside the control or jurisdiction of health and mental health systems. The significance of this is paramount when trying to establish a response to address the growing burden of mental health problems and disorders. The services responsible for responding to the growing demand for treatment are not necessarily responsible for or equipped to address preventive strategies (Zubrick et al., 2000b).

Figure 12.1
The scope of health promotion
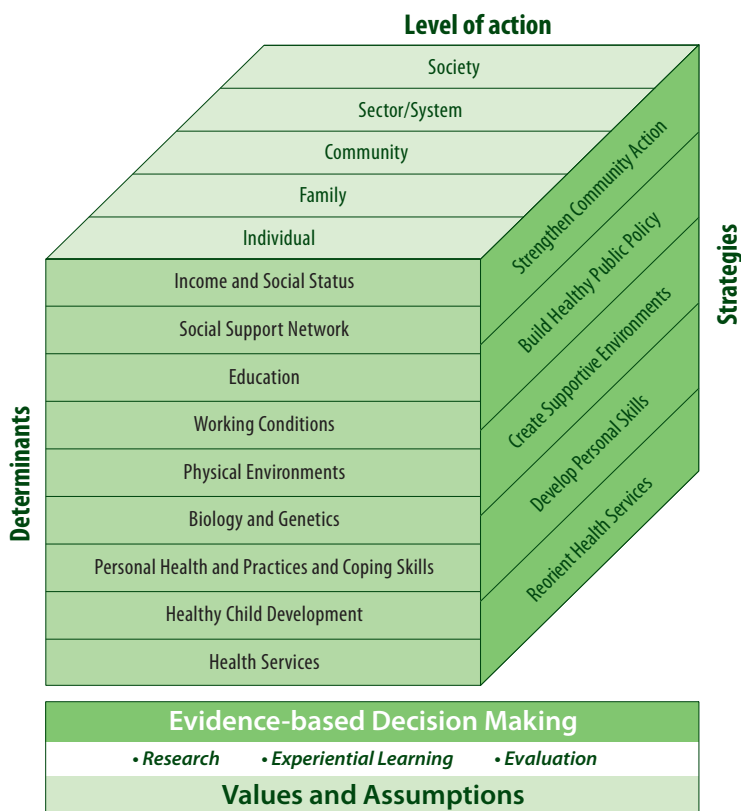
Adapted from: Evans & Stoddart, 2003.

The orientations of health promotion practitioners and mental health practitioners are not anti-thetical. Both recognize that positive mental health is embedded in and emerges from a wider social and material ecology. Thus, either through a focus on populations or a focus on individuals, they acknowledge that positive mental health is set within a larger sociopolitical, economic and cultural environment which in turn influences the distribution of material and social resources through a variety of institutional and individual mechanisms. Ultimately individual biology and genes are conditioned by and interact with these environments. As a consequence, indicators of positive mental health will of necessity need to reflect differing levels of influence.

Emerging frameworks or conceptual models of positive mental health, while at an early stage, already acknowledge the need to specify a range of indicators at differing levels of develop-mental influence on mental health (Korkeila, 2000; Lahtinen et al., 1999; STAKES and European Commission, 2000; Stephens, Dulberg & Joubert, 1999). These influences entail multisectoral interests (e.g. health, welfare, education and justice) and include macro-level measures of cultural, social and political-economic structural processes; distal measures of the social organization and behaviour of communities, schools, local neighbourhoods and workplaces; proximal measures of the demographic, material and social circumstances and behaviours of families and peers; and direct measures of the psychological, biological, social, material and demographic characteristics of individuals themselves.

Clearly, developing a framework to capture all or even some of this is an extensive undertaking. However, to the extent that distal and proximal measures reflect geographical settings, organiza-tional boundaries and social groupings, some of the indicators for these may be derived through the appropriate sampling, measurement and subsequent aggregation of direct measures on indi-viduals, and the disaggregation of select macro-level measures to describe the lower level distal and proximal settings and groups.

An example of this approach is shown in figure 12.2. The outcome variables include measures of the child's poor mental health status, academic problems (i.e. "poor grades") and the primary parent's level of happiness (see Zubrick et al., 2000a). The population described is a subpopulation (Western Australia) and the risk variables include unemployment, low income, poor education, sole parent family structure, poor parental mental health, family conflict, adverse life events and coercive discipline, all of which have well-documented evidence placing them on the causal pathway of the outcomes. An additional measure of school disadvantage has been used from educational administrative sources and added to the individual unit records to estimate the effect of this more distal exposure. The diagram has been contextually enriched by the provision of the family work arrangement and family structure, and then elaborated with other measures of time, income and human, psychological and social capital that are known to be on the causal pathways of the three response variables. This allows greater insight into the social ecology of, in this case, family work arrangements and more particularly into the material, social and psychological cir-cumstances that have a bearing on mental health promotion. For example, figure 12.2 shows the number of hours that couple and sole parent families spend in the work setting. Full-time employ-ment and income are associated with fewer academic problems in sole parent families. Child mental health is more likely to suffer in unemployed families. These families sustain high levels of negative life events, low family income and higher family conflict. Children in these families are most likely to go to a disadvantaged school.

Figure 12.2
Socio-ecological contexts of mental health outcomes

	Both FT	1 FT 1 PT	1 FT 1 home	Both PT	Both UE	Sole FT	Sole PT	Sole UE	
(Work Total Hrs/week)	(96)	(67)	(48)	(23)	(0)	(42)	(16)	(0)	
(Lowest family income)	4%	4%	3%	36%	46%	33%	84%	91%	
(Low ed mother)	14%	7%	13%	12%	27%	9%	10%	25%	
(Poor parent mental h.)	9%	11%	10%	17%	12%	19%	26%	20%	
(Family conflict)	17%	17%	18%	10%	34%	16%	27%	26%	
(Life events < 2)	11%	12%	15%	33%	41%	27%	25%	35%	
(Coercive discipline)	5%	5%	6%	3%	11%	1%	6%	8%	
(Disadvantaged school)	12%	25%	31%	39%	47%	22%	37%	49%	
(Population of children)	11%	34%	25%	4%	5%	2%	4%	7%	

FT = full time, PT = part-time, UE = unemployed, Home = not in labour force

Adapted from: Zubrick et al., 2000a, p. 23

Criteria for selecting indicators

Any presentation of indicators should attend to the criteria guiding their creation and selection; however, a full discussion of these criteria is well beyond the scope of this chapter. Suffice it to say, the selection of indicators should be guided by a logical sequence of activities (Zubrick et al., 2000a). These include:

- describing the theoretical basis for linking the indicators to the outcomes of interest;

- selecting from the quantity and range of what might be measured;

- identifying the value base underpinning such measurements;

- determining the feasibility of collecting such information;

- assessing the reliability and validity of the measures; and

- establishing the stability of the measures over time.

Most of these steps are predicated on a pool of already developed items or scales. Where these don't exist the additional task of item and scale development befalls the user. Too often, researchers and practitioners rely on readily available items and scales, particularly for the measurement of a variety of subjective phenomena, without considering the need to apply modern item theory to develop better measurements, establish their response characteristics and reduce the number of items for efficient measurement.

There are several desirable properties that indicators should possess to maximize their use (figure 12.3). Such properties include relevance, comprehensibility, stability, responsiveness to change and coverage. These are particularly crucial in ensuring that data and information based upon the indicators will have the capacity to produce desired responses in individuals, organizations and whole jurisdictions when combined with well thought through and deliberate dissemination strategies.

Figure 12.3
Desirable properties of indicators

Indicator items and scales should:

- Have community relevance and be easily and readily understood by the public
- Have relevance to the aims of the activities
- Have a stable meaning over time
- Be sensitive to changes over time
- Anticipate the future and provide baseline data for subsequent trends
- Provide complete coverage of the population or event being monitored
- Assess dispersion across given measures of well-being
- Measure progress in meeting goals at the national, state and local levels
- Provide a measure of variability between regions and nations
- Be available for relevant population subgroups

Adapted from: Moore, 1995

Macro-level indicators

No discussion of macro-level indicators of positive mental health can commence without noting that for mental health to flourish it must do so in an environment that is safe and capable of meeting (at a minimum) the basic needs of individuals. Where there is war and strife, hunger, disease, great poverty and denial of basic human rights the very basis for the development of positive mental health is compromised (see Chapter 7). This is not to say that in such circumstances positive mental health is altogether absent – there are always those who do well despite great adversity – but to acknowledge that there is a hierarchy of needs to be met in order to enable levels of population positive mental health to emerge. Many of these needs have been articulated in the Millennium Development Goals (see figure 12.4). These goals are relevant to developing countries, although there is good cause for developed countries to report against them as well.

The goals have 18 targets with a total subset of 48 indicators and have been reviewed by the UN Development Programme (2002). They are cited here as a reminder of the larger hierarchy of needs that confront developing countries particularly, where the relevance of and progress towards developing and using indicators of mental health (positive and negative) may be judged with some perspective.

Figure 12.4
Millennium Development Goals agreed at the Millennium Summit, September 2000

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop a global partnership for development

Source: UNDP, 2002

Linked closely with the Millennium Development Goals is the Human Development Report (Fukuda-Parr & Kumar, 2003). First commissioned in 1990, the Human Development Report features the Human Development Index (HDI), which is used to measure a country's achievements in three broad areas: longevity (life expectancy at birth), knowledge (adult literacy rate and the combined gross primary, secondary and tertiary enrolment ratio) and standard of living (gross domestic product per capita). The data used to calculate the HDI are taken from national-level collections that include census, administrative and economic sources. The HDI is a measure of achievement and is principally used to focus attention on, and advocate for, human outcomes rather than merely the economic performance of a country.

The HDI has not been free from criticism (Castles, 1999; Henderson, 2000; Jolly, 2000). In 2000 it was reviewed by the United Nations Statistical Commission following expressions of concern by statistical organizations and individuals through the 1990s about the quality and appropriateness of the data used to derive the index and the conclusions drawn from it. Since that time the United Nations Development Programme has undertaken to improve the statistical basis of the HDI and to ensure better statistical advice and overview of its use in the production of the Human Development Report.

The HDI is complemented by two Human Poverty Indices (HPI-1 and HPI-2). These are used to describe the dimensions of poverty for developing and developed countries respectively. Additionally, there is a gender-related development index (GDI) measuring the gender distribution of life expectancy, education and income distribution, and a gender empowerment index (GEM) describing the gender distribution of political and economic participation and decision-making and power over economic resources. While the development and use of these indicators is beyond the focus of this chapter, they provide examples of macro-level national indicators

that are relevant in characterizing some aspects of basic human development against which the interest in, and implementation of, measures of mental health (positive or negative) may be more appropriately assessed.

Whether or not the HDI or some other index of development is used (see Brink & Zeesman, 1997), characterizing populations and subpopulations by levels of income; the availability, distribution of and access to social benefits; and levels of employment and long-term unemployment are essential measures of the social and economic macro-environment and important determinants of mental health. Such measures may be derived from census and administrative data or alternatively measured at the individual level and aggregated upward to derive regional and national estimates.

Individual indicators of positive mental health

Most emerging positive mental health indicator frameworks specify a range of concepts and measures. Broadly, these measures concern individual perceptions and judgements about sense of coherence and meaning in life, personal self-esteem, sense of control over daily life and work, and dispositional optimism.

Sense of coherence

The Sense of Coherence (SOC) Scale (Antonovsky, 1987; see also Chapters 3 and 4) has been widely used and promoted as a potential indicator of well-being. The scale is available in 29-item and 13-item versions. Antonovsky (1987, p 19) defined SOC as:

> … a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges worthy of investment and engagement.

Factor studies indicate that the SOC scale measures a single underlying factor (Antonovsky, 1993). Chronbach alphas for the SOC-29 range from 0.82–0.95 and for the SOC-13 from 0.74–0.93. Test-retest stability has varied from 0.52 to 0.97, reflecting differences in populations measured, while validity indices have shown strongest associations with measures of self-esteem (0.63), general well-being (0.62), morale (0.71), low levels of trait anxiety (-0.75) and quality of life (0.76) (Antonovsky, 1993). The SOC scale was used in the 1994–95 Canadian National Population Survey. A secondary analysis of these data showed provincial differences. The SOC was positively associated with age and social support and negatively associated with childhood trauma (Stephens, Dulberg & Joubert, 1999). The scale has been criticized as failing to account for the affective component of coherence, nor is it clear whether coherence results from or is mediated by factors in the social environment (Siegrist, 1993).

Self-esteem

Self-esteem refers to a favourable or unfavourable attitude towards the self (Rosenberg, 1965) and has a lengthy history of use in psychosocial research (Blascovich & Tomaka, 1991). Notable measurement scales include the Rosenberg Self-Esteem Scale (RSE: Rosenberg, 1965), the Coopersmith

Self-Esteem Inventories (CSEI: Coopersmith, 1982) and the Single-Item Self-Esteem Scale (SISE: Robins, Hendin & Trzesniewski, 2001).

The RSE has been widely used. Administration is via self-report on a four-point Likert scale that assesses strength of agreement on 10 statements (e.g. "I take a positive attitude toward myself"). Factor studies have generally suggested two underlying factors, although the overall 10-item RSE has good internal reliability (0.80). The RSE has reasonable test-retest reliability and convergent validity (Blascovich & Tomaka, 1991). Used in the 1994–95 Canadian National Population Survey, the RSE showed consistent relationships with age, education, current stress and social support.

More recently, self-esteem has been measured using the SISE. The item, "I see myself as someone who has high self-esteem", is scaled on a five-point Likert scale. Robins, Hendin and Trzesniewski (2001) provided extensive validation data for the SISE. Disattenuated correlations between the SISE and the RSE scale ranged from 0.91 to 0.99 and were exhibited for males and females, varying ethnic groups, across occupations and for individuals aged 17 to 61 years.

Sense of control

Perceived control, or sense of control, over life in general and work in particular shows considerable association with health and well-being (Karasek et al., 1981; Lachman & Weaver, 1998; Marmot & Smith, 1991; Schnall, Landsbergis & Baker, 1994). Sense of control is sometimes referred to as "mastery" or "personal mastery" (Pearlin et al., 1981). Pearlin and Schooler's Personal Mastery Scale is frequently used to asses the extent to which "people see themselves as being in control of the forces that importantly affect their lives" (Pearlin et al, 1981, p. 340). The seven-item scale has reasonable construct validity and internal reliability (Seeman, 1991). It was used in the 1994–95 Canadian National Population Survey where it displayed significant positive associations with education and social support and was significantly negatively associated with increasing childhood trauma, stress and life events (Stephens, Dulberg & Joubert, 1999). Lachman and Weaver (1998) reported results from three extensive studies using three to seven items of the Personal Mastery Scale in addition to five new items. Analyses showed two underlying factors of personal mastery and perceived constraints – with the former showing internal reliability in the range of 0.59–0.70 across the three studies and the latter showing internal reliability in the range of 0.60–0.86. Results showed that higher perceived mastery and lower perceived constraints were associated with better health and life satisfaction and lower depressive symptoms and that these otherwise moderated the impact of lower income.

With respect to work settings, there is a considerable body of research relating aspects of control, as measured by job demand and decision latitude, to physical and mental health outcomes (Kohn, 1995; Marmot & Smith, 1991; Schnall, Landsbergis & Baker, 1994). Twenty-seven of the items from the 49-item Job Content Questionnaire (JCQ: Karasek et al., 1998) are constructed to measure decision latitude, psychological job demand, work-related social support, physical demands and job insecurity. Decision latitude is a combination of skill discretion, decision authority and skill underutilization, while work-related social support is a combination of supervisor and coworker support. Fourteen items measuring job demand and decision latitude[1] were used in the cross-sectional USA Quality of Employment Surveys (Schwartz, Pieper & Karasek, 1988). Karasek et al. (1998) report internal reliabilities of the various scales ranging from 0.61 (job insecurity) to 0.86 (physical

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[1] Two items measuring skill utilization were not used.

demands). The JCQ has been used in Japan and China where its properties have been shown to be robust (Cheng, Luhm & Guo, 2003; Kawakami et al., 1995) except for psychological job demands where coefficients of internal reliability have been more variable (Cheng, Luhm & Guo, 2003). Factor analytic studies are variable in their confirmation of the JCQ scales, although most studies report robust factor solutions for decision latitude and psychological demand (Karasek et al., 1998).

Optimism

Optimism is generally associated with physical and psychological well-being (Scheier & Carver, 1992) and individuals with optimistic dispositions are more likely to have stable, problem-focused coping strategies (Carver et al., 1993; see also Chapter 3). Optimism has been shown to be relatively distinct from measures of self-mastery, trait anxiety, self-esteem and neuroticism. When the effects of these predictors are simultaneously controlled, optimism significantly predicts planning, positive reinterpretation and growth, seeking social support and turning to religion (Scheier, Carver & Bridges, 1994).

The Life Orientation Test – Revised (LOT-R: Scheier, Carver & Bridges, 1994) is a 10-item self-report measure developed to assess dispositional optimism. Respondents are asked the extent to which they agree or disagree using a five-point Likert scale with six items (e.g. "In uncertain times I usually expect the best") plus four "filler items" – these latter items not being used for measurement. Although the negatively-worded and positively-worded items tend to load on two factors, the authors of the LOT-R favour reporting the measure to have a single underlying factor spanning the optimism–pessimism range. Internal reliability for the set of six items is 0.78 and test-retest reliability ranges between 0.56 and 0.79 in comparisons spanning 4 to 28 months (Scheier, Carver & Bridges, 1994).

Individual indicators of mental health distress

While the approach to this chapter has been principally to detail indicators of positive mental health, some discussion needs to take place with respect to indicators of negative mental health or, more specifically, mental health distress. These are measures that attempt to globally rate the level of mental health distress in individuals or to document specific behaviours such as suicide.

The Kessler-10 (K10)

The K10 is a 10-item self-report questionnaire intended to yield a global measure of "psychological distress" based on questions about the level of restlessness, anxiety and depressive symptoms in the most recent four-week period (Kessler et al., 2003). The instrument comprises both low and high threshold items and is designed to yield most precision around the 90th to 99th percentile of the general population (Public Health Division, 2002). Each item is rated on a five-level ordinal scale based on the amount of time the person experiences these symptoms (from none to all) during a four-week period. The measure (and the shorter K6) has been used extensively in population surveys in the USA, Canada, Europe, Australia, New Zealand, Latin America, the Middle East, Africa and Asia.

The K10 compares favourably to other measures such as the General Health Questionnaire (GHQ), the 12-item Short Form Health Survey (SF-12) and diagnosis of anxiety and affective disorders measured according to the Composite International Diagnostic Interview (CIDI) (Andrews & Slade,

2001). Reliability values of the kappa and weighted kappa scores ranged from 0.42 to 0.74. Kessler at al. (2003) reported receiver operating characteristics for serious mental illness to be similar for both scales (area under the curve 0.854 and 0.865 respectively). Of the several screening scales assessed, the K6 was the most efficient, with a sensitivity of 0.36 (SE 0.08) and specificity of 0.96 (SE 0.02). The K10's reliability, validity and brevity make it a popular instrument as an indicator of population-level mental health distress.

Short Form Health Survey – 36 Item (SF-36)

The SF-36 was designed for use in clinical practice, research, health policy evaluations and general population surveys (Ware & Sherbourne, 1992). Originally designed as part of the RAND Medical Outcomes Study (MOS), it has been translated into over 35 languages and dialects and has an extensive and growing literature. The 36 items assess eight health concepts: limitations in physical activities because of health problems; limitations in social activities because of physical or emotional problems; limitations in usual role activities because of physical health problems; bodily pain; general mental health (psychological distress and well-being); limitations in usual role activities because of emotional problems; vitality (energy and fatigue); and general health perceptions. An additional item assesses perceived change in health. The survey can be used in interview or self-report formats and is generally suitable for ages 14 and older. Higher scores indicate a more favourable health status.

Internal reliabilities for the individual scales range from 0.73 to 0.96 and test-retest reliability coefficients after two weeks are excellent and range from 0.63 to 0.81. Of particular interest here are the five-item emotional well-being scale, the three-item scale measuring role limitation due to emotional problems and the four-item vitality scale, which have internal reliabilities of 0.95, 0.96 and 0.96 respectively (Brazier et al., 1992). Once appropriate coding has been applied the indicator for emotional well-being measures increasing levels of happiness and peacefulness and decreasing levels of anxiety and low mood. Higher scores on the items measuring role limitations owing to emotional problems denote fewer restrictions with work or other daily activities. Similarly, higher scores on vitality measure increasing energy and "pep" and decreasing levels of tiredness and fatigue.

The history of the SF-36, the extensive literature attesting to its properties and uses and the ability to use reduced versions and/or subscales or a combination of subscales make it a viable candidate as an indicator of mental health distress.

Suicide, self-inflicted injury and suicidal ideation

Suicide is taken *sine qua non* as an indicator of psychological distress by lay and professional people alike. The relationship between suicide and psychiatric disorder has been demonstrated time and again and suicide rates are commonly used or recommended as an indicator of cause-specific mortality linked to psychological state and psychiatric illness. However, there are several features that make it problematic as an indicator. Jurisdictions in both developed and developing countries have differing definitions and capacities to routinely monitor suicide. Suicide is often an illegal act and associated with considerable social, cultural and religious stigma. These features can affect reporting rates. In population terms, suicide remains a relatively rare event and is subject to considerable volatility at state or regional levels, within smaller subpopulations (e.g. the elderly or the young) and over short timespans. Thus, the rarity of the event, the nature of its reporting and

the complexity of its causal pathways make suicide a poor contender as a principal indicator of population mental health distress.

Rates of suicide mortality conceal the more prevalent and potentially more modifiable morbidity of self-inflicted injury. Self-inflicted injury is a term that encompasses several phenomena, many (but not all) of which are directly linked to psychological distress or psychiatric disorder. The term "self-inflicted injury" does not carry with it the pejorative connotations that terms such as "para-suicide" and "attempted suicide" carry. It is less subjective than the term "deliberate self-harm" which entails judgements about intent and lethality. Because of the greater prevalence of self-inflicted injury and its links to many common determinants of psychological distress (e.g. drug and alcohol use, depression and violence), as well as its association with subsequent suicide, the monitoring of population rates may provide a useful proxy of mental health distress.

Questions about suicidal ideation offer another means of directly probing psychological distress. Here respondents are asked questions such as, "Have you ever felt that life was not worth living?" or "Have you ever considered taking your life, or perhaps made plans on how you would go about it?" In a national study of the Australian population, the 12-month and lifetime cumulative incidence rates of suicidal ideation were estimated to be 3.4% and 16.0% respectively (Pirkis, Burgess & Dunt, 2000). Twelve-month ideation was associated with anxiety and affective and substance abuse disorders. Approximately 12% of those reporting suicidal ideation had progressed to making an attempt. Studies of young adults have shown marked variability in rates of suicidal ideation. Sell and Robson (1998) reported rates of suicidal ideation in UK students in the order of

Indicators of Positive Mental Health for Children

Elise Maher, Elizabeth Waters

Every child has the right to enjoy the highest attainable standards of health and to have an adequate standard of living for physical, mental, spiritual, moral and social development (Convention of the Rights of the Child, UNICEF). To achieve this, mental health promotion activities will need to give special recognition to children, as described elsewhere in this volume. A childhood mental health promotion approach recognizes the local and broader influences in the everyday lives of children and seeks to address these in a systematic way (NPHP, 2004). This involves strengthening children's individual capacities and the resources and capacities provided by families in the key contexts or environments in which children and families play out their daily lives. These include social communities such as local neighbourhoods and peer groups, care settings and schools.

Indicators of positive mental health for children are not well established. As with the adult indicators, the focus has tended to be on distress, with childhood mental health surveillance generally assessing levels of depression, suicide, bullying, aggressive behaviour, delinquency and substance misuse. However, work is occurring on developing indicators of children's positive mental health at each level of influence – individual (child and family), organizational and community (neighbourhoods, peers, childcare and schools) and societal (cultural, political and economic).

Indicators of positive mental health at the individual level generally refer to the presence of social connections and a strong sense of self and self-worth. These indicators may include measures of a sense of belonging, self-esteem, engagement, self-determination and control and quality of life (VicHealth, 1999; Zubrick et al., 2000b). Family indicators may include parental mental health, freedom from violence, family cohesion, parent-child attachment and use of responsive, developmentally-appropriate family and parenting practices such as monitoring children's activities and providing safe, secure environments for children.

Organizational and community indicators of positive mental health include the presence of safe supportive environments (e.g. access to safe play areas). In addition, the potential for school and childcare environments to enhance the development of children's self-worth and skills is determined by the quality of the social and learning environment and the extent to which staff acknowledge and value children's skills and accomplishments. These characteristics may be assessed with organizational or system-wide audits of staff/student ratios and the presence of policies and practices that promote equity and social justice, ensure child protection and minimize violence and bullying.

Societal indicators of positive mental health will vary with the economic development of the society. For resource-poor countries, indicators of children's mental health may include measures of access to essential requirements – clean water, adequate food and safe shelter. For countries with these basic resources, mental health indicators may assess equity and social participation for parents (such as educational participation, women's participation in the workforce, access to affordable quality childcare) and evidence of societal valuing and protection of children (e.g. universal provision of education and health care, legislation on children's rights and protection, including protection against exploitation in industry or for sex). Ultimately, indicators of positive mental health may include integrated and supportive child public policy and programmes, a strong legislative platform for child mental health issues and adequate resource allocation for child mental health.

The development of positive mental health indicators for children remains in its infancy. There is much conceptual and research work to be done before indicators can be identified that demonstrate the desirable properties suggested within this chapter. It may be useful to recognize the overlap that exists between the mental health and quality of life literature, and to build upon the work on pan-European country indicators of children's social and emotional well-being and quality of life (such as the KIDSCREEN measure of health related quality of life funded by the European Union).

Note: We gratefully acknowledge the contribution of Julie Green and Jan Nicholson.

7–9%, Swiss rates have been reported to be 45% (Rey Gex et al., 1998), and Australian rates have been reported to be as high as 61% (Schweitzer et al., 1995).

Once again, use of the prevalence of suicidal ideation as an exclusive measure of mental health distress remains questionable, however. Both the volatility and variability of these rates require further investigation, and a consistent measure of suicidal ideation needs to be applied in population studies over time to assess the responsiveness and value of such measures.

Determinants of mental health

In line with the discussion of macro-level indicators, demographic information from individuals is an essential component of data collection, particularly for those variables that have known associations with mental health. In addition to demographic determinants, social support and exposures to stressful life events are two areas that, because of their documented association with mental health, should be measured.

Demographic variables

Census items often form the basis of such a collection. Developers of mental health surveillance and monitoring systems are encouraged to carefully consider using items well matched to census collections in their regions and countries to allow population comparisons whenever possible. Critical demographic variables to collect when seeking information from individuals include their age, sex, family structure, place of residence, level of education, income, labour force status, current employment and long-term unemployment. These variables are essential to characterize populations and subpopulations and provide a vital descriptive context for the planning and targeting of mental health promotion opportunities.

Stressful life events

The measurement of stressful life events has enjoyed a lengthy study in the social sciences (Brugha & Cragg, 1990; Cohen, 1988; Dohrenwend et al., 1978; Holmes & Rahe, 1967; Sarason, Johnson & Siegel, 1978; Wethington, Brown & Kessler, 1995). Moreover, their association with poor mental health and psychiatric outcomes is well documented (Brown & Harris, 1989; Stephens, Dulberg & Joubert, 1999), although the establishment of their causal relationship to mental illness is plagued with considerable methodological challenges (Kessler, 1997). Recently, prospective longitudinal findings have documented a gene–environment interaction between exposures to stress and the expression of depression (Caspi et al., 2003). Additionally, life events show moderate correlation across related family members (i.e. familiality) and are associated with anxiety and depression in community samples (Rijsdijk et al., 2001).

Both the Standardized Life Events and Difficulties Interview (SL) of Kessler and Wethington (1992) and the Life Events and Difficulties Schedule (LEDS) by Brown and Harris (1989) offer interview formats of considerable depth and complexity that are beyond the bounds of application in large-scale population surveillance and monitoring. Of the smaller measurement instruments available, the Perceived Stress Scale (PSS: Cohen, Kamarck & Mermelstein, 1983) and the List of Threatening Experiences (LTE: Brugha & Cragg, 1990) merit mention here.

The PSS measures the degree to which situations in one's life are appraised as stressful (Cohen, Kamarck & Mermelstein, 1983, p. 385). As such, the scale measures perceived stress rather than life events per se. Designed to be used in community samples, the PSS comprises 14 statements (e.g. "In the last month, how often have you been upset because something happened unexpectedly?") rated on a five-point Likert scale. The PSS has good internal reliability (0.85) with two-week test-retest reliability of 0.85 and six-week test-retest reliability of 0.55. The PSS score is correlated with measures of depressive and physical symptomatology and social anxiety and is weakly correlated with life event scores (Cohen, Kamarck & Mermelstein, 1983). This latter finding is in keeping with its theoretical basis as a measure of perceived stress rather than as a measure of specific life

events. Cohen, Kamarck and Mermelstein (1983) also report using a four-item "abridged version" of the PSS that has moderate internal reliability (0.72). A 10-item version (PSS-10) has also been developed and used in large random samples of adults (Cohen, 1988; Cole, 1999).

In contrast to the PSS, the LTE comprises 12 major life event categories (e.g. "Your parent, child or spouse died") available in both interview and questionnaire formats. Respondents are asked to indicate whether any of these events has occurred within the last six months. With the exception of one item ("Something you value was lost or stolen"), six-month test-retest reliability for the remaining 11 events ranged from 0.78 to 1.0. Coefficients of agreement (kappa) with nominated informants ranged from 0.7 to 0.9 and the LTE has good concurrent validity when compared with the LEDS.

Social support

Social support is often conceptualized as an environmental variable; however, research shows that it is influenced by genetic factors (Kendler, 1997), correlated with personality and relatively stable over time (Sarason, Sarason & Shearin, 1986). Importantly, social support is not latent within the environment but rather is reciprocally maintained through the actions of individuals. Its association with health and more particularly positive mental health has been documented in longitudinal work (Cederblad et al., 1995). Stephens, Dulberg and Joubert (1999), using data from the 1994–95 Canadian National Population Health Survey, found social support to be "second only to current stress in its importance for mental health" (p. 123). In his review of concepts, measures and models, Barrera (1986, p. 414) noted that the term social support is "insufficiently specific to be useful as a research concept" and instead argued that more specific terminology is needed to distinguish social support concepts and measures and their association with outcomes of interest.

Broadly speaking, social support concepts concern three principal domains: the extent to which individuals are attached to significant others as measured by their social ties, participation in organizations, contact with friends and family and/or the complexity of their social network (e.g. social embeddedness); the individual's cognitive appraisal (e.g. perceived social support) of the availability and adequacy of support irrespective of the extent of the support; and the responses of others in the provision of emotional support, information, tangible care or material assistance (Barrera, 1986; Ruehlman, Lanyon & Karoly, 1999).

Given the conceptual diversity of social support and its extensive history of use in the social sciences, it is not surprising that there are a number of measurement devices of varying length and respondent burden cited as being of potential use (Korkeila, 2000). Some, such as the six-item short form of the 27-item Social Support Questionnaire, require the respondent to generate a roster of individuals who provide or could provide various types of social support and to then rate the level of satisfaction with the amount of support provided (Sarason et al., 1983; Sarason et al., 1987). Other approaches require respondents to self-report perceived availability of social support.

The Medical Outcomes Study Social Support Survey (MOS-SSS) is a 20-item self-administered scale used in large studies of patients seeking health care from physicians (Sherbourne & Stewart, 1991). It was used in the 1998–99 Canadian National Population Health Survey. The scale measures perceived availability of social support in four areas: emotional/informational, tangible, affectionate and positive social interaction. The authors report high convergent and discriminant validity, good one-year stability for each of the four subscales (0.72–0.76) and excellent internal

reliability, with alphas for each subscale ranging from 0.91 to 0.96. An overall support index score can be derived and has high internal consistency (alpha 0.97) (Sherbourne & Stewart, 1991).

Quality of life (QOL)

Measures of QOL have a lengthy history of development and use (Andrews & Withey, 1976; Diener, 1994). The measure is almost always an omnibus measure comprising several domains and facets and its inclusion here as a determinant is disputable both on the grounds of theory and content. One example is the WHOQOL-100, which has 24 facets, of which positive feelings, self-esteem, energy and fatigue, social support, financial resources and spirituality are a subset (WHOQOL Group, 1998). Other measures include the Centers for Disease Control and Prevention's Health Related Quality of Life (HRQOL) that contains four items, one of which probes the number of days in a month that an individual has poor mental health (e.g. stress, depression and problems with emotions) (Hennessy et al., 1994).

Hagerty et al. (2001) reviewed 22 of the most used QOL indexes from around the world, applying 14 criteria for judging validity and usefulness. Many were found to be reliable and have time-series and subpopulation observations. Many others fell short in any of four areas: coverage and definition; inability to distinguish input, throughput and output; insensitivity to public policy input; and lack of convergent validity (Hagerty et al., 2001). A recent report on the HRQOL addressed some of these concerns, providing assessments of time-series and concurrent validity (CDC, 2000).

QOL measures are not molar measures of mental health or mental ill-health. However, they may contain items and domains that directly probe both of these aspects of mental health and for this reason they are cited here.

Capacity building in mental health promotion

Before leaving the domain of indicators entirely, the development of indicators of capacity building in mental health promotion should be mentioned. The field of health promotion has had barely 20 years of development and within it the specific area of mental health promotion is considerably more recent. Many of the generic features that apply to the implementation of health promotion programmes and interventions certainly apply to mental health as well. Among these are approaches to capacity building.

Capacity building refers to "interventions which have changed an organization's or community's ability to address health issues by creating new structures, approaches and/or values" (Crisp, Swerissen & Duckett, 2000, p. 100). Capacity building also explicitly encompasses the development of health promotion skills and capabilities in individuals (Hawe et al., 1998). Four broad approaches to capacity building have been suggested: top-down organizational, bottom-up organizational, partnerships and community organizing (Crisp, Swerissen & Duckett, 2000). Goodman et al. (1998) suggest that the key mechanisms of capacity building include coalition building; networking; planning, management, delivery and evaluation of programmes; and acquisition and availability of human and material resources for health promotion. Each of these approaches and mechanisms carries with it different methods for measuring capacity building.

Whatever the approach or mechanism, four broad categories of activities may be undertaken to build capacity: workforce development, organizational development, resource allocation and establishment of partnerships (O'Hanlon et al., 2002).

Workforce development

Indicators of workforce development are more likely to characterize bottom-up organizational approaches. Indicators might include the presence of workforce or professional development programmes; policies to guide their content, implementation and access; and direct measures of staff attitudes, knowledge and skills and frequency or extent of participation in the programmes.

Organizational development

Indicators here include the creation, dissemination and implementation of policies governing mental health promotion and are more likely to be seen in top-down organizational approaches to capacity building. Measures of uptake of and compliance with policies and of the extent to which services and programmes are reorientated to promote mental health would be appropriate.

Resource allocation

Measures of the resources earmarked for, and made available to, health promotion activities and programmes could be assessed at an administrative level. Such resources could reflect budget allocation, human resources and the extent to which other resources are leveraged from research, private and nongovernment agencies. While measures of resource allocation are characteristic of top-down organizational approaches to capacity building, there is good scope to assess mental health promotion initiatives by category of funding to assess the level of partnership development.

Partnerships

Indicators of capacity building for partnerships might include basic measures of network density, collaboration and information sharing between organizations and the levels of participation from the key partners (Crisp, Swerissen & Duckett, 2000). Importantly, the strategy used by the partnership should be assessed. Himmelman (2001) has proposed four levels of coalition or partnership activity: networking, coordinating, cooperating and collaborating. Collaborating partnerships are those that entail high levels of trust between the partners and considerable empowerment of all participants in the partnership. In Australia, the Victorian Health Promotion Foundation (VicHealth) has developed a checklist to enable agencies to assess the extent to which partnerships are moving towards collaboration (VicHealth, 2003).

Conclusion

This overview of indicators has been deliberately selective. Particular attention has been devoted to demographic and social determinants at the macro level and at the level of measures on individuals. These are indispensable in any proposed framework that measures positive mental health. With the passage of time certain measures of determinants will be favoured over others – hopefully in response to good evidence and the development of better measures. Mental health promotion practitioners need careful descriptions of the contexts into which their interventions are placed and to know if these are reaching, much less affecting, target populations. For this reason, measures of the social and environmental determinants are critical.

The monitoring of positive mental health (and mental ill-health) is also relevant to the wider issue of human development. As such, there is a hierarchy of need where nations may place greater or lesser emphasis on developing and implementing measures of mental health and promoting positive mental health. The measures themselves have had a wider use than otherwise might have been expected in a field so early in its development. However, in the tradition of measuring illness rather than wellness, their usage reflects a better development and wider implementation of indicators of psychological distress and measures of stress and social support than measures of positive mental health. Better development and demonstration of the measures of positive mental health is needed.

Capacity building, and the use and application of results from data, are central concepts and activities in the surveillance of health and risk factors (McQueen & Puska, 2003). Our presentation here has been tentative and brief. Surveillance occurs over time, may involve global, national, regional and local levels, and will fail without the development of sustainable workforces, resources, organizations and partnerships. These are essential capacities to measure, and in most cases are prerequisites to establishing a surveillance capacity for mental health promotion.

The coverage of this chapter has entailed many notable omissions. The presentation largely ignores the fact that the selection and use of indicators is governed by prevailing political, community and religious values, practices and cultural customs. Additionally, health jurisdictions and data stewards are notoriously attentive with respect to proposed changes in collection schedules, specific contents and their comparability over time, and the evidence required to change existing collection methods and items. Also not highlighted are measurement issues within specific organizational settings (e.g. schools and local neighbourhoods), nor are lifespan aspects in the measurement of positive mental health (e.g. children, young people, adults of varying ages) discussed. Quality of life measures are only broadly mentioned, largely in favour of more molar measures of positive mental health and distress. Similarly, we have avoided documenting measures of specific mental illnesses or disorders (e.g. depression, anxiety) or those factors shown to be collinear with them (e.g. happiness).

In many areas the technical development and presentation of item reliabilities, scale reliabilities and validity, and associated correlates in some (but not all) of the measures cited here remains to be done – particularly cross-culturally and in developing nations.

A considered approach to the development of indicators of positive mental health should flow from well-articulated theory and there is a critical need for more theoretical development and research to support this. Current practice in the use of indicators has been predominately, although not exclusively, driven from need. As a result there has been an epidemiological emphasis on illness rather than wellness and, within this, an emphasis on physical health rather than mental health. This of course is changing as increasing global evidence has documented the existing and predicted toll that poor mental health will exact on individuals, families, their communities and nations. The size of this burden is acknowledged to be greater than existing or future services can meet. This makes the establishment and sustainability of positive mental health all the more critical. If prevention seeks to maintain levels of physical and mental health, and treatments seek to restore individuals to optimal levels of function, then establishing the nature of positive mental health and documenting its modifiable determinants is essential to enabling the practice of mental health promotion.

Acknowledgements

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Chapter 13 • The Evidence of Effective Interventions for Mental Health Promotion[1]

Clemens MH Hosman, Eva Jané-Llopis

Introduction

To fight the burden of mental disorders and to improve the mental health of populations you not only need sound philosophies and theories on the development of mental health in a community context, theory-driven and feasible intervention strategies and programmes, a supportive political climate, motivated advocates and trained practitioners, but also evidence that such programmes and policies actually work.

Over the last two decades, numerous studies in mental health promotion and mental disorder prevention (which the authors consider to be functionally related and overlapping fields: Hosman, 1997a, 1997b) have proven that such programmes can be effective and lead to improved mental and physical health and social and economic development (e.g. Albee & Gullotta, 1997; Durlak, 1995; Hosman & Jané-Llopis, 1999; Hosman, Jané-Llopis & Saxena, in press; Mrazek & Haggerty, 1994; Price et al., 1988). This chapter describes just a few examples of programmes and policies that have been shown to improve mental health or its determinants. As discussed in Chapter 9, there is considerable debate surrounding the type of evidence available and required to show that such programmes have been effective. The evidence of effective health promotion in this chapter has come primarily from controlled trials, including quasi-experimental studies and studies using a time-series design. Where relevant, evidence has also been taken from observational and qualitative studies, particularly for evidence from low income countries where resources are lacking for expensive controlled studies. An extensive overview of evidence-based programmes to prevent mental illnesses and to reduce the risk of mental ill-health is available in a forthcoming separate volume by Hosman, Jané-Llopis & Saxena (in press).

Macro interventions

Interventions at the macro level include improving nutrition, housing and access to education, reducing economic insecurity, strengthening community networks and reducing misuse of addictive substances. Each of these is discussed below.

Improving nutrition

There is strong evidence that improving nutrition in socioeconomically disadvantaged children can lead to healthy cognitive development and improved educational outcomes, especially for those at risk or who are living in impoverished communities. The most effective intervention models are those that combine nutritional interventions (such as complementary feeding, growth monitoring, food supplementation) with counselling and psychosocial care (e.g. warmth, attentive listening). Such programmes are also cost-effective (WHO, 2002a). For example, iodine is known to play a key role in preventing mental and physical retardation and impairment in learning ability (WHO, 2002b). Global efforts, such as those supported by UNICEF, have led to 70% of the world's households using iodized salt. This protects 91 million newborns from iodine deficiency (UNICEF, 2002) and therefore from the associated mental and physical health problems. (Other examples of nutritional intervention programmes that have had positive outcomes are discussed in Chapter 14.)

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[1] This chapter is based on: Hosman C, Jané-Llopis E, Saxena S, eds (in press). *Prevention of mental disorders: evidence-based strategies and programmes*. Oxford, Oxford University Press.

Improving housing

Poor housing has been used as an indicator of poverty and as a target to improve public health and reduce inequalities in health. A recent systematic review on the health effects of housing improvement suggested it has a promising impact on self-reported physical and mental health, perceptions of safety and social and community participation (Thomson, Petticrew & Morrison, 2001).

Improving access to education

Low literacy is a major social problem in many countries, particularly in South Asia and sub-Saharan Africa. Illiteracy and low education tend to be more common in women. Lack of education severely limits the ability of individuals to access economic entitlements. While there have been impressive gains in improving literacy levels in most countries through better educational programmes targeting children, there has been much less effort directed to today's adults with low literacy skills. Ethnographic research in India suggests that such programmes can have tangible benefits in promoting mental health. Cohen (2002) used observational data and interviews with key people involved to evaluate literacy programmes in the Indian states of Himachal Pradesh, Rajasthan and Delhi and noted that such programmes had benefits beyond the acquisition of literacy skills: classes had the potential to bring about social change as they brought women together in new ways and provided them with information and ideas from the wider world. The impoverished literate women and girls who became volunteer teachers also benefited from an increased sense of pride, self-worth and purpose. The positive mental health impact was mediated through a number of pathways, including the acquisition of numeracy skills that reduced the risk of being cheated, the development of greater confidence in expressing one's rights and a reduction in the barriers to accessing opportunities.

Evidence also indicates the success of initiatives using subsidies to close gender gaps in education (World Bank, 2000). For example, in the first evaluation of a school stipend established in Bangladesh in 1982, the enrolment of girls in secondary school rose from 27% to 44% over five years, more than twice the national average (Bellew & King, 1993). Evaluation studies in Pakistan have also illustrated that improved physical access to school, subsidized costs and culturally appropriate design can sharply increase the enrolments of girls (World Bank, 2000). Better education increases female cognitive-emotional and intellectual competencies and job prospects, and contributes to reduced social inequity and lowered risk for certain mental disorders such as depression.

Reducing economic insecurity

In many developing countries indebtedness to "loan sharks" is a constant source of stress and worry. Nongovernmental organizations such as the Bangladesh Rural Advancement Committee (BRAC) have developed programmes for poverty alleviation targeting credit facilities, gender equity, basic health care, nutrition, education and human rights issues. An evaluation of the BRAC poverty alleviation programmes, which reach out to millions of the poorest people in Bangladesh, indicates that the psychological well-being of women who are BRAC members is better than that of those who are not members (Chowdhury & Bhuiya, 2001). (The value of such programmes is discussed further in Chapter 14.)

Strengthening community networks

Community interventions have focused on developing empowering processes and building a sense of ownership and social responsibility within community members. An example of a community intervention is the Communities That Care (CTC) Programme that has been implemented successfully across several hundred communities in the USA and is currently being adopted in the Netherlands, England, Scotland, Wales and Australia (Developmental Research and Programmes, 1997; Hawkins, 1999; Hawkins, Catalano & Arthur, 2002; Hawkins et al., 1999). The CTC programme is a strategy for activating communities to implement community violence and aggression prevention systems. The strategy helps communities use local data on risk and protective factors to identify risks and develop action. This includes interventions that operate simultaneously at multiple levels: community (e.g. mobilization, media, policy change), school (e.g. changing school management structures or teaching practices), family (e.g. parent training strategies) and individual (e.g. social competence promotion strategies). The CTC strategy supports communities in selecting and implementing existing evidence-based programmes that fit to the risk profile of their community. To date this system has only been evaluated in the USA, with pre–post designs and comparisons with baseline data involving about 40 communities in each field test. These evaluations have found improvements in youth behavioural outcomes, parental skills and family and community relations, and decreases in school problems, weapons charges, burglary, drug offences and assault charges (Hawkins, Catalano & Arthur, 2002). Outcome studies in other countries are currently being undertaken.

Reducing misuse of addictive substances

Taxation, reduced availability and bans on advertising

Price is one of the largest determinants of alcohol and tobacco use. A tax increase that raises the price of tobacco by 10% reduces consumption by about 5% in high income countries and 8% in low income and middle income countries. Similarly, although the impact of price on the use of alcohol 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 about 10% in low income countries, although this latter figure is based on very limited data (Anderson, Biglan & Holder, in press). Increases in alcohol taxes are therefore a significant tool to influence health behaviour in the population. As substance use is well-established as a multiple risk factor in health and mental health (e.g. Anderson, 1995; Krug et al., 2002), measures to reduce use can be expected to generate multiple benefits such as less alcohol-related liver disease, fewer traffic accidents and other intentional and unintentional injuries (e.g. from family violence) and reductions in associated negative mental health impacts.

Laws that increase the minimum legal drinking age also reduce alcohol sales and problems among young drinkers. This strategy has the strongest empirical support (Grube & Nygaard in Anderson, Biglan & Holder, in press). Reductions in the hours and days of sale and number of alcohol outlets and restrictions on access to alcohol are associated with reductions in both alcohol use and alcohol-related problems.

An econometric analysis across 22 high income countries over the period 1970 to 1992 suggested that a comprehensive set of tobacco advertising bans reduced tobacco consumption by over 6%, while a limited set of advertising bans had little or no effect (Saffer & Chaloupka, 2000). Time-series analysis of 1970–83 data across 17 countries with full bans, partial bans or no bans on

alcohol advertising found that countries with a ban on spirits advertising alone had 16% lower alcohol consumption and 10% fewer motor vehicle fatalities than countries with no such ban (Saffer, 1991). Countries with bans on beer and wine advertising had an additional 11% lower consumption and 23% fewer motor vehicle fatalities than countries with spirits bans alone (Saffer, 1991). A USA-based study also showed that local alcohol advertising was a significant factor in motor vehicle fatalities, although it had a smaller effect than price (Saffer, 1997).

Supportive environments for substance reduction

Restrictions on smoking in public places and private workplaces reduce both smoking prevalence and average daily cigarette consumption among smokers (Borland et al., 1990; Chaloupka, 1992; Chaloupka & Saffer, 1992; Wasserman et al., 1991; Yurekli & Zhang, 2000). For example, one econometric analysis found that workplace smoking bans reduced smoking prevalence by 4–6% and reduced average daily cigarette consumption among smokers by 10% (Farrelly, Evans & Sfekas, 1999).

Reducing substance use during pregnancy

There is strong evidence that alcohol, tobacco and drug use during pregnancy increases the likelihood of premature delivery, low birth weight, long-term neurological and cognitive-emotional development problems (e.g. lower intelligence, attention deficit and hyperactivity disorder, conduct problems, poorer school achievements) and perinatal mortality (e.g. Brown & Sturgeon, in press; Tuthillet al., 1999). Premature birth and low birth weight are known risk factors for adverse mental health outcomes and psychiatric disorders (Elgen, Sommerfelt & Markestad, 2002). Substance abuse by the mother is also associated with the offspring becoming dependent on substances during adolescence and young adulthood (Allen, Lewinsohn & Seeley, 1998). Educational programmes to encourage pregnant women to abstain from substance use can have long-term mental health benefits. For instance, Windsor et al. (1993) evaluated a 15-minute behavioural intervention for pregnant smokers that showed a 6% increase in cessation. The babies of those who had quit smoking were 200 g heavier at birth than those who had not. Cutting down smoking also increased birth weight, but by only half this amount.

Meso and micro interventions

The early stages of life

There is more development in mental, social and physical functioning during the early stages of life than in any other period across the lifespan. What happens from birth to age three influences how the rest of childhood and adolescence unfolds (UNICEF, 2002). A healthy start in life greatly enhances a child's later functioning in school, with peers, in intimate relations and with broader connections with society. The major dimensions of a healthy start of life are social, physical and psychological well-being. Factors that can negatively affect this are poverty, violence, armed conflict, HIV/AIDS in the family, physical disease, infirmities, injuries, abuse, neglect, exposure to drugs prior to birth, poor nutrition and the quality of parental care. During pregnancy and infancy, affect regulation systems in the brain are developing and will evolve well in a safe, caring and responsive environment. Early traumatic events and lack of care and sensitive responsiveness by parents can harm the neurobiological development of such systems leading to chronic vulnerability to stressful conditions.

The child's psychological well-being, including cognitive skills, coping with stress, emotional resilience and sense of mastery, changes dramatically during this time. As the child interacts with the environment it develops a view of itself and the surrounding world that will continually provide interpretation and meaning through all stages of life. This is the time that all emotions, such as shame and anger, are first expressed by the child. The child must find ways to deal not only with these emotions but also with the adaptive challenges faced by their environment. The child's sense of empathy and sense of right and wrong are also established (Brown & Sturgeon, in press). Policies targeting family well-being, such as policies to alleviate economic hardship, family-friendly policies at the workplace or policies to provide access to childcare can lead to overall mental and physical health improvements in children and future adults.

Some examples of programmes intervening at the early stages of life are discussed below.

Home visiting

Most home-based interventions focus on educational strategies enhancing resilience and competence in parents and families. Evidence from home visiting interventions during pregnancy has shown health, social and economic outcomes of great public health significance, including improvement in mental health outcomes in both the mothers and the newborns. One example is the Prenatal and Infancy Home Visiting Programme, a two-year educational and support programme of home visits by trained nurses focused on impoverished adolescents who are pregnant for the first time (Olds, 1997; Olds, 2002). The programme, evaluated in a longitudinal RCT, had benefits for the newborns that included an increase of up to 400 g in birth weight, a 75% reduction in pre-term delivery, more than a two-fold reduction in emergency visits, a lessening of severity of hospitalizations when they did occur and fewer reports of maltreatment by age 15 in comparison to a control group who did not participate in the programme. During the four-year period post-intervention there was less punishment used by the mothers and the mothers increased their employment by 82% and postponed their second child by more than 12 months. The children had higher IQ scores. By age 15 the children were 56% less likely to have problems with alcohol or drugs, reported 56% fewer arrests and 81% fewer convictions and had 63% fewer sexual partners compared with children in the control condition. Families were better off financially, and the reduction in the government's costs for such families more than compensated for the programme's cost. Furthermore, the programme was most effective with the mothers who had the highest levels of psychiatric symptoms and distress; such families often benefited from specific programmes that addressed their multiple needs. The Prenatal and Home Visiting Programme has been replicated in other communities within the USA with comparable success, although important adaptations have been made to address relevant risk and protective factors. Recently some European countries have adopted the programme.

When tested against a similar paraprofessional model, the nurse home visitors programme produced better outcomes, with the paraprofessional programme showing only modest gains over the control condition. This information, coupled with outcomes from other studies, suggests that a less expensive paraprofessional model with full effectiveness has yet to be fully developed. As programmes with paraprofessionals might have a better prospect of large-scale implementation and a wider reach in the population, however, their impact on the population's health and mental health might still be substantial. Cost-effectiveness studies are needed in combination with feasibility studies, especially in the context of low income countries.

In disseminating, adopting and implementing such home visiting interventions it should be kept in mind that some programmes with nurses and social workers have not been found to be effective (Villar et al., 1992). This stresses the need to identify what the active ingredients are in the effective programmes. This knowledge can be translated into guidelines for developing the next generation of programmes or for adapting successful programmes to suit local circumstances at new sites.

Parenting interventions

There are effective preventive interventions for children who present with beginning conduct problems (Schinke, Brounstein & Gardner, 2002; Barlow & Stewart-Brown, 2000). Parent management training, for example, provides a behaviourally-based intervention that increases positive interactions and reduces coercive interaction cycles between the child and the parent. Such programmes reduce serious conduct problems and improve the child's social functioning. While many of these programmes are based in a clinic, videotaped training programmes can be almost as successful in reducing parental stress and physical punishment (Webster-Stratton, 1990). Such programmes can be especially useful for divorcing mothers. Forgatch and DeGarmo (1999) found school achievement was enhanced along with behaviour in the programme they studied. This programme has recently been adapted for use throughout Norway. Parents' participation in a parent training programmes at the start of elementary school can be quite high provided barriers to participation (such as low accessibility, costs, public attitudes and stigmatization) are addressed, which indicates they have general acceptance.

Preschool educational interventions

There are many community programmes for families with young children, such as family reading programmes in libraries, health screening clinics, organized recreation activities and television programmes that teach elementary reading skills and socioemotional values. While many of these programmes are open to the general public, it is often the case that families with lower economic resources are not aware of or do not make full use of them.

The High/Scope Perry Preschool Project demonstrated very long-term effects from a weekly half-day preschool intervention combined with home visits during a two-year period at ages three and four. Children in the intervention, who were African-American and came from impoverished backgrounds, had improved cognitive development, better achievement and school completion and fewer conduct problems and arrests than the control children in a randomized study. For example, significant benefit was found at age 19 and age 27 on lifetime arrests (40% reduction) and repeated arrests (a 7-fold reduction: Schweinhart, 1997; Schweinhart & Weikart, 1997).

Speech and language skills of children born in impoverished families or families from minorities can often develop more slowly than in other children. There is strong evidence that early interventions starting at age two that promote basic reading skills, such as dialogic learning where children engage in conversations with their parents about picture books, improve reading skills and facilitate the transition to school (Valdez-Menchaca & Whitehurst-Grover, 1992).

A number of rigorous evaluations of preventive interventions for children born into poverty and for low-birth-weight infants have been conducted. The Carolina Abecedarian Project (Ramey & Campbell, 1984; Ramey, Campbell & Blair, 1998) involved a centre-based day care programme from infancy to age five. The intervention involved high-risk families, including those where the parents had low education and income, a family history of mild retardation or school failure, or

psychopathology or social maladaptation. Day care focused on a comprehensive programme of language, cognitive, perceptual-motor and social development, with attention also paid to nutrition. Improvements in IQ scores were dramatic, starting at 18 months and extending to 54 months. Throughout this time the intervention children's IQ scores were at the normal level while control children's scores declined (Ramey, Dorval & Baker, 1983). When the intervention was continued into elementary school, the incidence of grade failure dropped from 50% to 16% in this high-risk sample. Results on academic achievement were seen as far out as age 12. This study also provided one of the few tests of early versus later intervention: the strongest outcome was found in the group with the earliest intervention.

The Infant Health and Development Programme was aimed at improving outcomes for low-birth-weight babies (less than 2500 g) and premature babies (born before 37 weeks gestational age). From the time of neonatal discharge to age three these families received home visits and from 12 months to age three they attended a centre-based preschool five days a week. This intervention was intensive. The total programme cost was estimated at 15 000 US dollars per year per child. At 36 months the children in the intervention group had higher IQ scores, with the heavier children having double the gain of the children with the lowest birth weights (13 points compared with 7 points). Behaviour problems as reported by the mothers were also reduced. There were, however, no differences based on birth weight in failure to thrive. In the intervention group failure to thrive was related to low levels of programme participation. Mothers were more likely to be employed and return to work and health care services were more commonly used in the intervention group. By age five and again at age eight, the earlier beneficial effects on IQ and vocabulary were somewhat reduced, although still with better outcomes for the heavier low-birth-weight children.

Questions have been raised regarding whether home-based interventions and parenting approaches are effective uses of resources. The few cost-effective evaluations undertaken in this area seem promising, however (e.g. Olds, 1997). Moreover, interventions that can make a difference early in life and that have a simultaneous impact on the physical and mental health of parents and their babies have the potential to prolong their effects during the children's lives as well as have an impact on later generations.

School settings

Schools have become one of the most important settings where preventive and wellness promotion interventions for children and youth are conducted. This is due in part to the convenience of conducting interventions in a setting where the target population spends the majority of its time. It also reflects the fact that in addition to their central role of fostering academic development, schools serve an important role in the health and social-emotional development of students (Elias et al., 1997; Weare, 2000).

Many countries are committed to universal systems of primary education. This is not the case in all developing countries, however, but the number of youth attending school is increasing. Despite variation in the amount of time that children spend in school, these are the primary institutions for socialization in many societies.

To become well-rounded individuals, effective citizens and healthy adults, children need to develop social and emotional competencies (Domitrovich et al., in press). They also need the confidence to use these skills constructively and opportunities to enact their skills in order to facilitate the development of a sense of identity. This process, often called "social and emotional learning" (SEL),

is the means by which children acquire the competence to understand, manage and express the social and emotional aspects of their lives in ways that enable the successful management of life tasks (Elias et al., 1997). The CASEL website (www.casel.org/index.htm) offers a rich source of evidence-based programmes that enhance social-emotional learning, as well as numerous materials that can be downloaded to support the implementation of such programmes across communities, countries and regions.

There is ample empirical evidence that providing universal programmes to groups of students can influence positive mental health outcomes. Several types of interventions at the school level have been identified as achieving improved competence and self-worth, as well as decreasing emotional and behavioural problems. While some interventions target the school in an integrated approach, others target only one part of the school system (e.g. children in a given grade) or a specific group of students that are identified to be at potential risk for emotional or behavioural problems (targeted interventions). The following discussion looks briefly at examples of some of these. Recent reviews on mental health promotion and prevention programmes in schools by Domitrovich et al. (in press) and Greenberg, Domitrovich and Bumbarger (2001) provide more detailed descriptions of these types of interventions.

General social/emotional cognitive skill building programmes

Shure and Spivack (1982) created a universal skill building programme called "I Can Problem Solve" for children in kindergarten. Studies have demonstrated that the programme significantly improves cognitive problem-solving abilities and reduces inhibition and impulsivity. These effects were still found at one-year follow-up (Shure, 1997).

A similar programme for older students is the Improving Social Awareness – Social Problem Solving (ISA-SPS) Programme, which aims to promote social competence in middle school by teaching problem-solving and social skills. The programme has been shown to lead to improvements in youth self-reports of coping with stressors related to middle school transition and teacher reports of behaviour, along with significant reductions in measures of adjustment and psychopathology at six-year follow up. The comparison boys had higher rates of involvement with alcohol, violent behaviour toward others and self-destructive/identity problems. The comparison girls had higher rates of cigarette smoking, tobacco chewing and vandalism (Bruene-Butler et al., 1997; Elias et al., 1991).

Another example of an effective intervention is the Promoting Alternative THinking Strategies (PATHS) Programme (Greenberg & Kusche, 1994) that teaches students social, emotional and cognitive skills. This programme includes components for teachers, parents and the overall school context. Several RCTs of PATHS have demonstrated an improvement in student emotional knowledge and problem-solving skills and fewer internalizing problems (e.g. depression, anxiety, eating disorders) and externalizing problems (e.g. conduct disorders, aggression, substance use, vandalism) (Conduct Problems Prevention Research Group, 1999; Greenberg & Kusche, 1998; Greenberg et al., 1995).

As students get older and are faced with new challenges, such as peer pressure to engage in delinquent behaviour or substance use, social-emotional skills become particularly important to maintaining health and positive development. School-based skill building programmes that are geared for middle and high school students often serve as both mental health promotion and substance abuse prevention programmes, particularly when problem-solving is geared towards addressing these issues. The Positive Youth Development (PYD) Programme is one example that is

designed to promote general social competence, stress management, problem-solving skills and refusal skills related to alcohol and drug use. Weissberg, Barton and Shriver (1997) found that the 20-session school-based programme produced significant improvements in students' problem-solving and stress management skills as well as teacher reports of social adjustment.

Changing school ecology

Ecologically-focused preventive interventions attempt to address contextual variables in the child's home or school. An example of a programme aimed to promote a supportive environment in schools is the School Transitional Environment Project (STEP) (Felner & Adan, 1988; Felner, Ginter & Primavera, 1982; Felner et al., 1993). This programme involves restructuring the school environment and has been shown to reduce stress, anxiety, depression and delinquent behaviour as well as to improve students' academic progress.

The Good Behaviour Game (Barrish, Saunders & Wolf, 1969) is a universal programme that promotes positive behaviour and rule compliance in the classroom through reinforcement. Several evaluations of the programme have shown significant reductions in teacher ratings of aggression for both boys and girls, peer ratings of aggression and teacher ratings of shy behaviour for participants compared to comparison students (Dolan et al., 1993). Significant effects on teacher-rated aggression after five years were reported for boys who were rated moderately or highly aggressive at baseline (Kellam et al., 1994). The Good Behaviour Game has been adapted for use in the Dutch school system and similar outcomes were found in a population-based randomized trial evaluation (Van Lier 2002; Van Lier et al., submitted).

Other examples are the Child Development Programme (CDP), which through training school personnel to promote self-control and create a positive learning environment reduced student's self-reported delinquency (Battistich et al., 1996), and the Norwegian Bullying Prevention Programme, which used individual, school and community level strategies to reduce bully/victim problems and broader antisocial behaviour (Olweus, 1997, 1992).

Multicomponent programmes

Programmes that focus simultaneously on different levels, such as changing the school ecology as well as improving individual skills in the students, are more effective than those that intervene solely on one level because they take into account the wider environment in which the children live. Examples of effective multicomponent programmes include the Linking the Interests of Families and Teachers (LIFT) Programme, which demonstrated reductions in student aggression, particularly for those most at risk (Reid et al., 1999), and the developmentally-sequenced Seattle Social Development Project (Hawkins et al., 1992), which addressed multiple risk and protective factors across the individual, the school and the family over a six-year intervention. Students in this programme had significantly stronger attachment to school, improvement in self-reported achievement and less school misbehaviour than control students (Hawkins, Von Cleve & Catalano, 1991; Hawkins et al., 1999).

Targeted programmes

Interventions enhancing emotional resilience have been implemented with children and adolescents undergoing stressful life events and children vulnerable to depression or anxiety disorders. These programmes generally include teacher training, parent involvement and direct training of the children's cognitions and skills, which can be generic in nature (e.g. problem and social solving skills, self-efficacy) or specific to the problem (e.g. safety behaviour, coping with threat and fear).

School-based programmes targeting children suffering from high stress levels (Hains, 1992, Hains & Szyjakowski, 1990; Kiselica et al., 1994), children and adolescents from immigrant families (Barrett, Sonderegger & Sonderegger, 2001), refugee children (Barrett, Moore & Sonderegger, 2000) and children suffering from parental divorce (Alpert-Gillis, Pedro-Carroll & Cowen, 1989; Wolchik et al., 1993) or death of a parent (Sandler et al., 1992) have demonstrated improved emotional and behavioural functioning as well as reductions in depressive and anxious symptoms.

Recently, Australian researchers have made significant progress in preventing child anxiety disorders by modifying a successful CBT programme for anxiety disorders into a prevention format (Lowry-Webster, Barrett & Dadds, 2001; Dadds et al., 1999; Dadds et al., 1997). This so-called FRIENDS programme, based on the Coping Koala programme (Barrett, Dadds & Rapee, 1996), is an Australian modification of the Coping Cat anxiety programme for children (Kendall, 1990). Its efficacy has been demonstrated both for universal and targeted groups. For example, the preliminary results of a randomized trial involving children in classes from grades 5 to 7 suggest that the intervention resulted in a significant reduction of anxiety symptoms, regardless of the initial risk status (Lowry-Webster, Barrett & Dadds, 2001). In addition, 75% of children in the intervention group who were at risk at pre-test (high anxious group) were no longer at risk post-test, while 55% of children who were at risk at pre-test in the comparison group remained at risk at post-test. Similarly, a trial investigated a targeted group of children who had anxiety features but no disorder prior to an intervention. At six-month follow-up, 16% of the intervention group had progressed to a diagnosable disorder compared with 54% of the monitoring-only group. FRIENDS is widely used in public and private schools, community health centres and hospitals across Australia and has been adopted by other countries such as Sweden, the USA and the Netherlands.

Another school-based Australian resilience building programme is the Resourceful Adolescent Programme (RAP), which has both adolescent and combined parent-adolescent versions. The programme, evaluated with a quasi-experimental design and an equivalent control group, showed a two thirds reduction in depressive symptoms (Shochet et al., 2001). There were no significant differences between the two intervention versions.

Another example of an efficacious school-based programme for children at risk is the Penn Resiliency Programme (PRP) which aims to change cognitive distortions and improve coping skills in children with depressive symptoms (Gillham et al., 1995). Its outcomes have been replicated across trials and indicate reductions in depressive symptoms by half, which are sustained over two years. The PRP (also called the Penn Optimistic Programme) has been adapted and implemented with success in China, reducing and preventing levels of depressive symptoms for up to six months for children and adolescents at risk (Yu & Seligman, 2002). This programme's results are of great importance as they show the feasibility and effectiveness of programme adaptation to different cultural situations.

Adult populations

Reducing the strain of unemployment

Retrenchment and job loss can cause serious mental health problems. A study of maternal work status in a sample of USA women living in poverty indicated that not working and receiving welfare was associated with negative cognitive and behavioural outcomes for children, lower maternal mental health, less social support and more avoidant coping strategies (Brooks-Gunn et al., 2001). It has been recommended that work reforms be developed and implemented with the

ultimate goal of moving poor women out of low-wage work and into work that will allow them to become economically self-sufficient over the long term. Priorities include the provision of a living wage, post-secondary education and job training (O'Campo & Rojas-Smith, 1998).

Counselling or job search training for low income unemployed groups can be an effective strategy to enhance coping with unemployment and to reduce the negative outcomes on mental health, as evidenced by the JOBS Programme (Price, Van Ryn & Vinokur, 1992). This programme consists of five intensive half-day workshops held over one week that focus on identifying effective job search strategies, improving participant job search skills and increasing self-esteem, confidence and motivation to persist in job search activities. The programme is delivered by two trainers to groups of 12–20 job seekers. It has been tested and replicated in large-scale randomized trials in the USA (Caplan et al., 1989; Van Ryn & Vinokur, 1992; Vinokur et al., 1995; Vinokur et al., 2000) and Finland (Vuori et al., 2002). It has been shown to have positive effects on rates of re-employment, the quality and pay of jobs obtained and job search self-efficacy and mastery, as well as reduce depression and distress. The JOBS Programme has also been successfully disseminated in China and Ireland.

Stress prevention programmes at the workplace

There is evidence that work characteristics may cause or contribute to mental health problems (e.g. burnout, anxiety disorders, depression, sleeplessness), gastrointestinal disorders, cardiovascular illness and musculoskeletal disease, and produce a social and economic burden for health and human services (Price & Kompier, in press). Interventions to reduce work stress may be directed either at the coping capacity of employees or at the working environment. Coping capacity can be increased by stress management training, stress inoculation techniques, relaxation methods and social skills and fitness training. Several metastudies show that such methods are effective in preventing adverse mental health outcomes in work environments (Murphy, 1996; Van der Klink et al., 2001).

The outcomes of interventions to reduce stressors in the work environment have recently been discussed by Semmer (2003). Semmer distinguishes between task and technical interventions (e.g. job enrichment, ergonomic improvements, reduction of noise); interventions targeted at improving role clarity, conflict management and social relationships; and interventions that combine work-directed and person-directed interventions. These social interventions may cause – but do not guarantee – positive effects. For instance, Heaney, Price and Rafferty (1995) reported on a large-scale randomized trial testing the Caregiver Support Programme (CSP). This programme aimed to increase the ability of teams of caregivers in health and mental health facilities to mobilize socially supportive team behaviour and problem-solving techniques to increase their coping resources. The programme involved six training sessions and training groups consisted of approximately 10 home managers and 10 direct care staff. Results 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. The programme also enhanced the mental health and job satisfaction of those who attended at least five of the six training sessions. The CSP also had positive effects on the mental health of those employees most at risk for leaving their jobs.

The elderly

In the year 2000 more than 600 million people worldwide were aged over 60. This figure is expected to increase by 70% in the next 20 years. This rapid increase in the ageing population implies a shift in the demographic structures in both developing and developed countries and will bring with it an increase in age-related physical and mental health problems (Levkoff, MacArthur & Bucknall, 1995).

Different types of interventions have been successful in improving the mental health of universal elder populations, such as public awareness of elderly depression, social support and community empowerment interventions, and interventions promoting healthy lifestyles (Jané-Llopis et al., in press). Similarly, interventions to promote mental health have also proven efficacious in elder groups considered to be at risk for mental health problems such as depression or suicide. Effective strategies include patient education about chronic medical conditions and strengthening social support. As an illustration of such programmes we discuss the outcomes of exercise interventions, befriending programmes and the provision of hearing aids.

Exercise

Exercise has been frequently advised for elder populations to deal with the physical disabilities that age can bring. Although there is yet no convincing evidence that exercise can lead to increases in cognitive function such as memory (Fletcher & Breeze and Walters, 1999), recently some controlled studies have suggested that exercise, such as aerobic classes, t'ai chi and weight-lifting, does provide psychological benefits including reduced depressive symptomatology and increased mental well-being in clinical and non-clinical elder populations (Deuster, 1996; Fletcher, Breeze & Walters, 1999; Mather et al., 2002; Singh, Clements & Fiatarone-Singh, 2001).

Taiwan offers an example of a culture where physical exercise, specifically t'ai chi, is widely practiced by elders. Chen, Snyder and Krichbaum (2001) conducted a cross-sectional, comparative study to compare the differences in physical and psychological well-being of Taiwanese community-dwelling elders who had practiced t'ai chi for one year or longer with those who did not practice t'ai chi or exercise. Results showed that those who practiced t'ai chi had better physical and mental health status, lower blood pressure, fewer falls within the past year, less mood disturbance and more positive mood states than those who did not. Similar results were found in a Chinese cross-sectional study in Macao (Ning et al., 2001). Physical exercise among the elderly contributed independently to the prediction of the depressive symptoms measured by the Chinese CES-D. Even more convincing are the outcomes of an RCT on the impact of a six-month t'ai chi exercise programme performing slow rhythm movements. Results indicated that elderly people who participated in the programme showed higher levels of health perceptions, life satisfaction, positive affect and well-being and lower levels of depression, negative affect and psychological distress than controls (Li et al., 2001). Although these studies only partly offer causal evidence, their outcomes underscore the close relationship between mental and physical health among elders and the need for health promotion policies that integrate strategies to improve physical and mental health. (See Chapter 11 for a more detailed discussion of the relationships between mental health and physical health.)

Befriending

During the last two decades various studies have found evidence for the significance of friendship for the well-being of older people, especially for older women (e.g. Armstrong & Goldsteen,

1990). Friendships can have multiple functions, such as providing companionship and pleasure, providing support in situations that are problematical and stressful, and sustaining identity and meaning. Befriending is a widely used strategy to increase social support and to reduce loneliness and depression among the elderly but has only incidentally been evaluated using control groups. A study of one befriending programme for older women, consisting of 12 group sessions and based on theories of social support, friendship and self-help, found significant reductions in loneliness (Stevens & van Tilburg, 2000). Twice as many women who followed the programme were successful in reducing their loneliness significantly than in the matched control group (47% versus 25%). More than two thirds (67%) of the participants reported having made new friends since participating in the programme. Unfortunately, no other controlled outcome studies on befriending programmes are available among non-clinical community-dwelling elderly.

Hearing aids

Another example of mental health promotion among the elderly is an intervention set in primary care clinics to assess whether hearing aids could improve the quality of life of elderly people with hearing loss (Mulrow et al., 1990). A screening survey identified 194 elderly veterans with impaired hearing. Hearing aids were provided to 95 randomly selected veterans; the other 99 joined a waiting list control. At baseline, 82% of subjects reported adverse effects on quality of life due to hearing impairment and 24% were depressed. At follow-up, there were significant improvements in social and emotional function, communication function, cognitive function and depression in those subjects who received the hearing aid as compared to those who did not. For depression an effect size of 0.80 was found, pointing at a large mental health effect.

Conclusions

Especially over the last 20 years, major progress has been made in developing mental health promotion programmes and policies that work. As the examples in this chapter show, mental health promotion is a realistic option within a public health approach across the lifespan and in settings such as perinatal care, schools, workplaces and local communities. Well-designed interventions can contribute to better mental health and well-being of the population. In addition, growing evidence is available that mental health promotion also generates a variety of social and economic benefits.

Policy-makers, service providers, local authorities and practitioners who are searching for effective interventions in response to local or national mental health needs should take full advantage of interventions that have been developed, implemented and tested elsewhere. However, retrieving relevant scientific knowledge from the fast-growing number of publications on evidence-based interventions is time consuming. For this reason, people frequently refrain from searching for such knowledge. Especially in low income countries, access to scientific journals and books is also a serious problem. Such barriers and costs can be reduced by initiatives making evidence more easily accessible through electronic databases and registries, enabling direct access to publications through the Internet and regular reviews of recent research, and providing indicators to assist in estimating the quality of the offered evidence. Several organizations have developed or are currently developing internationally accessible databases on evidence-based prevention and health promotion programmes, including those targeting mental health. Examples of such databases are those provided by the USA Centers for Disease Control and Prevention (CDC), the

Cochrane library, CASEL, the USA Substance Abuse and Mental Health Administration (SAMHSA) and the Nijmegen Prevention Research Center in collaboration with the EU and WHO. Details of these databases are provided in table 13.1.

Although this chapter has presented a number of examples of effective interventions, and does not pretend to present an exhaustive overview, we still have to conclude that the evidence is rather limited. For many of the discussed programmes and strategies the evidence is based on only one or two well-designed outcome studies, mostly performed in affluent countries. Only recently has a new generation of studies emerged aiming to compare outcomes of programmes and policies across countries or cultures. Our knowledge on the robustness of findings across sites and their sensitivity to cultural and economical circumstances is still meagre. This is a serious problem in the context of the many recent efforts to disseminate best practice or model program-mes across communities and countries. We need to be cautious in assuming that a programme that may have worked in one place will work again when implemented in different communities under different circumstances. In addition, one needs to take into account that this chapter has presented only examples of success stories. There is ample reason to believe that mental health promotion programmes show a wide variation in effectiveness and that information on outcomes is still lacking for many programmes in practice. This means that initiatives to disseminate effec-tive or promising practices and to stimulate their adoption and implementation elsewhere should go hand in hand with efforts to perform new outcome studies. Developing the evidence base for mental health promotion is an incremental affair. Further investments in studying the efficacy and effectiveness of these programmes, supported by national research and development policies, are needed.

It is not realistic to expect that every country or district has the political will and the means to perform controlled outcome studies for each intervention they implement, however. Especially in low income countries, the lack of resources means authorities and practitioners take decisions on opportunities to promote mental health with a minimum of scientific evidence based on their own practices. This stresses the need to study not only the outcomes of programmes but also their working mechanisms, principles and effect moderators. Such knowledge and its translation into guidelines can support policy-makers, programme designers and practitioners in adapting programmes and policies to local needs, resources and culture so they will be effective. It also underlines the need to use the full spectrum of research methodologies, including less expensive qualitative studies, to build an evidence base incrementally that has validity for the country or community in question.

Table 13.1
Examples of electronic databases on evidence-based health promotion and prevention programmes

Name	Organization	Health Topics	Website
Guide to Community Preventive Services	USA Centers for Disease Control and Prevention	Alcohol, mental health, substance abuse, nutrition, pregnancy, violence, sexual behaviour, among others	www.thecommunityguide.org
Cochrane Library	Cochrane Foundation	Wide variety of health issues	www.cochrane.org
National Registry of Effective Prevention Programmes (NREPP)	USA Substance Abuse and Mental Health Services Administration (SAMHSA)	Substance abuse and mental health	www.samhsa.gov
Social and Emotional Learning Library	The Collaborative for Academic, Social and Emotional Learning (CASEL)	Social-emotional learning and school-based programmes	www.casel.org/home/index.php
International Mental Health Promotion Action Database (IMPHA)	Nijmegen Prevention Research Centre, in collaboration with EU and WHO	Mental health and substance use	www.preventioncenter.net

Source: Hosman, Jané-Llopis & Saxena, in press

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Chapter 14
The Evidence for Mental Health Promotion in Developing Countries

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Introduction

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, far less research has been conducted in developing countries than in wealthier countries (Patel & Sumathipala, 2001).

It is likely, therefore, that there will be little specific evidence, in particular based on RCTs, which demonstrates the impact of social and economic development policies and programmes on the promotion of mental health (see Chapter 9). The evidence that does exist includes narrative and case study material of specific programmes and evidence from the domain of physical health promotion that may be extrapolated to mental health. These programmes focus on three major areas of action: advocacy, empowerment and social support. Examples of such programmes and policies include equitable economic development, micro-credit schemes, literacy promotion, promotion of gender equality, and violence and crime prevention programmes. In this chapter we consider the practical implications of addressing the social and economic determinants of mental health, the types of evidence which should be generated in the future to study the impact of various programmes and policies on mental health promotion, the scope of activities which can legitimately be construed as mental health promoting in developing country contexts, and the nature of and possibilities for strategic alliances between mental health promoters and other role-players aimed at achieving mental health goals.

Human development and mental health

Earlier in this volume, the powerful influence of a range of social and economic factors on mental health has been documented (see, for example, Chapter 10). These include lack of education, lack of employment opportunities, financial difficulties, violence, conflict and social exclusion. These risk factors are similar to the various indicators used to measure human development. The first Human Development Report released by the UN Development Programme in 1990 opened with the lines:

> The real wealth of a 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 (UNDP, 1990, p.1).

It is our contention that mental health is an implicit component of this definition, for there is good evidence that poor mental health will compromise longevity, general health and creativity. Thus, the factors that influence human development will be those that also influence mental health; causality is not likely to be simple or unidirectional as 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, 2001b).

The indicators used to measure human development are varied, and show great variation between countries. As discussed in Chapter 12, the UN Human Development Reports rank countries according to an overall Human Development Index (HDI), which is computed on the basis of a number of variables: life expectancy at birth (as an indicator of a long and healthy life), adult literacy rate and combined school enrolment ratio (as indicators of knowledge) and adjusted per capita income (as an indicator of a "decent standard of living"). Of the 173 countries or territories for which the HDI was computed in the 2002 report, 53 were ranked as being in the high category, 84 in the middle category and 36 in the low category. A scan of the list of countries in each category reveals that two thirds of the countries in the high category are from Europe, North America, Australia and New Zealand; put another way, all the countries of Western Europe, North America and Australia/New Zealand are in the high HDI category. However, there are also countries from Asia (such as Japan and South Korea), the Caribbean (such as the Bahamas and Trinidad and Tobago), Latin America (Uruguay and Argentina) and at least one African country (Seychelles) in the high category. Most of these countries continue to be classified as "developing" on indicators of income. The link between economic prosperity and human development is not straightforward; thus, two countries with similar income levels can have very different HDI values and vice versa. At the other end of the scale, all but six of the low HDI countries are from sub-Saharan Africa and these six are all from South and South-East Asia.

The use of the HDI shows that there is a huge diversity between countries that have traditionally been lumped together as developing. These diversities are further reflected in a range of adverse social and economic factors that 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. A good example of an indicator that shows such variation is longevity, an indicator of overall health. The great diversity within developing countries is reflected in the fact that there is a gap of more than 20 years between sub-Saharan Africa (average life expectancy at birth of 48.7 years) and Latin America (70 years), which is almost the same as the difference between low HDI and high HDI countries (24 years). Similar gaps can be found in indicators such as school enrolment and educational achievement, access to clean drinking water and sanitation, burden of nutritional and infectious diseases (including HIV/AIDS) and infant mortality. Disparities are evident both between major geographical regions and within geographical regions; indeed, enormous disparities exist even within countries. Political commitment to public health and social welfare show similar disparities; sadly, some of the poorest countries in the world continue to spend more on the military than on education and health. The numbers of internally displaced people 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.

Despite this picture of diversity in HDI, and the fact that the HDI tends to be much worse in developing countries, it is important to recognize the reassuring finding 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.

The evidence

At the outset we must acknowledge that there are no experimental studies such as RCTs that are available from low or middle HDI countries (to the best of our knowledge, anyway) that demonstrate the impact of any intervention on the promotion of mental health in its broadest sense. In any event, we believe that such a methodology has a very limited role to play in demonstrating the effectiveness of interventions which, as the earlier discussion has suggested, is likely to be the result of macro-level policy changes on individual health outcomes. While it may be tempting to use indicators of mental illness and suicide in an ecological analysis of countries to test whether these policies are associated with better mental health, we believe that such an approach can lead to serious difficulties in interpretation for two reasons. First, the promotion of mental health, as other authors in this volume have set out, is more than the absence of mental illness. Second, ecological analyses may not be able to tell us about the role of unknown confounders that may influence the associations, not least because interventions are often diffuse and temporally spread out. (For a fuller discussion on the usefulness of suicide as an indicator of mental health, see Chapter 12.) On the other hand, if we choose the absence of mental illness as one indicator of mental health promotion there is some quantitative evidence that is available from developing countries that we present below. We also use other kinds of evidence, such as narrative evidence and case studies, which capture the impact of social and economic interventions on people's well-being and quality of life. As well, we present examples of interventions that target the known risk factors for poor mental health, even if specific evidence pertaining to mental health is not available. We believe that the lack of evidence is often because the programmes or policies were not implemented with mental health outcomes in mind and thus these were not measured. The lack of measurement does not imply lack of effectiveness, however. Finally, where possible, we extrapolate from evidence from high HDI countries to speculate on the impact of similar interventions in low HDI countries.

The following discussion presents the evidence under the broad classifications of advocacy, empowerment and social support (Dhillon & Philip, 1994). This is not to suggest, however, that programmes are strictly limited to only one of these domains.

Advocacy

The aim of advocacy is to generate public demand for mental health, place mental health issues high up on the political and community agenda and effectively convince all stakeholders to act in support of mental health. Advocacy may be directed to a variety of stakeholders, including politicians, religious leaders, professionals and community leaders.

Reducing substance abuse

The Global Burden of Disease Study has shown that alcohol and drug abuse disorders are among the leading causes of morbidity and mortality in developing countries, especially for men. There is a growing awareness of the epidemic of alcohol abuse disorders in different regions of the world, particularly in Latin America, Eastern Europe and South Asia (Patel, 1998; Pyne, Claeson & Correia, 2002). In India, the scale of social problems related to alcohol abuse has propelled the problem into a political issue: in recent years, entire elections have been fought, and won, on the issue of alcohol problems (Patel, 1998).

A community-based approach to combating alcoholism and promoting the mental health of families has been described in rural India (Bang & Bang, 1991). The programme began with participatory research to estimate the burden and impact of alcohol abuse in the community. The research demonstrated the enormous burden of the problem and identified a number of key prevention and promotion strategies. These included education and awareness building, action against drunken men, advocacy to politicians to limit the sale and distribution of alcohol in bars and shops, and mass oaths for abstinence. The programme was implemented though the "Darumukti Sangathana" (Liberation from Liquor), a community movement led by young people and women. The programme led to a marked reduction in the number of alcohol outlets in the area and a 60% reduction in alcohol consumption. As a result, there was more money for food, clothing and welfare and a reduction in domestic violence (Bang & Bang, 1995).

In another example, an unblinded matched community-based trial was conducted in Yunnan, China, to investigate the effectiveness of a multifaceted community intervention to prevent drug abuse among youths. The programme, like the one in India, involved multiple sectors and leaders in the community and emphasized community participation and action, education in schools, literacy improvement and employment opportunities. The programme led to a significant 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).

Spiritual enhancement

Meditation and spiritual enhancement have a wide range of meanings in different cultures. Meditation may be defined as a group of practices that train attention to enhance awareness through mental discipline with the ultimate aim of development of insight into the nature of mental processes, consciousness, identity, reality and spiritual values (Bhaskaran, 1991). Although meditation commands much public attention in developed countries, the roots of its use for personal growth are found in the cultures of many developing countries. Various studies have suggested that practices such as yoga and t'ai chi may have significant benefits for both mental and physical well-being (Brown et al., 1995; La Forge, 1997; Li, Hong & Chan, 2001). Given that such practices focus on both physical and spiritual components, they may be especially valuable in terms of their meaning to the vast majority of the world's population, who do not neatly divide the physical, emotional and spiritual worlds into separate categories. Other practices that make use of meditation practices, such as Qigong, have also been argued to have mental health benefits (Mason & Hargreaves, 2001). Once again, most such practices make use of a combination of spiritual and physical methods.

This wide array of meditation techniques may represent an individual-focused strategy to promote mental health. Apart from the potential of such techniques to enhance cognitive processes, they are often accompanied by a strong sense of belonging and group identity and social support from other members or participants. There are now innumerable variations and schools that teach meditation in developing and developed countries, and many have been subjected to research that demonstrates a range of physiological and behavioural changes (Bhaskaran, 1991; West, 1979). Some have also been evaluated as treatments for mental disorders, though there is limited evidence for their effectiveness (Grover et al., 1996; Shapiro, 1982). Apart from meditation techniques, there has also been a remarkable growth in syncretic religious belief systems in many developing countries, some of which have been shown to have a beneficial effect on coping and self-esteem (Bourguignon, 1976).

Raising mental health literacy

There is low awareness regarding mental illness and the importance of mental health in many communities in developing countries. Raising this awareness may help improve understanding about the risks to mental health and methods of coping with these risks, and thus promote mental health in the community. One such awareness programme was assessed in a controlled trial in Rawalpindi, Pakistan. The intervention was delivered in two secondary schools and the outcome measured was based on a self-report questionnaire asking about various aspects of mental health and illness. The experimental group showed significantly higher scores than the control group (Rahman et al., 1998). More impressive was the finding that parents, friends and even neighbours of the students in the experimental group showed significant improvements compared to the control group. This trial shows that delivering education regarding mental health and illness to secondary school students is effective in raising awareness in the wider community and may thus help raise mental health literacy and promote mental health at large. NGOs in many developing countries are now playing a key role in raising awareness about mental health and pioneering a range of community programmes targeted at different population groups to promote mental health and prevent mental illnesses. A recent book has documented 17 such programmes (Patel & Thara, 2003).

Empowerment

Empowerment is the process by which groups of people in the community who have been traditionally disadvantaged in ways that compromise their health can overcome these barriers and exercise their rights so they can lead a full, equal life in the best of health.

Economic empowerment

Farmers have been described as being uniquely vulnerable to mental disorders and suicide in developed countries. The reasons for this greater vulnerability include easy access to methods of suicide and greater exposure to economic uncertainties (Malmberg, Simkin & Hawton, 1999). As mentioned in earlier chapters, in many developing countries indebtedness to loan sharks and consequent economic uncertainty is a source of stress and worry. This is particularly so for farmers. 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 and/or "credit-worthiness" which are essential for accessing loans. Such uncertainties are compounded for small farmers who rely on seasonal rains for agriculture and face increasing competition from large transnational agricultural companies. The combination of failures of the seasonal monsoon and competition has been identified as a major reason for debt in India, and the associated stress has led to hundreds of suicides in recent years (Sundar, 1999).

The economic vulnerability of farmers in developing countries suggests there is potential for mental health promotion in revising the process by which local banks assess the credit-worthiness of people who belong to the poorest sectors of society. 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 loan facilities in areas where they did not exist and making loans to poor people who formerly did not have access to such facilities and services. Provision of loans to small farmers who are poor may reduce their risk of mental illness and suicide by removing the key cause of stress: the threat of financial ruin that is 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 (Chowdhury & Bhuiya, 2001). 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) that comprise the poorest members of each community. The primary activities are raising consciousness and awareness and compulsory savings. Once established, VO members can access credit for income generating schemes. BRAC has carried out evaluations of number of its programmes in different settings. Data used for evaluation come from baseline, seasonal and ethnographic surveys, as well as from 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 & Bhuiya, 2001).

Equitable economic development

The epidemiological evidence described elsewhere in this book clearly demonstrates that people living in socioeconomically disadvantaged situations have an increased risk of common mental disorders. The mechanism for this vulnerability is unclear, but it is notable that similar findings have also been reported for general health. Thus, the overall health of populations tends to be worse in communities where inequality of economic status is greater (Kawachi & Kennedy, 1997; Wilkinson, 1996). These findings suggest that equitable economic development which improves the lives of the poor could lead to improvements in mental health.

A study on the impact of economic development on mental health was conducted in a rapidly industrializing region of Sumatra, Indonesia (Bahar, Henderson & Mackinnon, 1992). Stratified random sampling of individuals and neighbourhood units was used to select 1760 people for interview. The study demonstrated that people living in relatively poorer circumstances (e.g. living in poorer traditional dwellings lacking electricity and being in the lower income groups) were at a significantly elevated risk for common mental disorders. The study was able to access data on the change in development levels of each village and found that the rates of mental disorder were lowest in people living in the villages that had shown the greatest improvements in living standards and socioeconomic development in the previous three years.

Community development programmes which include health sector reforms, participation of local community leaders and empowerment of the marginalized are being implemented across the developing world as a way of promoting health and preventing disease among the poor. Such programmes are essential to ensure that economic development and reforms do not leave the poor by the wayside. It is likely that such programmes will promote mental health, not only in the individuals who are direct recipients of the services but also in all who live in that community. Many of these programmes are led by "social entrepreneurs" and community-based NGOs (Antia, 1993). Details of the processes implied in such community development programmes are described elsewhere in this book (see, for example, Chapter 18).

Empowerment of women

Whereas sex is a term used to distinguish men and women on the basis of biological characteristics, gender refers to the distinguishing features that are socially constructed. Gender is a crucial element in health inequities in developing countries. 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 (WHO, 2000). Gender configures both

the material and symbolic positions men and women occupy in the social hierarchy as well as the experiences that condition their lives. Thus, gender can be conceptualized as a powerful social determinant of health that interacts with other determinants such as age, family structure, income, education and social support (WHO, 2000). The role of gender in public health in developing countries has been acknowledged and "mainstreamed"; thus, gender is a core component of major health programmes targeted at child and adolescent health, reproductive health and primary health care. The role of gender in explaining the excess morbidity of common mental disorders in women has been demonstrated in a number of studies in developing countries (Broadhead et al., in press; Patel, Rodrigues & De Souza, 2002). These studies have shown that the elevated risk for depression is at least partly accounted for by negative attitudes towards women, lack of acknowledgement for their work, fewer opportunities for them in education and employment, and greater risk of domestic violence.

Although the link between domestic violence and mental health problems has been firmly established in numerous studies (Heise, Ellsberg & Gottemoeller, 1999; WHO, 2000), 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 levels, including sensitization 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), 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 & Gottemoeller, 1999). Approaches that focus on strengthening intimate relationships, one of the commonest contexts for violence, include parenting training, mentoring and marriage counselling. Some of these, such as the Stepping Stones programme, have been shown in qualitative evaluations in African and Asian settings to have helped men communicate and given them new respect for women (WHO, 2002a). Many programmes have been demonstrated to be effective in reducing 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 as well.

Violence prevention in the community

Violence is a pervasive experience in many developing countries. Indeed, as the Human Development Reports show, developing countries have far greater levels of civil unrest, war and disasters than developed countries. Wars and civil unrest continue unabated in dozens of countries and exact a severe toll on the lives of people and destroy the fabric of communities. The magnitude of this is reflected in the stark finding that violence is among the leading causes of death in young adults, particularly men (WHO, 2002a). The recent World Report on Violence and Health (WHO, 2002b) highlighted the enormous burden violence places on health and advocated a public health approach to violence prevention and minimizing its adverse health consequences.

Many approaches are advocated to reduce violence, some of which are based on evidence (almost all of it derived from developed countries). Individual approaches aim to encourage healthy attitudes and behaviour in areas such as sexuality and substance use in children and young people (and are similar to life skills education described below). Social development programmes that emphasize competency and social skills appear to be the most effective in reducing youth violence. At the level of the community, approaches include public education, training for politicians and law enforcement agencies, community policing and improving the environments of

refugee camps. The creation of safe spaces for victims to express their feelings and the provision of basic relief and rehabilitation are critical for any programme aiming to help people affected by violence, as is well demonstrated in the efforts to promote the psychosocial rehabilitation of the victims of the riots in Gujerat, India, in 2002 (Sekar et al., 2002). A cornerstone of programmes aimed at promoting mental health in victims of trauma is to use people's own traditions, skills and approaches to crisis. In most developing countries, this typically means paying due attention to rebuilding external social worlds rather than to internal mental states, which is what is empha-sized in trauma counselling in developed countries (Summerfield, 1999). At the highest level, of course, we must acknowledge that a large fraction of the causes of violence lies in global political instability that is fuelled by a rapacious arms industry, political double standards, growing hatreds between different communities in the world and the lack of action by richer countries to bring about greater equity and equality globally.

Social support

In this section we take a life-cycle approach to presenting evidence on how intersectoral alliances and community action help promote mental health. We believe that programmes that invest in the future of our communities, children and youth, deserve special emphasis and prioritization. At the other end of the life-cycle, the elderly are an especially vulnerable group who also deserve special attention.

Promoting maternal mental health and appropriate parenting

Maternal mental health is a major public health issue in many developing countries because of growing evidence that poor maternal mental health not only compromises the mother but is also associated with poorer growth and development of babies (Lanata, 2001; Patel, De Souza & Rodrigues, 2003). For example, in a peri-urban settlement near Cape Town, South Africa, the rate of maternal depression in the puerperium was found to be 35%, roughly three times the rate generally reported in wealthier countries, and this depression was associated with disturbances in the mother-infant relationship (Cooper et al., 1999). There is also evidence that inappropriate parenting – including violence and neglect, which are associated with poor child and adult men-tal health – is one of the factors causing children in developing countries to run away from their parental homes. For these reasons, public health programmes on childhood development are beginning to focus on interventions that promote maternal mental health and appropriate paren-ting as ways to improve child outcomes.

There is some evidence that supportive interventions and counselling during the antenatal period improves maternal and child health outcomes. For example, a trial from Zambia demonstrated that mothers who received such support took more action to solve infant health problems, an indirect measure of maternal empowerment and problem-solving abilities (Ranjso-Arvidson et al., 1998). Women-to-women programmes have increased maternal self-esteem and empowerment in Peru (Lanata, 2001). In South Africa, preliminary data suggest that a community-based coun-selling and support intervention may have positive outcomes for infant mental health (Cooper et al., 2002) and an RCT based on these promising findings is currently underway. Similarly, an RCT is currently in progress in Goa, India, to evaluate the effectiveness of a community counselling intervention for the prevention of maternal depression in high-risk women. Pilot studies showed marked improvements in mental health status and early evidence from the main trial suggests a high compliance rate with the intervention (Marcus Hughes, personal communication).

Promoting childhood development in the midst of adversity

A recent review has examined the relationship between nutritional status and psychological deve-lopment of children, focusing on evaluations of programmes that targeted the most vulnerable children and families in the community (WHO, 1999). Malnutrition is a pervasive risk factor that not only leads to physical health problems but is also a risk factor for poor psychosocial develop-ment. Given that malnutrition is very common in some developing countries, particularly in some regions of South Asia where up to half of all children are underweight (Bhutta, 2000), interven-tions which target malnutrition may have an important effect in promoting mental health in later life. Several such programmes have been implemented in developing countries. Notable ones include the Integrated Child Development Scheme in India, the PANDAI (Child Development and Mother's Care) Project in Indonesia, the PRONOEI Programme in Peru, the PROAPE Programme in Brazil, the Integrated Programme for Child and Family Development in Thailand and the Hogares Comunitarios de Bienestar Programme in Columbia. All of these programmes target children under seven years of age and are implemented mainly through low-cost basic health workers (often women) recruited from the local community. A number are being implemented on a large scale; the ICDS in India, for example, is being put into operation across the country and has rea-ched more than 17 million children since its inception in 1975. Many programmes have been eva-luated in small-scale effectiveness studies in pre– and post-comparison designs and using control communities and participants. As pointed out in Chapter 13, the key findings of these evaluations are that nutritional and educational interventions improve psychosocial development in disad-vantaged populations and that interventions which combine both nutritional and psychosocial components (such as parent stimulation) have the greatest impact. Full-scale programmes that include both components have been implemented in some of the world's poorest countries.

Despite these favourable findings, it is important to recognize that children who are nutritionally or socioeconomically disadvantaged never fully catch up with children who are well nourished or privileged. There is a need to develop and test models of combined interventions that can reach a larger proportion of children, and to evaluate the impact of such child-focused interventions on adult mental and physical health.

Life skills education and adolescent mental health promotion

Adolescence refers to the passage from childhood to adulthood, whereas puberty refers to the biological changes that lead to reproductive capacity (Baucher, 1996). Adolescent health has become a major public health concern in many developing countries, to a large extent due to the HIV/AIDS epidemic and population growth as well as the recognition that sexual activity for many begins in adolescence. Despite this concern about reproductive health issues, there is also the recognition that the health, education, economic and employment needs of adolescents cannot be ignored (Bezbaruah & Janeja, 2000).

The successful negotiation of adolescence involves close interaction of a number of factors, including physiological development, acquisition of a mature concept of the self and self-esteem, educational achievements, family and peer relationships and sexuality – although the actual interpretation of adolescence as a phase of life remains a social construct that differs considera-bly between cultures. Recent research from the USA and China has demonstrated the universal nature of the role of protective factors in mitigating the risks for problem behaviours such as delinquency, problem drinking and substance abuse in adolescents (Jessor, Turbin & Costa, 2003). Factors related to role models (e.g. parental involvement in community activities), supportive

relationships (e.g. teacher interest in students) and controlling factors (e.g. negative individual attitudes towards deviant behaviour) accounted for a substantial proportion of the variation in problem behaviours in both settings, suggesting the importance of these factors in promoting adolescent mental health.

There is now growing evidence that broader issues pertaining to adolescence also need attention. Depression, suicide and attempted suicide are the most important causes of death and hospitalization in adolescents in developing countries (Andrew, Patel & Ramakrishna, in press; Eddleston, Rezvi Sheriff & Hawton, 1998). Girls are more likely to attempt suicide and this is inextricably linked with their lack of control in reproductive decision-making and restriction of reproductive rights (Khan & Reza, 1998).

Life skills education is a model of health promotion that seeks to teach adolescents to deal effectively with the demands and challenges of everyday life (WHO, 1997). Life skills include decision-making, problem-solving, creative and critical thinking, effective communication and interpersonal skills, self-awareness and coping with emotions and stress. Life skills are distinct from other important skills that young people acquire as they grow up, such as numeracy, reading and practical livelihood skills. There is evidence, entirely from developed countries so far, that life skills education is effective in the prevention of substance abuse, adolescent pregnancy and bullying; improved academic performance and school attendance; and the promotion of mental well-being and health behaviours (WHO, 1997; see also Chapter 13). This model is now being advocated, field-tested and implemented in a number of developing countries.

Ageing and mental health: who cares?

By 1990, a majority (58%) of the world's population aged 60 years and over was already to be found living in developing countries. By 2020 this proportion will have risen to 67%. Over these 30 years this oldest sector of the population will have increased in number by 200% in developing countries as compared to 68% in the developed world (Murray & Lopez, 1996). This demographic transition will be accompanied not only by economic growth and industrialization but also by profound changes in social organization and family life. For older individuals, as with younger ones, mental disorders are an important cause of morbidity and premature mortality. The elderly face a triple burden in developing countries: a rising tide of noncommunicable and degenerative disorders associated with ageing, falling levels of family support and lack of adequate social welfare systems (Patel & Prince, 2001).

Tout (1989) documented a wide range of programmes aimed at improving the quality of life of elders in developing countries. The most common types of programmes included some form of income generation, which enabled a degree of independence and provided finances for old age in societies where pensions and government schemes for the elderly were not accessible. HelpAge India has pioneered programmes aimed at recruiting children and youth to provide care for physically unwell elders. CEWA (Centre for the Welfare of the Aged) has set up day centres in which elders can spend time and reduce their social isolation. In South Korea, social events are organized to enable formal introductions between elderly men and women. Reduction in physical disabilities, such as visual disability, and rehabilitation are being implemented in many countries. The Good Neighbour Scheme in Malta includes identifying neighbours to visit lonely elderly people with the objective of providing social support and practical help. All of these examples target three risk factors for poor mental health in the elderly – financial difficulties, social isolation and poor physical health – and all are likely to have an important impact on the promotion of mental health.

Building the evidence base

It is apparent that the evidence base for mental health promotion in developing countries, such as it is, is largely speculative and anecdotal. Although we believe that building evidence is an important task to evaluate the effectiveness of macro and micro strategies for mental health promotion, we are equally aware of the difficulties and pitfalls of adopting a narrow approach which is the standard when evaluating effectiveness of disease prevention or treatment. (These difficulties are discussed in more detail in Chapter 9.) Perhaps the most important issue is that of measuring mental health across cultures in a reliable and valid way. The evolution of our current methodological understanding of the diagnosis and measurement of psychopathology across cultures has been well documented (Dohrenwend, 1990; Patel, 2001a). However, if mental health is not merely the absence of mental illness, then how is it to be measured? If diagnostic entities can vary across cultures, then what is the likelihood that we will be able to measure mental health, a much larger construct that is far more likely to be influenced by sociocultural contexts, across communities? A recent report defined the outcomes of mental health promotion to include constructs such as quality of life, increased coping skills and better psychological adjustment (WHO, 2002a). In our view, the first task is to invest in research that examines the validity of such a construct of mental health in developing countries. For example: What is meant by mental health? What are its component parts? How is it experienced? What value is placed on it? How is it perceived in relation to other aspects of a person's life? One particularly difficult problem in measuring mental health is finding a construct that is valid even when expectations about the constitution of well-being may be radically different across societies. Amartya Sen has pointed out that the people of Bihar self-report significantly fewer health problems than the people of Kerala, even though rates of morbidity are much higher in Bihar (Sen, 2002). Will we find a similar phenomenon in trying to assess mental health: that as social conditions improve, people's expectations about well-being change and thus they become more willing to identify mental health problems? Will the opposite be found in societies that exist in states of deprivation?

These questions, difficult in themselves methodologically, beg far more fundamental ones about the contributions mental health practitioners may or may not make to human welfare in a global context. As discussed in earlier chapters, the divisions between mental health and other desirable social values are to an extent arbitrary and informed by cultural perspectives on health, illness and well-being. For example, the distinctions drawn between the "physical", the "mental", the "spiritual" and the "social" are influenced by cultural belief systems. Some forms of healing do not necessarily divide up the world in this way. Those of us who are interested in mental health promotion in lower income countries need to engage with the question of the extent to which the very concept of mental health promotion may imply a set of attitudes and assumptions that are not universally held. Mental health promotion programmes, intertwined as they are with fundamental assumptions about how people can and should live their lives, can be accused of amounting to strategies of cultural or biomedical imperialism. We need to engage with this possible criticism by being reflective about what we do, but we also must not allow a form of radical relativism to disempower and dissuade us from exploring what we know from other contexts to be good for mental health.

A key task in building the evidence base is to compare the mental health status of populations that have had the benefit of specific interventions with the mental health status of populations that have not. Thus, the comparison of people who are members of a micro-credit scheme with

those who live in the same area but who are not members may enable us to estimate the effectiveness of such schemes. At the macro level, the mental health of representative samples in different states of large countries that have clearly different human development indicators may help describe the effectiveness of macro policies on mental health. As we suggested earlier, such ecological comparisons are, however, fraught with problems of confounders and thus careful selection of populations and measurement of covariates is essential if interpretations are to be made with confidence.

Finally, we must acknowledge that the interventions most likely to promote mental health are those that are set up with no specific mental health goal, such as interventions aimed at empowerment of specific groups in the population. There is much in life that we accept as being good for communities, from the way our political systems are organized (democracy is better than repression) to social development programmes (education is better than illiteracy; peace is preferable to war; women and men are equal) or the way health care is organized (universal health coverage is better than care based on how much a person can pay). None of these macro interventions or policies is based on evidence as defined by health researchers and policy-makers. They are all based on principles of human values which, to some extent, are more universal than specific definitions of mental health or mental illness. Thus, we believe that the best action for promotion of mental health in developing countries will come not from evidence-based programmes, but from our acknowledgement that human development and mental health are inextricably linked. The strategies most likely to promote mental health are likely to be those found within existing human development initiatives that combat the core social and economic inequities that are ultimately the basis of much human suffering today.

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Introduction

Earlier chapters have discussed the need to develop "upstream" interventions to promote mental health and considered the potential role of macroeconomic polices in improving and protecting mental health. In particular, they have discussed the impact on mental health of macroeconomic policy, urban design, housing, education and welfare policies and emphasized the need to focus on the effects of these policies on subpopulations (for example, by exploring the differential effects of interventions in different socioeconomic groups). The importance of a developmental approach has also been highlighted, with a need to focus on children and adolescents as targets for interventions. Implicit in these demands is the need to carry out quantitative and qualitative evaluations of the outcomes of intervening in people's lives. This chapter discusses the role of non-health sector policies and interventions in improving mental health, focusing particularly on areas where evidence is currently available and where the gaps in the evidence base may lie. In illustration, two examples of potential upstream interventions are discussed: employment and housing policies. The contribution of health economics to the assessment of such social interventions is also described.

The current evidence on policy interventions

Overview

As discussed in earlier chapters, the evidence on the health outcomes of government policies is patchy, at best. In short, there is good evidence for some interventions, particularly for those at the individual level, but not for others. This is best illustrated by an extensive overview undertaken by the Contributors to the Cochrane Collaboration and the Campbell Collaboration (2000) which aimed to synthesize evidence on policy interventions that either directly addressed mental health needs or that aimed to address factors strongly associated with poor mental health; the latter category included joblessness, homelessness and low income. Interventions for which there *was* evidence of effectiveness included supported employment and psychosocial rehabilitation for people recovering from mental health problems, home-based social support for pregnant women at high risk of depression, and social support and problem-solving or cognitive-behavioural training for unemployed people. In one case an intervention appeared to be harmful (psychological debriefing after trauma) and another intervention (education of students about violence or suicide) was found to either increase or decrease risk in vulnerable people. Other interventions appeared to be effective in addressing the determinants of poor mental health rather than being shown to have an impact on mental health itself by offering educational, employment, welfare or other supportive interventions. Preschool day care also seems to be beneficial, as it increases the chance of being in well-paid employment in adult life and thus reduces the risk of poor mental health (Zoritch, Roberts & Oakley, 2000). Many effective interventions aimed at tackling alcohol and drug misuse were also identified.

There are many policy interventions that may be expected to directly or indirectly affect mental health but for which strong evidence appears to be absent, however. Perhaps the most important of these "plausible interventions" is income supplementation. Poor mental health is consistently

associated with poverty and deprivation, so it might be expected that increasing the incomes of the worst-off in society would improve mental and physical health, yet good evidence of the positive health effects of income supplementation still seems to escape us. A recent review attempted to identify all RCTs of the health outcomes of interventions such as negative income tax, housing allowances and other forms of financial assistance, including lotteries (Connor, Rogers & Priest, 1999). Only one small study – an RCT from Canada – assessed mental health outcomes following increases in income through loans and allowances. No difference was found between the intervention and control groups, though as the study was small the possibility of a real effect of increased income could not be excluded. Referring to the studies of income supplementation that had not assessed impacts on health, the authors of the review referred to a "lost opportunity"; the same phrase can be applied to the evaluation of many other social interventions.

This "absence of evidence" should not of course be mistaken for "evidence of absence", and plausible preventive interventions can be applied in the absence of outcome evaluations, based for example on observational etiological research. However, this example does illustrate again the need to foster evaluative research on the mental health and other outcomes of policies. In addition, primary economic data on the relative costs and benefits of these interventions is lacking (Gilbody & Petticrew, 1999). We return to this issue later in the chapter.

Five reasons have been suggested for the absence of evaluations of the impacts of policy on mental health. First, the window of opportunity in policy-making is short, leaving little time to develop complex outcome evaluations requiring long lead times; second, the policy environment changes rapidly and data becomes obsolete quickly; third, experimental evaluations are often ill-suited to answer policy questions; fourth, the effects are often small and widely distributed, meaning that large samples and large units of randomization are required; and, finally, funding for this type of policy evaluation is more limited than for clinical research (Sturm, 1999). While many of these hurdles can (and sometimes have been) overcome, it is reasonable to suggest, as Sturm does, that there is still a valuable role for longitudinal observational studies which can inform policy by providing mental health monitoring data derived, for example, from repeated surveys and routine health service data. The call for more robust outcome evaluations does not therefore preclude the contribution that can be made from observational data on determinants and indicators of mental health (Herrman, 2001).

Policy-makers demand better evidence of the effects of upstream interventions. As discussed in Chapter 9, however, there are particular problems with collecting such evidence, as many of the major social determinants of mental and physical health are not amenable to randomization for practical or political reasons. Examples include new roads, new housing and area-based regeneration, all of which have been theorized to affect mental health. Recently, researchers in the field of health inequalities have recommended that more use should be made of "natural" experiments (for example, changes in employment opportunities, housing provision or other policy initiatives) as opportunities for estimating the health impacts of non-health sector policies.

There is clear potential for positive mental health to be promoted through non-health policies, and assessments of the "spillover" effects of such policies will make an important contribution to the mental health evidence base. The two examples outlined below – housing policy and employment policy – have both been identified as major determinants of mental health.

Employment conditions and mental health

Psychosocial conditions, such as low control, low support from colleagues and high stress in the workplace have been shown to be associated with poor mental health and sickness absence related to psychiatric disorders in the Whitehall studies in the UK (Marmot et al., 1999; see also Chapter 13). This raises questions about how working conditions can be altered in order to promote good mental health. For example, it is reasonable to ask whether low control in hierarchical organizations is amenable to change, whether power imbalances can be redressed to promote mental health and whether such changes are acceptable and affordable (Robinson & Pennebaker, 2002). These are difficult questions to answer because, while there are dozens (if not hundreds) of studies demonstrating the associations between work factors and poor mental health, there are relatively few evaluative studies which assess the benefits and harms of preventive interventions in organizations. As illustration, one recent systematic review that examined work-related psychological ill-health and sickness absences identified only six intervention studies, of which only three were RCTs. Three of the six studies were USA-based, two were Scandinavian and one was carried out in the UK. The interventions involved training and organizational change to increase decision-making opportunities and problem-solving skills, mobilization of support at work, and stress management and communication training (Michie & Williams, 2002). Skills to help mobilize support at work and to participate in problem-solving and decision-making resulted in improvements in ability to cope, better work team functioning and more supportive feedback. Stress management resulted in decreases in stress levels (as assessed by circulating stress hormone levels). The review made recommendations for the development of future research in this field, most importantly highlighting the need for robust experimental evaluations of interventions that seek to alter employment practices and management styles. The dearth of economic evaluations was also noted (only one study was found) and it was observed that economic evaluations are likely to be of key importance in helping employers to make decisions about whether to implement such interventions.

Another systematic review noted that there are a small number of studies which suggest that targeted and focused interventions aimed at changing a particular aspect of work may be more effective than interventions which attempt wider organizational change (Rick et al., 2002). The authors concurred that the evidence base is small, generally includes controlled but not randomized studies, and contamination is often a problem (that is, it may be difficult to restrict exposure to the intervention to the experimental group alone). As in most areas of public health, the evidence base around employment and mental health is dominated by high quality observational evidence demonstrating associations between working conditions and morbidity but there are relatively few studies to suggest what interventions may be effective or cost-effective. There is therefore a clear need for evaluative research on the mental and physical outcomes of organizational change.

Housing and mental health

As with employment, there is already good associational evidence suggesting that housing improvement improves mental health, but there are relatively few evaluations of the actual health impacts of housing policies. For example, a recent systematic review of the literature identified 18 studies that had monitored health gains following major housing improvement (Thomson, Petticrew & Morrison, 2001). The studies themselves were very diverse in terms of sample popu-

lation, location and type of housing improvement (for example, they ranged from installation of central heating through to complete refurbishment and associated neighbourhood improvements). The outcome measures also varied widely, making it difficult to synthesize the findings to allow a single estimate of the health impacts to be made. In addition, there were some conflicting findings between and within studies. However, when physical and mental health impacts were examined separately, evidence of a consistently positive mental health impact emerged. In one large prospective controlled study, the degree of improvement in mental health was directly related to the extent of housing improvement, demonstrating a dose-response relationship. This consistent pattern of improvements suggests that improving housing does indeed generate mental health gains; participants in these studies reported reductions in anxiety and depression, improvements in Nottingham Health Profile scores and self-reported reductions in mental health problems (Thomson, Petticrew & Douglas, 2003).

There are a number of other housing-related factors that have been linked to variations in mental health, most notably housing tenure, housing design, moving house and neighbourhood characteristics. Home ownership, for example, has been independently associated with improved health, though the direction of the relationship needs further investigation (Hiscock et al., 2000). Home ownership is not always health promoting, however. One UK study of the health impacts of mortgage arrears suggested that those living on the margins of home ownership suffer increased insecurity and detrimental mental health impacts (Nettleton & Burrows, 1998). Cultural variations in rates and meaning of home-ownership may also give rise to international variation.

Housing design is another key determinant of good mental health. Flat dwelling has been linked to factors associated with stressful living conditions such as increased social isolation and crime and reduced privacy and opportunities for safe play for children (Burridge & Ormandy, 1993). A recent review of epidemiological surveys showed a consistent pattern of decreased levels of mental health associated with housing height and multi-unit dwelling (Evans, Wells & Moch, 2000).

The possible mental health benefits of living in a better house may also be countered by the process of moving house and relocating to a new area. Moving house is considered to be a stressful, health damaging life event. In the field of social housing this has been attributed to lack of opportunity to negotiate with housing authorities regarding control around the move (Allen, 2000). Housing relocation has also been associated with loss of community, uprooting of social networks and unsatisfied social aspiration, all of which may undermine mental and physical health.

Mental health impact assessment

Clearly while policies aimed at improving public housing may have positive mental health effects, there is also significant potential for negative impacts, suggesting again the need to monitor and evaluate the actual health gains (and losses) caused by major changes to housing or other social policies. Expanding this "monitoring and evaluation" activity will be crucial for the success of Mental Health Impact Assessment (MHIA), which aims to recommend changes to public policies, programmes or projects in order to maximize any health benefits arising, to mitigate any negative effects and/or to prioritize areas of investment to enhance mental health. Successful and meaningful MHIA depends on (among other things) the availability of good evaluative evidence on the nature, size and likelihood of predicted mental health impacts. Given the scarcity of evaluations of public health interventions, however, other types of evidence will clearly be important. Data from qualitative studies, for example, can be used to identify the existence, nature and possible

mechanisms for unpredicted negative or positive impacts of interventions (Thomson, Petticrew & Douglas, 2003). Longitudinal life-course data can examine the long-term health effects of exposures to poor social and economic conditions and can identify aspects of the social environment or indeed populations where interventions may be most appropriately targeted. Kuh et al. (2003, p. 727) remind us that the collection of life-course data implies more than just a longitudinal study design; it implies underlying theoretical models that outline possible relationships between specific early exposures and later health outcomes. These hypotheses can be tested by new longitudinal studies such as new birth cohorts and by the re-establishment of historical cohorts.

Appropriate generalization from existing data is of course difficult, however, and evidence is often least available in areas that have the maximum need, such as in developing countries and areas affected by conflicts, where there is an increasing burden of mental health-related problems (WHO, 2002). In addition, in many cases the few resources available for the promotion of mental health end up being allocated to programmes for which there is no good evidence of effectiveness. Two European directories on mental health promotion and prevention programmes for children and adolescents have estimated that about 80 to 85% of the reviewed programmes which are being implemented across European member states are not evidence-based.

Health economics and mental health promotion

The key challenges in generating evidence

We noted earlier that primary economic data on the relative costs and benefits of interventions is lacking. Demands for such evaluation are sometimes seen as overly prescriptive and as inhibiting innovation. However, health promotion programmes aimed at positively influencing mental health outcomes in targeted populations necessarily require resources and expenditure for their development, implementation and continuation. Since the finite amount of resources available for public health investment could have been allocated elsewhere, questions relating to whether those valuable resources are being put to best use – in terms of the health gain that they generate – are never going to be far behind. To some, the addition of an economic perspective represents an unwelcome intrusion into the design, process and output of health promotion activities, its relevance restricted by a plethora of measurement problems. To others (and not just health economists), the application of economic theory and practice offers a useful set of methods for assessing the relative worth of different promotion activities, as well as providing new insights into the mechanisms underlying certain human behaviours (such as theories of addiction which draw on economic theories of utility) (Cohen, 1984).

As a methodology, economic evaluation has yet to be extensively applied to health promotion (or social welfare), although a number of texts have appeared which discuss key issues around its potential deployment (e.g. Byford & Sefton, 2002; Cohen, 1984; Godfrey, 2001; Hale, 2000; Shiell & Hawe, 1996). One (Hale et al., 2003) provides a step-by-step guide for performing an economic evaluation in this area. All of these highlight the challenges associated with using conventional methods and principles for economic evaluation in the context of health promotion programmes, in particular the limitations of experimental study design, the multifaceted, complex and long-term nature of anticipated programme benefits and the shortage of sensitive or suitable outcome measures. These key issues are briefly reviewed here and their consequences for the future evaluation of mental health promotion discussed.

Study design and perspective

In common with clinical evaluation, the preferred form of study design for most economic evalua-tions is a controlled, prospective experimental study design, preferably with randomization, since this provides the most compelling evidence for the attributable or causal effect of an intervention. Although randomized, controlled cost-effectiveness trials may be suitable for evaluating certain mental health promotion programmes (e.g. mental health education for depression in the work-place), their wider use is constrained by the fact that promotion activities (such as mass media campaigns) are most often pitched at the level of whole communities rather than at a specially recruited (and potentially unrepresentative) set of individuals drawn from a target population. In many instances, it may actually be unethical or unfeasible to recruit or randomly allocate subjects into a control group, either because that would necessitate the withholding of an effective inter-vention or, in the example of mass media, because all individuals are exposed to the intervention anyway. For this reason, community intervention trials that employ cluster randomization where the unit of analysis is whole populations rather than selected individuals, such as school children in two adjacent districts, are a commonly used alternative to RCTs for assessing activities such as health education programmes.

Where even this level of comparison is not possible, prospective observational studies, time-series analyses or ecological studies within a single population can be carried out. The absence of a control group, however, results in an inescapable loss of explanatory power resulting from the potential influence of (uncontrolled for) confounding effects or biases. As such, non-experimental study designs are only able to point to associations between, say, exposure to alcohol counter-advertising and reduced consumption or expenditure, rather than causal effects. Moreover, since cost-effectiveness is always a relative concept (cost-effective compared to what?), a study without a comparison group cannot be referred to as an economic evaluation in the true sense of the term. On the other hand, such studies may be more feasible to carry out and typically provide a closer representation of the real world (improved external validity and generalizability). These characteristics have particular significance for health promotion activities, which often look to modestly alter the behaviour, attitudes or outcomes of a whole population over the longer term. To illustrate, assessment of the longer-term costs and effects of upstream interventions such as income supplementation or improved housing on mental health in low income households might need to extend as far as 10 or more years, or even may need to attempt to capture intergene-rational effects. Although less rigorous than a controlled experimental study, a well-conducted longitudinal observational study may prove to be a more feasible study design, provide a more generalizable set of data and offer a satisfactory basis for policy implementation.

One other approach to evidence generation is via modelling studies which attempt to simulate empirical studies on the basis of publicly available data sources. Although subject to a number of concerns relating to the over-simplification of (public health) reality, the diversity of data sour-ces and the need for multiple assumptions relating to key parameters, modelling studies do not require recruitment and follow-up of live subjects and can therefore be undertaken relatively more quickly and cheaply. At the level of the total population – which will often be the prefera-ble public health perspective for mental health promotion – such models can provide decision-makers with a broad indication of the expected health gains of an intervention strategy as well as its associated costs.

Identification and measurement of outcomes

There are a number of potential consequences resulting from the implementation of a mental health promotion strategy that can complicate (or hamper) its appropriate and comprehensive measurement (Nutbeam, 1998). Figure 15.1 provides a set of outcome domains that could be included in an economic study. One initial question that can be asked is who the main targeted beneficiaries of the intervention might be: is it particular individuals at risk of developing behavioural problems, whole communities or the population in general? At each of these levels, it is necessary to consider a number of consequences of the intervention. One of these is the intermediate outcomes of health promotion activities, in particular changes in awareness, knowledge or behaviour, which provide an indication of the extent to which the process of health promotion has met its immediate goals (for example, shifting adolescent attitudes to substance misuse).

The "final" consequences of the intervention that directly follow on from this process can be seen both in terms of health and non-health outcomes. Health outcomes capture the effects of the intervention on the functioning, quality of life and possibly mortality of individuals exposed to the intervention. For interventions targeted at whole communities, emotional stress or physical violence at the household level may constitute relevant extra domains of health-related outcome. Developments have also been made in the measurement of population level health, most notably in the form of quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs), which deliberately compress mortality and morbidity outcomes into a single index in order to allow for better comparison between intervention or disease categories. Despite the opportunities that these measures offer to demonstrate the comparative value of health promotion activities, their application in this area has been restricted to date, partly as a result of their relative insensitivity to small changes in population level health that may result from interventions linked to vulnerable groups or in particular settings. For example, the effects on disability or quality of life of targeted individuals exposed to a mental health promotion programme may be considerable, but at the population level these effects are smaller and more elusive to measure accurately. These and other population indicators may be helpful, however, with another problem in measuring intervention outcomes operating in the opposite direction. This so-called "prevention paradox" is that large changes in population health can be achieved with small changes in individual health (Rose, 1981 cited in Rose, 1992, p. 12).

An alternative approach to the evaluation of these small changes in health outcomes is via techniques such as conjoint analysis or willingness-to-pay, which endeavour to elicit relative or monetized preferences for different health scenarios. It is partly because changes in health per se may constitute only one dimension of outcome that consideration of other, non-health, benefits of health promotion activities is required, encompassing social benefits such as increased social capital and economic benefits such as workforce participation or productivity. The development of valid and reliable measures of community level outcome, such as levels of social cohesion, represents a particularly needy area of research (McKenzie, Whitley & Weich, 2002; Shiell & Hawe, 1996).

Identification and measurement of costs

What marks an economic study from a straight outcome study is the inclusion and subsequent measurement of intervention costs. As shown in figure 15.1, it is likely that resources or expenditures will be incurred at a number of levels, including national or regional governments, local providers and communities and individuals. For most mental health care interventions, resource costs are largely incurred at the individual level in terms of health or social care contacts and time

Figure 15.1
Cost outcome domains for the economic analysis of mental health promotion

	Level 1: Individuals (e.g. school children or workers)	Level 2: Groups (e.g. households or communities)	Level 3: Population (e.g. regions or countries)
Resource inputs	Health-seeking time Health and social care Lifestyle changes (e.g. exercise)	Programme implementation Household support	Policy development and implementation
Process indicators	Change in attitudes or behaviour	Change in attitudes or behaviour	Change in attitudes or behaviour
Health outcomes	Functioning and quality of life Mortality (e.g. suicide)	Family burden Violence	Summary measures (e.g. DALYs)
Social and economic benefits	Self-esteem Workforce participation	Social capital / cohesion Reduced unemployment	Social inclusion Productivity gains Reduced health care costs

costs associated with accessing services or providing informal caregiving. By contrast, most of the resources directed towards mental health promotion will be incurred at a level above the individual or household. These include the administrative costs of developing, implementing and maintaining a health promotion programme, training and, in particular, media costs. Measurement of these programme costs has posed a considerable challenge to date, owing to the many agencies involved as well as the joint nature of these cost components with other programmes, but some clear progress is now being seen. For example, the costs of developing and maintaining programmes for the reduction of smoking, heavy alcohol use, unsafe sex and cardiovascular disease risk factors have been recently compiled for different regions of WHO (Johns et al., 2003).

Although there is currently little data comparing the cost-effectiveness of alternative mental health promotion strategies, a range of experimental, observational and modelling studies could be constructed in a way that would offer policy-makers and health care managers important population level information on the short– and longer-term costs and effects of key intervention strategies. As an example, figure 15.2 provides a summary of the main components of an economic evaluation for a school-based intervention on alcohol education (for further details about this and a number of other case studies see Hale et al., 2003). Even with the generation of such an economic evidence base, it is important to note that cost-effectiveness is only one of many criteria to be considered when deciding whether to implement a policy or strategy.

Figure 15.2
Components of an economic analysis of alcohol education in a school

Rationale for the evaluation	Substance misuse is a growing problem in adolescence; schools provide a suitable setting to promote sensible drinking; specialist agencies and teachers both have potential roles to play.
Hypothesis	Use of health promotion professionals in the delivery of school-based alcohol education is cost-effective
Comparison programme	Current health promotion programme delivered by teachers
Study perspective	Public sector costs, i.e. those incurred by the education and health services
Cost measures	Development and preparation of intervention programme; training; delivery of programme (especially health promotion professional time)
Effect measures	Change in knowledge and attitudes (e.g. awareness of health risks associated with alcohol use); change in behaviour (e.g. reduced episodes of binge drinking); health gain (e.g. reduced incidence of heavy alcohol use)
Cost-effectiveness measures	Cost per unit of intermediate or final effect (e.g. £1000 per reduced incident case of heavy alcohol use)

Source: Hale et al., 2003

Improving the availability of evidence: an Internet-based system

The European Commission has financed the development of an international Internet-based system to increase the availability and accessibility of evidence on mental health promotion and prevention programmes. Twenty-one European countries are participating with WHO on the system's development as part of the Implementing Mental Health Promotion Action (IMPHA) project.

The aims of this project are:

- to identify, describe and disseminate evidence-based strategies, programmes and policies in promotion and prevention in mental health through a standardized classification system and electronic searchable database, and to stimulate their implementation across countries and regions;

- to provide a tool for countries and regions to develop their own policies, strategies and programmes for promotion and prevention in mental health, including culturally sensitive guidelines for the adaptation and reinvention of evidence-based interventions in new settings;

- to create a resource that facilitates research synthesis and stimulates new international research projects, including outcome research, cross-cultural research and research on effect moderators and principles of effective policies, strategies and programmes; and

- to enhance the quality and effectiveness of prevention and promotion in mental health worldwide.

The overriding priority remains to collect new evidence on the mental health outcomes of interventions; both policies whose main intended outcome is not health, and programmes and projects that have as their main aim mental health improvement. As we have discussed, RCTs to evaluate those impacts are often not possible in some social settings, but more often they are simply not considered. Rychetnik et al. (2002) have pointed out the overlooked potential of RCTs of social interventions and of cluster trials to assess outcomes in communities, schools or other clusters, and their flexibility in accommodating non-standard social interventions. In situations where RCTs are not feasible the collection of observational evidence of the effects of interventions should be prioritized – for example by conducting controlled before-and-after studies. This provides one type of evidence – about outcomes – but, as Barry and McQueen emphasize in Chapter 9, evidence from other sources is also essential; qualitative evidence is required to inform decisions about the generalizability and implementation of interventions. Sound information on the scale of the problem and ongoing trends in risk factors can also provide evidence on where and when to intervene, and indicate high-risk populations. The WHO STEPwise approach outlines the critical components of a surveillance system for the monitoring of risk factors for noncommunicable diseases; such a system may also provide a basis for monitoring the effects of policies and other interventions (see: http://www.who.int/ncd_surveillance/media/en/269.pdf).

The mere provision of evidence is not, of course, the end of the story. The development of infrastructures to support research, implementation and cross-sectoral collaboration between public health and other public policy platforms is also necessary. In turn, policy-makers could make greater use of scientific knowledge as the basis for new legislation. For example, policy interventions could be screened before implementation to ensure that they meet a minimal set of (evidence-based) requirements as to their effects – as opposed to the present situation in many countries where policies are implemented in the absence of much evidence that their benefits outweigh their costs.

Conclusions

It is probably now well-accepted that the main determinants of poor mental health and mental health inequalities lie outside the health sector, and that as a result intersectoral action is required to redress them. For example, a recent systematic review of large adult population studies in the USA, Canada, Australia, the UK and the Netherlands showed clearly that there are consistent associations between the prevalence of mental disorders and a range of indicators of less privileged social position. The evidence for an association was most consistent for unemployment, low education and low income or standard of living (Fryers, Melzer & Jenkins, 2003). The implication is that intervening in these sectors would plausibly be expected to improve mental and other health and well-being outcomes, and that evaluations of interventions (for example policies) in these sectors would allow some quantification of the benefits. The absence of evaluative studies that have done this is often assumed to be largely due to the methodological difficulties inherent in evaluating complex interventions and to political difficulties (that is, policy-makers or other stake-

holders may not support rigorous evaluations of their activities). However, while these are important barriers the more obvious reason is that the measurement of health outcomes of policies has simply not been prioritized in the past. This is likely to remain the case without wider acknowledgement that promoting positive mental health is a legitimate outcome of social policies.

Finally, it has to be acknowledged that despite the clear evidence that adverse social conditions (being poor, unemployed and underprivileged) are important determinants of poor mental health, the implied interventions (such major redistribution of social and economic resources) are usually beyond the remit of mental health promotion alone. Thus, much of "the evidence" concentrates on helping at-risk individuals cope with adverse circumstances, rather than on bringing about major societal change (Secker, 1998). In short, we are still fishing for much of our evidence "downstream", rather than "upstream" where poor physical and mental health is created. We need now to prioritize the collection of evidence on the effectiveness and cost-effectiveness of the very policies that contribute to the creation of positive mental health and the prevention of poor mental health.

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Policy and Practice

Chapter 16 • Mental Health Promotion: An Important Component of National Mental Health Policy

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Investing in mental health promotion

An important debate for many countries is how they should invest their mental health resources. At one extreme, it has been argued that with minimal resources available these should be invested to maximize the mental health of whole populations through mental health promotion strategies, particularly when the base level of mental health in the population is low. At the other extreme, it has been argued that these minimal resources should be invested to maximize the mental health outcomes of those with severe mental disorders, a group whose rights are often violated and who are in great need of evidence-based treatment and care. As discussed in earlier chapters, however, an effective mental health system requires an investment in both promotion and treatment. While a dedicated mental health budget may be largely used for the treatment and care of people with a mental disorder, mental health policy can be influential in shaping activities in other sectors and harnessing resources for mental health promotion activities. Rather than being competing priorities, mental health promotion and mental health treatment and care are complementary components of the spectrum of strategies needed to improve the mental health of the whole community (WHO, 2002).

Mental health promotion needs to be integrated as an important part of policy to give it the status and strategic direction required for it to be implemented successfully. As discussed elsewhere in this volume, the goals of mental health promotion are not the sole responsibility of the mental health sector. Many other sectors have the potential to positively impact on the mental health of the community. Mental health policy should have a role in advising other sectors on how to promote mental health, for example by advising education departments about the school environment and promoting projects that support people who are unemployed. Many mental health promotion activities can (and should) be funded from other budgets and coordinated through a mental health policy or plan.

What is mental health policy and why is it important?

Mental health policy is an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. It outlines a vision for the future and helps to establish a model for action (WHO, 2003). When well formulated, mental health policies also identify and facilitate agreements for action among the different stakeholders in the mental health field and designate clear roles and responsibilities. Without policy direction, lack of coordination, fragmentation and inefficiencies in the system will weaken the impact of any mental health intervention.

Mental health policy may be subsumed as part of a larger and broader social policy, be integrated into a more general health policy or be designed as a stand-alone policy. Generally speaking, if it is developed as part of a broader social policy, the emphasis on and commitment to mental health promotion is likely to be more substantial because mental health is being conceptualized at a social, political and cultural level. There is also more opportunity to engage a wide range of stakeholders representing different sectors in policy development and implementation. If the scope of the policy narrows to the health level, the number of stakeholders with active involvement and commitment to all aspects of the policy is reduced, given that most of the primary

actors will be from the health sector. There is even further narrowing of opportunity as the scope of the policy moves from the health sector through to the mental health sector. This is not to argue that mental health promotion cannot be an important component of a stand-alone mental health policy, but rather that a concerted effort must be made to engage a large number of stakeholders from different sectors in the policy development and implementation process. Without this participation, the opportunities for identification of the broader determinants of mental health and implementation of strategies for long-term sustainable change are limited. Mental health professionals have a necessary, but not sufficient, role in mental health promotion (Herrman, 2001).

Components of policy

A policy normally comprises a vision statement, a statement of the underlying values and principles, a set of objectives that help implement it and a description of the major areas of action to achieve the policy objectives and fulfil the ultimate intentions of the policy.

Vision statement

The vision of a mental health policy represents a general image of the future of mental health in a given population. It should set high expectations as to what is desirable for a country or region in the realm of mental health. At the same time it should be realistic, taking account of what is possible with reference to available resources and technology. In its final formulation the vision statement should incorporate the main elements of a mental health policy and blend it into a description of what is to be expected or achieved some years after its implementation. Through the vision statement the overall orientation of the policy becomes clear (WHO, 2003). For example, a vision statement that specifies the improvement of mental health among all individuals is one that reflects a commitment to incorporating mental health promotion strategies. In contrast, a vision statement that focuses on reducing the mental health burden reflects an emphasis on treatment and care. It is common for a country's vision statement to incorporate both elements to varying degrees.

Values and principles

Values and principles are the basis from which governments develop objectives and courses of action and strategies. Values refer to the judgments or beliefs about what is considered worthwhile or desirable; principles refer to the standards or rules to guide actions and should ultimately emanate from values. During the process of formulating a mental health policy it is necessary to discuss which values and guiding principles should be adopted (WHO, 2003). For example, the value of "psychological well-being" may lead to the adoption of mental health promotion as one of the main principles guiding actions and strategies to improve mental health. It might also lead to a principle of intersectoral collaboration and community development as an important framework to be adopted to improve mental well-being.

Objectives

Objectives are measurable goals that break the policy's vision down into achievable tasks. Following guidance from the World Health Report 2000, objectives should aim to improve the health of the population, respond to people's expectations and provide financial protection against the cost of ill-health. Implicit in these objectives is a clear and certain role for mental health promotion to improve health and respond to people's expectations (WHO, 2000).

Areas for action and strategies

Once the objectives of the mental health policy have been clarified, a number of areas for action and strategies need to be identified in order to take these objectives forward. An effective mental health policy should consider the simultaneous development of several areas: financing, legislation and human rights, organization of services, human resources and training, promotion, prevention, treatment, rehabilitation, advocacy, quality improvement, information systems, research and evaluation (see figure 16.1). Some of the more important actions for mental health promotion are briefly discussed below. A more detailed description of the areas for action can be found in the *Mental Health Policy and Service Guidance Package* (WHO, 2003).

Implicit in a mental health promotion approach is that strategies to improve mental health should be available and accessible to all individuals, especially marginalized populations, disadvantaged groups and people living in poverty – those most likely to be excluded. This has implications for mental health financing, to ensure that mental health is included in basic health packages and health insurance schemes. It also has implications for the distribution of mental health resources in terms of equity and efficiency. Simply stated, resources committed to mental health promoting activities should consider the needs of certain disadvantaged groups as well as the whole population to promote equity and should be based on effectiveness and cost-effectiveness data to maximize efficiency.

In order to promote mental health and the well-being of populations, issues such as service accessibility, community integration, non-discrimination, autonomy, liberty, postpartum leave to foster mother-infant bonding, mental health promoting work environments and protection from domestic violence and sexual abuse need to be addressed.

A number of activities may be initiated to serve the objectives of mental health promotion. Services need to be reorganized and reoriented to deal with psychosocial aspects of mental health and to provide interventions to improve mental health at individual and community levels. Human resources need to be developed in line with these changes. Essential drug procurement and distribution processes need to ensure that cost-effective treatments are widely available. Quality improvement strategies are also needed to ensure that policy, legislation, regulations and funding are appropriately aligned to achieve mental health improvement goals. Information systems need to incorporate measures and indicators of quality of life and, as indicated throughout this book, investment in research and the evaluation of policies and services needs to contribute to the evidence base for mental health promotion to ensure that resources are allocated cost-effectively.

Advocacy is an important activity, but the emphasis of advocacy should not be exclusively on the protection of the rights of those with severe mental illness, which has traditionally been the case, but rather combine this with promotion of mental health in the general population. In other

words, advocacy for the rights of every citizen to have better mental health through changes in the social-political environment needs to become a major goal. Considering the methodological complexities of evaluating mental health promotion policies (see Chapter 9) and the longer time required to see positive results as compared with the evaluation of treatment and care, governments may be reluctant to invest in these types of strategies. Advocacy from community organizations is often required to encourage governments to implement mental health promotion strategies.

Both health and social services have an important responsibility to involve users and carers in the development and implementation of their services (Dunn, 1999; Mental Health Foundation, 2000). The impact of the stigma and discrimination associated with mental disorders is pervasive and affects people's willingness to seek health services, their housing circumstances and their opportunity to participate in education and employment (Hocking, 2003). Mental health promotion strategies to reduce the stigma of mental illness can have a positive impact on people's willingness to seek treatment for mental disorders as well as their ability to participate fully in civil society.

Figure 16.1
Principal areas for action in mental health policy

Areas for action

- Financing

- Legislation and human rights

- Organization of services

- Human resources and training

- Promotion, prevention, treatment and rehabilitation

- Essential drug procurement and distribution

- Advocacy

- Quality improvement

- Information systems

- Research and evaluation of policies and services

- Intersectoral collaboration

Intersectoral collaboration – making health promotion work

Mental health promotion depends on the expertise, resources and partnerships formed across all sectors and disciplines. Multisectoral action is fundamental and requires serious discussion and a clear understanding, acceptance and statement of the distribution of roles and responsibilities between different government sectors/ministries. Achieving multisectoral collaboration is challenging as the different sectors attempt to work towards a shared goal within differing cultural and organizational structures.

A number of key success factors for intersectoral collaboration can be identified. The engagement of key stakeholders at the beginning of the process is essential. The process of formulating a mental health policy and identifying mental health promotion interventions provides an opportunity to ensure all partners share a commitment to a common goal. Intersectoral collaboration requires broad policy support from a wide range of health and social policies. The inclusion of mental health promotion goals within a broad policy framework assists in obtaining the political support necessary for successful collaboration. Collaboration should include both horizontal linking (that is, linking mental health with the health, education, employment, social welfare, justice, user and family sectors) and vertical linking (that is, linking national, regional and local networks). A focus on concrete objectives and achieving results rather than setting up complex collaboration structures assists in keeping stakeholders committed and motivated. It is essential that the agenda is guided by the goals of the collaboration rather than the interests of a few stakeholders. Collaboration needs to develop over time. Policy assists in providing clear guidance on the roles and responsibilities of each partner and provides concrete strategies to achieve objectives. Finally, it is essential to invest in the alliance. Effective collaboration requires time and resources (Advisory Committee on Population Health, 1999).

Examples of strategies for mental health promotion

Mental health promotion works at three levels: strengthening individuals, strengthening communities and reducing structural barriers to mental health. At each level it is relevant to the whole population, to individuals at risk, to vulnerable groups and to people with mental health problems (mentality, 2003).

Such a framework is useful for conceptualizing the entry points for promotion within a mental health policy. Ultimately, however, the most appropriate entry point for mental health promotion will depend on information derived from a needs assessment and the social, cultural, gender, age-related and developmental contexts of specific countries. For example, an Iranian mental health initiative shows how changes in the sociodemographic status of a country can be reflected in mental health policy. The national programme, launched in 1988, was mainly focused on integration of mental health into primary care. In recent years there has been a rising number of young people (about 16.5 million school students) and a rapid process of urbanization. The associated psychosocial consequences are being addressed predominantly via mental health promotion activities in schools (Yasamy et al., 2001).

Other examples of strategies that could be considered for inclusion in mental health policies at each of the three levels are described below.

Strengthening individuals

This involves strengthening individuals and their emotional resilience through interventions designed to promote self-esteem and life and coping skills such as communicating, negotiating, relationship and parenting skills. Examples of mental health promotion activities that aim to strengthen individuals include mother-infant programmes and life skills programmes for children (Department of Health, 2001).

Mother-infant programmes

The psychosocial and cognitive development of babies and infants depends upon their interaction with their parents. Programmes that enhance the quality of these relations can substantially improve the emotional, social, cognitive and physical development of children. These activities are particularly meaningful for mothers living in conditions of stress and social adversity. For example, the USA-STEEP (Steps Towards Effective Enjoyable Parenting) Programme (Erickson, 1989) targeted first-time mothers and others with parenting problems, particularly in families with a low educational level. There was evidence of reductions in anxiety and depression, better organized family life and the creation of more stimulating environments for children as a consequence of participation in the programme. Mother-infant programmes which run throughout Europe (Fonagy & Higgitt, 2000; Olds et al., 1997) and the Triple P (Positive Parenting Programme) developed at the University of Queensland in Australia (Sanders, 2002; Sanders, Turner & Markie-Dadds, 2002) are other examples of effective programmes.

Life skills programmes for children

Teaching children life skills can foster healthy social and emotional development. Social and emotional skills such as problem-solving, creative and critical thinking, self-awareness, communication, interpersonal relations, empathy, emotional self-control and appropriate expression will enable children and adolescents to develop sound and positive mental health (Elias & Weissberg, 2000).

Strengthening communities

Strengthening communities involves increasing social inclusion and participation, improving neighbourhood environments, developing health and social services which support mental health, implementing anti-bullying strategies at schools, improving workplace mental health, ensuring community safety, providing childcare and encouraging self-help networks (Department of Health, 2001).

Neighbourhood and local community programmes

There is mounting evidence that high levels of social support, participation in social networks and opportunities for the exchange of skills and information can strengthen resiliency to a number of socioeconomic stressors. Such findings have led to a number of mental health promotion strategies to improve the cohesiveness and strength of small communities and neighbourhoods. This approach attempts to improve the key elements of social capital: social resources (social and other contacts between neighbours), collective resources (self-help groups and community safety schemes), economic resources (opportunities for employment) and cultural resources (libraries, local schools, markets, etc.) (Cooper et al, 1999; McKenzie, Whitley & Weich, 2002; mentality, 2003). National mental health promotion policies should advocate seriously for people-friendly commu-

nities that provide, for example, patient-friendly hospitals, customer-friendly malls, client-friendly offices and worker-friendly worksites.

School programmes

It is clear that schools remain crucial social institutions for the education of children in preparation for life. As such they need to be more involved in a broader educational role, fostering healthy social and emotional development of pupils. A child-friendly school that encourages tolerance and equality between boys and girls and different ethnic, religious and social groups will promote a sound psychosocial environment. Such a positive environment encourages active involvement and cooperation, avoids the use of physical punishment and does not tolerate bullying. It helps to establish connections between school and family life, encourages creativity as well as academic abilities and promotes the self-esteem and self-confidence of children. Whole-of-school approaches and specifically the inclusion of anti-bullying strategies are particularly useful (Lister-Sharp et al., 1999; Olweus, 1993).

Worksite programmes

There is a growing awareness of the role of work and the potential of the work environment to promote mental health. While there is a strong positive relationship between having work and good mental health, the work environment itself can also mediate the positive effects of personal identity, self-esteem and social recognition. This is not surprising given that a large number of people spend most of their adult life in a work environment. A number of areas of action have been identified: increasing an employer's awareness of mental health issues, identifying common goals and positive aspects of the work process, assessing workload, creating a balance between job demands and occupational skills, enhancing job control and decision-making latitude, enhancing social support and training in social skills, developing the psychosocial climate of the workplace and providing counselling and early rehabilitation strategies (mentality, 2003; Williams, Michie & Pattani, 1998).

Health and social services

Health and social services should aim to promote health for all as well as reduce discrimination against and promote the social inclusion of individuals and groups with mental health problems (mentality, 2003). Two important recommendations from the World Health Report 2001 are that mental health services be developed in the community and that mental health interventions be integrated into general health and social services (WHO, 2001). This will promote greater acceptability of services and improved access, thus achieving some important mental health promotion objectives. In addition, mainstreaming mental health services into general health and primary care provides an opportunity for all health care workers to deliver mental health promotion through early identification and management of mental health problems, educating the public about mental health and activities to improve mental health, providing information to patients on any identified problem and involving them in decisions about their care, and linking people with necessary social support and other formal and informal community services and resources (Department of Health, 2001; WHO, 2001).

Social services have similar responsibilities to health services in promoting mental health. They need to assess needs and match and refer people to available support services and activities. They can also incorporate mental health promotion activities as an integral part of the services that they provide. For example, youth drop-in centres could address issues such as interpersonal rela-

tionships, building of social skills, vocational guidance and stress management. Such services can also have a much broader focus tackling issues such as equity of access that are underpinned by mental health promotion values (Department of Health, 2001).

Reducing structural barriers to mental health

Structural barriers to mental health can be addressed through initiatives to reduce discrimination and inequalities; promote access to education, meaningful employment, housing and health services; and provide support to those who are vulnerable (Department of Health, 2001). Some examples are given below.

Labour and employment

The work environment should be free from all forms of discrimination and sexual harassment. Acceptable working conditions have to be provided and mental heath services provided, either directly or indirectly, through employee assistance programmes. Policies should also maximize employment opportunities for the population as a whole (e.g. programmes to create jobs, vocational guidance training) and retain people in the workforce, particularly because of the association between unemployment and the increased risk of mental and behavioural disorders and suicide. Work should be used as a mechanism to reintegrate people with mental illness into the community. Government policy can be instrumental in providing incentives for employers to employ people with severe mental illness and enforcing anti-discrimination policy (WHO, 2001).

Commerce and economics

Economic policies may either promote or worsen positive mental health depending on how they are formulated. Many economic reforms have had as a major goal the reduction of poverty, which could be expected to have the positive effect of promoting mental health. It has been noted, however, that such reforms can have the opposite effect because, although improving absolute income levels in a country, they may have an unintended effect of increasing inequalities in income and access to education, factors which are associated with poor mental health (WHO, 2000). Strategies to improve mental health need to include serious debate about and consideration of the effects of economic policies. Development programmes can ensure that economic reforms benefit poorer people in the country by reducing the regulatory load on small business, promoting core labour standards and improving access to financial markets (World Bank, 2001). Economic reforms need to reduce relative poverty in countries if they are to have a positive impact on the mental health of the population.

Education

An important determinant of mental health is education. Promoting education in the population will improve mental health. Positive impacts on mental health have been reported for children attending and completing primary school, with additional benefits being seen for those children proceeding onto and completing secondary school. The type of education offered, freedom from discrimination at school and the needs of special groups, such as children with learning disabilities, also need to be considered (WHO, 2001).

Evaluation of mental health promotion policy

As discussed elsewhere in this volume, the evidence of the effectiveness of specific mental health promotion interventions is limited. There has also been minimal evaluation of the impact of social and health policies on the mental health of the population. It is critical that any mental health promotion policy include evaluation strategies. This should not be limited to the evaluation of specific mental health promotion interventions but also include actions to assess the overall impact of the policy on the mental health of the community.

Mental health outcomes should also be included in the evaluation of broad health promotion programmes. Such evaluations would provide opportunities for advocacy, reduction of stigma and improvement in the cost-effectiveness of interventions. The inclusion of mental health indicators into the evaluation of general health promotion programmes may result in mental health funds and stewardship being diverted to general health problems with no appreciable benefits to the mental health of the community, however (WHO, 2002). A sound policy would consider thoughtful integration while keeping track of the mental health initiative. One example is the inclusion of mental health indicators as outcome measures for school health promotion programmes. While this would be an opportunity to integrate mental health promotion programmes with generic school health programmes, it is essential that the mental health components of the evaluation remain visible and encourage the understanding of mental health as a component of all health.

Conclusion

The inclusion of mental health promotion into the social and health policy agendas will ensure that mental health promotion strategies are well coordinated and integrated into the strategic direction of governments. A well-formulated policy can increase access, improve equality of outcomes (not only for health but also for education and other social programmes), improve social support, enhance social capital, increase acceptance of diversity (including people with mental health problems) and enhance the mental and physical health of whole communities. In many countries advocacy will be required to convince decision-makers of the value of including mental health promotion in their policy agenda.

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Chapter 17
Strategies for Promoting the Mental Health of Populations

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Introduction

This chapter looks at the broad issue of conceptualizing and planning strategies for mental health promotion. Our intention is to discuss mental health promotion first and foremost as a population-based exercise – that is, we are primarily concerned with aggregations of people rather than individuals, while at the same time not forgetting that these populations are indeed made up of thinking, feeling, intensely individual people in their family and community environments.

For any effective approach to mental health promotion, it is crucial to be clear about what is meant by "mental health". This relates to the outcomes desired from any action, the processes involved and, in particular, the whole paradigm within which strategies exist. As is discussed elsewhere in this book, mental health promotion should be operating out of a *positive* view of mental health. This is more than mere pleasant sounding rhetoric. The adoption of such a perspective dominates any other consideration and is the determining factor as to how mental health promotion is actually done. Still, to date, mental health promotion planning and action seem to slip easily back into a "negative" or pathologized view of mental health, where the driving motivation is prevention of disease and disorder – a deficits approach – rather than the promotion of good mental health – an assets or strengths approach. This is not to say that the prevention of mental disorders is not important or necessary. On the contrary, we think that the two activities are complementary and partially overlapping, but nonetheless based on different paradigms.

Another important assumption to start with is that mental health promotion has the capacity to go right to the core of what societies value most, and what their fundamental purpose is. It also relates fundamentally to the way that governments perceive their task. The ultimate goal of caring nation states and communities around the world is to provide for people's basic needs (e.g. peace, food, shelter, employment, income, education, social justice and equity) and to ensure living conditions and environments that promote and support their personal growth, health, mental health and well-being. Individuals who live in supportive "resourcing" environments are able to experience their intrinsic resourcefulness and to participate in and contribute to the global productivity and wealth of their communities and countries (Joubert & Raeburn, 1998).

It is within such a vision of good faith and shared responsibility that health, obviously including mental health, was formally recognized in the Ottawa Charter as a "major resource for social, economic and personal development and an important dimension of quality of life" (WHO, 1986). The view of health as a positive resource has been echoed in many other international conferences, declarations and documents before and since. Examples include the Thirtieth, Thirty-Second and Thirty-Fifth World Health Assemblies (WHO, 1977, 1979, 1982), the Second, Third and Fourth International Conferences in Health Promotion (WHO, 1988, 1991, 1997) and the Alma-Ata and Jakarta Declarations (WHO, 1978, 1997).

Despite these attempts to move towards a positive view of individuals' physical and mental health within the broader context of community and population health, and despite various studies indicating that huge investments in curative health services alone do not always lead to the expected substantial improvements in population health (Lalonde, 1974; Evans, Barer & Marmor, 1994; Hayes & Dunn, 1998), the systematic development of strategies and actions to promote people's health has remained secondary to the development of and investment in treatment and rehabilitation

services. In other words, most health systems and health organizations, and their related indus-tries (e.g. research, pharmaceuticals and new technologies), are still predominantly focusing on and financing the diagnostics, treatment and rehabilitation of physical diseases. Within this con-text, mental health represents a small fraction of overall health budgets, and what mental health funding there is goes mainly into the clinical treatment of mental diseases or disorders.

The imbalance of investment between the treatment of diseases and the promotion of health, in particular mental health, raises many questions, especially when considering the data on the extent of mental health related problems around the world and the associated human burden and economic costs (Murray & Lopez, 1996; Stephens & Joubert, 2001; WHO, 2001, 2003). Having said that, the intention is not to get into a discussion on the divergent interests or forces at play but rather to make a simple point: it will not be possible to move forward into promoting the mental health of individuals, communities and populations without going beyond solely a disease-based view of mental health.

Such a statement is not to deny that there are mental health problems or disorders that require attention. However, it is to remind ourselves that perhaps the majority of mental health problems encountered are the result of difficult life events, conditions and environments that diminish or disable people's resourcefulness or capacity to cope and access to social supports. Furthermore, the burden of mental health problems not meeting the criteria of a disorder may be similar to or even bigger than the actual disease burden. As stated almost 20 years ago in the Ottawa Charter, what is needed in order to better address the health, and mental health, of entire populations is actions that primarily focus on creating supportive environments and fostering individuals' resourcefulness and capacity to take control and make healthy choices. Such mental health pro-motion strategies are presented in this chapter.

Mental health and its promotion

But what are mental health and mental health promotion? How do they relate to the health of individuals, communities and populations? How also do they relate to considerations of treat-ment, prevention and recovery? These are concepts and questions that have been discussed extensively in earlier chapters. Our view is that mental health relates primarily to emotions, thou-ghts, relationships, behaviours and spirituality (Lahtinen, 1998); to individuals' capacity to enjoy life and to deal or cope with the challenges they face (Joubert & Raeburn, 1998); and thus to a positive sense of well-being. This includes individual resources such as self-esteem, optimism, a sense of mastery and coherence, the ability to initiate, develop and sustain mutually sustaining relationships and the ability to cope with adversity (Lavikainen et al., 2000). Nevertheless, most often, especially among professionals within formal and influential institutions and organizations, mental health is referred to, researched and debated within a pathological context – the language of which is of deficiency, disability and disorders. This is strongly illustrated by the content of numerous professional journals and reports produced worldwide on mental ill-health.

As most mental disorders are considered to be environmentally caused, there is a risk that human suffering, a likely reaction in extreme circumstances, is categorized as a mental problem and thus medicalized. When people are facing major stresses caused by unstable family, social, economic and political conditions, when their basic physical and mental needs are threatened, and when they are stigmatized and isolated while facing such situations, the suffering and the distress is tremendous. The reactions that individuals may display when they are distressed or are fighting

for their lives are frequently confused with mental disorders. However, a considerable body of longitudinal research shows that when their basic life conditions are restored, when the suffering experienced is recognized and legitimized, and when it is possible to count on family and social support, the capacity to recover – the resiliency – and the capacity to build meaning out of the suffering is astonishing. Furthermore, the vast majority of individuals are able to learn from adversity and to move on with their life in an enhanced way (e.g. Cyrulnik, 1999, 2001, 2003; Henderson, Benard & Sharp-Light, 1999; Pransky, 1991, 1998; Werner, 1994; Werner & Smith, 1992). These kinds of human processes are fundamental to a mental health promotion extended beyond a pathologized clinical and short-term frame of reference.

The approach for promoting the mental health of people that is presented in this chapter is first and foremost based on a fundamental faith and trust in people's humanity, a positive view of mental health and on a strong belief in all individuals, including people with mental health problems or disorders. This involves an inner resiliency, a capacity to "be, belong and become" on everybody's own terms within supportive environments. We believe that any mental health promotion activities should be based on a "people-centred" approach (Raeburn & Rootman, 1998) that focuses on empowering individuals and communities to take control over their own lives and mental health while showing respect for culture, equity, social justice, interconnections and personal dignity (Joubert & Raeburn, 1998). For instance, human or social enterprises aimed at promoting the mental health of entire populations should be considered a long-term investment by nations or governments. Such investment obviously requires initial financial and other support but would progressively pay itself off through reduced costs in health and social services. As a structural change, such an approach becomes sustainable because of individuals' and communities' direct involvement and participation, and the strength and productivity they get from their own involvement (see Durning, 1989; Lord & Farlow, 1990; Pransky, 1991; WHO 2002).

Three levels of action

It is probably helpful to consider the population approach to mental health promotion at three broad levels of analysis: macro or societal, meso or community and micro or individual. Each of these has its own set of conceptual and strategic considerations.

First, at the societal level the major preoccupation is with policy. Policy is often seen as a somewhat regulatory matter, but it can also be seen as representing a statement of principles and values by individuals, communities and societies relating to their goals and desired courses of action (see Chapter 16 and Jenkins et al., 2002). While much policy tends to be formulated by experts in their offices away from "real life", communities need the opportunity to deliberate together about mental health and its contribution to their overall health, sense of well-being and quality of life (Joubert, 2001a). In short, there is no reason why policy development should not be a participatory and empowering process in its own right, and therefore mental health promoting. An example of a step towards such participatory policy development processes has been provided by a few governments that allow a consultative debate on the Internet on policy proposals. Another example involves relevant stakeholders in participatory country situation appraisals prior to policy development (see Jenkins 2004 at www.mental-neurological-health.net).

Second, at the meso or community level, the desirable situation is that mental health promotion strategies and activities are decided on, developed and applied by people where they live their day-to-day lives. Here, "community" includes families, schools, workplaces and various community

organizations and settings as well as whole geographical localities and neighbourhoods. For example, in the workplace concerns about significant decreases of productivity in the private and public sectors have resulted in studies that have clearly indicated that in order to reduce high levels of stress, burnout and overall absenteeism, employers and employees have to work together to identify, discuss and agree on managerial and individual practices that need to be improved or radically changed (Marmot, 1997, 2003; Marmot & Wilkinson, 1999). Organizations and industries that have adopted healthy workplace guidelines and programmes focusing on increasing and fostering a sense of control, initiative, participation, appreciation, self-esteem and self-worth, as well a sense of belonging and support among employees and employers, have experienced major improvements in their human and business conditions (Lowe, 2003a, 2003b; Lowe, Schellenberg & Shannon, 2003). There are also examples of entire communities facing major social problems (e.g. high levels of violence, child abuse, delinquency, dropping out, drug trafficking and teenage pregnancy) that have succeeded in transforming what seemed to be intractable living conditions by primarily focusing on people's innate resiliency and capacity for well-being, for wisdom and for common sense instead of trying to change destructive conditions that kept people immersed in their problems (Durning, 1989; Pransky, 1991, 1998).

The third, micro or individual level is the oldest and most traditional sphere of mental health work. Here, mental health promotion strategies define themselves through various activities or practices that aim to promote, build on, increase or foster primarily individuals' strengths, resourcefulness or resiliency. Life skills such as social competence (responsiveness, cultural flexibility, empathy, caring, communication skills and a sense of humour), problem-solving (planning, help-seeking, critical and creative thinking), autonomy (sense of identity, self-efficacy, self-awareness, task mastery and adaptive distancing from negative messages and conditions) and a sense of purpose and belief in a bright future (goal direction, educational aspirations, optimism, faith and spiritual connectedness) are examples of individual mental health dimensions that are being targeted in programmes designed to increase resiliency in young people (Benard, 1991, 1993a, 1993b; Henderson, Benard & Sharp-Light, 1999; Rowling, Martin & Walker, 2002).

Many of the factors and conditions that impact negatively on the health and mental health of individuals, communities and overall populations often result from situations that go far beyond the direct control of individuals. Analysis of the health status of populations and its determinants has revealed how major economic, political and social decisions taken at the macro level by governments (for example, economic restructuring) can impact negatively on people's lives, health, mental health and well-being (Stephens, Dulberg & Joubert, 1999). At the opposite end of the spectrum, when these decisions are taken within a partnership and participatory approach that fully recognizes and supports individuals and communities in their capacity for self-determination, they become instrumental in major social changes that are beneficial to the whole population (Maxwell et al., 2003; MacKinnon, 2003; Phillips & Orsini, 2002). Mental health and social policies that espouse an empowering approach allowing for the participation and reinforcement of individuals' and communities' capacities to take control over their destinies would undoubtedly contribute directly to the health and wealth of populations and nations.

With respect to prevention, treatment and recovery/rehabilitation, the major and powerful characteristic of mental health promotion is that it is closer to the "natural" way people see and want to live their lives. It can be asserted that human beings are much more likely to be open and responsive to approaches that increase their capacity to cope with life on their own terms, than

to ones that are prescribed from above and which victimize and reduce them to their deficiencies or disabilities. In short, an approach to mental health is advocated in a mental health promotion context that is not pathologized or medicalized, but positive and likely to resonate with people in terms of its intuitive appeal and respect for them as resourceful human beings. It is also likely to reduce the stigma currently associated with mental illness-dominated approaches to mental health issues. Indeed, the potential for the application of the kinds of mental health promotion principles espoused here – involving strength-building, resilience, empowerment, positivity and community – is increasingly being used in the treatment and recovery sector (Falloon & Fadden, 1993; Hawe et al., 1998; Rowling, Martin & Walker, 2002). The research suggests that such approaches are highly effective (Barry, 2001; Durlak & Wells, 1977; Falloon & Fadden, 1993; Health Promotion Wales, 1996; Hosman & Llopis, 2000; Pransky 1991; Tilford, Delaney & Vogels, 1997; Vinokur, Price & Schul, 1995). Our view is that the application of positive mental health promotion principles across the whole mental health sector, and as part of the whole operation and thinking of governments with regard to the well-being of their populations, could usher in a new era of enlightened thinking. When a government puts the positive quality of life of their citizens first, then the nation is sure to prosper.

The Ottawa Charter for Health Promotion as a guide to population strategies

Mental health promotion is grounded in the older field of health promotion, but also has distinctive features that render it unique. To the extent that it shares characteristics with health promotion, the Ottawa Charter for Health Promotion can be seen as a useful broad template for considering strategic action in mental health promotion.

As discussed in Chapter 2, the Ottawa Charter is still widely respected and quoted as the source document internationally for thinking and action with regard to health promotion. Its advent in 1986 represented a sea change in the historic ideology of health promotion, which during the 1970s had largely been concerned with individual lifestyles and health education (e.g. Lalonde, 1974). The Ottawa Charter represented a more population-oriented approach, which identified broad social determinants as being crucial to the overall health and well-being of populations – such matters as war, peace, a clean environment, employment, economics, housing, adequate food supplies, social justice and so on. The health of a nation was considered to depend much more on overall policies developed and imposed by governing bodies than on what individuals were able to choose to do. That is, loosely speaking, the Charter favoured a "deterministic" point of view over a "free will" one, and this is shown by the "determinants of health" language that flowed from it. In retrospect, it is probably true that the Ottawa Charter was an overreaction to the individually focused lifestyle model of the 1970s, and as a consequence may have somewhat downplayed the role of active, deciding human beings in the health promotion equation, especially in developed nations. However, the Charter's definition of health promotion as "the process of enabling people to get control over, and to improve, their health" certainly implies that people are meant to be active agents in their own health destinies.

For mental health promotion, the *control* aspect is deemed especially important. It could be argued that one's mental healthiness is directly related to how in control of one's life one feels. Health psychologists emphasize the importance of a sense of personal control for dealing with stress and for health generally (e.g. Joubert et al., 1998; Sarafino, 1998; Steptoe & Appels, 1989).

In many respects, mental health promotion is an enterprise concerned with enabling people to have more control over their lives. As a result, any discussion of mental health promotion strategies has to make the control issue a central consideration. The Ottawa Charter represents a dilemma or contradiction with regard to control. On the one hand, the definition of health promotion implies that control by people is core to the health promotion enterprise. On the other, the rather remote, policy-driven, social determinants perspective contained within that document implies that it is "others" – governments and experts – who know best, while individuals and "people" as active agents in their own health and well-being are of less importance. In short, while the rhetoric includes an empowering, bottom-up perspective with regard to "people control", the overall sense is of having to change the world in a way that only governments and major players can do – in short, a top-down, "we know best" perspective. This is the core dilemma for health promotion and mental health promotion, but – in a broader sense – the same dilemma applies to any democracy: that is, to what extent do the wishes of communities and ordinary people actually play a role in overall political decision-making (see MacKinnon, 2003; Maxwell et al., 2003; Phillips & Orsini, 2002).

One way to balance the policy and people perspectives is through a focus on community. From this point of view, the community action stream of the Ottawa Charter, which is third in the list of five streams (see box 2.1 in Chapter 2), is actually the pivotal one both literally and figuratively. At the same time, it is crucial to recognize the role of policy as a framework for whatever is done in health promotion and mental health promotion (see Chapter 16). Therefore, we do not see the issue as being one of choosing a policy perspective versus a people perspective, but rather of requiring both – that is, the optimal approach involves both policy and people components, equally and synergistically balanced.

Since the Ottawa Charter was not put together with mental health promotion as we now understand it in mind, let us see what it has to offer to mental health promotion. Indeed, the implicit understanding in the Charter is that it is very much centred on physical health and disease. It is a document addressed more to governments and high-level decision-makers than to "the people". As stated, the Charter draws attention to health determinants that are beyond immediate individual control and which relate more to the macro than to the micro environment of people. This was an almost revolutionary statement for the time (1986) in the light of both the history of an individualistic view of health promotion and, on a wider scale, the move in a neoliberal direction economically by many developed countries, given the emphasis on the individual in those policies. But the Charter is even more revolutionary now, after almost two decades of free market macroeconomic policies throughout the world and the hegemony of the exponentially increasing understanding of the human genome and rapid development of medical technology. That is, we are in an era of individualism and the determinism of genetics as the ascendant social philosophies, at least in the developed countries, as discussed in Chapter 10.

Nevertheless, the Charter's implied suggestion is that the empowered and democratic actions of people in local communities can have a significant impact on the scheme of things. It is contended here that this people-driven democracy dimension represents a very significant consideration for action and strategy in population-based mental health promotion. The main goal which mental health promotion should be striving towards is people's resilience, obtained through self-determined action by and under the control of those people in their local, naturalistic settings – an "empowered community action" perspective.

The Ottawa Charter states that good health is an holistic and ecological matter, and that health is a positive concept, in line with the previous discussion. It also, as mentioned before, describes health as a "resource for living". Without good mental health people are impaired or struggle in their daily lives. Interestingly, the Charter does not state that good health is every person's right, or that governments have a responsibility towards their citizens with regard to good health. However, it implies that it is the duty of every government to attempt to optimize the conditions fostering mental health and well-being and quality of life of all its citizens. The Charter specifies that for the professionals concerned with health promotion, processes of advocacy, mediation and enabling are required. In mental health promotion the professional's role is seen primarily as one of the facilitation of self-determined, community-controlled processes, rather than doing things to or for people, which simply creates dependencies and is ultimately disempowering.

In order to bring about conditions of good health in their citizenry, the Charter encourages governments to look at action in five different areas: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (see Chapter 2). It is these "action streams" that most people have taken out of the Ottawa Charter as its main contribution, although regrettably often overlooking the implied empowerment agenda associated with them (which is that the people themselves should be determining the parameters and action with regard to these streams, rather than governments in a vacuum). The action streams provide a useful checklist of what should be looked at when considering strategies for any health promotion or mental health promotion endeavour.

Healthy public policies

The Ottawa Charter refers to all public policies, not just to health (or mental health) policies (Milio, 1986). Indeed, there is presently an increased awareness that most societal structures and actions will impact on health and mental health, and of the need for advocacy about this reality in the policy sphere. In recent years, the concept of considering and assessing the health impact of public policies has helped to operationalize this aspect of health promotion, which may be seen as one of the major political contributions of the Charter at the global level.

Even in developed countries, the mental health of populations has typically had a very secondary role compared to general health in health policies, not to mention other socioeconomic policies. For various reasons, among which is its association with mental diseases, mental health as an issue tends to remain isolated – politically, theoretically, organizationally and professionally. Perhaps one of the most essential tasks of mental health promotion is to engage in policy-related advocacy which aims to enhance the visibility and value of positive mental health at the level of governments, society at large, communities and individuals (Lavikainen, Lahtinen & Lehtinen, 2000). The objectives include the integration of positive mental health into general and public health agendas and the strengthening of societal action conducive to mental health.

Mental health and well-being are broad concepts, and the array of societal policies that can affect health and well-being is huge and diverse. The difficulty in providing unambiguous operationalization of this action stream, and the lack of availability of feasible indicators for processes, impact and outcomes, may make the concept of "healthy public policies" seem rather vague. It is suggested here that we divide policies with regard to mental health promotion into two broad types and look for indicators accordingly. One class of policies is those which have an indirect effect on enhancing mental health (as well as physical health and general well-being), such as employment,

housing, economic factors, education, safety, control of gambling and so on, which can be called policies to do with the "public good". The other class of policies is those where the direct intent is the enhancement of mental health and well-being, such as school curricula to do with communi-cation skills, parenting support, stress management in the workplace, facilities for the well-being of older people, support for community development and self-help, violence prevention, bullying prevention, promoting cultural awareness, media campaigns on how to improve mental health and so on. Effort needs to be put into delineating process and outcome criteria for the assessment of the impact of both types of policies on mental health and well-being, some of which have to be capable of measuring very long-term and sometimes tangential effects. As processes of mental health promotion have an essential role in changing attitudes and conceptions and improving knowledge, their importance can not be emphasized too much.

Development of mentally healthy policies is essential at all levels. International efforts in policy development bring stimulus and significant added value to the development of national, regional and local approaches and vice versa. Reflecting the Ottawa Charter's definition of health, this poli-cy development should probably be around the concept that positive or good mental health is a resource that is essential for the optimal operation of a society, including productivity. Favourable conditions for good mental health should also be regarded as being everyone's right as a citizen, and governments therefore have a duty to articulate and ensure this and to acknowledge that social factors – over which they have a great deal of influence – have a major impact on mental health. The challenge is to bridge, theoretically and practically, the gap between broad policies and individual and collective "people" dimensions of mental health, which we have already allu-ded to as the fundamental issue in the design of mental health promotion strategies.

Just as mental health has largely been viewed through a pathology lens, so too has it tended to be considered solely a matter for individuals to deal with. Only recently has mental health been accep-ted as a public or population health and societal issue (e.g. Ellis & Collings, 1997; Joubert, 2001b; Joubert, Williams & Taylor, 1996; WHO, 2001). Mental health seen at a societal level, and as some-thing that everyone "has", is an area that needs to be taken seriously by policy-makers (Jenkins et al., 2002). It is clear that overall capacity building for policy development and implementation for the promotion of positive mental health is an essential part of any state's social agenda. Broadly understood, identifiable leadership in public administration relating to the mental health of populations is a prerequisite of consistent policy and its implementation, and a knowledge base with good quality information, data and statistics is required for planning and follow-up activities. WHO strongly recommends that national mental health promotion policies take the form of a written policy document (WHO, 2003), which may in turn be important for getting an adequate financial commitment to the promotion of mental health. To consolidate any such policy, it should be reflected in legislation.

A mental health promotion policy is one that is based on a clear concept of positive mental health, needs assessment, and the definition of short-term objectives and long-term goals (see Chapter 16). As with any policy-making, mental health promotion policy should be continuously redrafted. Special attention should in this regard be given to communication with nongovern-ment organizations, communities and people. Any area of policy is enhanced by people-centred public consultation. For mental health promotion in particular, where the core values are those of a community-driven, empowerment approach, significant interaction between policy-makers and the community is essential. Mental health is a very personal, very intimate matter related to the

fabric of people's everyday lives (on which many policies directly impinge), and so it is essential to hear those voices which may normally be silent in the policy-making sector.

A final but perhaps most important point to make relates to equity. As discussed in earlier chapters, there is strong evidence that the worst mental and physical health occurs in situations of greatest societal inequity – in developed countries at least (Fryers, Melzer & Jenkins, 2003; Wilkinson, 1996). New research is indicating that the social gradient of health is strongly influenced by factors such as social position, relative versus absolute deprivation, sense of control and social participation, even among people who are not poor (Marmot, 2003). That means that both at a structural-political level, which involves such matters as a state's philosophies about economics and welfare, and at a more micro level, for example everyday procedures in public services and organizations, it is essential that all groups are heard and supported. Many modern societies are multicultural, often with recent migrant populations or with indigenous populations that have been colonized. Many nations have groups of displaced or disadvantaged people for whom the stresses of life are considerable. In policy development, the factor of culture – largely missing from the Ottawa Charter – needs to have top consideration, and the effort to hear the voices of the most oppressed, disadvantaged and suffering has to be made. There are many who would argue that the most disadvantaged in any society are the stigmatized mentally ill. Not only does this support call for a less pathologized approach to mental health, but it also says that the voices of those most negatively affected by sub-optimal mental health are vital in the input to overall mental health promotion policy-making.

Supportive environments

The role of health in the interaction between people and their environment is particularly underlined in health promotion. Environmental health strategies have become a standard part of health policies everywhere. However, the scope of environmental health is often still somewhat limited to "bugs and particles", such as water quality and air pollution, areas which are concrete and operational. Less attention has been paid to the social and macro environments, and to the mechanisms through which they exert an influence on health.

A large proportion of human physical and social environments are planned, and much of this involves planning for, rather than with, people. At the community level, the resulting structures either facilitate or block the development of social networks, neighbourhood collaboration and everyday connections for social contacts. In the same way, workplaces have their organizational structures and cultures that are innate and difficult to change without pressure from staff, unions or other interest groups. A mental health promotion perspective would support such concepts as the Movement for Socially Responsible Organizations, the "Nissan Way" or worker democracy, where those "lower" in the formal power structure have a significant and meaningful input into planning, policy and decision-making, a process which honours their expertise, experience and innate wisdom. Such general philosophies could also be applied to communities at large.

The interplay between the person and the environment is probably even more important for mental than it is for physical health promotion, due to the interactional, contextual and developmental determination of mental health. Particularly important here is the interaction between the sociopolitical environment and family structures. There is wide agreement about the importance of early life experiences and their influence on individuals' mental health that is often more powerful than genetic factors. Certainly, no matter how healthy the genes, a baby or child subjected to any

kind of abuse is likely to bear the scars of that, with likely ill-effects on later mental health, at least until recognized and healed. Phenomena such as abuse are closely related to economic, living and other stress conditions, which impinge directly on the structure and function of families and other early experiences in communities. The issue of the relationship between supportive environments and the development of individual resilience has therefore received increasing attention from a number of authors. Indeed, it has been argued elsewhere that the key to promoting mental health is to foster individual and collective resilience in a supportive environment (Joubert & Raeburn, 1998).

Although such matters as a clean, well-designed and safe environment are very important in the promotion of mental health, the nature of people's interactions with these environments tends to get more attention, as well as how these environments help to determine interactions between people. Also, the mental health impacts of settings become of high salience. Typical settings considered for health promotion are schools, workplaces, families, recreational facilities, health care settings, social care settings, prisons, orphanages, refugee camps, other organizations and the community as a whole (see, for example, Chapter 8). One can see that for each of these settings there are major psychological and social aspects that have mental health overtones, such as stress in the workplace or social support in communities. Therefore, "setting" as an ecological or environmental niche with its own particular impact on mental health is of paramount consideration for mental health promotion. Although the smaller environments implied by the concept of setting are crucial for mental health promotion, they should not allow us to lose sight of the larger physical and sociopolitical environment and the necessity to recognize factors in the macro environment which affect mental health. We need to develop interventions to modify these factors, as well as indicators to evaluate the processes, impact and outcome of these actions (Catalano & Dooley, 1980).

Community action

Earlier in this chapter we argued that community is the most important setting for the consideration of mental health promotion strategies. Community has many meanings – here we take locality community as the prototype, while not losing sight of the many other kinds of communities that exist and that are not necessarily tied to a particular locality. However, a sense of place is regarded as very important for mental health, and the relationship between the "network" aspect of community (which is universal) and the place or places in which those networks exist is of considerable relevance to any discussion of mental health promotion (Raeburn, 2001).

As mentioned before, community is seen as a meso level, ecological or social entity that sits at a pivot point between the macro level of whole populations with considerations such as policy and environments and the micro level of individuals, families and small groups of friends and supports. That is, community can relate readily "up" to the macro political level and "down" to the intimate concerns of everyday life. Appropriately resourced and organized, communities, we assert, have the potential to have considerable political and social influence. We also assert that humans are intrinsically social and community beings, and that even the most alienated and dislocated of us long for "a psychological sense of community" (Chavis & Pretty, 1999; Sarason, 1974, 1986). McMillan and Chavis (1986, p.1) define this sense of community as "a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to be together". This desire for community – for basic human relatedness, support and common endeavour – is one of the most fundamental human impulses and is central to mental health, as most existential and other wri-

ters about the human condition would agree. The essential processes and structures of community are the basis of what has come to be called social capital by academics and politicians – those social bonds, institutions and activities which are the lifeblood of rewarding and healthy human societal existence (e.g. Grootaert & van Bastelaer, 2001; see also Chapters 6 and 10). Community is also the major vehicle for participation in society. Participation is seen as the main instrument of a sense of empowerment, and hence of control, so any mental health promotion strategy needs to factor a sense of participation into anything it does (Lord & Farlow, 1990; Marmot, 2003; Rissel, 1994).

The community dimension of health promotion relates to various earlier social movements (Driscoll, 1998; Minkler, 1990). In particular, it relates to the concept of community development and the associated concept of empowerment. These concepts have been strongly influenced by what is happening in many developing countries, where economic and social development is often based on needs assessments and self-determined action by the people themselves. Such self-determined community action has a very "healthy" impact, in the sense that people are more in control of their own destinies and actions. Indeed, in 1989 a summary of a report by Worldwatch said that "[self-determined] grass-roots groups are our best hope for global prosperity and ecology", and constituted "perhaps the most important political development of our time" (Durning, 1989). In developed countries, such as the USA, the community development enterprise has more often been associated with human rights and the empowerment of minority groups, beginning (in the case of the USA) with the liberation of slaves and moving through movements such as those for women, Afro-Americans, homosexuals, the disabled, mental health consumers and others (Minkler, 1990). In some countries, the indigenous peoples have strongly asserted themselves to good effect. Such movements resonate well with the concepts of mental health promotion.

As the Ottawa Charter (WHO, 1986, p. 3) states:

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

A useful and simple planning model that incorporates a community-led approach – the PEOPLE System – is shown in box 17.1.

Personal skills

The action stream of personal skills is most closely related to the 1970s view of health promotion as being largely to do with individual behaviour and lifestyle. The lifestyle view, introduced by the Canadian Lalonde Report (Lalonde, 1974), was in itself a major new concept. Prior to its publication, most of the territory today described as "health promotion" was largely to do with the giving of information about how to live in a more healthy way ("health education" as it was then understood). Lifestyle turned the attention onto behaviour and brought the technology of behavioural psychology to bear on the enterprise. The Lalonde concept of lifestyle referred to a finite number

Box 17.1
A community-led approach: the PEOPLE System

The PEOPLE (Planning and Evaluation of People-Led Endeavours) System (Raeburn, 1992) is a simple seven-step approach to planning, organizing and evaluating any mental health promotion project involving groups of people, including whole populations. It incorporates many of the concepts of community or people ownership and control discussed in this chapter.

The seven stages of the PEOPLE System:

| 1 Objectives and values statement | 2 Needs/wishes assessment | 3 Goal-setting | 4 Organizational and resource arrangements | 5 Action | 6 Reviews | 7 Periodic outcome assessments |

All projects start with an initial period, sometimes quite lengthy, of discussing in general terms what it is that the population of interest (POI) wants to do, and how to do it. A more precise process then follows of assessing, through surveys, focus groups and so on, what the POI wants for itself – a clear specification and prioritization of its own needs, wishes and priorities for action. Explicit goal-setting then takes place for what the POI wants to achieve over a specified time period, usually 12 months, accompanied by a consideration of what resources are available and what sort of organizational structure is required to make it all happen. Action to meet these goals is then planned and undertaken, each goal area having a person responsible for it, who in turn may work with a number of people on relevant tasks.

As work proceeds, there are regular reviews where people responsible for various goals report back to the group on progress. Where there are difficulties, the group can participate in finding a solution. Finally, from time to time an overall assessment of progress is done, to see that the whole enterprise is on track and is having its intended impact.

Needs, goals and actions can be modified over time based on the review process with the aim of having a continuously improving enterprise. Goals are only changed as a last resort, since a degree of stability is required to ensure the system does not get too distracted by "the latest idea".

The PEOPLE System allows flexibility for cultural and local interpretation, and for spontaneity and creativity. It seems to be able to span cultures successfully and has been used in both urban and rural settings in New Zealand. It is most effective with training in its use, and the most usual form of application in community settings is for a facilitator familiar with the PEOPLE System to introduce it to the POI, go through all the steps with them over time (a typical comprehensive community project can take one or two years to go through all these steps fully) and then support the group into full independence, continuing to use the system as the basis of their organizational approach. As such, the PEOPLE System has assisted with the sustainability of projects. Indeed, some community groups in New Zealand have been using it as the basis for their community development project's organization for up to 30 years. More on the PEOPLE System can be found in Raeburn, 1992 and in Raeburn and Rootman, 1998.

of specific sets of behaviour known to be related to health status (e.g. smoking, eating, exercise, driving). However, it was embedded in a wider health field concept, in which environmental factors also featured. In spite of this larger perspective, the lifestyle component tended to be taken out of its social and especially cultural context to the extent that it was criticized as encouraging a "blame the victim" attitude, which put the responsibility for faulty lifestyles on individual choice. This was later eclipsed by the social determinants approach to health promotion.

The personal skills stream may be a compromise with the earlier, more individualistic approach. It represents an individual or micro perspective, as distinct from the other streams that are to do with whole populations, communities or systems. The adoption of the Ottawa Charter was preceded, and followed, by a lengthy debate about the similarities and differences between health promotion and health education. In the event, the major international body for health promotion practitioners, the International Union for Health Promotion and Education (IUHPE), by its very name seems to have decided that they are two separate but connected domains of activity.

WHO defines health education as consciously constructed opportunities for learning which are designed to facilitate changes in behaviour towards a pre-determined health goal. Health education aims to improve people's knowledge and understanding about the factors, individual as well as societal, which affect their lives, and their ability to make their own conscious choices (Seedhouse, 1997). The scope of health education varies widely. It can be a one-way mass communication on health or it can be interactive in various ways. Health instruction refers to situations where health issues are taught. Interactive forms of health education can also be included, such as one might find in a primary health care or counselling situation.

With regard to mental health promotion, much of what can be subsumed under the concept of developing personal skills is related to "life skills training", which is the staple of what is called "primary prevention", with its emphasis on keeping well those in danger of declining. As mentioned earlier, there is evidence from many studies that interventions to enhance living skills can have very positive and enduring effects on people's lives, ranging from parenting programmes through classroom instruction to peer-led substance abuse programmes (Pransky, 1991). Most life skills activities are conducted in small group settings, which is why they qualify as "personal" (as distinct from larger community or population-based) programmes. Life skills programmes tend to have an educational component, in that people need to know what to do to change behaviour. However,

there is also usually a strong emphasis on social support and small group dynamics, and the best of such programmes put a strong emphasis on empowering rather than top-down processes. The broad area of self-help and mutual aid, a feature in the Canadian *Achieving Health for All* framework for health promotion (Epp, 1986), also falls into this category.

Of special relevance for mental health promotion strategies at the personal skills level is the concept of stress and stress management (Pelletier & Lutz, 1991; Sarafino, 1998). It could be argued that stress underlies most considerations of mental health, and the concept of resilience is closely allied here. Resilience is really about how people cope with, bounce back from and learn from life's demands and adversities (Kulig & Hansen, 1996; see also Chapter 3). Stress is about having to react to and cope with life's demands (Sarafino, 1998). Most stress management processes are undertaken at a small group or individual level, so they fit well into the personal skills category. At the same time, much stress in modern society is systemic and political, or associated with environmental or workplace conditions that are more relevant to the other levels dealt with by the Charter. Stress is an under-used concept in the mental health promotion area, one which has its roots in the personal level but which transcends this to also be applicable to meso and macro considerations.

Reorientation of health services

The 1974 Lalonde Report was radical in that it identified that the traditional way in which governments had thought about public expenditure in the health arena – through health services and medical treatment – was only a relatively small part of the total picture of what determined health. The Ottawa Charter reflects this, in that very little of it relates explicitly to medical concepts or health services. Instead, the idea of "returning power to people" may be understood as taking the power from medicine and health professionals back to the people. Health services are seen as a powerful resource for health promotion, but only after an expansion from a narrow focus on treatment of symptoms to not only a more holistic biopsychosocial approach to treatment but also to a focus on positive enhancement of health. At the very least, conventional health services need to add a health promotion set of services to their treatment ones (Rowling, 2002). Viewed in this way, health promotion can be considered complementary to treatment. However, because of the quite different models and ideologies involved, there can sometimes be an unfortunate and unhelpful polarization between the two.

The frequent polarization between so-called medical treatment models and health promotion models of health is matched to some extent in the research area by a division between "positivist" and "postmodern" methodologies. The positivist paradigm favours hard facts, RCTs, a "risk" analysis (rather than a focus on broader social and societal determinants that cannot be addressed by RCT techniques) and a tendency to emphasize interventions by professionals in the context of top-down national policies. In contrast, the health promotion/New Public Health paradigm tends to favour a softer approach, often within an ecological framework, where bottom-up community and people-led processes are valued, qualitative information is often regarded as being of more value that purely statistical data, and research is oriented towards participatory action research models (Reason & Bradbury, 2001) and/or qualitative methods (Denzin & Lincoln, 1994). We are using the term "New Public Health" to signify the philosophy and worldview of the Ottawa Charter, with its social determinants perspective combined with an empowering approach to

enhancing health on an equity agenda. Both approaches are of course essential, complementary, and of great value for the mental health of populations.

Conclusion

Effective mental health promotion is based on a positive, non-pathologized approach to mental health that focuses on strengths and resilience building. The Ottawa Charter for Health Promotion provides a helpful starting place for looking at strategies for mental health promotion from a population perspective. The Charter's vision is one of the New Public Health, rather than one that is medicalized and oriented to deficits and the reduction of risk factors. Its breakdown into five action streams provides a useful checklist for mental health promotion strategies.

Mental health promotion as a recognized or formal enterprise is still in its infancy. But, as we said in the introduction to this chapter, mental health promotion as represented here is close to the natural way people see and want to live their lives. As such, it goes right to the heart of the most important matters of human existence and, at a population level, could well be a vehicle for empowerment of people around the world, and for indicating to governments that the well-being and quality of life of the populations over which they preside is of pre-eminent importance. Good mental health is the most important thing we have.

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Chapter 18 • Community Development as a Strategy for Promoting Mental Health: Lessons from Rural India

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Introduction

For decades, the Comprehensive Rural Health Programme (CRHP) in Jamkhed has used commu-nity development principles to improve health in over 400 villages in rural Maharashtra, India, through a comprehensive primary health care approach. While the objectives of the programme have not focused specifically on mental health, it is apparent that effective community develop-ment does result in improved mental health. We argue that community development is a compel-ling approach that should be included in any strategy for mental health promotion. This chapter briefly outlines community development as a concept then explores the effects of poverty and inequality on mental health, painting a picture of the factors that often exist in village settings that contribute to mental ill-health. The processes of community development in Jamkhed are described and the positive mental health impact on the villages is highlighted. The importance of village health workers is also examined using a case study of a woman called Sarubai.

Community development is a "grass roots", people-centred approach to development. It seeks to develop the social, economic, environmental and cultural well-being of communities, and has a particular focus on poor and marginalized members. It brings people together and uses participa-tory methods to help them make informed choices, identify solutions to common problems based on local priorities and take collective action. It acknowledges and builds upon existing communi-ty knowledge, social networks and capacities so that communities become more responsible and informed, reduce ignorance and create opportunities to improve their socioeconomic situation. An important feature of community development is the participatory evaluation of development efforts and processes (Frank & Smith, 1999; Poussard, personal communication, 2003).

To gain an understanding of how community development impacts on mental health in the villa-ges surrounding Jamkhed, it is useful firstly to consider some of the factors that have been linked with mental ill-health in the wider literature and discussed in earlier chapters. Some of these include low self-esteem, learned helplessness, less security, higher levels of life events, social isolation, distress, unemployment, thwarted aspirations, financial difficulties or economic depriva-tion, low social status, lack of confiding relationships, low levels of education, female gender and older age (McKenzie, 2000; Mumford et al., 1997; NIMH, 1995; OECD, 2001; Patel et al., 1999; Perry, 1996; WHO, 1990). These factors have all been identified in the village settings around Jamkhed. Desjarlais et al. (1995) identified three clusters of problems that exist in communities under stress that combine to amplify each other's effects on behaviour and health (see figure 18.1). Mental ill-health is an obvious part of this loop in the villages in India.

Everyday life in a village – the impact on mental well-being

There are many factors that are just a normal part of life in a poor Indian village that impact on mental health. This section illustrates some of those factors.

Poverty and vulnerability are constant factors for many villagers, causing both chronic and acute stress. A mother sees her children hungry and cannot help them; a father worries how he will col-lect enough money for his daughter's dowry; a farmer has no power to prevent the government taking his land to build a road, and cannot read the papers or afford a lawyer to negotiate the

Figure 18.1
Model of Overlapping Clusters of Problems

Social Pathologies
Substances Abuse
Violence
Abuse of Women
Child Abuse

Health Problems
Heart Disease
Depression
Stress-related Conditions
Behaviors Contributing
to Chronic Illness

Exacerbating Conditions
High Unemployment
Poverty
Limited Education
Stressful Work conditions
Gender Discrimination

Source: Desjarlais et al., 1995, p. 7

bureaucratic labyrinth to seek compensation; the daily labourer has no control over employment from day to day; a drought causes the crops to fail; the husband has to migrate to the city seeking work, leaving his wife to fend for herself and the children. Poor health is common and a cause of great stress. A woman cannot afford medicines or even a bus ticket to take her sick child to the health clinic; a wife whose husband has tuberculosis or HIV/AIDS has to care for him as well as earning an income to feed the family; influenza prevents a father working, so his children do not eat.

Difficulty accessing basic elements, such as water, can be the source of great stress and angst within a community. In drought-prone areas, a chronic shortage of water means struggling each day to get water from meagre sources. Many precious hours per day are spent gathering enough water for the family; neighbours fight over who was first in the queue for the tap, which runs out before everybody's container is full; a girl climbs down the 20-foot well to fill her can from the dregs at the bottom; a community is shocked and saddened when another person dies by falling into the well.

Waiting for the government tanker to come and fill the well

Jostling to get the water from the government tanker before it goes into the well[1]

Gender discrimination is ever-present in India. It begins in the womb and continues throughout a woman's life. A young man is valuable because he will bring income to the family when he marries, through his wife's dowry, and will remain with his parents into their old age to look after them. A girl, on the other hand, will cost her parents a dowry when she is married (which often forces families into debt for many years) and will have to leave her parents to live with her husband's family, so is useless to them in their old age. So the birth of a girl may often be the source of stress and resentment. Infanticide is still very prevalent in India, and discrimination against the girl-child is common, resulting in poor nutrition, fewer opportunities for education and social development and very low self-esteem. Caste and ethnic discrimination is another source of pressure in villages. "Low castes" are often stigmatized and cannot avail themselves of many common amenities like access to the school or to water from the communal source. For both women and low castes, to live a life where you are reminded every hour that you are an inferior being, that you are worth less than the family goat or bullock, entails immense mental stress. The combination of being a woman or of low caste and being poor greatly adds to the discrimination.

Domestic violence is common among the poor in India, and the reason for provocation is frequently trivial. For example, a man may beat his wife if she does not bring food to him on time or add enough salt to the meal, or if she allows a baby to cry within his earshot. Violence is often physical but can also be psychological, or social. For example, a high caste person may punish the whole low caste group for a minor grievance against one of them. Low castes are often economically dependent on the rich landlords of the village, which increases their vulnerability and can lead to sexual exploitation of low caste women. Women who need to go away from the house to collect water or firewood live in constant fear of being molested. Internalization of their own perceived low status can lead to violence by a woman against another woman, most commonly the mother-in-law against her son's wife. In this relationship the mother-in-law has power, which is often exercised through physical and emotional violence. Alcohol and drug abuse exacerbate the violence and can be enormously detrimental to mental health and family happiness.

The pressure on adolescent girls is substantial. Instead of receiving support at a time of biological, intellectual and emotional transformation, a girl in a rural village in India may find herself

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[1] The editors would like to thank Abel Desai for allowing us to use these photographs

the object of resentment within her home for being the pending cause of economic and social burden. The pressure increases for parents to marry off their daughter, which means collecting or borrowing money for a dowry and being prepared to meet other expenses related to pregnancy, delivery and sicknesses (a husband may expect his wife's family to pay these expenses). The negative attitude surrounding young women can be confusing and isolating, particularly if the girls of the village are discouraged from socializing with each other. There is often no time to adjust to transition for the girl. She is a child one day, and then the day she starts menstruating she is suddenly transformed into an adult with the associated responsibilities, obligations and social expectations.

The onus of sexual morality is entirely on the girl or woman, and the pressure for her to uphold the family reputation by observing social mores is intense. If a male engages in sex before or outside of marriage it is accepted, seen as a sign of strength or merely as his right. But a girl or woman would be chastized, beaten or thrown out of her home if she did not reject the advances of a man. If she were to become pregnant outside of marriage, her chances of marriage would be almost completely nullified. When a girl reaches puberty she has to be protected all the time. She cannot go alone even to the toilet because she is not trusted with her own virginity. This prevalent, almost pathological fear the family has about pregnancy out of wedlock reduces girls' sense of self-respect and self-determination. The constant negative discourse surrounding sex generates an abnormal view of it, which can impact negatively on her own experience of sex even when she is in a "legitimate" relationship.

It is clear that provision of psychiatric services would be an inadequate approach to addressing mental ill-health in a village setting. In order to improve mental health, the approach must be multifaceted, incorporating an understanding of the wider socioeconomic context and cultural complexity of villages.

The process of community development in Jamkhed

The CRHP is based strongly around the principles of primary health care and community development. The approach emphasizes that people take responsibility for the development of their own community and for their own health. The entry into villages of a programme such as CRHP must be related to priorities established by the people and will fail unless it considers the prevailing culture. In a male dominated society where women are not allowed to socialize either among themselves or with others it is logical to begin with men. CRHP began strategically in this way. Community development often involves facilitating the organization of people around their priorities, which in the case of the village men is usually agriculture, farm animals or employment. In Jamkhed, these groups are called Farmers Clubs. They share and learn techniques of water and soil conservation and methods for better crop yield, working together to address village issues, such as access to water, and to support each other at various times of the harvest cycle. As they realize the empowerment of working and meeting together, and as the pressure on individual farmers is reduced through the group support, they are open to thinking about other issues affecting the village, such as health and social issues.

To address health needs, the Farmers Club, or other groups that exist in the village, identify a suitable woman to receive training as a Village Health Worker (VHW) at CRHP. These women learn about health and technical skills such as weighing children, delivering babies, administering oral rehydration solution, taking blood smears and diagnosing leprosy and tuberculosis. They learn

programme skills such as income-generation and small loan management, mobilizing community action, providing health education and stimulating community groups. They also think and talk about their role as a woman, about self-esteem, and about why discrimination exists and how detrimental it is. They learn about common superstitious practices that exploit people's ignorance and about recognizing and using beneficial traditional herbs and medicines in conjunction with allopathic remedies.

With encouragement from the VHW, women's clubs are formed in each village, called Mahila Mandals. The women initially come together around their common concern, usually income generation, and then begin to learn from the VHW about issues she is learning at CRHP. With leadership from the VHW, the Farmers Clubs and Mahila Mandals work to improve the health of the people. Along with CRHP staff, they collect information about illness and disability through health surveys or various participatory methods. They display this information in their village on a board, provoking discussion in the village about the links between agriculture, water, the environment, education and health. The VHW keeps the village health records, for example on the weight of children, pregnant mothers' blood pressure, tuberculosis and leprosy. As the community gains confidence and skills in working together to improve life in the village, they begin to discuss various social issues like dowry, early marriages and discrimination. Active engagement with one another and with the life of the community allows relationships to develop which are supportive for individuals and which strengthen the social capital of the whole village (see Chapter 6 for a discussion of social capital).

An important part of the community development process is that communities assess their own needs. CRHP staff facilitate participatory activities where members of the community groups discuss various topics to help prioritize issues that the community wants to address. They may map the village, identifying power structures and different needs, be they economic, social, health or agricultural. Depending upon the problem they have identified, they sit down together and plan different approaches, working out where they can play a role and where they may need external assistance, such as training on how to use biogas instead of burning wood. Communities are also engaged actively in monitoring the progress of the development. They do this continuously and as a natural part of life, for example checking whether a woman is able to make loan repayments under the micro-credit programme and helping her to improve her productivity if possible.

By community members sitting down together for discussions about development activities, decision-making is transparent and corruption is reduced. Also, because the whole community has been part of the decision-making process, there is ownership and responsibility to make it a success. Community self-determination contributes to the wider sense of mental well-being and esteem.

To reduce deeply rooted caste discrimination, the programme uses many opportunities to show that people are the same, regardless of caste or race. The VHWs observe blood tests and x-rays that show that different castes have the same colour blood and the same size heart. When they stay overnight at CRHP for training, women from different castes find themselves sleeping in the same areas and using the same blankets and bathing facilities. This physical contact is very novel for them and helps break down caste issues. Low castes are typically not allowed to access water from the same source as the high castes, so CRHP hired a water diviner who found water in the "untouchable" part of the village, over which a tube well was dug. This gave the low castes some power as the higher castes had to come into their area for water. Different castes were not allowed to eat from the same pot. So when community kitchens were set up to feed children during a drought, CRHP required the children to bring some small ingredient for the meal. This meant that food from

different castes was cooked in the same pot and even if a mother from a high caste dragged her child away from the queue, he was so hungry he would run back to join the group.

The impact of community development at Jamkhed on mental health

In villages that have been the focus of community development work, many of the causes of stress described above are substantially reduced, as depicted in figure 18.2 and discussed below. (Many of these links have been made in the wider literature and readers are referred to Cullen & Whiteford 2001, Canadian Mental Health Association 2003 and WHO 1999 for further exploration of the impact of community development on mental health.)

Improved health of women and children, fewer illnesses, uncomplicated pregnancies, better nutrition and a cleaner village environment all contribute to an atmosphere of reduced stress. The presence of the VHW, with the support she has from the staff of CRHP, reduces the fear of an illness resulting in death. This security leads to better family planning and fewer children per household, which allows families to provide for the two or three children, freeing them from the worry of providing for large families. With women having some independence through income generation activities, they are more equal with their husbands and are able to contribute to decision-making in the household, which includes issues around family planning. Having water resources within a reasonable distance eliminates some stress and increases community harmony.
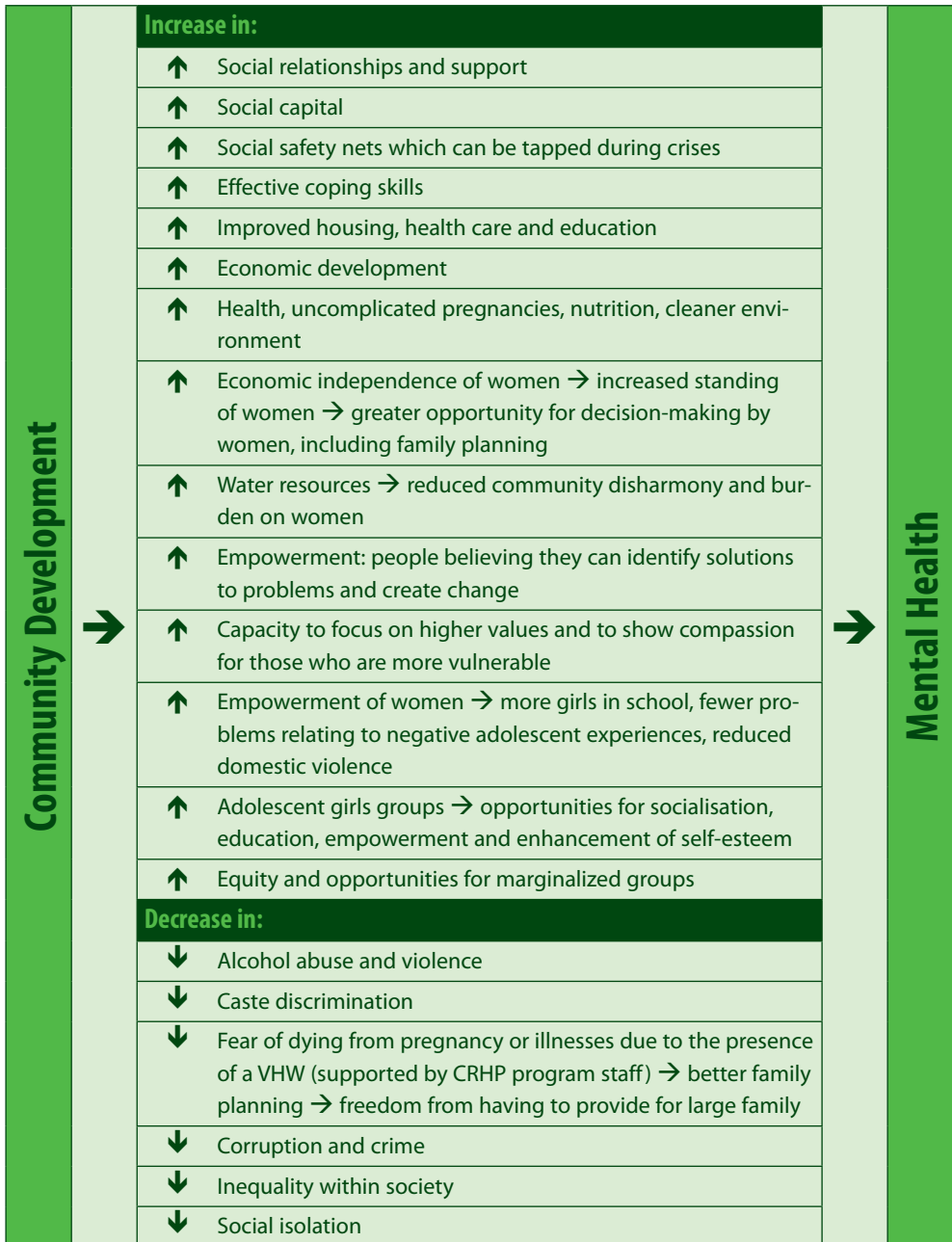
Community development creates empowerment, which happens when people experience personally that individually and collectively they can create changes in their lives, that their voices are heard, and that they can address complex issues affecting their lives. This empowerment impacts very positively on mental health. The community networks reduce isolation and increase feelings of support; attainment of skills gives people a greater position in society; financial autonomy allows freedom from vulnerability, greater ability to make decisions and increased respect in the village; and social empowerment follows, where, as a result of awareness, information and skills, people are able to see their lives from a wider perspective. People begin to see the social, cultural, economic and political factors affecting their lives and work together to look for solutions to some of the negative factors, such as why girls are married so early or why the dowry system is perpetuated.

When people's basic needs have been met, they are able to focus on higher values – respect, sharing, compassion, caring for one's neighbour as much as for oneself. The emphasis on values as part of the community development process at CRHP is vital and prioritized as much as teaching about health and other skills. Half of the VHW training is spent discussing values and reflecting on those that exist within themselves and their community.

Women and girls benefit greatly through changed attitudes in the community, largely through the influence of the VHWs and the women's and farmers' clubs. The men learn to see the value of all the work that women do and to respect their skills; the women become empowered by talking with each other about their roles; the girls are encouraged to go to school; support is given to individual women who have particular needs, for example protection from a husband who is beating her or assistance with child-minding while she harvests her crops. Women become able to earn and control their own income, which leads to better self-esteem and ability to assert themselves and to deal with gender discrimination. Eventually this leads to better relationships in the family and less violence from the husband. As women begin to see their worth they encourage their girl children

Figure 18.2
The relationship between community development and mental health in the villages

Community Development →	Increase in:	
	↑	Social relationships and support
	↑	Social capital
	↑	Social safety nets which can be tapped during crises
	↑	Effective coping skills
	↑	Improved housing, health care and education
	↑	Economic development
	↑	Health, uncomplicated pregnancies, nutrition, cleaner environment
	↑	Economic independence of women → increased standing of women → greater opportunity for decision-making by women, including family planning
	↑	Water resources → reduced community disharmony and burden on women
	↑	Empowerment: people believing they can identify solutions to problems and create change
	↑	Capacity to focus on higher values and to show compassion for those who are more vulnerable
	↑	Empowerment of women → more girls in school, fewer problems relating to negative adolescent experiences, reduced domestic violence
	↑	Adolescent girls groups → opportunities for socialisation, education, empowerment and enhancement of self-esteem
	↑	Equity and opportunities for marginalized groups
	Decrease in:	
	↓	Alcohol abuse and violence
	↓	Caste discrimination
	↓	Fear of dying from pregnancy or illnesses due to the presence of a VHW (supported by CRHP program staff) → better family planning → freedom from having to provide for large family
	↓	Corruption and crime
	↓	Inequality within society
	↓	Social isolation

→ Mental Health

to have proper nutrition and to gain an education. Many girls are either in school longer or involved in skills training or income generation and pressure is reduced for them to be married early. Adolescent girls' groups have also been set up in response to the community groups recognizing that they are a vulnerable group in the village and that they have particular needs. These opportunities for socialization and education given to the girls have resulted in empowerment regarding their role and status, increasing their self-esteem and assertiveness regarding their needs and rights.

Breaking down social barriers to reduce caste discrimination has been a significant outcome of the work of CRHP and one that impacts greatly on mental health. Elsewhere in India there are outbreaks of caste and ethnic violence among communities, but the Jamkhed area has been free of this. Money is a significant equalizer of people, and through community development (which especially focuses on improving the situation of the most vulnerable people in the community), the lower castes have been enabled to become economically independent of the higher castes, thereby increasing their own self-esteem and the community's respect for them, much the same as with women who become economically successful. Discussions about the caste system, as well as experience with different caste groups working together to achieve positive change, has increased harmony and reduced unjust practices.

The women's groups have provided much needed support to enable women to deal with stress related to alcohol and violence. It is not uncommon for men to sell some of the family's store of grains to buy alcohol or for a man to beat his wife or children when he is drunk. Violence creates fear, guilt, sorrow and anxiety. It reduces trust in relationships within families and within the community. Having a supportive women's group enables the women to protect each other, either by storing grain and other valuables for each other at certain times or by providing shelter for a woman and her children if the man is particularly violent. VHWs and the farmers' and women's clubs talk about the costs of alcohol and violence to the community and this helps the community to discuss and make decisions about how to handle these problems. Crisis intervention, either by the VHW or the women's group, in relation to situations of violence or when a family member has died or other traumatic experiences have arisen provides support to the individual and can help in preventing depression or anxiety.

One of the central values in the community development work of CRHP is equity. This has been significant in ensuring empowerment for the very marginalized groups. One example of this was during a large afforestation programme. In each group of ten people planting, the communities decided that the jobs had to go to equal numbers of men and women, and for each group, one out of ten people had to be from a marginalized group, for example the disabled, homeless, school dropouts or the elderly. If that one person was not able to do the same manual labour, he or she would perform another task, such as bringing water to the other workers or childminding while they were working. The wages earned for the manual work were shared between the ten. When conducting income generation skills training for girls, the most vulnerable girls were given priority. Enabling financial empowerment of the most vulnerable people reduces stress for those individuals and their families and allows the wider community a sense of well-being that they are taking care of those most at risk.

The extent of the empowerment in the Jamkhed villages has enabled them to look beyond their own needs to the mental health needs of others in crisis. For example, in 1993 there was a severe earthquake killing more than 20 000 people and injuring thousands. Three hundred volunteers from different Jamkhed villages came to work with the survivors. Sociologists and psychologists from the city helped them to identify the needs of the people and identify people who were trau-

matized and counsel them. These volunteers went to different villages and around 10 volunteers stayed in each community for two weeks, helping people express their grief, helping them in their household chores and being available to deal with the emotional trauma. In comparison to other assistance, such as donations of clothing and food, the psychological support that was offered by the villagers from Jamkhed was unique.

Conclusion

It is vitally important that public health policy-makers and practitioners identify and support effective means of promoting mental health; the personal, social and economic costs of mental ill-health are too great to ignore. The implementation of a sustained community development approach in the context of a comprehensive primary health care programme around Jamkhed in India appears to have had significant mental health benefits within the communities. The lessons learned from such a programme are enormously valuable in our attempt to reduce the widespread difficulties associated with mental ill-health. Important factors in the success of the programme are related to an understanding of the impact of poverty, inequality, gender dis-crimination and domestic violence on mental ill-health in rural village settings; a focus on the vulnerability of women and the empowerment of them to enable them to be key players in the improvement of village health; a programme that starts by working to enable communities to address issues that they identify as priorities, such as agriculture or water, before focusing on the more typical health programme activities such as immunization and nutrition; and a constant focus on empowerment and self-determination of communities so that they feel that their future is in their hands.

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Chapter 19
Developing Sustainable Programmes: Theory and Practice

Penelope Hawe, Laura Ghali, Therese Riley

Introduction

We still have much to learn in the field of health promotion in general and in mental health promotion in particular. However, the legacy of 20 or 30 years of experience is that we now have accumulated a lot of useful evidence about what works and what does not. Part 2 of this book provides considerable information about the effectiveness of mental health promotion, that is, evidence about impact. This chapter is concerned with helping to ensure that one-off programmes develop into longer-term solutions.

We review the definitions of sustainability in health promotion and give an overview of evidence on what makes programmes sustainable. A number of issues in this field remain vexed and unresolved. We discuss implications for practice, including a consideration of the challenges and issues facing this field.

Most of our examples come from more established areas of health promotion than mental health promotion. This is simply because areas like heart health, tobacco control and immunization promotion have been developed for longer. Sustainability has therefore become a field of enquiry in these areas. One advantage of being a relative newcomer on the scene is that practitioners in mental health promotion can learn from their colleagues.

What is programme sustainability?

Sustainability remains a vague term in health promotion. Most definitions refer to a general notion of continuation (Health Communication Unit, 2001) and sustainability is often used interchangeably with the notion of durability of effect, long-term viability or long-term maintenance (O'Loughlin et al., 1998).

It soon becomes clear, however, that many definitions of sustainability cover, and potentially confuse, sustainability of *effect* with sustainability of *effort* (e.g. Jackson et al., 2004). This is an important distinction.

Sustainability of effect has two components. It includes whether the initial effects in the original target group are maintained over time, that is, whether there is "backsliding" to the pre-intervention levels of the behaviour of interest (Green, 1977, Hawe, Degeling & Hall, 1990). Sustainability of effect can also refer to whether effects are seen in subsequent cohorts of people, as evidenced for example in the research by Bond and colleagues on whole-of-school interventions to create welcoming and socially cohesive climates in schools. Their intervention showed marked effects on smoking, alcohol and drug use in the original groups of students involved with the intervention and even more pronounced effects on the subsequent intake of students into intervention schools (Bond et al., 2004a, 2004b).

There can be many reasons why a programme might lose its effectiveness over time or fail to transfer its benefits to successive cohorts. One is that the guiding theory may be inadequate for the complexity of the environment in which change is expected to occur. The typical fault here is to use individual-level theory to guide community-level change processes (Hawe, 1994) or to fail to appreciate the immediate social context in which change is expected to be maintained (Perry, Baranowski & Parcel, 1990). In addition, other trends in the population may "wash out"

programme effects, making the novelty or edge indiscernible. In any event, effect duration and effect transfer should be key considerations in programme design and planning and their achievement or otherwise should be addressed in the primary evaluation of the programme (e.g. Green & Kreuter, 1999; Hawe, Degeling & Hall, 1990; Windsor et al., 1994).

Another important reason for diminished programme effects might be "fizzled out" programme effort. Sustainability of effort refers to whether actions, resources and strategies are still being applied over time to address the problem. Think of it as sustainability of the "stimulus" as opposed to sustainability of the "response". Sustainability of the stimulus is our focus here. This is not because we think duration or transfer of effect is not important but rather that once a lasting effect is seen to be obtainable, the question becomes how to achieve it long term. Concentrating attention on sustainability of effort allows us to examine the complexity of the programme as a phenomenon itself within the context of its host organization and community.

Therefore, we think of programme sustainability as the potential of an intervention to continue to deliver benefits or health gains beyond the initial funding or demonstration project stage. Programmes are said to be sustainable if, given limited resources, efforts towards achieving the benefits continue. As you will see, by adopting a definition like this we link programme sustainability to the general field of capacity building in health promotion (Hawe et al., 1997) and ground it in the notions of ecology (Trickett & Birman, 1989) and organizational change (Simnett, 1995). Others define sustainability more simply as continuation of the programme after the initial funding has ended (Chinman, Imm & Wandersman, 2004). But as we discuss later, continuation of the programme per se may not be what is most important.

What makes a programme likely to be sustained?

A number of studies have shaped the current thinking about how programmes become sustained. Goodman and Steckler (1987) led the way with a study that identified a cohort of programmes funded 10 years earlier and traced them through to assess their status in the present day. Their interest was in the factors that predicted which programmes "survived" and which ones "died". The results surprised many people. The presence of continued external funding was not the dominant predictor. The key factor was the presence of a "champion" higher up in the host organization, that is, someone who could advocate for the programme in the key decision-making forum. This vital role was not the same as that of the programme director. One of the chief lessons from the range of enquiries that have since focused attention on programme continuance is that the way a programme is set up in the first place is vital (Shediac-Rizzkallah & Bone, 1998).

Shediac-Rizzkallah and Bone (1998) have contributed the most widely quoted conceptual piece about what makes a programme sustainable. They group the factors contributing to sustainability into three domains: factors in project design and implementation; factors within the organizational setting of the programme; and factors in the broader community. Their conceptual framework appears in figure 19.1. Their work drew on published reports in community-based health promotion (mostly in the USA) and programmes in developing countries within the international development literature, enabling them to contrast programme survival stories in settings that are radically different in basic levels of service infrastructure.

Figure 19.1
The main features associated with programme sustainability

✓ There is evidence that the programme is effective

✓ Consumers, funders and decision-makers are involved in its development

✓ The host organization provides real or in-kind support from the outset

✓ The potential to generate additional funds is high

✓ The host organization is "mature" (stable, resourceful)

✓ The programme and host organization have compatible missions

✓ The programme is not a separate "unit" but rather its policies, procedures and responsibilities are integrated into the organization

✓ Someone in authority (other than the programme director) is a champion of the programme at high levels within the organization

✓ The programme has few "rival providers" that would benefit from the programme discontinuing

✓ The host organization has a history of innovation

✓ The value and mission of the programme fit well with the broader community

✓ The programme has community champions who would decry its discontinuation

✓ Other organizations are copying the innovations of the programme

Source: Shediac-Rizzkallah & Bone, 1998

Theories informing programme sustainability

Four types of theory appear to inform the research on programme sustainability. The first is **diffusion of innovations** (Orlandi et al., 1990). This literature treats any new programme as an entity or innovation that is more or less likely to be adopted by an organization or by a community according to a set of principles originally developed by Rogers (1962) and refined by Kolbe and Iverson (1981). An innovation is more likely to adopted if it is:

- compatible with the sociocultural value system of the host or adopter;

- flexible, or able to be "unbundled" and used in various ways in various settings;

- reversible, in that it is easy to revert to old practices if necessary;

- offering a relative advantage compared to current methods;

- simple, as complicated innovations are less likely to be adopted;

- cost efficient, the benefits must be perceived to outweigh costs; and

- risk-minimal, as a lot of uncertainty about an innovation will delay its uptake.

Diffusion of innovation theory can be used to anticipate and remove likely barriers to the uptake of programmes and improve a programme's appeal.

The second source of theory for programme sustainability planning relates to **organizations and organizational change**. Goodman and Steckler's original study of how programmes "institutionalize", or become embedded, within organizations was ground-breaking. They used initial formulations put forward by Yin (1979) and others to suggest that programmes exist and become more embedded in organizations along two dimensions. One dimension is extensiveness. This refers to the presence or penetration of a programme across the subsystems of the host organization. The second dimension is intensiveness. This refers to the depth of programme integration. Indications of an embedded programme would be, say, that the programme staff are no longer called project officers, but simply environmental health officers, social workers or whatever others in the organization are called; the programme budget and planning is done on the same cycle as others activities in the organization, that is, it does not "dance to the tune" of external funding agencies; the programme staff are housed on the executive floor of the organization, as opposed to residing in demountable buildings next to the car park; and the programme mission and objectives are contained within the organization's mission and objectives.

Change process theories, implementation theories and domain theories (which suppose human service organizations to be very different to business organizations) are also relevant to the area of organizational development and change (see Kouzes & Mico, 1979; Simnett, 1995).

The third area of theory to inform the field of programme sustainability comes from community and organizational level **capacity building**. Hawe and colleagues (1997, 1998) argue for mental health promotion to have a capacity building perspective. This requires practitioners to work with known problems and current solutions in a way that enhances the capacity of partners and participants to work on unknown problems and future solutions. They suggest that programme planners develop two sets of goals in relation to any health promotion programme: one to address the health problem of interest; the other to address the capacity building that goes alongside the programme, to sustain the programme and to build transferable problem-solving skills and structures.

The fourth theory field is **ecological thinking** within community psychology. Ecological thinking focuses on the dynamics of local systems and key resources in communities – people, settings and events – and how the programme conserves and manages those resources (Trickett & Birman, 1989; Trickett, Kelly & Vincent, 1985).

There are four issues central to thinking ecologically about a programme within a community (Kelly, 1966; Trickett & Birman, 1989; Trickett et al., 1985): cycling of resources, interdependence, adaptation and succession. Cycling of resources refers to the way resources such as health professionals, existing interventions and natural helping networks are defined and distributed in the community and how the programme affects the deployment of these resources in the system. Interdependence refers to the pre-existing connections among various components of the setting, such as interagency collaborations, and how a programme fits in with and/or produces "domino" effects across the system. Adaptation is how the local norms, values and characteristics of the setting constrain or subvert some aspects of the programme while facilitating others; and succession refers to the natural history of previous innovations and how the uptake, shape and meaning of the programme changes over time.

Ecological theory suggests that practitioners work in particular ways to harness and enhance community resources. Programme sustainability is tied to the success in making the programme a necessary aspect of the ecosystem in which it performs a function.

Beyond programmes: how the thinking about "what" gets sustained has evolved

An important observation on Goodman and Steckler's early work was made by Green (1987), who asked whether programme continuation should be the proper goal of grant-making. The point is that successful institutionalization or uptake of a programme may leave something worthwhile but what remains may not be a recognizable programme. The programme may have appropriately evolved into something quite different and its lasting imprint may lie in the skill sets of staff, the mission statement of the organization, a change in routines, higher expectations about prevention and so on. This underlines the argument that we might be better off thinking about sustainability as sustained capacity to address health problems, rather than thinking about sustained programmes per se.

Unfortunately, most of the research on programme sustainability to date has taken a very literal and technical definition of programmes as discrete entities. Impact on sustained problem-solving capacity has not been assessed, but the presence or absence of particular programme components has. For example, the investigators on the Minnesota Heart Health Programme assessed the incorporation of their programmes in study communities in annual surveys in the years following withdrawal of federal funding. They used the word "incorporation" to refer to programme transfer or adoption in communities, as opposed to "institutionalization" which they took to mean confined to organizational structures (Bracht et al., 1994). Their methods required programme staff and directors of citizen advisory boards to rate programme status for 78 programmes according to nine codes, which included "local provider is operating the programme", "local provider is operating the programme in modified form" and "adopted and dropped, no new source being actively sought". Using this method they were able to contrast uptake in different communities and across different sectors (comparing school programmes with hospital programmes, for example).

The programme incorporation research by Bracht and colleagues in Minnesota inspired others to follow up on the status of programmes in communities after primary funds had been withdrawn. One such study was of a large-scale North American tobacco control intervention known as Community Intervention Trial for Smoking Cessation or COMMIT (Thompson et al., 2000). This study investigated "durability", which they defined as being "some level of COMMIT-like tobacco control activities". To prompt survey respondents (key informants in the local media and health, education and community organizations), sections of the self-completed questionnaire were divided into subcategories, such as events in communities (like "quit and win" contests) and presence of school, hospital and worksite programmes. It also included an assessment of the activity and interest shown in smoking by the local media. A scoring system (presence or absence of the activity) and a rating of strength was devised based on factors such as whether a programme had paid staff.

What is interesting about the COMMIT trial is that in the first year after federal funds were withdrawn, the investigators only assessed durability of the intervention in the 11 intervention communities (ignoring the 11 comparison communities). In the second year they extended their study to the comparison communities as well. They found, to their surprise, that tobacco control activities were so high in the comparison communities that the overall levels were virtually indistinguishable from intervention communities. The intervention and comparison communities were statistically different in terms of tobacco activity in only two aspects: community cessation events and enforcement of prohibitions on youth smoking. It should be noted that COMMIT comparison

communities were not constrained by the trial investigators from pursuing tobacco control activities on their own, so their finding is not one about non-compliance with trial conditions. The finding is much more exciting than that.

One explanation for the vigour of activity in COMMIT comparison communities is the one offered by Syme (2003), commenting on the poor outcomes of the multiple risk factor cardiovascular intervention trial (MRFIT). Syme suggests that being "aroused" about a health issue but then left to one's own devices may be empowering. It may result in better and more prolonged effects than participation in programmes that require the rigid intervention protocol typically laid down by university-based managers working with the intervention communities. Syme's hypothesis is consistent with the Minnesota, COMMIT and MRFIT intervention trial outcomes, which overall were unable to show important differences between intervention and comparison communities (Susser, 1995).

The idea that programmes that give more control to communities have better effects has support elsewhere in the literature. For example, Eng, Briscoe and Cunningham (1990) examined the effectiveness of water supply projects in Togo and Indonesia. They contrasted the outcomes of programmes in regions where water supply companies involved local people in the decision-making about well location and implementation of the project with projects that did not. They hypothesized that projects which encouraged participation, thereby fostering community problem-solving capacity, would have higher well use by local villagers and that there would be other beneficial effects. They were right. In regions where local communities had a high level of participation and control over the project, childhood vaccination rates jumped by up to 30%. The study is a demonstration of what has been called the health multiplier effect of capacity building (Hawe et al., 1997).

This leaves those interested in capturing the sustainability of programmes at a crossroad about what to measure.

In a sense, their position is no different than at the start of a programme when one is designing a scheme to measure programme implementation. In implementation research, there is a growing trend to see beyond the technical aspects of programmes (the visible components such as the resource kits, the community events, the professional education workshops) to assess the cultural and political change processes that lie beneath (House, 1981; Ottoson & Green, 1987). Some of the sophistication that is creeping into implementation research is reviewed in Chapter 9. In practical terms, capturing change processes means setting up research designs which look for pre-specified components of programmes as well as employing more open ended (and necessarily) qualitative techniques to capture the observations and experiences of those involved (e.g. Hawe et al., 2004). Programme sustainability research could now mirror implementation research and do the same.

Issues and challenges

A number of issues and challenges pepper this field. At the centre is a dilemma. The weight of opinion is that the way one conducts a programme at the beginning largely determines whether or not the programme is sustained. So, for example, integrating a programme with the mission of the host institution, working to create programme champions, creating interorganizational partnerships and sharing responsibility for the programme are all part of recommended practice (Shediac-Rizzkallah & Bone, 1998). However, it can take several years before a programme shows

clear results. In effect, then, one has to institutionalize a programme before one knows it works. There are many examples of programmes in the preventive sciences that have actually turned out to do more harm than good (Berberian, 1976; Robertson, 1978; Robertson, 1980). There is also the concern that activities displaced by the new programme might be more worthwhile than the programme itself. This places practitioners in an invidious position. Heavily institutionalized programmes with poor evidence of effectiveness are unfortunately too common (see box 19.1)

Box 19.1
Some things are sustained that should not be

Project DARE

Project DARE (Drug Abuse Resistance Education) is the most widely disseminated substance abuse prevention programme in the USA. In terms of federal expenditures, it represents the largest single school-based prevention programme ever funded, with annual costs averaging three quarters of a billion dollars. DARE began in 1983 and by 1997 more than 33 million children had been exposed to the programme. This was despite multiple evaluations of the programme that have failed to demonstrate its efficacy (Lynman et al., 1999; Perry et al., 2003; Wysong, Aniskiewicz & Wright, 1994).

The DARE curriculum was developed as a result of collaboration between the Los Angeles Police Department and the Los Angeles Unified School District. Like many drug prevention programmes, it provides information about drugs and their effects, teaches peer-resistance skills and discusses media influences on decisions to use drugs. The curriculum is delivered by uniformed police officers who receive prior training (80 hrs) in a variety of topics, including specific knowledge about drug use and its consequences as well as teaching techniques and classroom management skills. Student participation is encouraged through role-playing and homework assignments. Early evaluations of the DARE curriculum reported short-term changes in knowledge, attitudes, beliefs and cigarette smoking behaviour that were only modest in size and not sustained in long-term studies (Clayton, Cattarello & Johnstone, 1996). A more recent meta-analysis published in June of 2004 showed similar results with an extremely small (0.011) and non-significant ($z = 0.73$) effect size for the included studies (West & O'Neal, 2004).

The numerous critiques of the programme led to a substantial revamping of the DARE programme in 2001, sponsored in part by a $13.7 million grant from the Robert Wood Johnson Foundation (Lord, 2001). No major evaluations of the "new DARE" programme have been completed yet.

Despite the continued criticism by researchers for lack of effectiveness in preventing adolescent drug use, DARE remains enormously popular with students and community members and its delivery in schools remains extensive.

A second challenge for sustainability is the nature of our "mission". As discussed in previous chapters, many sectors are involved in mental health promotion, such as health, housing, education, justice and municipal government. But it seems that some programmes in the public sector never have to think about sustainability the way we seem to in health promotion. Take health

care programmes for example. No one expects heart surgery to survive without funding. Yet, for preventive services and health promotion programmes we appear to have adopted the belief that "communities" can and should sustain what publicly funded services do not or will not. Without additional resources we can only expect people and organizations to do more of one thing if they do less of another. While health promotion programmes may survive beyond formal funding for a time, the question that has to be asked is, should they? Unfortunately, programme funding can quickly shift from being an "outside" gift to a "local" problem.

Further, being in receipt of core funding from the health sector should be considered in more than just its dollar value terms. Receipt of core funding has symbolic and political value. It could even be argued that by seeking to sustain or, to put it more bluntly, offload health promotion to communities and other sectors, we are setting ourselves at odds with the very essence of the Ottawa Charter for Health Promotion. That is, we could be accused of robbing ourselves of our chance to reorient the health system by retaining health promotion as an ongoing and accepted budget item.

A third issue is the paradox of innovation. Innovation has positive connotations. We are quick to harness this whenever we wish to engage a new sector or organization in a new initiative. Diffusion of innovation theory helps us talk up the benefits of innovation and minimize the costs. Ironically, though, this very same phenomenon can work against us when it comes to sustaining the programme we introduced. Once institutionalized, a programme loses its identity and therefore its appeal, and so sustainability is potentially undermined. A more exciting rival programme may appear on the horizon that may be more likely to attract the organization's interest. Therefore, a system rendered "addicted to innovation" by funding authorities that encourage new initiatives may unwittingly be creating an inherently unstable system in the long term.

A final challenge is to reframe our research on programme sustainability to better reflect appreciation of programme context. Research in programme evaluation is beginning to better understand that what we have tended to call in the past "programme effects" are in fact effects of programme-in-context interactions (Hawe et al., 2004; Israel, 1995). Similarly, while the focus of sustainability theory has always been led by interests in organizational and community contexts (Goodman & Steckler, 1987; Shediac-Rizzkallah & Bone, 1998), the bulk of the empirical work on programme sustainability has been about programmes, not contexts. We need to get much better at understanding and being able to attribute sustainability to contextual differences in, say, resources, staff training, morale, collaboration networks, routines, expectations, belief systems and so on. Much of the work on programme sustainability currently ignores the enormous stress and workloads of the people we usually seek to engage – providers in health systems and teachers in schools. It is arrogant to sidestep these issues and then seek to "market" programmes to communities in ways supposedly consistent with and sympathetic to local values and concerns.

Implications for building sustained interventions

So, given the complexity of sustainability goals and the number of unresolved issues, how should a practitioner act responsibly when it comes to sustainability?

Shediac-Rizzkallah and Bone (1998) argue that planning for sustainability should commence at the outset, during programme design. Chinman, Imm and Wandersman (2004) have built on the conceptual model offered by Shediac-Rizzkallah and Bone and others to produce a checklist for

sustainability planning. This appears in figure 19.2. Investigators stress that every case is different, however. Planning should start with an examination of the issues posed by each situation, including the possibility that the programme might be ineffective or could cause harm. Practitioners may need to partition a programme into various components, goals and objectives and consider whether it is appropriate, or moral, for what amounts to a cost transfer to be borne by particular agencies and people. Planning for sustainability is the type of field where open discussion and visible criteria for decision-making are vital if practitioners are to act responsibly and ethically (Trickett, 1998).

Figure 19.2
Checklist for sustainability planning

✓ Ensure that what is driving the programme is community needs

✓ Ensure that the initial host organization for the programme is well established and mature

✓ Ensure that the programme can be integrated with other programmes

✓ Ensure that the programme is adapted to local needs and preferences

✓ Ensure that the programme has a compatible mission with the host organization

✓ Ensure that the programme is endorsed at the top level in the organization and that there is a strong, stable programme champion

✓ Start discussion early with community members and other stakeholders about sustaining the programme

✓ Develop a consensus building process to reach a compromise for addressing potentially different stakeholder needs (community, funder, technical expert, policy-maker) about what should be sustained and how

✓ Ensure that the programme is achieving desired outcomes – make these clear and visible

✓ If the programme is harmful, stop it

✓ Begin a community and organizational assessment of local resources and potential locations or "homes" for the programme

✓ Consider a wide range of options (including a scaled-down version of the programme)

✓ Have clear strategies in place for (gradual) financial self-sufficiency

✓ Form a working group to formalize and implement the sustainability plan

✓ Make your intentions and actions open and visible

Based on Chinman, Imms & Wandersman, 2004

Programme sustainability is essentially about maximizing ongoing efforts to achieve the benefits, given limited resources. For this reason, practitioners are advised to follow models of health promotion practice that are based on ecological principles, such as those provided by Stokols (1996). These practice models recognize that programme success and sustainability are interlinked and

that both are intimately tied to an understanding that communities and organizations are themselves ecosystems with natural resources, processes and mechanisms for system change. In this sense, programme sustainability is less about adding programmes than it is about sharpening the functioning and capacity of systems – such as primary health care systems and school systems – to be more health enhancing. Thus, the need to "add and take away" or to "do differently" must be dealt with at the same time if we are not to overload providers.

Finally, even though the programme itself may not be successful in terms of resultant health gains, the capacity building within the community still can be (Hawe, 1994). The programme may leave in the community a wide range of capacity building outcomes – people with new skill sets, new and better mechanisms and structures for community consultation, a more aware and sensitive media, more people-focused agencies, new collaborative links and partnerships, optimism, confidence, tolerance, greater clarity of community values and goals and so on. Brainstorming and clarifying at the beginning how these outcomes might be recognized will aid in their achievement.

Conclusion

The future of sustainability research and practice lies with a better interrogation of what a programme "really" is and the dynamic context of the community and organizations involved with it. Building capacities of systems to solve problems and be more health enhancing should replace current overly technological approaches, which have tended to see programmes as packages and local providers simply as people who have to be trained to deliver them. Researchers in prevention and health promotion will need to develop more genuinely collaborative partnerships with communities (Greenberg, 2004). By this we mean that researchers who intend to foster sustainability will have to be willing to engage in helping organizations and communities to assess and balance the goals and strategies of the "new" programme with the other roles and activities of the organization. Sustainability involves priority setting. In other words, adding programmes, taking programmes away and doing business differently is an agenda that must be addressed holistically. Finally, good practice develops the resources and capacities of local communities (Trickett & Birman, 1989). It does not, however, ignore our ethical responsibilities (Trickett, 1998) and the imperative to advocate for more resources for health promotion and prevention on behalf of those we profess to serve.

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Introduction

Governments and communities promote or diminish mental health in populations and individuals without awareness of the implications of their decisions in many sectors of life. Hence, mental health involves everybody, and building awareness of how it is affected by actions of various types is an essential resource for communities and governments.

As described in earlier chapters, mental health promotion is now widely understood as an integral part of health promotion, a key principle of which is intersectoral action. A number of seminal WHO documents – the Declaration of Alma-Ata (WHO, 1978), the Ottawa Charter for Health Promotion (WHO, 1986) and the Jakarta Declaration (WHO, 1997a) – advocate for intersectoral action for health. The sectors, settings and organizations outside health have enormous capacity to affect health, including mental health and well-being. Modifying the determinants of health and intervening, for example, to enhance social inclusion, ensure freedom from discrimination and violence and improve access to economic resources, will not be achieved by health sector action alone. The complexity of the sociopolitical and economic determinants of mental health can only be accommodated by collaborative practice.

This chapter highlights the need to create different partnerships for different purposes and at varying levels, building on existing activity in settings and taking collaborative action horizontally between government departments and organizations and between policy, practice and research. The mental health promotion frameworks and case studies described here demonstrate some of the progress being made and the importance of shared planning and ownership through intersectoral action to achieve good outcomes and sustained change. Other examples of work, especially in low income countries where economic development and poverty reduction are high priorities, are provided in Chapters 14 and 18. The economic, social and cultural environments in different countries and regions have a great effect on the scope, needs and types of action.

Conceptualization of mental health and intersectoral collaboration

Professor Durie, a leading Maori psychiatrist and Maori health expert in New Zealand, has frequently used the image of a house to describe health and well-being. This house has four cornerstones: mental health (emotional and psychological), physical health, spiritual health and environmental health (social environment of family and community). Each relies on the other, and if one fails the house will fall (Ministry of Health, 2002). This image is a powerful one to begin an analysis of why intersectoral collaboration and partnerships are essential for effective mental health promotion. The Jakarta Declaration elaborates the challenges involved:

> There is a need to break through traditional boundaries within government sectors, between government and non government organizations, and between public and private sector. Co-operation is essential … this requires the creation of new partnerships (WHO, 1997a, p.3).

As pointed out by a number of the authors in this volume, there is no one homogenized view of mental health: concepts of mental health and mental health promotion are influenced by cultural

belief systems. This view of the role of culture resonates with holistic models of health that stem from indigenous paradigms that are now being seen as models of good practice for all. There is a strong connection, for example, between Durie's models of Maori mental health (Durie 1994–2000 in Ministry of Health, 2002) and the New Zealand mental health promotion framework.

A similar holistic concept is used by Samoan communities where the fonofale model of health is based on the traditional meeting house or "fale". In this model, the roof represents cultural values and beliefs; the foundation is the family, nuclear and extended; and the four posts represent physical-biological, spiritual, mental and emotional and "other" well-being (which includes variables such as gender, sexual orientation, age and social class) (Anae et al., 2002). Indigenous Australians also use an holistic approach to health. The interaction of elements is crucial in establishing well-being (Anae et al., 2002). Promoting mental health will need to involve broader areas of influence than the health sector alone, especially if it is to take advantage of the holistic view of health, and culturally sensitive approaches to mental health promotion will require the formation of partnerships with communities. Box 20.1 discusses the challenges for indigenous health promotion in more detail.

Box 20.1
Indigenous Health Promotion

Mason Durie

Many principles of health promotion have a generic dimension and are applicable to diverse peoples around the globe. But because they are closely aligned to community dynamics, the distribution of power within society, economic growth and the ways in which services are delivered, effective health promotional methodologies must also be consistent with the particular world views and contemporary conditions that distinguish populations. The "population-specific" dimension recognizes that cultural values, human aspirations and ecological adaptations are not universally shared, so that approaches relevant to one group might be ineffective or counter-productive for others. Populations may be defined according to a range of variables, including age, gender, occupation, geographic location, race and ethnicity. Race and ethnicity are related terms but whereas race has connotations of biological variation and genetic determinism, ethnicity emphasizes social and cultural distinctiveness and places greater importance on world views, lifestyles and societal interaction.

A particular type of ethnicity is indigeneity. There are some 5000 indigenous groups around the world with a total population of about 200 million, or around 4% of the global population. Despite significant differences in material and social well-being, levels of integration into mainstream societies and retention of customary lifestyles, indigenous peoples share a number of commonalities. Compared to non-indigenous populations, socioeconomic disadvantage is often severe; colonization has resulted in similar experiences of resource alienation, suppression of culture and the imposition of foreign rule; and there have been parallel patterns of disease – devastation by infectious diseases and malnutrition in the 19th century, then obesity, cancer, heart disease, diabetes, alcoholism, suicide and depression in modern times (see Kunitz, 1994).

Despite these socioeconomic similarities and comparable experiences with colonization and post-colonial development, the unifying characteristic of indigenous peoples is a

sense of unity with the environment (Kame'eleihiwa, 1992). Their bond with the land (Deloria, 1994), reflected in song, custom, hunting, approaches to healing, birthing and the rituals associated with death, constitutes an extension of tribal and personal identity (Walker, 1990).

Following an international consultation on the health of indigenous peoples arranged by WHO in 1999, a Declaration on the Health and Survival of Indigenous Peoples was prepared and presented to the UN Permanent Forum on Indigenous Issues in 2002 (Committee on Indigenous Health, 2002). Written in five parts, the Declaration proposes the following definition of health:

> Indigenous Peoples' concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously.

This holistic philosophy is a characteristic of indigenous peoples across all major continents (see Ember & Ember, 2004) and, in line with the definition's broad provisions, improving the health status of indigenous peoples requires an approach that covers a wide spectrum of interventions. Many indigenous groups have placed priority on the development of an indigenous health workforce that has both professional and cultural competence and have urged the adoption of indigenous health perspectives, including spirituality, in conventional health and social services (Waldrum, 1997). A return to traditional healing methods has also been suggested, though generally as part of comprehensive primary health care and in collaboration with health professionals (Warry, 1998).

Indigenous models for health promotion often draw on traditional icons and symbols and depend on indigenous peoples to provide leadership in identifying and implementing policies for change (Waldrum, Herring & Young, 1995). One indigenous model developed by Mäori in New Zealand uses the symbolism of a constellation of stars, the Southern Cross (Te Pae Mahotonga). The six stars making up the formation are used to highlight major health promotional goals: a secure cultural identity with ready access to the intellectual and physical elements of the indigenous world, a strong environmental ethic, healthy lifestyles, active participation in society and the economy, indigenous leadership and a degree of autonomy from the state (Durie, 2003b).

Inevitably, a specific indigenous approach to health promotion raises challenges. First, while governments recognize cultural diversity as a modern reality, not all are willing to acknowledge indigenous peoples as populations with unique rights based on a longstanding relationship with the territory that predates colonization.

Second, an indigenous view of health embraces a range of public policies usually developed and implemented in isolation from other sectors – environmental policy, policies that strengthen cultural identity, policies that facilitate equitable participation in education, society and the economy, and policies relevant to decision-making and the exercise of authority.

Third, particularly demanding for indigenous leaders will be the challenge to straddle the two worlds within which their people live. Most indigenous peoples spend their everyday lives on the border between the indigenous world and a set of norms constructed by a wider society. If indigenous leaders are unfamiliar with either world they will find it diffi-cult to understand the mixed circumstances of their people. Fourth, other practitioners of health promotion will also be challenged by indigenous perspectives. Intercultural misun-derstandings may create barriers that hinder rather than facilitate good health. Cultural safety and cultural competence are based on the observation that health practitioners who do not take culture into account in diagnostic and management protocols fall short of acceptable standards of practice.

Fifth, because self-determination is a key indigenous aspiration, self-managing indige-nous health services are important aspects of health promotion. Often the establishment of separate indigenous services creates tensions for governments and communities, but there is also evidence that indigenous-specific services are able to assist people who would otherwise remain outside the reach of conventional services. In those services the norms will be based as much on indigenous world views as on health sciences and, although being part of the health sector, they will also be well integrated into the wider indigenous network (Boldt, 1993).

Finally, there is a vital role for indigenous practitioners of health promotion and health education. Their contribution to indigenous health and more broadly to the practice of health promotion will stem from being at the interface between two worlds: the indige-nous world and the globalized world (Durie, 2003a). Living at the interface and inhabi-ting two spheres presents both threats and opportunities (Smith, Burke & Ward, 2000). It requires careful management not only to avoid the worst excesses of globalization but also to share the benefits of modern technologies and science in ways that strengthen indigenous world views and contribute to good health. Indigenous health workers are in a position to bridge the gap between a world where indigenous values dominate and a world dominated by science, technology and global imperialism.

Frameworks and action for mental health promotion

Frameworks developed in Australia (see Chapter 8) and New Zealand are examples of good prac-tice in mental health promotion. These allow priorities to be considered and established for each population and setting. The frameworks have a population health focus and so highlight the potential for cross-sector involvement at any level (local to national) or in any particular interven-tion (e.g. policy, practice, communication or evaluation).

The New Zealand national framework for mental health promotion – Building on Strengths (Ministry of Health, 2002) – envisions mental health as an inseparable component of health and well-being. The framework builds on the work of Marmot (1999) in describing the determinants of health and health inequalities and recent attention to the social and economic determinants of mental health. It acknowledges the influence of structural features of society, the economy and the environment, alongside individual features such as health behaviours, income and psychosocial factors on the health of individuals, families and communities (Howden-Chapman & Tobias, 2000).

Building on Strengths identifies three main determinants of mental health: participation in society, valuing diversity, and creating safe and cohesive communities. Addressing these elements is clearly beyond the scope of the health sector: the origins of mental health are structural and social as well as physical. The New Zealand strategy aims to reduce inequalities relating to mental health, create supportive environments and improve individual and community resiliency. As it points out:

> … action in the health sector alone is not enough. If the inequalities in mental health experienced by New Zealanders … are to be addressed the health sector will need to work closely with other government agencies, local government and local communities to co-ordinate mental health promotion activities that create supportive environments, strengthen communities and build the capacity of individuals to cope (Ministry of Health, 2002, p. 5).

The strategy is underpinned by two major documents: the Ottawa Charter for Health Promotion and the founding constitutional document of New Zealand, Te Tiriti o Waitangi (Treaty of Waitangi). As discussed in earlier chapters, the Ottawa Charter highlights the importance of healthy public policy across sectors and the need to look at the impact of such policy on (mental) health as well as stressing the need for supportive environments and community action. The Treaty of Waitangi principles of partnership, participation and protection are set at the heart of the government's national policy framework. Central to each of these principles is the relationship between individuals, communities and governments.

The Australian Mental Health Promotion and Prevention National Action Plan (CDHAC, 1999) identifies opportunities for promotion, prevention and early intervention across lifespan groups, population groups and priority groups. Particular emphasis is placed on the development of partnerships within the mental health sector and outside it. The challenge was put forward to:

> … everyone, within and across all sectors to work together to provide quality services, programmes and initiatives that involve a spectrum of interventions to reduce mental ill-health and to improve well-being (CDHAC, 1999, p.1).

Similarly, the framework for the promotion of mental health and well-being developed by VicHealth (1999) that is described in by Walker et al. in Chapter 8 of this volume establishes the centrality of intersectoral action.

Intersectoral approaches are not without their challenges, however. These include vertical funding within sectors, professional diversity of paradigms and views, competing priorities, diverse and often inequitable funding models, population group models of health, decision-making processes and, not least, the fact that all these factors contribute to complex processes of engagement. Additionally, as Patel, Swartz and Cohen identify in Chapter 14, the influences on mental health are likely to be even wider in developing countries. Mental health promotion in these countries is closely linked to human development. The lack of infrastructure, scarcity of human and material resources, and human rights violations contribute to the complexity of mental health promotion, resulting in the need for even more extensive intersectoral collaboration. This may be especially challenging in environments where there is civil disturbance.

In several countries links are developing between sectors in the area of working with young people (see box 20.2 for an example). Research shows connections between factors that affect mental health and factors associated with crime (National Crime Prevention, 1999), drug abuse (Resnick et al., 1997) and academic achievement (Zubrick et al., 1997). These factors include school attendance, connectedness to school and community and opportunities for success at school. The resultant mul-

Box 20.2
Zippy's Friends

Chris Bale, Brian Mishara

The programme

Zippy's Friends is a school based mental health promotion programme for children aged 6–7 years. It runs for 24 weeks and is built around a set of stories about a group of children and a stick insect called Zippy. The stories deal with themes that are familiar to young children – friendship, communication, feeling lonely, bullying, dealing with change and loss and making a new start. For example, Sandy's parents are separated. She's bullied at school. Tommy is lonely and worried about moving to a new class. Zippy dies. In each session, the teacher reads one of the stories and then the children take part in activities which teach them how to cope with difficulties, to identify and talk about their feelings and to explore ways of dealing with them.

Development

The programme was conceived by an international suicide prevention agency, Befrienders International, and the aim from the outset was to help as many children as possible. An international panel of experts guided the programme's development and experienced professionals produced high-quality teaching materials. Care was taken to make these materials generic rather than country-specific. A process of developing, testing, refining and re-testing the programme took place over five years, and was made possible by industry sponsorship from GlaxoSmithKline, which supported Zippy's Friends from the outset.

Evaluation

An initial pilot in Denmark produced promising results, but it was decided that more work was needed and so the programme was revised, placing greater emphasis on developing children's coping skills. A second pilot was then run and comprehensively evaluated in Denmark and Lithuania. This time the results were excellent. Based upon observations of children and interview data, the evaluators noted that the programme was successfully operated and tested in different languages, different grade levels and very different school environments in the two countries. They concluded that children in both countries showed clear improvements in coping abilities compared to control groups. Significant improvements were also observed in cooperation, empathy, assertion and self-control. Also, the problem behaviours of externalizing and hyperactivity decreased. The programme was equally effective with boys and girls. The evaluators concluded, "The results provide impressive evidence that this programme is successful in achieving its immediate goals".

Two further evaluations were conducted in Lithuania, where the programme soon became established in kindergartens nationwide. A study one year after children had completed Zippy's Friends found that the improvements recorded during the programme were maintained. The second study found that children who participated in the programme in their final year at kindergarten handled the transition to primary school more easily and more happily than children who had not joined the programme.

The feedback from teachers and parents was enthusiastic. One Danish teacher said, "It is a great joy to recognise the change in the children". Seventy-two per cent of parents surveyed in Lithuania said their children communicated more freely and appeared to be more thoughtful, attentive, friendly and sincere. One mother said, "The programme has transformed our family life. All my children now listen to each other. I couldn't believe it when I found out Zippy was just a stick insect!"

Dissemination

The hard evidence provided by professional evaluations was a strong selling point when Zippy's Friends was made available internationally. The programme was quickly picked up by agencies in Brazil, England and India, and discussions continue with more than a dozen other countries. Partnership for Children, which took over the programme from Befrienders International in January 2002, expects it to be running in at least 10 countries by 2005.

Unlike many programmes for children who either have mental health problems or are perceived as being at risk, Zippy's Friends promotes the mental health of children of all abilities and backgrounds. This is a new concept for many people, however, and school principals are sometimes reluctant to make time for it in an already overcrowded curriculum. Government backing is invaluable – in Lithuania, for instance, the Ministry of Education and Science's endorsement of Zippy's Friends greatly facilitated the programme's rapid expansion throughout the country.

Cost is invariably an important factor. To address this, Partnership for Children allows partner agencies to produce the teaching materials as cheaply as they wish. It also trains local trainers in each country. The programme is usually launched and evaluated initially in only a few schools, before greater resources are obtained to deliver it more widely.

For more information, see www.partnershipforchildren.org.uk.

tidisciplinary interest is another dimension of collaborative action involving varying ideologies, language and practice (Rowling, 2002). In this context, the horizontal linking of practice, research and development of policy benefits from drawing on the different sectors' perspectives. Recognizing the value of the synergy that this can create is essential to stimulate and sustain collaborative practice.

The words "intersectoral collaboration" and "partnerships" are often used interchangeably. For those in the business sector, the term partnership often means a joint commercial venture, whereas in the health sector it might mean developing one strategy between two sectors to meet a shared goal. A WHO briefing document for the Fourth International Conference on Health Promotion added another dimension: "partnerships imply a balance of power and influence is maintained between the partners and that each partner can maintain its core values and identity" (WHO, 1997b, p. 2).

The conditions for effective partnerships that have been identified are necessity, capacity, recognition, relationships, planned actions and sustained outcome (Harris et al., 1995). Intersectoral and multisectoral partnerships in policy development may involve international, national, state, regional and local levels as well as professional and nongovernment organizations, governments, donor agencies and private businesses. The contribution of a range of groups also provides the opportunity for increased consumer participation where services of various types are involved (see box 20.3). A successful intersectoral approach includes developing a unifying language, a

Box 20.3
An Intersectoral Approach to Mental Health and Pesticide Safety

Arabinda Chowdhury, Sohini Banerjee, Mitchell G Weiss

The Sundarban region of West Bengal, India, is a poorly served collection of mainland and island communities south of Kolkata (formerly Calcutta). It is situated at the mouth of the Hooghly River and other branches of the Ganges River system where they flow into the Bay of Bengal. Interests in the particular challenges of rural mental health led researchers and clinicians at the Institute of Psychiatry (IOP), Kolkata, to organize a series of community meetings in Namkhana, one of the 13 Sundarban development blocks, to assess local interest and priorities for a mental health programme.

Meetings with leadership councils (panchayats), teachers and others identified particular concerns about suicide and suicidal behaviour, poor access to treatment for serious mental disorders and various tensions arising from domestic and other conflicts, harsh economic conditions and a perceived breakdown of social values. These meetings showed the community wanted a mental health programme. Consequently, a project with participatory research and community service was developed. Suicide and suicide attempts soon became a principal focus and, as in many other rural areas, we found that ready access to pesticides made them a preferred method for deliberate self-harm. Findings also showed that many farmers were concerned about the safe and effective use of pesticides and were aware of their use for deliberate self-harm.

Health centre staff were trained to help them identify, manage and refer patients with mental health problems encountered in primary care and a monthly mental health clinic provided services of an IOP psychiatrist. Field research considered several questions, including rates of deliberate self-harm in the 13 Sundarban block primary health centres. A household survey in 21 villages studied pesticide use and storage and both accidental and deliberate poisoning with pesticides and other methods. Field research also evaluated the distribution of pesticides, showing that basic information about safe and effective use was frequently inadequate or totally lacking. Clinical study of patients after suicide attempts clarified the clinical psychiatric and cultural epidemiology of suicidal behaviour.

A series of facilitated focus groups and community meetings addressed research questions and disseminated information about safe pesticide use, suicide prevention and available mental health services. Posters and hoardings for display, and calendars and pens for distribution, were emblazoned with relevant slogans and information. A collection of illustrated informational brochures was prepared with more detailed information and distributed in the focus groups and other group meetings.

The community and local primary health care staff uniformly appreciated the health services and attention of research. The intersectoral agenda of group meetings, especially with farmers, provided an opportunity to discuss interests that were closely related to the community experience, but rarely integrated in community programmes. Our experience suggests that harmonizing clinical and community activities and integrating the interests of mental health and safe pesticide use in this project effectively engaged these Namkhana communities, promoted awareness and influenced practice. Additional action-oriented research is needed to test these hypotheses and further refine these interventions.

clear approach to allocation and sharing of resources and a strengthening of capacity across the individual, organizational and community dimensions.

Settings for intersectoral collaboration

Education

The WHO global programme for health promoting schools (WHO, 1996) has as one of its aims the increased involvement of girls in education. This is a particularly important outcome not only for education but also for health in low and middle income countries. Health promoting schools as a settings approach to health is widely used across the world. It is a key example of intersectoral collaboration between the health and education sectors. At national levels, memoranda of understanding have been developed between ministries responsible for health and for education. This policy formation has brought together the resources of both sectors. The horizontal linking and sharing has created sustained practice that is being built upon for a range of health issues in Europe (for example, in Ireland, England and Germany) and the western Pacific (for example, Australia, New Zealand, China, Laos and Viet Nam). The start of formal schooling is seen as a milestone and major transition. Schools are settings within which a range of interventions can be made. As the health of children and young people is linked to the health and well-being of their families, holistic approaches are recommended.

Effective interventions in schools include:

- mental health promotion using the health promoting schools framework;

- programmes designed to promote resilience and optimism;

- programmes that increase social problem-solving, build self-efficacy, enhance social competency and academic achievement or improve parenting skills, or a combination of these; and

- programmes aimed at altering school organization and changing school systems to reduce bullying and violence (CDHAC, 2000).

As shown in case study 20.1, a crucial component of an intersectoral approach to mental health promotion is the development of policy at a number of levels. First, national (and local) curriculum policy needs to set frameworks within which mental health can sit comfortably and where it can contribute to achieving national education goals. In the New Zealand example, the framework for Mentally Healthy Schools can contribute to the national education goal of "respect for the diverse ethnic and cultural heritage of New Zealand people, which acknowledges the unique place of Maori, and New Zealand's role in the Pacific … [to] provide a safe physical and emotional environment for students" (Ministry of Education, 1999 in MHF, 2001, p.12). Second, policy within the school environment needs to be strengthened to include matters such as student welfare and pastoral care, peer support, valuing of both diversity and inclusiveness, human rights, anti-bullying and suicide prevention. A third level involves the development of horizontally linked related policies in areas such as healthy youth development, physical health and employment practice.

Another example of an intersectoral approach to mental health promotion in schools is the development and dissemination of the MindMatters resource in Australia (see case study 20.2). Its implementation represents theoretical and practical partnerships between the health and education sectors at national and state levels. MindMatters is underpinned by research-based conceptual frameworks (Wynn et al., 2000) that schools can use to promote mental health. From an

Case study 20.1
Mentally Healthy Schools in Aotearoa New Zealand

Drawing on the health promoting schools framework, Mentally Healthy Schools in Aotearoa New Zealand linked curriculum, learning and teaching, school organization and ethos, and community partnerships and services. This involved a new approach to promoting mental health across the whole school. Four aspects were emphasized in the guidelines developed by the Mental Health Foundation of New Zealand for the programme: the importance of school ethos and climate, a comprehensive approach to mental health, empowerment and student involvement, and addressing barriers to learning (MHF, 2001).

According to the guidelines, mentally healthy schools have the following features:

- Student and staff well-being is supported through the maintenance of a safe social and emotional working and learning environment.
- Students and staff are valued and are encouraged to reach their full potential.
- A sense of self-worth of all members of the school community is fostered through the implementation of relevant policies and practices.
- A respectful attitude to all people in the school and its community exists, particularly regarding culture, sexual orientation, ethnicity, age, gender and disability.
- Positive help-seeking behaviour is encouraged by providing accessible and culturally supportive systems and services.
- Communication is respectful.
- Positive effort and achievement are acknowledged.
- Positive mental health is modelled (MHF, 2001).

intersectoral perspective, it builds on educational research regarding effective school change and programme and policy implementation. It is shaped by the understanding that school practices and the professional development of teachers are fundamental to the success of any innovation. The MindMatters approach marks a significant shift away from health sector interventions that emphasize individual deficits of young people and individually focused behaviour change models.

In MindMatters it was essential to establish the links between teachers' priorities, such as coping with poor student behaviour, the MindMatters activities, and mental health. This fostered teachers' participation and action. The process of dissemination of MindMatters was also critical in the Australian context to enable a state-based health and education system collaboration. Each state has a working party or reference group that represents a range of stakeholders involved in health promotion and education in that state.

This approach to mental health promotion uses education system processes and language in training and dissemination. As in Mental Healthy Schools, the programme aims to influence the overall approach of each school in a range of areas such as performance management, worker's compensation, student behaviour management and human resource management. In particular, decisions and practice in these areas are linked with teacher, student and parent participation.

Case study 20.2
MindMatters

MindMatters is an Australian resource that provides a guided, structured strategy to promote young people's mental health and well-being through all dimensions of the school environment. It consists of materials for review and planning for school improvement, now published as SchoolMatters (Sheehan et al., 2000), as well as other curriculum resources.

MindMatters, in its whole school development, takes an organizational approach focusing on the normal operations of the school so that they are more supportive of student mental health. This is done through:

- teaching and learning practices that increase students' sense of worth and social connectedness;
- creation of safe and supportive social environments for students and staff; and
- increasing links with families and the range of mental health related services and agencies in the community.

The intention in MindMatters is to create optimism, pride and a sense of ownership of mental health promotion within this setting. That is, there is a clear intention through collaboration and horizontal linking with education sector priorities to create conditions for school communities to feel in control of the process and the mental health issues they focus on. More information on MindMatters is available at: www.curriculum.edu.au/mindmatters.

The workplace

Workplaces are increasingly heralded as significant settings for attention and action by international bodies. The World Federation for Mental Health set the workplace as its focus for two consecutive World Mental Health Days in 2000 and 2001. This action identified the workplace and the role of employers as key entry points for promoting mental health and creating healthy environments. The global collaborative partnerships between WHO and the International Labour Organization (ILO) also highlight, through policy, practice and research, the importance of workplaces and employment in promoting mental health.

WHO identifies three main issues for employment:

- creating a positive work environment free from discrimination, with acceptable working conditions and employee assistance programmes;
- integrating people with severe mental illness into the workforce; and
- adopting policies that encourage high levels of employment, maintain people in the workforce and assist the unemployed (WHO, 2000, p.102).

This represents a broad view of the role of work for mental health and well-being. Not only does it identify the role of conditions within the workplace but also the importance of meaningful employment itself for positive mental health. As described in earlier chapters, social and economic disadvantage is linked to higher prevalence of mental illness (Desjarlias & Kleinman, 1997). This arises from many factors, including lack of income generation opportunities and the absence

Case study 20.3
Developing a healthy workplace – The Clifford Beers Foundation

The creation of a safe, healthy and supportive work environment is a vital component of an effective organization. The mental health of employees is essential for both their well-being and for the effective operation of the organization.

The most significant research in this area is in the context of how the organization of work can induce stress that in turn affects both health and productivity. The scientific evidence on stress, health and performance has concentrated on two paradigms:

■ the Demand/Control Model (Karasek & Theorell, 1990)

■ the Effort/Reward Imbalance Model (Siegrist, 1996).

The essence of these models is that too much demand coupled with too little job control and too much effort coupled with too little reward are stressors complicit in the production of numerous types of illness and injury. These harms range from the common cold to cancer and include injuries such as repetitive strains and back problems. Increasingly, it appears that both pairs of conditions are likely to co-exist in the same workplaces.

The Clifford Beers Foundation (www.charity.demon.co.uk) has developed a framework to assist employers to engage and interact with staff to address these issues. The framework calls for the concept of the healthy workplace to be an integral component of the business place and for:

■ a broad-based commitment of workers and management in all stages;

■ a partnership which permits all participants to address a full range of issues;

■ targeting of health issues which are a priority of workers;

■ researchers to act as technical resources and facilitators (e.g. to help answer, "what works?" and "what doesn't?");

■ long-term commitment; and

■ evaluation.

Results from the programme have demonstrated how the meaningful involvement of staff in decision-making about their own health and welfare at work leads to higher levels of satisfaction and reduced stress levels.

of a reliable income from employment. Work offers opportunities to engage in the civil and economic life of a community (Pavis, Platt & Hubbard, 2002). Economic factors directly affect mental health in both developed and developing countries. For example, the banking and credit sector has an enormous impact on the mental health of communities. Selling off farms to repay loans not only takes away the livelihood of individuals but also results in loss of identity and family cohesion. The mechanisms by which micro-credit and income generation schemes have an impact on mental health are detailed in Chapter 14.

The rationale for a focus on the workplace is clear:

> There is a need among employers to recognize mental health issues as a legitimate workplace concern. As disability costs and absenteeism increase in the workplace due to mental ill health (whatever the precipitating factors), more and more employers are faced with the challenge of developing policies and guidelines to address these issues (WHO, 2000, p.21).

As discussed in earlier chapters, the following key factors have been found to impact on workplace environments and employees: work schedule and flexibility; positive relationships with work colleagues; job satisfaction and security; job design and degree of autonomy; employee role status and degree of decision-making and planning; general management style and organizational culture; organization change; communication; and social, environmental and physical factors (ILO, 2001; WHO, 2000).

The past 30 years have seen significant workplace health improvements in some countries in respect of physical and toxic hazards, and workplace health promotion initiatives that have helped to encourage healthier behaviours by individuals. However, the situation in many low income countries remains severe in the face of human rights abuses such as forced labour and child labour. These abuses require a range of political and social interventions beyond the workplace as well as within (see Chapter 7). Even in affluent countries the social and psychological demands of work are increasing. These demands arise from managerial decisions that in turn are constrained by the wider economic, political, social and political environment (Polanyi et al., 2000).

Even within the workplace, successful promotion of mental health must extend beyond the traditional boundaries of occupational health and individually focused health promotion strategies. Neither the provision of a safe physical environment nor the promotion of a healthy lifestyle is sufficient. It is now time to:

> … tackle the bigger, more controversial task of creating healthier workplaces that can create the working conditions necessary for good health. This will require the difficult task of striving to balance economic strength, social equity and for survival over the longer term, environmental sustainability (Polanyi et al., 2000, p.155).

Such a move in no way negates the need for occupational health strategies or workplace health promotion programmes but rather calls for a greater emphasis than there is at present on organizational and societal determinants of worker health. A more comprehensive approach incorporating inter-related strategies is required. Employers who provide safe and supportive work environments for all their staff can do more than prevent stress and injury: they can provide mentally healthy environments which will promote mental health and potentially improve performance and productivity (McKernon, Allen & Money, 2002).

Promoting health and mental health in the workplace has developed as a priority from evidence that employers who attend to their responsibilities to be good employers and provide supportive work environments have reduced absenteeism, less workplace stress, fewer accidents, less staff turnover and higher performance. The work of the Clifford Beers Foundation (case study 20.3) in developing a research-based conceptualization of mental health and the workplace offers clear directions for policy development. It emphasizes that effective practice involves partnerships between employers and staff. Likewise, case study 20.4 shows the value of creating a shared agenda for mental health improvement that acknowledges the priorities of the employers for profit and productivity increases as well as organizational change.

Case study 20.4
Working Well – A practical guide to building mentally healthy workplaces

Based on the growing interest by employers in the area of workplace health and requests for information on how to support staff with mental health related problems, the New Zealand Mental Health Foundation developed a workplace mental health toolkit, "Working Well" (MHF, 2002). In its development phase, the Foundation market-tested the content and format of the toolkit. This consultative process drew on the wisdom and practices of the private sector partners, identifying that employers wanted practical and helpful tools that improved productivity. This process also enabled employers to see that a mentally healthy organization was also potentially a more enjoyable and profitable one.

The consultative process will hopefully contribute to relevance and sustainability of the resource and the partnerships. Alongside the resource, tailored training programmes and employer forums are expanding the programme of activity in response to employer feed-back. The goal is to create a community of mentally healthy employers in New Zealand.

The following table outlines some of views on mental health of staff and employers.

Definitions of mental health at work	Examples of being mentally healthy	Mentally healthy team and workplace culture
■ Accounting for people's feelings ■ Communicating effectively ■ Having satisfying workplace relationships ■ Dealing with difficulties quickly and efficiently	■ Communicating and relating – being able to express one's feelings, understand others and maintain good relationships ■ Balances between work and home life ■ Informal mentoring, mediating and counselling roles ■ Taking responsibility and initiative ■ Getting the company to provide a good working environment	■ Trust ■ Friendship ■ Practical support with problems ■ Shared goals and values ■ Equality ■ Effective teamwork ■ Rapid resolution of conflict and difficulties

Adapted from MHF, 2002

Communities

Arts programmes

Through involvement in arts activity, participants have been shown to develop supportive social networks and report increased feelings of well-being (Jermyn, 2001; Matarasso, 1997). At the individual level, participants can discover and develop skills, increase their self-esteem, build social networks and improve the sense of control over their lives. In the case of young people, involvement in creative activity can result in improved academic achievement, school retention rates and levels of self-esteem and reduced drug and alcohol consumption and juvenile offending (Heath & Soep, 1998).

Community-based arts activity can also make a considerable contribution to community health, development and renewal (Williams, 1997). Through collaborative and inclusive processes, social

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Case study 20.5
Taiho Theatre Company

In 2000, the Mental Health Foundation of New Zealand established a partnership with Taiho Theatre Company. Taiho is a collective of Maori women who use a combination of theatre and Maori processes to investigate local issues through the retelling in dramatic form of people's stories. The Hokianga, where Taiho is based, is one of the poorest and remotest regions in New Zealand, with a high proportion of young Maori and unemployment rates in some areas of over 50%.

O'Connor and colleagues (2003) suggest the power of working with stories with Maori is that, like most colonized and oppressed groups, they are more accustomed to their stories being systematically suppressed. Telling the stories becomes a liberating and democratizing process in itself.

Taiho theatre uses existing forums, including local iwi (tribe) sporting and cultural events and family reunion days on local marae (traditional meeting houses), and works in mental health facilities that operate within Maori models of healing. The layers of partnership relationships in the project are instructive in understanding the links between policy, partnership and theatre process in mental health promotion. Government policies to counter stigma and discrimination associated with mental illness led to funding of the national Project to Counter Stigma and Discrimination Associated with Mental Illness. Taiho theatre was able to access funds through this programme. Government priorities aimed at reducing economic and social disparities for Maori also provided funding opportunities.

In the series of theatre events staged by Taiho, the community explored their own stories and reflected on their needs and possible solutions. Government policies of "fixing mental health and Maori issues" became a process by which those who lived the stories attempted to understand how to better live with them. The devolution of responsibility for the work, from government to NGO, to consultant, to community group with existing relationships and structures within the communities, facilitated action. The Mental Health Foundation concluded that the way the Company worked meant it was seen as part of the community, rather than as an agent from outside that brought theatre to the community, and that this was one of its strengths.

Case study 20.6
The public art, health and environment project

A good community cultural development project will increase participants' sense of connection to community and their sense of opportunity (Thiele & Marsden, 2003). Public spaces mirror the community. They publicly reflect the values, beliefs, diversity, aspirations and identity of the people who live there. Public spaces have the power to uplift, challenge, inspire, celebrate and unite (City of Yarra, 2003). Public spaces therefore have an impact on mental health and well-being. As such, you can build health in or out of these spaces. In a public housing estate in Melbourne, Australia, the Public Housing Estate Arts Committee (made up of resident and community members) oversees an arts and environment project managed by local government. Planning for the project began in 2001 and has, over time, embraced many of the estate's 2400 residents. Residents have been consulted at each stage of the project and their aspirations for the area continue to be included and implemented where possible.

The new space is attracting people to participate in workshops (practical and cultural); see films, performance and art exhibitions; rehearse for theatrical performances; and design floats for arts festivals. Residents are taking a leading role in the transformation of the car park from a disused urban site to a creative space. As well as mosaic designs on the floor, murals have been painted by an Indigenous mural painting group that includes residents. New and improved lighting has also been installed, along with sculptural works, and fern gardens have been planted in the light wells.

The vast space is no longer feared and avoided by residents. It is a safe and friendly place where residents and people from the local communities can meet and organize events. The appointment of a part-time cultural officer (funded by Government) is likely to be a further boost to the area. Other mental health outcomes include the creation of social connections, drawing people out of their flats and into their community and thus breaking down residents' sense of isolation.

This partnership of local government and state government departments, combined with local community groups, has resulted in creative actions to achieve the transformation of a public space. The dual outcomes of improved mental health from the collaborative practice and the creation of a space that will continue to provide opportunities for connection and creativity breaks new ground in what can be achieved from intersectoral collaboration.

cohesion and a sense of belonging are fostered and issues of importance to the community can be discussed and explored in creative ways. Durable structures that support planning and decision-making, such as local committees, councils and voluntary agencies, are key factors in successful alliances and partnerships for health promotion (Gillies, 1997). In this context, the arts, in particular theatre arts, have traditionally been used in mental health promotion for two purposes: as events attached to the beginning or end of a campaign or project to give it media attention and as a communication strategy to convey a health message in a way that engages an audience. This latter strategy is particularly suited to low income countries, where there may be few resources but a long history of story-telling and education through drama and songs.

In both forms, however, the content and message have largely been predetermined by an external agency. More recently, the community development aspect of arts-based programmes has been highlighted. This involves such processes as groups being supported to determine their own stories and communicate them through music, song, dance and theatre. These more participatory and democratic forms of theatre process are being incorporated into health promotion strategies to create dialogic relationships and partnerships between health promoters and the communities they work within (O'Connor et al., 2003). Mental health outcomes include increased self-esteem, social inclusion and sense of well-being (Matarasso, 1997). Two effective arts-based mental health promotion programmes are described in case studies 20.5 and 20.6.

Globally, the use of theatre in health activities is accepted as an important and culturally appropriate contributor to engagement of communities in the process of articulating their health concerns. This practice provides opportunities to gain insight into the lived experiences of individuals and communities and facilitates understanding and healing. It also provides access for a wider audience because literacy skills are not prerequisites to engage in the activities.

Community involvement

Community development strategies have been the cornerstone of primary health care. This approach gives primacy to the development of collaborative relationships with communities that are respectful of their needs and priorities. That is, in activities between different sectors, agencies and communities, the process of negotiation and action is an integral part of relationship building – a process that can enhance the mental health and well-being of participants. Being respectful of members of communities that are excluded either socially or economically from full participation in society builds the capacity of both the community and its individual members (see, for example, Chapter 18 in this volume). Research indicates that communities with high rates of participation by individuals in community activities have better health outcomes than those with low levels of civic engagement (Marmot, 2000). The promotion of social cohesion and health for prevention of disease is well established (Wilkinson, 1996).

In a review of the effectiveness of alliances or partnerships, Gillies (1997, p. 2) concluded "the greater the level of local community involvement in setting agendas for action and the practice of health promotion, the larger the impact". The review highlighted the value of developing social capital and identified the strong association between the quality and level of infrastructure in the neighbourhoods where people live and the social and environmental determinants of health.

Case study 20.7 illustrates how intrasectoral and intersectoral action at different levels in a community can improve the mental health of older people through awareness raising and increasing social connectedness. Through the processes described, the practices of doctors and hospitals in Danang were altered, a health education programme was developed that linked older and younger people in a way that gave value to both groups and a sports centre became a hub for a range of activities that had an impact on the mental health of older people.

Conclusion

The frameworks and case studies described in this chapter demonstrate the significant impact on the social determinants of mental health the health sector can have when working in partnership with many other sectors, organizations and groups. They demonstrate the importance of shared planning and ownership to achieve quality outcomes and sustainability in mental health promotion.

Case study 20.7
Socializing the care and promotion of older people's health

Life expectancy in Viet Nam has increased in recent years. This has brought with it challenges to ensure the quality of this extended life. To accomplish this, a community-based multisectoral social health care programme for the elderly was developed in Danang, which is in one of the country's major tourist regions. One of the major features of the project is the promotion of elderly people's skills and contribution to their society. At the same time, emphasis is placed on staying healthy through being physically active and mentally alert.

The programme was pioneered by the People's Committee of Danang and carried out by related sectors in the city. For example, the Thaiphien sports centre gives guidance on physical exercise, massage and point acupuncture therapy to older people. More than 1800 older people are regular members of the Thaiphien club and get together twice a month, taking part in sport and entertainment activities, doing gardening, having talks with the city's authorities and giving constructive ideas.

The development of the "Model-like grandparents – Pious children" movement also has had remarkable influence on older people's health. "Model-like grandparents" means that grandparents and parents lead a healthy lifestyle such as not smoking, not drinking, being physically active, helping the children in their daily life. "Pious children" means that the children take a great deal of care of their grandparents' physical and mental life. Consequently, grandparents are happy and pleased with life. It has greatly improved their health.

There is no geriatric hospital in Danang; however, the general hospital, the oriental medicine hospital and the psychiatric hospital have all established wards that cater for older people's health problems or illnesses. There is a belief that many elderly people in Viet Nam have seen a hard life and they deserve a chance to enjoy all their years, so elderly health care has become an area of interest. Younger doctors are realizing the need to respect elderly people, to protect both their mental and physical well-being and to better understand them. In district health centres and health stations there have been doctors taking on elderly health care.

The older people in Danang are now a new power for the city's development.

If we consider the determinants of mental health and health in general and look to holistic models for our guiding definitions and frameworks, then the presence of intersectoral collaboration, partnerships and activity becomes essential. There are many examples across different countries and regions where the right ingredients come together and where research, policy and practice combine in an exchange of informed dialogue to create programmes that are responsive to individual, family and community needs and that address a wide range of factors affecting mental health.

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Chapter 21
Conclusions and Recommendations

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Governments, communities and health professionals in many parts of the world have focused attention in recent years on the need to act vigorously to prevent and treat mental illnesses. Reports over the past decade on the global burden of disease, the release of the world health report "Mental Health: New Understanding, New Hope" in 2001 and other national reports have resulted in a significant increase in awareness of and action to improve the outcomes for people affected by mental illness or at risk of becoming ill.

However, this welcome attention remains a restricted view of the public health approach to improving mental health. Mental health as described in this report is a positive set of attributes in a person or community, which can be enhanced or compromised by environmental and social conditions. As with all other components of health, illness is often the focus of attention. So much so, the term mental health is commonly understood as referring to mental illnesses and their prevention and treatment. This is unfortunate since optimal mental health is more than the absence of mental illnesses. Promoting mental health means enhancing the mental health of all in the community, of those with no experience of mental illness as well as those who live with or have a history of living with or one or more illnesses. Promoting mental health uses a range of actions that increase the chances of more people enjoying better mental health.

In this chapter we summarize what we know about promoting mental health and its consequences, what we can do now, and what more we need to know and do in order to promote mental health in countries throughout the world.

What do we know?

Sufficient evidence exists to draw two broad conclusions. First, promoting mental health is a global health priority, and second, a public health framework can be used to promote mental health.

Promoting mental health is a global health priority

Improved mental health is linked to better health, productivity and safety. Mental health is a key to optimum health and development in every country.

In all societies the high prevalence and burden of recognized and unrecognized mental illnesses and mental health problems is well known. Although considerable advances have taken place in early identification and treatment of these disorders and problems, the limitations of these methods in ameliorating symptoms and associated disability are all too obvious. This scenario in itself compels us to pay more attention to other public health strategies. While treatment is critically important for individuals with illnesses and their families and neighbours, effective promotion of mental health can benefit whole communities, with large cumulative gains. Increasing and persisting socioeconomic disadvantage in subgroups in a number of countries is a recognized risk to mental health, requiring serious investment in health promotion, as well as broader measures to alleviate poverty.

A public health framework is well suited for promoting mental health

Mental health promotion is often considered as ill-defined and different from other health areas, and a public health framework is rarely applied. The ideas and evidence presented here demonstrate

that promoting mental health requires and can be achieved using the modern approaches to public health and health promotion. Public health has been conceptualized as collective action for sustained population-wide health improvement.[1] Promoting mental health quite clearly falls within this remit. Public health strategies such as advocacy, public health education, communication, policy and legislative changes, community participation, research and evaluation can be used to promote the mental health of individuals, families and communities. Many of these interventions promote mental and physical health, illustrating the integration of mental health in health and public health.

Several other conclusions can be drawn. These add to the sense of urgency as well as suggest the types of action required.

Mental health has specific value in itself, is integral to health and is the foundation for well-being and effective functioning for individuals and populations

Promoting mental health is justified in itself as well as through its efficacy in helping to achieve other objectives such as increased productivity. While these benefits are important and may be decisive in terms of resource allocation, the promotion of mental health is fundamentally linked to human rights and equity as well as overall humanitarian and utilitarian values.

Adverse social, economic and political conditions cause serious risks of mental ill-health, and are also likely to compromise mental health

Such conditions include being poor, uneducated, unemployed, underprivileged, socially marginalized or displaced or living in conflict situations. Promoting mental health needs to be assigned a higher priority in such vulnerable groups.

Interventions need to be developed and evaluated locally

Those interventions found to be effective in one setting need to be adapted to the appropriate cultural and resource setting in another, and accompanied by continuing evaluation.

Promoting mental health needs to be undertaken with community participation

This not only ensures that the interventions are appropriate but also enhances sustainability.

Intersectoral collaboration is the key to effective programmes for mental health promotion

For some collaborative programmes better mental health is the primary objective. For the majority, however, mental health, even though valuable in its own right, is secondary to other social and economic outcomes.

What can we do now?

The opportunity to take mental health promotion forward is unprecedented. Evidence of several types and levels is available to demonstrate the effectiveness of programmes and interventions for enhancing the mental health of populations. These include:

- early childhood interventions (e.g. home visiting for pregnant women, pre-school psychosocial interventions, combined nutritional and psychosocial interventions in disadvantaged populations);

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[1] Beaglehole R, Bonita R (2004). *Public health at the crossroads. Achievements and prospects.* 2nd edn. Cambridge, Cambridge University Press.

- support to children (e.g. skills building programmes, child and youth development programmes);

- economic and social empowerment of women (e.g. improving access to education, micro-credit schemes);

- social support to old age populations (e.g. befriending initiatives, community and day centres for the aged);

- programmes targeted at vulnerable groups such as minorities, indigenous people, migrants and people affected by conflicts and disasters (e.g. psychological and social interventions during the reconsolidation phase after disasters);

- mental health promotion activities in schools (e.g. programmes supporting ecological changes in schools, child-friendly schools);

- mental health interventions at work (e.g. stress prevention programmes);

- housing policies (e.g. housing improvement);

- violence prevention programmes (e.g. community policing initiatives); and

- community development programmes (e.g. Communities That Care, integrated rural development).

Countries and communities need to adopt a public health framework as used to advance other areas of health, and thereby engage all relevant sectors to support and evaluate activities designed to promote mental health.

What do we need to know and do further?

Although knowledge about mental health promotion has increased at a rapid pace in the last few years, the area is still emerging as a recognized area of practice and research. More research of various types and systematic evaluation of programmes is needed to increase the evidence base and determine its relevance to widely varying cultures and resource settings. International action is necessary for generating and disseminating further evidence, especially within low and middle income countries.

Some of the key questions in this next phase follow.

Concepts

- How does any community become aware of the reality of mental health, its relevance to prosperity and safety, and its links to community actions?

- What methods can be used to assess the intrinsic value that people assign to mental health?

- How are governments, professionals, community groups and the media enlisted in promoting mental health?

- How can mental health promotion be understood as a necessary component of child and maternal health and HIV prevention and treatment programmes?

Evidence

- What are the determinants of mental health in each country, culture and population group?

- What are the practical implications of the relationship between mental health and social capital?

- What relationships exist between the positive dimensions of physical and mental health and what other factors influence these relationships?

- What methods of generating evidence for effectiveness and cost-effectiveness are most appropriate for mental health promotion?

- Which components of mental health promotion programmes remain effective across cultures and settings?

- How can the experience of promoting mental health in low income countries be added to the evidence base?

- Which indicators are most appropriate and feasible to monitor the mental health of communities, and allow cost-effectiveness studies of health promoting interventions and non-health sector policies?

- How can the impact of economic development on mental health be monitored?

- What is the cost-effectiveness of the mental health benefits of socioeconomic polices and interventions such as poverty reduction, employment generation and community development?

- How best can we disseminate the evidence that is gathered?

Practice

- How do cross-cultural variations in the concepts of mental health affect the practice of mental health promotion?

- To what extent does better implementation of international human rights conventions within countries enhance population mental health?

- How can evidence be best used to bring about policy changes and mobilize resources for mental health promotion?

- What skills do mental health professionals need to develop to collaborate with partners outside health sectors for mental health promotion?

- How can research and practice foster sustainable mental health promoting actions, integrated with community development?

As the new public health matures, and its political nature is more fully understood, the experience of promoting mental health will benefit and contribute. The "prevention paradox" (see Chapter 15) has posed a dilemma for public health professionals seeking to mobilize resources for heart health. So, too, do we need to understand and seek to resolve the dilemma posed by the directly equivalent "promotion paradox" in mental health: that interventions having a large effect across populations may have a relatively small effect at an individual level. As in all of public health, the challenge exists to demonstrate the reality of benefits that are discerned with systematic study of populations over time. We know enough, however, to make a compelling case for actions at several levels internationally and nationally to promote mental health and to build further understanding about how to do this across countries and cultures in a sustainable way.

Key recommendations

- Promotion of mental health can be achieved by effective public health and social interventions. Although more research and evaluation is required, sufficient evidence at varying levels is available to demonstrate the effectiveness of programmes and interventions for enhancing the mental health of populations. Interventions that have been shown to be effective (see p. 285-286) should be implemented where required and evaluated in a culturally appropriate way.

- Intersectoral collaboration should be fostered as it is the key to effective programmes for mental health promotion. For some collaborative programmes mental health outcomes are the primary objective. For the majority, however, these may be secondary to other social and economic outcomes but are valuable in their own right.

- Sustainability of programmes is crucial to their effectiveness. Involvement of all stakeholders, ownership by the community and continued availability of resources need to be encouraged to facilitate sustainability of mental health promotion programmes.

- More research and systematic evaluation of programmes is needed to increase the evidence base as well as to determine the applicability of this evidence in widely varying cultures and resource settings.

- International action is necessary for generating and disseminating further evidence, for assisting low and middle income countries in implementing effective programmes (and not implementing those that are ineffective), and for fostering international collaboration.

Promoting Mental Health

Mental health can be improved through the collective action of society. Improving mental health requires broadly based policies and programmes, as well as specific activities in the health field relating to the prevention and treatment of ill-health.

With the phrase, "No health without mental health", public health discourse now includes mental health, in its positive sense, as well as mental illness.

Just as public health and the population health approach are established in other areas such as heart health and tobacco control, so it is becoming clearer that, "Mental health is everybody's business".

This Report offers:

- a discussion of the concepts of mental health and mental health promotion, and a description of the relationship of mental health to mental illnesses;

- a rationale for the place of mental health promotion within public health, alongside prevention of mental illness and the treatment and rehabilitation of people living with mental illnesses and related disabilities;

- the various perspectives that open when considering mental health as a public health issue, the types of evidence that exist in this area, and the feasibility of mental health promotion strategies;

- examples of the interventions possible and the responsibility of various sectors; and

- a way forward to activities that could be undertaken immediately within a variety of resource settings.

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