



Guest Editorial

From evidence to practice: mental health promotion effectiveness*

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Introduction

Mental health problems and mental and behavioural disorders are not exclusive to any special group, and are found in people of all regions, all countries and all societies (WHO, 2001). In Europe, mental and behavioural disorders have been estimated to cause 20 per cent of all Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries. DALYs is a methodology introduced in the Global Burden of Disease. It accounts for the disability and chronicity caused by disorders (Murray & Lopez, 1996). The DALY is a measure of health gap, which combines information on disability and other non-fatal health outcomes and premature death. One DALY is one lost year of healthy life.

Depression alone causes 6 per cent of disability, the third leading cause in Europe (Chisholm, Sekar, Kumar et al., 2004; Ustun, Ayuso-Mateos, Chatterji et al., 2004). Suicide rates are the highest in the world and still 80 per cent higher in Eastern than in Western Europe (Health For All [HFA] database). It is estimated that one in four persons will develop one or more mental or behavioural disorders during their lives (WHO, 2001) and projections

estimate that poor mental health is increasing (Murray & Lopez, 1996; WHO, 2002).

But it is not only the burden on the individuals that suffer from a mental illness. One in four families are likely to have at least one member with a behavioural or mental disorder (WHO, 2001). These families not only provide physical and emotional support, but also bear the negative impact of stigma and discrimination. So in most circumstances the burden of poor mental health is underestimated.

The costs of mental disorders are estimated to be between 3 and 4 per cent of Gross National Product (WHO, 2003), of which half are estimated to be healthcare costs. The rest are costs associated with lost productivity, loss of employment, social welfare or premature mortality and costs falling, for example, under labour, justice or education sectors.

Practice and policy in mental health promotion

The European World Health Organization (WHO) Ministerial Conference on Mental Health, *Facing the Challenges, Building Solutions*, held in January 2005, has put mental

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health promotion on the political agenda of Ministers of Health across Europe.

To support policy development, the publication *Mental Health Promotion and Mental Disorder Prevention: a Policy for Europe*, supported by the European Commission, presents a policy framework outlining areas for evidence-based action in mental health promotion (Jané-Llopis & Anderson, 2005a; 2005b). However, a list of policy options, a book reviewing the evidence, or a proposal for an action plan, although essential contributions to move the field of mental health promotion forward, will not suffice to move evidence into practice and support implementation.

In addition to political will and the preparation of key documents, some major processes need to be addressed, developed and implemented, if an integrated evidence based action for mental health promotion is to be achieved. As outlined elsewhere (see Mittelmark, Fosse, Jones et al., 2005; Slama, 2005; Speller, Wimbush & Morgan, 2005) these processes can be conceptualised into four categories:

1. Collate, review and summarise evidence of health promotion effectiveness;
2. Disseminate the evidence in appropriate ways to policy-makers and to practitioners;
3. Assess capacity to implement evidence-based policy, programmes and practices;
4. Learn from effective practice to support further capacity building and improve the evidence base.

This paper will use these categories to structure a brief analysis of initiatives that aim to close the gaps in getting the evidence into practice for mental health promotion.

Collating the evidence of mental health promotion effectiveness

In the last decades a number of literature reviews have demonstrated that prevention of mental disorders and promotion of mental health can be effective across the lifespan (Albee & Gullotta, 1997; Durlak, 1995; Mrazek & Haggerty, 1994; Price, Cowen, Lorion & Ramos-McKay, 1988) and can provide cost-effective outcomes (Hosman & Jané-Llopis, 1999).

Topic-specific literature overviews have confirmed that prevention and promotion approaches can be efficacious in reducing mental

health problems and symptoms of mental disorders, including child abuse (MacMillan, MacMillan, Offord & Griffith, 1994a; MacMillan et al., 1994b), conduct disorder (Reid, Eddy, Fetrow & Stolmiller, 1999), violence and aggression (Yoshikawa, 1994), depression (Gillham, Shatte & Freres., 2000; Muñoz, 1993; Muñoz & Ying, 1993), substance use (Gilvarry, 2000), and in different settings, including schools (Greenberg, Domitrovich & Bumbarger, 2001).

Meta-analyses have been undertaken to assess programme efficacy, quantifying outcome studies and identifying programme ingredients that might be responsible for programme effects. To date, meta-analyses have been relatively topic and age specific, and have been undertaken in the fields of harmful drug use for children and adolescents (Tobler, 1992; Tobler, Lessard, Marshall et al., 1999; Tobler & Stratton, 1997), mental health for children (Durlak & Wells 1997, 1998), interventions for infants and children up to 6 years of age (Brown, Berndt, Brinales et al., 2000), programmes to prevent child sexual abuse (Davis & Gidycz, 2000) and programmes to prevent depressive symptoms (Jané-Llopis, Hosman, Jenkins & Anderson, 2003).

Finally, two recent major publications lead by the World Health Organization (WHO), and one developed by the International Union for Health Promotion and Education (IUHPE) under the Global Programme on Health Promotion Effectiveness (GPHPE), have reviewed the evidence of what works in mental health promotion and mental disorder prevention (WHO 2004a,b; Hosman, Jané-Llopis & Saxena, in press; Herrman, Saxena & Moodie, 2005; Jané-Llopis, Barry, Hosman & Patel, 2005).

Based on the evidence, the following sections provide a summary of some of the health, social and economic outcomes that have been achieved through mental health promotion and mental disorder prevention interventions.

Health and mental health outcomes

Interventions to promote mental and physical health during parenthood aim to develop personal resources, coping strategies, and parenting skills, as well as to create supportive environments for the individuals and their

children. Efficacious parenting approaches, which include home-based programmes and parenting interventions, have shown increases in positive attitudes towards children, better knowledge about child behaviours, and healthier psychosocial and physical development of children. Home-based interventions, especially for families at risk, such as those living in poor economic backgrounds or those where one parent suffers from a mental illness, have shown significant increases in subjective positive mental health and quality of life, such as life satisfaction and increased well-being, and decreases in maternal stress (Jané-Llopis et al., 2005). This has shown to be especially beneficial for the children because of the creation of healthy attachment from birth on, a better organised family life, and more stimulating environments throughout childhood. However a meta-analysis of 167 interventions for children from 0 to 6 years of age (Brown et al., 2000), whilst confirming the evidence of programme effects for health and social outcomes, indicated a large variation in outcomes across programmes, which calls for continuous evaluation of interventions and implementing those that have proven to be efficacious.

Interventions for pre-school (for example see Box 1) and school mental health promotion using a holistic school approach, that includes skills building components and environmental

approaches (Weare, 2000), have shown improved psychological adjustment, competence enhancement and improvements in self-esteem, sense of mastery, and a better ability to solve personal problems. Such interventions have also shown decreases in feelings of self-blame, loneliness, learning problems, behavioural problems and aggression, and depressive and anxiety symptoms, and lead to more general improvements in mental well-being (Domitrovich, Weare, Greenberg et al., in press; Greenberg et al., 2001).

Efficacious interventions for adults include workplace mental health promotion initiatives, interventions for those out of work, and community services for retired people. These types of interventions have led to a range of health outcomes (Jané-Llopis et al., 2005; WHO, 2004a, 2004b). For example, legislation and environmental interventions at the workplace have been shown to lead to increases in mental health and well-being as well as reductions in symptoms of anxiety, depression, and stress-related problems (Price & Kompier, in press; WHO, 2004b). Exercise and social network interventions for elder populations have led to increased physical and mental health and well being, and decreases in depression (WHO, 2004a, 2004b).

BOX 1

The High Scope/Perry Preschool Project (Schweinhart & Weikart, 1998)

The High Scope/Perry Preschool Project targeted at risk 3 to 4 year old African-Americans living in poverty. It combined half a day preschool intervention using a developmentally appropriate curriculum with weekly home visits.

Health and social short term results

In the short term, the programme led to reduced mental retardation, better social adjustment, school success and academic achievement, and increased high school graduation.

Health and social long term outcomes

When results were followed through childhood and adolescence of programme participants, up to age 27 years, the programme was shown to lead to increased social competence, a 40% reduction in lifetime arrests, a 40% increase in literacy and employment rates, fewer social problems and welfare dependence, and improved social responsibility.

Economic outcomes

The Perry Preschool Project cost US\$1000 per child, but the benefit produced was estimated at around US\$7000, due to decreased schooling costs, increased taxes paid on higher earnings, reduced welfare costs, decreased justice system costs, and decreased crime victim costs (Barnett, 1993).

Social outcomes

The effects of home-based interventions, pre-school programmes like the Perry Preschool (Box 1), and holistic approaches to school mental health promotion, have also resulted in short and long-term social outcomes. For example, social aspects associated with mental health effects in school-based interventions include improvement in peer sociability, adaptive social skills, tolerance and compliance with rules, and adaptive assertiveness (Greenberg et al., 2001). Long term social outcomes of home-based and pre-school interventions include, for example, decreases in teenage pregnancies, divorce-related events, crime and arrests, as well as increases in employment, literacy rates and social adjustment and responsibility (Olds, 1989, 1997; Olds, Henderson, Cole et al., 1998; Schweinhart & Weikart, 1998).

Legislation and environmental interventions at the workplace can lead to increased productivity and reductions of sick leave. Interventions such as the Jobs Program (Box 2) have led to decreases in unemployment, better jobs in terms of pay, stability and possibilities of finding a job more quickly (Price, Van Ryn & Vinokur, 1992). The Jobs program has been adopted and proven to be efficacious when implemented in different countries, like the evaluation undertaken in Finland that replicated the USA results (Vuori & Silvonen, in press; Vuori, Silvonen, Vinokur &

Price., 2002). Importantly for employers, there is also evidence of decreases in the frequency of sick leave due to mental disorders, such as depression.

Economic outcomes

The cost-effectiveness studies of the Perry Preschool Project and the Jobs Program have demonstrated the economic benefits of these types of interventions (Barnett, 1993; Vinokur, Van Ryn, Gramlich & Price, 1991). Unfortunately, to date, very few cost benefit and cost effectiveness studies have been attempted to quantify the economic impact of mental health promotion programmes. For example, a meta-analysis of 167 programmes only identified two percent of the trials that had any reference to the costs and benefits of the interventions (Brown et al., 2000).

However, in line with the World Health Organization report for mental health (WHO, 2001), not all the related costs or benefits for society can be estimated in economic terms. There are other mental health promotion intervention outcomes that are not expressed as specific financial costs and benefits that have an indirect economic impact. Indirect benefits might include increased productivity, lowering of the prevalence and incidence of disorders and related accidents and mortality, as well as reducing individual suffering and burden to families (Hosman & Jané-Llopis, 1999).

BOX 2**The Winning New Jobs Program: Promoting re-employment and mental health (Price et al., 1992)**

The Winning New Jobs Program was developed in the United States to help unemployed workers to seek re-employment and cope with the challenges of unemployment and job-search (Caplan et al., 1989; Price et al., 1992; Price & Vinokur, 1995). The programme is based on theories of active learning process, social modelling, gradual exposure to acquiring skills, practice through role playing, and inoculation against setbacks. The five workshops focus on identifying effective job-search strategies, improving participant job-search skills, increasing self-esteem, confidence, and the motivation of participants to persist in job-search activities. The intervention is designed to achieve its goals through the creation of supportive environments and relationships between trainers and participants and among participants themselves.

Health and social outcomes

The intervention showed increased quality of re-employment, increased self-esteem and decreased psychological distress and depressive symptoms, over 2 years, particularly among those with higher risk for depression (Price et al., 1992). In addition, the programme has been shown to inoculate workers against the adverse effects of subsequent job loss because they gain an enhanced sense of mastery over the challenges of job-search.

Economic outcomes

Cost effectiveness analysis of the Jobs Program showed a three-fold return on the investment after 2½ years, and more than a ten fold return after five years (Vinokur et al., 1991).

Dissemination of evidence on mental health promotion in Europe

Information on efficacious mental health promotion could be of use across countries with different cultural and economic backgrounds. Evidence-based practices should be adapted to be culturally sensitive, tailored to different population groups, and developed according to the principles of effective implementation (Barry, Domitrovich & Lara, 2005). Unfortunately the evidence does not always reach countries and regions that are most in need of this information (WHO, 2002), and only a small number of countries have access to, and implement, effective programmes. For example two European directories on mental health promotion and mental disorder prevention for children and adolescents demonstrated that about 80-85 percent of the collected programmes that were being implemented across Europe could not be considered as evidence-based approaches (Mental Health Europe, 2000, 2001).

A European initiative co-sponsored by the European Commission, aims to close this information-dissemination gap. An Internet database systematically describes mental health promotion and mental disorder prevention programmes, policies, their outcomes and their implementation essentials (www.imhpa.net). The provision of information on what works and what are the critical conditions for implementation (how, what and by whom should an action be undertaken) are pre-requisites for the translation of evidence into practice. However, in some cases programmes are already implemented and sustained in a country or region, although no formal evaluation has been undertaken. In those situations, guidelines for evaluation and programme improvement, such as those proposed by the Preffi instrument (Molleman, Ploeg, Hosman & Peters, 2004) can facilitate the use of evidence in practice.

Assessing the capacity for implementation

Unfortunately, the evidence base for mental health promotion and its dissemination across countries alone will not suffice to achieve action and to improve the populations' mental health. Along with information on what works, it is crucial to have insight on, for example: what training is in place to develop capacity, what

infrastructures are available to lead implementation, what workforces in health and other sectors can be engaged, who will be responsible to implement what, or what are the support mechanisms for programme and policy implementation. Lack of information on these issues creates serious barriers to successful development and implementation of mental health promotion.

An initiative to map capacity in mental health promotion is the Mental Health module of HP-Source-net, a tool for health promotion (for further information see www.hp-source.net under the European mental health promotion module and Mittelmark et al., 2005). This speciality module aims to assess and provide an overview of the available infrastructures, policies and resources for mental health promotion and mental disorder prevention at the country or regional level. Information includes, for example, availability of training programmes for professionals, identification of key stakeholders, and evaluation initiatives. This information is translated into country profile descriptions, and can be used as a tool for the further development of infrastructures, as a baseline for monitoring development at the country level, or as a supporting document to develop an action plan or a specific policy for prevention or promotion in mental health.

The questionnaire has been piloted in four countries, Poland, Norway, England and Scotland. To ensure a reliable collection of data, groups of experts from different professional backgrounds in the fields of public and mental health were invited to provide the information and to support it with the relevant documents and references. The sections below present a brief summary of some of the information captured during this first pilot around the issues of training, infrastructures and implementation of mental health promotion and mental disorder prevention.

Policy priority and funding

Mental health promotion seems to be considered a priority area across the four countries in which the questionnaire was piloted, as evidenced in speeches from politicians and policy makers and reflected in country policy documents. However, when respondents were asked whether mental health promotion is a real priority, respondents

concluded across all four countries that mental health promotion is less of a real priority than seems to be indicated in the policy documents. This also seems to be reflected in the low level of resources allocated to promotion and prevention in Poland and in England during the last four years. Conversely, the current Scottish budget of £24 million for improving mental health and well being for the years 2003-2006, provided through the Scottish Executive's Health Improvement Fund, is impressive and illustrates that resources can be made available and priorities put into practice. As for where resources are allocated, in both Poland and Norway, governmental funding for prevention and promotion in mental health is available for national centres and institutes. In Norway the funding is also dedicated to research, screening and early detection, health professional education and specific events such as conferences and seminars.

Infrastructures for implementation and available programmes

Across the four countries different organisations are involved in developing the knowledge base and implementing mental health promotion and mental disorder prevention, including Mental Health centres, non-governmental organisations, universities, and other semi-governmental organisations. Across countries, the home, the schools and the workplace are the settings with larger availability of programmes for mental health promotion and mental disorder prevention. Identified settings with lesser availability of implementation include hospitals and elder care facilities. Interestingly programmes on the Internet are widely available in Scotland whereas they are not available in Poland. This highlights the potential and possible barriers to using existing new technologies to close information gaps across Europe.

Training

Training on mental health promotion and prevention of mental disorders is integrated in existing curricula in the UK and Norway, whereas in Poland no trainings for mental health promotion are available. In the training of primary and secondary healthcare professionals, teaching practical strategies for promotion of mental health and well-being (as distinct from

treatment of mental disorders) does not seem to receive attention or be considered as a high priority.

Some barriers for implementation

In Poland, for example, the lack of non-governmental organisations, the lack of political will to implement the policies stated in governmental documents, the lack of training in the curricula of university studies, and the lack of cooperation between state agencies that get some funds for mental health promotion, have been identified as key barriers for the development of mental health promotion and mental disorder prevention. These barriers, among others, will apply to many different countries across Europe, and strategies need to be developed to facilitate overcoming these problems and translating evidence into practice.

Developing capacity through training

Mental health promotion requires a broad based professional workforce and strategies to build capacity are urgently needed across Europe. This could involve embedding mental health promotion and mental disorder prevention components in existing training initiatives for health promotion, public health, primary healthcare, mental healthcare and related disciplines; by ensuring that the practicing health workforce has access to continuing education programmes; and that the education of professionals in other sectors prepares them to recognise the importance and benefit of their policies and actions for the population's mental health (Jané-Llopis & Anderson, 2005a, 2005b). Interdisciplinary research training programmes should also be made available to develop research skills to conduct evaluations, to improve the quality and effectiveness of practice (Mittelmark, 2003) and to stimulate the evaluation and improvement of implemented programmes through the creation of partnerships between research and practice organisations.

The WHO recommends that, since not all countries have the current opportunities for training for prevention and promotion in mental health, international training initiatives should be undertaken in collaboration with organisations that already have the capacity for and the experience to support these countries (WHO, 2004a; 2004b).

One of such initiatives is the newly created training network for promotion and prevention in mental health, developed under the European Platform for Mental Health Promotion and Mental Disorder Prevention. The training modules are based on the cascade model of training the trainers and aim to stimulate the development of capacity for promotion in mental health at the country level. Training modules include problem solving skills in primary healthcare, programme development and evaluation, programme implementation, and advocacy in mental health. The aim of the training modules is to translate the evidence into usable practice based skills that can be applied across different situations and countries. For example, a first pilot in the Netherlands, training general practitioners in mental health promotion, showed the possibility of using problem solving skills in primary healthcare daily practice. Some of the problems identified in getting the intervention into practice included the lack of confidence of the general practitioners in delivering problem solving skills because of limited training, how to overcome the resistance of patients, or how to deal with the time restrictions of real life consultations. Training modules should adopt their core components in the light of the barriers that are identified in practice, translating practice into evidence, so that the circle of intervention development, implementation, and improvement can be completed (for a more detailed discussion of how to make evidence-based practice in health promotion work, see Speller, Wimbush & Morgan, 2005).

From evidence to practice in mental health promotion

Assisting policy development

To move from evidence to practice, policy approaches to mental health promotion need to be developed. One of the key barriers identified by the four countries is that, although there is interest in mental health across political audiences, as evidenced in political speeches, still little action is undertaken. Therefore it is crucial to facilitate the translation of knowledge into practice, through policy guidelines and frameworks for action that make sense to policy makers and that respond to their needs. All policies need a firm knowledge base and

decisions should be based on scientifically sound and socially relevant and feasible bases. The publication *Mental Health Promotion and Mental Disorder Prevention: a Policy for Europe* (Jané-Llopis & Anderson, 2005a) is based on the available evidence and provides such a policy framework for action. Prevention and promotion in some situations are included in larger mental health policies or plans, such as the recently published WHO Mental Health Action Plan (WHO, 2005) that has been endorsed by all European ministers of health.

However high-level documents only serve as frameworks and guidelines on which to base action and indicate how mental health problems could be tackled across European countries. The need is that action plans with support for implementation are developed in each European country, which fit its culture and needs. Efforts should be dedicated to compile evidence that not only makes sense to policy makers, but will also stimulate either the development of country based action plans for mental health promotion, or the integration of specific prevention and promotion components in existing general action plans for mental health.

Increasing efficiency: links between physical and mental health

In spite of the evidence for the efficacy of prevention and promotion in mental health, the challenge remains to increase efficiency of interventions, to implement effective strategies in the real world and to ensure their sustainability while simultaneously monitoring their impacts. Mental health and physical health are interrelated and their links are bidirectional. Physical ill health is detrimental to mental health as much as poor mental health contributes to poor physical health. For example, malnourishment in infants can increase the risk of cognitive deficits; heart disease and cancer can increase the risk of depression (Blane, Brunner & Wilkinson, 1996; Marmot & Wilkinson, 1999); mood disorders can lead to an increased risk of accidents, injuries and poor physical and role function (Wells, Stuart, Hays et al., 1989); learned helplessness, hopelessness and depression are associated with decreased immunological activity and an increased risk of tumour growth and infections (Kopp, Skrabski & Szedmak, 2000). Because of this

interrelationship, often outcomes of interventions to improve physical health lead to improved mental health and vice versa (Herrman & Jané-Llopis, 2005). For example, interventions promoting a healthy start to life have led over time to reductions in crime, violence, harmful substance use, birth weight, child abuse, psychological distress, and increased employment (Olds, 1997; Schweinhart & Weikart, 1998).

These relationships between mental and physical health provide an opportunity to increase efficiency of interventions (Herrman & Jané-Llopis, 2005; Jané-Llopis & Barry, 2005). Especially in those cases where resources are scarce for mental health promotion, multi-component interventions that tackle generic determinants of mental and physical health can lead to multiple outcomes including the reduction of negative consequences such as unemployment and the increase of mental well-being and quality of life. An efficient strategy is to embed mental health promotion components in existing health promotion programmes, such as those that are already implemented in the community making use of existing available resources in every situation (Jané-Llopis, Saxena & Hosman, 2004). In the field of mental health promotion the case is made to strongly mainstream mental health promotion activities within health promotion, while the advocacy for mental health should remain distinct (Herrman & Jané-Llopis, 2005).

Conclusions

In the continuous efforts to put evidence into practice, key stakeholders should continue collating, reviewing and summarising the evidence of health promotion effectiveness; disseminating the evidence efficiently to key stakeholders; assessing capacity for implementation; and continuously learning from effective practice to support further capacity-building and improve the evidence base. In these processes it is therefore crucial to pay attention to the levels of evidence for effectiveness, the cultural appropriateness and acceptability of practice across implementation areas, the financial, personnel, technical and infrastructural requirements needed, along with estimating the overall benefits and potential for large scale and efficient application. The barriers in

implementing effective programmes, especially in countries with low level of resources, call for collective efforts of all organisations, sectors and professionals with responsibility for mental health (WHO, 2002) to work together and support development at the country and European levels.

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