HEALTH PROMOTION CHALLENGES

Promoting mental health as an essential aspect of health promotion

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SUMMARY
This paper advocates that mental health promotion receive appropriate attention within health promotion. It is of great concern that, in practice, mental health promotion is frequently overlooked in health promotion programmes although the WHO definitions of health and the Ottawa Charter describe mental health as an integral part of health. It is suggested that more attention be given to addressing the determinants of mental health in terms of protective and risk factors for both physical and mental conditions, particularly in developing countries. Examples of evidence-based mental health programmes operating in widely diverse settings are presented to demonstrate that well-designed interventions can contribute to the wellbeing of populations. It is advocated that particular attention be given to the intersectoral cooperation needed for this work.

Key words: mental health; promotion; advocacy

INTRODUCTION
It is of great concern that mental health promotion is frequently overlooked as an integral part of health promotion (Desjarlais et al., 1995; WHO, 2001; Lavikainen et al., 2000).

This is surprising because, in theory, mental health is accepted as an essential component of health (WHO, 2001), the close relationship between physical and mental health is recognized (WFMH, 2004) and it is generally known that physical and mental health share many of the same social, environmental and economic determinants (WHO, 2004). We know that facilities for those with mental health problems are more poorly resourced than those for physical illness in many parts of the world (Desjarlais et al., 1995; WHO, 2001) and it is important that mental health promotion does not get similarly affected.

THE RELATIONSHIP BETWEEN HEALTH PROMOTION AND MENTAL HEALTH PROMOTION

Health is defined by the World Health Organization (WHO) as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ [(WHO, 2001a), p. 1] and health promotion is understood as ‘actions that support people to adopt and maintain healthy lifestyles and which create supportive living conditions or environments for health’ [(WHO, 2004), p. 5].

In these definitions it is clearly recognized that mental health promotion is an integral component of health promotion. Not only are there complex interconnections between physical and mental health, they share many of the same determinants (Raphael et al., 2005). Therefore, while mental health promotion will focus more specifically on the determinants of
mental health and the creation of conditions that enable optimum psychological and psychophysiological development, these efforts will impact positively on physical health (Herrman et al., 2005).

Two of the five strategies set out in the Ottawa Charter for Health Promotion ‘strengthen community action’ and ‘develop personal skills’ (WHO, 1986)—essentially refer to mental health promotion activities: for example, programmes aimed at reducing social inequality and building social capital (WHO 2004). It is also recognized that strategies that maximize the active ownership and participation of people in health promotion initiatives contribute positively to the sustainability of the programmes (WHO, 1997). In this sense health promotion is facilitated by mental health promotion. Conversely, when the focus of the intervention is more directly on the promotion of mental health, physical health issues must not be ignored.

Mental health can be understood 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 own community [(WHO, 2001b), p. 1].

Other definitions of mental health refer to the individual’s subjective feelings of well-being, optimism and mastery, the concepts of ‘resilience’, or the ability to deal with adversity, and the capacity to be able to form and maintain meaningful relationships (Lavikainen et al., 2000). Although the expression of these qualities will differ contextually and individually from culture to culture, the basic qualities remain the same.

THE RELATIONSHIP BETWEEN PHYSICAL AND MENTAL HEALTH

The artificial division of ‘physical health’ from ‘mental health’ common in the western developed world is not shared by many traditional cultures in which physical conditions have long been considered as being closely related to the emotional, social or spiritual health of the person (Swartz, 1998).

The reciprocal relationship between physical and mental health now is widely recognized (Raphael et al., 2005). It is known that mental well-being, social support and social networks are protective factors for physical health. Positive mental health significantly assists people to deal with physical conditions. Conversely, the promotion of physical health impacts positively on mental health, for example, in older people (Li et al., 2002; WFMH, 2004). It is recognized that diabetes, cancer, cardiovascular disease and HIV/AIDS affect and are affected by the mental state of individuals, and particularly by depression (Raphael et al., 2005). Heart disease is found to double in people with depression and approximately one-half of people with heart disease suffer an episode of major depression (WFMH, 2004).

Clearly, to be effective, promotion and prevention programmes addressing health conditions should take mental health factors into account, and mental health and health programmes are best implemented together.

THE BURDEN OF MENTAL ILL-HEALTH

Apart from aiming to increase positive mental health, mental health promotion has an important role to play in relation to mental disorders, in that positive mental health is a strong protective factor against mental disorders (WHO, 2004a). Mental health promotion includes ‘strategies to promote the mental well-being of those who are not at risk, those who are at increased risk and those who are suffering or recovering from mental health problems’ (WHO 2004a).

The size and cost of the burden of mental and behavioural disorders is perhaps not fully appreciated. Mental and behavioural disorders (expressed in disability adjusted life years, or DALY’S) represented 11% of the total disease burden in 1990, and this is expected to rise to 15% by 2020 (WHO, 2001c). Five of the 10 leading causes of disability worldwide in 1990 were mental or behavioural disorders. Depression was the fourth largest contributor to the disease burden in 1990 and is expected to rank second after ischaemic heart disease by 2020. It is estimated that one in four people will develop one or more mental or behavioural disorders in their life-time and that one in four families has one member suffering from a mental or behavioural disorder (Murray et al., 1996; WHO, 2001c).
The social and economic costs of only attempting to deal with these issues through individual and treatment paradigms is not only prohibitive, but impossible in many parts of the world where there are few mental health professionals (Desjarlais et al., 1995). A public health approach to mental health promotion is imperative, in which, in addition to treatment, efforts are made to support the factors that have been shown to promote mental health and address the factors that constitute risk factors for mental disorders (VicHealth, 1999; Herrman et al., 2005). Unless this is done, the burden of mental illness will continue to grow (Desjarlais et al., 1995).

THE EVIDENCE BASE FOR MENTAL HEALTH PROMOTION

Determinants

The evidence-based determinants of mental health in terms of risk and protective factors include individual, social and societal factors and their interaction with each other. Social and economic disadvantage, giving rise to poverty and lack of education, constitute risks for mental illness, and often create and interact with other known risk factors such as displacement, racial injustice and discrimination, poverty, unemployment, poor physical health, access to drugs and alcohol, violence and delinquency (Desjarlais et al., 1995; Herrman et al., 2005; WHO, 2004; Patel and Kleinman, 2003).

It is these known risk factors that are addressed in effective mental health promotion programmes. If not addressed, these conditions create the ‘poverty traps’ all too frequently found in developing countries, in countries with civil unrest and in deprived communities worldwide. The mental health of a community is mutually dependent on the mental health of its citizens. Clearly, the promotion of mental health and the protection of human rights are closely associated. Protective factors include integration of ethnic minorities, empowerment, social participation, social services and social support and community networks (WHO, 2004).

Evidence based mental health promotion programmes

Evidence exists for the effectiveness of a wide range of exemplary mental health promotion programmes and policies. Their outcomes show that mental health promotion is a realistic option within a public health approach across the lifespan and across settings such as perinatal care, schools, work and local communities. In many fields of life, well-designed interventions can contribute to better mental health and well-being of the population. [(WHO, 2004), p. 34].

Examples will be given of such mental health promotion programmes addressing issues throughout the life cycle and on individual and community levels that are aimed at removing structural barriers.

There are evidence-based mental health programmes that target early childhood through home visiting, which have positive outcomes well into the children’s adolescence. The most well known of these is the Prenatal and Infancy Home Visiting Programme, which impacts successfully on a range of behaviours including child abuse, conduct disorders and substance abuse. (Olds, 1997; Olds, 2002; Olds et al., 1998). Parent training programmes, such as ‘The Incredible Years’ (Webster-Stratton and Reid, 2003) and the Triple P Positive Parenting Programme in Australia (Sanders et al., 2002) improve parent–child interaction. The Perry Preschool Project combines home visiting and preschool intervention to produce impressive long-term results in deprived communities regarding cognitive development and conflict with the law (Schweinhart and Weikart, 1997).

Other programmes directly or indirectly address the mental health of communities. Communities that Care (CTC) is a programme, replicated in many countries, that mobilizes communities to use multiple interventions to prevent violence and aggression (Hawkins et al., 2002). Programmes that address economic insecurity, human rights and empowerment issues are shown to impact positively on mental health, for example the poverty alleviation programme run by BRAC in Bangladesh (Chowdhury and Bhuiya, 2001) and adult literacy programmes (Cohen, 2002). When communities can be effectively mobilized to address issues such as substance abuse, the outcomes often indicate improvements in other areas as well, such as domestic violence (Bang and Bang, 1991; Wu et al., 2002).

Schools are obvious locations for mental health promotion programmes that target issues such as improving problem-solving abilities and the reduction of substance abuse, bullying
and aggression. There are many examples of effective programmes such as ‘I Can Problem Solve’ (Shure, 1997), the Improving Social Awareness-Social Problem-Solving Programme (Bruene-Butler et al., 1997), the Good Behaviour Game (Kellam et al., 1994), the Linking the Interests of Families and Teachers (LIFT) Programme (Reid et al., 1999) the Seattle Social Development Project (Hawkins et al., 1991) and the Positive Youth Development Programme (Caplan et al., 1992).

Programmes that target unemployment and impact successfully on re-employment, mastery and depression include the JOBS Programme (Caplan et al., 1989; Vinokur et al., 2000), which has been tested and replicated in large-scale randomized trials in several countries (Vuori et al., 2002). The Care Giver Support Programme, also evaluated in a large-scale randomized trial, increased various work behaviours and enhanced the mental health and job satisfaction of the participants (Heaney et al., 1995).

With regard to older people, controlled trials have demonstrated that exercise improves general mental well-being (Li et al., 2001), and there is some evidence that befriending (Stevens and van Tilburg, 2000) and early screening (Shapiro and Taylor, 2002) also have positive outcomes, although more evidence is required. Information regarding other evidence-based programmes can be accessed from data bases such as those provided by the USA Center for Disease Control and Prevention (CDC), the Collaborative for Academic, Social and Emotional Learning (CASEL), the Substance Abuse and Mental Health Services Administration (SAMHSA) and Implementing Mental Health Promotion Action (IMHPA).

The level of evidence is more forthcoming from better-resourced developed countries. A challenge to the health sector is to document and disseminate the mental health promotion programmes currently being offered, often at very low cost, by a wide variety of sectors and to facilitate improved levels of evidence (Jane-Lopis et al., 2005; Herrman et al., 2005; Herrman and Jane-Lopis, 2005). A recent joint publication by the WHO and the World Federation for Mental Health is another example of such an initiative (WHO, 2004b). It is significant to note the variety of organizations involved in the programmes and that in most cases the programmes were managed by partnerships between several organizations.

**THE WAY FORWARD**

As many determinants of health, and particularly mental health, largely lie outside the health sector, addressing promotion requires an understanding and commitment from stakeholders from many constituencies. In a public health approach, the health sector requires the knowledge, attitudes and skills to advocate, persuade and collaborate with these other sectors to engage in activities that enhance mental health.

The activities of mental health promotion are mainly socio-political: reducing unemployment, improving schooling and housing, working to reduce stigma and discrimination of various types... The key agents are politicians, educators, and members of nongovernment organizations (WHO, 2004), p. 26].

The main motivation for these other sectors to engage in promotion programmes may not be their impact on health or mental health per se, but outcomes of the programmes more closely connected to their own disciplines and interests. If they are carrying the cost, this is understandable and acceptable. They need to be convinced that these programmes would address their own needs. In order to persuade other sectors to adopt policies and programmes conducive to mental health promotion, the health sector needs to be able to communicate with them in their own language and to see the policies and programmes from their perspective. This applies whether engaging in policy development at the national level, encouraging non-governmental organizations to initiate programmes or engaging with service user groups. In addition, the mental health outcomes of programmes not primarily aimed at mental health promotion need to be evaluated.

Working with other sectors is particularly important in developing countries where a wide range of initiatives, including community and social development programmes, are needed to address the multiple factors associated with poverty that impact negatively on health and mental health. The process followed in addressing these multiple factors is guided by the principles of advocacy, participation and empowerment, which are intrinsic to the promotion of mental health (Patel, 2001; WHO, 2004). The positive mental health outcomes of these programmes suggests that maximum use
of these partnerships will further the cause of mental health promotion.

CONCLUSION

It is advocated that mental health assume its rightful place in health promotion. The significant number of evidence-based mental health programmes concerned with well-being from early childhood to old age, aimed at individuals, groups or at community structural issues demonstrate that well designed interventions contribute significantly to the well-being of populations. Efforts need to be made to strengthen this evidence, particularly in developing countries. A further challenge is for mental health professionals to become more skilled in the process of advocacy in order that such evidence is used to maximum effect in ensuring that mental health promotion is recognized as an integral and central component of health promotion.

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REFERENCES


