HEALTH PROMOTION AND DISEASE PREVENTION **A Handbook for Teachers, Researchers, Health Professionals and Decision Makers**	
Title	**Promoting Mental Health**
Module: 5.5	**ECTS: 1.0**
Author(s), degrees, institution(s)	**Ognjen Brborovic**, MD, PhD Candidate, Teaching Assisstant Andrija Stampar School of Public Health University of Zagreb School of Medicine, Croatia
Address for Correspondence	**Ognjen Brborovic**, MD Andrija Stampar School of Public Health University of Zagreb School of Medicine Rockefeller street 4 Zagreb, Croatia Tel: + +385(0) 1 4590 100 Fax: 385(0) 1 4684 441 E-mail: info@snz.hr
Key words	concepts in health psychology, risk behaviours, stress, stressful events, coping strategies, health communication
Learning objectives	At the end of this topic students should: • be familiar with terms mental health, mental illness, mental disorders, positive mental health, and mental health problems; • understand the extent of the mental health problem; • understand basic concepts of mental helath promotion.
Abstract	Mental health promotion is an umbrella term that covers a variety of strategies, all aimed at increasing internal capacity or having a positive effect on mental health. In praxis, the encouragement of individual skills and resources for improvements in the socio-economic environment are leading among them. But, defined by WHO in 1998 health promotion is action and advocacy to address the full range of potentially modifiable determinants of health. That means that mental health promotion requires multisectoral action, involving a number of government sectors such as health, education, employment/industry, environment, transport and social and community services as well as non-governmental or community-based organizations such as health support groups, churches, clubs and other bodies.
Teaching methods	Teaching methods include introductory lecture, small group discussions, self-learning, and case study. After the introductory lecture students need carefully to read the recommended readings on the subject. Afterwards they need to discuss the issue - first in small groups and afterwards in a whole group of students. They are also addressed to find a case of mental health promotion in their neighbourhood (if existent), and critically discuss with other students the situation discovered.

Specific recommendations for teachers	• work under teacher supervision/individual students' work proportion: 30%/70%; • facilities: a computer room; • equipment: computers (1 computer on 2-3 students), LCD projection equipment, internet connection, access to the bibliographic data-bases; • training materials: recommended readings are available in the internet; • target audience: master degree students according to Bologna scheme.
Assessment of Students	Short written examination.

PROMOTING MENTAL HEALTH

Ognjen Brborovic

Nature and extent of the problem

To answer the question in title we should first discuss what is the *problem*? Is it a *mental health?* Or, maybe *mental hygiene*? Is it *mental diseases, ill-health, disturbances* even *mental health problems*?

One could look for an answer at respectable sources. In Encyclopedia Britannica mental health is mentioned in explanation of *mental hygiene* – as a science of maintaining *mental health* and preventing disorders to help people function at their full mental potential. Still they say little about mental health. The WHO World Health Report 2001 named *Mental Health – New Understanding New Hope*, begins with words of Director-General Dr. Gro Harlem Brundtland "Mental illness is not a personal failure..." and more or less continues with the same perspective of mental health. In a series of review articles published in British Medical Journal during 1997 named *ABC of mental health* you can find for clinicians quite important information, how to manage, asses or treat *mental illness.*

So logical conclusion could be *mental health* is about mental disorders, precisely omission of mental health, but we should look at other sources as well before final conclusion. In *Mental Health: A Report of the Surgeon General* by U.S. Department of Health and Human Services there is distinction between Mental Health and Mental Illness.

1. Mental health.
   Mental health: the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.

2. Mental illness.
   Mental illness: the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning.
   In EU there is similar distinction yet little different. In Public *Health Action Framework on Mental Health* done by National Research and Development Centre for Welfare and Health, Finland Ministry of Social Affairs and Health and accepted by European Commission there is *positive mental health* as opposite of *mental health problems*.

3. Positive mental health.
   Positive mental health includes:
   - a positive sense of well-being;
   - individual resources including self-esteem, optimism, and sense of mastery and coherence;
   - ability to initiate, develop and sustain mutually satisfying personal relationships and
   - ability to cope with adversities (resilience).

   These will enhance the person's capacity to contribute to family and other social networks, local community and society.

Mastery, coherence, resilience, etc. – there is no need to look further since these is clearly showing terminological chaos and by searching more one could get even more confused. What is important to distinct is that mental health in public health context could be both ease and disease. For practical reasons we should think of a *mental health* as *internal capacity* that allows person to act within individual and social boundaries with final aim to achieve freedom, financial/material independency and sense of well-being.

4. Mental health problems.
   Mental health problems include:
   - psychological distress usually connected with various life situations, events and problems;
   - common mental disorders (e.g. depression, anxiety disorders);
   - severe mental disorders with disturbances in perception, beliefs, and thought processes (psychoses);
   - substance abuse disorders (excess consumption and dependency on alcohol, drugs, tobacco);
   - abnormal personality traits which are handicapping to the individual and/or to others;
   - progressive organic diseases of the brain (dementia);
   - sexual disturbances not physiologically induced, and
   - sleep disorders (that are not symptom of other mental disorder).

5. Mental disorders.
   Mental disorders are defined in the classifications of diseases (International Classification of Diseases *ICD10* or Diagnostic Statistical Manual *DSM IV)* by the existence of clusters of symptoms. The criteria for disorders are met when the clusters of symptoms are relatively severe, long-lasting, and accompanied by reduction of functional capacity or disability.
   Distinction between mental health and mental health problems is important for practical and contextual reasons. Practically it means that promotion of mental health is aiming to increase internal capacity while preventing mental health problems is aiming at decreasing prevalence and severity of mental diseases, distress and disturbances. Contextually, difference is important to understand linkage, but not predestination, between mental health and mental health problems and complexity of diverse factors that contribute to health. 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 or transition, and the risks of violence and physical ill-health. Also, physical activity and physical health are quite important determinants of mental health (1).

Mental health status

It is known that medicine could psychologically asses someone and find mental health problems if they exist (cynic would say that everyone has a mental health problem) but it is

easily to assume that it is impossible to asses mental health of an individual or population. From the end of 20th century we have some quite useful tools for assessing mental health in form of questionnaires. Some assess only components of mental health while other tries to assess generic mental health. Most prevalent (especially in US) questionnaire in use is SF-36 (Short Form 36 questions) that assess both mental health and physical health on scales from 0-100 (0 means total disease while 100 means complete health) (2). There are several shortened questionnaires derived from SF-36 and most common are SF-12 and MHI-5 (Mental Health Inventory with only 5 questions). A score of 52 or less on the MHI-5 scale is taken to indicate a psychological distress (3). Other questionnaires that are common are GHQ-12 (General Health Questionnaire) that could identify people with a probable mental health problem and CIDI (Composite International Diagnostic Interview) the only one mentioned here that could give a probable diagnose.

In almost all EU countries some of these questionnaires have been nationally surveyed but unfortunately in South Eastern Europe (SEE) surveys have been conducted occasionally. Consequences from the recent wars and conflicts, stress of transition and its enormous social costs, lack of the economic and political stability as well as the changes in family and social networks must have had important impact. Yet little is done to explore those changes and even less to empower health care and social systems to better cope with those. Hence we should look at EU to see what the state of mental health is there with the idea that in SEE region mental health is probably feebler. One of the components of mental health in SF-36 is *vitality scale* that is showing person's vigor and dynamism that is quite opposite of depression and anxiety. From surveys conducted in 11 EU countries analysis shows that Italy, Portugal, France and Sweden are in group with lowest score while Belgium, Netherlands and Spain are among group of highest average score. In all those studies males have consistently higher scores than females. The highest average score for man is 68.98 in Spain while the lowest is 61.66 in Italy. The highest average score for females is 63.36 in Spain while lowest is 55,12 in Portugal where is also found the biggest difference in MH-5 score between males and females with odds-ratio of 3.17 (source: Eurobarometer). Various possible factors are contributing to the differences in the mental health of men and women but it is mainly agreed that socio-economic gradient is single most important. In recent history Portugal is passing through tremendous changes, especially in social and economic area of life, so has much in common with countries in transition like SEE countries (4).

Mental health problems status

Describing mental health problem status in countries or region is like describing painting. Without seeing it (or living and working there) one could get only a partial picture. Two main reasons for that is traditional epidemiological mortality statistic and stigma of mental diseases. First is greatly neglecting existence of mental health problems since that group is seldom burdened with death as final outcome (except suicides; more than 850 000 people die by suicide every year worldwide) while mortality statistics still has predominant role. The other is reducing the number of clinically detected problems since people are ashamed of exposing them. One in four patients visiting a health service has at least one mental, neurological or behavioural disorder but most of these disorders are neither diagnosed nor treated, so it is said that detected mental health problems are like visible part of an ice berg (not exactly true but useful for illustration) . Acknowledging a huge gap in existing methods, not only for mental health problems, World Bank has started with Harvard University in

1993 Global Burden of Disease study. The idea was to introduce universal measure that could describe burden of disease nevertheless is it with mortal outcome or not. That study introduced DALYs and in 1998 WHO accepted it as a meaningful measure of population ill health. DALYs express years of life lost to premature death and years lived with a disability, adjusted for the severity of the disability. One DALY is one lost year of healthy life. In 1998, an estimated 43% of all DALYs globally were attributable to non-communicable diseases. In low and middle income countries the figure was 39%, while in high income countries it was 81%. Neuropsychiatric conditions, accounting for 10% of the burden of disease measured in DALYs in low and middle income countries and 23% of DALYs in high income countries. Actually, Burden of Diseases study raised attention on mental health since one of main results were exposing until 1999 neglected scourge of depression and other mental health problems especially in high income countries (EU, USA, Canada, Japan). Eventually WHO published World Health Report 2001 *Mental Health – New Understanding New Hope* where among many conclusion experts put that 20-25% of all people at some time during their life will be affected by mental or behavioral problems and moreover, projection for depression within the next 20 years shows that it will become the second leading cause of disease burden in the world.

Table 1. Rank of selected conditions among all causes of disease burden (WHO)

Disease or injury	Rank		
	World	High income countries	Low and middle income countries
Unipolar major depression	4	2	4
Alcohol dependence	17	4	20
Bipolar disorder	18	14	19
Psychoses	22	12	24
Obsessive-compulsive disorder	28	18	27
Dementia	33	9	41
Drug dependence	41	17	45
Panic disorder	44	29	48
Epilepsy	47	34	46

Source: World Health Report, 2001

Depression and depression-related problems are today among the most pressing public health concerns in Europe. Estimates for total disease burden quoted WHO report indicate that they account for more than 7% of all estimated ill health and premature mortality in Europe, only exceeded by ischemic heart disease (10.5%) and cancer (11.5%) (5).

There are other burdens caused by depression, beyond the health systems. These include the loss of quality of life for the affected and their families, a loss of productivity for firms and an increased risk of unemployment for individuals. Depression can mean that people withdraw from family life, social life and work, and far too many people with depression commit suicide. Depression and depression-related problems directly affect about 2–10% of our European citizens. To illustrate the magnitude of the disorder, it is estimated that in any given year, some 33.4 million people in the WHO European Region suffer from major depression. About 15% of patients with severe depression commit suicide, whilst 56% attempt suicide and the majority have suicidal ideas during depressive episodes (6).

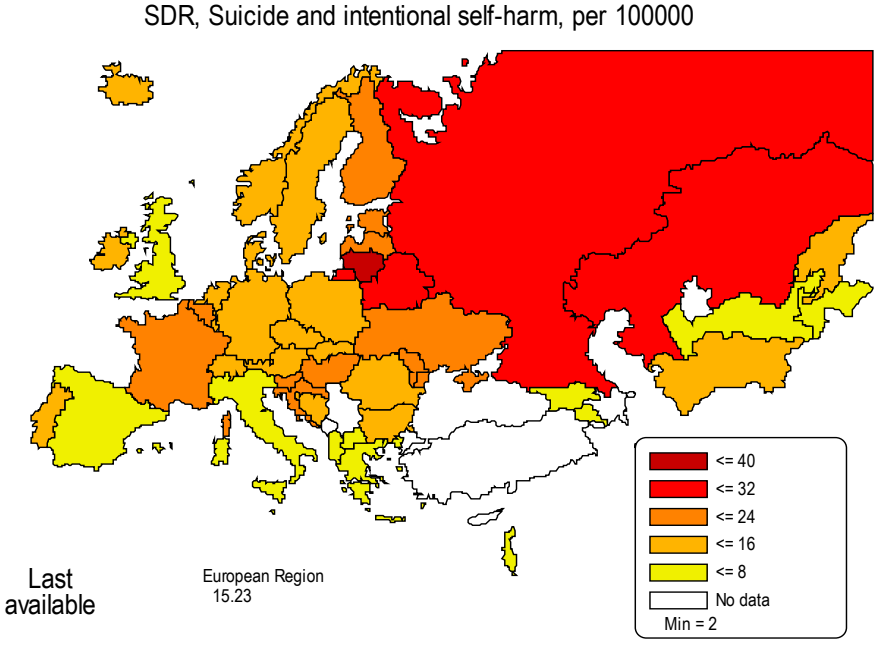
A vast number of working days a year are lost to depression affecting our economies and our social, community and family life. Depression affects quality of life more than most physical illnesses, and in some cases it even leads to suicide or suicide attempts. There are also well established links between physical illness and depression and vice versa.

However, without stating two very important issues less is said about mental health status in Europe. Suicides attempts and psychosis are the worst outcomes of any mental health disorders, one because of its acuteness the other because of its chronicity.

Mental health literature suggests that the prevalence of schizophrenia vary enormously between countries. Estimated average lifetime prevalence of schizophrenia in Europe would be about 1%, but pockets with very high and very low prevalence have been detected. Even in some countries differences in schizophrenia prevalence across regions could be twofold, even threefold higher. Also, epidemiologists are quite tactful to estimate schizophrenia prevalence since there is obvious gap between diagnosed psychosis and diagnosed psychosis symptoms. Although schizophrenia is rare, psychosis symptoms are rather common in the general population (some studies state prevalence of symptoms up to 20% during lifetime). These findings are quite important for mental health promotion since persons with prepsychotic states should be in focus for prevention of chronicity of psychosis (4).

Rates of suicide across Europe steadily rose after the 2nd World War so that during ‘80s suicide was one of the most frequent causes of death, especially among younger people. In ‘80 almost as many deaths yearly in the World were caused by suicide (about 800,000) as by traffic accidents (about 850,000) or as by war (about 320,000), violence (about 280,000) and HIV infection and AIDS (about 300,000) combined. Although in some countries Health for All policy managed to decrease rates of suicide, number of deaths in transportation is still comparable with the number of accomplished suicides. There are huge differences in rates across Europe and the differences are explained by tradition, culture, mentality etc. Traditionally low risk area is Mediterranean basin (Greece, Albania, Malta, Italy) while northern and eastern areas of Europe have higher rates of suicide (Lithuania, Russian federation, Belarus, Finland, Estonia). Although some countries have arguably low rate of suicides and quite high rate of deaths from undetermined events (like Portugal) suicide statistics is generally available (4). In contrast to the situation for suicide, statistics on nonfatal suicidal acts (attempted suicide) seldom exist. However, agreement seems to be that the frequency of attempted suicide would be about ten times the frequency of completed suicide hence area for suicide prevention seems to be enormously huge requiring great resources in human power as well as finance.

Figure 1. Standard Death Rates for suicides and intentional self-harm per 100,000 population in Europe (last available).



Source: WHO Health for All Database, 2005

Many more information about mental health problems one could easily find at *Health for All* database by WHO Regional Office for Europe. Second reliable source is Atlas for Neurological Disorders by WHO.

Promotion of mental health

Mental health promotion is an umbrella term that covers a variety of strategies, all aimed at increasing internal capacity or having a positive effect on mental health. In praxis, the encouragement of individual skills and resources for improvements in the socio-economic environment are leading among them. But, defined by WHO in 1998 health promotion is action and advocacy to address the full range of potentially modifiable determinants of health. That means that mental health promotion requires multisectoral action, involving a number of government sectors such as health, education, employment/industry, environment, transport and social and community services as well as non-governmental or community-based organizations such as health support groups, churches, clubs and other bodies.

Research has shown that mental health is affected by non-health policies and practices as well, for example in housing, education, and child care (1). Despite some uncertainties in the evidence, link between social experience and mental health is clear and serves as compelling case to apply locally appropriate policy and practice interventions to promote mental health. 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. This accentuates the need to promote mental health trough policy and practice interventions in diverse health and non-health areas.

Multisectoral linkage is the key for mental health promotion. Mental health is everybody's business. 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. The promotion of mental health must have focus 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 model of medicine, which centers on specialists trained to return function to individuals.

In many fields of life, well-designed interventions can contribute to better mental health and well-being of the people. Over the last two decades, numerous studies in mental health promotion have proven that such interventions can be effective and lead to improved mental health.

Depression is excellent example of well studied mental health promotion interventions. Focus here is on positive mental health promotion and the prevention of the secondary consequences of depression rather than on treatment, though clearly a pharmacotherapy, psychotherapy and other approaches play an important role in treatment of depression (6).

Strategies to promote positive mental health and reduce the potential impact of depression can be implemented at several different levels:

Population level

Stigma and discrimination associated with mental health problems and a fear of being labeled can be compounded by a lack of awareness of the availability and accessibility of services. Therefore awareness campaigns have been the primary mechanism used with the general public. However, evidence on the effectiveness of information campaigns alone influencing public attitudes toward mental health problems is generally very limited unless supported by a range of actions at local level and sustained over time.

Primary Health Care level

Systematic review of studies on the detection and management of depression in primary care has been conducted. Body of evidence supporting a range of health promotion and primary care interventions has steadily built up showing that primary health care could be effective and efficient way of handling depression. It is of great importance to recognize that combination of both patient and professional education, liaison between primary care physicians and other health professionals, and the provision of counseling and support services is needed.

Settings level – school and workplace

Some school setting studies have shown benefits of early intervention across multiple sectors to help prevent some of the adverse consequences of childhood mental health problems including depression.

There is evidence that effective workplace health and mental health promotion interventions are available to help reduce the risks of stress and depressive disorders at work. Such interventions can ameliorate the adverse consequences and improve productivity. Systematic, organization wide approaches are of greatest effect in reducing work-related stress, and have been recommended to include staff support, communication structures, enhanced job control, increased staff involvement and improved working environment.

Conclusion

As a conclusion, mental health promotion should follow the WHO definition of health and goal of improved mental health should be seen as a part of holistically improved health of individual and society.

Prevention (USTFCP)

Health promotion and disease prevention are necessarily related and overlapping activities because the former is concerned with the determinants of health and the latter focuses on the causes of disease. But usually when speaking about prevention it is about screening and better health care services. Among mental health issues the biggest burden of disease comes from depression. Hence, many clinical diagnostic tests for depression exists but there is not enough evidence to distinguish one upon other as the best screening tool (Mental Health Inventory MHI-5, Zung Self-Assessment Depression Scale, Beck Depression Inventory, General Health Questionnaire GHQ). It is recommended by U.S. Preventive Services Task Force as a recommendation class B (*clinicians should routinely provide screening to eligible patients*) to do primary care screening on depression for adults. No matter which test is used as long as positive screening outcome triggers full diagnostic interview. As for children or adolescents the evidence is insufficient to recommend for or against routine screening for depression.

There is no hard evidence that screening for suicide risk reduces suicide attempts or mortality. There is limited or insufficient evidence on the accuracy of screening tools to identify suicide risk in the primary care setting as well as that treatment of those at high risk reduces suicide attempts or mortality. It is worthwhile to mention that early recognition of persons with depressive episode might reduce suicides as well. Anyhow, secondary prevention aiming at reducing consequences of suicide attempts or attempts itself (field task groups, police experts on suicides, call centers etc.) proved to be of some efficiency (7).

Exercise

Task 1:

Carefully read the contents of the module and recommended readings.

Task 2:

Discuss with other students theoretical and conceptual frameworks of mental health promotion.

Task 3:

Find a case of mental health promotion in your country/city, if exist. If not, try to think about reasons for this. Discuss the cases with other students.

References

1. World Health Organization, Department of Mental Health and Substance Abuse. Promoting mental health: concepts, emerging evidence, practice: summary report. Geneva: WHO, Department of Mental Health and Substance Abuse, Victorian Health Promotion Foundation (VicHealth), University of Melbourne; 2004. Available from: URL: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf (Accessed: September 18, 2007).
2. Rumpf HJ, Meyer C, Hapke U, John U. Screening for mental health: validity of the MHI-5 using DSM-IV Axis I psychiatric disorders as gold standard. Psychiatry Res 2001; 105:243-53.

3. Vollebergh WA, Iedema J, Bijl RV, de Graaf R, Smit F, Ormel J: The structure and stability of common mental disorders: the NEMESIS study. Arch Gen Psychiatry 2001; 58:597-603
4. Research EO. The State of Mental Health in the European Union. Bruxelles: European Commission, 2004. Available from: URL: http://ec.europa.eu/health/ph_projects/2001/monitoring/fp_monitoring_2001_frep_06_en.pdf (Accessed: September 18, 2007).
5. World Health Organization. World Health Statistics 2007. Geneva, World Health Organization, 2007. Available from: URL: http://www.who.int/whosis/whostat2007.pdf (Accessed: September 18, 2007).
6. European Commission. Actions against depression. Bruxelles: European Commission, 2004.
7. USPSTF. The Guide to Clinical Preventive Services. Rockville: Agency for Healthcare Research and Quality, 2006. Available from: URL: http://www.ahrq.gov/clinic/uspstfix.htm (Accessed: September 18, 2007).

Recommended readings

1. Saxena S, Preston J. Garrison PJ, editors. Mental health promotion: case studies from countries. Geneva: World Health Organization; 2004. Available from: URL: http://www.who.int/mental_health/evidence/en/case_studies_report.pdf (Accessed: September 18, 2007).
2. World Health Organization, Department of Mental Health and Substance Abuse. Promoting mental health: concepts, emerging evidence, practice: summary report. Geneva: WHO, Department of Mental Health and Substance Abuse, Victorian Health Promotion Foundation (VicHealth), University of Melbourne; 2004. Available from: URL: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf (Accessed: September 18, 2007).
3. World Health Organization, Regional Office for Europe. Mental health in Europe. Country reports from the WHO European Network on Mental Health. Copenhagen: WHO, Regional Office for Europe; 2001. Available from: URL: http://www.euro.who.int/document/e76230.pdf (Accessed: September 18, 2007).