Eero Lahtinen, Ville Lehtinen, Eero Riikonen and Juha Ahonen (Eds.)

Framework for Promoting Mental Health in Europe

STAKES
NATIONAL RESEARCH AND DEVELOPMENT
CENTRE FOR WELFARE AND HEALTH

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National Research and Development Center for Welfare and Health
Ministery of Social Affairs and Health
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ISBN 951-33-0823-5

Cover design: Harri Heikkilä

Oy Kotkan Kirjapaino Ab
Hamina 1999

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Framework for Promoting Mental Health in Europe

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Foreword

This document reports the results of the first phase of a project, the sc. *Key Concepts Project*, which aims at elaborating a framework for the promotion of mental health in Europe. According to the project agreement (No SOC 96 202134 05 F03/96CVVF3-466-0) the general task of the project is to develop and evaluate the best options for the key concepts of mental health promotion in Europe. The agreement also states that these concepts are needed in the planning, evaluation and monitoring of both national and transnational mental health promotion and prevention programmes / policies.

The first phase of the Key Concepts Project, resulting in this document, was implemented during 1997. In the agreement mentioned above the project was planned to run for four years, divided into three distinct phases. The task of the first phase was to (1) outline the process of the development of key concepts in mental health promotion in Europe and (2) collect relevant information.

Several experts, including members of other mental health networks, have participated in the process. The Mental Health R&D Group of STAKES, the National Research and Development Centre for Welfare and Health (FIN), was responsible for co-ordination of the Project. Many experts at STAKES have also contributed to the project.

The *European Network on Mental Health Policy*, chaired by Research Professor Ville Lehtinen (FIN) and co-chaired by Dr. Rachel Jenkins (UK), has been responsible for implementation of the Project. Through the network most of the Member States have participated in the Project. The participants have been either mental health officers at Ministries of Health, advisers of the Ministry of Health or leading national experts.

The project was conducted in practice by an *Executive Group,* with five members. They were, in addition to the above chair persons, Professor Vivianne Kovess (FR), Dr Meni Malliori (GR) and Dr Christiane Redel (G). Dr Eero Lahtinen (FIN) has functioned as the secretary of the Executive Group. A complete list of participants and experts can be found in the beginning of this report.

The report consists of seven sections, including this foreword. The second is the *executive summary*. The third contains *recommendations for action* for the European Institutions concerning the promotion of mental health. The fourth sets out the background: a *conceptual framework* showing how the main concepts have been understood and used in this document; a picture of the *burden of mental ill-health;* an outline of *mental health policies* in the Members States; a description of *implementation approaches;* and examples of *effective projects*. The *fifth,* final section presents rationales and recommendations regarding several *prioritised areas of action*. The sixth section consists of an appendix, concentrating on *disorder-specific prevention* of mental ill-health. The final, seventh section is a list of *references*.

During the last two decades, health promotion has become an international process (1) stating shared values regarding health, (2) defining outlines of health strategies and (3) implementing these strategies at different levels. Health promotion action has been adopted also by the European Union. One consequence of this has been the establishment of the Health Promotion Programme that is the framework of this project.

In health promotion, as in so many other contexts, mental health has come second to physical health. Values, strategies and efforts in the promotion of mental health have tended to remain ambiguous and vague. In its recent work plans the European Commission has explicitly emphasised the *importance of mental health for general health and well-being,* and thus implied the key value of promotion of mental health. The Commission has also considered the *definition of shared European concepts and strategies for the promotion of mental health* as a central challenge and, in addition, paid attention to the *implementation and prioritisation of the investments in mental health*. This project is one result of this emphasis.

The authors of this report believe that the comprehensive approach adopted by the Commission will contribute in a very significant way to the promotion of mental health in Europe. Preparing this report has revealed the striking political, administrational, economic, organisational, cultural and conceptual differences regarding mental health issues in the Member States. The project can therefore be viewed as a concrete step towards shared understanding and action in the field throughout Europe.

This undertaking of the European Commission has been met with great enthusiasm among the experts in the field. The editors of this report would like to express their gratitude to the remarkable number of experts who have contributed to its preparation and to the representatives of the European Commission DG V/F/3, involved in the process, for their advise and support.

Helsinki, January 1998
Eero Lahtinen, Ville Lehtinen, Eero Riikonen

Executive summary

Health promotion has become part of European Union (EU) action. Within health promotion, the role of mental health has recently been emphasised by the Commission. By supporting projects related to mental health, the Commission has thus signalled to Member States that mental health issues are important and that all countries should be aware of the challenges and possibilities related to mental health and its promotion.

The aim of this document, which is the result of a one-year project supported by European Commission DG V/F/3 and co-ordinated by STAKES (the National Research and Development Centre for Welfare and Health, FIN), is to outline the key concepts and a framework for the action needed to promote mental health in Europe. The framework is required in planning, implementing, evaluating and monitoring national and transnational mental health promotion and prevention programmes and policies. The document stresses that mental health and issues related to it call for our special attention because they affect everybody and because they cannot be left to the responsibility of mental health care alone.

Mental health is seen as an essential component of general health. Mental health is a result of various predisposing factors (e.g. early childhood experiences); precipitating factors (e.g. stressful life events); social context; and individual resources (e.g. self-esteem) and experiences. *Positive mental health* refers to mental health as a capacity to perceive, comprehend and interpret our surroundings, to adapt to them and to change them if necessary, to think and speak, and to communicate with each other. It is determined by four main influences: individual factors and experiences, social interaction, societal structures and resources, and cultural values.

Mental ill-health (*negative mental health)* encompasses a continuum, which extends from the most severe mental disorders to a variety of symptoms of different intensity and duration, resulting in a variety of consequences. Much mental ill-health is experienced as a part of normal life and is not, usually, presented for care or recorded in epidemiological studies. Such everyday mental problems are correlates of personal distress and can take the form of, for instance, lack of motivation, poor concentration or worrying.

Mental health and well-being are, indeed, issues of everyday life, and should therefore be of interest to every citizen and every employee, and to all care, education and administration sectors. Mental health is created, and jeopardised, in families and schools, on streets and in workplaces. It is the results of, among other things, the way we are treated by others, and the way we treat other people and ourselves.

There are many false assumptions concerning mental health. It is, for instance, widely believed that mental ill-health cannot be treated or prevented. The worst social consequence of such false assumptions is the stigma of mental ill-health. Moreover, the cultural influences of negative attitudes towards mental health tend to maintain this situation. Unlike physical ill-health, which can in many cases be openly discussed, topics related to mental health are often linked with shame.

As a public health concern, mental ill-health is as serious as physical ill-health. Mental disorders are as common as physical disorders. Mental disorders increase mortality, cause disability and suffering, bring about economic losses, lead to exclusion, and influence the development of subsequent generations, possibly even more than physical ill-health. And yet, in western societies mental health has a secondary position to physical health. Mental health receives less attention at the level of policy formulation, decision-making and health service provision. The same concerns investments in health promotion.

We are justified in investing in the *promotion of mental health. Promotion of mental health is a comprehensive strategy and a set of positive activities aiming to:*

- enhance the visibility and value of mental health at the level of societies, sections of societies and individuals; and
- protect, maintain and improve mental health.

The expression promotion of mental health is normally used as an umbrella concept. It covers a wide range of strategic approaches and paradigms. Promotion of mental health and *prevention of mental disorders* are seen in this report as necessarily inter-related and overlapping activities. Promotive efforts are also preventive, and vice versa.

Promotion of mental health puts special emphasis on participation and empowerment and on intersectoral co-operation. 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.

Because mental health is partially culturally determined, the approaches, methods and tools used for promoting mental health must be adjusted to the social, cultural, gender, age-related and developmental contexts in question.

Promotion of mental health, like health promotion in general, can work at individual, interactional, structural and cultural levels.

Practical efforts promoting mental health strive to find and enhance factors and processes that protect mental health and reduce factors harmful to mental health. When the efforts are effective, they result in improved well-being, less human suffering, a lower prevalence and incidence of mental disorders, better use of services, higher quality of life, improved social functioning, enhanced social integration and other related outcomes.

Mental health promoting efforts can be action-, development- or research-oriented. A large volume of studies, mostly focusing on individual or interactional determinants of mental health, demonstrates the effectiveness of mental health promotion. However, research projects attempting to enhance the visibility or the value of mental health have not been reported. There are also no studies analysing or comparing mental health policies.

The following areas of priority, either general, concerning development and research, or action-oriented, are emphasised in the report:

- *Enhancing the value and visibility of mental health*
    - Establishing large scale public information campaigns on mental health
    - Starting mental health impact evaluation in all administration
    - Identifying EC action linked with mental health and providing a supportive information exchange capacity

- Integrating mental health aspects to all health promotion programmes
- Including mental health instruction in school education thoroughly
- Emphasising mental health in all professional training

• *Empowerment, participation and Information Society*

- Enhancing participatory, community-based mental health promotion
- Raising awareness concerning strengths-based approaches and effective forms of self- and peer-help.
- Establishing innovative projects to develop 'good telematic content' and 'good telematic interfaces'
- Evaluating the risks of marginalisation resulting from increased use of information technology
- Reorienting mental health services and promotion in line with the developing Information Society
- Setting up a network focusing on the telematics of social inclusion and mental health promotion.

• *Towards mental health promoting working life*

- Raising employers' awareness of the importance of mental health and its promotion in the work place
- Disseminating information on practices in work place mental health promotion, e.g. by
- Identifying common goals and enhancing the positive aspects of the work process and environment
- Recognising the balance between job demands and occupational skills
- Enhancing social skills training and possibilities for collaboration and joint opportunities
- Developing the psychosocial climate at the work place
- Providing counselling for special groups, e.g. carried out before organisational or other changes
- Applying strategies focusing on enhancement of working capacity and early rehabilitation'

- *Unemployment, underemployment and re-employment*
    - Evaluating comprehensively real effects of unemployment
    - Preventing stigmatisation of unemployment
    - Supporting re-employment trough job creation
    - Supporting re-employment by developing the physical and mental resources of the unemployed
    - Searching actively intermediate statuses between work and unemployment
    - Developing multimodal programmes focusing on unemployment leading to marginalisation

- *Support and protection of children, young people and families with children*
    - Developing written strategic plans on promoting the mental health of children and young people
    - Increasing knowledge of the pathways leading to healthy development or marginalisation
    - Collecting data on the extent of child exploitation and creating protection for the children affected
    - Sharpening the focus on children's needs in all health promotion programmes targeted at adults
    - Focusing on self-esteem, non-violent behaviour; and good communication and social skills in education
    - Collecting and disseminating information on programmes supporting early parent-child interaction

- *Enhancing quality of life of elderly people*
    - Preventing stigmatisation of old age and discrimination of elderly people
    - Supporting independent living by policy and programme measures
    - Developing programmes promoting self-support by intellectual and physical measures
    - Developing effective and feasible measures of preventive action

• *Promoting mental health of alcohol and drug abusers*

- Developing measures focusing on prevention and reduction of combined substance abuse
- Developing tolerant services for mentally ill intoxicant users who are out of the scope of rehabilitation efforts
- Supporting research and development regarding the co-occurrence of intoxicant misuse and psychiatric disorders

• *Supporting research and development*

- Emphasising transnational comprehensive evaluation of activities in promotion of mental health
- Emphasising long-span implementation research looking at factors associated to effectiveness and at quality
- Establishing mental health policy surveys and a policy data base
- Studying and developing the role of health care and social services in promotion of mental health
- Enhancing information exchange between the researchers, administrators and implementers
- Emphasising dimensions with European relevance like equity, participation and experienced quality in all R&D action

• *Development of information and dissemination systems concerning mental health*

Establishing a comprehensive mental health monitoring system by, e.g.

- Collecting information on existing mental health indicators and their definitions
- Collecting information on existing mental health information systems and analysing their quality, coverage and validity
- Developing a mental health monitoring system for the use of the Member States and the Commission

- Testing the dimensions of the mental health monitoring system in pilot projects
- Establishing a high-capacity network for the collection, dissemination and analysis of relevant information

The recommendations for European action, presented in detail in the following section of the report, underline the need for R&D activities such as policy surveys, mental health monitoring and assessment of mental health promoting programmes; specific practical efforts; and the need to foster European co-operation in mental health issues. The recommendations include general guiding principles for action.

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1 Recommendations for European action

The report gives many reasons why European Union should support efforts to promote mental health and why mental health should be firmly on the European agenda.

Health promotion and preventive activities are in most Member States not given appropriate support on national level. The European Union has an increasingly important role in this field. The support of Commission signals to Member States that the issues are important and that all countries should be aware of the challenges and possibilities related to mental health.

On the basis of the foregoing analysis it is suggested that the following (1) challenges, (2) key areas of action, (3) ways of enhancing co-operation and (4) general principles guiding R&D should be prioritised by the EC.

1. General challenges

1.1. Mental health policy surveys are needed

In order to effectively support activities aiming at promotion of mental health in Europe it is necessary to deepen knowledge concerning mental health policies of Member States. Surveys on national mental health policies should include the following methods and areas:

- interviews of key players
- content and value analysis of mental health policy documents
- analysis of the implementation of high quality mental health promotion projects in Europe
- analysis of the legislation of Member States when it relates to mental health

It is especially important to develop a capacity to monitor how children's and adolescents' developmental needs are taken into consideration in developing mental health policies, community planning, education and work life related programmes.

1.2. A comprehensive mental health monitoring system must be created

There exists an evident need to develop a system of population level indicators for mental health, including positive mental health. The work includes collection of information on the existing mental health indicators and their definitions as well as the mental health information systems developed in the different EU Member States or by international organisations including WHO and OECD, and analysis of their quality, coverage and validity.

- creation of a system of mental health indicators to be used by the Member States and the Commission in which information concerning both adults and children / youth is included
- testing the feasibility and usefulness of the indicators and the monitoring system in pilot projects
- production of a set of recommendations concerning the methods of data collection
- creation of an information exchange network

1.3. Assessment of mental health promotion projects and programmes must be enhanced

There exists a definite need to develop quality assessment methods and quality indicators for European mental health promotion activities. The following conclusions were reached

- quality assessment methods and indicators should be useful also to health and social services and respect the great importance of social support and social participation for mental health. They must therefore include dimensions like equity, participation and experienced quality.
- R&D activities focusing especially on process and implementation analysis should be encouraged
- developmental contexts of children and youth (e.g. family, day care and school) should be seen as integrated wholes when R&D activities are planned, implemented and evaluated

2. Specific actions for promoting mental health

It is suggested that the European Commission should prioritise support for activities that combine the efforts of several Member States and focus on the following issues:

2.1. Enhancing the visibility and value of mental health among the population, in work organisations and among decision makers

The efforts can concern, for example, the methods and strategies for

- creating or refining national mental health policies and good policy documents
- emphasising the relevance of mental health in political decision-making
- supporting public health information focusing on mental health issues

2.2. Mental health promotion of children, youth and families

The action is especially important if it links with

- the importance of salient knowledge and skills in supporting good early relationships
- supporting the coping skills, healthy life-styles and non-violent behavioural strategies of both boys and girls in educational settings of all kinds

2.3. Mental health promotion at work

These activities should preferably be targeted at work organisations and work places and aim at alleviating problems caused, for example, by burn-out and exhaustion due to excessive workload, lack of adequate training and organisational factors

2.4. Finding best approaches for preventing and diminishing marginalisation of specific groups

The action should focus on

- long-term unemployed persons and concern employment strategies/models for people with mental health problems (or psychosocial problems)
- physically or psychologically disabled persons and aim at enhancing the quality of life, opportunities for social participation, active life and re-integration to working life
- social integration of substance abusers
- other groups with specially high risks of marginalisation (immigrants, other minority groups, etc.)

2.5. Quality of life of elderly people

The action should relate to finding effective ways of maintaining and enhancing social activity, social networks and social participation of elderly people.

2.6. Reaching a deeper consensus concerning the best models and strategies for promoting mental health in Europe

This type of transnational action has to be extended. It can take many forms (e.g. networking, seminars, and theoretical work). A deeper consensus is needed to integrate the activities of the key players

2.7. Understanding the potentials, benefits and dangers of the emerging Information Society for mental health

This work can relate, for example, to

- the risks of marginalisation linked with the increasing use of information and communication technology in working life and the changing professional qualifications
- the possibilities of information and communication technology for supporting mental health promotion and social integration

3. Enhancing the co-operation

As promotion of mental health is, due to its many dimensions, the area most prone for fragmentation within health promotion, special emphasis must be given to co-operation. Activities aiming at promoting mental health should be supported and augmented by linking them, when possible, with other EC action. The following issues must be carefully considered by a group / groups of experts working jointly with relevant EC institutions and officials:

- Finding the best ways to identify EC action that might be linked with mental health (e.g. R&D Framework programmes, ESF and Community Initiatives, occupational health initiatives, development of new work forms, learning and

education related programmes, ICT related programmes, consumer protection, equity issues) and enhancing co-operation with the relevant EU Institutions
- Inclusion of indicators linked with mental health to relevant statistical instruments in EU
- Creation of an information exchange capacity / network gathering and disseminating information on matters relevant for mental health and taking place in the EU Institutions.

4. Guiding principles for promoting mental health in Europe

The following principles and notions should be taken into consideration in the action of European Commission:

- It should be made evident for the general public, EU's decision makers and Member States that mental health must be valued as highly as physical health.
- The EU should use all available means to facilitate international co-operation and alliances between Member States in the field of mental health promotion. This is likely to facilitate innovation, transfer of knowledge and enthusiasm.
- Mental health promotion requires multi-sectorial and multi-level efforts. Action should preferably involve health and social services as well as services of other sectors. The probability of success increases if action at the different levels of administration (central, regional and local) is included and integrated.
- Respect for cultural norms, local conditions and cultural differences is essential in programmes aiming at promoting mental health.

- The focus should be on empowerment of groups and individuals as well as on integration of mental health promotion with other measures of personal and social development (e.g. promotion of physical health and undertakings aiming at improving sustainable conditions).
- Collaboration with service users, community leadership, lay organisations, NGOs and professional associations is a prerequisite for successful programmes.
- Staff employed in health and social services and in the field of education is a key factor in mental health promotion and everything possible should be made to guarantee that they hold mental health in high esteem and that they receive training, which is appropriate.
- In the evaluation of R&D effort inputs, processes, impacts and outcomes should be taken into consideration.
- Special emphasis should be given to issues relating to equity, participation and experienced quality.

2 Background

A society concerned to enhance factors and processes that promote mental health is a better society for everybody.

1. Conceptual framework

1.1. Mental health

Health is a state of equilibrium between the individual and the environment. Mental health is an essential element of general health, as there is no health without mental health. *Positive mental health* is a potential (Figure 1) which is determined by:

- *individual* factors and experiences
- *social* interaction
- *societal* structures and resources
- *cultural* values and factors.

Healthy mental abilities and functions enable us to experience life as meaningful, helping us to be, among other things, creative and productive members of the community. Mental health is essential to our ability to perceive, comprehend and interpret our surroundings, to adapt to them and to change them if necessary, to think and speak, and to communicate with each other. It is necessary for forming and sustaining relationships and for living our daily lives. Mental health is also a major factor in social integration and community participation.

Mental health and well-being are issues of everyday life, and should therefore be of interest to every citizen and every employee, and to all care, education and administration sectors. Mental health and well-being originate in families, schools, on streets and in workplaces. They are a result of the influence of various predisposing factors (e.g. early childhood experiences), precipitating factors (e.g. stressful life events), socialinteraction and individual resources.

Figure 1. Conceptual dimensions of mental health.

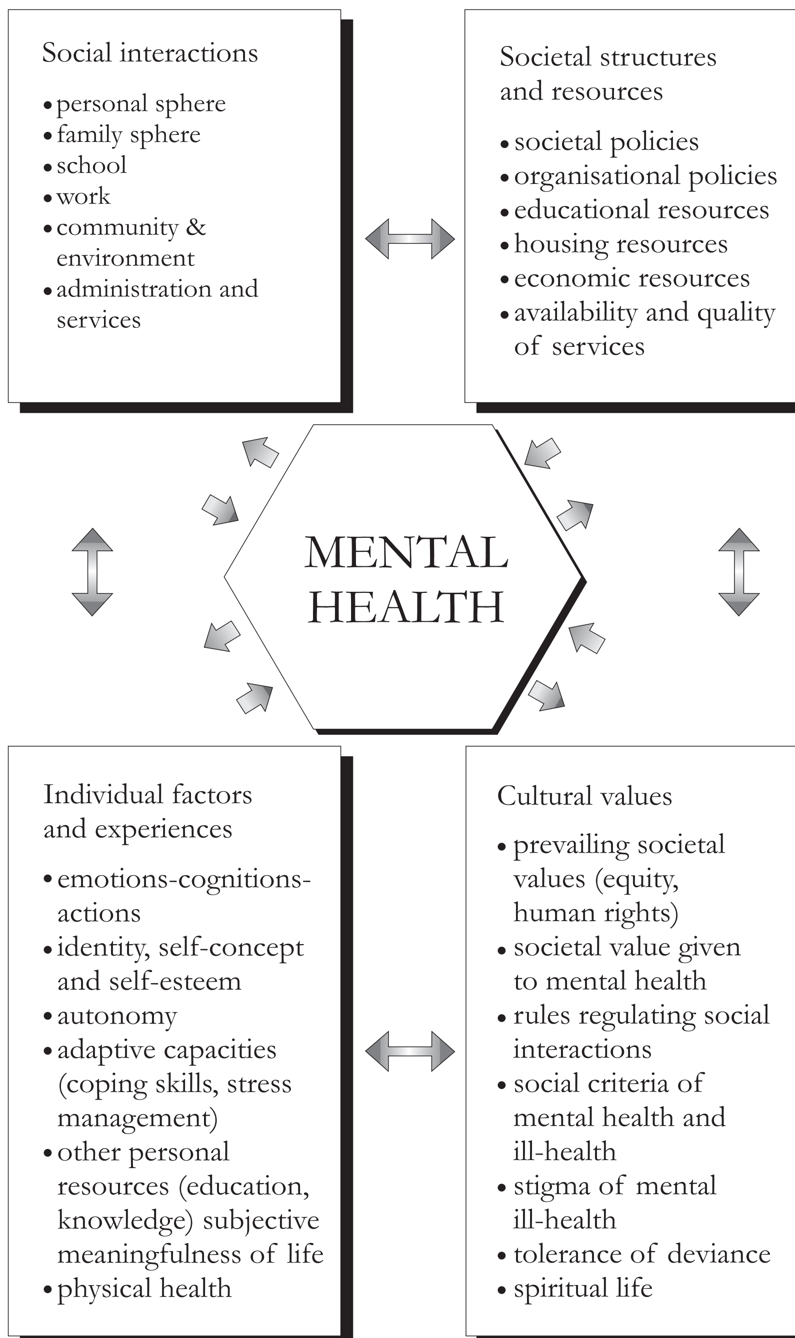
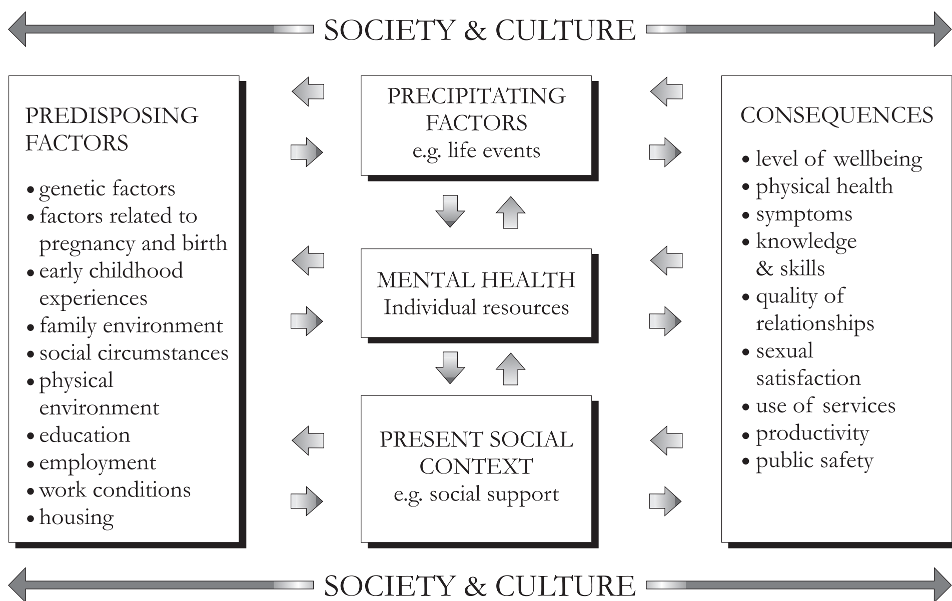


Figure 2 presents an functional model of mental health (modified from Hosman 1997), seeing mental health as a process or state of equilibrium, in which it is defined by past and present antecedents, personal resources, life events, social interaction and various consequences. This process of mental health is continuously reflected in our everyday experiences and interactions with other people, the environment, society as a whole and the culture we live in.

Figure 2. Functional model of mental health for promotion (modified from Hosman, oral communication 1997).



Mental ill-health encompasses a continuum, which extends from the most severe (1) mental disorders to a variety of (2) symptoms of different intensity and duration.

(1) *Mental disorders* are defined by the existence of symptoms (with the exception of psycho-organic disorders, and substance abuse disorders). If these symptoms, such as impaired mood and perceptions, thought processes, cognition and dependence, are of sufficient severity they are

called clinical disorders, e.g. depression, schizophrenia and personality disorders. Misleadingly, but as an attempt to avoid stigma, the term mental health has often been used to describe mental disorders themselves.

A state is called a disorder when the symptoms are

- long lasting
- beyond the control of the individual who cannot alleviate the symptoms by turning his/her attention to something else
- out of proportion to the possible external causes
- reduce the functional ability.

(2) *Mental symptoms also exist before* the criteria for clinical disorders are reached, for example, in the mild stages of depression, anxiety or fatigue. Such symptoms, often called *sub-clinical,* may also cause suffering and a marked reduction in productivity. Everyday mental symptoms are a consequence of persistent or temporary personal distress and take the form of, for instance, lack of motivation, poor concentration or worrying. Much of such distress, experienced as a part of everyday life, is not usually presented for care or recorded in epidemiological studies.

Mental ill-health leads to suffering, reduced functional capacity, lack of meaningfulness of life, diminished experience of success and enjoyment or impaired quality of life in general. Clinical disorders and mental symptoms can all contribute to a variety of social consequences, such as difficulties at work, in family life or in other relationships. Their associations with physical ill-health and with a wide variety of risk behaviours, such as smoking and alcohol or drug abuse, are also widely recognised.

One way of looking at mental health is to place the two continuums, mental ill-health and positive mental health, in parallel. There is no single intersection point between mental health and ill-health: Some aspects of positive mental health will always be present in a state of mental ill-health, too. It is evident that mental health can be affected by tackling either mental ill-health or positive mental health.

1.2. Promotion of mental health

Promotion of mental health is a comprehensive strategy and a *set of positive activities aiming to*

- *enhance the value and visibility of mental health at the level of societies, sections of societies and individuals*
- *protect, maintain and improve mental health.*

Promotion of mental health strives to find and enhance factors and processes that protect mental health and to reduce factors harmful for mental health. Effective promotion of mental health results in improved well-being, less human suffering, a lower prevalence and incidence of mental disorders, better use of services, higher quality of life, improved social functioning, enhanced social integration, and in other related outcomes.

Promotion of mental health puts special emphasis on participation and empowerment and on intersectoral co-operation. It can work with whole societies, communities, social groups, risk groups or individuals. Promotion of mental health underlines and highlights values that support sustainable development. Promotion of mental health uses a variety of approaches, methods and tools which must be adjusted to the social, cultural, gender, age-related and developmental contexts in question.

Promotion of mental health, like health promotion in general, works with resources, potentials and factors, the determinants of mental health, at individual, interactional, structural and cultural levels.

Health promotion is nowadays used as an umbrella concept, covering a wide range of strategic approaches and the paradigms on which they rely. Consequently, in this report, promotion of mental health and *prevention of mental disorders* are seen as necessarily inter-related and overlapping activities. Their differences, currently widely discussed, are apparent on the theoretical level, but in practice, the similarities are more striking.

In general, health promotion includes societal activities directed at the determinants of health whereas prevention focuses, with evidence-based and cost-effective interventions, explicitly at the causes of diseases, accidents or other departures from good health. In the promotion of

mental health, promotive efforts are also preventive, and vice versa, due to their emphasis on both the protective determinants of mental health and the risk factors of mental illness. The protective and risk factors are, as a matter of fact, often opposite ends of one and the same continuum, e.g. a good vs. bad family environment.

If real differences do exist between promotion and prevention in the field of mental health, they may concern implementation, which, in prevention, mainly refers to linear processes focusing on individuals, in contrast to the system-oriented or social objectives of the promotion of mental health.

A concrete and important example of this overlap of promotion of mental health and prevention of mental disorders is seen in the *mental health services*, when they treat not only the patient, but focus also on the patient's social network. Becoming severely mentally ill is a catastrophe both for the patient and for family members and other people important in the patient's life. The treatment procedures therefore always include elements of

- *primary prevention* (focusing on healthy people possibly at risk, e.g. the children in a family)
- *secondary prevention* (early detection and treatment)
- *tertiary prevention* (prevention of relapses and complications, rehabilitation).

By applying these preventive measures, the mental health services make a significant contribution to the mental health of the community.

The variety of pragmatic strategies in the promotion of mental health is even more extensive than that in general health promotion. For example, the many approaches of psychiatry, psychology and psychotherapy have different ideas about mental health and how it can be influenced. The promotion of mental health requires, in most cases, multidisciplinary expertise, often emerging clearly from outside the purview of people working in the health sector. Consequently, the promotion of mental health can also be considered as the area of health promotion most prone to fragmentation. It is therefore essential to underline the importance of intersectoral co-operation between experts, administration and other key players in the promotion of mental health.

Co-operation with citizens is also essential. In practice, most health promotion interventions have aimed at changing individuals by educating or guiding them in an authoritative manner. In these interventions, the role of health promoters is to give incentives to individuals and to support them in their attempts. However, a substantial amount of health information is contradictory and people are often sceptical about following the educational messages of health promotion. The promotion of mental health should therefore always actively involve the general public, alongside experts, in planning and decision making.

The process through which people gain greater control over their health is called *empowerment.* Empowerment takes place through

- enhancement of those individual capacities needed for action in the community
- the continuous development of societal values and structures enabling a true interplay between citizens and society
- the resulting genuine possibility to influence what is happening to oneself, to others and to the environment.

Empowerment is a continuous process requiring active efforts on all levels of society; it is not something that takes place spontaneously. As a result of empowerment, *society itself* may be seen as a shared means towards the shared goals of its members.

1.3. Reasons for urgency of action

The most important motivation for promoting mental health is the heavy burden caused by mental ill-health. On the level of societies financial costs and loss of productivity can describe this burden. The burden of individuals is characterised by stigmatisation and enormous suffering, a perceived lack of meaning in life, and marginalisation. Mental ill-health also affects not only individuals but also their family members, classmates or colleagues. The burden of mental ill-health, which seems to be continuously growing and becoming one of the leading causes of disability in the new millennium, is discussed in chapter 3.

To be categorised as a *public health problem*, a disease, a group of diseases or other societal health concerns must (1) be frequent and (2) have severe consequences. They must also be (3) amenable to (4) ethically acceptable solutions. Mental disorders, which are a major cause of disability and also increase the risk of mortality, satisfy all of these criteria and therefore deserve to become a subject of public health action. Traditional health care and mental health services can, however, never be increased to an extent that would enable them to meet all the needs.

New forms of more effective action in the field of mental health are also motivated by the de-institutionalisation of the mental health care system. The role of mental health services in supporting the social network of patients cared for in ambulatory settings needs to be emphasised. Additionally, there has been a growing interest in and demand from citizens and different organisations to focus on mental health rather than mental illness, to provide information on mental health issues in general and on self-help methods, and to develop alternative services.

The current allocation of resources for health promotion does not reflect the proper contribution of mental health to general health and to changes in society. This lack of balance is apparent in health policies, health services, education, organisational strategies and many other areas of society.

The prevailing position of mental health as secondary to physical health and the consequent neglect of the promotion of mental health are based on inaccurate assumptions of mental health. Public health authorities seem to have a tendency to dichotomise health into physical and mental health and to neglect the contribution made by mental health to general health. It has also become customary to think wrongly that it is not possible to protect or promote mental health and prevent mental ill-health effectively.

Although the causes of mental ill-health are complex and multifactorial, research has shown that mental health can be promoted and mental ill-health prevented. Furthermore, many studies have demonstrated that the promotion of mental health and the prevention (as well as treatment) of mental disorders are cost-effective.

This document emphasises the necessity of supporting and developing activities to promote mental health in the European Union and simultaneously to strengthen the value and visibility of mental health.

1.4. Entry points for promoting mental health

It is difficult to find social phenomena that are not connected with mental health and do not influence it directly or indirectly. Thus, there are many pathways to mental health and ill-health and, consequently, a variety of possible entry points for promoting mental health. These entry points can be defined in many ways.

Tackling (1) *the factors that predispose to, precipitate or maintain mental ill-health* is a common way of looking at the determinants of health. Genetic factors, early experiences and poor parenting are examples of predisposing factors. Stressful social or environmental events are typical precipitating factors. Chronic social adversity or other stresses and stigma are examples of maintaining factors of mental ill-health, social support of maintaining factors of mental health.

Entry points can also be defined by referring to (2) *the target groups* of activities. The promotion of mental health can focus on either entire populations or smaller groups defined by, e.g., age, gender, profession, specific risk or different forms of deprivation (unemployed, homeless, refugees, immigrants, prostitutes).

Furthermore, it is possible to look at (3) *the settings* of interventions, such as the family, day care, school, work place, health and social services, media, prisons or armed forces, or to define on which (4) *level*, e.g. international, national, regional, local or individual, mental health promotive action takes place.

Within (5) *public health*, action is hierarchically classified into four levels: *policy*, *programme* (e.g. focusing on a group of diseases), *specific action* (e.g. developing services) and *specific product* (e.g. model interventions). Finally, entry points of promotion of mental health may be categorised by (6) *methods* of action and interventions. In the promotion of mental health, the means of action are many and include dissemination of information

and dialogue between administrators, professionals and citizens. They also include development of public services, integration of mental health issues in education and curricula, reorienting research on mental health and its promotion and various innovative measures, for example, use of information technology.

1.5. General principles of prioritisation

As stated above, promotion of mental health is a multidimensional activity. As nearly everything in society can have effects on mental health, prioritisation of action is not easy. Decisions concerning priorities can be made by referring to

- societal costs of burden
- face value of importance (initiatives from experts, administration or citizens)
- specific needs of the community.

Additionally, when new methods are introduced to public health or social services, they must be

- evidence-based and cost-effective
- socially and culturally acceptable.

2. The burden of mental ill-health

The promotion of mental health is motivated by the heavy burden mental ill-health creates for society. This chapter deals with some aspects of the burden laid on individuals, families, social networks, service systems and indeed society as a whole.

Mental ill-health should be seen as a continuum comprising, not only the everyday mental health problems we all have, but also well-defined mental disorders, i.e. schizophrenia, depression and long-lasting anxiety states, psycho-organic disorders including dementias, alcohol and drug abuse as well as disorders of personality. Mental ill-health is studied by *psychiatric epidemiology*. As psychiatric epidemiology traditionally takes a comprehensive approach, also focusing on social and societal factors and the protective elements of mental health, it is a valuable source of information for the promotion of mental health.

2.1. Mental disorders are common

Mental disorders are more frequent than the most frequent physical disorders. As shown in population studies summarised in table 1., any one time at least 15-20% of the population show symptoms of some mental disorder satisfying the criteria (frequency and severity of symptoms) of disease classifications. Mental disorders affect not only adults, but also children and adolescents. In several large-scale epidemiological studies conducted in Europe, the prevalence of mental disorders among these age groups has been as high as among adults or even higher. The lifetime occurrence of any mental disorder has been estimated to be as high as 50%.

Of the population, 1-2% suffers from the most severe forms of mental disorder such as schizophrenia or other forms of psychoses, or dementia. The occurrence of mental disorders is mainly due to depressive and anxiety disorders, somatisation and alcohol problems. The prevalence of these states seems to vary between 5% and 10% in different studies. An alarming sign is the clearly noticeable increasing tendency for the risk of depression, especially among young adults. Another increasing group is alcohol and substance abuse disorders, affecting all age groups but especially adolescents and young adults.

Table 1. Prevalence (%) of mental disorders according to some recent extensive population studies.

Study	Country	Study	Age	Sample	Period	Prevalence	Prevalence	
Prevalence				years				(%)
(%)	(%)							
						males	females	total
Mini-Finland	Finland	1979-80	30+	7 217	1 mo	14.9	19.8	17.6
Cantabria	Spain	1981	17+	1 223	1 mo	8.1	20.6	14.7
ECA	USA	1980-84	18+	18 571	1 mo	14.0	16.6	15.4
Upper Bavaria	Germany	1980-83	20+	1 382	1 mo	20.4	21.1	20.8
Nijmegen	The Netherlands	1983	18-64	3 232	1 mo	7.2	7.5	7.3
Edmonton	Canada	1983-86	18+	3 258	6 mo	18.9	15.3	17.1
NCS	USA	1990-92	15-54	8 098	12 mo	27.7	31.2	29.5
OPCS Survey	Great Britain	1994	16-64	9 792	1 week	12.3	19.5	16.0

2.2. Mental disorders cause higher mortality

Mental disorders are associated with clearly increased mortality rates. The standard mortality ratio (SMR) among patients with mental disorder has ranged from 2 to over 5. This means that the risk of death is several times higher than in the population as a whole. An alarming finding is that mortality among patients in the younger age groups has been especially high in comparison with the general population. In recent studies from Norway and Finland the increased risk of death of both men and women was ten or more times higher among 20 to 29-year-old patients than in the general population of corresponding age. The main causes are suicides and other violent deaths.

Over 100,000 suicides are committed in the EU every year; the estimated number of attempted suicides is tenfold. These figures clearly exceed the number of deaths from accidents. Besides suicides, the increase in mortality is based on comorbidity: mental health affects physical health

and vice versa. People with severe mental disorder have high death rates from cardiovascular diseases, respiratory diseases and malignancies. The promotion of mental health may therefore also be regarded as the prevention of excess mortality.

2.3. Mental disorders cause disability

Mental disorders affect functional and working capacity in many ways. When the disorder begins during childhood or adolescence, it means that the person's working capacity may be significantly reduced or totally lost for a long period, even for the total productive life span. Together with cardiovascular diseases and musculo-skeletal disorders, mental disorders are usually one of the three leading causes of disability. In many European countries the proportion of people with disability pensions due to mental disorders is increasing.

A report 'Global Burden of Disease' was published in 1996 by the Harvard School of Public Health, World Health Organisation and the World Bank together with over 100 collaborators from around the world. The report estimated that psychiatric and neurological conditions together account for 28% of years of life lived with disability. Depression alone accounts for more than 10% of years of life with disability. When the total global burden of diseases is calculated on the basis of years lived, years of life lost and mortality, psychiatric and neurological conditions account for 10.5%. Note that consequences of mental retardation are even not mentioned in these reports.

The same report also presented calculations concerning the future disease burden, showing that by 2020 mental disorders and neurological conditions may increase their share of the total burden of disease from 10.5% to 15%. This is a bigger increase than that predicted for cardiovascular diseases. Depressive disorders are predicted to assume fourth place among all diseases causing disability.

2.4. Mental disorders - a heavy economic burden

Both the high prevalence of mental disorders and the fact that their onset is often in adolescence or young adulthood create a heavy economic burden for society. Some European countries have calculated the total costs of mental disorders (including both direct costs from use of services and indirect costs from the loss of productivity), arriving at figures that range from 2% to 3.6% of GDP. In most of the calculations the indirect costs clearly exceeded the direct costs, in a ratio of 2:1. The direct care costs for mental disorders in the UK, for instance, were £1.76 billion in 1989, accounting for 23% of total NHS expenditures.

Depression seems to produce the heaviest burden for society. In a Finnish calculation, for example, depression accounted for about 50% of the total costs of mental disorders, and schizophrenia for about 30%. In an Australian estimate the costs of schizophrenia were half of those of myocardial infarction. In Finland it has been estimated that the direct costs of schizophrenia are clearly higher than the health care costs caused by smoking.

A number of studies have emphasised the financial difficulties of families with mentally ill members. To some extent, difficulties may arise because caring for a patient with a long-term mental disorder limits opportunities for an adequate income. In some instances, the caregiver, usually the mother of a schizophrenic child, has been forced to leave her job to enable her to carry out her care-giving task. The most severe problems occur when the patient has formerly been the breadwinner, particularly if circumstances prevent relatives from taking over the role. Such situations lead to impoverishment of the whole family.

2.5. Mental disorders affect social status

Many studies have demonstrated a clear association between psychiatric morbidity and low socio-economic status, most clearly for men. Mental ill-health has a clear connection with low income and poverty, low educational status and often also unemployment. There are also clear

gender differences in the occurrence of mental disorders. Women seem especially prone to anxiety disorders and depression, whereas men suffer from more alcohol and substance abuse disorders. These differences seem to be based on psychosocial rather than biological factors. Further, not being married is associated with mental disorders, as are lack of social support, physical morbidity and many forms of social exclusion.

2.6. Mental disorders cause suffering

Apart from material losses, mental disorders produce enormous subjective suffering, which cannot be measured in monetary terms. Psychic pain taking the form of anxiety, depression, guilt and shame can subjectively be as incapacitating as the most severe physical pain. All kinds of vicious circles easily develop in these circumstances.

During the last two decades, in parallel with the deinstitutionalisation of mental health services, the pressure on families and other close relatives has increased. In the event of severe mental disorders the burden always affects not only the patient but also his or her family members and other close relatives. The burden is especially heavy for the parents of chronically ill young patients. The mental disorders of old age, including dementias, which are increasing together with the increasing number of the elderly, create demands for the children of the patient.

Many of the studies focusing on the burden on families have shown that the most significant consequences are psychological, and are reflected in higher levels of depression, anxiety, helplessness, hopelessness, emotional exhaustion, low morale, distress, sense of isolation, guilt, and anger. In a Swedish study, 78% of families of schizophrenic patients expressed a heavy burden and 48% needed practical help; 88% felt that the situation had a negative impact on family life. Three out of four relatives had significant guilt feelings because of their relative's illness.

2.7. Mental disorders lead to exclusion

Mental disorders stigmatise and lead to discrimination. People suffering from mental disorders are in many respects the most marginalised in European societies. Associated problems such as poverty, homelessness, criminality, alcohol and drug addiction often lead to a very low quality of life.

Marginalisation has several causes. First of all, the stigma, negative attitudes and prejudices often lead to unemployment. Second, the rapid and, in many countries, uncontrolled process of deinstitutionalisation has gone ahead without sufficient alternatives for community care being developed. Third, due to the character of the mental disorders themselves, persons suffering from these disorders are not always capable of coping in our complex societies without help and support from other people.

2.8. Mental disorders affect subsequent generations

Mental disorders cause suffering not only now but also in the future. Besides hereditary factors, the mediating mechanisms are many. A parent's mental illness and the social consequences of this often result in poor parenting and affect the important early relationship between parent and child. The psychosocial development of children is often further complicated by the adverse social situation initially caused by the parent's mental disorder. Not only the mentally ill parent but also the children are easily stigmatised. This and the consequent lack of social learning can frequently lead to poor educational and social outcomes.

3. Promotion of mental health in practice

3.1. Mental health policies in the Member States

Some reviews of European prevention and health promotion policies exist or are currently in preparation. There have, however, been no systematic reviews or studies of the mental health policies of the Member States of the European Union.
It was therefore decided at the February 1997 meeting of the European Network on Mental Health Policy that an orientation inquiry should be carried out into the mental health policies of the Member States. This task was also entered in the Key Concept Project agreement.

A Mental Health Policy Questionnaire consisting of twelve questions was sent to the Members of the European Network on Mental Health Policy or to the Ministries of Health and Social Affairs in each country. The first eight questions could be answered by using yes/no options (grounds for these choices were also requested), the last four were open-ended. The questions were the following:

(1) Has your country carried out a national mental health needs assessment (an assessment of what needs to be done to develop the mental health services/care, prevention and mental health promotion)?
(2) Does your country have a functioning system for monitoring the mental health/mental well being of the population?
(3) Does your country have a written mental health policy statement or relevant documents setting out the government's overall mental health strategy with a timetable for implementation?
(4) Does your country have a document outlining the necessary service inputs in specialist mental health care (buildings, people, training) covering all age groups and all sub-specialities?

(5) Does your country have a document(s) outlining the necessary service processes in mental health care (information systems, inter-agency working, treatment protocols etc.)?
(6) Does your country have a document outlining the relationship of primary care and basic services to mental health care?
(7) Does your country have a document(s) outlining the relationship of mental health care with the work and action of other key agencies (social services, criminal justice system, schools, workplaces)?
(8) Does your country have a document(s) outlining the government's strategic goals for mental health, e.g. outcome targets?
(9) What do you see as the critical success factors for developing and implementing a national policy of mental health/mental health promotion in your country?
(10) What do you see as the main obstacles for developing and implementing a national policy of mental health/mental health promotion/prevention of disorders of mental health in your country?
(11) Would you in your role as a mental health policy maker value any particular support from the ENMHP? If so, what kind of support would be helpful?
(12) Please describe the most important mental health promotion projects or programmes in your country (only projects or programmes which have started in or after 1987). Give a short outline of the projects/programmes with a few lines and enclose material concerning them, if available.

Replies were received from 14 countries or regions before the deadline. Table 2 summarises the answers and Appendix 2 gives explanations and open-ended answers to each question.

*Table 2. Summary of the answers to the Mental Health Policy Questionnaire (Q= question; + = yes; - = no; * = open ended question has been answered)*

Country/region	**Q.1**	**Q.2**	**Q.3**	**Q.4**	**Q.5**	**Q.6**	**Q.7**	**Q.8**	**Q.9**	**Q.10**	**Q.11**	**Q.12**
Belgium (French c.)	-	-	-	-	-	-	-	-	*	*	*	*
Belgium (Fl. c.)	+	+	+	+	-	+	+	+	*	*	*	*
Denmark	+	+	+	-	-	-	-	+	*	*	*	*
England	+	-	+	+	+	-	+	+				
Finland	+	-	-	+	+	+	-	-	*	*	*	*
France	-	+	+	+	-	+	+	+	*	*	*	
Germany	+	-	+	+	+	-	-	-	*	*	*	*
Greece	+	+	+	+	+	-	-	+	*	*	*	*
Ireland	+	-	+	+	+	+	-	+	*	*	*	
Italy	-	-	-	+	-	-	-	-	*	*	*	
Luxembourg	+	-	+	+	-	+	+	+	*	*	*	*
The Netherlands	-	-	+	+	+	-	+	-	*	*	*	
Portugal	-	-	+	+	-	+	+	+	*	*	*	*
Scotland	+	+	+	+	+	+	+	+	*	*	*	
Sweden	-	-	-	-	-	-	-	-	*	*	*	*

The 14 sets of responses reveal that there are significant differences in the extent, nature and implementation of official Mental Health Policies. There were, for example, countries which gave affirmative answers to most or all of the first eight questions, which were directly linked with the existence of various kinds of written policy documents or national scale studies. The countries giving 6-8 affirmative answers were England (6), France (6), Greece (6), Ireland (6) Luxembourg and Scotland (8). No affirmative answers to the first eight questions were given by Sweden and Belgium (French).

Some countries (England, Ireland, Portugal and Scotland in particular and France and Greece to some degree) have clearly put significant effort into developing the policies; in many countries no such effort has been made.

The Mental Health Policy Questionnaire revealed that it is extremely difficult to compare the level and quality of mental health policies on the basis of written answers to questions, how ever well they may be formulated. Understanding national policies requires a more detailed study of the original documents, the values backing them, the quality of implementation strategies and also of the wider societal and historical context.

Furthermore, the answers to the questionnaire indicate that the Member States clearly need information gathered by such means. The answers emphasise, among other things, the importance of the dissemination of information, the exchange and comparison of policy papers, the establishment of indicators and provision of other methodological support, the development of collaboration, and the co-ordination of activities.

It is therefore to be recommended that the present inquiry should be used as a starting point for future, more extensive research. The methods used then should include interviews of key persons and careful reading and comparison of all relevant material. Studies of this kind require intensive co-operation between the persons/organisations representing the country in question and the organisations representing a more global view.

3.2. Many approaches are needed

Mental health is a result of many interacting factors and there is no single way to promote it. Promoting activities should therefore reflect the diversity of needs and contexts (Health Education Authority 1997).

Activities promoting mental health commonly include a number of complementing approaches. Furthermore, within the different approaches there is a multitude of entry points related, for example, to the variety of risk and protective factors, and settings of society or target groups. The action also results in a variety of impacts and outcomes. This is due to the manifold links of mental health with various aspects of individual and societal life.

Discourses in the field of promotion of mental health are further complicated by the variety of ways in which authors use concepts. The following list attempts to give an overview of the most central approaches and concepts, describing how they have been referred to in this report. As can be seen the overlaps between them are significant.

Promotion of mental health is an umbrella concept covering all positive activities, including individual, interactional, structural or cultural approaches, aiming both to:

- increase the value and visibility of mental health and
- encourage concrete efforts to protect, maintain and improve mental health.

Individual approaches focus on coping and social skills, and are carried out in settings such as education, care or counselling, or by securing appropriate social circumstances.

Interactional approaches look at how interactions in various contexts (familial, group-related, peer-help organisational, cultural) can be influenced for the better.

Structural approaches are directed at structures of society (legislation, social benefits, employment), the community (environment, housing), education (provision, way it is organised, content, quality, e.g. learning environment and atmosphere), the work place (the way work is organised, work conditions, opportunities to influence work) and services (quality, availability). The aim is to provide measures which can make it easier for people, families and organisations to enhance health and well-being as well as social integration and participation.

Cultural approaches influence the values held by a community (equity, human rights) and the value assigned to mental health (administration, care, education), diminish stigmatisation of mental ill-health, and increase tolerance of deviance and understanding of subcultures.

Public policy approaches, which are a specific element of the structural approaches, emphasise the value given to mental health and its preconditions at policy level. They also address decision-making and underline the need for mental health impact evaluation transversally and horizontally throughout society.

Mental health education is an umbrella concept covering all educational approaches to increase knowledge and promote skills related to mental health (at population, group or individual level). The methods available to mental health education include dissemination of information (*public mental health information*, see below), instruction and counselling. Mental health education takes place in the media, educational institutions, services and other settings.

Public mental health information (i.e. health education at population level) aims to increase the visibility of mental health and understanding of mental health issues, to reduce the stigma of mental disorders and to encourage the appropriate use of services and self-help methods. Media and information technologies are the channels of public mental health information. Non-governmental organisations are important carriers of this information.

Mental health instruction describes the one-way communicative efforts through which education provides the information and teaching skills needed in mental health and its promotion, and the contexts in which these efforts are embedded, e.g., curricula, the professional training of teachers and care personnel, work place health programmes and, for instance, prenatal parent education programmes.

Mental health counselling is an interactional (group or individual) form of mental health education. The focus is on personal growth. Mental health counselling concentrates on individual and interactional determinants contributing to mental health, such as, autonomy, self-esteem or coping, negotiating, relationships, parenting skills and life skills in general.

Prevention of mental ill-health aims to reduce mental ill-health at population level (*universal prevention*), in specified groups (*selective prevention*) and in groups at specific risk (*indicated prevention*) with different methods or tools shown to be cost effective as well as socially and culturally acceptable. Efforts to prevent mental ill-health are often made in care settings and use, in the first place, educational or counselling methods.

Primary prevention of mental ill-health is directed at reducing the incidence (rate of occurrence of new cases) in the population. Primary prevention efforts are targeted at people who are essentially normal or believed to be 'at risk' of developing a particular disorder. It focuses on risk factors and seeks to eliminate or mitigate them. Prevention can focus on such areas as relationship or parenting skills, coping skills and social competence in general.

Secondary prevention of mental ill-health is carried out by the health care services and focuses on early detection and prompt treatment of mental disorders. The goal is to shorten the duration, reduce the severity and prevent the recurrence of a disorder by early detection and prompt treatment. At population level secondary prevention is directed at reducing the prevalence (the rate of cases).

Tertiary prevention of mental ill-health is designed to reduce the severity and disability associated with a particular disorder. It aims to shorten the duration of mental disorders, prevent complications or disability, and promote rehabilitation.

3.3. Promotion of mental health is effective

Studies concerning the effectiveness of promoting mental health have recently been extensively reviewed in various reports, e.g. those of Health Promotion Wales (1995) and the Health Education Authority (1997). Although these reports mainly deal with work done in Anglo-Saxon cultures, they cover approaches to mental health promotion systematically.

Instead of reviewing the field once more, this section presents only a few examples of different, successful approaches, both to illuminate the broad spectrum of possibilities available to mental health promotion and to demonstrate the diversity of the approaches emphasised in research. Aspects of the primary prevention of specific mental disorders are covered in appendix 2.

3.3.1. Enhancing the value and visibility of mental health

There are many examples of large community-based health promotion programmes, especially those focusing on cardiovascular diseases, which have been supported with public funds and gained remarkable visibility. These programmes, such as the North Karelia Project and Heartbeat Wales, have also been evaluated in depth.

The literature lacks reports of mental health promotion activities of similar extent. This may be due, in the first place, to the secondary position of mental health compared with physical health, but also to the fact that the mainstream orientation of mental health promotion has remained at the level of individuals.

Several efforts aiming to enhance the value and visibility of mental health have been made. One good example of these activities is the World Mental Health Day, a project repeated every year by the World Federation of Mental Health. In the UK, where health promotion is embedded institutionally in the National Health Service, this campaign has been launched effectively with the help of local players. The results, an increase in awareness of mental health issues, in administration and the service sector and also among the public, have been promising.

3.3.2. Empowerment

Empowerment is a concept referring to positive approaches leading to better self-control of health and related issues. The focus of interventions is systemic rather than problem- or disorder-oriented.

Social interaction

'Friends can be good medicine', a community-based mental health promotion study, used the mass media to provide education about the role of supportive relationships and to encourage people to invest more in their relationships with others. The campaign in the media was backed up by community activities. It was found that the campaign had a measurable impact on knowledge, attitudes, behavioural intentions and support enhancing behaviours. The results were maintained over the course of a year (Hersey et al. 1984).

Strengthening community action

'Drivkraft' - 'Driving Power' (translation by the authors) is a campaign launched by a regional health authority in Sweden. It provides a framework for developing the school environment without restricting or focusing efforts in any significant way. The programme provides a structure for the process of development. The needs evaluation is made by the students and teachers together. Preliminary results show that the programme has had a positive impact in the schools that have adopted it. The physical environment, the social climate, communication practices and the potential for democratic influence have all improved (Folkhälsogruppen, oral communication). Further evaluation of the programme is in process. This innovative programme seems to be unique in that, although developed by a health authority, the approach is not limited by medical thinking.

Community-based programmes

Dalgard and Tambs (1997) recently reported the findings of a longitudinal study on the relationship between mental health and the urban environment. The study was carried out through questionnaire-based interviews in five types of neighbourhood. Ten years later, the interviews were repeated using the same questionnaire. Between the interviews, only one of the communities, an initially poorly functioning neighbourhood with poor mental health among the residents, showed substantial improvement as part of further development of the area. Specific interventions seeking to foster social participation and interaction were also carried out. Along with the improvement in the social environment

there was a significant improvement in mental health among those who continued to live in this area, as opposed to those who continued to live in the other areas.

3.3.3. Support and protection of children, young people and families

There is a large volume of studies focusing on the mental health promotion of children, young people and families. These studies can be classified in many ways. The following examples of effective programmes concern children of pre-school and school age.

Parent-child interaction

In a programme focused on the parent-child interaction of pre-school children, the parental intervention included group training, involving instruction and role-play practice. Individual sessions consisted of modelling and conversation exercises, story reading and dramatic play with the child. At one year follow-up, ratings regarding hostility, anxiety and hyperactivity showed significantly greater improvements in the intervention group than in the control group (Strayhorn and Weidman 1991).

Coping strategies in pre-school children

Another programme, carried out in a nursery, focused on interpersonal problem-solving in young children. The intervention consisted of daily 20-minute sessions over a period of eight weeks. Children were taught skills to help them think about solutions and consequences relevant to hypothetical interpersonal problems. Pictures, puppets and simple role-playing techniques were used to facilitate these processes. A significant amount of the behavioural gains observed seemed to be due to the children acquiring new cognitive skills. Identified aberrant behaviours in the intervention group were less likely to persist to the end of kindergarten (Shure and Spivack 1982).

Deprived families with children

The *Houston Parent-Child Development Centre project* looked at the children of families suffering from economic deprivation and with poor family management practices. Mothers were visited in their homes, where the project provided 25 lessons of 1 1/2 hours each. Topics included awareness of developmental processes, support for language development, encouragement of curiosity and promotion of cognitive development with the aid of inexpensive toys. In the second year of the intervention, mothers and their children attended a special centre for four mornings a week, where they were taught home management and how to cope with problem behaviours. At follow-up, teacher ratings reported better cognitive competence, less obstinate, disruptive and aggressive behaviour and lower rates of grade retention in school (Johnson 1990, 1991).

Mental health services for families and children

A community-based mental health service was set up for families with children of pre-school age in which the children had emotional and behavioural problems, the parents parenting difficulties and the family psychosocial problems in general. . Interventions were home-based and conducted by health visitors and paediatric community medical officers trained in parent counselling, parenting issues and child-behavioural management. The approach was to create a respectful partnership with the parents. The aims were to promote and support the parents' own exploration of the identified problems, and to help them establish clear aims and problem management strategies (Davis et al, 1996). As a result of the programme, self-esteem improved and levels of stress, anxiety and depression were reduced. There were also clear improvements in the behaviour of the children. (Davis and Spurr 1996).

Developing teaching practices

A project carried out in a school setting involved a change in teaching practices. The objectives were greater involvement and more effective learning for low-achieving students. Teachers attended a training course with three main components: proactive classroom management, interactive teaching and co-operative learning. Low achievers in

experimental classrooms showed more favourable attitudes to school, higher expectations of continuing in school and less serious misbehaviour in school (Hawkins et al. 1988).

Psychosocial and learning problems

Carefully designed preventive studies have been reported by Kellam and Rebok (1992). The intervention in this case involved two programmes among first-grade children: a mastery learning programme designed to strengthen reading skills, and a good behaviour game, which is a team-based management strategy promoting co-operative behaviour among shy and aggressive children. The good behaviour game resulted in a reduction in aggressive and shy behaviour and the mastery learning intervention improved reading skills of low achieving boys. The intervention group also had better outcomes in long-term follow-ups (Kellam, oral communication).

3.3.4. Examples of approaches promoting mental health in adults

Several studies, using diverse approaches, have reported effective programmes seeking to promote mental health in adults.

Relationship skills

A relationship enhancement programme was set up with the goal of preventing problems from developing in couples' relationships rather than focusing on solving current problems. Couples learnt a set of skills, techniques and principles designed to help them manage negative emotions and foster positive communication. Couples practised using the skills while receiving feedback from trained consultants. Evaluation at 4- and 5-year follow-ups showed that couples who participated in the programme were less likely to break up or get divorced (Markman et al. 1993).

Work-related programmes

Vincour et al. (1991) have reported the results and given a cost-benefit analysis of the *Jobs programme*, a long-term preventive intervention programme among the unemployed. This intervention was designed to enhance job-seeking confidence, increase motivation and reduce the negative feelings that often accompany rejection and disappointments in the job-seeking process. The programme was implemented over eight 3-hour sessions, which focused on job-seeking skills, finding and initiating job leads, writing a CV, sharing information and rehearsing job interviews. The intervention group found jobs more quickly, had higher job-seeking confidence with increased motivation, and were more likely to be better paid and have more job stability than the control group.

Preventing depression in primary health care

A depression-prevention programme among Spanish speaking women attending primary care services has been reported by Munoz and Ying (1993). The intervention consisted of eight 2-hour weekly sessions, which focused on the relationship between thoughts and feelings; the manner in which thoughts and activities influence mood; the search for pleasant activities; the construction of social relationships; and planning for the future in thinking preventatively. Significant benefits were shown at one year follow-up, as measured by the Beck Depression Inventory.

Postnatal depression

A group of women identified as depressed six weeks after giving birth received counselling from health visitors in ways of managing and reducing depression. The intervention consisted of eight weekly counselling visits lasting at least half an hour each. The emphasis was on the importance of listening to the women and encouraging them to make their own decisions. Sixty per cent of the women in the intervention group compared with 38 per cent in the control group showed no evidence of major or minor illness at follow-up (Holden et al. 1989).

Support of caregivers
A controlled trial of social intervention in families with schizophrenic members had three psychoeducative components: a short educational programme of two sessions on the aetiology, symptoms, course and management of schizophrenia; a relatives support group; and family sessions which included the patient and were held at home. The relapse rate in the intervention group was much lower than that in the control group (Leff et al. 1985)

Preventing schizophrenia in primary care
In a study focusing on early detection and family-based treatment of schizophrenia, a questionnaire on early symptoms was used in a primary health care setting. Individuals, identified by the screening questionnaire, their families and other persons important to those identified were given a psychoeducational, outpatient-based treatment package. Primary care physicians supervised by experts were responsible for the medical aspects of the treatment. The overall outcome of the project was good, resulting in much less use of hospital care and, it is claimed, a drastic reduction in the incidence of schizophrenia in the area (Falloon and Fadden 1993).

3.3.5. Promotion of mental health among the elderly

Studies regarding ways of promoting mental health among the elderly have not been reported extensively.

Crisis intervention
'Widow to widow', a programme focusing on bereavement, is one of the few examples in this area. Targeted at the newly widowed elderly, it relies on social and emotional peer-support, seeking to facilitate higher levels of social interaction and new social roles. The intervention involves one-to-one support by another widow, help in identifying community resources and small group meetings. Widows who participated in the programme were more likely to have started new relationships and activities than were those in a randomised control group. They also experienced fewer depressive symptoms.

3 Priorities for policy and action

1. Enhancing the value and visibility of mental health

1.1. Introduction

There are many examples of large community-based health promotion programmes, especially those focusing on cardiovascular diseases, which have been supported with public funds and gained remarkable visibility. These programmes, such as the North Karelia Project and Heartbeat Wales, have also been evaluated in depth.

The literature lacks reports of mental health promotion activities of similar extent. This may be due, in the first place, to the secondary position of mental health compared with physical health, but also to the fact that the mainstream orientation of mental health promotion has remained at the level of individuals.

Several efforts aiming to enhance the value and visibility of mental health have been made. One good example of these activities is the World Mental Health Day, a project repeated every year by the World Federation of Mental Health. In the UK, where health promotion is embedded institutionally in the National Health Service, this campaign has been launched effectively with the help of local players. The results, an increase in awareness of mental health issues, in administration and the service sector and also among the public, have been promising.

1.2. Relevant knowledge

As shown in the previous section, the mental health policies and practices of the Member States cover a diverse range. Some of the Member States do a lot is done in the field, others lack policy level strategies altogether. Administrators and decision makers have long acknowledged the relationship between physical health and the ability to engage in daily activities. Health protection has, however, usually concerned only physical

health, and evaluation of impacts on physical health has become a relevant criterion in decision-making in industrialised countries. The importance of mental health has hitherto been less explicitly recognised and valued.

The promotion of mental health has also been given less attention than the promotion of physical health. Massive resources have been poured into, for example, community-based programmes to prevent cardiovascular diseases and campaigns to prevent road accidents. Corresponding efforts have not been made in the field of mental health, despite evidence of effective intervention measures.

Resources can be allocated to different areas of health on the basis of data on mortality, morbidity, disability, effectiveness and quality of procedures or on the basis of values. In many societies, mortality data have played a central role, partly because it has been easier to collect convincing national data on mortality than on health. Many studies have shown that mental disorders also contribute to a clear increase in the mortality rate. The most frequently used indicator of mental health has been the suicide rate. Yet, it is clear that promotion of mental health cannot be motivated solely by increased mortality due to mental disorders.

Authorities responsible for the development of health services do not give attention to mental health and services to promote mental health in the same way as they do to physical health, although mental ill-health results in increased use of both primary and somatic secondary care. That mental health receives less emphasis than physical health is indicated by, e.g., economic figures. Investments in mental health services, in which the human resources of professionals play the main role, tend to be scarce compared with those in the technological development of physical medicine.

Mental health has also remained in a secondary position in schools and the occupational health sector. Companies and organisations have occupational health policies focusing on physical health but not explicitly and directly on mental health or on working environments and organisational structures supporting mental health. Many schools include education about physical health matters in their curricula. Topics cover the importance of physical exercise, diet, contraception and safe sex, and the risks of alcohol and drug abuse. However, it is still unusual to

find schools paying attention to mental health education, for example, teaching coping skills, self assertion or negotiating techniques, parenting skills, relationship skills, preparing for life's major transitions etc. Even more unusual is to find schools consistently emphasising qualities supportive of mental health in the work and environment of the school.

To some extent, mental health has also been forgotten by epidemiologists focusing on the burden of disease. For example, the World Bank Report of 1993, which made the immense burden created by mental disorders unequivocally clear, did not include mental health services in the minimum set of essential clinical services it proposed.

1.3. Current challenges

The European Commission and the governments of the Member States need to be sensitised to the public health importance of mental ill-health. At national level, the lack of *policy frameworks* emphasising the importance of mental health poses a major barrier. The awareness of governments and policy makers concerning mental health issues must be raised. This process should be advocated by a body of experts in the area.

Enhancing the visibility of mental health in decision-making also calls for tools for mental health *needs assessment*. There is a need for mental health indicators which focus on mental health, mental ill-health and related services.

There is a clear need for *public health education* in mental health issues. Public health education should focus on areas such as general knowledge of mental health, self-care possibilities, and availability and the use of mental health services. It is also important to reduce the stigma linked with mental ill-health and to stress that mental ill-health can be prevented and treated effectively.

There are some *key principles* that need to be borne in mind when planning campaigns to enhance the value of mental health. It is essential to:

- emphasise the early years of life, because behavioural tendencies, coping strategies and core values are all shaped in early life and are more difficult to change later
- ensure that mental health education messages, while being disseminated in different contexts by different agencies, are mutually supportive, not contradictory, in both content and principles
- translate the complexities of mental health promotion processes and outcomes into language that everyone can understand, in order to underpin the commitment of different sectors of the population
- recognise that enhancing the value of mental health will inevitably have implications for many spheres of life.

1.4. Key areas of action

1. Public campaigns

What was said above and in the other sections of this report emphasises the importance of supporting campaigns to enhance the value and visibility of mental health. The campaigns should place special emphasis on messages:

- acknowledging that mental health is an essential component of general health
- indicating that mental ill-health can be both prevented and treated
- describing self-help methods
- aiming to reduce the stigma caused by mental ill-health.

The use of modern telematic means will greatly help to increase the visibility of mental health issues in all sectors of society.

2. Basic education
The topic of mental health should be included in several subjects in comprehensive schools. Moreover, mental health instruction should be highlighted in school health education. Teachers need special postgraduate training and supervision to help them with these questions.

3. Professional training
Mental health issues should be integrated thoroughly into the curricula of professional educational institutions. The role of mental health, the importance of the promotion of mental health and practical counselling skills should receive special emphasis in such sectors as education, health care and the social services.

4. Integration
Better results can be achieved when issues related to mental health are integrated into all health promotion campaigns and programmes focusing on communities, special settings or individuals. Assessment of the workplace atmosphere and of other mental health issues together with assessment of physical risks should become a routine measure in occupational health care systems.

5. Mental health impact evaluation
Every major political decision that has an impact on the everyday life and well-being of people should be preceded by a mental health impact evaluation as is already done for our natural environment. Support should be given to campaigns introducing this practice in decision-making at national, regional and local levels.

2. Empowerment, participation and Information Society

2.1. Introduction

All human beings have an equal right to physical and mental health. Equity in mental health implies that social differences in mental health are narrowed and that all people have equal opportunities to improve or maintain their health. Equity should be a basic priority in all mental health promoting actions. Commitment to the needs of the most deprived groups is required in all health promoting actions and resource allocation.
Discussion of mental health, marginalisation and deprivation cannot bypass issues linked with societal development as such. The Information Society can pose a significant threat to people who suffer from mental health problems or belong to certain risk groups. The use of new technologies could, however, be harnessed to create a more inclusive society.

2.2. Relevant knowledge

Owing to their circumstances, many severely disabled persons have to rely on others for their practical needs. There is nothing unusual in medical experts or family members taking over the decision-making of disabled persons. Experiencing lack of control over one's own life may lead to emotional difficulties, i.e., lowered self-esteem and a sense of worthlessness.
The bulk of the major determinants of physical and mental health are environmental risk factors. Poor housing, long-term unemployment and ethnic and racial discrimination have clear negative outcomes from the viewpoint of psychosocial well-being. Influencing these factors lies outside the jurisdiction of mental health services.

It is essential for the promotion of mental health that other sectors (e.g., educational, housing and employment policies) take the mental health consequences of their policies into account. More supportive physical

and social environments are needed, to enable the deprived groups to expand their capabilities, mitigate their psychological distress and boost their self-esteem.

Empowerment and strengths-based models encourage us to look at mental health and well-being as inherently relational processes linked with everyday practices. The core of these views is the conviction that mental health has a lot to do with how well people treat each other and themselves in the various domains of life. Empowerment-based approaches therefore have natural links with concerns related to equity and participation. At the same time it is evident that problems of mental health do not have to be viewed only in a medical perspective. They can also be conceptualised as exclusion from health- and well-being generating practices and interactions. Indeed, studies which have focused on the social environment and community development have given promising results.

The implications of current social and societal trends in Europe are multiple. The *increasing use of information and communication technologies (ICTs)* is reflected both in the ever growing amounts of information available to citizens and in the increasingly knowledge-based production of goods and services. The general tendency is from hierarchical work organisations with simple jobs towards more decentralised and network-oriented organisations with complex jobs requiring higher qualifications.

All this will have significant consequences for the qualifications needed to find and keep a job. The development of ICTs will bring about changes in the roles of professionals and citizens / users. These technologies create new threats for mental health and add to the risk of professionally less qualified citizens being marginalised.

By no means all rewarding and socially integrating activities can, of course, be implemented, organised or even supported telematically. It is also true that not all people can have access to or afford to subscribe information technology services, or live in locations where the information infrastructure is well-developed. Moreover, there are people who find ICT-based services difficult to use. All these difficulties are more common among those with severe mental disorders.

Thinking about mental health promotion and social inclusion in terms of the Information Society prompts two general conclusions. Because it stresses the active role of citizens and makes relevant information more

easily available, advances in the Information Society support health promotion approaches, making them *more citizen- or client-driven and strengths-based*. Activities aiming at mental health promotion should rely predominantly on *clients and people's own ideas, intuitions and preferences,* on what clients and the representatives of their social networks have themselves done, can do, or could do to change things for the better. This direction means that activities based on peer-help and self-help should be more vigorously encouraged and supported.

Recent studies of the efficacy of self-help and peer-help activities in mental health have shown that, in the long run, these forms of action are effective, being in many cases as effective as or even more effective than professional interventions. It has also been noted that the results of rehabilitative action and re-employment efforts targeted at persons with mental health problems are more successful if they are based on the preferences and genuine motivation of the people themselves.

Using expressions such as 'mental health telematics' and mental health promotion telematics' in Internet searches produces a wide range of responses. The exercise shows that activities in this new field are more or less haphazard. In addition to the numerous telematic information sources linked with privately run data banks, practices and services, there are numbers of home pages with separate sections for and links to self-help material. So far, however, there has been a lack of studies or serious evaluative efforts concerning the telematics of mental health. The few studies done represent more traditional medical/psychiatric approaches (telediagnostics, teletherapy) and do not share a health promotion perspective.

2.3. Current challenges

Despite the need to emphasise community participation, self-help and other empowering approaches in the promotion of mental health, it is important to recognise the potential of ICTs. In the field of mental health promotion, ICTs could be used, for instance, to:

- support the implementation and integration of mental health-related R&D programmes

- help in the dissemination of information and knowledge concerning good models and practices serving both citizens and users of mental health and employment facilities
- disseminate educational material
- give specific groups of people with mental health problems new opportunities for learning computer and Internet-related skills

Some forms of telematic services could fulfil many of these functions simultaneously. An example could be an electronic, telematically distributed magazine available for all those interested. New resources can often be created at a low cost with the aid of enhanced networking made possible by telematics. The benefits of participation in telematically supported networks will come from the increased availability of new information and knowledge resources, from the enhanced joint planning and organisation capacity and from various training and conference modalities made possible by ICTs. Through the integrative and supportive functions of telematic systems, the participating organisations, projects and programmes will develop not only common forums but also various practical links and synergy.

The EU funds a small number of projects explicitly related to mental health or mental health promotion. Searching Cordis using the words 'mental health telematics' produces only four projects. There are some telematics-linked efforts focusing on social exclusion (e.g. Periphera and Epitelio) in which issues relating to mental health are relevant. What is definitely lacking are mental health promotion and mental well-being related ICT applications:

- run by public authorities and targeted at large sectors of the population
- integrated with national or EU-level R&D activities
- constructed jointly and systematically by professionals and the users;
- assessed for their quality and usefulness
- combining mental health promotion with other strategies for countering social exclusion
- backed by mental health promotion-oriented views

2.4. Key areas of action

Efforts of the following types would clearly deserve support:

1. Seeking to enhance community-based mental health promotion action

This can take place through a search for routes for social participation and common values and goals in the community. Self-help or peer-help groups, social clubs, cafes, centres where people can live independently, clubhouses and half-way houses are needed for the homeless, severely disabled, those recovering from mental illness and other disadvantaged groups.

2. Approaches aiming to change the physical and social environment

Many of the determinants of social inequalities in mental health are beyond the scope of the health care system. Besides other approaches, broader policies are needed that aim to incorporate structural improvements in living and working conditions, i.e., making initiatives in education, labour, welfare and housing policies. Better education, housing, etc. are needed to enable the deprived groups to expand their capabilities, mitigate their psychological distress and develop their self-esteem.

3. Strenghts based approaches

Attempts to raise awareness concerning empowerment and strengths-based approaches and effective forms of self- and peer-help are necessary.

4. Telematic content and interphase

Innovative projects seeking to deepen knowledge of how to develop 'good telematic content' and 'good telematic interfaces' in the field of mental health promotion should be established. The work should involve both users and specialists.

5. Research and development
Studies attempting to outline how mental health services and efforts focusing on prevention and promotion should be reoriented in the light of societal changes correlating with Information Society development.

6. Networking
Setting up an European network or forum focusing on the telematics of social inclusion and mental health promotion will stimulate the field.

3. Towards mental health promoting working life

3.1. Introduction

Important aspects of mental health are social integration and a person's opportunities to fulfil his / her social roles in a satisfying and useful way. Regarding the adult population, special emphasis should be given to the mental health promoting aspects of work places and the work process itself.
Work influences an individual's life in many ways. It imposes a time structure on the day and enforces regularity of activity. Work unites people in the striving for collective goals and purposes that transcend their own. It implies regularly shared experiences and gives a person a sense of belonging. It also permits goal-oriented interaction with others and mutual social support. Work can provide an opportunity to acquire and enhance skills, and it defines important aspects of the worker's identity and status.

Thus, many of the essential ingredients of mental health and well-being are interwoven with work and employment. In mental health promotion, it is important to develop positive aspects of work and enhance positive social interaction at work places as well as to find ways of controlling psychosocial health hazards.

3.2. Relevant knowledge

Rapid changes in working life, an increase in job demands and ageing of the work force are common features throughout Europe today. Requirements for flexibility and a wider range of work skills have become more common. Moreover, in many work tasks, the need for social skills has increased.

During the recession of the 1990s, many work places trimmed the number of their personnel. This means that a smaller number of employees are trying to cope with a growing work load. Psychological stress has increased along with the hectic pace. Studies show that physical and mental exhaustion and symptoms of burn-out have also increased. At the same time, the unemployed are facing marginalisation and the risk of dropping out of the active work force permanently.

There are several factors at a work place that can promote employees' psychosocial well-being and mental health. According to experts the following nine features are especially important in this respect:

1. Opportunity for control: this refers to the opportunities provided by a job for the person to control activities and events at the work place, e.g. the opportunity to decide and act in one's chosen way and the potential to predict the consequences of one's action. Of all the environmental influences, the opportunity for control is thought to be the principal foundation for mental health.

2. Opportunity for use of skills: A related feature is the degree to which the environment encourages or inhibits the utilisation or development of skills. Opportunities for skilled performance ensure personal development and growth at one's job and are a crucial element in job and life satisfaction. It is important that the opportunities for action perceived by the individual should be equal to his or her capabilities, i.e., the challenges should be balanced by the person's capacity to act.

3. Externally generated goals: A third feature important for mental health is the presence or absence of goals generated by the environment. An environment which gives rise to the creation and pursuit of goals is thought to lead to activities which both intrinsically and through their consequences have a positive impact on mental health.

4. Variety: Sometimes externally generated goals and associated actions are repetitive and invariant. Variety is crucial for mental health since it can introduce novelty and break up excessive uniformity of activity and location.

5. Environmental clarity: The fifth feature important for mental health concerns the degree to which a person's environment is clear or opaque. Environmental clarity consists of a) the availability of feedback about the consequences of one's actions, b) the degree to which other people and systems in the environment are predictable, i.e., the possibility to develop a conception of the future, and c) the clarity of role requirements and normative expectations.

6. Availability of money: A positive relationship between income and mental health has been reported in many studies.

7. Physical security: Environments need to protect a person against physical threat and to provide an adequate level of physical security. Many physical and chemical factors at work places produce emotional reactions and lower job satisfaction.

8. Opportunity for interpersonal contact: Interpersonal contacts reduce feelings of loneliness and meet personal needs for friendships. They give opportunities for social, emotional and instrumental support at work places. Many goals can be achieved only through the interdependent efforts of several people. Many tasks in the modern work place can only be accomplished through team work and joint efforts.

9. Valued social position: From the viewpoint of mental health, it is good to have a position in a social structure which carries some esteem from others. Usually, a person is a member of several social structures.

Other experts have put special emphasis on the role of job demands, decision latitude and social networks in employees' health and well-being. In 'active work' the individual has high job demands and good opportunities to affect his/her work. Active work brings about new learning opportunities, improves work skills and increases mastery of work. In 'passive work' the reverse holds true: the demands of work are low but there are no opportunities for control, either. This situation may have such effects as disruption of acquired work skills, frustration, loss of work motivation and job satisfaction, and finally problems in well-being and health. However, the most stressful situation is the one in which the job demands are very high, but decision latitude is very low. Increasing stress leads to health problems and problems in carrying out work tasks.

The processes of involuntary employment transition, rationalisation in the private sector and privatisation in the public sector seem to have negative mental health outcomes. In all of them, the anticipation phase includes many uncertainties, as the change approaches but the employees are not sure how they will be affected. According to studies, fear of job loss or changes in employment make significant contributions to depression and other psychological morbidity.

3.3. Key areas of action

Strategies based on traditional occupational health actions usually aim at treating an employee's psychiatric symptoms or enabling him / her to deal with them. Many work characteristics are, however, clearly associated with workers' mental health and well-being. From the viewpoint of mental health promotion, more comprehensive approaches are needed. The action should aim both at enabling employees to deal with their problems and, at the same time, to develop the work process and the work environment. When strategies are planned for mental health promotion, special attention should be paid to those intrinsic and extrinsic factors at the work place that have been found to be important for employees' psychosocial well-being and health.

It it of importance to note that the same actions that maintain and advance the mental health and welfare of employees prevent the economic losses caused by impaired working capacity. Many large companies now realise that their employees' productivity is connected with their health and well-being. More emphasis has however, been placed on physical rather than mental health and well-being. It is important to raise employers' awareness of work stress and mental health issues and of the possibilities for mental health promotion at work places.

Eight action areas or strategies in mental health promotion at the work place can be listed:

1. Campaigns to raise employers' awareness of mental health issues and of the importance of maintaining and promoting the mental health and working capacity of their employees

Special emphasis should be given to a) the connections between employees' mental health, working capacity and productivity, and b) the mental health consequences of the employees' opportunities for control, skill use and learning. Information on *good practices in maintaining and promoting the working capacity and mental health of employees should be gathered and disseminated.*

2. Identifying common goals and enhancing the positive aspects of the work process and environment

Efforts should be mobilised to enhance employees' participation in identifying common goals and principles at work.

Actions should be targeted at making the work environment more supportive of the mental health and psychosocial well-being of employees. Attention should be paid to redesigning jobs so that they give better opportunities for mental growth and development and use of skills. Another strategy would be to assist workers in recognising opportunities for action, to set goals that are reachable and make the work process innately rewarding.

Measures might include increasing the decision latitude at work, improving employee participation, decreasing role ambiguity or role conflict, and enhancing the variety of work tasks. Especially important would be actions to improve and develop the leadership practices of foremen and

supervisors (e.g., giving social and instrumental support and giving feedback at different phases of the work process). Supportive managers or supervisors could prevent work overload by allocating specific tasks only to persons capable of handling them well, and role ambiguity by giving clear, straightforward directions.

3. Creating a balance between job demands and occupational skills

One of the most important sources of stress is the feeling that one's work skills are not compatible with the work tasks. Both from the viewpoint of the employee and the employer it is useful to balance the opportunities for action against the person's capabilities. Measures include support and counselling in career planning, securing possibilities for continuous learning and skill development at work, securing opportunities for training, and arranging possibilities for skill use.

4. Social skills training, improving possibilities for collaboration, and creating joint opportunities

At present, many jobs presuppose good social and co-operative skills, and problems in collaboration seem to be a major source of stress in certain occupations. Practising these skills in various groups, including representatives from different occupations or even firms or nations, could be both motivating and useful from the viewpoint of both productivity and mental health. This might also include improvements in the physical work environment that would enhance the prospects for true collaboration.

5. Developing the psychosocial climate at the work place

Interpersonal conflicts at work increase the employees' work stress and have a negative impact on job satisfaction and mental well-being. They can cause depression, sleep disturbances, alcohol and drug abuse and lowered working capacity. Extreme cases of scapegoating and psychological harassment at work places may have very severe consequences such as suicide. Conflict situations need to be worked out and open discussion on social relations encouraged. Interpersonal conflicts

are sometimes caused by organisational problems, i.e., role ambiguity or role conflict. Solution-focused approaches to these problems are recommended.
Joint opportunities for relaxation and physically and mentally stimulating leisure activities (literary clubs, sports clubs, hobby circles) can create mental well-being in the work community. Physical activity and keeping fit have positive effects for mental well-being.

6. Counselling targeted at employees before organisational or other changes (crisis intervention)

Counselling should be offered individually or in groups before or during organisational changes and other transition phases. Measures might include stress management, coping with anticipated change, encouragement for realistic expectations, career planning, etc.

7. Counselling and social support targeted at special groups

Employees with mental health problems or physical disabilities may need counselling or social support at the work place. The accessibility of social support should be as good as possible. During the last 10 years, what are known as 'natural supports' have started to function at many US work places. The possibility of such a supports should be assessed in Europe, too. More attention should be paid to the ways in which help is sought and offered in work places.

8. Enhancement of working capacity and early rehabilitation strategies

Taking care of employees' working capacity and mental well-being should be given priority in all companies and work places, whether large, medium-sized or small. According to the multidimensional model of working capacity, attention should be paid to employees' physical and mental resources and coping skills, occupational skills and abilities as well as to

the situational aspects and social context of the work place. Special attention should be paid to employees with disabilities or at risk of lowering their working capacity.

9. Guidelines

Plans for and the implementation of mental health promotion activities at the work place should take the following guidelines into account:

1. The benefits and advantages of the activities should be assessed with the groups and individuals involved in them, i.e., strategic choices should be shared by the key shareholders.

2. The commitment and participation of individuals and groups should be enhanced. At many work places, policies and practices are changed without reference to employees, although awareness has started to grow of the importance of involving staff in shaping companies' health promotion programmes.

3. Activities should be based on intersectoral collaboration. The management and personnel departments of work places, labour unions, workers' representatives and so on should be involved more closely in health promotion programmes; sole responsibility should not be left to occupational health specialists.

4. Successful activities are usually comprehensive, i.e., not only individuals but also their environment should be taken into account.

5. The processes and impact of activities should be analysed, discussed and made available. Identifying good practices and learning from failures are important prerequisites for good programme development.

4. Unemployment, underemployment and re-employment

4.1. Relevant knowledge and current challenges

At the present time, unemployment poses a serious threat to European citizens. Technological change and the decline of many manufacturing industries have led to increasing unemployment and doomed many people to a life with no possibility of paid work. According to several studies, redundancy and unemployment are associated with impaired mental health and psychosocial well-being.

In Western countries there is a strong normative belief that paid employment is a socially acceptable means of earning a living. The strong emphasis on the importance of paid work - reinforced by education and social institutions - often prevents the unemployed or non-employed from seeing their increased free time as an opportunity for creative leisure. However, there are many goal-directed activities outside paid employment that could be similarly rewarding, e.g. household maintenance activities, child care, the pursuit of hobbies and a whole range of leisure pastimes.

Mental health promotion actions should include other non-employed groups such as housewives and members of farming families, who are easily marginalised from the mainstream services.

The danger of increasing anxiety and depression and lowering of self-esteem during changes in employment status has been pointed out in many studies. Especially if sufficient income and meaningful work outside employment are not provided, the loss of control is likely to lead to general passivity. Loss of a time-perspective, apathy, helplessness and social isolation and disintegration have all been reported as possible outcomes of long-term unemployment. They may cause problems for eventual later employment, even when labour market conditions have improved.

The effects of unemployment are not universal, for a small minority of people show gains in mental health after losing their jobs. With some people, stable unemployment is a better alternative than physically or mentally distressing work or living with the continuous uncertainty of losing one's job.

The psychological effects of unemployment depend very much on people's social networks and opportunities for social support. Those with strong social supports suffer less psychological damage. If work has been the only source of motivation, losing one's job is especially disturbing. Persons with long stable careers or strong career prospects are particularly vulnerable, notably single men with few relatives or friends. Health consequences can be especially serious for young people who have never had a chance to adapt to working life. There is evidence that unemployment may lead to increased alcohol consumption, particularly among younger men.

High unemployment also affects the social atmosphere of the community. It influences the lives of those who are not directly affected, by bringing about a sense of insecurity and loss of control. It causes mental distress to the families and friends of the unemployed, to those who fear that they or their children may become unemployed and to those whose career prospects are impaired in this situation. Unemployment can lead to erosion of the foundations of society. The costs of these mental health consequences of unemployment are hard to measure.

4.2. Key areas of action

1. Evaluation of the costs

Many governments have not taken full account of the real costs of unemployment, which - besides the loss of potential output - include the psychosocial and mental health consequences of unemployment. Economic evaluations of these costs are needed. Mental health consequences should be taken into account when assessing the economic costs and benefits of rationalisation activities, on the one hand, and job creation activities, on the other.

2. Adressing stigma and values

Efforts should be made to change educational and social ideologies in society to prevent stigmatisation of unemployment. Paid employment should not be so heavily emphasised. An especially important task would

be to change attitudes towards the unemployed and non-employed. At present, the sense of being excluded, not needed and without purposeful activity constitutes a great psychological burden for such people. There are nevertheless clear positive advantages to staying outside paid employment, e.g., parents can have more time for children and there is time for active participation in community activities. Also, the value of work done by housewives and members of, say, farming families should be emphasised in public.

3. Re-employment

Re-employment has been shown to be one of the most effective ways of promoting and protecting the mental health of the unemployed. Both active job creation and more individual measures are needed: a) An active labour market policy and different forms of job creation (e.g. support for entrepreneurship, work co-operatives) should be used to prevent long-term unemployment. b) Unemployed persons' chances to get jobs should be increased by developing their physical and mental resources. These activities could include career counselling, vocational training, supported training (e.g. for older job-seekers) and training in social and job-seeking skills, but also multimodal activities enhancing and improving their working capacity, health related activities, coping skills and labour market abilities.

4. New forms of work

Intermediate statuses between work and unemployment should be actively sought. More opportunities for social integration and participation are needed for persons outside the labour market. These could include different forms of voluntary work, social clubs, member communities, social firms and work co-operatives. These activities should also be available to those who are not employed due to physical or mental problems. Young unemployed or non-employed people are in particular need of possibilities to exercise purposeful activities outside paid work, e.g. in workshops, clubs and hobby circles.

5. Supporting programmes
Different kinds of multimodal programmes, e.g. counselling, coping skills and stress management training, assertiveness training and time management should be available for groups at special risk of passivity, depression, isolation and other forms of severe marginalisation. Special risk groups include men living alone, those who have dropped out of a long and stable work career or aged workers (over 55 years). These groups may become alienated from mainstream services and society at large and therefore special attention should be paid to lowering the threshold for help-seeking.

5. Support and protection of children, young people and families with children

5.1. Introduction

Children and adolescents represent the future, the development and the renewal of cultures and societies. They are thus a deposit of resources that enliven and improve society. Children are not only the promise of a better future but they also bring joy to the present, adding to the well-being of people and societies.

Hence it is understandable that societies should try to promote conditions that foster children's healthy development and well-being by providing support to families, for instance, in the form of financial benefits such as paid parental leaves and child allowances. Other important prerequisites for children's health and well-being are good housing, good community planning and satisfactory working conditions for the parents. Services such as day care facilities and schools for the children and primary health care services for both them and their parents play an important role in mental health promotion.

Where children are concerned, the preventing and promoting role of the health care services is important for the whole life span. It is important that the forms of support provided for adults should also address their parenting and relationships with their children.

5.2. Relevant knowledge

The promotion of mental health and prevention of mental disorders in childhood are essential for a number of reasons. The importance of the first few years of a child's life for later personality and social development is well documented. Interventions to promote mental health in the early years have been shown to be the most effective also for promoting good parenting and preventing child abuse and neglect. In contrast, adverse conditions during these years may result in vulnerabilities that jeopardise developmental outcomes or mark the onset of psychiatric disorders

The prevalence rates of emotional and behavioural disorders among children and adolescents are alarmingly high, ranging from 12% to 20% in various studies. Only a relatively small proportion (10-15%) find their way to mental health services, added to which it is not certain whether those who receive treatment are the ones most in need. The literature also suggests that by the time disturbed children and their families reach mental health services, the disturbance has already existed for so long that their quality of life has already deteriorated and the outcome of treatment is likely to be of limited value. As a result the actual cost of effective therapy, not to mention the social and indirect financial cost, is high, being both time consuming and requiring highly trained personnel.

Much is known about the risk of and protective factors in developmental and mental disorders in children. One major route to developmental vulnerability is a social environment deficient in resources and functions. There are three main signs of such an environment: poverty or low socio-economic status; vulnerabilities of parents, affecting their capacity to adequately care for their children (such as very young age, disturbances in mental health, stressful life events, poor family functioning); and lack of social support.

According to recent research, interventions focused on the time around a baby's birth are the most effective in preventing mental health problems in children. The quality of early relationships and the interaction between the child and the caregivers have been shown to be of great importance in both mediating and alleviating the harmful effect of existing risk conditions.

Good relationships in the family represent a great resource of satisfaction, providing a buffer against adverse experiences in life. Good early relationships promote mental health for parents and children alike. Furthermore, promoting mental health of children is essential because untreated impairment in the early years persists into later childhood and adulthood and is responsible both for individual suffering and for great cost and concern for society.

Mothers of small children increasingly have jobs outside the family. This trend, together with changes in family structure, makes it necessary to look at the situation of children at EU level, not merely national level. Increased mobility across the borders of countries creates new demands for understanding different ways of parenting in different cultures.

5.3. Current challenges

Data collection and statistical information should be reviewed in the perspective of children and adolescents: what do they tell us about the living conditions of children and their use of services?

New knowledge is needed about mobility, unemployment, poverty and violence as experienced by children and adolescents. Children's good experiences of education, peer relationships, hobbies and sports should guide both the allocation of resources and planning of actions.

At population level greater efforts should be made to promote understanding of the importance of children's needs and good parent-child interactions as the basis of sound psychosocial development. Professionals working in social or health care need to be trained to foster satisfactory parent-child interactions and to support parents in their parenting role. This should become a multiprofessional commitment.

Many European countries have established an efficient network of primary health care services. The traditional task of these services has been to monitor the physiology of pregnancy and growth, and the normal development of children. The good quality of perinatal care throughout these health care systems should be stressed, as the early detection of minor impairments increases the possibilities for early rehabilitation and

a good developmental outcome. To promote the mental health of children and families, primary health care services need to pay more attention to the psychosocial aspects of pregnancy, to encouraging a good early parent-child interaction and to supporting the problem-solving skills of parents.

To achieve this end, new, adequate training programmes need to be developed for public health personnel. In fact, intervention projects drawing on the input of trained primary health care personnel have sometimes been as effective as more time-consuming and intensive therapeutic interventions. Good results with this type of service have already been achieved in a number of countries.

For young children, services providing reliable care, and opportunities for learning and socialisation should be established. Such services would allow the parents, too, to develop their skills through education and working activities, resulting in better self-esteem and self-satisfaction and promoting the well-being of whole families. The role of day care in promoting good language and social skills can be substantial and help prevent educational and social problems in later childhood and adolescence. In families in which the parents' resources are limited for one reason or another day care may provide enough stimulation and socio-emotional support for children who otherwise might show signs of deprivation and develop problems. The day-care personnel can also support the parents in their task of upbringing the child.

For school-aged children and adolescents, school and education are important entry points for mental health promotion as they are the main supporters of separation, individualisation and socialisation. School is in most cases the first stage at which a child practises participation outside the family. The process of marginalisation seen in adulthood often starts during childhood and adolescence, leading to aggressive behaviour, delinquency, substance abuse, and, in the case of young girls, to teen-age pregnancy.

Behavioural problems and learning difficulties are the individual factors most closely linked to marginalisation in the young. Enabling these children to increase their own competence is a major demand for all health promotion. Both teachers and school health care personnel should

be adequately trained to support the healthy mental development of children, to foster good parent-child interactions and to promote the problem-solving skills of families.
Being a very important part of the promotion of healthy development throughout childhood, efforts in social and health care and in schools should be targeted at mitigating non-violent behaviour in families and children and at reducing all kinds of incidents of violence in which children are either victims or perpetrators.

New ways of helping families build up social networks of their own should be developed. This is especially important with families who have lost the natural network of an extended family as is so often the case in urban societies of today. Adequate social support is crucial in promoting the mental well-being of first time mothers, who may experience devastating isolation when their freedom of movement is restricted by the demands of the infant. Equally important is the provision of opportunities for the fathers to share and discuss their role as a parent and spouse in the demanding situation created by the birth of the baby. Help should be readily available for couples suffering marital discord at this phase, as there is ample evidence that parents' frequent quarrelling poses a risk to the development of the child. A positive relationship with the spouse is also effective in preventing depression in mothers and thus promotes the development of a good parent-child interaction.

Advances in global information technology create a fast and unpredictable flow of information to societies and families. This may conflict with national traditions and values both in families and in larger contexts. It is not easy for children to distinguish between the virtual and the real worlds. Families and parents face uncertainty about preferable coping strategies. Developing children and adolescents need the continuity and security provided by the family and community. Communities are becoming more risky for healthy development from the children's perspective.

At community planning level, children's needs are still unrecognised and their point of view often ignored. The empowerment of children, the participation of children themselves and the ability to listen to their point of view are important as are also seeing that they get their share of

the society's resources. Statistics at both EU and national levels do not give salient information on children, which makes it difficult to elaborate policies and services supportive of children's developmental needs.

5.4. Key areas of action

1. Legislation

At European level there is a clear need to look at how the protection of children's healthy development is taken into consideration in EU legislation and directives. More vigorous efforts are needed to introduce supportive and protective legislative measures ensuring the well-being of children.

2. Monitoring activities

The information currently available on the mental health of children and young people should be collected to form a European standard for statistics of children's mental health and coping. The statistics should be reviewed regularly in order to provide a barometer of the coping success of children and adolescents.

3. Research and development

Within the area of research and development there is a need to foster joint activities at EU level with the aim of:

- increasing knowledge of the pathways leading to healthy development or marginalisation
- collecting data on the extent of child exploitation and creating protection for the children affected
- sharpening the focus on children's needs in drug, family violence and HIV-prevention programmes targeted at adults.

4. Guaranteeing the basic prerequisites

The basic prerequisites for good mental health should be the right of every child. Responsibility for ensuring this right is the responsibility of national, community and NGO programmes. Parents should be supported

both in concrete material ways and in the education and upbringing of their children when need for support is indicated. The Member States should give priority to developing:

- a national strategic plan, in written form, for promoting the mental health of children and adolescents, giving due attention to facilities supportive of children's development within adult services such as mental health care and substance abuse programmes
- an education system that promotes the mental health and self-esteem of children and adolescents by integrating mental health and life skill strategies into the curriculum, by early detection and rehabilitation of learning disorders and by promoting non-violent behaviour and good communication and social skills
- the means to collect and disseminate information on mental health promotion programmes with the thrust on supporting and treating early parent-child interactions.

6. Enhancing quality of life of elderly people

6.1. Introduction

Self-determination and autonomy are linked to the enhancement of the quality of life. Independent living, autonomy and self-determination have, indeed, been formulated as important goals for social policy concerning the elderly both on the national and the European level. In addition, there are many ongoing international processes focusing on strategies for maintaining autonomy in old age and the rights of the elderly.

One of the most important ways to, and a result of, autonomy in old age is mental health and well-being. Autonomy is also protected by good physical health, functioning capacity, living conditions, life skills and social support. Various aspects of living conditions, especially those related to the satisfaction of physiological needs, such as adequate housing and nutrition, are determined both by existing societal structures and by the economic, intellectual and practical resources of the individual. Availability

of and access to, e.g. health, social and transportation services that have special features for the care of the needs of elderly people, are of great importance.

While the youngest of the elderly (65-70 years of age) are healthier than before and have relatively good functional capacity, the risk for chronic diseases and declining capacities grows with rising age. Thus, many of the elderly live their lives with a disease or a disability that causes great suffering and reduces the ability to live an independent life.

As the relative proportion of elderly people is growing in the industrialised countries and as the threshold to disability is lower in old age, the pressure on the service systems of societies will increase. Independent living can therefore also be argued for from an economic viewpoint. Consequently, all efforts supporting social integration, physical well-being and autonomy in old age are of special importance.

6.2. Relevant knowledge and current challenges

The image of old age and values related to it prevailing in western societies are of central relevance in health promotion for elderly people. In our performance-orientated industrial societies, ageing is presently associated with passivity, deficits, uselessness and consequent increased societal costs. For example, it is not uncommon to think of old age as a period without sexual desire. Since the sixties, such hostile attitudes have been described as ageism.

However, old age is not a period of passive reception. Due to an increased life expectancy and better health, the period of old age now comprises 20 - 30 years. The elderly generation hence may occasionally consist of up to two generations. It is possible to distinguish between the young elderly and the old elderly. In many European societies, elderly people have traditionally been an important resource for the society in many ways, e.g. by supporting the everyday activities of the families of next generation. In many cases this age-group has also become an important supporter of the work of non-governmental organisations.

Life expectancies are continually rising in the European countries. While life expectancy at birth was 63.4 years for men and 68.5 years for women in 1950-55, it had risen to 68.9 and 77.0 in 1990-95. In 2030-35 it is expected to be 75.6 for men and 82.0 for women. At the same time the proportion of people aged 65 or more is growing. In 1950 they comprised 7.6% of Europeans; it is expected that in 2020 13.7% of the European population will be 65 years or older. In some European countries the share of old people will be over 20%.

Declining health and functional capacity make the ageing person dependent on help from other people. Physical illness, such as cardiovascular and musculo-skeletal diseases, may result in physical dependency. Alzheimer's disease as well as other dementias and other mental problems impair cognitive functions, which leads to a reduction in the capacity for self-determination.

Impaired hearing and eyesight may cause communication problems and social isolation which, in turn, may have consequences such as depression and paranoia. The use of alcohol and drugs among the elderly is difficult to assess, since surveys do not necessarily reach the most problematic groups. However, international studies indicate that between 2% and 10% of people aged 65 years are abusers of alcohol and /or drugs.

The social conditions of the elderly are different in various cultures. In many European societies the majority of the elderly live alone and up to 50% of them have feelings of loneliness and social and emotional isolation. However, studies also indicate that the elderly in such family-centred countries as Portugal and Greece are the loneliest in the European Union. Extensive studies have revealed the importance of social relations which could be described as 'intimacy at a distance', social contacts that have meaning despite of geographical distance. The decreasing number of significant others makes elderly people more vulnerable to bereavement and other kinds of losses.

Sufficient economic resources and good housing conditions are important preconditions for independent living. Although the standard of living has improved in most European countries during the past decades, poor housing conditions are a major problem in many countries.

In Finland some research indicates that about 20% of the elderly live under poor housing conditions. Living conditions were deemed poor if there was no indoor plumbing, hot water, toilet or washroom, or if there was only wood heating. In many cases the forms of independent living provided by the society have resulted in ghettoising of old people into special areas or buildings. This approach can be rationally motivated by easier provision of necessary services but it results in more severe disintegration from the remaining society and has consequences for mental health.

In institutions, old people often have to submit themselves to rigid structures: They may not be allowed to bring their own furniture with them; their meal times are dictated to them; and they generally cannot autonomously decide on their own affairs. However, new forms of home-like care settings and new treatment approaches have been developed especially in the Scandinavian countries. These successive experiments have, however, shown that transition to new traditions in care is not easy and requires training focusing on values, attitudes and practices.

General life satisfaction and satisfaction with different aspects of life, such as health and economy, seems to be quite high among the elderly. About 80% to 90% of the elderly in different studies report that they are satisfied with their lives. Furthermore, between 70% and 80% of the elderly report that their quality of life is good, meaning that they feel safe, needed and happy, and they have enough to do and loneliness is not a problem. However, when asked whether they ever feel lonely, about 50% of the elderly tend to answer that they feel lonely sometimes or often.

The situation of mentally ill elderly people is more difficult. They tend to become socially isolated. Their possibilities to get sufficient services are even more restricted than those of elderly people in general, as the ambulatory care for the elderly often has traditionally stressed place on, physical health. Especially in rural areas with weak infrastructure, professional help in ambulatory mental health care is often hard to find. On the other hand - and fortunately - better social support usually exists in these areas.

The pressure to disregard their own needs and the long-lasting physical and psychosocial stress turn caregivers themselves into a risk group for mental and physical ill-health. If even a small number of present caregivers would refuse to look after people with dementia at home, the additional costs for the public health systems would increase remarkably. Consequently, different approaches supporting home carers of this group of patients have become an important part of care systems in many European countries.

6.3. Key areas of action

1. Programmes aiming at changing values, attitudes and practices regarding ageing

The role and cultural meaning of "normal ageing" should be discussed in public. Academic and professional training, and specific campaigns as well as the media in general could help to sensitise the broader public to the discussion and to furnish information on the subject. As the proportion of elderly people is growing in the European Countries, this group should not be seen only as a burden for the society in the form of increasing welfare and health costs. The growing group of elderly people, no longer active in working life, is also a great potential for societies as a resource for different activities with societal relevance. There is a need for policies which guarantee flexibility in extending people's productive phase of life. This, however, necessitates structures which make it possible to adjust the content of the work to the capacity of ageing workers.

2. Policies and programmes focusing on independent living

It is of special importance to support policies and programmes, developed by experts and elderly people together. The focus should be on development of

- forms of strengthening the organisations representing the elderly
- pension systems to prevent poverty among old people
- housing policies focusing on social integration

- new integrative service approaches, including new forms of counselling, taking place outside of the traditional health and social services
- enhanced support for caregivers
- new possibilities for intellectual and physical activities for elderly people, outside a competitive setting with younger people
- technological measures (especially by information technology) supporting daily activities and maintenance of cognitive functions
- professional training regarding the special needs of elderly people for the staff of public services

The principle of equity should be emphasised in all these strategies, whether applied to practice or to research and development.

3. Programmes promoting self-support

The promotion of self-support measures aims at two targets: Firstly, this type of help is generally cheaper and often more efficient than guided or professional work done by 'outsiders'. Secondly, this method brings about a special advantage for the elderly, because self-supporting measures strengthen group ties among the elderly themselves and thus prevent loneliness.

Primarily initiatives that promote peer help are worthy of attention here. A good example are the 'walking therapists in Zürich: Elderly people who have attended a special seminar regularly take old people and/or those suffering from dementia for a walk in town. On the way, they take care that the people helped get new information and at the same time engaging in already learned practices.

Educational programmes supporting the independent living of elderly people should be developed. An important step could be a 'train-the-trainer' system to build up networks with competence to self-support elderly people.

4. Programmes focusing on prevention

A good example of a preventive programme is, for instance, the regular screening of elderly clients carried out by community nurses in the UK. The nurses regularly check elderly people's sight and hearing, and since the beginning of the nineties, they also test clients with regard to depression.

Screening practices in the primary care settings need also to be developed.

7. Promoting mental health of alcohol and drug abusers

7.1. Introduction

Alcohol and drug abuse causes severe damage not only to the individuals concerned but also to their immediate environment and the whole community. The problems, which seem to be increasing, take many forms - mental, physical, social and financial. One of the major risks is the threat of marginalisation and exclusion from society.

One sign of the exclusion is that substance abusers may experience difficulty in getting the help they really need from the social and welfare services. Attitudes to misusers may be extremely negative, partly because their problem is regarded as self-inflicted. Often the intoxicant misusers in the most critical state, who would need the most committed services, in fact receive the poorest treatment or none at all. Special emphasis must therefore be given to the development of services for this group of people.

7.2. Relevant knowledge and current challenges

To reduce the harm resulting from all substance abuse we need to regulate and try to diminish the total consumption in the general population. As substance abuse is usually a sign of mental ill-health of some kind, one

may assume that general promotion of mental health can work positively in this respect, too. New tools of prevention are needed as are community-level services for high consumers at an early stage.

The out-law situation regarding drug misuse makes it more difficult to approach the many problems involved than in the case of alcohol abuse. One answer to these problems is the European Monitoring Centre for Drugs and Drug Addiction established in 1994. With antennas (local points) in all EU countries, it enables information to be collected and joint activities concerning drug problems to be planned on a pan-European scale.

A common feature of drug-related problems is their episodic nature, as sober periods alternate with relapses. Services should therefore support, not turn away, those who have once again fallen victim to their habit. Therefore, it is essential to establish treatment units that people feel they can contact without difficulty and which can give them help instantly and flexibly.

Such services should seek to ensure that the lives of their clients do not deteriorate still further, to slow down the debilitating process and any associated criminality, and, in the last resort, to relieve pain.

There are links between substance abuse and psychiatric disorders, and both may occur concomitantly. Planned, long-term assistance tends to be short in supply for those to whom this dual diagnosis refers. Inherent in co-occurring substance and mental disorders is the increased risk of serious somatic illness, particularly in cases of intravenous drug misuse and of infections transmitted through sexual contact (HIV, hepatitis). This risk, too, needs to be given due attention in the provision of services. Research into this population is urgently needed to enable appropriate treatment and prevention modalities to be developed.

Combined substance use (including sedatives and other medication) is a highly complex problem. The chaotic use of several substances can in itself cause or contribute to mental disorders. Synthetic drugs appear to be a growing problem among young people in all EU countries. There is a tendency to regard these new psychostimulants as a harmless way to get the powerful experience of 'feeling high' or to simply to relax quickly after a 'boring' week at school or work. As these drugs have become socially accepted among young people and more openly used in groups,

they have found a new market niche. They are easy and cheap to produce yet difficult to detect, and so present a completely new challenge to prevention, treatment and even repression.

The prevalence of the dual diagnosis, in which a serious psychiatric disorder is often linked to substance abuse, is thought to have increased. Several studies have pointed to the co-occurrence of depression and intoxicant problems. The increase in numbers of dual diagnosis cases can be partly attributed to the greater attention paid to the condition in the last 15 years. During this time diagnostic methods have improved and changed, resulting in a greater number of positive findings. Another obvious reason, however, is the drastic decrease in the number of beds in psychiatric hospitals. Since an ever greater number of mentally ill people are now treated only as outpatients, and are thus not always able to obtain sufficient help and support, the risk of their turning to abuse behaviour is aggravated. Moreover, psychiatric patients are often without means, and hence may end up living in deprived areas where substance abuse and drug trafficking are features of the local culture, and drugs are readily available.

An important entry point for interventions is the maternity care setting, where special emphasis should continuously be given to detecting high risk mothers and preventing the foetal alcohol syndrome, caused by frequent use of alcohol during pregnancy.

7.3. Key areas of action

1. Combatting combined substance abuse

Combined substance abuse is a growing problem and requires a greater input of our development efforts. The need for new ways of affecting the demand for illicit drugs is particularly acute.

2. Protecting mentally ill intoxicant misusers

Among mentally ill intoxicant misusers are persons who are prevented by age or other reasons from being rehabilitated and returning to normal life. Actions should be created to take responsibility for these people,

satisfy their basic needs and prevent them from being abandoned. Such programmes must tolerate deviant behaviour and should not actively seek to change the way people behave.

3. Tackling the problem of comorbidity

Dual diagnosis, which refers to both intoxicant misuse and mental illness, is a broad, superficial and imprecise concept. More research is therefore needed into the co-occurrence of intoxicant misuse and psychiatric disorders.

8. Supporting research and development

8.1. Introduction

One of the key areas in enhancing promotion of mental health is research and development. This is the area where co-operation between Member States could give the most added value in the EU. There is also a clear need for integration of activities of different European institutions related to the promotion of mental health. Co-operation with other research institutions, universities and NGOs is also important.

There is clear evidence in the literature that mental health promotion programmes are effective. Nevertheless, there is still a need for further research in the field. Relevant R&D tasks at EU-level might concern any of the three levels (individual, interactional and structural) of mental health mentioned in chapter 4 (Conceptual framework). All three levels must therefore be taken into consideration when promotive activities are conceptualised, developed and evaluated. This chapter outlines some relevant approaches for research and development.

8.2. Current challenges

It is important to continue with efforts to deepen the consensus among researchers and key players concerning the most useful theoretical models and concepts. The ways in which experts define both mental health and mental health promotion vary widely. Greater agreement is absolutely necessary to reach better understanding of the existing values and paradigms, and to make effective co-operation and evaluation possible.

A clear need exists to find ways to support and augment mental health-related actions in the field of public health by linking it with other types of Commission activities and organisations, e.g. the European Social Fund and its Community initiatives, occupational health issues, development of work forms and organisations, learning and education-related programmes, information and communication technology-related programmes, and consumer protection and equity issues.

The participation of users, their relatives and citizens in general in planning, decision-making and implementation has been stressed throughout this report. This approach has been conceptualised with the term ‘empowerment’. Here the challenge is how to ensure that citizens’ and users’ views have a place in R&D. Not only must users’ voices be heard but efforts must be made to ensure users’ active participation in the planning and implementation of R&D activities and especially in their evaluation.

The role of mental health services in promoting mental health must be clarified, for instance, in primary health care, mental health services and social care, where the range of opportunities is considerable. One of the challenges is that the general points of departure of mental health promotion are not sufficiently well known among professionals in the health and social services. Another challenge is the need to develop quality indicators and criteria that are useful not only for the health and social services but also for mental health promotion activities in general. The indicators and criteria must respect the crucial role of social support and social participation in mental health.

8.3. Key areas of action

1. Enhancing research, development and information exchange

More R&D in the promotion of mental health is needed in Europe. One major obstacle is the lack of resources. Only very few researchers are currently interested in this field. There is an urgent need both to provide material resources (mental health research and development centres, research funds) and to increase knowledge of and attitudes to research in mental health and its promotion. The following actions could be taken to foster R&D in the field of mental health promotion in Europe:

- establish R&D programmes and allocate research funds specifically for mental health promotion
- establish a group / groups of experts working jointly with relevant Commission institutions and officials
- create an information exchange network.

2. Policy research

Bases for action in the EU are the mental health policies and strategies of the Member States. At the moment, however, relatively little is known about these policies. Such knowledge is necessary for future development of a shared European strategy in promotion of mental health. This will also bring more added value in the EU context.

Research on mental health policy should include the following measures and areas:

- interviews with key players
- research into the values, attitudes and opinions of the general public concerning mental health
- analysis of the content and value of mental health policy documents
- detailed analysis of models for implementing the most important projects related to mental health promotion
- more detailed analysis and comparison of the results achieved by these projects
- research into mental health legislation.

3. Role of services in promotion of mental health

The role of the health services in preventing specific mental disorders is well-established, but their role in promoting mental health is less well understood and many questions with relevance for research currently lack satisfactory answers. For example it is not known:

- how to effectively foster interest and encourage innovation in mental health promotion among the health and social services
- how to successfully develop and maintain the co-operation needed between the health and social welfare services in planning and implementing mental health promotion programmes
- how to ensure integration of activities provided by different service sectors in multisector, multilevel programmes
- how to provide appropriate training for the personnel in these services with a view to filling the gap in their knowledge of the promotion of mental health.

4. Development of adequate quality indicators and criteria

The evaluation of mental health promotion programmes needs well-established and reliable quality indicators and criteria able to provide a means to measure the achievements of mental health promotion. This is a relatively new task, and methods are still at the development stage. The indicators should cover at least the following four aspects:

- input (the specific resources that go into an activity)
- process (what actually happens during the activity)
- impact (the consequences that can be attributed to the process)
- outcome (relating back to the goal of the activity).

In developing these indicators it is essential that they should be clearly linked to the relevant statistical instruments of the EU. Therefore they must include dimensions such as:

- equity
- participation
- experienced quality.

5. Research into implementation

The biggest problem in the promotion of mental health is not apparently the lack of effective and feasible programmes but the implementation of these programmes. The following obstacles have been encountered:

- the results of the programmes are not immediately available and it may be some time before the final outcome is known. However, politicians in particular need and want results instantly
- many of the programmes need a multisectorial approach - the necessary co-operation between different sectors may often call for a change to traditional working styles. This is not always easy and may prompt resistance
- professionals working in services and focusing mostly on care alone may be sceptical about promotion

Research with the thrust on implementing programmes should focus on the means to overcome these problems. As many programmes have been found effective only under ideal circumstances, research on predictors and mediators of effectivity should be given a high priority

9. Development of information and dissemination systems concerning mental health

9.1. Introduction

There exists a great need for joint efforts to define models of good practice for promoting mental health. What is needed are indicators and methods of assessment that can:

- enhance the capacity for monitoring mental health and well-being in Europe
- give dependable information on the prevalence of problems indicating a need for more effective promotive efforts
- be used for comparing factors impacting upon mental health and well-being
- reveal the needs and preferences of service users and citizens as identified by themselves.

The need for a comprehensive European health monitoring system has been stressed on several occasions. As mental health is an essential part of general health and well-being, it should clearly be covered by a comprehensive description, information and evaluation system. More specifically, this health monitoring system needs feasible and valid mental health indicators.
A new Community action programme on health monitoring within the framework for action in the field of public health (COM(95) 449 final) has just been adopted by the European Parliament and Council. This programme mentions mental health as one of the areas needing special attention.

9.2. Relevant knowledge

Most existing indicators for mental health actually refer to the mental health services, describing their structure, processes, quality and outcome. The literature contains very few, and even then only tentative, descriptions of efforts to develop indicators measuring mental health at population or group level. Previous research and developmental work in the field have clearly focused on measures of pathology rather than of health. This certainly is true in all health monitoring. There seem to be very few indicators in use which were developed specifically to measure what is known as positive mental health.

It is evident that there is no simple solution to the problem of creating valid, useful and compact data sets, which would serve as a sound basis for planning, implementing and evaluating future mental health promotion policies and activities in Europe.

One problem is that research in the field focuses more on pathology than on aspects of health and well-being. Another difficulty is how to tackle the basically subjective nature of mental health.

The following presents some relevant findings from the search for associations between mental health and its disturbances on the one hand, and different individual, social, economic, ecological and service-related characteristics on the other. These findings should be a central starting point in establishing relevant mental health indicators. Six categories of indicators are suggested: namely, demographic indicators, social stress indicators, indicators of health and social functioning, indicators reflecting the subjective experience of the individual, indicators based on the use of and demand for services, and indicators describing morbidity and mortality. These categories, which are shortly presented in the following, could serve as a basis for developing the comprehensive mental health information system so urgently needed in Europe.

9.2.1. Demographic indicators

A number of demographic variables have obvious links to mental health and well-being, notably gender, age, marital status, place of living, education and social class. Many surveys have found higher rates of psychiatric morbidity and lack of mental well-being among women, with 'neurotic symptoms' or depression often comprising the gender difference. Age does not usually show the same striking contrast as gender although in most surveys the prevalence has been highest among later middle-age groups. As to the other variables, mental health disturbances appear to accumulate among the unmarried and divorced, and those of lower education or socio-economic status. As these indicators cannot be significantly influenced by mental health promoting activities, it is clear that they can only be used for assessing needs, not for measuring outcomes.

9.2.2. Social stress indicators

Various objective social difficulties and problems correlate with different measures of mental health and well-being. It has been customary to explain these links by mediating processes such as diminishing social support and stressful life events. Expression of oppression or violence, unemployment, poverty, family problems, work-related stresses, and symptoms of social disintegration with their correlates and interrelationships can all add to the stress and risk of mental disorder and psychological suffering.

Negative life events and stresses tend to accumulate and create vicious circles of various types by several mechanisms. Socially disintegrated communities and societies often have above-average rates of unemployment, poverty, drug and alcohol misuse, divorce, poor parenting, child abuse, suicides and mental health disturbances. Life events are stressful changes such as separation and divorce, the death of a spouse or conflict at work. These are often interrelated with more long-lasting stresses, such as financial problems and poverty, housing difficulties, long-term illness and protracted interpersonal (often marital) discord.

9.2.3. Indicators of health and social functioning

Epidemiological studies in particular have used different direct measures of health and social functioning as important indicators of health outcome. Many measures have distinct somatic, psychological and social dimensions but there are also combined measures. These rating scales and questionnaires focus on such issues as general health status, appearance/frequency of positive and negative feelings, general well-being, anxiety, depression, coping mechanisms, social support and sense of coherence.

9.2.4. Indicators reflecting the subjective experience

No list of mental health indicators is complete without measures that reflect health as a subjective experience of the individual. Such information can only be collected as part of a health or well-being

interview focused on a representative sample of the general population or the respective group of people. Examples of such indicators are satisfaction measures, e.g. satisfaction with health, with social relationships, with work, with housing, and with life in general. Some of these methods also focus on the future, asking the respondent to assess the possible changes in different important aspects of his/her life. Much attention has been paid in recent years to methods measuring satisfaction with mental health services as an important part of their outcome indicators.

Here we are also dealing with the various aspects of the quality of life. Research into the quality of life is a potentially promising source of information for assessing population needs in respect of mental health. It taps directly into clients' and users' needs. Assessment of the quality of life is also emerging as an important criterion with which to judge the performance of services. Quality of life approaches occupy, in a sense, an intermediate position between expert-defined assessments of need and client/user-defined demand. They are planned and used by experts but often collect information about what the respondents value, want and prefer.

9.2.5. Indicators based on use of and demand for services

The utilisation of and demand for services reflect population needs but especially the utilisation is problematic here. Many researchers claim that the utilisation of mental health services tells more about the availability of these services than about the real need of the respective population. Furthermore, a great proportion of the mental health services are provided by the primary health care and even social welfare sector, and such visits are not usually recorded by diagnosis in existing statistical systems. Therefore, one should be cautious in drawing too far-reaching conclusions based only on such data.

In theory, demand should reflect need more accurately than utilisation but this concept is not without problems either. There are many reasons why at least some part of the mental health need will not be reflected as demand. Mental health matters still bear a stigma; many people are not willing to express their experienced mental problems as demand for professional help for fear of being stigmatised and excluded, e.g., from

work or social relationships. The shame connected with mental problems may also function as too high a threshold for asking help from others. Nevertheless, demand should be included in the set of relevant indicators because it reflects the importance of the user's viewpoint.

9.2.6. Indicators describing morbidity and mortality

The suicide mortality rate has been widely used as an indicator of psychiatric morbidity in the population, although its usefulness for this purpose is rather limited. We clearly need more specific indicators of both severe and milder mental health disturbances in the general population. Statistical data on, say, alcohol consumption, use of psychotropic drugs, and granting of disability pensions due to mental disorders could provide additional information.

The total psychiatric morbidity in the population cannot, however, be described by this kind of statistical or indirect data alone. We also need extensive epidemiological population studies using valid, comparable and reliable case-finding methods.

9.3. Current challenges

There are several reasons why this area should be of great interest to both individual EU Member States and all European institutions:

1. All EU Member States need to keep a close watch on the situation and current trends in the mental health of their populations because of the increase in mental health problems and disturbances (e.g. depression and substance abuse disorders) all over Europe. Among the reasons for this increase are the high unemployment rate in many countries, changes in working life, and cuts in the budgets of help and support systems. All these contribute to the increasing insecurity of individuals and families, and also to the risk of marginalisation.

2. The health strategies and policies of different countries are beginning to show a greater awareness of mental health issues. At national level there is an increasing need to be able to evaluate the effects and impacts of these new strategies. At European level the key interest lies in the ability to compare the policies of different countries, as they may differ substantially from one country to another. This task requires a standardised and comprehensive system for describing and evaluating the impacts of the policies.

3. Further development of quality assessment is necessary in promotion of mental health. Since health promotion is concerned with commitment, action and process more than direct health outcomes, feasible measures need to be elaborated for assessing operations at various levels, in different contexts and among different target populations. An essential feature of these measures is that they permit comparison of separate projects. This underlines the need for development in the field of telematics so that the information can be shared.

4. Mental health indicators and a monitoring system are also needed for evaluating the outcome of the various activities provided by the health and social welfare services, including prevention, treatment and rehabilitation programmes for mental health disturbances. There is a need for this kind of evaluation at all levels - local, regional, national and European level.

5. The traditional approaches of epidemiology measure health outcomes in terms of pathology. Although the psychiatric epidemiology has traditionally also looked at protective factors, there is a need for an epidemiology of *health*, which estimates health potentials in addition to risk factors. Mental health promotion is a natural domain for the development of indicators for this new epidemiology, since many of the components of health potential are directly or closely associated with mental health. Thus, the development of valid and reliable mental health indicators has a clear research implication.

6. Efforts made so far to produce health indicators have encountered special problems, especially in the field of mental health, because of the ambiguity of concepts, the lack of commonly agreed definitions due to insufficient theoretical research into mental health promotion, and the difficulty of defining relevant measures. The key issues here are how to improve the quality of the information and how to ensure adequate data collection in all EU Member States.

7. A central problem in establishing objective indicators and criteria for mental health and mental health disturbances lies in the subjectivity of the concept mental health. Mental health is closely connected to a person's inner experience of his/her own situation, and to his/her feelings and emotions. Therefore, the objective measures of mental health do not always coincide with the subjective experience of mental well-being. Development of the mental health monitoring system must take sufficient account of people's own views of the concept.

9.4. Key areas of action

A comprehensive mental health monitoring system with unanimously defined indicators according to the principles and recommendations stated in the Community Action Programme for Health Monitoring (COM(95) 449 final) must be developed. To this end there is a need to:

- collect information on existing mental health indicators and their definitions as well as on the mental health information systems developed in the EU Member States or by international organisations including WHO-Euro (Health for All Indicators) and the OECD, and to analyse their quality, coverage and validity;
- propose a system of mental health indicators for the use of the Member States and the Commission following the principles and recommendations proposed in the Community Action Programme for Health Monitoring; this task requires careful evaluation of the existing indicators and clearly also development of new indicators;

- establish clear and unambiguous definitions of the indicators selected, ensuring that they are acceptable to all Member States;
- give recommendations concerning the methods of data collection for these indicators; some of the indicators should be available in existing data bases and statistics, but some will clearly need information from separate health surveys or epidemiological studies;
- test in pilot projects the feasibility and usefulness of the indicators selected and the mental health monitoring system established;
- establish a high-capacity network for the collection, dissemination and analysis of the relevant information.

4 Appendix

1. Primary prevention of specific mental disorders

1.1. Introduction

Prevention is traditionally divided into primary, secondary and tertiary prevention (Caplan 1964). *Primary prevention* is directed at reducing the incidence (rate of occurrence of new cases) in the population. Primary prevention efforts are targeted at people who are essentially normal or believed to be 'at risk' of developing a particular disorder. It focuses on risk factors and seeks to eliminate or mitigate them. The goal of *secondary prevention* is to shorten the duration, reduce the severity and prevent the recurrence of a disorder by early detection and prompt treatment. On population level, secondary prevention is directed at reducing the prevalence (the rate of cases). *Tertiary prevention* is designed to reduce the severity and disability associated with a particular disorder.

The second major development in the concept of prevention has been the introduction of three further definitions. *Universal prevention* comprises the forms of prevention regarded as desirable for everyone, and the decision to implement them is taken if their benefits clearly outweigh their costs and risks. *Selective prevention* measures are deemed to be appropriate when the individual is a member of a subgroup of the population (in terms, for instance, sex, age or occupation) and has an above-normal risk of becoming ill. *Indicated prevention* is aimed at groups with a sufficiently high risk of a certain illness.

This appendix deals mainly with the opportunities for the primary prevention of some specific mental disorders. The main focus will be on universal or selective measures.

Attempts to apply prevention in psychiatry have encountered a number of difficulties (Paykel 1994). One prerequisite for primary prevention is an adequate base of knowledge of aetiology. In respect of psychiatric disorders this is only partly available, although a substantial body of knowledge has now been built up about, for instance, socio-economic factors. Knowledge about the importance of the early relationship between infant and the care-giver is also increasing.

An important point is that most mental disorders have a multifactorial cause. Furthermore, single causes, such as adverse early home environments or recent stressful life events, may contribute to many disorders. A single disorder almost always has many contributing causes. Therefore, a single preventive measure may not affect only one specific disorder, but many in varying degrees. On the other hand, effective prevention may require comprehensive intervention targeting several contributing factors. This also applies to physical illness; smoking, for instance, may contribute to many diseases.

The causal factors of disorders may be divided into *predisposing factors* (e.g. genetic loading, loss of mother in childhood) and *precipitating factors* (e.g. stressful life events). The increase in knowledge has provided a greater number of practical opportunities for prevention in the domain of precipitating factors than in that of predisposing factors. In practice, this has meant a shift of interest from 'high risk populations' to 'high risk situations' and events.

1.2. Relevant knowledge

An key issue in the prevention of specific mental disorders is whether there exists an adequate knowledge base. Pardes et al. (1989) highlight some of the cornerstones of research into preventive efforts. Briefly they argue that such efforts rest on:

- *The refinement of psychiatric diagnosis.* Greater specificity and validity of diagnostic criteria make epidemiological studies much more informative while enabling psychiatrists to tailor treatment to diagnosis more appropriately and to carry out more specific studies of homogeneous groups of illnesses.
- *Epidemiology.* Epidemiological studies provide insight into environmental and sociodemographic risk factors. The increasing use of longitudinal designs, linkage with health service utilisation data, and replication design and methods in multiple sites will produce valuable information for the evaluation of preventive interventions.
- *Genetics.* Molecular genetic technology is advancing understanding of the genotypes of illnesses, including Alzheimer's disease, schizophrenia and affective disorders. Genetic counselling may become a significant element in primary prevention, although the ethical and emotional implications need to be clearly addressed.
- *Neurobiology and biotechnology.* New non-invasive methods of visualising the brain are permitting us to increase our understanding of cerebral function and dysfunction in relation to particular psychiatric illnesses, and may in the long run aid in the identification of prophylactic measures.

In choosing objectives for prevention (Jenkins 1994) it is important to consider: (a) the social cost or burden of illness involved in a particular problem or condition, e.g. death, disablity, days off work, impaired functioning or extent of suffering; (b) current knowledge of the aetiology of the condition, and the persuasiveness of the evidence that interventions are effective; (c) the feasiblity of a proposed programme in terms of political acceptance, the nature of public attitudes, a balance between risk and gain factors, and the availability of funds; (d) the appropriateness of mental health personnel taking the lead in developing or organising the activity, for example, in improving the availability of public housing or in ensuring better prenatal care for teenage mothers.

The following looks more closely at the most important mental disorder categories, that is, affective disorders (including depression), anxiety disorders, schizophrenia, drug and alcohol-related problems and psycho-organic disorders (especially dementia).

1.2.1. Affective disorders

Aetiology

Affective disorders comprise several diagnostic entities ranging from transient adjustment disorders with a depressive component to severe psychotic bipolar disorder with alternating manic and depressive episodes. Disorders at the two ends of the spectrum show considerable differences, as may their causative factors. The following causal categories should be considered (Scott & Paykel 1994):

1. *Genetic factors.* Bipolar affective disorder is the most familial form, with a morbid risk in first degree relatives of approximately 20%. The corresponding figure for unipolar major depressive disorder is about 10%. The genetic loading is clearly less striking in milder forms of depression. The mode of inheritance is not clear and probably involves multiple genes. Some evidence for linkage to the X chromosome has been found for bipolar disorder.

2. *Biological causes.* Biological research has revealed consistent findings of changes in monoamine neurotransmission in the brain in depression, but the extent to which these represent causes or secondary consequences of the disorder remains unclear.

3. *Personality.* Most work on personality has been in relation to vulnerability to stress. There is some evidence that dependency and neuroticism may be associated with an increased risk of depression. Depression may also be one feature of the s.c. borderline personality disorder.

4. *Predisposing psychosocial factors.* It has recently been shown that many childhood adversities are connected with adult depression (Veijola et al. 1997). Findings regarding, say, parental loss through death are, however, inconsistent and the effect is at best only a small one. There are more consistent associations with loss for other reasons, usually parental divorce, but here other interpretations arise, such as the effects of parental discord before the breakdown. There is some evidence that sexual abuse or corporal punishment in childhood could have some effect on later depression, but here, too, several interpretations are available. The greater risk of women than of mencontracting depression has produced several interpretations, ranging from biological to social and psychological factors. Many epidemiological studies have suggested an inverse relationship between socio-economic status and depression.

5. *Precipitating social factors.* There is a consistent body of data implicating psychosocial stress in the onset of depressive episodes. While unemployment is likely to lead to lower socio-economic status, its association with depression may arise from other mechanisms. Many studies have shown that people suffering from depression experience a significant excess of adverse life events six months prior to the onset of the disorder. Loss and separation are particularly common, although they show only weak specificity for depression.

Opportunities for primary prevention

1. *Genetic counselling.* The ethical problems connected with genetic counselling in general apply here, too. Furthermore, its value when aimed at avoiding the birth of high-risk individuals is restricted by inadequate knowledge of the mode of inheritance, the absence of reliable genetic markers and limited heritability. The exceptions are the few families with a family history of high frequency of cases, families in which both parents are affected or mothers with severe postpartum affective disorder, in whom the 1:5 risk in subsequent pregnancies suggests that the next pregnancy should be postponed until the index infant is sufficiently old not to be very vulnerable.

2. *Interventions in parent-child relationships.* Associations between adult depression and damage to the early parent-infant relationship suggest that careful consideration should be given to the opportunities for early intervention. Attempts to improve parental care, focusing on depressed or vulnerable mothers, have been tried, at least in the US, UK and Australia.

3. *Event centred interventions.* Most life events implicated in studies of depression, e.g. interpersonal difficulties, unemployment, departure of a child, and death of spouse, are unavoidable. In developed European countries, at least, there are few opportunities for further reducing their occurrence, although a good employment policy might, in theory, help. Yet another possibility might be to strengthen the coping mechanisms of individuals, to prepare them better to resist the negative impact of losses and adverse life events. An alternative approach could be to use the knowledge of the timing of the occurrence to signal that action should be taken (Eaton et al. 1995). Examples of this strategy include counselling for forthcoming pensioners or for patients undergoing surgery for carcinoma.

1.2.2. Anxiety disorders

Aetiology

Anxiety is both a drive that is essential for survival as well as a symptom that can cause distress and suffering. Anxiety is present in almost all mental disorders but in some of them it is the main symptom. These are called anxiety disorders, and they include phobias, generalised anxiety disorder, panic disorder and obsessive-compulsive disorder. The specific aetiology of anxiety disorders is unknown, but the following assumptions have been made.

1. *Heredity.* A number of studies confirm a heritable contribution to vulnerability to anxiety disorders. For example, in panic disorder a four- to eight fold risk has been found among patients' first-degree relatives. The mode of heredity is, however, still unclear.
2. *Psychoanalytic theories.* These theories go back to Freud's assumptions about the origin of anxiety. He divided anxiety into traumatic and signal anxiety, the former being the response to an actually present overwhelming and dangerous traumatic situation but the latter the response to cognitive processes anticipating a traumatic situation.

3. *Cognitive-behavioural theories.* These theories put forward a variety of conditioning, personality and cognitive hypotheses. These include concepts such as classical conditioning, the 'fear of fear' principle and interceptive conditioning, catastrophic misinterpretation, and anxiety sensitivity. Central to these theories is the notion that anxiety is in some way the result of a wrong learning process.

4. *Biological theories.* Biological theories of panic anxiety have rested on observations that pharmacological treatment may reduce anxiety and block panic attacks, and that panic can be induced in the labratory through the administration of various compounds. However, it remains unclear which biological abnormalities found in anxiety states are indicative of pathophysiological processes in contrast to aetiological determinants.
Opportunities for primary prevention
According to current knowledge, opportunities for the real primary prevention of anxiety disorders are rather minimal. As some traumatic experiences in early childhood, such as separation from parents, have been shown to be a risk factor for later anxiety disorder, this should be considered, for instance, when young children need long-term hospitalisation or placement apart from their parents. One preventive possibility might lie in parental counselling.

1.2.3. Schizophrenia

Aetiology

Schizophrenia is a very severe mental disorder marked by an impaired sense of reality with delusions and hallucinations, blunted affect and withdrawal from social interaction. The aetiology of schizophrenia, although basically unknown, is most probably multilevel, multifactorial and complex. It is also possible that schizophrenia, as it is actually defined, is not a single disorder but a cluster of disease entities with different aetiologies. Here, too, it is useful to discriminate between the factors associated with the susceptibility to schizophrenia (predisposing factors) and with its onset (precipitating factors). The following factors seem to contribute to its occurrence (Johnstone & Leff 1994):

1. *Genetic factors.* Twin and adoption studies have shown that genetic factors are important in some cases, but it is not yet clear which genes are deviant, or whether the same genes are involved in all cases that have a genetic underground. On the other hand, a substantial proportion of schizophrenic patients do not have a family history of the disorder. A balanced polymorphism with a rather high rate of mutations seems to be the most likely interpretation, providing rather limited prospects for preventive interventions.

2. *Neuroimmunovirology.* Immune and viral hypotheses of schizophrenia are nothing new. Recent studies have shown that schizophrenia has a north-south gradient in the Northern hemisphere, and is associated with a winter birth excess, suggesting a viral contribution, particularly during the second trimester of pregnancy. These epidemiological associations have, however, been rather weak. Viral theories nevertheless remain popular despite the difficulty of validating any particular pathophysiological mechanism.

3. *Birth and pregnancy complications.* Some studies have indicated that obstetric or perinatal problems may be associated with the later development of schizophrenia. The very similar incidence of schizophrenia across a wide range of countries with widely varying obstetric and infant mortality makes it unlikely that this effect is very strong.

4. *Psychosocial factors.* Several individual psychological theories on the aetiology of schizophrenia have been developed during the present century, but none of them have been able to prove its validity. Some investigators have demonstrated pathological patterns of interaction in families of schizophrenic patients (e.g. Alanen et al. 1966), producing hypotheses about their contribution to aetiology. A number of studies indicate a triggering role for different life events, usually connected with an important transitional phase in the person's life, but since such phases occur in everyone's life, there cannot be any specific link with schizophrenia. Epidemiological studies have very consistently shown the inverse relationship between the occurrence of schizophrenia and social status, but according to most authors the premorbid social drift hypothesis seems more plausible than the social causation hypothesis.

Opportunities for primary prevention

In the present state of knowledge there are few opportunities for the specific primary prevention of schizophrenia. Activities must therefore mainly be part of more general programmes for mental health promotion in an effort to reduce the risks contributing to schizophrenia. Possible activities include better pregnancy and birth control, and screening of risk families with deviant communication patterns. Unfortunately, there is so far no firm scientific evidence of the effects of such efforts.

1.2.4. Drug and alcohol-related problems

General

Drug and alcohol related problems seem to be increasing throughout our western world, especially among young people. Given the consequences of this trend, the difficulties of treatment and the high mortality rate, it is beyond dispute that prevention is better than cure. Prevention not only benefits the individual but is also crucial for society as a whole. Drug trafficking is associated with organised crime and threatens the social structures of whole countries. In addition, the increasing spread of HIV poses what may well be the most serious threat to the health of the world population and has made the prevention of drug misuse by injection a necessity in all countries. (Johns & Ritson 1994)

Although the need for prevention is clear, the best course of action is not. As the causes of drug and alcohol misuse are complex and multi-factorial, it follows that no single intervention is likely to have a dramatic or immediate effect. Therefore, a comprehensive approach is needed.

Strategies for action

The measures currently available for the prevention of drug and alcohol misuse can be listed under the following categories (Johns & Ritson 1994):

1. *Supply or availability control.* Strategies to control the availability of drugs of misuse rely on statutory control and law enforcement. In all countries, laws control the production, supply, import, export, sale, prescription and possession of drugs of misuse with the intention of ensuring that a sufficient amount is available to meet any genuine medical need and that none are diverted for illicit use. Actions taken include crop-control measures, interception and interdiction measures, controls on prescribed drugs, and taxation and legislative controls on tobacco and alcohol.

2. *Demand reduction.* Despite the best efforts of measures to control supply, alcohol and a wide variety of illicit drugs continue to be widely available in European countries. Supply-strategies must therefore be linked to

attempts to reduce demand. These measures include educational efforts and advertising controls. The last-mentioned measure has been confronted with hard economic reality (i.e. the interests of alcohol and tobacco companies, the commercial media and sports organisations). Some countries have attempted to tackle alcohol and drug problems through 'community development' strategies stimulating the members of communities to be directly involved with the developmental activities needed.

3. *Damage reduction.* The last decade has seen a much greater emphasis on the need to prevent, or at least reduce, the damage caused by alcohol and drug use. Such activities cannot, however, be included in the category of primary prevention.

1.2.5. Psycho-organic conditions

General

Psycho-organic disorders include dementias, organic psychoses and personality and behavioural disorders due to brain disease, damage and dysfunction. The most important category is dementia, which is a syndrome characterised by an acquired impairment of memory and other cognitive functions, change of personality, and a progressive erosion of personal and social skills (Jolley 1994). In some instances, dementia is symptomatic of underlying physical or other mental illness, and treatment of the underlying cause may resolve the dementia. The most common type of dementia is, however, dementia of the Alzheimer type, followed by multi-infarct dementia.

Dementia of the Alzheimer type has been shown to have genetic origins (the ApoE4 genotype) in some families, particularly when the onset is in the pre-senium or early senium. The search for environmental factors has revealed some evidence of e.g. late sequel viral infection (herpes simplex virus 1), direct toxic effect (e.g. aluminium), diabetes or an auto-immune process (Lancet Conference 1996).

Multi-infarct dementia is associated with male sex and with the occurrence of atherosclerosis, which is predicted by various risk factors contributing to heart disease, stroke and other atherosclerotic diseases. Hypertension has been identified as a risk factor in the development of multi-infarct dementia.
Head injuries causing brain damage may lead to different psychiatric outcomes including dementia, delirium, amnestic syndrome or alteration of personality. The key measure in their prevention is, of course, accident prevention, especially on the roads and at work places.

Strategies for primary prevention of dementias
1. *Symptomatic dementias.* Essential measures are the avoidance, early detection and treatment of those physical illnesses or other mental disorders which produce dementia-type syndrome.

2- *Alzheimer-type dementia.* Genetic counselling may be possible in the case of high-risk families. Genetic counselling has proved to be an effective measure in Huntington chorea; unfortunately, however, understanding and the provision of early markers are not as well developed in Alzheimer's disease. Work protection measures to avoid contamination by neurotoxic substances are important. There is also some evidence that education may prevent Alzheimer-type dementia; thus continuous education and intellectual exercises, even at a high age, are recommended. The unusual form of Alzheimer-type dementia associated with repeated head trauma, particularly from boxing, could clearly be avoided by banning sports in which such trauma occurs.
3. *Multi-infarct dementia.* A number of risk factors are well documented for the development of atherosclerotic changes in general. Energetic efforts and large-scale programmes to reduce these risk factors have reduced the incidence of coronary heart disease and stroke morbidity and mortality. Similar strategies would probably lower the incidence of multi-infarct dementia, too.

5 Literature

Alanen YO, Rekola JK, Stewen A et al. The family in the pathogenesis of schizophrenic and neurotic disorders. Acta Psychiatr Scand Suppl. 189, 1996.

Caplan G. Principles of preventive psychiatry. New York: Basic Books, 1964.

Dalgard OS, Tambs, K. Urban environment and mental health: A longitudinal study. British Journal of Psychiatry 1997:171, 530-536.

Davis H, Spurr P, von Roenne A, Hahn K, Cox A, Lynch MA. A description and evaluation of a community child mental health service. Manuscript, 1996.

Davis H, Spurr P. Parent counselling: an evaluation of a community child mental health service. Manuscript, 1996.

Eaton WW, Badawi M, Melton B. Prodromes and precursors: epidemiologic data for primary prevention of disorders with slow onset. Am J psychiatry 1995:152, 967-72.

Falloon et al 1993: Falloon IR, Laporta M, Fadden G, Graham-Holev. Managing stress in families: Cognitive and behavioural strategies for anhancing coping skills. Routledge: London, 1993.

Hawkins JD, Doueck HJ, Lishner, DM. Changing teaching practices in mainstream classrooms to improve bonding and behaviour of low achievers. American Educational Research Journal 1988:25, 31-50.

Health Education Authority. Mental health promotion: a quality framework. London, 1997.

Health Promotion Wales. Effective mental health promotion: literature review. Technical reports no 13. Cardiff, 1995.

Hersey JC, Kilnamoff LS, Lam DJ, Taylor RL. Promoting social support: the impact of California's 'Friends can be good medicine' campaign. Health Education Quarterly 1984:11 (3), 293-311.

Holden JM, Sagovsky R, Cox JL. Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. British Medical Journal 1989: 298, 223-226.

Jenkins R. Principles of prevention. In: Paykel ES, Jenkins R. Prevention in psychiatry. London: Gaskell, 1994, 11-24.

Johns A, Ritson B. Drug and alcohol-related problems. In: Paykel ES, Jenkins R. Prevention in psychiatry. London: Gaskell, 1994, 103-112.

Johnson DL. Primary prevention of behaviour problems in young children: The Houston Parent-Child Development Centre. In: Price R, Cowen EL, Lorion RP, Ramos-McKay J (Eds.). Fourteen Ounces of Prevention: A Casebook for Practitioners. Washington DC: American Psychological Association, 1991.

Johnson DL. The Houston Parent-Child Development Center Project: Disseminating a viable program for enhancing at-risk families. Prevention in Human Services 1990:7, 89-108.

Johnstone EC, Leff J. Schizophrenia. In: Paykel ES, Jenkins R. Prevention in Psychiatry. London: Gaskell, 1994, 80-89.

Jolley DJ. Old age psychiatry. In: Paykel ES, Jenkins R. Prevention in psychiatry. London: Gaskell, 1994, 148-156.

Kellam SG, Rebok GW. Building developmental and etiological theory through epidemiological based preventive intervention trials. In: McCord J, Tremblay RE (Eds). Preventing antisocial behaviour. New York: Guildford Press, 1992.

Lancet Conference. The challenge of dementias. Lancet 1996:347:1303-07.

Leff et al 1985: Leff JP, Kuipers L, Berkowitz R, Sturgeon D. A controlled trial of social intervention in the families of schitzohprenia patients: Two-year follow-up. Br J Psychiatry 1985:146:594-600.

Lehtinen V, Riikonen E, Lahtinen E. Promotion of Mental Health on the European Agenda. STAKES, National Research and Development Centre for Welfare and Health. Helsinki 1997.

Markman, HJ, Penik MJ, Floyd FJ, Stanley SM, Clements M. Preventing marital distress through communication and conflict management training: A 4 and 5 year follow-up. Journal of Consulting and Clinical Psychology 1993:61, 70-77.

Munoz RF, Ying YW. The prevention of depression. Baltimore: Johns Hopkins, 1993.

Murray CJL, Lopez AD (eds). The Global Burden of Disease. World Health Organisation, Harvard School of Public Health, World Bank. USA 1996

Pardes H, Silverman M, West A. Prevention and the field of mental health: a psychiatric perspective. Annual Rev Publ Health 1989:10:403-22.

Paykel ES. Introduction. In: Paykel ES, Jenkins R. Prevention in psychiatry. London: Gaskell, 1994, 3-10.

Price RH, Cowen EL, Lorion RP and Ramos-McKay (eds). 14 Ouces of Prevention. A Casebook for Practitioners. American Psychological Association. USA 1995.

Scott J, Paykel ES. Affective disorders. In: Paykel ES, Jenkins R. Prevention in psychiatry. London: Gaskell, 1994, 53-66.

Shure MB, Spivack, G. Interpersonal problem-solving in young children: A cognitive approach to prevention. American Journal of Community Psychology 1982:10, 341-351.

Strayhorn JM, Weidman CS. Follow-up one year after parent-child interaction training: Effects on behaviour of pre-school children. Journal of American Academy of Child and Adolescent Psychiatry 1991:30, 138-143.

Tudor K. Mental health promotion. Paradigms and practice. Routledge, London 1996.

Vega WA, Murphy J. Project Bienestar: An example of a community based intervention. In: Culture and the Restructuring of Community Mental Health: Contributions in Psychology. Series No 16. Westport CT: Greenwood Press, 1990, 103-122.

Veijola J, Puukka P, Lehtinen V, et al. Sex differences in the association between childhood experiences and adult depression. Psychol Med 1997 (in press).

Veijola et la 1998: Veijola J, Puukka P, lehtinen V, Moring J, Lindholm T, Väisänen E. Sex differences in the association between childhood experiences and adult depression. Psychol Med 1998:28:21-27.

Vinokur D, Ryn MV, Gramlich EM, Price RH. Long term follow-up and benefit-cost analysis of the Jobs-Program: A preventive intervention for the unemployed. Journal of Applied Psychology 1991:76, 213-219.

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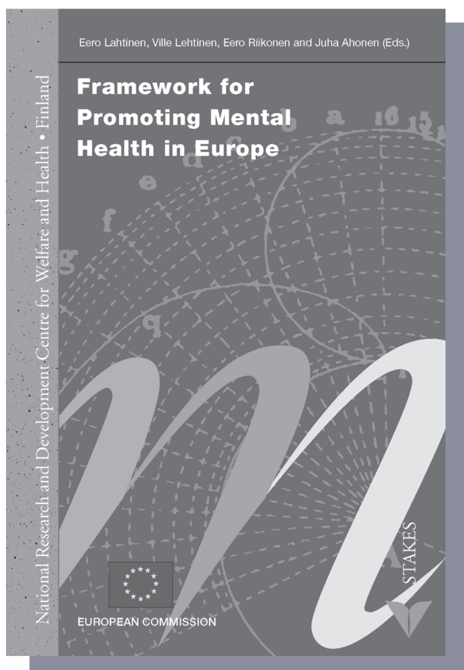

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