Imhpa

Implementing Mental
Health Promotion Action

**Integrating mental health promotion interventions into countries'
policies, practice and mental health care system
(the IMHPA Project)**

**Grant Agreement
nº SPC.2002474**

II. ANNEXES

**Final Report to the European Commission
DG SANCO/G**

October 25th, 2005

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ANNEX 1. COMPOSITION OF THE PROJECT PARTNERS

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1.4 Networks

Four European networks related to mental health with its four network representatives acted as partners of Imhpa. In addition the World Health Organization (WHO, European Office) was a partner in the project and the regional adviser for mental health its representative.

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1.5 Consultants

In addition the Impha project had four official consultants who provide guidelines and develop content work for the project products. In addition, Prof. Dr. M. Mittelmark acts as the country observer for Norway and its country based team leader.

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ANNEX 2.   MEETINGS

2.1   Barcelona: First Partner Meeting
4-5 September 2003,
Spain

2.1.a   Agenda

Thursday 4th September

9.00 - 9.45h:	Welcome and scope of the meeting : Eva Jané-Llopis
	Introduction of the Prevention Research Centre : Clemens Hosman
	Introduction of participants (30 minutes)
9.45 - 10.45h:	Project introduction
	Overview project : Eva Jané-Llopis
	Overview policy action plan : Peter Anderson
	Overview training manual : Evelyn van Weel-Baumgarten
	Overview database : Kristian Wahlbeck
	Discussion (30 minutes)
10.45 - 11.15h:	Coffee Break
11.15 - 12.00h:	Linking Ongoing Global projects
	WHO Mgap and promotion-prevention initiatives : Shekhar Saxena
	WHO Mental Health Promotion report : Helen Herrman
	IUHPE global effectiveness project, MHP : Maurice Mittelmark
	Discussion (30 minutes)
12.00 - 13.00h:	Task forces group work
13.00 - 14.00h:	Lunch break
14.00 - 15.30h:	Task forces group work
15.30 - 16.00h:	Coffee break
16.00 - 17.30h:	Task forces group work
	Discussion about foreseen difficulties, countries' special needs, dissemination-implementation-sustainability
17.30 - 18.00h:	Wrap up day 1
18.00 - 20.30h:	Spare time (meet at lobby at 20:30h)
20.45h:	Typical Catalan dinner

Friday 5th September

9.00 – 11.00h: Report task forces
Policy action plan: tasks, working style and foreseen difficulties
Training manual : tasks, working style and foreseen difficulties
Database : tasks, working style and foreseen difficulties
Adaptation to countries' special needs
Dissemination, implementation and sustainability
Discussion

11.00 – 11.30h: Coffee break

11.30 - 13.00h: Database discussion session
Content and headings of the database
Discussion
Agreement

13.00 - 14.00h: Lunch break

14.00 - 15.30h: Country based dissemination implementation: discussion session
Country based work and meetings
General discussion: next steps
Wrap up

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Thursday 4th September, 2003

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Thursday 4th September, 2003

Part I. INTRODUCTION TO THE IMHPA PROJECT AND ITS TASKFORCES

A)   Welcome by Eva Jané-Llopis to all participants.

B)   Presentation by Prof. Dr. Clemens Hosman of the Prevention Research Centre on Mental Health Promotion and Mental Disorder Prevention (PRC) of the universities of Nijmegen and Maastricht, from where the IMHPA project is coordinated (*presentation no.1*).

C)   All participants introduce themselves.

D)   Presentation by Eva Jane-Llopis: Overview of the project (*presentation no. 2*).

E)   The chairs of the three task forces (1. Policy Action Plan, 2. Primary Health Care and 3. Internet Database) introduce the background, aims and proposed work plan of each task force:
  1.   Presentation by Peter Anderson: Overview of the Policy Action Plan (*presentation 3*).
  2.   Presentation by Evelyn van Weel-Baumgarten: Overview of the Training Manual for primary health care professionals (*presentation 4*).
  3.   Presentation by Kristian Wahlbeck: overview of the Internet Database (*presentation 5*).

F)   Plenary discussion

The presentations are followed by a plenary discussion where the issue of the scope of the term "Mental Health" is discussed. There are different attempts made to define Mental Health, like in the in the WHO reports of 2001 (WHO, 2001) and 2002 (WHO, 2002). The term and its boundaries are also discussed in different chapters of the two books to be published by the WHO on the Prevention of Mental Disorders (Hosman, Jané-Llopis and Saxena, 2004) and Mental Health Promotion (Herrman, Moodie and Saxena, 2004). It is agreed that definitions of mental health will be developed for the scope of the Imhpa project.

It is noted that the indistinctness of the scope of the term Mental Health will also lead to indistinctness among inclusion of programs in the internet database. It is agreed that inclusion criteria for programmes in the database should be clearly specified. Inclusion

criteria could be defined at the outcome indicator level of a given programme. When outcomes include mental health indicators, interventions would be included, even thought the intervention itself would not be primarily targeting the promotion of mental health or the prevention of mental disorders (e.g. poverty). Another possibility would be to restrict inclusion of interventions within the field of Mental Health, including only those that primarily target promotion or prevention in mental health. A decision for inclusion criteria will be taken within the database taskforce.

Similarly, the difference between Mental Health Promotion (MHP) and Mental Disorder Prevention (MDP) should be made clear as both have different underlying paradigms. The two fields are different but can be seen as overlapping and contributing to each other. These distinctions will be further developed during the Imhpa project. On the website theories on prevention and promotion paradigms will be included to provide more background information on this issue. Examples will be helpful to challenge definitions and set boundaries. Since this discussion has been going on for years within the field, no absolute conclusions are reached during this meeting and it is agreed that this issue will keep needing attention during the whole project.

Discussion around the training manual states the importance to find possibilities to meet the needs of each specific country at the level of primary health care practice. There will be differences between countries, for example on activities of general practitioners (GPs). To ensure the training is feasible it is agreed that the training will take 2,5 days. The training manual is a tool for raising awareness for mental health problems and their relation with physical health. A longer training would be nice, but is not pragmatic/ practical. In addition, it is proposed that the training manual will be developed for Primary Health Care workers. This group is in need of information on Mental Health and the relation with mental and physical health. It is stated that there needs to be a theoretical discussion on illness conditions and illness diagnostic categories because different countries use different strategies and have different infrastructures (or none at all). In the next version of the country profiles questionnaire this needs to be taken into account. The fact that there are even differences within countries should be taken into account as well.

In terms of the scope of the project it is agreed that for now the project will focus on primary prevention and mental disorders. Substance abuse is a topic for a next project.

It is unclear what status the Impha project has and whether it is a network or just a group of experts. Although we are not a network at the moment it is suggested to explore the options of forming such a network, which would focus on mental health promotion and mental disorder prevention. In addition, every partner of the Impha group will explore options to enlarge the group identifying experts and professionals at the country levels.

It is also stated that the WHO will look at the products of this group very seriously because there is not much of this kind of initiatives in the world.

Part II. EXPLORING SYNERGIES WITH EXISTING INITIATIVES

1. Presentation by Shekhar Saxena: WHO Mental Health: Global Action Programme and promotion-prevention initiatives (*presentation 6*).
2. Presentation by Helen Herrman: WHO Mental Health Promotion Report
   (*presentation 7*).
3. Presentation by Maurice Mittelmark: IUHPE Global Effectiveness Project MHP (*presentation 8*).

The plenary discussion focuses on how the Imhpa project can be linked with existing initiatives and how it can contribute to developing MHP and MDP at the European level.

In relation to the work undertaken by the WHO, it is suggested that the Impha project could bring more attention of MHP and MDP at the WHO European office where to date the focus is still mainly on treatment and rehabilitation.

It is discussed that it would be important to link Imhpa with the forthcoming WHO Ministerial Conference in 2005. The WHO-European Ministerial Conference will gather all ministers of health of the European region including the EU member states to discuss about mental health, and what actions should be undertaken by countries in the European Region. Since it is an invitational conference the representation of the Imhpa group needs to be explored. It is also important to try to bring forward in the conference the work undertaken by Imhpa. Stakes, partner in the project and present at this meeting, has an organizing role in the Ministerial Conference and will help to explore how to link Imhpa with the preparations of the Ministerial conference. It is agreed that project leaders and partners will be engaged in exploring ways of how to link up with the Ministerial Conference.

It is also discussed that Imhpa should link up with other projects in the field of mental health promotion and prevention and in other relevant public health areas. This would include for example linking with existing European networks some of which are already partners in the project. Networks and relevant European organizations could facilitate the implementation of the Imhpa products by distributing the project outcomes through their members.

Part III. TASKFORCES GROUP WORK

Partners split into groups according to the task forces created for each of the 3 strands of Imhpa. Taskforce participants and background papers for each of the 3 groups are available separately and can be accessed at www.preventioncentre.net/imhpa. A short summary of the discussions and decisions undertaken in the taskforces group work is presented below.

1.   Policy Action Plan Taskforce

The discussion of the taskforce is focused around the Policy Action Plan background paper. The main topics of discussion and decisions taken in relation to the background paper were added to the existing background paper leading to the second version of the Policy Action Plan background paper.

It was also discussed that the Country Profiles Questionnaires should be revised and a second version should be drafted before data is gathered again. The data and their evaluation from the 38 questionnaires gathered so far will be translated into country profiles case studies by the project coordinators and distributed across Imhpa members. Maurice Mittelmark offers to take over the development of the second version of the questionnaire. This new version would be linked to a health promotion EC funded project that gathers information on health promotion infrastructures across Europe. The project is called HP Source, is coordinated by Prof. M. Mittelmark at the University of Bergen in Norway and its partners include the London School of Hygiene and Tropical Medicine and the International Union of Health Promotion and Education (IUHPE).

The chair of the task force (Peter Anderson) and the project leader of Imhpa (Eva Jané-Llopis) will draft the policy action plan. The taskforce will comment on the first draft of the Action Plan and the Technical Document.

The Policy Action Plan taskforce feels that there is a need for a taskforce meeting during the development of the action plan and asks the project coordinators to consider the options of calling such meeting.

2.   Primary Health Care Taskforce

The discussion of the taskforce is focused around the Training Manual background paper. The main topics of discussion and decisions taken in relation to the background paper include:

Cultural Differences

Since the Primary Care system and Mental Health services are not organised in the same way in all European countries the structure and content of the training manual could be adopted in relation to the situation of a specific country. The structure of the training manual will include some core components that should be included at all times. In addition, there will also be some components that could be used in different combinations depending on the target group, the country and its cultural environment. Country sensitive components for the training manual and adoptions-adaptations could be undertaken at the country levels if needed or could be developed in a future project.

Feasibility

According to a discussed timeline the first products are planned to be ready in October. Every task force participant was given an allocated task to come to this result. The Training manual should finally consist of background information on mental (ill) health, including a list of signs and symptoms, a list of risk factors to identify groups at risk and protecting factors/resources. It might be useful to add an appendix with guidelines on diagnostic criteria and treatment of mental disorders and interview techniques. The training course (full and shortened version) will consist of a Communication Skills component and a Problem Solving Skills component. It should be decided if and which other components should be taken into account. The issues of supervision and follow-up are also points of discussion.

Piloting

Once the training manual is developed, it is planned to do a training pilot in two or three countries (Croatia/Slovenia, United Kingdom/ Netherlands). The focus will be on Primary Care Physicians.

Manual development

The chair of the task force (Evelyn van Weel-Baumgarten), the primary health care consultants (Laurence Mynors-Wallis and Peter Anderson) and the project leader of Imhpa (Eva Jané-Llopis) will draft the Training Manual for health care professionals. The taskforce members will provide some background material and will work on specific tasks for the Training Manual. Once the first draft of the Training Manual is developed the taskforce members will provide comments and feedback on the first draft which will lead to a second, revised, version.

3.   Internet Database Taskforce

The discussion of the taskforce is focused around the Database background paper. The main topics of discussion and decisions taken in relation to the background paper include:

Software discussion

It is agreed that the software for the database will be a relational database which is compatible with different servers worldwide (Typ-0-3). It will include links to other relevant databases. The coding and entering of the programmes will be done from the University of Nijmegen.

Inclusion criteria for programmes included in the database

It is decided that both evaluated and non-evaluated programmes will be included, although the non-evaluated will be in a different section of the database with a shorter description and encouragement for evaluation. The non-evaluated section could be linked to the Case Report Project of the WHO. Also non-effective programmes will be included in a separate section of the database to give insight in non-effective strategies and discourage their implementation.

Language Bias

The language of the database will be English. To prevent language bias it is decided that for programmes available in languages other than English, Spanish and Dutch (handled by the project coordinators), partners will make sure the programme is translated, at least in a 2-page description.

Other sources of information are identified to search for potential programmes

- Literature searches
- Products of other networks
- Contacting key people in the filed
- Web search on e.g., "Prevention"
- Contact universities and other relevant organisations (use country profiles-information)

Quality of programmes

To check the quality of the included programmes, there needs to be a set of quality standards agreed by the partners. Quality includes issues such as evaluation methodology, type of research designs, internal and external validities. Different quality standards could be applied to different types of programmes. Existing quality assessment systems such as those developed by the Cochrane collaboration or the CDC "Community guide" could be explored and used.

Descriptives of the Programme

Each study, based on a programme, will be entered separately. This implies that each version of a specific intervention will describe the programme and its evaluation linking the different versions of the same intervention with related codes. Conclusions will be drawn both at the individual level and at the level of the intervention with repeated evaluations.
It is suggested that the order of the programme descriptives, as it is in the appendix of the Database background paper, is changed:

1:      Summary
2:      Programme background
3:      Intervention Description
4:      Implementation Characteristics
5:      Dissemination Characteristics / Implementation history

6:      Replication
7:      Context characteristics
8:      Infrastructure and Resources
9:      Evaluation design
10:     Outcomes
11:     Effect Predictors
12:     Contact details

More information about the taskforce and the work division can be found at
www.preventioncentre.net/imhpa

Friday 5th September, 2003

Part IV. FEEDBACK OF TASKFORCE WORK AND DECISIONS

The reporters of the three task forces present the issues discussed during the group work in the policy action plan, primary health care and internet database taskforces.

Presentation by John Kenneth Davies: Policy Action Plan Taskforce Outcomes.
Presentation by Jurgen Pelikan: Training Manual Taskforce Outcomes (*presentation 9*).
Presentation by Clemens Hosman: Database Taskforce Outcomes (*presentation10*).

Discussion following the presentations:

Policy Action Plan

The taskforce proposes that the Country Profiles Questionnaires should be revised and a second version should be drafted before more data is gathered. The data and their evaluation from the 38 questionnaires gathered so far will be translated into country profiles case studies by the project coordinators and distributed across Imhpa members. Maurice Mittelmark will take over the development of the second version of the questionnaire linking it to a health promotion EC funded project to gather information on health promotion infrastructures across Europe: HP Source.

Training Manual

Within this training manual for health care professionals existing information on mental health for primary health care will be brought together. The training manual is based on Problem Solving Theory (PST) which has proven to be effective in treating depression in primary health care. This foundation is considered a good starting point since it uses the same language GPs use. For now, the focus will be on prevention of emotional problems (depression, anxiety and stress). However, attention will also be paid to health promotion as this manual could be also seen as a health promotion tool because it promotes patient control.

Database

It is important to link the Imhpa database to other initiatives of this kind, such as the WHO initiatives or the SAMHSA database. However this will be only to the extent permitted in the limited time span of 1,5 years available within this project. It is also needed to link as soon

as possible with the network of DG Sanco, for example by publishing a report on the database in their website.

Part V. IMPLEMENTATION

The final session of the meeting is devoted to discussing dissemination and implementation of the Imhpa products across European Member States, both at the national and international levels.

During the discussion it is proposed to explore the existing science on dissemination. Some proposals are put forward on how to deal with the implementation part of the Imhpa project.

In some European countries there is still a daily struggle to develop and effectively implement mental health services. Although there is some concern on how MDP and MHP could be introduced and disseminated in such situations, there is a strong need for new input so problems with dissemination could be overtaken.

The dissemination of project products to NGOs (non-governmental organizations) is of great importance because they take initiatives in areas where ministries might have lost interest or are not considered as priorities. Examples are the IUHPE or MHE, both partners of Imhpa.

Other important entries for dissemination can be the already mentioned WHO Ministerial Conference, Eurohealth or other existing conferences in the field (WFMH conference, IUHPE conference, etc.). It is important to develop strategies to make sure these conferences are covered and Imhpa is represented.

The issue is raised that funding of the implementation of the products might be an even bigger problem than the dissemination. A solution could be to merge the implementation from these products with already existing initiatives.

Since one of the important starting points of this project is enhancing the implementation of effective programmes throughout Europe, the issue of resistance in practice to so-called model programmes is raised. This can be explained by the fact that people want to be creative in their implementation, they do not want to be hindered too much by strict protocols in implementation, they want to be able to change it to their own needs. Since this can hinder what is being implemented and therefore the effectiveness of the programmes, there will be information on the importance of implementation and on effective strategies in the Internet Database. Although it is recognized that there will always be resistance to change, the focus should be on what makes people move from this resistance to implement the new intervention. With the implementation of programmes the issue of authorship and copyright is addressed. The EC regulations on this should be consulted.

Finally, it is suggested that a small dissemination task force could be created to prepare a paper with thoughts about dissemination and a proposed dissemination plan both at the European and National levels. This will be placed for the moment within the Policy Action Plan taskforce. The project leader (Eva Jané-Llopis) will gather all the ideas and shared thoughts of dissemination into a first draft paper to discuss during the next general Imhpa meeting in May 2004.

Part VI. FINAL ANNOUNCEMENTS

Before official closure of the meeting some general logistic issues are raised:
- The next meeting will be hosted in Nijmegen, The Netherlands.
- The date for the next meeting will be proposed once attendance possibilities for some options in May 2004 are checked with all partners.
- Tickets will not be booked from the University of Nijmegen anymore. It is asked if partners will book their own flight, taking into account the maximum of 450 Euros available. Exact procedures will be announced later on.

Following these announcements Eva Jané-Llopis thanks all participants for their participation and closes the meeting.

References:
- World Health Organisation (2001). *The World Health Report 2001: New understandings New Hope.* Geneva: World Health Organisation.

- World Health Organisation (2002). *The World Health Report 2002: Reducing risk, promoting healthy styles.* Geneva: World Health Organisation.

- Hosman, C., Jané-Llopis, E., & Saxena, S. (Eds) (2004). "Prevention of mental disorders: An overview on evidence-based strategies and programs". Oxford: Oxford University Press. (In finalization)

- Herrman, H., Moodie, R. & Saxena, S. (Eds) (2004). "Promoting Mental Health: Concepts, Evidence and Practice". Geneva: WHO. (In finalization)

Relevant Internet sites:
- www.who.int/2001/2001/main/en/.

- http://mh-atlas.ic.gc.ca

- www.preventioncentre.net

2.2 Nijmegen: Training Manual Meeting
4 December 2003,
The Netherlands

2.2.a Agenda

Thursday 4th December

9.00h.	Welcome and brief catching up
9.10h.	Revision of core component of the brief PST
10.30h.	Coffee break
10.45h.	Revision of core component of the brief PST
12.30h.	Lunch
13.30h.	Revision of core component of the brief PST
15.00h.	Discuss and agree on the way forward for the communication skills component
15.30h.	Coffee break
16.00h.	Discuss and agree on the new evidence presentation about PST and the presentation about 7 stages
16.30h.	Discuss and agree on the way forward on the prevention stuff and risk factors
17.00h.	Discuss about the meeting with the expert group of GPs during the Wonca Conference
17.30h.	Any other business and wrap-up

2.2.b   Participants to the training manual meeting

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2.2.c   Minutes of the Training Manual meeting

Introduction

The meeting focuses firstly on having a general discussion on the training manual background development, its testing and follow-up implementation strategy. The second part of the meeting focuses on providing feedback on the components developed of the Brief Problem Solving module of the Imhpa training manual for health care professionals.

PART I. General discussion on the principles and way forward of the training

1.   Who is the training for?

-   For health care professionals in general

2.   Process after the training has been developed

-   First feasibility testing through focus groups
-   Testing materials: in 2 countries, including Netherlands and the UK
-   After testing there needs to be an agreement of how to publish the training and how it will be provided
-   A natural after step would be to seek its implementation and evaluation through a multi-country evaluation. Funding for this should be explored. For the evaluation process the MRC stages for piloting up to a large RCT will be followed

3.   Who is providing the training?

-   Laurence Mynors-Wallis and Evelyn van Weel-Baumgarten would lead the IMHPA pilots, in a staged process in 2-3 phases
-   Laurence Mynors-Wallis' team can start and pull a group for testing in the UK
-   Evelyn van Weel-Baumgarten will propose this to the medical registrars at her university
-   A source for funding for testing the materials will be explored
-   More thinking will be done around who could be trained as trainers (we need trained health care professionals). This will be defined and added in the manual. It is important that there is understanding of how primary health care functions also across European countries
-   The first pilot will focus on testing the materials. It will be done only in 2-3 countries. A detailed description of its goals and outcomes will be developed prior the testing of the materials

4.   What about the other interventions as modules?

Brief interventions can include:
-   Activity scheduling
-   Exposure and response prevention – simple measures in primary care
-   Breathing techniques
-   Insomnia
-   Add some guidance when to use different interventions

The manual can be supported by small components (handout)

It is decided that the training will include 3 basic Modules:
-   Communication
-   Depression: brief problem solving (bps)
-   Prevention of anxiety

5.   Training description

Training duration

-   2 days minimum for BPS
-   1 day for anxiety module

Course length

Size group: 6 participants x 2 trainers = 12 participants per group
Depends on the trainers 1 trainer to 6 participants
2 groups of 6; two role play one is the observer and provides feedback

Prevention-promotion

Prevention component, be aware of:

-   target group
-   provide a case for the need of mental health promotion and prevention
-   provide examples of anxiety and depression prevention

Revision core component BPS

-   Name changes: treat for help
-   Authorship order changes: Evelyn, Laurence, Eva, Peter
-   Add communication skills component

PART II. Feedback on the developed draft 1 of the training manual

A.   Outline of the training sessions

DAY ONE.

First session: 1.30h

-   Introduction
-   Prevention
-   Problem solving overview (some goals)

(20 min break)

Second session: 1.30h

-   PST 7 stages and video (in DVD format and transcribed for those cases where there is no facilities)

Lunch (1.00h)

Third session: 1.30h

-   Stage one and embedded communication skills (is a refresher, in a later stage add an appendix on communication skills. Peter looks for a good book).

(20 min break)

Fourth session: 1.30h

-   Stage 2 and 3

DAY TWO.

Fifth session: 1.30h
- 20 minutes dealing with issues day before
- 20 minutes introduction
- Stages 4,5, and 6 (40 minutes)
- 10 minutes general session

Coffee break

Sixth session: 1.30h
- Introduction stage 7 : evaluation (20 minutes)
- Explain how it fits in a gp consultation everyday practice (rest)
- Handout 4

Lunch

Seven session: 1.30h
- Consolidation: practice visits 2-3 of bps in a row (20 minutes each + 10 minutes feedback), make the video as an option

Coffee break

Eight session: 1.30h
- Wrap up session
- Problems with problem solving
- Any other queries
- Laurence has a presentation
- Evaluate the training
- Administrative stuff

B. Time plan for draft 2
- Mid February: first draft of completed version is sent among 4 leaders
- Feedback is provided to Evelyn van Weel-Baumagarten
- End March second meeting to endorse the completed version
- 8th April distribute the draft training manual to the IMHPA taskforce
- May 10-12 Impha taskforce provides feedback
- June 1st expert meeting with a group of GPs at the Wonca conference for exposure of the training manual and provision of feedback among primary health care experts of 5 countries

C. Other questions to gather feedback on
Who should we train?
Who will use these skills in practice?
Does it need to be adapted to cultural context?
Are there other components that you think could be added?

2.3 Nijmegen: Policy Meeting
14-15 January 2004,
The Netherlands

2.3.a Agenda

Wednesday 14th January

10.00h:	Country profiles questionnaires discussion:

- Introduction to results of country profiles: Eva Jané-Llopis
- Introduction to version II of the country questionnaire: Maurice Mittelmark
- Discussion about the new version and future steps

11.00h:	Coffee break
11.20h:	Country profiles questionnaires discussion
12.30h:	Lunch
14.00h:	Policy document discussion
15.30h:	Coffee break
16.00h:	Policy document discussion
17.30h:	Wrap up day 1
18.30h:	Dinner

Thursday 15th January

8.30h:	Brainstorm on dissemination – implementation strategy
10.00h:	Coffee break
10.15h:	Content discussion on technical document
11.30h:	Next steps
12.30h:	Lunch
14.00h	Possible discussion of any other issues left unsolved (with those who stay)

2.3.b   Participants to the Policy Plan Meeting

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2.3.c   Minutes of the Policy Plan meeting

A. THE COUNTRY PROFILES QUESTIONNAIRES

A.1. Discussion of Country Profiles Questionnaire version 1

Following a general discussion on the country profiles questionnaires the following points are agreed:

1.   Use and purpose of the questionnaires

- Raise awareness of the problem, need, and possibilities for intervention
- Drive interventions and implementation
- Stimulate the process of closing gap between policy and research
- Provide alternative models according to country situations and monitor change

2.   Comparisons across countries

- It is not the primary goal at this stage
- It might be considered in the future as it can work as a motivating factor for some countries to improve their situation in comparison to other countries. The different information systems will have to be addressed.

3.   Country coalitions

- Sweden will form a country coalition to complete version 2 of the questionnaire
- In forming country coalitions other countries can make use of the existing Mental Health Councils or other mental health groups (e.g., Poland)
- Imhpa will provide a guideline paper on types of coalitions and their formation

4.   Implementation plans

- We will focus on the process of the coalition and use it in defining an implementation plan for the products and mental health promotion-prevention
- We need to raise awareness that the definition of an implementation plan is important and should be planned ahead

5.   Solutions to the problems that raised during the completion of version 1

During the completion of the first version of the country profiles some problems were identified. Solutions to deal with each of the problems are presented and discussed. It is agreed that the second version will include in the questionnaire:
- Part I: A short accompanying paper with instructions and a glossary
- Time: Respondents will be provided with one month to complete the questionnaire
- User friendly: The questionnaire will be made user friendly, in a word file which can be printed or easily be filled directly at the computer
- Within countries inconsistencies: every country will be encouraged to form a country coalition and to fill in the questionnaire through consensus; one person per country will be assigned as the questionnaire responsible
- Between countries inconsistencies: only items that are objective enough will be compared; documents for proof of statements ("pedigree") will be used for cross-checking

- Construct validity: the new version of the questionnaire will ask to provide documents as proof of statements ("pedigree") which will be used as a checking system for validity; other problems encountered will be discussed among the members of the country coalitions
- The profiles will include both national and sub-national/regional levels although countries will be encouraged to fill it in at the national level when possible

A.2. Link with HP Source and Country Profiles Questionnaire 2

HP Source project is a European database for capturing the infrastructures available for health promotion. Maurice Mittelmark is the project leader of HP Source and, following his first talk about it during the Barcelona meeting, he presents the project to the Action Plan Taskforce with the open question whether Imhpa would like to join HP Source.

HP Source is intended as a general country-driven research tool. At the moment all European Union countries and Norway are included. To date has captured infrastructures available for health promotion in general in all its member countries. HP source has now become a self-sustained database. All partners who decide to join in have to contribute a one-time 4000 Euro entry-fee.

After discussion it is decided that IMHPA will link up with HP Source in the form of a cooperative coalition. This link with IMHPA would be the first expansion of HP Source project for a topic area: Mental Health Promotion. This will mean that IMHPA will be the case example for HP Source in their expansion to other topic areas that are under consideration at the moment. The added value for IMHPA includes having a direct public relations strategy to all other health promotion areas, use of database and a systematic comparison to other health promotion areas; easier data management using existing software, visibility and future options to expand globally. This link does not exclude Imhpa to link with other projects.

The difference with HP Source and IMHPA is that IMHPA has the intention to capture more (e.g. implementation issues) than only the infrastructures available for health promotion, like HP Source does. This larger aim will not be a problem and all the other questions will be included in the IMHPA section of HP source.

Important issues concerning HP Source that Imhpa will consider:
- One person per country should be nominated the responsible person for the questionnaire (in HP source the responsible is called researcher).
- In HP source all questions have proven answerable except funding-questions.
- For validity reasons it is necessary to ask for (original) documentation ('pedigree') as proof of the statements and to be certain of the quality of the information included in the database. HP source will do quality control studies. In addition this becomes a rapid gateway to certain documents.

Agreements on Country Profiles Questionnaire version 2

- There should be a coalition description of its members
- Everyone agrees on the idea of "pedigree" (proof documents)
- In most items it was decided to separate Mental Health Promotion and Mental Disorder Prevention. This decision came about thinking about its political consequences as some governments are more MHP oriented or vice versa. Furthermore, Mental Health promotion is basically not the same as Mental Disorder Prevention. The introduction should explain why this distinction was made. Definitions will be added to the glossary.
- Publication plans on the questionnaire should be kept in mind.

NEXT STEPS and TIMETABLE for Country Profiles Questionnaire version 2

Action points for members of taskforce

- Maurice will take on the improvements of the Version 2 of the questionnaire according to the specific comments that were made during its discussion
- Eva takes on the instructions and adds a glossary
- Eva drafts list of arenas for questions 15-16 of page 17/18
- Clemens will write the question that includes the RIAGGs, in section VII; he will provide a list of types of organisations
- Maria will draft a question on how Mental Health Promotion is integrated in the existing Health Promotion – Public Health system
- Peter will re-draft question 10

Timetable

- 30th January: Task force members send Maurice their agreed tasks (see above)
- 20th February: Maurice sends the next version to taskforce members
- 5th March: Taskforce members provide feedback on draft version 2
- 11th March: Maurice sends second revisions in a second draft
- 19th March: All final comments for fine-tunings sent to Eva
- 26th March: Final version ready for pilot testing in Sweden
- 27th March: Questionnaire version 2 is sent to all Imhpa partners
- 27th April: Comments from Imhpa partners back
- 3rd May: Telephone feedback with Lars about pilot testing
- 10th-12th May: Impha meeting: presentation of new questionnaire and pilot test

B. THE POLICY ACTION PLAN

The first draft of the Policy Action Plan is discussed. It is agreed that it is targeted at a policy audience at country, within-country and European levels that have responsibility for mental health, health promotion or public health.
It is agreed that the Action Plan will include 3 different documents:

1. The policy action plan: 30 pages.
2. A technical document providing all the evidence to doc 1: 150 pages
3. A short summary: 2-3 pages (Including an easy check-list for ministers), which would be the summary of the Action Plan itself

Targets and action points:
they should be concrete; should only be used if they can be measured, so must be made measurable (indicators issue); realistic and precise targets should be used; countries are given the freedom to set their own targets.

General discussion and agreements for inclusion

- More emphasis will be given at the beginning about action, about what we know and what can be done.

- The health gap: conceptual analysis of health (mental health should be defined), will start with a general view about health, mental health is part of health; this section will make use of the Ottawa charter
- Make sure the values in which we base ourselves are stated throughout
- Social policy will be included to provide the examples of their influence in mental health, which can be used in the different sectors. The most convincing issues will be selected and pulled out as a core
- A section will be added on the relation-definitions of prevention and promotion
- Missing settings will be included (e.g. prisons)
- Make a clearer call for action with stronger language, highlighting the evidence
- The disorder section will start with a mental health promotion introduction to achieve a better balance between prevention-promotion
- Both health services and social perspectives will be integrated
- Language should be rephrased making more use of provocative language
- Tertiary prevention is too complex to mention it briefly so it will be left out. This will be clarified in the introduction.
- Recommendations should reflect the need for European data and research
- The short document will be made practical (adding a 'checklist') so priorities in a country can be set easily
- Imhpa will try to get important health related organizations to endorse this document (e.g. WHO, EC, IUHPE) so that it is clear it is not another document, but a framework to be used as a model in countries and regions.

NEXT STEPS

- Two drafts will be finished for the next IMHPA meeting in May:
  - Draft 1 of policy action plan
  - Draft 1 of the longer technical document of policy action plan. This document will follow the structure of the Policy action plan.

Assigned tasks:

- Eva and Peter will work on the two docs adjusting them to the above comments.
- John will provide a written part on the issues he raises including: art culture and spiritual health, the role of mass media and advertising, fear of crime, etc. for the technical document. A summary of this will be added to the action plan
- Maurice will assist in providing a few indicators of mental heath promotion to link parts III and IV (intro to part IV on mental health promotion)
- Lars and Maria will read and give comments
- John and Eva will work on linking Imhpa and the training on mental health promotion with existing training projects John is leading
- Eva will contact Simo Kokko at WHO about the Ministerial conference and the Imhpa action plan for prevention-promotion. Will do this also through John Henderson and Kristian Walhbeck.

Timetable

- 15th March: Second draft action plan will be send to taskforce members
- 31st March: Task force members will send comments back to Eva & Peter
- 11th April: Complete draft 1 of the Action Plan is sent to all Imhpa partners
- 10-12 May: IMHPA meeting, the action plan will be discussed and endorsed

C. BRAINSTORM ON DISSEMINATION – IMPLEMENTATION STRATEGY

The brainstorm session is divided into identifying areas for dissemination and implementation at the European level and at the country levels. Different areas at both levels were identified:

- Influencing policy through link with national ministries and European networks
- Use national/ international events and conferences
- Provide training
- Expand research
- Search for funding options
- Integrate or link IMHPA with existing projects and networks (e.g., healthy schools network)
- Publication plans/ PR/ media

The brainstorm ideas that were identified for dissemination and implementation will be used to draft a strategy and implementation plan that will be presented and discussed during the May meeting. Eva will make the draft.

The strategy plan could be put in a form of product pack (guidelines) to distribute. This could be in a format for example of a Mental Health Promotion Kit that could include different materials (e.g. CD's, lectures, press releases, slogans etc.).

2.4 Amsterdam: Training Manual Meeting
29 March 2004,
The Netherlands

2.4.a Agenda

Monday 29th March 2004

14.00h.   Welcome and brief catching up

14.10h.   Revision and comments on training manual BPS

16.00h.   Coffee break

16.15h.   Revision and comments of training manual BPS (continuation)

17.30h.   Discuss Imhpa meeting and next steps

17.45h.   Discuss ideas on new proposal: efficacy trial

18.10h.   Discuss meeting with the expert group during Wonca

18.30h.   Any other business and wrap-up

2.4.b   Participants to the training manual meeting

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2.4.c   Minutes of the Training Manual meeting

Amsterdam, 29th March - Meeting on Training manual

1. Framework, add the symptoms treatment
Patient with anxiety/depressive symptoms
Make diagnosis to:
Q1 ? PHYSICAL/STROKE/PSYCHOLOGICAL Condition
IF YES, TREATMENT
IF NO,
Q2. Is there a specific symptom that can be treated?
If yes, symptoms
anxiety management
Insomnia
If no, then problems,
Then brief problem solving

2. Length of course
Pull together both trainings into a 2 day course
Managing emotional symptoms and problems to prevent mental disorders
2 day training course covering both PST and Anxiety, we need:
12 trainees
2 trainers

3. Distribution of both anxiety training and BPS into one manual
Session 1: Introduction
       1 hour
       Chat
       Introduction to course
       What prevention is,
       Risk factors, symptoms
       Symptoms/ conditions
30 minutes
       What is anxiety
       What is depression
       Framework

Session 2: (option 1)
Symptoms and problems
    ↓
Listen etc: communication skills
    ↓
Explanation and reassurance: reattribution

Remind and rehearse communication skills
Link between problems and symptoms
Understanding that problems can lead to both psychological and physical symptoms
Treatment can focus on problems or on symptoms

Session 2: (option 2)

Stages and goals of problem solving (20 mins)
Video (20 mins)
Communication skills (40 mins) Stage 1
De-briefing and questions
[? new video 30 minutes (3*10 minutes)]

Session 3: (option 2)
Introduction to Stages 2 and 3: 5 mins
Vignette:
Working on gertie and pulling though 25 mins (Gertie from Lawrence)
Role play: 45 mins for stages 2 and 3

Session 4: (option 2)
Stages 4,5,6 (worksheets sessions 3 and 4)
(Optional patient handout)

30 minute coffee breaks
Lunch 1 hour

End of day 1

Session 5
Where we have got to so far and goals and stage 7: 15 mins
How to manage it in 10-15 minutes
Plan number of appointments and outline 25 minutes
Discussion 30 minutes
Patient leaflet + Worksheet 5 mins
Introduction to vignette 15 mins
Session 6
Bringing it all together
Role play in groups of 3
We've talked a lot about problem solving, now we will look at conditions for which there are proven interventions.

Session 7
Icebreaker to change thinking 30 mins
Managing symptoms
Second session of 'anxiety'
Short refresher Framework, going onto symptoms
What is anxiety - it is not a heart attack
Education and reassurance
Distraction; Over breathing; Exposure; Exercise; Insomnia
2 Vignettes for role playing

Check list of what needs to be said
Teaching aid of check list to be made by Lawrence check list of reattribution

Session 7 deals with   unexplained physical symptoms (30 mins)
                                        Generalized anxiety   (30 mins)
Role play in pairs
10 mins introduction

20 mins practice

Session 8
Third session of 'anxiety'
Evaluation
Symptom management:
Unexplained physical symptoms: reattribution
Symptom of generalized anxiety: education and reassurance, distraction, exercise
Symptom of avoidance behaviour; exposure and response prevention
Symptom of insomnia: simple sleep hygiene

Session 8
Avoidance behaviour 30 mins (vignette from Lawrence)
Insomnia 30 minutes (from Lawrence)
Well done and questions: 10 mins
Evaluation 20 minutes

Visual aids for each session (incorporating presentations)
In printed manual and in the trainees session

4. Trainings to develop and layout
Manuals for trainers and Manuals for trainees, including: Handouts, Background material, Visual aids,
For IMHPA just trainers manual: Use course participants; Use the word interventions

Ordering: Session plan, Aims and objectives, Background notes for trainer, Visual aids, Handouts. Headers with session 1 aims and objectives; Session 1 background notes; Visual aids like handouts with 3 visual aids and notes
Ordering: Content; Comment on content; Layout; Check layout;
Copied and printed as a book, with photocopies of vignettes, handouts etc. In the future as a ring binder

5. Timetable
Monday 19th send to all
Lawrence away from 9th and back on 19th.
Lawrence gets stuff to Evelyn by 2nd April
Evelyn starts to work on it and discuss with Eva on 8th April
Milou gets everything on Wednesday 14th
Milou sends it out on Friday 16th
Evelyn works on it on 19th
Lawrence works on it on 20th
Julie sends it to Milou on 21st
Send out pdf file on 23rd April.
Evelyn sends it to the WONCA people

6. Taskforce meeting in May
Evelyn and Lawrence are the experts. Peter will chair it. Move the discussion from the difficult issues.
Presented by Evelyn to main group; Jurgen take notes for report; Send whole document to the whole group with a background note that includes questions for the task force. Some include: Fit

in your country, which groups to train, expected barriers. Announce that the next version after WONCA will be sent in August to the whole group

Explanatory note:
This has what has been developed. This is a training manual for trainers to give to health care providers. There will be a manual for trainees. As we agreed in Barcelona we are doing something on anxiety and something on brief problem solving. This is a draft unedited version.

Questions to send to task force:
Is there a need for something like this
Would it fit in your country
What kind of health professionals would be trained
What would be the barriers and facilitators to implementing the training
What are the key organizations that need to be contacted in your country
Needs for adaptation
How can it be translated
General comments on the training manual
If there are detailed comments for corrections or editing please put them in writing

7. Pilots
Proposal to cover the Dutch pilot, To take place in Nijmegen, Get accreditation: fund raise for it through the NFGV
Consider accession countries: we could try to pilot in Slovenia, involve Andrej
Evaluation of pilot; After pilot some revision
Evelyn and Lawrence to determine dates
Budget needed: €6000 to cover Lawrence's costs
Need a publication with all the task force as members acknowledged

8. Efficacy:
New study: Multi country RCT; Based on WONCA group plus Spain and Austria
England, Netherlands, Belgium, Germany, Italy

2.5   The Hague: Second partner meeting
10-11-12 May 2004,
The Netherlands

2.5.a   Agenda

Monday 10th May

14.00 - 14.40h:	Welcome and scope of the meeting
	Short round of introductions
14.40 - 15.30h:	Policy action plan session
	Overview on the WHO Ministerial Conference on MH: Simo Kokko
	Using economics in mental health policy: David McDaid
	Introduction to the European Policy Action Plan
	Discussion
15.30 - 15.50h:	Coffee Break
15.50 - 17.20h:	Plenary discussion and feedback on the Policy Action Plan
17.20 - 17.30h:	Any other issues and wrap up day 1
	Evening programme
18.20 - 19.00h:	Optional walk around Scheveningen (meet in the lobby at 18.20h)
19.00h:	Dinner at the Carlton Beach Hotel restaurant

Tuesday 11th May

9.00 - 9.30h:	The Country profiles questionnaires
	Short results of Imhpa questionnaire version I: Eva Jané-Llopis
	Overview on Imhpa questionnaire version II: Maurice Mittelmark
	Overview on the pilot of questionnaire II in Sweden: Lisa Ineland
9.30 - 10.45h:	Plenary discussion and feedback on the Imhpa questionnaire version II
10.45 - 11.15h:	Coffee Break

11.15 - 12.45h:	Breakout session: task forces work
12.45 - 14.00h:	Lunch break
14.00 - 15.30h:	Plenary feedback on task forces group work
	Plenary discussion on the Imhpa database
15.30 - 16.00h:	Coffee break
16.00 - 17.30h:	Breakout session: Dissemination-Implementation plan
	Discussion in groups about the dissemination and implementation of the Imhpa products, expected difficulties and countries' special needs
17.30 - 17.40h:	Any other issues and wrap up day 2
	Evening programme
18.00h:	Optional guided walk in The Hague centre (meet in the lobby at 18:00h)
19.15h:	Indonesian dinner in The Hague centre

Wednesday 12th May

9.00 - 10.30h:	Plenary discussion on dissemination and implementation plans
	Report of group discussions
	Difficulties and adaptation to countries' special needs
	Discussion about next steps on dissemination-implementation
10.30 - 11.00h:	Coffee break
11.00 - 12.30h:	Plenary discussion on the country coalitions and other synergies
	Creation of country coalitions and use of country meetings
	Exploring creating synergies with existing initiatives and networks
	Next steps and Imhpa phase II
	Any other issues and meeting wrap up
12.30 - 14.00h:	Light lunch

2.5.b   Participants to the second partner meeting

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2.5.c   Minutes of the second partner meeting

Present:

Peter Anderson; Margaret Barry; Josipa Basic; Hartmut Berger; Czeslaw Czabala; John Kenneth Davies; Ines Garcia Sanchez; Maria Heitor dos Santos; John Henderson; Emma Hogg; Clemens Hosman; Lisa Ineland; Eva Jané-Llopis; Simo Kokko; Athanasios Constantopoulos; Karl Kuhn; Beatrice Lamboy; Milou Leunissen; David McDaid; Maurice Mittelmark; Laurence Mynors-Wallis; Jurgen Pelikan; Dainius Puras; Mirella Ruggeri; Marco Stegagno; Airi Varnik; Tom Vermeulen; Kristian Wahlbeck; Evelyn van Weel- Baumgarten.

Monday 10ᵗʰ May, 2004

Part I. OPENING OF THE MEETING

A)   Welcome by Eva Jané-Llopis to all participants and explanation of the scope of the meeting. Apologies are presented for Marco Stegagno and Toker Erguder who are unable to attend the meeting.

B)   Short round of introductions by all participants.

C)   Presentation by Eva Jané-Llopis: The WHO Ministerial Conference on Mental Health *(annex 1).* Presentation is available on the IMHPA website (www.imhpa.net).

D)   Presentation by David McDaid: Mental Health Economics *(annex 1).*

Part II. PLENARY DISCUSSION ON THE POLICY ACTION PLAN

The policy action plan is a framework to stimulate action at the European and country levels. The discussion around the Policy plan was structured into 4 themes:

1.   General comments

The purpose of the policy action plan is to provide advice to health ministers, to technical staff working in the ministries of health and to the European Commission. The document is meant as an advisory document which is not legally binding.

At the country level the document should be seen as a framework that could be used to support the development of country based action plans. Because each country is unique the action plan should clearly state the mental health promotion (MHP) and mental disorder prevention (MDP) principles that guide policy and action and that are applicable throughout European countries, the EC and the WHO. The document could mention existing binding approaches to policy, like the articles in the Amsterdam treaty.

The document can be used to send out three messages:
1. There is overwhelming evidence that MHP and MDP can improve MH in Europe.
2. MH does not yet have the priority it needs; this needs to be changed.
3. Advocate that all countries would develop a national action plan for MHP and MDP as a first step to improving the action in MHP and MDP.

The first draft of the policy action plan is noted to be a broad, idealistic and over inclusive document. Since the whole piece is too broad to digest it is suggested to make it into working

parts. However, because the purpose of the technical document is to provide one framework it is decided to keep it as a whole.

It is recognized that priorities and realistic objectives should be included in draft 2 along with the references to the presented evidence. It is difficult to select priorities for action and that will be left to the countries to decide according to their national situations. One option to support national prioritization is to select mental health areas where support already exists from different organizations.

There will be two documents, a technical and a political document. It is proposed to specify actions with convincing and straightforward use of language. Easy prescriptions, such as "all resources for implementation should dedicate 10% for evaluation", could be used to identify minimum actions that countries and governments could undertake. From the country profiles best examples could be used.

It is also suggested that shorter versions for different stakeholders could be developed. This is received very positively although it is recognized that such initiative should be left for a possible future project.

Final decisions

In line with the original IMHPA plans, it is decided that two different documents will be developed. A first document is a technical document, including references, of about 50 pages presenting the evidence of what works and objectives for action. The document will also include a two page summary and a 1-page with ten key action points. The second document will be a policy document that takes into account the political climate, reflects the EC situation, tries to integrate MH and uses existing directives. It will be a shorter document with a maximum of 20 pages, with the 2-page summary and the 1-page with ten key action points. These two documents are agreed to be spread out among 4 target audiences in the following way:

- The European Commission: policy and technical document
- The WHO ministerial conference: policy document. It is suggested that IMHPA prepares and proposes several statements to the WHO to be considered for inclusion in the conference declaration.
- Policy makers and ministers: policy document with persuasive statements.
- Technical staff at the ministry of health: both policy and technical documents

2. Structure

Draft 1 of the Policy action plan has a list of 10 action points in the beginning of the document. It is noted that this list might be too overwhelming. It is suggested that the minimum action to recommend is that each country develops a national action plan for MHP-MDP. The rest of action points should be made optional.

It is discussed that within the big five there should be a balance between MHP and MDP and an emphasis on positive early years (not so much focussing on illness). The conditions not included in the big five should be mentioned in the introduction of the section (e.g. schizophrenia, dementia).

In relation to the ordering of the document it is suggested to move section 1.6 (MH and human rights) and section 1.7 (promoting MH and MDP) up front and to add a new section 1.9: summarizing the major progress already been made, to point out that it is actually possible. Another idea is to add a new section about what health and social care ministries specifically can do. Since they have the first responsibility to mental health their role should be emphasized.

3. Use of targets

Targets need to be feasible and more realistic. It is suggested to change the word "targets" into: "what should be done"; followed by: "how it can be done" and to use strategic objectives that include both process and outcome indicators. It is proposed to have a summary and a selection of targets that combined can describe a mentally healthy society. Mental Health Impact Assessment (MHIA) is a target that should be suggested.

4. Section on life transitions (Section 2.3.1)

Although it is agreed that not all life transitions can be described in this section, the following topics are suggested to be added: societal stress and social transitions, caregivers, transition from work to retirement, physical ill health and family breakdown. It is suggested to change the 'stressful life events' into 'stressful life conditions' and to include a piece of text about armed conflicts in the migrants section.

Tuesday 11th May, 2004

Part III. THE IMHPA COUNTRY PROFILES QUESTIONNAIRE VERSION II

A)   Introduction by Eva Jané-Llopis to results of IMHPA Questionnaire I (annex 1).

B)   Presentation by Maurice Mittelmark: IMHPA Questionnaire II and HP Source *(annex 1).*

C)   Presentation by Lisa Ineland: Pilot of the Country Profiles Questionnaire II in Sweden *(annex1).*

D)   Plenary discussion on the IMHPA Questionnaire Version II.

General issues:

The creation of country coalitions and the completion of the IMHPA questionnaire through the country coalitions bring different health and mental health stakeholders around the table and gets the discussion on MH issues started. This leads to discussions about the national situation of MH, stimulates awareness of MH issues and can promote action at the country level. The intention of IMHPA is to have the questionnaire filled out at the national (whenever possible) or regional level through country groups or coalitions.

Mental health is structured into the care system in different ways across countries. For example in Sweden as in many other countries, MH falls under Public Health; in Finland there is a delegation of authorities. This diversity of constructions can make it difficult to get a clear picture of the situation of MH. To avoid difficulties in the provision of information the introduction of the questionnaire should explain how the information will be used.

It is noted that translation of the questionnaire might be necessary for some countries. Funding options should be explored.

For the questionnaire to be well received across countries it is suggested: to involve the EU to request countries to fill out the questionnaire (e.g., a covering note from the commissioner could be helpful to get ministry people interested), to distribute the reports regularly (linking up with other initiatives) and to make the information available to the public arena.

To expand the value of the questionnaire it would be an idea to link up with e.g. WHO research data or with working parties of the EC. Another way to ensure sustainability is to try to build some of its items into regular data collection in countries (Eurostat).

Specific issues:

- Questions 2.1, 2.2, 2.3 and 2.4 highlight the presumption that there is a general government working on MH. However, for example in Finland this is against the law. Therefore one should formulate the questions reflecting the complexities of every country's structure. This could be discussed with the coalition when completing the questionnaire and specified in the forms accordingly.
- Question 2.5 needs to be completed by asking what recent trends in allocation of resources there are; what is the actual budget?
- Question 6 can be completed by asking in relation to implementation what the actual principle bodies are on national or regional level.
- Question 8: lacks the opportunity to provide the programme(s) itself. This will be provided by the country coalition to the database taskforce following the programme description template of the database.
- In addition, it has been suggested to add a general question at the end of the questionnaire about what the country considers as a need for international support.

Part IV. TASKFORCES GROUP WORK

Partners split up into groups according to the task forces created for each of the 3 IMHPA strands. A short summary of the taskforce discussions is presented below.

1.   Policy Action Plan Taskforce

Issues discussed include: relation to EU directives, link to the WHO conference and the prioritization of action points. Agreed next steps include:

Technical document.

Edit the present document into the technical document of about 50 pages in length with a good summary and references. Reframe the relevant parts of the document towards existing EU legislation and directives. Give emphasis to the need for country action. Change the word "targets" into "what should be done", with strategies for action emphasizing how it can be done.

Policy document.

Draft a short policy document/action plan based on the above, modelled e.g. on the European Alcohol Action Plan (10-15 pages).

Media briefing pack-press release.

Prepare a media briefing pack and a press release.

2.   Primary Health Care Taskforce

General issues. All members of the taskforce congratulate the authors on developing a manual. It provides a clear useable product. All members feel it would be useful in their countries. The manual has elements of training on health promotion, prevention and early intervention and different aspects of the manual could be targeted to different professional groups. A key aspect of the manual is the development of empowerment, both for health professionals delivering the contents of the manual and for patients. It is noted for example that

in Germany and Austria, the training would need to be an intervention in order to attract payment for general practitioners.

Recommended improvements to the manual. On content, there is a discussion as to whether there should be a specific section on mild depressive symptoms. It is noted that there are aspects of the intervention appropriate for mild symptoms of depression throughout the manual, but it is felt that the manual could be extended. It is also noted that some practitioners might need a greater emphasis on communication skills. This will not be incorporated into the manual, but if necessary, a communication skills course could be provided. Format wise it is recommended that the manual was designed in a modular form rather than to be delivered over 2 or 3 days. The manual would need to be adapted for the participating countries, including translation and inclusion of country specific references. In terms of implementation the training should be marketed alongside other available trainings.

Next steps. The next step with the manual is to pilot its feasibility in the UK and The Netherlands. Other countries express a desire to be involved in the pilot. It is agreed that subject to funding, the UK and Netherlands pilots should go ahead. The feedback from the taskforce, the general practitioner's input at the Wonca meeting and the feedback from the pilots will compose a revised version of the manual. This revised manual will then be the final product of IMPHA under the current fund. The further evaluation and dissemination of the manual would require a separate task group and funding.

3. Internet Database Taskforce

The main topics of discussion and decisions undertaken in relation to the discussion items include:

Inclusion criteria for programmes included in the database. It is recognized that it will be difficult to clearly separate in the database between effective and non-effective programmes. The differences between programmes can be made at two levels: level of evidence and level of effectiveness. Instead of making a distinction at the level of effectiveness starting with the level of evaluation (evidence) could be a good alternative suggestion. However, it is also argued that the information of what does not work is very important and therefore there is a plea to include non-effective programmes. Non-effective programmes can also have effective side-effects which underlines the difficulties with setting a cut off point. It is considered to include non-effective programmes at a later stage in the database. However, models of good and best practice should be included in the database at this stage. For the use of already existing reviews it is suggested that the primary focus will be on the inclusion of evaluated programmes.

Programme retrieval at the country level. It is agreed that all Imhpa partners should identify and deliver examples of programmes of their countries in order to deal with the retrieval of 'unpublished literature'. The risk of asking only one person from one organization captures the chance of receiving a biased response (e.g. programmes only from that organization). It is suggested that a link is made with the IMHPA country profiles questionnaire to get an objective opinion from each country coalition of what are the best national programmes. No restrictions in topic area are made for the programmes to be collected at the country levels. The Nijmegen group will receive the programmes according to the programme description template and will have the final responsibility before placing the country best examples in the database.

Programme descriptions. The developed programme description template is received well. The discussed 'Clarke' example is longer than the original 2-pager description but it is expected that this will not be the case. It is noted that documentation is very important and to support this links to other databases and (original) programmes should be made.

Lay-out. The lay-out of the website and the database should be as clear and user-friendly as possible. Non-necessary extra icons should be skipped and terms that apply both to prevention and promotion should be used.

Part V. FEEDBACK OF TASKFORCE'S WORK, CREATION COUNTRY
COALITIONS AND DISCUSSION IMHPA DATABASE

The reporters of the three taskforces present the issues raised during the group work. The general discussion in this session focuses on the country coalitions and the database:

The purpose of the country coalitions is to move forward with a motivated subgroup of interested members, to make some essential adjustments and to test it with those interested countries. The ideal would be that all partner countries would fill in the questionnaire to have an impressive impact. Most partners seem interested to do so.

For the descriptions of policies in the database there is no template developed yet. It is agreed that the collection of programmes for the database will be linked with the second version of the country profiles questionnaire. In relation to the issue of inclusion of non-effective programmes it is suggested that non-effective programmes should still be included but maybe should only be described shortly. The WHO-HEN website has dealt with the same difficult issue, it might be helpful to take a look how they solved it.

Part VI. DISSEMINATION – IMPLEMENTATION GROUP WORK

The partners split up in three randomly created groups to discuss the dissemination and implementation plans of the IMHPA products briefly presented in the background paper.

Wednesday 12th May, 2004

Part VII. FEEDBACK OF GROUP WORK AND DISSEMINATION PLANS

A summary of the issues discussed during the group sessions on dissemination and implementation is distributed *(annex 2)*.

For dissemination and implementation at the country level it is necessary to have a coordinated approach, to identify national activities and allow flexibility. Once again it becomes clear that translation of the products is an important issue to take into account.

The country coalitions are expected to play an important role in dissemination and implementation. They could be used to fill in the questionnaire and involve as many key persons as possible. The coalitions could also make sure the policy action plan will be published and translated. In addition, they can report on IMHPA activities in their country.

For dissemination and implementation on the European level it might be useful to contact EU parliamentarians and to involve more European organisations, networks and associations. It is suggested to explore options to influence the parliament and other EU institutions.

The ministerial conference should be used wisely by providing ministers with helpful information. A media briefing pack could be used in the conference as well as in multiple other occasions and for other sectors.

Dissemination-implementation plans could be made specifically for each of the IMHPA products. Therefore the timeline of finalization of the products should be taken into account very carefully:

- Training manual: the pilots will be undertaken during the autumn 2004; a revised and completed manual will be prepared at the beginning of 2005.
- Database: will be launched around the summer. By the end of the autumn 2004 all programme descriptions should be sent in by the partners to the Nijmegen team.
- Policy action plan: the policy document will be finished in time for the WHO ministerial conference (January 2005).
- Country profiles questionnaire: will be ready to be filled in across the interested countries from autumn 2004 and should be sent to the Nijmegen team by the end of the year.

Part VIII. FINAL ANNOUNCEMENTS

The idea of having a third meeting (before or after the ministerial conference) is received well in terms of coming together to discuss a vision of future dissemination-implementation plans and engagement. However, whether a third meeting would be possible is depending on the project's budget and the EC's response on the application of IMHPA II. The proposal for IMHPA II has been sent out and is now under review. Plans for IMHPA II will be distributed to the IMHPA members.

Following these announcements Eva Jané-Llopis thanks all participants for their participation and closes the meeting.

Annex 1: PRESENTATIONS

Summary of presentations

C)   *Presentation by Simo Kokko: The WHO Ministerial Conference on Mental Health.*

In January 2005 in Helsinki, Finland the WHO will organize for the first time ever a WHO ministerial conference on Mental Health. Before the ministerial conference 8 pre-events are being held in different European locations covering different mental health issues. In the conference both promotion and prevention in mental health have a strong presence. Two Imhpa members are on the keynote conference programme for promotion and prevention: Maurice Mittelmark and Eva Jané-Llopis. For the IMHPA project the ministerial conference will be an opportunity to introduce itself and to disseminate the developed products.

D)   *Presentation by David McDaid: Mental Health Economics.*

Although the cost-effectiveness of mental health promotion (MHP) and mental disorder prevention (MDP) interventions is hardly available, economics are a useful tool to present to and convince policy makers of the benefit of these kinds of interventions. Stronger evidence exists in some areas such as for interventions for work, employment and the prevention of conduct problems. Economic evaluations should be integrated in ongoing intervention research and information on cost, benefits and cost-effectiveness should be made available to policy makers to support the decision making process.

Tuesday 11th May, 2004

A)   *Introduction by Eva Jané-Llopis to results of IMHPA Questionnaire I.*

Since the use of IMHPA Questionnaire Version I pointed out some very important problems (e.g. no matching answers when more than one response within country) there was the need for an improved version. It is recommended that the second version is completed in each country by an expert group of actors with different backgrounds that represent the MHP and MDP field.

The purpose of the questionnaire is to get an idea what is happening in different countries in the area of MHP and MDP. In addition it will give an overview of what is lacking where at the moment. A second purpose is to create movements and action on MHP and MDP across Europe. The country expert group will bring key players around the table, to get them to understand the actual situation and create or stimulate the discussion how this can be improved.

B)   *Presentation by Maurice Mittelmark: IMHPA Questionnaire II and HP Source.*

HP Source is a European database that captures the infrastructures available for health promotion in general. The link with IMHPA is the first expansion of the project towards a modular topic area development, with mental health being the first topic area to be included. HP Source has the very ambitious goal to create 25 partnerships by the year 2008 for different health issues.

C)   Presentation by Lisa Ineland: Pilot of the Country Profiles Questionnaire II in Sweden.

For the pilot testing of the Questionnaire Version II Lars Jacobsson and Lisa Ineland gathered 5 different people in Sweden who are in some way involved with MHP and MDP. This national group of people consisted of: one person from the ministry of health, two people from the national board of health, one person from the national institute of health and one professor in the field. The creation of the group and engagement of the experts was facilitated by the personal contacts of Lars Jacobsson. One problem related to the Swedish situation is that it is not possible to find one person in the ministry solely responsible for mental health since mental health in Sweden is incorporated in public health in general. In addition, this has the consequence that there is no financial support specially earmarked for MH purposes.

General issues the group faced while filling out the questionnaire were:

- The difficultly of making a distinction between prevention and promotion

- The difference of use of the word "action" by the bureaucrats and by the practitioners

- The time: the group was together for three hours in Stockholm which was not enough to have filled out the questionnaire completely; it is a very time consuming activity.

More specific problems were related to policy and priority issues:

- Questions 8.1 turned out to be the most difficult to answer. How available a programme is, does not mean automatically it is also implemented, e.g. there are many interventions available on the internet but not necessarily being used. This question was difficult to complete although it underlined the problem. However the bureaucrats themselves were happy with the situation and did not want to go into further discussion.

  Solution: compromise for the question 8.1. to join prevention and promotion together. Ask for availability of infrastructures only (not implementation).

- Questions 2.3 and 2.4 were difficult to answer. These questions highlight a presumption that there is a centralized health and budget mandate which is not always the case. These questions also have the presumption that governments put words into action.

Annex 2: DISSEMINATION - IMPLEMENTATION

Summary of suggested dissemination and implementation plans in the group work

General issues

- Since countries and regions are very different, strategies for dissemination and implementation could be created tailoring those specific situations. This means there are different starting points, for example the 3 levels of resources of the WHO 2001 report. The different resources would imply different situations: a menu of possibilities for dissemination could be proposed of which countries can choose from, if applicable.

- Every country could make a plan for dissemination at the country level.

- The creation of country coalitions seems to be a way to do this. The coalition could support the creation of the country plan.

- The creation of regional examples could stimulate dissemination at the country level for other regions.

- Identify and link with existing strategies and make use of specific opportunities in the country.

- Each of the project products might need different strategies directed at different target groups.

- Barriers:
  - Language; documents could be translated, e.g. the short policy action plan and the training manual. The translation process would happen at the country level. Ways to fund this could include: using part of Imhpa resources, through support of the ministry of health and through national units devoted to preserving language. Opportunities for funding translations could be identified and approached for support.
  - Political will; the WHO ministerial conference could be used to reach decision makers at the country levels.
  - Resources; financial and human resources are lacking. A recommendation for resources could be used for positive areas that have evidence; identifying priorities could be helpful to enhance resources. The stimulation of earmarking taxes is an argument that could be made explicit, like has been done e.g. in Scotland.

Possible actions at the Country level

- In countries there could be 3 levels of dissemination-implementation: national, sub-national and regional levels.

- The national circumstances and opportunities could be identified and used.

- Each country would choose their priority issues.

- Key players in the countries could be identified to know who is active in doing what.

- A country coalition could be created most optimally by a multidisciplinary group of relevant stakeholders. The coalition group could be developed in two phases:
  Phase 1: Create a core group to fill in the questionnaire and database.
  Phase 2: Use the coalition for dissemination-implementation: involve different stakeholders and stimulate a cascade model that would identify champions from other sectors who would move the dissemination into those sectors. These could also include some countries' existing networks, professional associations and insurance companies.

- Champions or key opinion leaders could be identified and engaged.

- Part of the products could be translated. The short policy action plan seems to have the higher priority but this would depend on the country situations.

- Target groups to reach could include: practitioners, NGO´s, governments, etc. The cascade model would go further, for example reaching the civil society and federations. In the modern society the power might lay with the market economy so on the long run also federations of employers, business, big enterprises etc. could be targeted.

- It would be interesting to think of a follow-up strategy in 1 year, 5 years and 10 years.

- In some countries it might stimulate to have visits from experts from other countries to give visibility to the dissemination-implementation.

- National counterparts could be approached and engaged.

- National events (e.g. conferences and meetings) could be identified and used, by making presentations or other briefings.

- National publications (scientific and non-scientific) could be undertaken.

Possible actions at the European level

- Use the EU Parliament to create a cascade that would stimulate the dissemination - implementation through ministers at the country level.

- Identify, approach and use regional structures, language affinity groups and other networks, such as regions for health and health promoting schools.

- Document everything, including dates (relevant to EC).

- Stimulate publications (scientific and non-scientific). Identify what journals are relevant for the different products.

- A pamphlet could be created from the IMHPA country profiles of the second country profiles questionnaire to distributed e.g. in the Ministerial conference or to be put in the conference bag.

- The Imhpa website could have a section on the dissemination -implementation plans and processes to inform all partners about actions and what is being done in other countries.

- Use website links: link with existing projects and initiatives from the EC and others.

- Develop a project product pack with presentations and materials of the IMHPA products that could be used in conferences and other presentations.

- Identify relevant professional groups and associations and approach them for partnership (e.g. families, users at the European level).

- WHO Ministerial conference:
    - Contact other speakers in the WHO conference and lobby
    - Have a gathering (e.g. reception) at the exhibition
- Use the European Health Forum: mental health is on the agenda.
- Use the Council of Europe.
- Use the European foundation of work and living conditions (Dublin).
- Approach others who might be able to lobby at the European level.
- Make news: make clear statements of what MHP and MDP is to get the concept clear across Europe (include this in project product pack).
- Make strategy for European launch of policy action plan
- Use specific event in Europe for launching products.
- Use the IUHPE conference.

2.6 Amsterdam: Training Consultation with general practitioners for training manual
1 June 2004,
The Netherlands

2.6.a Agenda

Welcome

Round of introductions

Revision of the training manual

Answers to the questions posed in advance:

1. Is there a need for something like this?
2. Would it fit in your country?
3. What health professionals could be trained
4. Barriers and facilitators for implementing the training

5. Needs for adaptation
6. General comments to the training
7. Structured comments

Discussion on preparing a multi-country RCT proposals for funding

2.6.b   Participants to the Training Consultation with general practitioners for training manual

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2.6.c Minutes of the Training Consultation with general practitioners for training manual

Primary health care expert meeting

Introductions

Revision of the training manual

Questions posed

1. Is there a need for something like this?

Yes because the recognition is low. Some parts of it could be used in medical training. An issue is the increase of the use of SSRI so this is a good alternative for something to do. From the evidence it might not be very convincing and it might be hard to prove it works especially with symptoms and not severe disorders. From the GP perspective is good to provide some skills to GPs who are not trained. The trial of Tony: 3 groups wherein patients recovered at the same rate, the 2 nurse group was twice more expensive, patients in the nurses groups were more satisfied. Useful in the education at undergraduate and post-graduate.

2. Would it fit in your country?

In the Netherlands it will work most likely because there has already been some contact with the Royal College of General Practitioners.

Potential in UK: undergraduate trainings for medical, nurses, psychologists, masters level, GP vocational training, CME, etc. GPs in the UK would not take it up in great numbers but it could be in vocational training as an optional course. It is not being offered at the moment, there are some courses for addiction-substances, etc. offered by the royal college of GP. Each GP is now developing their own specialties and this could fit for MH.

In Germany, training opportunities this could be included in university undergraduate courses and CME.

In Italy undergraduate is very difficult to include it at the moment because the courses are very theoretical. There are some universities now thinking around these training options in Rome, Bari. As vocational training is possible, in each region is structured in one way, it would be possible in the Veneto region. The problem is the human resources. The funding is difficult, normally funded by the pharmacological companies. System of accreditation so if this could be accredited doctors could be interested. The accreditation comes posed by a scientific society. The problem is who pays it, because the local trust pays only those courses that pay off in terms of savings. Now it is possible to ask doctors to pay themselves.

3. What health professionals could be trained?

Many different professionals. In the UK: psychologists, GPs with special interest in MH, practice nurses or nurse practitioners (more independent). In Italy for psychiatric nurses a training like this would be interesting.

4. Barriers and facilitators for implementing the training

Barrier in Italy: most doctors have no appointment system, include a section or session in the training to talk and convince about the need for an appointment system.

Barrier for GPs is the first reaction of GPs why should I do another course. This training includes very generic skills so if the GPs realizes that it would be more easily convincing. This would be a marketing enterprise. In addition is important to realize that the old doctors like to do it themselves and they should be convinced.

Barrier in Germany: they do not like to be "taught". Incentives should be needed. Accreditation could be an incentive because if they do not get points their salary diminishes. Need to get the course accredited.

Barrier: need to convince that BPS is effective

5. Needs for adaptation

This training manual is not really very culturally oriented so there are not many needs for cultural adaptation at least in the Eastern European countries.

In Italy there should be more time for talking for the participants especially during the first two sessions.

6. General comments to the training

The reattribution: concern that Linda Gazt, Richard Mauritz, in England have more extensive training in reattribution. This might be too little or short and would this be effective?

Session 8 is not as good as the other sessions. Too compact and not very in detailed described also with the examples. It should be mentioned that the anxiety bit only points the people in the right direction. A possibility could be a second course that would give feedback on the problem solving and would provide the anxiety bit as well.

It is important that we put an end point to BPS because the doctor could be continuously asked about new problems. Revise the training in the light of this comment.

7. Structured comments

Problem: lay out needs to be worked on. Each section in each session should be clearly identifiable, e.g. A, B, C, …

Pg 28 describe the difference between BPS and PST

Problem: distinguish between a clear diagnosis from not a diagnosis. Need of much better assessment at the beginning. Eg. a given patient might have an attitude against a psychological intervention so it will not work. It might be helpful to have a guide for the question with which patient should I use this or not (e.g., patient who had had antidepressants before might want them again and it will work with them)

Session 5: pg 77, make a clear boundary, BPS should not be used forever.

Training: it should be good to have trainees who are gps who have already worked with bps or other psychological interventions in a 10 minute intervention

Anxiety symptoms: need to specify more clearly to whom the intervention should be given. Questions such as do I use this with medication, etc…

Why is insomnia introduced? Rational should be made more clearly. An idea would be to find what GPs would like to see included in the manual. We will do this during the pilot in the Netherlands and the UK.

Appendix: feedback training,

RCT Proposals

Would this be a way to go?

Problems for funding in the UK: complex intervention for the Medical Research Council. You need to go through several steps or phases before an RCT. Feasibility testing and pilot testing

so it would not be funded. We need more developmental work. NHS would also not commission such study. The royal college might do a bit of developmental work. In Germany there might be opportunities for funding. Think of a research proposal that allows different research options.

2.7 Brussels: Third Partner Meeting
14-15 March 2005,
Belgium

2.7.a Agenda

Monday 14th March

10.00 - 10.30h: Welcome

Short round of introductions
Scope of the project and meeting (see background paper)

10.30 -11.15h: Imhpa and Emhpa: Brief overview, update and new developments
- Update policy documents: *Eva Jané-Llopis*

- Database update,   - evidence committee: *Kristian Wahlbeck*

                                - country based pilot: *Emma Hogg*

- Training platform and update GPs training pilots: *Milou Leunissen*

- Mental health economics: *David McDaid*

- Country infrastructures: *Maurice Mittelmark*

Discussion and questions at the end of each area

11.15 - 11.45h: Coffee break

11.45 - 12.30h: Intro issue 1: Country coalitions (see pg. 13-31)
Feedback on questionnaire phase I: *Czeslaw Czabala, Elizabeth Gale*

Commission's green paper and request: *Jürgen Scheftlein*

Discussion and questions

Introduction to afternoon session

12.30 - 13.30h: Lunch

13.30 - 14.30h: Breakout session 1: Comments on the questionnaire and process
14.30 - 15.15h: Plenary: group feedback, discussion, work process and timeline

Intro issue 2: European Conference in 2006 (see pg. 32-34)

15.15 - 15.45h: Coffee break

15.45 - 16.40h: Breakout session 2: Brainstorm about the conference and participation
16.40 - 17.30h: Plenary: group feedback and discussion on the conference

Any other issues and wrap up day 1

Evening

18.50h:	Meet at the lobby: walk to the restaurant
19.15h:	Dinner at Babeko restaurant

Tuesday 15th March

9.00 - 10.00h: Intro issue 3: European Platform (see pg. 10-12)

Breakout session 3: What do we expect from the European Platform?

10.00 - 10.45h: Plenary: group feedback and discussion on the Platform

Intro issue 4: Country level implementation reports

10.45 - 11.15h: Coffee Break

11.15 - 12.15h: Breakout session 4: What should the country implementation reports include?

12.15 - 12.45h: Plenary: group feedback and discussion on implementation reports

12.45 - 13.45h: Lunch break

13.45 - 15.15h: Plenary discussion on the work forward

Plenary feedback from the evidence committee and discussion

Overview and plenary discussion on the issues discussed over 2 days

List of agreed tasks, deadlines and next steps

Any other issues and meeting wrap up

15.15 - 16.00h: Coffee

2.7.b   Participants to the third partner meeting

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2.7.c Minutes of the third partner meeting

Present:

Peter Anderson; Angelo Barbato; Margaret Barry; Josipa Basic; Hartmut Berger; Peter Breier; Joan Colom; Athanassios Constantopoulos; Czeslaw Czabala; John Kenneth Davies; Helja Eomois; Elizabeth Gale; Pol Gerits; Antoni Gual; Marjon Harbers; Maria Heitor dos Santos; John Henderson; Emma Hogg; Cyril Höschl; Clemens Hosman; Lars Jacobsson; Eva Jané-Llopis; Heinz Katschnig; Tanja Kamin; Costas Kyranides; Maria Kopp; Vivianne Kovess; Karl Kuhn; Milou Leunissen; Andrej Marusic; David McDaid; Maurice Mittelmark; Juergen Pelikan; Eleni Petridou; Dainius Puras; Jürgen Scheftlein; Maris Taube; Toma Tomov; Bogdana Tudorache; Kristian Wahlbeck; Raymond Xerri.

Part I. OPENING OF THE MEETING and the EUROPEAN PLATFORM

A) Welcome by Eva Jané-Llopis to all participants. Apologies were presented for Marco Stegagno and Toker Erguder who were unable to attend the meeting.

B) Short round of introductions by all participants.

C) Overview on the scope of the meeting and project. Officially Imhpa would finish on April 2005 but an amendment for a prolongation has been accepted by the EC to ensure that all products can be delivered within the duration of the project. Imhpa will now officially finish on August 1st 2005. Because of bureaucratic reasons, the Imhpa network cannot be called Imhpa in its second phase. Instead the new project, which has a broader aim and includes the goals of Imhpa, will expand to develop a European Platform for Mental Health Promotion and Mental Disorder Prevention. The contract for the European Platform is being finalized at the moment. For its completion we still miss the real salary costs for some partners. Those who have not sent their salary justification yet are kindly requested to do so as soon as possible. All products developed during Imhpa will be integrated and expanded under the European Platform, which will act as a European network for promotion and prevention in mental health. A presentation of the products developed by Imhpa and how they are embedded into the European Platform followed. The presentation is available on the website (www.imhpa.net). The framework of the different strands of the European Platform, and what will be developed in the new project, was presented by several partners:

1. Policy

- The short policy document was launched during the WHO Ministerial Conference on MH by the Finnish Minister of Health and in the presence of mr. Robert Madelin, director general, Health and Consumer Protection, European Commission. The background technical document is being finalized and will be published in August 2005.

2. Programmes Database

- At the moment the database is on line and presents the programmes submitted by 5 countries.
- An evidence committee will be created in the new project to develop a set of guidelines to monitor the different levels of evidence across programmes. This is linked to the Evidence Taskforce, EC Mental Health Working Party (presented by Kristian Walhbeck).
- A country pilot in Scotland will collect all available programmes and practices for children and adolescents. This work, in collaboration with the evidence committee, will explore the

possibility of developing such systematic initiatives in other countries. A final report will be available in April 2006 (presented by Emma Hogg).

3. Training

- The Imhpa training manual for primary health care professionals has been piloted in the Netherlands and Slovenia. The course was received very positively. The revised manual and the report of the pilots will be available in the website (by Milou Leunissen).
- The European Platform will create a network of training, which integrates other manuals developed for programme development, evaluation and implementation (under the Mindful project); and an advocacy training, which will be developed during the project.

4. Mental Health Economics

- The new project will gather information on the costs of not intervening and estimate the potential benefits of promotion and prevention in mental health. Existing information will be complemented with country information (by David McDaid).

5. Dissemination

- The project will develop dissemination strategies at the country level through the networks created by each partner; and at the European level through the European networks involved in the Platform and by the European Conference in Barcelona 2006.

6. Mental Health Impact Assessment

- The work for mental health impact assessment will be presented in the next meeting.

7. Infrastructures database

- The database is on line and contains the data already submitted by 4 countries. A user friendly data entry form is available on line (by Maurice Mittelmark).

Part II. DISCUSSION ON THE COUNTRY COALITIONS and COUNTRY PROFILES

The IMHPA-HP source questionnaire has been developed in three phases: 1) development, testing, improvement; 2) pilot test in Sweden; 3) final revision, data collection. Data has been gathered so far in Scotland (Emma Hogg), Norway (Maurice Mittelmark), Poland (Czeslaw Czabala) and England (Elizabeth Gale). Two countries briefly reported.

1. Update Country coalition creations and IMHPA-HP source Questionnaire

Czeslaw Czabala reported on Poland. The country coalition was built on an existing council on mental health, which includes representatives of different ministries and other stakeholders. Two meetings were held to discuss the situation of promotion and prevention in mental health in Poland. In general it was felt important to bring the coalition together to discuss mental health. As an outcome of the meeting, the coalition suggested to organise a national MH conference and to create a national network in the near future. Suggestions for improving the questionnaire include: more questions on implementation and better operationalization of items.

Elizabeth Gale reported on England. Several national top organisations and experts were involved in completing the questionnaire. All completed questionnaires were sent by email and

Elizabeth, at Mentality, summarized and prioritised the gathered information, as a meeting to reach consensus was difficult to organize. Some problems raised include: limitation of regional information, the fact that collected data are already out of date at the moment of reporting it; and the inevitable subjectivity of the reported information, as choices are made when no consensus is possible.

2. Feedback on IMHPA-HP source Questionnaire

Partners divided into groups to discuss the questionnaire and the process of creating country coalitions. The issues raised, presented by group raporteurs, included: the reliability and inevitable subjectivity of the data; the methods for consensus; the need for better operationalization of some items; the consideration that different parts could be answered by different stakeholders; the prioritization of information when there is too much; and the need to specify whether the data are regional or applicable to the country level.

In the general discussion it was agreed to do only minor changes on the questionnaire at this stage. This is a first step in an evolving process; more information can be added in future versions of the questionnaire. It was agreed that data entry will be done on line (on the user friendly data entry form) by each country partner. Everyone will receive a code to access the data entry forms. It was agreed to add a method section on the process of gathering the information and describe the problems with subjectivity etc., when necessary.

3. Linking the Country Profiles to the EC Green Paper on Mental Health

Jürgen Scheftlein, head of Mental Health at the European Commission, DG Sanco, presented the developments on MH at the EC. The EC is currently preparing a Green Paper on Mental Health. This will be a consultation document which will explain the relevance of mental health for the EU, will present evidence based options in mental health promotion and mental disorder prevention and will propose strengthened cooperation at Community level. It is planned that the green paper will be launched before the summer and consecutively, a one year consultation process will take place starting with the presentation of the document, with an awareness-raising event being considered for 19 September 2005. The consultation process would last until the end of June 2006. Although the outcome of the consultation process can not be anticipated at this stage, the intention is to prepare a second Communication (white paper) on mental health. This would wrap up the consultation process and present a proposal for a strategy on mental health at EU-level.

In this context, a request to the network was put forward by Jürgen Scheftlein. He would like to have by September 2005 country profiles presenting the situation on mental health promotion and mental disorder prevention in all member states. These could be based on the information gathered by the country coalitions with the infrastructures questionnaires. These country profiles would be gathered and presented as short country stories (2-3 pages) in an independent publication, published through the European Platform and the Commission's own means, and it would complement the Green paper. The purpose of these country profiles would be to initiate and nurture the discussion with Member States about their respective situations, challenges and practices.

During the discussion, concerns were expressed about linking the country profiles to the Green paper, as this would put the country profiles publication at a higher level. The issue was raised about authorization for developing the country stories and the potential links that can have with governments. Concern was also expressed about the timeframe.

In general all partners felt this is an important development, this information does not exist at the moment and it can complement and support the further development of the field of

prevention and promotion in mental health, at the country and European levels. Taking into account the concerns raised, some solutions were agreed:

1) A very strong foreword and method section in the publication will clarify: that the country stories are based on the information available that could be collected in the time available; that it has not been an exhaustive exercise but only a first step to start gathering information; that the profile is a first draft of a process, and Member States will be asked whether and how they would wish to use or further develop the profiles; that the purpose of this publication is not to do country comparisons or benchmarking; the purpose of this exercise is to provide a draft base line of prevention and promotion in mental health across Member States; it is intended that the country stories are updated and refined with new or more specific information so that the base line can be updated and completed; the intention is not to compare negatively across countries but to learn from success stories and stimulate collaboration across member states.

2) The country stories will provide statements of the situation rather than a full description based on all the data collected through the questionnaires; that data of the questionnaires will be available online on the Imhpa-HP Source database.

3) The country stories will be written by the country partners and will be edited by the Nijmegen group. All country stories will be distributed to all partners for comment during the process, including the final version. Jürgen Scheftlein has suggested printing the country stories in the EC corporate design, to ensure it is understood these are working documents.

4) A general introductory chapter drafted by the Nijmegen group will also provide an overview at the European level, outlining the general situation on prevention and promotion and presenting success stories. Analyses and reporting will be done without identifying countries to avoid direct comparisons. A section presenting the methodology used to gather the information and complete the country stories will be described in this chapter as well. This chapter will also be distributed for comment to all partners.

5) Strong statements will be added across the publication, and in each separate country story, to make sure it is clear this is not the responsibility of those who have prepared this publication, it is only a first step in depicting the situation and information is welcome to improve the country stories presented in this version.

6) Because of the different positions of the partners at the country level (e.g., working at the ministry of health, consultant, university employee, etc.), while in some cases the country stories could be authored (eg. by experts) in other cases it would be more sensitive to leave them as un-authored reports, acknowledging the country coalition involved in providing the information. This will vary depending on each situation and it can be decided at a later stage.

7) The foreword could also express that it is the wish of the EC to have this publication and that the EC supports its development and aims it to complement the Green Paper.

It is planned to use the country stories publication at the Green paper consultation event considered by the Commission for September 19th 2005. To stimulate participation at the country level including governmental bodies and to highlight the importance this work has for the EC, Jürgen Scheftlein proposed to provide an official letter that comes from the EC, would include the name of each partner, and is directed to the different stakeholders and the ministries that might be involved in each country to provide the information. The purpose of this letter is to engage the stakeholders in the process by asking their full participation, and to make sure that the partners are seen as having the mandate from the EC to engage in this arduous task.

Part III. BRAINSTORM ON THE BARCELONA CONFERENCE

To bring together professionals of European countries and to consolidate the European Platform for mental health promotion and mental disorder prevention a European conference will take place in Barcelona in September 2006. The conference will coincide with the end of the consultation process on the EC Green Paper. Jürgen Scheflein expressed the EC support to this conference and their interest that it takes place at the end of the consultation process. Partners divided into groups to continue the brainstorm on the aims and process of the conference, which were presented as a first draft in the background paper.

A paper integrating all feedback from the groups and presenting a first draft of the programme for the conference will be sent separately within a few weeks. Some of the major topics that were raised across groups included: 1) there is general enthusiasm about the conference and its importance to move forward prevention and promotion in mental health at the European level; 2) the main aim of the conference is to achieve active participation which can be done through round table discussions, dialogue sessions, etc., as opposed to more traditional conferences with a set of plenary and parallel presentations and little time for discussion; 3) the role of all project partners will be twofold: to identify up to 10 people at the country level to attend the conference, and to be actively involved developing the programme and during the conference itself; 4) a common concern is that of funding; it is agreed that extra funds will be searched to ensure equal participation from all countries; when available, participants from new member states will be supported with grants; 5) the programme can include a variety of topics; the work developed by all partners, eg. country profiles or country success stories will be presented, although session formats have to be decided; 6) to ensure success it is important: a balanced participation from all countries; a format that allows full participation and working towards developing country networks and sustaining the European Platform; especial attention should be paid to developing an exciting and special social programme; 7) the audience includes policy makers, practitioners and researchers; in many cases participants could be the members of the country coalitions; 8) the focus of the conference will be to stimulate discussion between and within member states and identify collaboration; the focus of the conference will not be scientific or focused on presenting but rather discussing. This is also to avoid possible overlap with the 3rd World Conference on Mental Health Promotion and Mental Disorder Prevention that will take place in Oslo one month later; after some discussion, the proximity of the two conferences was perceived as beneficial, synergies between the two will be explored. Joan Colom, at the Catalan ministry of Health which will host the conference, expressed the importance of the conference and their excitement to co-organize it, and welcomed everyone to Barcelona in 2006.

Part IV. NEXT STEPS

At the end of the meeting the following next steps were identified:

- All partners will send to Nijmegen by email:

- The justification of their salary costs (for those who have not done it yet)
- The list of individuals' names and organizations to whom the policy books have been sent
- A list of names to whom the EC letter to support the country profiles should be directed to
- Specific comments on the IMHPA - HP source questionnaire

- All partners will receive from Nijmegen by email:

- The revised version of the IMHPA - HP source questionnaire
- The structure (headings) for the country story
- The Scottish country story example
- The time schedule for the finalisation of the country stories
- The feedback on the Barcelona conference and first draft of a programme
- The EC letter supporting the country profiles initiative and stimulating ministries and key stakeholders to support the information collection
- A code for each partner to access the Imhpa-Hp source database to enter the data gathered for the Imhpa-Hp source questionnaire

Next meeting: it was proposed to link the next Platform meeting with the Green paper consultation event considered by the Commission to take place in Luxembourg on 19th of September, 2005, at which the country profiles would be presented. The Platform meeting could take place during 20th and 21st of September. The dates were preliminarily pencilled in all agendas. The meeting and its location will be confirmed as soon as possible.

ANNEX 3   A STANDARDIZED INTERNET DATABASE

3.1   Programme description template

Programme name

Intro:
Short description (Target group, Setting, Duration)
Aims/goals of the programme (bullet points)

Developing the programme

Theory driven development and/or theoretical principles
Practice driven development
History of program development and pilot evaluations and/or
improvement
Needs assessment
Involvement of community leaders, target groups etc. in the
development of the programme
Diffusion, adaptation, adoption
Changes to the programme
Cultural sensitivity, fit to local culture

Effects
(percentages)

Target group

Description of target group, including level of risk or problem severity.
If applicable to the intervention (not the specific research) name age, gender, socio-economic
status, ethnicity, educational level etc.

The programme

Prevention/Promotion (whole population (universal), at risk (selective),
symptoms (indicated), mhp for the mentally ill or the mentally disabled
Setting
Duration, dosage, time of intervention
Program providers
Methods and mechanisms of change and their techniques (bullet points)

Risk and protective factors addressed
Describe the risk and protective factors that are addressed by the programme

Implementation essentials

Start with the 'name' of the program providers
Training of providers (incl. level of hours of training
Supervision of providers (incl. feedback systems)
Manuals for programme provision
Programme fidelity
Context characteristics

> Include those elements present in the social, economic and physical context of a target population that have an influence on the development and implementation of the intervention moderating the expected chain of effects (Context characteristics that might have influenced the programme implementation: Unforeseen community resistance to a programme, Conflicting messages from alternative sources, Social pressure against behaviour change by others not involved in the programme, Unexpected budget reductions leading to less investment in programme implementation, Pressure to change from the social network, Facilitating municipal policies, Public incidents that trigger attention and motivation)

Infrastructural conditions and resources

> Include those characteristics that comprise the infrastructural conditions and resources that are available or absent for programme development, diffusion and implementation, where the quality of the implementation depends on the availability of resources and facilitating infrastructures. Any relevant information for the readers on infrastructure and resources would be captured. (Infrastructure and resources: Availability of trained prevention experts, Sufficient budget and manpower, Organization policies for training health promoters, Effective dissemination systems or agencies, Inter- organizational collaboration, Outcome oriented health promotion policy, Budget for evaluation, Collaboration between research centres and practice, Accessibility to scientific knowledge)

Institutionalisation
Sustainability
Implementation barriers

> Barriers specific to this version (bullet points)

Evaluation and outcomes

Evaluation

Short description of the type of research methodology utilised and research design
Sample size

Outcomes (e.g. in a box)

Outcomes (per subgroup) using percentage rate
Info on what predicts effect, what makes the program effective, core elements
Relation with subgroup outcomes
Mediation and moderation
Add a couple of graphs
Information on costs and benefits

Adaptation, history and replication

Adaptation
Diffusion, adaptation, adoption
Changes to the programme
Cultural sensitivity, fit to local culture

History of other implementations
Report here if the intervention is implemented in other communities/countries as well. Report implementation barriers if mentioned.

Replication studies
Information (including design and outcomes) on replication studies

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Contact information

Name of the contact person and degree
Organisation, address, city and postal code, country, phone, fax, e-mail, website

Relevant publications

Short described additional information to be entered separately (level 1 and 2):

Mental health area(s)
Mental health area(s) which are addressed by the programme

Setting
Setting were the programme takes place

Target group

Research design
Research design of studies performed on the programme

Availability of the programme in different countries and languages

---

3.2 Examples of programme descriptions according to the template

The 'Coping With Depression' Course

The Coping with Depression Course is a group-based prevention program designed to reduce symptoms of depression and to prevent the onset of depressive disorder in adults with sub-clinical depressive symptoms.
The course consists of 12 sessions and aims to:

- Decrease depressive thinking
- Decrease depressive symptoms
- Increase engagement in pleasant activities
- Increase self-esteem
- Increase social skills and social support
- Prevent unipolar depression

Developing the programme

The Coping with Depression Course is a cognitive-behavioural psycho-educational intervention, which was originally developed as a group treatment for people suffering from unipolar depression (Lewinsohn & Clarke, 1984). This course was found to be effective in reducing symptoms in people with clinical depression (Brown & Lewinsohn, 1984). Different versions of the course were developed for the treatment of different target groups. In the Netherlands the course has also been implemented on a national scale for adults with sub-clinical depressive symptoms.
The course is based on the social-learning theory of depression in which depression is perceived as a pattern of learned responses that can be unlearned. Techniques that are used in the programme, such as suggesting pleasant activities and teaching cognitive and social skills, have been effective in cognitive therapy, relaxation training and social skills training.

Target group

The Coping with Depression Course is designed for adults (18-65 years old) with sub-clinical depressive symptoms who are potentially at risk for a depressive disorder.

The programme

The Coping with Depression Course consists of 12 professionally-led two-hour weekly sessions implemented in a Mental Health Care setting and carried out by a trained psychologist and a graduate psychology student. The sessions consist of a series of lectures, discussions, homework assignments and practical skills training. Six weeks after completion of the course there is a booster session.
During the course participants are taught techniques to influence their mood and to enhance their coping skills for problems related to their depressive symptoms. The course is focussed on six problem areas that are associated with depression. These topics are tackled by: 1) providing information on depression and the cognitive-behavioural perspective on depression, 2) offering relaxation techniques, 3) suggesting and planning pleasant activities, 4) teaching cognitive skills,

5) social skills and assertiveness, and 6) relapse prevention techniques. Homework assignments, involving monitoring and introducing new behaviour into daily life, are an essential part of the course.

Risk and protective factors addressed:

- Negative thinking
- Self-esteem
- Coping skills
- Pleasant activity levels
- Social skills and social support

Implementation essentials

The implementation of the course is supported by a trainer's guide (Lewinsohn et al., 1984) and a participant workbook entitled "Control your depression"(Lewinsohn et al., 1992). The psychologist and graduate psychology students receive two-day training and work with a detailed protocol to ensure fidelity to the programme design (Lewinsohn et al., 1984).

Evaluation

Allart et al., (2003) conducted a randomised controlled trial of the programme in The Netherlands. Participants were recruited through advertisements in local newspapers and on local television. In total, 324 people were screened for psychopathology. Inclusion criteria for participation in the study were:

- an elevated level of depressive symptoms (score of 10 and above on the Beck Depression Inventory)

- willingness to give informed consent

- having no current diagnosis of major depression or a lifetime history of bipolar disorder or any other current psychiatric diagnosis, measured by a structured computer-assisted diagnostic interview for DSM-IV diagnosis (Composite International Diagnostic Interview).

The final sample of 110 sub-clinical depressive participants was randomly assigned to an experimental condition (Coping with Depression Course; n=68) or a control condition (assessment-and-advice-only; n=42). Participant status was reassessed one month after the intervention, and at 6 months and 12 months follow-up.

Outcomes

Participants who followed the Coping with Depression Course showed fewer depressive symptoms one month after completion of the course. More participants in the course group scored in the non-symptomatic range (52.5%) compared to participants in the control group

(31.7%). In addition, at post-test the course participants showed beneficial effects on depressive symptoms, pleasant activities, self-esteem, social skills, social support and depressive thoughts.

Depression

Beck's Depression Inventory

	Intake	Post	6-months	12-months
Coping with Depression	15.8	9.8	10.8	10.5
Advice-only	14	14.1	13.8	11.8
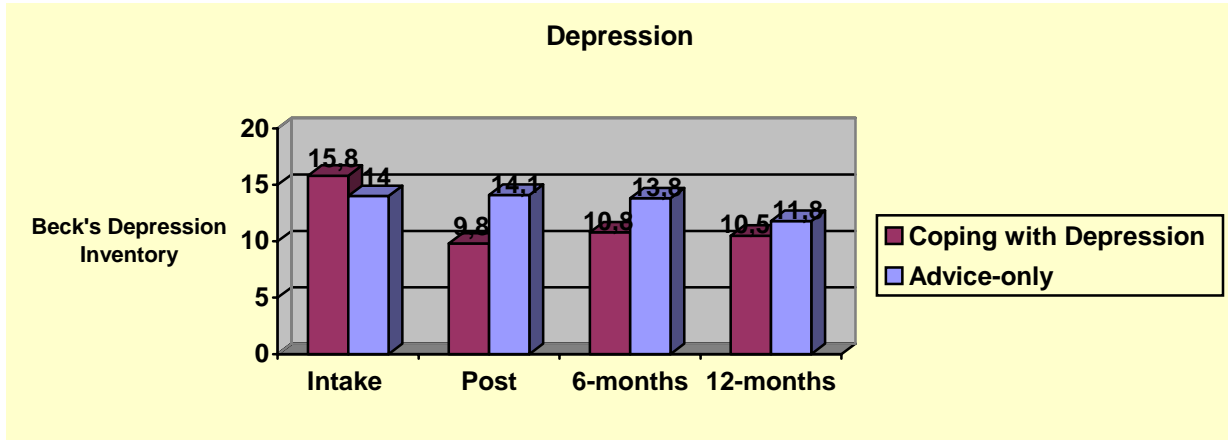
At 6 months and 12 months follow-up the reduction in depressive symptomatology was maintained.
However, the effect appeared to be restricted to those participants with initial low depressive symptomatology (BDI ≤14) . For participants in this range, 79,3% (at 6 months follow-up) and 69,0% (at 12 months follow-up) had BDI scores below 10.

Depression: Participants with low levels of initial depressive symptoms

Beck's Depression Inventory

	Intake	Post	6-months	12-months
Coping with Depression	10.3	6.5	6.5	6.9
Advice-only	9.2	11	12.9	11.6
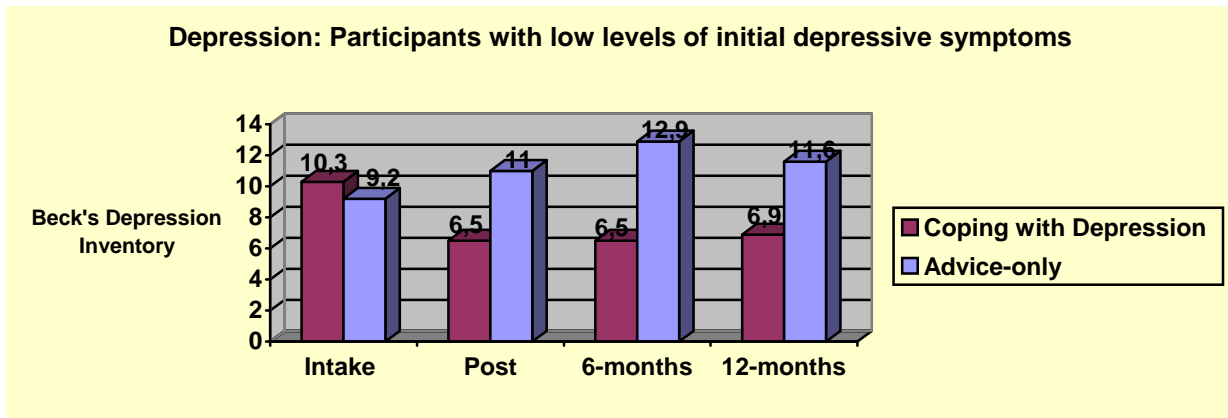
The Coping with Depression Course did not appear to have an effect on the prevention of depressive episodes. Furthermore, the short-term effects on constructive thinking, pleasant activity level, social skills and self-esteem, disappeared in the follow-up period for the complete sample. However, the low-symptom intervention group still showed positive effects on negative thinking and self-esteem at follow-up, compared to the control group.

Adaptation

Although the course was originally developed as a treatment course for adults with major depression, over the years it has been implemented in various settings, under various conditions and adjusted to several types of target groups in the form of a preventive intervention. In The Netherlands the Coping with Depression Course has led to the development of adapted versions for different target groups: elderly, people with chronic illness, adolescents and people of Turkish and Moroccan ethnicity. At the moment, a majority of the Dutch community mental health centres (69%) offer the Coping with Depression Course to the public in one version or another.

History of other implementations

Before the implementation of the Coping with Depression Course in The Netherlands, this course and a few comparable indicated prevention programmes were carried out in the United States. Effect studies showed positive long-term preventive effects on the development of depressive symptomatology and/ or new cases of depressive disorder.

For example, Jaycox and colleagues (1994) developed the cognitive-behavioural Penn Prevention Programme directed at middle-school aged children (10 to 13 years old) at-risk due to elevated depressive symptoms or family conflict. A total of 143 children considered at risk for future depression were allocated to one of the three intervention conditions (n=69) or to the combined control condition (n=74). At 2-year follow-up children in the intervention group reported fewer depressive symptoms than children in the control group and they were half as likely to report moderate or severe depressive symptoms. However, after two years the programme's effect on depressive symptoms diminished.

Clarke and colleagues (1995) conducted a randomised controlled trial with a modified version of the Coping with Depression Course, the 'Coping with Stress Course' (hyperlink). The 'Coping with Stress Course' was the first published report of the actual prevention of unipolar affective disorder in high school adolescents. One-hundred fifty adolescents with elevated risk of depressive symptomatology were randomly assigned to either a 15-session after school cognitive group intervention (n=76) or a "usual care" control condition (n=74). Results at 12 month follow-up showed a significant advantage for the prevention programme compared to the control condition in the prevention of depressive disorder.

Clarke and colleagues (2001) conducted a few years later a randomised controlled trial of a group cognitive intervention in order to prevent depression in adolescent offspring of depressed parents. Ninety-four adolescents were randomised to the 15-session group prevention programme (n=45) or to a usual care condition (n=49). Results after 12 months indicated similar reductions in onset of depression for the experimental condition (9,3%) compared to the control condition (28,8%).

Contact information

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Relevant publications

Allart., E., Hosman, C.M.H., Hoogduin, C.A.L., Schaap, C.P.D.R (2003). The "Coping with Depression" Course: Short term outcomes and mediating effects of a randomized controlled trial in the treatment of subclinical depression. *Behavior Therapy, 34*, 381-396.

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Additions to the database template

Target group
Adults

Mental health area
Depression

Setting
Primary care

Languages of the programme
English, Dutch

Research design
Randomised controlled trial

Zippy's Friends

Zippy's Friends is a school-based mental health promotion programme for five to seven year old children. The programme aims to prevent the development of serious psycho-social problems later in life, including suicidal behaviour, through expanding children's range of effective coping skills.

The objectives of the programme are:

- To increase children's capacity to cope with everyday difficulties, helping them to explore, find their own solutions and expand their range of coping strategies
- To enable children to identify and talk about feelings
- To encourage children to help others with their problems and to ask for and use help when they are in need

Developing the programme

Zippy's Friends has been developed to expand the coping skills of young children with different abilities and backgrounds, in diverse countries and cultures. Children use a wide range of coping skills, these are developed at an early age and may be maladaptive (Boekaerts, 1996). A number of studies have suggested that early training of young children can help to prevent adaptation problems later in life (Cowen et al., 1989; Rhodes & Englund, 1993; Segal, 1983).

The programme was originally piloted and evaluated in Denmark from October 1998 until April 1999 (Mishara & Ystgaard, 2000). It was then revised and further piloted in Denmark and Lithuania, between October 2000 and April 2001. The expansion of Zippy's Friends is being co-ordinated by Partnership for Children, a non-profit agency in England. This organisation does not deliver Zippy's Friends, in the various countries, but seeks strong local partner agencies which have the capacity to implement the programme with large numbers of children. These partners are typically national or local education authorities or non-profit agencies. In addition to Denmark and Lithuania, the programme is now also available in the UK, Norway, Poland, Canada, China, India and Brazil.

Target group

The target group of Zippy's Friends is 5-7 year old children. The programme is designed for all children and is not focused on specific behavioural problems or children at risk.

The programme

Zippy's Friends is taught in schools and kindergartens by teachers who have been specially trained.
The programme runs for 24 weeks, with one 45-minute session each week. The heart of the programme is a set of 6 stories about Zippy, a cartoon stick insect, and his friends (a group of young children). Each session has activities, to reinforce the messages of the stories. These include role play, games, drawing, work with puppets and a visit to a graveyard. The stories show the group confronting issues that are familiar to young children – friendship, communication, feeling lonely, bullying, dealing with change and loss, and making a new start. Young children learn through repetition and key messages are reinforced throughout the programme.
Over the course of six months, the programme teaches children how to cope with everyday difficulties, to identify and talk about their feelings and to explore ways of dealing with them. It

encourages children to explore and think for themselves and affirms a child's ability to both use and give support. Rather than highlighting inadequate behaviour, the programme emphasises the child's ability to learn, adapt and improve skills. Crucially, the programme fosters coping strategies that include children's abilities to be helpful and supportive of others. This contrasts with programmes that emphasise personal competence over collective involvement.

Risk and protective factors addressed:

- Behavioural problems
- Coping skills
- Social skills

Implementation essentials

Successful implementation of the programme requires a strong, respected and enthusiastic partner agency which takes overall responsibility for programme delivery.
All teachers involved in Zippy's Friends are required to complete a two-day training course. This sets out the programme goals, theory, components and organisation. In addition, on-going support days are organised during the programme and at its conclusion, to bring groups of teachers together to share experiences and resolve any difficulties. Parents are also encouraged to reinforce the programme's teaching. Schools and kindergartens organise parents' meetings and each parent is given an explanatory booklet. After the training session, teachers are able to conduct the programme as planned with minimal on-going help and supervision (Mishara & Ystgaard, 2000).

Evaluation

The evaluation of Zippy's Friends in Denmark and Lithuania (Mishara & Ystgaard, 2001) had two primary goals: to determine if the programme was successfully implemented as planned and to identify any significant short term effects.

The evaluation compared children who participated in Zippy's Friends with a control group, children in other schools who did not participate in the programme (Mishara & Ystgaard, 2001). The study used:
- teacher observation
- interviews with the children
- questionnaires on social skills and coping completed by the children

In Denmark, a total of 322 participating children (160 boys, 162 girls) in 17 classes in 12 schools were compared to 110 control group children (53 boys, 57 girls) in 6 classes in non participating schools. The average age of the children was 7,5 years old. Rather than observing and interviewing a new control group, the control group of the evaluation of the previous version of the programme was used(there were no significant changes in that control group from Pre-test to Post-test).

In Lithuania, 314 kindergarten children (171 boys, 143 girls) in 16 classes in 11 schools were compared to 104 control group children (52 boys, 52 girls) in 6 classes in other schools. The average age was 6 years old.

Outcomes

The short-term effects of the programme were similar in Denmark and Lithuania, and showed clear improvements in children's abilities to cope with adversities.

Based on findings from interview data and teacher observation, children who participated in the programme used a significantly greater number of coping strategies and showed improved co-operation, empathy, assertion and self-control. In Lithuania, where the evaluation included additional categories of behaviour, 'externalising problems' and 'hyperactivity' decreased.

A follow-up study in Lithuania found that one year later improvements were maintained in both coping behaviours and social skills (Mishara & Ystgaard, 2001).

Adaptation

Evaluation of implementation was based upon reports and interviews provided by the teachers who facilitated the programme. The evaluation in Denmark and Lithuania (Mishara & Ystgaard, 2001) established that the programme had been successfully implemented in both countries with few problems. However, if the programme is used with children in the younger age group (kindergarten), substituting illustrations and non-verbal cues in those exercises that depend upon reading skills would enhance its effectiveness.

Support for the programme and participation levels were similar in Denmark and Lithuania, suggesting that the programme can be successfully implemented in different languages, for different age groups and in very different types of school environment. For example, the Danish education system is decentralised and well-resourced, whereas the Lithuanian system is more centralised and less well-resourced. Although the key principles of the programme are fixed, adjustments or additions may be needed to make the programme suitable for a particular country or culture (Bale, 2003).

History of other implementations and sustainability

The first pilot study was done in Denmark in 1999 by Mishara and Ystgaard. The study involved 214 Danish children who participated in the programme compared to 109 Danish children in a control group (Mishara & Ystgaard, 2000). The results showed improvements in the social skills of co-operation, empathy and self-control, but no effect on coping. In response, the programme was suspended for a year and the materials were comprehensively revised, with the addition of an extra module and more emphasis on the development of coping skills.

Replication studies

Mishara & Ystgaard (2001) concluded that long-term follow-up would be desirable in order to determine if short term improvements would be sustained and a one year follow up study was conducted in Lithuania (Mishara & Ystgaard, 2002). Of the original 314 children in the experimental group in the first evaluation, 229 were observed and interviewed. The original plan was to include the 104 control group children in the follow up. However this was not possible as during the year after the initial study, the Minister of Education approved the programme for use in Lithuanian schools and there was a phenomenal increase in the number of schools offering the programme in kindergarten and first grade.

The results of the follow-up indicated that the changes were generally maintained one year later. Based on teacher observation and interviews with the children, all social skills and problem behaviours which improved from the pre-test to the post-test scores were found to have maintained their improved level one year later. Although the improvement in the number of coping mechanisms used was only marginally significant, there was no indication of a decrease in coping abilities.

Monkeviciene (2002) conducted another study of children's adaptation to first grade in a new school by comparing 224 children who had participated in Zippy's Friends in kindergarten with 122 control group children who had not participated in the programme. Children who had participated in the programme were observed to be significantly better adapted to school life, were more cheerful in the morning and at the end of the school day, were more likely to have found new friends, coped more successfully with difficulties, more often helped other children cope with their problems and were observed to use more appropriate coping skills.

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Relevant publications

Bale, C. (2003). Early start to suicide prevention: Children's programme shows promising results. *Suicidologi, 8* (2).

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Additions to the database template

Target group
Children

Mental health area
Coping

Setting
School

Languages of the programme
English, Norwegian, Danish and Polish

Research design
Quasi-experimental

ANNEX 4 INFRASTRUCTURES MONITORING

4.1 IMHPA-HP source questionnaire: Version 1

**A tool to assess the availability of strategies for the
promotion of mental health and the prevention of mental disorders
at the country or regional level**

**Eva Jané-Llopis, PhD
Prevention Research Centre, University of Nijmegen, The Netherlands**

Please cross the box or ring the option corresponding to your answer or write your answer where indicated.

PART I. PERSONAL DETAILS

Name:
Organisation:
Professional background:
Address:

Telephone:
Fax:
Email:
Country:
If you are answering for a region rather than your country as a whole, which region is it?

Date of completing the questionnaire (dd-mm-yy):
Main position description (mark what applies):

     __ Governmental professional
     __ Non-Governmental professional
     __ Program manager
     __ Practising health care professional
     __ Researcher
     __ Other, please specify:

Taking into account your experience, in which of the following areas would you be interested to be involved and provide your expertise?

     ❑ Evidence-based programmes in mental health promotion-mental disorder prevention
     ❑ Promotion and prevention of mental health in the health care service
     ❑ Policy and practice guidelines on promotion-prevention in mental health

PART II. GOVERNMENTAL SUPPORT: prevention and promotion in mental health

1.

In your opinion, is mental health a high priority in your country as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers?

❑ Yes, mental health is clearly a high priority

❑ Yes, there is interest in mental health but it does not seem to be much of a priority

❑ No, mental health is not at a priority

❑ Do not know

Please comment when applicable:

2.

In your opinion, is mental health a high priority in your country as evidenced by the increased amount of resources put into the field over the last 3 years?

❑ Yes, mental health is clearly a high priority and there are increased resources

❑ Yes, there is interest in mental health but it does not seem to be much of a priority as there is not much increased resources

❑ No, mental health is not at a priority

❑ Do not know

If yes, please specify where and how these resources have been increased and allocated:

3.

Is there a part in an official governmental written policy for the prevention of mental disorders or the promotion of mental health?

❑ Yes, a written stand alone policy on prevention and promotion

❑ Yes, part of a written overall mental health or public health policy

❑ No, but in preparation

❑ No

❑ Do not know

4.

If there is a part on a mental health promotion and/or prevention strategy, does the governmental policy include?

Governmental policy on prevention-promotion in mental health includes:	Yes	No	Do not know
A national strategy on training			
A national funded research strategy			
Interventions by primary care professionals			
School interventions integrated in the curriculum			
Interventions for groups at risk			
Interventions for the general public			

Other, please specify:

If yes, please specify the strategy components:

5.

Is there an identified person within the Department of Health that is responsible for overseeing or managing mental health including prevention and promotion strategies?

❑ Yes, for mental health in general

❑ Yes, specifically for mental health promotion - mental disorder prevention

❑ No

❑ Do not know

If there is an individual person, could you provide his/her contact details?

6.

Is there an unofficial (non-governmental) written policy on the prevention of mental disorders or the promotion of mental health?

❑ Yes, written stand alone policy on prevention and promotion

❑ Yes, part of written overall mental health policy

❑ No, but in preparation

❑ No

❑ Do not know

7.

If there is a part on a mental health promotion and/or prevention strategy what does the non-governmental policy include?

Non-governmental policy on prevention-promotion in mental health includes:	Yes	No	Do not know
A national strategy on training			
A national funded research strategy			
Brief interventions by primary care professionals			
School interventions integrated in the curriculum			
Interventions for groups at risk			
Interventions for the general public			

Other, please specify:

If yes, please specify the strategy components:

8.

Is there any central governmental or non-governmental funding supporting research, development of supporting infrastructures, implementation of programmes or training in mental health in general of specifically for mental health promotion (MHP) or mental disorder prevention (MDP)?

Funding is available for:	From Governmental Organizations				From Non-Governmental Organizations			
	Yes in general	Yes for MHP-MDP	No	Do not know	Yes in general	Yes for MHP-MDP	No	Do not know
Research								
Infrastructure development								
Implementation								
Training								
Programme development								

If yes, could you please specify contact details of such programme:

PART III. INTERVENTION: prevention and promotion in mental health

9.

In your country, have policy or practice guidelines on mental health promotion or mental disorder prevention been developed?

❑ Yes
❑ No
❑ Do not know

If yes, could you please e-mail/post copies of such guidelines or provide the contact details of those responsible for their development?

10.

In your country, has a registry or database of programmes or strategies for the promotion of mental health or the prevention of mental disorders been developed?

❑ Yes
❑ No
❑ Do not know

If yes, could you please e-mail/post a copy of such registry or database or provide the contact details of those responsible for its development?

11.

In your country, has a training programme for health care professionals (in primary or secondary health care), which includes mental health promotion or mental disorder prevention, been developed in your country?

❑ Yes
❑ No
❑ Do not know

If yes, could you please e-mail/post a copy of such training programme manuals or information about them or provide contact details of those responsible for its development?

12.

Please give your professional opinion of the extent of the availability of practices, programmes or strategies for the promotion of mental health and the prevention of mental disorders in various settings in your country (Please ring appropriate number):

	Widely available	Available	Partially available	Hardly available	Not available
Home-based	5	4	3	2	1
Schools	5	4	3	2	1
Work places	5	4	3	2	1
General/family practice	5	4	3	2	1
Hospital clinics	5	4	3	2	1
Elderly homes	5	4	3	2	1
Other community based settings	5	4	3	2	1
Internet sites	5	4	3	2	1
Public or media campaigns	5	4	3	2	1

If there are any of these strategies available, could you please name and describe them briefly?

13.

Is there a governmental or semi-governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues that could include the prevention/promotion of mental health (e.g., a dissemination institute, national network)?

❑ Yes, for health in general

❑ Yes, for mental health in general

❑ Yes, and it includes prevention promotion of mental health

❑ No, but such structures are being prepared

❑ No

❑ Do not know

If yes, could you please specify contact details of such structure?

14.

Is there any central governmental or non-governmental infrastructure/s (e.g., a national institute for health) that could support or currently supports the implementation of mental health promotion and mental disorder prevention practices in your country?

- ❑ Yes, for health in general
- ❑ Yes, for mental health in general
- ❑ Yes, and it includes promotion and prevention of mental health
- ❑ No, but such infrastructures are being prepared
- ❑ No
- ❑ Do not know

If yes, could you please provide the contacts of such infrastructure/s:

15.

Have national or regional training programmes for prevention and promotion in mental health been developed and implemented in your country for health professionals (e.g., health care professionals, psychologists, prevention or social workers)?

- ❑ Yes, developed and implemented
- ❑ Yes, developed but not implemented
- ❑ No, but being developed
- ❑ No
- ❑ Do not know

If yes, please specify for what professionals these trainings are provided:

If yes, please specify and provide contact details of training programmes:

16.

Is there a nationwide or region-wide mental health coalition formally constituted involving different parties?

❑ Yes

❑ No

❑ Do not know

If yes, what organizations are represented in the coalition? (please mark all that apply)

❑ Governmental organizations

❑ Non-governmental organizations

❑ Health professional organizations and/or groups

❑ Scientific organizations and/or groups

❑ Patient organisations/groups

❑ Other, (please specify):

If there is such a nationwide or region-wide mental health coalition formally constituted does it also include a strategy on mental health promotion and mental disorder prevention?

❑ Yes

❑ No

❑ Do not know

PART IV. RESEARCH and the HEALTH CARE SYSTEM: prevention and promotion in mental health

17.

Have there been any evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented in your country that have been published in peer-reviewed journals or in government publications?

❑ Yes

❑ No, but such studies are being undertaken

❑ No

❑ Do not know

If yes, could you please e-mail/post copies of publications or provide contact details of primary investigator

18.

Have there been any evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention in your country that have been published in peer-reviewed journals or in government publications?

❑ Yes

❑ No, but such trials are being undertaken

❑ No

❑ Do not know

If yes, could you please e-mail/post copies of publications or provide contact details of primary investigator

19.

Have there been any studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health in your country?

❑ Yes

❑ No, but such trials are being undertaken

❑ No

❑ Do not know

If yes, could you please e-mail/post copies of publications or provide contact details of primary investigator

20.

Are the promotion of mental health or the prevention of mental disorders integrated in the professional, specialist or vocational training of primary or secondary health care, and are there programmes for accredited continuing medical education available (please use 1 for promotion and 2 for prevention and fill in every box it applies):

Prevention and promotion of mental health integrated in training of:	Professional vocational training			If yes, is it compulsory or voluntary?	Accredited continuing medical education			If yes, is it compulsory or voluntary?
	Yes	No	Do not know		Yes	No	Do not know	
General practitioners Family doctors								
Nurses or doctors' assistants working in general practice								
Health care professionals working in chronic diseases care								
Midwives/Obstetric care professionals								
Geriatric care professionals								

PART V. PERSONAL EVALUATION: prevention and promotion in mental health

21.

What would you say have been the most significant advances, if any, in the implementation of evidence based programmes for the promotion of mental health or the prevention of mental disorders in your country since 1st January 2000?
Please suggest the three to five most important, and please give the date of the advance.

22.

What would you say are the key barriers to progress or issues or challenges facing you in your country in 2004-2005 in the implementation of country based mental health promotion and prevention strategy based on the project products (i.e., guidelines for policy and practice, a registry of promotion-prevention programmes and a training manual for health care professionals)? Please suggest the three to five most important

23.

What are the key advances you would like to see in 2004-2005 in the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders in your country? Please suggest the three to five most important

24.

What needs to change to make these advances possible?

25.

Can you please identify up to ten persons or organisations in your country whose work is related to mental health, health promotion or mental health promotion and could be involved in the implementation of the country strategies and the dissemination of the products developed by the current project (i.e., guidelines for policy and practice, a registry of promotion-prevention programmes and a training manual for health care professionals)?

PART VI

Other relevant information

Difficulties encountered in completing the questionnaire or other comments

4.2   Country Profiles based on questionnaire: Version 1

COUNTRY PROFILES

ON MENTAL HEALTH PROMOTION

AND MENTAL DISORDER PREVENTION

In EUROPE

Based on the Imhpa Country Profiles Questionnaire I

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CROATIA

Governmental support and funding

In Croatia, there is interest in mental health but it does not seem much of a priority as evidenced by the number of references to it in policy documents by politicians and policy makers. This attitude is also reflected in the amount of resources put into the field, which has not increased much during the last three years. However, several initiatives are underway, such as the preparation of a Croatian Institute for Mental Health, governmental support for scientific research also in relation to mental health promotion and the opening of centres for children, youth and families with the goal of preventing behaviour disorders and promotion of positive development.

There is a written policy on prevention and promotion as part of an overall mental health or public health policy. This policy does not include a national strategy on training, but includes interventions by primary care professionals, interventions for groups at risk, interventions for the general public and a national funded research strategy. It is not known whether this policy includes school interventions integrated in the curriculum.

Within the department of health R. Gregurek is responsible at the moment for mental health services as part of health and the social field.

From the governmental organizations there is funding available for mental health promotion and mental disease prevention research, which is mainly funded by the Ministry of Science and Technology. Projects are among others "Models of intervention with the purpose of prevention of behaviour disorders" or "Evaluation of integral method in the work with pre-school children and their families". There is also funding for infrastructure development, implementation, training (School of Medicine, University of Zagreb) and for programme development.

Non-governmental support and funding

The respondents do not know whether an unofficial non-governmental policy on prevention of mental disorders or the promotion of mental health exists. There are certain professional or scientific organisations whose programs are close to the field of mental health promotion or mental disorder prevention, but are not written as a policy. They focus on a national strategy on training, brief interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public. It is not known if they also include a national funded research strategy.

Non-governmental organizations have funding available to support research, infrastructure development, implementation, training or programme development, but it is not known exactly to what extent those programs are in the field of mental health promotion and mental disorder prevention.

Implementation and dissemination of interventions

Policy or practice guidelines on mental health prevention or mental disorder prevention have not yet been developed in Croatia. Neither does there exist a database of programmes or strategies. However respondents describe some attempts been made in this direction, such as: "*at the moment the Government Committee for Prevention of Behaviour Disorders in Children and Youth is trying to list the programs in the field of prevention of behaviour disorders. Also one*

of the goals of the project 'Counties that Care as model of prevention of behaviour disorder' is to create such a registry in the County of Istra. Creation of such registry could be a model for other counties". A training programme for health care professionals which includes mental health promotion or mental disorder prevention is in place, developed by the Clinic for psychological medicine and 'Andrija Stampar'- School of Public Health at the School of Medicine, University of Zagreb.

In Croatia, practices, programmes and strategies for the promotion of mental health and the prevention of mental health disorders differ in their availability in various settings. Home-based interventions are not available. In schools (Health promoting schools; Integral Method for work with pre-school children and their families) and hospital clinics interventions are available, just as in public or media campaigns. In workplaces (AA clubs in workplaces) and the general/family practice interventions are partly available. For other community based settings and the Internet, interventions are hardly available. The same counts for interventions in elderly homes, but recently some mental health promotion and mental disorder prevention programmes have become available in some of them.

There is no structure in place for the dissemination of knowledge to health professionals or prevention workers on programmes and strategies on health issues, including prevention and promotion in mental health. At the moment such structure is in preparation by the Committee for Mental Health at the Ministry of Health. For the implementation of mental health promotion or mental disorder prevention practices there is no central infrastructure. However, it is expected that the Croatian Institute for Mental Health will soon be established to take up this role.

National and regional training programmes have been developed and implemented in Croatia. These trainings are provided for health care professionals, psychiatrists, social pedagogues, social workers, psychologists and other professionals. The programmes involve for example post-graduate studies in 'Social psychiatry and social pathology', 'Child and adolescent psychiatry' and 'Behaviour disorders', all provided by the University of Zagreb. Moreover, there are various seminars and education (organised by the Council for children, Government Committee for the Prevention of Behaviour Disorders in Children and Youth, the State Institute for the protection of family, maternity and youth) and Schools of Psychotherapy.

There is no nationwide or region-wide mental health coalition present at the moment.

Research and training

Evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented in Croatia have been undertaken. These have been undertaken under master or doctorate theses, summaries of which are available in the library of the School of Medicine, University of Zagreb. The same counts for evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention. It is not known whether studies have been undertaken to assess how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health.

The promotion of mental health or the prevention of mental disorders has only been integrated in the professional training of General Practitioners, but this training is voluntary. For continuing medical education, mental health promotion or prevention of mental disorders is present for General Practitioners, but this training is also voluntary. For the other professions promotion and prevention in mental health are not integrated in the professional, specialist or vocational training of primary or secondary health care.

Implementation, key barriers and advances

Since January 2000, the most significant advances in the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders are "Croatia in the 21st Century" (a strategy for health development), the "Stability Pact for South Eastern Europe" (with recently significant movements toward mental health promotion), the "Health Protection Law" (with the decision about funding the Croatian Institute for Mental Health) and the establishment of the Committee for Mental Health within the Ministry of Health.

The key barriers facing Croatia regarding the implementation of country based mental health promotion and prevention strategy based on the project products are the absence of a formal system for promotion and prevention in mental health, a lack of coordination between organisations and professionals who work in the field of prevention and promotion in mental health and the lack of communication and exchange of information between existing structures. Moreover, the education is inadequate and there is the need for defining and registering existing programs.

The key advances that need to be made in 2004-2005 for the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders include the creation and start of evidence-based programmes and a registry of prevention and promotion programs in mental health. There is also a need to have information available on professionals who work in the field of mental health promotion and mental disorder prevention. The Croatian Institute for Mental Health should become a key organisation, with coordination of organisations and people who work in the field of promotion and prevention in mental health.

The changes needed to make these advances possible are technical assistance and financial support (from governmental structures), the establishment of new graduate and postgraduate studies for promotion and prevention in mental health and a different professional training and education (management in MHP and MDP organisations, program implementation and evaluation, institutionalisation of such programs).

ESTONIA

Governmental support and funding

In Estonia, there is interest in mental health but it does not seem to be much of a priority as evidenced by the number of references to it in policy documents by politicians and policy makers. "*Taking care of mental health is a rather new topic, which is understood among professionals but is not taken very seriously at the governmental level. A first step that has been made is the 'Mental Health Policy Basic Document'. This document was developed last year, in co-operation between mental health professionals and the Ministry of Social Affairs*".

The low priority for mental health is also reflected in the amount of resources put into the field, which has not increased much during the last three years. However, there is a Health Promotion Fund at the Estonian Health Insurance Fund and a discrete amount of the general budget is dedicated to Health Promotion projects. Mental health is one of its five priorities.

At the moment there is no written policy on prevention and promotion as part of an overall mental health or public health policy, but this is in preparation. The document is only a "Mental Health Policy Basic Document", which is given to the government to work out a mental health policy. Topics that are included are a national strategy on training, interventions by primary care professionals, interventions for groups at risk, school interventions integrated in the curriculum and interventions for the general public. A national funded research strategy is only shortly discussed. It is not yet clear to which topics from the basic document the government will give priority. The policy document has been introduced to the government in April 2003 and will be adopted when the program with budget is ready.

No specific person carries the responsibility for overseeing and managing mental health including prevention and promotion strategies. This is done by the Public Health Department at the Ministry of Social Affairs.

From the governmental organizations there is funding available for research in general (grants from the Estonian Scientific Fund) and for mental health promotion and mental disease prevention research (from the Health Promotion Fund of the Estonian Health Insurance Foundation-financing the SUPRE MISS project). Funding for infrastructure development in general comes from "Usaldus"- an emergency telephone line financed from state budget. Implementation in general is funded by the Health Insurance Budget. The funding for mental health promotion and mental disorder prevention implementation comes from the Health Promotion Fund. There are funds available for training in general and specifically for mental health promotion and mental disorder prevention. Funding for programme development in general comes from some resources in the state budget to develop a National Mental Health Policy. Specific funding for mental health promotion and mental disease prevention programme development are coming from the Health Promotion fund at the Estonian Health Insurance Foundation, which has supported the development of National Suicide Prevention Strategy and the development of a National Mental Health Policy.

Non-governmental support and funding

In Estonia there is an unofficial non-governmental policy on prevention of mental disorders or the promotion of mental health. This policy includes a national strategy on training, brief interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public. A national funded research strategy however is not included. Non-governmental organizations have funding available to support implementation and training both in general and specifically for

prevention and promotion in mental health. There are also funds for programme development in general. It is not known whether there is funding for research and infrastructure development.

Implementation and dissemination of interventions

Policy or practice guidelines on mental health prevention or mental disorder prevention have been developed in Estonia, or are currently being developed. A database of programmes or strategies does not exist. A training programme for health care professionals which includes mental health promotion or mental disorder prevention is in place, namely a psychiatric trainees' programme.

Practices, programmes or strategies for the promotion of mental health and the prevention of mental health disorders are limited in their availability in various settings. Home-based interventions are not available, just like interventions in the workplace. School-based interventions, interventions for general practice and interventions in elderly homes are hardly available. In hospitals and other community settings interventions are partially available. This is also true for interventions in the Internet. However public or media campaigns hardly exist. "*It is difficult to specify programmes, but it is possible to get general knowledge from the family doctor about prevention of mental health problems. Sporadic and on different levels, there are projects about different mental health problems in school or in elderly homes. These are very often about drug addiction and abuse problems and less about other mental health issues. Public and media campaigns are also more drug-oriented. Estonian society is not talking so much yet about avoiding stress, better coping strategies or healthy child rearing*".

There is a structure of health in general for the dissemination of knowledge, programmes and strategies on health issues, including prevention and promotion in mental health, to health professionals or prevention workers. For the implementation of mental health promotion and mental disorder prevention practices in Estonia there is a central infrastructure. The Tervise Arengu Instituut/ National Institute for Health Development is for health in general and it also includes promotion and prevention of mental health. National and regional training programmes have been developed and implemented in Estonia. These trainings are provided for PHC specialists (ESSI programme), health care professionals at the emergency department (SUPRE MISS project, ESSI programme) and school psychologists (National child health program, subprogram mental health). For psychiatrists there is an existing training plan and the number of eligible professionals has been analysed. Until now it was not possible to execute the training because there was not enough funding available to provide it to all psychiatrists.

There is a nationwide mental health coalition present at the moment, which has been created while developing the National Mental Health Policy. Organisations that are represented in the coalition are governmental, non-governmental, health professional organisations and/or groups, scientific organisations and/or groups and patient organisations and/or groups. This coalition does also include a strategy on mental health promotion and mental disorder prevention.

Research and training

In Estonia no evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented have been undertaken. Neither are there evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention, nor studies on how to increase the involvement of primary or secondary health care professionals for prevention and promotion in mental health.

The promotion of mental health or the prevention of mental disorders has been integrated in the professional training of General Practitioners and nurses, and is in both cases compulsory. For continuing medical education, mental health promotion or prevention of mental disorders is present for General Practitioners and nurses, this training is also compulsory. For

the other professions it is not known whether prevention and promotion in mental health are integrated in the professional, specialist or vocational training of primary or secondary health care.

Implementation, key barriers and advances

Since January 2000, the most significant advances in the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders include the Estonian Mental Health Policy Basic Document; a strategy for suicide prevention; the SUPRE MISS project; a HIV/AIDS Prevention National Programme and the Public Health information system development project.

The key barriers facing Estonia regarding the implementation of a country based mental health promotion and prevention strategy based on the project products are the lack of evidence based data about mental health epidemiology, the lack of a mental health policy, the lack of mental health professionals and a proper network between them, a general ignorance and presence of taboos towards mental health as something abstract and not important and finally the lack of resources to develop and generate psycho-educational (mass-media) programs for larger population groups. There is also no priority setting for financing, the political will is tackled by financial decisions.

There are several key advances that need to be made in 2004- 2005 for the implementation of evidence based programmes. These include the development and implementation of a suicide prevention programme, attention on promotion, continuous training and connected education of professionals with similar basic principles for mental health area professionals, training of the public for crisis situations, evaluation of implementation, development of scientific work on mental health epidemiology, development of good level databases on mental health statistics, psycho-education for different not-ill population groups and employers.

The changes needed to make these advances possible include political will and adequate financing for public health and health promotion programs. In Estonia, "currently dominates the financing of single projects to develop innovative ideas but a stable financing for implementation is missing." Also the general attitude in the community and among politicians has to change.

FINLAND

Governmental support and funding

In Finland, there is interest in mental health but it does not seem to be much of a priority as evidenced by the number of references to it in policy documents by politicians and policy makers. This attitude is also reflected in the amount of resources put into the field, which has not increased much the last three years. However the government has granted during two years special funding for local applicants for the development of mental health services for children and youth. "*Mental health is well represented in discussion, yet it is not very clearly seen at the level of resource allocation*".

There exists a written policy on prevention and promotion as part of an overall mental health or public health policy. This policy does not include a national strategy on training, interventions by primary care professionals, interventions for groups at risk or interventions for the general public, but it does include a national funded research strategy. It is not known whether it includes school interventions integrated in the curriculum. Basically, there is no overall strategy, but a country–wide research is developed financed by the ministry on preventive and promotive mental health services, suicide prevention and crisis-work.

Within the department of health several officials are in general responsible for mental health services as part of health and the social field.

From governmental organisations there is no funding available neither for research and infrastructure development, nor for implementation or training. There is funding available for mental health promotion and mental disease prevention programme development, granted by the ministry to Stakes for developing mental health practices locally.

Non-governmental support and funding

There is no unofficial non-governmental policy on prevention of mental disorders or the promotion of mental health as part of a written overall mental health policy. Non-governmental organizations have no funding available to support research, infrastructure development, implementation, training or programme development.

Implementation and dissemination of interventions

The Finish Association for mental health, together with pilot municipalities, has developed policy-practice guidelines in mental health with a focus on promotion and prevention. No database on prevention and mental health promotion programmes or policies exists in Finland. A training programme for health care professionals which includes mental health promotion-mental disorder prevention developed by Stakes and the ministry of social affairs and health is in place. *"The need of training and empowerment of professionals, and guidelines for training have been prepared and presented. However, no systematic practical training programmes have been accomplished in a countrywide scale. In the connection of various projects, training has been organized on specific topics such as suicide prevention, recognition and treatment of depression. Training for crisis interventions can be considered to have spread in a countrywide scale in Finland. However, a specific training is going on to provide Finnish health care and social services means to help families and to prevent children's mental disorders when a parent suffers from mental health problems."*

Practices, programmes or strategies for the promotion of mental health and the prevention of mental health disorders differ in their availability in various settings. Home-based interventions are hardly available, just like interventions in hospital clinics. Interventions in elderly homes are not available. In schools, workplaces and general/family practice interventions are available. The same counts for Internet sites and public or media campaigns. In other community based settings programmes are only partially available.

For the dissemination of knowledge, programmes and strategies on health issues to health professionals or prevention workers there is a structure in place for prevention or promotion of mental health. Part of this structure is the project for prevention of suicides, Crisis Help Chain, Mental Health as Strength for Childhood and Youth and "Mielekäs elämä" (Meaningful Life). There is also an infrastructure that supports the implementation of health promotion and disorder prevention practices, which includes promotion and prevention in mental health. In this infrastructure Stakes, the ministry of social affairs and health, and mental health non-governmental organizations are present.

National or regional training programmes for prevention and promotion in mental health have been developed and implemented. There are special programs for long-term unemployed, in order to find solutions to the problems caused by the unemployment ("Vuoden työmaa", Job for a Year).

A nationwide or region–wide health coalition does not exist. However, regionally or locally different kinds of coalitions are functioning. Usually they are multi sectoral and include multi professional groups for local planning.

Research and training

Evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented in Finland have been undertaken. An example is the implementation of the Nation Suicide Prevention Project, which has been evaluated by an internal and external peer-evaluation. Evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention have also been undertaken. Studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health are available, for example "IMPRO" a project of Stakes for prevention of suicides or "Mielekäs elämä" (Meaningful Life) by the ministry of health. The promotion of mental health and the prevention of mental disorders have not been integrated in the professional, specialist or vocational training of primary or secondary health care.

Implementation, key barriers and advances

The most significant advances in the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders since January 2000 include the "Efficient Family", an evidence based study on two preventive interventions in families with mentally ill parents.

The key barriers facing Finland regarding the implementation of a country based mental health promotion and prevention strategy based on the project products are that treatment is mostly in the focus, the lack of political interest and financing, negative attitudes and sceptics regarding the effectiveness of mental health promotion and mental disorder prevention and unclearity about who is responsible for what (caused by the field's multifactorial, multisectoral and multiprofessional nature).

The key advances that need to be made in 2004-2005 for the implementation of evidence based programmes for promotion and prevention in mental health are the development of a national mental health policy and program, which binds municipalities and

other partners to invest in promotion and prevention. Financial resources for building programmes and designs for evaluation in real-life situations in collaboration with local people are necessary. Also the 'ability to read' mental health has to be improved and the influences on mental health have to be taken in consideration and evaluation.

The changes needed to make these advances possible are a change of attitudes, the reduction of stigma and increase of knowledge and good practices promoting mental health.

FRANCE

Governmental support and funding

In France, mental health is clearly a high priority as evidenced by the number of references to it in policy documents by politicians and policy makers. However, this interest in mental health does not seem to be reflected in the amount of resources put into the field, which has not increased much during last three years.

A written stand-alone policy on prevention and promotion in mental health exists in France. This policy does not include a national strategy on training or a national funded research strategy, but it does include interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups as risk and interventions for the general public.

Within the Department of Health Catherine Dartiguenave and Muriel Rabord are at the moment the persons responsible for overseeing or managing mental health in general.

From the governmental organizations there is no funding available for research, infrastructure development, implementation, training or programme development.

Non-governmental support and funding

An unofficial non-governmental policy on prevention of mental disorders or the promotion of mental health exists in France as part of a written overall mental health policy. This policy includes a national strategy on training, but not a national funded research strategy. It is not known whether the non-governmental policy includes brief interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk or interventions for the general public. Non-governmental organizations have no funding available to support research, infrastructure development, implementation, training or programme development.

Implementation and dissemination of interventions

In France, policy or practice guidelines on mental health prevention or mental disorder prevention have been developed. A database of programmes and strategies does not exist. A training programme for health care professionals which includes mental health promotion or mental disorder prevention is in place, such as the Phase IV of the WHO brief alcohol intervention in primary care, coordinated by the Association National de Prevention et Alcoolisme.

Practices, programmes or strategies for the promotion of mental health and the prevention of mental health disorders in various settings are mostly not available in France. There are no home-based interventions, nor interventions in workplaces, general/family practice, elderly homes, other community based settings, Internet sites or public or media campaigns. Interventions in schools are partially available, in the form of life skills education programs. Interventions in hospitals are available through the health promoting hospitals.

For the dissemination of knowledge, programmes and strategies on health issues, including the prevention/promotion of mental health, to health professionals or prevention workers there is a structure in place for health in general. As part of a structure for health in general there is also an infrastructure that supports the implementation of mental health promotion and mental disorder prevention practices.

National or regional training programmes for prevention and promotion in mental health are currently being developed.

A nationwide or region–wide health coalition does not exist in France.

Research and training

No evaluation studies on the effectiveness or cost-effectiveness of mental health promotion or mental disorder prevention programmes implemented in France have been undertaken. Similarly, no studies have been undertaken to assess how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health.

There is no information whether promotion of mental health or the prevention of mental disorders are or not integrated in the professional, specialist or vocational training of primary or secondary health care.

Implementation, key barriers and advances

The most significant advances in the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders since January 2000 are the implementation of a suicide prevention programme with regional extension and the current implementation for a brief intervention programme for general practitioners on alcohol related problems.

The fact that no specific organization is focusing on mental health promotion and that there is no academic support, or no university member who is involved in health promotion research or mental health promotion research are seen as the key barriers facing France regarding the implementation of a country based mental health promotion and prevention strategy based on the project products.

The key advances that need to be made in 2004-2005 for the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders, include the development of such programmes, the development of structures working in promotion and prevention in mental health and the development of studies and theses in universities and research centers.

The changes needed to make these advances possible include awareness raising of the need for prevention and promotion for relevant key persons in the country, information dissemination on what can be done in this field and what results are possible (by informing about its success in other countries) and having the means for implementing the programmes.

GERMANY

Governmental support and funding

In Germany, there is interest in mental health as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers, but it does not seem to be much of a priority. Mental health has some importance in the context of health promotion, but health promotion is overwhelmingly oriented toward somatic health. The awareness and priority given in mental health differ depending on the type of mental disorder. Mental health does not seem to be much of a priority as evidenced by the amount of resources put into the field, which has not increased much the last years. However there has been a remarkable increase in governmental funding for research in the mental health field, although this is not the most important of its topics.

There is an official governmental written policy for the prevention of mental disorders or the promotion of mental health as part of a written overall mental health or public health policy. The promotion of mental health and the prevention of mental ill health is part of the national law on Health and Safety (Occupational Safety Act, ArSchG, 1996). Work is a very important domain in a person's life that is why this is an area where protection of physical and mental health is necessary. The national law on Health and Safety promotes a holistic view, including a demand to employers to promote mental health at work. In addition, this governmental policy includes a national strategy on training, school interventions integrated in the curriculum (drug prevention and the prevention of violence), interventions for groups at risk and interventions for the general public. It does not include a national funded research strategy nor does it include interventions by primary care professionals.

Dr. Brockmann is the identified person within the Department of Health that is responsible for overseeing or managing mental health in general. For health promotion and disorder prevention Dr. Drohsel is the identified person.

Funding from governmental organizations for health in general is available for research, infrastructure development and program development. There is no funding available for implementation and training.

Non-governmental support and funding

There is an unofficial (non-governmental) written policy on the prevention of mental disorders or the promotion of mental health. This non-governmental policy includes brief interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public. It does not include a national strategy on funding nor does it include a national funded research strategy. In addition, funding from non-governmental organizations for health in general is available for research, infrastructure development, implementation, training and programme development.

Implementation and dissemination of interventions

Policy or practice guidelines on mental health promotion or mental disorder prevention have been developed in Germany. It was developed within the European Project on 'Mental health Promotion & Prevention Strategies for Coping with Anxiety, Depression & Stress Related Disorders in Europe' (2001-2003), but only for working adults aged between 25 and 60. There is also a national suicide prevention programme, which might include such guidelines. There is a

database of programmes strategies developed for the promotion of mental health or the prevention of mental disorders. This is not organised at a national level but on a regional level.

No training programme for health care professionals (in primary or secondary health care), which includes mental health promotion or mental disorder prevention has been developed in Germany. Mental health promotion or disorder prevention might be part of the training programmes of psychiatrists, psychiatric nurses, psychologists or other mental health care workers, but usually it does not have a very prominent position in the respective curricula.

Programmes or strategies for the prevention of mental health and the prevention of mental health in schools ("MindMatters-Mental Health", a project based on the concept of the promotion of mental health in schools) are available. They are partially available in work places (Crisis Intervention Service, give support to employees of aid agencies), general/family practice, community based settings, internet sites and in public or media campaigns. These programmes or strategies are hardly available in home-based settings, hospital clinics and in elderly homes.

There is a governmental or semi-governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies for mental health in general. Also FIOSH (Federal Institute for Occupational Safety and Health) is involved in dissemination of preventive strategies. In addition there are central governmental or non-governmental infrastructure/s that could support or currently support the implementation of mental health promotion and mental disorder prevention practices. These include FIOSH (Federal Institute for Occupational Safety and Health) and the Ministry for Education and Research.

In Germany no national or regional training programmes for prevention and promotion in mental health have been developed and implemented. There is a nationwide (the German Network for Mental Health) or region-wide mental health coalition formally constituted involving governmental, non-governmental and scientific organizations.

Research and training

Only a few evaluation studies on the effectiveness of prevention and/or promotion in mental health have been undertaken in Germany. No evaluation studies have been undertaken on the cost effectiveness of programmes for mental health promotion or mental disorder prevention. Nor have there been any studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health. Prevention and promotion of mental health are not integrated in the professional training of general practitioners/family doctors, nurses or doctor's assistants working in general practice, health care professionals working in chronic diseases care, midwives/obstetric care professionals or geriatric care professionals.

Implementation, key barriers and advances

The most significant advances in the implementation of evidence based programmes for the promotion of mental health or the prevention of mental disorders in Germany since 1 January 2000 include:
- The foundation of a national network for mental health
- The announcement of the funding of a nation wide program for health promotion and prevention, including probably mental health promotion by the Ministry of Education and Research in collaboration with the Ministry of Health
- The announcement of the government to give prevention priority

Germany is facing some key barriers in 2004-2005 in the implementation of country based mental health promotion and prevention strategy based on the project products. The most important are:

- Mental health is still tabooed in public, so many mentally ill people will probably not seek for help, because they do not want to be stigmatised
- The system is too much curative and medical oriented, even non-medical professionals are not enough interested in mental health promotion
- Lack of training and education of professionals and at universities

Key advances that are would be needed in 2004-2005 to facilitate the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders in Germany include:
- The government and all forces interested in health promotion should explicitly mention mental health promotion as one of the major topics
- Informing the broader public to make clear that mental health can affect all of us, that the person suffering from a mental disorder is not guilty for his/her state of health
- To clarify that mental disorders are serious diseases that not only affect the person suffering but also his/her social environment

To make these advances possible there need to be international support or the challenge of international concurrence. In addition the communication among all experts in the field of mental health needs to be intensified.

GREECE

Governmental support and funding

In Greece there is interest in mental health as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers, but it does not seem to be much of a priority. The main focus is on the closure of large institutions and 'rehousing' of long-term patients. When it comes to resources mental health is clearly a high priority as evidenced by the increased amount of resources put into the field over the last three years.

However, there is no part in an official governmental written policy for the prevention of mental disorders or the promotion of mental health.

There is an identified person within the Department of Health that is responsible for overseeing or managing mental health including prevention and promotion strategies.

Funding for mental health in general from governmental organizations is available for infrastructure development, implementation, training and programme development.

Non-governmental support and funding

There is no non-governmental written policy on the prevention of mental disorders or the promotion of mental health in Greece. Although there is no non-governmental policy there is non-governmental funding for mental health in general, available for infrastructure development, implementation, training and programme development.

Implementation and dissemination of interventions

No policy or practice guidelines on mental health promotion or mental disorder prevention have been developed in Greece. Neither there have a registry of programmes or strategies for the promotion of mental health or the prevention of mental disorders been developed. It is unknown if a training programme for health care professionals, which includes mental health promotion or mental disorder prevention has been developed.

There are no programmes or strategies for the promotion of mental health and the prevention of mental disorders available in work-places, general/family practice and elderly homes; they are hardly available in home-based settings and schools and partially available in hospital clinics and public or media campaigns. Some more extra information was provided on the type of programmes available.

In Greece, there is no governmental or semi-governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues that could include the prevention/promotion of mental health.

For mental health in general there is a central governmental or non-governmental infrastructure that could support or currently supports the implementation of mental health promotion and mental disorder prevention practices (EPIPSY).

No national or regional training programmes for prevention and promotion in mental health have been developed and implemented for health professionals, although some references are provided in relation to their current development.

There is no nationwide or region-wide mental health coalition formally constituted involving different parties.

Research and training

There have been no evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented in Greece published in peer-reviewed journals or in governmental publications. Nor have there been any evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention or studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health.

The promotion of mental health or the prevention of mental disorders is not integrated in the professional, specialist or vocational training of primary or secondary health care.

IRELAND

Governmental support and funding

In Ireland, there is interest in mental health as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers but it does not seem to be much of a priority. However, a new national mental health policy is in the developing process. That mental health is not much of a priority is also reflected in the amount of resources put into the field, which has not increased much the last three years.

There is a part in a written overall mental health or public health policy for the prevention of mental disorders or the promotion of mental health. This governmental policy includes school interventions in the curriculum, interventions for groups at risk and interventions for the general public.

In the Department of Health there is a person responsible for overseeing or managing mental health in general and one responsible for overseeing or managing mental health promotion/mental disorder prevention.

Funding is available for infrastructure development for mental health in general. For mental health promotion and mental disorder prevention funding is available for research, implementation and programme development.

Non-governmental support and funding

There is no unofficial (non-governmental) written policy on the prevention of mental disorders or the promotion of mental health. Funding is available for implementation in mental health promotion and mental disorder prevention.

Implementation and dissemination of interventions

In Ireland no policy guidelines or a database on programmes and policies for prevention and promotion in mental health have been developed. A training programme for health care professionals has been developed including mental health promotion or mental disorder prevention strategies. This is a module on mental health promotion as part of a masters programme in health promotion at National University of Ireland, in Galway.

There are no programmes or strategies for the promotion of mental health and the prevention of mental disorders available in hospital-clinics, general/family practice and elderly homes; they are hardly available in workplace settings, other community based setting and the internet. Public and media campaigns are hardly available and are run by voluntary organizations such as 'Aware' and the Mental Health Association of Ireland. Home-based interventions (such as the Life start programme) are only partially available. However, school based programmes are available and include a social, personal and health education curriculum that is now compulsory at post-primary level.

In Ireland, there is no governmental or semi-governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues that could include the prevention/promotion of mental health.

For mental health in general there is a central governmental or non-governmental infrastructure that could support or currently supports the implementation of mental health promotion and mental disorder prevention practices. This is the Health Promotion unit at the Department of Health and Children.

No national or regional training programmes for prevention and promotion in mental health have been developed and implemented for health professionals.

A national strategy group on mental health policy has been formed recently. This strategy includes both mental health promotion and mental disorder prevention.

Research and training

Some evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented in Ireland have been undertaken and published in peer-reviewed journals or in governmental publications. No evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention have been undertaken. Some trials have been undertaken to evaluate how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health.

The promotion of mental health or the prevention of mental disorders is not integrated in the professional, specialist or vocational training of primary or secondary health care. General health promotion does feature in undergraduate and postgraduate training for health professionals. Mental health promotion is part of the curriculum for postgraduate training in health promotion at the National University of Ireland in Galway.

Implementation, key barriers and advances

The most significant advances in the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders since January 2000 include the development of a regional strategy for MHP based on evidence based programmes in the North Western health board, and small scale investment by the Department of Health and Children in the development and evaluation of mental health promotion programmes.

The key barriers facing Ireland regarding the implementation of a country based mental health promotion and prevention strategy based on the project products include the lack of resources and coordination and the absence of a national strategy to guide the development of MHP at a national level.

The key advances that need to be made in 2004-2005 for the implementation of evidence based programmes for promotion and prevention in mental health include training of practitioners and coordination, strategy development and evaluation put in place. To make these advances possible a national strategy needs to be developed with a resourced plan of action.

LITHUANIA

Governmental support and funding

In Lithuania there is interest in mental health, but it does not seem much of a priority as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers. There is an increasing number of political statements about the importance of public mental health and there are some national programmes developed, however, in the level of implementation, the mental health field is still suffering from old approaches, including emphasis on "negative" mental health and the historical principle of funding large mental institutions. Over the last three years financial resources for mental health have increased which indicates that there is interest in mental health, but it still does not seem to be much of a priority. There was no substantial funding for programs in the field of MHP or MDP.

There is an official governmental written policy for the prevention of mental disorders or the promotion of mental health as part of a written overall mental health or public health policy. Mental health promotion and prevention of problems are integrated into the National programme for prevention of mental disorders. The term "prevention" in this programme covers primary, secondary and tertiary prevention, treatment and rehabilitation, so it is not specifically only for prevention/promotion. This governmental policy does not include a national strategy on training, a national funded research strategy, interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public. However, training, research and interventions for the general public are mentioned in the National program as important issues, including some quantitative goals.

Within the department of health Dr. Davidoniene is at the moment the responsible person for overseeing or managing mental health in general.

Funding from governmental organizations for MHP/MDP is available for research, infrastructure development, implementation, training and programme development. But there are no governmental organizations that could see as their priority to support of prevention/promotion activities in the field of mental health.

Non-governmental support and funding

There is no unofficial (non-governmental) written policy on the prevention of mental disorders or the promotion of mental health, but it is in preparation. However funding is available from the non-governmental organisation Open Society Foundation for research, training and programme development.

Implementation and dissemination of interventions

In Lithuania, no policy or practice guidelines on mental health promotion or disorder prevention have been developed. Neither has a registry or database of programmes or strategies for the promotion of mental health or the prevention of mental disorders been developed. No training programme for health care professionals (in primary or secondary health care), which includes mental health promotion or mental disorder prevention is available in Lithuania.

Programmes or strategies for the prevention of mental disorders and the promotion of mental health are partially available in the schools, in hospital clinics, interventions on the Internet and public or media campaigns. Home based interventions and interventions in

workplace, for general/family practice, in elderly homes, in community settings are hardly available.

There are governmental or semi-governmental structures for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies for mental health in general, including the State Mental Health Center and the National Service for Public Health Care. These organizations are also involved in providing support to the implementation of practices for mental health in general.

A national or regional training programme for prevention and promotion in mental health for health professionals does not exist yet but it is in preparation.

There is a nationwide or region-wide mental health coalition formally constituted involving governmental, non-governmental, health professional organizations, scientific organizations and patient organizations.

Research and training

In Lithuania, no evaluation studies have been undertaken on the effectiveness of mental health promotion or mental disorder prevention programmes nor have there been any evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention. Neither have there been any studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health.

Prevention and promotion of mental health is integrated in the professional vocational training of general practitioners/family doctors, nurses or doctors' assistants working in general practice, health care professionals working in general practice or working in chronic diseases care, midwives/obstetric care professionals and geriatric care professionals.

Implementation, key barriers and advances

The most significant advances in the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders in Lithuania since 1 January 2000 include:

- An annual (2001) report of a National Health Board (a body at the parliament) was delivered in June 2002 in the plenary session of Parliament, with strong emphasis on the field of public mental health, including promotion and prevention issues.
- A country profile in the field of mental health services was completed in 2002 by a group of independent researchers (in collaboration with Queensland university, Australia and London Institute of Psychiatry, UK).
- A decision was taken in 2002 by Vilnius city Council (capital city) to develop a child mental health strategy for the city.

The key barriers Lithuania is facing in 2004-2005 for the implementation of country based mental health promotion and prevention strategy based on the project products include:

- Lack of political will to develop public health approaches in the field of mental health, which is still dominated by the model of clinical psychiatry
- Lack of research capacity in the field of mental health promotion and evidence-based mental health policy
- A written document with clearly expressed priorities for the promotion/prevention and funding for the implementation of the programmes. Currently both components are missing.
- Lack of will to integrate mental health issues in the infrastructure of public health services which were for many decades restricting scope of their activities to protection of physical environment and prevention of communicable diseases

- Attitudes among the general population, with strong tendencies to stigmatise vulnerable groups and make pressure to politicians to solve mental health problems in the tradition of isolation, institutionalisation and stigmatisation.

Key advances that would be needed in 2004-2005 in the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders in Lithuania include:
- To make use of EU accession process, through raising research capacity and implementation of model programs in the field of MHP and MDP
- To develop a suicide prevention program, based on a modern public health approach (Lithuania has the highest suicide rate in Europe).
- To integrate mental health issues in the national concept of public health

To make these advances possible a shift in understanding that mental health is a much broader field than psychiatry is needed and more active assistance of EU bodies to change the approach of national authorities of accession countries, facilitating their understanding that mental health is indivisible part of health.

Country Description: NETHERLANDS

Imhpa Project[1]

NETHERLANDS

Governmental support and funding

Mental health is clearly a high priority in the Netherlands as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers explicitly recognized in presentations by the former Minister of Health in international speeches. Its high priority is also evidenced by the increased amount of resources put into the field over the last three years, around 30-40% of the budget for research and development in prevention (national Programme) was spent on mental health issues over the last 5 years.

There is also a written stand-alone policy on prevention of mental disorders and promotion of mental health. A new governmental paper is in preparation; mental health is a clear priority issue in the new Prevention Programme of the National Health Research and Development Council. The governmental policy on prevention and promotion in mental health does not include a national strategy on training. However, it does include a national funded research strategy, interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public.

There is an identified person within the Department of Health that is responsible for mental health in general.

Governmental funding is available for research, infrastructure development, implementation and program development.

Non-governmental support and funding

The known non-governmental policy on prevention and promotion in mental health includes: a national strategy on training, brief interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public. Non-governmental funding is available for research, implementation and programme development.

Implementation and dissemination of interventions

In the Netherlands, policy or practice guidelines on mental health promotion or mental disorder prevention have been developed. There is also a registry or database of programmes or strategies for the promotion of mental health or the prevention of mental disorders under development and there is a training programme for primary health care professionals for mental health in which a component on prevention is being developed.

Programmes or strategies for the promotion of mental health and the prevention of mental disorders in the schools and workplaces are widely available. The settings in which they are available are home-based, general/family practice, partially available in hospital clinics, Internet sites and public or media campaigns. They are hardly available in elderly homes.

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[1]Imhpa project: Implementing Mental Health Promotion Action. This project is financially supported by the European Union (Public Health – Health Promotion Programme), the Ministry of Health in the Netherlands and the Ministry of Social Welfare and Health in Finland.

There is a governmental or semi-governmental structure for the dissemination to health professionals and prevention workers of knowledge, programmes and strategies on health issues that include the prevention/promotion of mental health.

The implementation of mental health promotion and mental disorder prevention practices are supported by a governmental or non-governmental infrastructure. And national or regional training programmes for prevention and promotion in mental health have been developed and implemented for health professionals.

However, there is no nationwide or region-wide mental health coalition formally constituted involving different parties.

Research and training

Evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented in the Netherlands have been undertaken and published in peer-reviewed journals or in government publications. Studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health have not been done in The Netherlands.

Prevention and promotion of mental health are integrated in the training of geriatric care professionals but it is voluntary. Programmes for accredited continuing medical education are also available, but also voluntary. At least two Dutch universities (Maastricht, Health Sciences; and Nijmegen, Clinical Psychology) have academic training programmes in prevention and health promotion. Most of the around 1000 health educators, health promoters or prevention experts have followed a kind of specialized training in this field.

Implementation, key barriers and advances

The 4 most important significant advances in the implementation of evidence based programmes for the promotion of mental health or the prevention of mental disorders since 1 January 2000 are:

1. The Beardslee Family Education Program to prevent transgenerational transfer of mental disorders in families with parents suffering from depression or anxiety disorders.
2. The Mother-baby home-visiting program for baby's and depressed mothers to prevent insecure attachment and promote safe attachment.
3. The coping with depression course for adults at risk, originally developed by Lewinsohn and Muňoz. The programme has been translated into Dutch and implemented at large scale in the Netherlands. Different versions have been made for different population segments such as adolescents, chronically ill people and the elderly.
4. The Good Behaviour Game, an evidence-based prevention program to reduce aggression in primary school children. The program has been implemented and evaluated in a large scale outcome study in Baltimore, with randomisation of schools, classes and teachers. The program has been adopted and the RCT has been replicated in the Netherlands with positive outcomes.

The key barriers to progress or challenges facing the Netherlands in 2004-2005 in the implementation of a country based mental health promotion and prevention strategy based on the project outcomes are the lack of a structural collaboration on a national level between representatives of primary health care, mental health services and the prevention/health promotion sector.

There are problems financing the time to be spent by primary health care workers physicians and district nurses, and getting willingness to participate in such a program.

Another barrier is identifying evidence-based effective prevention/promotion programs that fit into the tasks, expertise, opportunities and (the limited) available time of primary health care

workers. There also needs to be the right combination of interventions that have the power to influence significantly the onset of mental health problems and mental disorders at population level or population at risk to be found.

Guidelines need to be accepted by national professional organizations of primary care professionals. This will probably require first a pilot project of several years on a small scale combined with a process and outcome evaluation.

Key advances that would liked to be seen in 2004-2005 in the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders are the implementation of the second round of the national Prevention Research and Development Program by the National Health Research and Development Council and a new national system of financing preventive work implemented by primary care, public health and health care services because the current system of specialized prevention experts in mental health services is under pressure.

Other advances are a national law or national measures that safeguards that 10% of the (mental) health care services should be spent to prevention/health promotion in mental health, a national agreement between all parties involved on a division of tasks within the field of prevention and health promotion in mental health, as well as agreements on structural collaboration between core parties and a comprehensive system of prevention, health promotion and health education training across all relevant disciplines. To make these advances possible some changes needs to be made.

The Netherlands has a very extended system for health promotion and prevention within public health services, addiction clinics, mental health services, custodial care and several other non-governmental agencies. Many of these services have specialized health promotion or prevention teams. However, a strong national coalition for prevention/promotion in mental health needs to be developed across disciplines, NGO's and governmental agencies and there needs to be more clarity on the economic benefits and mental health outcomes of the currently implemented interventions.

NORWAY

Governmental support and funding

Mental health clearly seems a high priority in Norway as evidenced by the number of references to mental health in speeches and policy documents by politicians and policy makers. This high priority is also evidenced by the increased amount of resources put into the mental health field over the last three years.

In Norway there is a written stand-alone governmental policy on prevention and promotion. This governmental policy on prevention and promotion in mental health includes: a national strategy on training; a national funded research strategy; school interventions integrated in the curriculum; interventions for groups at risk; and interventions for the general public.

For mental health in general is an identified person within the Department of Health.

Funding from governmental organizations is available for research, infrastructure development, implementation, training and programme development.

Non-governmental support and funding

There is no non-governmental written policy on the prevention of mental disorders or the promotion of mental health in Norway. Although there is no non-governmental policy there is funding available from non-governmental organizations for research and programme development.

Implementation and dissemination of interventions

In Norway policy or practice guidelines on mental health promotion or mental disorder prevention have been developed. It is unknown if a registry or database of programmes or strategies for the promotion of mental health or the prevention of mental health disorders has been developed. There is a training programme for health care professionals, which includes mental health promotion and mental disorder prevention.

Programmes or strategies for the promotion of mental health and the prevention of mental health disorders are hardly available in home based settings, general/family practice, hospital clinics and Internet sites. They are partially available in work places and elderly homes. Prevention and promotion in mental health are available in the schools (prevention of bullying), other community based settings and through public or media campaigns.

There is a governmental or semi-governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues for mental health in general. In Norway, there is a central governmental or non-governmental infrastructure/s that could support or currently supports the implementation of mental health in general.

Norway has also developed and implemented national or regional training programmes for prevention and promotion in mental health for health professionals.

It is unknown if there is a nationwide or region-wide mental health coalition.

Research and training

Evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented in Norway have been done, but it is unknown if they have been published in peer-reviewed journals or in government publications. It is also unknown if any studies on how to increase the involvement of primary or secondary health care

professionals in the prevention of mental disorders and the promotion of mental health have been undertaken.

Prevention and promotion of mental health are integrated in the training of midwives/obstetric care professionals and geriatric care professionals.

Implementation, key barriers and advances

No significant advances in the implementation of evidence-based programmes for the promotion of mental health or the prevention of mental disorders since the 1st of January 2000 have been made.

The key barriers to progress or challenges facing Norway in 2004-2005 in the implementation of country based mental health promotion and prevention strategy based on the project products are that primary health care is the municipalities' responsibility, and central initiatives are hard to disseminate. A series of dissemination conferences could overcome this barrier.

One of the key advances that would like to be seen in 2004-2005 in the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders is the need to write a book on best practice, translated into the various European languages. More money is what is needed to make these advances possible.

POLAND

Governmental support and funding

Mental health is not a priority in Poland as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers or by the limited increase amount of resources put into the field over the last three years.

However, officially there is a special law on mental health promotion issued by the government. The Ministry of Health has appointed the National Council on Mental Health Promotion. The Council has been working for three years and during this time the experts have published the report on the mental health problems in Poland and the state of art of mental health promotion in Poland. The Council has also prepared the draft project of mental health promotion in Poland. But since 2001 the new Minister of Health has not supported the Council activities and the Council practically stopped its activity.

Policy for the prevention of mental disorders or the promotion of mental health is part of a written overall mental health or public health policy which includes a national strategy on training, a national funded research strategy, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public. More specifically the strategy components include:

1) To develop appropriate knowledge and skills in the society needed for self-development and self-actualisation, coping with stress and environmental demand;
2) To develop and introduce in schools educational curricula activities aimed at enhancement of the skills of solving problem situations and coping with stress;
3) To develop educational programmes on mental health promotion and their implementation in the curricula of under- and postgraduate training of professionals involved in teaching and upbringing, treatment and care provision, re-socialisation and rehabilitation, management and organisation of labour;
4) To introduce educational programmes in working places, enabling the development of healthy relationships;
5) To provide different forms of psychological, educational, marital and family counselling, vocational guidance, etc., as well as to improve these services provision in the hitherto existing facilities, such as e.g. child guidance clinics or social welfare organisational units;
6) To provide psychosocial support for children and adolescents at risk for mental health;
7) To organise and promote the development of various forms of social support, especially self-help groups, to people with mental disorders;
8) To establish crisis intervention centres for people suffering from emotional crises and for families experiencing difficult life situations;
9) To establish provincial and communal centres providing counselling, guidance and psychosocial support to people at risk for mental health;
10) To provide professional training for those professionals who are involved in mental health promotion, counselling and other psychosocial support, and;
11) To support research on psychosocial factors promoting the enhancement and maintenance of mental health, and on factors detrimental to mental health.

There is an identified person within the Department of Health that is responsible for overseeing or managing mental health including prevention and promotion strategies.

However there is no governmental funding available for research, infrastructure development, implementation, training and programme development in mental health.

Non-governmental support and funding

There is no unofficial written policy on the prevention of mental disorders or the promotion of mental health. Similarly there is no funding available from non-governmental organisations for prevention or promotion in mental health.

Implementation and dissemination of interventions

There have been policy or practice guidelines on mental health promotion and mental disorder prevention developed. A registry or database of programmes or strategies for the promotion of mental health or the prevention of mental disorders has not been developed. There is also no training programme for health care professionals that includes mental health promotion or mental disorder prevention.

There is no governmental or semi-governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues that could include the prevention/promotion of mental health. There are however central governmental or non-governmental infrastructure(s) that could support or currently support the implementation of mental health promotion and mental disorder prevention practices in Poland.

No national or regional training programmes for prevention and promotion in mental health have been developed and implemented in Poland for health professionals.

There is no nationwide or region-wide mental health coalition formally involving different parties.

Research and training

There have been evaluation studies on the effectiveness of mental health promotion and mental disorder prevention programmes implemented in Poland that have been published in peer-reviewed journals or in government publications. No evaluation studies have been done on the cost effectiveness of programmes for prevention and promotion in mental health neither have there been studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health.

It is unknown if training on the promotion of mental health or the prevention of mental disorders is integrated in the professional, specialist or vocational training of primary or secondary health care.

Implementation, key barriers and advances

The most significant advances in the implementation of evidence based programmes for the promotion of mental health or the prevention of mental disorders in Poland since 1 January 2000 is a report published by the National Council for Mental Health Promotion on the "Mental Health – treats and promotion" which describes the current situation in Poland on factors threatening the mental health in family, schools, work place and unemployment, it reports data on mental health in the Polish population and presents most known mental health promotion programmes in Poland and other countries. The Council has also drafted the National Mental Health Promotion Programme and National Programme on Suicide Prevention.

The key barriers to progress or the challenges facing Poland in 2004-2005 in the implementation of country based mental health promotion and prevention strategy based on the project products are that the Ministry of Health stopped being interested since 2001 on the development and implementation of strategies for mental health promotion. This means a lack of resources for any activities in the field, including the Council for Mental Health Promotion activities. This lack of support for mental health development is also seen on the level of

government and parliament, the National Mental Health Programme and important amendments in Mental Health Law are waiting for adoption since 2001.

The key advances liked to be seen in 2004-2005 in the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders are the amendments to the Mental Health Law, which could legally include National Mental Health Programme into governmental policy. It could help to plan special resources for mental health in the budget. It could also provide the National Council on Mental Health Promotion with the financial resources to finalise its tasks: the national mental health promotion programme development, implementation and monitoring. Another key advance that would be liked to see is to build the European Action Plan on Mental Health Promotion which could be used as a guideline for Polish government.

PORTUGAL

Governmental support and funding

Mental health does not seem to be a high priority in Portugal as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers but there is interest in it. Drug problems and Aids have been the highest priorities in health. Mental health is not a priority as evidenced by the increased amount of resources put into the field over the last three years.

An official governmental written policy for the prevention of mental disorders or the promotion of mental health is in preparation (National Plan of Mental Health). This policy will include a national strategy on training, interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public. Although still in preparation there will be strong components on:

- Training of primary care professionals and articulation with mental health teams;
- Development of guidelines for primary care professionals' interventions and for consultation-liaison psychiatry at the general hospital;
- Promotion of mental health and prevention of mental disorders in children and adolescents and in old people;
- National strategies/campaigns against stigma and discrimination of people with mental disorders and for mental health promotion for the general public.

In the Department of Health is an identified person that is responsible for overseeing or managing mental health including prevention and promotion strategies.

The existing governmental funding is not specific for Mental Health, it is for health in general. It is available for infrastructure development, training and programme development. Because of national counterpart budget constraints, the funding is mainly used for infrastructure development.

Non-governmental support and funding

There is no non-governmental written policy on the prevention of mental disorders or the promotion of mental health. Similarly, there is no non-governmental funding available for promotion and prevention in mental health.

Implementation and dissemination of interventions

In Portugal, although policy or practice guidelines on mental health promotion or mental disorder prevention have not yet been developed they are in preparation. A registry or database of programmes or strategies for the promotion of mental health or the prevention of mental disorders has not been developed. Training programmes for health care professionals, which include promotion and prevention in mental health have been prepared but are not yet implemented because of lack of funding.

Programmes or strategies for the promotion of mental health and the prevention of mental disorders are partially available in schools and workplaces and available in general/family practices. In the schools some training of teachers and students was started. In workplace settings it comes to some local programmes on stress management. When it comes to general/family practice settings there are several local experiences of articulation of mental health teams with primary health care and representatives of the community.

There is a governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues that include the prevention and promotion of mental health. There is also a central governmental infrastructure that supports the implementation of health in general with a specific department for mental health. National or regional training programmes for health professionals on prevention and promotion in mental health are being developed.

A nation wide mental health coalition is constituted (National Council of Mental health) with representatives of governmental, non-governmental, health professional, scientific, and patient organizations. This coalition also includes a strategy on mental health promotion and mental disorder prevention.

Research and training

No evaluation studies on the effectiveness or on the cost-effectiveness of mental health promotion or mental disorder prevention programmes implemented in Portugal have been developed or published in peer-reviewed journals or in governmental publications. There have been studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health (DepCare, secondary prevention of depression in primary health care).

Prevention of mental disorders is integrated in the professional vocational training of general practitioners and family doctors and nurses or doctors' assistants working in general practice and it is compulsory. However it is not integrated in the accredited continuing medical education. The promotion of mental health or the prevention of mental disorders is also not integrated in the professional vocational training and accredited continuing medical education of health care professionals working in chronic diseases care, midwives/obstetric care professionals and geriatric care.

Implementation and key barriers

The key barriers to progress or challenges facing Portugal in 2004-2005 in the implementation of a country based mental health promotion and prevention strategy based on the project products are lack of funding, lack and/or heterogeneity of human resources in mental health in Portugal and a decrease of compliance (poor motivation, less availability of time, etc.) among health care professionals.

There are some key advances that would like to be seen in Portugal in 2004-2005 in the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders. This would include the implementation of evidence-based programmes during pregnancy and early childhood, in schools, in health care services, in the general public and at the workplace. An advance would also be the performance of cost-effective evaluations of implemented programmes.

To make these advances possible some changes need to be made. These changes include the availability of resources for the implementation of the National Plan for Mental Health, which should incorporate evidence-based programmes. This could be facilitated by a change of policy priorities.

SCOTLAND

Governmental policy and funding

In Scotland and the North West region, mental health is clearly a high priority as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers. The priority of mental health is evidenced by the increased amount of resources put into the field over the last three years in Scotland, however this is not the case for the North West region. "National money specific to promotion and prevention became available for the first time in October 2001 from the Scottish executive health department. 4 million for 3 years till 2003 increased to additional 24 million for 2003- 2010."

An official governmental stand-alone policy on prevention and promotion has been written. This policy already includes (or has in development) interventions by primary care professionals, schools interventions integrated in the curriculum, interventions for groups at risk (e.g. 'Choose Life'- the Scottish Executive Suicide Prevention strategy; 'Breathing Space'- a telephone advice and referral service for people suffering from low mood or depression) and interventions for the general public ('See Me'- anti stigma campaign). In Scotland, but not in the North West region, there is also a national strategy on training and a national funded research strategy.

Within the department of health there is a person responsible for overseeing or managing specifically mental health promotion-mental disorder prevention.

In Scotland governmental funding especially for mental health promotion and mental disorder prevention is available for research, infrastructure development, implementation, programme development and training. In the North West region, funding exists for the same areas, except for training.

Non-governmental policy and funding

Both in Scotland and the North West region there is no non-governmental written policy on the prevention of mental disorders or the promotion of mental health. However, there is some non-governmental funding specifically for mental health promotion and mental disorder prevention in the fields of research, infrastructure development, implementation, training and programme development.

Dissemination and implementation of interventions

In the Scotland and the North West region policy or practice guidelines on mental health promotion or mental disorder prevention have been developed. Those are for example 'Making it Happen', guidelines in connection with the suicide strategy (including information on promotion) written by Scottish Development Centre (SDC) for Mental Health on behalf of the national programme and the SDC report- 'What Works: evidence into practice.' A registry or database of programmes or strategies for mental health promotion and mental disorder prevention has been created by Mentality. In Scotland, training programmes for health care professionals (in primary or secondary health care), which include mental health promotion or mental disorder prevention, are mostly run locally as multi agency health promotion courses which health care professionals attend. The beginnings of some overarching training programmes such as the 'Mental Health First Aid training' can be seen however. For the North West region, no locally based or other training programmes exist.

The availability of practices, programmes or strategies for the promotion of mental health and the prevention of mental disorders varies in the different settings. Basically, each locality has a mental health promotion strategy. The guidance is that these are based on settings. Home based interventions are only partially available, interventions in schools are partially available in Scotland (through the Scottish Executive Education Department) but they are widely available in the North West region. Interventions in the workplace are partially available (for example SHAW Scotland's Health At Work). Interventions are partly available in general/family practice, but both in hospital clinics and elderly homes they are hardly available. In other community based settings programmes are partly available, just as interventions on internet sites. Public and media campaigns are available, such as the 'See Me' campaign on anti-stigmatisation.

The Scottish Executive has a structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues and it includes prevention and promotion of mental health. The implementation of prevention and promotion practices in mental health is supported by a central infrastructure. The organization is that each region has a mental health promotion lead through NIMHE, each of these will have/develop a regional network of all the local mental health promotion leads. The local leads will coordinate a multi agency group. This creates a structure for dissemination/communication form the centre to localities.

Regional training programmes for health professionals on prevention and promotion in mental health have been developed and implemented both in Scotland and the North West region.

There is a nationwide or region wide mental health coalition formally constituted involving different parties. This is not a single and formally constituted coalition, but a number of different groupings of agencies. Organisations that are represented in the coalition are governmental organisations, non-governmental organisations, health professional organisations, scientific organisations and patient organisations. This coalition also includes mental health promotion and mental disorder prevention.

Research and training

In Scotland and the North West region evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes have been undertaken and published in peer-reviewed journals or in government publications. Unfortunately it is very difficult to pinpoint these. However, no evaluation studies regarding cost-effectiveness of programmes for mental health promotion or mental disorder prevention have been done, except for the North West region (published in the Journal for Mental Health Promotion). Studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health are executed by Mentality and PriMHE.

The promotion of mental health or the prevention of mental disorders has not been integrated in the professional, specialist of vocational training of primary and secondary health care, and there are no programmes for accredited continuing medical education available. "My overall sense is that teaching practical strategies for promotion of mental health and well-being (as distinct from treatment of mental disorders) does not receive a high priority in the training of the above professionals".

SLOVENIA

Governmental support and funding

In Slovenia there is interest in mental health but it does not seem to be much of a priority as evidenced by the number of references to it in policy documents by politicians and policy makers. The fact that mental health is not a priority is also reflected in the amount of resources put into the field which has not increased much over the last three years.

There is no official written policy for the prevention of mental disorders or the promotion of mental health. Promotion and prevention in mental health are part of general strategies in health or social care or as ongoing projects.

Within the department of health there is no person responsible for overseeing or managing mental health. Andrej Marusic who works at the Institute of Public Health of the Republic of Slovenia is the WHO National Coordinator for Mental Health (not employed by the Ministry of Health).

From the governmental organizations there is funding available for research, infrastructure development, implementation and training for health in general. The funding is available at the level of the government and the different ministries (Ministry of Health, Ministry of Education, Science and Sport). There is no funding for programme development.

Non-governmental support and funding

In Slovenia there is no unofficial non-governmental policy on prevention of mental disorders or the promotion of mental health. Non-governmental organizations have no funding available to support research, infrastructure development, or programme development. It is not known by the respondents if there exists non-governmental funding for implementation or training.

Implementation and dissemination of interventions

At the moment Slovenia has no policy or practice guidelines on mental health promotion or mental disorder prevention. There does not exist a database of programmes or strategies, nor a training programme for health care professionals which includes mental health promotion or mental disorder prevention. Practices, programmes or strategies for the promotion of mental health and the prevention of mental disorders are mostly partially available in this country. Home-based interventions are hardly available, but interventions in hospital clinics, elderly homes schools, workplaces and other community settings are partially available. In general/family practice interventions are available. Internet sites and public or media campaigns are only partially available.

For the dissemination of knowledge, programmes and strategies on health issues, including the prevention/promotion of mental health to health professionals or prevention workers there is a structure in place for health in general, namely the Ministry of Health. There is also an infrastructure that supports the implementation of health promotion and mental disorder prevention practices, which includes promotion and prevention of mental health. This is the Centre for Health Promotion at the Institute of Public Health. National or regional training programmes for prevention and promotion in mental health have been developed and implemented. These programmes are for family doctors (assessment of depression and suicide risk), social workers (establishment of community mental health) and teachers (assessment of suicide risk). There does not exist a nationwide or region–wide mental health coalition.

Research and training

Evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes are currently in preparation. Evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention have not been undertaken. Studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health are also in preparation.

The promotion of mental health or the prevention of mental disorders has been integrated in the professional, specialist or vocational training of general practitioners and nurses and is compulsory. For other professions, such as chronic diseases care, midwives and geriatric care, prevention and promotion are not present. This is also not the case for the accredited continuing medical education.

Implementation, key barriers and advances

The most significant advances in the implementation of evidence based programmes for promotion and prevention in mental health since January 2000 include:
- The preparation of mental health legislation, which would also cover legislation in relation to prevention and promotion of mental health
- The establishment of the Centre for Health Promotion at the Institute of Public Health, which will also cover mental health promotion and prevention
- The foundation of a Council for Mental Health at the Government

The key barriers facing Slovenia regarding the implementation of country based mental health promotion and prevention strategy based on the project products include finances, lack of staff, traditionalism of the country and the reluctance of 'traditional' psychiatrists and heads of large psychiatric hospitals towards community care, insufficient support of leading politicians and interest groups and finally the stigma of mental disorders.

The key advances that need to be made in 2004-2005 for the implementation of evidence based programmes for the promotion of mental health and the prevention of mental disorders, include entering the Euro and its networks (counteracting the financial and staff barriers) and responding to Euro expectations (counteracting the traditionalism issue) and the enthusiasm of some mental and public health workers. Other key advances are the development of community care, broader network of psychiatric services and the mental health act.

The changes needed to make these advances possible include increased public and political awareness of the importance of mental health. *"Time is on our side. Hence, what need to change is speed. Increase in speed is needed!"*

SWEDEN

Governmental support and funding

There is interest in mental health in Sweden as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers, but it does not seem to be much of a priority as "*there are lots of words, but very little action*". As evidenced by the amount of resources put into the field over the last three years there is interest in mental health but it does not seem to be much of a priority as there is not much increased resources.

There is a part in an official governmental written policy for the prevention of mental disorders or the promotion of mental health as part of a written overall mental health or public health policy. The governmental policy on prevention-promotion in mental health does not include a national strategy on training nor is there a national funded research strategy. It does include interventions by primary care professionals, school interventions integrated in the curriculum (there is a very clear policy regarding prevention of alcohol and drug abuse including information programs in schools), interventions for groups at risk (high quality health care programs for pregnant mothers and new born children, which also includes mental health components) and interventions for the general public.

There is an identified person within the Department of Health in Sweden that is responsible for overseeing or managing mental health including prevention and promotion strategies.

Funding from governmental organizations for mental health in general is available for research and infrastructure development.

Non-governmental support and funding

There is a non-governmental written policy on the prevention of mental disorders or the promotion of mental health, which is part of a written overall mental health policy. This non-governmental policy on prevention-promotion in mental health includes school interventions integrated in the curriculum and interventions for groups at risk. There is a national program for suicide prevention, which is not sponsored by the government. There is also a national program for early intervention of psychoses adopted in some parts of the country. This non-governmental policy does not include a national strategy on training, a national funded research strategy, brief interventions by primary care professionals and interventions for the general public.

Funding supporting research for mental health promotion or mental disorder prevention is available from non-governmental organizations.

Implementation and dissemination of interventions

There have been no policy or practice guidelines developed in Sweden on mental health promotion or mental disorder prevention. A registry or database of programmes or strategies for the promotion of mental health or the prevention of mental disorders has also not been developed. A training programme for health care professionals, which includes mental health promotion or mental disorder prevention, has been developed.

Practices, programmes or strategies for the promotion of mental disorders are hardly available in home-based settings and Internet sites. They are, however, partially available in schools, work places (there are programs to improve health including mental health in working places adopted by labour unions and some big companies), general/family practice, hospital clinics, elderly homes, public or media campaigns and in other community based settings.

There is a governmental or semi-governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues for health in general as for mental health in general. There is also a central governmental infrastructure that could support or currently supports the implementation of mental health promotion and mental disorder prevention practices.

National training programmes for prevention and promotion in mental health have been developed and implemented in Sweden for health professionals.

There is no nationwide or region-wide mental health coalition formally constituted involving different parties.

Research and training

There have been no evaluation studies on the effectiveness of mental health promotion and mental disorder prevention programmes implemented in Sweden published in peer-reviewed journals or in governmental publications.

Nor have there been any evaluation studies on the cost effectiveness of programmes for mental health promotion or mental disorder prevention or studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health.

The promotion of mental health or the prevention of mental disorders is not integrated in the professional, specialist or vocational training of primary or secondary health care. Although there are small parts included in the training at all levels in prevention-promotion they are insignificant.

Implementation, key barriers and advances

No advances in the implementation of evidence based programmes for the promotion of mental health or the prevention of mental disorders are suggested because it is difficult to identify any significant advances in the field since January 2000.

The perceived lack of evidence based programs for prevention and promotion, the shortage of money in a strained economy, the lack of interest of mental health professionals for a number of reasons and the lack of political interest are seen as the key barriers to progress in Sweden in 2004-2005 in the implementation of a country based mental health promotion and prevention strategy based on the project products.

The key advances liked to be seen in 2004-2005 in the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders are:
1) Clear evidences for the possibility of prevention and promotion in the mental health field;
2) A significant body of expertise to deal with mental health promotion issues and prevention aspects; and,
3) A renewed interest from politicians to support this area.

The changes needed to make these advances possible are evidence that prevention and promotion are possible and a brake through our understanding of the nature of the major mental disorders especially schizophrenia and affective disorders including anxiety and depression. This would enable the development of more effective prevention and promotion strategies.

Country Description: UNITED KINGDOM*

(* this section includes the United Kingdom without Scotland)

UNITED KINGDOM

Governmental support and funding

In the United Kingdom (this overview does not include the Scottish region) mental health is clearly a high priority as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers. "Mental health is one of the key priority areas within the NHS, alongside cancer and coronary heart disease. A National Service Framework for mental health was launched in 1999, and included seven standards. Standard One of the NSF focuses on mental health promotion and gives health and social services a clear remit to promote mental health and reduce the discrimination and social exclusion associated with mental health problems". This priority is also reflected in the increased amount of resources put into the field over the last three years. However, these resources are not specifically for mental health promotion and competition exists with many other priorities.

There exists an official governmental policy on prevention and promotion: this policy does not include a national strategy on training, but it does include a national funded research strategy (the National Institute for Mental Health England: NIMHE, Mental Health Research Network, managed by the Institute of Psychiatry and Manchester University), interventions by primary care professionals, school interventions integrated in the curriculum (The Healthy Schools initiative), interventions for groups at risk (National Suicide Prevention Strategy) and interventions for the general public (the Mind Out for Mental Health campaign, aimed at reducing stigma and discrimination surrounding mental illness).

Within the department of health Professor Anthony Sheehan and Professor Louis Appleby are at the moment the responsible persons for overseeing or managing mental health in general.

Funding from the government is available for research in general (coming from the Department of Health-NIMHE) for specific mental health promotion and mental disorder prevention implementation and programme development (coming from Health Action Zones) and for training (funding from the Department of Health- Section 64 Grant).No funding is available for infrastructure development.

Non-governmental support and funding

There does not exist a non-governmental written policy on the prevention of mental disorders or the promotion of mental health in the U.K. There is also no non-governmental funding available (or not known of) for infrastructure development, implementation, training and for programme development. There is non-governmental funding for research in general in some academic units, e.g. Hull University is doing research into student suicide.

Dissemination and implementation of interventions

In the U.K. policy or practice guidelines on mental health promotion or mental disorder prevention have been developed, such as the National Service Framework for mental health of Making it Happen- a guide to delivering mental health promotion. Also, a database of programmes or strategies for the promotion of mental health or the prevention of mental disorders had been developed by NIMHE. A training programme for health care professionals

(in primary of secondary health care), which includes mental health promotion and mental disorder prevention has been provided by Mentality (a national mental health promotion charity). This programme is for people across many different sectors, with an interest in gaining mental health promotion skills and expertise. The course aims to develop the knowledge and expertise required to deliver mental health promotion and to contribute to the implementation of standard one of the national service framework for mental health. Other locally based health and social services will also have their own training programmes for staff, those are often multi-disciplinary programmes.

The availability of practices, programmes or strategies for the promotion of mental health and the prevention of mental disorders varies in the various settings. Home based interventions are only partially available (for example the Sure Start programmes for 0-4 year olds), interventions in schools are available. The National Healthy Schools scheme includes a module on emotional health and well-being. This programme is widely available in primary schools and available in secondary schools. Interventions in the workplace are hardly available, mostly when there exists a local Health at Work programme. In general/family practice programmes are partially available, but for hospital clinics there are hardly any programmes and not at all in elderly homes. For other community based settings such as day centres or carers support, interventions are available, such a voluntary sector programmes. For available interventions on the internet there are the sites of Mentality or the NIMHE. Finally, intervention in public or media campaigns are partially available, such as the Mind Out for Mental Health programme.

For the dissemination of knowledge, programmes and strategies on health issues, including prevention and promotion of mental health, to health professionals or prevention workers there are several structures available. Governmental structures are the NIMHE and its eight regional development centres, semi-governmental include a number of voluntary organisations such as MIND, Rethink, Mentality and the Royal College of Psychiatrists.

For the implementation of mental health promotion and mental disorder prevention practices the Department of Health has set up the NIMHE. Its regional development centres, located in eight regions of the country, enables them to disseminate information/guidance/training etc locally.

Training programmes for prevention and promotion in mental health are being developed at the time in the U.K. for health professionals. This training is provided by Mentality and commissioned locally in six regions in England by the end of 2004.

In the U.K. there are mental health coalitions, but mostly on the regional level. However, the NIMHE is planning to develop a (informal) national network. Organisations that are represented in the local coalitions are governmental organisations, non-governmental organisations, health professional organisations, and patient organisations. These coalitions are not specifically for mental health promotion and mental disorder prevention.

Research and training

There have been done evaluation studies on the effectiveness of mental health promotion or mental disorder prevention programmes implemented in the U.K. that have been published in peer-reviewed journals or in government publications (for example several reports from the Health Development Agency and Mentality). However, no evaluation studies regarding cost-effectiveness of programmes for mental health promotion or mental disorder prevention have been undertaken. Studies on how to increase the involvement of primary or secondary health care professionals in mental health promotion and mental disorder prevention do not exist as such, but a resource has been published to support mental health promotion in primary care developed by PriMHE with funding from NIMHE.

The promotion of mental health or the prevention of mental disorders has not been integrated in the professional, specialist of vocational training of primary and secondary health

care, and there are no programmes for accredited continuing medical education available, except for a professional training for midwives on post natal depression. "Most health care professionals have a very narrow view of mental health promotion, although it may be touched on briefly in their training".

4.3   IMHPA-HP source questionnaire: Version 2

HPSource.net

"The Health Promotion Discovery Tool"

Imhpa

Implementing Mental Health
Promotion Action

European Mental Health Module
Version 1.09.04©

A Collaboration between the

"Implementing Mental Health Promotion Action" (IMHPA)

and

HP-Source.net

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IMHPA Introduction

The IMHPA network

IMHPA, "Implementing Mental Health Promotion Action", is a network of professionals interested in mental health and has been financed by the European Commission, the Ministry of Health, Welfare and Sports in the Netherlands and the Ministry of Social Welfare and Health in Finland. The network aims to develop and disseminate evidence-based mental health promotion (MHP) and mental disorder prevention (MDP) strategies across Europe and to facilitate their integration into countries' policies, programmes and primary health care. The Imhpa group has the participation of 20 countries of the European Region (Austria, Belgium, Croatia, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Sweden and the United Kingdom), the collaboration of four European Networks (Mental Health Europe; the International Union of Health Promotion and Education; the European Network for Workplace Health Promotion; and the Network of Health Promoting Hospitals) and the support of the World Health Organization. Country representatives include governmental and non-governmental officials, research institutions, practitioners and other health care providers.

Goals

"Implementing Mental Health Promotion Action" (IMHPA) aims to:

1. Identify and describe evidence-based programmes and policies in MHP and MDP through a standardized searchable database, and to stimulate implementation;
2. Help integrate primary prevention of emotional problems and the promotion of mental health in primary health care;
3. Provide a tool for countries and regions to identify available infrastructures and policies and support developing targeted policies and strategies for MHP and MDP;
4. Develop an European policy action plan which can be adapted across European countries to different regional needs and situations, and;
5. Enhance the quality and effectiveness of prevention and promotion in mental health.

Since April 2003 and led by three task forces, IMHPA is developing three strands of products to be disseminated, implemented and tested across European countries.

Database Task Force

The IMHPA internet-based database gathers and outlines the evidence on prevention and promotion programmes and policies in mental health with detailed program descriptions, effects and cost-effectiveness. It provides a set of implementation guidelines for adoption and adaptation and recommendations to develop and implement effective strategies for MHP and MDP in specific country situations.

Care Task Force

The IMHPA specialised training manual for primary care will provide health care professionals with increased awareness of mental health problems and their relationship with physical ill health, and will train skills to provide strategies throughout daily practice for mental health promotion and prevention of emotional problems for those at risk.

Policy Action Plan Task Force

The IMHPA European Policy Action Plan on mental health promotion and mental disorder prevention provides a framework for policy development to be used as a guide for the development of country based action plans.
However, for an action plan to be developed at the country level there is a need for an overview of the situation of mental health promotion and mental disorder prevention programmes and of the available infrastructures policies and programmes.

Country profiles on infrastructures, policies and programmes for mental health

The IMHPA-HP Source questionnaire aims to provide an overview of the available infrastructures, policies and programmes for mental health promotion and mental disorder prevention at the country or regional level. The completion of the questionnaire will result in a country profile description, will provide the basic information about the infrastructural situation in every country and could be used as a tool for the further development of infrastructures, as a baseline for monitoring development at the country level, or as a supporting document for the development of an action plan or a specific policy in MHP and MDP.
To complete the questionnaire it is recommended that a country or regional coalition is created to facilitate a reliable collection of the information that reflects the country or region situation. The country coalition or country group would involve experts from different professional backgrounds and positions in the field of public and mental health. It is recommended that the questionnaire is completed through discussion and common agreement between all country coalition members.

HP-Source.net Introduction

HP-Source.net is a voluntary, international collaboration of researchers, practitioners and policy makers, having the common goal to maximise the efficiency and effectiveness of health promotion policy, infrastructures and practices by:

➢ Developing a uniform system for collecting information on health promotion policies, infrastructures and practices;

➢ Creating databases and an access strategy so that information can be accessed at inter-country, country and intra-country levels, by policy makers, international public health organisations and researchers;

➢ Analysing the databases to support the generation of models for optimum effectiveness and efficiency of health promotion policy, infrastructure and practice;

➢ Actively imparting this information and knowledge, and actively advocating the adoption of models of proven effectiveness and efficiency, by means of publications, seminars, conferences and briefings, among other means.

At the time of issue of HP-Source.net Version 2, the HP-Source.net web site displays the data collected with the Version 1 questionnaire. Following a period of data collection, the web site will continue to display the version 1 database, but also the Version 2 database (expected early 2005).

HP-Source.net Version 2 provides a searchable database with links to many other information sources. The areas of inquiry in HP-Source.net Version 2 are:

➢ Politics, policies and priorities
➢ Evaluation
➢ Monitoring and/or surveillance
➢ Knowledge development
➢ Implementation
➢ Information dissemination for health care professionals
➢ Programmes and strategies
➢ Professional workforce
➢ Funding

HP-Source.net collaborators make every reasonable effort to collect valid data, but expert judgements are also called into play. Also, the database is periodically, not continually, updated. For these reasons, actual conditions in a given country or region at any given time may vary from conditions as described in the database.

Imhpa - HP-Source.net Glossary

A Database of Strategies for Infrastructure, Policies and Practices
in Mental Health Promotion and Mental Disorder Prevention
at the Country and Regional Levels

Health promotion: The term "health promotion" as used here refers to all aspects of public health practice emanating from the Ottawa Charter[1], which includes building healthy public policy, creating supportive environments, developing personal skills, reorienting health services and strengthening community action.

Health: Positive health is more than just the absence of disease. Health is a resource and has a value on its own. It contributes to the individual promoting well-being and quality of life and to the society and economy by increasing social functioning, and social capital.

Infrastructures for health promotion: Infrastructure for health promotion refers to the system for policy development, priority setting, monitoring and surveillance, research and evaluation, workforce development, and program delivery that direct and support action to promote, protect and maintain the health of the population.

Mental health: Positive mental health is more than just the absence of mental disorders. Mental health is a resource and has a value on its own. It contributes to the individual promoting well-being and quality of life and to the society and economy by increasing social functioning, and social capital.

Mental ill health: Mental ill health includes mental health problems, symptoms and disorders. Mental ill health is not only restricted to diagnosable disorders according to current classification systems but also includes mental health strain and symptoms related to temporary or persistent distress.

Mental health promotion: The term "mental health promotion" refers to actions intended to contribute to positive mental health, including the building of individuals' and communities' strengths, competencies and resources, and quality of life.

Mental disorder prevention: The term "prevention of mental disorders" refers to actions intended to contribute to reduction of the incidence, prevalence or seriousness of mental health problems and disorders, and/or related disability, mortality, morbidity and risk behaviour outcomes.
For this questionnaire, mental disorder prevention deals only with primary prevention, including preventive strategies directed to the whole population; to those identified to be at increased risk for a mental disorder as evidenced by the presence of risk factors and the absence of protective factors; and to those who are already suffering from signs or symptoms of a mental disorder but who do not fulfil a diagnostic criteria at this time.

Programmes and strategies: Planned actions for which responsible persons are identified, objectives are set, resources are committed, methods are specified, actions are taken, and processes and outcomes are documented.

Public policy: The term public policy refers to an explicit framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem. Central to this definition is the notion that public policy is more than simply the programmes of a government, and includes guiding principles as well as particular outcomes.

Pedigree: The HP Source database standard includes the use of 'pedigrees' to (1) allow verification of the accuracy of the data, and (2) provide links to key documents. In the common meaning of the term, a 'pedigree' is a formal, usually written, record of the history of an ancestral line. In the present sense, the tern 'pedigree' refers to written and publicly available records that substantiate the health promotion and/or disease prevention origins of infrastructures, policies and practices that are entered into the database.
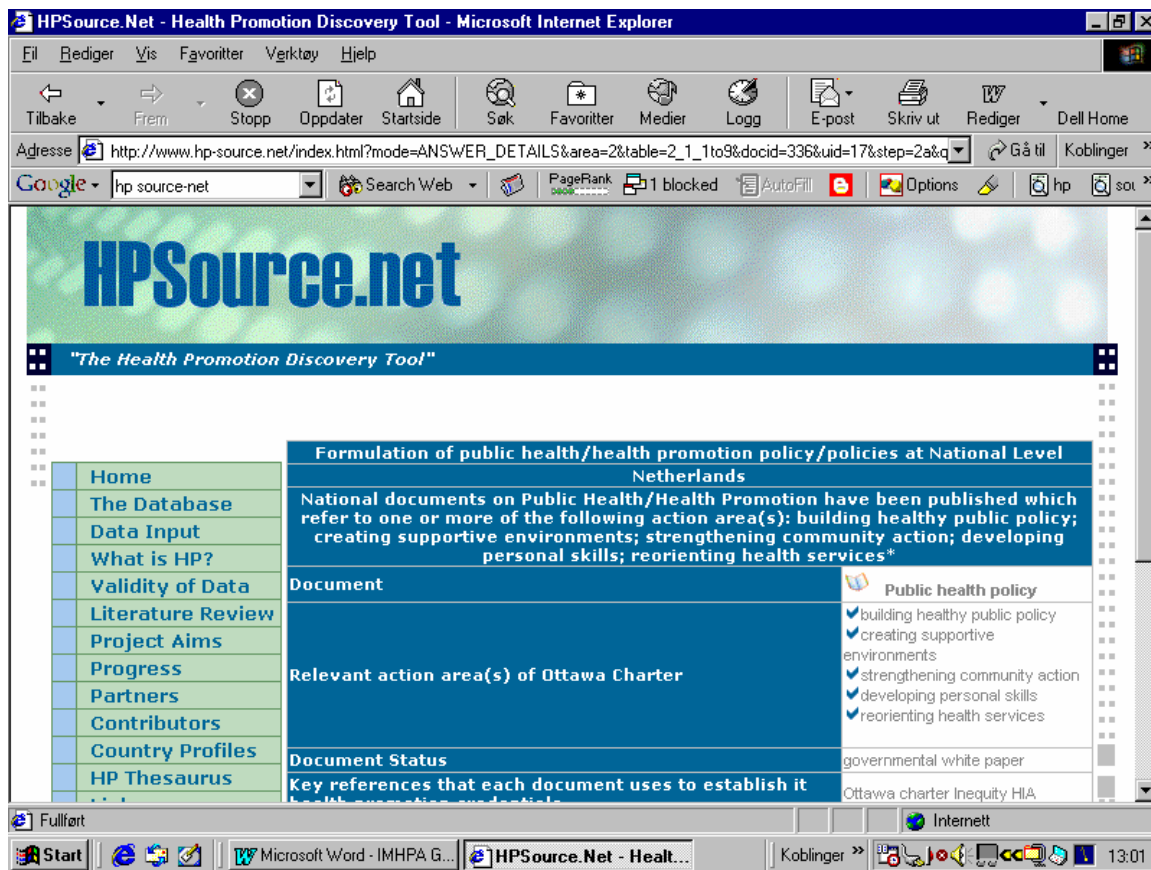
For example, a written policy on health promotion could be expected to refer to one or more core health promotion documents or concepts, such as the Ottawa Charter on Health Promotion of 1986, or its emphasis on healthy public policy. The database asks for such written policies to be documented.

Illustrating this is the HP Source question (Version 1):

> "Have national documents on Public Health/Health Promotion been published which refer to one or more of the following action area(s): building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; reorienting health services?"

The answer in the Netherlands is 'yes', and the panel above provides details about the document that stands behind the 'yes' answer. A final word about the idea of a pedigree – the use of pedigrees is intended in part to provide the possibility of independent verification that answers to the questionnaire are based on fact. This provides protection for the researcher doing the data entry, who might otherwise feel implicit or explicit pressure to provide affirmative responses to all the questions, whether valid or not. More importantly however, the ability to trace pedigree documents opens the door for researchers to more easily contrast and compare the situation in various countries regarding the state of health-related infrastructure, policy and practice.

IMHPA

European Mental Health Module Questionnaire

The IMHPA European Mental Health Module questionnaire aims to capture information on the infrastructures and strategies on mental health promotion and mental disorder prevention that are available across countries of the European Region.

Mental health promotion and mental disorder prevention are considered as separate but overlapping strategies and therefore information on both is distinctively required across the items of the questionnaire.

Mental disorder prevention deals in this questionnaire only with primary prevention, including preventive strategies directed to the whole population; to those identified to be at increased risk for a mental disorder as evidenced by the presence of risk factors and the absence of protective factors; and to those who are already suffering from signs or symptoms of a mental disorder but who do not fulfil diagnostic criteria at this time.

The IMHPA database includes complete reference to the pedigree documents (documents that provide a proof of statements, e.g., a policy action plan; a written evaluation of an implemented programme), permitting independent assessment and verification of the basis for inclusion of policies, programmes and actions in the database. The database does not contain information on strategies that cannot be documented as described above.

The IMHPA Data Entry Form is an adaptation of the *HP Source.net* standard for documenting health promotion infrastructure, policies and programmes, with modifications required to suit the objectives of the IMPHA project.

> *Instructions for data entry*

Where you see **[Document Reference]** or **[Organisation Reference]**, you are asked to provide a standardised set of information for each document. This is done using the HP-Source.net Document Reference Template or the HP-Source.net Organisation Reference Template. Save the completed form with a file name in the format 'question number-hpsource-country-last name of questionnaire respondent-date of data entry in format dd/mm/yy.doc'.

Example: 2.1-hpsource-norway-mittelmark-11.10.03.doc

At the point where you see the relevant **[Document Reference]** or **[Organisation Reference]** in the questionnaire, insert the file name, so that a clear cross reference is available, permitting linkage of questions to documents.

Data Entry Form

**A Database of Strategies for Infrastructure, Policies and Practices
in Mental Health Promotion and Mental Disorder Prevention**

---

1. Background information

1.1   Respondent's name (last, first):

1.2   Respondent's country:

1.3   Respondent's e-mail address:

1.4   Respondent's telephone number:

1.5   Respondent's fax number:

1.7   Respondent's present work (tick one):

     ❑   Practising health care professional
     ❑   Academician
     ❑   Manager/administrator
     ❑   Policy maker
     ❑   Other _____

1.8   Are you a government employee? Yes ❑ No ❑

1.9   Professional qualifications (degrees):

1.10   Number of years in employment in your professional area:

1.11   Self-rating of expertise level in the area of <u>mental health promotion in your country</u> (tick one):

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
↑	2	3	4	5	6	7	8	9	↑

<u>Slightly</u> conversant   <u>Fully</u> conversant

1.12 Self-rating of expertise level in the area of <u>mental disorder prevention in your   country</u> (tick one):

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
↑	2	3	4	5	6	7	8	9	↑

<u>Slightly</u> conversant   <u>Fully</u> conversant

1.13 If this questionnaire is completed at the region, rather than at the whole national level, specify for which <u>region.</u>

1.14 If this questionnaire was completed with the collaboration of other people,   provide **[Organisational Reference(s)]** for each participant (in the notes section, indicate the type of contribution, i.e., provided data, endorsed your work, other).

1.15 Provide **[Organisational Reference(s)]** for nation-wide and/or regional   coalitions (task forces, action groups, collaborative bodies) in the arenas of   mental health promotion and mental disease prevention.

2. Politics, Policies and Priorities

2.1 Do relevant politicians/policy makers refer to <u>mental health promotion</u> in a manner that suggests it is a priority area?

 ❑ Yes, in speeches, talks, press conferences, etc.
 ❑ Yes, in documents **[Document Reference(s)]**
 ❑ No

2.2 Do relevant politicians/policy makers refer to <u>mental disorder prevention</u> in a manner that suggests it is a priority area?

 ❑ Yes, in speeches, talks, press conferences, etc.
 ❑ Yes, in documents **[Document Reference(s)]**
 ❑ No

2.3 In your opinion, taking into account everything you know, what level of <u>real</u> priority does the present government place on <u>mental health promotion</u>? Real priority means translations of words into at least some action.

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
↑	2	3	4	5	6	7	8	9	↑
Low priority, Mostly rhetoric									High priority, much action

2.4 In your opinion, taking into account everything you know, what level of <u>real</u> priority does the present government place on <u>mental disorder prevention</u>? Real priority means translations of words into at least some action.

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
↑	2	3	4	5	6	7	8	9	↑
Low priority, Mostly rhetoric									High priority, much action

2.5 What is the recent trend (past several years) in resource allocation to mental health promotion and mental disorder prevention? If there is a budget allocated especially to MHP or MDP, what is it?

- ❑ Large increase in resources
- ❑ Small increase in resources
- ❑ No or little change in resources
- ❑ Small decrease in resources
- ❑ Large decrease in resources

2.6 Have <u>national</u> level, governmental policy documents on mental health promotion and/or the prevention of mental disorders been published in the following areas (tick all that apply)?

- ❑ Poverty and social exclusion **[Document Reference]**
- ❑ Employment and labour policies **[Document Reference]**
- ❑ Policies and programmes for infants and toddlers **[Document Reference]**
- ❑ Education policies and school programmes **[Document Reference]**
- ❑ Policies to prevent depression, anxiety and suicide **[Document Reference]**
- ❑ Policies to prevent violence and aggression **[Document Reference]**
- ❑ Policies to support research **[Document Reference]**
- ❑ Policies to support training **[Document Reference]**
- ❑ Policies to support implementation **[Document Reference]**
- ❑ Other **[Document Reference]**

2.7 Have <u>regional</u> level, governmental policy documents on mental health promotion and/or the prevention of mental disorders been published in the following areas (tick all that apply)?

- ❑ Poverty and social exclusion **[Document Reference]**
- ❑ Employment and labour policies **[Document Reference]**
- ❑ Policies and programmes for infants and toddlers **[Document Reference]**
- ❑ Education policies and school programmes **[Document Reference]**
- ❑ Policies to prevent depression, anxiety and suicide **[Document Reference]**
- ❑ Policies to prevent violence and aggression **[Document Reference]**
- ❑ Policies to support research **[Document Reference]**
- ❑ Policies to support training **[Document Reference]**
- ❑ Policies to support implementation **[Document Reference]**
- ❑ Other **[Document Reference]**

2.8   Have non-governmental (private enterprise, research institute, NGO, etc) policy documents on mental health promotion and/or the prevention of mental disorders been published in the following areas (tick all that apply)?

❑   Poverty and social exclusion **[Document Reference]**
❑   Employment and labour policies **[Document Reference]**
❑   Policies and programmes for infants and toddlers **[Document Reference]**
❑   Education policies and school programmes **[Document Reference]**
❑   Policies to prevent depression, anxiety and suicide **[Document Reference]**
❑   Policies to prevent violence and aggression **[Document Reference]**
❑   Policies to support research **[Document Reference]**
❑   Policies to support training **[Document Reference]**
❑   Policies to support implementation **[Document Reference]**
❑   Other **[Document Reference]**

2.9   Name up to five of the most senior government officials with responsibility to oversee/manage mental health issues **[Organisation References]**

3. Evaluation

3.1   Are <u>national</u> mental health promotion and or mental disease prevention policies evaluated and <u>reported</u> (tick one)?

❑   Yes – provide **[Document Reference]** for the most recent report
❑   No

4. Monitoring and/or surveillance

4.1   Are <u>national</u> mental health promotion and or mental disease prevention monitoring and/or surveillance activities <u>reported</u> (tick one)?

❑   Yes – provide **[Document Reference]** for the most recent report
❑   No

5. Knowledge development

5.1   Provide **[Organisational Reference(s)]** for the principal bodies (e.g. academic bodies, public health laboratories, agencies, government units) that are involved in developing the knowledge base for mental health promotion and/or mental disease prevention.

6. Implementation

6.1   Provide **[Organisational Reference(s)]** for the principal bodies (main providers) that are involved in implementing intervention programmes and other actions for mental health promotion and/or mental disease prevention.

7. Information dissemination for health care professionals

7.1   Provide **[Organisational Reference(s)]** for the principal bodies that are involved in information dissemination and other actions to keep health care professionals informed about mental health promotion and/or mental disease prevention.

8. Programmes

8.1   How available are programmes for mental health promotion and mental disease prevention? (please circle the category that best applies). Provide **[Organisational Reference(s)]** for some of the key programmes that exemplify high quality.

Programmes	Not available				Widely available
8.1.1 Home-based	1	2	3	4	5
8.1.2 School	1	2	3	4	5
8.1.3 Work place	1	2	3	4	5
8.1.4 Primary health care	1	2	3	4	5
8.1.5 Hospital/clinic	1	2	3	4	5
8.1.6 Elder care facilities	1	2	3	4	5
8.1.7 Churches, clubs, recreation centres	1	2	3	4	5
8.1.8 Internet	1	2	3	4	5
8.1.9 Protective services	1	2	3	4	5
8.1.10 Custodial settings (jails, etc.)	1	2	3	4	5
Other (write in):					
8.1.11_____	1	2	3	4	5
8.1.12_____	1	2	3	4	5
8.1.13_____	1	2	3	4	5
8.1.14_____	1	2	3	4	5
8.1.15_____	1	2	3	4	5

9. *Professional Workforce*

9.1 Is higher education in mental health promotion and/or mental disease prevention available from at least one institution of higher education (tick one)?

❑ Yes – provide **[Organisational Reference(s)]** for each institution
❑ No

10. *Funding*

10.1. Are funds dedicated to mental health promotion and/or mental disease prevention clearly identifiable in the most recent <u>national</u> budget?

❑ Yes
❑ Funds are available for mental health, but mixed in with other funding and hard or impossible to link explicitly with mental health (skip to item 10.2).
❑ No (skip to item 10.2).

Indicate the arena/activities for which <u>earmarked</u> funds are provided, and provide **[Document Reference]** for each relevant activity (tick all that apply):

❑ 10.1.1 National centre(s) and/or institutes
❑ 10.1.2 Research
❑ 10.1.3 Masters/doctoral training
❑ 10.1.4 Community education programmes
❑ 10.1.5 Screening and early detection
❑ 10.1.6 Health professional education
❑ 10.1.7 Conference(s), workshops, seminars, symposia, etc.
❑ 10.1.8 Other _____
❑ 10.1.9 Other _____
❑ 10.1.10 Other _____

10.2. Are funds dedicated to mental health promotion and/or mental disease prevention clearly identifiable in the budgets of <u>non-governmental</u> institutions (foundations, private institutes, welfare societies, professional groups, etc, associations)?

❑ Yes
❑ No (skip to item 11).

Indicate the arena/activities for which <u>earmarked</u> funds are provided, and provide **[Document Reference]** for each relevant activity (tick all that apply):

- ❏ 10.2.1 National centre(s) and/or institutes
- ❏ 10.2.2 Research
- ❏ 10.2.3 Masters/doctoral training
- ❏ 10.2.4 Community education programmes
- ❏ 10.2.5 Screening and early detection
- ❏ 10.2.6 Health professional education
- ❏ 10.2.7 Conference(s), workshops, seminars, symposia, etc.
- ❏ 10.2.8 Other _____
- ❏ 10.2.9 Other _____
- ❏ 10.2.10 Other _____

11. *Personal evaluation of the state of the field*

11.1. List up to five key recent advances in your country related to <u>mental health promotion</u>, with their date (max 300 words):

11.2. List up to five key recent advances in your country related to <u>mental disorder prevention</u>, with their date (max 300 words):

11.3. List up to five key barriers/obstacles/issues that stand in the way of achieving, in your country, action on <u>mental health promotion</u> (max 300 words):

11.4. List up to five key barriers/obstacles/issues that stand in the way of achieving, in your country, action on <u>mental disorder prevention</u> (max 300 words):

11.5. List, in descending order of importance, up to five key advances that are needed to support implementation of evidence-based <u>mental health promotion</u> in your country (max 300 words):

11.6. List, in descending order of importance, up to five key changes that are needed in your country, to achieve the advances in (11.5), above (max 300 words):

11.7. List, in descending order of importance, up to five key advances that are needed to support implementation of evidence-based <u>mental disorder prevention</u> in your country (max 300 words):

11.8. List, in descending order of importance, up to five key changes that are needed in your country, to achieve the advances in (11.7), above (max 300 words):

11.9. List up to ten persons who you believe are important for action on mental health promotion and mental disorder prevention in your country **[Organisational Reference(s)]**

12. *Comments about this IMHPA Data Entry Form:*

13. *Inclusive dates of data entry (dd/mm/yy through dd/mm/yy):*

HP-Source.net Document Reference Template

Where you see **[Document Reference]** in the Imhpa - HP-Source.net questionnaire, you are asked to provide a standardised set of information using this Document Reference Template. Save the completed form with a file name in the format 'question number-imhpa-country-last name of questionnaire respondent-date of data entry in format dd/mm/yy.doc'.

Example: 2.1.-imhpa-norway-mittelmark-11.10.03.doc

At the point where you see the relevant **[Document Reference]** in the questionnaire, insert the file name, so that a clear cross reference is available, permitting linkage of questions to documents.

1. File name:

2. Document title in original language:

3. Document title translation to English (if needed):

4. Author(s):

5. Date of issue:

6. ISBN:

7. Place of issue:

8. Issue authority/publisher:

9. Publisher's suggested reference (if available):

10. Issue authority's address:

11. URL (web-site address) where document, or summary, is available:

12. Document abstract (up to 300 words):

13. Source of abstract (tick one):

    ❏ Abstract from the document itself

    ❏ Abstract written by HPSOURCE respondent

14. Key words (5-10):

15.

<u>Mental Health Promotion or Mental Disorder Prevention</u> arenas covered by document (tick all that apply):

- ❑ Policy
- ❑ Policy implementation
- ❑ Funding
- ❑ Infrastructure development
- ❑ Research
- ❑ National research strategy
- ❑ Evaluation
- ❑ Monitoring, surveillance, reporting
- ❑ Training; workforce development
- ❑ National strategy on training
- ❑ National implementation strategy
- ❑ Interventions in communities
- ❑ Interventions at the school integrated into regular curricula
- ❑ Interventions at the workplace
- ❑ Interventions for groups at risk
- ❑ Interventions for the general public
- ❑ Interventions; others

16. Status of the document (tick one):
    - ❑ Governmental committee proposal
    - ❑ Governmental green paper (policy draft issued for comment)
    - ❑ Governmental white paper (official policy statement)
    - ❑ Book
    - ❑ Article
    - ❑ Bill decided by parliament
    - ❑ Other - [max 50 words]

17. At what levels are actions proposed or required? (tick all that apply)
    - ❑ Local
    - ❑ Regional
    - ❑ National
    - ❑ International

18. Does the document contain specific goals (i.e. statements of aim, purpose)?
    - ❑ Yes
    - ❑ No

19. Does the document propose specific quantitative objectives or targets (e.g. to reduce mortality by 10%)?
    - ❑ Yes
    - ❑ No

HP-Source.net Organisation Reference Template

Where you see **[Organisation Reference]** in the Imhpa - HP-Source.net questionnaire, you are asked to provide a standardised set of information using this Organisation Reference Template. Save the completed form with a file name in the format 'question number-imhpa-country-last name of questionnaire respondent-date of data entry in format dd/mm/yy.doc'.

Example: 2.1-hpsource-norway-mittelmark-11.10.03.doc

At the point where you see the relevant **[Organisation Reference]** in the questionnaire, insert the file name, so that a clear cross reference is available, permitting linkage of questions to documents.

1. File name (as instructed above):

2. Organisation title:

3. Contact Job Title:

4. Contact Name:

5. Address:

6. Telephone:

7. Fax:

8. E-mail address:

9. Website - URL:

10. Notes/remarks:

NOTE: A separate form should be used for each **[Organisation Reference]**

4.4   Instructions IMHPA Country Coalitions

The IMHPA-HP Source questionnaire aims to provide an overview of the available infrastructures, policies and programmes for mental health promotion and mental disorder prevention at the country or regional level. The completion of the questionnaire will result in a country profile description, will provide the basic information about the infrastructural situation in every country and could be used as a tool for the further development of infrastructures, as a baseline for monitoring development at the country level, or as a supporting document for the development an action plan or a specific policy in MHP and MDP.

To complete the questionnaire it is recommended that a country or regional coalition is created to facilitate a reliable collection of the information that reflects the country or region situation. The country coalition or country group would involve experts from different professional backgrounds and positions in the filed of public and mental health.
To ensure a heterogeneous group of professionals it would be excellent when the following actors (but not only) could be represented in the coalition:

- A governmental representative based at the ministry of health
- A non-governmental representative based at an NGO to do with mental health issues (better if it is prevention and promotion)
- A researcher based at a national centre for mental health (prevention-promotion)
- An expert based at a university (prevention-promotion mh)
- A programme implementer working in the field (prevention-promotion mh)
- A public health expert based at a governmental organization

These are only guidelines and every country might have other types of actors involved in prevention and promotion for mental health. As Lars Jacobsson and Lisa Ineland reported from the pilot in Sweden, the enrolment of professionals with different backgrounds in the coalition made the discussion richer and underlined the issues that needed attention at the country level.

It is recommended that one person is the responsible at the country level to fill in the questionnaire during the meeting (which is discussed and completed through common agreement between coalition members) and who collects the documents to back up the information gathered in the questionnaire. The provision of the backup documents (called Document Reference in the questionnaire) is crucial for the data to be reliable. All documents or references to the documents will be entered to the database as well.

The final part of the questionnaire aims to assess the views of the coalition or its members on the barriers and facilitators expected at the country level when implementing mental health promotion or mental disorder prevention initiatives. This last part is the most relevant for us and we kindly request you to try to develop this section.

With very great thanks for your co-operation

Dr. Eva Jané-Llopis, on behalf of Imhpa

If you have any further questions please do not hesitate to contact me at:

E-mail: Llopis@psych.kun.nl
Tel: + 31 24 361 2667   Fax: +31 24 361 55 94

4.5   IMHPA Data Entry Instructions

BRIEFING NOTE ON IMHPA DATA ENTRY 26/05/2005

From: Maurice B. Mittelmark, Director, HP-Source.net Coordinating Centre

Dear IMHPA colleagues,

The purpose of this briefing note is to provide instructions and guidance in completing the IMHPA questionnaire which is now online and ready for you to complete. It is a good idea to read this note carefully before you start data entry.

1. Based on the discussions at our recent Brussels meeting, I have composed this text that will be posted at the HP-Source.net web site, in the section on data validity. It relates to all data available at HP-Source.net, including IMHPA data:

> "Several conditions regarding the data available from HP-Source.net should be noted. Although the data are reported at the country level, data entry has not been undertaken on behalf of, or approved by, authorities in any country, nor has HP-Source.net sought approval from any authority. All data available at HP-Source.net are intended to meet stated goals and objectives of the HP-Source.net partners, and we take no responsibility for any other use to which the information may be put. HP-Source.net respondents (persons who undertake data entry) use documented information that is available to the public at the time of data entry. HP-Source.net and partners make no representation regarding either the completeness or the accuracy of the information available at HP-Source.net. The information provided is necessarily selective, and does not represent the full breadth of policy, infrastructure and programmes available in any country. A complete mapping of country-level activities is beyond the resources and remit of HP-Source.net."

2. A number of you expressed the desire to be able to include information about the context within which you enter data, e.g., special features of governance in your country, level at which health services are administered, etc. This information should be entered in a new item, number 1.15 (limit 5000 characters). It is here, also, that you may enter comments about the procedures and methods you used to gather the data.

3. You may choose to complete the questionnaire for one region within your country, if you wish. To do this, enter the name of the region in item 1.12. If you wish to complete additional forms for additional regions, please contact me so that arrangements can be made.

4. Item 2.1 and 2.2 ask "Do relevant politicians/policy makers refer to …?" This refers to any and all government representatives, elected or appointed.

5. For items 2.6, 2.7, 2.8, 3.1, and 4.1, please make document references only for documents that are publicly available at the time you complete the questionnaire. Do not refer to documents whose distribution is restricted. Also, you may be selective if many documents are available. You may choose to refer only to documents that you feel are the most significant/recent/comprehensive.

6. Before starting data entry please review the material in the Appendix to this note.

7. In case of questions, please contact Magui Baldomir at the HP-Source.net Coordinating Centre, at Andrea.Baldomir@iuh.uib.no .

8. We will build a FAQ (frequently asked questions) section on the HP-Source.net web site, based on your questions and our answers.

9. To get started, go to www.hp.source-net and see this screen:

Click Data Input and see this screen:
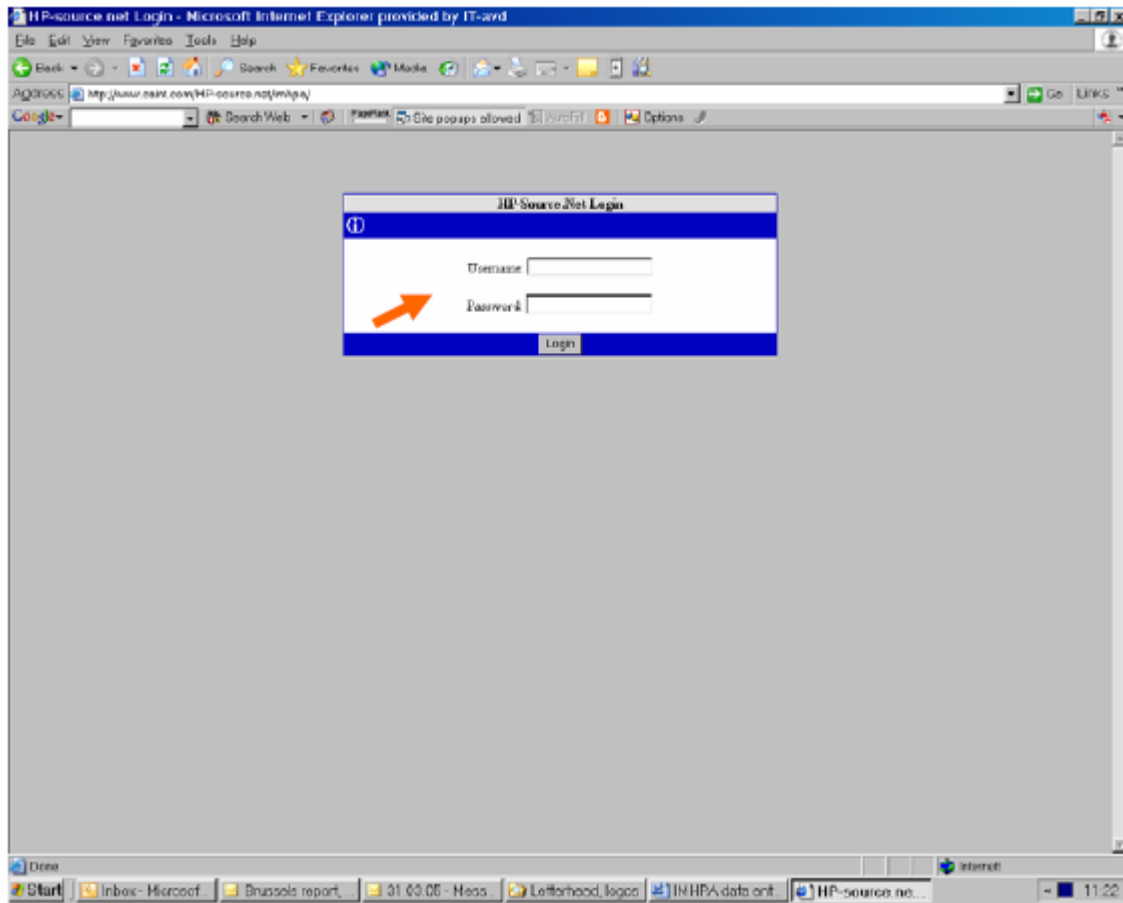
Enter your user name and password (case sensitive), which you will receive from IMHPA, click Login, and see this screen:
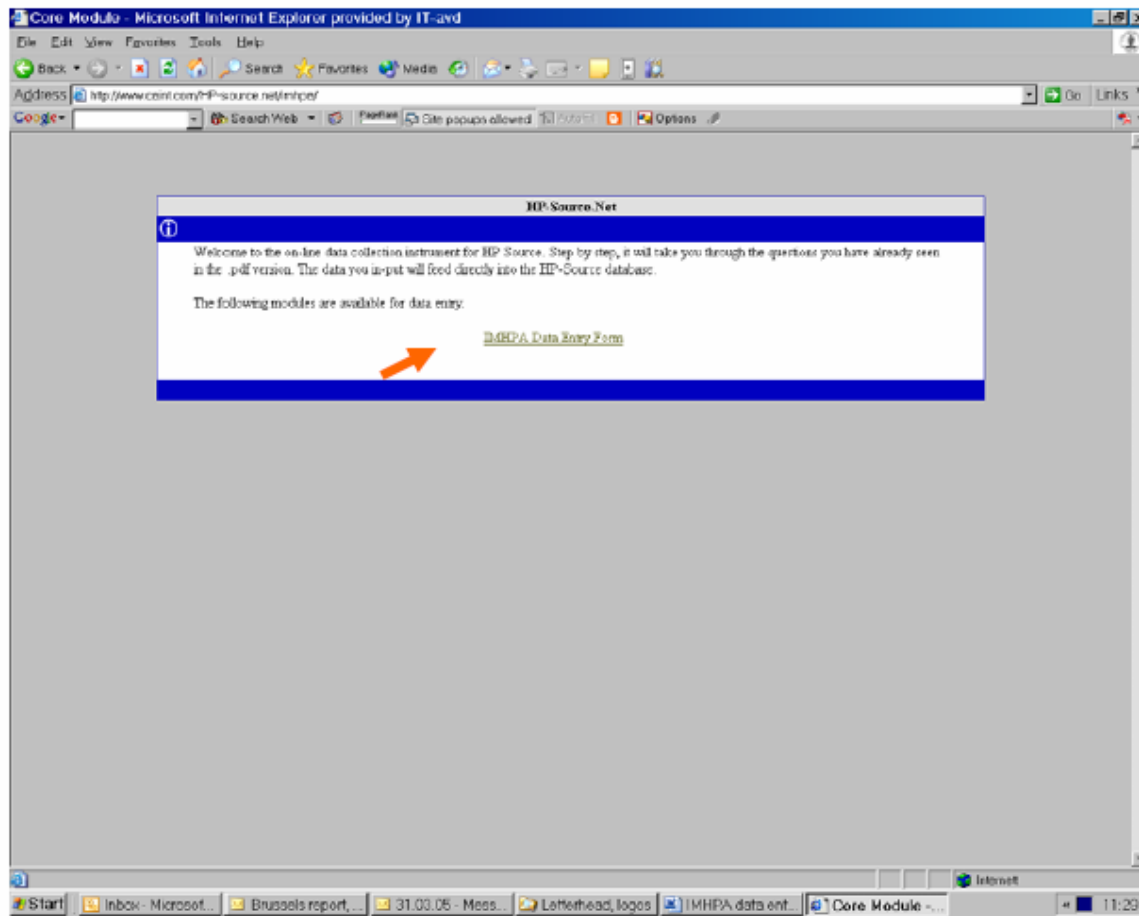
Click IMHPA Data Entry Form and you will see this screen:
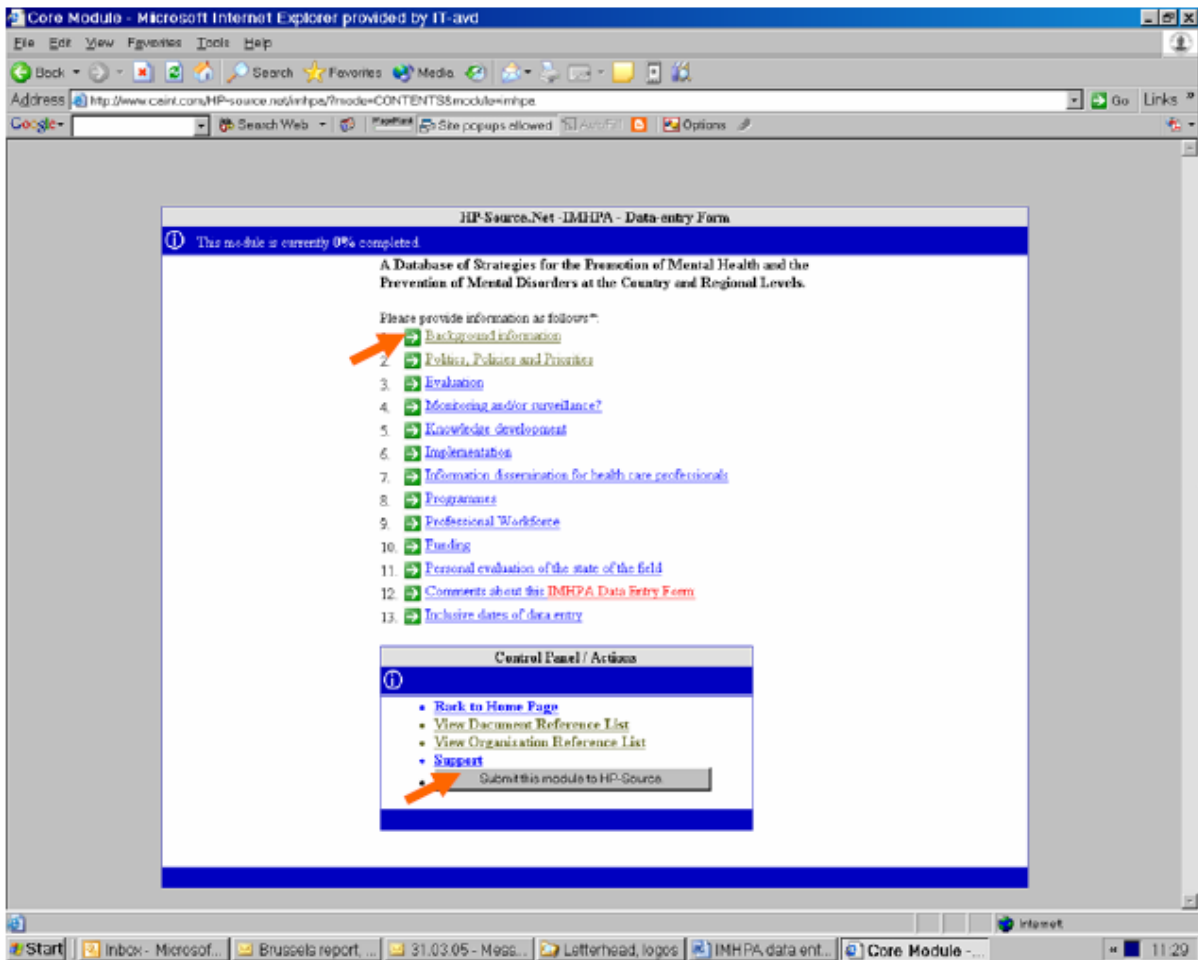
Click Background information, and get started with data entry!

If you make a mistake, don't worry, you can re-enter data and update data whenever you wish.

Whenever you wish to stop data entry for the day, or just to take a break, click Submit this Module to HP-Source, so that the work you have done is saved.

When you wish to search the IMHPA data, go to www.HP-Source.net and click The Databases.

ANNEX 5   DISSEMINATION AND IMPLEMENTATION

5.1   Dissemination and Implementation issues

Issues to discuss during the group work

Introduction

An important issue from the project's outset has been the dissemination and implementation of the project's products to ensure the stimulation of mental health promotion and mental disorder prevention action at the country and European levels. A brainstorm session with the Policy Action Plan Taskforce identified a specific set of possible activities and strategies that could, on one hand, support the dissemination and implementation of the project products and, on the other hand, stimulate mental health promotion action. The summary of the identified actions is provided in the folder of background papers for the meeting.

The session on dissemination and implementation aims to:

1. Discuss the creation of country coalitions at the country level

2. Discuss possible strategies for dissemination and implementation of the project products at the country or within country regional levels

3. Propose a framework or plan of action for the dissemination and implementation of the project products at the country or within country regional levels and identify what action could be undertaken to move the field of mental health promotion and mental disorder prevention forward at the country or within country regional levels.

The following sections propose a set of questions that could facilitate the group discussion.

1.   CREATION OF COUNTRY COALITIONS

- How can the country coalition be created?

- Who should be involved in the country coalition?

- What would be the processes or strategies needed to motivate coalition members to join?

- In addition to completing Imhpa questionnaire II, what other tasks could be undertaken by the country coalition?

- How could ownership be developed so that coalition members become advocates for mental health promotion and mental disorder prevention?

2. STRATEGIES FOR DISSEMINATION AND IMPLEMENTATION

- What are the Imhpa products that would be most interesting to be distributed in your country?

- What strategies are needed to enhance the dissemination of the products?

- How could information dissemination be enhanced?

- Should different products be translated into the different country languages? If so how could this be achieved? If not all products would need translation which ones would?

- What are the target groups to whom the products should be distributed?

- How would the distribution of the products be undertaken?

- What are the barriers foreseen in the dissemination of project products and how could these barriers be overcome?

3. PLAN FOR DISSEMINATION AND IMPLEMENTATION

- What would you as a group recommend as a framework plan of action to be undertaken at the country level for the dissemination and implementation of the Imhpa products?

- What are linked actions to the dissemination of the Imhpa products that could be further undertaken to move the field forward in the different countries? (e.g., development of country based policy action plans).

- What are the first steps to be undertaken for this to be achieved?

5.2 Brainstorm on possible actions for dissemination and implementation: at the EUROPEAN and COUNTRY levels[2]

1. INFORMATION DISSEMINATION AND ADVOCACY

1.1. *Create awareness*

- Organize a conference inviting people from different countries
- Inform and involve the EC Working Party MH
- Identify and be present at scientific international conferences and events
- Publish articles in scientific (inter)national journals
- Use national/international events and conferences
- Stimulate regular reporting, e.g. newsletter to countries
- Link with regional/ local events
- Link with Health Day
- Develop publication plans (scientific and lay) in national journals
- Organize a National conference
- Write contests in schools

1.2. *Make use of the media*

- Press releases for specific purposes
- Media releases for the general public
- Roll-out (a big, high event at an important place)
- National launch of the National Policy Action Plan

1.3. *Develop advocacy tools*

- Develop a product pack
- PowerPoint presentations free available
- Sex up documents for political audiences
- Develop a lecture manual
- Improve IMHPA logo
- Develop IMHPA slogan/s
- E-net Public Relations for Research Centres
- Develop a MHP advocacy kit
- Website

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[2] This list of activities is the result of a brainstorm session with the policy action plan taskforce

1.4. Advocate

- Present products to European Parliament
- Present products to Council of Europe
- Present products to Euronet
- Present products to the European Health Forum
- Present products at the Ministerial conference 2005
- Conference display booth
- Report to the European Commission
- Meeting with the European Commission
- VIP visits
- Litigation against unhealthy workplaces
- Involve national well-known people to trigger attention of population
- Develop a national policy action plan
- Present products to national parliaments and Health Commissions
- Develop Parliamentary Commission reports
- Set national targets and priorities

2. CREATE PARTNERSHIPS

2.1. Create country coalitions

- Create a national country coalition form mhp-mdp
- Involve Ministry of Health
- Involve universities or scientific
- Involve NGO´s

2.2. Explore synergies

- Identify, link and explore synergies with existing EC projects
- Identify, link and explore collaboration with existing EC networks
- Link with organisations and institutes on alcohol and drugs
- Link with Health Promotion and Public Health organizations
- Link with civil society movements
- Involve labour units
- Link with the WHO
- Identify and link with relevant websites
- Link with the prevention consortium
- Develop a European network of prevention research centres on MH
- Expansion beyond Europe
- Link with national ministries
- Link with national organisations and institutes on alcohol and drugs
- Link with national Health Promotion and Public Health
- Link to professional, national organisations
- Expansion of country Health Promoting Schools including MHP and MDP

3. EXPAND THE KNOWLEDGE BASE

3.1. Provide training

- Develop a MHP module for the EU masters programme on HP
- National training seminars with mental health and primary health care professionals
- Training/ seminar for national VIP's to develop national policies
- Training the trainers
- Develop summer schools or summer courses

3.2. Expand research

- Good cost-benefit and cost-effectiveness analyses
- Health impact assessment of public policy for MH
- Provide good grabbing statistics

3.3. Stimulate information exchange

- Stimulate national information system including the products (e.g. database)
- Develop and make available data and information on effectiveness and efficacy research

4. SEEK AND SECURE FUNDING

- Develop an application for the EC 2004 PH Framework
- Develop an external funding plan for the database management
- Explore further funding opportunities
- Follow-up project areas focussing at certain topics (multi-country projects)
- Develop country based research applications

ANNEX 6 BACKGROUND TECHNICAL DOCUMENT FOR THE DEVELOPMENT OF THE PUBLICATION: "MENTAL HEALTH PROMOTION AND MENTAL DISORDER PREVENTION: A POLICY FOR EUROPE"

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SUMMARY

Positive mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"; it is a global public good; it is an essential part of the health and well-being of the citizens of Europe and a fundamental human right; it is a prerequisite for a viable, socially responsible and productive Europe; it enhances social cohesion and social capital and improves safety in the living environment.

A lack of positive mental health is a threat to public health, the quality of life and the economy of Europe. In the year 2002, mental and behavioural disorders accounted for almost one quarter of all European ill-health and premature death; one third of this was from depression alone. The social and economic costs of mental ill health for societies are wide ranging, long lasting and enormous. Mental disorders reduce employment, productivity and earnings and increase criminal activity, motor vehicle accidents, child abuse and neglect, divorce, homelessness domestic violence and suicide. Mental disorders also lead to discrimination and marginalization. This in turn results in increases in economic instability and decreases in social capital, social cohesion and the economies of Europe.

Positive mental health cannot be gained by treatment alone. Mental health is everybody's business; it is not only an issue of public health but also one of public policy. Action for mental health is an issue of shared responsibility, and health and economic gains can be achieved by the support and action of many different sectors in society. Links need to be created and support mobilized with, amongst others, environment, social welfare, labour, education, criminal justice and housing.

To ensure that mental health is a global public good, and to reduce the enormous health and economic burden of mental disorders, each European country and the Community as a whole needs to pay attention to the following ten action points:

1. A secure knowledge base for mental health

European countries and the European Community should use and report on a common set of mental health indicators, including indicators of mental health, mental disorders, determinants of mental health, and the effective infrastructures, policies and programmes that are in place to promote mental health and prevent mental disorders.

2. Mobilizing partners for mental health

European countries and the European Community should ensure that structures and processes exist at all levels to facilitate harmonized collaboration of all actors and sectors in mental health development. The health sector can provide leadership by engaging in active promotion and advocacy for mental health and by encouraging other sectors to join in multisectoral activities, sharing goals and resources. Small changes in the way that industry does business can unlock money which will not only improve mental health but also increase profitability.

3. Making a Policy Action Plan

European countries and the European Community should develop Policy Action Plans for mental health promotion and mental disorder prevention that are endorsed by the highest political body at each level. Earmarked financial incentives could be offered, for example from a special Mental Health Fund paid for by tobacco and alcohol taxes, to implement the Policy Action Plans.

4. Focus on the big five

European countries and the European Community could focus their action on the big five determinants of disability and premature death from mental and behavioural disorders: depression; anxiety and stress; conduct disorder, bullying, aggression and violence; addictive substances; and suicide.

5. Take a lifespan approach

European countries and the European Community should adopt a lifespan approach to promoting mental health and preventing mental disorders, because the determinants of mental disorders have their strongest impact at specific and sensitive periods during the life span that extends across generations. For example, child abuse and parental mental illness during infancy and early childhood can led to depression and anxiety later in life as well as in the next generation, while secure attachment and family social support can reduce such risks. Action is required to ensure a healthy start of life for children and families, school strategies that enhance resilience and prevent mental disorders and the promotion of mental health in adulthood and old age that increases social capital.

6. Adjust public policies

European countries and the European Community should enable the necessary adjustments to be made in legislation, policy implementation and resource allocation across many sectors that will lead to gains in mental health as well as improving the social and economic development of society. Attention should be paid to reducing economic insecurity, enhancing social cohesion through cultural and migration policies, strengthening community networks and local Neighbourhoods, expanding access to education, developing healthy work through employment and labour policies, building better housing, improving nutrition in disadvantaged groups, and promoting mental health through urbanization, transport and environmental policies.

7. Build capacity

European countries and the European Community should build capacity by ensuring that all education of health care professionals imparts the relevant knowledge, attitudes and skills for mental health promotion and mental disorder prevention; that the education of public health professionals prepares them to act as enablers, mediators and advocates for mental health in all sectors, and to work with a broad set of partners in society; and that the education of professionals in other sectors prepares them to recognize the importance and benefit of their policies and actions for population mental health.

8. Undertake impact assessment

European countries and the European Community should require all sectors of society to be accountable for the mental health impact of their policies and programmes, recognizing the benefits to themselves of promoting and protecting mental health. Mental health impact assessment must therefore be applied to any social and economic policy or programme, as well as development projects, likely to have an effect on mental health.

9. Ensure accountability

European countries and the European Community should create mechanisms for mental health policy audits, litigation for health damages and reports on mental health impact assessments to

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be in the public domain to ensure that both the public sector and private industry are publicly accountable for the mental health effects of their policies and actions. Accountability can be achieved through mechanisms for coordinating, monitoring and evaluating progress in policy implementation and through procedures for reporting to elected bodies, as well as through the mass media. Non-governmental organizations are essential partners for accountability for mental health; they are a vital component of a modern civil society, raising people's awareness of issues and their concerns, advocating change and creating a dialogue on policy. Of particular importance are those organizations which deal with civil, cultural, economic, political, and social rights, including those that deal with the rights of children, religious or ethnic minorities and persons with physical and mental disabilities. Their role in mental health promotion and mental disorder prevention should be strengthened.

10. Set targets and monitor their achievement

European countries and the European Community should set targets for mental health improvement. Targets make policy objectives more specific, allow progress towards them to be monitored and inspire many partners to actively support mental health promotion developments. Targets requires an assessment of the present situation and help to determine priorities; they can focus discussion on what it had been hoped to achieve and why, and whether or not this was successful, and why; they provide a powerful communication tool, taking policy-making out of bureaucratic confines and making it a clearly understood public issue; they give all partners a clearer understanding of the scope of the policy; they strengthen accountability for mental health; and they motivate people for action.

I. THE NEED FOR ACTION IN EUROPE

1.1 Investing in mental health

There is no health without mental health. Health has been defined by the World Health Organization as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Positive mental health is a global public good; it is an essential part of the health and well-being of the citizens of Europe and a fundamental human right; it is a prerequisite for a viable, socially responsible and productive Europe; it enhances social cohesion and social capital; it improves safety in the living environment; and it promotes economic development. In contrast, mental health disorders are a threat to public health, the quality of life and the economy of Europe.

1.2 The determinants of mental health

The major socio-economic and environmental determinants of mental ill-health include poverty, inequity and armed conflict. Poor people live without the basic freedoms of security, action and choices that tend to be taken for granted, including adequate healthy food, housing and education. People living in poor socio-economic circumstances are at increased risk of poor mental health, depression and less subjective well-being. Urbanisation, racial discrimination, economic instability, armed conflict and displacement increase the risk of mental disorders. Armed conflict can lead to posttraumatic stress disorders, depression, anxiety and alcohol-related disorders. Further, such traumas increase the risk of mental disorders in the children of traumatized and depressed parents.

The individual and family determinants of mental disorders are biological, emotional, cognitive, behavioural, interpersonal and related to the family context. They have their strongest impact on mental health at specific and sensitive periods during the life span. They also have a strong impact across generations. For example, child abuse and parental mental illness during infancy and early childhood can led to depression and anxiety later in life as well as in the next generation, while secure attachment and family social support can reduce such risks.

Risky maternal behaviour during pregnancy and adverse life events early in life can cause neuropsychological vulnerabilities. Marital discord can lead to conduct problems in children, depression among women and alcohol use disorders in both parents.

Other risk factors are closely related to individual histories of problem behaviours and disorders, such as earlier depressive episodes. Anxiety disorders increase the risk of depression, while depression increases the risk of later cardiovascular diseases. Sometimes such causal trajectories can include a succession of problems across the lifespan, for example: attention deficit hyperactivity disorder in early childhood, problem behaviour in late childhood, conduct disorders during adolescence, and alcohol-related problems and depression during adulthood.

Elderly populations, who are medically ill, may suffer from a range of subsequent risk factors and problems, including chronic insomnia, alcohol problems, elder abuse, personal loss and bereavement.

1.3 The health gap

Mental and behavioural disorders are found in people of all ages, countries and societies, being present at any point in time in 10% of the global adult population. Worldwide, more than

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one person in four will develop one or more mental or behavioural disorders during their life. At any one time, one in five European adolescents and adults suffer some form of mental health problem. Mental ill-health is common in people with physical illness; for example 22% of people with myocardial infarction, 27% of people with diabetes and 33% of people with cancer suffer from depression.

Five of the ten leading causes of disability and premature death worldwide are mental and behavioural disorders, including depression, harmful alcohol use, schizophrenia and compulsive disorder. In the year 2002, mental and behavioural disorders accounted for more than 23% of all European ill-health and premature death; unipolar depression alone accounted for 7.5%, the first leading cause.

1.4 The economic gap

In addition to the health burden, the social and economic costs of mental ill health for societies are wide ranging, long lasting and enormous. Besides the health and social service costs, lost employment and reduced productivity, the impact on families and caregivers, levels of crime and public safety, and the negative impact of premature mortality, there are many other immeasurable costs that have not been taken into account, such as lost opportunity costs to individuals and families.

The direct health care costs (inpatient and outpatient) and social costs (community health and social services) of mental disorders are enormous and have been estimated in the United Kingdom to be larger than the costs of cancer, ischaemic heart disease or diabetes.

The indirect costs of mental disorders are found to be twice the direct costs of care. Mental disorders reduce employment, productivity and earnings and increase criminal activity, motor vehicle accidents, child abuse and neglect, homelessness and divorce. Mental disorders can reduce employability by over 10% and are a major reason for disability pensions.

Severe mental disorders, including schizophrenia and depression can lead to reduced earnings of between 20% and 25%, while neuroses and other mental disorders can lead to reduced earnings of between 5% and 15%.

1.5 Social cohesion and democratization of society

Mental disorders not only reduce the ability to work and function in society but also lead to discrimination and marginalization of the citizens of Europe. This in turn results in increases in economic instability and decreases in social capital, social cohesion and the economies of Europe.

1.6 Mental health and human rights

A climate that respects and protects basic civil, political, economic, cultural and social rights is fundamental to the promotion of mental health and the prevention of mental disorders. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of health. The right to mental health is enshrined in a number of international agreements. The Constitution of the World Health Organization states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. Article 12 of the International Covenant on Economic, Social and Cultural Rights states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and

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the Convention on the Rights of the Child recognizes the right of the child to the enjoyment of the highest attainable standard of health.

Mental health is also a pre-requisite of action within the European Community. Article 3 of the European Community Treaty states that the activities of the Community shall include a contribution to the attainment of a high level of health protection; Article 95 states that the Commission, in its proposals concerning health, safety, environmental protection and consumer protection, will take as a base a high level of protection, taking account in particular of any new development based on scientific facts; and Article 152 states that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health.

1.7 The need to promote mental health and prevent mental disorders

In addition to the benefit that treatment can have for mental disorders, two recent publications of the World Health Organization (WHO) have presented the evidence that mental health promotion and mental disorder prevention are effective in leading to health, social and economic gain.

Unfortunately, despite the evidence, many remain unconvinced that promotion and prevention can reduce the increasing burden and costs of mental ill health. It should be noted however, that, although treatment for mental disorders can be effective, this is only so once mental ill health has emerged. A public health policy that only comprised treatment would have clear disadvantages. In addition to the harm of only starting to take action after often long-lasting suffering of individuals and families, evidence shows that only a minority of those with a mental health problem receive appropriate treatment. Of these, as many as one in two, suffer from a mental health problem again. Further, for the same money it costs to treat one person of depression it can be prevented in 30 people. Thus, the health, social and economic burden of mental disorders cannot be alleviated by treatment alone.

Mental health is everybody's business; it is not only an issue of public health but also one of public policy. Action for mental health is an issue of shared responsibility, and health and economic gains can be achieved by the support and action of many different sectors in society. Links need to be created and support mobilized with, amongst others, environment, social welfare, labour, education, criminal justice and housing.

1.8 A policy framework for promotion and prevention in mental health

Individual and social capital of European societies can be increased and the health and economic burden of mental ill health reduced by the implementation of evidence based mental health promotion and mental disorder prevention. However, to date, implementation of effective mental health promotion and mental disorder prevention has been poor across European countries and within the Community as a whole. This policy action plan aims to address this deficiency and presents a framework to promote mental health and prevent mental disorders. Chapter 2 describes action to promote mental health and prevent mental disorders across the life span. Chapter 3 responds to five key mental disorders. Chapter 4 describes the gains that public polices can have on mental health. Section 5 outlines the conditions needed to make these policies happen, leading to a comprehensive public health response to mental health. It concludes with a checklist of priority actions.

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II. MENTAL HEALTH POLICIES ACROSS THE LIFESPAN

The drafting of legislation and the implementation of policies specially designed to promote mental health problems and prevent mental disorders can lead to substantial gains in mental health and improvements in the social and economic development of society. This section reviews the effective options for designing a mental health policy across settings and the lifespan to improve mental health and to reduce the risks of mental disorders.

1. A HEALTHY START OF LIFE: CHILDREN AND FAMILIES

During the first months and years of life there is more development in mental, social and physical functioning than at any other time across the lifespan (Unicef, 2002). What happens from conception, through birth to age 3 years influences how the rest of childhood and adolescence unfold. A healthy start in life greatly enhances the child's later functioning in schools, with peers, in later intimate relations, and with broader connections with society leading to increased social capital (WHO 2004a). The major dimensions of a healthy start of life are physical and psychological well-being including the freedom from violence, poverty, physical disease, abuse and neglect, exposure to drugs prior to birth, and the availability of healthy nutrition, healthy attachment to the mother, and readiness for school including verbal, language, and social skills (Brown & Stturgeon, in press).

Interventions at the early start of life, including home-based, parenting and pre-school interventions, are mostly concentrated on enhancing the resilience and competence of parents and families through educational strategies. Such interventions improve both parents' and children's physical and mental health, and children's competence, mental well-being and functioning in society, with an impact across generations (WHO 2004a, WHO 2004b, Brown & Stturgeon in press, Jane-Llopis et al., 2005).

1.1 Home based interventions

The case for action

First time mothers

First time pregnant women, especially those who are single, adolescent or from impoverished backgrounds, are at increased risk of mental health problems and more likely to fail in providing a healthy start of life for their children. Poverty is the most important risk factor (Marmot & Wilkinson, 1999). Mothers with mental disorders are also at increased risk for poor parenting that in turn can lead to the development of mental disorders in their children.

Consequences of preterm delivery

Preterm delivery and low birth increases the risk of cognitive and behavioural problems and mental disorders in childhood and adult life and reduces educational achievement.

Pregnancy free of addictive substances

The use of the addictive substances alcohol, tobacco and illicit drugs during pregnancy can cause harm to the foetus and child. In particular, tobacco doubles the risk of low birth weight, with all the subsequent consequences of low birth weight (Institute of Medicine 2001).

What works

Home-visiting interventions during pregnancy and early infancy, addressing maternal substance use during pregnancy, coping with stress, parental care giving and child-parent interactions, strengthening the links to support systems and health services and supporting the life course development of the new mothers can lead to health, social and economic gain, including increased birthweight, improvement in mental health outcomes in both mothers and children, less use of health services, reductions in child maltreatment, long term reductions in children and adolescent problem behaviour and improvements in children's educational achievements (Olds, 1989; Olds 1997; Brown & Sturgeon, 2004). Home based visiting interventions are cost-effective, especially when long term outcomes are taken into account.

Educational programs to help smoking pregnant women to quit smoking increase birth weight with both immediate and long term mental health gain (Institute of Medicine 2001).

1.2 Parenting interventions

The case for action

Positive proactive parenting involving praise, encouragement, and affection can increase children's self esteem, their social and academic competence, and protection against later disruptive behaviour and substance use disorders.

What works

Group-based parent-training programmes can reduce parental depressive symptoms by between one third and one half and can improve the disruptive behaviour of children between the ages of 3 and 10 years (Barlow & Parsons, 2003; Barlow & Coren, 2003) They are more cost-effective and successful in the long-term than methods that involve working with parents on an individual basis.

1.3 Pre-school interventions

The case for action

The language skills of children born in impoverished families or in families from minority groups can develop slower than among other children.

What works

Parental early interventions starting at age 2 years that promote basic reading skills lead to improved literacy and cognitive, emotional and language growth, facilitating the transition to school. Preschool active-learning with home visits with children of impoverished backgrounds can lead to improved cognitive development, educational achievement and less conduct and criminal problems through to early adulthood (Schweinhart & Weikart, 1998)..

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that all children achieve a health start in life, free of poverty and exposure to harmful substances during pregnancy

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➢ All parents of first born children are given the opportunity of developing their positive proactive parenting skills

➢ All children are given the opportunity for pre-school attendance of at least one day a week from the age of 3 years

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ Implement fiscal polices through taxation and child benefit measures, particularly to single parent families, that lift children out of poverty

☞ Ensure that all pregnant women and their families who smoke are offered free treatment for smoking cessation by all relevant health care providers, including midwives and obstetricians who have been trained for the task

☞ Ensure that all pregnant women among high risk populations receive home-based interventions

☞ Ensure that all first time parents receive education in improved parenting skills which include a component on child-parent relationships and interaction and a component on pre-school preparation through stimulating reading skills

☞ Ensure that all children from the age of three years have access to pre-school education at least once a week.

2. ENHANCE RESILIENCE AND PREVENT MENTAL DISORDERS IN CHILDREN AND ADOLESCENTS

The case for action

School has a significant influence on the behaviour and development of all children. Poor school performance and poor academic achievement increase the risk of social and mental problems, antisocial behaviour, delinquency, substance use disorders, teenage pregnancy, conduct problems and involvement in crime (Domitrovich 2005). Conduct disorder and developmental learning disorders are associated with educational failure, accidents, injuries, physical illness, unemployment and poor work performance, criminal activity, adult problems in intimate relationships, substance use disorders, anxiety disorders and depression. The social and economic costs of conduct disorder, aggressive and violent behaviour are enormous, including the costs of treatment, justice and the criminal system, social services, academic failure, and the emotional and economic costs for individual and families. Some children and adolescents are specifically at risk for poor educational attainment and mental disorders and should be identified and reached in the school setting. These include children who have suffered child abuse or neglect during infancy and childhood, those who have suffered parental loss, parental divorce, or those who have a mentally or chronically ill parent; such children are up to as much as 50% increased risk of suffering from school problems such as underachievement and mental disorders such as depression.

Conversely school achievement is related to positive social and emotional development, increased employment and earnings, and access to health, social, and community resources (Weare, 2000). Achievement promotes mental health and can counteract a range of adversities such as poverty, living in high crime neighbourhoods, parental substance use disorders and family conflict.

Schools provide an efficient means of promoting the health, academic and emotional development of young people. There is no other setting where such a large proportion of children and adolescents can be reached systematically. The health promoting school concept, as promoted by the WHO and the European Network of Health Promoting Schools (ENHPS), provides an organising framework for a comprehensive approach to mental health promotion in the school setting. In addition, community measures and programmes should be developed provide effective mental health promotion and mental disorder prevention strategies to out of school and marginalized children and adolescents.

What works

Enhancing resilience in schools

General skill-building programs

General cognitive, and problem solving and social skill-building programs in primary and middle school can significantly improve cognition, emotional knowledge and problem-solving skills and reduce internalising and externalising problems, with 50% reductions in depressive symptoms (Greenberg et al., 2001).

Changing school ecology

Ecologically focused programmes that restructure the school and classroom environment promoting positive behaviour and rule compliance through reinforcement can lead to sustained reductions in aggressive behaviour (Felner et al., 1993).

Combining both approaches: multi-component programs

Prevention and promotion programs that focus simultaneously on different levels, such as changing the school ecology as well as improving individual skills in the students and involving parents are more effective than those that intervene on solely one level. Such programmes should adopt a whole school approach and be implemented for more than one year (Weare, 2000).

Preventing mental disorders

Prevention of conduct disorders, bullying, aggression and violence

Effective programmes to improve the behaviour of children at risk of behavioural problems and later aggression are those that combine strategies of classroom behaviour management, enhancing social skills and involving parents (Reid, et al., 1999). Such programmes can cut disruptive behaviour and aggression, including bullying, theft, and vandalism by half. Similarly, programmes targeting children of parents of substance use disorders can reduce problem behaviour by half.

Prevention of depression and anxiety

School-based prevention programmes for children at risk using cognitive-behavioural models, life skills problem solving and stress management techniques can cut depressive and anxiety symptoms by more than half and reduce the risk of anxiety and depression disorders by more than two-thirds (Greenberg et al., 2001; Merry et al., 2004). These programmes should be

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tailored to the children group addressed, such as children of mentally ill parents or those who have suffered parental loss or divorce.

Reducing the use of addictive substances

School programmes based on informational approaches and teaching students about the effects and the dangers of drug use have been found to increase knowledge and change attitudes toward alcohol, tobacco, and drug use, but actual substance use has remained largely unaffected. When school based interventions have used the most recent normative education and resistance-skill training innovations, they have generally produced modest effects on use, but these seem to be short-lived unless accompanied by ongoing booster sessions. Very few have demonstrated substantive effects on the harm from substance use, such as intoxication or injuries (Babor et al., 2003).

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that all children have access to a high standard of education independent of income
➢ Ensure that all children have access to a mental health promotion component of effective problem solving and social skill building programmes
➢ Ensure that all children at risk of behavioural and mental disorders have access to appropriate school based interventions

Action points: strategies for implementation

Recommended actions to achieve these outcomes include the following:

☞ All schools should be supported in implementing a whole school approach that addresses mental health through skill building strategies and changing the school environment.

☞ Integrate evidence-based mental health components to increase social learning into existing school health promotion programmes, many of which are already implemented through the Health Promotion Schools initiative.

☞ Implemented programmes that have not been evaluated should be evaluated or incorporate evidence based elements.

☞ Provide school based interventions by trained personnel to children identified at risk of behavioural and mental disorders.

3. WORKPLACE MENTAL HEALTH AND PREVENTION OF WORK RELATED STRESS

The case for action

Merllie and Paoli, in a European wide study showed that 27 per cent report that 'my health and safety is at risk because of my work'. Backache (33%), stress (28%) and fatigue (23%) are the three most common work-related health problems. The same study showed that, today, most European employees work under tight deadlines (60%) or at very high speed (56%)

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more than 50 per cent of the time. When compared with those of 1990 and 1995 (Paoli, 1992, 1997), these percentages are higher. It appears that large numbers of European employees have little job control and autonomy in their work: 36 per cent has no choice over their order of tasks, 29 per cent has no choice over their pace of work, and 30 per cent has no choice over their methods of work.

Stressors such as noise, work overload, time pressure, repetitive tasks, interpersonal conflict and job insecurity, can cause mental health problems and increase the risk for anxiety, depression and stress related problems.

Mental health difficulties can affect an individual's functional and working capacity in numerous ways (ILO 2000).

What works

Effective interventions at the workplace include (1) task and technical interventions (e.g., job enrichment, ergonomic improvements, reduction of noise, lowering the workload); (2) improving role clarity and social relationships (e.g. communication, conflict resolution); and (3) interventions addressing multiple changes directed both at work and employees (Price & Kompier, in press). Notwithstanding the existence of (inter)national legislation with respect to the psychosocial work environment that puts an emphasis on risk assessment and risk management, most programs aim at the reduction of the cognitive appraisal of stressors and their subsequent effects (Murphy 1996), rather than at the reduction or elimination of the stressors themselves (Schaufeli & Kompier, 2001).

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that there is an approved national legislation with respect to the psychosocial work environment which is based on existing evidence based (inter)national legislations
➢ Ensure that 100% of workplaces endorse and comply with the (inter)national legislation with respect to the psychosocial work environment
➢ All workplaces include worker compensation laws and policies, and programs for employee assistance to deal with alcohol, drug or mental health problems for those who are suffering or are at risk of suffering these conditions

Action points: strategies for implementation

Recommended actions to achieve these outcomes include the following:

☞ Develop a national legislation with respect to the psychosocial work environment that puts the emphasis on risk assessment and risk management
☞ Develop and implement new policies at the work place that include effective interventions focused on job redesign, modifications in ergonomics, time and workload, and in social support and role clarification
☞ Develop and implement stress management programmes for those at risk
☞ Develop and implement effective programs for employee assistance to deal with alcohol, drug or mental health problems once they have already occurred

4. AGEING MENTALLY HEALTHY

The case for action

In the year 2000 more than 600 million people were aged over 60 in the world and this figure is expected to increase by 70% in the next 20 years   . This rapid increase in the ageing population implies a shift in the demographic structures in society bringing associated problems such as an increased risk of some mental illness (e.g., dementia), age-related chronic diseases and decreases in the quality of life (Levkov et al, 1995). In addition to loss of health and functional and cognitive abilities, elder populations are more likely to experience individual losses both within their social network (e.g., bereavement, diminished social contacts) as well as within their personal positioning in life (e.g., facing retirement, loss of income), placing them at risk for suffering mental health problems (Reynolds et al., 2001).

Age, pain, visual impairment, stroke, functional limitations, negative life events, loneliness, lack of social support and perceived inadequacy of care were found to be risk indicators for depression (Jongenelis,-K; Pot,-A-M; Eisses,-A-M; Beekman,-A-T; Kluiter,-H;Ribbe,-M-W SO: J-Affect-Disord. 2004 Dec; 83(2-3): 135-42 PY: 2004)

What works

The mental health of older populations has been successfully improved through interventions to increase physical activity (Mather et al., 2002; Deuster, 1996) and by improving social support (WHO, 2000a) through, for example, befriending. The use of patient education methods for chronically ill older people and their caregivers, early screening, interventions in primary care, and programmes using life review techniques have been successful in improving the mental health of older people who are at risk for mental disorders. The risk of dementia is likely to be reduced by preventing cranio-cerebral traumas, and reduced raised blood pressure and cholesterol levels (WHO 2004a).

Aims

By the year 2020, all countries of the European Union should:

- ➢ Ensure that all people of older age have access to health care and social services independent of income
- ➢ Ensure that there are social support community networks for people of older age
- ➢ Ensure that 100% of elderly homes provide physical activity programmes and healthy diets
- ➢ Ensure the access of the chronically ill elderly to patient education methods independent of income

Action points: strategies for implementation

Recommended actions to achieve these outcomes include the following:

- ☞ Develop a health and social welfare policy where all the population of older age have access to health and social benefits and nursing home access for those with low economic background
- ☞ Implement and provide access to physical activity interventions such as aerobic exercises or Tai-Chi, for older people

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☞ Support the development of community support centres for older people to increase social support

☞ Develop early geriatric screening and case management including in-home geriatric assessment, regular contacts and social services for older groups at risk

☞ Develop social support, life review meetings and reminiscence therapy in nursing homes

5. GROUPS AT RISK FOR MENTAL DISORDERS: DEALING WITH LIFE TRANSITIONS AND STRESSFUL LIFE EVENTS

The case for action

Although there are many life transitions and stressful life events, this section discusses refugees and migrants, people suffering from involuntary job loss, societal stress, carers, and those suffering from physical illness.

Refugees and migrants

Exiled refugees, physically or sexually tortured war victims and war veterans are at risk of considerable human suffering and large psychiatric disability including posttraumatic stress disorders, depression and anxiety, substance use disorders and suicidal behaviour. Migrants and refugees are less likely to integrate in the new country, less likely to find steady jobs and more likely to be on welfare benefits in the long run.

Involuntary job loss

The mental health problems associated with involuntary job loss and unemployment include elevated levels of anxiety, depression, alcohol use disorders, child mistreatment and marital disruption. The social and economic burden associated with involuntary job loss and extended unemployment is substantial and includes increased health care costs, increased costs in the welfare system, and increases in crime rate, traffic accidents, divorce, and a variety of other societal consequences (Price, 1992; Vinokur 1997).

Physical ill health

Mental ill-health is common in people with physical illness; for example 22% of people with myocardial infarction, 27% of people with diabetes and 33% of people with cancer suffer from major depression (WHO, 2003). Also physical illnesses such as those due to age related injuries (e.g. falls), impairments (e.g., hear loss) and cardiovascular diseases are frequently accompanied by a set of psychological consequences, which can lead to depression, anxiety and stress (WHO 2004a).

What works

Refugees and migrants

Integration policies for migrants and refugees in terms of neighbourhood design to avoid the creation of isolated or segregated living areas, equal school enrolment rights to ensure diversity across schools and equal labour opportunities to prevent racial discrimination, will avoid

social exclusion and increase social participation and social inclusion of refugees and migrant populations.

Involuntary job loss

Job loss interventions include legal policies governing the benefits available to unemployed workers or organizational practices and policies associated with improving job security. Although not popular amongst employers, during economic difficulties workplace policies to reduce the risk of job loss and unemployment can include job sharing, job security policies, cutbacks on pay and reduced hours. For those most at risk for involuntary job loss policies and practices include policies involving individual job retraining for workers whose jobs may soon become obsolete or job search interventions designed to help workers cope with impeding or current job loss. For those already adversely affected by prolonged unemployment policies include legal and policy interventions such as welfare and public assistance. In the workplace, outplacement services, unemployment insurance and increased severance pay are also options that can buffer the stressful effects of unemployment (Price & Kompier, 2005).

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that migration policies for social inclusion for refugees and migrants are in place
➢ Ensure that legal and welfare policies are in place for those suffering from unemployment to increase job opportunities and job security

Action points: strategies for implementation

Recommended actions to achieve these outcomes include the following:

☞ Implement inclusion interventions for migrants and refugees
☞ Implement legal policies governing the benefits available to unemployed workers or organizational practices and policies associated with improving job security

6. PREVENTION OF DEPRESSION, ANXIETY AND SUICIDE

6.1. Depression

The case for action

Depression represents one of the most prevalent psychiatric disorders, affecting 10% of the European general population at one point in time and as much as 33% in cancer patients (WHO 2003). In Europe, unipolar depression alone was the first most important cause of disability in 2002 accounting for 6.1% of all ill-health and premature death (Ustun et al., 2004), and thus, is not only the most important mental disorder to tackle, but also the most important health problem to tackle.

Implementing Mental Health Promotion Action

The onset of depression and its recurrence is influenced by a wide range of depression-specific determinants (e.g. parental depression and depressive thoughts), generic determinants (e.g. poverty, inadequate parenting, child abuse and neglect, stressful life events) and lack of protective factors (e.g., sense of mastery, self esteem, self efficacy, stress resistance and social support) that can be influenced throughout the different stages of the life span (WHO 2004a). As a consequence, effective community approaches to prevent depression in the population should comprise multiple actions and be identified as a priority.

What works

A comprehensive strategy across the lifespan is needed to tackle depression. Such a strategy should include home-based parenting interventions for families with low socio-economic backgrounds, school-based programmes with a holistic approach integrating depression prevention for children at risk, stress management policies at the workplace, identification of depressive symptoms and provision of problem solving skills in primary and secondary health care for those at risk, postpartum depression prevention especially professionally based home visits, such as intensive individually based nursing home visits and flexible postpartum care provided by midwives shows evidence for the prevention of postpartum depression especially for mothers at risk (Dennis & Creedy, 2004); and mental health promotion components in secondary care for those suffering from physical illness, and the support of community networks and physical activities in older age (WHO 2004a).

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that all regions have access to a prevention of depression strategy that encompasses actions across the lifespan

Action points: strategies for implementation

Recommended actions to achieve this target include the following:

☞ Ensure all children at risk for depression have access to a depression prevention programme at the school based on effective cognitive-behavioural models
☞ Ensure that all first time mothers from low socio-economic backgrounds have access to parenting home-based educational programmes to develop their proactive parenting skills
☞ Ensure that all the working population have access to a healthy workplace with policies conducive to positive mental health
☞ Ensure that primary and secondary health care providers are trained and provide problem solving skills to those patients identified to be at increased risk
☞ Ensure that all people of older age have access to community networks and services that include physical activity, interventions to enhance social support and interventions for those at risk (e.g. suffering from chronic physical conditions)

Implementing Mental Health Promotion Action

6.2. Anxiety and stress

The case for action

Anxiety disorders, like depression, are among the most prevalent of psychiatric disorders. Among children, anxiety disorders represent the most common form of psychopathology with annual prevalence rates ranging from 6% to 18%. Generalized anxiety disorders, social phobia and posttraumatic stress disorders (PTSD) are the forms of anxiety disorders that, to date, have been commonly addressed by primary prevention.

Stress is characterized by the combination of high arousal and displeasure. The most common source for stress in Europe is that associated with stressful work conditions where the demands on the worker (e.g., hours worked, the pace of work, physical demands, social stressors) exceed the worker's capacity to respond to them. Backache (33%), stress (28%) and fatigue (23%) are the three most common work-related health problems (Merllie & Paoli, 2001). Today, most European employees work under tight deadlines (60%) or at very high speed (56%) more than 50 per cent of the time (Merllie & Paoli, 2001). The health and mental health risks associated with work stress include emotional distress, anxiety, depression, burn-out, and gastrointestinal, cardiovascular and musculoskeletal disorders. The social and economic burdens of stress include absence, turnover, lost productivity and health and welfare costs. Other sources of stress are associated with stressful life events (e.g., loss of family member, poverty) or emergency situations that can result from natural, man made or technological disasters (e.g., earthquakes, armed conflict or chemical explosions).

What works

Effective school-based programmes in reducing aggressive and delinquent behaviour, bullying and child abuse may contribute to reductions in anxiety symptoms and stress (Olweus). Strengthening the emotional resilience and cognitive skills have proven effective and can be widely used in schools, health centres and hospitals. In reducing anxiety due to stressful medical treatment, while only providing preparatory information prior to treatment has showed no effect, anxiety reactions have been reduced when information is combined with the provision of modelling videotapes and with training in coping skills.

Critical incident stress debriefing after a traumatic event has not been found to prevent the onset of PTSD or other psychiatric disorders. Although victims generally find the one session intervention helpful in their process of recovering, psychological debriefing can retraumatize victims and can increase the risk of PTSD (Rose et al., 2002). Conversely, cognitive-behavioural therapy, including education about trauma reactions, relaxation training, imagining exposure to traumatic memories, cognitive restructuring of fear-related beliefs, and in vivo exposure to avoided situations has shown to be an effective early intervention reducing the 6-month incidence of PTSD from 67% to around 15% (Bryant, Sackville, Dang et al., 1999; Bryant, Harvey, Dang et al., 1998).

Effective workplace stress reduction policies are described in section 2.3.2. Reductions in psychosocial stress from emergency situations and the reduction of traumatic events can be the result of effective safety measures in traffic, workplaces and neighbourhoods, safety legislation, emergency preparedness, freedom from violence and armed conflict and reductions in economic insecurity.

Aims

By the year 2020, all countries of the European Union should:

> ➢ Ensure that all people have access to an anxiety and stress prevention strategy that encompasses actions across the lifespan

Action points: strategies for implementation

Recommended actions to achieve this target include the following:

☞ Ensure all children at risk for anxiety and stress have access to effective comprehensive school approaches based on effective cognitive-behavioural and competence-skill building models

☞ Ensure that stress at the workplace is reduced by implementing policies at the work place that include effective interventions on job redesign, modifications in ergonomics, time and workload, and in social support and role clarification

☞ Develop and implement stress and anxiety management programmes for those at risk

☞ Develop a plan for emergency preparedness establishing a supportive political, legal, managerial, financial and social environment for the coordinated and effective use of available resources including PTSD management

6.3. Suicide

The case for action

The most important risk factors for suicide are psychiatric disorders, (mostly depression, alcohol dependence and schizophrenia), post or recent social stressors (e.g., childhood adversities, sexual or physical abuse, unemployment, social isolation, serious economic problems), suicide in the family or among friends or peers, low access to psychological help and access to means for committing suicide.

What works

Among young people, suicide education in school settings has failed to show any impact on suicide behaviours; such education may even increase the number of students who consider suicide as a possible solution to their problems. An effective strategy for adolescent suicide prevention implemented in the USA encompasses a multi-component school-based approach including suicide prevention school policy, teacher training and consultation, education to parents, stress management and life skills curriculum for students and the establishment of a crisis team in each school.

The most effective strategies to prevent suicides include the prescription of antidepressant drugs to patients suffering from depression and reducing access to the means to commit suicide. The latter has shown the clearest and most dramatic results and includes strategies such as detoxification of domestic gas and car exhaust, safety measures on high buildings and bridges, control of the availability of sedatives and pain-killers, and restricted access to pesticides. The World Health Organization has proposed the reduction of access to means of suicide as an essential strategic component of its "human-ecological" model for suicide prevention.

Aims

By the year 2020, in all countries of the European Union:

> ➢ Suicide rates should be reduced by at least one third, with the most significant reductions achieved in countries and population groups with currently high rates

Action points: strategies for implementation

Recommended actions to achieve this target include the following:

- ☞ Training in primary health care on recognition and treatment of depression
- ☞ Development and implementation of policies for the detoxification of domestic gas and car exhaust
- ☞ Development and implementation of policies on safety measures for high buildings and bridges
- ☞ Development of policies to control the availability of sedatives, pain-killers and pesticides

7. PREVENTION OF VIOLENCE AND SUBSTANCE USE DISORDERS

7.1 Conduct disorder, bullying, aggression and violence

The case for action

Conduct disorder and developmental learning disorders are associated with educational failure, accidents, injuries, physical illness, unemployment and poor work performance, criminal activity, adult problems in intimate relationships, substance use disorders, anxiety disorders and depression. The social and economic costs of conduct disorder, aggressive and violent behaviour are enormous, including the costs of treatment, justice and the criminal system, social services, academic failure, and the emotional and economic costs for individual and families. For example, the average yearly cost of a British child diagnosed with conduct disorder is estimated at €25,000. Bullying may be responsible for up to 30% of depressive symptoms among high school students.

Aggression and violence at home and in the community lead to mental and physical harm, including anxiety, depression, delinquency, theft and vandalism, physical and sexual abuse and murder and homicide. Women who have suffered violence have high rates of depression, anxiety, stress, pain syndromes, phobias, substance use disorders and poor subjective health.

What works

Effective programmes to improve the behaviour of children at risk of behavioural problems and later aggression are those that combine strategies of classroom behaviour management, enhancing social skills and involving parents. Such programmes can cut disruptive behaviour and aggression, including bullying, theft, and vandalism by half. Similarly, programmes targeting children of parents of substance use disorders can reduce problem behaviour by half.

Effective community based efforts to prevent violence include public education campaigns, improved urban infrastructures and community policing. These efforts not only reduce violence but they also have positive effects on the mental health and well-being of the population.

At the macro level, human rights and criminal justice legislation, policy reform, and enforcement are strategies that can also be utilised to reduce discrimination, violence and bullying.

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that all schools have a holistic mental health promotion approach in the curricula which includes aggression and violence prevention
➢ Ensure that all countries have a violence prevention strategy in place that includes community policy initiatives and neighbourhood prevention programmes
➢ Ensure that policies at the macro level such as criminal justice legislation and policy reform are developed and enforced

Action points: strategies for implementation

Recommended actions to achieve this target include the following:

☞ Develop a school holistic mental health promotion approach in the curricula which combines classroom behaviour management and enhancing social skills
☞ Develop community support for violence prevention and implement effective violence prevention approaches
☞ Develop a macro strategy to violence prevention that includes school, neighbourhood, regional and national intersectoral policy approaches to violence

7.2. Addictive substances

The case for action

Addictive substances (tobacco, alcohol and illicit drugs) can cause intoxication and injuries, a very wide range of harm and dependence. Together they cause between one fifth and one quarter (tobacco 12%; alcohol 9% and illicit drugs 2%) of the total burden of ill health and premature death in Europe. They cause harm not only to the user but those surrounding the user and they are an important cause of socio-economic inequities in health. Their use and associated harm is increasing in younger people. They cause an enormous economic burden to society and economic productivity. Some 10% to 15% of the total health care budget arises from treating the harm done by substance use. Substance use disorders are a classified mental disorder as well as being co-morbid with a wide range of mental and behavioural disorders including depression and suicide.

What works

The European Alcohol Action Plan, the Action Plan for a Tobacco free Europe and the Framework Convention on Tobacco Control of the World Health Organization provide a platform for effective strategies. Illicit drugs fall within the requirements of United Nations Conventions. Public health policies concerning substances need to be formulated by public health interests, without interference from commercial interests or other pressure groups. Industries that produce alcohol and tobacco need to be accountable for the harm arising form these substances.

Successful and cost effective options to reduce substance use disorders are environmental options that influence the price, availability and marketing of substances. Taxation is the most effective policy option, with increases in the price of tobacco and alcohol (and illicit drugs) reducing both use and harm. Increases in taxes also increase government revenue, allowing for the hypothecation or earmarking of such revenue to be used for additional mental health promotion policy measures. Advertising bans and restrictions on the availability of substances are also effective. Other policy measures include media and comprehensive community interventions. Educational-based interventions, although having limited effectiveness

in reducing harm over the long term, are important to increase awareness of the health risks that can arise from substance use and of the benefits of reducing or stopping use. Educational-based interventions are effective in increasing public awareness of the importance of and the need for policy options to reduce the harm done by substances. Interventions based in primary health care are effective in reducing tobacco and alcohol related disorders, being amongst the most cost-effective of all health care interventions. Harm reduction strategies for illicit drugs are effective in reducing side effects of drug use, such as the risk of HIV/AIDS from contaminated needles.

Aims

By the year 2020, all countries of the European Union should:

➢ The proportion of non-smokers should be at least 80%, in over 15-year-olds and close to 100% in under 15-year-olds;
➢ Per capita alcohol consumption should not increase or exceed 6 litres per annum, and should be close to zero in under 15-year-olds;
➢ The prevalence of illicit psychoactive drug use should be reduced by at least 25% and mortality by at least 50%.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ Educational and intervention strategies aim at improving the life skills and psychosocial wellbeing of people, helping them to manage life situations and make healthy choices;

☞ Regulatory practices to limit exposure to environmental tobacco smoke and reduce alcohol intoxication, including drinking and driving, are enforced;

☞ Risk-containment strategies are implemented to reduce the harm done by drug use;

☞ Internationally agreed conventions for illicit drugs and tobacco products are implemented, and an internationally agreed convention for alcohol products is developed;

☞ Fiscal and regulatory policies are established to limit the availability, accessibility and marketing of tobacco and alcohol products, notably to young people; a complete advertising ban is placed on tobacco and severe advertising limitations are placed on alcohol in all countries;

☞ Brief interventions for smoking and hazardous and harmful alcohol consumption are widely delivered in all countries;

☞ Communication strategies aim at generating public support for reducing the harm from addictive substances.

8. THE ROLE OF PRIMARY AND SECONDARY HEALTH CARE

The case for action

The Eurobarometer survey found that 5% of men and 7% of women reported that they had visited their general practitioner (GP) within a year with a mental health problem. A higher proportion of patients visiting a GP will not be aware that they are suffering from a mental health problem, which is often expressed through a range of physical symptoms. However the relation between somatic symptoms and depression is infrequently recognized by patients. In a global study the range of patients who reported only somatic symptoms was from 45% to 95%, and

11% of the depressed patients denied psychological symptoms of depression on direct questioning. Those with psychiatric disorders consult their GP twice as often, have more physical illnesses and take more time off work.

Depression is also highly prevalent at any point in time in patients suffering from physical illness, being as much as 29% in hypertension patients, 33% in cancer patients, 27% in patients with diabetes and 31% in stroke patients. Health services need to be reoriented emphasising that health is a shared responsibility among individuals, community groups, health professionals, health service institutions and governments. The reorientation of health services should include attention to mental health research, changes in professional education and training and a change in the organisation of health services including the mental health needs of the individual as a whole person. Mental health promotion and mental disorder prevention should be provided in primary and secondary health care especially to those at risk.

What works

Brief interventions in primary health care including educational programs to stimulate pregnant women to sustain from substance use can have long-term mental health benefits. Minimal 15 minute behavioural interventions in primary health care for pregnant smokers have showed a 6% increase in cessation. Among those who quit, their babies were 200 grams heavier at birth; cutting down smoking increased birthweight by half this amount.

Brief educational sessions for general practitioners to identify depression have increased recognition, diagnostic skills and early treatment. Problem solving training in primary care is effective in managing depression and depressive symptoms. Health care professionals in primary care can also be successfully trained to work with new mothers and families to promote the psychological well being of children in order to prevent the risk for the development of psychological and social problems.

Aims

By the year 2020, all countries of the European Union should:

- ➢ Ensure that all people have access to primary and secondary health care independent of income
- ➢ Ensure that accredited training in vocational and continuing education of all primary and secondary health care professionals includes the provision of effective brief interventions for emotional problems and for substance use disorders
- ➢ Ensure that all primary health care practices provide effective brief interventions for emotional problems and substance use disorders free of charge
- ➢ Ensure that throughout secondary health care effective interventions for emotional problems and substance use disorders are available for those who need it independent of income

Action points: strategies for implementation

Recommended actions to achieve these outcomes include the following:

- ☞ Set a health policy in place where all the population has access to primary and secondary health care, especially those from low socio-economic backgrounds
- ☞ Provide training courses for primary health care professionals on effective brief interventions for emotional problems and substance use disorders

☞ Integrate training of evidence-based interventions for emotional problems and substance use disorders into curricula of vocational and continuing education of health professionals

☞ Secondary health care should be supported in implementing effective interventions to prevent postpartum depression and mental health promotion-depression prevention interventions for patients with chronic medical conditions

9. PROMOTING SOCIAL INCLUSION AND PREVENTING STIGMA

9.1 Reducing Economic Insecurity

The case for action

Mental health is highly sensitive to socioeconomic circumstances, even in the most affluent societies, and therefore amenable to socioeconomic policy and action. The main determining factors include income, education and employment. Changes over time in the mental health status of disadvantaged groups are a powerful indicator for assessing the success of socioeconomic policies.

Absolute income levels determine the poor mental health associated with poverty. Relative income differences, irrespective of social class, are related to the gradient in mental ill health that stretches across all levels of the social hierarchy. As income differentials widen, the risk of mental ill health widens. Social class differences in mental ill health are seen at all ages, with lower socioeconomic groups having greater incidence of premature and low birth weight babies, depression, and substance use disorders in adults. Risk factors for mental ill health are clustered in the lower socioeconomic groups and their effects on mental health accumulate during life. The longer people live in stressful economic and social circumstances, the greater the mental strain they suffer, and the less likely they are to enjoy a mentally healthy old age.

Income distribution is important not only for mental health but also for social cohesion. Societies in which there are high levels of income inequality also tend to have higher levels of violent crime. Deprivation leads to stress and economic hardship and reduces people's ability to fulfil roles. Income inequality must, however, also be looked at in the wider perspective of the extent to which social goods (e.g. free education) are available to lower income groups.

Socially cohesive societies are those with well functioning institutions and developed civic communities. With reduced income inequality, people can form and participate in social networks across society and through a variety of social organizations, purposes and activities. A sense of moral collectivity and social purpose remains important. When inequalities increase, social divisions become deeper.

Societies which pursue more egalitarian policies often have faster rates of economic growth and higher standards of mental health. The cost of inequality is a cost incurred for no economic benefit, but one that imposes a substantial economic burden and reduces the competitiveness of the whole society.

What works

The life course contains a series of critical transitions: emotional and material changes in early childhood, the move from primary to secondary education, starting work, leaving home and starting a family, changing jobs and facing possible redundancy, and eventually retirement. Each of these changes can affect mental health by pushing people onto a more or less advantaged path. Because people who have been disadvantaged in the past are at the greatest risk in each

subsequent transition, welfare policies need to provide not only safety nets but also springboards to offset earlier disadvantage. Good mental health involves reducing levels of educational failure, reducing insecurity and unemployment and improving housing standards. Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will be mentally healthier than those where people face insecurity, exclusion and deprivation.

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that all children are born into and grow up in families free of poverty.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ Implementation of policies to ensure more equitable distribution of income and wealth, such as progressive tax systems and social security benefits to specific age groups or low-income families. Supplementing the income of low-income people who are starting families results in higher birth weight babies.

☞ Complement policies that address income distribution by those that guarantee free health care and education, as well as subsidized housing.

☞ Target employment and social services to improve mental health and reduce social exclusion.

☞ Promote solidarity, civic participation and integrity, and pluralistic social and political networks to develop mentally healthy communities.

9.2. Expanding access to education

The case for action

Education is an important determinant of mental health. Educational levels produce a gradient in mental ill-health similar to that produced by income. The material and cultural resources of a family have a major influence on a child's educational attainment. There is thus a strong social class gradient in educational qualifications – and this, in turn, is a strong predictor of subsequent mental health, occupation and income. Education is a strong predictor of making healthy choices. Higher and other forms of education foster innovation, which in turn sustains social well-being and socio-economic development.

Low literacy and poor education remain a problem in some European countries, being more common amongst women. Lack of education limits the ability of individuals to access economic entitlements. Better education increases cognitive-emotional and intellectual competencies, job perspectives and reduces social inequity and the risk of mental disorders, including depression.

Children who are raised in limited learning environments or enter school with depressed symptoms are less likely to benefit from primary school, and this poor start can lead to slower achievement and a higher rate of school failure later in life. Delays in language development and failure to learn in primary school increases the risk of adolescent symptoms and later mental disorders, reduces self-efficacy, and results in poor educational achievement. Since lifetime

economic productivity is strongly associated with educational achievement, the economic consequences due to a poor start during childhood can be high.

What works

Parental interest in and enthusiasm for education needs to be supported. Preschool education needs to be provided to help break the link with deprivation. There should be further improvement in the level of, and access to, education, more particularly for women but also for other disadvantaged groups. Economic resources should be allocated to educational programmes according to children's' needs and the requirement of social equity. Higher educational standards should be set and smaller class sizes ensured. Teachers need to be educated and trained in mental health issues.

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that all children should have free access to pre-school education, adopting the principles of the health promoting pre-school
➢ Ensure that all children should have free access to school education up to 16 years, adopting the principles of the health promoting school

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ Implement fiscal polices through taxation and child benefit measures, particularly to low socio-economic families that allow children access to pre-school and school education and to extracurricular educational activities when these are not integrated in normal curricula;
☞ Ensure good parental relationships with schools to increase parental knowledge of children's emotional and cognitive needs, to stimulate cognitive development and pro-social behaviour in the child and to prevent child abuse.

9.3. Enhancing social cohesion through cultural and migration policies

The case for action

Poverty, relative deprivation and social exclusion have a major impact on mental health, and the chances of living in poverty are loaded heavily against some social groups. Absolute poverty – a lack of the basic material necessities of life – continues to exist, even in the richest countries of Europe. The unemployed, many ethnic minority groups, guest workers, disabled people, refugees and homeless people are at particular risk. Those living on the streets suffer the highest rates of mental ill health. Relative poverty means being much poorer than most people in society and is often defined as living on less than 60% of the national median income. It denies people access to decent housing, education, transport and other factors vital to full participation in life. Being excluded from the life of society and treated as less than equal leads to worse mental health and greater risks of premature death. The stresses of living in poverty are particularly harmful during pregnancy, to babies, children and old people. Social exclusion also results from racism, discrimination, stigmatization, hostility and unemployment. These processes prevent people from participating in education or training, and gaining access to services and citizenship activities. They are socially and psychologically damaging, materially

costly, and harmful to health. People who live in, or have left, institutions, such as prisons, children's homes and psychiatric hospitals, are particularly vulnerable. The greater the length of time that people live in disadvantaged circumstances, the more likely they are to suffer from a range of mental health problems. Poverty and social exclusion increase the risks of divorce and separation, disability, illness, addiction and social isolation and vice versa, forming vicious circles that deepen the predicament people face. As well as the direct effects of being poor, mental health can also be compromised indirectly by living in neighbourhoods blighted by concentrations of deprivation, high unemployment, poor quality housing, limited access to services and a poor quality environment.

What works

Integrated government policies that eliminate absolute poverty and reduce material inequalities will promote mental health and reduce premature death and disability that results from mental ill health. Integrated policies are needed to support vulnerable groups. The health of migrants and refugees can be improved if access is ensured to a system of family health services, adequate housing, and educational and employment opportunities. As far as possible, vulnerable groups must be guaranteed financial coverage which secures their rights to health care at the same level as the rest of the population. Integrated programmes developed at community level – involving a broad range of sectors and agencies – can be effective in tailoring services to the specific cultural, attitudinal and other characteristics of the groups concerned.

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that integrated policies on taxes, benefits, employment, education, housing, and economic management are targeted to support vulnerable groups, and increase social cohesion.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ All citizens should be protected by minimum income guarantees, minimum wages legislation and access to services
☞ Interventions to reduce poverty and social exclusion are needed at both the individual and the neighbourhood levels
☞ Legislation can help protect minority and vulnerable groups from discrimination and social exclusion
☞ Public health policies should remove barriers to health care, social services and affordable housing
☞ Labour market, education and family welfare policies should aim to reduce social stratification.

9.4. Prevention of stigma and discrimination

The case for action

People with mental disorders have been the victims of stigma, lack of care and, in some cases, abuse of human rights. Stigma results in an individual being shunned or rejected by others. The stigma associated with all forms of mental illness is strong but generally increases the more an individual's behaviour differs from that of the 'norm' (WHO, fact sheet 2000). Stigma leads to persons with mental disorders being rejected by friends, relatives, neighbours and employers. This in turn has shown to aggravate feelings of rejection, loneliness and depression. Stigma has a detrimental effect on a mentally ill person's recovery, ability to find access to services, the type of treatment and level of support received and acceptance in the community (WHO fact sheet 2000).

Those with mental disorders are also often denied equal participation in family life, normal social networks, and productive employment (WHO fact sheet 2000) which leads to reduced mental health and quality of life.

Rejection of people with mental illness also affects the family and caretakers of the mentally ill person and leads to isolation and humiliation; and

What works

- providing accurate information on the causes, prevalence, course and effects of mental illness;
- countering the negative stereotypes and misconceptions surrounding mental illness;
- providing support and treatment services that enable persons suffering from a mental illness to participate fully in all aspects of community life;
- ensuring the existence of legislation to reduce discrimination in the workplace, in access to health and social community services;
- openly talking about mental illness in the community.

10. CREATE SUPPORTIVE ENVIRONMENTS LINKING WITH OTHER POLICIES

Adjustments in legislation, policy implementation and resource allocation across many sectors can result in substantial gains in the mental health of European citizens. In addition to improving the health, social and economic development of society such public policy changes can decrease the risk of mental disorders. This section reviews the consequences that sound and integrated public policies can have for improved mental health and reduced risk for mental disorders.

10.1. Developing healthy work through employment and labour policies

The case for action

Both the quantity and quality of work have strong influences on many mental health-related factors, including income, social networks and self-esteem. Unemployment leads to poor health, as well as to labour market disadvantage. In a number of countries, the labour market has shifted away from secure unskilled or semi-skilled work, with on-the-job training, to work that

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requires a high level of pre-employment education and training, a development which has exacerbated youth unemployment, in particular.

Much has been made of the virtues for overall economic growth and development of a more flexible labour market, in which a high proportion of all jobs are temporary and a higher proportion of all workers are on short-term contracts or are formally self-employed freelance workers. Such job insecurity is associated with poorer mental health. Estimates of production costs, however, rarely take into account losses in mental health and the quality of life that are related to job insecurity.

Unemployment puts mental health at risk, and the risk is higher in regions where unemployment is widespread. The health effects of unemployment are linked to both its psychological consequences and the financial problems it brings – especially debt. The mental health effects start when people first feel their jobs are threatened, even before they actually become unemployed. This shows that anxiety about insecurity is also detrimental to health. Job insecurity increases both anxiety and depression. During the 1990s and early 2000s, changes in the economies and labour markets of many industrialized countries increased feelings of job insecurity. As job insecurity continues, it acts as a chronic stressor whose effects grow with the length of exposure; it increases sickness absence and health service use.

Because very unsatisfactory or insecure jobs can be as harmful as unemployment, merely having a job will not always protect mental health: job quality is also important. Within employment, there is a clear association between grade of employment and mental ill health, including sickness absence rates. The relationship is maintained even when allowance is made for other factors, such as level of education and housing tenure. The relationship seems to be explained by higher levels of work control, stimulation, and support in the higher grades.

Stress at work plays an important role in contributing to the large social status differences in health, sickness absence and premature death. Jobs with both high demand and low control carry special risk. Health suffers when people have little opportunity to use their skills and low decision-making authority. Having little control over one's work is particularly strongly related to an increased risk of low back pain, sickness absence and cardiovascular disease.

What works

Government management of the economy that reduces the highs and lows of the business cycle can make an important contribution to job security and the reduction of unemployment. For those out of work, unemployment benefits set at a higher proportion of wages are likely to have a protective effect on mental health. Credit unions may be beneficial by reducing debts and increasing social networks. A variety of workplace policies are available to be applied during times of economic difficulty to reduce the risk of job loss and unemployment including job sharing, job security policies, cutbacks on pay, and reduced hours, among others. To equip people for the work available, high standards of education and good retraining schemes are important.

Mental health and productivity at work are related and a virtuous circle can be established. Improved conditions of work can lead to a healthier work force, which will lead to improved productivity, and hence to the opportunity to create a still healthier, more productive workplace. Appropriate involvement in decision-making is likely to benefit employees at all levels of an organization. Mechanisms should therefore be developed to allow people to influence the design and improvement of their work environment, thus enabling employees to have more control, greater variety and more opportunities for development at work. Social support in the workplace may be protective for good mental health.

Aims

IMHPA

Implementing Mental Health Promotion Action

By the year 2020, all countries of the European Union should:

> ➢ Ensure that labour policy aspires to prevent unemployment and job insecurity; to reduce the hardship suffered by the unemployed; and to restore people to secure jobs.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

- ☞ Securing adequate financial and social support systems for unemployed groups;
- ☞ Promotion of training and employment, especially of those who have experienced less favourable conditions in early life;
- ☞ Investment in secure employment to benefit health and long-term productivity;
- ☞ Inclusion in economic analysis of the stress of a high workload and job insecurity, in order to yield a better picture of the true outputs of economic activity;
- ☞ Flexible arrangements for sharing work;
- ☞ Alternative forms of social and community work, to avoid long-term structural unemployment; and
- ☞ Adjustment of labour market policies to diminish the risk of discrimination on the basis of gender, age or ethnicity.

10.2. Strengthening Community Networks and Local Neighbourhoods

The case for action

     Social support and social relations are important for mental health. Social support provides the emotional and practical resources that people need. Belonging to a social network of communication and mutual obligation gives value and esteem to people. This has a powerful protective effect on mental health. Supportive relationships may also encourage healthier behaviour. Support operates on the levels both of the individual and of society. Social isolation and exclusion are associated with increased rates of premature death. People who get less social and emotional support from others are more likely to experience less well-being, more depression, a greater risk of pregnancy complications and higher levels of disability from chronic diseases. In addition, poor personal relationships can lead to poor mental health. Poverty can contribute to social exclusion and isolation. Social cohesion – defined as the quality of social relationships and the existence of trust, mutual obligations and respect in communities or in the wider society – helps to protect people and their mental health. Inequality can diminish good social relations. Societies with high levels of income inequality tend to have less social cohesion and more violent crime. High levels of mutual support will protect health while the breakdown of social relations, sometimes following greater inequality, reduces trust and increases levels of violence.

What works

     Experiments suggest that good social relations can reduce the physiological response to stress. Intervention studies have shown that providing social support can improve patient recovery rates from several different conditions. It can also improve pregnancy outcome in vulnerable groups of women. Reducing social exclusion can lead to greater social cohesiveness and better standards of mental health. Improving the social environment in schools, in the workplace and in the community more widely, will help people feel valued and supported in more

areas of their lives and will contribute to their mental health. Designing facilities to encourage meeting and social interaction in communities can improve mental health.

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that all people should have greater opportunities to live in healthy physical and social environments at home, at school, at the workplace and in the local community.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ The safety and quality of the home environment should be improved, through increased personal and family skills for mental health promotion and protection, and the mental health risks from the physical home environment should be reduced;
☞ People with mental health disabilities should have substantially improved opportunities for access to home, work, public and social life;
☞ Mechanisms are set up to allow people to influence the design and improvement of their living and work environment, and to participate in promoting health and wellbeing in their community;
☞ Social organizations play a decisive role in increasing social cohesion and improving access to community coping resources;
☞ All sectors concerned support the integration of health-related issues into a comprehensive approach that enables pre-schools and schools to promote the physical, social and emotional health of students, staff, families and communities;
☞ The process of creating healthy companies and workplaces is encouraged and supported, a healthy company being one which includes a safe working environment, mentally healthy working practices, programmes to promote mental health and address psychosocial risk factors at the workplace, mental health impact assessment for marketed products, and contribution to mental health and social development in the community;
☞ The process of creating healthier cities is encouraged and supported, with the participation of partners from the fields of health, the environment, the economy, ecology, education, town planning and urban management.

10.3. Building better housing

The case for action

The home is the physical environment in which people spend most of their time and it should be conducive to positive mental health. Poor housing conditions are an indicator of poverty and a target for improvement in public health and reduction in inequalities in health. Poor housing conditions are related to impaired mental health strain and are a risk for mental disorders. The housing stock in Europe varies considerably, from high-standard apartments and single-occupancy houses to low-standard multiple-occupancy blocks of flats. Homelessness and its mental health consequences, strongly related to poverty, remain an urgent problem.

What works

Interventions to improve housing conditions improve mental health and broader social factors such as increased safety, crime reduction and social and community participation. Interventions include those generated by health needs, by relocation or community regeneration and improved energy efficiency measures such as for heating.

Housing policy is part of the broader context of urban and rural planning, covering improvement of the housing stock, reversal of urban and rural decline, and shrinkage of areas of deprivation. Adequate health and welfare services, public transport, shopping and recreational facilities, and effective control of pollution and noise are essential for a mentally healthy home environment. Policies should particularly aim to protect people who may be at risk of becoming homeless.

Housing and neighbourhood design should look for solutions to counteract loneliness and strengthen social networks. Social networks and support improve mental health, increase social cohesion and lead to safer communities. Housing and neighbourhood design should encourage daily physical activity and make provision for groups with special needs, such as disabled and older people.

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that all citizens have access to affordable housing to a given minimum standard

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ Mental health considerations should be introduced into urban and regional development plans when housing stock is newly built and rebuilt;

☞ Housing standards and building regulations should ensure the use of safe and suitable materials and proper building techniques; the availability of adequate lighting; a safe water supply; the provision of sanitation, heating and ventilation systems; resistance to damage from natural causes; proper insulation from cold and outside noise; and a safe and continuous supply of energy for lighting, heating and cooking.

10.4. Improving nutrition in disadvantaged groups

The case for action

Social and economic conditions result in a social gradient in nutritional quality that contributes to health inequalities. Improving nutrition in socio-economically disadvantaged children can lead to improved cognitive development and educational outcomes and reduced risk for mental ill health. Mental retardation and impaired learning abilities are associated with a lack of iodine in the diet. Iodine deficiency can affect the intelligence level of even the apparently healthy population living in an iodine deficient area.

What works

Food supplementation and fiscal policies to reduce poverty in disadvantaged families improve nutrition and eliminate vitamin and mineral deficiencies. There is scope for considerable health gain if people, especially those living in poverty, could have greater access to a diet rich

in vegetables, fruit, unrefined cereal, fish and small quantities of good-quality vegetable oils, so that they consume a nutrient-rich diet lower in fat and energy density. Iodine deficiency can be prevented by iodization of salt or other elements of the food chain.

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure a substantial increase in the availability, affordability and accessibility of safe and healthy food.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ Fiscal, agricultural and retail policies throughout the food chain to increase the availability, affordability, accessibility and consumption of whole-grain cereals, pulses, vegetables and fruits and to reduce the consumption of high-fat food;
☞ Universal iodization of salt or other elements of the food chain to eliminate iodine deficiency disorders;
☞ Targeted education and food supplementation for low income families.

10.5. Promoting mental health through urbanization, transport and environmental policies

The case for action

Nearly four fifths of the population live in cities, which have direct implications for mental health. Urban shape, zoning strategies, noise levels and public amenities are important elements which can promote urban health and help to reduce stress, social dislocation and violence. Within many urban environments, localized areas of deprivation exist, particularly in run-down city centres or chaotic peripheral zones, where environmental degradation and social exclusion go hand in hand. They are places of functional impoverishment with poor housing, insufficient equipment and inadequate social and recreational facilities. A city's degree of social integration or social cohesion and its patterns of poor mental health are closely interrelated. Interventions in high-risk groups have shown that the provision of social services and support improves mental health. Socially underprivileged and disintegrated neighbourhoods contribute to people's sense of stress and frustration and inhibit the development of supportive networks.

In poor districts, many factors make healthy lifestyles more difficult. There are fewer recreation areas; a heightened sense of crime inhibits people from going outdoors, socializing, engaging in a physical activity; access to public transport is poorer; healthy nutrition is less available or affordable; and primary health care services are less available than in more advantaged areas.

Cycling, walking and the use of public transport provide physical activity, reduce fatal accidents, increase social contact and reduce air pollution. Regular physical activity promotes a sense of well-being and protects older people from depression. Reducing road traffic would also reduce the toll of road deaths and serious accidents. In contrast to cars, which insulate people from each other, cycling, walking and public transport stimulate social interaction on the streets. Road traffic can cut communities in two and divide one side of the street from the other. With fewer pedestrians, streets cease to be social spaces and isolated pedestrians may fear attack. Further, suburbs that depend on cars for access isolate people without cars – particularly the young and old. Social isolation and lack of community interaction are strongly associated with poorer mental health. Walking and cycling make minimal use of non-renewable fuels and do not

lead to global warming. They do not create disease from air pollution, make little noise and are preferable for the ecologically compact cities of the future.

What works

Recreation areas, safe streets, and access to public transport and basic amenities and services are essential resources for a healthy and safe community and strong social networks, and they should be maintained and improved. The urban infrastructure should allow a high-quality environment which will promote and protect the mental health of the inhabitants. Sustainable urban patterns can be achieved through balanced land use and the efficient use of space. The segregation of groups and individuals should be avoided as far as possible, and facilities and public spaces need to be accessible to all. Citizens can be encouraged to live peacefully together by promoting active interchange between generations and among ethnic, cultural and socioeconomic groups.

Promoting efficient transport management through urban road pricing, integrated public transportation, vehicle priority schemes, traffic calming, traffic bans in designated areas and parking controls can reduce air pollution, congestion, noise and accidents. Orienting urban renewal projects towards improving the quality of urban life, reducing the use of water, energy and materials and implementing programmes for separate waste collection, recovery and recycling can result in more sustainable cities. Well planned urban environments, which separate cyclists and pedestrians from car traffic, increase the safety of cycling and walking. Increasingly, the evidence suggests that building more roads encourages more car use, while traffic restrictions may, contrary to expectations, reduce congestion.

Aims

By the year 2020, all countries of the European Union should:

➢ Ensure that people and their living conditions should be the central consideration for town planning.
➢ Ensure that transport policy plays a key role in combating sedentary lifestyles by reducing reliance on cars, increasing walking and cycling, and expanding public transport.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ Roads should give precedence to cycling and walking for short journeys, especially in towns;
☞ Public transport should be improved for longer journeys, with regular and frequent connections for rural areas;
☞ Incentives need to be changed, for example, by reducing state subsidies for road building, increasing financial support for public transport, creating tax disincentives for the business use of cars and increasing the costs and penalties of parking;
☞ Changes in land use are also needed, such as converting road space into green spaces, removing car parking spaces, dedicating roads to the use of pedestrians and cyclists, increasing bus and cycle lanes, and stopping the growth of low-density suburbs and out-of-town supermarkets, which increase the use of cars.

V. MAKING IT HAPPEN: COMMON PRINCIPLES FOR SUCCESS

5.1. The need for an intersectoral approach

Mental health results from the combined actions of society. Though many of the key mental health burdens are due to risk factors such as substance use or child abuse, the major causes of mental ill health are poverty and socioeconomic deprivation. It is important to note that for the same level of income, societies with less income inequality tend to have more social cohesion, less violent crime and lower death rates from mental disorders. It follows that enlightened economic policies, social support and good social relations can make an important contribution to mental health. An integrated multidisciplinary and intersectoral approach to mental health development is thus more effective, efficient and cost-effective than separate vertical approaches.

The bureaucratic, hierarchical organization and management systems and styles of old will not suffice to achieve these goals, and new systems for multisectoral and organizational cooperation and coordination will be required. The general public and a broad range of organizations, institutions and sectors must be informed and motivated about what needs to be done to achieve mental health improvement, and they must be drawn into active coalitions for mental health. The relevant management skills to promote change throughout complex modern, plural societies will be at a premium and will require substantial development.

Good governance for mental health can be defined as the careful and responsible management of the well-being of the population. Although governance for mental health is a responsibility of government, this does not mean that government needs to fund and provide all interventions. Responsibilities for different aspects of governance may be divided between central and sub-national authorities, local government, other ministries such as finance, planning, civil service commissions, audit commissions, parliamentarians, professional associations, ombudsmen, inspectorates, insurance funds, other purchasing agents and providers. But a country's government, through its health ministry, should carry the main responsibility to ensure collective provision of effective governance.

Mental health is embodied in the Ottawa Charter for Health Promotion, which calls for health public policy, supportive environments, community action, the development of personal skills and a reorientation of the health sector towards health promotion. Health21, the health for all policy of the European Region of the World Health Organization provides the framework for effective governance to implement policy for promoting mental health and preventing mental disorders. Policy requires action in three main areas: strengthening the knowledge base for mental health; mobilizing partners for mental health; and planning, implementing and monitoring action plans for mental health promotion.

5.2   Strengthening the knowledge base for mental health

Research to develop better tools to promote mental health and prevent mental disorders and mental health information systems are two key areas for change.

5.2.1. Research

BACKGROUND

All policies and actions to improve mental health need a firm knowledge base. Research and evidence are amongst societies' most valuable and important tools for laying the foundation of better strategies to improve mental health. The growing role of research means the scientific community should be more involved in developing scientifically sound, socially relevant and

feasible bases for decisions. However, there must be a much better match between the needs for mental health promotion research as perceived by decision-makers and planners on the one hand, and the research priorities set by the research community on the other. In addition, there need to be systematic mechanisms for ensuring that new evidence from research is actually introduced into daily practice.

If all existing knowledge about which mental health promotion and mental disorder prevention approaches work and which do not were fully applied, this would have a major impact on improving mental health and increasing individual and social capital.

PROPOSED STRATEGIES

European mental health promotion oriented research policies need to be developed. There need to be mechanisms to identify gaps in evidence. European gaps should be filled with new research in areas where the knowledge base is insufficient, including the assessment of the cost-effectiveness of interventions. There is also a need to develop new approaches to deal with broader societal changes, such as socioeconomic deprivation. Special efforts should be made to develop research for anticipating future trends, needs and challenges in mental health promotion, covering not only direct indicators of mental health but also indicators of structural, environmental, behavioural and social determinants.

One very important task is to establish a permanent European mechanism that will make a systematic review of all major national and international research outcomes in the main areas of mental health promotion and mental disorder prevention, such as registries and databases. International research collaboration at the European level should be strengthened, with greater emphasis placed on needs-based research, an increase in the number of inter-country research programmes and better exchange of research information.

5.2.2 Mental health information and intelligence support

BACKGROUND

Information systems are another key component making knowledge more widely available. Information on mental health status and risk factors is crucial. European countries should use and report on a common set of mental health indicators. The European Commission has taken a lead in developing and testing a set of health indicators including mental health.

Intelligence is broader than information. It implies identifying and interpreting essential knowledge for making decisions from a range of formal and informal sources – routine information, research, the media, opinion polls, pressure groups, etc. Intelligence should include:

Current and future trends in mental health and system performance: For example, on levels, trends and inequalities in key mental health areas; mental health risk factors; vulnerable groups; organizational or institutional challenges in promoting mental health and preventing mental disorders; governance.

Important contextual factors and actors: The political, economic and institutional context; the roles and motivation of different actors; user and consumer preferences; opportunities and constraints for change; events and reforms in other sectors with implications for mental health.

Possible policy options, based on national and international evidence and experience: For example, intelligence on different policy tools and instruments for similar problems, on their effects in different settings, and on managing change. It includes information on relatively specific things such as cost-effective interventions, and on possible institutional arrangements for different functions.

PROPOSED STRATEGIES

European mental health information must become much more widely available and easily accessible, if mental health is to be improved. Decision-makers, health professionals, economists, architects, teachers, research workers, the media, the general public, etc. all need to be informed about mental health issues in a way which arouses both their interest in and commitment to the implications and processes of mental health improvement. This information should be available on electronic media and be published regularly in a publicly accessible form, so as to promote an informed and open debate among politicians, professionals and the public concerning mental health outcomes and determinants, and future priorities for action and investment.

Aims

By the year 2008, all countries of the European Union and the European Union as a whole should:

> ➢ Have research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to promote mental health and to prevent mental disorders.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ All countries and the European Union as a whole formulate multi-sectoral research strategies to promote mental health and to prevent mental disorders, striking a balance between basic and applied research;

☞ European cooperation is strengthened, leading to an increase in the number of inter-country research programmes and better exchange of research information;

☞ The public sector strengthens communication and cooperation between the scientific community and decision-makers for the application of new knowledge to mental health promotion and mental disorder prevention;

☞ Health and health-related information bases are set up and maintained to support the monitoring and evaluation of mental health promotion policies and programmes, enhance accountability for mental health, facilitate the sharing of knowledge within and between countries, and help raise people's awareness of the importance of mental health promotion and mental disorder prevention;

☞ The resources and expertise of the media and communication sector are fully engaged to inform, educate and persuade all people of the individual and collective importance of mental health promotion and mental disorder prevention, and to give them options for action.

5.3 Mobilizing partners for better mental health

BACKGROUND

A wide range of partners need to be involved if multisectoral societal policies and actions are to be developed and harnessed for mental health. Many of these potential partners are not

aware of the benefits they can gain from investing in mental health promotion. There is therefore a need to overcome the problems posed by single-sector approaches and specific organizational objectives, budgets and activities; one of these problems is the lack of mechanisms to bring partners together in systematic cooperation. Partnership implies that all partners must take responsibility for the mental health consequences of their policies and actions and assume their share of accountability for mental health promotion and mental disorder prevention.

PROPOSED STRATEGIES

Partnerships for health are required at different levels: international, country, regional and local. They are needed for the formulation of mental health promotion policy; for increasing people's perception and understanding of mental health issues; for developing the political will for action; for target-setting; for carrying out policies and programmes, including the selection of priorities and resource allocation; and for monitoring and evaluation of outcomes. The role of certain sectors has been discussed in Chapter 4. The role of other partners is further outlined here.

Governments. It is ultimately a government's responsibility to define and be accountable for a clear mental health promotion policy for the whole country. Governments should reflect a shift in societal values such that economic growth becomes only one objective among many – to be balanced with others, such as mental health advancement, sustainability, equity, social cohesion and environmental quality. In undertaking this task, governments will increasingly have to recognize the need for full participation by a wider range of partners, and for transparency in the processes of policy development.

Governments need to establish effective and permanent coordination machinery, such as a national mental health council, comprising senior representatives of many ministries and other partners, to ensure that a coherent approach is taken to mental health promotion policies and that mental health objectives are properly balanced in both political and technical forms.

Health sector Professionals. As the key providers of health care, health professionals and their organizations can take a leading role in promoting mental health and preventing mental disorders. Health professionals can make a highly significant contribution to improving population mental health. They can foster a feeling of security in individuals and a climate of confidence in society; factors which are important for the development of the economy and, more generally, for society as a whole. Mental health promotion and mental disorder prevention can be integrated within primary health care. The work of health care providers should target mental health improvement, client satisfaction and cost-effectiveness, as opposed to traditional management practices in which the health care system has been viewed from an input perspective, with plans developed according to inputs.

The education of health professionals should be designed in accordance with the health needs of society and aimed at ensuring that they acquire the necessary knowledge and skills. All settings where health care is provided, such as homes, schools, workplaces, primary care settings and hospitals, should be integrated into education as key learning environments. The education of health professionals at different levels – undergraduate, postgraduate and continuing education – should be strongly interlinked to create a continuous process. The strategies and content of education for mental health at the different levels should be defined accordingly.

Public health should take a comprehensive "horizontal" view of the needs for mental health improvement across society as a whole, to analyse broader strategies for mental health, to create innovating networks for action among many different actors and, in general, to be a *catalyst for change*. Public health practitioners need to use political awareness for the benefit of populations and mobilize broad-based political and cultural support for equitable, sustainable

and accountable approaches to mental health development. They must be able to motivate and assist people, organizations, communities and countries to manage and adapt effectively to changing environments, as well as facilitate the development of local capacities. Furthermore, they must be able boldly and effectively to challenge groups whose activities are detrimental to the public's mental health.

Professionals outside the health sector. Many professionals outside the health sector contribute to mental health. Teachers in both pre-school and school can educate and inspire their pupils to respect the basic values of equity; can encourage pupils to adopt mentally healthy lifestyles and train them to resist peer pressure; prepare them for the challenges of adolescence; instil in them the value of social interaction and the importance of social networks; and help prepare them eventually to become good parents themselves.

Engineers, architects and town planners need to broaden their understanding of the impact which their work can have on the mental health of individuals and communities. They should not only be aware of safety concerns relevant to the design of housing, neighbourhoods and cities, but also look for imaginative new solutions that will stimulate physical activity, promote the development of neighbourhood-based social networks, and break down the social isolation of many of today's modern urban environments.

Economists should increasingly consider mental health outcomes produced by different sectors. For example, it will be necessary to look more critically at the mental health costs of industrial and infrastructure development projects. Earmarked financial incentives could be offered, for example from a special Mental Health Fund paid for by tobacco and alcohol taxes, to improve mental health promotion and mental disorder prevention.

More vigorous and open involvement of journalists and other professionals working in the media and the communication industry in creating and sustaining public knowledge and debate about mental health promotion issues will be vital to create an emphasis on public participation and the transparency of policy-making and implementation processes.

Nongovernmental organizations. Non-governmental organizations are essential partners for mental health; they are a vital component of a modern civil society, raising people's awareness of issues and their concerns, advocating change and creating a dialogue on policy. Of particular importance are those organizations which deal with civil, cultural, economic, political, and social rights, including those that deal with the rights of children, religious or ethnic minorities and persons with physical and mental disabilities. Their role in mental health promotion and mental disorder prevention should be strengthened.

Industry and the private sector. All countries need a viable industrial base as a source of goods, services, employment and wealth. Sustainable and profitable industrial activity is that which invests in mental health and in the environment and, through labour policy, in human development and wellbeing. Small changes in the way that industry does business can unlock money which will not only improve mental health but also increase profitability. Mental health is a domain worthy of investment, and mentally healthy products can lead to better business.

The private sector is expanding its view of who has a legitimate stake in its operations. Companies' stakeholders include not only shareholders, lenders and regulators but also employees, customers, suppliers, trade associations, community and environmental groups, the public at large and, in the widest sense, future generations. Industry is increasingly setting public goals for mental health improvement and adopting the requisite investment programmes. Producers marketing products representing a direct risk to health, such as the tobacco and alcohol industries still have to take full responsibility for the economic and health cost of their products.

Private sector activities should become more comprehensive and mental health-focused than they are today. It is vital that the private sector pays close attention to the mental health of its employees. One way forward would be to promote the concept of a "healthy company or enterprise" or "health promoting company", based on partnership between employers and employees. This should comprise a three-pronged approach: the creation of a mentally healthy workforce, the production of mentally healthy company products, and active support by the company to local community or national mental health promotion programmes.

Finance. The finance sector has an important role to play in supporting work towards health objectives. Pricing and taxation policies are among the strongest means of action for governments, sectors, communities, individuals and society. Yet these instruments are under-utilized when it comes to promoting human development and sustainable economic activity that generate wellbeing and mental health. Fiscal policy that reduces income inequalities, promotes sustainable development, and promotes mental health needs to be adopted. Taxes can be used as incentives for the production of health-promoting products, and as discouragement to produce those that damage health. Measure of gross national product can be adjusted to reflect positive and negative impacts on mental health and human development.

Social welfare and services. The social sector responds to problems arising from poverty and social exclusion and aims to prevent social ills. As such, the sector has an important contribution to make to the promotion of mental health and wellbeing. Social welfare policy is under debate in many countries, in the light of a perceived increasing welfare burden resulting from changing demographic trends and persistent unemployment. Social welfare policy needs to provide a social safety net, especially in economies in transition or decline. Welfare policies should be family-friendly, with caring and parenting recognized as social rights. Standards for housing, income and social support services should be set, tailored to the needs of different target groups. Closer collaboration should be made with the health care sector in the provision of community-oriented primary health care.

The judiciary and legislation. The judiciary has a responsibility for the implementation of legislation to protect and promote mental health, as well as a responsibility for legal action when health protection laws are infringed. This should include harmonizing legal systems and liability regimes in different European countries and ensuring that activities undertaken in one country will not damage the mental health or cause injury in others and facilitating litigation against trade and industry in the case of actual mental health damage.

The media. The mass media in all their forms are increasingly influencing values and shaping public opinion, perceptions and behaviours about mental health. Mass media influence has been enhanced by rapid developments in communications technology, including telecommunications. Mental health and wellness topics are one of the growth areas in media and communications. On the one hand, this gives an opportunity to provide mental health information and publicly expose activities that lead to mental health risk. On the other hand, there is danger that advertising and marketing in all its forms serves the interests of risk producers, for example the alcohol and tobacco industries, in promoting mentally unhealthy choices.

Individual citizens. Making mentally healthy choices the easier choices is a vital strategy for helping people to accept more responsibility for the "healthiness" of their own lives, recognizing mental health as a resource to be protected and actively enhanced.

Homes. The informal setting of the family environment does not require formal mechanisms, but respected family health care providers can be very effective in initiating constructive discussions among family members on their mental health challenges.

Schools, worksites, and other settings. Pre-schools, schools, workplaces, prisons, and other settings are important places for mental health action. They require a mental health promotion committee, provided with meaningful resources for action, composed of the major partners, and given clear responsibility to promote local mental health.

Neighbourhoods and local communities. The tasks of designing a local mental health promotion policy, complete with targets and an action programme and of executing, monitoring and evaluating its implementation must be tackled on a properly planned basis by every neighbourhood and local community. For this to happen, there must be a local mental health council or similar body charged with this responsibility and involving the elected local council, representatives of major sectors such as health, education, social affairs, etc., and the principal non-governmental organizations, the media and the local population.

National and sub national levels. The formulation of a countrywide mental health promotion policy and programme is indispensable to ensure the rational use of resources and to facilitate a society-wide movement towards better mental health that is actively supported by all ministries, national professional associations, organizations of labour and industry, the media and others. It is indispensable to have a clear, visible mechanism, such as a national mental health council, to develop this collective commitment. Such a council should receive technical support and leadership from the ministry of health. It should be the body to draft national policies and programmes, to monitor and evaluate the implementation of such policies and programmes, and to report on progress. This process will help create public accountability, heightening awareness of mental health development goals throughout society and generating the will to achieve them.

European Union level. For the 25 countries of the European Union and the applicant countries, a collaborative mechanism already exists in the Mental health working party. Partnership with other major intergovernmental bodies is of the utmost importance if health is to be achieved across Europe. Such bodies include the World Health Organization, the World Bank, the Council of Europe. Partnerships should also include the main European non-governmental organizations active in mental and behavioural disorders and substances, represented for example, in the Health Policy Forum of the European Commission, as well as organizations active in health promotion, such as the International Union for Health Promotion and Education. Existing collaborative networks including Regions for Health, Healthy Cities, Health Promoting Schools and Health in Prisons, can facilitate the exchange of knowledge and experience; other possible health-oriented networks of this type include parliamentary health committees and international associations of teachers, economists, lawyers, engineers and architects.

Bringing partners together for action

For a strategy of partnership in mental health development to be truly effective, special mechanisms must be established to ensure focus and sustainability. The involvement of all sectors of the community and civil society is fundamental to ensuring that programs reflect priorities, have widespread support and are sustainable. All these initiatives focus on the development of participatory planning models, for example formal statutory committees and

councils with long term mandates, formal partnership groups, specialized working groups, as well as more informal and ad hoc arrangements for partnership.

The identification of partners is a crucial step, as this determines the legitimacy and the ability of the initiative to develop new insights, ideas, approaches and establish consensus positions. Roles and responsibilities of all partners need to be clearly specified and agreements reached on their investments in public policy.

Within the partnership the identification and analysis of issues form the basis for the subsequent development of strategic plans of action, which are partnership agreements. Action plans set goals, targets and develop strategies for implementation and monitoring. Action strategies and commitments of the different partnership groups need to be identified.

Systems of organization which are based on concepts of bureaucracy, hierarchy, professional authority, disciplinary specialization and sectoral analysis may impede intersectoral approaches and cross cutting approaches. Institutional restructuring and adjustment may involve internal reforms within government departments in order to support the partnership approach. Mechanisms need to be identified to enable inter-jurisdictional cooperation in implementing policies and plans, decentralization of structures to facilitate local involvement and involvement of sectors and better coordination with government structures

Aims

By the year 2008, all countries of the European Union should:

➢ Ensure that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote mental health;

➢ Ensure that the health sector engages in active promotion and advocacy for mental health, encouraging other sectors to join in multisectoral activities and share goals and resources;

➢ Ensure that structures and processes exist at international, country, regional and local levels to facilitate harmonized collaboration of all actors and sectors in mental health development.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ All education of health care professionals imparts the relevant knowledge, attitudes and skills for mental health promotion and mental disorder prevention, including good quality public health practice, and the essential aspects of economics and social sciences relevant to attaining mental health for all;

☞ Education programmes focused on primary health care are established in all educational institutions and universities where physicians, nurses and other health professionals are trained;

☞ The education of public health professionals prepares them to act as enablers, mediators and advocates for mental health in all sectors, and to work with a broad set of partners in society;

☞ The education of professionals in other sectors prepares them to recognize the importance and benefit of their policies and actions for population mental health;

☞ Existing partnerships for mental health and social development, such as the networks of cities, schools and workplaces, are strengthened and the potential for new

partnerships at all levels is explored;

☞ All sectors and actors in mental health identify and take into account the mutual benefits of investment in mental health;

☞ Mechanisms are in place to facilitate the joint development, implementation and evaluation of policies and strategies for promoting mental health and preventing mental disorders;

☞ Emphasis is placed at each level on building alliances and partnerships for mental health, empowering people and creating networks;

☞ Public health leadership is provided which motivates, inspires, facilitates and engages all sectors for mental health;

☞ International solidarity for health development is strengthened, using the European structures for intergovernmental cooperation and action.

5.4 Planning, implementing and evaluating Action Plans

BACKGROUND

Making a reality of promoting mental health and preventing mental disorders means creating a broad societal movement for mental health involving the whole of civil, administrative, commercial and political society.

PROPOSED STRATEGIES

Providing a clear action plan. The actions which are needed to promote mental health call for sustained and determined efforts by many partners. Unless there is a written policy document on mental health promotion and mental disorder prevention, the many partners who must be involved will not clearly understand why they should work together for mental health, or what their particular input might be. An action plan at country and, when appropriate, sub-national and local levels with clear objectives, strategies and targets, is required.

Creating awareness. Policy, actions and a commitment to mental health promotion and mental disorder prevention will not happen by themselves. Regular reports on mental health promotion at international, national, regional and local levels that are accessible to a wide public audience are essential.

Agreeing on the process. The policy development process must be transparent and ensure as broad a participation as possible by different sectors, levels, and interest groups. Unless those who are to carry out mental health promotion policies and programmes also take part in their formulation and evaluation, they will feel little commitment to putting them into practice. Agreement on a policy development process should include moves to create or strengthen mechanisms and infrastructures that facilitate cooperation among all major partners. Thus at country level, a special mental health council could bring together all the key governmental and non-governmental players and stakeholders across different sectors and levels of society.

Long-term commitment. Changes in government at national, regional and local levels can make it difficult to secure commitment to long-term policies for mental health promotion, which may not produce results until beyond the electoral cycle. However, it is easier to achieve

long-term cross-party commitment when politicians at national, regional, city and local levels are involved at an early stage. Building a strong base of consumer or public support can also help to impart the necessary continuity and sustainability to policies for mental health promotion and mental disorder prevention.

Setting targets. Targets make policy objectives more specific, allow progress towards them to be monitored and inspire many partners to actively support mental health promotion developments. Targets requires an assessment of the present situation and help to determine priorities; they can focus discussion on what it had been hoped to achieve and why, and whether or not this was successful, and why; they provide a powerful communication tool, taking policy-making out of bureaucratic confines and making it a clearly understood public issue; they give all partners a clearer understanding of the scope of the policy; they strengthen accountability for mental health; and they motivate people for action. Whichever way is chosen for formulating objectives and targets, these must be expressed in a clear and transparent manner in the written policy and strategy document. They can be legitimized by means of a broad, transparent consultation process.

Creating new alliances. The formulation and implementation of mental health promotion policy requires not only the creation of new alliances with different sectors and with the many public and private partners involved, but also a different approach to building partnerships with these bodies. In building alliances with other sectors, there must be a search for common or converging objectives.

Broadening the range of instruments for policy implementation. The action which may be taken to implement a mental health promotion policy may differ according to the level of responsibility and the existing policy environment. Certain laws or regulations can only be passed at the country level, or the regional level in federal countries. More use should be made of administrative, financial and management instruments, and of measures to affect research and training. The further use of health mental impact assessments and mental health promotion policy audits will be essential. Much more thought should also be given to mechanisms to inform, involve and promote the rich networks of influence and development within civil societies. It is here, at a decentralized level within societies that much of the commitment to and activities for mental health promotion will actually occur.

Coordinating, monitoring and evaluating progress. An effective approach to mental health development requires all sectors of society to be accountable for the mental health impact of their policies and programmes and recognition of the benefits to themselves of promoting and protecting mental health. Mental health impact assessment must therefore be applied to any social and economic policy or programme, as well as development projects, likely to have an effect on mental health.

Accountability also rests with government leaders who create policy, allocate resources and initiate legislation. Mechanisms such as mental health policy audits, litigation for health damages and public access to reports on mental health impact assessments can ensure that both the public sector and private industry are publicly accountable for the mental health effects of their policies and actions.

European countries should also aim to ensure that their foreign aid and trade policies are not detrimental to mental health in other countries, and that they contribute as much as possible to the development of disadvantaged countries. Closer cooperation between countries, and the development and implementation of international codes of conduct and regulatory mechanisms, can minimize such problems.

Accountability can be achieved through mechanisms for coordinating, monitoring and evaluating progress in policy implementation and through procedures for reporting to elected bodies, as well as through the mass media.

Aims

By the year 2008, all countries of the European Union should:

➢ Ensure that policies for mental health promotion and mental disorder prevention at country level provide motivation and an inspirational, forward-looking framework for policies and action in regions, cities, and local communities and in settings such as schools, workplaces and homes;

➢ Ensure that structures and processes are in place for mental health promotion policy development at country and other levels that bring together a broad range of key partners – public and private – with agreed mandates for policy formulation, implementation, monitoring and evaluation;

➢ Ensure that short-, medium-, and longer-term mental health promotion policy objectives, aims, indicators and priorities are formulated, as well as the strategies to achieve them, and progress towards their achievement is regularly monitored and evaluated.

Action points: strategies for implementation

Recommended actions to achieve these aims include the following:

☞ Policy Action Plans for mental health promotion and mental disorder prevention are developed and endorsed by the highest political body at each level;

☞ Public health infrastructures and functions are strengthened and modernized in line with the needs of mental health promotion and mental disorder prevention at country, regional and local levels;

☞ Mental health status and trends are regularly assessed, the health development process is monitored, and the impact of policies on mental health outcomes and mental health determinants is evaluated;

☞ Countries carry out periodic population-based mental health surveys, based on agreed European methodology;

☞ All countries have a harmonized, comparable data collection system for monitoring progress towards improved mental health, and greater efforts are made to streamline data collection and establish a more uniform selection of mental health promotion indicators, to ensure that mental health information and communication systems are internationally coordinated and harmonized;

☞ Policies and strategies for mental health promotion and mental disorder prevention are formulated through the full mobilization of partners.

Annex. Glossary of terms

Accountability – The result of the process which ensures that decision-makers at all levels actually carry out what they are obliged to do, and that they are made answerable for their actions. The process of setting explicit objectives and targets for health and defining the means of monitoring progress towards them has facilitated the attempt to achieve greater accountability through public disclosure or "transparency". *(2)*

Community action for health – Community action for health refers to collective efforts by communities which are directed towards increasing community control over the determinants of health, and thereby improving health. *(4)*

Community participation – The active involvement of people living together in some form of social organization and cohesion in the planning, operation and control of primary health care, using local, national and other resources. *(1)*

Determinants of health – The range of personal, social, economic and environmental factors which determine the health status of individuals or populations. The factors which influence health are multiple and interactive. Health promotion is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health – not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environments. These, in combination, create different living conditions which impact on health. Achieving change in these lifestyles and living conditions, which determine health status, are considered to be intermediate health outcomes. *(4)*

Disability – In the context of health experience ... any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. *(1)*

Disease prevention – Measures not only to prevent the occurrence of disease, such as immunization or disease vector control or anti-smoking activities, but also to arrest its progress and reduce its consequences once it is established. *(1)*

Environmental health – Those aspects of human health and disease that are determined by factors in the environment. It also refers to the theory and practice of assessing and controlling factors in the environment that can potentially affect health. Environmental health ... includes both the direct pathological effects of chemicals, radiation and some biological agents, and the effects (often indirect) on health and wellbeing of the broad physical, psychological, social and aesthetic environment, which includes housing, urban development, land use and transport. *(1)*

Equity – Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. The term *inequity* ... refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust. *(1)*

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Goal – A general aim towards which to strive. Within the health sector WHO has defined the goal of health for all by the year 2000, which means that "as a minimum all people in all countries should have at least such a level of health that they are capable of working productively and participating actively in the social life of the country in which they live". *(3)*

Governance – The system through which society organizes and manages the affairs of diverse sectors and partners in order to achieve its goals. *(7)*

Health – 1. A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. 2. The reduction in mortality, morbidity and disability due to detectable disease or disorder, and an increase in the perceived level of health. The first definition, that of the WHO Constitution, expresses an ideal, which should be the goal of all health development activities. It does not, however, lend itself to objective measurement, and for working purposes a narrower definition is required. The second definition is usually used for this purpose (e.g. in health statistics). *(2)*

Health competence – Individual competence to influence factors determining health. *(1)*

Health development – The process of continuous, progressive improvement of the health status of a population. *(3)*

Health education – Consciously constructed opportunities for learning which are designed to facilitate changes in behaviour. *(1)*

Health gain – An increase in the measured health of an individual or population, including length and quality of life. *(3)*

Health impact assessment – An estimation of the total, direct and indirect, effects of a policy, programme, service or institution on health status and overall health and socioeconomic development. *(6)*

Health policy – A set of decisions or commitments to pursue courses of action aimed at achieving defined goals and targets for improving health. *(3)*

Health potential – The fullest degree of health that an individual can achieve. Health potential is determined by caring for oneself and others, by being able to make decisions and take control over one's life, and by ensuring that the society in which one lives creates conditions that allow the attainment of health by all its members. *(1)*

Health promotion – The process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. An evolving concept that encompasses fostering lifestyles and other social, economic, environmental and personal factors conducive to health. *(1)*

Health-promoting hospital – A health-promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health-promoting organizational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health-promoting physical environment and actively cooperates with its community. *(4)*

Health-promoting school – A school which aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment. It constantly strengthens its capacity as a healthy setting for living, learning and working. *(2,4)*

Health sector – The health sector consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health-related nongovernmental organizations and community groups, and professional associations. *(4)*

Health service – Any service which can contribute to improved health or the diagnosis, treatment and rehabilitation of sick people and not necessarily limited to medical or health care services. Also, a formally organized system of established institutions and organizations, the multi-purpose objective of which is to cope with the various health needs and demands of the population. *(3,2)*

Health status – A general term for the state of health of an individual, group or population measured against defined standards. The WHO health indicators provide internationally accepted standards for various aspects of health status. *(3)*

Healthy company – The principles of a healthy company include: a safe working environment; healthy working practices; programmes to promote health and to address psychosocial risk factors at the workplace; health impact assessment for marketed products; and contribution to health and social development in the community.

Health system – A formal structure for a defined population, whose finance, management, scope and content is defined in law and regulations, which provides for services to be delivered to people contributing to their health and health care, delivered in defined settings such as in homes, educational institutions, workplaces, public places, communities, hospitals and clinics and which may affect the physical and psychosocial environment. *(3)*

Healthy city – A city that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their full potential. The Healthy Cities project is a long-term development project that seeks to put health on the agenda of decision-makers in the cities of Europe and to build a strong lobby for public health at the local level. The Healthy Cities network is a network of European cities that experiment with new ways of promoting health and improving the environment. *(2)*

Healthy public policy – An explicit concern for health and equity in all areas of policy and an accountability for health impact. The main aim ... is to create a supportive environment to enable people to lead healthy lives. *(1)*

Impairment – In the context of health experience, any loss or abnormality of psychological, physiological, or anatomical structure or function. *(1)*

Indicators – Variables that help to measure [changes in the health situation] directly or indirectly and to assess the extent to which the objectives and targets of a programme are being attained. For the regional HFA targets, both quantitative and qualitative indicators are used. *(1)*

Intergovernmental organization – An organization which is established by intergovernmental agreement. Examples: WHO, Council of Europe, OECD, other specialized agencies of the United Nations system. *(2)*

Intersectoral action – Action in which the health sector and other relevant sectors collaborate for the achievement of a common goal, the contributions of the different sectors being closely coordinated. *(1)*

Investment for health – Investment for health refers to resources which are explicitly dedicated to the production of health and health gain. They may be invested by public and private agencies, as well as by people as individuals and groups. Investment for health strategies are based on knowledge about the determinants of health and seek to gain political commitment to healthy public policies. *(4)*

Life skills – Those personal, social, cognitive and physical skills which enable people to control and direct their lives and to develop the capacity to live with and produce change in their environment. *(2)*

Mental disorders - refer to a clinically recognizable set of behavioural or psychological problems, accompanied by distress or disability (that is, impairment in one or more important areas of functioning) or with a significantly increased risk of suffering dearth, pain, disability or loss of freedom. Neither deviant behaviour in itself, not a conflict that is primarily between the individual and society, is a mental disorder unless the behaviour or conflict is a symptom of dysfunction (WPRO Office).

Mental health - Is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental ill health: Mental ill health includes mental health problems, symptoms and disorders. Mental ill health is not only restricted to diagnosable disorders according to current classification systems but also includes mental health strain and symptoms related to temporary or persistent distress.

Mental health promotion: The term "mental health promotion" refers to actions intended to contribute to positive mental health, including the building of individuals' and communities' strengths, competencies and resources, and quality of life.

Mental disorder prevention: The term "prevention of mental disorders" refers to actions intended to contribute to reduction of the incidence, prevalence or seriousness of mental health problems and disorders, and/or related disability, mortality, morbidity and risk behaviour outcomes.

Multisectoral action – For practical purposes it is synonymous with intersectoral action, but emphasizing the contribution and accountability of a number of sectors. *(1)*

Nongovernmental organization – A national or internationally based organizational entity such as a citizens' group, an association, a church group or a foundation, that provides an independent and flexible counterbalance to government and the for-profit business sector. *(2)*

Outcome – In the field of health, the result or impact of policy measures or health interventions in terms of a change in health status or health behaviour. *(2)*

"Polluter pays" principle – The principle incorporated in laws of some countries that those producers who are responsible for pollution should pay the costs of compensation for damage and the cost of "cleaning up" the pollution afterwards. *(3)*

Primary care – The first level of care, generally provided in an ambulatory setting (as opposed to secondary and tertiary care which would normally be hospital-based). *(1)*

Primary health care – Primary health care is the central function and main focus of a country's health system, the principal vehicle for the delivery of health care, the most peripheral level in a health system stretching from the periphery to the centre, and an integral part of the social and economic development of a country. *(1)*

Public health – The science and art of preventing disease, prolonging life and promoting mental and physical health and efficiency through organized community efforts. Public health may be considered as the structures and processes by which the health of populations is understood, safeguarded and promoted through the organized efforts of society. *(2,10)*

Public health management –The structures and processes by which the changes necessary for health improvement throughout society are defined and effectively implemented. *(10)*

Quality of care – The extent to which the care provided, within a given economic framework, achieves the most favourable outcome when balancing risks and benefits. *(1)*

Quality of life – The perception of individuals or groups that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfilment. *(1)*

Regions for Health network – A network of regions in Europe set up by the WHO Regional Office for Europe to achieve change in the thinking about, and action for, the protection, maintenance and promotion of health in regions. It aims to support the commitment of national governments to HFA through the development of appropriate health policies at the regional level. *(2)*

Reorienting health services – Health services reorientation is characterized by a more explicit concern for the achievement of population health outcomes in the ways in which the health system is organized and funded. This must lead to a change of attitude and organization of health services, which focuses on the needs of the individual as a whole person, balanced against the needs of population groups. *(4)*

Risk factor – Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury. *(4)*

Secondary care – Referral services in the first instance provide secondary health care, which is of a more specialized kind than can be offered at the most peripheral level, for example radiographic diagnosis, general surgery, care of women with complications of pregnancy or childbirth, and diagnosis and treatment of uncommon or severe diseases. This kind of care is provided by trained staff in such institutions as district or provincial hospitals. *(1)*

Settings for health – The place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing. *(4)*

Social capital – Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms and social trust, and facilitate coordination and cooperation for mutual benefit. *(4)*

Social marginalization – The process by which certain vulnerable groups may be prevented from participating fully in social, political and economic life in a community. This occurs when the necessary intersectoral policies and support mechanisms are not in place to enable their full participation. *(1)*

Strategy – A long-term considered and comprehensive course of action that provides the framework for individual activities and events. *(1)*

Supportive environments – Supportive environments for health offer people protection from threats to health, and enable people to expand their capabilities and develop self reliance in health. In a health context ... both the physical and the social aspects of our surroundings. It encompasses where people live, their local community, their home, where they work and play. It also embraces the framework which determines access to resources for living, and opportunities for empowerment. Thus action to create supportive environments has many dimensions: physical, social, spiritual, economic and political. Each of these dimensions is inextricably linked to the others in a dynamic interaction. *(4,1)*

Sustainable development – Development that meets the needs of the present without compromising the ability of future generations to meet their own needs. *(11)*

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