Implementing Mental Health Promotion Action

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

I. Final Report to the European Commission
DG SANCO/G
October 25th, 2005

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Grant Agreement:
no SPC.2002474

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In addition, find enclosed in the documents provided:

1. Mental Health Promotion and Mental Disorder Prevention: A policy for Europe
2. Mental Health Promotion and Mental Disorder Prevention: A policy for Europe (polish translation)
Presentation of the final report

The current final report is sent to the commission according to the conditions described in the article 5.2 of the grant agreement nº SPC.2002474 signed between the European Commission and Academic Centre of Social Sciences, University of Nijmegen, the Netherlands.

The report has been organized in two parts:

- Part one, the final report itself, which describes the background and aims of the project, the organization and project tasks, the project outcomes and the conclusions.

- Part two includes annexed documents that present detailed information about the work that has been developed in the framework of the IMHPA Project (Implementing Mental Health Promotion Action). Annex one presents the list of project partners. Annex two describes the meetings that have taken place over the project’s period. Annex three describes the products of the database strand and annex four products of the infrastructures monitoring strand. Finally, annex five presents dissemination and implementation issues.

- In addition, enclosed to the final report and the annex products are included of the training manual strand and the policy strand.
Integrating mental health promotion interventions into countries’ policies, practice and mental health care system (the IMHPA Project)

Grant Agreement
nº SPC.2002474

I. FINAL REPORT

Final Report to the European Commission
DG SANCO/G

October 25th, 2005
1. INTRODUCTION AND BACKGROUND

Strong evidence has demonstrated that mental health promotion and mental disorder prevention work across the lifespan providing cost-effective outcomes. Although in EU Member States mental health promotion practices and policies exist, European Commission (EC) funded projects such as the Mental Health Europe (MHE) directories on children and adolescents demonstrate that most programs implemented across Member States are not considered to have sufficient evidence base to be good practice. Countries are in need of information on effective practices and guidelines for effective policy and program development and implementation. Moreover, in general, there is no integration of mental health promotion within the health care system. The challenge we face is to help countries to address mental health promotion and prevention with comprehensive country based strategies that facilitate and make implementation feasible at the policy, practice and primary health care levels and bring promotion-prevention and care in balance.

2. AIMS AND OBJECTIVES

The Imhpa project, Implementing Mental Health Promotion Action, aims to develop and disseminate evidence-based mental health promotion (MHP) and mental disorder prevention (MDP) interventions and to integrate them into practice, policy and health care professionals’ daily clinical work. The Imhpa project created four development strands to achieve these aims. The first strand aimed to develop and integrate MHP and MDP in the practice field and for this purpose a taskforce had been created to develop an Internet Database. The second strand aimed to develop MHP and MDP in the primary health care field and for this purpose a taskforce had been created to develop a training manual for primary health care professionals. The third strand aimed to develop policy guidelines at the European and national levels for MHP and MDP and for this purpose a policy taskforce had been created. The fourth strand aimed to provide an overview of the MHP and MDP situation of available infrastructures, policies and programmes and for this purpose all partners have been involved in the development of country coalitions and dissemination action. To achieve these major aims and objectives of Imhpa, each taskforce created sub-aims and project outcomes which are briefly described below. All project partners were also involved in the other taskforce work and provided input to the development of all the IMHPA products presented in this document.

1) A STANDARDIZED INTERNET DATABASE

The Imhpa standardized Internet database strand aimed to collect and disseminate evidence-based MHP and MDP interventions throughout different countries for different problem areas (e.g., depression), target groups (e.g., children) and settings (e.g. community, school), presented through summarized programme descriptions, including evaluation outcomes and implementation essentials.

This internet database system aimed:

a) To gather and outline the evidence based prevention and promotion programmes and policies in mental health with detailed program descriptions, effects and cost-effectiveness, being sensitive to countries with different situations;

b) To provide a set of implementation guidelines for adoption and adaptation and recommendations for policy makers and practitioners to develop and implement effective strategies for mental health promotion and mental disorder prevention in specific country situations;

c) To provide background information on what are programme elements that predict interventions effect in the field of mental health promotion and mental disorder prevention; to outline the available evidence on such effect predictors from
quantitative and qualitative evaluation studies and to provide recommendations to improve existing interventions that are already implemented in practice.

(2) A TRAINING MANUAL FOR PRIMARY HEALTH CARE PROFESSIONALS

The Impha primary health care strand aimed to develop a training manual for primary health care to increase primary health care professionals’ awareness and skills to promote mental health and prevent emotional problems including depression, anxiety and stress related problems. This strand proposed to increase the profile of mental health in primary health care by developing a training manual package to:

- Raise the awareness of primary health care professionals of the reach and burden of mental ill health;
- Raise the awareness of primary health care professionals of the relation between physical ill health and mental ill health;
- Provide primary health care professionals with a set of skills, tools and strategies based on problem solving skills for mental health promotion and mental disorder prevention to use with patients suffering from emotional symptoms and those who are at risk.

(3) GUIDELINES FOR MENTAL HEALTH PROMOTION AND MENTAL DISORDER PREVENTION

The Impha policy strand aimed to develop guidelines for prevention and promotion in mental health through the development of a policy for mental health promotion and mental disorder prevention for Europe. The purpose is to provide a policy framework with recommendations for evidence based action on MHP and MDP so that country based action plans for prevention and promotion in mental health can be developed. The policy provides specific mental health policies for promotion and prevention in mental health and describes public policies that can also have an impact on mental health. The policy guideline is structured into:

1. A 46 page summarized proposal for policy makers and implementers of the key policy actions that should be taken throughout European Member States if an effective policy for mental health promotion and mental disorder prevention is to be achieved.

This document has been based on reviewing existing publications and the scientific literature on mental health promotion and mental disorder prevention. A background technical document providing the evidence base was developed prior to the production of the 46 page summary, outlining: 1) the case for action, 2) what works, 3) targets, and 4) the action points with strategies for implementation for each aspect of the policy for mental health promotion and the prevention of mental disorders (technical document presented in annex 6).

(4) COUNTRY BASED COALITIONS FOR INFRASTRUCTURE MONITORING

The Impha infrastructure monitoring strand aimed to provide an overview of the situation of the available infrastructures, policies and programmes for mental health promotion and mental disorder prevention at the country or regional level across European Member States. Country groups or coalitions were formed for this purposed, composed of with national experts from different professional backgrounds and positions in the field of public and mental health. A first collection of data on infrastructures available was gathered through a standardised questionnaire by the country partners in collaboration with the country coalition or country group.
3. THE IMHPA NETWORK

The IMHPA project partners and observers included representatives of 14 European Union countries, 5 countries in accession (at the time) and Norway, representatives of 4 European Networks and the World Health Organization (WHO). In addition, Imhpa was approached by several other institutions in order to explore the options to be involved in the project to a certain extent. New partnerships and expansion of the Imhpa group were created in consultation with the European Commission.

The Imhpa group consisted of different sub-groups: project leaders, partners, networks and experts. Each of these groups with its project participants had different roles, tasks and responsibilities to be carried out.

3.1. COMPOSITION

**Project leaders, coordinators and assistants**

The project leaders and coordinators were based at the Prevention Research Centre on Mental Health Promotion and Mental Disorder Prevention, Academic Centre for Social Sciences, of the University of Nijmegen. Secretarial support, management and administrative tasks were coordinated and performed by researchers and assistants at the Prevention Research Centre in Nijmegen (see annex 1).

**Partners and observers**

Since its start in April 2003 Imhpa included 14 partners from European Member States with 14 country representatives that act as partners and country based team leaders. The following countries were included: Austria, Belgium, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom (England). In addition, Prof. Dr. M. Mittelmark acted as the country observer for Norway and its country based team leader.

Furthermore, four previous countries in accession (at the time) and its 5 country representatives acted as observers within the project and as country based team leaders, including Estonia, Slovenia, Poland and Lithuania. An expert from Croatia, was represented in the network giving expert advice but at the same time sharing the country situation.

Annex 1 provides an overview of all country partners and observers, their affiliations and address details.

**Networks**

Four European networks related to mental health with its four network representatives acted as partners of Imhpa. These four networks included Mental Health Europe (MHE), International Union for Health Promotion and Education (IUHPE), European Network for Workplace Health Promotion (ENWHP) and the WHO Network of Health Promoting Hospitals (ENHPH). In addition, the World Health Organization (WHO, European Office) was a partner in the project and the regional adviser for mental health its representative (see annex 1).

**Consultants**

In addition, the project had five official consultants who provided guidelines and developed content work for the project products (see annex 1). Three consultant have been involved in the development of the training manual of which two were also involved in the pilot testing of the manual. The third consultant has also been actively involved in the development of the policy document for mental health promotion and mental disorder prevention for Europe. Finally, the fourth consultant had supported the completion of the programme descriptions of the Internet database.
**Developed partnerships and synergies**

The Imhpa project received a lot of interest both at the country and the European level. A synergy had been created with HP Source, a database to monitor infrastructures for health promotion in Europe. Imhpa became the first module partner to develop the European Mental Health Promotion Database.

### 3.2. THE FRAMEWORK AND PARTNER'S RESPONSIBILITIES

#### 3.2.1. Framework of the project

The following framework illustrates the structure of the IMHPA organization:

![Diagram of IMHPA organization structure]

#### 3.2.2. Participants' responsibilities

*Project leaders, coordinators and assistants in the Management Team*

1. Project Coordination (correspondence with participants, information and dissemination of products and materials, etc.)
2. Project Management (financial and technical aspects, etc.)
3. Organization of the Meetings
4. Development of products and materials
5. Preparation of reports
6. Participation in taskforces
7. Overview and participation in all product development and creation of synergies*
Partners, observers, networks and consultants in Database Taskforce

1. Give comments and feedback to the development and materials required for the Internet database
2. Meeting attendance
3. Preparation of inclusion criteria for programme descriptions on the internet database
4. Gathering information and preparation of programme descriptions for the database
5. Involvement in project products’ dissemination at the country level

Partners, observers, networks and consultants in Training Manual Taskforce

1. Give comments and feedback in the development of the training manual components
2. Meeting attendance
3. Preparation of background materials for the training manual components
4. Pilot testing of training manual
5. Involvement in project products’ dissemination at the country level

Partners, observers, networks and consultants in Policy Taskforce

1. Give comments and feedback in the development of the policy action plan
2. Meeting attendance
3. Preparation of background materials for the Policy Action Plan
4. Preparation of background materials for the Country Profiles Questionnaires
7. Involvement in project products’ dissemination at the country level

Every taskforce had a chair that was responsible for the development of the work in the taskforce during the development of the project products. In addition, every taskforce had a rapporteur that was responsible during the meetings to provide a short description and minutes of the work of the taskforce breakout groups and provide feedback on the decisions of the taskforce to the rest of the project participants.

The participants in the taskforces had different roles in addition to being members of a given taskforce. In every taskforce members were asked to take the role of thinking about possible challenges or problems that the taskforce can face during the development of its products. Other members were responsible to think about special needs and possible adoption – adaptation of the project products to those countries with different situations (e.g. countries in accession to the European Union). A third group of people in each taskforce had the role to take into account the dissemination – implementation phase of the project products and their sustainability. Partners were all responsible for each of the above roles and responsibilities. In addition all partners contributed to providing programme descriptions for the database and all were involved in a first assessment of the infrastructural situation of prevention and promotion in their countries. In most instances country experts were involved in providing information for the country infrastructure assessment. The contribution to the project product developments of the countries who were involved as observers was voluntary and it was agreed from the set out that the time dedicated to product development is a contribution to Imhpa at their own cost.

In addition, experts and networks had some extra responsibilities which are described below.

Networks

1. Use their network as a dissemination platform for the project products
2. Use the network as a stimulus for implementation of the project products
Consultants

1. Development of project products (given products have been commissioned to experts)
2. Provide expert advice to the products developments and their outputs
3. (If applicable) Provide training in the developed products in the form of pilot testing
4. Meeting attendance

Infrastructure Monitoring (all partners)

1. Give comments and feedback in the development of the country questionnaires
2. Formation of country based groups
3. Completion of the standardised country questionnaire on MHP and MDP infrastructure, policies and practices
4. Involvement in project products’ dissemination at the country level
4. WAY OF WORKING AND PROCESS

4.1 GENERAL TIME SCHEDULE

To achieve the project aims the following activities were planned globally over the more than two year project period.

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At the end of the first year of the project the time plan continued as expected and first drafts of all products had been developed as expected. In addition, a first revision of some products had already take place (for example the policy book).

At the end of the second year a prolongation of four months of the project was granted by the EC in order to complete the extra tasks the network took on board and that were not originally planned for. Since the beginning of the project, interest at the country and European levels for Imhpa products led to developing an even larger amount of deliverables than those originally stated in the grant agreement. Imhpa has been engaged developing synergies with other EC co-financed projects, which has lead to gathering much more information than was originally expected, which has been made available by the partners and new synergies. For example, after the success of the first pilot of the training manual for primary health care professionals (in the Netherlands), a second pilot was undertaken in a New Member State (Slovenia). In addition, the launch of the policy document during the WHO Ministerial conference in Helsinki increased the visibility and the demand of the Network to be represented in different country based and European events. Furthermore, two Internet databases on mental health promotion and mental disorder prevention were developed (instead of the one accounted for), and the effective dissemination strategy of the Network led to collect increased ammount of information (than previously expected) which demanded extra time to input the information collected into the databases.

Because of this unexpected expansion of the tasks an amendment to the contract agreement was approved formally by the European Commission.

In addition to the expansion of tasks one planned activity, namely visits to countries, was not undertaken and instead a third general partner meeting was organized using existing resources for the country visits, after consulting and agreeing with the EC.
4.2 TASKFORCES, ACTIVITIES AND TIMELINES

Partners, networks and consultants were divided over the three taskforces and all took part in the country based Infrastructure Monitoring tasks. Each of the taskforces had different aims and objectives and their members had different roles and responsibilities. The members of the taskforces and the strand agreed activities and timelines as described below.

DATABASE TASKFORCE

PARTICIPANTS OF THE DATABASE TASKFORCE

1. Kristian Wahlbeck   Chair task force
2. Clemens Hosman   Rapporteur task force
3. Karl Kuhn   Foreseen challenges-problems
4. Milou Leunissen   Foreseen challenges-problems
5. Pierre Arwidson/Beatrice Lamboy   Foreseen challenges-problems
6. Margaret Barry   Dissemination-implementation phase
7. Stephan van den Broucke/ Tom Vermeulen   Dissemination-implementation phase
7. Valentina Kranzelic   Adoption in countries with special needs
8. Martina Feric   Adoption in countries with special needs
9. Elizabeth Gale/Mary Tidyman   Foreseen challenges-problems
10. Emma Hogg   Dissemination-implementation phase
11. Eva Jané Llopis   Project leader

Timeline

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<td>Data coding</td>
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<td>Entry of preliminary data and testing of software</td>
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<td>Launch database</td>
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<td>Development of data entry and testing</td>
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<td>Editing of all programme descriptions</td>
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<td>Preparation of new areas to include</td>
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Phase 1: Development of the Internet database

1. First draft of content and structure database (August 2003)

In addition, Dr. Shekhar Saxena was invited as a content specialist to the Barcelona meeting.
a. Preparation of background paper to present to taskforce

2. Meeting with taskforce (September 2003)
   a. Presentation of goals of task force
   b. Discussion on the structure and software of database
   c. Discussion on the inclusion criteria and descriptives of programmes
   d. Final decisions on critical issues
   e. Task division and time line
   f. Accessibility plan

3. Development of database
   a. Development of structure database
   b. Cooperation IT company
   c. Developing coding system
   d. Development programme description template
   e. Email-telephone contact with partners and inclusion of their prepared products

4. Revision of the database descriptions based on feedback
   a. Contact with partners
   b. Exposure of the descriptions for feedback
   c. Development of second draft

5. Imhpa meeting taskforce (May 2004)
   a. Exposure of internet database for feedback
   b. Discussion of database and descriptions
   c. Presentation of the database to all Imhpa partners
   d. Agreements on final decisions

6. Revision of database after Imhpa meeting

Phase 2: Development of searches and programme descriptions

1. Systematic literature searches
2. Development of programme descriptions
3. Coding and preliminary data entry
4. First testing pilot of the software and improvements
5. Launch database

Phase 3: Evaluation and report on future steps

1. Development of programme descriptions
2. Development of data entry and second round of software testing
3. Refinement of the system
4. Entering all programme descriptions
5. Editing of all programme descriptions
6. Preparation of future steps, options for continuation and expansion and new areas to include
TRAINING MANUAL TASKFORCE

PARTICIPANTS OF THE TRAINING MANUAL TASKFORCE²

1. Evelyn van Weel-Baumgarten  Chair of the task force
2. Jurgen Pelikan   Rapporteur
3. Hartmut Berger   Foreseen challenges-problems
4. Michele Tansella/Marco Stegagno Foreseen challenges-problems
5. Josipa Basic    Foreseen challenges-problems
6. Mirella Ruggeri Dissemination – implementation phase
7. Ines Garcia Sánchez Dissemination – implementation phase
8. Andrej Marusic Adoption in countries with special needs
9. Airi Varnik Adoption in countries with special needs
10. Laurence Mynors-Wallis Invited expert to help develop the manual
11. Eva Jané Llopis  Project leader

Time line

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<th>Phase 3</th>
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Phase 1: Development of the training manual

1. First draft of content and structure training modules (August 2003)
   a. Preparation of background paper to present to task force

2. Meeting with task force (September 2003)
   a. Presentation of other options
   b. Discussion of presented proposal (pros and cons)
   c. Final decisions on critical issues (presented to the group)
   d. Task division and time line
   e. Piloting options
   f. Consider adoption and adaptation to different situations across European Member States
   g. Dissemination plan

3. Development of training manual modules
   a. Development of Imhpa training manual modules
   b. Feedback with a national group
   c. Email-telephone contact with partners and inclusion of their prepared products

4. Imhpa meeting with consultant group (December 2003)
   a. Exposure of the training manual first draft for feedback

5. Revision of the manual modules based on feedback
   a. Contact with partners

² In addition, Prof. Dr. John Tsiantis was invited as a content specialist to the Barcelona meeting.
b. Development of second draft

6. Imhpa meeting with consultant group (March 2004)
   a. Exposure of the training manual second draft for feedback
   b. Search for contacts for second phase piloting

7. Test course (small group colleagues: feasibility, comprehensibility, etc.)

8. Imhpa meeting task force (May 2004)
   a. Discussion of training manual modules after the comprehensibility pilot-test
   b. Presentation of the training manual to all Imhpa partners
   c. Agreement on final changes

Phase 2: Training pilot 1-2 countries

1. Feedback from a group of expert general practitioners (June 2004)

2. Revision of manual modules after Imhpa meeting and general practitioners meeting

3. Creation of a piloting group

4. Approach to a group of general practitioners in 1-2 countries


Phase 3: Pilot evaluation and report on future steps

1. Development of the evaluation questionnaire

2. Distribution of the evaluation forms during follow-up

3. Assessment of satisfaction with training manual and possible outcome evaluation (e.g., number of patients identified to be at risk; number of patients given the intervention; etc.)

4. Report on pilot training evaluations and outcomes

5. Exploration on future steps and options for adoption/implementation in other Member States (i.e., further development and rigorous RCT testing)

POLICY TASKFORCE

**PARTICIPANTS OF THE POLICY TASKFORCE**

1. Peter Anderson Chair task force
2. John Kenneth Davies Rapporteur
3. Athanassios Constantopoulos Foreseen challenges-problems
4. Yolanda Wagner Foreseen challenges-problems
5. John Henderson Dissemination-implementation phase
6. Maria Heitor dos Santos Dissemination-implementation phase
7. Czeslaw Czabala Adoption in countries with special needs

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3 In addition, Prof. Dr. Helen Hermann was invited as a content specialist to the Barcelona meeting.
8. Dainius Puras  Adoption in countries with special needs
9. Lars Jacobsson  Dissemination-implementation phase
10. Maurice Mittelmark  Dissemination-implementation phase
11. Eva Jané Llopis  Project leader

Time line

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Phase 1: Development of Action Plan

1. First draft of content and structure of Action Plan (August 2003)
   a. Decision on content
   b. Finalisation of background paper on the taskforce to present to taskforce

2. Meeting with task force (September 2003)
   a. Presentation of goals of task force
   b. Discussion of presented draft of the table of contents
   c. Discussion on the country profiles questionnaires
   d. Final decisions on critical issues
   e. Task division and time line
   f. Adoption and adaptation to different situations across European countries
   g. Dissemination plan

   a. Development of different sections of the background technical document for the Imhpa Action Plan
   b. Development of feedback for the second version of Country Profiles
   c. Feedback within task force
   d. E-mail/telephone contact with partners and inclusion of their prepared products

4. Imhpa meeting with task force members (January 2004)
   a. Exposure of the draft of the technical background document on the Action Plan and the Country Profiles second version

5. Revision of the background technical document of the Action Plan based on feedback (January – April 2004)
   a. Contact with partners
   b. Development or continuation of second draft

6. Imhpa meeting task force (May 2004)
   a. Discussion of Action Plan, Country Profiles and summary policy report
   b. Presentation of the three products to all Imhpa partners for endorsement (sent in advance)
c. Agreement on final changes

Phase 2: Finalization of Action Plan and dissemination plan

1. Development of the Mental Health Promotion and Mental Disorder Prevention: A policy for Europe
2. Development of the first draft of the Country Profiles Report
3. Official launch of the Mental Health Promotion and Mental Disorder Prevention: A policy for Europe at the Helsinki WHO Ministerial Conference on Mental Health

Phase 3: Dissemination and evaluation of country profiles for future steps

1. Report on launch of Action Plan and dissemination strategy
2. Dissemination at country level through country partners
3. Translation of action plan into Polish
4. Country based meetings where applicable

INFRASTRUCTURES MONITORING

All partners, observers and consultants were included in gathering infrastructure monitoring information, although questionnaire development and country profiles development was also described under the policy strand. All partners commented to the first version of the questionnaire and completed the questionnaire gathering information on infrastructures and policies at the country level. A first report of the country profiles was developed and discussed at the Second Partner meeting (May 2004). Comments on the questionnaire and country profiles were taken on board and a second version of the questionnaire was developed and commented up on. This lead to the partnership with the EC co-financed project HP-Source. All this background information and development of country profiles in the 14 partner countries of the Imhpa project provided a first stage and some crucial background information for the development of the publication: “Mental Health Promotion and Mental Disorder Prevention Across European Member States: A collection of Country Stories”, which is currently being developed by the EC co-financed project: “European Platform for Mental Health Promotion and Mental Disorder Prevention”.

4.3 PROJECT MEETINGS

All project collaborators and partners were invited to attend several general and taskforce-related meetings. Subsistence and travel costs were covered by the project according to the conditions specified by the European Commission. During the two years, seven meetings were organized. The first meeting was a general meeting which invited all project partners, observers, network representatives and consultants. The second meeting was held to develop the training manual with a reduced training manual group which included the chair, two consultants and the project leader. A third meeting was held with the policy taskforce to provide feedback on the first draft of the policy action plan. The fourth meeting was held with a reduced training manual group to...
provide feedback and revise the first version of the training manual. The fifth meeting was a general meeting including all project partners, observers, network representatives and consultants, and discussions were held to evaluate the progress during the first year and to discuss the planning for continuation of product developments into the second year. The sixth meeting was held with a reduced training manual group to consult an international group of general practitioners on the technical content of the training manual. The seventh meeting was the last general meeting, which also included representatives of new Member States as potential experts to be involved in the continuation phase, and the meeting served for evaluating the developed products and assess the possibilities and need for new products to develop in the future.

The specific goals of each of these meetings are described below. More detailed information on each of these meetings including the agendas, list of participants and minutes are provided in annex 2.

The first meeting took place on 4th and 5th of September 2003 in Barcelona (Spain) with attendance of 32 participants and had the following objectives (see Annex 2.1):

- To set up three task forces, one for each strand of the project: the database, the training manual and the policy action plan;
- To agree within task forces on the development of the task forces’ products;
- To reach a general agreement on the set up and dimensions of the database;
- To identify possible problems or challenges that we might face in the development of the project products;
- To identify the possible needs for adoption-adaptation of some project products for specific country situations;
- To start the discussion on the dissemination-implementation phase of the project once the project products have been developed, and determine the first steps towards the development of country-based strategies.

The second meeting was held on 4th of December 2003 in Nijmegen (the Netherlands) with attendance of 4 participants of the training manual taskforce and had the following objectives (see Annex 2.2):

- To comment on and discuss the first draft of the training manual for health care professionals, problem solving component
- To discuss and agree on the way forward for the communication skills component and the background materials
- To discuss and agree on an anxiety prevention component
- To discuss about the meeting with an expert group of GPs during the Wonca Conference

The third meeting was held on 14th and 15th of January 2004 in Nijmegen (the Netherlands) with attendance of 11 participants of the policy taskforce and had the following objectives (see Annex 2.3):

- To discuss the country profiles questionnaires and agree on a second version of the country profiles questionnaire
- To agree with this taskforce on the direction of further development and expansion of the country profiles questionnaire
- To discuss the first draft of the background document for the European policy
- To brainstorm on dissemination and implementation strategies for the project products both at the European and national levels
The fourth meeting was held on 29th of March 2004 in Amsterdam (the Netherlands) with attendance of 4 participants of the training manual taskforce and had the following objectives (see Annex 2.4):

- To revise and give comments on the training manual for brief problem solving and anxiety management
- To discuss next steps and ideas on a new proposal of an efficacy trial
- To discuss meeting with the expert group during Wonca

The fifth meeting was held on 10th, 11th and 12th of May 2004 in The Hague (the Netherlands) with attendance of 31 participants and had the following objectives (see Annex 2.5):

- To discuss the results of the first country profiles questionnaires and the country descriptions
- To discuss creation of country coalitions
- To discuss the second draft of the background document for the European policy book
- To discuss further dissemination-implementation plans for the project products both at the European and national levels

The sixth meeting was held on 1st of June 2004 in Amsterdam (the Netherlands) with attendance of 3 participants of the training manual taskforce and 4 European general practitioners and had the following objectives (see Annex 2.6):

- To consult general practitioners on the technical content and applicability of the training manual in daily practice
- To brainstorm about further testing of the training manual throughout Europe

The seventh meeting was held on 14th and 15th of March 2005 in Brussels (Belgium) with attendance of 42 participants and had the following objectives (see Annex 2.7):

- To provide an overview of the developments of Imhpa and its interface with the European Platform for Mental Health Promotion and Mental Disorder Prevention
- To discuss the creation of country profiles through completing the infrastructures questionnaire
- To give feedback on the questionnaire working towards a revised version
- To brainstorm on and discuss the European Conference on Mental Health Promotion and Prevention of Mental Disorders (Barcelona 2006)
- To brainstorm and agree on the goals and tasks of the European Platform (identifying how to support country based development and bridge challenges across countries)
- To present a preliminary basis for evaluating evidence of prevention and promotion programmes to be included in the database
- To brainstorm and discuss the dissemination reports
- To identify the possible needs for adoption-adaptation to some specific country situations
5. PRODUCTS

Over more than two years Imhpa has been very active developing four different strands of work, which has resulted in a series of products described below. The expected developments and planned tasks have been developed according to schedule. However, since interest for Imhpa products at the country and European levels had led to a larger amount of deliverables than originally expected and accounted for an amendment of four months to the contract agreement was approved formally by the European Commission.

Project meetings were undertaken according to a scheduled plan and all project partners agreed to a common set of project goals and products to be developed. Synergies were created with other existing and ongoing EC co-financed projects. During the first year drafts of planned products were developed according to schedule. During the second year drafts of planned products were revised, pilot tested, finalised and launched according to the extended time schedule. The developed products are described below.

5.1 A STANDARDIZED INTERNET DATABASE

5.1.A INTRODUCTION TO THE DATABASE (background paper)

Introduction

The World Health Report (WHO, 2001) has raised the awareness that mental and behavioural disorders are not exclusive to any special group, and are found in people of all regions, all countries and all societies. One in four persons will develop one or more mental or behavioural disorders during their lives (WHO, 2001). In addition, projections estimate that, mental ill health is increasing and by the year 2020, neuropsychiatric conditions will account for 15% of disability worldwide (Murray & Lopez, 1996).

In addition to treatment practices to alleviate mental health problems once they have emerged, there is strong evidence that mental health promotion and mental disease prevention work across the lifespan providing cost-effective outcomes (Hosman & Jané-Llopis, 1999). The ongoing World Health Organization (WHO) prevention report and the WHO-Oxford University Press publication on evidence based prevention programmes and policies for mental health have reviewed that evidence and provide a state of art report of the possibilities of preventing mental illness (Hosman, Jané-Llopis, & Saxena, in press). Similarly the WHO promotion report provides further evidence of the effective mental health promotion programmes and the relationships between mental health and physical health (Herman, Moodie & Saxena, in press). A third global initiative lead by the International Union for Health Promotion and Education (IUHPE) provides the evidence and translates it into practice, underlying what strategies can be undertaken to promote mental health in countries and regions (Jané-Llopis, Barry, Hosman & Patel, in progress).

Effective prevention is applicable to different countries and regions with different cultural and economic backgrounds. However, in spite of the existing evidence, the reality is that only a small number of countries have access and implement effective programmes. A large proportion of countries lack information on which are effective programmes and the little resources applied to the prevention of mental ill health end up being allocated to programmes that do not work. For example two European directories on mental health promotion and prevention programs for children and adolescents demonstrate that about 80-85% of the programs implemented across European member states are not considered to be evidence based (Mental Health Europe, 1999; 2001).

It is crucial that the existing evidence gathered in the different global initiatives and across European Member states and countries in accession, reaches countries and regions that are in need of information on effective practices and guidelines for effective policy and program development and implementation. In addition countries with different levels of
resources will be in need for different actions and this diversity should be kept in mind when recommending countries and regions to implement mental health promotion and prevention strategies. The challenge we face is to help countries to address mental disorder prevention and set their implementation strategies on informed decisions, which are sensitive to their level of available resources and developed infrastructures. For that reason, there is a need that the evidence based programmes and policies for the promotion of mental health and the prevention of mental illness are accessible and appropriate for different country situations and tools for adoption and adaptation available and sensitive to the diverse levels of resources in countries and regions.

The development of an electronic searchable database

To make this possible one of the strands of the Imhpa project is the development of a registry system which would include descriptions of available programmes and a set of evidence based guidelines on effective mental disorder prevention programmes and policies. The registry system aims to:

1) Gather and outline the evidence based prevention and promotion programmes and policies in mental health with detailed program descriptions, effects and cost-effectiveness, being sensitive to countries with different situations;

2) Provide a set of implementation guidelines for adoption and adaptation and recommendations for policy makers and practitioners to develop and implement effective strategies for mental disease prevention in specific country situations;

3) Provide a background on effect predictors in the field of mental health promotion and mental disorder prevention; outline the available evidence on effect predictors from quantitative and qualitative studies and provide recommendations for effect management.

Relevance

It is crucial that countries and regions are provided with an accessible registry of available evidence based programs and policies for the prevention of mental ill health that is sensitive to their level of resources and developed infrastructures. This project aims to develop an information system which would provide sufficient information with summarized descriptions of the programmes, their outcomes and their effective ingredients so that they can be adopted and adapted to country based situations, according to their needs and possibilities. The evidence-based programs would be indexed by primary topic area (depression, anxiety, etc.), target group (children, adolescents) settings (school, home-based, etc), type of research quality (experimental designs, high quality), type of outcomes (effective, not effective). This user-friendly structure would aim to facilitate searches throughout the information system and stimulate decisions based on needs assessment of countries’ specific situations and their resources levels.

In addition the evidence based guidelines would provide countries and regions with a set of tools for adoption and adaptation for the implementation of effective programmes and policies for the prevention of mental ill health, which are also sensitive to high, medium and low levels of resources and infrastructures.

The current project could serve as a pilot of the registry system by translating it into a user-friendly tool (information system), comprising in the first instance a set of programmes gathered through systematic literature reviews and other non-published interventions. It is proposed that effective and non-effective programmes would be included and classified according to their levels of efficacy. The inclusion of non-effective programmes is crucial to get an exhaustive vision of the efficacy in a given area of mental health promotion and
mental disorder prevention and to understand what elements might lead to increased efficacy.

It is proposed that the tool would be disseminated across countries and regions of participating countries in the project through an Internet site. Feedback from countries and regions could be followed up after 3 and 6 months to explore if such a tool has an impact on program development and implementation and to consider improving the system according to the feedback of the users.

CHARACTERISTICS OF THE DATABASE

It is proposed that the database includes strategies, programs and policies:

- in the field of mental health,
- aimed at the promotion of mental health and primary prevention of mental and behavioural disorders, i.e. including universal, selective and indicated prevention,
- that could provide science-based evidence on their outcomes or are currently involved in such an outcome study, or
- that are implemented and sustained in countries or regions independently of whether a formal controlled outcome evaluation has been undertaken;

The building of the content in the database would be defined as a staged process with well defined intermediate actions. Groupings of programmes could be developed to make the searches and management of the database efficient. A stepwise process would be for example:

- Depression prevention in children and adolescents
- Depression prevention in adults
- Depression prevention in elder populations

The same type of descriptions could be made for other topic areas: anxiety, conduct behaviour, aggression, and settings: schools, primary health care, communities. Once the first is finished we could move on onto the second.

It is proposed that the database will provide descriptions of programmes and policies for mental health promotion or mental disorder prevention, including general abstracts and standardized information on the following descriptive dimensions:

- Programme characteristics
- Implementation characteristics
- Characteristics of programme development
- Characteristics of dissemination
- Characteristics of the infrastructures
- Target group characteristics
- Social context characteristics
- Methodological characteristics of trials: evaluation and design

In addition the database would provide guidelines for implementation, adoption, adaptation and dissemination of programs according to the experience of different countries and regions.

Specific sections on topic related issues, for example, prevention of depression, could be developed, where information could be detailed on epidemiological burden, risk and protective factors and with general syntheses on general effective strategies for each defined problem area.
The project is based on the view that the building of an evidence-base for the efficacy and effectiveness of a policy, strategy or program is a long-term affair and a step-wise process. Therefore, the Imhpa Database would be updated regularly, would be open for evidence from different scientific and empirical sources, and would offer an indication of the different available levels of evidence.

1. The audience

The database would be targeted to support: Policy makers, advocates, practitioners, program designers and researchers in governmental and non-governmental organizations across countries and regions.

2. The usability

It is proposed that the descriptions of programs and policies would be available by two different strategies, through a search engine and by topic area/setting. Firstly, programmes could be accessed by a searchable electronic engine system on the basis of key words to identify specific combinations of programme dimensions, for example:

- problem area (e.g. Depression prevention programs)
- target group (e.g. children)
- setting (e.g. schools)
- country of implementation (e.g. Spain, this would also include replications)
- language (e.g., in Spanish)
- level of evidence (e.g. only RCTs’)
- Prevention or promotion

So an example in the search would be:

prevention + depression + children + Spain

where all programmes with such descriptors would be displayed.

In the general topic area or setting, three levels of display could be provided:

- One list with all available programmes (effective, not effective, promising, etc.) which would only include contact details and whether a programme is effective or not (e.g., like an output in a literature search)
- A table with a more detailed description (a few descriptors) of the programme and target group, risk factors, level of prevention, etc.
- A two pager description on a specific programme

Secondly, different chapters could be displayed in the database identified on the basis of problem area or setting, and these would bring together programme descriptions and effective preventive strategies’ descriptions (see section 7 on prevention strategies). These chapters could be defined by:

- Problem area (i.e. disorders or risk factors)
- Setting (e.g. schools)

The chapters could include the following areas:

- Depression prevention
- Anxiety prevention
- Problem behaviour/aggression prevention
- Competence enhancement
- School interventions
- Home-based interventions
- Community interventions
- Interventions in primary and secondary care

3. Sections in the database (database lay-out)

It is proposed that the database in the future could include:

3.1 General introduction on the database and its functioning

3.2 A separate section with different sub-sections on prevention related background information, providing definitions, evidence based information on risk and protective factors, comorbidity, etc…

3.3 A separate section on the evidence debate

3.4 A separate section with the development of the database and the descriptions, including programme inclusion criteria, the coding system, etc.
   a. Tables with names and contact details of all programmes assessed (effective – non effective, high quality evaluation-lower quality evaluation, research base – practice base)
   b. Tables with some information on evidence based programmes and strategies (and the significance of their effects)
   c. 2-pagers with detailed descriptions on programmes

3.5 A separate section on implementation-adoptions-adaptation with state of the art on theory and empirical evidence on these issues, a set of recommendations for implementation and implementation assessment

3.6 A separate section on effect predictors

3.7 A separate section on preventive strategies

During the current project and as specified in the contract agreement, it is agreed that only programmes on mental health promotion and mental disorder prevention will be developed and entered into the database. However the general structure of the database and what other sections, as described below will have to be developed in the future, is discussed and agreed by all project partners. The following section proposes a more detailed description of what could be included under each heading:

3.1 General Introduction

First page; Very short and user friendly

Underlines the purpose of the database, how to use the database, table of contents, search engine, acknowledgements (e.g., PRC, EU, Ministry of Health, partners, etc)

Has a link to a longer introduction

This database and other databases: Description of this system; comparison to other existing systems (and links)

Headings in general introduction of links to go to:
   - Prevention programming
   - The evidence debate
   - Programmes’ descriptions
3.2 Prevention programming
This section could include several chapters, describe the theoretical frameworks in prevention and underline principles for prevention and prevention programmes. Could include:

- Prevention and promotion definitions and context
- Risk and protective factors (malleability, attributable risk, generic-specific RF)
- The co-morbidity issue
- Theories and theoretical underpinnings
- Programme development
- Setting definitions

All the different issues could be developed to different extents. Hyperlinks to other databases or sources of information on specific topics could be provided as well as references to key publications referent to each topic.

3.3 The evidence debate
This section could include several chapters or section on the evidence debate, for example:

- Gold standards (RCT’s)
- Quantitative vs qualitative research
- Effective vs non-effective
- Research base vs practice base
- Efficacy vs effectiveness

Sources could include: WHO prevention book, WHO promotion report, IUHPE 1st book, Campbell and Cochrane Collaborations, etc.

3.4 Programmes’ descriptions: prevention and promotion in mental health
This section would be one of the more important of the database as we would perceive it at the moment. It would include the programmes descriptions. The section could be divided in different sub-sections according to the levels of evidence. It is proposed that programmes would be included when there has been outcome evaluation performed on mental health outcomes or when a programme would be implemented in a region or country and it would be sustained in that community independently of its evaluation. Different levels of evidence would be identified and programmes classified according to such standards. This section would also include chapters on the selection process, the coding system, etc. The headings in this section could include:

A. Intro to the programmes’ registry
3.4.1. Description of database and positioning with other existing registries
3.4.2. Description of criteria for inclusion
3.4.3. Search sources and strategies (added as annexes)
3.4.4. Coding procedures and process
3.4.5. Comparison of inclusion criteria among existing databases and review processes
B. Programmes’ registry

3.4.6. Information tables with contact details on all other gathered practices

3.4.7. General descriptive tables with effective - non effective; research base vs practice base (include a list of descriptors to be determined)

3.4.8. Separated chapters/sections for effective - non effective; research and practice (include introductions on each of those sections; distinguished by colour schemes, etc.)

3.4.9. Two-pagers with detailed descriptions of programmes and their outcomes for those programmes selected as effective and evidence-based (including a series of headings for description and a section on mediators-moderators of effect, what was related to programme outcomes, etc. to as much detail as possible) (see distributed examples)

3.5 Implementation

It is proposed that this section would underline the issues related to implementation of programmes and policies through to sustainability issues. It can include different chapters/sections such as:

- Introduction about the importance of implementation and its principles
- Adoption (e.g., theories of adoption, …), Adaptation
- Innovation and reinvention
- Replication: within and across countries
- Going to scale
- Implementation guidelines
- Building capacity, and training
- Creating partnerships and involving different stakeholders
- Programme sustainability, supportive infrastructures and accountability

3.6 Effect predictors

It is proposed that this section would include the state of the art information about effect determinants in each of the programme areas reviewed. Information on effect prediction would be based on different sources, including theoretical sources, individual trial evaluation studies, review studies and meta-analyses in the field of mental health.

In addition to the knowledge available on effect predictors, updates using meta-analytical techniques would be undertaken using the data that is extracted from the programmes included in the different topic-areas in section 4. The section could be divided according to effect predictors or to topic areas depending on the type of information available.

3.7 Prevention strategies

It is proposed that this section would be divided according to the different topic areas reviewed and would synthesise the presented evidence in section 4 (including effective and non effective) to draw conclusions on whether prevention works, the size of its effects and what strategies are most appropriate and effective to tackle different mental health problems. Sections would be described according to problem areas and settings. Some programmes might overlap and be present in more than one section but this would not be a problem as long as those overlapping programmes fit in the inclusion criteria defined for each of the topic area or setting sections. Areas will include:

- Depression prevention
- Anxiety prevention
- Problem behaviour/aggression prevention
- School interventions
- Home-based interventions
- Community interventions
- Interventions in primary and secondary care

It is proposed that this section would link with the strand of the European Policy Action plan of the IMHPA project.

**Two-Pager Summaries**

It is agreed, as described in the contract agreement that prevention and promotion programmes in mental health will be identified and described according to a general structure. These programme descriptions, which originally aim to be Two-Pager Summaries will include information on:

1. **Summary:** brief description on what, why and how the programme runs (provides enough info to know what the program is about). Descriptive areas needed in the summary include:
   - aims of the programme
   - target group
   - setting
   - duration
   - universal-selective-indicated
   - effects

2. **Programme background: underpinning**
   Include the characteristics of the way in which a programme has been developed.
   - Theory driven development of the intervention
   - Accurate needs assessments of the target population
   - History of pilot evaluations and/or improvement
   - Involvement of community leaders, target groups, etc. in the development of the programme
   - Empirical basis of the intervention
   - When it started
   - Infrastructural support
   - Language
   - Program history and designers
   - Country of origin
   - History of implementation across communities and countries for each program
   - Cultural sensitivity

3. **Intervention Description**
   Include those elements that comprise the core of the intervention, defining the content of the intervention and how it is organized. Includes:

   3.1. **Target group and target population**
   Describe both the target group of the intervention and characteristics that might be responsible for changes in expected programme effects

   Description including target group to whom the program is directed (e.g., children of parents with psychiatric problems)
   Include: age, gender, socioeconomic status, etc, ...
   Description of intermediate target groups
Individual differences such as gender, age, educational level, ethnicity, and pre-intervention attitudes
Level of risk or problem severity
Motivation to change
Group characteristics, e.g., heterogeneity

3.2. Goals and Risk-protective factors
Ultimate and intermediate goals of the programme
Ultimate and intermediate risk and protective factors addressed
Their theoretical underpinning
Level of prevention (indicated, selective, universal)

3.3. Programme description
Methods and mechanisms of change and their techniques
Link between methods used, goals and risk-protective factors addressed
Setting
Duration, dosage, time of intervention, …
Programme providers (incl. type, education, etc)

4. Evaluation design
These include those characteristics of the research design and analytical procedures that are responsible for the effective evaluation of a given intervention.

Short description of type of research methodology utilised and research design
Equivalence of intervention-control groups
How the outcomes were measured
Use of non-validated measures
Participation
Levels of attrition
Sample size
Appropriate statistical tests
Research design indicators (Cochrane scale)

5. Outcomes
Bullet points on different outcomes using percentage rates
Include clearly when these are only subgroup effects
By when these were obtained
Add a couple of graphs of the results

6. Implementation characteristics
Those elements present in the implementation process that influence the effective implementation of the programme. Includes:

Training of providers
Supervision of providers
Manuals for programme provision
Programme fidelity
Level of hours of training
Feedback systems
Institutionalization
Description of any context characteristics that might have influenced the programme implementation
Barriers to implementation

7. 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.
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

8. Dissemination characteristics
Are those elements present during the process of disseminating an evidence-based preventive programme that influence the adoption of the programme in a new setting or community.
Diffusion
Adaptation
Adoption
Info on: Community relevance; relative advantage over existing practices; ability to be observed; transferability; fit to local culture; ability to be piloted; adaptability; complexity; and costs

9. Replication
Number of replications
Number of replications by the same investigators (and results)
Number of replication by different investigators (and results)
Location of replications (same country, different countries) and results
Changes to the programme (adoption-adaptation or testing different components in the replication studies and results)
Barriers to replication

10. Effect predictors
Info on what predicts effects
Relation with partial outcomes
Mediation and moderation

11. Infrastructure 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.
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

12. Contact information
Name contact person and degree
Organisation, Address, City & postal code, Country, Phone, Fax, Email, Website
Relevant publications, links and websites

13. Relevant publication
References of relevant publications

5.1.B DEVELOPED PRODUCT

The main product of the database strand is a standardized Internet database on mental health promotion and mental disorder prevention. Following the discussions within the general Imhpa meetings, the taskforce, the database leaders, and through active email contact the project group agreed that the Internet database taskforce would develop the products as described below.

1) A STANDARDIZED INTERNET DATABASE

The Internet database, accessible through http://www.imhpa.net, is an ongoing process of collection of programmes and aims to provide a systematic information system with evidence based programmes and policies on mental health promotion and mental disorder prevention. Two-pager descriptions were not necessarily two pages as the richness of the information provided would be lost in short summaries.

Development of the database

For the software development of the searchable electronic database a cooperation had been created with an IT organisation that develops customer specific applications based on a existing content management technique. The content management system is based on the open source project “Typo3” which is a first-rate and complex content management system marked by it’s scalability and flexibility.

Based on the benefits of the use such a system the following objectives were strived for during the process of database development:

- A good maintenance process for the different programmes and results
- A flexible construction with the possibilities of uncomplicated up-grading
- A suitable structure possible to modify
- Multiple language functions prepared/finished
- Possibilities for visitors to save results in PDF format of print outcomes
- Getting insight on activities of connected members
- An attractive design which is representative
- Getting clear management information on visitors of the site
- Possibilities of up-grading to create more interactivity
- Flexible structure possible to expand in the future
Set up of the database

The database was built up as a user-friendly structure that aims to facilitate searches throughout the information system and stimulates decisions based on needs assessment of countries’ specific situations and their resource levels. The database is searchable by mental health area (e.g. depression, anxiety), target group (e.g. children, adolescents), setting (e.g. school, home-based), country of implementation (e.g. Portugal, Germany) and types of outcomes (e.g. effective, not effective). In addition, an own chosen keyword can be entered in the open search field (see figure 1).

Figure 1. Level 1 of the Database

The database consists of three levels that move from short general information to comprehensive descriptive details on MHP and MDP programmes. To start the search, a keyword can be entered in the open search field and the items in the fixed areas have to be chosen. After having hit the ‘search’ button an overview of the programmes with some main characteristics is provided at the first level (see figure 1).

In order to make a selection of the hits that come out of the first level search and to view some programmes more into detail one can select the programmes by clicking on a little box in front of the title of the programme. The database structure has been developed in such a way that one or more programmes can be selected before hitting the ‘select programme’ button. Hereafter, an overview of the selected programmes with some main characteristics is provided at the second level (see figure 2).

In order to view the more detailed programme description of one specific intervention one can click with the mouse on that programme to enter the third level (see figure 3 and 4). At level 3 programmes are being presented through completed summarized programme descriptions. The following information is provided at this level: short introduction to the programme, development history, the target group, the content and set up of the programme,
risk- and protective factors, implementation, evaluation (including research design), process and effect outcomes, adaptation, history of other implementations, replication studies, contact information and references (two examples of completed programme descriptions are included in annex 3.2).

In addition, in order to view the detailed programme description directly it is also possible to move from the first level to the third level by clicking directly with the mouse on the programme at level 1.

Figure 2. Level 2 of the Database
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 subclinical 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 relapse 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 (Kendall & Chaisson, 1984). The 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 subclinical depressive symptoms.

The course is based on the social-cognitive 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 watching 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 subclinical depressive symptoms who are potentially at risk for a depressive disorder.

Figure 3. Level 3 of the Database

The Olweus Bullying Prevention Programme

The Olweus Bullying Prevention Programme is a school-based prevention programme attempting to create safe and positive learning environments for schoolchildren six to fifteen years old. It is a multilevel and multicomponent programme. It contains school-wide, classroom-level and individual-level interventions. The programme aims to:
- Reduce existing bullying problems inside and outside the school setting
- Prevent the development of new bullying problems
- Improve peer relations
- Reduce opportunities and rewards for bullying

Developing the programme

In 1983, the Ministry of Education in Norway commissioned Professor Dan Olweus to conduct a large-scale research and intervention project on bullying problems. His first studies showed that intervention efforts in the domain of bullying should not be primarily focused on changing the victims but rather the behavior and attitudes of the social environment, in particular the aggressive bullies (Olweus, 1991).

As a result, the Olweus Bullying Prevention Programme was developed at the University of Bergen. Since 1983, the programme has been refined and evaluated. The programme is now implemented on a large-scale basis all over Norway and also in other countries.

The programme is built around a set of key principles derived from research on the development and modification of bullying behaviour (Olweus, 1985). It is considered important to create a school environment characterized by warmth, positive interaction and involvement from adults and on the other hand firm limits to unacceptable behaviour. An important premise of the Olweus Bullying Prevention Programme is that bullying behaviour can be checked and redirected into more prosocial directions through a systematic restructuring of the social environment. Among other outcomes, this restructuring is expected to result in changes in the opportunity and reward structures for bullying behavior, resulting in fewer opportunities for bullying and fewer or similar rewards for displaying such behaviour (Olweus, 1993a; 2001b; Olweus & Limber, 1999).

Figure 4. Level 3 of the Database
**Programme retrieval**

Programmes to be included in the database are identified through systematic literature searches and through partners at the country level, who identify examples of prevention-promotion programmes being implemented and evaluated in their country. Programme summaries are prepared by the partners according to the template developed, edited and agreed by the Imhpa database taskforce before being entered into the database. Programmes identified through literature searches were retrieved and programme descriptions prepared by the Nijmegen Research Team. In total there are 58 programmes described in the database, of which 26 are European and the rest belong to low and middle income countries across the world.

2) **PROGRAMME DESCRIPTION TEMPLATE**

A structured programme template was developed in order to standardise the description of programmes and initiatives on mental health promotion and mental disorder prevention. The instrument was based on an existing classification system, the Society for Prevention Research “International Registry of Preventive Trials” (Brown, Mrazek & Hosman, 1999; Brown, 2000), and adapted according to the content characteristics of the European Database. The format of the programme descriptions have been pilot tested and revised several times.

The programme template provides a framework to share details of any programme which come out of the systematic literature searches or which partners felt constituted effective mental health promotion and/or mental disorder prevention practice. Questions on programme development, the target group, the programme structure, risk- and protective factors, implementation essentials, evaluations, effect outcomes and replication studies were included (see annex 3.1). In addition, the structure of the programme template was used as protocol for the development of summarized descriptions of the programmes. These programme descriptions were finally entered into the internet database. Two examples of European interventions are included in annex 3.2.

5.1.C **FUTURE DEVELOPMENT**

Following the discussions within the general Imhpa meetings, the taskforce and the project’s leaders it was agreed that on the long term the aims of the database are:

- to recommend what is ready to disseminate
- to recommend what the strategies for programme improvement are
- to recommend what might predict effect of prevention and promotion programmes in mental health

In addition, the intention for the database is that, in the future, there is a separate section for each country. It is up to each country representative to identify and select what effective programmes are available and would like to see representing their country. For the purposes of this project, only identified and described programmes will be included.
5.2 A TRAINING MANUAL FOR PRIMARY HEALTH CARE PROFESSIONALS

5.2.A INTRODUCTION TO THE TRAINING MANUAL (background document)

Mental health problems in primary care

In the European Union important causes of morbidity range from mild forms of depression through to complex psychiatric disorders. Between 15% and 20% of adults and from 17% to 22% of teenagers under 18 suffer some form of mental health problem (European Commission, 2003).

The Eurobarometer survey found that 5% of men and 7% of women reported that they had visited their general practitioner (GP) within a year due to mental health problems (European Opinion Research Group, 2003). A higher proportion of patients visiting a general practitioner will not be aware that they are suffering from a mental health problem, which is often expressed through a range of physical symptoms. A worldwide study to examine the relation between somatic symptoms and depression found that the range of patients who reported only somatic symptoms was 45% to 95%, and 11% of the depressed patients denied psychological symptoms of depression on direct questioning (Simon, G., et al., 1999). Moreover, those with psychiatric disorders consult their GP twice as often, have more physical illnesses and take more time off work.

Mental and behavioural disorders are increasing in the population (Murray & Lopez, 1996; WHO, 2001, 2002) and this will be reflected in consultation rates in primary health care, even though only part of all health problems, including mental health problems present there. Because of patients’ physical expression of their symptoms, their denial of psychiatric symptomatology or the stigma associated with mental illness, mental health problems are often not presented to primary health care professionals. These difficulties, in addition to the limited education on mental health problems during primary health care professionals’ training and the perception that treating mental illness might not be part of primary health care providers’ daily practice, limit the identification of emotional problems in primary health care.

As a consequence of many of these reasons mental health problems are not fully recognised or labelled as mental illness in primary health care (Rutz, 1992). For example, a study has shown that between one third and one half of depressed patients consulting their primary health care physician were not recognized to be suffering from a mental health problem (Van Os, 1999). To address these deficiencies, continuing education courses have been developed in primary health care to improve physicians’ diagnostic skills and their treatment of mental health problems. Continuing education courses have led, at least in the short term, to better management and treatment of depression and to the secondary prevention of suicide (Rutz, 1992; van Oss, 2002).

Although different studies have demonstrated that pharmacological treatment can be effective in treating depression and dysthymia in secondary health care and community settings, there have been very few studies in general practice settings. Thus, we should remain cautious in extrapolating the results to primary health care settings. More efficacy and effectiveness trials with long term follow-ups would enable us to determine if better diagnosis leads to better treatment and to better outcome in primary health care (Tiemens, 1996; Dowrick, C. 1996).

In addition to continuing education for diagnosis and improved pharmacological treatment, problem solving treatment (PST) based on behavioural therapy principles, has been used successfully with depressive patients in different settings in primary health care. For example, in a controlled study with community nurses, skills training in problem solving led to fewer disability and sick days for primary care patients who received the problem solving treatment (Van Os, 1999).
solving treatment and in the long term resulted in significantly greater socio-economic savings (Mynors-Wallis, 1997). Similarly, problem solving treatment was found to be as effective as pharmacological treatment (SSRI) in managing depression in primary health care (Mynors-Wallis et al., 2000). A study testing the feasibility of problem solving treatment in the training programme for GP-trainees and the effectiveness of PST for patients with emotional symptoms in primary health care is ongoing in the Netherlands (van Weel-Baumgarten E, in progress).

The field of treatment in primary health care has advanced in the last decades and several interventions show promising success. However, the debate about the difficulties and cut-off points of current diagnostic criteria of mental health problems (WHO, 2001) leaves many people with mental health problems or minor symptoms in need of effective action and at risk of developing a full-blown disorder. Because of the efficacy of problem solving treatment in primary health care, the generality of its principles and the burden of emotional problems in primary health care, the application of PST principles to the prevention of emotional problems in primary health care could lead to important gains in public health.

**Prevention and promotion of mental health in primary care**

In addition to treatment for those who are already suffering from mental disorders, prevention and promotion strategies for mental health are effective across the life span and can bring about health, social and economic development (Hosman, Jané-Llopis & Saxena, in press). A recent meta-analysis of programmes to prevent depression found that prevention programmes were more effective when delivered by health care professionals than when delivered by lay personnel (Jané-Llopis et al., 2003).

There have been little efforts to integrate mental health promotion and primary prevention strategies in primary health care. One example is a collaborative European project that has developed a training manual for health care professionals in primary care to work with families to promote the psychological well-being of children and to prevent the development of psychological and social problems (Puura, K. et al., 2002). Primary health care providers have been trained in five European countries to conduct health promotion interviews with all prospective mothers one month before and one month after birth. A counselling model is used with mothers identified at risk to try to prevent the onset of child mental health difficulties (Puura, K. et al., 2002).

To date, no training manual has been developed in primary health care to integrate prevention and promotion in mental health in primary health care daily practice. Problem solving treatment has proven to be effective with depressed patients in primary care. In addition, problem solving skills are frequently used with success in mental health promotion and mental disorder prevention programmes. This evidence suggests that problem solving skills could also be helpful as a preventive strategy to work with primary health care patients being at risk or already suffering from emotional problems but not yet fulfilling diagnostic criteria for full-blown disorders. Ultimately engaging primary health care could have a large reach in the population and improve prevention and promotion practice in mental health.

**Problem focus**

The training manual would focus on the adult population visiting primary health care (aged over 18 years) and being identified to be at risk for emotional problems, including those who suffer from symptoms of depression, anxiety or signs of stress or those patients who are at risk for developing an emotional problem.

**The training manual**

The training package would focus on providing background information on mental health and on providing a set of skill-building modules, based on problem solving training, to
enhance promotion of mental health and prevention of mental disorders in primary health care.

The package would contain:

1) A 2 day training course, based on Problem Solving Training (e.g., the course developed by Laurence Mynors-Wallis) and applied to prevention of mental ill health and promotion of mental health;

- The training course would include background information on mental health and its links to physical health, a list of symptoms description and recognition; and a list of risk factors to identify groups at risk for emotional disorders;
- The training course would include communication skills to be taught to primary health care providers;
- The training course would include basic training on Problem Solving Skills

If needed, an annex could be provided with the evidence of effective psychological and pharmacological treatments and references to available treatment guidelines to provide more information to interested health care providers on what can be done for those patients who visit primary care with full-blown disorders. However, a focus on treatment is not the purpose of this training manual and should not be made a priority.

The manual would be prepared in the English language. It will be designed for easy adaptation and translation to different cultures and languages.

The training sessions would be preferably provided in small groups of around 12 participants per group. Methods used for the training provision would be skills based and involve group work such as brainstorming, role-play, experiential exercises, and individual work (including home work). Although one trainer could provide the complete package, it would be preferable if at least two trainers would be involved in the provision of the courses to ensure adequate skills training.

Pilot

The first pilot to test the materials will be undertaken in two countries and will include feasibility, acceptability, and comprehensibility issues. Evaluation items could include: assessment of satisfaction with training manual, length and feasibility, problems faced, areas for improvement, etc.

In addition a future pilot to be undertaken under another project could include some simple measures for outcome evaluation (e.g., number of patients identified to be at risk; number of patients given the intervention; and if possible maybe include some measure on symptom relieve, etc.). A future project will subsequently be set up for rigorous testing using an RCT design.

The present pilot would serve as a first step to examine the potential of the developed training course and improve it before testing its implementation (adoption and adaptation across countries and so on).
5.2.B DEVELOPED PRODUCTS

The main product of the primary health care strand is a training manual to train primary health care professionals to recognize patients at risk or who are already suffering from symptoms of depression, anxiety or signs of stress and to teach patients basic problem solving strategies to help them to cope with and to relieve emotional problems. The training manual for health care professionals is based on problem solving skills and anxiety management techniques. The manual aims to increase primary health care professionals’ awareness and skills to promote mental health as well as to provide patients with skills to tackle mental health problems and early symptoms of depression, anxiety and stress. Following the discussions and work within the general Imhpa meetings, the taskforce, the training manual leaders, and through active email contact it was decided to include the brief problem solving component and an anxiety module into one manual. The project group agreed that the training manual taskforce would develop the following products:

- Trainer’s version of the training manual:
  ‘A training manual for prevention of mental illness: Managing emotional symptoms and problems in primary care. Materials for training of primary health care professionals to help patients with emotional symptoms’

- Participant’s version of the training manual:
  ‘A training manual for prevention of mental illness: managing emotional symptoms and problems in primary care. Materials for primary health care professionals to help patients with emotional symptoms’

These publications are enclosed to this report separately and are made available through the Imhpa website (www.imhpa.net).

5.2.C REPORT ON THE DEVELOPMENT AND PILOT OF THE TRAINING MANUAL

Mental health promotion and mental disorder prevention in primary care

Mental and behavioural disorders are increasing in the population (Murray & Lopez, 1996; WHO, 2001, 2002). Globally, one out of four families has at least one member with a mental disorder and nearly 1 million people commit suicide every year (WHO, 2003). In Europe, approximately 30 million people are suffering from anxiety and depression, over 21 million people from alcohol use disorders, over 7 million from Alzheimer’s disease and other dementias, over 4 million from schizophrenia, over 4 million from bipolar affective disorder and over 4 million from panic disorders (WHO, 2005). By the year 2020 it is estimated that mental ill health will account for 15% of the burden of disease worldwide and that depression will become the second leading cause of disability (Murray & Lopez, 1996; WHO, 2002).

In addition to a higher expected treatment burden, consultation rates in primary health care are consequently expected to increase as well. Mental health problems are a common reason for a visit to primary care, although these problems are often expressed through a range of physical symptoms or are denied by patients because of the stigma associated with mental illness. These difficulties in combination with the limited education on mental health problems during primary health care professionals’ training and the perception that dealing with mental illness might not be part of primary health care providers’ daily practice, limit addressing emotional problems in primary health care.

In addition to continuing education for diagnosis and improved pharmacological treatment, problem solving treatment, based on behavioural therapy principles, has proven to be effective with depressed patients in different settings in primary care. For example, in a
controlled study with community nurses, skills training in problem solving led to fewer disability and sick days for primary care patients who received the problem solving treatment and in the long term resulted in significantly greater socio-economic savings (Mynors-Wallis, 1997). Similarly, problem solving treatment was found to be as effective as pharmacological treatment (SSRI) in managing depression in primary health care (Mynors-Wallis et al., 2000). A study testing the feasibility of problem solving treatment in the training programme for registrars in general practice and the effectiveness of problem solving treatment for patients with emotional symptoms offered by these registrars in primary health care is ongoing in the Netherlands (van Weel-Baumgarten E, in progress).

However, until now little efforts have been made to integrate mental health promotion and primary prevention strategies into primary health care daily practice. One example is a collaborative European project that has developed a cross cultural training manual for health care professionals in primary care to work with families to promote the psychological well-being of children and to prevent the development of psychological and social problems. Primary health care providers have been trained in five European countries to conduct health promotion interviews with all prospective mothers one month before and one month after birth. A counselling model is used with mothers identified at risk to try to prevent the onset of child mental health difficulties. Outcomes on children’s psychological development and family adaptation will be evaluated two years later, in comparison with matched groups not receiving the intervention (Puura, K. et al., 2002).

To date, no training manual on problem solving principles has been developed in primary health care to integrate prevention and promotion in mental health in primary health care daily practice. Because of the efficacy of problem solving treatment in primary health care, the generality of its principles and the burden of emotional problems in primary health care, the application of problem solving treatment principles in mental health promotion and mental disorder prevention programmes could lead to important gains in public health. Problem solving skills are expected to be helpful as a preventive strategy in primary care for adult patients who are at risk or who are suffering from emotional problems, but who do not yet fulfil the diagnostic criteria for a full-blown mental disorder.

Since no population group is immune to mental disorders (WHO, 2003), engaging primary health care could ultimately have a large reach in the population, supporting people of all ages, ranks and classes. In addition, it could contribute to the stimulation of prevention and promotion in mental health and reduce the development of full-blown mental health disorders in general.

A training manual for primary health care professionals

Development of the training manual on problem-solving skills and anxiety management

Because of the expected efficacy of problem solving skills as preventive strategy in primary health care, a training manual on problem-solving skills for primary health care professionals was developed to address emotional problems in populations at risk and to integrate prevention and promotion strategies into primary care daily practice. In addition, a module on anxiety management was included since anxiety symptoms are presented frequently in primary care and there has proven to be a high comorbidity between depression and anxiety.

During the first phase of the Imhpa project a training manual taskforce had been created in order to stimulate and support the process of developing a training manual for primary health care professionals. The taskforce consisted of several mental health experts including psychiatrists, psychologists, general practitioners and researchers.

The development of the manual took place in several phases, including in each phase the feedback from the Imhpa training manual taskforce and members of other taskforces, either by general Imhpa meetings or through active email contact. Two extra meetings were organized with the authors of the training manual in order to discuss content
issues, the ongoing development and the time schedule. In addition, during a meeting with part of the training manual taskforce and a European group of general practitioners the relevance of such a manual in daily practice had been discussed and comments from primary health care professionals were included in the finalization of the manual. Finally, some final revisions were made in the light of the pilot evaluations.

Content of the training manual

The training manual has the aim to provide health professionals in primary health care with a set of skills, tools and strategies to tackle mental health problems throughout their practice and to work with early symptoms of depression, anxiety and stress in patients at risk. In general, the training is developed to increase awareness of mental health problems in health professionals, and to integrate mental health promotion and prevention in primary care daily practice. With its implementation, it is intended to provide patients skills to tackle their own mental health problems and early symptoms of emotional problems such as depression, anxiety and stress.

Based on problem solving principles and training of practical skills through role play and feedback techniques, a two-day group-based training has been developed that consists of two modules:

- Brief problem solving (BPS) (including information on the impact of prevention and a refresher on communication skills and a set of skill-building modules, based on the 7 stages of problem solving treatment).
- Symptom management of anxiety (including education and reassurance, distraction and exercise, simple exposure, and reattribution) and insomnia.

The training is presented as two continuing days, with a total of 8 sessions of 1,5 hours. The first one and a half day (sessions 1-6) is focused on the brief problem solving module, whereas the last half day (sessions 7-8) deals with the anxiety symptom management module. The content is ‘fixed’ but the length of the sessions may be varied according to the pre-existing knowledge and skills of the participants, or the wishes of the trainers.

The manual package includes for each session a session plan, statement of aims and objectives, a list of required materials, background notes, visual aides (PowerPoint presentations) and handouts of case vignettes. The material is prepared separately for the trainers and for the participants of the course. Both trainer’s and participant’s manuals are written in English which is expected to make dissemination on a large scale possible since English language is a commonly used and well recognized language throughout Europe. However, translation of the manual in different languages could make implementation at the country level easier and more feasible. For example, in the Netherlands the training has obtained the accreditation from the Dutch College of General Practitioners (NHG) and extra funds have been raised for its translation into Dutch, which was finalized in October 2005.

Pilot evaluations

The training manual for primary health care professionals had been pilot tested in two European countries: the Netherlands and Slovenia. The first training and process evaluation took place in the Netherlands (November 2004) and the second one was carried out in Slovenia (February/March 2005). During both trainings, observers were present to follow the educative process carefully. At the end of the two trainings a general evaluation form was completed by all participants. In addition, in the Netherlands after each of the eight training sessions participants were asked to fill out a separate evaluation form specified to that
certain session. Three months after the pilot a follow-up meeting took place in Netherlands, whereas Slovenia participants were asked to send in follow-up evaluation forms by mail.

**Pilot training in the Netherlands**

In November 2004 the first pilot testing of the training manual took place at the Radboud University Nijmegen Medical Centre in the Netherlands. A group of 7 general practitioners (5 men and 2 women) followed the two-day training on brief problem solving and anxiety management which was carried out by two professional trainers (a psychiatrist/senior researcher from the United Kingdom and a general practitioner/senior researcher from the Netherlands). General practitioners from different general practices throughout the whole country were recruited for the pilot training which was offered to them for free and through which they earned two days of CME-accreditation points for following the full training programme. Although there was a great interest in the training, recruitment was not as easy as expected since for a number of general practitioners originally invited, it proved impossible to get a locum in the practice for two full days on the specific dates planned for the IMHPA training.

In general, participants responded very positive to the pilot training. Although they experienced the training as a heavy and full two-day training, it was considered manageable. Participants were interested and enthusiastic about the content of the training and motivated to try to use the learned skills which they considered relevant to implement in practice.

Although some individuals experienced minor problems with the English language, in general people responded well to the language and were able to understand the trainers and read the materials well. At times, when they had to express themselves in their own words (e.g. during role plays) and were not able to speak in their own native language, English was perceived most difficult.

The use of role-play during the training was received very well. Participants seemed to enjoy this technique very much and considered it as one as the major learning experiences of the training. Although the training consists of multiple role-plays the participants would have liked even more time to practice the skills with this technique. Sometimes they asked for clearer instructions from the trainers before starting the role-plays, for example to know better what stages of problem solving one was supposed to practice.

In order to prepare properly for the two-day training participants suggested to send out some materials in advance in the future. The materials received at the start of the training were considered clear and useful, although not all PowerPoint sessions were considered as relevant as others. For example, PowerPoint presentations on communication skills, reattribution and insomnia were mentioned as less relevant compared to others.

In relation to specific components of the training the most difficult parts of the brief problem solving module were considered to be the practicing of defining and breaking down the problem (stage two), establishing achievable SMART goals (stage three) and applying ‘activity scheduling’ within the 7 stages of brief problem solving. In addition, anxiety management is considered interesting and relevant for practice, but participants feel less confident to carry it out because there was not as much time to practise this module as the brief problem solving module.

The trainers were rated very positively for their part in giving clear instructions (although this could even have been more comprehensive during role play) and for giving good feedback. To motivate and keep participants involved they included personal examples from their own experiences. At times they took the freedom to change the time schedule according to the needs and pre-existing knowledge and skills of the general practitioners. After the Dutch pilot study an alternative session planner was developed.

Finally, problems such as selecting the appropriate patients and not being experienced in (of having no experience with) the learned skills were mentioned as possible implementation barriers for bringing the techniques into practice. In addition, Dutch general practitioners expected a problem in finding enough time to use the interventions in every-day practice.
Pilot training in Slovenia

Based on outcomes of the first pilot study in the Netherlands some adjustments had been made to the training manual for primary health care professionals, for example rescheduling of the prevention session, simplification of the communication session in the brief problem solving module and using interactive plenary sessions instead of role-play for unexplained physical symptoms and insomnia. This adjusted version of the training manual was used for a second pilot study with general practitioners in Slovenia.

In March 2005 a second pilot training took place in Slovenia at the regional public health centre in Celje. The purpose of a second pilot study was to test the feasibility of the training in a new European Union member state. Trainers wanted to experience how such a (English spoken and written) training would be picked up and would fit into the Slovenian situation and how different cultural issues could possibly play a role in the implementation of the training.

A group of 9 general practitioners (1 man and 8 women) from health care centres around the city of Celje followed the free two-day training on brief problem solving and anxiety management. Recruitment of the general practitioners was done by the Institute of Public Health of the Republic of Slovenia and the Regional Public Health Centre Celje. One difficulty during recruitment seemed to be the duration of the training. Two full days away from daily practice turned out to be a big investment for a Slovenian general practitioner because of work pressure and having no replacement in practice. Therefore the recruitment turned out, just as in the Netherlands, to be harder than originally expected.

The training on brief problem solving and anxiety management was carried out by the same two trainers who carried out the first pilot training in the Netherlands (a psychiatrics/senior researcher from the United Kingdom and a general practitioner/senior researcher from the Netherlands). Because of logistic reasons the sequence and time frame of the training was rescheduled, being different form the time schedule in the first pilot training or the alternative session planner (developed after the first pilot training). In particular, some sessions were shortened because of a late arrival of one of the trainers.

In general, the reaction of the participants to the training was very positive. They were satisfied about the (PowerPoint) presentations and content of the manual. The provided information was considered helpful, relevant and useful for everyday practice. The general practitioners indicated to be willing to receive more training and supervision later on, after having tried to implement the learned techniques in practise.

Although for most participants it was difficult to be away from practise for two full days, they did not consider the training to be too long. Instead, general practitioners believed the training should be even longer, and for example spread out over a longer period of time in different parts.

The use of English language during the training was perceived as manageable but quite difficult at times, even though students for Medical School in Ljubljana have to read some literature in English and statistics have indicated that the percentage of pupils learning English in Slovenia is above the European average (EU-15) (Andren et al., 2003). Difficulties with English were most evident during role plays, when the English language had to be used actively. After the role-plays, observers noticed that general practitioners looked physically tired, probably because speaking English seemed to take more energy than speaking in their own mother language. In addition, although participants showed overall interest, only few questions were asked throughout the training. This might be because of a language barrier since Slovenian observers noticed that topics were being discussed during breaks in Slovene language and questions were asked among each other, but might also be culturally defined. In contrast, the written materials and presentations in English were understood well.

The materials of the training were considered relevant. Although the manual contains a lot of information, this was experienced as positive. The basic information about the topics was learned through the PowerPoint presentations, and more information should be read at home.
Although participants experienced some language difficulties during role-plays, role-plays were considered very helpful and informative. The trainers had the impression that role-plays were less common for Slovenian participants compared to Dutch participants and that they were less at ease with this technique. However, in the current educational system in Slovenia general practitioners experience a lot of role playing during postgraduate studies and during various workshops and seminars, organized by different organizations and institutions. The participants in the pilot training had experienced some role playing during their studies in a family practice course.

In relation to the specific components of the training the most difficult parts of the training were considered to be parts of the brief problem solving module. In particular, explaining the patient the relation between problems and symptoms (stage one) and establishing achievable SMART goals (stage three) were experienced as most difficult.

The role of the trainers was rated with high scores since they were considered very capable of delivering the training. Although the trainers felt that the interaction between them and the participants started slower than with the Dutch general practitioners, according to the Slovenian observers the interaction between the participants and the trainers was good.

In relation to implementing the learned skills into their consultations, Slovenian general practitioners expected a difficulty in finding enough time to use the interventions in every-day practice. Another possible difficulty was expected with the lack of patients’ compliance since Slovenian patients are expecting to receive medication as treatment of emotional symptoms rather than psychological-based interventions. Furthermore, more repetition of the learned skills during the training and translation of some pieces into their own native language were mentioned as possible improvements to the training.

**Follow-up testing**

Three months after the pilot training a follow-up meeting was carried out in the Netherlands. The general practitioners turned out to be very interested in such a meeting since at the end of the training’s second day they (partly) took the initiative to organise the follow-up meeting themselves. The follow-up session took place at the same location as the two-day training, the Radboud University Nijmegen Medical Centre. The meeting with 4 general practitioners was conducted by one of the trainers in combination with one observer. During the follow-up meeting participants shared their experiences on applying the newly learned skills in their daily practise according to a follow-up evaluation form that was sent out by email on forehand. Several questions were posed to each other and to the trainer about problems they encountered when using the skills learned in the training. In general, feedback of the trainer was considered to be very helpful to stay motivated and to continue implementing the learned skills in everyday practice. Three general practitioners were not able to attend the meeting and sent in the follow-up evaluation forms by mail, one of them asked and received feedback over the phone.

Because of organisational reasons no follow-up meeting could be arranged for participants in Slovenia. However they were asked to return the follow-up evaluation forms by mail three months after the training. In total 4 participants returned the forms.

Although both modules were considered relevant for practise the Dutch general practitioners seemed to have used only the brief problem solving module with patients. The newly learned anxiety management skills were not brought into practise by the Dutch participants because they expressed that most of its content (if they did not already use these techniques before) was forgotten or they experienced a lack of confidence to put them into practise, particularly in relation to the reattribution technique. In addition, participants mentioned that before starting reattribution for unexplained physical symptoms with patients, they first have to perform a thorough physical examination to make sure there is no physical explanation for the behaviour. Therefore, applying anxiety management was considered to be only applicable to a limited amount of patients with no physical causes. This was considered relevant by the trainers because these are the patients for which reattribution is actually meant.
In contrast, the Slovenian general practitioners seemed to have brought the anxiety management skills in practice with at least one or two patients. In their view patients were able to understand the skills easily and actually used them in daily life. Some general practitioners experienced resistance from the patients, such as insisting to continue with doing more tests and follow-up specialised examinations or expressed feelings of not being competent enough to apply the learned skills. In general, Slovenian general practitioners considered the anxiety management skills relevant and feasible in the given consultation time.

The brief problem solving techniques seemed to have been practised with more patients than the anxiety management skills. In the Netherlands full practise of the 7 stages was only done with a limited number of patients, with an average of two patients over a period of three months. However, all general practitioners mentioned to have used parts of brief problem solving techniques on a more regular base. For example activity scheduling, making a clear problem definition, specifying the goals, and setting SMART goals (breaking the problem down in smaller parts and setting realistic goals) had been applied several times with various patients. In Slovenia, most general practitioners also applied the technique with an average two patients, whereas one practitioner even used it with 10 patients.

Both Slovenian and Dutch general practitioners thought patients were able to understand the skills easily and apply them in their daily live. However, some problems mentioned by Dutch general practitioners during practise were: breaking the problem into smaller parts (stage two), setting a SMART goal (stage three) and a lack of imagination during the stage of brainstorming (stage four). In addition, some general practitioners had problems motivating the patients to come up with their own problem definitions and solutions. General practitioners had to be very attentive not to take this over for the patients and make sure the patient was allowed the opportunity to do this him- or herself.

In addition to the encountered problems, in both countries general practitioners did not experience much resistance from the patients during the sessions when BPS was provided. However, with Dutch patients some resistance was noticed in relation to the overall aim of changing behaviour by moving away from old well established behaviour to new behaviour. In addition, scepticism was expressed by patients about the feasibility of the technique. More specifically, the brainstorm phase could be perceived as difficult ('If I had the solution I would not be here!'). In contrast, Slovenian patients asked in particular for medication (e.g. pill or tablets) to solve their problems instead of accepting this (new) way of dealing with problems, like expected on forehand as possible implementation difficulty.

General practitioners from both countries considered the brief problem solving skills as very relevant. However, different opinions were expressed within countries about the feasibility within the given consultation time. Some Dutch participants suggested to book a double consultation appointment in order to complete the sessions.

Conclusion and recommendations

The training on brief problem solving skills and anxiety management techniques was received well in two pilots studies carried out in the Netherlands and Slovenia. General practitioners in both countries were enthusiastic about the content and presentation of the training and considered the learned skills as very relevant and useful for everyday practice.

The techniques used in the brief problem solving module were received positively, in particular the role-play practises. Since in both countries the full seven stages of BPS had only been applied in a limited number of cases, using parts of this technique seemed to be more feasible (in any case initially) than applying the whole procedure. The most difficult component of brief problem solving was considered to be establishing achievable SMART goals (stage 3). In addition, in the Netherlands the practicing of defining and breaking down the problem (stage 2) and ‘activity scheduling’ were also perceived as difficult, whereas Slovenian general practitioners experienced difficulties with explaining the relation between
problems and symptoms to the patient (stage 1). This is consistent with the general orientation of Slovenian patients on medical solutions instead of psychological-based interventions, and which also turned out to be a reason for patients’ resistance. However, in general in both countries patients responded positively and with limited resistance to the new approach offered to them.

The anxiety management module seemed to have been practised more often after the training by the Slovenian than by the Dutch participants. General practitioners in the Netherlands were already more familiar with these skills before the training and already used them (partly) in their practice. Slovenian general practitioners considered the anxiety management skills as relevant and feasible in the given consultation time and seemed to have brought them in practise about as many times as the brief problem solving skills.

In both pilot trainings the use of English language has been an important barrier. Although general practitioners from both countries seemed to be trained in using English language in professional related topics English was perceived difficult at times, in particular during role plays and especially for Slovenian participants. The English language barrier stresses the importance of the ‘training the trainers’ philosophy. Experienced trainers (both as therapist in the specific interventions of the manual as well as in training of the interventions) are needed to transfer the skills and train the trainers courses are therefore recommended. Translation of the training manual into different languages (like done in the Netherlands into Dutch) or at least (difficult) parts of the training and role-plays in participant’s own language, in combination with trainers who speak the same language would be expected to enhance the implementation process, participants’ satisfaction and the effectiveness of the training even more.

Furthermore, role-play techniques were considered very relevant during the training in both countries. Through role-plays participants practised the skills under the supervision and feedback of the trainers. However, role-plays also seem to be dependable on participants’ previous skills and knowledge of practising such technique before.

Other factors and possible barriers that were considered to play an important role in the implementation of the training in both countries were:

- (lack of) general practitioner’s (subjective feeling of) competence
- first experiences in using the learned skills (bad first response leads to less confidence/ lower self-efficacy and less new tries in practise)
- (lack of) patients’ compliance
- (lack of) time to fit each session into normal consultation time
- personal commitment and motivation of the general practitioner of wanting to apply the learned skills into practise (being convinced of the relevance and effectiveness of the techniques)
- fitting the new skills into the general practitioner’s way of working (some components could be implemented better in the usual work strategy than others)

In order to optimise feasibility of the implementation of the training throughout different countries in Europe attention needs to be paid to adapting the training to different cultural issues (for example, participants’ experience with practicing of role-plays and in strategies to motivate patients). In addition, it should be taken into consideration to add follow-up meetings to the training. Alternatively, the training sessions can also be spread out over a longer period of time, so that skills can be used in every-day practice between training sessions. Furthermore, the combination of brief problem solving and anxiety management in the training could be discussed. It might be better to divide the training into two different parts or trainings, to ensure that BPS can be consolidated better and enough time can be used for training of anxiety management. With this aim an alternative solution was suggested by the trainers and one of the Dutch participants to train BPS first in a two-day programme, followed by a one day training some weeks or months later in order for this follow-up session to
contain feedback by the trainers on experiences with applying BPS to real patients, as well as training in anxiety management.

The first preliminary results of the training on brief problem solving and anxiety management has shown positive results in two European Union member states. Further implementation and dissemination of the training might have a broad beneficial impact in enhancing mental health in populations at risk throughout different member states in Europe. In the future, experimental studies with high quality research designs are needed in different counties in order to measure the outcome effects of the training, especially in relation to culturally related issues. In addition, in order to have an even broader reach in the population the possibilities of applying the training to different groups of participants (for example nurses, social workers or primary health care psychologists) in different settings should be explored.

According to the outcomes of the pilot trainings a final revision of the training manual has been completed which is available as publication. Both the trainer's manual ('A training manual for prevention of mental illness: Managing emotional symptoms and problems in primary care. Materials for training of primary health care professionals to help patients with emotional symptoms') and the participant's manual ('A training manual for prevention of mental illness: managing emotional symptoms and problems in primary care. Materials for primary health care professionals to help patients with emotional symptoms') are available through the Imhpa website (www.imhpa.net). In addition, the translated versions into Dutch are also accessible through this site.

References


5.1.D FUTURE DEVELOPMENT

As a second phase of the Imhpa training manual, it is proposed to undertake a multi-country Randomized Controlled Trial (RCT) which could involve a small number of European countries. This new follow-up project aims to test the efficacy of the Imhpa training manual. The trial would include process and outcome evaluation of general practitioners and patients in primary health care on indicators of depression, anxiety and stress and on indicators on mental well-being.

The trial could have a scope of 4 years. Necessary adoption and adaptation of the training manual would be developed in the first year. Training within primary health care would be undertaken at the end of the second year and during the first half of the third year according to different country timetables. Outcomes of the training effects both on primary health care providers’ behaviour and on patients’ outcomes would be measured before the training and at one, six, twelve and eighteen months after the training. Expected publications would include a short-term and a long-term outcome publication and a collaborative publication with the number of countries involved to be submitted to peer-reviewed journals.

A first draft of what the randomized trial proposal could consist of (see below) was discussed in one of the meetings and future exploring for funding for the sustainability and efficacy testing of the training manual are undertaken at the moment.

Draft ideas for a Proposal for a Multi-country Randomized Controlled Trial

Goals of the study
To test the efficacy of the Imhpa training manual for primary health care in changing General Practitioner’s (GP) behaviour, patients’ emotional symptomatology and eventually the prevention of depression and anxiety disorders. Whenever possible the study would aim to estimate the cost-effectiveness of training general practitioners on managing emotional symptoms.

The trial would include a minimum of 5 European countries. The trial would be undertaken at the region level. Statistical comparisons would be undertaken within countries. Differences across countries would be described.

Target group
A/ Intermediate target group:
Programme providers would be General Practitioners. The provider should be the same in each participating country. When in all countries the GP would not be the primary provider a decision should have to be taken on what would be the provider to involve in the RCT. Optimally it should be the same in each of the countries.

B/ Ultimate target group:
Patients in primary care with an increased risk for depression, anxiety or stress related problems. Increased risk would be defined by the presence of symptoms, risk factors or emotional problems to any given extent always when there is no diagnosis for a full-blown depression or anxiety disorder (selective-indicated prevention).

Research Questions
1. How frequently are emotional problems presented in general practice? (This would assess the level of emotional risk in primary care)
2. What is the (cost) effectiveness of the IMHPA skills training intervention on changing the GPs' behaviour?

3. What is the (cost) effectiveness of the IMHPA intervention on changing the level of emotional problems and symptoms of patients who received the intervention?
   a. Are depressive symptoms reduced?
   b. Are anxiety symptoms reduced?
   c. Are stress related problems reduced?
   d. Is mental well being and/or quality of life of patients increased?
   e. Is the incidence of depression reduced?
   f. Is the incidence of anxiety reduced?

4. Is there a difference in the (cost) effectiveness of the different components of the IMHPA intervention?

Randomization procedures

Cluster Randomised Controlled Trial

A cluster randomised controlled trial is proposed in which general practices with their patients are randomised to an equally-sized intervention group and control group. Cluster allocation is needed to avoid the risk of contamination, as the outcomes for individual patients are not independent. Patients within a general practice are likely to respond in a similar manner. Data will be gathered at the level of the general practice (pre (T0) and post (T1)) and at the level of the patient (inclusion (T0) and follow-up (T1)). Both effect and process outcomes will be collected.

Selection of region/s

Region selection would be dependent on each participating country and project leader organization

Random allocation

General practices which would volunteer to participate would be stratified by the primary care regions, to avoid a bias caused by differences in the primary care regions with regard to the organisation of primary care, specialised mental health care, to the health insurance policy, and to the routine Continuing Medical Education (CME training) of GPs. Next, the general practices would be randomized by computerised schemes to an equal-sized intervention group and control group according to pre-determined power calculations. Although the allocation of general practices would be performed before the pre-measurement of providers' attitudes and behaviour with regard to providing the Imhpa intervention the practices would be informed after the pre-measurement to avoid the possibility of bias caused by the allocation to intervention group or control group. If the Imhpa intervention would be successful, it could be offered to the practices in the control arm after the study period (waiting list control).

Training process

Trainers in all participating countries would be all trained simultaneously (train the trainers by Imhpa).

An assessment at the country level should be undertaken to estimate whether the training manual should need to be translated and back-translated
The training manual should be tailored to the RCT study. This would imply that a new session should be included and provided which would train on the assessment and screening of patients in primary care. This session (with eventual role-play if needed) should also be provided during the training itself.

**Instruments for screening and assessment of outcomes**

**A/ Inclusion criteria**

A standardized screening instrument should be identified or developed for the GP to assess and identify potential patients to whom the screening and intervention will be provided. This instrument should be short and easy to use in the form of a checklist for inclusion in the trial. It should be clear to use and translated and back translated for each of the participating countries.

**B/ Outcomes’ assessment**

1. Validated instruments across the different participating countries should be identified for their use in the RCT. These could include instruments to assess:
   - Depressive-anxiety and stress related symptoms
   - Depressive and anxiety disorders
   - Mental well being
   - Quality of life

2. A short checklist questionnaire should be developed to assess GP Behaviour or clinical records could be assessed to assess GP behaviour. (For this a protocol for the use of clinical records should be made available so that data could be compared within and between countries)

3. Process outcomes. In addition to the effect outcome measures, process information would also be collected. General practitioners would be asked about the feasibility of providing BPS and anxiety management to patients with emotional problems who are at risk for depression and anxiety disorders. GPs would also be asked about the barriers and facilitators for intervention provision and about their satisfaction and assessment of the different elements of the Imhpa intervention.

**Time points**

Outcome variables would be assessed:

**At the GP level:**
Prior the intervention and 18 months after

**At the patient level:**
Prior the intervention, one month, six months, 12 months and 18 months after the intervention

**Outcome measures**

Some of the outcome measures could include:

**Primary outcome measure**

- Proportion of patients who, with an initial (instrument/s of choice) score of XX or more, have a reduced score at follow-up
- Proportion of patients who, with an initial (instrument/s of choice) score of XX or more, have been given the intervention

**Secondary outcome measures of patient behaviour**

- Average instrument score (e.g., GHQ)
- Proportion of patients with increased depressive symptomatology
- Proportion of patients with increased anxiety symptomatology
- Proportion of patients with incidence of a depressive disorder
- Proportion of patients with incidence of anxiety disorder

Secondary outcome measures of provider behaviour and attitudes
- The number of patients that were screened for inclusion
- Proportion of patients who received BPS or anxiety management
- Attitudes towards working with mental health problems in primary health care (instrument?)

Prevalence information
- Proportion of patients who score at risk for a mental disorder according to instrument

Process information
- Surveys of providers asking about the feasibility of the implementation of the IMHPA intervention and the feasibility of providing BPS and/or anxiety intervention in daily practice.
- Surveys of facilitators asking about the feasibility of the multi-tailored implementation program.

Cost information
- Estimate of cost of the different elements in the IMHPA intervention

Cost effectiveness information
- Estimate of the cost effectiveness of the intervention in terms of disability adjusted life years prevented.

**Participating countries and research staff**

IMHPA has at the moment 20 partner countries. Some countries have indicated a special interest on being involved in a future testing of the manual. Involvement in the RCT would require some experience or previous work or contacts with primary health care in each country or region.

Wonca or Primary health care interested parties currently include: Belgium, Germany, Italy, the Netherlands and the United Kingdom.

It is suggested that research staff in the RCT in each participating country include at least a senior researcher to act as project leader, a junior researcher (PhD or postdoc position) to coordinate and undertake the efficacy trial at the country level and one-two trainers if this would not be the same as the project leader.

**Potential grant givers and proposed time line**

1. European Commission: research framework (call for proposals expected around end autumn 2004)
2. European Science Foundation (call for proposals expected around spring 2005)
3. National grant givers

Time line proposed is of a 4 year project from the moment the project would be granted. Some of the activities during each year would include:

Year 1:
- preparation of the training manual
- pilot translations
- practices’ enrolment and randomization
- selection, development of screening and assessment instruments, etc.

Year 2:
- train the trainers
- train general practitioners
- intervention provision
- measurements of baseline and one month after the intervention

Year 3:
- measurements for 6 and 12 months follow-up
- analysis of quantitative data
- analysis of cost effectiveness
- writing up publications-reports

Year 4:
- last measurement (18 months)
- analysis and long term results
- analysis of cost-effectiveness
- writing publications/report
5.3 GUIDELINES FOR A EUROPEAN POLICY ACTION PLAN

5.3.A INTRODUCTION TO A POLICY FOR EUROPE

Mental and behavioural disorders are found in people of all ages, regions, countries and societies (WHO, 2001), being present at any point in time in 10% of the adult population. More than one in four of us will develop one or more mental or behavioural disorders during our lives. It is estimated that, by the year 2020, mental ill health will account for 15% of the burden of disease worldwide (Murray & Lopez, 1996; WHO, 2002). In the European Union many of the important causes of morbidity range from mild forms of depression through to complex psychiatric disorders (European Commission, 2003). Between 15% and 20% of adults and between 17% and 22% of teenagers under the age of 18 years suffer some form of mental health problem (European Commission, 2003).

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, such as lost opportunity costs to individuals and families that have not been taken into account.

Mental health promotion and mental disorder prevention are effective and can lead to health, social and economic gain (Durlak, 1995; Mrazeek et al., 1994; Price et al., 1992; Price et al., 1988; Albee et al., 1997; Hosman, et al., 1999; Hosman et al., in press). Topic-specific literature overviews have confirmed that prevention is effective for mental health problems including child abuse (MacMillan, MacMillan, Offord, & Griffith, 1994a; MacMillan, MacMillan, Offord, & Griffith, 1994b), conduct disorder (Reid, Eddy, Fetrow, & Stoolmiller, 1999), violence and aggression (Yoshikawa, 1994), depression (Muñoz, 1993; Muñoz, Ying, Perez-Stable, & Miranda, 1993; Gillham et al., 2000), and in different settings, including schools (Greenberg et al., 2001). Similarly meta-analyses have been undertaken to assess programme efficacy in the fields of harmful drug use for children and adolescents (Tobler, 1992; Tobler, Lessard, Marshall, Ochshorn, & Roona, 1999; Tobler et al., 1997), mental health for children (Durlak et al., 1997; Durlak & Wells, 1998), interventions for infants and children up to 6 years of age (Brown et al., 2000), programmes to prevent child sexual abuse (Davis & Gidycz, 2000) and programmes to prevent depression (Jané-Llopis et al., 2003).

However, in spite of their efficacy, in general, countries and regions do not have prevention and promotion programmes in place. Nor have they developed policy action plans to make the available programmes sustained. It is imperative that if we are to improve peoples’ mental health and to prevent the onset of new cases of mental disorders, countries, their governments and the European Commission will have to develop a policy action plan to tackle this growing public health problem.

The Country Profiles

In order to develop a policy action plan there is a need to have information on the existing policies, programmes and infrastructures for mental health promotion and mental disorder prevention that are available across the European Member States and the countries in accession.

To these ends, it is proposed to develop a questionnaire to assess the policy, infrastructural, research and health care system resources and interventions that are in place across participating countries in this project. Input from the country profile questionnaires can be depicted in a country profiles report and used to inform the policy action plan.
The Policy Action Plan

It is proposed that the policy action plan has two components: a technical longer report that covers the situation across the European Member States and countries in accession, providing an overview on the policies and strategies that could be adopted to improve mental health for internal purposes of the project; and a shorter summary version entitled: “Mental Health Promotion and Mental Disorder Prevention: A policy for Europe” targeted at policy makers, politicians and European parliamentarians.

5.3.B DEVELOPED PRODUCTS

The main product of the policy strand is the publication of a policy on mental health promotion and mental disorder prevention in Europe. Following the discussions within the first two general Imhpa meetings, the taskforce meeting, and through active email contact the project group agreed that the Policy strand would develop the following product as described below.

A POLICY ON MHP AND MDP – SUMMARY DOCUMENT

The publication "Mental Health Promotion and Mental Disorder Prevention: A Policy for Europe" presents a policy framework with an overview of the mental health and public policies that can improve population's mental health. The document presents the case for action, the evidence of what works and targets for implementation for each policy option. It outlines a set of recommendations for policy makers to develop a policy strategy on prevention and promotion for mental health and provides a framework on which to base the development of effective action plans at the country or regional levels. This book has been developed in several phases with the Imhpa Policy taskforce, and the comments of the other Imhpa members and some of the partners of the European Platform.

The book was finalized in December 2004 and formally launched during the WHO Ministerial Conference on Mental Health in Helsinki, January 2005, by the Minister of Health of Finland Dr. Liisa Hyssälä, and Mr. Robert Madelin, Director General, Health and Consumer Protection, European Commission.

The Imhpa policy book received a lot of interest both at the country and the European level. Following this interest the book was translated into Polish and was presented during the first national conference on Mental Health Promotion in Poland (14th-15th October 2005).

The English version of the Policy book and the Polish translation are enclosed to this report separately and are made available through the Imhpa website (www.imhpa.net).
5.4 INFRASTRUCTURES MONITORING

5.4.A INTRODUCTION TO A MONITORING SYSTEM

The Impha infrastructure monitoring aimed to provide an overview of the situation of the available infrastructures, policies and programmes for mental health promotion and mental disorder prevention at the country or regional level across European Member States.

5.4.B DEVELOPED PRODUCTS

The main product of the infrastructure monitoring strand is the provision of an overview of the situation of the available infrastructures, policies and programmes for mental health promotion and mental disorder prevention at the country or regional level across European Member States through an internet database.

Following the discussions within the general Imhpa meetings, the project leaders, and the active email contact the project group agreed that the Policy strand would develop a combination of product. A first questionnaire was developed for the purposes of IMHPA only and distributed across 16 European countries for partners to provide information on available infrastructures on prevention and promotion for mental health. In the following months, exploring synergies, IMHPA and HP-Source developed a joint initiative where an improved questionnaire was developed in order to gather the available information. Wherever possible the data were gathered in a first number of 4 countries by means of a small country coalition or country group, created for this purpose, with national experts from different professional backgrounds and positions in the field of public and mental health.

1) COUNTRY PROFILES QUESTIONNAIRE

In order to identify what the available infrastructures and policies on mental health promotion and mental disorder prevention at the different country and regional levels are a country profiles questionnaire was developed and completed by European Member State countries. During the first year of the Imhpa project a draft of the questionnaire was developed and was completed by 16 countries.

The analyses of the results of the draft questionnaire highlighted that when different professionals in a same country would complete the questionnaire, there would be different responses to each question. This highlighted the lack of information across professionals in the same country and the need to develop a monitoring system on infrastructures that would capture the real situation of the country as opposed to the knowledge of the respondent. A second questionnaire (improved version of the first) was developed and a partnership was created with the health promotion initiative HP-Source.net (http://www.hp-source.net) under the leadership of Maurice Mittelmark.

The IMHPA-HP Source questionnaire aimed 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 resulted in a country profile description, providing 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.

Some of the data collected by the questionnaire was entered by each country representative into the HP Source website and served as a first collection of information for the continuation of the European Platform work in the development of the publication: Mental health

2) COUNTRY COALITIONS

To pilot what later on would be developed by the European Platform for Mental Health Promotion and Mental Disorder Prevention, country groups were created in some countries for gathering the information and completing the questionnaire. The country coalition or country group involved experts from different professional backgrounds and positions in the field of public and mental health. A heterogeneous group of professionals was suggested by the project leaders as representatives in the coalition (which would be later on taken on board at the European Platform project). For example:

- 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

All answers to the questionnaire are supported by background documents that 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 in the future, now being available under this project for: England, Norway, Poland and Scotland.

To guide the process of answering the questionnaires and country coalition formations at the country levels instructions and guidelines were sent out to the partners (annex 4.3).

3) EUROPEAN MENTAL HEALTH PROMOTION DATABASE

In collaboration with HP Source a first pilot of the Internet database for infrastructures was developed and pilot tested. Several phases of improvement of the software and instructions were developed during this project and the final database loaded onto the Imhpa website: http://www.imhpa.net/infrastructures-database.

5.4.C FUTURE DEVELOPMENT

It is expected that the work of the European Platform for Mental Health Promotion and Mental Disorder Prevention will continue gathering information on infrastructures for more countries than those involved in the Imhpa project, and that the information will be inputted and updated in the HP-Source – IMHPA database.
6. DISSEMINATION AND SYNERGIES

6.1 PR and visibility

An important issue from the project set out has been the dissemination and implementation of the project products once they have been developed to ensure the stimulation of mental health promotion and mental disorder prevention action at the country and European levels. During the Imhpa meetings brainstorming on possible actions for dissemination and implementation were held (see annex 5.1 and 5.2).

Secondly dissemination was supported firstly through the development of an Imhpa website (www.imhpa.net), which was distributed through the engaged networks and partners in the project. Thirdly, Imhpa has been engaged in several PR activities to disseminate its products across Europe. Some of these activities are listed below:

Presentations at different key European-World Conferences:
- WHO-Europe meeting of the Mental Health counterparts
- Alcohol Policy Network
- Wonca (general practice) European and World Conferences
- Third World Conference on Mental Health Promotion and the Prevention of Mental and Behavioural Disorders
- Pre-Conference of the WHO-EC-Council of Europe on the Mental Health of Children and Adolescents
- Gastein EC Health Forum
- WHO ministerial conference on mental health
- EC Ministerial conference on E-Health
- Health Promoting Hospitals conference
- World Psychiatric Association Conference

Representation and partnership building:
- Representation of Imhpa at the meeting of the World Consortium on Mental Health Promotion and Mental Disorder Prevention led by World Federation Mental Health
- EC Working Party of Mental Health
- Partnership in other EC projects, eg. MH Economics phase II; HP-Source; EAAD; EMIP

Press releases-publications
- Information prepared for press release during the Gastein Health Forum
- Inclusion in the info sheet for the WHO Ministerial Conference background papers on Research and Information
- Inclusion in the info sheet for the WHO Ministerial Conference background papers on Mental Health Promotion and Mental Disorder Prevention
- Description in the Special issue of Promotion and Education “The Evidence of Mental Health Promotion Effectiveness: strategies for action”.

Launches - other profiling
- Stand at the WHO Ministerial Conference
- Launch of the publication ‘Mental Health Promotion and Mental Disorder Prevention. A Policy for Europe’ by the Minister of Health of Finland (Dr. Liisa Hyssälä,) and Robert Madelin at the WHO ministerial conference
- Invited at the EC Ministerial Conference on e-health

Translation-dissemination-use:
- Translation of the training manual for primary health care into Dutch
- Translation of the policy document into Polish and dissemination at national conference on Mental Health Promotion
- Use of the policy document to support develop the MH policy of Kaliningrad
- Dissemination of the policy document across countries by partners

All partners were invited to disseminate information about Imhpa across their own country or to explore further links of the network (and the European Platform) with other groups or networks.

6.2 Exploration of synergies development and follow up strategy

During year 1 Imhpa members have raised the importance of continue developing synergies with existing networks, groups and ongoing projects that have a relation to mental health promotion and mental disorder prevention. Synergies were created before the start of the project with the WHO and 4 European Networks which all became Imhpa partners. In addition during year 1 a synergy was created with HP Source, a database to monitor infrastructures for health promotion in Europe. Imhpa has become the first module partner in HP Source to develop the Mental Health Promotion Topic Area. Other synergies of Imhpa developed during the second year with other organizations include the European Alliance Against Depression, Mental Health Economics European Network, or EMIP.

A second issue that had the attention of Imhpa partners in relation to next steps towards the end of the project was related to the development of a follow-up strategy to continue the work and expertise that Imhpa has develop. It was strongly recommended by all partners to seek new opportunities for continuation and explore funding options. After these requests, the Imhpa management team explored the possibility of an EC grant of the continuation of the work developed by Imhpa. Although it is not a second round or continuation of the project, the creation of the European Platform of Mental Health Promotion and Mental Disorder Prevention, which builds on what was developed by Imhpa and expands its work, has been seen as means to support and continue the input and work of the Imhpa network.
7. PRODUCTS DEVELOPED AND OUTLOOK ON THE FUTURE

7.1 Product development

During the two-year Imhpa project expected developments and planned tasks have been developed according to schedule. Project meetings have been undertaken according to plan and all project partners have agreed to a common set of project goals and products to be developed. Synergies have been created with other existing and ongoing projects such as HP Source. The products Imhpa include:

A Standardized Internet Database
- Software development for the database
- Programme descriptions template
- Systematic search strategies
- A searchable and user-friendly database
- 58 programmes described and entered into the database

A Training Manual for Primary Health Care Professionals
- A Training Manual to prevent emotional problems and to promote mental health in Primary Care – Trainers manual
- A Training Manual to prevent emotional problems and to promote mental health in Primary Care – Participants manual
- A pilot of the training manual in Netherlands
- A pilot of the training manual in Slovenia
- An evaluation report of both training pilots
- A first draft of a proposal idea for the formal evaluation of the training manual

Policy Guidelines
- An unpublished background paper with the evidence for mental health promotion and mental disorder prevention
- A publication: “Mental Health Promotion and Mental Disorder Prevention: A policy for Europe”
- Country profiles Questionnaires to assess infrastructures for prevention and promotion in mental health across the Europe
- Country profiles descriptions of assessed countries’ infrastructures based on the first developed questionnaire

Country support and coalitions
- Country groups an dexpert teams created in each country to support project development
- Country dissemination strategies for the dissemination of the project products

A project website
- Development of a project website with project aims, descriptions of strands, and partners
- Inclusion of publications, links to other relevant projects and links to the 2 databases developed by Imhpa. Web site: http://www.imhpa.net

The above products are presented in annexes 2 – 4 and the enclosed documents with this report and are available in the IMHPA website, http://www.imhpa.net.
7.2 Future development: European Platform for Mental Health Promotion and Mental disorder prevention

During the different brainstorm sessions and project meetings key areas that needed further development were identified by project partners. Long discussions were held around the lack of access to the evidence base, the lack of information at the country level of the situation of prevention and promotion that could identify the gaps and help build action; the lack of a trained workforce for prevention and promotion and the lack of information systems that would make the knowledge available across Europe. In order to continue and build forward on the products and synergies that had been created during the Imhpa project and with the intention to move the field forward and close the gaps between needs for action, a new project, the European Platform for Mental Health Promotion and Mental Disorder Prevention was outlined. This project aims to build on the Imhpa project and expand its work and partners to become the European Network for Promotion and Prevention in Mental Health. The aim of this network and new project development is to develop a comprehensive strategy to tackle prevention and promotion in mental health developing an integrated approach to information, intervention, training, policy and implementation, as identified during the IMHPA project. The three main objectives include:

1. The creation of a European Platform for mental health promotion and mental disorder prevention;
2. The development and integration of indicators, interventions, training and policies for mental health promotion and mental disorder prevention; and
3. The development of capacity, dissemination and implementation of information and action across European Member States and applicant countries.

The European Platform, with the collaboration of all its partners, will develop a comprehensive strategy for MHP and MDP, composed by the work and products developed under seven work packages:

1. An information system on available policies and infrastructures on MHP - MDP across Europe.
   Aims to assess and develop a monitoring system on available infrastructures and policies for mental health promotion and mental disorder prevention. This work package is linked to the HP-Source database for Health Promotion and builds on the work already started by the Imhpa project. Following the model initiated by Imhpa, country coalitions for mental health will be created in each country and the assessment of available infrastructures and policies will be undertaken through consensus. A final country story will be prepared for every country, describing the infrastructural situation of mental health promotion and mental disorder prevention in each country. All country profiles will be published in a book which will accompany the EC green paper on mental health.

2. An internet information system (database) on efficacious prevention programmes for depression, suicide and eating disorders.
   To develop, coordinate and operate a mental health information system on available evidence based programmes and policies for mental health. This builds on the IMPHA database. Priority areas for this new phase include suicide, depression and eating disorders prevention. The aim on the long run is that every country can have its own website on programmes and policies. A country pilot with this purpose will be developed in Scotland, to assess systematically all available programmes and practices for children and adolescents. In addition an evidence committee will work on developing a set of guidelines to rate evidence and provide recommendations on which programmes have sufficient evidence base so that could be recommended for adoption across member states.
3. A network of training in Europe, including the delivery of advocacy training on MHP and MDP.
   This training network aims to develop, coordinate and operate information on available 
   trainings for mental health promotion and mental disorder prevention. This builds on the 
   previously EC financed training development for programme design, implementation and 
   evaluation, (Mindful project) and the training for primary health care professionals 
   (IMPHA project). A new training module on advocacy for MHP and MDP will be 
   developed under the Platform and offered to all countries.

4. Development of indicators for mental health impact assessment of social policies.
   To develop better understanding of the effects of country-based and Community policies 
   and actions on mental health, developing and piloting the assessment of indicators for 
   mental health impact of other policies such as education, or assessing partnership 
   opportunities between mental health and other sectors.

5. Development of an economic model to assess costs and benefits of MHP and MDP.
   To develop understanding and knowledge on the economics and mental health and the 
   costs and benefits of mental health promotion and mental disorder prevention 
   interventions. This will include a review of the cost-effectiveness of mental health 
   promotion and prevention programmes, gathering available information on the costs of 
   mental health and the costs of not intervening and providing information across member 
   states in the developed country reports.

6. A dissemination plan, including a European conference on MHP and MDP.
   Ensure the development of the networking purpose of the Platform and how it can best 
   support European countries. Dissemination and implementation of the platform’s 
   products at the national and European levels through creating country coalitions, 
   developing national dissemination plans, establishing partnerships with existing 
   European networks and organizations, and organizing a European Conference on 
   dissemination, policy and implementation.
8. REFERENCES


*IMHPA - Final report*


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