Chapter 17
Strategies for Promoting the Mental Health of Populations

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Introduction

This chapter looks at the broad issue of conceptualizing and planning strategies for mental health promotion. Our intention is to discuss mental health promotion first and foremost as a population-based exercise – that is, we are primarily concerned with aggregations of people rather than individuals, while at the same time not forgetting that these populations are indeed made up of thinking, feeling, intensely individual people in their family and community environments.

For any effective approach to mental health promotion, it is crucial to be clear about what is meant by "mental health". This relates to the outcomes desired from any action, the processes involved and, in particular, the whole paradigm within which strategies exist. As is discussed elsewhere in this book, mental health promotion should be operating out of a *positive* view of mental health. This is more than mere pleasant sounding rhetoric. The adoption of such a perspective dominates any other consideration and is the determining factor as to how mental health promotion is actually done. Still, to date, mental health promotion planning and action seem to slip easily back into a "negative" or pathologized view of mental health, where the driving motivation is prevention of disease and disorder – a deficits approach – rather than the promotion of good mental health – an assets or strengths approach. This is not to say that the prevention of mental disorders is not important or necessary. On the contrary, we think that the two activities are complementary and partially overlapping, but nonetheless based on different paradigms.

Another important assumption to start with is that mental health promotion has the capacity to go right to the core of what societies value most, and what their fundamental purpose is. It also relates fundamentally to the way that governments perceive their task. The ultimate goal of caring nation states and communities around the world is to provide for people's basic needs (e.g. peace, food, shelter, employment, income, education, social justice and equity) and to ensure living conditions and environments that promote and support their personal growth, health, mental health and well-being. Individuals who live in supportive "resourcing" environments are able to experience their intrinsic resourcefulness and to participate in and contribute to the global productivity and wealth of their communities and countries (Joubert & Raeburn, 1998).

It is within such a vision of good faith and shared responsibility that health, obviously including mental health, was formally recognized in the Ottawa Charter as a "major resource for social, economic and personal development and an important dimension of quality of life" (WHO, 1986). The view of health as a positive resource has been echoed in many other international conferences, declarations and documents before and since. Examples include the Thirtieth, Thirty-Second and Thirty-Fifth World Health Assemblies (WHO, 1977, 1979, 1982), the Second, Third and Fourth International Conferences in Health Promotion (WHO, 1988, 1991, 1997) and the Alma-Ata and Jakarta Declarations (WHO, 1978, 1997).

Despite these attempts to move towards a positive view of individuals' physical and mental health within the broader context of community and population health, and despite various studies indicating that huge investments in curative health services alone do not always lead to the expected substantial improvements in population health (Lalonde, 1974; Evans, Barer & Marmor, 1994; Hayes & Dunn, 1998), the systematic development of strategies and actions to promote people's health has remained secondary to the development of and investment in treatment and rehabilitation

services. In other words, most health systems and health organizations, and their related industries (e.g. research, pharmaceuticals and new technologies), are still predominantly focusing on and financing the diagnostics, treatment and rehabilitation of physical diseases. Within this context, mental health represents a small fraction of overall health budgets, and what mental health funding there is goes mainly into the clinical treatment of mental diseases or disorders.

The imbalance of investment between the treatment of diseases and the promotion of health, in particular mental health, raises many questions, especially when considering the data on the extent of mental health related problems around the world and the associated human burden and economic costs (Murray & Lopez, 1996; Stephens & Joubert, 2001; WHO, 2001, 2003). Having said that, the intention is not to get into a discussion on the divergent interests or forces at play but rather to make a simple point: it will not be possible to move forward into promoting the mental health of individuals, communities and populations without going beyond solely a disease-based view of mental health.

Such a statement is not to deny that there are mental health problems or disorders that require attention. However, it is to remind ourselves that perhaps the majority of mental health problems encountered are the result of difficult life events, conditions and environments that diminish or disable people's resourcefulness or capacity to cope and access to social supports. Furthermore, the burden of mental health problems not meeting the criteria of a disorder may be similar to or even bigger than the actual disease burden. As stated almost 20 years ago in the Ottawa Charter, what is needed in order to better address the health, and mental health, of entire populations is actions that primarily focus on creating supportive environments and fostering individuals' resourcefulness and capacity to take control and make healthy choices. Such mental health promotion strategies are presented in this chapter.

Mental health and its promotion

But what are mental health and mental health promotion? How do they relate to the health of individuals, communities and populations? How also do they relate to considerations of treatment, prevention and recovery? These are concepts and questions that have been discussed extensively in earlier chapters. Our view is that mental health relates primarily to emotions, thoughts, relationships, behaviours and spirituality (Lahtinen, 1998); to individuals' capacity to enjoy life and to deal or cope with the challenges they face (Joubert & Raeburn, 1998); and thus to a positive sense of well-being. This includes individual resources such as self-esteem, optimism, a sense of mastery and coherence, the ability to initiate, develop and sustain mutually sustaining relationships and the ability to cope with adversity (Lavikainen et al., 2000). Nevertheless, most often, especially among professionals within formal and influential institutions and organizations, mental health is referred to, researched and debated within a pathological context – the language of which is of deficiency, disability and disorders. This is strongly illustrated by the content of numerous professional journals and reports produced worldwide on mental ill-health.

As most mental disorders are considered to be environmentally caused, there is a risk that human suffering, a likely reaction in extreme circumstances, is categorized as a mental problem and thus medicalized. When people are facing major stresses caused by unstable family, social, economic and political conditions, when their basic physical and mental needs are threatened, and when they are stigmatized and isolated while facing such situations, the suffering and the distress is tremendous. The reactions that individuals may display when they are distressed or are fighting

for their lives are frequently confused with mental disorders. However, a considerable body of longitudinal research shows that when their basic life conditions are restored, when the suffering experienced is recognized and legitimized, and when it is possible to count on family and social support, the capacity to recover – the resiliency – and the capacity to build meaning out of the suffering is astonishing. Furthermore, the vast majority of individuals are able to learn from adversity and to move on with their life in an enhanced way (e.g. Cyrulnik, 1999, 2001, 2003; Henderson, Benard & Sharp-Light, 1999; Pransky, 1991, 1998; Werner, 1994; Werner & Smith, 1992). These kinds of human processes are fundamental to a mental health promotion extended beyond a pathologized clinical and short-term frame of reference.

The approach for promoting the mental health of people that is presented in this chapter is first and foremost based on a fundamental faith and trust in people's humanity, a positive view of mental health and on a strong belief in all individuals, including people with mental health problems or disorders. This involves an inner resiliency, a capacity to "be, belong and become" on everybody's own terms within supportive environments. We believe that any mental health promotion activities should be based on a "people-centred" approach (Raeburn & Rootman, 1998) that focuses on empowering individuals and communities to take control over their own lives and mental health while showing respect for culture, equity, social justice, interconnections and personal dignity (Joubert & Raeburn, 1998). For instance, human or social enterprises aimed at promoting the mental health of entire populations should be considered a long-term investment by nations or governments. Such investment obviously requires initial financial and other support but would progressively pay itself off through reduced costs in health and social services. As a structural change, such an approach becomes sustainable because of individuals' and communities' direct involvement and participation, and the strength and productivity they get from their own involvement (see Durning, 1989; Lord & Farlow, 1990; Pransky, 1991; WHO 2002).

Three levels of action

It is probably helpful to consider the population approach to mental health promotion at three broad levels of analysis: macro or societal, meso or community and micro or individual. Each of these has its own set of conceptual and strategic considerations.

First, at the societal level the major preoccupation is with policy. Policy is often seen as a somewhat regulatory matter, but it can also be seen as representing a statement of principles and values by individuals, communities and societies relating to their goals and desired courses of action (see Chapter 16 and Jenkins et al., 2002). While much policy tends to be formulated by experts in their offices away from "real life", communities need the opportunity to deliberate together about mental health and its contribution to their overall health, sense of well-being and quality of life (Joubert, 2001a). In short, there is no reason why policy development should not be a participatory and empowering process in its own right, and therefore mental health promoting. An example of a step towards such participatory policy development processes has been provided by a few governments that allow a consultative debate on the Internet on policy proposals. Another example involves relevant stakeholders in participatory country situation appraisals prior to policy development (see Jenkins 2004 at www.mental-neurological-health.net).

Second, at the meso or community level, the desirable situation is that mental health promotion strategies and activities are decided on, developed and applied by people where they live their day-to-day lives. Here, "community" includes families, schools, workplaces and various community

organizations and settings as well as whole geographical localities and neighbourhoods. For example, in the workplace concerns about significant decreases of productivity in the private and public sectors have resulted in studies that have clearly indicated that in order to reduce high levels of stress, burnout and overall absenteeism, employers and employees have to work together to identify, discuss and agree on managerial and individual practices that need to be improved or radically changed (Marmot, 1997, 2003; Marmot & Wilkinson, 1999). Organizations and industries that have adopted healthy workplace guidelines and programmes focusing on increasing and fostering a sense of control, initiative, participation, appreciation, self-esteem and self-worth, as well a sense of belonging and support among employees and employers, have experienced major improvements in their human and business conditions (Lowe, 2003a, 2003b; Lowe, Schellenberg & Shannon, 2003). There are also examples of entire communities facing major social problems (e.g. high levels of violence, child abuse, delinquency, dropping out, drug trafficking and teenage pregnancy) that have succeeded in transforming what seemed to be intractable living conditions by primarily focusing on people's innate resiliency and capacity for well-being, for wisdom and for common sense instead of trying to change destructive conditions that kept people immersed in their problems (Durning, 1989; Pransky, 1991, 1998).

The third, micro or individual level is the oldest and most traditional sphere of mental health work. Here, mental health promotion strategies define themselves through various activities or practices that aim to promote, build on, increase or foster primarily individuals' strengths, resourcefulness or resiliency. Life skills such as social competence (responsiveness, cultural flexibility, empathy, caring, communication skills and a sense of humour), problem-solving (planning, help-seeking, critical and creative thinking), autonomy (sense of identity, self-efficacy, self-awareness, task mastery and adaptive distancing from negative messages and conditions) and a sense of purpose and belief in a bright future (goal direction, educational aspirations, optimism, faith and spiritual connectedness) are examples of individual mental health dimensions that are being targeted in programmes designed to increase resiliency in young people (Benard, 1991, 1993a, 1993b; Henderson, Benard & Sharp-Light, 1999; Rowling, Martin & Walker, 2002).

Many of the factors and conditions that impact negatively on the health and mental health of individuals, communities and overall populations often result from situations that go far beyond the direct control of individuals. Analysis of the health status of populations and its determinants has revealed how major economic, political and social decisions taken at the macro level by governments (for example, economic restructuring) can impact negatively on people's lives, health, mental health and well-being (Stephens, Dulberg & Joubert, 1999). At the opposite end of the spectrum, when these decisions are taken within a partnership and participatory approach that fully recognizes and supports individuals and communities in their capacity for self-determination, they become instrumental in major social changes that are beneficial to the whole population (Maxwell et al., 2003; MacKinnon, 2003; Phillips & Orsini, 2002). Mental health and social policies that espouse an empowering approach allowing for the participation and reinforcement of individuals' and communities' capacities to take control over their destinies would undoubtedly contribute directly to the health and wealth of populations and nations.

With respect to prevention, treatment and recovery/rehabilitation, the major and powerful characteristic of mental health promotion is that it is closer to the "natural" way people see and want to live their lives. It can be asserted that human beings are much more likely to be open and responsive to approaches that increase their capacity to cope with life on their own terms, than

to ones that are prescribed from above and which victimize and reduce them to their deficiencies or disabilities. In short, an approach to mental health is advocated in a mental health promotion context that is not pathologized or medicalized, but positive and likely to resonate with people in terms of its intuitive appeal and respect for them as resourceful human beings. It is also likely to reduce the stigma currently associated with mental illness-dominated approaches to mental health issues. Indeed, the potential for the application of the kinds of mental health promotion principles espoused here – involving strength-building, resilience, empowerment, positivity and community – is increasingly being used in the treatment and recovery sector (Falloon & Fadden, 1993; Hawe et al., 1998; Rowling, Martin & Walker, 2002). The research suggests that such approaches are highly effective (Barry, 2001; Durlak & Wells, 1977; Falloon & Fadden, 1993; Health Promotion Wales, 1996; Hosman & Llopis, 2000; Pransky 1991; Tilford, Delaney & Vogels, 1997; Vinokur, Price & Schul, 1995). Our view is that the application of positive mental health promotion principles across the whole mental health sector, and as part of the whole operation and thinking of governments with regard to the well-being of their populations, could usher in a new era of enlightened thinking. When a government puts the positive quality of life of their citizens first, then the nation is sure to prosper.

The Ottawa Charter for Health Promotion as a guide to population strategies

Mental health promotion is grounded in the older field of health promotion, but also has distinctive features that render it unique. To the extent that it shares characteristics with health promotion, the Ottawa Charter for Health Promotion can be seen as a useful broad template for considering strategic action in mental health promotion.

As discussed in Chapter 2, the Ottawa Charter is still widely respected and quoted as the source document internationally for thinking and action with regard to health promotion. Its advent in 1986 represented a sea change in the historic ideology of health promotion, which during the 1970s had largely been concerned with individual lifestyles and health education (e.g. Lalonde, 1974). The Ottawa Charter represented a more population-oriented approach, which identified broad social determinants as being crucial to the overall health and well-being of populations – such matters as war, peace, a clean environment, employment, economics, housing, adequate food supplies, social justice and so on. The health of a nation was considered to depend much more on overall policies developed and imposed by governing bodies than on what individuals were able to choose to do. That is, loosely speaking, the Charter favoured a "deterministic" point of view over a "free will" one, and this is shown by the "determinants of health" language that flowed from it. In retrospect, it is probably true that the Ottawa Charter was an overreaction to the individually focused lifestyle model of the 1970s, and as a consequence may have somewhat downplayed the role of active, deciding human beings in the health promotion equation, especially in developed nations. However, the Charter's definition of health promotion as "the process of enabling people to get control over, and to improve, their health" certainly implies that people are meant to be active agents in their own health destinies.

For mental health promotion, the *control* aspect is deemed especially important. It could be argued that one's mental healthiness is directly related to how in control of one's life one feels. Health psychologists emphasize the importance of a sense of personal control for dealing with stress and for health generally (e.g. Joubert et al., 1998; Sarafino, 1998; Steptoe & Appels, 1989).

In many respects, mental health promotion is an enterprise concerned with enabling people to have more control over their lives. As a result, any discussion of mental health promotion strategies has to make the control issue a central consideration. The Ottawa Charter represents a dilemma or contradiction with regard to control. On the one hand, the definition of health promotion implies that control by people is core to the health promotion enterprise. On the other, the rather remote, policy-driven, social determinants perspective contained within that document implies that it is "others" – governments and experts – who know best, while individuals and "people" as active agents in their own health and well-being are of less importance. In short, while the rhetoric includes an empowering, bottom-up perspective with regard to "people control", the overall sense is of having to change the world in a way that only governments and major players can do – in short, a top-down, "we know best" perspective. This is the core dilemma for health promotion and mental health promotion, but – in a broader sense – the same dilemma applies to any democracy: that is, to what extent do the wishes of communities and ordinary people actually play a role in overall political decision-making (see MacKinnon, 2003; Maxwell et al., 2003; Phillips & Orsini, 2002).

One way to balance the policy and people perspectives is through a focus on community. From this point of view, the community action stream of the Ottawa Charter, which is third in the list of five streams (see box 2.1 in Chapter 2), is actually the pivotal one both literally and figuratively. At the same time, it is crucial to recognize the role of policy as a framework for whatever is done in health promotion and mental health promotion (see Chapter 16). Therefore, we do not see the issue as being one of choosing a policy perspective versus a people perspective, but rather of requiring both – that is, the optimal approach involves both policy and people components, equally and synergistically balanced.

Since the Ottawa Charter was not put together with mental health promotion as we now understand it in mind, let us see what it has to offer to mental health promotion. Indeed, the implicit understanding in the Charter is that it is very much centred on physical health and disease. It is a document addressed more to governments and high-level decision-makers than to "the people". As stated, the Charter draws attention to health determinants that are beyond immediate individual control and which relate more to the macro than to the micro environment of people. This was an almost revolutionary statement for the time (1986) in the light of both the history of an individualistic view of health promotion and, on a wider scale, the move in a neoliberal direction economically by many developed countries, given the emphasis on the individual in those policies. But the Charter is even more revolutionary now, after almost two decades of free market macroeconomic policies throughout the world and the hegemony of the exponentially increasing understanding of the human genome and rapid development of medical technology. That is, we are in an era of individualism and the determinism of genetics as the ascendant social philosophies, at least in the developed countries, as discussed in Chapter 10.

Nevertheless, the Charter's implied suggestion is that the empowered and democratic actions of people in local communities can have a significant impact on the scheme of things. It is contended here that this people-driven democracy dimension represents a very significant consideration for action and strategy in population-based mental health promotion. The main goal which mental health promotion should be striving towards is people's resilience, obtained through self-determined action by and under the control of those people in their local, naturalistic settings – an "empowered community action" perspective.

The Ottawa Charter states that good health is an holistic and ecological matter, and that health is a positive concept, in line with the previous discussion. It also, as mentioned before, describes health as a "resource for living". Without good mental health people are impaired or struggle in their daily lives. Interestingly, the Charter does not state that good health is every person's right, or that governments have a responsibility towards their citizens with regard to good health. However, it implies that it is the duty of every government to attempt to optimize the conditions fostering mental health and well-being and quality of life of all its citizens. The Charter specifies that for the professionals concerned with health promotion, processes of advocacy, mediation and enabling are required. In mental health promotion the professional's role is seen primarily as one of the facilitation of self-determined, community-controlled processes, rather than doing things to or for people, which simply creates dependencies and is ultimately disempowering.

In order to bring about conditions of good health in their citizenry, the Charter encourages governments to look at action in five different areas: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (see Chapter 2). It is these "action streams" that most people have taken out of the Ottawa Charter as its main contribution, although regrettably often overlooking the implied empowerment agenda associated with them (which is that the people themselves should be determining the parameters and action with regard to these streams, rather than governments in a vacuum). The action streams provide a useful checklist of what should be looked at when considering strategies for any health promotion or mental health promotion endeavour.

Healthy public policies

The Ottawa Charter refers to all public policies, not just to health (or mental health) policies (Milio, 1986). Indeed, there is presently an increased awareness that most societal structures and actions will impact on health and mental health, and of the need for advocacy about this reality in the policy sphere. In recent years, the concept of considering and assessing the health impact of public policies has helped to operationalize this aspect of health promotion, which may be seen as one of the major political contributions of the Charter at the global level.

Even in developed countries, the mental health of populations has typically had a very secondary role compared to general health in health policies, not to mention other socioeconomic policies. For various reasons, among which is its association with mental diseases, mental health as an issue tends to remain isolated – politically, theoretically, organizationally and professionally. Perhaps one of the most essential tasks of mental health promotion is to engage in policy-related advocacy which aims to enhance the visibility and value of positive mental health at the level of governments, society at large, communities and individuals (Lavikainen, Lahtinen & Lehtinen, 2000). The objectives include the integration of positive mental health into general and public health agendas and the strengthening of societal action conducive to mental health.

Mental health and well-being are broad concepts, and the array of societal policies that can affect health and well-being is huge and diverse. The difficulty in providing unambiguous operationalization of this action stream, and the lack of availability of feasible indicators for processes, impact and outcomes, may make the concept of "healthy public policies" seem rather vague. It is suggested here that we divide policies with regard to mental health promotion into two broad types and look for indicators accordingly. One class of policies is those which have an indirect effect on enhancing mental health (as well as physical health and general well-being), such as employment,

housing, economic factors, education, safety, control of gambling and so on, which can be called policies to do with the "public good". The other class of policies is those where the direct intent is the enhancement of mental health and well-being, such as school curricula to do with communication skills, parenting support, stress management in the workplace, facilities for the well-being of older people, support for community development and self-help, violence prevention, bullying prevention, promoting cultural awareness, media campaigns on how to improve mental health and so on. Effort needs to be put into delineating process and outcome criteria for the assessment of the impact of both types of policies on mental health and well-being, some of which have to be capable of measuring very long-term and sometimes tangential effects. As processes of mental health promotion have an essential role in changing attitudes and conceptions and improving knowledge, their importance can not be emphasized too much.

Development of mentally healthy policies is essential at all levels. International efforts in policy development bring stimulus and significant added value to the development of national, regional and local approaches and vice versa. Reflecting the Ottawa Charter's definition of health, this policy development should probably be around the concept that positive or good mental health is a resource that is essential for the optimal operation of a society, including productivity. Favourable conditions for good mental health should also be regarded as being everyone's right as a citizen, and governments therefore have a duty to articulate and ensure this and to acknowledge that social factors – over which they have a great deal of influence – have a major impact on mental health. The challenge is to bridge, theoretically and practically, the gap between broad policies and individual and collective "people" dimensions of mental health, which we have already alluded to as the fundamental issue in the design of mental health promotion strategies.

Just as mental health has largely been viewed through a pathology lens, so too has it tended to be considered solely a matter for individuals to deal with. Only recently has mental health been accepted as a public or population health and societal issue (e.g. Ellis & Collings, 1997; Joubert, 2001b; Joubert, Williams & Taylor, 1996; WHO, 2001). Mental health seen at a societal level, and as something that everyone "has", is an area that needs to be taken seriously by policy-makers (Jenkins et al., 2002). It is clear that overall capacity building for policy development and implementation for the promotion of positive mental health is an essential part of any state's social agenda. Broadly understood, identifiable leadership in public administration relating to the mental health of populations is a prerequisite of consistent policy and its implementation, and a knowledge base with good quality information, data and statistics is required for planning and follow-up activities. WHO strongly recommends that national mental health promotion policies take the form of a written policy document (WHO, 2003), which may in turn be important for getting an adequate financial commitment to the promotion of mental health. To consolidate any such policy, it should be reflected in legislation.

A mental health promotion policy is one that is based on a clear concept of positive mental health, needs assessment, and the definition of short-term objectives and long-term goals (see Chapter 16). As with any policy-making, mental health promotion policy should be continuously redrafted. Special attention should in this regard be given to communication with nongovernment organizations, communities and people. Any area of policy is enhanced by people-centred public consultation. For mental health promotion in particular, where the core values are those of a community-driven, empowerment approach, significant interaction between policy-makers and the community is essential. Mental health is a very personal, very intimate matter related to the

fabric of people's everyday lives (on which many policies directly impinge), and so it is essential to hear those voices which may normally be silent in the policy-making sector.

A final but perhaps most important point to make relates to equity. As discussed in earlier chapters, there is strong evidence that the worst mental and physical health occurs in situations of greatest societal inequity – in developed countries at least (Fryers, Melzer & Jenkins, 2003; Wilkinson, 1996). New research is indicating that the social gradient of health is strongly influenced by factors such as social position, relative versus absolute deprivation, sense of control and social participation, even among people who are not poor (Marmot, 2003). That means that both at a structural-political level, which involves such matters as a state's philosophies about economics and welfare, and at a more micro level, for example everyday procedures in public services and organizations, it is essential that all groups are heard and supported. Many modern societies are multicultural, often with recent migrant populations or with indigenous populations that have been colonized. Many nations have groups of displaced or disadvantaged people for whom the stresses of life are considerable. In policy development, the factor of culture – largely missing from the Ottawa Charter – needs to have top consideration, and the effort to hear the voices of the most oppressed, disadvantaged and suffering has to be made. There are many who would argue that the most disadvantaged in any society are the stigmatized mentally ill. Not only does this support call for a less pathologized approach to mental health, but it also says that the voices of those most negatively affected by sub-optimal mental health are vital in the input to overall mental health promotion policy-making.

Supportive environments

The role of health in the interaction between people and their environment is particularly underlined in health promotion. Environmental health strategies have become a standard part of health policies everywhere. However, the scope of environmental health is often still somewhat limited to "bugs and particles", such as water quality and air pollution, areas which are concrete and operational. Less attention has been paid to the social and macro environments, and to the mechanisms through which they exert an influence on health.

A large proportion of human physical and social environments are planned, and much of this involves planning for, rather than with, people. At the community level, the resulting structures either facilitate or block the development of social networks, neighbourhood collaboration and everyday connections for social contacts. In the same way, workplaces have their organizational structures and cultures that are innate and difficult to change without pressure from staff, unions or other interest groups. A mental health promotion perspective would support such concepts as the Movement for Socially Responsible Organizations, the "Nissan Way" or worker democracy, where those "lower" in the formal power structure have a significant and meaningful input into planning, policy and decision-making, a process which honours their expertise, experience and innate wisdom. Such general philosophies could also be applied to communities at large.

The interplay between the person and the environment is probably even more important for mental than it is for physical health promotion, due to the interactional, contextual and developmental determination of mental health. Particularly important here is the interaction between the sociopolitical environment and family structures. There is wide agreement about the importance of early life experiences and their influence on individuals' mental health that is often more powerful than genetic factors. Certainly, no matter how healthy the genes, a baby or child subjected to any

kind of abuse is likely to bear the scars of that, with likely ill-effects on later mental health, at least until recognized and healed. Phenomena such as abuse are closely related to economic, living and other stress conditions, which impinge directly on the structure and function of families and other early experiences in communities. The issue of the relationship between supportive environments and the development of individual resilience has therefore received increasing attention from a number of authors. Indeed, it has been argued elsewhere that the key to promoting mental health is to foster individual and collective resilience in a supportive environment (Joubert & Raeburn, 1998).

Although such matters as a clean, well-designed and safe environment are very important in the promotion of mental health, the nature of people's interactions with these environments tends to get more attention, as well as how these environments help to determine interactions between people. Also, the mental health impacts of settings become of high salience. Typical settings considered for health promotion are schools, workplaces, families, recreational facilities, health care settings, social care settings, prisons, orphanages, refugee camps, other organizations and the community as a whole (see, for example, Chapter 8). One can see that for each of these settings there are major psychological and social aspects that have mental health overtones, such as stress in the workplace or social support in communities. Therefore, "setting" as an ecological or environmental niche with its own particular impact on mental health is of paramount consideration for mental health promotion. Although the smaller environments implied by the concept of setting are crucial for mental health promotion, they should not allow us to lose sight of the larger physical and sociopolitical environment and the necessity to recognize factors in the macro environment which affect mental health. We need to develop interventions to modify these factors, as well as indicators to evaluate the processes, impact and outcome of these actions (Catalano & Dooley, 1980).

Community action

Earlier in this chapter we argued that community is the most important setting for the consideration of mental health promotion strategies. Community has many meanings – here we take locality community as the prototype, while not losing sight of the many other kinds of communities that exist and that are not necessarily tied to a particular locality. However, a sense of place is regarded as very important for mental health, and the relationship between the "network" aspect of community (which is universal) and the place or places in which those networks exist is of considerable relevance to any discussion of mental health promotion (Raeburn, 2001).

As mentioned before, community is seen as a meso level, ecological or social entity that sits at a pivot point between the macro level of whole populations with considerations such as policy and environments and the micro level of individuals, families and small groups of friends and supports. That is, community can relate readily "up" to the macro political level and "down" to the intimate concerns of everyday life. Appropriately resourced and organized, communities, we assert, have the potential to have considerable political and social influence. We also assert that humans are intrinsically social and community beings, and that even the most alienated and dislocated of us long for "a psychological sense of community" (Chavis & Pretty, 1999; Sarason, 1974, 1986). McMillan and Chavis (1986, p.1) define this sense of community as "a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to be together". This desire for community – for basic human relatedness, support and common endeavour – is one of the most fundamental human impulses and is central to mental health, as most existential and other wri-

ters about the human condition would agree. The essential processes and structures of community are the basis of what has come to be called social capital by academics and politicians – those social bonds, institutions and activities which are the lifeblood of rewarding and healthy human societal existence (e.g. Grootaert & van Bastelaer, 2001; see also Chapters 6 and 10). Community is also the major vehicle for participation in society. Participation is seen as the main instrument of a sense of empowerment, and hence of control, so any mental health promotion strategy needs to factor a sense of participation into anything it does (Lord & Farlow, 1990; Marmot, 2003; Rissel, 1994).

The community dimension of health promotion relates to various earlier social movements (Driscoll, 1998; Minkler, 1990). In particular, it relates to the concept of community development and the associated concept of empowerment. These concepts have been strongly influenced by what is happening in many developing countries, where economic and social development is often based on needs assessments and self-determined action by the people themselves. Such self-determined community action has a very "healthy" impact, in the sense that people are more in control of their own destinies and actions. Indeed, in 1989 a summary of a report by Worldwatch said that "[self-determined] grass-roots groups are our best hope for global prosperity and ecology", and constituted "perhaps the most important political development of our time" (Durning, 1989). In developed countries, such as the USA, the community development enterprise has more often been associated with human rights and the empowerment of minority groups, beginning (in the case of the USA) with the liberation of slaves and moving through movements such as those for women, Afro-Americans, homosexuals, the disabled, mental health consumers and others (Minkler, 1990). In some countries, the indigenous peoples have strongly asserted themselves to good effect. Such movements resonate well with the concepts of mental health promotion.

As the Ottawa Charter (WHO, 1986, p. 3) states:

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

A useful and simple planning model that incorporates a community-led approach – the PEOPLE System – is shown in box 17.1.

Personal skills

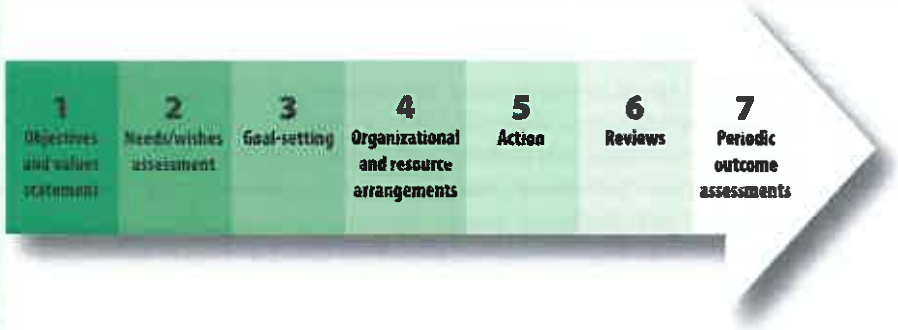
The action stream of personal skills is most closely related to the 1970s view of health promotion as being largely to do with individual behaviour and lifestyle. The lifestyle view, introduced by the Canadian Lalonde Report (Lalonde, 1974), was in itself a major new concept. Prior to its publication, most of the territory today described as "health promotion" was largely to do with the giving of information about how to live in a more healthy way ("health education" as it was then understood). Lifestyle turned the attention onto behaviour and brought the technology of behavioural psychology to bear on the enterprise. The Lalonde concept of lifestyle referred to a finite number

Box 17.1

A community-led approach: the PEOPLE System

The PEOPLE (Planning and Evaluation of People-Led Endeavours) System (Raeburn, 1992) is a simple seven-step approach to planning, organizing and evaluating any mental health promotion project involving groups of people, including whole populations. It incorporates many of the concepts of community or people ownership and control discussed in this chapter.

The seven stages of the PEOPLE System:



All projects start with an initial period, sometimes quite lengthy, of discussing in general terms what it is that the population of interest (POI) wants to do, and how to do it. A more precise process then follows of assessing, through surveys, focus groups and so on, what the POI wants for itself – a clear specification and prioritization of its own needs, wishes and priorities for action. Explicit goal-setting then takes place for what the POI wants to achieve over a specified time period, usually 12 months, accompanied by a consideration of what resources are available and what sort of organizational structure is required to make it all happen. Action to meet these goals is then planned and undertaken, each goal area having a person responsible for it, who in turn may work with a number of people on relevant tasks.

As work proceeds, there are regular reviews where people responsible for various goals report back to the group on progress. Where there are difficulties, the group can participate in finding a solution. Finally, from time to time an overall assessment of progress is done, to see that the whole enterprise is on track and is having its intended impact.

Needs, goals and actions can be modified over time based on the review process with the aim of having a continuously improving enterprise. Goals are only changed as a last resort, since a degree of stability is required to ensure the system does not get too distracted by "the latest idea".

The PEOPLE System allows flexibility for cultural and local interpretation, and for spontaneity and creativity. It seems to be able to span cultures successfully and has been used in both urban and rural settings in New Zealand. It is most effective with training in its use, and the most usual form of application in community settings is for a facilitator familiar with the PEOPLE System to introduce it to the POI, go through all the steps with them over time (a typical comprehensive community project can take one or two years to go through all these steps fully) and then support the group into full independence, continuing to use the system as the basis of their organizational approach. As such, the PEOPLE System has assisted with the sustainability of projects. Indeed, some community groups in New Zealand have been using it as the basis for their community development project's organization for up to 30 years. More on the PEOPLE System can be found in Raeburn, 1992 and in Raeburn and Rootman, 1998.

of specific sets of behaviour known to be related to health status (e.g. smoking, eating, exercise, driving). However, it was embedded in a wider health field concept, in which environmental factors also featured. In spite of this larger perspective, the lifestyle component tended to be taken out of its social and especially cultural context to the extent that it was criticized as encouraging a "blame the victim" attitude, which put the responsibility for faulty lifestyles on individual choice. This was later eclipsed by the social determinants approach to health promotion.

The personal skills stream may be a compromise with the earlier, more individualistic approach. It represents an individual or micro perspective, as distinct from the other streams that are to do with whole populations, communities or systems. The adoption of the Ottawa Charter was preceded, and followed, by a lengthy debate about the similarities and differences between health promotion and health education. In the event, the major international body for health promotion practitioners, the International Union for Health Promotion and Education (IUHPE), by its very name seems to have decided that they are two separate but connected domains of activity.

WHO defines health education as consciously constructed opportunities for learning which are designed to facilitate changes in behaviour towards a pre-determined health goal. Health education aims to improve people's knowledge and understanding about the factors, individual as well as societal, which affect their lives, and their ability to make their own conscious choices (Seedhouse, 1997). The scope of health education varies widely. It can be a one-way mass communication on health or it can be interactive in various ways. Health instruction refers to situations where health issues are taught. Interactive forms of health education can also be included, such as one might find in a primary health care or counselling situation.

With regard to mental health promotion, much of what can be subsumed under the concept of developing personal skills is related to "life skills training", which is the staple of what is called "primary prevention", with its emphasis on keeping well those in danger of declining. As mentioned earlier, there is evidence from many studies that interventions to enhance living skills can have very positive and enduring effects on people's lives, ranging from parenting programmes through classroom instruction to peer-led substance abuse programmes (Pransky, 1991). Most life skills activities are conducted in small group settings, which is why they qualify as "personal" (as distinct from larger community or population-based) programmes. Life skills programmes tend to have an educational component, in that people need to know what to do to change behaviour. However,

there is also usually a strong emphasis on social support and small group dynamics, and the best of such programmes put a strong emphasis on empowering rather than top-down processes. The broad area of self-help and mutual aid, a feature in the Canadian *Achieving Health for All* framework for health promotion (Epp, 1986), also falls into this category.

Of special relevance for mental health promotion strategies at the personal skills level is the concept of stress and stress management (Pelletier & Lutz, 1991; Sarafino, 1998). It could be argued that stress underlies most considerations of mental health, and the concept of resilience is closely allied here. Resilience is really about how people cope with, bounce back from and learn from life's demands and adversities (Kulig & Hansen, 1996; see also Chapter 3). Stress is about having to react to and cope with life's demands (Sarafino, 1998). Most stress management processes are undertaken at a small group or individual level, so they fit well into the personal skills category. At the same time, much stress in modern society is systemic and political, or associated with environmental or workplace conditions that are more relevant to the other levels dealt with by the Charter. Stress is an under-used concept in the mental health promotion area, one which has its roots in the personal level but which transcends this to also be applicable to meso and macro considerations.

Reorientation of health services

The 1974 Lalonde Report was radical in that it identified that the traditional way in which governments had thought about public expenditure in the health arena – through health services and medical treatment – was only a relatively small part of the total picture of what determined health. The Ottawa Charter reflects this, in that very little of it relates explicitly to medical concepts or health services. Instead, the idea of "returning power to people" may be understood as taking the power from medicine and health professionals back to the people. Health services are seen as a powerful resource for health promotion, but only after an expansion from a narrow focus on treatment of symptoms to not only a more holistic biopsychosocial approach to treatment but also to a focus on positive enhancement of health. At the very least, conventional health services need to add a health promotion set of services to their treatment ones (Rowling, 2002). Viewed in this way, health promotion can be considered complementary to treatment. However, because of the quite different models and ideologies involved, there can sometimes be an unfortunate and unhelpful polarization between the two.

The frequent polarization between so-called medical treatment models and health promotion models of health is matched to some extent in the research area by a division between "positivist" and "postmodern" methodologies. The positivist paradigm favours hard facts, RCTs, a "risk" analysis (rather than a focus on broader social and societal determinants that cannot be addressed by RCT techniques) and a tendency to emphasize interventions by professionals in the context of top-down national policies. In contrast, the health promotion/New Public Health paradigm tends to favour a softer approach, often within an ecological framework, where bottom-up community and people-led processes are valued, qualitative information is often regarded as being of more value that purely statistical data, and research is oriented towards participatory action research models (Reason & Bradbury, 2001) and/or qualitative methods (Denzin & Lincoln, 1994). We are using the term "New Public Health" to signify the philosophy and worldview of the Ottawa Charter, with its social determinants perspective combined with an empowering approach to

enhancing health on an equity agenda. Both approaches are of course essential, complementary, and of great value for the mental health of populations.

Conclusion

Effective mental health promotion is based on a positive, non-pathologized approach to mental health that focuses on strengths and resilience building. The Ottawa Charter for Health Promotion provides a helpful starting place for looking at strategies for mental health promotion from a population perspective. The Charter's vision is one of the New Public Health, rather than one that is medicalized and oriented to deficits and the reduction of risk factors. Its breakdown into five action streams provides a useful checklist for mental health promotion strategies.

Mental health promotion as a recognized or formal enterprise is still in its infancy. But, as we said in the introduction to this chapter, mental health promotion as represented here is close to the natural way people see and want to live their lives. As such, it goes right to the heart of the most important matters of human existence and, at a population level, could well be a vehicle for empowerment of people around the world, and for indicating to governments that the well-being and quality of life of the populations over which they preside is of pre-eminent importance. Good mental health is the most important thing we have.

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