Margaret M. Barry · Aleisha M. Clarke
Inge Petersen · Rachel Jenkins *Editors*

Implementing Mental Health Promotion

Second Edition

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Editors
Margaret M. Barry
WHO Collaborating Centre for Health Promotion Research
National University of Ireland Galway
Galway, Ireland

Inge Petersen
School of Applied Human Sciences
University of KwaZulu-Natal
Durban, South Africa

Aleisha M. Clarke
Child Mental Health & Wellbeing
Early Intervention Foundation
London, UK

Rachel Jenkins
Institute of Psychiatry
Kings College London
London, UK

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This book is dedicated to all who work for the improvement of mental health and wellbeing.

Preface

Good mental health is fundamental to population health and wellbeing and contributes to the functioning of individuals, families, communities and society. As recognised by the World Health Organization, strategies focused on treating mental ill-health alone will not necessarily deliver on improved mental health at a population level. Mental health promotion is concerned with strengthening protective factors for good mental health and enabling access to resources and supportive environments that will foster the mental health and wellbeing of individuals and populations. There is compelling international evidence that there are effective and feasible interventions for promoting mental health, which when implemented effectively can enhance protective factors for good mental health, reduce risk factors for mental disorders and lead to lasting positive effects on a range of health, social and economic outcomes. Mental health promotion strategies have been introduced in many countries globally as one of the most sustainable methods of improving population mental health, reducing the increasing burden of mental disorders and improving overall health and wellbeing. While there have been significant research and policy developments in advancing mental health promotion in many countries, the capacity to deliver effective strategies needs to be strengthened.

This second edition of *Implementing Mental Health Promotion* provides a practical guide to the implementation of mental health promotion interventions with different population groups across the life course in key settings, such as the home, school, community, workplace and health services. The text is written from a 'how-to' perspective, combining an exploration of current research and evidence with practical advice to support the planning and implementation of interventions in real-life settings. This revised edition provides updated examples of effective intervention approaches, illustrating the process of implementation. Case studies of practical aspects of intervention development, implementation and evaluation from high-, middle- and low-income countries are included in order to demonstrate the successful implementation and scale-up of interventions across diverse country settings. This second edition draws on the improved evidence base to illustrate how information from research can be used to inform effective and sustainable intervention development and implementation.

Since the first edition of *Implementing Mental Health Promotion*, there have been a number of important international developments in mental health promotion research, policy and practice. These developments are incorporated in this second edition of the text, with a focus on global policy frameworks, intersectoral partnership working, the role of mental health in the Sustainable Development Goals and the implementation and scaling-up of the expanded evidence base for effective action in diverse country settings. The writing of the first edition of *Implementing Mental Health Promotion* was motivated by the paucity of available texts on mental health promotion and also by the fact that issues of practical implementation were typically not addressed in the majority of publications. In this second edition, we also focus on the importance of implementation and demonstrate how advances in implementation science can inform the effective delivery of mental health promotion interventions globally. The different dimensions of implementing mental health promotion, spanning conceptual, policy and practice perspectives are addressed across the 16 chapters of the book, and the key factors affecting the quality of implementation are examined for a range of interventions in key settings. The practical challenges of implementing mental health promotion interventions are explored, including the challenge of translating evidence into action and ensuring effective implementation in different sociocultural settings with differing financial and human resource constraints.

The leading authors in the field have contributed case study examples of implementing evidence-based interventions across diverse country contexts, in order to provide an insight into how high-quality implementation can be ensured through the use of research-based, theoretically grounded and culturally appropriate interventions. Drawing on new literature and research since the first edition, the key factors and conditions that can improve the quality of implementation are highlighted, and recommendations for practitioners, policy-makers and researchers are discussed.

In terms of the structure of the book, Part I provides an introductory overview of the field of mental health promotion, and a strong theoretical and conceptual base for action is outlined. A review of the theoretical and international evidence base for effective mental health promotion interventions is provided, introducing key concepts, principles and frameworks for practice and identifying evidence-based priorities for action. International policy developments and frameworks are discussed, and the necessary infrastructure to support effective policy and practice is addressed, including capacity and workforce development. In Part II, a detailed account of the practical steps involved in intervention planning and delivery is provided, including an overview of current implementation research, frameworks and strategies for intersectoral working. A generic template for action is presented, which can be used to guide planning and implementation across a range of interventions and settings, and recommendations for supporting quality intervention implementation are outlined. Parts III, IV, V, VI, VII, and VIII demonstrate the implementation of evidence-based approaches with a range of population groups across the life course (children, adolescents, adults and older people) in key settings including the home, school, workplace, community, primary care and mental health services. Each section introduces the rationale for mental health promotion in that setting and provides an

overview of current concepts and research findings together with examples of evidence-based interventions and case studies on the implementation of exemplary and innovative approaches. An updated set of evidence-based practice examples and case studies is selected from across low-, middle- and high-income countries. Based on the research and case studies reviewed, generic principles of best practice are identified for implementing mental health promotion in that setting.

As in the first edition, it is important to acknowledge that the book does not address all relevant settings, nor indeed does it include all evidence-based intervention approaches. However, we have endeavoured to include a representative sample of interventions that will illustrate key principles of good practice in programme implementation. The practice examples and case studies have been updated in this edition to include a greater selection of examples from low- and middle-income countries in order to address the particular implementation challenges when working in resource-scarce settings. Across the chapters, we have taken a population level and life course approach, including mental health promotion actions for the general population, those deemed to be at higher risk and also people with mental health problems. In keeping with the principles of mental health promotion, this approach adopts the view that we all have mental health needs and that positive mental health can be promoted for all, including those experiencing mental disorders, across a range of everyday settings. This second edition of *Implementing Mental Health Promotion* primarily addresses the implementation of discrete interventions, as this is where most evidence has been collated to date. However, we are mindful that mental health promotion embraces a much broader range of activities than defined programmes and that it also includes policy changes and broader macro-level interventions. At this point, we have focused on presenting a selection of the evidence-based approaches that have been successfully applied and the factors that have been identified as making them work.

This second edition is written for a broad range of readers, including practitioners, policy-makers and researchers working in mental health, health promotion and public health. Health promoters and professionals working across a range of sectors and settings, including communities, schools, workplaces, primary care and mental health services, will gain useful insights into evidence-based practice and the practical steps that are needed to ensure successful programme implementation. This book provides policy-makers and decision-makers with a guide on what is needed to be put in place in order to translate the evidence in mental health promotion into best practice and policy. This revised edition will also appeal to researchers, academics, teachers and trainers interested in gaining a greater academic understanding of the core concepts and principles of mental health promotion, the strength of the current evidence base and its translation in practice. The text provides a useful resource for postgraduate students, as they will be able to access in one text the multidisciplinary literature that informs mental health promotion research and practice, together with practical guidance on successful intervention design and implementation from diverse countries globally.

This revised edition of *Implementing Mental Health Promotion* brings together the literature from research, practice and policy in order to advance the

implementation of effective, feasible and sustainable mental health promotion action for diverse population groups and settings. We hope that you will find the book both useful and enjoyable and that it may stimulate the development, implementation and evaluation of high-quality interventions and initiatives that will promote population mental health and wellbeing.

Galway, Ireland — Margaret M. Barry
London, UK — Aleisha M. Clarke
Durban, South Africa — Inge Petersen
London, UK — Rachel Jenkins

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Contents

About the Editors

Margaret M. Barry, Ph.D. holds the Established Chair in Health Promotion and Public Health and is Head of the World Health Organization Collaborating Centre for Health Promotion Research at the National University of Ireland Galway. She has published widely in mental health promotion and works closely with policy-makers and practitioners on the development, implementation and evaluation of mental health promotion interventions and policies at national and international level. She has extensive experience of coordinating international and European collaborative projects, serving as project leader on WHO global projects and European Union funded research initiatives. She also serves on a number of international steering groups and scientific committees and has acted as expert adviser on mental health promotion policy and research development in a number of countries around the world. She was reappointed in 2016 for a second term to the European Commission Expert Panel on Effective Ways of Investing in Health (2016–2019) and was elected as Global President of the International Union for Health Promotion and Education in 2019.

Aleisha M. Clarke, Ph.D. is Head of What Works, Child Mental Health & Wellbeing at the Early Intervention Foundation in London, UK. Prior to this, she held a Marie Skłodowska-Curie postdoctoral research fellowship at the Department of Psychology, Health and Technology at the University of Twente in the Netherlands. Her research interest lies in the development, implementation and evaluation of evidence-based mental health and wellbeing programmes for children and young people. She completed her doctorate and postdoctoral studies at the World Health Organization Collaborating Centre for Health Promotion Research, National University of Ireland Galway. Her PhD focused on the evaluation of Zippy's Friends in Ireland and her postdoctoral research on the use of online technologies to support positive youth mental health. She trained as a primary school teacher and taught in a primary school in Dublin, Ireland, for four years.

Inge Petersen, Ph.D. is Director of the Centre for Rural Health at the University of KwaZulu-Natal and Visiting Professor, Institute of Psychiatry, Psychology and Neuroscience, King's College London. She is a Public Mental Health Psychologist with expertise in policy development, research and training in low- and middle-income countries with a specific focus on integration of mental health into primary health care as well as mental health promotion and prevention. She has played a leading role on a number of international research consortiums focused on increasing access to mental health services in low- and middle-income countries. Among other roles, she has also been a WHO (World Health Organization) Special Adviser on mental health promotion and prevention to the Eastern Mediterranean Region to scale up action on mental health (2014); lead author on the population- and community-level intervention chapter for the DCP3 volume on mental, neurological and substance abuse disorders; and Member of the Advisory Group for scaling up mental health in preparation for the 2016 World Bank-World Health Organization high-level event 'Out of the Shadows: Making Mental Health a Global Development Priority'.

Rachel Jenkins, MD (Cantab) is Emeritus Professor of Epidemiology and International Mental Health Policy, Department of Health Service and Population Research; was former Director of the WHO Collaborating Centre (1997–2012), Institute of Psychiatry, King's College London; and, prior to that, was Principal Medical Officer, Mental Health Division, Department of Health, England (1987–1996). As a Psychiatrist, Epidemiologist and Policy-Maker, she provides policy support and training on request to governments and carries out research in the UK, Africa, the Middle East and Asia. She has both led and collaborated on multiple international research, policy and implementation projects, has been a trustee of a variety of national and international non-governmental organisations and has been a frequent consultant to the WHO, EC, DFID and the World Bank.

Case Study Contributors

CHAMP (Collaborative HIV Adolescent Mental Health Program)

Arvin Bhana, Health Systems Research Unit, South African Medical Research Council; Centre for Rural Health, College of Health Sciences, University of KwaZulu-Natal, South Africa
Inge Petersen, Centre for Rural Health, College of Health Sciences, University of KwaZulu-Natal, South Africa
Mary McKay, Brown School, Washington University in St Louis, USA
Claude Mellins, HIV Center for Clinical and Behavioral Studies, Mailman School of Public Health, Columbia University, USA
Carl C. Bell, Clinical Psychiatrist Emeritus, Department of Psychiatry, University of Illinois at Chicago, USA

Act-Belong-Commit

Julia Anwar-McHenry, Curtin University, Bentley, Western Australia
Rob Donovan, University of Western Australia, Nedlands, Western Australia

Toward Flourishing: Mental Health Promotion for New Parents

Mariette Chartier, Manitoba Centre for Health Policy & Department of Community Health Sciences, University of Manitoba, Canada
Laurie McPherson, Consultant (formerly manager, Mental Health Promotion, Winnipeg Regional Health Authority, Canada
Jennifer Volk, Department of Community Health Sciences, University of Manitoba, Canada
Marion Cooper, Canadian Mental Health Association, Manitoba and Winnipeg, Canada

Incredible Years: Disseminating the Incredible Years® Basic Parenting Programme in Wales

Judy Hutchings and Margiad Williams, Centre for Evidence-based Early Intervention, Bangor University, Wales, UK

Parenting for Lifelong Health Programmes: Implementing the Parenting for Lifelong Health Programmes-Lessons Learned from Low-resource Settings

Inge Wessels and Catherine L. Ward, Department of Psychology, University of Cape Town, South Africa
Anna Booij and Nomagugu Masuku-Mukadah, Clowns without Borders South Africa
Lucie Cluver, Department of Social Policy and Intervention, University of Oxford, Department of Psychiatry and Mental Health, University of Cape Town, South Africa
Peter Cooper and Lynne Murray, Department of Psychology, University of Reading, UK
Frances Gardner, Department of Social Policy and Intervention, University of Oxford, UK
Judy Hutchings, Centre for Evidence-based Early Intervention, Bangor University, Wales, UK
David Jeffery, Mikhulu Trust, South Africa
Jamie Lachman, Department of Social Policy and Intervention, University of Oxford; Social Policy and Public Health Sciences Unit, University of Glasgow; Clowns without Borders South Africa
Mark Tomlinson, Department of Psychology, Stellenbosch University, South Africa

Zippy's Friends: Implementation and Scale-up of Zippy's Friends in Lithuania

Ona Monkevičienė, Department of Childhood Studies, Lithuania University of Educational Sciences, Lithuania
Caroline Egar, Partnership for Children, Kingston upon Thames, England, UK

MindOut Programme: Implementation of the MindOut Programme in Irish Post-primary Schools

Anne Sheridan, Health Service Executive West, Letterkenny, Co Donegal, Ireland.
Katherine Dowling, Health Promotion Research Centre, National University of Ireland Galway, Ireland
Margaret M. Barry, Health Promotion Research Centre, National University of Ireland Galway, Ireland

MindMatters: Case Study of Developing the First National School Mental Health Promotion Programme in Australia

Louise Rowling, Sydney School of Education and Social Work, University of Sydney, Australia.

Implementation of a Whole School Approach in Pakistan

Rachel Jenkins, Institute of Psychiatry, Kings College London, UK
Asima Khan, Department of Psychiatry, Punjab Institute of Medical Sciences, Pakistan

British Telecom's Approach to Mental Health in the Workplace

Catherine Kilfedder, Head of Wellbeing, BT (2006-2017)

Promoting Career Management and Mental Health: Towards Successful Seniority Programme

Jukka Vuori, Salla Toppinen-Tanner and Mikko Nykänen, Finnish Institute of Occupational Health, Finland
Richard H. Price, University of Michigan, USA

Mentor Mothers: Helping by Proxy: Improving Maternal Mental Health During the Course of a Generalist Health Promotion and Prevention Intervention in South Africa

Mark Tomlinson and Xanthe Hunt, Department of Psychology, Stellenbosch University, South Africa
Mary Jane Rotheram-Borus, Semel Institute and the Department of Psychiatry, University of California, Los Angeles, USA

City of Sheffield Social Prescribing Model: "People Keeping Well Programme"

Lorraine Jubb, Head of Commissioning—People Keeping Well, Sheffield City Council, England, UK
Steve Thomas, GP and Clinical Director, NHS Sheffield Clinical Commissioning Group, England, UK

The Friendship Bench, Zimbabwe

Dixon Chibanda, University of Zimbabwe Clinical Research Centre, Harare, Zimbabwe

Implementation of SPARX Computerised Self-help Cognitive-Behavioural Therapy for Adolescents in New Zealand

Theresa Fleming, Department of Psychological Medicine, University of Auckland, New Zealand, and School of Health, Victoria University of Wellington, New Zealand
Mathijs F. G. Lucassen, Department of Psychological Medicine, University of Auckland, and School of Health, Wellbeing and Social Care, The Open University, Milton Keynes, UK
Tuuli Kuosmanen, Health Promotion Research Centre, National University of Ireland Galway, Galway, Ireland

Burans: A Community Mental health Programme in Uttarakhand, North India

Michelle Kermode, Nossal Institute for Global Health, University of Melbourne, Australia
Kaaren Mathias, Emmanuel Hospital Association, India; Mental Health in India

Headspace: Australia's National Youth Mental Health Foundation

Debra J. Rickwood, Faculty of Health, University of Canberra and Chief Scientific Advisor to headspace National Youth Mental Health Foundation, Australia

Part I
Introduction to Mental Health Promotion

Concepts and Principles of Mental Health Promotion

Margaret M. Barry

Introduction

Mental health promotion is concerned with achieving positive mental health and well-being at an individual, community, and population level. The focus of this multidisciplinary area of practice is on strengthening protective factors for good mental health, enhancing supportive environments and enabling access to resources and life opportunities for individuals and communities that will promote their social and emotional well-being. Mental health promotion focuses on the whole population with the aim of enhancing population mental health and well-being. While focussing on the positive aspects of mental health, mental health promotion also has relevance for people experiencing mental health problems and disorders. This involves creating supportive environments, reducing stigmatization and discrimination, and supporting the social and emotional well-being of service users and their families. The underlying principle of this approach is that mental health is an integral part of overall health and is, therefore, of relevance to all. Mental health is a positive concept which is embedded in the social, economic, and cultural life of the community. An environment and sociocultural climate that respects and protects basic civil, political, socioeconomic, and cultural rights is fundamental to the promotion of population mental health. Alongside strategies for strengthening individuals' skills and competencies, mental health promotion also focuses on improving the social, physical, cultural, and economic environments that determine the mental health of populations and individuals. The delivery of mental health promotion strategies and interventions requires the development of intersectoral policy and actions that extend beyond the clinical and treatment focus of current mental health service delivery to address the broader social determinants of population mental health.

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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The Importance of Mental Health

Mental health is fundamental to good health, well-being, and quality of life. Positive mental health is a resource for everyday life which enables us to manage our lives successfully. As a resource, mental health contributes to the functioning of individuals, families, communities, and society. The need to address mental health as an integral part of improving overall health and well-being is clearly endorsed in the global WHO Mental Health Action Plan 2013–2020 (WHO 2013). The interconnected relationship between mental and physical health is increasingly being understood whereby poor physical health increases the risk for poor mental health, as people with chronic physical health conditions have a higher prevalence of mental disorders such as depression and anxiety than the rest of the population, and poor mental health increases the risks for poor physical health (Prince et al. 2007; Moussavi et al. 2007; Scott et al. 2016). Higher levels of positive mental health or flourishing have also been found to be associated with improved physical health and protective health behaviours (Lehtinen et al. 2005; Keyes 2007; Van Lente et al. 2012). The concept of mental health cannot be separated from that of overall health, which was defined in the World Health Organization Constitution of 1946 as a state of complete physical, mental, and social well-being and not merely the absence of disease or injury. Subsequent definitions have gone on to describe health as a resource for living and as a positive concept emphasizing social and personal resources, as well as physical capacities (WHO 1986). Mental health has also been defined as a positive resource for living, which contributes to the social, human, and economic capital of society (Foresight Mental Capital and Well-being Project 2008) and the promotion of positive mental health is, therefore, important in its own right. The increasing understanding of the inextricable link between physical and mental health (Prince et al. 2007) is captured in the phrase "there is no health without mental health", which clearly conveys a positive sense of mental health. Mental health is, therefore, intrinsic to good health, well-being, and quality of life, and as such, is firmly placed within the broader public health and health promotion agenda.

Box 1 Key Messages from the WHO Fact Sheet on Mental Health: Strengthening Our Response (WHO 2018 at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response)

- Mental health is more than the absence of mental disorders.
- Mental health is an integral part of health; indeed, there is no health without mental health.
- Mental health is determined by a range of socioeconomic, biological, and environmental factors.
- Cost-effective public health and intersectoral strategies and interventions exist to promote, protect, and restore mental health.

Mental Health as a Positive Concept

The term mental health is often misunderstood and is frequently interpreted as referring to mental ill health. Indeed, many mental health services and mental health professionals are concerned with the treatment of mental disorders rather than with mental health per se. The concept of positive mental health is more than the absence of symptoms of mental disorder. The WHO definition of mental health as a 'state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and fruitfully, and makes a contribution to his or her community' (WHO 2001, p. 1) challenges the idea that mental health is simply the opposite of mental ill health. This definition highlights the different aspects of positive mental health including subjective well-being and affective balance, the development of abilities to manage life, maximize one's potential, participate in, and contribute to society. Drawing on these different dimensions, various definitions have been proposed including defining mental health as "the embodiment of social, emotional and spiritual well-being. It provides individuals with the vitality necessary for active living, to achieve goals, and to interact with one another in ways that are respectful and just" (VicHealth 1999) and " the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness" (p. 7, HEA 1997).

Positive mental health has been conceptualized in different ways; as a positive emotion or affect, e.g., subjective sense of well-being and feelings of happiness; a personality attribute encompassing concepts of self-esteem and sense of control; and resilience in the face of adversity and the capacity to cope with life stressors (Kovess-Masfety et al. 2005). However, positive mental health is conceptualized as being broader than the related concept of resilience, which has been defined as a process for coping with and positively adjusting to adverse life events (Rutter 2006) and the ability to adjust and thrive regardless of the presence of a stressful environment (Masten 2001). In contrast, positive mental health is not limited to actual or potential adversity, but is concerned with promoting optimal functioning irrespective of adversity. Resilience is conceptualized as being determined by the interaction of both internal factors, such as personal strengths and competencies, and external factors including peers, family, and environment. Mental health promotion interventions can, therefore, increase resilience through supporting positive coping skills and creating supportive environments for individuals and communities dealing with challenging, adverse, and traumatic events.

The concept of positive mental health, therefore, encompasses the abilities to develop psychologically, emotionally, intellectually, physically, socially, and spiritually. This holistic perspective and sense of balance and harmony across the different dimensions of well-being is also clearly articulated in indigenous wellness frameworks. For example, the First Nations Mental Wellness Continuum Framework (Health Canada 2015), a national framework for promoting mental wellness among First Nations in Canada, encompasses a 'whole person' perspective with an emphasis on balance and interconnectedness that respects and values First Nations'

cultural knowledge, approaches, languages, and ways of knowing. The continuum of mental wellness is centered firmly within indigenous culture, based on individuals having a sense of *purpose* in their daily lives, *hope* for their future and that of their families, a sense of *belonging* and connectedness, and a sense of *meaning* and understanding of how their lives are part of creation. A cultural intervention model is employed in enabling and supporting indigenous individuals, families, and communities to enjoy optimal levels of mental wellness. Reflecting these broad dimensions, the Public Health Agency of Canada (2015) defines mental health as "the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity". Mental health is, therefore, characterized as a multidimensional construct, of universal relevance, since we all have mental health needs, and of concern to all sectors of society.

Mental ill health is an umbrella term which encompasses a continuum from the most severe disorders to a variety of common mental health problems and mild symptoms of different intensity and duration. Mental disorders usually refer to diagnosable clinical conditions which exceed a defined threshold of severity and chronicity of symptoms and that significantly interfere with the individual's functioning and abilities. Mental disorders are defined by the existence of symptoms such as impaired mood, abnormal perceptions, thought processes, and cognitions. Some of the main mental disorders include major depressive disorders (e.g., unipolar and bipolar disorders), psychosis (e.g., schizophrenia), and dementia. The term 'mental illness' has also been used to refer to mental disorders. Common mental disorders include anxiety, depression, and mixed anxiety-depression, which are those mental conditions without psychotic symptoms which, nonetheless, also exceed a defined threshold of severity and duration and interfere with social functioning and the ability to carry out the tasks of daily living. Both psychotic disorders and common mental disorders are usually precipitated by life stresses, although some individuals are more vulnerable than others either because of early life experiences such as child abuse, current adverse life experiences, or because of a higher genetic risk. It is important to understand that both non-psychotic and psychotic symptoms are continuously distributed through the general population, so that the categories used to distinguish mental disorders rely on the application of human-made criteria and thresholds for symptom severity and duration (see further details in DSM-5 (American Psychiatric Association 2013) and ICD-10 (WHO 2016) international classification manuals). For both psychotic and non-psychotic disorders, early attention is important, partly because the longer the disorder lasts, the more severe it may become, and the more difficult it can be to treat; and partly because of the deleterious impact on the person's social functioning, which can itself serve as an additional stressor. A further point to note is that a large proportion of the general population have a few fluctuating symptoms at any one time, which do not exceed the threshold for a disorder, but which nonetheless interfere with well-being and social functioning. These may be termed mental health problems.

Concepts of mental health vary as a function of time, place, culture, and context (Rogers and Pilgrim 2003). Through the years, there have been competing perspectives on the nature of mental health and mental ill health. With some exceptions, the mental health literature has focussed primarily on the study and treatment of mental disorder, which has been conceived as a medical, psychological, and/or sociological phenomenon. While these perspectives have merged to some extent into the biopsychosocial model, there has been an increasing focus on exploring the concept of positive mental health as an entity that is distinct from, and more than the absence of, mental disorder. The focus on positive mental health clearly aligns with a health promotion focus on health rather than illness and the development of theory and research in areas such as positive psychology and the study of well-being.

A focus on the positive aspects of human functioning can be traced to the work of humanistic psychologists such as Allport, Frankl, and Maslow, who articulated the human need for meaning, positive self-concept, and self-actualization. Marie Jahoda in her 1958 book titled, "Current Concepts of Positive Mental Health", one of the few early publications addressing this topic, sought to define positive mental health in terms of a number of key attributes including: an efficient perception of reality, self-knowledge, the exercise of voluntary control over behaviour, self-esteem and self-acceptance, and the ability to form affectionate relationships and productivity. Likewise, sociological research on quality of life also explored the positive indicators of life satisfaction and overall well-being (Gurin et al. 1960), as did the seminal work on subjective well-being that was conducted in the 1980s and 1990s (Diener 1984). The emergence of positive psychology has brought a greater focus on the study of optimal human functioning (Seligman and Csikszentmihalyi 2000; Seligman et al. 2005). This includes studying positive psychological constructs such as optimism, love, emotional intelligence, creativity, hope, humour, and a focus on positive subjective experiences, positive individual characteristics (strengths and virtues), and positive institutions and communities. Peterson and Seligman (2004) documented six broad character strengths and virtues, which appeared to be universal across cultures and religions, and included wisdom, courage, humanity, justice, temperance, and self-transcendence. However, many of the attributes that feature in current definitions may be specific to culture, gender, time, and place. Kovess-Masfety et al. (2005) point out that the definition of mental health is clearly influenced by the culture that defines it and may have different meanings depending on socioeconomic and political influences. Pilgrim and Rodgers (1993) argue that mental health may be seen as being socially constructed and socially defined, and different cultures, societies, and professional groups may, therefore, have different ways of conceptualizing the nature and determinants of mental health and ill health. What we understand by positive mental health depends on our values, assumptions, the nature of society, and our role within it (Caplan and Holland 1990; Tudor 1996). As mental health is embedded in the social and cultural framework of societies, a cross-cultural perspective is needed in understanding what constitutes positive functioning in a given cultural context and how it is influenced by cultural beliefs regarding health and illness, societal values, norms, and social influences.

Antonovsky's salutogenic model (1996) provides a useful theoretical framework to understand positive mental health as it focuses on positive well-being rather than illness and the 'salutary' factors rather than pathogenic factors. Antonovsky posited the construct of sense of coherence as being vital to positive health as it involves the capacity to comprehend and make sense of one's experiences and the ability to manage and respond flexibly to the inevitability of life stressors. The merging of the pathogenic and salutogenic perspectives was proposed by Keyes in outlining a complete state model of mental health (Keyes 2002; Keyes 2014). Keyes' model proposes that the constructs of mental health and 'mental illness' or mental ill health are distinct, as they belong to two separate but correlated dimensions, also known as the dual continua model (see Fig. 1). Analysis of the findings from the Midlife in the Unites States (MIDUS) study (Keyes 2005) and other studies of well-being (e.g., Greenspoon and Saklofske 2001; Headey et al. 1993; Huppert and Whittington 2003) supports the dual continua model, where one continuum represents the presence of positive mental health and the other indicates the presence or absence of mental disorders. Keyes reports that while the latent factors of mental health and illness are correlated ($r = 0.53$), only 28.1% of their variance is shared in the MIDUS data (Keyes 2005). Support for the model has also been reported from samples of US adolescents (Keyes 2006) and adults in the Netherlands (Westerhof and Keyes 2010) and South Africa (Keyes et al. 2008). On the dual continua model, the absence

Fig. 1 Keyes' dual continua model of mental health and mental illness. Reprinted with author's permission

of mental ill health does not imply the presence of mental health and the presence of mental health does not imply the absence of mental ill health.

Keyes (2005, 2007) reports data from the MIDUS study in the US, indicating that some 50% of the general adult population are moderately mentally healthy, 17% are flourishing, 10% are languishing and a further 23% meet the criteria for diagnosable mental disorders such as depression. These data show that while the majority of the adult population report being free from mental disorders, a much smaller percentage report experiencing good mental health or flourishing. Keyes' studies also show that, when compared with those who are flourishing, moderately mentally healthy and languishing adults have significant psychosocial impairment and poorer physical health, lower productivity, and limitations to daily living (Keyes 2005, 2007). Analysis of data from the 10 years follow-up of the MIDUS study from 1995 to 2005 shows that the mental health of individuals is dynamic over time (i.e., they can move in and out of the mental health or illness continuum) and that losses of good mental health, from flourishing to moderate and from moderate to languishing, increase the incidence of new cases of mental disorder over time (Keyes et al. 2010). Keyes (2014) argues that these data support the need for population mental health promotion as protection against the loss of good mental health and mitigation of the risk of future mental ill health.

To date, much of the scientific endeavour in areas such as positive psychology has focussed on individual-level interventions to increase happiness and enhance positive emotions and characteristics and, there has been a lack of progress in studying the social conditions necessary for flourishing and optimal functioning. Kovess-Masfety et al. (2005) argue that the challenge now is to gain a better understanding of the mechanisms that enable people to develop and maintain positive mental health and to determine how these vary across populations and cultures. The development of validated indicators of positive mental health for different population groups is essential to support this endeavour and advance our understanding of the field.

Indicators of Positive Mental Health

Existing information on population mental health and its determinants is derived mainly from community epidemiological studies of psychiatric morbidity, which tend not to include the positive dimensions of mental health and social well-being (Keyes 2007).

While empirical studies by Keyes (2005, 2007) and Huppert and Whittington (2003) clearly support the independence of positive and negative mental health and well-being, indicating that individuals without a mental disorder may experience varying degrees of positive mental health, the majority of population surveys tend to include only negative indicators of mental health status. Keyes (2007) describes this situation as the 'roadmap to health is through illness'. Epidemiological studies need to include indicators of positive mental health so that a greater understanding

can be attained of the distribution and determinants of mental health at a population level and patterns of difference among population groups.

Positive mental health is a broad concept and there are a range of constructs and theories relevant to its understanding and assessment. As outlined above, positive mental health is usually conceptualized as encompassing aspects of emotional (affect/feeling), psychological (positive functioning), social (relations with others and society), physical (physical health), and spiritual (sense of meaning and purpose in life) well-being. The emerging literature on positive mental health and well-being considers the necessary or sufficient elements of positive functioning (Keyes 2002; Huppert et al. 2005; Kovess-Masfety et al. 2005; Zubrick and Kovess-Masfety 2005; Ryff et al. 2006). At least two dimensions of positive mental health have been identified: (1) the hedonic component which refers to subjective well-being and life satisfaction; and (2) the eudaimonic component which includes positive functioning, engagement, fulfillment, and social well-being. Ryff (1989), for example, operationalized six theory-guided dimensions of psychological well-being derived from the literature. The scales included measures of self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. Taking a more sociological perspective, Keyes (1998) operationalized the concept of social well-being as involving the fit between the self and society, including the dimensions of social coherence, social actualization, social integration, social acceptance, and social contribution.

In contrast to the number of validated scales for measuring negative mental health, there are relatively few scales designed to measure positive mental health. Those scales that are available have based their indicators on similar constructs to those outlined above, including resilience, self-esteem, self-efficacy, optimism, life satisfaction, hopefulness, perceptions and judgements about sense of coherence and meaning in life, and social integration (Antonovsky 1996; Ryff and Singer 1996; Tennant et al. 2007; Zubrick and Kovess-Masfety 2005). Keyes' Mental Health Continuum—Short Form (MHC-SF) assesses a tripartite model of emotional, psychological, and social well-being with three categories of flourishing, moderately mentally healthy, and languishing (Keyes 2005). Huppert and So (2013) developed a 10-item scale that includes vitality and resilience or the ability to restore oneself to normal state after emotional turmoil. The 14 item Warwick Edinburgh Mental Well Being Scale (WEMWBS), which also covers hedonic and eudaimonic dimensions of mental well-being, has been validated for use in population surveys in England and Scotland and is employed in addition to more traditional measures of mental ill health such as the GHQ-12 (Tennant et al. 2007).

A set of short self-report indicators of mental health, which include measures of both positive and negative mental health, have been compiled for use across Europe (Lavikainen et al. 2006). Drawing on existing measures, positive mental health is assessed using the Energy and Vitality Index (EVI) from the RAND SF-36 questionnaire (Kovess and Beaudet 2001; Lavikainen et al. 2006). Such measures combined with indicators of social well-being and negative mental health have been successfully incorporated into national population health surveys in Europe (see for example, Lehtinen et al. 2005 and Van Lente et al. 2012). The European Social

Survey (ESS Round 3 (2006/7) and Round 6 (2012/3) Questionnaire) included measures of both the hedonic and eudaimonic components of well-being, drawing on the work of Huppert et al. (2005) and others in developing theoretical models and indicators of well-being (see further details at: www.europeansocialsurvey.org/). The use of these measures has elucidated the association between indicators of subjective well-being and aspects of economic and social progress, including inequities in reported well-being related to socioeconomic and cultural factors. The Public Health Agency of Canada has developed a comprehensive suite of positive mental health indicators which can be used for monitoring positive mental health and its determinants at a population level in Canada. Orpana et al. (2016) describe the development of a Positive Mental Health Surveillance Indicator Framework, which contains five positive mental health outcome indicators and 25 determinant indicators, organized within the four domains of individual, family, community, and societal levels. Orpana et al. (2016) report that the psychometric properties of the indicators are empirically supported and measures have been developed for both adults aged over 18 years and children and youth aged 12–17 years.

Indicators of positive mental health, which include both general measures and validated scales of specific constructs, clearly show positive associations with better physical health, fewer limitations in daily living, higher educational attainment, employment, and earnings, better quality of life, relationships, and positive health behaviours, such as not smoking, healthy diet, and higher levels of physical activity (Lyubomirsky et al. 2005; Lehtinen et al. 2005; Keyes 2005; Barry et al. 2009; Friedli 2009; Van Lente et al. 2012). Further population level research is needed to understand the factors and conditions that support emotional and social well-being and enhance positive mental health and the nature of their relationship with the broader determinants of health and population well-being. The development of this knowledge will be key to realizing the potential of promoting positive mental health and well-being and addressing the determinants of mental health at a population level.

Determinants of Mental Health

Mental health is determined by multiple biological, psychological, social, cultural, and environmental factors which interact in complex ways (Mrazek and Haggerty 1994). In keeping with Dahlgren and Whitehead's model of the determinants of health, the interacting layers of influence on mental health extend from individual and lifestyle factors through to social and community networks and living and working conditions to the wider socioeconomic, cultural, and environmental conditions (Dahlgren and Whitehead 1991). Therefore, the determinants of mental health lie in the physical and psychological make-up of the individual, their interpersonal and social surroundings, and the external environmental and broader sociocultural influences, which interact with each other in complex ways. Demographic factors such as age, gender, and ethnicity are important determinants of mental health.

However, mental health promotion tends to focus on those modifiable determinants, which can be altered effectively in order to promote positive mental health and reduce the likelihood of mental ill health. At the population level, these include a range of psychosocial and environmental factors, including living conditions, education, income, employment, access to community resources, social support, personal competencies, and life skills. The factors that determine mental health may be clustered into three key areas (HEA 1997; Lehtinen et al. 1997; Lahtinen et al. 1999; WHO and Calouste Gulbenkian Foundation 2014):

- Individual-level factors such as the ability to increase control over one's life, to manage thoughts and feelings, acquire social and emotional skills, emotional resilience, and the ability to cope with stressful or adverse circumstances.
- Community-level factors including a positive sense of belonging, social support, and a sense of citizenship, social inclusion, and participation in society.
- Structural-level factors which include environmental, social, economic, and cultural factors that are supportive of positive mental health, including healthy structures such as good living environments, quality housing, education, employment, transport, supportive political and social structures, and cultural values.

These determinants translate into risk and protective factors that influence the mental health of individuals and population groups. Risk factors or vulnerability factors increase the likelihood that mental health problems and mental disorders will develop and may also increase duration and severity when a mental disorder occurs. Exposure to multiple risk factors over time can have a cumulative effect (Kazdin and Kagan 1994). Protective factors enhance and protect positive mental health and reduce the likelihood that a disorder will develop. Protective factors enhance people's positive mental health, social and emotional well-being, and their capacity to successfully cope with and enjoy life and mitigate the effects of negative life events. In relation to both risk and protective factors, it should be noted that the strength of association and evidence of causation vary considerably. Risk and protective factors interact with each other in complex ways and exert their influence across the lifecourse.

Table 1 below provides illustrative examples of risk and protective factors operating across the individual, social, and structural levels.

The social determinants exert their influence at both the societal and individual levels as risk and protective factors operate at the level of the individual, the family, community, and at the macro-level of society as a whole. Individual or endogeneous characteristics such as a person's adaptability, plasticity, and resilience interact with social or exogeneous factors in the person's physical, social, and psychological environments. The social determinants model of mental health, therefore, asserts that social and environmental factors, through their independent and combined effects, can influence individual-level risk and protective factors, including the genetic determinants of health and illness through gene-by-environment interactions (Compton and Shim 2015). Therefore, a socio-ecological perspective provides the most useful framework for understanding and addressing these factors and endorses the need for comprehensive mental health promotion

Table 1 Examples of risk and protective factors for mental health

	Protective factors	Risk factors
Individual level	Positive sense of self	Low self-esteem
	Sense of control	Low self-efficacy
	Good coping skills	Poor coping skills
	Attachment to family	Insecure attachment in childhood
	Social skills	Poor social skills
	Good physical health	Physical and intellectual disability
Social level	Positive experience of early attachment	Adverse early life experiences—abuse and violence
	Supportive caring parents/ family	Disorganized and unsupportive family
	Good communication skills	Poor communication and social skills
	Supportive social relationships	Lack of social support, separation, and loss
	Sense of social belonging and social inclusion	Social exclusion
Societal level	Safe and secure living environment	Neighbourhood violence and crime
	Quality housing	Poor quality housing and housing instability, homelessness
	Income and economic security	Poverty, income inequality
	Employment	Unemployment/employment insecurity
	Positive educational experience	Lack of access to education, negative experience, school failure/dropout
	Social justice	Social injustice
	Freedom and equality	Racial, gender, social, or cultural discrimination
	Social and political participation	Denial of human rights
	Access to health and support services	Lack of access to health and support services

interventions and system-based approaches. Many of the social determinants of mental health, such as education, income, employment, and socioeconomic status, lie outside the health area and there is, therefore, a need for intersectoral collaboration and upstream policy action in order to address the wide range of risk and protective factors (Bell 2017).

Drew et al. (2005) articulate how a human rights approach can provide a useful perspective for identifying and addressing the determinants of mental health. A climate that protects basic civil, political, social, cultural, and economic rights is fundamental to the promotion of mental health. They point out that the principles of equality and freedom from discrimination, which are integral to the international human rights framework, call for particular attention to the vulnerable, disadvantaged, and marginalized groups in society. This approach underscores the need for social and policy changes as well as those that target individual skills and competencies. The Melbourne Charter for Promoting Mental Health and Preventing Mental

and Behavioural Disorders (VicHealth 2009) also clearly endorses the importance of the sociocultural and economic determinants of mental health and asserts that mental health and well-being are "a fundamental right of every human being, without discrimination". The Charter also affirms that mental health is most threatened by poor and unequal living conditions, conflict, and violence and is best achieved in equitable, just, and non-violent societies and advanced through "respectful, participatory means where culture and cultural heritage and diversity is acknowledged".

The risk factors for mental health are strongly associated with social inequities, with higher risk being associated with greater inequity. There is a large body of evidence building on the Commission on Social Determinants of Health (2008), including the Marmot Review (Marmot Review Team 2010), WHO European Review (Kieling et al. 2011), and other studies, which clearly shows that social determinants such as poverty, social disadvantage, human rights abuses, violence, and social exclusion have a negative and detrimental impact on the health and mental health of people from all regions of the world where data have been collected (WHO and Calouste Gulbenkian Foundation 2014). Across all countries, people who have fewer financial and educational resources have poorer health and well-being and people with access to better financial and educational resources and who live in more equal societies experience better health and well-being (Wilkinson and Pickett 2009; Pickett and Wilkinson 2010; Fisher and Baum 2010; Friedli 2009). Social inequities in mental health have been found to emerge before adulthood and to be evident in children as young as 3–5 years of age (Kelly et al. 2011). In addition, social and economic inequities have also been found to be perpetuated across generations, entrenching mental health inequities over time (Campion et al. 2013).

Adopting a Life Course Perspective

Research from a life course perspective is providing new insights into how health develops across the life course and how the various determinants of health interact over time and at different life stages. A life course perspective demonstrates how exposure to certain risk and protective factors during the formative stages of life (i.e., critical or sensitive life periods) can lead to latent effects later in adult life, while exposure to ongoing risk (e.g., poverty or stress) and protective factors (e.g., social support) throughout life can also produce cumulative effects. In addition, other protective or risk factors, such as social position, can have an influence at each life stage, thereby impacting on mental health and influencing the development of mental health across the lifespan. Research is also demonstrating how complex developmental processes integrate a range of behavioural, social, and environmental influences that modify gene expression, modulate physiological and behavioural functions, and dynamically shape different pathways of health production (Halfon et al. 2014). Halfon and Forrest (2018) developed a Lifecourse Health Development framework, which brings together a number of transdisciplinary theories (e.g., from epigenetics, neuro-development, psychology, sociology, and chronic disease epidemiology) and conceptual models to explain how health develops across the lifespan.

The model is based on seven principles, which are outlined in Box 2 below. Summarizing how these principles are organized into a coherent whole, Halfon and Forrest (2018) explain that: "health and development are unified into a single construct (*health development* principle) that adaptively unfolds over the lifecourse (*unfolding* principle) according to the principles of complex adaptive systems (*complexity* principle). Change in health development results from time-specific processes (*timing* principle) that influence biobehavioural systems during sensitive periods when they are most susceptible (*plasticity* principle), and the balanced alignment of molecular, biological, behavioural, cultural, and evolutionary process (*harmony* principle) can result in developmental coherence. Health development provides instrumental assets that enable individuals and populations to pursue desired lived experiences (*thriving* principle)" (p. 38). This theoretical framework provides a useful perspective for understanding how positive mental health develops across the lifespan and how various risk and protective factors interact in shaping lifelong developmental trajectories.

A life course approach, which takes into account the differential exposure to risk and protective factors throughout life, calls for actions to improve the conditions in which people are born, grow, live, work, and age (WHO and Calouste Gulbenkian Foundation 2014). Analysis of patterns across the life course shows that the impact of exposure to risk and protective factors accumulates over time, influencing the development of individuals and the social conditions of families and communities.

Box 2 Adapted from Principles of the Lifecourse Health Development Framework (Halfon and Forrest 2018)

- Health development – integrates the concepts of health and developmental process into a unified whole.
- Unfolding – health development unfolds continuously over the lifespan, from conception to death, and is shaped by prior experiences and environmental interaction.
- Complexity – health development results from adaptive, multilevel, and reciprocal interactions between individuals and their physical, natural, and social environments.
- Timing – health development is sensitive to the timing and social structuring of environmental exposures and experiences.
- Plasticity – health development phenotypes are systematically malleable and enabled and constrained by evolution to enhance adaptability to diverse environments.
- Thriving – optimal health development promotes survival, enhances well-being, and protects against disease.
- Harmony – health development results from the balanced interactions of molecular, physiological, behavioural, cultural, and evolutionary processes.

The accumulation of positive and negative determinants of mental health across the life course indicates the need to address determinants at each stage of life in order to reduce exposure to conditions which increase vulnerability and increase access to positive life experiences, resources, and environments that will create and protect positive mental health and well-being and lead to flourishing.

Promoting Positive Mental Health: Theoretical Frameworks for Practice

As a multidisciplinary area, mental health promotion derives its theoretical base from a number of diverse disciplines and is underpinned by sound conceptual and theoretical frameworks which provide coherent models for designing, conducting, and evaluating interventions. In considering these frameworks, it is useful to make a distinction between the practice of mental health promotion and the prevention of mental disorders. These two areas, while clearly related and overlapping, are informed by different sets of principles, and hence, tend to operate within different conceptual frameworks. Mental health promotion focuses on positive mental health and its main aim is the building of psychosocial strengths, competencies, and resources and the creation of supportive environments. In contrast, the area of prevention concerns itself primarily with specific mental disorders and aims to reduce the incidences, prevalence, or seriousness of targeted problems, i.e., mortality, morbidity, and risk behaviour outcomes. Articulated as such, these two fields have different starting points and seek to impact on different outcomes. In practice, however, there is much common ground between the two areas, particularly with regard to primary prevention and mental health promotion interventions. The current conceptual frameworks and models informing both the mental health promotion and prevention areas will now be considered.

Prevention Frameworks

One of the most widely used prevention frameworks in the mental health area is that put forward by Caplan (1964). This framework distinguishes between three types of prevention:

1. Primary prevention aimed at reducing the incidence of mental disorders of all types in a community.
2. Secondary prevention aimed at reducing the prevalence of disorders by reducing duration.
3. Tertiary aimed at reducing the impairments which may result from disorders.

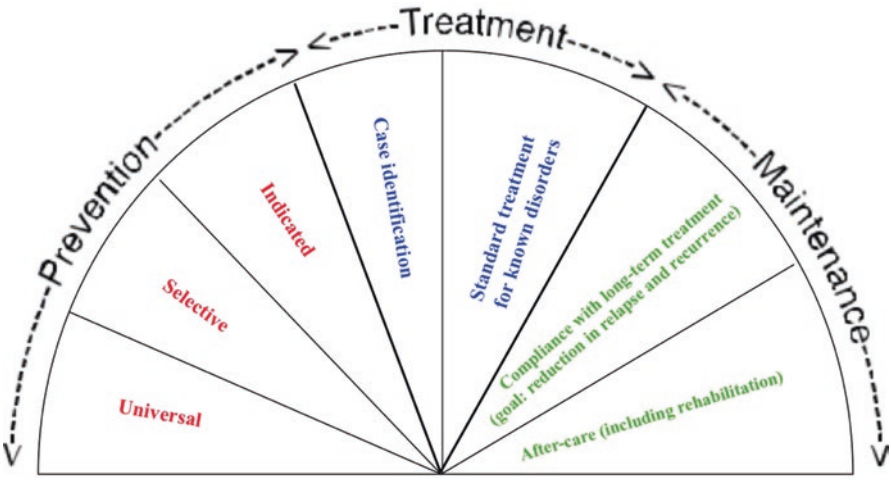

Fig. 2 The mental health intervention spectrum for mental disorders. Adapted from Mrazek and Haggerty (1994). Reprinted by permission of the National Academies Press

Caplan's framework proposes a continuum between prevention and treatment as part of a wider spectrum of activities designed to reduce the incidence and prevalence of disorders. However, this framework has been criticized for blurring the distinction between early treatment and prevention interventions. An alternative prevention framework was put forward by Mrazek and Haggerty (1994) in the Institute of Medicine (IOM) report entitled; "Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention". This framework, originally depicted as a half circle, places prevention activities in the wider mental health intervention spectrum of treatment, maintenance, and rehabilitation (see Fig. 2). Three main categories of prevention activities are identified:

- Universal—targeting the whole population.
- Selected—targeting individuals or groups considered to be at higher risk.
- Indicated—targeting high-risk individuals or groups with minimal but detectable signs or symptoms of mental disorder.

While clearly articulating the different types of prevention, this framework does not include interventions focussing on promoting positive mental health, nor does it explicitly identify links across the different areas of prevention, treatment, and rehabilitation. However, it would appear that, at least conceptually, there is quite an overlap between universal prevention activities, as outlined in the framework, and those of mental health promotion. Taking the lead from Mrazek's (1998) own suggestion that perhaps the second half of the circle depicting the mental health intervention spectrum consists of mental health promotion, the circle has been completed by Barry (2001) (see Fig. 3) to include mental health promotion indicating some core concepts by way of example, and not meant to be exhaustive or exclusive. This amended circle depicts mental health promotion as the largest part of the circle

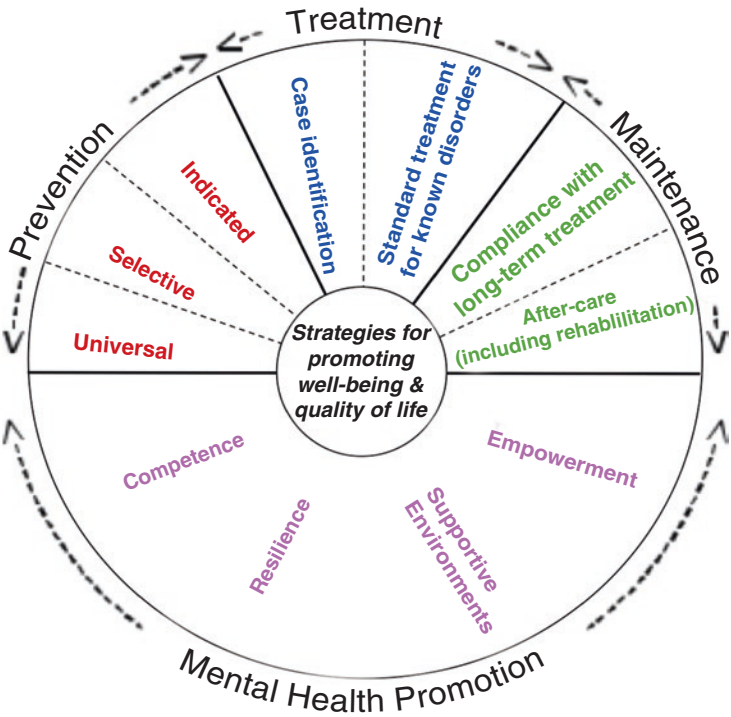

Fig. 3 Modified mental health intervention spectrum. Adapted from Barry (2001) and reprinted by permission of the International Journal of Mental Health Promotion

given its universal relevance and indicates the unifying central area between the different interventions as that centred on strategies for promoting well-being and quality of life.

Promotion, prevention, treatment, and rehabilitation programmes, all have at their core the overall goal of promoting well-being and quality of life. While these intervention categories clearly differ in their target populations, intervention objectives, content, and process, they may share many core intervention components derived from underlying theoretical constructs. For example, there is an extensive literature on the potency of core constructs such as self-efficacy, sense of control, self-esteem, resilience, social support, and supportive environments, which have been successfully applied across the spectrum of health promotion and mental health interventions. Clearly, there is much opportunity for shared learning and development around the application of these constructs with different populations across the diverse areas of practice.

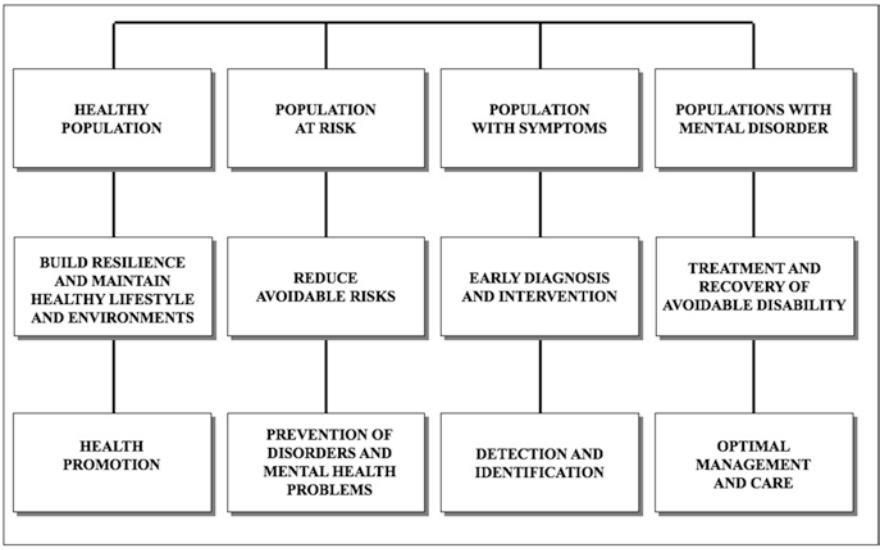

Fig. 4 Opportunities for mental health promotion: A population perspective. Adapted from Building capacity to promote the mental health of Australians (Health Australia Project 1996)

A Population Health Framework

A population perspective on promoting mental health was outlined in the Australian discussion document 'Building capacity to promote the mental health of Australians' (Health Australia Project 1996). This model, outlined in Fig. 4, clearly shows the relevance of mental health promotion across populations ranging from healthy populations to those with mental disorders. The framework outlines the opportunities for mental health promotion across these different population groups and articulates the diverse aims and goals of mental health promotion strategies across the different areas of practice. These range from building resilience and promoting health for healthy populations to reducing risk and early identification for high-risk groups, to treatment and optimal care for those with mental disorders. This framework covers the spectrum of promotion, prevention, treatment, and rehabilitation and, though not explicitly identified, holds open the possibility of links across the different areas of practice.

A Health Promotion Framework

Adopting a health promotion framework locates mental health within a holistic definition of health, and therefore, builds on the basic tenets of health promotion as outlined in the Ottawa Charter for Health Promotion (WHO 1986) and subsequent

WHO directives. The underlying principle of this approach is that mental health promotion is an integral part of overall health and is, therefore, of universal relevance to all. Health promotion was introduced by the WHO as a comprehensive approach to bring about social changes for improved health at the population level. Health promotion is based upon a social model of health and has been defined by the WHO (1986) as "the process of enabling people to increase control over, and improve, their health". Health promotion emerged as a dynamic force within the new public health, aimed at addressing the major determinants of health and thus contributing to the positive development of health at a population level. Health promotion has shifted the focus from an individual, disease prevention approach towards the health actions and wider social determinants that keep people healthy.

Health promotion is rooted in a salutogenic view of health (Antonovsky 1996) and is aimed at whole populations across the life course and across settings. The salutogenic view means strengthening people's health potential. Health promotion not only focuses on the level of the individual, but also on groups, communities, and settings where people live their lives and on entire populations. Adopting a settings-based approach, health promotion emphasizes that health is created within the settings where people live their lives and, as such, these everyday contexts or settings, such as the home, school, workplace, and community, are where health can be promoted. The principles of health promotion practice, as articulated in the Ottawa Charter for Health Promotion (WHO 1986), are based on an empowering, participative, and collaborative process, which aims to increase control over health and its determinants. As described by Kickbusch (2003), the Ottawa Charter initiated a redefinition and re-positioning of actors at the 'health' end of the disease-health continuum. This re-orientation shifts the focus from the modification of individual risk factors or risk behaviours to addressing the context and meaning of health action and the protective factors that keep people healthy. Mental health promotion addresses the critical question of where and how mental health is created and what strategies are needed to create the greatest mental health gains for the greatest number of people. The challenge of improving population mental health is, therefore, reframed to focus on the mental health potential of people and their everyday settings for living. The inextricable link between people and their environments forms the basis of this socio-ecological approach to health (McLeroy et al. 1988) and provides a conceptual framework for practice.

The concept of health promotion is positive, dynamic, and empowering and provides a useful framework to inform the conceptualization and practice of promoting mental health. Based on this framework, the following principles of mental health promotion may be articulated:

- Involves the population as a whole in the context of their everyday life, rather than focussing on people at risk from specific mental disorders.
- Focus on protective factors for enhancing well-being and quality of life.
- Addresses the psychosocial, physical, cultural, and economic environments that determine the mental health of populations and individuals.

- Adopts complementary approaches and integrated strategies operating from the individual to socio-environmental levels.
- Involves intersectoral action, working across sectors and settings extending beyond the health sector.
- Based on public participation, engagement, and empowerment.

The Ottawa Charter for Health Promotion (WHO 1986) provides a socio-ecological framework for mental health promotion as it draws attention to a systems approach spanning individual, social, and environmental factors that influence health. The Ottawa Charter outlined five key areas for action to promote health; to build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services. Using this framework, each of the five areas may be applied to promoting mental health.

- Building healthy public policy puts mental health promotion on the agenda of all policy makers and calls for coordinated action across health, economic, and social policies for improved mental health. Building healthy public policy involves multisectoral policy development and includes diverse approaches such as investment in government and social policy, the implementation of legislation and regulations, organizational change, and intersectoral partnerships. This action area endorses the important influence of policies beyond the health sector on mental health, e.g., employment, housing, social protection, transport, education, and child care policies, and calls for increased attention to assessing the impact of such policies on the mental health of the whole population.
- Creating supportive environments moves mental health beyond an individualistic focus to consider the influence of broader social, physical, cultural, and economic environments. This action area emphasizes the importance of the interaction between people and their environments and highlights the importance of mediating structures such as homes, schools, communities, workplaces, and community settings as key contexts for creating and promoting positive mental health.
- Reorienting health services requires that mental health services embrace promotion and prevention activities as well as treatment and rehabilitation services. This calls for a health care system which contributes to the pursuit of health as well as the treatment of illness. This action seeks to integrate mental health promotion as a core part of primary health care and mental health services for different population groups such as children, young mothers, people with chronic health problems, and mental health service users and their families. Reorienting health services to promote mental health requires greater attention to the organization and structure of health services and the training and education of health professionals.
- Strengthening community action focuses on the empowerment of communities through their active engagement and participation in identifying their needs, setting priorities, and planning and implementing action to achieve better health and take control of their daily lives. Community development approaches strengthen

public participation and lead to the empowerment of communities and increase capacity to improve mental health at the community level.

- Developing personal skills involves enabling personal and social development through providing information, education, and enhancing life skills. Improving people's knowledge and understanding of positive mental health as an integral part of overall health form an important part of this action area, highlighting the need for improved mental health literacy. Developing social and emotional skills such as self-awareness, improved self-esteem, sense of control, and self-efficacy, relationship and communication skills, social skills, problem-solving, and coping skills have all been shown to improve mental health and to facilitate people to exercise more control over their life and their environments.

The Ottawa Charter underscores the importance of synergistic action across these different action areas, highlighting the need for top-down policy and bottom-up community action working together to achieve common goals. The most effective health promotion interventions have been shown to employ comprehensive strategies that operate at multiple levels—structural, community/social group, and individual level—and include a combination of integrated actions to support each strategy (Jackson et al. 2006; Mittelmark et al. 2005; McQueen and Jones 2007).

The health promotion framework has been applied to the promotion of mental health, underscoring the need for integrated multilevel action, as outlined in seminal WHO publications (Herrman et al. 2005) and a number of foundational documents that clearly positioned mental health promotion as an integral part of health promotion and advocated the same basic principles of practice, e.g., the UK Health Education Authority Mental Health Promotion Quality Framework (Health Education Authority 1997), the Victorian Health Promotion Foundation Mental Health Promotion Plan Foundation Document 1999–2002 (VicHealth 1999), and Commonwealth Department of Health and Aged Care (2000). A health promotion framework is used to guide action for key population groups (young people, adults, older people, minority, and indigenous groups) in key settings (home, communities, workplaces), with a clear focus on addressing the social determinants of mental health (e.g., social inclusion, freedom from discrimination and violence, economic participation) and reducing health inequities. Friedli (2001) advocated a strategic approach to mental health promotion that includes a balance of developing individual coping skills, promoting social support and networks, and addressing structural barriers to mental health in areas such as education, employment, and housing. The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders (VicHealth 2009) also endorsed a health promotion approach to promoting mental health and outlined the principles and actions that can be taken by governments, communities, and organizations to influence the interconnecting social, economic, cultural, environmental, and personal factors that influence and determine mental health and well-being. These seminal documents draw attention to the relationship between social determinants and mental health, endorsing the view that success in promoting mental health can only be achieved and sustained by the involvement and support of the whole community and the development of

partnerships between a range of agencies in the public, private, and nongovernmental sectors.

The Bangkok Charter for Health Promotion (WHO 2005), which builds upon the values, principles, and action strategies of health promotion established by the Ottawa Charter (WHO 1986), called for an integrated policy approach across sectors and settings, strong political action, broad participation, and sustained advocacy in order to progress towards a healthier society (WHO 2005, p. 3). The Bangkok Charter identified four key commitments to make the promotion of health; central to global development, a core responsibility for all of government, a key focus of communities and civil society, and a requirement for good corporate practice. These commitments are also key to the promotion of global mental health and are being advanced through a number of global initiatives, including the framework of the sustainable development goals, as outlined further in chapter "Advancing Evidence-based Action for Mental Health Promotion", and adopting a 'mental health in all policies' approach. As described earlier in this chapter, this approach clearly recognizes that public policies in all sectors have a significant impact on population mental health and reflects the need for engagement and collaboration across sectors and levels of government.

The health promotion framework provides a distinctive conceptual model for mental health promotion practice, underpinned by a socio-ecological perspective and multidisciplinary theoretical concepts and principles. In this respect, it is useful to consider the relationship between the practice of mental health promotion and the prevention of mental disorders. In particular, the two interrelated conceptual approaches of the risk reduction model and the competence enhancement model will be outlined.

Current Conceptual Models

The Risk Reduction Model

Advances in the understanding of risk and protective factors for mental health problems form the basis of the risk reduction model. The IOM report (Mrazek and Haggerty 1994) endorsed the risk reduction model as the best theoretical model to guide preventive interventions at the time. This model is concerned with the reduction of risk factors for general as well as specific mental disorders and the enhancement of protective factors. Current research indicates the presence of generic risk and protective factors that are common to many disorders and dysfunctional states. Mrazek and Haggerty (1994) suggest that, rather than attempting to identify risk factors unique to specific mental disorders, "there may be greater value in clarifying the role of those risk factors that appear to be common to many mental disorders, especially in view of the frequent co-morbidity of these disorders" (p. 182). Applied to prevention interventions, this model aims at reducing 'modifiable' risk factors and strengthening protective factors. The risk reduction model draws on the findings

from aetiological and treatment research and adapts intervention techniques, for example, cognitive-behavioural or social learning approaches, to the area of prevention.

The IOM report (Mrazek and Haggerty 1994), which reviewed 39 prevention programmes tested by randomized trials, concluded that there is strong evidence that preventive interventions can lead to a reduction of risk factors and enhancement of protective factors associated with the first onset of substance abuse and mental health problems. However, the report found at the time that there was minimal evidence that mental disorders have been prevented through such risk reduction. Mrazek and Haggerty (ibid.) recommended that the most fruitful approach for preventive interventions may be to use a risk reduction model that includes the enhancement of protective factors and to aim at clusters or constellations of risks or protective factors. The goal of preventive interventions, therefore, becomes the reduction of risk rather than the prevention of disorders per se.

A number of examples of risk reduction interventions are included in this book, see for example, Communities that Care (Hawkins et al. 2014) in chapter "Community Mental Health Promotion Principles and Strategies" and the JOBS intervention programme (Vinokur and Schul 1997) in chapter "Addressing Mental Health Problems at Work", which, respectively, seek to reduce the risk factors for adolescent health and behavioural problems, such as substance misuse and crime, and the negative impacts of unemployment on depression. The conceptual frameworks guiding these interventions focus largely on increasing protective factors through the enhancement of relevant skills and personal control and reducing exposure to risk factors. These interventions have produced impressive outcomes and are good examples of interventions that operate on both risk and protective factors simultaneously.

It is interesting to note that the 2009 report by the U.S. Committee on Prevention of Mental Disorders and Substance Abuse of Children, Youth and Young Adults (O'Connell et al. 2009) strongly recommended the inclusion of mental health promotion in the spectrum of mental health interventions. The report endorsed the view that mental health is more than the absence of disorder, and that a focus on wellness and the promotion of mental health will have far-reaching benefits that extend beyond a specific mental disorder.

The Competence Enhancement Model

While the risk reduction model begins with a focus on reducing risks for mental disorders, the competence enhancement model focuses on enhancing competence and positive mental health. The competence approach signals a shift from an individual-centred, deficit-focussed approach to one embracing an emphasis on psychological strengths, social and emotional well-being, and resilience. The goal, therefore, becomes enhancing potential and well-being rather than focussing solely on reducing disorders. This perspective is in keeping with the basic thrust of health promotion which clearly articulates that "Health promotion involves the population

as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases" (WHO 1985, p. 6). Mental health is, therefore, re-conceptualized in positive rather than in negative terms. Mental health promotion programmes adopting a competence perspective are primarily concerned with building life skills and competencies and feelings of efficacy in diverse life areas (Weissberg et al. 1991). An enhancement model assumes that, as an individual becomes more capable and competent, their psychological well-being improves. This approach builds on the theoretical base of areas such as lifespan developmental theory and the ecological perspective of community psychology.

Cowen (1991) argued for a comprehensive life span approach to the promotion of wellness, one that takes into account age, situation, group, and society-related determinants of, and impediments to, wellness. Four key concepts were proposed to guide the pathway towards the promotion of psychological wellness:

- Competence—life skills and competencies such as social, academic, and work competencies that are critical for psychological well-being.
- Resilience—the ability to survive and cope effectively with major life stressors.
- Social system modification—changing social environments and systems so that they promote people's wellness.
- Empowerment—enhancing people's perceived and actual control over their life.

These constructs were put forward by Cowen as providing the knowledge base to guide the formulation of programmes, policies, and practices designed to promote psychological wellness. In developing the concept of psychological wellness, an ecological perspective is employed that stresses the interdependence of the individual, the family, community, and society. Mental health is viewed, therefore, as both a community and individual resource. From this community psychology theoretical perspective, which draws on Lewin's (1951) person-in-context principle, mental health is conceptualized as the interaction over time, between person and social settings and systems, including the structure of social support and social power (Orford 1992). This perspective clearly moves the concept of mental health beyond an individualistic focus to consider the influence of broader social, economic, and political forces.

A key concept underpinning this ecological perspective is that of interdependence, i.e., that behaviour is influenced by multiple interacting systems. Bronfenbrenner's (1979) model of nested systems provides a useful set of constructs to understand the nature of these different levels. Bronfenbrenner postulates a set of nested structures ranging from the micro-, meso-, exo-, and macro-levels to indicate the way in which systems operating at individual, family, community, and broader societal levels interact with and mutually influence each other. This model emphasizes the importance of the larger sociocultural and policy context within which individuals, group systems, and social settings are embedded. The ecological model underscores the important role of mediating structures such as schools, workplaces, and communities in providing key contexts for social interventions operating from the micro to the macro levels.

As a multilevel construct, empowerment plays a key role in this framework as it is capable of operating at many different levels from the micro to the macro, but particularly at the level of organizations and community. Empowerment has been defined as " a social action process through which individuals, communities and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life" (Rappaport 1984, 1985; Wallerstein 1992). Embracing an empowerment philosophy of mental health requires that attention be focussed away from an exclusive concern with individual factors to consider the interface between the individual and wider community and social forces. This points to a need to address poverty, economic and social disadvantage, social injustice, and discrimination as key determinants of mental health. This approach, therefore, underscores the importance of social interventions addressing systems of socialization, social support, and control and operating at multiple levels of analysis.

Interventions focussing explicitly on competence enhancement appear to concentrate primarily on children and adolescents. Reviews of successful interventions (Durlak et al. 2011; Weare and Nind 2011) point to strong evidence that high-quality comprehensive programmes that focus on developing young people's social and emotional skills and enhancing their socializing environments (e.g., at home and in schools) can produce long-lasting positive effects on mental, social, and behavioural development.

Adopting a Competence Enhancement Approach

Based on the models and frameworks reviewed, there is a compelling case for focussing on interventions that promote psychological strengths, social and emotional skills, and competence. Interventions promoting positive mental health have universal relevance across all population groups, have been found to result in impressive long-lasting positive effects on multiple areas of functioning, and also have the dual effect of reducing risk. Such interventions would, therefore, appear to hold the greatest promise as cost-effective strategies. There is consensus that there are clusters of known risk factors and protective factors, and there is considerable evidence that interventions can reduce identified risk factors and enhance known protective factors. For these reasons, interventions with the explicit goal of developing competence and promoting social and emotional well-being through enhancing protective factors and reducing risk factors appear to offer the most feasible approach rather than interventions focussing only on preventing symptoms or the onset of specific mental disorders.

Moving from disorder prevention to a competence enhancement approach requires that current frameworks accommodate this shift in emphasis to locate the promotion of positive mental health within the broader spectrum of intervention activities. Mental health promotion re-conceptualizes mental health in positive rather than in negative terms and is concerned with the delivery of effective policies

and programmes designed to reduce mental health inequities in an empowering, collaborative, and participatory manner. While prevention programmes are primarily concerned with the reduction of the incidence and prevalence of mental disorders, mental health promotion focuses on the process of enabling and achieving positive mental health and enhancing well-being and quality of life for individuals, communities, and society in general. Mental health promotion endorses a competence enhancement perspective and seeks to address the broader social determinants of mental health. In keeping with the fundamental principles of health promotion as articulated in the Ottawa Charter (WHO 1986), this calls for integrated approaches including interventions at the level of individuals, families, and communities and 'upstream' policy interventions across the non-health sectors in order to reduce structural barriers to mental health. This perspective underscores the importance of developing supportive environments for good mental health, e.g., in homes, schools, workplaces, and communities, reorienting existing services, and advocating the development of mentally healthy public policy designed to promote and protect positive mental health at a population level.

Principles of Mental Health Promotion Implementation

Based on the adoption of a health promotion framework, the following key principles can be identified that underpin the implementation of mental health promotion interventions (Barry 2007).

Adopting a Socio-Ecological Perspective Adopting a socio-ecological approach means recognizing the importance of the broader context of intervention delivery, such as the socio-environmental influences on individual behaviour and attitudes. This perspective shifts mental health promotion beyond an individualistic focus to also consider structural determinants of mental health, including the influence of broader social, cultural, economic, and environmental factors (e.g., social values, norms, poverty, education, employment, housing) and how these are mediated through community and family structures. The ecological model underscores the importance of supportive environments and endorses the role of schools, workplaces, neighbourhoods, and communities as providing key contexts or settings for promoting mental health.

Embracing an Empowerment Philosophy Embracing an empowerment philosophy signifies an emphasis on 'process', seeking to deliver interventions in an empowering and participatory manner. Empowering interventions engage the active participation of individuals, communities, and organizations in gaining awareness, understanding, knowledge and skills that will enable them to control the determinants of mental health as encountered in their everyday circumstances. As outlined by Rappaport (1990), adopting an empowerment agenda means being; "committed to identifying, facilitating, or creating contexts in which heretofore silent and

isolated people, those who are "outsiders" in various settings, organizations and communities, gain understanding, voice and influence over decisions that affect their lives" (p. 52). This description draws attention to the importance of engaging socially excluded and marginalized individuals and communities as a core principle of implementing mental health promotion.

Intersectoral Collaboration and Partnership Working Collaborative working is at the core of mental health promotion practice. Interventions need to be delivered in a collaborative manner with clear strategies for partnership working and participation of key stakeholders at all stages. Implementing effective interventions requires good intersectoral collaboration and partnerships with key stakeholders across diverse sectors and settings.

Addressing Inequities Existing evidence demonstrates the influence of poor living and social conditions on mental health, including poverty, poor working conditions, racism, and discrimination. Population groups at the bottom end of the social hierarchy are at greatest risk of experiencing mental health problems, and this effect appears to be most pronounced in more unequal as well as poorer societies. Mental health promotion needs to be incorporated into the wider development and social inclusion policy agenda in order that the broader determinants of mental health such as poverty, social exclusion, exploitation, and discrimination can be successfully addressed.

Adopting a Life Course Approach Comprehensive action across the life course is needed to improve the conditions of daily life from before birth through to older age that will provide opportunities both to improve population mental health and well-being and reduce the risk of mental disorders that are associated with social inequalities.

Conclusions

Mental health promotion practice intervenes at the level of strengthening individuals, strengthening communities, reorienting health services, and promoting intersectoral policy and programmes to remove the structural barriers to mental health at a societal level (Barry and Friedli 2008). A number of cross-cutting principles can, therefore, be identified to guide the implementation of effective mental health promotion action. These include:

- A socio-ecological approach to intervention development in order that programmes and policies will seek to bring about positive change at the level of the individual, the family, social group or community, and broader society.
- A social competence approach addressing a range of protective and risk factors emphasizing the promotion of psychological strengths, life skills, social and emotional competence, and access to resources and life opportunities.

- Theory and evidence-based interventions grounded on established theories of human functioning and social organization and best available research.
- Intersectoral, comprehensive, and sustained interventions that are not once-off, but are designed to produce long-term effects that will improve population mental health and well-being and reduce inequities.
- High-quality intervention design, planning, and delivery based on a supportive implementation system and capacity development.
- An implementation process that is empowering, collaborative, and participatory, carried out in partnerships with key stakeholders.
- Systematic evaluation methods assessing intervention process, impact, and outcomes that will contribute to the ongoing improvement and sustainability of effective interventions.
- Intervention sustainability built on organizational and system-level practices and policies that will ensure the long-term impact of effective, high-quality interventions.

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Reframing the Challenge of Promoting Population Mental Health

Margaret M. Barry

Introduction

Mental health promotion has a critical role to play in meeting the global challenge of improving population mental health. While traditional healthcare approaches have focussed primarily on treating mental ill health, it is increasingly recognized that treatment approaches alone are not sufficient to address the growing global burden of mental disorders and to bring about improvements in mental health and well-being at a population level. Mental and behavioural disorders are common and are present across all ages, cultures, and population groups. The burden of mental disorders is substantial and the estimated global cost attributable to mental, neurological, and substance use disorders (MNS) in 2010 was estimated to be US$ 2.5–8.5 trillion, with the figure projected to double by 2030 (Bloom et al. 2011). The burden arises from individual suffering, disability, premature death, loss of economic productivity, poverty, family burden, and intergenerational cycles of disadvantage (Chisholm et al. 2016; Jenkins et al. 2001), exceeding the cost attributable to other health problems such as cancer, AIDS, and respiratory disease (Marshall-Williams et al. 2005). Added to this, the hidden costs of mental disorders and health problems such as the impact on individuals, their families, and communities, stigma, and violations of human rights may go unmeasured leading to underestimates in the level of burden caused.

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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Addressing the Global Challenge of Mental Ill Health

WHO World Report in 2001 (WHO 2001) reported that more than 450 million people experience mental disorders worldwide and one in four persons will develop a mental or behaviour disorder throughout their lifetime. The first Global Burden of Disease study in 1990 (Murray and Lopez 1996) drew attention to the rise in mental disorders as a major public health problem to be addressed in the twenty-first century, with five of the ten leading causes of the global burden of disease being related to mental disorders. It was predicted that, by the year 2020, mental disorders such as depression would constitute the greatest health problem in the developing world, being second only to cardiovascular disease as the leading cause of disease burden worldwide. Since then, the public health burden of MNS disorders has sharply increased, rising by 41% between 1990 and 2010, accounting for one in every 10 years of lost healthy years (Patel et al. 2015). Within the MNS grouping (including depression, bipolar disorder, selected anxiety disorders, schizophrenia, dementia, epilepsy, Parkinson's disease, multiple sclerosis, and alcohol and drug use disorders), mental disorders account for the highest proportion (56.7%) of disability-adjusted life years (DALYS), with DALYS occurring across the lifespan but peaking between the ages of 20 and 30 years (Whiteford et al. 2015). DALYS are made up of two components; years of life lost and years lived with disability. The Global Burden of Disease Study 2010 (Whiteford et al. 2013) shows that MNS disorders account for 10.4% of disability-adjusted life years (DALYS) worldwide, 2.3% of global years of life lost due to premature mortality, and 28.5% of years of life lived with a disability. However, these figures are thought to underestimate the overall burden of mental disorders, as they do not take into consideration the excess mortality associated with these disorders or the significant social and economic consequences for affected persons, their families, and society (Patel et al. 2015). People with MNS disorders have a significant reduction in life expectancy, up to 20 years shorter than the population as a whole, with risk of mortality increasing with the severity of the disorder (Walker et al. 2015). Among the MNS disorders, depression is identified as one of the most prevalent and disabling disorders globally. Linked to the rise in depression are the increasing levels of suicidal behaviour in many countries, especially completed suicides, which are strongly associated with the presence of both diagnosed and undiagnosed mental health problems (WHO 2014; Arsenault-Lapierre et al. 2004). By 2030, depression is expected to be the leading cause of disability in high-income countries (HICs), the second leading cause of disability after HIV/AIDS in middle-income countries (MICs), and the third leading cause of disability after HIV/AIDS and perinatal conditions in low-income countries (Whiteford et al. 2013).

Inequities in Mental Health

The existence of social inequities in the distribution of common mental disorders, such as anxiety and depression, is well documented (Campion et al. 2013; Fryers et al. 2003). The poorest and most disadvantaged in society are at highest

risk of experiencing common mental disorders and suffer disproportionately from their adverse consequences (Lund et al. 2011; Patel and Kleinman 2003; Fryers et al. 2003). Systematic inequalities between population groups that are judged to be avoidable are deemed to be inequitable and unfair. Therefore, systematic differences in mental health by gender, age, ethnicity, income, education, or geographic area of residence are inequitable and can be reduced by action on the social determinants of mental health (WHO and Calouste Gulbenkian Foundation 2014). Fryers et al. (2005) reviewed the evidence from nine large-scale population-based studies carried out in Europe over 20 years and concluded that common mental disorders are significantly more frequent in socially disadvantaged populations. They report that the evidence is strongest when material indicators of social position, education, or unemployment are used to define disadvantaged groups. Markers of social disadvantage, such as having poorer material circumstances (housing tenure and lack of car ownership), being unemployed or economically inactive, and less education (having left schooling before the age of 16), were all found to be associated with higher prevalence rates of common mental disorders, after adjusting for gender and age. Lund et al. (2011) also report strong associations between a variety of poverty measures and common mental disorders in low- and middle-income countries. In a study among countries of the former Soviet Union, Roberts et al. (2010) reported significant variations with higher levels of psychological distress reported by women compared to men and by those experiencing higher levels of poverty, unemployment, low education, disability, lack of trust in others, and lack of support. Epidemiological studies examining the social distribution of positive mental health have also reported significant associations between higher levels of positive mental health and social support, being young and male, and having higher levels of education, employment, and income (Lehtinen et al. 2005; Van Lente et al. 2012). Patel (2005) argues that, irrespective of the average per capita income of a society, those at the bottom end of the social hierarchy are at greatest risk of experiencing mental health problems, and this effect appears to be most pronounced in more unequal as well as poorer societies. Those lower on the social hierarchy are more likely to be exposed to higher levels of stress and less favourable circumstances throughout life and to have less access to supports and resources for coping that could mitigate the negative effects. The experience of inequity is corrosive of social cohesion and has a negative impact on people's mental health and their capacity for emotional and social well-being (Friedli 2009; Bell 2017).

Addressing the Social Determinants of Mental Health

As an early proponent of mental health promotion and prevention, Albee (1982) characterized the incidence of mental health problems as an equation, with incidence being determined by the relationship between risk factors, such as organic causes, stress, and exploitation, and protective factors such as coping skills, self-esteem, and support systems. Strengthening both sides of the equation, i.e.

boosting protective factors and reducing risk factors, provides an effective approach to prevention and promotion.

Albee et al. (1988) highlighted the influence of degrading and exploitative social conditions, including poverty, poor working conditions, racism, and sexism on mental health. Likewise, the influence of these social determinants of mental health was also underscored in one of the early policy documents on mental health promotion from Australia; "The mental health of a population is determined by the extent to which the environments within which people live and work ensure that all people have access to the resources they need to achieve and maintain optimal health" (p. 25, Building Australia's Capacity to Promote Mental Health 1997). The WHO Calouste and Gulbenkian Foundation (2014) report has also endorsed the importance of the social determinants of mental health stating that; "Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live" (p. 8). The report calls for actions to improve the conditions of daily life, including the adoption of comprehensive and universal actions across the life course and in multiple sectors and levels. The report argues that policy-making at all levels of governance and across sectors can make a positive difference to mental health outcomes and advocates for actions and public policies that are universal and inclusive, yet proportionate to need, in order to address existing inequalities (see Box 1). The principle of proportionate universalism, as put forward in this report, posits that focussing only on the most disadvantaged will not reduce inequities and that universal action, calibrated proportionately to the level of disadvantage, is required to address the steepness in the social gradient.

Box 1 Key Messages from the WHO and Calouste Gulbenkian Report (2014)

- Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live.
- Social inequalities are associated with increased risk of many common mental disorders.
- Taking action to improve the conditions of daily life from before birth, during early childhood, at school age, during family building and working ages, and older ages provides opportunities both to improve population mental health and reduce the risk of those mental disorders that are associated with social inequalities.
- While comprehensive action across the life course is needed, scientific consensus is considerable that giving every child the best possible start will generate the greatest societal and mental health benefits.
- Action needs to be universal: across the whole of society, and proportionate to need, in order to level the social gradient in health outcomes.

In order to reduce inequities in mental health, action needs to be taken to improve everyday living conditions, beginning before birth and progressing into early childhood, adolescence, adulthood, and old age (WHO and Calouste Gulbenkian Foundation 2014). In view of the close association between physical and mental health, such actions would also reduce the inequalities in physical health and lead to improvements in overall health and well-being. Adopting a social determinants approach to mental health requires actions across sectors and across the life course to address the range of risk and protective factors that operate at multiple levels including the individual, family, community, structural, and societal level (Barry 2009). Addressing the social determinants of mental health calls for change at the level of social policies and systems in order to reduce poverty and improve equity in access to education and good living and working conditions. Similarly, the impact of racism, sexism, discrimination, and bullying also requires policy interventions alongside changes in social norms and values at a societal level. This requires different sectors (civil rights, employment, education, housing, planning, media, etc.) to work together in order to create more supportive environments for positive mental health through policy, organizational, and societal level change. Therefore, the full range of modifiable factors influencing mental health, including those at the broad social, organizational, and structural levels, needs to be addressed.

Compton and Shim (2015) conceptualize the social determinants of mental health as stemming from unequal distribution of opportunity in society, including inequity in resources, money, power, voice, and choices at the level of the structure of society. The unequal distribution of opportunity is driven by public policies and social norms, and Compton and Shim (2015) argue that the social determinants of mental health are, therefore, best addressed by working at the upstream levels of the environmental and social factors that shape the more proximal risk and protective factors. This is also referred to as addressing 'the causes of the causes' (Marmot 2005). Interventions addressing the proximal risk and protective factors do not necessarily address the underlying causes of those risk and protective factors which may be shaped by society, culture, social policies, and social norms. It gives an important perspective to examine social determinants through the lens of social justice so that they can then be best addressed through advocacy, political will, and policy interventions (Marmot 2005; Marmot and Wilkinson 2006). A striking case in point is the documented increases in suicides in Europe related to changing economic and employment conditions. Stuckler et al. (2009) report that there was a 0.79% increase in suicides for those aged under 65 years of age related to every 1% increase in unemployment based on analysis of data from 26 EU countries over the period 1970–2007. Following the sharp increase in unemployment during the economic crisis in Europe post 2008, unemployment rates rose sharply in EU Member States and the downward trend in suicide rates evident prior to 2007 began to reverse (Stuckler et al. 2011). Barr et al. (2012) report similar findings from the economic recession in England with greater increases in male unemployment related to increases in suicides. Many EU countries have also witnessed decreasing levels of youth mental well-

being and increases in youth suicides since the economic crisis (Thomson et al. 2014). Based on an analysis at country level, Stuckler et al. (2009) also report that strong social protection policies, with investment in active labour markets, can have a protective effect in such circumstances.

Policy-making at all levels across sectors can make a critical difference to improving population mental health, supporting the view that a 'mental health in all polices' approach is needed to effectively improve population mental health and reduce mental health inequities. Social policies in education, social protection, justice, employment, housing, and support services can have a major impact on life experiences and can empower individuals and groups in optimizing the potential for positive mental health in everyday life. Understanding population mental health as being influenced by these upstream determinants places the responsibility for improving mental health and reducing inequity within the sphere of policies, politics, and governance and calls for a whole-of-government and whole-of-society approach (WHO 2013a). Cross-sectoral policies and actions are, therefore, a critical component of effective mental health promotion action at international, national, and local levels.

Adopting a Comprehensive Public Health Approach

To address the global burden of mental ill health, it is recognized that treatment approaches alone are not sufficient and that a more comprehensive population level or public health approach is required that will improve population mental health and reduce mental health inequities. The World Health Organization has clearly endorsed the need for a comprehensive and integrated public health approach, embracing promotion and prevention, alongside treatment and recovery (WHO 2013a). A public health approach with a focus on mental health promotion brings a paradigm change in thinking about mental health and how to bring about improvements in population mental health and well-being. A mental health promotion perspective shifts the focus from a deficit model of illness to a broader understanding of mental health as a positive concept and a resource for living with relevance for the whole population. Mental health promotion addresses the critical question of where and how mental health is created and what strategies are needed to create the greatest mental health gains for the greatest number of people. Drawing on a health promotion perspective, the challenge of improving population mental health is, therefore, reframed to focus on the mental health potential of the population and the everyday settings and social contexts in which they live (McQueen and Jones 2007; Kickbusch 1996).

The WHO (2001) World Health Report advocated a comprehensive public health approach to mental health, including mental health promotion and prevention, in order to promote well-being and reduce the burden of mental health problems at a population level. The Prevention and Promotion in Mental Health report (WHO 2002) further prioritized the role of promotion and prevention,

acknowledging that policies focussed on curing or preventing mental ill health alone will not necessarily deliver on improved mental health at a population level. The report clearly laid out the rationale for adopting a mental health promotion approach and advocated that "priority should be given to prevention and promotion in the field of mental health to reduce the increasing burden of mental disorders" (p. 7). The WHO reports on Promoting Mental Health: Concepts, Emerging Evidence, Practice (Herrman et al. 2005) outlined the concepts relating to the promotion of mental health, the evidence for the effectiveness of interventions, and public health policy and practice implications. A separate WHO report on the Prevention of Mental Disorders was also published in tandem (Hosman et al. 2005). Through these landmark publications, the rationale for mental health promotion, its conceptual and research base, and its distinctive approach to mental health improvement have become more clearly established internationally.

A population approach to mental health underscores the universal relevance of mental health for the general population and identifies the need for strategies that can be applied across the life course for diverse population groups and settings. These strategies range from promoting social and emotional well-being and creating supportive living environments for healthy populations, to enhancing resilience and reducing risk for populations at higher risk of developing mental health problems, to promoting recovery and well-being for people with mental disorders. A population approach to mental health improvement requires the development of policy and programme interventions, which extend beyond the clinical and treatment focus of current mental health service delivery, in order to address the influence of the broader social determinants of mental health and reduce inequities.

Progress has been made in advancing the case for the promotion of mental health. There is consensus that there are clusters of known risk and protective factors for mental health (Mrazek and Haggerty 1994). There is also a growing body of international evidence that interventions exist which can modify these factors. There is compelling evidence from high-quality studies that interventions promoting mental health, when implemented effectively, can lead to lasting positive effects on a range of health, education, employment, and social outcomes (Friedli 2003; Keleher and Armstrong 2005; Herrman et al. 2005; Barry and Jenkins 2007; Barry et al. 2013; Petersen et al. 2015). The accumulating evidence base demonstrates the feasibility of implementing effective mental health promotion interventions across a range of diverse population groups and settings, indicating that there is sufficient knowledge to guide effective practice and policy in this field (Jané-Llopis et al. 2005; Jané-Llopis and Barry 2005; Barry and Jenkins 2007). There is also increasing recognition of the wider policy and economic case for investing in promoting mental health and well-being at a population level. Good mental health is recognized as a key asset and resource for population health and well-being and for the long-term social and economic prosperity of society (WHO 2005, 2013a; Lehtinen et al. 2005; Foresight Mental Capital and Well-being Project 2008). Interventions promoting mental health and well-being that can be implemented and sustained at a reasonable cost, have been shown to generate clear health and social gains for the general population

and, therefore, represent a strong case for policy investment (WHO 2002, 2003; Friedli and Parsonage 2007; Zechmeister et al. 2008; Knapp et al. 2011).

The global WHO Mental Health Action Plan for 2013–2020 (WHO 2013a) reinforces the adoption of a comprehensive public health approach with the overall goal of promoting mental well-being, preventing mental disorders, providing care, enhancing recovery, promoting human rights, and reducing the mortality, morbidity, and disability for persons with mental disorders. The implementation of strategies for mental health promotion and prevention is clearly outlined and the Plan seeks to support and strengthen actions by governments in promoting population mental health. In keeping with this international momentum, mental health promotion policy and practice have been introduced and strengthened in a number of countries.

Embracing a Well-Being Focus

Alongside the development of a public health perspective on mental health, the importance of positive mental health for well-being and overall development at a population level has also been recognized (WHO 2002, 2013a). For example, the World Health Organization Mental Health Declaration and Action Plan for Europe clearly stated that the social and economic prosperity of Europe will depend on improving mental health and well-being; "Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies" (WHO Mental Health Action Plan for Europe 2005, p. 1). The Foresight Mental Capital and Wellbeing Project (2008), which provided advice to the UK government on how to achieve the best possible development of mental well-being, identified the following key message: "… if we are to prosper and thrive in our changing society and in an increasingly connected and competitive world, both our mental and material resources will be vital. Encouraging and enabling everyone to realize their potential throughout their lives will be crucial for our future prosperity and wellbeing" (p. 9).

The last two decades have seen a growing interest in how a focus on population well-being could influence the future direction of public policy. The assumption that a continuing increase in economic growth in wealthy countries results in an increase in well-being has been challenged (Layard 2005) and there has been a rethinking of how public policies in areas such as education, employment, culture, and sustainable development impact on well-being and human flourishing (Marks and Shah 2005; Pickett et al. 2006; Eckersley 2006; Marks et al. 2006; Friedli 2009). This was articulated succinctly in the question posed by the New Economics Foundation (NEF) in their 2003 Well-being Manifesto for a Flourishing Society: "What would politics look like if promoting people's well-being was one of the government's main aims?" This document called for the integration of social, economic, and ecological policies in order to ensure that maximizing population well-being is viewed

as being complementary and equal in importance to maximizing economic growth. The focus on population well-being was also accompanied by the development of well-being indicators to capture people's sense of well-being and how their lives are progressing, alongside indicators of economic growth. The National Accounts of Wellbeing (New Economics Foundation 2008) urged national governments to 'measure and act on wellbeing within the broader context of societal and environmental stability' (p. 6). In the UN Political Declaration Rio+ Summit (United Nations 2012) conference on Sustainable Development, all member states committed to improving the well-being of the planet and its inhabitants going beyond a focus on gross domestic product (GDP) as the sole indicator of a country's growth and development.

Initiatives from the OECD, the World Economic Forum, New Economics Foundation, and the UK and French governments (Anderson et al. 2012; New Economics Foundation 2012; OECD 2011) have advocated focussing on well-being and the production of alternative headline indicators of progress. Through its Better Life Initiative and Index "How's Life", the OECD has developed internationally comparable indicators that provide country profiles of population well-being and social progress. A number of countries, such as Australia and Canada, have also developed country-level initiatives that provide a composite index of population well-being. Most notably, Bhutan developed the Gross National Happiness (GNH) Index, which is composed of nine domains and serves as a measure of a social progress designed to inform policy-making. A number of well-being indices are composed of comparable domains such as living standards, education, health, leisure and culture, ecological resilience, time use, good governance, democratic engagement, community vitality, and psychological well-being. The Bhutan GNH also has a clear focus on living in harmony with nature, spirituality, and concern for others, which also resonates with indigenous frameworks for wellness. The development of population well-being indicators is designed to bring a focus on well-being into the centre of the policy-making process alongside indicators of economic development in order to guide a more holistic vision of human development and integrated approach to growth and social progress. The importance of positive mental health for population well-being is clearly evident in these developments. Reflecting this positive well-being focus, new policy frameworks are being adopted and mental health policies advocating for a flourishing society based on promoting population mental health and well-being have been introduced in a number of countries (e.g. Australia, Canada, England, Finland, New Zealand, and Scotland).

International Policy Frameworks

Current policy frameworks for mental health and well-being clearly endorse the central role of intersectoral actions across government and society in creating the conditions that will protect and promote people's mental health and well-being, enhance their resilience, reduce exposure to risk factors, empower people, their

families, and communities in maximizing their health and well-being across the lifespan, and reduce inequities.

The global Mental Health Action Plan 2013–2020 (WHO 2013a) clearly endorses the essential role of mental health in achieving health for all and has at its core the principle that "there is no health without mental health" (p. 6). The plan calls for comprehensive multisectoral strategies for promotion, prevention, treatment, and recovery in a whole-of-government approach. Four key objectives are outlined in the plan:

1. to strengthen effective leadership and governance for mental health
2. to provide comprehensive, integrated, and responsive mental health and social care services in community-based settings
3. to implement strategies for promotion and prevention in mental health
4. to strengthen information systems, evidence, and research for mental health.

Objective 3 calls for multisectoral actions across the life course that will protect and promote the mental well-being of all citizens. The plan emphasizes that responsibility for action extends across all sectors and all government departments, including social and economic determinants such as income level, employment status, education level, material standard of living, physical health status, family cohesion, discrimination, violations of human rights, and adverse life events including sexual violence, child abuse, and neglect. Both universal and targeted interventions for promoting mental health and preventing mental disorders, including suicide prevention, are proposed, which are integrated into national mental health and health promotion strategies. The plan provides a global framework for action, together with a series of global targets, which has been adopted by Member States and supported by regional action plans.

Within the European region, for example, the European Mental Health Action Plan 2013–2020 (WHO 2015) follows the agenda of the global action plan and places as its first of four core objectives that "Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk" (p. 3). Objective 1 aims to raise awareness of mental well-being and the factors that support it at the level of individuals, families, in everyday settings, and in wider society. The plan calls for increased support for mental health promotion across the life course, including improved capacity to enhance mental health promotion in primary care and in the workplace (including return to work) and reduce suicide rates. Measuring well-being and the determinants of population well-being, alongside measures of negative mental health, is also identified as being important in assessing progress at a population level. The European action plan clearly recognizes the central role of governments in creating conditions that empower individuals and communities to promote and protect their well-being and strengthen resilience. The European Mental Health Action Plan (WHO 2015) recommends actions that are both universal and targeted, integrated and coordinated, and at a scale and intensity that is proportionate to the

needs of vulnerable and disadvantaged groups. The European Health Strategy, Health 2020 (WHO 2013b) also addresses the importance of strengthening mental health promotion programmes and policy development at a country level and acknowledges that multisectoral policies and legislation can create structures and resources that can empower people to participate more fully in family and societal and family life and create the conditions for enhancing and protecting population mental health.

There is a growing emphasis on mental health promotion in a wide range of policies on population health and mental health. A review of international policy developments in mental health promotion (GermAnn and Ardiles 2009) outlined the different types of policy models that have been adopted across a number of high-income countries, including Australia, England, Ireland, New Zealand, and Scotland. Across these countries, there has been a focus on developing a population-based approach to mental health improvement in successive policies and national strategies (see for example, successive policies in Australia and the Department of Health (2011) public mental health framework in England), either through a stand-alone mental health promotion policy or as part of a more comprehensive mental health policy or both. Countries such as Australia, Finland, and Scotland have led the way over the past decades in developing policies for mental health promotion, while in other countries population health policies have embraced a focus on promoting positive mental health and well-being as a core component of population health improvement. The relevance of mental health improvement to the broader policy context of addressing social inequities and the social determinants of health has also been evident in a number of policies, e.g. in Scotland and New Zealand, which recognize that mental health is both a contributor and a consequence of social and economic development and equity. In such policy models, a whole-of-government and whole-of-society approach is advocated, with responsibility for promoting mental health extending across government departments and the engagement of diverse sectors across society, encompassing a concern with the impact of economic, cultural, and social policies on population mental health and well-being.

Adopting a Whole-of-Government and Whole-of-Society Approach

Jenkins and Minoletti (2013) argue that mental health should be a priority in all public policies, given its importance for quality of life, social relationships, productivity and social capital, and for the high burden associated with mental ill health worldwide. As outlined earlier, addressing the social determinants of mental health calls for supportive public and social policies and effective action across governmental and nongovernmental sectors. Intersectoral action and healthy public policy

are integral elements of health promotion for achieving population health and health equity (WHO 1986, 2011; UN 2011, 2012) and are also clearly reflected in the WHO Health in All Policies approach (WHO 2013c).

The WHO Helsinki Statement on Health in All Policies (HiAP) outlined HIAP as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful impacts in order to improve population health and health equity" (WHO 2013c). As a concept, HIAP reflects the principles of participation and collaboration across sectors and levels of government, recognizing that public policies in all sectors have a significant impact on population health. Following publication of the WHO Helsinki Statement and the HiAP Framework for Country Action (WHO 2014), this approach has also been applied to mental health promotion, where mental health is incorporated in all policies and the impact of policies across diverse sectors is taken into account in producing mental health outcomes. A Mental Health in All Policies (MHiAP) approach underscores the importance of actions by different policy sectors and at all levels of decision-making – international, national, regional, local – in effectively promoting mental health at a population level. The significant influence of sectors outside of health on the determinants of mental health calls for coordinated policy action from sectors such as welfare and social services, childcare, education, employment, housing and urban planning, media, public finance and debt management, human rights, leisure, and culture. A MHiAP approach recognizes the need for upstream policy interventions to address the social determinants of mental health such as healthy living and working conditions, access to education, life opportunities, housing, and safe communities and to reduce inequities caused by the structural determinants such as poverty, racism, gender inequality, social marginalization of minority groups, and discrimination arising from stigma and prejudice. The full range of public policy mechanisms are required to effectively promote population mental health, including legislation, regulation, and a broad range of fiscal, socioeconomic, and environmental policies to ensure that the conditions that create and support population mental health and well-being are accessible to all.

Systematically monitoring and accounting for the mental health implications of policy decisions in other sectors can be supported by intersectoral policy analysis and the use of tools such as mental health impact assessment (Cook et al. 2011). Efforts are also needed to enhance mental health literacy and the understanding of mental health impacts among decision-makers, organizations, and members of the general population. Greater awareness of how social, economic, cultural, and physical environments impact mental health throughout the life course will lead to a greater appreciation of the need for mental health promotion to be incorporated across policy sectors and their role in shaping population mental health and well-being through parenting, child care, schools, workplace, communities, welfare, cultural, health, and social care settings. Policy coherence is a major consideration in supporting the implementation of integrated whole-of-government policy approaches and remains a significant challenge. Lack of coherence across policies, e.g. in relation to health and education, social protection, and employment, can lead to greater inequities. Policy coherence and alignment between different levels and mechanisms of governance are

critical for effective whole-of-government approaches. Political commitment and inter-departmental governmental structures are critically important in supporting effective intersectoral policy development and implementation, as is creating a culture of collaboration and capacity for effective intersectoral partnership working (Skeen et al. 2010; Jenkins and Minoletti 2013; Corbin et al. 2016).

The social determinants of mental health demand a broad cross-sectoral approach involving the building of partnerships not only across governmental departments at a policy level, but also with a wide range of nongovernmental and civil society actors, agencies, organizations, and community groups. Adopting a whole-of-society approach seeks to engage a broad range of actors who can play an important role in influencing the mental health potential of everyday settings and environments, e.g. through culture, recreation and creative arts, sports, youth services, citizen well-being, and at the level of local authorities, municipalities, and local communities. Facilitating the participation of the wider community, including marginalized and vulnerable groups such as minorities and indigenous people, is a critically important challenge in enabling a wider set of actors to contribute and have a meaningful role in creating the conditions for positive mental health and well-being at a whole-of-society level. New models of intersectoral working are required including effective leadership, participatory processes, and partnership working in implementing a whole-of-society approach that will lead to creating a flourishing and mentally healthy society. Engaging partners from other sectors, identifying opportunities for intersectoral collaboration, negotiating agendas, mediating different sectoral interests, and promoting synergy to facilitate effective partnership working across sectors are all core elements of implementing a whole-of-society approach. Chapters "Implementation Processes and Strategies for Mental Health Promotion" and "Community Mental Health Promotion Principles and Strategies" provide further details on effective intersectoral collaboration and community participation for mental health promotion. Adopting a whole-of-government and whole-of-society approach to population mental health, therefore, entails integrated action implemented across upstream policy approaches and bottom-up community action with vertical and horizontal integration through intersectoral partnerships and participatory processes. The practice of mental health promotion, therefore, requires theoretical frameworks that can embrace this broader cross-sectoral population approach.

International Developments

Mental health has moved onto the political agenda in many countries and there have been a number of significant international developments which have placed mental health promotion on the global political agenda (Herrman and Jané-Llopis 2012). In 2013, the World Health Assembly's 194 Member States adopted the WHO Comprehensive Mental Health Action Plan 2013–2020 (resolution 66.8), recognizing the importance of mental health and declaring their commitment; "to promote

mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce mortality, morbidity and disability for persons with mental disorder", and to monitor implementation, progress, and impact. Promoting mental health is increasingly acknowledged as being integral to population health improvement.

Integrating Mental Health into the Global Health and Development Agendas

The Centers for Disease Control and Prevention (2011) in the US published a Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention in recognition of the contribution of mental health promotion and prevention to the control of non-communicable disease. The focus on universal health coverage within health systems development globally also reflects the increasing emphasis on access to promotion and prevention for population health improvement. The WHO advocates for universal health coverage so that all people and communities can have equitable and affordable access to the full range of quality health services, including universal population health promotion and disease prevention alongside curative, rehabilitative, and palliative health services, without being exposed to financial hardship. Such initiatives afford an opportunity to place mental health promotion squarely at the centre of the global health agenda. To enable progress on the global mental health action plan and universal health coverage, mental health will need to be integrated into public health policies and broader social and development policies. It is clear that since mental health has an impact on numerous interconnected social and economic areas of life, government policy needs to integrate mental health promotion strategies not only into health, but also into education, social protection, employment, criminal justice (including the courts, police, and prisons), and community development policy. Therefore, developing and implementing an intersectoral approach to mental health promotion policy is crucial for the achievement of these broader health and development agendas.

Mental Health and the Global Development Agenda

Population mental health is also being recognized as a critical element of sustainable development. With the adoption of the Sustainable Development Goals (SDGs) by the general Assembly of the United Nations in 2015, mental health has for the first time been included explicitly as an essential component of the global development agenda. The overall aim of the 17 goals in the Agenda 2030 for Sustainable Development (UN 2015) is "to ensure that all human beings can fulfill their potential in dignity and

equality in a healthy environment". Goal 3 is to "Ensure healthy lives and promote well-being for all at all ages" and directly addresses mental health as part of its fourth target: "By 2030, reduce by one third premature mortality from non-communicable disease (NCDs) through prevention and treatment and promote mental health and wellbeing" (Target 3.4). Aspects of mental health are also included in Target 3.5; "Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol". Both mental disorders and substance misuse contribute to premature mortality from NCDs, partly from suicide, non-suicidal trauma and accidents, and comorbidity between mental ill health, physical illness, and substance misuse. Thus, SDG 3.4 and 3.5 require policy attention to the promotion of mental health and the prevention and treatment of mental disorders.

Many of the other SDGs also have implications for mental health. Progress on the goals related to poverty reduction, gender equality, economic development, and reducing social inequities will contribute greatly to mental health promotion as mental health is strongly influenced by levels of poverty, financial hardship and debt, education, and low productivity. Likewise, mental disorders are generally more common in women, ethnic minorities, people with disabilities, and other marginalized groups (Foresight Mental Capital and Wellbeing Project 2008; Beddington et al. 2008). The interlinked nature of the SGDs requires action across multiple sectors to ensure healthy lives and to promote mental health and well-being. The SDGs place mental health at the centre of the global development agenda, thereby acknowledging that improving population mental health will lead to a broad range of health, socioeconomic, and development outcomes (Scorza et al. 2018). The Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development (WHO 2016) clearly underscores that health and well-being are essential to achieving sustainable development and reaffirms health as a universal right, an essential resource for everyday living, a shared goal, and a political priority for all countries. Likewise, the Lancet Commission on global mental health and sustainable development (Patel et al. 2018) supports broadening and reframing the global mental health agenda within the sustainable development framework from a focus on reducing the treatment gap for mental disorders to the improvement of mental health for whole populations based on the recognition that mental health is global public good and relevant to sustainable development globally.

The Role of International Organizations

International organizations have played an important role in stimulating collaborative action to promote the value placed on mental health promotion at national and international levels. The World Health Organization through its landmark publications (WHO 2001, 2002) and global action plans (WHO 2013a) has instituted a wide range of initiatives designed to increase the global awareness and understanding of mental health and mental health promotion and how it can be advanced (see Box 2).

Box 2 World Health Organization Landmark Publications and Initiatives

- WHO publication of the World Health Report in 2001, which for the first time was devoted to mental health.
- The WHO (2002) "Prevention and Promotion in Mental Health" report, which laid out a clear rationale for adopting a mental health promotion approach and advocated that priority should be given to prevention and promotion in the field of mental health.
- The WHO publications on; "Promoting Mental Health: Concepts, Emerging Evidence, Practice" (Herrman et al. 2005) and "Prevention of Mental Disorders: Effective Interventions and Policy Options" (Hosman et al. 2005), which outlined the core concepts and principles of promotion and prevention, reviewed the evidence of effectiveness, and examined the public health policy and practice implications.
- Launch of the Mental Health Gap Action programme (mhGAP) in 2008 to provide governments and key stakeholders with an integrated package of evidence-based interventions for the prevention and treatment of priority mental health conditions that can be feasibly scaled-up, especially in LIMC settings.
- The adoption of the Global Mental Health Action Plan 2013–2020 (WHO 2013a) which provides a global framework for multisectoral comprehensive action, with a clear focus on promoting the mental health and well-being of the whole population as a core objective.

There have also been influential reports from the Institute of Medicine in the US (Mrazek and Haggerty 1994; O'Connell et al. 2009), which have endorsed the importance of including prevention and mental health promotion as critical strategies for mental health improvement at a population level. Pioneering developments in prevention science and policy development in countries such as Australia, Canada, England, Finland, The Netherlands, Scotland, and New Zealand have served to inform the development of regional- and country-level mental health promotion strategies. At a European level, the European WHO Ministerial conference held in Helsinki in 2005 brought together all 52 countries in the WHO European region and the conference's Declaration and Action Plan acted to drive the policy agenda on mental health in Europe for the coming years by setting out the details of commitments and responsibilities of both the WHO and national governments (WHO 2005). While a European-level strategy was not developed, the European Pact for Mental Health and Well-being was launched in 2008 with the aim of supporting combined action by EU Members State and key stakeholders in promoting population mental health and well-being, strengthening preventive action and self-help, and providing support to people who experience mental health problems and their families. These initiatives serve to strengthen mental health policy and practice, exchanging experiences and expertise, and stimulating joint research and practice developments on a cross-European basis.

The International Union for Health Promotion and Education (IUHPE) included mental health promotion as a priority area in initiatives such as the Global Programme on Health Promotion Effectiveness (GPHPE), with seminal publications on the evidence for mental health promotion produced for policy makers and practitioners (Hosman and Jané-Llopis 1999; Jané-Llopis et al. 2005). The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders (VicHealth 2009), a joint initiative by the Victorian Health Foundation, the Clifford Beers Foundation, the Carter Centre, and the World Federation for Mental Health, identified the key principles and actions that governments, communities, organizations, and individuals can take to influence the interconnecting social, economic, cultural, environmental, and personal factors that influence mental health and well-being. Progress in advancing mental health promotion internationally has also been supported by the development of dedicated journals (e.g. International Mental Health Promotion, Advances in School Mental Health Promotion, Global Health Promotion) and a series of world conferences on the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders organized by the World Federation for Mental Health and the Clifford Beers Foundation in collaboration with the Carter Centre and WHO. A Global Consortium for the Advancement of Promotion and Prevention in Mental Health (GCAPP) was also established to act as a catalyst for building international consensus and synergy of action through effective collaboration and partnerships among relevant international organizations.

Important advances have also been made in establishing a sound evidence base for mental health promotion. There is compelling evidence from high-quality studies that mental health promotion interventions, when implemented effectively, enhance protective factors for good mental health, can reduce risk factors for mental disorders, and lead to lasting positive effects on a range of health, social, and economic outcomes (Herrman et al. 2005; Jané-Llopis et al. 2005; Saxena et al. 2006; Barry et al. 2013; Knapp et al. 2011; WHO 2013a). The accumulating evidence base demonstrates the feasibility of implementing effective mental health promotion interventions across a range of diverse population groups and settings in high-, middle-, and low-income countries (Jané-Llopis and Barry 2005; Barry et al. 2013, 2015; Petersen et al. 2015). The strength of evidence from systematic reviews supports the value of such interventions as cost-effective initiatives capable of impacting positively across multiple domains of functioning. See, for example, the series of review papers published from the European DataPrev project, in a special issue of Health Promotion International in 2011 (Vol. 26, Suppl. 1), and the UK Foresight Mental Capital and Well-being Project (2008). Syntheses of effectiveness studies show that interventions carried out in collaboration with individuals, families, and wider communities can impact on multiple positive outcomes across personal and social health domains, education, employment, and social functioning (Jané-Llopis and Barry 2005; Durlak et al. 2011; Barry et al. 2013; Petersen et al. 2016). As discussed earlier, most interventions have been found to have the dual effect of increasing protective factors for good mental health and reducing risks for poor mental health. While acknowledging gaps in the evidence base, extant reviews conclude

that there is sufficient knowledge to move evidence into practice and provide recommendations for action in terms of strengthening mental health at the level of the individual, community, and wider society.

Conclusions

Mental health promotion offers a distinctive framework for promoting population mental health and reducing mental health inequities, based on the underpinning principles of health promotion and intersectoral actions addressing the social determinants of mental health across the life course. A comprehensive public health approach is needed to meet the challenge of addressing the global burden of mental ill health, promoting mental health at a population level, and reducing mental health inequities. Mental health promotion brings a paradigm change in thinking about mental health and shifts the focus from the illness to the health end of the mental health continuum. Embracing a mental health promotion perspective, the challenge of improving population mental health is reframed to focus on the mental health potential of people in the context of their everyday lives. Current international policy frameworks endorse the critical role of intersectoral actions across government and society in creating the conditions and environments that will protect and promote mental health and well-being at a population level. Promoting mental health is increasingly acknowledged as being integral to population health improvement and to overall population well-being at a societal level. The integration of mental health within the global health agenda and the framework of the sustainable development goals is further recognition of the importance of population mental health for a broad range of health, socioeconomic, and development outcomes. Looking to the future, it will be important to build on the progress that has been made to date, with further strategic and innovative developments that will advance mental health promotion policy, research, and practice globally.

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Advancing Evidence-Based Action for Mental Health Promotion

Margaret M. Barry

Introduction

There is a solid case for investing in mental health promotion, whether on the grounds of improving population health and well-being, reducing social and health inequities, protecting human rights, or improving economic efficiency and development (WHO 2013a, b). Strategies focused on curing mental ill health alone will not necessarily deliver on improved mental health at a population level (WHO 2001, 2002, 2013a). Mental health policies which embrace a public health perspective, focussing on promotion and prevention strategies at a population level, have been introduced in many countries globally as the most sustainable method of reducing the increasing burden of mental disorders and improving overall health and well-being. There is a demand for evidence-based mental health promotion interventions that can be implemented and sustained at a reasonable cost, whilst generating clear health and social gains in the population. Evidence from high-, middle- and low-income countries clearly show that there are effective and feasible interventions for promoting mental health that represent a cost-effective use of resources and a strong case for policy investment.

Identifying Evidence-Based Priority Actions

Drawing on existing reviews of the evidence across high-, middle- and low-income countries, it is possible to identify a number of priority actions and 'best practices' for implementation globally. Priority mental health promotion interventions

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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delivered across the life course and diverse platforms are identified based on a synthesis of best available evidence, including the following reviews: (1) a review of the evidence of mental health promotion interventions in LMICs completed for the WHO Task Force on Mainstreaming Health Promotion (Barry et al. 2011), (2) a systematic review on interventions for young people in LMICs (Barry et al. 2013), (3) a review of population and community level mental health promotion and prevention interventions prepared for the World Bank Disease Control Priorities publication (Petersen et al. 2015) and (4) an evidence synthesis briefing prepared for WHO to guide the implementation of priority actions for mental health promotion and primary prevention across the high-, middle- and low-income countries in the Eastern Mediterranean Region (Barry et al. 2015).

Barry et al. (2015) employed the Assessing Cost-Effectiveness in Prevention Project (ACE-Prevention) grading system (Carter et al. 2000) to assess the strength of available evidence on mental health promotion and primary prevention interventions. For this exercise, 'best practices' were understood to be interventions for which there is not only evidence of their cost-effectiveness but also evidence of their feasibility in relation to their cultural acceptability and the capacity of existing service delivery systems to deliver the intervention to the intended target population within existing resource constraints (Carter et al. 2000). 'Good practices' were defined as interventions that do not meet all these criteria but are recommended based on the best available evidence. Given the paucity of cost-effectiveness studies on mental health promotion and prevention research in LMICs, a set of 'best practices' were identified based on cost-effective evidence from high-income countries (HICs) and evidence of feasibility, including task-sharing with delivery by non-specialist implementers, in LMICs.

Table 1 provides a summary overview of the priority areas for implementation that were identified. These priority actions are based on the available evidence on mental health promotion and primary prevention interventions from HIC and LMIC countries in terms of their ability to improve mental health, lead to social and economic gains/benefits, and the feasibility of their implementation. The interventions cover population groups across the lifespan from infancy to adulthood and include actions which can be delivered across different settings and delivery platforms.

Actions Strengthening Individuals and Families

Early Years: Promote Infant (0–3 Years) and Maternal Mental Health

Systematic reviews show that integrating mental health promotion within routine prenatal and postnatal care services, including home visiting parenting programmes, lead to improved child development and parenting skills, reduced behavioural problems and improved maternal health and social functioning (Barlow et al. 2010, 2014; Britto et al. 2017; Kendrick et al. 2013; Stewart-Brown and Schrader-McMillan 2011; Tennant et al. 2007). Antenatal screening and targeted prevention interventions lead to improved detection and management of postnatal depression

Table 1 Evidence-based priority actions

Delivery platform • Delivery channel	Core set of actions	Evaluation	Evidence from high-income countries (HIC), low- and middle-income countries (LMIC)
Population			
• Legislation/ regulation	• Laws and regulation to reduce demand for alcohol use [taxes, restrictions to access, ad bans, enforcement of BAC limits]	• Best practice	• Sufficient evidence from HIC and LMIC
	• Laws to restrict access to means of self-harm/suicide	• Best practice	• Sufficient evidence from HIC and LMIC
	• Integrate mental health into occupational Health and Safety regulations	• Good practice	• Sufficient evidence from HIC and promising evidence from LMIC
• Information/ awareness	• Mass promotion public awareness campaigns to improve mental health literacy and reduce stigma	• Good practice	• Sufficient evidence from HIC and insufficient evidence from LMIC
Community			
• Workplaces	• Integrate mental health into workplace Health and Safety practices	• Good practice	• Sufficient evidence from HIC and promising evidence from LMIC
• Schools	• Universal SEL programmes adopting whole school approaches	• Best practice	• Sufficient evidence from HIC and LMIC
	• Targeted interventions for vulnerable children	• Best practice	• Sufficient evidence from HIC and LMIC
• Community	• Preschool education and community-based parenting programmes	• Good practice	• Sufficient evidence from HIC and promising evidence from LMIC
	• Multi-component out-of-school youth empowerment programmes	• Good practice	• Promising evidence from HIC and LMIC
	• Economic and/or health empowerment programmes for families living in poverty	• Good practice	• Promising evidence from LMIC
	• Parenting and family strengthening for school-going children (3–16 years old)	• Good practice	• Sufficient evidence from HIC and promising evidence from LMIC
Health care			
• Primary Health Care (PHC) (including community outreach)	• Promote infant and maternal mental health (including parenting skills) as part of routine antenatal and postnatal care and home visitation programmes	• Best practice	• Sufficient evidence from HIC and LMIC
	• Training PHC providers in opportunistic mental health promotion and prevention interventions for adults and older people	• Good practice	• Sufficient evidence from HIC and promising evidence from LMIC

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for women at risk of depression and intimate partner violence (Rahman et al. 2013; NICE 2007; Shaw et al. 2006). The effects of early years interventions are especially evident for the most vulnerable families, including those living in poverty, war-torn areas and mothers with depression (Baker-Henningham and Lopez Boo 2010; Nores and Barnett 2010; Dybdahl 2001). Economic analyses of several childhood interventions demonstrate that effective interventions can repay their initial investment with savings to the government and benefits to society, with those at risk making the most gains (Karoly et al. 2005; Galinsky 2006; Friedli and Parsonage 2007; McDaid and Park 2011; Knapp et al. 2011).

There is convincing evidence of the feasibility of implementing home visiting interventions in LMICs with trained community workers (Peacock et al. 2013; Cooper et al. 2009; Klein and Rye 2004), leading to long-term positive effects on the children's development, including those who are underweight and undernourished (Walker et al. 2006), and improved mental health for mothers from very poor communities (Baker-Henningham et al. 2005; Rahman et al. 2013). Home visiting interventions, which have demonstrated long-term positive outcomes for mothers and babies (Walker et al. 2006), have the potential to be scaled up in LMICs. Chapters "Promoting the Mental Health of Children and Families in the Early Years" and "Implementing Mental Health Promotion in Primary Care" in this book provide further details and case study examples of specific interventions that have been successfully implemented across HIC and LMIC contexts.

Preschool: Promote Early Child Mental Health Development (3–6 Years) through Preschool Education and Community-Based Parenting Programmes

Systematic reviews from HICs indicate that high-quality early childhood enrichment programmes provided through preschool result in enduring gains in children's social and emotional well-being, cognitive skills, problem behaviours and school readiness (Geddes et al. 2011; Burger 2010; Manning et al. 2010). Longitudinal studies from HICs and LMICs show evidence of long-term effects on school attainment, social gains and occupational status (Manning et al. 2010; Baker-Henningham and Lopez Boo 2010; Kagitcibasi et al. 2009; Aboud and Yousafzai 2015) with greater benefits for higher risk and more disadvantaged children (Engle et al. 2011).

Economic analyses of preschool programmes indicate a benefit to cost ratio as large as 17.6:1 (Karoly et al. 2005; Schweinhart et al. 2005; Knapp et al. 2011) with favourable benefit-cost ratios being reported for even the most higher-cost intensive programmes (Campbell et al. 2012). Early childhood development interventions have also been identified as a good investment for reducing inequities in the development of children's potential perpetuated by poverty, poor health, poor nutrition, and restricted learning opportunities (Engle et al. 2011). Interventions that can be implemented by community workers, teachers and local mothers offer an important advantage when considering the feasibility of implementation and scaling up in

LMICs. Examples of the successful implementation of preschool programmes are further described in chapter "Implementing Parenting and Preschool Programmes". Due to limited evidence on the potential for scaling up in LMICs, preschool education and community parenting interventions are recommended as a 'good practice'.

Families: Parenting and Family Strengthening for School-Going Children (Good Practice)

Studies from HICs indicate that universal and targeted parenting and family strengthening interventions promote child emotional and behavioural adjustment, particularly in younger children (3–10 years), and can prevent conduct disorder in 'at-risk' families (Stewart-Brown and Schrader-McMillan 2011; Barlow et al. 2010; Furlong et al. 2012). In relation to the latter, economic modelling exercises indicate that the benefits of targeted parenting programmes for the prevention of persistent conduct disorders outweigh the costs in the region of 8:1 in HICs (Knapp et al. 2011), with benefits accruing mainly in the criminal justice system. In view of limited evidence from LMICs, parenting/family strengthening interventions for school-going children are suggested as a 'good practice'. Examples of interventions that demonstrate the effectiveness and feasibility of parenting/family strengthening interventions in both HIC and LMIC settings may be found in chapters "Implementing Community-based Mental Health Promotion Strategies" and "Implementing Parenting and Preschool Programmes".

Actions Strengthening the Community

Schools: Promote Young People's (6–18 Years) Life Skills and Resilience through Whole School-Based Interventions in Primary and Post-Primary Schools (Best Practice)

Universal Social and Emotional Learning (SEL) Interventions: Systematic reviews from HICs demonstrate that universal SEL interventions in primary and post-primary schools lead to long-term benefits in children's social and emotional functioning and academic performance (Durlak et al. 2011; Weare and Nind 2011; Fazel et al. 2014; Taylor et al. 2017). The promotion of social and emotional well-being is a core feature of the WHO's Health-Promoting Schools initiative (WHO 1998), with interventions employing a whole school approach (involving staff, students, parents, school environment and local community) being more likely to be effective than curriculum-only programmes, including addressing problems such as bullying (Ttofi and Farrington 2011; Menesini and Salmivalli, 2017). A review of school-based interventions in LMICs (Barry et al. 2013) concluded that evidence-based

interventions can be feasibly delivered by teachers in low-resource settings by integrating SEL and lifeskills development into a health promoting schools approach. However, capacity needs to be developed, including teacher training, teacher support and supervision, as well as implementation within the whole school environment.

Targeted Interventions for Vulnerable Children and Young People: Interventions for children and young people at higher risk, which enhance coping skills, resilience and cognitive skills, are effective in promoting mental health and preventing the onset of mental health problems such as anxiety, depression and suicide (Werner-Seidler et al. 2017; Brunwasser and Garber 2016; Neil and Christensen 2009; Calear and Christensen 2010; Wasserman et al. 2015) with some interventions being adapted for LMIC settings (Rivet-Duval et al. 2011). The evidence is particularly strong for school-based anxiety and depression prevention interventions employing cognitive behavioural techniques, with targeted interventions for depression prevention delivered by mental health professionals showing larger effect sizes (Werner-Seidler et al. 2017). Targeted interventions for children affected by war, conflict and complex emergencies have also been implemented in countries on a broader scale. Classroom-based interventions (CBI), which aim to reduce distress and enhance resilience and coping skills, have been shown to improve psychological functioning and coping (Jordans et al. 2010, 2013; Tol et al. 2011, 2014; Persson and Rousseau 2009). As some studies have reported that positive findings are differentiated by age, gender and factors such as pre-intervention levels of conflict exposure, the evidence indicates the need to carefully tailor such interventions to the particular needs of the target population and the specific implementation context (Tol 2015).

Economic analyses indicate average returns on investing in school-based interventions that impact on young people's mental health and well-being ranging from 11:1 (Belfield et al. 2015) to 25:1 from high-quality programmes (McDaid and Park 2011), with net savings in terms of the impact on reduced crime, improved education and employment outcomes (Knapp et al. 2011). Both universal and targeted school-based interventions are recommended as 'best practices', with the delivery of universal and targeted approaches being balanced carefully to meet the needs of all young people in school. The tiered approach adopted by the WHO's Health Promoting School framework recommends the use of universal strategies to support the mental health and well-being of all students, selective interventions for students at higher risk of developing problems and requiring additional support, and indicated interventions for students with more complex needs and exhibiting mental health problems and clinical symptoms. Chapters "Promoting Children's and Young People's Mental Health in Schools" and "Implementing Universal and Targeted Mental Health Promotion Interventions in Schools" provide further details on both universal and targeted interventions that have been successfully implemented in schools across a diverse range of countries globally.

Community: Promote the Mental Health and Social Well-Being of Adolescents and Young People (12–18 Years+) through Out-of-School Multicomponent Interventions (Good Practice)

There is promising evidence that out-of-school youth development programmes can improve the mental health and well-being of young people in HICs and lead to positive academic and social outcomes for young people, including those who are disadvantaged and socially excluded (Catalano et al. 2004; Durlak et al. 2010; Barry et al. 2018). While the existing evidence is derived mainly from the USA, some promising evidence from youth programmes in LMICs is also available. Youth empowerment interventions that promote lifeskills have been found to lead to greater gender equity, reduced intimate personal violence and poverty reduction, thus addressing some of the key social determinants of mental health (Barry et al. 2013; Brady et al. 2007). A number of multicomponent community-based interventions are available that address emotional and sexual health, HIV prevention, substance misuse, violence prevention, literacy and social functioning among vulnerable youth, which show the potential for scaling up (Balaji et al. 2011; Jewkes et al. 2008; Bell et al. 2008). Details of scaling up these youth programmes are discussed further in chapter "Implementing Community-based Mental Health Promotion Strategies". The implementation of youth development and empowerment programmes is recommended as a 'good practice'.

Economic Empowerment: Facilitate Community Empowerment Interventions to Promote Mental Health and Reduce the Risk of Mental Disorders for Families in Poverty and Debt (Good Practice)

A number of LMICs have developed community banks and microcredit schemes, which provide loans to the poor, thus promoting mental health and well-being and reducing the risk of mental disorders and suicide (Chowdhury and Bhuiya 2001). Reviews of the evidence on the impact of microfinance (micro-credit and micro-savings) for people living in poverty report positive impacts on people's savings, health, food security and nutrition (Stewart et al. 2010). However, the impact depends on the type of programme, monitoring, sustainability of microcredits and contextual factors (Arrivillage and Salcedo 2014). The research to date indicates that the more traditional microcredit schemes, which incorporate health and education training, especially for women, alongside the provision of credit, are more effective in terms of mental health benefits.

Combined microfinance and health training interventions leading to positive mental health and social benefits, including reduced risk of violence, empowerment and improved social participation and economic well-being, are further described in chapter "Implementing Community-based Mental Health Promotion Strategies".
Research clearly demonstrates the impact of poverty and debt on mental health (Jenkins et al. 2008; Lund et al. 2010; Patel et al. 2010) with studies from HICs

showing a 33% higher risk of developing depression and anxiety for those experiencing unmanageable debt (Skapinakis et al. 2006). Economic analyses based on modelling show that debt advice services can be cost-effective from both a societal and public health expenditure perspective (Knapp et al. 2011). While there is a need for further quality evaluations, microfinance interventions for young adults and women provide encouraging evidence that combined microfinance and training interventions promoting essential lifeskills, asset building and resourcefulness can result in significant mental health and well-being benefits and are recommended as a 'good practice'.

Actions Targeted at Reorienting the Health Sector: Primary Care

Primary Care: Train Primary Health Care (PHC) Providers in Opportunistic Mental Health Promotion and Prevention Interventions for Adults and Older People (Good Practice)

There is good evidence from HICs that training of PHC providers in screening and brief interventions for alcohol misuse can reduce harmful alcohol use (Botelho et al. 2011) and that training in the identification and management of mental disorders can prevent suicide. Given that many patients first seek care from PHC practitioners, these interventions are recommended as 'good practices' with brief advice by PHC practitioners on alcohol consumption being considered as a cost-effective approach. As recommended in the WHO mhGAP Intervention Guide, brief interventions for depression and psychological distress should also be considered given evidence from HIC that these interventions can reduce symptoms (WHO 2016).

Policy Actions on Removing Structural Barriers to Mental Health

Workplace Legislation and Regulations: Advocate for Workplace Policies and Programmes that Will Improve the Mental Health of Working Adults (Good Practice)

Policy and legislation to support the mental health of workers include initiatives for creating healthy working environments through integrating mental health into health and safety regulations, workers' rights, job security, increased job control and autonomy, and anti-bullying measures (NICE 2009; WHO and Burton 2010). There is evidence from HICs that integrated workplace interventions combining both individual and organizational level approaches can improve and maintain mental health at work (Nytrø et al. 2000; Montano et al. 2014) with the gain from comprehensive approaches being reflected in reduced absenteeism, improved well-being and productivity (Leka and Jain 2017; WHO and Burton 2010). Economic analyses

(McDaid et al. 2011; Whiteford et al. 2005) indicate that workplace interventions addressing depression and anxiety through screening and cognitive behavioural therapy courses are cost-saving due to a reduction in both absenteeism and presenteeism (lost productivity while at work).

While there is a paucity of evidence from LMICs on the effectiveness of mental health policies and interventions in the workplace, interventions such as the New SOLVE training package, developed by the International Labour Organization (ILO), have been implemented in several LMICs (Probst et al. 2008). This intervention integrates workplace health promotion into occupational health and safety policies and aims to reduce the incidence of work-related stress, workplace violence (physical and psychological), tobacco, alcohol and drug misuse, and HIV/AIDS. Such interventions are recommended for implementation supported by more rigorous research on effectiveness in diverse cultural settings. Examples of effective workplace mental health promotion policies and programmes are further detailed in chapters "Promoting Mentally Healthy Workplaces" and "Addressing Mental Health Problems at Work".

Suicide Prevention: Advocate for the Implementation of Policies and Regulations to Prevent Suicide and Self-Harm (Best Practice)

There is growing evidence to support the implementation of a broad range of interventions to reduce suicidal behaviours and prevent self-harm in different settings and cultural contexts. Some of the interventions that have been found to be effective include restricting access to the means of suicide, responsible media reporting, training of health personnel for early recognition and management of priority mental, neurological and substance use disorders (WHO 2014b; Teuton et al. 2014), school-based skills training and social support for at-risk students (Cusimano and Sameem 2011; Surgenor et al. 2016). Chapter "Implementing Universal and Targeted Mental Health Promotion Interventions in Schools" of this book provides further details of specific suicide prevention programmes that have been found to be effective. Recommended actions at a policy level include reviewing the legal status of suicide and self-harm in countries where it is still treated as a criminal act, improving access to real-time accurate data on suicide and self-harm at a national level and regulations restricting access to commonly used lethal means of suicide (Scott and Guo 2012; WHO 2012a).

As alcohol misuse can be a serious contributing factor for suicide, self-harm and depression, policies and regulations on alcohol consumption are also identified as a cost-effective strategy for reducing harmful alcohol use globally. Raised tax/price on alcohol products is regarded as the most cost-effective strategy, followed by restricted access to alcohol and bans on alcohol advertising, particularly in countries where the rate of harmful drinking is high (van der Feltz-Cornelis et al. 2011; Rehm et al. 2006).

Public Awareness: Promote Mental Health Literacy and Reduction of Stigma through Multicomponent Public Awareness Campaigns and Community-Based Educational Training Interventions (Good Practice)

Systematic reviews and meta-analyses (Corrigan et al. 2012; Jorm 2012; Griffiths et al. 2014) indicate that the following interventions for promoting mental health literacy and reducing stigma can be identified: mass promotion through the media, setting up of dedicated websites, school education programmes and mental health first aid training. The evidence for their effectiveness comes primarily from HICs. Therefore, at this point, the decision to scale-up these interventions in LMICs has to be taken based on the context of individual countries. Furthermore, there have been no studies on the cost-effectiveness of such interventions.
Public awareness campaigns, as outlined in Chapter "Implementing Mental Health Promotion Approaches in Mental Health Services" of this book, have the capacity to improve the general public's knowledge and awareness of mental health and to a certain extent can reduce prejudice towards people with mental health problems. However, country-level campaigns can be costly to implement, and evidence on their broader impacts can be difficult to establish. Traditionally, mental health literacy has focussed on knowledge about mental disorders, stigma and help-seeking rather than on positive mental health. In keeping with the broader literature on health literacy (Nutbeam 2008; Sørensen et al. 2012; Kickbusch et al. 2013; Rudd 2015), mental health literacy is evolving to encompass an understanding of how to maintain and protect good mental health (Kutcher et al. 2016). There is a need to engage with a broader concept of mental health literacy that can empower and mobilize individuals and communities in shaping and initiating their own actions to promote mental health and build a greater understanding of positive mental health and its determinants. As mental health literacy is the outcome of individual, cultural, educational and social processes, interventions that seek to create mental health literate organizations (e.g. in schools, workplaces, welfare, justice, health and social care settings) have a special role to play in advancing population mental health and well-being.

Conclusions from the Current Evidence

This evidence synthesis has identified a number of high-quality interventions that have produced consistent evidence of their effectiveness across multiple robust trials in a diverse range of settings and countries. The findings confirm that mental health promotion interventions implemented across the health, education and community sectors can contribute to achieving the goals of population health, social and economic well-being and reduced inequities. In addition to the priority actions identified above, there is also promising evidence concerning the impact of a wide range of other interventions that promote mental health and well-being, including the use of online technologies to promote mental health, especially in relation to young people, comprehensive workplace interventions,

community development approaches and environmental interventions. Further details of these specific interventions are discussed throughout the various chapters in this book.

Much of the evidence from the synthesis of reviews is focussed on individual-level interventions with fewer studies examining the impact of integrated approaches operating at the community and policy level. The findings do, however, support the provision of high-quality universal child and maternal health interventions, preschool education especially for vulnerable families and children at risk of adverse outcomes, and universal whole school approaches that integrate a focus on social and emotional well-being as a core part of their routine service. Although policy impact was not examined directly, the evidence from these effective interventions lends support to the implementation of health policies which support the delivery of universal primary health and childcare services, including the delivery of home visiting and parenting programmes, family support policies that provide high-quality preschool education and childcare support, educational policies that promote the emotional and social well-being of young people as a core component of school policy and practice, and policy initiatives that address poverty and the wider structural determinants of population mental health and social inequities.

While good progress is being made in building the evidence for mental health promotion interventions, a number of gaps in the evidence base can be identified and these will now be considered.

Lack of Evidence on Upstream Interventions

There is a need to generate evidence of the effectiveness of interventions operating at different levels, from the individual, community to macro-level policy, in promoting positive mental health. Much of the evidence has focussed on individual-level interventions, and there is a paucity of evidence on the effectiveness of upstream policy interventions such as improved housing, social protection, education and employment in improving mental health. This situation has been described by Petticrew et al. (2005) as fishing for much of our evidence ‘downstream’ rather than ‘upstream’ where mental health is created. There are many plausible policy interventions, which may be expected to directly or indirectly affect mental health, for which evidence appears to be absent. However, the ‘absence of evidence’ should not be mistaken for ‘evidence of absence’, and there are many plausible interventions such as improved housing that can be reasonably expected to generate mental health gains (Petticrew et al. 2005). Chapter “Implementing Community-based Mental Health Promotion Strategies” in this book provides an overview of community-based environmental interventions, including access to green spaces and quality of the built environment, that lead to improvements in mental health and well-being. There is clear potential for positive mental health to be promoted through

non-health policies such as the planning of new residential areas, building of new houses, area-based regeneration, and the assessment of the impact of such policies on population mental health will make an important contribution to the evidence base. The need to generate better evidence of the impact of 'upstream' interventions in non-health sector policies and programmes, remains a critical area for development.

Evidence from Low-and Middle-Income Countries

There is a particularly urgent need to expand the evidence base to be more relevant to the realities of those working and living in LMIC countries and scarce-resource contexts (Petersen et al. 2010). The WHO (2002) report highlighted that evidence is 'least available from areas that have the maximum need, i.e., developing countries and areas affected by conflicts' (p. 27). In many countries, implementing interventions entails working with minimal resources, little of which can be allocated to large intervention research programmes. In the absence of dedicated funds from donors and governments to conduct research in LMICs, the challenge is how to document and uncover innovative forms of practice. Traditional documentation may be lacking, as non-English language, unpublished intervention studies conducted outside of the European/American axis are under-represented in the current knowledge base (McQueen 2001). As much of the current evidence-base of efficacy and effectiveness trials originate in HICs such as the USA, investment is needed in developing and supporting intervention research in LMICs and examining to what extent the existing evidence can be used effectively across diverse sociocultural settings. In particular, there is an urgent need to identify effective interventions that are transferable and sustainable in low-income country settings, particularly low-cost, replicable interventions based on empowerment principles that can be sustained in disadvantaged community settings (Barry and McQueen 2005; Petersen et al. 2010). Examples of innovative and effective interventions that have been successfully implemented in diverse LMIC settings are illustrated in this book, and readers are referred to the chapters in Parts II to VIII of the book for further details.

Evidence on Implementation and Scaling Up

There is an increasing number of evidence-based interventions available for promoting mental health, however, challenges related to their effective implementation and their transferability and sustainability across diverse sociocultural contexts can limit their reach and impact. The implementation of evidence-based interventions is fragmented in many countries, especially in low resource settings.

The actual implementation of evidence-based interventions is under-researched. Implementation research enhances our ability to map the critical connections between the local context, intervention activities and the intended intermediate and

long-term outcomes. Understanding the implementation process is, therefore, critical to the effective adoption, replication and dissemination of interventions and facilitates the translation of research into effective practice and the development of practice-based evidence. However, typically little information is provided in the published research concerning the process and extent of intervention delivery which must occur in order for positive outcomes to be produced. Thus, whilst the importance of adopting an evidence-based approach to mental health promotion is increasingly recognized, the development of research and evaluation to inform effective implementation practice in settings has not kept pace (Dooris and Barry 2013). This is also the case in relation to scaling up of effective interventions where relatively only little is known about the quality of implementation when interventions are disseminated across diverse cultural and economic settings outside the research context (Gottfredson and Gottfredson 2002).

Economic Analyses of Mental Health Promotion Interventions

In addition to the data on intervention effectiveness, economic data on the cost-effectiveness of mental health promotion interventions have an important contribution to make in strengthening the evidence base for the promotion of mental health. Such data can usefully inform resource allocation decisions and lead to a better understanding of the long-term economic benefits of interventions for individuals and society and the related costs of inaction. These include economic benefits in terms of reduced treatment costs but also reduced indirect costs such as work disability, justice, welfare and support service costs and family burden. Economic evaluation needs to be applied to the full range of mental health promotion interventions, as there is currently quite limited data on the cost-effectiveness of alternative mental health promotion strategies. While it is acknowledged that many of the related costs and benefits to society cannot be estimated in economic terms alone, the generation of reliable data on the short-term and long-term costs and benefits of interventions can usefully inform decision-making on the best use of scarce resources and inform decisions on which interventions and approaches to prioritize. Mental health promotion interventions that can be implemented and sustained at a reasonable cost, whilst generating clear health and social gains in the population, represent a cost-effective use of resources and a strong case for policy investment (WHO 2002).

Implementing an Evidence-Based Approach to Mental Health Promotion Practice

While acknowledging that there remain important gaps in the evidence base, a major task is to promote the translation of existing evidence into practice and policy globally, particularly in disadvantaged and low-income countries and settings. The

challenge is twofold: translating research evidence into effective practice and translating effective practice into research so that currently undocumented evidence may make its way into the published literature and serve to build on and expand the existing evidence base. While researchers are more likely to be concerned with the quality of the evidence, its methodological rigour and contribution the knowledge base, the different stakeholders in the area may bring different perspectives to bear on the types of evidence needed. As described by Nutbeam (1999a) each of the stakeholders will view the evidence from different perspectives:

- Policymakers are likely to be concerned with the need to justify the allocation of resources and demonstrate added value.
- Practitioners need to be able to have confidence in the likely success of implementing interventions.
- The potential users or population who are to benefit need to see that both the programme and the process of implementation are participatory and relevant to their needs.

This calls for critical consideration of how best to assemble and apply evidence which is congruent with the principles of mental health promotion practice and which is inclusive of the realities of intervention implementation across diverse cultural and socioeconomic settings (Barry and McQueen 2005). As mental health promotion is an interdisciplinary area of practice, evaluation methods are needed that will cross disciplinary methodological boundaries and will evaluate initiatives in terms of their process and their outcomes. Different methodological approaches are required to encompass the different elements of process, impact and outcome evaluation. While outcome focussed studies may lend themselves to more quantitative approaches, process-focussed research requires more qualitative and naturalistic methods. Standards of rigour and quality can equally be applied to evidence derived from different methodological perspectives. The quality of the different types of evidence should be judged on criteria derived from their respective paradigms and ultimately on their appropriateness to the research questions being addressed.

The complexity of the evidence debate in health promotion is well documented, and researchers have called for the establishment of rules of evidence that take into account the diversity, multidisciplinary and contextualized nature of health promotion practice (Tones 1997; Nutbeam 1999b; McQueen 2001; Rootman et al. 2001; Potvin and McQueen 2008; McQueen and Jones 2007). In keeping with these developments, there is a need for an expansion of the current range of evaluation methodologies and analytical frameworks applied in mental health promotion and a widening of the evidence base to be more inclusive of the realities of practical applications from a more global perspective. A continuum of approaches is required ranging from RCTs to more qualitative process-oriented methods and integrated systems-wide impact evaluations. The adoption of a more pluralistic range of evaluation methods signals a more inclusive approach to setting standards of evidence and evaluation research in mental health promotion. As mental health promotion draws on a diverse range of disciplines, different theoretical and methodological

perspectives may be brought to bear in establishing a sound evidence base that can capitalize on the multidisciplinary nature of the field.

In response to this challenge, there has been an increased focus on multi-method evaluation, on developing an 'evidence into practice into evidence' cycle and on generating understanding not only of what works but also of how, why and when.

The emerging science of implementation sets out to examine explicitly the adoption and implementation of evidence-based interventions, including those that are scaled up, also known as Type II translational research (Fixsen et al. 2005). This calls for a focus on systematically researching the process of implementing interventions in complex naturalistic settings and identifying the factors and conditions which can facilitate high-quality implementation. Evaluation approaches are required that permit a better understanding of the actualities of intervention activities and lead to a better-informed assessment of implementation processes and outcomes.

The generation of practice-based evidence and theory in mental health promotion is an important challenge and will require researchers and practitioners to work in partnership in documenting and analysing the implementation of mental health promotion policies and programmes. Through the development of more collaborative and participatory evaluation methods, there will be an opportunity to include the knowledge base of programme implementers and participants into the evaluation process, thereby incorporating the 'wisdom literature' into the evidence base. In addition, there is a need for analytic frameworks that integrate process and outcome data in meaningful ways so that clear statements can be made about how and why intervention changes have come about. Contrasting and complementary perspectives and methods are needed to fill out the larger picture and to tap previously undocumented areas of knowledge and practice (Barry and McQueen 2005). For example, adopting an ecological settings-based approach requires a shift in focus away from delivering single discrete interventions and measuring their 'linear' impact on individuals. Implementation and evaluation strategies are needed that will capture the synergistic interaction and impact of multiple interdependent interventions and systems operating at different levels and spheres within the context of specific settings such as school, workplaces and communities. Inevitably, this is challenging, requiring an appreciation that the process of change is non-linear and involves multiple interdependent systems (Dooris and Barry 2013).

The current evidence base on mental health promotion interventions is largely based on research methods developed to answer questions about efficacy and effectiveness, grounded in linear models of cause and effect, thus lending themselves to traditional experimental research designs. Cook and Campbell (1976) led the way in consideration of quasi-experimental research designs in field settings and set out the theoretical threats to internal and external validity of the findings in each design scenario. However, in recognition of the need for more upstream interventions and policy changes that will address the social determinants of mental health, a systems approach may be more appropriate. Many upstream interventions, such as population level policy interventions and those involving organizational change or whole school approaches, do not lend themselves to RCT designs,

and therefore, alternative methodologies need to be applied. Traditional evaluation approaches, which focus on individual-level outcomes rather than complex multiple systems may have limited reach and impact at a population level. Traditional experimental designs are also not the most appropriate for researching the implementation process in field settings, due to the methodological challenges involved in capturing complexity and determining the extent of systems change and transformation. Weiner et al. (2009) have called for a stronger knowledge and theory base to guide the implementation of complex innovations and interventions in organizational settings. Greenhalgh et al. (2005) have also called for development of the theory-driven research, a focus on process rather than 'package' with a greater emphasis on ecological analyses, a common language, measures and tools, collaboration and coordination, multidisciplinary and multimethod research, meticulous details, and participation between practitioners and researchers. A complex systems approach, which uses a broad spectrum of methods to design, implement and evaluate interventions that bring about change at a whole systems level, may offer a useful alternative model for capturing the multiple interacting factors within the system that can shape a desirable set of outcomes (Rutter et al. 2017). Complex multi-causal determinants require more than single interventions. Research methods that can capture shifts within multiple elements across influencing systems are required as this will enable the identification of how to influence complex systems to achieve improved mental health and well-being and reduced inequities at a population level.

Innovative research approaches are needed that will shift the focus from linear causal models to a consideration of how processes and outcomes operating within multilevel systems may drive synergistic change. As the change process within systems is typically not linear, researchers will need to track proximal, intermediate and distal processes and outcomes in order to determine the impact of interventions at different timepoints and at different levels of the change process. Evaluation studies employing systems-based non-linear approaches will need to be adopted, examining the whole and mapping and elucidating the interrelationships, interactions and synergies within and between settings (Dooris 2005). There is a growing interest in the application of systems science and related methodologies to public health (Carey et al. 2015), and Rutter et al. (2017) argue that a complex systems approach need to be incorporated into public health research, policy and practice. Systems methodologies enable researchers to examine system components, and the dynamic relationships between them, at multiple levels from cells to society (Lich et al. 2013). Emphasis is placed on understanding the whole system rather than focussing only on individual components. Systems methodologies, which have been applied to a wide range of public health issues, ranging from obesity to tobacco to the social determinants of health, seek to model systems or subsystems in order to identify potential points for interventions and change.

Translating Evidence into Practice

Bridging the science-to-practice gap is concerned with how the mental health promotion evidence base can be used to create change and bring about improved mental health for individuals, families and communities, especially those most in need. The evidence base should serve the needs of practitioners and policymakers concerned with the practicality of implementing successful interventions that are relevant to the needs of the populations they serve. This calls for the active dissemination and translation of validated interventions and guidelines on best practices based on efficacy, effectiveness and dissemination studies. There is a need for investment in capacity development, including training in intervention planning, implementation and evaluation, the provision of technical support and leadership, and the development of knowledge translation (KT) strategies and practice guidelines for effective implementation of feasible and sustainable interventions. The ultimate test is how the evidence base can be effectively used to inform practice and policy that will bring about improved mental health and reduce inequities.

It is important that knowledge about what works is applied in order to inform decision-making and bring about lasting change in the broader policy and practice context. While continuing to build on systematic reviews of specific topic areas, it is important to identify cross-cutting themes and generic processes that underpin the successful implementation of interventions (Speller et al. 1997). There is a need for practice and policy guidelines based on the existing evidence to inform practitioners and decision makers concerning effective intervention planning, delivery and evaluation, and the critical factors that are needed to ensure the implementation of successful interventions. This information is beginning to emerge, and there are some useful practitioner-oriented publications, which provide practical guidance on evidence-based interventions and their implementation.

A number of international and national organizations have developed user-friendly information systems and databases in order to make the evidence base accessible to practitioners and policy makers. Examples include:

- Blueprints for Healthy Youth Development registry of evidence-based positive youth development programmes (http://www.blueprintsprograms.com/programs)
- Centers for Disease Control and Prevention Guide to Community Preventive Services (www.thecommunityguide.org)
- Cochrane Health Promotion Public Health and Field (www.cochrane.org) and (www.vichealth.gov.au/cochrane)
- Early Intervention Foundation Guidebook (http://guidebook.eif.org.uk/)
- Evidence for Policy and Practice Information Centre (EPPI-Centre) (http://eppi.ioe.ac.uk)
- the NHS Centre for Reviews and Dissemination (www.york.ac.uk/inst/crd/wph.htm)
- National Institute for Health and Care Excellence (NICE) in the UK—provides practical guidance on putting evidence into practice and implementing evidence-

based interventions (https://www.nice.org.uk/about/what-we-do/into-practice/implementing-nice-guidance)
- Public Health Agency of Canada, Canadian Best Practices Portal (http://cbpp-pcpe.phac-aspc.gc.ca)
- RAND Health (https://www.rand.org/health.html)
- Social and Emotional Learning Library, The Collaborative for Academic, Social and Emotional Learning (CASEL) (www.casel.org/inex.htm)
- US Mental Health and Substance Abuse (SAMHSA) (www.samhsa.gov)

However, databases are more of a passive than active form of dissemination, and there have been a number of initiatives to explore more active ways of translating the evidence base into practice. Publications specifically targeting policy makers and practitioners play an important role in influencing national policy and encouraging evidence-based practice. Targeted evidence briefings, such as policy briefs and practice briefs, which consist of summaries and syntheses of existing systematic reviews on a range of topics, have also been produced. However, as noted by Kelly et al. (2004), for the evidence to be applicable in the field, a further step is required to make the evidence accessible, contextualized, usable and implemented by practitioners.

More active KT strategies are required for disseminating the evidence base and providing technical assistance and capacity-building resources for mental health promotion to enable practitioners to implement evidence-based interventions and engage successfully with the complex processes involved. Translating from research into effective policy and practice requires not only scientific research evidence but also the skills of effective implementation. This involves bridging the science-to-practice gap by promoting the effective use of evidence for mental health promotion through fostering networks, knowledge sharing and providing a range of evidence-based tools, methods and KT services to support best practice and policy. Additionally, KT is a strategic process that promotes the best available evidence, and a number of KT models and frameworks have been developed internationally. KT is described as 'The synthesis, exchange, and application of knowledge by relevant stakeholders to accelerate the benefits of global and local innovation in strengthening health systems and improving people's health' (WHO 2012b). The overall aim is to reduce the 'know-do' gap, facilitating the best use of existing or evolving research to create positive change. The KT process covers the phases of knowledge production, dissemination, reception and adoption, appropriation and use. A number of frameworks (see, e.g., the knowledge-to-action framework by Graham et al. 2006) and knowledge-sharing strategies and tools have been developed to guide the process of integrating the application of knowledge in a given context. Initiatives such as the establishment of the National Collaborating Centres (NCCs) for Public Health in Canada were established to promote and improve the use of scientific research and knowledge to strengthen public health practices and policies. As one of the six centres, the NCC for Healthy Public Policy at L'Institut national de santé publique du Québec in Montréal has developed specific KT resources for promoting population mental health and well-being (http://www.

ncchpp.ca/550/Population_Mental_Health.ccnpps). Developing capacity for KT in mental health promotion will facilitate easier access to research and evidence by policymakers and practitioners and provide them with tools and support to make evidence-informed decisions in relation to advancing mental health promotion policy, practice, education and training. Furthermore, KT capacity entails increasing the ability to share new strategies and practices with others, including documenting innovative practice at the local level. Learning will then be a two-way process in terms of innovation, adaptation and dissemination of promising approaches and creative practice.

Building the Infrastructure for Mental Health Promotion

The generation and provision of evidence of itself is not enough to guarantee effective action, and there is a need to develop the necessary infrastructures to support effective implementation. Both political will on the part of policymakers and skilful practice by practitioners is needed to ensure that evidence translates into policy and practice that will produce affirmative action on the ground. This requires a focus on both the policy and practice of creating positive mental health.

Mutisectoral Policy Development and Implementation

The promotion and maintenance of mental health at a population level calls for the creation of effective policies and strategies at international, national, regional and local levels. A supportive policy context is critical to ensure that initiatives to promote mental health are sustained (Scanlon 2002). This includes investment in the necessary infrastructure such as research, training, policy and practice development, dedicated resource allocation and strategic leadership in driving forward the mental health promotion agenda. As outlined earlier, factors such as poverty, unmanageable debt, housing, employment, education, safe neighbourhoods, cohesive and socially just societies are recognized as powerful determinants of people's mental health potential. Creating a mentally healthy society entails addressing these broader socio-environmental and political influences and working across diverse sectors in order to address the upstream determinants of mental health. The political context of this work needs to be recognized as the development and implementation of policy is mediated through political processes. This is evident in terms of the prioritization of areas for action and the provision of dedicated funding and resources. There needs to be political will and commitment to ensure that the necessary resources are put in place to enable effective policies and plans to be put into action.

Despite its growing importance, promoting population mental health is poorly developed in many countries and remains low on the public health and policy agenda, especially in low- and middle-income countries. There is a substantial gap between the need for mental health services and their availability, and mental health may be an implicit rather than explicit part of public health policy and remains hidden and not of high priority. Public health policies still tend to focus primarily on physical health, while mental health policies are mainly concerned with addressing the urgency of providing treatment for mental ill health. In almost all countries, the implementation of policy is identified as a key challenge, and there is a need to build and strengthen the infrastructure for policy implementation requiring sustained leadership, advocacy, technical expertise and coordinated action at multiple levels. Advocacy is required to advance the position of mental health on the political agenda (Saxena et al. 2005). In 2002 the World Health Assembly adopted a resolution urging the WHO, as the lead international agency with responsibility for health, to facilitate the effective development of policies and programmes to strengthen and protect mental health (WHA55.10). The resolution called for 'coalition building with civil society and key actions in order to enhance global awareness-raising and advocacy campaigns on mental health' (WHO 2002), and this commitment is further endorsed in the WHO global mental health action plan (WHO 2013a). Advocacy initiatives have been established globally including the Global Movement for Mental Health, a network of individuals and organizations that advocates for improved services for people living with mental disorders worldwide and the international initiative of global mental health leaders called FundaMentalSDGs, which advocated for the inclusion of mental health in the SDGs (Detlev 2015). Political commitment needs to be mobilized so that promoting population mental health is given greater priority in terms of policy development, including policies which promote mentally healthy and sustainable living, working and social environments. Among the key agents are politicians, policymakers, educators, opinion leaders and members of civil society. There is a need to raise awareness of the determinants of population mental health at public and policymaking levels in order to place mental health promotion on the multisectoral policy agenda (Petek et al. 2017). Public participation is critical to this process, as policy development needs to be based on greater public awareness of, and engagement with, the importance of good mental health to overall health and social well-being. In other words, the visibility and value of mental health as a public asset needs to be enhanced.

Recognition of the public health potential of mental health promotion will promote greater awareness of what mental health promotion can contribute to wider health and social gain (WHO 2013a; WHO and Calouste Gulbenkian Foundation 2014; Foresight Mental Capital and Wellbeing Project 2008). As demonstrated by the current evidence, effective mental health promotion strategies have the potential to contribute to a range of improved health and social outcomes in terms of physical health and well-being, educational achievement, employment, reduced crime and delinquency, improved sexual health, improved family and social relationships and

reduced inequities. There is a persuasive case for governments to invest in mental health promotion as an effective strategy for creating health and social gain (WHO 2013b; Moodie and Jenkins 2005). Global policy frameworks, as outlined in chapter "Reframing the Challenge of Promoting Population Mental Health", advocate making mental health an inseparable part of public health and the global development agenda (WHO 2013a, 2016; UN 2015), thus recognizing the need for high-level policy action across sectors and consideration of the impact of all policies on mental health.

Infrastructures at the country level are needed to adopt a whole-of-government and a whole-of-society approach to mental health promotion. As outlined in Box 1, this includes creating supportive policies that provide a mandate for action, including legislation, national strategies and intergovernmental collaboration, mechanism for quality implementation and accountability, funding and capacity development for practice and research. The delivery components include sustainable mechanisms for embedding mental health promotion practices into mainstream support and service delivery in childcare, schools, workplaces, communities, health and social services and communities. The effective implementation of mental health promotion requires investment in developing the necessary policy, practice and research infrastructures for effective action, with strategic leadership to ensure the development of organizational and workforce capacity (see Box 1).

Box 1 Developing the Infrastructure for Promoting Population Mental Health (Adapted from Barry and Jenkins 2007)

- Create a supportive policy framework that provides a mandate for intersectoral action.
- Develop a strategic action plan which identifies priority actions for implementation.
- Coordinate an intersectoral and partnership approach to policy implementation at national, regional and local levels.
- Invest in research to guide evidence-based mental health promotion policy and practice.
- Invest in human, technical, financial and organizational resources to achieve priority actions and outcomes.
- Support capacity development and training of the mental health promotion workforce to ensure effective practice and intervention delivery.
- Identify models of best practice and support the adoption and adaptation of high-quality, effective and sustainable interventions, particularly those that will reduce mental health inequities.
- Engage the participation of the wider community.
- Put in place a system of monitoring policy implementation and equity impact.
- Systematically evaluate intervention process, impact, outcome and cost effectiveness.

The integration of mental health promotion across a range of health and social policies is a critical element of infrastructure development. As mental health promotion is relevant across the entire spectrum of mental health and social services, effective strategies require engagement with a broad range of service and community sectors such as primary care, mental health, public health, community, prison, family and social welfare services and agencies. Likewise, the socio-environmental nature of the determinants of mental health demand the building of intersectoral partnerships and collaboration across government departments and diverse sectors and community groups beyond the health sector. Rowling and Taylor (2005) describe the most significant components of an intersectoral approach as being the adoption of a unifying language with which to work across sectors, a partnership approach to allocation and sharing of resources and a strengthening of capacity across the individual, organizational and community dimensions. In keeping with the concept of a mental health in all policies approach (WHO 2014a), an intersectoral, integrated approach is needed that will ensure that mental health promotion is embedded firmly in policies and practices across a range of sectors. These efforts need to be coordinated across the various sectors, and the impact of all policies on population level mental health needs to be assessed.

Developing Effective Practice

The skills of effective implementation are also required in order to translate from research and policy into effective practice. This entails developing creative and skilful solutions to local problems and the implementation of innovative and effective interventions. As knowledge about effective interventions has grown, a science of implementation has been developed to guide research and practice in diverse fields, and a number of universal implementation concepts and principles have been identified (Durlak 2016; Durlak and DuPre 2008; Meyers et al. 2012; Fixsen et al. 2005). Implementation science is concerned with promoting the uptake of research findings and evidence-based strategies into routine practice. This is essentially concerned with the how-to of evidence-based practice, encompassing the practical realities of intervention delivery and the groundwork that needs to take place by practitioners in order to ensure effective implementation.

Within the field of mental health promotion, the body of research on implementation is limited but growing, further details of which are outlined in chapters "Implementation Processes and Strategies for Mental Health Promotion" and "A Generic Template for Implementing Mental Health Promotion" of this book. The range of practice skills required for effective implementation include identifying and responding to local needs, working creatively with local resources, engaging participation of key stakeholders, effective communication, mobilizing support and the necessary resources, systematic planning, evaluation and project management, successfully navigating the process of collaboration and partnership building across sectors and providing leadership for changing practices and organizational capacities

at the wider implementation system level. Developing sustainable initiatives requires imagination, skill, high level motivation and the ability to foster a positive ethos and climate of collaboration. The generic processes underpinning effective implementation are discussed in chapter "A Generic Template for Implementing Mental Health Promotion", and recommendations for improving the quality of intervention implementation are made. Adopting an evidence-based intervention does not in itself guarantee success. Practice skills and creativity are required for quality planning and effective intervention delivery.

Implementing interventions in complex multilevel systems such as schools, workplaces and communities requires a focus on the complex interaction of characteristics of the intervention, the implementer, the participants, the organizational capacity and support of the delivery system (both general and intervention-specific capacity) and the specific contexts in which the intervention is being implemented (Chen 1998). The recognition of implementation complexity and the importance of relevance to the local context and community are critical considerations (Fixsen et al. 2005). Current research indicates that implementation is often variable and imperfect in field settings and that the level of implementation influences outcomes (Durlak and DuPre 2008). The importance of a supportive implementation system in ensuring successful intervention implementation and replication is underscored by the literature (Mihalic et al. 2002; Barry et al. 2005). Influencing factors include the quality of training and support, facilitatory and inhibitory factors in the local context such as readiness, mobilization of support, ecological fit of the intervention, cultural sensitivity, and the extent of participation and collaboration with key stakeholders. The level and extent of all these aspects of the implementation system need to be carefully planned and documented in order to ensure the quality and sustainability of intervention delivery. Throughout this book, a number of best practice interventions and case studies are presented to illustrate how effective implementation can be ensured through the use of research-based, theoretically grounded and culturally appropriate approaches.

Facilitating Intersectoral Partnerships and Collaboration

As our understanding of the nature of mental health and its determinants broadens, so also does our appreciation of the role of a wider set of sectors and actors in promoting population mental health and well-being. Mental health promotion cannot be undertaken by any one sector or any single organization on its own. Effective policy and practice requires that the different sectors and organizations work together, including international organizations, national governments, nongovernmental organizations, prospective donors and professional associations (WHO 2013a). Active engagement with these different sectors is needed to promote greater understanding of the concept of positive mental health and its importance for overall health and well-being. To increase the visibility of mental health promotion at a societal level, it is necessary to 'remove the shadows' of the stigma surrounding mental ill health and to promote greater public and professional understanding of

the importance of promoting positive mental health in its own right as a resource for everyday life and societal well-being. Partnership working and intersectoral collaboration is now very much at the core of modern health promotion practice where community members, health professional, governmental and non-governmental agencies work together in achieving agreed goals and objectives in promoting health and well-being. Developing intersectoral partnerships based on existing strengths and resources is, therefore, a key strategy for mental health promotion.

Workforce Capacity Development

The development and sustainability of mental health promotion is dependent on having a skilled and informed workforce. Mental health promotion requires skills to work with populations, communities and individuals. Partnership working and the implementation of multiple strategies call for high-level expertise in order to engage and facilitate the participation of diverse sectors. Education and training is required to develop the competencies and multidisciplinary knowledge base of the core concepts, principles, theory and research of mental health promotion and its application in practice.

The development of skills to support the implementation of policy initiatives and to ensure the development of best practice is key to the future growth and development of mental health promotion as a multidisciplinary area of practice. A skilled and trained workforce with the necessary competencies to work at the level of policy, population groups, communities and individuals is recognized as being critical to effective implementation (Barry 2007). Leadership, advocacy, partnership and intersectoral working call for high-level expertise in order to engage and facilitate the participation of diverse sectors and mobilize and mediate diverse interests. While much of the knowledge and skills required are inextricably linked to health promotion generally and as such can be provided though continuous professional education programmes and postgraduate training (Mittelmark 2003), workforce capacity needs to be developed in order to ensure that practitioners are equipped with the required competencies to implement current knowledge, research and best practice in mental health promotion. Building the capacity of workforce in developing and implementing mental health promotion is fundamental to advancing and sustaining action in this area.

Workforce capacity development can range from increasing awareness about the promotion of mental health (i.e. among health professionals and decision makers in diverse sectors), to training and skills development needed to support and implement specific initiatives, (e.g. among school teachers, childcare workers, nurses, community workers, health promotion staff, primary care and mental health service staff), to dedicated mental health promotion specialists who facilitate and support the development and implementation of policy and practice across a range of settings. Given the diversity of the workforce for mental health promotion, there is a need to identify the specific mix of skills, knowledge and expertise that is required for practice in order to strengthen mental health promotion workforce capacity.

Continuing professional development and training is required to enhance the quality of practice and update the skill set required to work within changing social and political contexts. International developments in identifying core competencies for health promotion (Allegrante et al. 2009; Barry et al. 2009) provide useful frameworks that could inform workforce development and training in mental health promotion.

In particular, the CompHP Core Competencies Framework for Health Promotion, which was informed by the domains of core competency identified in the Galway Consensus Conference Statement (Allegrante et al. 2009; Barry et al. 2009), have particular relevance for mental health promotion practice. In this framework, competencies are defined as 'a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion' and core competencies as 'the minimum set of competencies that constitute a common baseline for all health promotion roles. They are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field' (Barry et al. 2012a, p. 649). As shown in Box 2, the framework identifies 11 domains of core competency. Building on the core concepts and principles of health promotion, the framework presents a common language and shared understanding of what constitutes health promotion practice, based on an extensive consensus-building process. The domains of Ethical Values and the Knowledge Base are depicted as underpinning all health promotion action detailed in the nine other domains. The Knowledge domain encompasses the multidisciplinary concepts, theories and research that makes health promotion practice distinctive and the Ethical domain is seen as being integral to practice, providing the context within which all other competencies are practiced. The remaining nine domains include; Enable Change, Advocate for Health, Mediate through Partnership, Communication, Leadership, Assessment, Planning, Implementation, and Evaluation and Research. Each of these domains, and the related competency statements, articulate the specific skills needed for competent practice, and these are further detailed in Barry et al. (2012a, b). The combined application of all 11 domains is considered to constitute the CompHP Framework, and all areas identified as being core competencies should be addressed in order to provide a solid basis for quality assurance of health promotion practice, education and training.

The CompHP Core Competencies Framework for Health Promotion provides a resource for health promotion workforce development, through articulating the necessary competencies that are required for effective practice (see Box 2). This framework could be adapted and elaborated to identify the essential knowledge, abilities, skills and values that are needed for effective mental health promotion practice. A competency framework that meets the specific demands of the mental health promotion workforce would provide a strong basis for workforce preparation and development at various levels of practice.

A number of levels are envisaged including those working as mental health promotion specialists, whose main role and function is dedicated to promoting mental health, those working in other professional areas whose role includes mental health promotion (e.g. public health and primary care) or those in other sectors involved in

Box 2 CompHP Core Competency Domains for Health Promotion (Adapted from Barry et al. (2012a, b))

- *Ethical Values Underpinning Health Promotion Core Competencies*: Ethical values and principles for health promotion include a belief in equity and social justice, respect for the autonomy and choice of both individuals and groups, and collaborative and consultative ways of working.
- *Knowledge Base Underpinning Health Promotion Core Competencies*: The core competencies require that a health promotion practitioner draws on a multidisciplinary knowledge base of the core concepts, principles, theory and research of health promotion and its application in practice.
- *Enable Change*: Enable individuals, groups, communities and organizations to build capacity for health promotion action to improve health and reduce health inequities.
- *Advocate for Health*: Advocate with, and on behalf of, individuals, communities and organizations to improve health and well-being and build capacity for health promotion action.
- *Mediate through Partnership*: Work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion action.
- *Communication*: Communicate health promotion action effectively, using appropriate techniques and technologies for diverse audiences.
- *Leadership*: Contribute to the development of a shared vision and strategic direction for health promotion action.
- *Assessment*: Conduct assessment of needs and assets in partnership with stakeholders, in the context of the political, economic, social, cultural, environmental, behavioural and biological determinants that promote or compromise health.
- *Planning*: Develop measurable health promotion goals and objectives based on assessment of needs and assets in partnership with stakeholders.
- *Implementation*: Implement effective and efficient, culturally sensitive and ethical health promotion action in partnership with stakeholders.
- *Evaluation and Research*: Use appropriate evaluation and research methods, in partnership with stakeholders, to determine the reach, impact and effectiveness of health promotion action.

partnerships to promote population mental health and well-being (e.g. teachers and community development workers). At all of these levels, the development of workforce capacity through education and training in mental health promotion is a central plank of the infrastructure required for promoting population mental health.

Quality criteria for training health and social care professionals in mental health promotion were outlined by Greacen et al. (2012) as part of the European PROMISE project. The following ten quality criteria were identified: embracing the principle

of positive mental health; empowering community stakeholders; adopting an interdisciplinary and intersectoral approach, including people with mental health problems; advocating; consulting the knowledge base; adapting interventions to local contexts; identifying and evaluating risks; using the media; evaluating training, implementation processes and outcomes. The project also produced resource kits and evaluation checklists linked with each of the quality criteria. A number of initiatives have also been undertaken in countries to support the integration of mental health promotion into more generic public health practice, two examples of which will now be considered.

Public Health England (PHE) well-being and mental health programme identifies workforce development as a priority area and proposes a framework for building capacity across the wider and specialist public health workforce in understanding and integrating mental health and well-being into public health. PHE outlines six overall ambitions for workforce development at a number of different levels including; leaders who can advocate for mental health as a resource for thriving communities and economics, the public health specialist workforce with dedicated expertise to lead mental health as public health priority, local workforce working with communities, and frontline staff working across sectors, health and social care workforce. For each of these ambitions, core principles and competencies are identified that describe the common knowledge, beliefs and skills the entire public health workforce, including leaders, will need (Public Health England 2015). In Canada, the National Collaborating Centres for Public Health developed a collection of discussion papers to increase the understanding of how to integrate and strengthen public health practice in promoting population mental health for children and youth (National Collaborating Centres for Public Health 2017). The collection of papers outlines key concepts and explores the role of public health practitioners from a variety of perspectives in promoting population mental health. A number of entry points for public health practitioners are identified, and resources are identified in order to guide professionals on how to integrate mental health promotion as a core focus of their practice, including applying a health equity lens.

Traditionally, public health training has focussed mainly on physical health. Therefore, many public health practitioners may lack confidence and adequate training in integrating mental health promotion in their practice. However, well-trained public health practitioners are versed in the science and practice of prevention and promotion and are familiar with the skills required for implementing intersectoral actions to promote population health and reduce inequities. In contrast, mental health professionals have a strong body of knowledge in mental health and its determinants but may lack adequate training in the paradigms of promotion and prevention and the skills needed to address mental health inequities at a population level. To bridge this gap, training in the specific competencies and multidisciplinary knowledge base of mental health promotion is required. A new hybrid of public health/mental health promotion practitioner is required with the combined core skills and competencies required. While some countries have created specialized mental health promotion posts and developed postgraduate

education and training programmes, these are very few in number and are not generally available in many countries. Identifying the core knowledge, skills and competencies required for mental health promotion practice and developing a common language with which to communicate with key stakeholders in other sectors, including the wider public, is a critical step in strengthening capacity for mental health promotion action.

Investing in Research

In addition to practice skills, research skills are required to develop and evaluate interventions, to monitor mental health status and patterns at a population level and to improve our understanding of the determinants of mental health. Effective policies and strategies need to be based on sound epidemiological data and effective intervention approaches. While national health surveys of physical health status and its determinants are routinely collected in many countries, only limited data on mental health status is collected at a population level, particularly with regard to positive mental health and the pattern of differences among population groups. To determine this information requires the regular assessment of mental health status, including both positive and negative indicators, and its determinants at a population level.

Investment in research and evaluation is critical to support the implementation of evidence-based policy and practice in mental health promotion. There is a need for different types of research including the following:

- Monitoring and surveillance systems for assessing mental health status and its determinants at a population level.
- Policy analysis including research on intersectoral policy development, policy implementation and impact assessment.
- Efficacy studies which provide information on intervention outcomes under controlled research conditions.
- Effectiveness studies which evaluate intervention process, impacts, outcomes, equity and costs in more uncontrolled 'real world' conditions.
- Implementation research trials to examine the conditions necessary to ensure the successful adoption and transferability of evidence-based interventions across diverse cultural contexts, population groups and socioeconomic settings.
- Translational research which documents the scaling-up and sustainability of interventions, especially in low-resource settings.

The European ROAMER project (Forsman et al. 2015) identified a number of priority recommendations for public mental health research including research to identify the causes, risk and protective factors for mental health across the lifespan; to advance the implementation of effective public mental health interventions through the use of robust and appropriate research methods and research that will address increasing equity and reducing disparities in mental health.

Strengthening research on the implementation and dissemination of mental health promotion interventions was also highlighted as was the critical need for innovative implementation and translational research to identify the facilitators and barriers for translation from knowledge into action. The complexity of mental health and its broader conceptualization requires innovative and complementary research approaches and interdisciplinary collaboration to better serve the needs of this field.

The development of innovative multidisciplinary methods for both intervention research and evidence synthesis is needed to support effective policy and upstream approaches to promoting population mental health and well-being. Evaluation methods need to be developed and applied that can take account of the complexity of systems (e.g. in schools, workplaces, communities, among others) and the diverse contexts within which interventions are delivered. This means moving beyond conventional evaluation approaches that are both linear and reductionist and engaging with systems theory, which places more emphasis on the organic, emergent nature of innovation and adaptation. New research skills are required, including adapting methods and techniques from other disciplines that are more advanced in the application of complex systems methodologies (Rutter et al. 2017).

To advance mental health promotion, there is a need to combine the art, science and politics (i.e. practice, research and policy) of promoting mental health for effective action (Barry 2005). The research base needs to be strengthened in order to provide a strong foundation for effective policy and practice. Innovative research approaches and new research paradigms are required in order to capture the complexity of multilevel interventions and to measure the synergistic system-level changes which they produce. Insights from transdisciplinary research could support the use of innovative methodological approaches that can inform the development of effective mental health promotion action into the future. KT and dissemination research, together with further systematic studies of intervention implementation, adoption, adaptation and sustainability, are needed so that practice-based theory may be generated that will guide capacity development for effective intervention delivery, especially in scarce-resource settings. Mobilizing political commitment is also crucial in order that mental health is given greater priority in policy development, including multisectoral policies which promote mentally healthy living, working and social environments and health equity. There is a need to improve mental health literacy by raising awareness of the importance of positive mental health and the social determinants of population mental health at public and policymaking levels. Public participation is critical to this process, as policy needs to be accompanied by greater public engagement with the importance of good mental health for overall population health and socioeconomic and cultural well-being. We, therefore, need to ensure that the art, science and politics of mental health promotion as outlined in Fig. 1, work in tandem, thereby enabling practice, research and policy that supports the development of a flourishing society, which creates, promotes and maintains the mental health of the whole population.

Fig. 1 The art, science and politics of promoting mental health (Adapted from Barry (2005) and reprinted by permission of the Journal of Public Mental Health)

Conclusions

The body of knowledge on the effective implementation of mental health promotion policy and practice has grown considerably, and the strength of the evidence base makes a strong case for investment. Strengthening the links between research, policy and practice is key to advancing the implementation of effective, feasible and sustainable mental health promotion action. This includes the following actions:

- Advocate for mental health promotion through multisectoral policy development among decision makers and policy-makers at all levels of governance.
- Create an enabling policy structure for comprehensive and universal actions on a cross-sectoral basis.
- Strengthen effective implementation through multi-stakeholder partnerships, delivery systems and support structures for cross-sectoral action to effect systems change.
- Invest in the organizational and workforce capacity needed to scale-up and integrate priority mental health promotion actions across the life course.
- Develop new research paradigms to advance the use of innovative methodologies for implementation, evaluation and translational research.
- Engage with a wider public audience to build a greater understanding of mental health promotion and its importance to health and social well-being.
- Mobilize and empower communities and civil society to shape and initiate actions to promote mental health and well-being and advocate for change.

The following chapters of this text outline the main concepts, principles and practice of implementing mental health promotion and draw on the current evidence base to demonstrate how effective and sustainable interventions can be implemented with population groups across the life course (children, adolescents, adults and older people) in key settings such as the home, school, workplace, community, primary care and mental health services.

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Part II
Implementing Mental Health Promotion

Implementation Processes and Strategies for Mental Health Promotion

Margaret M. Barry

Introduction

Having overviewed the key concepts, principles and approaches to mental health promotion in chapter "Concepts and Principles of Mental Health Promotion", in this chapter we focus on the process involved in implementing interventions successfully. Before an intervention can be put in place, a great deal of preparation and pre-implementation planning needs to take place. This includes assessing the needs and resources of the particular population group and implementation setting, engaging the participation and collaboration of key stakeholders, selecting and adapting a suitable intervention, developing an implementation plan and building capacity and organizational support to make intervention delivery possible. Enabling structures in policy and implementation are required to support the implementation of mental health promotion interventions in a feasible and sustainable manner within existing services and organizations.

An overview is given of the implementation literature, including key concepts, frameworks and strategies, in order to provide a deeper understanding of why implementation is important and the lessons that can be drawn from research that has been carried out to date. This information will provide a useful conceptual and empirical basis for informing the more practical steps involved in successfully putting interventions into practice. Before detailing each of these steps, it may be useful at this point to cross reference the key principles of practice that should underpin the implementation of mental health promotion interventions. These cross-cutting principles have already been described in chapter "Concepts and Principles of Mental Health Promotion". Here we remind the reader of their relevance and

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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importance in guiding the implementation of effective mental health promotion action. These include adopting:

- A socioecological approach to intervention development in order that programmes and policies seek to bring about positive change at the level of the individual, the family, social group or community and broader society.
- A social competence approach emphasizing the promotion of positive strengths, life skills, social and emotional competence and access to resources and life opportunities.
- Theory and evidence-based interventions grounded on established theories of human functioning and social organization and best available research.
- Intersectoral, comprehensive and sustained interventions that are not once-off but are designed to produce long-term effects that will improve population mental health and well-being across the lifecourse and reduce inequalities.
- High-quality intervention design and delivery based on a supportive implementation systems and capacity development.
- Systematic evaluation methods of programme process, impact and outcomes that will contribute to the ongoing improvement and sustainability of effective interventions.
- Sustainability planning built on organizational and system-level practices and policies that will ensure the long-term impact of effective, high-quality interventions.

These principles underscore the importance of developing sustainable interventions that will create supportive environments for promoting good mental health, adopting an empowering competence enhancement approach across the lifecourse approach, based on sound theory and a strong evidence base, delivered through intersectoral collaboration, quality implementation systems and subject to systematic evaluation.

The Process of Implementation

Implementation refers to the actuality of putting an intervention into practice. Durlak (1995) defines implementation as 'what an intervention consists of in practice' (p. 5) and how much it is delivered according to how it was designed. Implementation is essentially concerned with the central issues of the 'what' is to be implemented, 'how' interventions and their associated tasks/activities will be carried out and 'who' shall carry out the work of implementation. Implementation information is needed to know about what actually happens during intervention delivery, what takes place on the ground, the quality of the intervention as delivered and whether the intended audience is reached. It allows for a greater understanding of the internal dynamics and operations of the intervention in practice, how the intervention activities fit together, how the implementers and intervention recipients interact in the local context and the obstacles they face and resolve in the process. Implementation data are also critical to interpreting positive or negative outcomes

as they strengthen any conclusions that are made about the intervention's role in producing change. Without measuring implementation quality, an intervention may be incorrectly judged as ineffective when, in fact, negative outcomes are a result of a poor quality implementation or shortcomings in the delivery process. This leads to the danger of a Type III error, i.e. the intervention is delivered so poorly as to invalidate outcome analyses. Information on implementation is also important in informing the replication and maintenance of interventions in other settings, thereby advancing knowledge on best practices. Careful delineation and monitoring of the implementation process provides a clear account of what was actually done, how well it was done and whether the outcomes were as a result of what was done. Intervention monitoring and evaluation, therefore, plays a critical role in enabling practitioners and evaluators to determine intervention strengths and weaknesses and identifying which factors may have facilitated or hindered successful delivery and enhances the validity of outcome evaluation and provides feedback for continuous quality improvement.

Overview of Implementation Research

Within the field of mental health promotion, the body of research on implementation is limited but growing. However, it is recognized that the effective implementation of feasible and sustainable interventions that promote mental health is a key challenge. Evidence-based interventions need to be implemented and brought to scale across diverse settings and population groups. The translation of evidence into real-world practice requires an increased focus on developing structural mechanisms and capacity in local contexts that will support high-quality implementation of the most effective approaches. As knowledge about effective interventions has grown, a science of implementation has been developed to guide research and practice in diverse fields. Implementation science is concerned with the scientific study of methods to promote the uptake of research findings and evidence-based strategies into routine practice. In essence, it is concerned with developing an evidence base to guide implementation practice, identifying the how-to of implementation as distinct from effectiveness outcomes.

Findings from implementation science have confirmed that one of the most important factors affecting intervention outcomes is the quality of implementation (Durlak and DuPre 2008). Evidence of the importance of quality of implementation has been produced in multiple areas including mental health, education, healthcare, technology and management (Durlak and DuPre 2008; Fixsen et al. 2005). A number of core underlying principles have been found to be important regardless of the type of intervention, characteristics of the target population or specific programme goals. Studies show that stronger outcomes are obtained when implementation is better and that positive outcomes are not achieved when implementation is poor. In a systematic review of the literature on the quality of implementation of prevention programmes for children and adolescents, Durlak and DuPre (2008) identified eight key components of implementation (see Box 1). These consist of fidelity, dosage,

Box 1 Definitions of the Major Components of Programme Implementation (Adapted from Durlak 2016)

- Fidelity – the degree to which the major components of the programme have been faithfully delivered
- Dosage – how much of the programme is delivered
- Quality of delivery – how well or competently the programme is conducted
- Adaptation – what changes if any are made to the original programme
- Participant responsiveness or engagement – to what degree does the programme attract participants' attention and actively involve them in the intervention
- Programme differentiation – in what ways is the programme unique compared with other interventions
- Monitoring of control conditions – in what ways might the control condition mirror or overlap with critical parts of the new programme
- Programme reach – how much of the eligible population participated in the intervention

quality of delivery, adaptation, participant responsiveness or engagement, programme differentiation, monitoring of control conditions and programme reach. These components have been included in a number of research studies, with fidelity and dosage receiving the most attention to date.

Research clearly indicates that quality of implementation is a critical factor associated with positive mental health outcomes (Durlak 2016). There are a number of studies concerning the implementation of social and emotional learning (SEL) programmes in school that illustrate this point. Durlak et al. (2011) in a meta-analytic review of over 200 school-based SEL programme studies found that for students receiving programmes associated with higher-quality implementation, their gains in academic performance, reduced conduct problems and emotional distress were twice as high compared to those students who received poorly implemented programmes. They reported that school programmes with good quality implementation, producing larger effects, were characterized by high levels of intensity, consistency, clarity and programme fidelity being favoured over loose guidelines and broad-based principles. Reviews of bullying prevention programmes (Smith et al. 2004) and youth-mentoring programmes (DuBois et al. 2002) have also reported that outcomes, such as increased social competence and lower levels of bullying, were two to three times greater for youth participating in programmes implemented with high quality. Findings from evaluation studies of school programmes in the USA such as the Child Development Project (Battistich et al. 2000), PATHS (Kam et al. 2003), Responsive Classroom (Rimm-Kaufman et al. 2014), the KidsMatter national programme in Australia (Dix et al. 2012; Slee et al. 2009) and Zippy's Friends in Ireland (Clarke et al. 2014) clearly show that the level of

programme implementation is variable across sites, is significantly associated with student outcomes, and that positive academic and social–emotional outcomes are not achieved when the quality of implementation is low.

Researchers have pointed out that ignoring the level of implementation can lead to misleading results and misinterpretations of programme outcomes (Durlak 2016; Lendrum and Humphrey 2012). Without considering implementation, the absence of positive outcomes can be attributed to ineffective interventions, when in fact the reason for poor outcomes is due to poor-quality implementation. The studies considered above clearly show that in a number of evaluations, there was no overall effect; however, additional analyses indicated that positive effects were associated only with well-implemented programmes but not when they were poorly conducted. Understanding the importance of implementation quality and the wide range of influencing factors is, therefore, critical to effective evidence-based practice.

Understanding Implementation Systems

A number of reviews and evidence syntheses have contributed to advances in our understanding of implementation (Durlak and DuPre 2008; Fixsen et al. 2005; Meyers et al. 2012a). The overall conceptualization of implementation that emerges is that quality implementation is a systematic process that involves a coordinated series of planned actions: '*quality implementation is best achieved by thinking about the implementation process systematically as a series of coordinated steps, and that multiple activities that include assessment, collaboration, negotiation, monitoring, and self-reflection are required to enhance the likelihood that the desired goals of the innovation will be achieve*d' (Meyers et al. 2012a, p. 475).

To assess implementation adequately, information is needed about specific intervention activities or components, how they are delivered and the characteristics of the context or settings in which the intervention is conducted (Dane and Schneider 1998). Chen (1998) points out that although an intervention is regarded as the major change agent, the 'implementation system' also makes an important contribution to intervention outcomes as it provides the means and the context for the intervention. Therefore, as well as having a clear intervention theory and establishing the essential intervention components that contribute to outcomes, it is necessary to understand the conditions required for successful implementation and the contextual factors that may affect and moderate their effects. Understanding the context and the wider implementation system is even more critical when implementing interventions in school and community settings, as changing the setting itself can constitute the focus of the intervention.

Durlak and DuPre (2008) report convergent evidence from a number of systematic reviews (e.g. Fixsen et al. 2005; Greenhalgh et al. 2005; Stith et al. 2006) of the necessity for a multilevel ecological framework for understanding implementation.

Building on the work of Chen (1998) and Greenberg et al. (2005), their review underscores the importance of variables related to the characteristic of the implementer (e.g. knowledge, skills and motivation), implementing organization (e.g. structure, ethos, history, resources), intervention activities (e.g. quality and availability of training, materials), participants (identifying, recruiting, engaging and retaining the target population) and the specific context (environment, local policies, agencies and collaborations, etc.), as well as those associated with the intervention delivery and support systems. The review of findings from over 500 studies provides strong empirical support for the conclusion that the level of implementation affects the outcomes obtained and that the multiple ecological factors identified above interact to affect the implementation process.

Intervention characteristics reported to be consistently related to implementation include the adaptability or flexibility of the intervention and the contextual appropriateness or fit with the organization. Other important influences identified are the local community politics, funding, policy, and prevention/promotion theory and research. With regard to provider characteristics, Durlak and DuPre (2008) report that four variables have consistently been found to be related to implementation in schools, perceptions related to the need for and potential benefits of the intervention, self-efficacy and skill proficiency. Factors related to organizational capacity include general organizational features (e.g. openness to change), specific organizational practices and processes (e.g. effective leadership, having at least one programme champion, a collaborative approach, shared decision-making) and specific staffing considerations (skills, attitudes, motivations, etc.). The delivery system is also found to be critical to effective implementation, including that providers are prepared effectively for their roles, e.g. through development of intervention skills.

The importance of assessing the context-specific factors that influence the quality of implementation in the local setting is clearly underscored in the literature, including organizational structures and policies, readiness to implement the intervention both in terms of general organizational capacity and intervention specific capacity, mobilization of support and generally determining the ecological fit of the intervention in the local context. Careful delineation and monitoring of the implementation process in settings is needed to provide a clear account of what is actually done (as opposed to planned), how well it is done, influencing factors and whether the outcomes occur as a result of what was done.

Implementation research is, therefore, critical to understanding intervention strengths and weaknesses, determining how and why interventions work, documenting what actually takes place when an intervention is conducted and providing feedback for continuous quality improvement in delivery (Domitrovich and Greenberg 2000). Greenhalgh et al. (2005) and Fixsen et al. (2005) have emphasized the importance of the complex interaction between individual and organizational factors and how these in turn interact with the characteristics of the intervention to be implemented. Flaspohler et al. (2008) suggest that different types (individual, organizational and community) and levels of capacity (general capacity and innovation-specific capacity) are critical determinants of effective implementation. Drawing on these reviews and various models, Wandersman et al. (2008) outline an

interactive systems framework (ISF) for dissemination and implementation, as a basis for understating the key systems, functions and relationships relevant to the implementation and dissemination process. This framework describes three interacting systems:

- *Prevention Synthesis and Translation System* – distils and translates the scientific knowledge on effective innovations and approaches and transfers it into user-friendly formats.
- *Prevention Support Systems* – capacities needed to use the innovation effectively, including innovation-specific capacity (knowledge, skills and motivation, training, etc.) and general capacity such as effective structural and function factors (infrastructure, general level of organizational functioning).
- *Prevention Delivery Systems* – individuals, organizations and communities that utilize the evidence-based interventions in practice.

This framework combines the research-to-practice and community-centred models of implementation and dissemination and provides a potentially useful structure for organizing theory and research on the implementation of mental health promotion interventions. The ISF has particular relevance for implementation in settings such as schools, workplaces and communities as it focuses on the infrastructure and systems that are needed for effective implementation to take place and highlights the importance of capacity within the various systems in a particular setting. Durlak and DuPre (2008) extended the ISF model to embrace a multilevel ecological framework and posited that effective implementation is dependent on the favourable interaction of a constellation of factors operating within these systems (e.g. the intervention/innovation, providers, communities, prevention delivery system and the prevention support systems) which are specific to the local context. This emphasis on interacting systems in the ISF model highlights the need for a clear focus on contextual factors in the school or community when implementing settings-based mental health promotion interventions. The capacity of the setting for change needs to be determined, including structural and organizational change, so that the implementation process addresses change in the setting itself as well as change for the people to be found in the setting. Attention to the broader contextual factors is critical to ensure effective integration of settings-based interventions within the wider policy and practice systems.

Implementation Frameworks

A number of generic implementation frameworks have been developed, which provide conceptual models of the factors that are important for quality implementation. Syntheses of reviews (Fixsen et al. 2005; Meyers et al. 2012a) indicate that quality implementation of evidence-based interventions is a multistage and multilevel process that requires different activities and skills at different stages of the process together with collaboration among multiple stakeholders for positive outcomes to be achieved. Fixsen et al. (2005) proposed an Active Implementation Framework,

which conceptualizes the progression of the implementation process as involving four stages: (1) exploration and adoption, (2) programme installation, (3) initial implementation and (4) full implementation. These stages are assumed to interact and impact on each other in a complex and non-linear fashion. Aarons et al. (2011) also proposed a multilevel, four-phase model of the implementation process – exploration, adoption/preparation, implementation, sustainment (EPIS). The EPIS model considers factors operating across levels within each phase, including those in the outer context (sociopolitical and service environments, systems, policy, funding, inter-organizational networks, etc.) and inner contexts (characteristics of the organization, providers and individual adopters) that could be applied to public sector services. Different variables are considered influential at different stages of the implementation process.

Several other conceptual frameworks have been developed to describe the process of quality implementation. A synthesis of the literature by Meyers et al. (2012a) identified 14 common dimensions of implementation, building on previous reviews (Durlak and DuPre 2008; Fixsen et al. 2005; Greenhalgh et al. 2005). Meyers et al. (2012a) found that there is substantial consensus as regards the steps involved in implementation and their temporal sequence, and these were grouped into five main categories and four phases as outlined in Box 2 below. From this synthesis, Meyers et al. (2012a) developed the Quality Implementation Framework to identify the main components of quality implementation. The different phases outlined in the framework correspond with those in the EPIS model and also identified by Fixsen et al. (2005). Phase 1 covers the exploration and preparation stages, Phases 2 and 3 address initial and full implementation and Phase 4 deals with sustainability.

Drawing on the ISF discussed earlier, the Quality Implementation Framework draws attention to factors operating at different levels and stages of the implementation process and underscores the importance of building capacity and employing a team-based approach to foster quality implementation. Critical steps in the implementation process are outlined including a checklist of important questions to be answered at each stage. Durlak (2016) points out that 10 of the 14 steps relate to actions that must be completed before an intervention actually begins, highlighting the importance of the pre-implementation phase.

Researching Implementation Outcomes

While there is consensus in the literature concerning the important key factors in the implementation process, there is a lack of evidence concerning the relative importance of each factor and how they may interact to influence implementation for any given intervention in a given context. To date, few of the conceptual models have been subject to empirical testing in a comprehensive manner where aspects of implementation at different levels within multiple systems are assessed. Evaluating the complexity of multifaceted and multicomponent interventions presents a particular methodological challenge. Mental health interventions are typically composed of multiple components that are designed to be delivered across different ecological levels (e.g. individual, interpersonal, organizational, community and

Box 2 Quality Implementation Framework (Meyers et al. 2012a)

Phase 1: Initial Considerations Regarding the Host Setting

- Assessment Strategies – conducting a needs and resources assessment, a fit assessment and capacity/readiness assessment
- Decisions about Adaptation – possibility for adaptation
- Capacity-Building Strategies – obtaining explicit buy-in from critical stakeholders and fostering a supportive community/organizational climate, building general/organizational capacity, staff recruitment/maintenance, effective pre-innovation staff training

Phase 2: Creating a Structure for Implementation

- Structural Features for Implementation – creating implementation teams, developing an implementation plan

Phase 3: Ongoing Implementation Support Strategies

- Technical assistance/coaching/supervision
- Process evaluation
- Supportive feedback mechanism

Phase 4: Improving Future Applications

- Learning from experience

macro-policy levels). For example, whole-school approaches to mental health promotion are composed of multiple levels of activities, with actions at each level being logically connected to supportive activities at the next level (i.e. developing young people's skills in the classroom is linked to supportive school practices and policies in the wider educational system). This type of multicomponent intervention requires an implementation and evaluation model that is capable of capturing the sequence of events needed for effective outcomes at each level. Logic models are frequently used for this purpose as they provide a framework for guiding the planning, implementation and evaluation of interventions. Detailed process analysis of intervention implementation is required for the collection of data and the recording of contextual factors as the intervention unfolds and plays a crucial role in detecting intermediate-level changes that lead to ultimate programme outcomes. Frameworks such as the Consolidated Framework for Implementation Research (CFIR) have been developed to guide the systematic assessment of multilevel implementation contexts (Damschroder et al. 2009) and identify factors that influence intervention implementation and effectiveness. The CFIR has been found to be a useful tool for guiding the systematic evaluation of implementation and providing a better understanding of the barriers and facilitators to practice transformation within complex healthcare delivery systems (Keith et al. 2017).

Dynamic community and school-based interventions involve an ongoing process of synergistic change producing effects at different levels in different spheres, and as such they require a continuous flow of information from process evaluation in order to fine-tune interaction activities to respond to changing circumstances. In this sense, process evaluation becomes an integral part of the core activities of implementation. Implementation research enhances knowledge of the relationship between process and outcomes and increases an understanding of the critical connections between the local context, intervention activities and the intended intermediate and long-term outcomes. Understanding the implementation process is, therefore, critical to the effective adoption, replication and scaling-up of evidence-based interventions.

Evaluation studies use varying approaches to measure how well an intervention or programme is implemented. Proctor et al. (2011) advanced the concept of implementation outcomes as distinct from intervention outcomes and argue that implementation outcomes serve three key purposes: as indicators of implementation success, proximal indicators of implementation processes, and intermediate outcomes in effectiveness research.

They propose a taxonomy of eight distinct implementation outcomes:

- Acceptability—perception among stakeholders that a given intervention or programme is agreeable or satisfactory.
- Adoption—uptake or utilization of an intervention.
- Appropriateness—perceived fit and relevance for a given practice setting, population group or issue.
- Cost—cost impacts of an implementation effort, including cost-effectiveness and cost–benefit.
- Feasibility—the extent to which a given intervention can be successfully used within a given agency or setting.
- Fidelity—the degree to which intervention is delivered as intended—adherence, dose, integrity, quality of delivery, programme differentiation, participants' responsiveness.
- Penetration—intervention reach and integration within a service setting.
- Sustainability—extent to which an intervention is maintained, integrated or institutionalized within the ongoing routine operations of a service.

Proctor et al. (2011) suggest that the measurement of these implementation outcomes will help specify the mechanisms and causal relationships within implementation processes and thereby advance the evidence base on successful implementation. While some of the implementation outcomes are increasingly being measured in evaluation studies (e.g. acceptability, appropriateness, fidelity and penetration), others such as feasibility and sustainability feature less frequently. This is likely to be partly attributable to the fact that these complex and multidimensional constructs are more difficult to assess and measure accurately. Advancing the conceptualization of implementation outcomes is needed to develop clearer and more refined approaches for communicating about the implementation strategies that are needed for moving evidence-based interventions into real-world practice.

Adaptation and Fidelity

When interventions are implemented across diverse sites, they are often altered and adapted to suit the particular characteristic of local conditions. A critical issue debated in the literature is how much adaptation is permissible without compromising the integrity of the intervention. Researchers have cautioned against programme drift, where modifying an intervention too much may actually decrease its effectiveness or dilute its effects (Elliot and Mihalic 2004). Durlak and DuPre (2008) in their review concluded that it is not a question of either–or and that the critical issue is to find the right mix of fidelity and adaptation to reliably produce intended outcomes.

There is general agreement in the implementation literature that when the core components of an intervention are known (i.e. the active ingredients of an intervention that are responsible for its effectiveness), these elements should not be modified and should be implemented without adaptation. The identification of core components needs to be based on both theoretical underpinnings and empirical data. It is acknowledged, however, that beyond intervention core components, other aspects can be modified, for example, to suit the cultural background of the participants or the particular circumstances of a given setting, as long as the core components of the intervention are delivered. When the core components of intervention are not clearly identified, however, the decisions made about adaptation are more critical. Where possible, decisions should be made in collaboration between those with technical knowledge of the intervention and key stakeholders in order to ensure that any modifications made will not compromise positive outcomes being achieved. In all cases, the adaptions made should be documented so that their impact can be monitored.

Sustainability and Scaling-Up

Sustaining interventions over time and across different implementation sites and practitioners is a major challenge and has been far less researched than the initial implementation stage. Implementing a well-defined and well-researched intervention to the point of successful functioning and sustainability is estimated to take 2–4 years (Fixsen et al. 2005) and can involve multiple decisions regarding changes to structures and support systems in order to integrate new interventions into existing services and systems in a way that facilitates their long-term stability. Changes in the context in which the intervention is being implemented, such as funding, level of organizational support and staffing, can greatly impact intervention integrity and effectiveness over time. Cooper et al. (2015) studied a variety of state-wide school and community-based programmes for youth violence prevention and delinquency across different communities in Pennsylvania. The study examined data from 243 funded initiatives over a 4-year period concerning 77 evidence-based programmes (including programmes such as Life Skills Training, Big Brother Big Sisters, and

the Strengthening Families programme). They reported that 69% of the programmes were sustained 2 years or more beyond their initial funding; however, more than half were only able to be sustained at a lower level of functioning and with limited impact. With regard to the predictors of sustainability, they found that factors such as organizational support and readiness for programme implementation, a good programme fit (i.e. that aligns closely with the existing functions and resources of the implementing organization, well-trained staff and sustainability planning from the outset) were key predictors of sustainability. Ogden and Fixsen (2014) also underscore the importance of developing implementation capacity for sustainability, including establishing implementation teams that operate across implementation sites and agencies, and who can work to ensure ongoing support for several interventions and innovations.

Delivering mental health promotion interventions to scale has received much less attention than initially implementing evidence-based interventions into practice. Scaling-up is the process by which evidenced-based interventions, shown to be effective in controlled research trials, are expanded into broader policy or practice, with the explicit intent of reaching new settings or target groups and are accompanied by a systematic strategy to achieve this objective (Milat et al. 2015). A number of generic frameworks have been developed for scaling-up health interventions on a population-wide basis, including the WHO and ExpandNet (WHO 2010) model, which proposes a series of nine steps for developing a scaling-up strategy. In a narrative review of existing scaling-up models, the majority of which focus on low- and middle-income country contexts, Milat et al. (2015) identified a number of key success factors in scaling-up health interventions, including the following:

- Strong leadership and governance.
- Political will and advocacy.
- Infrastructure to support implementation such as training, delivery systems and technical resources.
- Active engagement of a range of implementers and of the target community.
- A well-defined scale-up strategy tailored to the local context.

This review also reported that establishing monitoring and evaluation systems, including costs and economic modelling, are critically important in informing strategic decisions about implementation at the various stages of scaling-up interventions. As pointed out by Ogden and Fixsen (2014), interventions delivered at scale need to serve a much more heterogeneous population, employ a diverse range of service providers working within variable and sometimes insufficient service infrastructure and with variable resources. There is, therefore, a need to rigorously test evidence-based interventions in more typical resource-constrained conditions before rolling out on a larger scale, including addressing external validity and contextual issues in order to enhance the scaling-up of potentially effective approaches.

Implementation Strategies

Implementation strategies are methods or techniques used to enhance the adoption, implementation and sustainability of evidence-based programmes or practices (Curran et al. 2012). Implementation strategies draw on the conceptual frameworks described above and suggest critical steps that practitioners and organizations can take to achieve stated goals. There are a number of practical tools that have been developed to assist the implementation of evidence-based interventions and innovations with quality. This chapter will focus on only a few of these tools, and some additional useful resources are also outlined in Box 3.

Drawing on their synthesis of implementation frameworks, Meyers et al. (2012b) developed the Quality Implementation Tool (QIT), which identifies specific steps that practitioners can take to facilitate high-quality planning, monitoring and evaluation of interventions. The tool aims to support the 'how to' of implementation and can be used to plan fundamental aspects of system-level infrastructure, such as developing an implementation team or policies that make it easier for practitioners to use the innovation or intervention. It is recommended that the QIT is used with a comprehensive planning process to ensure that the intervention adopted is appropriate for the setting and that it is adequately planned and evaluated. The importance of considering the capacities that will be needed to support implementation is also emphasized. The QIT builds on the Getting to Outcomes (GTO) planning model, which describes ten steps for successful implementation. Developed by Wandersman et al. (2000), this results-based approach entails six planning steps, two evaluation steps and two sustainability steps:

- Assessing needs and resources.
- Setting goals and desired outcomes.
- Selecting an evidence-based innovation or best practice.
- Assessing innovation fit.
- Assessing organizational/community capacities for an innovation.
- Planning.
- Implementation and process evaluation.
- Outcome evaluation.
- Continuous quality improvement.
- Sustainability.

Developed with support from the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA), further details on the use of GTO methods, including a toolkit for community-based youth prevention interventions, are available at https://www.rand.org/health/projects/getting-to-outcomes.html.

The QIT is designed to be completed with the GTO model, employing a collaborative team-based approach with members of the intervention support and

delivery systems. A number of action steps are outlined to accompany each of the components of implementation quality as follows:

- *Develop an Implementation Team* – To inform, prepare and support members in effectively using the intervention or innovation. The structure of the team will depend to some extent on the nature of the organization's broader infrastructure, but its purpose is to oversee and support quality implementation. Action steps include identifying team leaders, content specialists and other key agencies and stakeholders that need to be involved and assigning them clear roles, processes and responsibilities.
- *Foster supportive organizational/community wide climate and conditions* – Actions include identifying a programme champion(s) to foster buy-in and support; communicating the perceived need for and benefits of the intervention; establishing supportive practices and policies to enhance delivery such as counterbalancing resistance to change, creating policies that enhance accountability and foster shared decision-making, and effective communication; and ensuring adequate administrative support.
- *Develop an Implementation Plan* – List specific tasks (e.g. make sure structural supports are in place such as funding, policies, technology, among others), establish a timeline and assign implementation tasks to specific stakeholders.
- *Receive Training and Technical Assistance* – Determine specific needs for training and engage trainers that will support practitioners in implementing the intervention within the specific context of the organization's needs and resources.
- *Practitioner–Developer Collaboration in Implementation* – Collaborate with expert developers on the factors that impact on quality of implementation and engage in problem solving to address problems that arise in the implementation process.
- *Evaluate the effectiveness of the implementation* – Measure fidelity, dosage, quality of delivery, participant responsiveness, programme differentiation, programme reach, and document all adaptations that are made

The tool developers report that while the QIT is designed to help plan, monitor and evaluate the implementation process, it can also be used to guide discussion on capacities that are needed to implement with quality.

More specific guidelines on implementation processes have also been developed, a number of which support the quality implementation of school-based programmes. For example, the Collaborative for Social and Emotional Learning in the USA (CASEL) has developed a suite of tools for initiating and sustaining high-quality SEL programming at a school-wide level, based on ongoing structural support and resources provided at higher levels of the education system including policies at the national or district level. Jones et al. (2017) also developed a practical resource for schools, which assists them in making decisions as regards the best evidence-based SEL programme for their particular context and needs. This in-depth guide, covering 25 leading SEL programmes for elementary schools, provides detailed information on curricular content, including specific skills targeted, instructional methods used and key programme features such as training and

supports, and allows practitioners to compare programme content and methods across the best evidenced SEL programmes.

The majority of structured evidence-based interventions include specific guidelines and resources to assist practitioners in implementing these interventions effectively, including training, planning and implementation tools. In most cases, these intervention-specific supports will need to be supplemented with on-site assistance and a supportive implementation structure locally to achieve and sustain high-quality implementation after initial implementation. Information sources to guide practitioners in making decisions regarding the practical aspects of intervention implementation are also included in Box 3 for further reference.

Box 3 Useful Implementation Resources

Blueprints for Healthy Youth Development—provides a useful website outlining descriptions of programme components, implementation requirements, practical aspects of training and organizational support and programme costs for a range of evidence-based prevention and intervention model programmes for children and young people at http://www.blueprintsprograms.com/programs. A useful publication based on this series is by Mihalic et al. (2004). *Blueprints for Violence Prevention*, Office of Juvenile Justice and Delinquency Prevention (NCJ 204274), Office of Justice Programs: US Department of Justice. Accessible at: https://www.ncjrs.gov/pdffiles1/ojjdp/204274.pdf

The Collaborative for Social and Emotional Learning in the US (CASEL)—provides accessible information for stakeholders on the steps necessary in planning and implementing social and emotional learning programmes in schools. In CASEL's district resource centre, (https://drc.casel.org/district-framework/) specific resources are provided to support each step outlined in the process. Factors known to promote sustainability and impact are addressed including ongoing professional development, ongoing assessment and evaluation, infrastructure and schoolwide integration, family–school–community partnerships and ongoing communication. Further details on tools to support the sustainable schoolwide implementation of SEL are available at http://casel.org together with a suite of practical resources, including CASEL's Practice Rubric for helping school leaders assess and monitor their school's progress.

The UK National Institute for Health and Care Excellence (NICE)—provides practical guidance to organizations on how to implement a range of evidence-based interventions, and a number of tools have been developed to put this evidence into practice (see further details at https://www.nice.org.uk/about/what-we-do/into-practice/implementing-nice-guidance) including those that promote social and emotional well-being—https://www.nice.org.uk/guidance/ph20

The journals—*Implementation Science* and *Prevention Science.*

Implementation of Collaborative Practice and Intersectoral Partnerships

A core feature of health promotion is intersectoral collaboration (2013b; WHO 1986, 2013a), which is also integral to mental health promotion practice. The process of collaborative working involves building links and cross-sectoral partnerships among a diverse range of sectors, organizations, groups and agencies that have a stake in the issues being addressed. A collaborative style of working leads to the development of inter-organizational and intersectoral collaborative structures, varyingly titled as coalitions, partnerships and strategic alliances between health agencies, community members and different sectors. Effective community-based collaborations need to include community representatives, local leaders, activists, policymakers, local organizations and agencies as well as local mental health and health professionals. Adequate start-up time is needed for a new initiative to develop linkages in the community, building trust, establishing common goals and agreeing a common vision, thereby laying the foundation for effective implementation and sustainability. The breadth and diversity of membership is one of the key strengths of collaborative working and, needless to say, is also one of the major challenges in making them work effectively.

There is a body of literature which identifies best practice in building collaborative mechanisms and effective community coalitions (Fawcett et al. 1995; Foster-Fishman et al. 2001; Gillies 1998; Goodman et al. 1996, 1998; Kreuter et al. 2000; Weiss et al. 2002; Wolff 2001). Different forms of structures have also been identified for organizing collaborative working, and Hauf and Bond (2002) highlight that the sharing of resources, power and authority differentiates collaboration from other less dynamic forms of inter-group cooperation. Collaborative practice brings together a broad range of actors and representatives of community institutions and diverse sectors in order to strengthen action for promoting mental health and well-being including; building community resilience, promoting social connectedness, economic development, intergroup relations, civic participation, and reducing inequities in health.

Creating and sustaining intersectoral partnerships is a core element of implementing mental health promotion. This includes: identifying and engaging partners from diverse sectors, identifying opportunities for collaboration, negotiating agendas, mediating different interests and promoting synergy (WHO 2014). Partnerships can be defined as collaborative working relationships where partners can achieve more by working together than they can on their own (Corbin and Mittelmark 2008; Jones and Barry 2011a). Himmelman (2001) identifies partners as collaborating when they demonstrate their willingness to enhance each other's capacity for mutual benefit and a common purpose by sharing risks, responsibilities, resources and rewards. Effective partnerships produce synergy when the complementary skills, resources, perspectives and shared know-how of the partners lead to more effective actions and solutions (Jones and Barry 2011b). Partnership working, however, can be challenging and can fail to deliver on their goals on mutuality and equal stakeholder involvement (Aveling and Jovchelovitch 2014).

It is crucial that implementation of an intersectoral partnership approach builds on what is already understood about effective processes. While there is no universally agreed theory of partnership, there is a growing body of research on partnership functioning, and theoretical frameworks have been proposed (Butterfoss and Kegler 2009; Koelen et al. 2012; Lasker et al. 2001; Roussos and Fawcett 2000). The Bergen Model of Collaborative Functioning is a theoretical model that has been empirically tested in a number of diverse health promotion initiatives and provides an analytical frame to examine collaborative working arrangements, a guide for practice and as an evaluation tool (Corbin and Mittelmark 2008). Based on systems thinking, the model describes functioning in terms of inputs, throughputs and outputs, while emphasizing the interaction and dynamics between these elements. A review of the international literature on effective processes which contribute to successful health promotion partnerships, undertaken by Corbin et al. (2016), identified nine core elements that contribute to effective intersectoral partnerships and which can inform best practices. These partnership elements are outlined in Box 4. Partnership tools have also been developed to assist organizations in developing a clear understanding of the purposes of collaborations. For example, 'The Partnership Analysis Tool: A Resource for Establishing, Developing and Maintaining Partnerships for Health Promotion' (Victorian Health Promotion Foundation 2016) and 'Working in Partnership: Developing a Whole Systems Approach' Community-wide Self-assessment Tool (Department of Health 2001) can be used to assist partnerships in reflecting on the nature of the partnerships that they have established and develop ways to strengthen new and existing partnerships.

Implementation Factors Influencing Effective Partnership Working

Drawing on the literature, a number of implementation factors that are critical to the effectiveness of partnership working, and which can make the difference between the success and failure, will now be examined.

Choosing an Organizational Structure

There are many different forms of organizational structures involving people from more than one sector working together in order to achieve a common goal. These include alliances, partnerships, coalitions, community boards, task forces and grassroots structures. Drawing clear distinctions between various terms can be difficult as they are often used interchangeably. Community boards and task forces tend to bring together key leaders from different segments of the community to work together towards achieving intervention goals and initiating change. The involvement of high-profile persons in the community is used to garner local support and resources. On the other hand, grassroots structures are more akin to community

Box 4 Recommendations for Core Processes in Developing Intersectoral Partnerships (Based on Corbin et al. 2016)

- Develop a shared mission—that can be aligned to the partners' individual or institutional goals.
- Engage participation—includes a broad range of participation from diverse partners, including community members.
- Incorporate leadership—that inspires trust and confidence, is inclusive of diverse partners, especially community members and adopts a collaborative and transparent approach to decision-making.
- Effective communication—of appropriate frequency, mode and style with regular monitoring of how communication is perceived by partners and adjusting accordingly.
- Balance formal and informal roles and structures—depending upon the mission, a balance can be observed between loose structures and inclusiveness of inputs and tighter structures and production of focussed outputs. Role clarification promotes accountability and leads to increased synergy.
- Build trust—trust-building mechanisms should be built into the partnership from the beginning and maintained for the duration of its work.
- Balance partner and financial resources—attention should be paid to balancing the power that comes from contributing significant financial resources with recruiting in-kind partner resources. These dynamics may serve different purposes for different partnerships, but any particular strategy should be entered into with an understanding of the possible ramifications.
- Pay attention to power dynamics—shared power is a key element of partnership functioning as partners can represent several different sectors including health and civil society which already experience power imbalances. Power in partnerships must include the power to define problems and propose solutions.
- Ensure a balance between maintenance and production activities—partnerships need to balance the time spent working on maintaining partnership activities (administration, funding, reporting, etc.) and the production of core activities to achieve the overall mission.
- Consider the impact of context—including the political, economic, cultural, social and organizational contexts that affect power relations, communication and other elements of functioning.
- Evaluate partnerships for continuous improvement—assess how the partnership is functioning at different stages of its development, communicate successes, anticipate upcoming issues and learn from and respond to existing problems.

development approaches and are characterized by the collective action of community members to address the root causes of local issues or social problems. One of the features of grassroots organizations is that the initiators and leaders are not professionals whose job it is to run an intervention but rather the process is owned and driven by local members acting collectively to pursue shared goals. The choice of structure will depend on the degree of commitment to an underlying philosophy of community working, the issue being addressed, and to a certain extent the particular context of a given community setting. However, it is worth noting that different structures may vary considerably in the degree of community and citizen participation, influence and ownership that they engender and as a consequence may differ substantially in the types of planning, consultation and implementation processes employed.

Developing a Shared Mission and Clear Objectives

Critical to the early success of partnerships is the development of a clear vision and mission of purpose and agreement on what is to be achieved. The overall goal and objectives need to be clear to all participants, and they need to be concrete, attainable and measurable. A visioning process may be used in helping to shape the shared goals and objectives at the early stages of development. The active engagement of community members in setting goals and determining priority objectives is an important part of setting the groundwork for building community ownership. A collaborative process for fine tuning objectives in conjunction with project evaluators has already been outlined in this chapter. The setting of goals and objectives may need to be revisited at regular intervals in the course of the partnership and reshaped in response to changing community and intervention developments.

Establishing Clear Structures, Roles and Responsibilities

There is no single set structure that has emerged from the literature as the most effective for running community partnerships. Whatever structure is selected needs to reflect organizational capacities in establishing clear roles and responsibilities, decision-making processes and adequate staffing and resources to support the partnership to achieve its objectives. For example, the decision-making structure in community partnerships may be particularly complex due to the diversity of interests and members involved. In this case, clarifying roles and responsibilities for group members is identified as a critical process. Explicitly identifying, writing down and agreeing the key roles and responsibilities of group members is an important exercise that should be undertaken. Bracht et al. (1999) refer to this exercise as ‘responsibility charting’ and use a sample form to list the specific tasks and responsibilities assigned to members.

Establishing Clear Communication

The importance of clear communication, both within the partnership and in communication to other parties externally, is crucial to effective functioning. Meetings need to be facilitated to enhance clear lines of communication and to also provide time for more informal networking and flow of information. Keeping detailed minutes and recording the details of planning and review sessions is all part of this process and serves as an explicit reminder to members of what has been collectively agreed upon. Formal rules and procedures, clearly defined roles and expectations, written goals and objectives and memoranda of understanding among participating organizations have all been associated with successful implementation (Butterfoss et al. 1993; Kreuter et al. 2000).

Regular monitoring of how communication is perceived by partners is recommended so that necessary adjustments can be made at different stages of the partnership development.

Engaging Active Membership

The match of mission and membership is identified by Kreuter et al. (2000) as being critical to a partnership's long-term survival. Partners must have a strong enough sense of common purpose to set aside individual allegiances and conflicts. As the participating members are recognized as the partnership's greatest asset, issues of representation (e.g. based on age, gender, ethnic and cultural diversity) and trust need to be addressed from the outset, including considering how well partners represent the most and least powerful members of the community. A unique characteristic of community partnerships is that they seek to engage with the whole community. Recruiting members from a broad section of the community is, therefore, essential to success, including minority members, grassroots and end-user groups (Lasker and Weiss 2003). Deciding on how to engage with community members is a key challenge for community groups. In discussing community representation, McKinney (1993) distinguishes between substantive and descriptive representation. In substantive representation, members are selected and accountable to different interests in a community, while in descriptive representation, members may simply mirror social or demographic profiles but have little accountability to groups. The building of partnerships is an ongoing task as new players and partners may need to be recruited as the partnership develops. Likewise, sustaining active membership in partnerships is also an ongoing challenge. Kaye (1997) summarizes the reasons people participate as the six Rs: recognition, role, respect, reward, results and relationships. A supportive ethos and culture engenders a sense of ownership and a stake in the partnership and its activities and achievements. By recognizing the six Rs identified above, partnerships can create and foster an ethos where participation is facilitated and members gain a sense of ownership of the process.

Building Relationships and Trust

Relationships are at the heart of partnerships. The bringing together of diverse groups of people around a shared or common goal is what makes partnerships work. Fostering good quality relationships that are based on trust and mutual respect is vital to the smooth and efficient functioning of partnerships. Trust is one of the most important factors that make partnerships function effectively and contributes to synergistic outcomes (Jones and Barry 2011a; Weiss et al. 2002). Building trust and enabling groups to work together collaboratively calls for skilled facilitation and management of group dynamics. Early stages of partnership formation are frequently marked by initial mistrust among members, and there is a need to focus on building relationships that foster trust and real collaboration. This requires recognizing the needs and strengths of group members and managing conflicts and tensions within the group. 'Trying to "leapfrog" past the important phase of building trust with key stakeholders risks damaging or significantly delaying even the best intentioned efforts' (Potapchuk et al. 1997, p. 39). It is important that due attention is given to the dynamics of the group and that opportunities are created for enhancing the relationships between members such as creating a space, during and after meetings, for members to meet and chat, informally socialize and network. An induction process early in the life of the partnership, together with facilitated workshops around the group process, can play an important role in setting the stage for creative use of tensions and the productive management of conflicts, which inevitably arise.

Developing Collaborative Leadership

Leadership skills, such as group organization, securing resources, motivating and facilitating group activities, are key determinants of effective partnership working (Jones and Barry 2011b; Weiss et al. 2002). However, leadership of a partnership is not often located in a single charismatic person who launches and sustains the partnership (Wolff 2001). Rather, successful partnerships disperse their leadership and develop it among all participating members. Leaders who practice a democratic decision-making style and demonstrate strong conflict resolution, communication and administrative skills are recognized as being particularly effective (Kumpfer et al. 1993). This is known as collaborative leadership and seeks to expand leadership among members by identifying leadership roles and delegating responsibility. Collaborative leadership or 'integrative' leadership (Silvia and McGuire 2010) in partnerships is characterized by the ability to understand the social and political contexts, communicating and sharing a vision and implementing policy decisions. Integrative leadership is required in situations where there is no one person or organization in charge, and power is distributed across a number of organizations, as is the case in community partnerships where leadership is dispersed formally or informally among the partners.

Building Competencies and Capacities

It is important that groups embarking on partnerships identify and develop competencies and capacities within the partnership structure. Collaborative capacity is defined as the necessary conditions for promoting effective collaboration and building sustainable change (Goodman et al. 1998). Foster-Fishman et al. (2001), based on a review of the literature, identified core competencies and processes needed within collaborative bodies in order to facilitate their success. These core capacities include (1) building member capacity in terms of the knowledge, skills, motivation, experience and expertise of current members; (2) creating relational capacity such as intergroup interactions, group norms about participation, decision making and conflict resolution, build consensus and external relationships; (3) building organizational capacity including leadership, task focus, formalizing roles and processes, creating infrastructures and resources, developing management, planning and monitoring systems; (4) building programmatic capacity in terms of planning processes and designing innovative strategies to meet identified needs. These different types of capacity are regarded as being highly interdependent with each other, as a shift on one level of capacity will affect the others. Ongoing training and development of these skills needs to be incorporated into the working programme and is recognized as being critical to the ongoing sustainability and functioning of the working partnerships.

Boundary spanning skills have also been identified as being critical to enabling effective partnership functioning. These include negotiating skills and being able to see new opportunities (Jones and Barry 2011b). People with boundary-spanning skills, who can connect up partners with common interests or goals, have been identified in the literature as bringing a range of benefits to partnership functioning, serving as ‘spark plugs’ and ‘collabronauts’ (Williams 2002) and establishing a climate of trust, optimism and perseverance (Gray 1989).

Fostering Action

The partnership’s ability to effect change and to achieve outcomes that impact on the local community is vital to the partnership members, funders and the overall credibility of the partnership at the wider community level. In common with other intervention approaches, partnerships can foster action by developing written action plans; creating task forces or subcommittees that set clear goals, objectives and realistic work plans and outlining measurable indicators of success (Wolff 2001). In moving from consultation into the action phase, it is important to realize that communities may be at different stages of readiness for implementing interventions, and this readiness may be a key factor in determining the ultimate success of the intervention. Community readiness may be described as the extent to which the community or particular setting is ready to work together across a range of sectors in

addressing issues at the local level. One consideration which may be relevant is whether the impetus for the intervention comes from within or outside the community, that is, internal motivation to respond to local concerns or an approach from an external agency to work together on addressing an identified issue. In either case, issues of community ownership, prior history of collaboration and current ability to collaborate and avoid competition between and within partners is critical to determining the readiness of communities.

The extent to which partnerships lead to synergistic outcomes is often regarded as an indicator of success. Weiss et al. (2002) recommend measuring partnership synergy as a 'proxy' for effectiveness as, in theory, a partnership that has maximized synergy has achieved the full potential of collaboration. Synergy is the degree to which the partnership combines the complementary strengths, perspectives, values and resources of all the partners in the search for better solutions (Gray 1989) and can be regarded as both a process and product of a partnership. Jones and Barry (2011b) examined the key factors that influence health promotion partnership synergy. Based on data from 40 health promotion partnerships, employing multidimensional scales, they found that trust, leadership and efficiency were the most important predictors of partnership synergy. The findings highlight the importance of incorporating trust-building mechanisms into the partnership forming stage and sustaining it throughout the collaborative process.

Management Skills

How a partnership is managed is a key component of its success (Weiss et al. 2002). Expertise to effectively administer and manage the operations of the partnership is required. In addition to communication, leadership and decision-making skills, as outlined above, skills in securing and managing the necessary resources and funding to achieve the partnership's core objectives are also required. An appropriate funding strategy needs to be in place, which clearly identifies the funds required and the sources of funding to ensure continuity. Very often partnerships may be formed in response to available funding opportunities. In such cases, it is vitally important that appropriate management of funds takes place and that a strategy for securing additional funding for the sustainability of partnership activities is put in place. In-kind resources from partner organizations are also recognized as a major source of support for community partnerships, including specialist expertise, support, secretarial and other services which can make a major contribution to the development and sustainability of the partnership. Attention needs to be paid to balancing the power that comes from including partners who contribute significant financial resources with recruiting partners who can provide such in-kind resources. Balancing these power dynamics in the partnerships is important for sustainability and ensuring effective management processes.

Conclusions

Successful implementation of mental health promotion interventions is critical to achieving positive mental health and well-being outcomes. Effective implementation requires supportive implementation structures including wider policy support, leadership, training and technical support, integrated delivery, capacity development and organizational support. A number of key principles to guide effective action across the various stages of the process are outlined in Box 5. Implementation research emphasizes the importance of quality of implementation and clearly shows that if evidence-based interventions are not implemented with quality, positive

Box 5 Principles to Guide Effective Mental Health Promotion Action (Adapted from Barry et al. 2014)

- Focus on the modifiable determinants of population mental health and well-being by addressing the psychological, social, cultural and environmental factors that influence mental health at a population level.
- Collaborate across sectors such as education, employment, housing and community as well as health and social services to enhance mental well-being and reduce inequities.
- Engage communities and work in partnership with individuals, families, community groups as well as health professionals and NGOs to strengthen competencies and local resources.
- Adopt a socioecological framework, recognizing the broader context of intervention delivery, to address multiple risk and protective factors that interact in the development of mental health and the prevention of mental disorders.
- Adopt a life course approach that is sensitive to particular developmental vulnerabilities and opportunities associated with life course development.
- Base decisions on the best available evidence, focussing efforts where they can reap the largest mental health and social gains.
- Adopt a comprehensive and integrated approach to intervention delivery, operating at the individual, community and policy level in promoting the mental health and well-being of individuals, families and communities.
- Invest in developing capacity for implementation to meet national and local priorities, employing the most cost-effective approaches, balancing universal and targeted interventions.
- Contextualize interventions within local conditions and resources ensuring that they are culturally appropriate, feasible and sustainable.
- Mainstream interventions by integrating mental health promotion within existing health, community and social services.
- Invest in developing research to monitor the implementation and outcomes of local interventions.

outcomes cannot be achieved. The implementation literature also emphasizes that implementation is a multistage process that is influenced by a broad range of factors operating at multiple levels within implementation systems, structures and contexts in which interventions are delivered. The conceptual models and frameworks outlined in this chapter identify a number of core principles and common dimensions that are associated with quality implementation. Drawing on these models and principles, it is possible to identify implementation strategies that can inform practical actions to achieve quality implementation of evidence-based interventions, and these are detailed further in chapter "A Generic Template for Implementing Mental Health Promotion".

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A Generic Template for Implementing Mental Health Promotion

Margaret M. Barry

Introduction

This chapter provides a step-by-step guide to mental health promotion intervention planning and implementation. Based on the review of implementation frameworks, strategies and research in Chapter 'Implementation Processes and Strategies for Mental Health Promotion', a generic template for the implementation process is outlined, which includes the stages involved in the process of pre-adoption or initial planning, implementation planning, delivery and sustainability. The template includes conducting needs assessment strategies, developing mechanisms for consultation and collaboration, developing capacity and organizational implementation structures, selecting suitable evidence-based approaches and building a base of support for intervention implementation, maintenance and evaluation. These different steps may be divided up into different phases as follows:

Phase 1: Intervention Initiation and Initial Planning Stages
- Conduct needs assessment and consultation.
- Assess the local context.
- Select evidence-based intervention strategies.
- Mobilize support and develop partnerships.
- Project manage intervention delivery.

Phase 2: Develop the Implementation Plan
- Develop an implementation team.
- Formulate intervention goals, objectives and desired outcomes.
- Develop a sequential work plan that facilitates the systematic implementation of the intervention.

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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- Specify intervention components.
- Identify and recruit intended intervention recipients.
- Build organizational capacity and resources including the necessary staffing and skills.
- Put in place the training and technical skills needed for delivery.
- Develop and pilot intervention materials.
- Build networks and partnerships for ongoing sustainability.

Phase 3: Deliver the Intervention
- Implement intervention components.
- Monitor quality of intervention implementation.
- Feedback and communication.
- Ongoing consultation, training and support.
- Manage resources.

Phase 4: Intervention Maintenance and Sustainability
- Integrate interventions activities.
- Assess intervention effectiveness in terms of process, impact and outcomes.
- Feedback findings to ensure continuous quality improvement.
- Put in place strategies to sustain the intervention over time and enhance its potential for scaling-up.

Phase 1: Intervention Initiation and Initial Planning Stages

Successful implementation of a mental health promotion intervention is dependent on good planning. Planning entails a number of interrelated activities involving clear analysis of the need for the intervention, identifying key target groups and intervention recipients, resources needed, understanding of structures, capacity and values in the local context, inter-agency and cross-sectoral involvement to build collaborative partnerships and facilitate broad level participation. There are a number of systematic guidelines and models available for the practitioner to use in planning health promotion interventions (e.g., Green and Kreuter 2005; and the Getting to Outcomes model by Wandersman et al. 2000, already described in Chapter 'Implementation Processes and Strategies for Mental Health Promotion'), which may also be employed in relation to mental health promotion interventions. Only the major planning steps will be highlighted here by way of illustration (see Box 1).

Box 1 Phase 1: Intervention Initiation and Initial Planning Stages
- Conduct needs assessment and consultation.
- Assess the local context.
- Select evidence-based intervention strategies.
- Mobilize support and develop partnerships.
- Project manage intervention delivery.

The initial planning stage is characterized by consultation and collaboration with all key groups who will be involved in the intervention's development. It may, therefore, be helpful to engage in a collaborative planning exercise with key stakeholders in order to formulate a broad picture of what is required and to understand the local context and what support and involvement needs to be mobilized. Interactive implementation planning with key stakeholders and agencies may include funders, implementing organizations and staff, potential participants and intervention evaluators. A planning workshop is a useful way of engaging key players in the intervention and mobilizing their participation and interest (Price and Smith 1985—see Box 2). At this stage, it may also be useful to consider setting up an advisory group or core-planning group to guide the planning process. The inclusion of intervention evaluators at this point in the process is also useful in order to help with initial clarification of intervention aims and objectives and to document and monitor the planning process from the outset.

At the beginning of the implementation process, initial clarification of the overall plan for delivery is needed. It is important to be clear about what the intervention can and cannot do when informing key stakeholders about its existence. In collaboration with key stakeholders, it is useful to agree on preliminary goals and

Box 2 Worksheet for Programme Planning
Based on interactive workshop format developed by Price and Smith (1985)

- Agree on the characteristics of the target population.
- Identify key strengths, resources and major stresses affecting the target population.
- What positive mental health outcomes (changes in attitudes, behaviours, environments) within the target population should be promoted with a mental health promotion intervention?
- What skills does the target population need to develop?
- Identify the agencies or the groups in the community that must be involved in planning for this target population. Which persons need to be involved?
- What steps will be taken to secure the interest and cooperation of the community groups or agencies?
- Establish several tentative objectives for the intervention project.
- Identify intervention strategies to achieve these objectives.
- How will the programme be evaluated to identify needed administrative changes while the project is underway?
- How will the programme be evaluated to determine the extent to which intervention objectives have been or are being met for the target population/group?
- What level of resources (information, money, support, space, expertise) will be needed? What sources for these resources should be approached?

objectives, which can be fine-tuned at a later stage. Early clarification will help to ensure smooth running of the implementation planning and delivery phase. These initial ideas once formulated then need to be anchored in the realities of the local context, both in terms of the organizational context of the delivery agency and in the context of the community or setting of the target population. This requires a clear understanding of both the culture and structure of the delivery organizations involved and the infrastructure, capacities and possible enablers and barriers in the local setting.

Undertaking Needs Assessment Strategies

In planning to implement a new intervention, the first objective is to carry out a comprehensive needs assessment. This entails: (1) clarifying the need for the intervention and developing a clear rationale for its implementation in the local context; (2) clearly identifying the target population including a profile of their age, gender, education, socioeconomic status, geographic area, level of risk and protective factors, assets, values, etc.; and (3) assessing the local context, including the unique characteristics (strengths, problems, resources, barriers and facilitating factors) of the community, school or workplace setting in which the intervention will be implemented. A detailed needs assessment helps to inform the selection of an appropriate intervention that will have a good fit with the intended population, delivery organization or community. Selecting an intervention that does not fit with the local context, even if carried out with quality, can lead to unsuccessful outcomes (Mihalic 2004).

Clarifying the Need for the Intervention The need for the intervention may be highlighted from a number of sources. These include:

- Emerging local concerns, such as a call for action in order to counter rising rates of adolescent mental health problems.
- Priorities identified by policymakers or health service decision-makers as areas for strategic action (e.g. need to promote parenting skills among low-income teenage mothers).
- Practitioners' interest in implementing 'best practice' approaches in order to fill a gap in existing service provision (e.g. implementation of a successful workplace mental health promotion programme).

In all cases, the initial planning for the intervention requires that there is a clear understanding of why the intervention is needed and what can be achieved realistically within a given timeframe. This is referred to as having a clear rationale for the intervention. It is useful from the outset to consult existing literature and research in the area when deciding on how best to address an identified problem or need. Contact with implementers who have direct experience of delivering possible intervention approaches is also recommended in order to get a realistic view of what is entailed.

Identifying the Target Population Identifying the intended or target population involves deciding for whom the intervention will be designed and implemented. Needless to say, the available resources need to be considered when making decisions about the scope and reach of the intervention approach adopted. As outlined in Chapter 'Advancing Evidence-based Action for Mental Health Promotion', interventions may range from a universal approach (i.e. provided to everybody within a defined community, school or work site), or it may entail a more targeted approach for those most likely to benefit from the intervention or those most in need or at higher risk. Criteria such as identified need or more general vulnerability factors may be used in making this selection. Consulting the literature is also useful as it frequently will identify particular population groups where an intervention has been known to have most success. For example, in relation to school-based programmes, existing evidence clearly endorses the effectiveness of universal approaches where social and emotional learning programmes are delivered to all students on a school-wide basis (Durlak et al. 2011; Weare and Nind 2011). However, in relation to depression prevention interventions, the evidence suggests that targeted approaches for those students already exhibiting symptoms or those at high-risk are more efficacious than universal approaches (Werner-Seidler et al. 2017). Therefore, a balance of universal and targeted delivery for those with higher needs is likely to be required.

Assessing the Local Context We now consider the process of identifying and assessing needs, barriers, opportunities and resources involved in initiating a mental health promotion intervention in the local context. This is an important step in shaping the design of the intervention and in adapting implementation plans to the unique characteristics of the local setting or community. It is important that the assessment identifies strengths as well as problems, including local perceptions and attitudes, current resources, readiness, capacity for mental health promotion and infrastructures for successful implementation. Undertaking a needs assessment provides a unique opportunity to engage local people and organizations and to develop an awareness of the intervention and to build commitment to local action. The cooperation of local people is needed to undertake a comprehensive local needs assessment, as this involves gleaning information on local power structures, values and capacities. Participatory research methods and structured planning models may be used to actively engage members of the local community or setting in this process (see Chapter 'Community Mental Health Promotion Principles and Strategies' for further discussion).

In this section, we concentrate primarily on undertaking a focussed needs assessment of the local setting for the purposes of planning. Consulting existing data sources may be useful in providing readily available information and also identifying gaps in knowledge. However, the planning information needed for a specific area will more often than not require the collection of some original data from the local site. This includes specialized studies such as systematic surveys, key informant interviews, focus groups with members of the local community, agency staff, local organizations/groups and influential people in the local setting. A focussed

needs assessment seeks to gather information from people most likely to be interested in or affected by a new intervention. In addition to its planning function, the process of needs assessment may be designed to identify potential collaborating organizations, groups and individuals that can actively participate in the building of a sustainable intervention.

There is a wide range of strategies that may be used for needs assessment. Among the methods most commonly employed are the following:

Utilizing Existing Sources of Data:

- Demographic, social, educational, employment and economic information related to the mental health profile or needs of people in the area.
- Local mental health status data or studies concerning behavioural, social and environmental risks and protective factors.
- Health service data on patterns of service use from which inferences may be made about current and future needs, including identifying high demand groups or groups with significantly low uptake.
- Previous surveys of relevance to the topic that have been carried out in the area.

Collecting New Data:

- Resource surveys entailing a broad level analysis of general characteristics of the setting or community including key functions, structure and history, current level of provision, local organizational infrastructures and capacities, potential barriers and openness to change.
- Local surveys on perceptions of mental health needs, awareness, attitudes, stigma, knowledge of support services, specific areas of concern.
- Key informant interviews with knowledgeable community members and agency staff concerning their views on local strengths, resources, barriers and areas of concern.
- Focus groups with key members of the target population to garner their views and understanding of particular issues of importance locally and how they might best be dealt with in the local context.
- Community meetings and open fora for inviting discussions with a wide range of participants on their perceptions of local issues, concerns, strategies for tackling these issues and readiness for change.
- Co-design workshops and collaborative approaches with key stakeholders to consider feasible intervention approaches.

Successful implementation depends on accurate analysis and understanding of the local context and conditions for the intervention including wider community, social and political factors. Once collected, the needs assessment data should be converted into programme operations in order to inform the next stage of planning. This may be done by compiling a summary report which synthesizes the data, in order to prioritize areas for action. This information can then be disseminated in an appropriate manner to key stakeholders who will play an active role in the design of the intervention approach. In setting priorities, it may be useful to invite local

stakeholders to review, in a collaborative manner, the information gathered in order to arrive at a consensus concerning priority areas and action strategies. This consultative approach helps to ensure that interventions will be sensitive to the local culture and will also provide the basis for continuing local participation and collaboration.

Select Evidence-Based Intervention Strategies

In selecting intervention strategies, it is useful at this stage to review the literature for examples of intervention approaches that have been successfully evaluated. There is increasing awareness among practitioners and policymakers of the need to utilize evidence-based interventions and best practices. In applying these interventions to the specific context of a school, workplace or community, there are numerous challenges in creating readiness, developing an effective model of training, mobilizing contextual support, monitoring implementation and evaluating outcomes. Alternative interventions can be considered in the light of available evaluation information and their appropriateness to the specific context. A number of evidence-based registries have been developed which provide information on available evidenced-based interventions in given areas (Mihalic and Elliott 2015), for example:

- Blueprints for Healthy Youth Development (http://www.blueprintsprograms.com)
- CDC Community Guide (https://www.thecommunityguide.org)
- National Institute for Health and Care Excellence (NICE) (https://www.nice.org.uk)
- Public Health Agency of Canada, Canadian Best Practices Portal (http://cbpp-pcpe.phac-aspc.gc.ca)
- RAND Health (https://www.rand.org/health.html)

Contacting others who have practical 'hands-on experience' of implementing such interventions is also useful, as this will provide valuable advice that is often absent from published studies and reports.

In selecting specific interventions, it is important to clarify the rationale behind the choices that are being made, whether adapting existing interventions or developing new ones, and to articulate assumptions about why a particular programme or intervention method should or should not work in a particular context.

- Is there theoretical and empirical support for the intervention approach?
- Has the intervention been applied successfully in a similar environmental context?
- Are there manuals or clearly outlined guidelines for implementation and training available?
- Importantly, has the intervention been shown to work and achieve its objectives?

The intervention needs to be clearly defined in order that all stakeholders and implementers are clear about the purpose of the initiative and that progress towards the desired goals and objectives of the intervention can be assessed.

In exploring the theories on which the interventions are based, it is useful to note that a number of common risk factors appear to be associated with a range of problem behaviours. Likewise, clusters of protective factors have also been identified as playing a critical role in promoting positive mental health and well-being outcomes. Interventions should be developed which target the underlying determinants of several theoretically and empirically related behaviours. For example, the rationale or basis for social and emotional learning programmes in schools is based on the knowledge that increasing students' social and emotional skills and competencies impacts not only on mental health and well-being outcomes but also on outcomes across the academic, employment, general health and behavioural domains including problem behaviours such as substance misuse, antisocial behaviour and sexual health (Durlak 2016). Further details on social and emotional learning programmes may be found in Chapters 'Promoting Children's and Young People's Mental Health in Schools' and 'Implementing Universal and Targeted Mental Health Promotion Interventions in Schools'. The known clustering of risk and protective factors strongly supports comprehensive intervention approaches that seek to address a common set of protective factors (such as sense of control, social and communication skills, emotional regulation, coping strategies, problem solving) within the context of creating supportive socio-environmental conditions and structures.

Mobilizing Support and Developing Partnerships

When implementing a new intervention, it is important to consider whose engagement and support is needed to get the initiative underway. It is extremely important to secure the interest and cooperation of key stakeholders early on in the planning process. Building a strong base of support requires time and effort, and this needs to be included in the planning process. Support may need to be secured from a number of different levels (e.g. among decision makers, organizations and individuals who will be directly or indirectly involved in implementing and using the intervention). In order to mobilize the necessary local support, it is important to understand the local policy and organizational structures in the community or setting and its value system. Some of this information will already have been gathered in the needs assessment. For example, there is a need to identify the influential individuals or groups whose support is vital to the successful implementation of the intervention and to build in a mechanism for their involvement in the planning process at the earliest stages of intervention design. This will set the stage for the continuing participation of key players in the process of implementation and ensures that the intervention will be tailored for and acceptable to the local population. Intervention designers should also seek to engage with the professionals already working with the target population about the intervention to be offered. The purpose of this is to seek their assistance in developing an intervention that will have a good ecological fit and align well with the needs and resources of the local context. As Price and

Smith (1985) point out, the presentation of the project in its early days is critical to its successful implementation. The project or intervention needs to be tailored for the local audience and setting. It is important to invite, and hear the views of, local groups and agencies that are well positioned to know about what will and will not work in the local setting. Begin to identify agency staff and community members who are particularly interested in the project and those who are not. Identify 'project champions' who will support the intervention and provide needed support to see it through its various stages of implementation and maintenance.

Develop a plan for collaboration and partnership working with the agencies and cross-sectoral groups that will become involved. Consider what the intervention has to offer these groups, what outcomes they would like to see from the intervention, whether it fits in with their existing work and how current levels of inter-agency links and cooperation may influence intervention delivery. Questions to consider include:

- What goals and objectives would other professionals like to see for the intervention?
- How does the proposed intervention fit in with their existing work?
- How do these professionals or groups interact with each other; are there inter-agency links and cooperation?
- Are there coordinating agencies or organizations that should be contacted?
- Are key stakeholders and agency staff clear about the aims and objectives of the intervention and characteristics of the groups who will participate in its implementation?

Failure to enlist the active involvement of all key players from the outset, including implementing staff and recipients, can seriously jeopardize intervention success. Once engaged, ensure effective communication with partners as the planning proceeds, building trust to ensure ongoing cooperation and effective partnerships for intervention implementation and sustainability.

Project Manage Intervention Delivery

The planning stage also entails putting in place a mechanism for project management in order to oversee the smooth running of the intervention and the management of resources. This involves choosing an organizational structure such as a steering group or advisory group who will play an active role in overseeing the implementation of the intervention at the local level. The steering or advisory group should represent the key partners who have an investment in the intervention, and careful attention should be given to how the members of the group are selected. This is particularly important in relation to community steering groups where representation in terms of age, gender, race, socioeconomic status, religious and ethnic affiliations needs to be carefully considered. The function and purpose of the group should be clearly identified from the outset, and the key roles and responsibilities of the group members should be agreed on in a collaborative fashion. It is worth putting some time into clarifying the functions of the group and also attending to the

internal dynamics and working relationships of the members (see Chapter 'Community Mental Health Promotion Principles and Strategies' for further discussion of these points).

In terms of managing resources, it is useful to draw up a plan of all the required resources for intervention planning and implementation, including tangible and non-tangible resources. This includes securing appropriate funding for assessment, planning, start-up and maintenance of the intervention. A written budget with projected costing should be drawn up, together with an outline of required resources in terms of staffing, training needs, any required accommodation, intervention materials, transportation costs for intervention recipients and any incidental costs such as crèche and meal costs. Failure to understand and secure all the resources necessary to implement an intervention can result in poor implementation and possibly intervention failure down the line. A comprehensive plan should aim at securing appropriate administrative and managerial support for the intervention as it develops through its various stages of implementation.

In summary, these initial planning tasks all need to reflect a concern for detailed documentation and a commitment to working in an open, participatory and collaborative manner. Negotiation and consensus building early in the life of intervention planning sets the tone for the working relationships and helps to minimize barriers and resistance. As Price and Smith (1985) highlight concerning early stages of planning, 'The first phase is characterized by careful observation and documentation, systematic thinking, and an effective interactive style'.

Phase 2: Developing the Implementation Plan

This next phase involves shifting from needs assessment and consultation to the formulation of intervention goals and objectives and developing a sequential implementation plan for delivery (see Box 3). By this stage, needs assessment data

Box 3 Phase 2: Develop Implementation Plan

- Develop an implementation team.
- Formulate intervention goals, objectives and desired outcomes.
- Develop a sequential work plan that facilitates the systematic implementation of the intervention.
- Specify intervention components.
- Identify and recruit intended intervention recipients.
- Build organizational capacity and resources including the necessary staffing and skills.
- Put in place the training and technical skills needed for delivery.
- Develop and pilot intervention materials.
- Build networks and partnerships for ongoing sustainability.

relevant to the population and setting will have been collected, and some preliminary collaborations and organizational partnerships will have been developed. Consultation with the local population may also have been undertaken to prioritize the interventions to be delivered and determine the modes of delivery that will best suit the local audience. Alternative intervention strategies relevant to the target population and setting may also have been identified. A focus on intervention goals, objectives and desired outcomes provides an opportunity to use the information collected to clearly formulate the actual intervention and to prioritize the intervention activities to be delivered.

Develop an Implementation Team

Developing an implementation team will support the effective delivery of the intervention especially if there are a number of sites involved. The structure of the team will depend on the specific intervention and the infrastructure of the implementing organization or setting, but its purpose is to oversee and support quality implementation. Key steps include identifying team leaders, content specialists and other key stakeholders that need to be involved and assigning them clear roles and responsibilities in supporting a high-quality implementation process.

Formulate Intervention Goals, Objectives and Desired Outcomes

The formulation of goals and objectives is an important conceptual phase in the planning of the intervention and should be a collaborative exercise which brings people together and helps to focus more precisely on what the intervention aims to achieve. It is also an opportunity to develop a shared understanding of the key purpose of the intervention and to mobilize interested parties towards a common goal. Focussing on the goals and objectives provides a common ground for identifying criteria by which the intervention will be judged to have been successful or not, and it also focusses on what outcomes are to be achieved in evaluating the impact of the intervention. It may also be useful at this point to incorporate a theory of change approach into the collaborative process in designing and evaluating complex mental health promotion interventions. Developing a theory of change provides a comprehensive description of how and when change is expected to happen in a given implementation context. This is achieved by mapping out what a specific intervention or change initiative does and how this leads to desired goals or outcomes being achieved. Long-term outcomes are first identified, and then working backwards, the intermediate and short-term outcomes are also specified. The preconditions necessary to achieve these outcomes are outlined, together with articulation of the assumptions about the specific context and the intervention activities needed to achieve the changes required. Measurable indicators are also identified to assess the intervention process and outcomes. A pathway of change can be represented graphically to depict the change process and articulate the theory underpinning the links

between intervention activities and their expected outcomes. A theory of change helps specify the causal mechanisms underlying a specific intervention approach and how and why it works (Anderson 2005) and also provides a framework for monitoring and evaluation across the implementation cycle (De Silva et al. 2014).

In formulating intervention goals and objectives, it may be useful to consult programme evaluation texts, particularly with regard to specifying how operational statements of goals and objectives serve as criteria to be used in evaluation and accountability. In brief, a project goal is a general statement that specifies the condition or state of affairs that is desired as a result of the intervention. A project objective, on the other hand, is a specific statement of the outcomes that indicate progress towards the goal or the removal of barriers within a specific timeframe. An intervention outcome may be stated as 'improved understanding of mental health'. However, the criteria that allow us to know whether the results are being achieved must be specified. This will be linked to the intervention components delivered and may be stated as '70% of the population targeted will show improved attitudes and reduced stigma as measured on x questionnaires by the end of the intervention'. The characteristics of well-formulated objectives have been identified as follows: explicit, specific, measurable, scheduled, prioritized, owned by those involved, related to each other and communicated.

Develop a Sequential Implementation Plan

Having developed an initial list of intervention goals and objectives and how they might be achieved, a detailed action plan for the intervention needs to be drawn up. The major elements of the plan for intervention implementation need to be clearly defined and operationalized in order to guide the implementation process and generate a record of intervention implementation. Once the intervention has been defined, the exact details of the intervention and what will need to be delivered by implementation staff should be clarified (i.e. what activities actually make up the intervention and the order in which they will be delivered). Careful documentation of planned intervention activities is recommended early on in the life of the project. The exact details of what is being delivered, how often and under what circumstances, call for detailed monitoring and documentation throughout the process of implementation. Intervention activities may be documented through independent observation, structured ratings and reports by project staff and implementers. These various sources will inform how the intervention is actually being delivered on the ground and will detail what obstacles or critical sources of support were encountered and any unanticipated effects.

The delivery plan needs to detail who does what, with whom and when. Who is actually going to implement the intervention? Depending on the intervention, implementers may range from teachers delivering curricula in classroom settings, health visitors or nurses carrying out home visits, employment and training agency staff delivering a job search intervention, to peer-led youth and community interventions. In all cases, the delivery plan needs to consider what staffing, including necessary qualifications, skills and training, is required to adequately deliver the

Box 4 CASEL's 10-Step Implementation Plan for School
(Adapted from http://crisisresponse.promoteprevent.org/webfm_send/2230)

Phase 1: Readiness
- School leaders commit to schoolwide SEL.
- School leaders engage stakeholders and from a steering committee.

Phase 2: Planning
- The school community develops, articulates and effectively communicates a shared vision of student social, emotional and academic development.
- The steering committee conducts a needs and resources assessment.
- The steering committee develops an action plan.
- The school community selects an evidence-based SEL programme.

Phase 3: Implementation
- Programme developers provide initial staff development for those launching the programme.
- Teachers piloting the programme launch SEL in select classrooms.
- All school staff engage in instruction and integrate SEL schoolwide.
- The school community revisits activities and adjusts for improvement.

intervention. See, for example, CASEL's 10-step implementation plan for schools in Box 4. The delivery plan will also specify clearly the intended scope of intervention, including the number of participating agencies and a recruitment strategy for engaging the expected number of intervention recipients. These areas will now be elaborated on in more detail.

Written action plans or intervention protocols have been shown to be a critical forerunner of successful change efforts (Fawcett et al. 1997). They also maximize the use of available community resources in the plan and adapt to local constraints and values. Intervention cost estimates should also be included, along with the time frames. Developing a sequential plan or practical plan of work includes setting out both short-term and long-term goals and scheduling the process in a sequential fashion with incremental implementation steps. The intervention goals, principles and key intervention components must be identified and clearly communicated to all relevant players involved in the implementation. Failure to commit to the underlying principles and to implementation of the key intervention components can seriously undermine intervention success (Mihalic 2004).

Specify Intervention Components

It is extremely useful from the outset to clarify and obtain agreement on the exact details of the intended intervention (i.e. the specific activities to be delivered and the process by which they should be implemented). Intervention managers and staff, in

collaboration with evaluators, should clearly identify the components that make up the intended intervention. These include the strategies, activities, processes and technologies to be used. Intervention evaluators can often help in this process, using tools such as evaluability assessment and application of intervention theory. This involves identifying the key intervention elements or activities, what Durlak (1998) refers to as 'the active ingredients of an innovation, that is, those elements believed to be responsible for a program's effects' (p. 7). A clear description of intervention components is needed to provide the foundation for assessing intervention delivery. Components are the strategies, activities, behaviours, media products and technologies needed to deliver the intervention, along with the specification of the intended recipients and delivery situations. For example, the Nurse Home Visitation Intervention by Olds (1988) identified three major activities carried out by the nurses during their home visits to enable parents to create a supportive health environment for their child's development:

1. Parent education about influences on foetal and infant development.
2. The involvement of family members and friends in the pregnancy, birth, early care of the child and support for the mother.
3. The linkage of family members with other formal health and human services.

The manual for the Life Skills Training intervention (Botvin 1983) lists five major intervention components, each of which consists of two to six classroom lessons designed to be taught in sequence:

- Knowledge and information
- Decision-making component
- Self-directed behaviour change
- Coping with anxiety
- Social skills

Many interventions develop a structured manual for delivery which clearly specifies the core elements of the intervention, their objectives, amount of time given to each component, together with the sequence and the manner in which they should be delivered. For example, intervention materials for school-based curriculum interventions are frequently included in a structured teacher's manual containing detailed lesson plans, describing both the content and activities to be included in each session. Student guides, including classroom exercises, homework assignments, video clips and online resources, may also be included. The use of instructional manuals helps to specify all the intervention components for intervention delivery including instructional strategies, workshop protocols and handouts for participants. In the absence of an already created manual, it is useful to develop a detailed written intervention protocol specifying as far as possible the component elements and the intended sequence in which the activities are to be delivered. The use of structured logic models are helpful in this respect, as they provide a graphic illustration of the necessary inputs or resources required, the sequences of specific intervention activities, expected short-term and long-term outcomes as well as possible indicators for success that can be measured (see further details in the W.K. Kellogg Foundation Logic Model Development Guide (2004)).

Identify and Recruit Intended Intervention Recipients

Specification of the intended recipients may include criteria such as background characteristics appropriate for the intervention including age, gender, socioeconomic group or income level, ethnicity and health status. In some cases, eligibility requirements for the intervention may need to be specified (e.g. only those unemployed for 6 months or more, first time low-income mothers, students aged 14–16 years). These decisions can be made based on prior studies and evaluation findings concerning identified levels of need and/or optimal intervention effectiveness.

Appropriate mechanisms for recruiting participants will also need to be identified. This may include recruitment through existing community organizations (e.g. women's groups, youth groups, rural organizations); schools, work sites and health services (hospitals, GP, antenatal clinics, community health centres), via social media, local media adverts and word of mouth. Once the recruiting mechanism is identified, it may also be necessary to agree on a selection process i.e. random selection, self-selection, first-come first-served, competitive application or screening by predetermined criteria (e.g. high-risk status). The full details of the recruitment arrangements need to be planned in advance and the necessary cooperation secured from recruiting agencies.

Build Organizational Capacity and Resources Including Staffing and Skills

When applying a new intervention to the specific context of a school, workplace or community, there are numerous challenges in establishing readiness, developing an effective model of training, mobilizing contextual support, monitoring implementation and evaluating outcomes. Implementation of new interventions will require developing capacity within the key organizations involved such as the health, education and support agencies in the community. Capacity building can include developing supportive practices and policies in the local context to enhance delivery and ensuring that the necessary administrative and support mechanisms are in place for quality implementation. Developing organizational and workforce capacities includes both generic implementation skills and specific intervention knowledge, skills and competencies for effective delivery in the context of local structures and settings. It will be important to determine the specific needs for training and technical support required to support quality implementation of specific intervention approaches.

The selection of staff who will deliver the intervention is a critical component of intervention implementation. In selecting staff, it is useful to consider the essential and desirable staff characteristics that are required for successful intervention delivery. These may range from appropriate qualifications and background to necessary skills or appropriate attributes, competencies and level of interest. A useful distinction can be made between personal qualities (such as self-confidence, empathy, likes working with people), and skills and experience such as group facilitation, experience of using specific techniques. For example, the implementation manual

for the JOBs depression prevention programme (Curran et al. 1999) advises distinguishing between attributes that can be improved through training (such as active listening skills) and those that should already be possessed by the person (e.g. empathy and reliability). The Incredible Years Parent, Teacher, and Child Training Series (Webster-Stratton et al. 2001), which provides an intervention to overcome conduct problems in children, specifies that the interventions can be delivered by trained professionals from a variety of backgrounds and disciplines including teachers, school counsellors and psychologists. Experience in working with children and parents, or in individual counselling, together with group leader experience is highlighted as being desirable. In this intervention, successful facilitators have been characterized as those who have a background in social learning theory and child development principles; are warm, caring and collaborative in their interpersonal style; and are able to provide effective leadership using the skills of persuading, coaching, humour, role play and practice. It is interesting to note that reports from the intervention have found that the facilitators' effectiveness is determined not by their educational or professional background but by their degree of comfort with a collaborative process and their ability to promote intimacy and assume a friendship role with families.

Put in Place Training and Technical Skills Needed for Delivery

The importance of quality training and staff development for successful implementation cannot be overemphasized. Good training and technical support is critical to good implementation. Staff charged with intervention implementation may lack confidence in working with the new intervention methods and materials and as a result may feel poorly equipped to use the new intervention techniques. High-quality training ensures that implementers become more comfortable with their new roles by providing a situation in which they can learn and practice new techniques prior to actual implementation. Many interventions provide comprehensive training, including technical support, extensive training materials and a facilitator certification process.

Where training is required, conducting a formal training workshop is recommended. Structured training will provide a general understanding of the area and a thorough grounding in the intervention approach. For example, Botvin and Tortu (1988) outline the elements of a teacher training workshop for the Life Skills Training (LST) intervention as follows:

- Provide an understanding of the issue of substance abuse and with LST's theoretical rationale.
- A full description of the intervention and the curriculum materials needed to implement it successfully.
- Familiarize participants with intervention contents and activities.
- Demonstrate the techniques needed to implement the intervention.

- Provide participants with opportunities to practice the techniques in small group settings and receive feedback on their performance.
- Provide guidelines for scheduling and implementation.
- Generate a sense of enthusiasm and commitment among those who will be delivering the intervention.

In general, training should aim to provide a conceptual framework for the intervention, guidelines for implementation, skill demonstration and skill practice. It is useful to highlight that a collaborative model of training has the added value of increasing engagement in the intervention, building good quality relationships with intervention users and creating a climate of support and trust. Research suggests that the collaborative process has the multiple advantages of reducing attrition rates, increasing motivation and commitment, reducing resistance, increasing situational generalization and giving participants a joint stake in the outcome of the intervention (Mihalic et al. 2004). In short, collaborative training empowers participants by strengthening their knowledge, self-confidence, skill base and their autonomy, instead of creating dependence and a sense of inadequacy. Following initial training, many interventions recommend providing ongoing support, supervision and additional training as necessary.

Develop and Pilot Intervention Materials

The materials needed for delivery may include a wide range, from the use of instructional manuals, leaflets and take-home instructional packs to audiotapes, videos, use of drama and interactive workshops. It is important to ensure that any material used should be culturally appropriate and meaningful, in terms of presentation, content and sensitivity to the local situation. The delivery plan should include provision for the piloting of an initial trial of the intervention materials in the hands of local staff. Using formative evaluation techniques, the feasibility of implementing the intervention materials in the local setting can be piloted and carefully evaluated. It is important to include feedback from both intervention implementers and intervention recipients at this stage. The findings from the formative evaluation may then be used to make any necessary changes and to fine-tune the intervention before being implemented more widely. Cost data from the pilot may also be useful in informing projected intervention expenditure through the process of full implementation.

Build Networks and Partnerships for Ongoing Sustainability

To elicit the collaboration of multisectoral agencies, it is important to identify and communicate with individuals or groups with a vested interest in intervention delivery and who are in a position to make decisions about adopting a new intervention. These may range from mental health service staff, to voluntary agencies,

community groups, schools, parents, teachers, employers, managers and local health departments. For example, support for implementing a new school-based intervention will be needed from several levels, from district level down to school board members, principals, classroom teachers and parents. Parental support is critical, and it is, therefore, important to ensure that parents are fully informed and supportive of any new intervention that is being introduced. Regardless of the setting, the intervention details including its background rationale, together with results of previous evaluations, should be clearly communicated to all interested parties. The views and concerns of the key stakeholders should be heard and taken into account in the process of refining the intervention. All parties engaged in key decisions should be informed of progress at regular intervals as the intervention proceeds. As the intervention is implemented, fostering shared decision-making and good communication ensures ongoing cooperation and lays the groundwork for strengthening intervention partnerships and sustainability.

Phase 3: Deliver the Intervention

This next stage involves implementation of the intervention together with careful monitoring and support of the implementation process (see Box 5).

Implement Intervention Components

It is important that the intervention be delivered as planned with clear agreed-upon objectives for each intervention component. Shortening or omitting core intervention components is not recommended as this may dilute the effectiveness of the intervention. If other adaptations are made, these should be carefully documented in order to monitor their effects. Likewise, particular obstacles or unexpected barriers to implementation that are encountered should be documented and notified as the intervention proceeds. As far as possible, the already developed intervention protocol should be followed in the recommended order and format. This is referred to as maintaining intervention integrity and methods of ensuring this will now be outlined.

Box 5 Phase 3: Deliver Intervention
- Implement intervention components.
- Monitor quality of intervention implementation.
- Feedback and communication.
- Ongoing consultation, training and support.
- Manage resources.

Monitor Quality of Intervention Implementation

As outlined earlier in this chapter, current research indicates that implementation is often variable and imperfect in field settings and that the level of implementation influences outcomes. A weakness in many interventions is the absence of detailed information on the quality and quantity of intervention implementation. Durlak (1998) suggests that a starting point for measuring implementation is for an intervention to specify its core intervention components or active ingredients. These should be observable and include all materials and activities used in the intervention. Factors such as the quality of trainers, quality of training, feedback from implementers or other system level variables, such as organizational support, may also influence how these core components are delivered. Although an intervention is the major change agent in an intervention, the implementation system is likely to make an important contribution to intervention outcomes (Chen 1998). The implementation system provides the means and a context for the intervention and is affected by a number of factors such as characteristics of the implementers, the nature of the implementing organization and the quality of the linkages between the organization and the broader community. The level and extent of these aspects of the implementation system should be carefully documented. Once the intervention's core components are established, an objective assessment system is needed to monitor the quantity and quality of the intervention.

Assessing implementation is a complicated process, as the gaps between plans and delivery may be either positive or negative. It is likely that successful implementation requires more than just faithfully replicating intervention components. Interventions are adjusted to meet the needs and capacities of local communities or to allow participants to gain ownership of interventions. It is critical to consider the debate between fidelity and adaptation as outlined earlier. Interventions may need to be adapted to meet the perceived ecological needs of the context in which the intervention is being delivered. In all cases, this type of local adaptation should be documented and its impact monitored.

The concepts of implementation quality have been outlined in Chapter 'Implementation Processes and Strategies for Mental Health Promotion', and it is important to assess and monitor each of these different aspects of quality, in order to determine how well the intervention is being implemented in comparison with the original intervention design. An evaluation of the trial implementation of the KidsMatter national whole-school framework for primary schools in Australia (Dix et al. 2012; Slee et al. 2009) examined how the level of programme implementation was significantly associated with student outcomes. In this study, an implementation index was developed to measure implementation quality of the whole-school approach, based on the underpinning principles of fidelity, dosage and quality of delivery, as identified by Domitrovich et al. (2008). A pool of items from questionnaires completed by parents, teachers and project officers were used to gain multiple perspectives on these different aspects of school-level implementation from across over 100 schools. The indicators were then combined to form an implementation index which was used to classify schools into high- and low- implementation

categories. Latent Class Analysis was used to identify the index items that best discriminated between schools. Further details of the development of the Implementation Index is reported in Askell-Williams et al. (2013). Examining the relationship between the Implementation Index scores and students outcomes, it was found that the level of implementation was significantly associated with academic outcomes, with the difference in students' academic performance between high- and low-implementation schools being equivalent to 6 months of schooling. Improvements in children's social and emotional competencies were also found to be significantly related to level of implementation, with no significant changes being found for students in low-implementing schools.

Process Evaluation

Process evaluation techniques, based on careful description, documentation and monitoring of the implementation process, may be used to assess both the quantity and quality of intervention implementation and the factors that influence this in the wider implementation system (Durlak 2016). Process evaluation is concerned with improving our understanding of how an intervention achieves what it does. It is used to interpret intervention outcomes and to inform others wishing to learn from the experiences of the intervention. If intervention implementation is not monitored and assessed, an outcome evaluation may be assessing an intervention which differs greatly from that originally designed and planned. This seriously limits the strength of conclusions that can be drawn from outcome results. Process evaluation is critical to the validity of intervention evaluations. This includes:

- Making confident connections between interventions and outcomes (internal validity).
- Replicating interventions in other settings (external validity).
- Determining how or why an intervention works (construct validity).
- Variability in implementation introduces error variance that reduces the power of statistical analyses (statistical conclusion validity).

Implementation or process data are critical for interpreting both positive and negative outcomes; positive findings cannot be attributed to the intervention unless it is clear that the intervention was actually conducted. Negative results can arise when an intervention is poorly implemented and is, therefore, not fairly tested. Intervention evaluations that fail to consider implementation lead to a Type III error (i.e. potentially useful interventions will be prematurely and unfairly rejected not because the intervention per se does not work but because it has not been properly implemented) (Dobson and Cook 1980). As Durlak (1998) points out, unless we assess implementation, we do not really know what we are evaluating and run the risk of misinterpreting evaluation findings.

Process evaluation may also be viewed as a feedback mechanism that provides data on the range and extent of intervention delivery and whether key objectives are being achieved. This information helps to identify areas where the intervention may

be working well or where objectives are not being met. This information may lead to modifications in order to improve and fine-tune aspects of the intervention and its delivery, thereby ensuring continuous quality improvement as the intervention progresses. The collection of systematic data on intervention implementation also plays an important role in advancing knowledge on best practices for replication in 'real-world' settings. Comprehensive documentation of intervention delivery provides data on the practical realities of implementation, including intervention modification or necessary adaptations for the local setting. This information provides the basis for developing a useful practical guide for others contemplating implementation of a similar intervention.

For all of the above, we need to know how well the proposed intervention was actually conducted. Both the quantity and quality of implementation needs to be assessed, including how much of the intervention was administered and how well each part was conducted. Process evaluation involves assessing the active ingredients or components of the intervention. In addition to the content and structure of the intervention, information is also needed on the delivery process and structure of the wider implementation system. This entails gaining an insight into the internal dynamics and operations of the intervention: how the various parts of the intervention fit together and how the users interact with each other and with the trainers or implementers. Although less frequently monitored, information is also needed on the outer context of the intervention, including organizational processes, any obstacles encountered in the local setting and how they were resolved, together with any unexpected benefits. In essence, intervention monitoring seeks to understand the strengths and weaknesses of the intervention as implemented in the local setting.

Data for process evaluation are usually gathered using mixed-methods approaches, such as using intervention records (such as forms and activity logs kept by practitioners), focus groups, direct observation by the evaluator and information gathered from intervention staff and participants through written questionnaires, telephone or in-person interviews. Monitoring implementation is important at each stage, from initial pilot studies through to large-scale implementation.

Among the key questions to be asked:

- Are members of the intended target population being reached successfully?
- What is the profile of actual participants?
- Are the intervention activities being delivered as intended?—frequency, intensity, quality of delivery—feedback from observations, interviews with participants, trainers and intervention providers.
- Is the intervention progressing towards key objectives—are key objectives being addressed and is there preliminary evidence that the objectives are being met?
- Is there successful engagement of intervention participants, local agencies and professionals?—interviews with key players and recipients on their perceptions and experience of the intervention.
- Is there evidence of inter-agency and intersectoral cooperation?
- What is the unique aspect of the intervention and its added value compared to other approaches?

Feedback and Communication

Feedback from the results of the process evaluation may be used to inform key players, managers and intervention sponsors of intervention performance. Reviewing intervention activities, using results from process evaluation, could be undertaken in an interactive workshop format. Ongoing planning and review sessions with key stakeholders may be put in place to take stock of what has been achieved, identify strengths and weaknesses and alter, where needed, the course of action. Evaluators and key stakeholders have an important contribution to make in these sessions, and it is important that findings are presented in a format targeted for specific audiences and that there is a willingness and openness to consider both problems and achievements. Putting in place a transparent and frequent feedback system is critical to ensuring good quality communication and cooperation as the intervention develops.

Ongoing Consultation, Training and Support

Ongoing consultation, training and support is needed as the intervention moves through the different stages of planning and implementation. For example, the training process may not end with the formal training workshop, as it may be necessary to offer continuing support, guidance and consultation as the intervention is being implemented. Regular site visits are also helpful in maintaining contact with implementation and provide an opportunity to get feedback, review satisfaction levels and learn first hand of any concerns and difficulties. Ongoing consultation plays an important role in consolidating collaboration and enhancing the sense of efficacy of staff in relation to the intervention and also decreases the likelihood of loss of interest or that the intervention will be diluted or abandoned due to lack of support services.

Manage Resources

Ongoing management of staff and financial resources is needed as the intervention unfolds. Once materials and training have been purchased, the ongoing costs of implementation of each intervention activity, including instructors' fees, facilities, equipment etc., should be estimated and actual expenditure carefully monitored. A budget for intervention delivery should be developed and potential sources of support identified, both in kind and financial. Budgeting for sustainability also needs to be taken into account at this point, including what further investments may be needed in terms of training, staff and other resources for ongoing maintenance of the intervention in the long term. Due to the likely turnover of intervention staff and advisory or steering group members, it may be necessary to recruit and involve new

people in the intervention on an ongoing basis. New sources of energy, commitment and support may be needed as the intervention progresses.

Phase 4: Intervention Maintenance and Sustainability

By this stage, implementation staff will be experienced with the intervention, problems may have been encountered and resolved and the intervention is being successfully delivered into the local organizational context or setting. Box 6 outlines the steps involved in maintaining and sustaining the intervention.

Integration of Intervention Activities

Intervention integration may be planned for early in the life of the intervention, or it may take place later, as intervention staff and the local organization gain confidence and become more comfortable with the intervention. As outlined earlier in this chapter, factors such as organizational support and intervention readiness, having a good intervention fit that aligns well with the implementing organization, well-trained staff and sustainability planning have been identified as key predictors of sustainability (Cooper et al. 2015). Fostering ongoing supportive organizational conditions with good communication and relationships between key players is critical in promoting and maintaining interventions in the longer term. Building trust and good quality relationships is central to building the intervention on a foundation of respect, an appreciation of different strengths and an acknowledgement of the contribution of different members. This applies at all levels, from the steering or advisory group through to trainers, implementation staff, evaluation personnel and intervention recipients. A positive implementation process, which fosters an ethos of participation, collaboration and empowerment, provides the right environment in which enthusiasm, creativity and good quality work can be promoted and maintained. Putting in place ongoing training and capacity building opportunities for implementation staff and their organizations should also be considered at this stage. Capacity building will assist with the continuing quality improvement of intervention delivery and consolidates the intervention by building on achievements to date.

Box 6 Intervention Maintenance and Sustainability

- Integrate intervention activities.
- Assess intervention effectiveness in terms of process, impact and outcomes.
- Feedback findings to ensure continuous quality improvement.
- Put in place strategies to sustain the intervention over time and enhance its potential for scaling-up.

Assess and Feedback Findings on Intervention Effectiveness

A formal system of evaluation needs to be put in place in order to systematically assess intervention inputs, process impact and outcomes. Multiple methodologies may be needed, including naturalistic or descriptive studies, experimental trials and adaptive design studies (Spoth et al. 2013). The ongoing monitoring of intervention activities makes possible the periodic review of achievements and progress towards desired goals and objectives. A variety of quantitative and qualitative indicators of success can be evaluated (Zubrick and Kovess-Masfety 2005). These include information on awareness, participation, knowledge, attitudes, behaviour and environmental change together with intervention reach, participant engagement, partnership building, inter-agency cooperation and cross-sectoral partnerships. These indicators provide evidence of intervention performance, and they can be used to demonstrate intervention accountability and provide feedback to intervention managers, funders and key stakeholder groups. Results from the various types of process and outcome data will be helpful in assessing the intervention's successes and challenges. Further details on the different types of evaluation methods employed in specific interventions and case studies are outlined in later chapters. However, it suffices to highlight at this point the importance of providing feedback of evaluation findings together with opportunities for key stakeholders to systematically review intervention results in order to take stock of intervention achievements and identify areas for modification. This allows for decisions concerning the intervention's future to be made based on empirical data as well as more anecdotal evidence.

Put in Place Strategies to Sustain the Intervention over Time

As an intervention progresses to more widespread implementation, another critical step involves identifying what factors increase the potential for sustainability and scaling-up of effective interventions. Sustainability is used as a general term to refer to the process of continuation. A distinction can be made, for example, with terms such as 'integration' or 'institutionalization', which imply continuation or survival within an organizational structure; however, sustainability may also occur at other levels such as at the community or network level. Here it is used as a broad term which indicates continuation without specifying or limiting the form that it may take. Among the operational indicators that are used in monitoring sustainability over time are maintenance of health benefits achieved, level of integration of interventions within mainstream services and/or organizations and measures of capacity building in the recipient community. Akerlund (2000) defines a sustainable intervention as one that is endurable, liveable, adaptable, supportable, replicable and is of reasonable cost. Shediac-Razallah and Bone (1998) present an organizing framework for conceptualizing and measuring sustainability and tentative guidelines to facilitate sustainability in community interventions. They emphasize that sustainability is a dynamic process and that goals and strategies for achieving it must continuously adapt to changing environmental conditions.

There is a need to consider the organizational structures and policies that are necessary to support long-term maintenance and sustainability of quality interventions. To effectively maintain quality interventions, practitioners in collaboration with intervention evaluators, will need to identify key intervention elements needed for a high probability of success such as organizational capacity, quality training, funding, stability, commitment and resources. Some interventions may need new sponsors, and other interventions may need to be significantly changed. Developing a strategy or plan for continued collaboration and partnerships is critical to the continued sustainability of the intervention. Such a plan should include key players such as agencies motivated by the intervention, intervention participants, intervention staff and funders. Disseminating information on intervention activities and evaluation results increases the intervention visibility, acceptance and level of interest among potential support sources. Maintaining high visibility and ensuring that key decision-makers learn about the intervention may also be critical in determining whether resources will be made available for its continuance. An opportunity to witness the intervention in action and to speak with intervention implementers and recipients may also be useful in convincing decision-makers about the value and worth of the intervention.

Existing frameworks for scaling-up health interventions, already referred to earlier in this chapter, point to the importance of strengthening leadership and governance, political will and advocacy; enhancing infrastructures to support delivery systems, training, technical resources; and the active engagement of key stakeholders in tailoring and integrating approaches in the local context. A combination of good quality relationships, a high standard of implementation, rigorous evaluation, together with widespread intervention acceptance and support, provides the basis for effective and long-lasting mental health promotion practice.

Conclusions and Recommendations

In this chapter, we have outlined the various stages and steps involved in intervention planning and implementation. It is important to note that these stages begin as early as when an intervention is being considered and planned (pre-adoption), through to intervention implementation (delivery) and intervention consolidation and maintenance (sustainability and scaling-up). As an intervention moves to more widespread implementation and replication, practitioners working in collaboration with intervention evaluators will need to identify key intervention elements needed for a high probability of success and identify system-level factors and structures that increase the potential for sustainability of effective interventions. This entails clearly identifying core elements of the intervention content, together with the implementation system and organizational structures needed to support the long-term maintenance and sustainability of the intervention. Barry et al. (2005) provide an overview of the strategies that can be used to improve the overall quality of implementation and delivery of mental health promotion interventions. Drawing on

this work, recommendations for practitioners, policymakers and researchers in supporting and evaluating the quality of intervention implementation are outlined in Boxes 7 and 8.

Box 7 Recommendations for Practitioners in Improving Intervention Implementation
(Adapted from Barry et al. (2005) and reprinted by permission of the IUHPE journal *Promotion and Education*)

Intervention Initiation and Planning Phase

- Assess the characteristics and resources available in the local context.
- Identify the problem and associated risk and protective factors for that community.
- Select an evidence-based intervention strategy, verifying that the intervention approach is appropriate for implementation in the given context.
- Involve key stakeholders in the decision-making process, including implementation staff, management and potential intervention recipients.
- Mobilize support and develop partnerships, ensuring buy-in of all parties by providing documentation that supports the need for the intervention (e.g. the evidence base for the intervention and the match between the approach adopted and the needs in the community).
- Identify the key components of the intervention based on underlying intervention theory.
- Identify and communicate intervention objectives, principles and the mechanisms that will be used to achieve them, to all relevant players at the planning stage.
- Provide decision-makers and stakeholders with the necessary information to secure adequate resources to implement the intervention.
- Lay the foundation for successful cooperation and collaboration by clearly defining the roles of all parties involved and establish a system for discussing and resolving problems.
- Plan for the long-term sustainability of the intervention.

Implementation and Delivery Phase

- Assess readiness to implement the intervention.
- Make modifications or adaptations in delivering the intervention, balancing intervention fidelity with the needs of the local site.
- Develop an implementation team and sequential work plan.
- Draw on the 'wisdom knowledge' of those with experience of the intervention.
- Develop a theory of change and a detailed intervention description or structured manual to facilitate intervention implementation.
- Build organizational capacity and secure the necessary resources and technical supports for implementation.

(continued)

Box 7 (continued)

- Train intervention staff to conduct the intervention effectively.
- Provide ongoing support and supervision once the intervention has begun.
- Partner with an evaluator to develop an implementation monitoring system that includes assessment of the intervention (i.e. intervention fidelity, exposure, quality of delivery, participant responsive and intervention differentiation), support system and key system factors.

Intervention Maintenance and Sustainability Phase

- Develop a plan for the integration of the intervention based on existing funding, long-term priorities and resources.
- Use implementation information and process evaluation data to fine-tune and improve intervention delivery.
- Provide regular updates and evaluation information to key stakeholders.
- Document the provision of feedback and any subsequent changes that are made to the intervention.
- Assess intervention effectiveness in terms of process, impact and outcomes.
- Provide ongoing training and feedback findings to ensure continuous quality improvement.
- Put in place strategies to sustain the intervention over time.

Box 8 Recommendations for Policymakers and Researchers in Improving Intervention Implementation
(Adapted from Barry et al. (2005) and reprinted by permission of the IUHPE journal *Promotion and Education*)

Policymakers

- The decision to adopt a best practice intervention does not guarantee success without attention to good quality implementation.
- Provide adequate resources for intervention development and implementation including the necessary staff skills, training, supervision and organizational support needed to implement the intervention to a high level of quality.
- Invest in capacity development and evaluation in order to facilitate and enhance knowledge translation and best practice in intervention implementation.

Researchers

- Systematically monitor and assess intervention implementation as a core part of intervention evaluation.
- Collect qualitative data on the barriers, obstacles and facilitating factors encountered in the course of intervention delivery.

(continued)

Box 8 (continued)

- Gather information from multiple sources, including intervention recipients, implementers and researcher observation, in order to reduce bias in assessing the quality of implementation.
- Identify key mediating variables that are theorized to be responsible for the intervention outcomes.
- Relate variability in implementation to short-term and long-term intervention outcomes.
- Work in partnership with practitioners, employing collaborative evaluation methods, in order to feedback implementation findings and to ensure continuous improvement of intervention quality.

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Part III
Community Mental Health Promotion

Community Mental Health Promotion Principles and Strategies

Margaret M. Barry

Introduction

Community settings are complex and dynamic, composed of many sub-settings such as schools, workplaces and neighbourhoods, in which population groups from childhood through to old age live, grow, learn, work and play. As such, the community setting offers important opportunities for promoting mental health with diverse population groups across a range of different settings and sectors. Working at the community level speaks to the policy imperative of adopting a whole-of-community perspective to population mental health, as endorsed by the World Health Organization (WHO) Global Mental Health Action Plan 2013–2020 (WHO 2013a). A whole-of-community approach to mental health promotion means engaging the wider community composed of multiple actors, sectors and systems, to address the social determinants of mental health and reduce mental health inequities. A community approach to mental health promotion views mental health as a positive resource for individuals and communities embedded within the social, cultural, environmental and economic contexts of everyday life. This approach is based on a socio-ecological perspective, as outlined in chapter 'Concepts and Principles of Mental Health Promotion', and conceptualizes mental health as resulting from the interaction over time of the person with the environment, placing a particular emphasis on social settings and systems and the influence of broader social, economic and political forces. Community practice, therefore, calls for comprehensive multilevel interventions addressing systems of socialization, social support and control operating at multiple levels.

There are many different definitions and meanings of the term 'community', from those that describe a geographically based community such as a local neigh-

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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bourhood, city or rural locality, to groups of people who share a common identity or interests, for example, communities based on ethnic, sexual, religious or cultural identities, who may not be geographically based. The majority of definitions do, however, refer to such key features as a group of people sharing values and institutions, a sense of belonging or shared social meaning, and social structures that serve to connect interdependent social groups (Rifkin et al. 1988). Community approaches for promoting health and wellbeing are well documented in the health promotion literature and there are many excellent examples of their application which the reader may wish to consult (Bracht 1999; Laverack 2006; Minkler 2012). The area of community mental health promotion is probably less well documented. However, many of the fundamental principles of community health promotion programme planning and delivery apply equally well to the practice of community mental health promotion.

Community working is essentially characterized by collaborative practice, based on the facilitation of active community participation and the enhancement of community empowerment. These are the fundamental guiding principles of a community model of practice. In this chapter we explore the application of these principles and examine the main factors which influence their successful implementation in practice. The rationale for implementing community mental health promotion is outlined and the underlying principles are discussed. Many of these principles, for example, those relating to good practice in developing collaborative partnerships, equally apply when working in other settings such as schools, workplaces and health services, as discussed in the other chapters in this book. Following an overview of the main conceptual approaches to community practice, structured frameworks for community-based intervention planning, implementation and evaluation are outlined and the steps involved in translating concepts of community practice into reality are considered. The Communities That Care initiative is highlighted as a practice example of a community-wide system for engaging community stakeholders in a structured process of planning and implementation of evidence-based community interventions.

Rationale for Community Mental Health Promotion

Community mental health promotion provides a unique opportunity to put into practice the principles of community participation and empowerment, which were outlined in the World Health Organization's Declaration of Alma-Ata (WHO 1978), the Ottawa Charter for Health Promotion (WHO 1986) and subsequent health promotion declarations. The concepts of participation and empowerment occupy a special importance in community mental health promotion practice. Community engagement strategies that embrace participation and empowerment have a positive impact on the development and delivery of more appropriate and acceptable interventions and have positive effects on social cohesion, social support and the individual self-efficacy of those who are actively engaged (O'Mara-Eves et al. 2013). It is well recognized that enduring change is more likely to occur if the key

stakeholders, including citizens, community groups, health professionals, statutory and voluntary agencies, are involved in a process of bringing about change at a wider socio-environmental level. A whole-of-society approach recognizes the value of engaging a broader set of community actors in addressing the social determinants of mental health and bringing about positive and enduring change (WHO 2013b). A community perspective shifts the 'center of gravity' from a focus on individuals to the community as the locus of practice (Robertson and Minkler 1994), building on the community assets of skills and knowledge, social networks and organizations, to enhance good health and wellbeing (South 2015).

Conceptual Approaches to Community Practice

There are two main conceptual approaches to community working that can be identified; interventions which adopt a community-based or community organization approach and interventions that embrace a community development approach. Interventions adopting a community-based approach are those where the main purpose of the community setting is to consult with, and reach, as wide a range as possible of community members. Community-based approaches can include engagement with communities at different levels; ranging from consultation or collaboration on intervention development and design, through to involving community members more directly in the delivery of interventions such as peer-based or lay delivered approaches. Community organization approaches have been defined as those involving and mobilizing major agencies, institutions and groups in a community to work together to coordinate services and create programmes for the united purpose of improving the health of a community (Robinson and Elliott 2000). Examples of these approaches are the large-scale community interventions, such as the Communities that Care initiative (Hawkins et al. 2002), as described in this chapter. Community development approaches, on the other hand, are often described as 'bottom-up' or grassroots initiatives where community members actively participate in identifying their own needs and organize themselves in planning and devising strategies for meeting shared needs, gaining increased self-reliance and decision-making power as a result (Labonté 1993). The principles of active participation and empowerment are central to this collective process. The community development approach, in which local communities identify and address local concerns, appears to hold much promise for community mental health promotion, especially when working in low-resource settings.

There are clearly ideological differences between the community organization and community development approaches with consequent implications for planning and implementation processes such as consultation mechanisms, community participation, empowerment, ownership and control. While models may vary in the degree and extent of community participation, control and ownership, a key feature of community approaches is that community members are actively engaged in community change. Adopting a community approach calls for a change in the style of

practice and the role of the professional in implementing such programmes within the community setting. Professional skills and competencies are required in facilitating effective community participation and the development of structures and collaborative mechanisms for the implementation of community interventions. Minkler (2012) provides a useful resource for orienting practitioners towards community approaches and methods of collaborative working.

A community health development continuum is a useful way of conceptualizing the process of translating community participation and empowerment principles into practice on the ground. Community development may be portrayed as involving a series of stages each with varying degrees of potential for maximizing community empowerment (Jackson et al. 1989; Labonté 1989). The stages include: personal development, mutual support, issue identification in community organizations, participation in organizations and coalitions, and collective political and social action. These stages represent a continuum from personal to collective levels of empowerment. Both the psychological and community empowerment process is embraced with the potential for empowerment being maximized as one moves from the individual to the collective action end of the continuum. Individual level empowerment may entail personal development and capacity building such as skills training or improved self-efficacy. This level of empowerment may be necessary for a person to function within and participate in a group process or indeed in society. Likewise, social involvement may lead to increased personal development. Active participation in community groups or partnerships is recognized as offering important opportunities for both personal and community empowerment (Florin and Wandersman 1990). Participation in the group collective process is a way of increasing awareness of the influence of wider social structures on health issues and also of acquiring skills and capacities required to strengthen local community capacities. Ideally, community participation should lead to increased empowerment among community members and increased capacity and control as a result of the process. Interventions operating at these different levels of the continuum are discussed in this chapter to highlight the application of empowerment principles in mental health promotion practice.

Principles of Community Practice

At a theoretical level, community mental health promotion practice draws on a socio-ecological model of health, which underscores the importance of the larger socio-environmental context within which individuals, group systems and social settings are embedded. Individuals, families, communities and the wider socio-economic, cultural and structural determinants of mental health interact with each other at each of these different levels forming complex and synergistic systems (Vaandrager and Kennedy 2017). Interventions that are informed by this perspective are directed at multiple levels such as community norms, social structures, policies and services. Stokols et al. (1996) describe ecologically informed programmes as

addressing '… interdependencies between socio-economic, cultural, political, environmental, organisational, psychological, and biological determinants of health and illness' (p. 247). The community may be seen as the interface between multiple interacting systems, that is, individual, group, organizational, environmental and policy systems. As such, community interventions have the capacity to address these multiple interacting levels thereby increasing the synergistic or interactive effects of the intervention. This perspective, which has been outlined in chapter 'Concepts and Principles of Mental Health Promotion', emphasizes the importance of mediating structures such as schools, workplaces and community settings as providing key contexts for social interventions operating from the micro to the macro levels.

Community Engagement and Participation

Community engagement has been defined as constituting a continuum of approaches for engaging communities in activities to improve their health and reduce health inequalities (Popay 2006). These approaches range from more restricted forms of engagement, such as information sharing and community consultation, to more active engagement strategies involving community participation and empowerment strategies. Shediac-Razallah and Bone (1998) argue that at the core of these related concepts is the idea of; 'the process of enabling individuals and communities, in partnership with health professionals, to participate in defining their health problems and shaping solutions to those problems' (p. 95). Community participation has been identified as one of the key mechanisms of enabling people to gain control over their health and that of their community. The Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development (WHO 2016) identified cities and local communities as having a major role in promoting equity and social inclusion through meaningful local engagement. The process of community participation is recognized as a prerequisite of empowerment, promoting a sense of control and ownership, which in turn leads to increased capacity or competence and promotes more sustainable change (Bracht and Kingsbury 1990; Flynn 1995; Robertson and Minkler 1994). As Bracht et al. (1999) point out 'participation facilitates psychological empowerment by developing personal efficacy, developing a sense of group action, developing a critical understanding of social power relationships and developing a willingness to participate in collective action' (p. 87).

Community participation is also seen as mutually benefiting both the community and the success of the intervention, as change is more likely to occur when the people it affects are involved in the change process (Kreuter et al. 2000). Obtaining meaningful community participation, however, can be challenging. Practitioners need to be mindful that participation may occur in different ways and at different levels ranging from token involvement (e.g. information sharing and consultation) to real control of the process (partnership, delegated power and control). Participation can be manipulative and passive, rather than empowering and may risk obscuring the need for analysis of larger institutional structures such as socio-economic

systems and policies, which can override local determinants of wellbeing (Labonté 2009; Wallerstein et al. 2011). The classic depiction of the degrees of participation in Arnstein's (1971) 'ladder of participation' and Brager and Specht's (1973) 'spectrum of participation' are useful reminders of the need to ensure maximal levels of participation in the development of the community organization process.

Community engagement is recognized as a critical strategy in addressing the social determinants of mental health and health inequities. A review by O'Mara-Eves et al. (2013) found good evidence that community engagement interventions have a positive impact on health behaviours, leading to improvements in health and self-efficacy and social support in disadvantaged groups. However, it is unclear whether one particular model of community engagement is more effective than another. Readers are referred to the National Institute for Health and Care Excellence (NICE) Guidelines on 'Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities' (NICE 2016), which outline a useful set of overarching principles of good practice, and guidelines on implementation and evaluation.

Community Empowerment

Empowerment has been defined as a social action process through which individuals, communities and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life (Rappaport 1985; Wallerstein 1992). Empowerment is, therefore, viewed as an action-oriented concept with a focus on transforming power relations and removing psychological and structural barriers to change. Empowerment processes have been informed by the writing of Paulo Freire, who described consciousness-raising processes based on a continuous process of dialogue, critical reflection, participation and action (Freire 1970). Community empowerment may be differentiated from empowerment at the individual level, since as a multilevel concept it operates at the different system levels of the group, organizational and wider community levels (Zimmerman 2000). Labonté (1990) links these levels of empowerment through the idea of a continuum. This continuum ranges from personal and small group empowerment to community organization, coalition building and political action. Israel et al. (1994) argue that empowerment at the individual level is linked with the organizational and community levels through the development of personal control and competence to act, the availability of social support, and the acquisition of interpersonal, social and political skills. An empowered community is where individuals and organizations apply their skills and resources in collective efforts to meet their respective needs. Through participation, individuals and organizations within an empowered community provide enhanced support for each other, address conflicts within the community and gain increased influence and control over the quality of life in their community. An empowered community has the ability to influence decisions and make changes in the larger social system. A community empowerment approach recognizes the cultural, historical, social, economic and political context

within which the individual exists. Therefore, empowerment at the community level is connected with empowerment at the individual and organizational levels. A model of empowerment that links all three levels (individual, organizational and community) is regarded as providing the most effective means to collectively provide the support and control necessary to develop needed skills, resources and change.

Social Inclusion and Cohesion

Belonging to a social network of communication and supportive relationships is protective of good health and positive wellbeing (Wilkinson and Marmot 2003). There is a large body of evidence which shows that more socially isolated people have poorer health and increased mortality (Berkman and Glass 2000; Holt-Lunstad et al. 2010; House et al. 1988) and that more socially cohesive societies are healthier and have lower mortality rates (Kawachi 2010). A socially inclusive society may be defined as one where 'all people feel valued, their differences are respected, and their basic needs are met so that they can live in dignity' (VicHealth 2005). Durkheim (1951) was one of the first to propose that a lack of cohesion in society or 'anomie' contributes to negative mental health and is a leading factor influencing rates of suicide. Variations in suicidal behaviour and anti-social behaviour have been linked to the presence or absence of social cohesion (OECD 2001). Among the factors identified as being protective of good health and positive social outcomes are: a culture of co-operation and tolerance between individuals, institutions and diverse groups in society; a sense of belonging to family, one's school, workplace and community and a good network of social relationships (Moodie and Jenkins 2005). Strong social networks are associated with improved health and wellbeing and can act as buffers against everyday stressors (Marmot Review Team 2010). Social contact and support can play a critical role in fostering greater self-confidence, reducing isolation and enhancing community resilience (Friedli 2009).

It is widely recognized that social exclusion damages mental and physical health and contributes significantly to inequities (Wilkinson and Marmot 2003; Commission on Social Determinants of Health 2008; WHO and Calouste Gulbenkian Foundation 2014). A very comprehensive definition of social exclusion has been provided by the WHO (2006), which includes: living in conditions of deprivation and vulnerability, such as poverty; inadequate access to education, health and other services; lack of political influence, civil liberties and human rights; geographic isolation; environmental exposure, racism or historical trauma; disruption of social capital and social isolation; exposure to wars and conflicts, and alienation or powerlessness. Social exclusion can lead to individuals and communities feeling marginalized, fearful and disempowered in their ability to influence decisions and to participate fully in the social, economic, political and cultural systems that affect their lives.

The concept of social capital describes the features of social relationships within a social group or community. Putnam (2001) defines social capital as 'the connections among individuals - social networks and the norms of reciprocity and trustworthiness that arise from them' (p. 19). Social capital is not conceived as an

individual resource but is seen as an ecological characteristic, which emerges from the interactions and shared norms that are inherent in the structure of social relationships and that are external to the individual (Henderson and Whiteford 2003). A distinction is made between different forms of social capital, with bonding social capital referring to trusting and cooperative relationships between members of a community or group who share a common social identity (e.g. based on race, ethnicity or social class), whereas bridging social capital refers to connections between people who do not share a common social identity. Bonding social capital can be associated with the formation of groups based on exclusivity, which can be damaging for those who are not included, while bridging social capital has been found to be more strongly related to improved wellbeing (Kawachi 2010), thereby highlighting the importance of social inclusion.

Research on social capital and inequality indicates the importance of community cohesion such as levels of trust, reciprocity and participation in civic organizations, as important influences on health status. Putnam (2001) indicates that economic inequality and civic inequality are less in areas with higher values of social capital. Similarly, Putnam (2001) reports that in areas with low levels of social capital and high levels of perceived inequality, self-reported wellbeing and levels of happiness are lower. Empirical studies also show that higher levels of income inequality are associated with a higher prevalence of mental disorders (Pickett and Wilkinson 2010; Pickett et al. 2006). Wilkinson (1996) emphasizes the importance of psychosocial pathways in examining the relationship between income inequality, social capital and health and Wilkinson and Pickett (2009) examine how inequalities erode trust in societies and lead to increases in anxiety and illness. In their book *The Sprit Level*, Wilkinson and Pickett (2009) showed that in all countries where information was available, societies with larger income differences have poorer health including: lower life expectancy, higher rates of infant mortality, higher levels of mental ill-health, lower levels of child wellbeing, illicit drug use and obesity. Greater inequality was also found to damage social relationships and be associated with less community cohesion and trust, and more social problems such as violence and homicide rates. In their 2018 book *The Inner Level*, Wilkinson and Pickett elaborate on the psychological impacts of inequality and present data showing how low social status is associated with higher levels of stress, anxiety and depression. They also discuss how the presence of material inequalities and social hierarchies affect mental health through influencing social values, sense of self-worth and how people relate to each other. Friedli (2009) also argues that the experience of inequality is corrosive of good social relations and impacts negatively on people's mental health and their sense of social and emotional wellbeing. In reviewing the relationship between social capital, mental health and inequalities, Whiteford et al. (2005) and Friedli (2009) identify the potential of mental health promotion interventions to enhance social capital and community resilience. For example, community actions designed to build social trust and cohesion and strengthen community networks and increased participation by excluded groups can make an important contribution to promoting community mental health and wellbeing (Friedli 2009; Whiteford et al. 2005; Wilkinson and Pickett 2009).

Supportive Physical Environments

Access to safe, clean and welcoming environments that provide opportunities for interaction with people and nature can foster a sense of belonging and community connectedness, which in turn contribute to promoting positive mental and physical health and wellbeing (Kent and Thompson 2014). Environmental interventions that improve the quality of the built environment, including improving housing and urban regeneration projects which address the psychosocial aspects of deprivation, can also lead to positive mental health impacts (Ellaway et al. 2001; Thomson et al. 2003, 2006; Weich et al. 2002; Whitley et al. 2005). There is a growing body of literature on the relationship between health and place that indicates that access to natural or green spaces and the quality of the built environment have a beneficial impact on mental health (Dalgard and Tambs 1997; Depledge et al. 2011; Ellaway et al. 2001; Weich et al. 2002; Whitley et al. 2005). While a number of studies have identified the features of the environment that are associated with mental health problems such as depression and anxiety, including air pollution, traffic levels, high density living, crime and violence (Echeverria et al. 2008; Gary et al. 2007; Gee and Takeuchi 2004; Latkin and Curry 2003), fewer studies have focused on how improvements to the environment can lead to improvements in mental health and wellbeing. There is a paucity of studies assessing how environmental improvements can lead to positive mental health impacts, especially in low and middle-income countries (LMICs). A systematic review by Turley et al. (2013) reported that slum upgrading programmes involving physical environment and infrastructure interventions (e.g. improvements to water, sanitation, waste management, energy upgrades and transport infrastructure) in LMICs can positively influence the mental and physical health of residents by reducing stress, injury and disease transmission.

Despite a limited evidence base, a number of reviews from high-income countries (HICs) support the association between mental health and aspects of the physical environment, including: high-rise living, graffiti, damp housing, noise, overcrowding, fear of crime and the importance of having a place to meet others and socialize (Clark et al. 2007; Evans et al. 2003). Chu et al. (2004) identified five key environmental domains that can promote a sense of wellbeing: control over the internal environment, quality of housing design and maintenance, presence of valued 'escape facilities' such as access to green spaces and community facilities, absence of crime and fear of crime, and social participation. However, Guite et al. (2006) point out that many studies fail to take account of the influence of socioeconomic deprivation and factors such as type of housing, ethnicity and other sociodemographics on the association between the environment and mental health. In a cross-sectional survey of residents in council properties in Greenwich, London, Guite et al. (2006) reported that both the design and social features of residential areas are important for residents' mental wellbeing and interventions need to address both aspects. The most important factors identified in their study were: neighbour noise, sense of overcrowding in the home, access to green space and

community facilities, and fear of crime. A number of studies indicate that green space can offer a salutogenic and stress-reducing environment, especially in deprived urban communities (Beyer et al. 2014; Roe et al. 2017; Ward Thompson et al. 2016). Mental health impact assessments, such as the Mental Well-being Impact Assessment Toolkit (MIWA) developed in the United Kingdom, can play a useful role in determining the potential of environmental changes in improving population mental health (Cook et al. 2011), including determining the impact of climate change and natural disasters on the mental health of local communities (Ampuero et al. 2015).

As it is estimated that over half of the world's population live in urban environments, urban planning has an important role to play in promoting community mental health and wellbeing. The importance of the health impact of urban planning has been central to the WHO Healthy Cities and Communities initiative, which aims to develop healthy sustainable cities and integrate health considerations into urban planning processes at the local level (Barton et al. 2003). The UN Sustainable Development Goals (UN 2015) bring a clear focus on the importance of creating greener and healthier living environments globally, through, for example, SDG 11 – *Make Cities and Human Settlements Inclusive, Safe, Resilient and Sustainable*. In addition, the Shanghai Declaration (WHO 2016) identified key roles for cities and local authorities in advancing policies that create co-benefits between health and wellbeing and other city policies.

With regard to healthy community design, environmental health planners recommend 'mixed-use design' (Lee and Maheswaran 2011) where land is used for varying purposes from residential use to retail and employment, with connectivity and short distances between places of interest. In a review of the evidence, Brown and Grant (2007) recommend paying attention to the following aspects: green design of roads and transport routes in order to reduce stress for those travelling on them; providing a range of open spaces for people to use including parks, gardens, verges, river banks, trees for shade and shelter and visual interest; balancing soft surfaces and vegetative cover for local air hygiene and temperature control and using nature as an integrated element of planning. Access to green space, community gardens, natural green playgrounds for children have all been found to have a positive influence on mental health and wellbeing (Vaandrager and Kennedy 2017). As outlined in chapter 'Implementing Mental Health Promotion in Primary Care. Inge Petersen', the Green Gyms initiative in the United Kingdom provides an opportunity for local communities to improve their health and local environment through participation in practical gardening and conservation activities, with positive physical, social and mental health benefits for participants. Community gardens have also been found to promote active lifestyles and contribute to healthy diets (van den Berg and Custers 2011). An important aspect of these initiatives is not only the green environment but also the social opportunities afforded for different community groups to connect and network and the empowerment gained through the collaborative group activity and social engagement. Local environ-

ments that facilitate outdoor activities, physical activity, meaningful engagement, socialization with neighbours as well as aesthetic enhancements contribute to better health and wellbeing (Vaandrager and Kennedy 2017).

Virtual Communities

Online platforms and social media that stimulate social connections are increasingly being used to connect communities and share information among 'virtual communities' and are potentially an effective way of reaching hard-to-reach populations. In addition to increasing access to health services through innovative mhealth and ehealth interventions, digital platforms are also being employed to advance the empowerment of disenfranchised communities, including the social participation and economic empowerment of women in low-income countries, as endorsed in the Sustainable Development Goals (UN 2015). The innovative use of apps and social network sites has the potential to transform the delivery of online campaigns, training and education with regard to civic engagement, advancing human rights, gender equity and political participation. With regard to the impact on mental health and wellbeing, the literature on online social networks suggests that empowering and social support processes can take place within online social networks with potential beneficial effects for psychological wellbeing (Batenburg and Das 2015). However, research on Social Networking Sites also shows that using online social platforms can have a negative impact on the wellbeing of young adults leading to negative social comparisons, negative self-perceptions and psychological distress (Haferkamp and Kramer 2011) and a decline in life satisfaction (Kross et al. 2013). On the positive side, the innovative use of online platforms and mobile apps has been applied to strengthen mental resilience and community engagement. For example, the Fit in je Hoofd app was launched in Belgium by the Flemish Institute for Healthy Living (www.fitinjehoodfd.be) and the Place Standard app in Scotland (www.placestandard.scot), developed by the Scottish Government, NHS Scotland and Architecture and Design Scotland was designed to enable increased community engagement between planners and communities to design healthy spaces and places. While online social networks have the potential to reach and connect isolated people and marginalized communities, there is also concern that, due to the digital divide, inequities could be increased rather than decreased. As technical and literacy skills vary greatly between socio-economic and socio-demographic groups, the use of online technologies, including use of dedicated mobile and ehealth technologies, could impact negatively and increase social and health inequities. It is estimated that about half the world's population do not have online access and that issues such as accessibility, affordability, inadequate digital education and lack of digital literacy constitute real barriers to realizing the potential of online technologies for many communities around the world.

Planning the Implementation of Community Mental Health Promotion Interventions

Building on the rationale and principles of community mental health promotion practice, community interventions cannot succeed unless they are adequately planned and implemented. The importance of good planning in implementing mental health promotion interventions has already been outlined in chapters 'Implementation Processes and Strategies for Mental Health Promotion' and 'A Generic Template for Implementing Mental Health Promotion'. These implementation steps are also followed in working in the community setting. Adopting a community planning model or overarching framework for guiding the planning process is strongly recommended. The Five-Stage Community Organization Model by Bracht et al. (1999) provides a useful structured framework for community-based planning and delivery. This model, outlined in Box 1 below, is based on the principles of partnership and empowerment. Employing a theoretical model such as this ensures that the development of the intervention is guided by a systematic framework and allows each stage of the process to be viewed within the context of an overarching structure. This model, which draws on earlier models of community organization practice, proposes five stages, each of which has a number of key elements. Bracht et al. (1999) point out that the stages are in fact overlapping and that community involvement is recommended at all stages. These stages correspond quite closely with those outlined in the generic template for action in chapter 'A Generic Template for Implementing Mental Health Promotion'. The Rural Mental Health Project in Ireland (Barry 2003) applied Bracht's five-stage model in engaging the participation of local communities in planning and implementing a range of interventions designed to improve mental health at the community level. The adoption of a structured planning model is identified as being critical to the successful implementation of complex, multifaceted community-based mental health promotion interventions (Barry 2005).

A community perspective to promoting mental health calls for implementation strategies that will ensure that the desired processes of community engagement and participation take place and that programme outcomes can be achieved. Working at the community level requires skills in collaboration, partnership working and political savvy concerning local power structures. Interventions need to be tailored to the local community setting and have the flexibility to evolve organically in response to local needs, interests, capacities, emerging opportunities and challenges. The WHO Healthy Cities and Communities movement provides many examples of how intersectoral partnerships and community participation are used in mobilizing resources for building healthier and resilient communities (de Leeuw 2009; Heritage and Dooris 2009; Norris 2001). For all these reasons, the implementation of community-based interventions requires an implementation process that will guide effective planning and delivery based on the principles of collaborative working and partner-

Box 1 Model of Community Organization (Bracht et al. 1999)

1. Community Analysis and Assessment

   Define the community.
   Collect data.
   Assess community capacity, barriers and readiness for change.
   Synthesize data and set priorities.

2. Design and Initiation

   Establish a core planning group and select a local organizer or co-ordinator.
   Choose an organizational structure.
   Identify and recruit organization members.
   Define organization's missions and goals.
   Clarify roles and responsibilities of citizen members, staff and volunteers.
   Provide training and recognition.

3. Implementation

   Determine priority intervention activities.
   Develop a sequential work plan.
   Generate broad citizen participation.
   Plan media interventions.
   Obtain resource support.
   Provide a system for intervention monitoring and feedback.

4. Program Maintenance and Consolidation

   Integrate intervention activities into community networks.
   Establish a positive organizational climate.
   Establish an ongoing recruitment plan.
   Acknowledge the work of volunteers.

5. Dissemination and Reassessment

   Update the community analysis.
   Assess the effectiveness of intervention programs.
   Summarize results and chart future directions.

ships, facilitating meaningful community participation and empowerment. Readers are referred to chapter 'Implementation Processes and Strategies for Mental Health Promotion', which outlines core processes in implementing effective intersectoral partnership working.

Plan for Intervention Monitoring and Evaluation for Continuous Improvement

The complexity of multifaceted community interventions presents a particular challenge in terms of evaluation, both in terms of the methodologies applied and the role of the evaluator. Brown (1995) outlines the following challenges for evaluators of comprehensive community initiatives:

- Broad multiple goals dependent on an ongoing process of synergistic change.
- Programmes are purposively flexible and responsive to local needs and conditions.
- The principles of community empowerment, participation and ownership are central to their mission.
- Recognize the nature of longer-term community change requiring longer time frames than more narrowly defined approaches.
- Produce impacts at different levels in different spheres.

Selecting appropriate research designs for comprehensive community initiatives is, therefore, critically important. The following key elements are identified: define interim and long-term outcomes, develop reliable and appropriate indicators of change, select measures/tools for assessing change, and build the capacity of the local community to contribute to the evaluation process. Complex multicomponent community interventions call for equally complex evaluation designs that will focus as much on implementation as on outcomes (Komro et al. 2016). Evaluation approaches also need to assess how interventions strategies are adapted as the community initiative evolves over time to address new and emerging issues in a dynamic and changing environment (Patton 2008). Based on adopting a theory-based evaluation approach, Lafferty and Mahoney (2003) outline some useful recommendations for developing an evaluation plan for a community asset-building initiative. Further details on the methodological issues involved in evaluating community partnerships and comprehensive community initiatives may also be found in the writings of Connell et al. (1995), Henricks Brown et al. (2017) and Komro et al. (2016). The reader is also directed to the resources listed in Box 2 on community intervention evaluation methods.

Process evaluation takes on a particularly important role in the context of multifaceted multilevel community interventions. Comprehensive process evaluation systems are necessary to track the quality of implementation and to ensure adequate documentation of effective processes and activities leading to desired outcomes (Cunningham et al. 2000). As highlighted earlier in this chapter, the formulation of logic models provides a useful opportunity for evaluators and practitioners to share their perspectives and expertise in formulating intervention design and sequential planning. Logic models also provide a useful blueprint for sharing perspectives in monitoring the process of implementation and collaboration, and identifying desired outcomes. The practitioner and/or programme implementer has a key role to play in this process, as data on intervention implementation are collected as

Box 2 Online Community Intervention Evaluation Resources

- The *Action Catalogue* is an online decision support tool that is intended to enable researchers, policymakers and others wanting to conduct inclusive research, to find the method best suited for their specific project needs.
- *CDC Evaluation Resources* provide an extensive list of resources for evaluation, as well as links to key professional associations and key journals.
- *Evaluating Community-Based Initiatives* is a special edition of The Evaluation Exchange, a periodical from the Harvard Graduate School of Education. The issue provides ample information about community initiatives.
- *The Role of Community-Based Participatory Research* is a comprehensive website developed by the US Department of Health and Human Services that is dedicated to providing information on CBPR.

Print Resources

- Barrett, N. F. (2015). *Program evaluation: A step-by-step guide* (revised edition), Springfield, IL: Sunnycrest Press.
- Fawcett, S., Paine, A., Francisco, V., Schultz, J., Richter, P., Lewis, K., … Lopez, M. (1994). *Work group evaluation handbook: evaluating and supporting community initiatives for health and development.* Lawrence, KS: Work Group on Health Promotion and Community Development, University of Kansas.
- Harris, M. (2010). *Evaluating public and community health programs.* San Francisco, CA: Jossey-Bass.
- Potvin, L. and Richard, L. (2001). Evaluating community health promotion programmes. In I. Rootman, M. Goodstadt, B. Hyndman, D. V. McQueen, L. Potvin, J. Springett, E. Ziglo (Eds.), *Evaluation in health promotion: principles and perspectives* (pp. 213–240). WHO Regional Publications, European Series, No. 92. Copenhagen, Denmark: World Health Organization Regional Office for Europe.
- Wholey, J., Hatry, H., Newcomer, K. (2010). *Handbook of practical program evaluation.* San Francisco, CA: Jossey-Bass.

events occur. Using multiple methods, data may be recorded in the form of activity logs, records of meetings, process reports together with critical observations and reflections. This detailing of the intervention in action permits an accurate record of the intervention as it unfolds and plays a crucial role in informing the detection of intermediate level changes that lead to ultimate outcomes. As outlined in chapter ‘Implementation Processes and Strategies for Mental Health Promotion’, use of a theory of change approach and evaluation logic models provides a systematic

framework for intervention monitoring and feedback on intervention activities and impacts, and can be incorporated as an integral part of intervention planning and delivery. Realistic evaluation (Pawson and Tilley 1997) has been identified as a useful framework for evaluating community initiatives as this approach seeks to link the specific context of an initiative with the mechanisms of change, that is, how interventions achieve change over time in specific contexts. At a more general level, Gabriel (2000) points out that in the spirit of a community approach, evaluators must become partners with practitioners and the community in '… adapting their designs, assessment techniques and reporting strategies to fit the local context and needs' (p. 340). This calls for a movement away from traditional evaluation approaches to one characterized by partnership with key players. Participatory evaluation approaches may be used for this purpose, including empowerment evaluation (Cox et al. 2009; Fetterman and Wandersman 2005), community-based participatory research (Minkler 2010), collaborative and utilization-focused evaluation (Patton 2008). Empowerment evaluation emphasizes building the evaluation capacity of individuals and organizations so that evaluation is integrated into the intervention management process. A useful seven-step guide to empowerment evaluation is provided by Cox et al. (2009). Participatory action research approaches may also be employed in order to identify outcome and process goals and objectives that are consistent with the community empowerment concept (Israel et al. 1994). Participatory action research entails involving community members in all aspects of the intervention action and research in a collaborative and reflective process.

Community Implementation Strategies

Implementing Multilevel Community Interventions

The implementation of comprehensive community interventions calls for the use of appropriate implementation models and strategies that will guide the sequencing of intervention delivery and ensure that desired outcomes are achieved. Complex community interventions are typically composed of multiple components that may be planned to be delivered across different levels of the social ecology: at individual, organizational, community and macro-policy level. Interventions at each level may in turn be composed of multiple elements, which may also be linked across levels, with each programme element logically connected to supportive activities at the next level, that is, individual skills building linked to supportive community organization activities. These types of multi-component interventions require an implementation approach that will plot the sequence of events that are needed for effective outcomes to be achieved at each level. The use of a theory of change approach, as previously outlined in chapter 'Implementation Processes and Strategies for Mental Health Promotion', is recommended for such complex interventions. In developing a theory of change, Connell and Kubisch (1998) recommend starting with the

identification of the long-term outcomes and working backward towards needs and resources assessment. Intermediate and short-term outcomes can then be identified, together with input from stakeholders regarding their assumptions about the intervention activities that lead to these outcomes. Logic models can also be helpful in articulating a theory of change as they provide a graphical depiction of the anticipated process and outcomes.

Based on social ecology principles, Goodman (2000) recommends four key strategies for implementation of complex community interventions. These are:

- Developing logic models as a strategy for mapping out complex community-based interventions and providing a framework for collecting data as events occur permitting the accurate monitoring and recording of the intervention as it unfolds. This type of qualitative data forms the basis of a detailed process analysis of intervention implementation.
- Using the logic model as a strategic blueprint for assuring the quality of implementation as planned.
- Staging the implementation of the multiple intervention strategies or elements (as represented in the logic model) sequentially across the different social ecological levels, that is, individual, organization, community and policy levels. Each intervention may require its own staging so that it fully matures.
- Employing strategies that foster the development of community capacities to implement multifaceted interventions and to manage complex exchanges.

An example of such an ecologically oriented multi-component programme is the Midwestern Prevention Project (MMP), a comprehensive intervention designed to prevent adolescents' use of tobacco, alcohol and marijuana (Pentz et al. 1990, 1997). This community-based intervention consists of five elements or components: school-based programme, parent programme, community organization, health policy change, mass media coverage and programming. The intervention project, which runs over a 3–5 year period, integrates demand and supply reduction strategies through the school-based programmes for teaching youth drug resistance skills and community policy change aimed at institutionalizing intervention programming and limiting youth and community access to drugs. Mass media is also used to communicate messages regarding non-drug use, and seeks to bring about changes in health policies and community practices to reduce youth access to targeted substances. Each ecological domain – the school, home, community and policy – is targeted in a specific timeline beginning with the school intervention in the first year and ending with the health policy changes. The policy changes are implemented by parents together with school and community leaders as part of the parent and community organization programmes. A highly structured co-ordinating mechanism was employed to facilitate programme planning and implementation across the different intervention modalities. A detailed process model was used to guide the practical steps taken in planning, implementing and evaluating the different programme elements and Pentz et al. (1997) reported that the process involved continual programme planning even after community acceptance and support of each programme component. The MMP has been shown to be equally effective with both high-risk

and low-risk groups of young people with evaluations showing net reductions of up to 40% in adolescent daily smoking and marijuana use, and similar though smaller reductions in alcohol use, which have been maintained through high school graduation (Pentz et al. 1997). The programme has also demonstrated significant reductions in parent alcohol and marijuana use, and increased positive parent–child communication about drug use. Another example of a highly structured, multilevel community-based programme is Project Northland (Perry et al. 1996, 2002), which addresses youth alcohol use and also illustrates the importance of a systematic planning and implementation process in successfully implementing multifaceted community programmes.

The Communities That Care (CTC) initiative is a comprehensive community-wide system, which aims to provide communities with a framework or operating system to assist them in the focussed planning and implementation of interventions for positive youth development (Hawkins et al. 2002). The CTC system is described by Hawkins (1999) as a research-based system that helps to guide and empower communities in engaging in planning through objectively assessing their own profiles of risk and protection, and choosing and implementing effective strategies to address their unique strengths and needs. This programme has been introduced in over 500 communities in the United States and has also been replicated in Europe and Australia. We will now examine the CTC in more detail.

Practice Example: Communities That Care (Hawkins and Catalano 2002; Hawkins et al. 2002)

The Intervention

Communities that Care (CTC) is a community-based prevention system for mobilizing communities to address adolescent health and behaviour problems, such as substance misuse, youth crime and antisocial behaviour, through a focus on empirically identified risk and protective factors and the implementation of evidence-based interventions (Hawkins and Catalano 2002; Hawkins et al. 2002). CTC provides the community with a structured process for engaging community stakeholders in forming a coalition or community prevention board and a process for developing a shared community vision and action plan based on the selection of tried and tested intervention approaches. The CTC system is manualized and includes training events, guides and structured protocols for community leaders and coalition members. Training and tools are provided for the assessment of community risk and protective factors for youth health, the prioritization of specific risk and protective factors to be addressed (at individual, peer, family, school and community level), and the setting of specific measurable community goals. Based on the community assessments, CTC guides the community coalition in developing a strategic community action plan for the implementation of evidence-based intervention approaches and supports the ongoing monitoring and evaluation of the

implementation of the plan. The interventions are, therefore, tailored to the needs of each community and include services and programmes (e.g. mentoring, family-based or school-based programmes), designed to address multiple risk and protective factors in as many participants as possible. While communities may implement interventions targeting higher-risk youth, CTC emphasizes the delivery of a more universal approach to promoting positive youth development and reducing community-wide problem behaviours for the general population of young people (van Horn et al. 2014).

Collaboration between multiple community actors and sectors is a core element of the theory of change, as CTC seeks to generate greater community participation and ownership in developing evidence-based community approaches to address youth health and behaviour problems. The CTC system brings together a wide range of stakeholders including young people and their families, schools, community leaders, elected officials, law enforcement agents, community agencies and organizations, health professionals, youth services, business community and local residents. The process of building collaborative capacity in communities is based on the Social Development Model (Catalano and Hawkins 1996). This model is an integration of social control theory and social learning theory, and asserts that the most important units of socialization – family, school, peers and community – influence behaviour and youth development sequentially. Therefore, providing youth with opportunities, skills and recognition can strengthen bonding with family, school and community, which in turn motivates young people to adopt healthy and prosocial behaviours. The CTC theory of change suggests that it takes 2–5 years of implementing tested, effective interventions for community-level impact on risk and protective factors to be observed and 4–10 years for community-level impact on problem behaviours such as adolescent substance use, delinquency and violence.

CTC Implementation Stages

The installation of the CTC operating system in communities is supported through a programme of six training events delivered over the course of 6–12 months by certified CTC trainers. The implementation of the CTC system consists of five stages with a series of milestones and benchmarks to guide progress:

- *Phase 1 – Community Readiness Assessment*: Involves defining the community, identifying and gaining the support of community members, leaders and organizations and assessing current capacities and barriers.
- *Phase 2 – Involving the Community:* Local community coordinators and coalition members are trained in the CTC approach including: educating them in community activation processes and engaging in the CTC planning process, choosing an organizational structure to oversee planning and implementation activities, and citizen recruitment to form a community prevention board or coalition. The community coalition is organized to carry out the subsequent stages of the CTC, key roles and responsibilities are defined and members attend a 2-day orientation training.
- *Training in Compiling a Baseline Community Profile:* The community prevention coalition receives training in developing a data-based profile of the

community's strengths and challenges, for example, through a community or school-based survey, including levels of youth problem behaviours and risk and protective factors as well as an inventory of existing community resources. Coalition members participate in a 2-day training event on how to interpret the collected data and prioritize two to five risk factors for prevention action. A 1-day resource assessment training is held to assist coalition members in identifying if existing policies, programmes and services can address the priority areas.

- *Training to Develop a Community Youth Development Plan*: A 2-day training in community planning is held where the results of the community profile and assessments are examined and evidence-based policies and programmes are reviewed. The coalition members define clear measurable outcomes with respect to the prioritized risk and protective factors. Policies, actions and programmes are then selected from a list of tested, effective intervention approaches. An action plan is developed for implementing the selected new interventions and an evaluation plan is put in place to measure progress.
- *Implementation and Evaluation of the Plan*: CTC coalition members receive the Community Plan Implementation Training to develop the skills necessary to implement and monitor the community action plan. The training includes skills in identification of resources to support the plan, clarifying roles, developing good communication and monitoring of progress towards desired outcomes. From years 2–5, technical assistance and training is provided on implementing the selected interventions and the monitoring of progress towards the process and outcome goals. Intervention-specific implementation checklists are completed by the programme providers and 10–15% of programme sessions are observed to ensure high quality implementation. Local media is also engaged at this stage to educate the local community about the new interventions and mobilize their support.

Technical assistance is provided to local CTC coordinators and coalition members in implementing each of the five phases through twice-yearly site visits, weekly phone calls and email support.

Evaluation

The CTC strategies have been applied across diverse communities and have been shown to reduce the initiation of tobacco use, alcohol use, delinquency and violence among a longitudinal panel of students followed from Grades 5–10 in the United States (Hawkins et al. 2009, 2012). Implementation studies show that 18 months after the initial training began, the CTC system was implemented successfully with fidelity in the intervention communities (Quinby et al. 2008), and the selected evidence-based interventions were also well implemented (Fagan et al. 2008). The Community Development Study (CYDS) was the first community randomized trial of the CTC, which was conducted in 24 communities located across seven states in the United States. In this 5 year study, community sties were matched within states and were then randomly assigned to 12 intervention and 12 control communities (Hawkins et al. 2008). From 2003 to 2008 each of the 12 intervention communities

was provided with CTC training and funding for a local coordinator and the costs of implementing selected interventions in years 2–5. To test the effects of CTC in achieving change in delinquent behaviour and substance use, intervention communities were asked to focus on interventions for young people aged 10–14 years (Grades 5–9) and their families. The study shows that the priority risk factors and interventions differed between intervention communities, with 13 different interventions being implemented during 2003–2004 and 16 programmes implemented during the 2005–2006 school year. An average of three programmes covering school, family and community-based interventions were implemented in each community (e.g. Life Skills Training, All Stars, Lions Quest Skills for Adolescents, Big Brothers Big Sisters, and Strengthening Families). Data from a panel of 4407 Grade 5 students were collected annually from 2004 to 2009 until they reached Grade 12, assessing levels of adolescent drug use and delinquent and violent behaviour. One and half years after implementation of the CTC programmes, evaluation findings showed significant positive effects on delinquent behaviours with mean levels of targeted risks significantly lower in CTC communities compared with control communities (Hawkins et al. 2008) and significantly fewer were initiating delinquent behaviour between Grades 5 and 6 in CTC communities. No significant effects on substance use initiation were observed.

At 3 years follow-up, however, significant positive effects were also reported on the incidences of initiation of alcohol, cigarette and smokeless tobacco use and the start of delinquent behaviour (Hawkins et al. 2009). The prevalence of alcohol and smokeless tobacco use in the last 30 days, binge drinking in the last 2 weeks and delinquent behaviours in the last year were significantly lower among young people in the CTC communities. Significant effects were also found at 6 years follow-up (i.e. 1 year after study-provided resources for CTC installation were withdrawn), on the incidence of delinquent behaviour, alcohol use and cigarette use, and the prevalence of current cigarette use and past-year delinquent and violent behaviour in CTC communities (Hawkins et al. 2012). At 8 years follow-up, CTC participants at 12th Grade (aged 17–18 years) were also found to be more likely to have abstained from any drug use, drinking alcohol, smoking cigarettes and engaging in delinquency and violent behaviour compared to controls (Hawkins et al. 2014). There were, however, no significant differences between the groups in the prevalence of past-month or past-year substance use or past-year delinquency or violence. Oesterle et al. (2015) reported a significant gender effect at age 19 years with males in CTC communities significantly more likely than males in control communities to have abstained from any delinquent behaviour and from using cigarettes. Van Horn et al. (2014) examined the specific effects of CTC for young people with different profiles of problem behaviours. Using cross-sectional samples of 8–10th Grade students collected 6 years apart (in 2000 before the CTC interventions were implemented and in 2010, 2 years following external support to CTC communities was withdrawn) the study found a significant reduction in the likelihood of young people being an alcohol user in CTC communities but no intervention effects were found on the probability of being an experimenter with substance use for either grade. Significant positive effects were also reported for protective factors, including

opportunities and recognition for prosocial involvement and attachment, prosocial skills, healthy beliefs and clear standards, at community, school and peer/individual domains, but not on family domain (Kim et al. 2015).

While the positive effects of CTC were demonstrated using a longitudinal panel from the community randomized trial, as described above, similar effects on problem behaviours were not reported from an evaluation study by Rhew et al. (2016) using a repeated cross-sectional design in the same sample. A cluster randomized control trial (RCT) study was also conducted with 20 communities in Australia to examine the impact of CTC on alcohol use and alcohol-related crime in rural communities (Shakeshaft et al. 2014). This study reported significant reductions in the reporting of average weekly alcohol consumption and experience of alcohol-related verbal abuse in CTC communities at post-intervention, however, the evaluation found little evidence that CTC had reduced risky alcohol consumption and alcohol-related harm. The study authors concluded that legislative action may be required to reduce alcohol harm more effectively at a community wide level.

A cost–benefit analysis study (Kuklinski et al. 2015) reported that the net value of CTC 5 years from implementation was positive, ranging from USD 1.749 to USD 3.920 per young person. The cost–benefit ratio varied between USD 4.23 and USD 8.22 per dollar invested, indicating a significant economic return to society from CTC's impact on reducing delinquency, underage drinking and tobacco use initiation in young people at a community-wide level.

Recommendations for Replication

Hawkins (1999) reported that with adequate training, communities could effectively use the CTC in assessing their own profiles of risk and protection, and improve inter-agency collaboration, reduce duplication of services, co-ordinate allocation of resources, strategically target prevention activities to priority areas, increase use of research-based approaches and increase professional and community involvement. Analysis of the differences between the CTC and control communities showed that the CTC sites were more likely to adopt evidence-based interventions and to have greater levels of community collaboration 18 months after introducing CTC (Brown et al. 2007).

To date, the CTC has been implemented in a number of countries outside the United States including, Australia, Canada, Croatia, Germany, the Netherlands and the United Kingdom (Crow et al. 2004). A study by Burkhart (2013) examined the feasibility of implementing CTC in the European context. Based on reports from implementation of the CTC system in Europe, they commented on the need to take into account socio-cultural differences in how the concept of community is understood in different country contexts, and that it may, therefore, be necessary to consult with communities over a longer period than envisaged in the original CTC system. They also referred to the fact that evidence-based prevention programmes may not be as readily available outside of the US context. The European Monitoring Centre for Drugs and Drug Prevention (2017) identifies CTC as a promising approach but highlights the need for further evaluation of its effectiveness in the European context.

The CTC system is available for dissemination and has been placed in the public domain by Substance Abuse and Mental Health Services Administration in the United States. A menu of tested evidence-based interventions for 10–14 year olds included in the Communities That Care Prevention Strategies Guide is available at http://ncadi.samhsa.gov/features/ctc/resources.aspx and the Communities That Care PLUS website (www.communitiesthatcare.net) provides further details on getting started and access to digital tools and online workshops and support. A system for training new CTC trainers and technical assistance providers is offered to agencies and organizations that wish to build capacity to provide CTC to communities.

Further details of the training and other materials may also be accessed from the Blueprints for Healthy Youth Development website at: http://www.blueprintsprograms.com/factsheet/communities-that-care.

Conclusions

While it is acknowledged that there is no one best way of implementing community interventions, on the basis of the reviewed literature, a number of critical factors and conditions are identified that are needed to succeed. These key principles are now summarized.

Clarifying Boundaries of the Community

As there are many different definitions and meanings of the term ‘community’, ranging from community as a place or geographically based to communities of shared interest or social and cultural identity, clarity about community boundaries or sense of community is critical to effective intervention planning and development. Communities are complex and dynamic as they may be made up of unconnected people who have little sense of communality or shared identity or may be composed of numerous smaller communities. The initial task may be, therefore, to identify the appropriate unit of practice be that social group, neighbourhood or regional level.

Determining Community Readiness

Community readiness may have a particular significance when addressing mental health promotion as communities may not feel empowered or willing to take on interventions promoting positive mental health for groups in the community. It is, therefore, important not to rush into intervention planning and implementation in advance of determining the degree of readiness in the community to engage with mental health issues locally. As Wolff (2001) points out, the most successful community coalitions take time to establish relationships, personally visit the key local players and build strong personal links and support in order to engage effectively with, and mobilize the community.

Creating Clear Structures

The key feature of effective community-based interventions is successful collaborative working (Foster-Fishman et al. 2001; Wolff 2001). Structures for planning and delivery will vary between interventions but an agreed organizational structure is critical to effective community-based interventions. Clear lines of communication are important and can be enhanced, for example, by detailed minutes of planning, review sessions, clearly defined roles and expectations and a good flow of information. Successful community coalitions and partnerships are characterized by shared decision-making and a collaborative style of leadership, expanding leadership among members and delegating responsibility rather than relying on a single charismatic person.

Generating Community Participation

The active involvement of community members and representatives enables community interventions to be more responsive and understanding of local needs. Community participation also enhances acceptance for an initiative within a community and can lead to individual and community empowerment through building capacity locally, and enhancing control of the local environment. New members may need to be recruited as the intervention develops and there is an ongoing need to build trust and positive relationships between diverse groups of people around a shared goal. It is crucial to demonstrate that desired outcomes can be achieved, and clearly sequenced action plans and implementation teams, can all foster the translation of plans into action.

Translating Plans into Action

The importance of moving beyond the consultation and planning stages into concrete action is critical for success. Developing written action plans and realistic work plans, including measurable indicators of success, are important steps in translating key project aims and objectives into action. Feedback on the success and impact of intervention activities through process and interim evaluations can play an important role in motivating action or indeed changing the focus and direction of action. Action plans may need to be regularly reviewed in the light of evaluation findings and feedback from participants. Disseminating successes and media publicity of achievements play an important part in enhancing the motivation for change, increasing the visibility of the intervention and consolidating its role in the community.

Technical Assistance

The planning and implementation of community interventions is a highly complex task requiring a range of skills and expertise that may not be readily available within the community. In recognition of this, external technical assistance may need to be provided in assisting with planning, conducting needs assessment, designing strategies, facilitating partnership group processes, managing conflicts, dealing with start-up and sustainability and intervention evaluation.

Developing Core Competencies and Capacities
Ongoing training and support in developing a range of skills is critical to the functioning of working community partnerships. Skills in communication, leadership, management, facilitation and evaluation are all examples of core capacities from which community intervention projects can benefit. In this way sustainability will be ensured in terms of strengthening resources from within the community project team.

Sustaining Community Programmes
Planning for sustainability should begin early in the life of a community-based intervention and not in the last year of funding. Long-range plans for receiving ongoing support should be developed, including concrete funding goals and strategies for a diversified, broad and stable funding base. It may be useful to develop a timeline for seeking additional funds identifying possible sources and when they become available. The success of the sustainability plan should be regularly reviewed. Intervention integration with other service providers may also be considered along with support in-kind, volunteer engagement and so on. If an intervention does have to be ended then it is important that this also should be planned, signalled well in advance and carried out with sensitivity and due regard for the community members and organizations involved.

Comprehensive Evaluation
The complexity of multifaceted community interventions calls for equally complex and comprehensive evaluation study designs, incorporating the rigorous use of a range of methodological approaches to assess the relationship between intervention processes and outcomes. Gabriel (2000) argues that the traditionally detached and external role of the evaluator does not meet the needs of dynamic community interventions. This may be especially the case for interventions employing a community development or empowerment model. Partnership between the evaluator and the intervention community will enable the evaluator to have a better understanding of the actualities of the intervention activities and leads to a better-informed assessment of intervention processes and outcomes. The use of theory of change and logic models are recommended by a number of community researchers in order to articulate the critical connections between local community needs, the partnership/intervention activities and intended intermediate and long-term outcomes, thereby providing an effective blueprint for process and outcome evaluation. Participatory evaluation approaches, including empowerment evaluation and utilization-focused evaluation approaches, may also be employed in order to identify outcome and process goals and objectives that are consistent with the community empowerment concept. These community-based participatory research approaches enable the involvement of community members in the intervention research in a collaborative and reflective process and emphasize building the evaluation capacity of individuals and organizations as an integral part of the intervention process.

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Implementing Community-Based Mental Health Promotion Strategies

Margaret M. Barry

Introduction

In this chapter, we examine intervention strategies and methods for translating the key principles of community mental health promotion into action. In particular, we will focus on the following approaches:

- Implementing multilevel community interventions based on collaborative partnerships.
- Strengthening community participation and social networks.
- Facilitating community empowerment.
- Implementing peer support strategies.

A range of different implementation strategies are presented that may be applied with diverse groups in the community setting. Case studies and best practice examples illustrating the practical implementation of community interventions employing these different strategies are used to guide the reader in applying the research and theory to practice.

Community-Based Interventions Based on Collaborative Partnerships

Community-based approaches that build on the strengths and assets of the local community help to create a sense of ownership and empowerment among community members, especially those who are disadvantaged or marginalized.

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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Collaborative approaches involve community members, families and local services working together in identifying local needs, planning, implementing and evaluating community interventions. O'Mara-Eves et al. (2013) describe a continuum of community engagement approaches ranging from consultation in determining local priority needs, through to community involvement in the design and planning of interventions and direct involvement in intervention delivery. Engaging community members as partners in the design and delivery of interventions is based on the understanding that involving communities will result in interventions that are better matched to local needs and resources and will have a better ecological fit with the sociocultural environment in which they will be delivered. For example, a community action model is employed by the Healthy Communities Collaborative in the UK to reduce health inequalities by creating new partnerships across agencies and with residents in some of the most deprived communities in England and Scotland (Slater et al. 2008). Collaborative partnerships are particularly important when working in low-resource settings, where intervention delivery needs to be tailored to local resources and conditions. In many low-income community settings, there may be a paucity of health professionals and directly engaging community members in the delivery of interventions may be the most feasible and sustainable form of delivery.

Community-based interventions, which aim to strengthen family systems, skills development and access to supports and services, have been found to lead to positive outcomes for both parents and young people. The Strengthening Families programme, which has been widely replicated in community settings across diverse cultures, has been found to lead to positive benefits for mental health and substance misuse (Spoth et al. 2004; Trudeau et al. 2007). The Familias Fuertes intervention is an adapted version of the Strengthening Families programme, which has been implemented with adolescents and parents in Honduras, where it has also lead to a reduction of drug use in adolescents and family members, improved emotional functioning and improved parenting behaviour (Vasquez et al. 2010). Balaji et al. (2011) also report that a multicomponent community-based youth health intervention in India, based on active community involvement in programme planning, resulted in significant improvements in participants' depression scores, reported levels of suicidal behaviour, and knowledge and attitudes about mental health.

The Collaborative HIV Prevention and Adolescent Mental Health Program (CHAMP) and Stepping Stones are examples of community-based interventions involving community partnerships that address HIV prevention by strengthening family relationships as well as peer influences through enhancing social and emotional skills development (e.g., problem-solving and peer negotiation skills). The Stepping Stones intervention is a participatory HIV prevention programme that aims to improve sexual health through building stronger, more gender equitable relationships (Jewkes et al. 2008). The programme is designed for males and females aged 15–26 and is delivered to single sex groups over the course of six to eight weeks (50 h). Programme facilitators are the same age as participants and receive three weeks of programme training. Evaluations of the Stepping Stones intervention

show a reduction in known risk factors for HIV in young men and women and improvements in the levels of sexual violence and substance misuse among males (Jewkes et al. 2008). The CHAMP HIV prevention programme seeks to strengthen family relationships as well as targeting peer influences (Bell et al. 2008). A key feature of CHAMP is the high level of intensive community involvement in designing interventions that are culturally and contextually relevant and that can overcome barriers within targeted communities. Community caregivers are trained as facilitators to deliver the intervention. Initially focussed on vulnerable youth and their families in the US, CHAMP has been replicated in multiple international settings. The results from evaluations of this multilevel intervention indicate that the programme has a direct impact on caregivers' relationship with their children, reduces adolescent and family drug use, and improves HIV transmission knowledge (Bell et al. 2008; Bhana et al. 2010).

Collectively, these interventions illustrate the effectiveness of engaging local community members in intervention planning and delivery with local community caregivers and peers successfully delivering interventions tailored for local community needs. The adaptation of the US-developed CHAMP intervention in South Africa is illustrated in the case study below. The involvement of community members in every aspect of the CHAMPSA programme from the design of the intervention, to pilot testing, delivery and research improves the relevance and acceptability of this intervention to families in underserved communities, with important implications for intervention sustainability and scaling-up.

Case Study: CHAMP (Collaborative HIV Adolescent Mental Health Program)

Arvin Bhana
Health Systems Research Unit, South African Medical Research Council;
Centre for Rural Health, College of Health Sciences,
University of KwaZulu-Natal, Durban, South Africa

Inge Petersen
Centre for Rural Health, College of Health Sciences,
University of KwaZulu-Natal, Durban, South Africa

Mary McKay
Brown School, Washington University in St Louis, St Louis, MO, USA

Claude Mellins
HIV Center for Clinical and Behavioral Studies, Mailman School of Public Health, Columbia University, New York, NY, USA

Carl C. Bell
Clinical Psychiatrist Emeritus, Department of Psychiatry, University of Illinois at Chicago, Chicago, IL, USA

Background

The Collaborative HIV/AIDS Adolescent Mental Health Program (CHAMP) is a developmentally timed family strengthening intervention targeted to pre-adolescent children and their caregivers. This intervention aims to strengthen caregiver–child connectedness and communication, as well as promote active caregiver monitoring, as these serve as protective factors against risk behaviour in adolescents. The intervention is informed by the Triadic Theory of Influence (TTI), an ecological theory of youth risk. The TTI emphasizes two dimensions: levels of causation (proximal, distal and ultimate) and cultural/environmental, social situational and biological/personality streams of influence (Bell et al. 2007; Bhana et al. 2010). Subsequent adaptations of the CHAMP intervention have used Social Action Theory (SAT), which references developmentally driven self-regulatory and social interaction processes and the mechanisms by which these variables foster adaptive health behaviours (Ewart 1991).

Two distinct phases characterize the adaptation of the US CHAMP for the South African context. The first phase of adapting the US-based programme was informed by a focused ethnographic study (Paruk et al. 2005, 2009), which identified several key issues that were hindering effective parenting in low-income, scarce-resource black South African communities at a time when stigmatizing attitudes and misconceptions about HIV transmission were common. Caregivers of youth complained of being disempowered as a function of the erosion of traditional norms and social practices associated with positive parenting and an overemphasis on the rights of the child. In addition, the changing social and political landscape created mistrust and the erosion of social networks (Paruk et al. 2005). The original CHAMP programme was adapted to include a session on parental and adolescent rights and responsibilities to address parental disempowerment in addition to improving self-esteem and self-efficacy skills in relation to assertive and refusal skills among adolescents, improving family processes such as strengthening communication between youth and parents, and enhancing peer social networks.

The sessions and the order of the sessions was established through a consultative process involving key stakeholders delivering services to the community in question. The content of the sessions was then mapped onto a storyline and cartoon representation of events and circumstances that reflected the topic focus. The cartoons assisted in containing anxiety by providing distance from the actual topic. Each of the ten sessions followed a format of reviewing the previous session (and homework assignments), a review of the session objectives followed by separate parallel sessions for parents and children, and then a critical family discussion of the topic. The sessions were ended with homework assignments. The sessions were delivered on a weekly basis, but could be modified to be delivered over a longer period (Bhana et al. 2004). The second phase of adaptation employed a pilot study with process evaluation interviews at the beginning and end of each session in the pilot study to understand the processes involved in the changes in behaviour, as well as to ensure authenticity and usefulness of the cartoon storyline, and the

appropriateness and usefulness of the exercises and homework tasks. On the basis of the pilot study, text and drawings were significantly altered to accommodate the participants' critiques (Bhana et al. 2004; Petersen et al. 2006).

The Intervention

The CHAMP family-based intervention is comprised of ten sessions (see Table 1) delivered through multiple family sessions and parent/child group sessions over weekends in community facilities (schools), using trained parent facilitators who were selected from amongst parents who had attended the programme. The training of facilitators involved a week-long training workshop as well as weekly training and debriefing sessions that were run by psychologists. Each session is oriented around a coherent story line formatted into cartoons with characters with whom community members are easily able to identify. Participants were required to close the session narratives through discussion exercises promoting critical awareness and renegotiation of social representations and practices (Petersen et al. 2006) (see Table 1).

Evaluation

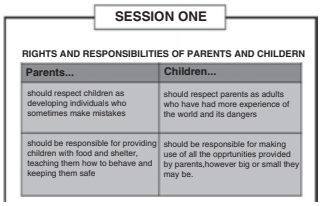
In South Africa, evaluation of the CHAMP intervention delivered to 245 caregivers and 281 children (233 caregivers and 298 controls) showed enhanced knowledge of HIV and its transmission in the intervention group and lower externalizing stigma compared to controls. Caregivers also expressed greater comfort and frequency in communicating with their children (Bell et al. 2008). In US-based studies, caregivers demonstrated better coping with youth emotional difficulties, conduct problems and impairment, family decision-making and communication, parental monitoring, comfort related to family communication. Youth also had better HIV treatment knowledge and support by parents for medication adherence and reduced exposure to situations of sexual possibility (McKay et al. 2004).

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

- The use of a focussed ethnographic study was vital to understanding local contexts in adapting the US-based content of how local communities deal with perceived risk.
- Given the varying levels of literacy among caregivers, and the need to facilitate small group participatory experiential learning, participatory graphic narrative (cartoon strip) and micro-media elements were introduced to engage participants.

Table 1 CHAMP sessions: aims and content

Session name		Session aim	Primary content
1	Children's and parents' rights	Helping disempowered parents understand their rights and responsibilities	Disrespectful scenes between son/daughter and parents; focus on rights and responsibilities of parents and children 
2	Parenting styles	Understanding different parenting styles and its impact on relationship with their child	Parental responses to: boy tempted by drug-using friends and girl who wishes to attend a dance. Focus on four styles of parenting: Rejecting/neglecting, authoritarian, permissive; democratic/balanced 
3	Talking and listening	Enhancing communication between parents and children focusing on passive, aggressive, manipulative and assertive forms of communication	Scenarios around dating, negative peer pressure and cheating on homework sets up need for specific types of communication between parents, and between parents and children emphasizing both talking and listening

(continued)

Table 1 (continued)

Session name		Session aim	Primary content
4	Puberty	Explain changes that children go through during puberty	Physical and emotional changes in boys and girls illustrated through scenes reflecting interest, awareness (and fearfulness) of changes by parents and children. Focus on cognitive, social, emotional and spiritual elements 
5	Getting to know you/ hard to tell stuff	Topics that are difficult to talk about (sex, drug and alcohol use)	Physical maturation related to puberty, interest in the opposite sex, interest in drugs and alcohol scenarios, including scenes of inappropriate sexual behaviour
6	Identifying risk	Reducing children's exposure to negative contexts	Developing strategies to deal with risky environments and situations by identifying what may be risky contexts involving a neighbourhood mapping exercise

(continued)

Table 1 (continued)

Session name		Session aim	Primary content
7	HIV/AIDS	Have a sound understanding of HIV/AIDS and its transmission	Myths, stigma and information about HIV/AIDS and its transmission told through metaphor of invaders (HIV) seeking to invade a castle (body) and ways in which to protect against HIV and AIDS 
8	Stigma	Awareness of stigma and discrimination of people with HIV/AIDS	Family is challenged to help a poor family with a mother known to be infected with HIV/AIDS. Experience of discrimination highlighted by exercise that reflects on excluding participants using beads of various colours 

(continued)

Table 1 (continued)

Session name		Session aim	Primary content
9	Surviving loss and bereavement	Raise awareness of reactions and responses to loss and coping with such loss by adults and children	A mother dies and support and help from neighbours and friends is emphasized. Ways of coping with loss including a memory box is suggested
10	Support networks	Understand the role of support networks	Scenarios involving reaching out to others (family and friends) to seek support and advice is presented for discussion

The innovation takes the form of a series of ten illustrated booklets containing a sequential cartoon narrative in which cartoon characters form part of a coherent story line (Petersen et al. 2006).

- Trained parent facilitators at the early pilot stages of CHAMP facilitated successful transition into the field. The caregivers were usually from the community, spoke the same language at a level that everyone understood and empowered caregivers both as women and as parents (Paruk et al. 2009).
- CHAMP in both the US and South Africa advocated strong community involvement at all stages of implementation. CHAMP's successful involvement of the community was established through community partnerships in the form of a Community Advisory Board (CAB). Regular meetings with the CAB ensured that communities were kept informed, but also became an important part of problems solving through ensuring risky contexts such as taverns and liquor outlets were better monitored or policed or even shut down if they were perceived to contribute to a negative environment in general and risky context for adolescents specifically.

Implementation Challenges and Experiences that Arose in the Course of Delivery

- The lack of involvement of fathers or male caregivers proved challenging. Some of the reluctance associated with participation in CHAMP is related to stereotypical attitudes and perceptions that raising children is 'women's work'. Homework assignments were used to reach other family members. While there are strong cultural factors that mitigate against men's involvement, future interventions could examine ways in which men could participate in sessions that specifically focus on men's relationships with their children.
- A key issue is the sustainability of the intervention as it requires multiple sessions over an extended period of time. This could be addressed by creating an intervention that is modular with essential core elements and additional modules that focus on specific issues. Elements that promote adaptive behaviour through enhancing self-efficacy, self-esteem and communication and awareness may be core elements with other modules added dependent on the need.
- CHAMP is resource intensive, especially in rural contexts where distances are significant, and without adequate provision of transport many are unable to participate on a regular or ongoing basis.

Key Recommendations for Replication

- Given the burgeoning problem of HIV-positive adolescents and associated risks for engaging in high-risk behaviour, CHAMP has been adapted for HIV-positive adolescents and their families. This adaptation is called the VUKA programme, and uses the same methodology and implementation strategies as that of CHAMP (Bhana et al. 2014, 2016; Petersen et al. 2010). The VUKA programme targets a highly vulnerable group of perinatally infected HIV adolescents with the objective of strengthening adherence to medication, communication about sensitive topics, improved self-concept and self-efficacy and future orientation and improved social support with parental monitoring underpinning a task-sharing model of delivery in a public health setting (Bhana et al. 2014).

Future Directions for Application of the Intervention

- Given the resource intensive nature of the CHAMP programme, efforts are afoot to develop a scaled down version of CHAMP (VUKA_Ekhaya). VUKA_Ekhaya uses a structured basis to expose HIV-positive adolescents and their caregivers to the core elements of the intervention in three sessions. These include: promoting self-regulatory mechanisms that enhance adaptive behaviour (dealing with loss and bereavement; internalized and external stigma and disclosure); developing self-efficacy skills in managing HIV transmission and treatment adherence and negotiating risky situations; and social interactions that focus on identity and coping, communication, supervision and social support (mediated through parental monitoring). Additional support in the form of take-home booklets for parents and adolescents is also provided as well as associated electronic text messages.
- The CHAMP/VUKA programmes provide a template for addressing a wide range of mental health concerns and could be modified as a school-based intervention to broadly address adolescent mental health concerns through raising mental health awareness and literacy (reducing stigma), self-regulation processes (self-efficacy) and enhancing social regulation factors such as family support, supervision and involvement. Improving mental health literacy may assist in reducing stigma and improved opportunities for early identification and referral.

Strengthening Community Participation and Social Networks

Strengthening community networks increases social support and social inclusion, giving people a greater sense of agency and control over their lives, which in turn impacts positively on their mental health and well-being. The mental health benefits of community participation, including activities such as arts, drama, physical activity, sports and culture, have been recognized both for the general population and for people with a mental disorder who may experience higher levels of social exclusion due to prejudice and stigma. Moodie and Jenkins (2005) report on a number of

initiatives, such as Arts on Prescription in the UK, the Women's Circus in Melbourne for survivors of physical and sexual abuse, and the Victorian Health Foundation's Sport and Active recreation programme, all of which promote self-esteem, identity, strengthen communities and social inclusion. Community-based arts activities can make a significant contribution to community health, fostering social cohesion and sense of belonging through collaborative and participatory processes (Rowling and Taylor 2005). Art in this context refers to a wide range of creative activities including painting, sculpture, photography, music, poetry, drama, dance and other performance arts, and is distinct from art therapy, a professional discipline with a long tradition as a psychological therapy. Through involvement in community arts activity, participants have been shown to develop supportive social networks and report increased feelings of self-esteem and well-being. Arts and creativity are seen as a means to empower communities, explore and affirm identity, strengthen social cohesion and challenge the stigma attached to mental ill-health (Callard and Friedli 2005). The more participatory forms of community arts, where community groups determine their own process, are being incorporated into health promotion and community development strategies (Rowling and Taylor 2005). In a review of 60 community-based arts projects, Matarasso (as cited in Mentality 2003) found that participation in these projects brought a wide range of benefits, including increased confidence, community empowerment, self-determination, improved local image and identity and greater social cohesion. In spite of some encouraging findings, much existing evaluation is based on qualitative or small-scale studies examining short-term or intermediate outcomes, which fail to identify arts specific aspects of the programmes. The increasing recognition of the value of art and creative expression as a resource for the whole community calls for more robust evaluation of the impact of participation in the arts on mental health and well-being.

There are a number of innovative community-based youth interventions, involving a wide range of activities including creative arts, sports, outdoor and adventure activities, and engagement in community and social action projects, which have been shown to lead to improvements in social and emotional skills, self-esteem and self-efficacy, quality of peer and adult relationships, academic achievement and problem behaviours (Barry et al. 2018; Bungay and Vella-Burrows 2013; Clarke et al. 2015; Catalano et al. 2004; Durlak et al. 2010; Lubans et al. 2012). Bungay Vella-Burrows (2013) conducted a rapid review of the literature, the majority of which were conducted in the UK, examining the effect of participating in music, drama, singing and visual arts on the health and well-being of children aged 11–18 years. Despite the limitations of the studies, it was found that participating in creative activities can have a positive effect on young people's behavioural changes, self-confidence, self-esteem, levels of knowledge and physical activities. While there is a relatively limited evidence-base concerning the effectiveness of these approaches outside of the US, the potential of these interventions to lead to positive outcomes for disadvantaged and socially excluded young people have been highlighted as warranting further investigation (Barry et al. 2018; Farahmand et al. 2012; Kremer et al. 2015). The majority of these community interventions are delivered to young people identified as being at risk of developing social, emotional behavioural problems and/or engaging in risk behaviours.

Community Youth Interventions

Existing studies endorse the importance of a number of implementation features for successful community youth interventions; these include the adoption of a structured approach to delivery with specific and well-defined goals, a focus on skill enhancement, a direct and explicit focus on desired outcomes, the provision of training and implementation over a longer period of time (Catalano et al. 2004; Clarke et al. 2015; Durlak et al. 2010). Examples of youth community interventions that have been scaled up at a country level include Project K in New Zealand and Youth Social Action interventions in the UK. Project K is a youth development programme for adolescents with low self-efficacy, which combines a wilderness adventure, community service and an individual mentoring partnership with a trained mentor. Delivered over a 14 month period, evaluations have reported significant improvements in participants' sense of efficacy (Deane et al. 2017) and positive effects on self-efficacy, resilience and well-being (Furness et al. 2017). Youth social action interventions focus on supporting young people to lead projects in their communities through building their skills in community engagement, youth volunteering, leadership, social and emotional development (confidence, self-awareness, communication, empathy etc.). The Youth Social Action Trials in the UK were implemented in areas of deprivation and involved multiple components, including residential retreats, structured training, coaching and delivering social action campaigns. An randomised controlled trial (RCT) evaluation by Gorard et al. (2016) reported positive outcomes from youth social action projects involving the uniformed organizations, including improved confidence, teamwork and civic engagement for participating young people. The National Citizen Service is a major youth social action project involving thousands of young people in local communities across the UK. A quasi-experimental evaluation by Booth et al. (2014) reported improvements in young people's well-being, problem-solving skills, trust in others, leadership, social competence, communication skills and greater community engagement, education and career aspirations. In view of the growing interest in community-based interventions to support young people's social and emotional development, in particular those at risk, further evaluation of these interventions using more robust evaluation methods and long-term follow-up assessments is warranted.

Social Inclusion Interventions for Adults

There is a limited evidence base on community interventions designed to promote social inclusion and strengthen social networks for adults in the general population. A number of studies, however, can be found in relation to interventions for older people, including volunteering and befriending. Volunteering includes a range of activities in which time is given freely to benefit another person, group or organization, and befriending usually involves a supportive relationship offered to vulnerable people who find living in their community difficult. A meta-analysis by Jenkinson et al.

(2013) reported a positive relationship between volunteering and health outcomes such as mental well-being and self-rated health. A meta-analysis of volunteering by older adults also supports an impact on reducing the risk of mortality (Okun et al. 2013). Seymour and Gale (2004) report evidence in support of a range of interventions for older people that focus on risk factors such as isolation and loneliness, and on protective factors such as meaningful activity and social support. Based on a systematic review of 30 studies (RCTs and non-randomized controlled trials) that evaluated the effectiveness of health promotion interventions to address social isolation and loneliness among older people, Cattan et al. (2005) found that some ten intervention trials were judged effective, with nine of the ten being group activities with educational or support input. Programmes that enable older people to be involved in planning and delivering activities were found most likely to be effective. There is some review level evidence to suggest that volunteering undertaken by older people improves the quality of life of those who volunteer, with those participating in face-to-face direct volunteering achieving the greatest benefit compared with those involved in indirect, less formal helping roles (Butler 2006; Rabiner et al. 2003; Wheeler et al. 1998; Windle et al. 2008). Tabassum et al. (2016) analysed data from the longitudinal British Household Panel survey to examine the association of volunteering with mental well-being across the life course. They found that the association varied by age, becoming apparent over the age of 40 years and continuing up to old age.

A community-based initiative addressing social inclusion for men is the international Men's Shed movement. Men's Sheds in Australia originated in the 1990s and were designed as a community extension of the backyard shed, where men would go to carry out practical and useful tasks, learning and passing on skills. Men's Sheds were conceived as a way of encouraging social activities and friendships among older and more isolated men, while providing a setting for informal learning and promoting the health and well-being of their members. Men's Sheds are run by committed volunteers with the input of members. Surveys of Men's Sheds in Australia show that members are usually comprised of older, retired, less educated men from lower socioeconomic backgrounds (Golding et al. 2007; Misan et al. 2017). Although health benefits are not amongst the main motivations for attendance, Men's Sheds provide a platform for promoting health programmes for men who typically may not engage with the health services. Health interventions include organized health checks, the distribution of leaflets and information and health talks. Indirect health interventions include members 'looking out' for one another, the recognition of symptoms and mutual advice. Peer advice is seen as being relevant, believable, understandable and endorsed by men in Men's Sheds. A quasi-experimental evaluation of the benefits of Men's Sheds on the physical and mental well-being of their members was examined in a study by Flood and Blair (2013). They reported that Shed membership was related to health with Shed members scoring significantly higher on physical functioning, physical roles, general health, vitality, mental health and mental well-being than non-Shed members. Shed members were found to be significantly more likely to seek help if they were experiencing depression or anxiety than the non-Shed group and mental well-being was found to increase with length of Shed membership. Through providing a supportive and socially inclusive environment, Men's Sheds show potential as a community setting for promoting men's mental health and well-being.

Next, we showcase a community intervention developed in Australia that encourages community members to be active in ways that increase their sense of belonging to the communities in which they live and to promote their mental health and well-being.

Case Study: Act-Belong-Commit

Julia Anwar-McHenry
Curtin University
Bentley, WA, Australia

Rob Donovan
University of Western Australia
Nedlands, WA, Australia

Background

Act-Belong-Commit is a population-wide, comprehensive, community-based mental health promotion campaign designed to enhance mental health and prevent mental ill-health (Donovan et al. 2006). While there are school and worksite interventions that aim at building positive mental health, past and current community-wide campaigns dealing with mental health tend to focus on issues related to mental ill-health, such as increasing awareness about mental disorders, providing education on stress reduction and coping strategies, encouraging help-seeking, early detection and treatment, and reducing stigma (Patterson 2009; Saxena and Garrison 2004). Furthermore, while there have been health promotion campaigns targeting physical health issues such as tobacco, alcohol, physical activity, obesity, road safety and sun protection for several decades, very little attention had been paid to promoting what people can and should do for their mental health. However, in the early 2000s, the Western Australian Health Promotion Foundation (Healthway) decided to fund research into people's beliefs about mental health with a view to informing a mental health promotion campaign.

The Act-Belong-Commit messages and framework were based on this primary research into lay people's understanding of, and beliefs about, factors contributing to good mental health, which were then confirmed through an extensive review of the scientific literature. The words Act, Belong and Commit represent the three behavioural domains that the scientific literature as well as lay people in Australia considered an integral part of positive mental health:

- *Act*: Keep physically, mentally, spiritually and socially active (i.e. 'do something').
- *Belong*: Keep up friendships, engage in group activities, participate in community events (i.e. 'do something with someone').

- *Commit*: Set goals and challenges, engage in activities that provide purpose in life, including taking up causes and volunteering to help others (i.e. 'do something meaningful').

In short, the Act-Belong-Commit message encourages people to be physically, spiritually, socially and mentally *act*ive in ways that increase their sense of *belong*ing to the communities in which they live, work, play and recover, and that involve *commit*ments to causes or challenges that provide meaning and purpose in their lives (Donovan et al. 2003, 2007). There is substantial evidence that the three behavioural domains—Act, Belong and Commit—contribute to increasing levels of both physical health and mental health (Donovan and Anwar McHenry 2014), and act as protective factors against mental disorders, such as depression and anxiety, and cognitive impairment (Santini et al. 2017). Furthermore, the three domains have been shown to be universal across cultures, although the articulation and emphasis of each of the domains may vary between cultures (Koushede et al. 2015; Takenaka et al. 2012).

In line with the principles of mental health promotion, Act-Belong-Commit's overarching framework allows for implementation at the population level, as well as in specific settings and for targeted groups (Donovan and Anwar McHenry 2015). Act-Belong-Commit provides a framework for individuals, health professionals and policy makers to take action to build and support good mental health. It uses a community-based social marketing approach that encourages individuals to engage in mentally healthy behaviours, and partners with organizations that provide supportive environments for good mental health and well-being. Thus, in conjunction with a mass media advertising umbrella, the campaign utilizes social franchising of government authorities, commercial and not-for-profit organizations, and local community groups to reach both the general population and specific target groups (Donovan and Anwar McHenry 2015).

The campaign hub is based within Curtin University in Perth, with ongoing funding from the Health Promotion Foundation of Western Australia (Healthway) and the Mental Health Commission of Western Australia. Partners are not actively solicited; rather, they respond to the campaign's advertising and publicity with requests to get involved in the campaign. Partners range from statewide non-governmental organisations (NGOs), state government departments, local government municipalities, large and small sporting clubs, mental ill-health organizations, theatre and arts groups, to small knitting groups and dragon boat clubs. Any organization offering mentally healthy activities is welcome as a partner (Donovan and Anwar McHenry 2015).

Ongoing evaluation of the campaign in Western Australia shows widespread awareness of the campaign (around 75% of the total population), with many of those aware taking specific actions to improve their mental health as a result of exposure to the campaign. A significant finding is that a greater proportion of people with a diagnosed mental disorder or a recent experience of mental ill-health respond to the campaign than other population groups (Anwar-McHenry et al. 2012; Donovan et al. 2016).

Intervention Implementation and Recommendations

Key Factors of Successful Implementation

Act-Belong-Commit partners sign a memorandum of understanding (MOU) to ensure message integrity and brand consistency, the sharing of activities and strategies between partners, and the provision of evaluation data to assess the impact of the campaign (Donovan and Anwar McHenry 2015). In return, partner organizations are provided with various supports, such as training, strategic direction, access to resources and assistance with seeking funding. The use of social franchising in this way has enabled the Act-Belong-Commit campaign to expand its impact and geographical reach across both health services and sectors other than health, such as local governments, schools, workplaces, community organizations, and sporting and recreational clubs statewide, nationally, and internationally without necessarily increasing the size and hence ongoing costs of the franchiser 'hub' (Beckmann and Zeyen 2013). The campaign has 162 community and organizational collaborators or partners in Western Australia, five partners in other Australian states, and international partners or collaborators in Denmark, the Faroe Islands, Fiji, Japan and Norway.

In Western Australia, the campaign has been supported by a mass media campaign, which, while limited in budget, has contributed to high ongoing awareness among the general population and hence sensitizing people to on-the-ground activities held under the Act-Belong-Commit banner. The campaign also has a number of supporting resources (available in print and online) including a self-help guide ('A Great Way to Live Life: The Act-Belong-Commit Guide to Keeping Mentally Healthy'), self-assessment questionnaires, a website search tool to find clubs and organizations of interest by geographic area, organizers and planners, factsheets, curriculum materials for schools, and print and video advertisements (see actbelongcommit.org.au). Over the years, the campaign has implemented a Schools programme (currently 52 schools in Western Australia), a Youth Connectors programme, an Act-Belong-Commit in Recovery programme (see Chapter 'Re-orienting Mental Health Services to Mental Health Promotion' for further details), and a pilot adaptation in a regional Aboriginal Community.

In addition to the franchising approach, a number of factors have contributed to the successful implementation of the campaign as follows:

1. The campaign brand message was based on what members of the general population intuitively believed enhanced and protected good mental health. Hence there was widespread acceptance of the campaign messages by individuals as they perceived the campaign as validating their subjective beliefs.
2. The message is seen as simple with straightforward implications for action (i.e. take a walk, read a book, join a book club, attend community events, learn a new skill, volunteer etc.). These implications also appealed to a wide variety of community organizations and local governments who were motivated to contact the campaign and ask how they could get involved.

3. Funds were available to pilot the campaign over two years in six regional towns, with office accommodation and staff resources provided by the Western Australian Country Health Services. As the first comprehensive campaign of its type, this pilot was crucial for refining and understanding how a social franchising campaign could be implemented on a state wide or national basis.
4. The campaign reframes 'mental health' from having primarily 'illness' connotations, to positive 'health' connotations. This enhanced the acceptance of the message, and also led to acceptance and adoption of the campaign message by individuals with a diagnosed mental disorder (Donovan et al. 2016).
5. Within the limits of the MOU with respect to ethical and evidence integrity issues, partners have a great deal of flexibility and autonomy in program implementation within their own jurisdictions.
6. The campaign hub is located within a university setting, which provided access to research resources as well as student placements to develop specific resources.
7. The campaign's initial and ongoing funder (Healthway) stated a long-term commitment to mental health promotion from the outset. This allowed the team to focus on longer-term objectives and facilitated engagement with partners.

Implementation Challenges

An initial challenge was to convince policy makers and the state mental health authority that a positive mental health promotion campaign was relevant and could have an impact on people's mental well-being. Despite increasing interest in the importance of mental health promotion globally, governments and policy makers have tended to focus programmes and funding on the treatment of mental disorders and service delivery (Reavley and Jorm 2014). As such, despite recommendations to invest more in upstream prevention and promotion interventions to reduce the burden of disease from mental ill-health, the downstream services of mental ill-health treatment and service delivery both in Australia and globally receive a greater allocation of funds (National Mental Health Commission 2014). In addition, the allocation to mental health and mental ill-health within government health budgets falls well short of that allocated to physical health services, facilities and high-technology equipment (Donovan and Anwar McHenry 2015). However, given the success of the pilot campaign, mental health authorities increased their support for the campaign, and this support has continued over the years. Nevertheless, the state public health authorities still allocate far more generous media and staffing budgets to issues such as tobacco, alcohol, sun protection and healthy eating campaigns.

A further challenge resulted from the campaign's widespread acceptance, resulting in a limited number of staff having to respond to numerous requests by individuals and organizations wanting to get involved with the campaign and/or seeking resources tailored to their setting. Hence, many resources were developed via short-term, one-off grants or student placements in response to these specific requests.

Recommendations for Replication

The above key success factors and challenges provide a basis for recommendations for other jurisdictions wanting to implement Act-Belong-Commit or any mental health promotion campaign. The adoption and adaptation of the campaign in Denmark also illustrates some of these factors and challenges, such as the necessity for qualitative formative research with general population members, the benefits of being based in a university setting and identifying a major suitable funder (Koushede et al. 2015; Nielsen et al. 2016). We would recommend the following for organizations wishing to implement the campaign in a municipality, state or nation. Organizations can also partner directly with Act-Belong-Commit in Australia.

1. *Contact Act-Belong-Commit* for access to background information, resources, ongoing assistance and perusal of existing MOUs.
2. *Establish a small team* of individuals who have a strong intrinsic motivation to promote mental health—preferably including individuals from within a tertiary institution or health authority.
3. *Undertake qualitative research* with members of the general population with respect to their understanding of mental health and acceptance of the three behavioural domains of Act, Belong and Commit.
4. *Undertake discussions with key stakeholders* in mental health, health in general, policy makers, and legislators to gain an understanding of their attitudes towards mental health promotion and how they could be persuaded to support the campaign either financially and/or politically.
5. *Identify a single major funder*–corporate philanthropy or government—as well as smaller funders for specific topics.
6. *Obtain sufficient funds* to begin with a community-wide awareness campaign. Obtain university or other organizations' expertise in this regard (e.g. university media schools to assist in adapting television and other ads, website development, and a mobile app).
7. As campaign awareness and interest increase, *obtain specific funding for staff* and other resources to introduce campaign subprograms to meet demand, such as school materials, a recovery programme, worksite materials, migrant/refugee resources and an indigenous adaptation (if and where relevant).
8. *Learn from the Australian experience,* and also from campaign adaptations in Denmark (Koushede et al. 2015; Nielsen et al. 2016), Norway, Japan and other parts of the world via the Act-Belong-Commit intranet and direct contact with specific individuals.

Overall, a key to the campaign's implementation success in a variety of different contexts is the universality and consistency of the key messages that can be customized and delivered in ways that are most relevant for any given population or target group. In Western Australia and Denmark, stakeholders and key influencers are invited onto a campaign steering committee with regular contact maintained with key funders and major supporters. Mentally Healthy Western Australia (WA) regularly engages in research and evaluation activity to build evidence for the campaign

and evaluate the impact of different strategies and programs. A suite of evaluation tools is available to Act-Belong-Commit partners to conduct evaluation at the local level and among their unique populations and cultural groups.

Future Directions for Application of the Intervention

With respect to specific activities, we envisage developing more targeted resources for groups such as those who work in remote sites or gas platforms where the work roster may be two or more weeks on the job in provided accommodation, followed by a week at home (often referred to as 'fly in, fly out'—FIFO workers), retirees and the ageing, defence force veterans and police/emergency workers, and programmes in specific settings, including assisted-living villages, workplaces and prisons. Future directions could also include assisting partners to increase activities within their jurisdictions, such as offering 'how to act-belong-commit' workshops to their members and the public, and increasing cooperation with programmes in specific areas such as suicide prevention. Overall, to achieve our vision of a society where mental health and physical health receive equal attention, a major future activity is greater advocacy to policy makers and legislators across all areas of government such that 'mental health is everybody's business' moves from rhetoric to reality.

Implementing Community Empowerment Programmes

Drawing on the definition and principles of empowerment outlined in Chapter 'Community Mental Health Promotion Principles and Strategies', an empowered community may be defined as one where individuals and organizations apply their skills and resources in collective efforts to meet their respective needs, gain increased influence and control over the quality of life in their community, and have the ability to influence decisions and make changes in the larger social system. Therefore, community empowerment is interconnected with empowerment at the individual and organizational levels and seeks to uncover mechanisms of control through psychological, social and political processes (Wallerstein 2006). Community empowerment strategies are primarily employed in working with deprived communities and marginalized or disenfranchised groups. As Israel et al. (1994) point out, a clear rationale for a community empowerment approach is provided by epidemiological, sociological and psychological evidence of the relationship between control and health, and the association between powerlessness and mental and physical health status. There is a large body of evidence that poverty and economic powerlessness are associated with high rates of social dysfunction, poor mental health and increased morbidity and mortality (Commission on Social Determinants of Health 2008; Narayan and Petesch 2002; Patel et al. 2005; WHO and Calouste Gulbenkian Foundation 2014). The World Bank draws attention to the role of agency in marginalized communities with regard to exercising choice and transforming lives, and the

role of opportunity, institutional structures and wider political, economic and governmental contexts that allow or inhibit effective action (Uphoff 2003). Wallerstein (2006) emphasizes that empowerment cannot be given to people but it must come from processes where people empower themselves. However, she also cautions that empowerment cannot be seen as a stand-alone strategy but needs to be part of a more comprehensive approach where policy makers are engaged to promote the structural and/or legal changes needed to support community change. While empowerment strategies are frequently employed in working with disadvantaged and poor communities, participatory approaches alone may not be sufficient if strategies do not also build capacity for redressing power imbalances and bringing about real change to community living conditions (Wallerstein 2006). Empowerment strategies are, therefore, most likely to be successful when integrated within macroeconomic and policy strategies aimed at enhancing economic, political and human rights and creating greater equity.

Adopting a community approach in addressing health inequities has been recognized by community initiatives such as the Health Action Zones in the UK (Barnes et al. 2005) and the Healthy Communities Movement in the USA (Norris 2001). Mental health promotion may be incorporated as part of these wider community health development initiatives and included as an integral component of a community strategy for tackling health inequities. Effective interventions in low and middle-income country (LMIC) settings include: economic empowerment initiatives such as micro-credit schemes and community banks, literacy promotion, interventions that promote gender and racial equality, violence prevention and crime reduction in marginalized communities (Brady et al. 2007; Kim et al. 2009; Mohindra et al. 2008; Patel et al. 2005; Plagerson et al. 2010).

A review by Ribeiro et al. (2009) found that the frequency of exposure to violence in LMICs was very high, especially among women and children, and was significantly associated with mental health problems such as depression, anxiety, alcohol and drug misuse and suicidal ideation. The importance of addressing the role of poverty and other social and structural factors such as education, gender and cultural beliefs has been demonstrated in effective interventions for violence prevention and the prevention of HIV (Harrison et al. 2010). Interventions need to move beyond a focus on individual risk and protective factors to consider the upstream determinants of mental health and well-being operating at the societal and structural level.

Interventions Promoting Gender Equality

The promotion of gender equality, including interventions that confront traditional beliefs and cultural norms, is a critical part of violence prevention programmes which have been implemented in many LMICs, with promising interventions in school and community settings (Patel et al. 2007). A meta-analysis of 40 case studies from diverse cultures by Kar et al. (1999) found that even the most disenfranchised and deprived women and mothers can and do lead successful social action

movements that are self-empowering and significantly enhance the quality of life of their families and communities. They report that involvement in social action movements ranging from a Community Kitchen Movement in Peru to a Committee to Rescue our Health in Puerto Rico and Women against Gun Violence in USA, regardless of their specific goals, can have strong empowering effects both in terms of the enhancement of the women's subjective well-being, self-esteem and self-efficacy and as a result, their quality of life and social status in the community. Raeburn (2001) also argues that community development economic and ecological projects, involving collective community efforts, can have a direct and beneficial mental health promotion impact, whether that is their explicit aim or not.

Community development programmes, based on the empowerment of marginalized people and the participation of local community leaders, provide a useful model for promoting mental health in low-income settings. Arole et al. (2005) provide an interesting account of how a community development approach, without specific targeted mental health objectives, can impact very positively on mental health. They describe the effects of poverty and inequality on mental health in village settings in rural Maharashtra, India and describe how building the social capital of communities through the Comprehensive Rural Health Programme has worked to achieve outcomes for mental health. This community development programme, which has been running since 1970, directly targets poverty, inequality and gender discrimination and has led indirectly, through empowerment and increased participation of women, to significant gains in mental well-being (Arole et al. 2005; Kermode et al. 2007). Based on the principles of equity, integration and empowerment, the project engages with local people through Farmers' Clubs, women's groups and adolescent girls' groups. With a strong focus on women, the interventions include income generation, agricultural and environmental programmes, education, and health services development. Central to the programme are village health workers, who are trained volunteers often recruited from low status groups in the community. While the primary aim of the initiative was to improve physical health through the process of empowering individuals and communities to gain more control and influence over the decisions that affect their lives, many of the project activities were also found to address the social and economic determinants of mental health, including social inclusion, freedom from discrimination and violence, and the economic participation of women (Kermode et al. 2007).

Interventions Promoting Economic Empowerment

Microfinance interventions, involving community banks and micro-credit schemes that provide loans to the poor, have been implemented in a number of LMICs in order to reduce the risk of mental disorders and suicide by removing the key cause of stress. Findings from the Bangladesh Rural Advancement Committee, which provides health care and education alongside credit for income generating schemes, show that the members have better nutritional status, better child survival, higher educational achievement, lower rates of domestic violence and improved well-being and

psychological health (Chowdhury and Bhuiya 2001). Reviews of the evidence on the impact of microfinance on economic outcomes tend to be less positive with few significant impacts (Banerjee 2013; Duvendack et al. 2011; Stewart et al. 2010). In a review of the evidence of micro-credit and micro-savings schemes on poor people in sub-Saharan Africa, Stewart et al. (2010) found that microfinance did have positive impacts on people's savings, health, food security and nutrition. The review found some evidence that micro-credit is empowering women; however, this was not consistent across the reviewed studies. Evidence of the impact of microfinance on education was varied with some evidence indicating the negative effect of micro-credit on the education of clients' children. A systematic review of microfinance-based interventions for HIV/AID prevention concluded that most of the reviewed interventions did have beneficial effects; however, the impact depended on the type of programme, monitoring, sustainability of micro-credits and contextual factors (Arrivillage and Salcedo 2014). The research to date indicates that the more traditional micro-credit schemes, which incorporate health and education training alongside the provision of credit, are more effective in terms of their mental health benefits.

An example of this approach is the Intervention with Microfinance for AIDS and Gender Equity (IMAGE), which is a poverty focused microfinance initiative developed in South Africa for women aged 14–35, combined with a gender and HIV education curriculum (Kim et al. 2009; Pronyk et al. 2006). The IMAGE intervention offers microfinance services through a group lending model for the development of income generating activities. Women also take part in the Sisters-for-Life (SFL), a 12–15 months curriculum covering a range of topics including gender roles, gender inequality and domestic violence. Local women are trained as facilitators for one week and are provided with ongoing support by project staff. Employing randomized controlled trials, the outcomes of IMAGE indicate that women who participated in the combined microfinance and IMAGE curriculum showed significant improvements in empowerment indicators, participation in social groups and household economic well-being; however, no change was evident for the microfinance only intervention. In addition, the risk of physical or intimate partner sexual violence was reduced by more than half (Kim et al. 2009; Pronyk et al. 2006). The IMAGE study provides encouraging evidence that a combined microfinance and training intervention can have health and social benefits such as reducing the levels of violence experienced by participants and increasing empowerment and well-being. Ssewamala et al. (2009, 2012) also report that a comprehensive microfinance economic empowerment intervention for AIDS orphaned children in Uganda had a significant positive impact on participants' self-esteem and levels of depression.

Many authors have pointed out that the training content of microfinance interventions is critical in catalysing health gains. Others have stressed the importance of the training process, in particular the value of participatory group-based learning (Kim et al. 2009). Violence against women and girls remains a major public health challenge in LMICs. These studies show that economic empowerment interventions can have a positive impact on mental health by increasing women's sense of competence and control and consequently their mental health. However, as highlighted by Kim et al. (2009), there are limits to locally based interventions for overcoming

the political, socioeconomic or institutional forces that maintain inequities and empowerment and that such strategies are more likely to be successful when they are integrated within macroeconomic and policy strategies aimed at reducing poverty and creating greater equity.

Peer Support Models of Community Mental Health Promotion

Community peer support programmes can facilitate change by providing learning and growth opportunities, through the medium of supportive linking relationships, in facing stressful life events and coping with critical life transitions. Learning comes from the relationship with other persons who provide support and nourishing relationships with a peer or mentor. The peer support model is seen as facilitating change through emphasizing the value of other persons as helpers. While peer support usually occurs naturally, it can also be provided through formalized interventions where peer support workers and/or mentors draw on their own life experiences to support others and serve as role models in addressing life challenges or difficult life transitions. The effectiveness of peer support programmes is supported by research indicating positive benefits for both community members in receipt of and community members delivering the programmes.

In the case of mutual help models, the special mutuality in this relationship is seen as being particularly important. A mutual exchange takes place which involves people who share a common problem, which one of them has previously coped with successfully. The helping person has expertise based on personal experience in solving the particular problem. For example, Cattan et al. (2005) report that self-help groups, bereavement support and counselling were all found to be effective in reducing social isolation and loneliness among older people. Wheeler et al. (1998) also report on the positive effects on mental well-being for older people who volunteer and also the effectiveness of peer counselling in reducing depression for older people who receive support from an older volunteer.

Online peer support has also emerged as a promising aspect of online mental health interventions (Ali et al. 2015). Meta-analyses of peer support interventions for depression in adults report positive effects on depressive symptoms (Pfeiffer et al. 2011) and a review of internet support groups for a range of health related conditions also found positive impacts on depression (Griffiths et al. 2009). As the majority of young people use the internet to connect with other people, online peer-to-peer support is seen as a potentially powerful aspect of digital interventions for promoting young people's mental health and well-being There are a variety of online peer support platforms, including asynchronous formats such as internet support groups, discussion groups, bulletin board and forums, and synchronous format such as chat rooms and virtual reality environments, with some supporting evidence of their beneficial effects on coping strategies, supportive communication and emotional well-being. Readers are referred to Chapter 'Implementing Universal and

Targeted Mental Health Promotion Interventions in Schools' for further details on the use of a computerized mental health gaming intervention, SPARX-R, for young people.

Volunteer community programmes have been developed for bereavement support. The nature of bereavements and their inevitability means that bereavement cannot be prevented; however, it is possible to prepare people for bereavements and to promote coping strategies that will reduce the distress and pain that are often part of this life experience. For many people experiencing bereavement, effective help comes from family, friends and existing social supports networks. However, for those who do not have such support, mutual help programmes offer an effective and acceptable means of meeting the needs of the bereaved in a non-judgmental, accessible community context. Silverman's (1988) Widow-to-Widow programme is essentially a peer-support programme which values the experiential knowledge of community members and seeks to avoid any negative labelling that may be associated with receiving professional support. Details of the programme are provided below. Following that we also present an example of community mentoring programme for at-risk young people—Big Brothers Big Sisters—that has been widely implemented internationally.

Practice Examples: Widow-to-Widow Programme–A Mutual Support Bereavement Programme (Silverman 1986, 1988)

The Widow-to-Widow programme is a volunteer community programme for recently widowed persons, where other widowed persons are the primary helpers providing support to the newly widowed still experiencing bereavement and the problems of coping with the loss of a loved one (Silverman 1986). A community outreach service is provided which usually involves an unsolicited offer of help to the newly widowed by trained volunteer helpers. The programme sets out to identify the unmet needs of the newly widowed six weeks to two months after the death, and focuses on promoting people's ability to cope with their pain and to deal effectively with the changes in their lives. A mutual help model is employed which emphasizes the value of other widowed people as helpers. The outreach volunteers or helpers are seen as neighbours who contact the bereaved and offer support. The basis of the help is a widow-to-widow relationship, thereby reducing the potential stigma attached to accepting this kind of help. Many programmes provide a progression of services from outreach to group discussion and social activities to becoming involved as helpers in turn. Some have developed telephone hotlines instead of outreach services.

Programme Implementation

- *Establishing community outreach:* To legitimize the service in the community, Silverman points out that a Community Advisory Board was established which was composed of representatives of the major religious and ethnic groups in the

community. This Board helped develop the criteria for choosing helpers and procedures for recruiting them. Important links were also established with local funeral directors and religious groups in helping to identify bereaved people in the community.

- *Recruiting helpers:* The qualities of the helpers were identified as being crucial to the success of the programme. Among the desirable characteristics identified are: attractive, engaging people who saw the value in talking to other people about their grief, had developed some perspective on their own grief so that they could share their experience, and had an ability to listen to other people's stories without getting unduly upset or needing to use the occasion to deal with their own grief at the time. All helpers were female in the initial programme; however, subsequent replications of the programme have included both males and female helpers on a strictly volunteer basis.
- *Role of professional support:* As the initiator of the programme Silverman (1988) points out that for professionals to work successfully with this type of mutual-help programme, they need to be able to relinquish control and accept the value of experiential knowledge. The skills required extend beyond those employed in clinical work and call for the skills of consultant and facilitator together with an understanding of organization development and process
- *Clear procedures for reaching out:* Contact with the new widow is made two months after the death. The contact letter clearly states that the helper too is widowed, and a time is given for a visit to the house and phone number if this time needed to be changed. Contact is maintained about twice a month over the first year and most often this contact was on the phone. Following initial one-to-one contact, group discussions are set up providing an opportunity for recently widowed people to meet others and extend their social network and participation in social activities.
- *Extends participation in to the wider community:* The mutual support model is a way of helping people to create more caring communities, break down social barriers and legitimizes people's needs for each other and their ability to use their experiences on each other's behalf.
- *Self-generating programme:* The programme is in essence self-generating as some people who receive help from the programme go on to become involved as helpers.
- *Low cost replicable bereavement support programme:* The programme is staffed by community volunteers, which avoids professionalization of the support offered, and has the potential to be taken up by community groups with minimal resources. Specific standards for training and programme delivery were not established in the original programme, although training manuals were developed in subsequent versions of the programme.

Evaluation

Evaluation of the initial programme focused on demonstrating the feasibility of the mutual-help model and its acceptance by the newly widowed (Silverman 1986). The programme was replicated in Toronto, and its impact was evaluated in a randomized

controlled study (Vachon 1979; Vachon et al. 1980, 1982). The evaluation results showed that the intervention had a positive impact and significantly facilitated the process of adaptation to bereavement. The programme was also found to be most effective with those who were at highest risk in terms of higher initial distress. Widows who participated in the programme were found to have begun new relationships and activities and experienced less distress than women who were not in the programme.

It would appear that the quality of the support offered in the Widow-to-Widow programme is the discriminating factor and explains the power of the intervention. Many of those who refused the original programme and were managing well felt that they were already involved with others who were widowed and therefore, the help offered was redundant. The findings support the original supposition on which the programme is based, that is, that another widow is the most effective helper.

Recommendations

Many variations of the programme have developed subsequently in many different countries. The Widow-to-Widow programme demonstrates the benefits of a mutual support model and the evaluation findings underscore the value of mutual help programmes and peer support in meeting the needs of the widowed. The programme has a universal focus and seeks to meet the needs of the bereaved in an accessible community context. Through sharing the expertise that people gain from their life experiences, the model highly values the role of experiential knowledge in mental health promotion and embeds the programme in the wider context of socially shared knowledge. As help is provided in the form of peer support, the programme avoids any negative labelling that may be associated with more targeted provision for those at 'higher risk' or deemed not to be coping successfully with their loss. Help is provided by neighbours, who have gone through the same personal experience, thereby, reducing any perceived stigma attached to receiving help. It would appear that the mutual help model employed in the Widow-to-Widow programme does have the potential for application to other interventions for the bereaved. It would be interesting to determine whether the model could be applied to programmes for other bereaved groups such as parents following the death of a child; children and young people following bereavements; and the effects of traumatic incidents such as suicide.

Big Brothers Big Sisters (BBBS) Community Mentoring Programme (Grossman and Tierney 1998; Tierney et al. 1995)

BBBS is one of the oldest and largest international youth mentoring programmes, which matches a volunteer adult mentor with a child or adolescent to promote positive youth development and delay or reduce antisocial behaviours. This structured mentoring programme works with 'at-risk' youth aged 6–18 years who come from disadvantaged situations, such as living in poverty, experiencing a lack of support, bereavement and parental separation/single parent-homes, as well as physical, emotional and sexual abuse. Mentors are typically young (20–34 years) with a

university degree. The BBBS programme aims to help youth reach their potential through the establishment of positive relationships. The BBBS programme is based on the theory of social control, which posits that attachments to prosocial and supportive adults, commitment to socially appropriate goals and involvement in conventional activities, allows youth to feel more socially accepted and bonded and restrains them from engaging in delinquent activities or other problem behaviours.

The Programme

BBBS seeks to establish matches between youth and volunteer adults that result in consistent interaction and a high level of relationship quality, marked by friendship, bonding and trust. On average, the youth–adult pair meet three to four times per month for at least a year. Interactions are aimed at: decreasing or delaying antisocial activities; improving academic performance, attitudes and behaviours; improving relationships with family and friends; strengthening self-concept; and providing social and cultural enrichment. Children and their families are referred to the BBBS programme by schools, other social service agencies, clergy, relatives or the families themselves. In matching adult volunteers ('Bigs') with youth ('Littles'), BBBS agencies often consider practical factors such as gender, geographic proximity and availability, as well as the match preferences of volunteers, youth and parents. Prior to acceptance on the programme youth undergo a screening process involving a written application, interview with the parent and young person, and a home assessment.

Programme Implementation

The programme is delivered by carefully screened and trained volunteer mentors who are closely supervised and supported in their work by BBBS staff. All volunteers are required to complete induction training prior to being matched. Staff monitor the relationship and maintain contact with the mentor, child and parent/guardian throughout the matched relationship. Weekly supervision and guidance is provided by BBBS Case Managers who suggest activities in which the matched pairs are to engage. The *Standards and Required Procedures for One-To-One Service* (Big Brothers Big Sisters of America National Office 2003) are used to outline the schedule of contacts made with the volunteer, as well as with the parent and/or child.

Characteristics of successful implementation of BBBS include the following:

- Thorough volunteer screening to select adults who will keep their commitment and not pose a safety risk to youth.
- Mentor training in communication and relationship-building skills.
- Matching procedures that take into account youth and mentor preferences and oversight by a professional case manager.
- Intensive supervision and support of each match by a case manager.

Evaluation

The BBBS of America (BBBSA) programme has multiple evaluations, employing both RCT and quasi-experimental designs, conducted with a variety of population groups. The most robust evaluation was conducted by Public/Private Ventures with 1138 young people (aged 10–16) from eight BBBS sites in the US (Grossman and Tierney 1998; Tierney et al. 1995). Employing an RCT design, the young people were

randomly assigned to receive the BBBS programme or were placed on a waiting list control for 18 months. The matched young people met with their mentors for an average of 12 months and at 18 months follow-up both groups ($N = 959$ with 60% boys and 56% minority youth) were re-interviewed. The results showed significant reductions in adolescent initiation of alcohol and illicit drug use, with a particularly strong effect for minority youth, as well as lowered incidence of hitting other people. Adolescents who participated in the mentoring programme also showed improvements (marginally significant, $p = 0.10$) in school attendance and academic performance, particularly for minority females, and improved relationships with parents and peers relative to the control group. Matches lasting longer than 12 months showed significant improvements in self-worth, perceived social acceptance, parental relationship quality, psychosocial and behavioural outcomes, alcohol and drug use, and academic outcomes (Grossman and Rhodes 2002). A smaller-scale RCT evaluation ($N = 71$) conducted in Canada reported only marginally significant programme effects (De Wit et al. 2006) and another RCT in Ireland ($n = 164$; mean age = 12) reported significant positive effects on emotional well-being and social support (Dolan et al. 2011).

Replication

BBBS International was founded in 1998 to promote and support the development of Big Brother Big Sister mentoring programmes operating independently in various countries. Standards and required procedures are provided to govern screening of volunteers and young people, orientation and training of the volunteer and the young person, and the creation and supervision of matches. Local agencies must adopt these standards to be formally designed as a BBBS programme. There are principal documents available for local Big Brothers Big Sister (BBBS) affiliates, including the Standards and Required Procedures for One-to-One Service and the Program Management Manual (Big Brothers Big Sisters of America National Office 2003). Further details on the programme are accessible from http://www.bbs.org/

Conclusions

In this chapter, we have presented a number of innovative evidence-based interventions that illustrate the effective translation of community mental health promotion principles into practice. Effective interventions have been successfully implemented across high, middle and low-income countries including strengthening family systems, social participation, interventions that promote the social inclusion, gender equality, peer support models and economic empowerment in marginalized communities. These interventions illustrate the importance of engaging local community members in intervention planning and delivery in order to design and tailor interventions to meet local community needs. Community mental health promotion that is based on the participation of local community members and the empowerment of marginalized people provides a useful model for promoting mental health and addressing inequities, especially in low-resource settings. We conclude this chapter by outlining the advantages of employing a community approach to mental health approach as outlined in Box 1.

Box 1 Advantages of Adopting a Community Approach to Mental Health Promotion

1. Community interventions have the capacity to address multiple interacting systems at the level of the individual, family, group and the wider environment, thereby increasing the synergistic effects of change strategies operating from the micro to the macro levels.
2. Community-wide interventions have the potential to reach a wider range of population groups across a range of setting and sectors.
3. Cross-sectoral community approaches provide an opportunity to engage with multiple stakeholders through collaborative partnerships in addressing the broader social determinants of mental health.
4. Community interventions can reinforce positive social norms, and promote structures and environments that are supportive of positive mental health across multiple segments of the community.
5. The development of interventions for the whole community is more likely to avoid the stigma and negative labelling associated with interventions targeted at specific groups, such as those who are disadvantaged, excluded or regarded as being at higher risk of mental health problems.
6. The process of community engagement and participation, which is central to community practice, is recognized as promoting a greater sense of control and enhancing overall community competence and capacity.
7. Interventions that are planned and designed through community partnerships and collaboration are more likely to be ecologically valid, that is, relevant, meaningful and culturally appropriate for the community in which the interventions are implemented.
8. Collaborative community practice, through the empowerment of community members, contributes to the development of local capacity, which increases the possibility of sustaining local initiatives after initial funding.

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Part IV
Mental Health Promotion for Children and Families

Promoting the Mental Health of Children and Families in the Early Years

Aleisha M. Clarke

Introduction

The early years of life are recognized as a particularly sensitive period in human development as they lay the foundation for cognitive functioning, behavioural, social, emotional, physical and intellectual development throughout the lifecycle (Center on the Developing Child at Harvard University 2016; Mistry et al. 2012). During childhood, the brain, especially the circuitry governing emotion, attention, self-control and stress, is shaped by the interplay of the child's genes and experiences. As children grow, the genetic and environmental factors that determine their development become increasingly intertwined and shape brain development (Boivin and Hertzman 2012). The home is identified as a crucial setting and context for early childhood development as it provides a key environment for supporting lifelong health and wellbeing (Britto et al. 2017). Positive experiences and supportive environments in early childhood can have significant effects on future cognitive, social and emotional skill development. Skills beget skills with the development of skills in middle childhood, adolescence and through to adulthood building on the capacities established between preconception and early childhood (Black et al. 2017). Establishing a nurturing home environment in early childhood may avoid costly and less effective solutions required to address problems later in life (Centre on Developing Child at Harvard University 2010; Miller et al. 2011a, b).

Of the many determinants that influence early childhood development, a home environment that is sensitive to children's emotional and physical needs, a secure early attachment with a parent or caregiver, good communication, appropriate stimulation with opportunities for play and exploration and protection from adversities have been identified as protective factors supporting a child's psychological

A. M. Clarke (✉)
Child Mental Health & Wellbeing, Early Intervention Foundation, London, UK
e-mail: aleisha.clarke@eif.org.uk

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development (Black and Aboud 2011; Clinton et al. 2014; Rutter 1988; Schweinhart 2003). These domains interact with each other and can be mutually reinforcing through the process of development (Black et al. 2017). Protective factors extend beyond families to include community care givers and support for families (Farnsworth et al. 2014). Black et al. (2017) identify a range of factors within a systems model that influence early childhood development, including the environment for caregivers, family and the community; and the social, economic, political, climatic and cultural context. The caregiver's environment represents personal resources, including maternal education and maternal physical and mental health, while community resources include safety, sanitation and absence of stigma. The broader social, economic, political and cultural context includes structural aspects including policies, laws, supportive organizational systems and structures and financial wellbeing, in addition to exposure to wars, conflicts and drought. Therefore, multi-layered strategies are required including policies and programmes at the level of communities, families and individuals in order to secure the health and wellbeing of children.

Rationale for Promoting the Mental Health of Children and Families

The importance of the early years in providing a foundation for good mental health is clearly recognized. Developmental theorists have highlighted the importance of early attachment, a supportive family, a secure and safe home environment and informal sources of support in the local community as protective factors for a child's positive psychosocial development (Rutter 1988). Children's mental health and wellbeing are influenced by their interaction with their caregivers, families and local communities. Ecological models of human development (Bronfenbrenner 1992) underscore how children are influenced by multiple interacting systems, including the social context in which they live such as neighbourhoods, physical environments, culture and society. Poverty, racial segregation, crime and violence, common to many low-income communities, may, however, hinder the ability of families to protect themselves and their children (McLoyd 1998). Poverty influences on the local community may impact on children directly through poor housing, and a lack of resources such as safe playgrounds, recreational centres and positive role models. At a broader level, children may be affected indirectly by influences from the larger society that impact on their family's financial, emotional and physical health status. Therefore, a wide range of policy measures are required to fully address the determinants of childhood poverty and disadvantage, including those to reduce health inequities. Integrated approaches are needed where inter-agency interaction and cross-sectoral partnerships are put in place. It is, therefore, important that interventions seek to enhance supportive environments as well as promote individual skills and competencies. Interventions need to take account of the broader environmental

context and the values, culture and norms of the community, in their efforts to enhance children's wellbeing, while recognizing that families serve as a critical link between children and other aspects of their environment.

There is strong evidence that early childhood adversities may not only influence a child's mental health early on but can also have a significant impact on later childhood, adolescence and long-term adult physical and mental health. Examining evidence from longitudinal studies for childhood determinants of adult mental disorders, Fryers and Brugha (2013) reported that young children with multiple adversities are three to four times more likely to develop anxiety, depression or exhibit suicidal behaviours and be admitted to hospital for a serious mental disorder during adulthood. Children from low-income and disadvantaged families are at higher risk of mental health and adjustment problems, including delinquency, substance misuse, teenage pregnancy, violence and school failure (Dryfoos 1991; McLoyd 1998; Walker et al. 2011). Extensive evidence from neuroscience indicates that the longer we wait to support children and families who are at greatest risk, the more difficult and costly it will be to achieve positive outcomes (Lupien et al. 2009; Shonkoff et al. 2009).

Early childhood interventions are designed to provide a protective influence and to compensate for the various risk factors or adversities that potentially compromise healthy child development in the years before school entry (Karoly et al. 2006). The value of early intervention approaches lies not only in their ability to reduce risk factors for negative developmental outcomes, but also in their potential to enhance positive child and family functioning through promoting competence, nurturing relationships and supportive environments for development. Early intervention approaches are supported by a large array of social contexts, from the home, childcare, schooling and wider community. No single intervention can meet the diverse developmental needs of all children, and there is, therefore, a need for a continuum of supports and services that have documented effectiveness. In making recommendations for successful, smart and sustainable early childhood interventions, Britto et al. (2017) call for the meaningful integration of early childhood interventions through a multi-strategy, coordinated approach which allows services to intervene with the family as a unit rather than the child alone. They propose three multisectoral intervention packages, which include:

1. Family support and strengthening package: this consists of three elements; access to quality services (e.g., antenatal care, immunization and nutrition), skill building (e.g., positive and responsive parenting to promote stimulation and reduce harsh discipline) and support (e.g., social protection, safety networks and family support policies).
2. Multi-generational nurturing care package: emphasizes care and protection of the mother and father's physical and mental health and wellbeing while enhancing their capacity to provide nurturing care to the child.
3. Early learning and protection package: concerned with the provision of a nurturing environment in early childhood centres, classrooms and community settings to support children's social, emotional and cognitive development.

Practical examples of home visiting family support interventions are presented in this chapter, whilst examples of parenting programmes and early childhood education interventions are presented in "Implementing Parenting and Preschool Programmes".

Home Visiting Family Support Programmes

The most common type of early years intervention is intensive home visiting programmes and centre-based support. Home visiting programmes may have a variety of goals and service elements; however, they all share a focus on the crucial role of parents in shaping children's lives and the importance of the home as a place or setting for promoting positive mental health. Home visiting programmes are, in general, manualized interventions that involve an intensive series of home visits which begin prenatally (not all programmes) and continue during the child's first 2 years of life. The programmes seek to improve the lives of children and families by encouraging changes in the attitudes, knowledge and/or behaviour of parents. Common themes across home visiting programmes include early infant care, infant health and development and parenting skills but they may also include maternal health and wellbeing, diet, smoking, drug/alcohol use, exercise, transition to parenthood and the parents' relationship with their partner.

A shared assumption of home visiting programmes is that children's earliest experiences play a fundamental role in shaping their life opportunities and parental care-giving is the most important of these earliest experiences. Most of the programmes assume that vulnerable families/parents need additional support to promote their children's development more effectively. Home visiting programmes are grounded on the belief that parents mediate changes for their children. As a result, most programmes train practitioners not to interact directly with children but to encourage and train parents to help their children (Sweet and Appelbaum 2004). Most of the programmes provide both social support and practical assistance to parents, in many cases linking families with other community services, child development, education and parenting programmes. Home visiting programmes can be provided by trained health care professionals such as health visitors/nurses, social workers, psychologists and also by trained community volunteers.

There are several advantages of home visiting programmes including the convenience of home-based service delivery, which eliminates transportation costs and the issue of childcare, thus maximizing the likelihood that families will participate (Nievar et al. 2010). Another benefit of home visiting is that the service is brought to socially isolated or disadvantaged families in their own homes which may increase their sense of control and comfort, allowing them to get the most benefit from the services offered (Peacock et al. 2013). In addition, offering the programme in the home environment allows home visitors to provide a more tailored approach to service delivery (Zercher and Spiker 2004). Home visitors see the environment that families live in and can, therefore, gain a better understanding of the families' needs in order to tailor services to meet those needs.

Programmes differ in terms of the types of families they serve (e.g., single, teenage mothers, families of particular ethnicities, socioeconomic backgrounds or social risk factors), ages of children targeted (e.g., enrolling pregnant mothers or after the birth of the child), programme intensity (e.g., weekly or monthly and duration). Staffing and training requirements also vary. Some programmes engage community volunteers to provide support to mothers. As part of the Community Mothers Programme, which was developed in Ireland and implemented in a number of countries globally, non-professional mothers from the community, supported by family development nurses, provide monthly visits to new mothers during the first years of the child's life to facilitate capacity building and empowering strategies to encourage maternal self-esteem and self confidence in child rearing (Johnson et al. 1993; Molloy 2002). Community Mothers has been found to be a feasible and cost-effective form of delivery with positive effects reported for families in disadvantaged communities including rates of immunization, cognitive stimulation and nutrition and enhanced maternal nutrition and self-esteem (Johnson et al. 1993). A 7-year follow-up of a randomized control trial of the programme reported sustained benefits for families in the intervention group (Johnson et al. 2000).

Home Instruction for Parents of Preschool Youngsters (HIPPY) trains paraprofessionals to deliver a home-visiting programme for parents of children aged 3–5 years living in disadvantaged communities. The programme was developed in Israel and is implemented in ten countries around the world (Baker et al. 1999). HIPPY aims to help parents prepare their child for school by improving the home-literacy environment, increasing the quality of parent–child verbal interaction and teaching parents' specific skills for scaffolding their children's learning. The programme consists of 30 sessions (bimonthly visits) that take place over 2 years, spanning the transition from preschool to primary school. Results from a randomized control trial (Baker et al. 1999) and quasi-experimental trial (Nievar et al. 2011), both conducted in the USA, revealed improvements in children's cognitive skills, classroom adaptation, school readiness and maths achievement. These studies also showed enhanced parental involvement in children's learning and improvements in the home environment.

The Roving Caregivers Program (RCP) is a Caribbean home-visiting programme implemented with vulnerable families with children from birth to 3 years, which aims to support parenting practices in order to enhance healthy child development. Twice per week for a maximum period of 3 years, an RCP facilitator, the 'Rover', visits the home of the child for 45 min. In the presence of the child's caregiver, the Rover engages in age-appropriate stimulating activities with the child through play. The programme has been implemented in Jamaica since 1993 and has since been extended to other Caribbean islands. The programme aims to reach the most vulnerable children in a community (Janssens and Rosemberg 2014). A quasi-experimental trial of the programme conducted in St Lucia indicated significant improvements in children's eye-hand coordination and early reading readiness. The programme was shown to be more effective with young children (average age 12 months at programme introduction) than older children (average age 24 months) (Janssens and Rosemberg 2014).

In South Africa, Mothers2Mothers is an example of home visiting which aims to prevent mother-to-child transmission of HIV by providing education and support for pregnant women and new mothers living with HIV. The Mentor Mothers Model empowers mothers living with HIV, through education and employment, to help pregnant and newly delivered women access essential services and medical care (Teasdale and Besser 2008). Mentor mothers also provide an early childhood development programme which is designed to improve the child's social, emotional, cognitive and physical development. They also work with adolescent girls and young women providing age-appropriate support aimed at promoting access to sexual health services, building their skills and competencies, fostering healthy relationships and greater resilience through role modelling and involving youth in decision making. An independent cross-sectional study of Mothers2Mothers reported a significant uptake in the use of 'preventing mother-to-child transmission services'. Women who received Mothers2Mothers services were significantly more likely to have taken medication to reduce transmission rates in their babies; disclosed their HIV status to a partner or other person during their pregnancy and selected an exclusive infant feeding method while pregnant (Teasdale and Besser 2008).

A number of systematic reviews and meta-analyses have examined the effectiveness of home visiting programmes. The results from these reviews provide evidence that home visiting programmes are associated with significant improvements in parents' behaviour and skills and child outcomes (Casillas et al. 2016; Filene et al. 2013; Kendrick et al. 2000; Munns et al. 2016; Peacock et al. 2013; Sweet and Appelbaum 2004). Positive findings are particularly evident for programmes that start antenatally, are of high intensity, medium to long duration (follow up to at least 12 months) and are designed for parents at higher risk (e.g., low-income parents, teenage parents, single parents and mothers coping with post-natal depression (Stewart-Brown and Schrader-Mcmillan 2011; Tennant et al. 2007). In the review of 21 home visiting programmes, Peacock et al. (2013) reported significant improvements in the development and health of young children from disadvantaged families including; (1) the prevention of child abuse, (2) developmental benefits in relation to cognition and problem behaviours, and (3) reduced incidence of low birth weight and health problems in older children. A meta-analysis of 60 home visiting programmes revealed significant benefits for parents in terms of their improved parenting attitudes and behaviour and benefits for children in terms of enhanced cognitive and socio-emotional outcomes (Sweet and Appelbaum 2004). Similar results were reported by Filene et al. (2013) in their meta-analyses of home visiting programmes. Furthermore, Kendrick et al. (2000) reported significant improvements in the quality of the home environment and parenting skills as a result of home visiting programmes.

A number of reviews have investigated the impact of a low intensity intervention, skin-to-skin contact between mother and infant. Skin-to-skin contact involves placing the naked infant on the mother's body at birth. Moore et al. (2007) found it to be associated with a range of improved outcomes including mother–infant interaction, attachment behaviours, infant behaviour and infant physical symptomatology in

full-term and pre-term infants. Moore et al. (2012) reported improvements in breastfeeding outcomes, cardio-respiratory stability and a reduction in infant crying.

Economic analyses of home visiting and parenting interventions indicate substantial societal returns on investment for both higher cost/more intensive programmes and lower cost/less intensive programmes, especially when impacts beyond the health sector are taken into account (Knapp et al. 2011; McDaid and Park 2011). There is some evidence that the economic returns are larger when programmes target disadvantaged or at-risk children (Edwards et al. 2007; Karoly et al. 2006). Cost–benefit analyses of effective high quality programmes show that they can repay the initial investment with savings to government and benefits to society, with those most at risk making the greatest gains (Friedli and Parsonage 2007; Karoly et al. 2006; Knapp et al. 2011). For example, economic analysis of the Nurse Family Partnership Programme (see Practice Example) based on outcome data over 15 years post-intervention indicates that benefits outweigh costs by a factor of 5.7 to 1 for high-risk women and 1.26 to 1 for low risk women due to impacts on reducing abuse, violence and the need for social welfare benefits (McDaid and Park 2011).

Several reviews have attempted to identify home visiting components associated with programme outcomes. There is evidence from across the reviews that home visiting programme effectiveness is greater when the characteristics outlined in Box 1 are present.

The type of staff who deliver the programmes is inconsistently related to programme outcomes and effect sizes across outcome groups. Nievar et al. (2010) found that programmes employing nurses or mental health professionals as providers were not significantly more effective than programmes delivered by paraprofessionals. In another meta-analysis, Sweet and Appelbaum (2004) found that for child cognitive outcomes, professional home visitors were associated with higher effect sizes than non-professional home visitors. However, regarding potential child abuse

Box 1 Characteristics of Effective Home Visiting Programmes

- A higher dose of the interventions over a longer period of time is used (Nievar et al. 2010; Peacock et al. 2013; Sweet and Appelbaum 2004).
- Mothers are approached during pregnancy (Peacock et al. 2013).
- Home visitors are trained to adequately meet the needs of the families that they are serving (Munns et al. 2016; Peacock et al. 2013).
- The programme's focus is on a particular issue rather than trying to remedy multiple problems (Peacock et al. 2013).
- Role plays are included in the training of home visitors (Casillas et al. 2016).
- Supervision is a component of programme implementation (Casillas et al. 2016; Munns et al. 2016).
- Programme fidelity is monitored (Casillas et al. 2016).

outcome, paraprofessionals were associated with higher effect sizes than were professionals and non-professional home visitors. Overall, a common finding across all systematic reviews is that no clear and consistent pattern of effective home visiting components emerges across all outcome domains. Furthermore, some reviews identified a number of home visiting programmes that report no significant benefit (e.g., Peacock et al. 2013). This finding points to how difficult it is to bring about significant and enduring change for families, particularly given the challenges socially high-risk families encounter. Intervention programmes tend to focus primarily on parents and children, and as such cannot address the wider structural factors such as poor, disorganized or violent communities. By themselves such programmes are insufficient to alleviate the effects of poverty on child development and family functioning. There is a need for wider policy support including policies addressing child poverty, child protection and family support. If families live in communities where poverty is entrenched, programmes that focus solely on individual change rather than broader policy solutions may have limited impact. Weiss (1993) cautions against viewing home visits in the early years as a lone silver bullet or panacea.

We will now examine a best practice programme which has been tested and refined and replicated across multiple countries and rigorously evaluated: the Nurse Family Partnership programme (Olds 2006). This programme, which was originally known as the Prenatal and Infancy Home Visitation by Nurses programme, and is also known as Family Nurse Partnership (FNP) in the United Kingdom, has a strong and rigorous evidence base which has been developed over 30 years. The programme has been shown to benefit the most vulnerable young families in the short, medium and long term across a range of outcomes helping to improve social mobility and break the cycle of inter-generational disadvantage and poverty. This theory-driven, research-based model has been delivered to disadvantaged first time mothers and their babies by trained nurse home visitors from early pregnancy until age two.

Practice Example: Nurse Family Partnership (Olds 1997, 2006; Olds et al. 1998c)

The Nurse Family Partnership (NFP) is a comprehensive, intensive and cost-effective programme developed by David Olds and his colleagues in the USA in the 1980s. Since then, the programme has been implemented widely across multiple sites and countries including the USA, Australia, Canada, the UK, the Netherlands and Norway. The programme is designed for low-income first time mothers and has three major goals:

- To improve the outcomes of pregnancy by helping women improve their prenatal health.
- To improve the child's health and development by helping parents provide more sensitive and competent care of the child.

- To improve parental life course by helping plan future pregnancies, complete their education and participate in the workforce (Olds 2006).

Programme Content

The programme is based around a trained nurse visiting a woman at home during her first pregnancy and the subsequent 2 years after the child's birth. One nurse visitor is assigned to each family for the duration of the programme. The nurse visits the family once a week for the first month after registration and then every other week through delivery. After delivery, the visits are scheduled for once a week, and gradually phased out to once a month until 24 months postpartum. Visits typically last 60–90 min. The nurse may visit the family more frequently if the family exhibits crises that would warrant more intensive support, e.g. health problems associated with the pregnancy or adverse domestic conditions. The nurse follows a strict protocol which has been developed and tested over a 20-year period. This protocol provides guidance to the nurses on a day-to-day basis and may be subtly adapted to meet the individual needs of each family.

Research suggests that the comprehensiveness of the programme is responsible for its success. The content of the programme focuses on the care and development of the child including the physical care of the child, promotion of the child's social, emotional and cognitive development and providing a positive and safe home environment. In addition, the programme focuses on the promotion of the mother's self-efficacy with respect to her health-related behaviours, completing her education, participating in the workforce and planning future pregnancies. The integration of these elements is seen as being critical to maximizing the opportunities for creating and sustaining change (Olds et al. 1994). Also, critical to the programme is the close working relationship that nurses develop with the mothers, identifying small achievable objectives in order to build the mother's confidence and pave the way for setting and reaching life goals. Home visitation is used in conjunction with family, friends and various statutory and voluntary services in order to enable families to develop their strengths and achieve their goals.

Evaluation Findings

Trials of the programme have been conducted in several US states, in Germany, the Netherlands and England. It has also been replicated in various "demonstration site" communities to determine how to develop the programme e.g., in high-crime urban areas or delivering the programme with paraprofessionals instead of registered nurses. The findings from the three main randomized controlled trials (Elmira, New York; Memphis, Tennessee; and Denver, Colorado) will now be summarized.

The first trial of the programme was held in Elmira, New York (Olds et al. 1994; Olds et al. 1997; Olds et al. 1986; Olds et al. 1988). A sample of 400 women were recruited during pregnancy and followed through the child's 15th birthday. A randomized control design was used, stratifying for demographics, and women were randomly assigned to receive either home visitation services (intervention group) or comparison services (control group). A total of 85% of enrolled women were either low-income, unmarried or teenaged and none had previous live births. Impressive results were demonstrated in relation to prenatal conditions, child development, and

maternal life course at the end of the programme. In comparison with the control group, the mothers in the intervention group exhibited the following positive outcomes: an improved diet, fewer kidney infections, greater social support and made better use of formal community services. Among the women who smoked, the intervention mothers showed a 25% decrease in smoking rates during pregnancy, had 75% fewer pre-term deliveries and the young adolescent mothers had babies with higher birth weight. Regarding child development, the effect on child abuse and neglect approached significance ($p = 0.07$[1]), as there were fewer child injuries and ingestions, and the children had developmental quotients that were higher than their counterparts in the control group (Olds et al. 1986). Finally, in terms of maternal life course, women in the intervention group experienced a reduced number of subsequent pregnancies.

A follow-up study of the Elmira trial assessed the impact of the programme during the child's 3rd and 4th years of life (Olds et al. 1994). No enduring effects were found on the rates of child abuse and neglect or on the children's level of intellectual functioning. However, the evaluation did report several lasting programme effects on household safety; 35% fewer instances of the child visiting the emergency department; 40% fewer child injuries and ingestions; 45% fewer child behavioural/parental coping problems; and an increased quality of care which low-income, unmarried teenagers provided to their children (Olds et al. 1994). The follow-up study also demonstrated that women in the intervention group were more likely to participate in the workforce (increased by 83%) and to delay subsequent pregnancies (reduced by 42%) during the first 4 years after delivery as compared to the control group (Olds et al. 1988).

A follow-up of the Elmira study at 15 years confirmed additional significant enduring effects on child development and maternal life course (Olds 1997; Olds et al. 1997). In relation to primarily white families, the following findings were reported for the first-born child of mothers in the intervention group: 79% fewer verified reports of abuse and neglect; 60% fewer instances of running away; 56% fewer arrests; 81% fewer convictions of violations of probation; 63% fewer lifetime sex partners; 56% fewer days of alcohol consumption and 40% fewer cigarettes smoked per day. Maternal life course results were also encouraging, as women who had participated in the programme achieved an average of 2+ years interval between first child and second child, 69% fewer maternal arrests, increased workforce participation, 44% fewer maternal problems due to alcohol and drug abuse, and 30 months less in receipt of social welfare. It is of interest to note that these positive effects were found not for the whole sample, but were specific to higher risk families i.e., poor unmarried women and their children who participated in the programme.

A second evaluation of the programme took place in city of Memphis, Tennessee (Kitzman et al. 1997). The sample consisted of 1139 low-income, primarily African-American unmarried women, randomly assigned to intervention and control groups. Again, notable results were demonstrated in relation to prenatal conditions, child

[1] Result approaching significance.

development, and maternal life course. In comparison with the control group, the women in the programme had greater use of community services, they were more likely to be employed ($p = 0.06$) and they exhibited fewer instances of pregnancy induced hypertension. The first-born child had fewer injuries and ingestions, fewer days hospitalized due to injuries and ingestions, and lived in a home more conducive to child development. Finally, the mothers themselves had fewer subsequent pregnancies and fewer months in receipt of social welfare. A follow-up when the children were 6 years old (Olds et al. 2004) demonstrated the continuing positive impact of the programme. Mothers in the intervention group were in receipt of less social welfare support and had better family planning skills, while children had higher behavioural and educational outcomes.

A third randomized controlled study of this programme in Denver, conducted with 1178 pregnant women, examined the unique contributions that nurses and lay community health visitors might make when both were trained in the prescribed programme model. Results indicated that the nurses made significant impacts on a wide range of maternal and child outcomes. The findings from paraprofessionals were less strong (Olds et al. 2002).

The first evaluation of NFP outside of the USA was carried out in the Netherlands (Mejdoubi et al. 2013, 2014). This independent randomized control trial included 460 pregnant women at risk of child abuse. Data was collected between 12 and 28 weeks gestation through to 6 months post-partum. Results from this study indicated a significant reduction in the percentage of women smoking during pregnancy (40% intervention group, 48% control group) and at 2 months post-birth (49% vs 62%). After birth, the intervention group smoked 50% less cigarettes compared to the control group. Significantly more women in the intervention group were still breastfeeding their baby at 6 months post birth. Results also indicated a significant reduction in self-reported intimate partner victimization at 32 weeks of pregnancy. These results were maintained at 24 months after birth. In addition, the number of child protection service agency reports for the intervention group was significantly lower than that of the control group 3 years after birth (11% vs 19%). The long-term home environments and internalizing behaviours of children in the intervention group were also improved.

Another independent replication of NFP was carried out in England with first time mothers aged 19 or younger. Result from this study showed less positive findings (Robling et al. 2015). A total of 1645 women were randomly assigned to NFP plus usual care (publicly funded health and social care) or to usual care alone with post-intervention assessment conducted 24 months after birth. Results indicated that adding NFP to usual care provided small, significant impacts on intention to breastfeed, maternally reported child cognitive development, language development, levels of social support, partner-relationship quality and general self-efficacy. No additional short-term benefits were detected for smoking cessation, rates of second pregnancies and emergency hospital visits for the child.

In Germany, a randomized control trial of the intervention was carried out with 755 low SES mothers with at least one social risk factor, such as low education or experience of violence (Sierau et al. 2016). Programme influences on family

environment, maternal competencies and child development were assessed from mothers' programme intake in pregnancy and at children's second birthday. Results at 24 months post birth indicated small but significant positive treatment effects on parental self-efficacy, social support and knowledge of child rearing. Subgroup effects were found for high-risk mothers in the treatment group. This group of mothers had children with higher developmental scores compared to participants in the control group who had access to standard community services. Post-hoc analyses revealed the quality of the helping relationship as a significant indicator of treatment effects.

Programme Implementation Features

The programme has been refined and adapted over the last 30 years. Research of the dissemination process and experience (Olds et al. 1998a, b; Racine 2001) has indicated the following key features of the planning and implementation of this programme:

Model based on theoretical foundations: The programme is grounded on the integration of three well-established theories of human development and change. In terms of self-efficacy (Bandura 1977), the content of the programme focuses on developing the mothers' confidence in their abilities as parents, helping mothers plan for themselves and their babies and through setting short-term achievable goals to gradually assist mothers in gaining a sense of control over the direction of their lives. Human attachment theory (Ainsworth and Bowlby 1991; Bowlby 1977) highlights the importance of the child's level of attachment to a caregiver for their healthy emotional and social development. The programme focuses on the formation of the mother–child relationship and teaches mothers how to recognize and respond to the child's emotional needs. Human ecology theory (Bronfenbrenner 1992) emphasizes the importance of the social context, such as other family members, social networks and the wider community on human development. This theory focuses the programme on the parent–child relationship in the context of other family and community relationships and the need to manage such relationships so that they are supportive of positive development.

Recruitment and retention of target population: This programme has been found to be most effective with women who are unmarried and from low-income households. The programme is based on voluntary participation, and women's interest in participating will be affected by their desire to have questions answered about their pregnancy, the health of their baby, and the need to find needed resources in the community. Eligible women are typically identified through referrals from health clinics, hospitals, doctor's offices, schools and facilities serving low-income women. In randomized trials, 80–95% of the women who were offered the opportunity to participate accepted (Olds et al. 1998b). Many families are difficult to engage, however, for reasons such as distrust of the nurse visitor or the inability to manage competing time commitments (Gomby et al. 1999). Therefore, the programme model takes the position that, unless a mother explicitly asks to be dropped from the programme, she is retained on the programme caseload. While this may border on being intrusive, evaluation proves that many mothers thank the nurses for persisting with them during their crises or through the early days of distrust.

Staffing: The successful selection of home nurse visitors and supervisors is critical to successful implementation, as the home visitor is the embodiment of the programme for families (Gomby et al. 1999). The programme model recommends full-time female nurses who have a recognized qualification, previous relevant experience, and strong interpersonal skills. Past experience with the programme has proven the importance of recruiting nurses who have formal training in women and children's health and competence in managing complex situations often presented by at-risk families. A full-time nurse visitor should carry a caseload of no more than 25 families, due to the intensity of intervention. In Germany, the programme has been adapted using social workers or midwives rather than nurses as home visitors (Sierau et al. 2016). In addition to the home visitor, a nursing supervisor is responsible for overseeing implementation and assuring clinical supervision on a regular basis so that participating nurses may discuss cases and obtain feedback. Supervisors play a vital role in collaborative relationships with ancillary service providers upon whom the programme depends for multidisciplinary support. A full-time supervisor should support no more than eight home visitor nurses.

Training and technical assistance: Staff training for this programme includes an initial one-week session for nurses and their supervisor, followed by a 3-day and 2-day follow-up training on-site to coincide with the nurses' need to begin using the infancy and then toddler protocols with the families (Olds et al. 1998b).

Key community contacts: Communities must decide what organization will take the lead for administering the programme. In the USA, this role has been filled generally by a local health department. In England, the programme was adapted for use in a publicly funded healthcare system (Robling et al. 2015). The programme's success depends on strong local leadership and commitment to effective implementation in order to target services and ensure programme integrity. A local multidisciplinary planning group or task force, including national and/or local directors of health and social services, should help to determine which agencies should be involved in developing the programme. Once in operation, the programme relies on coordination and co-operation among a variety of statutory and voluntary service providers. In England, for example, this involved coordination with publicly funded health and social services such as universally offered screening, education, immunization and support from birth to the child's second birthday. Coordination and commitment across services must be obtained from the outset to ensure integration across the health and social service systems.

Inter-agency collaboration: Though nurses are the primary providers of this programme, they do not have the capacity to manage all types of physical, mental and social health problems, particularly in high-risk families. The programme requires active multidisciplinary support. As nurses will have to refer mothers and families to various health and social service providers, the nurses themselves must understand and have a working relationship with those other services. Agreements may need to be established with certain agencies and primary care providers to contract services to the programme.

Funding and resources: In 1997, it was estimated that the programme costs $3200 per family per year during the start-up phase (first 3 years of implementation) and $2800 per family per year once nurses are trained and working to full capacity. Communities in the USA retained a variety of local, regional and governmental funding to support the programme. When the programme focuses on low-income women, the costs to fund the programme are recovered by the time the first child reaches age 4 (Olds et al. 1998a, b). It is reported that by the time children from high-risk families reach age 15, the cost savings are four times the original investment because of reductions in crime, welfare and health care costs and as a result of taxes paid by the working parents (Karoly et al. 1998). Based on a review of outcome data from 177,517 pregnant women enrolled in NFP from 1996 to 2013, Miller (2015) projected that by 2031, NFP will prevent an estimated: 500 infant deaths in the United States, 10,000 pre-term births, 13,000 dangerous closely-spaced second births, 42,000 child maltreatment incidents, 36,000 intimate partner violence incidents, 90,000 violent crimes by youth, 36,000 youth arrests and 41,000 cases of youth substance abuse. When implementing this programme outside of the USA, funding will need to be considered in the light of each individual country's funding for health and social services. Several resources are important for the implementation of this programme. A single administrative home for the programme will centralize communications and act as a home base for the visiting nurses. The nursing staff must have relevant training, as well as copies of the programme protocols and record keeping forms. Finally, the nurses will require standard treatment tools e.g., blood pressure cuffs and baby scales.

Programme modifications in response to family needs: Although there are specific protocols to guide each nurse visit, the protocols are designed to be adapted to the individual needs of each mother and her family. For example, the nurse will need to concentrate more on smoking cessation and the consequences of prenatal cigarette smoking for women who smoke. Specific educational and behavioural change approaches are set in motion on the basis of the nurses' individualized assessments. The programme has also been modified to meet the needs of populations with greater ethnic and racial diversity. In the Netherlands, the programme was adapted for Dutch women and their health care system with more of an emphasis on home delivery, supporting women to stop smoking during pregnancy and providing more information about the advantages of breastfeeding (Mejdoubi et al. 2013). In Germany, in addition to employing social workers or midwives instead of nurses, a German developmental screening instrument was utilized as well as providing information on children's check-ups (Sierau et al. 2016).

Recommendations for Replication

Integrate the programme into existing health services: The adaptation of the programme to local conditions may require the involvement of professionals from different disciplines and different agencies to implement the programme effectively. A particular challenge may be integrating the programme into a health system that already has existing programmes for young families whose funding may by threatened by the financial support demands of implementing this model (Olds et al. 1998b).

In addition, local and national public policy support is paramount for the eventual upscaling of this programme in order to give both credibility and necessary resources (Racine 2001).

Foster community support: Community support and positive relationships are vital to this programme's success. Indeed, a study by McGuigan et al. (2003) suggests that families are more likely to drop out of the programme if they come from certain communities, e.g., with high levels of violence, even when confounding influences on attrition were controlled for such as nurses' empathy, educational background, and the mother's marital status. Given the strong evidence of this programme's effectiveness, communities may have to make difficult choices such as elimination or transformation of certain programmes that evidence suggests do not work. In doing this, programme implementers must be cognizant of minimizing damage to professional relationships and enhancing the strength of community service delivery systems for families.

Monitor implementation and gradual dissemination: Formative evaluation, as prescribed, will monitor programme fidelity and highlight the features of successful implementation. According to David Racine, who has been involved in replicating and upscaling the programme, the fidelity to the purpose of the programme ("functional fidelity") and the fidelity to its components ("structural fidelity") are crucial to reproducing the positive outcomes of the clinical trials (Racine 2001). It is imperative that programme implementers prevent this intervention from becoming diluted and compromised in the process of development. It is particularly noted that the programme should not be rolled out on a large scale in a short period of time. Systematic monitoring and evaluation of the process of implementation will help ensure that the programme's fidelity is maintained. Rapid dissemination without sufficient planning and capacity building will compromise the quality of programme implementation and effectiveness (Olds et al. 1998b).

Adapt the programme to fit cultural context: Thus far, this programme has been implemented and evaluated in the United States, Germany, the Netherlands and England, UK. As outlined, alterations were made in order to adapt the programme to contexts outside of the USA. It is recommended that in adapting programme, implementers need to set up a local advisory committee to review the programme content and materials, thus ensuring relevance and sensitivity to the new populations served (Olds et al. 1998b). It is also recommended that nurses undertake relevant training regarding racial and ethnic diversity e.g., working with ethnic minority groups and asylum seekers. Engaging family members and friends of the mother participating in the programme helps integrate programme delivery with respect to cultural and situational circumstances. Continuous process evaluation will help to fine-tune programme components to suit the local context.

The integration of evidence-practice programmes into standard service delivery is challenging and requires careful planning, stakeholder engagement and intersectoral partnerships. We will now examine a case study on the Towards Flourishing Project, a Canadian initiative that promotes the mental wellbeing of parents and their families through the incorporation of a mental health promotion strategy in

Manitoba's Families First home visiting programme. This case study provides a useful insight into the process of integrating a mental health promotion strategy into an existing home visiting programme and developing mechanisms for strengthening the public health workforce capacity to address mental health promotion. This case study also highlights the challenges around embedding mental health promotion strategies into mainstream services and the importance of strengthening workforce capacity to support quality implementation and creating strong partnerships for sustainable delivery.

Case Study: Toward Flourishing—Mental Health Promotion for New Parents

Mariette Chartier
Manitoba Centre for Health Policy & Department of Community Health Sciences, University of Manitoba, Winnipeg, MB, Canada

Laurie McPherson
Winnipeg Regional Health Authority, Winnipeg, MB, Canada

Jennifer Volk
Department of Community Health Sciences, University of Manitoba, Winnipeg, MB, Canada

Marion Cooper
Canadian Mental Health Association, Manitoba and Winnipeg, Winnipeg, MB, Canada

Background: The Programme

Towards Flourishing (TF) is a mental health promotion strategy that was created as an augmentation to the Families First home visiting programme and public health practice. The Families First home visiting program provides weekly visits by paraprofessional home visitors to families with preschool children who are living in conditions of risk (See Towards Flourishing Website, Manitoba Government 2018). The Towards Flourishing strategy is comprised of multiple components and focuses on promoting and protecting positive mental health as well as addressing mental disorders and distress of parents in the post-partum period. In the development phase, the specific objectives of the TF strategy included:

1. Improve the mental health of parents and children enrolled in the home visiting programme.
2. Decrease mental disorders/distress of parents and children in the home visiting programme.
3. Strengthen public health workforce capacity to address mental health promotion.

4. Ensure that the strategy has cultural relevance and reflects the distinct worldviews of all families in Manitoba, with a specific mandate to reflect the experience of Indigenous, Francophone and Newcomer populations.
5. Support collaboration between mental health and public health systems.
6. Create and sustain mechanisms for embedding effective mental health promotion interventions in community settings across Manitoba.

Healthy Child Manitoba Office, the Winnipeg Regional Health Authority, and the Manitoba Centre for Health Policy at the University of Manitoba worked with multiple partners from community, service and government sectors to create the TF Strategy. These lead partner organizations (the TF team), were responsible for programme development, implementation, and evaluation as well as policy development. All significant decisions were jointly made by this TF team, in consultation with other partners. Funding from the Public Health Agency of Canada was secured in 2010 for a 5-year evaluation period to respond to the high levels of mental distress among families in the Families First home visiting programme and to increase public health's capacity to address mental health for all parents in the post-partum period. Maternal distress has known links to poor family functioning, children's developmental delays and poor academic outcomes (Kingston et al. 2012). In 2015, based on preliminary findings and the feasibility, acceptance and usefulness of TF, the provincial government continued funding the strategy and its evaluation.

TF was inspired by the Dual Continua Model of Mental Health that emphasizes the benefit of enhancing mental health with every person, regardless of their life circumstances (Keyes 2002). Another influential idea described by Embry and Biglan (2008) was that mental health can be maintained and enhanced by embedding simple, evidence-based practices into everyday life. Many simple strategies have been scientifically proven to improve mental health because they have reliable effects on at least one specific behaviour (Embry and Biglan 2008). These simple strategies are the "active ingredients" found in more complex interventions. They are easily taught by word of mouth, incur no cost, and fit well within home visiting programmes and within public health practice. In consultation with public health staff, the TF team chose nine simple everyday strategies and developed parent-friendly handouts. These included: physical activity (Crews et al. 2004), nasal breathing (Block et al. 1989), progressive muscle relaxation (Pawlow and Jones 2005), 3 min breathing break (Segal et al. 2002), community belonging (Jones et al. 2014), reflecting on three good things (Masuda et al. 2004), creating a vision (Czuchry and Dansereau 2003), connecting with others (Audet et al. 2014; Fried et al. 2004) and self-monitoring (Petscher and Bailey 2006).

The TF Strategy consists of many components as illustrated in Fig. 1. Essentially, TF capitalized on the mental health expertise of the mental health services sector and the population health and health promotion expertise of public health. The TF curriculum itself was conceptualized as an "enhanced" mental health promotion curriculum that would work in companionship with existing home visiting curriculums and within public health nursing practice. Once service providers receive training in using the curriculum, it can be embedded in most programs or in public health practice. For example, when conducting their usual home visit, public health

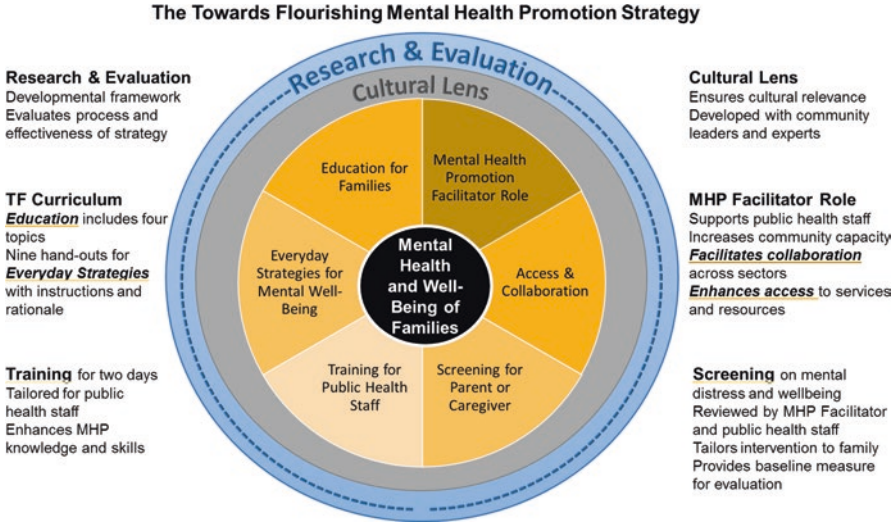

Fig. 1 Components of Towards Flourishing Strategy

nurses and home visitors introduce a section of the TF curriculum conversation topics to help build the parents' understanding of the role of mental health promotion strategies in enhancing overall wellbeing. These topics include changes and expectations that parents experience during the post-partum period, the concept of flourishing or protecting and maintaining mental health, coping strategies to face life challenges and exploring social support and community resources. Next, they introduce and demonstrate one or more of the TF everyday strategies and provide a handout to the parent so that they can use the strategy in the future. Over a period of months, public health staff could cover all four topics and several of the strategies with the parent. Mental health promotion facilitators (MHPF) provide training and ongoing support to public health staff to ensure population-based implementation of the mental health promotion strategy.

Evaluation

The Evaluation was embedded within the strategy where a developmental evaluation framework guided the process and used emerging findings to refine the strategy. Interviews, focus groups, surveys, formal and informal meetings were used to evaluate the process and short-term impacts of TF implementation. The everyday strategies are evidence-based, meaning that if these strategies were used correctly and regularly, they will be effective in improving mental health and decreasing mental distress. The TF evaluation essentially aimed to examine how TF was implemented by public health and to determine the effectiveness of TF in improving the mental health of families. Throughout the development and early implementation of the TF Strategy, we interviewed 31 parents, 36 home visitors, 35 public health nurses, six

mental health promotion facilitators, and eight decision-makers across rural and urban regions of the province. Stakeholders reported that integrating a mental health promotion strategy into an existing public health programme was feasible, acceptable and useful for the parents receiving the services and for the service providers delivering them. These perceptions were consistent among minority groups including Indigenous, Francophone and newcomer parents. The TF curriculum provided a mechanism for parents and service providers to dialogue about mental health. Support from the mental health promotion facilitators, training in mental health promotion, and the trusting relationship that home visitors develop with the families facilitated the introduction of TF. Early impacts described by parents include normalizing the post-partum mental health experience, an increase in relaxation, enhanced positive thoughts and feelings and increased awareness of existing supports in their networks and communities (Chartier et al. 2015). All stakeholders provided valuable perspectives into how to improve the strategy's implementation.

A stepped wedge cluster randomized trial is currently being conducted in nine urban sites and nine rural and northern sites (see Brown and Lilford 2006; De Allegri et al. 2008 for a description of the study design). All participating intervention and control sites began collecting mental health measures. Families in the control condition received the home visiting programme as it was usually delivered. Sites were then randomly assigned to three groups that initiated the TF strategy in succession. When data collection is complete, the database will include 450 control families and 1050 TF families to test the strategy's effectiveness. Given the available data, it is premature to make strong conclusions about the TF's effectiveness in improving mental health and decreasing mental distress. However, an interim analysis using roughly half the required sample and fewer follow-up measures provided some early promising results. These preliminary findings suggest that TF is associated with higher levels of emotional, psychological and social wellbeing and lower parental distress scores but not with other outcomes of mental distress. In the longer term, health and social services, educational outcomes and justice system involvement of children from these families can be followed using data linkage to administrative databases.

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Implementation Included the Following

Responding to a Perceived Need Through previous work that had examined post-partum mental health, service providers and decision-makers at local and provincial levels recognized the need to address mental health among new parents (Healthy Child Manitoba 2010) and were prepared to participate in a process that would address this need.

Developed Within Intersectoral Partnerships Strong partnerships were forged between governments, service providers and academia to work jointly in planning,

implementation and evaluation. Partnerships were critical to the successful implementation of the TF strategy but also a product of the strategy. These partnerships were characterized by common goals, shared leadership, respect of the differences in approaches, key stakeholders' engagement early in the process, learning about and respectfully engaging in the processes that partners engage in, dedicated attention to the relationships within the team, and celebration of successes.

Initial Investment in Development, Evaluation and Knowledge Exchange Special funding was granted to develop and evaluate TF and share findings and lessons learned during implementation. Establishing a rigorous and comprehensive evaluation design at the onset ensured the feasibility, acceptability and usefulness of TF. Evaluation findings and stories, tailored to specific audiences, were shared to showcase the value of the TF strategy and to engage stakeholders.

Ensured Skill Building and Ongoing Support for Service Providers Funding a mental health promotion facilitator (MHPF) in each health region ensured that mental health promotion knowledge and skills were provided to all home visitors and public health nurses. Regular contact with the MHPF ensured ongoing coaching to service providers to address the mental health needs of families in the postpartum period. According to decision-makers and service providers, the MHPF's role was credited with being the liaison that brought the public health and mental health programmes together. The skill set needed for the role is broad, ranging from understanding concepts in mental health, community development, policy and practice development as well as skills in teaching, facilitating, working intersectorally with communities and an array of service providers (Barry and Jenkins 2007). Collaboration between mental health services and public health established a process to ensure that parents could access mental health services when necessary.

Sensitivity to Available Resources During the course of the development phase, many decision-makers feared that TF would be another example of an effective programme that was discontinued due to lack of resource planning. These decision-makers encouraged ongoing discussions to ensure sustainability. The challenge of scarce resources was addressed by embedding TF within a public health programme, thereby capitalizing on the existing workforce and by utilizing simple, cost-effective, evidence-based strategies. A cost-sharing model was promoted that required partnering service providers to match some funds in order to ensure dedicated resources could support the strategy once grant funding ended. An economic analysis by the TF team suggested that economic benefits could be realized by implementing TF in the province of Manitoba as had been shown elsewhere (Knapp et al. 2011). Considering the prediction that mental health issues will be the leading cause of disability in Canada by 2030, combined with the fact that Canada spends less than most developed countries on mental health (Jacobs et al. 2010), the analyses made it clear that investments in mental health promotion were warranted.

Implementation Challenges

A number of implementation challenges and experiences arose in the course of the TF implementation. Nurses, home visitors and parents provided feedback that was critical in improving the strategy. For example, early in the pilot phase, they reported that the literacy levels and the complexity of some of the concepts made the discussion challenging and so the materials were simplified. Barriers were overcome to some extent through problem-solving with service providers and decision-makers. Holding a series of knowledge exchange events was critical in increasing an understanding of TF and its potential. These events included information sessions, small meetings, guest speakers and creating forums for intersectoral discussions.

Initially, many decision-makers and service providers lacked a basic understanding of mental health promotion. Addressing mental health within a public health programme was deemed risky because of a lack of mental health expertise and the perception that broaching the topic of mental health may distress parents. Feedback from parents confirmed that they appreciated the opportunity to discuss mental health and wellbeing and that ignoring mental distress or their need for mental health promotion was not beneficial to their personal and parental functioning. Staff training emphasized that introducing mental health promotion is in fact an important role for public health and staff were encouraged to reach out to the MHPF or to mental health services when parents' needs were beyond their scope of practice.

Other barriers to implementation expressed by parents and home visitors included time pressures, stigma and economic factors (Chartier et al. 2015). There was a perception by some that TF would dramatically increase the public health workload and potentially distract from traditional public health responsibilities. This concern was addressed by helping staff understand how the TF strategy could enhance the mental health and wellbeing of parents, thereby placing the parents in a better position to engage in and benefit from the regular home-visiting curriculum. For example, families living in high stress situations benefit from understanding simple but helpful strategies to cope with life's struggles in addition to reaching out for supports and services.

Some within the mental health sector voiced concerns regarding screening for mental health challenges among parents in the post-partum period due to potentially increasing the number of referrals to overburdened mental health services. These challenges were addressed through engaging stakeholders in the process and by helping them see that screening facilitated parents being referred to the most appropriate services, which resulted in improved access rather than overburdening services. Screening processes also helped to determine which supports and services were in greater demand and helped to facilitate policy and programme changes for better access.

Programme Replication

Time, effort and involvement of an intersectoral and committed team is required for successful implementation. Mental health promotion is not universally well understood; therefore, it is critical to ensure that all levels of key stakeholders are engaged in understanding and implementing mental health promotion. This included increasing mental health promotion knowledge and skills of the existing workforce through training workshops tailored to the service provider needs. Perspectives of service providers and parents regarding the intervention can be obtained through interviews and focus groups and utilized to adapt or enhance the implementation. Finally, embedding an evaluation plan into the intervention from the start ensures that information relevant to all stakeholders is collected. For example, calculating the economic impact of mental health promotion provided rationale for decision-makers to allocate resources.

In summary, key recommendations for replicating the TF strategy in other jurisdictions are the following:

- Create strong intersectoral partnerships.
- Engage key stakeholders early in the process.
- Nurture the relationships within the team and with partners.
- Embed mental health promotion within existing systems.
- Dedicate resources to secure a MHPF position to build capacity and support existing staff to implement the strategy.
- Integrate a rigorous evaluation design in the planning stage.
- Share stories and evaluation results to engage others and to showcase the value of the strategy.
- Tailor messages and knowledge exchange activities to the audience.

Implement a cost-sharing model that requires health regions who are partners to match some of the funds in order to ensure dedicated and sustainable resources.

Future Directions for Application of the Intervention

This case study has described how TF was embedded within public health practice but it can also be adapted to a wide range of populations, for example, within schools, community agencies, primary health care clinics and child protection agencies. A community agency that serves clients experiencing mental disorders has partnered with a health region and trained their personnel in utilizing TF. To include primary care physicians, a series of short mental health promotion workshops are being tailored for their learning needs, thereby enabling them to use the mental health topics and everyday strategies with their patients.

Conclusions

The early years of life are recognized as a particularly critical period in human development as they lay the foundation for cognitive functioning, behavioural, social, emotional, physical and intellectual development throughout the lifecycle. A safe and secure home environment, a supportive family and early attachment have been identified as key protective factors for a child's positive psychosocial development. This chapter examined the role of home visiting programmes in providing ongoing support to families during pregnancy, infancy and early childhood with the goal of empowering parents and their children. Drawing on the research evidence and interventions reviewed in this chapter, the following characteristics of effective home visiting programmes have been identified (Sweet and Appelbaum 2004; Nievar et al. 2010: Peacock et al. 2013; Munns et al. 2016; Casillas et al. 2016; Olds 1997, 2006)

Model Based on Theoretical Foundation
The programme is based on well-established theories of human development and change centred around empowering parents to believe in their own capabilities to parent and the importance of the child's level of attachment to a parent/caregiver

Home Visitors are Trained to Adequately Meet the Needs of the Families That They Are Serving
Training and ongoing supervision is critical to high quality implementation of home visiting programmes employing good facilitation skills and an empowering and strengths-based approach

Create Strong Intersectoral Partnerships
Integration of the programme into existing services, combined with local and national public policy support is paramount for the upscaling of home visiting programmes. Home visitors often have to refer families to various health and social service providers, thus the health visitor must have a solid understanding and good working relationship with these other services.

Programme's Focus is on a Particular Issue Rather than Trying to Remedy Multiple Problems
Research suggests that programmes are more effective when the content of the programme is focused on improving specific outcomes rather than trying to address multiple risk factors or family adversities.

Programme Fidelity is Monitored/Monitor Implementation
Systematic monitoring and evaluation of the implementation process will help in ensuring that programme fidelity is maintained. Rapid dissemination without planning and capacity building has been shown to compromise the quality of programme implementation and its effectiveness.

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Implementing Parenting and Preschool Programmes

Aleisha M. Clarke

Introduction

Interventions that enhance parenting skills and provide quality preschool programmes have the potential to achieve long-term mental health benefits for both the child and the parents. In terms of parenting programmes, these entail a focus on helping parents improve their relationship with their child and supporting social, emotional and behavioural skill development in both children and parents. Early childhood or pre-school programmes provide children under 5 years with the knowledge, skills and social competence required for normal development and successful adjustment in school. When parenting and preschool programmes are implemented effectively, they are capable of producing positive effects across a range of outcomes including mental health, social functioning and general health behaviour. The effects of these programmes are most evident for vulnerable families from disadvantaged backgrounds. We will now examine a number of parenting programmes in detail, followed by preschool programmes, exploring their ability to promote the positive mental health and wellbeing of children and their parents and reduce risks for negative developmental outcomes.

Parenting Programmes

There is a consensus that interventions aimed at supporting parent–infant interaction and parenting practices are key to promoting the mental health and wellbeing of children. Parenting programmes are focussed, short-term interventions that are designed to promote the capacity and skills of parents in supporting their children's

A. M. Clarke (✉)
Child Mental Health & Wellbeing, Early Intervention Foundation, London, UK
e-mail: aleisha.clarke@eif.org.uk

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development through empowering parents and enhancing psychosocial skills and competence in both children and parents (Barlow et al. 2010). Both universal and targeted parenting programmes are designed to meet the needs of all families with young children and those at higher risk or dealing with child behaviour problems. The focus on parents as modifiers of their children's behaviour began in the 1960s when it was shown that parents could successfully decrease a range of behaviour problems in children through the use of behaviour modification (Rose 1974). Much of the early work in parenting support was conducted with families at the individual level but has since expanded to group-based parenting programmes and online parenting programmes (Barlow and Parsons 2010).

Parenting programmes typically involve the use of a manualized and standardized curriculum and are aimed at increasing the knowledge, skills and understanding of parents. They are generally delivered over the course of 8–12 weeks for about 1–2 h each week. They can be delivered on a one-to-one basis or to a group of parents. Underpinned by different theoretical approaches (e.g. cognitive-behavioural, family systems, Adlerian, social learning theories and psychodynamic), parenting programmes differ in the focus of their content (e.g. knowledge of typical child development, parent empowerment, communication skills, discipline or behaviour management strategies, positive interaction skills and behaviour management) and the types of families served (disadvantaged/low-income groups, adolescent parents, at-risk children or those identified with problems) (Barlow et al. 2010). Parenting programmes utilize different delivery techniques to engage parents and teach relevant content (e.g. group discussion and role play). They can be delivered in a variety of settings ranging from hospital/social work clinics to community-based settings such as GP surgeries, schools and churches. Most programmes have been developed for parents of children age 3–10 years old (Kaminski et al. 2008; Stewart-Brown and Schrader-McMillan 2011).

Examples of evidence-based parenting interventions include: Family Foundations, a group-based universal parenting programme for couples who are expecting their first child. It was developed at Penn State University in the USA (Feinberg et al. 2016). The programme consists of four prenatal and four postnatal weekly sessions, with each 2-h session administered to groups of six to ten couples. Sessions are led by a trained male–female team. The programme focuses on co-parenting and the co-parenting relationship. Parents learn strategies for enhancing their communication, conflict resolution and the sharing of childcare duties. The programme has been implemented in the USA and the United Kingdom. Results from two randomized controlled trials (RCTs) conducted in the USA with couples expecting their first child ($N = 169$ couples, Feinberg and Kan 2008; $N = 399$ couples, Feinberg et al. 2016) indicated significant improvements in child outcomes including infant self-soothing at 12 months (Feinberg et al. 2009), improved prosocial behaviour at 3.5 years (Feinberg et al. 2010), reduced internalizing and externalizing problems at age seven (Feinberg et al. 2014). A range of positive parent outcomes were also reported across the two studies including improved co-parental support, parenting-based closeness, parent–child interaction, couple behaviours, reduced parenting negativity, parenting stress, reduced depressive symptoms,

anxiety symptoms, inter-parent physical violence and parent–child physical violence (Feinberg et al. 2010, 2016).

The Family Check-up (FCU) for Children is a strengths-based intervention focussed on parenting practices. The programme addresses the needs of parents and children aged 2–5 years and can be implemented in the home, school and community setting. This intervention, which was developed in the USA, motivates parents to use parenting practices that support child competence, mental health and risk reduction. The intervention consists of two phases. Phase one is a brief, three session programme that involves three 1-h sessions: interviews, assessment and feedback. Phase two consists of a family-management training programme aimed at enhancing parents' skills in positive behaviour support, healthy limit-setting and relationship-building. Phase two can be limited to one to three sessions (health promotion strategy) or can range from 3 to 15 sessions (treatment approach). Results from two randomized controlled trials conducted in the USA revealed significant improvements in parent–child interaction, child behaviour and reduced maternal depression (Dishion et al. 2008; Lunkenheimer et al. 2008; Shaw et al. 2006, 2009).

'Learning through Play' is an example of another evidence-based parenting programme. This was originally developed in Toronto, Canada for use by lay home visitors working with at-risk multi-ethnic parents and children and adapted for use in many low- and middle-income countries (LMICs) (Rahman et al. 2009). The programme aims to stimulate early child development. The central feature of the programme is a pictorial calendar devised for parents, depicting eight successive stages of child development from birth to 3 years, with illustrations of parent–child play and other activities designed to promote parental involvement, learning and attachment. The programme is flexible as it can be carried out by a variety of non-specialist staff after appropriate training and can be delivered in a variety of formats with individual parents or group of parents. A cluster randomized trial of this intervention was carried out with 209 mothers and 24 community health workers in Pakistan. Results from this study showed that the programme was successfully integrated into the existing health system and accepted by community health workers. The programme succeeded in improving the knowledge and attitudes of mothers about infant development (Rahman et al. 2009).

Regarding the impact of parenting interventions on child and parent outcomes, results from a number of meta-analyses indicate that there is robust evidence on improved maternal psychosocial health, parenting skills, parent–child interaction and child emotional and behavioural adjustment (Barlow and Parsons 2003; Barlow et al. 2010, 2011, 2012, 2016; Furlong et al. 2013; Morrison et al. 2014). A meta-analysis of 48 group-based parent training interventions on parental psychosocial wellbeing (Barlow et al. 2012) revealed significant short-term improvements in parental depression, anxiety, stress, anger, guilt, confidence and satisfaction with the partner relationship. Results pertaining to reduced stress and enhanced confidence were maintained at 6 months follow-up. Another two meta-analyses examined the impact of parent interventions on children's emotional and behavioural adjustment. Regarding children aged 3 years or less, Barlow et al. (2010) reported a significant improvement in their emotional and behavioural adjustment at

post-intervention (both parent report and independent observations). The small number of studies included in the review ($N = 8$), however, limits the conclusion that can be drawn from this review.

Furlong et al. (2013) examined the impact of group-based parenting programmes for early-onset conduct problems in children aged 3–12 years. Results from 13 studies indicate that parent training produced a significant reduction in child conduct problems (parent report and independent observations). These interventions were also shown to enhance parental mental health, positive parenting skills and reduce negative or harsh parenting practices. These group-based parenting programmes achieved these results at a cost of approximately $2500 per family. These costs are viewed as modest when compared with the long-term social, educational and legal costs associated with childhood conduct problems. Examining the effectiveness of parenting programmes for teenage parents, Barlow et al. (2011) reported improvements in parent responsiveness to the child at post-intervention, infant responsiveness to the mother at follow-up and an overall parent–child interaction at post-intervention and follow-up. The conclusions were, however, limited by the lack of consistent measurement across the various studies.

Whilst the substantial literature on parenting interventions comes from high-income countries, these programmes are increasingly being implemented in LMICs (Butchart et al. 2006; Eshel et al. 2006; Knerr et al. 2013). Parenting programmes form an important evidence-based strategy for promoting positive parenting skills and reducing harsh and abusive parenting across many LMICs. In South Africa, for example, Chapter 8 of the Children's Amendment Act (Act 41 of 2007) mandates the South African government to provide interventions to support and develop positive parenting. This chapter recognizes that programmes that develop parenting skills are critical to promoting children's wellbeing (Wessels et al. 2016). Recently, a number of systematic reviews have examined the evidence base in order to address gaps in understanding of what works in the context of LMICs. Britto et al. (2017) conducted a meta-analysis of the impact of parenting interventions implemented in LMICs on non-cognitive outcomes and concluded that parenting programmes increased scores on measures of psychosocial development and motor development, in addition to child cognitive development. The most effective parenting programmes used several behaviour-change techniques, including media such as posters and cards that illustrate enrichment practices, opportunities for parental practice of play and responsive talk with their child, guidance and support for changing practices and problem-solving strategies (Aboud and Yousafzai 2015).

Regarding the prevention of child maltreatment in LMICs, Knerr et al. (2013) examined the effectiveness of parenting interventions aimed at reducing abusive parenting and increasing positive parenting practices. Results from 12 studies indicated improved parent–child interaction, parent attitudes and knowledge and reductions in harsh parenting. However, the quality of these studies was weak and only two interventions had large enough trials that were judged to be of low risk of bias.

Findings from the two high-quality trials provide evidence that parenting interventions may be feasible and effective in improving parent–child interaction and parental knowledge and thus may be important in addressing the prevention of child maltreatment in these settings. These two studies also highlight the potential of using non-professional local staff, delivery through home visits and adding interventions to routine services for mothers. These factors are of particular relevance in low- resource settings, where professional staffing is often not feasible or affordable at scale. Mejia et al. (2012) discuss other considerations regarding the implementation of parenting interventions in LMICs. They highlight the potential of adapting existing evidence-based parenting programmes from high-income countries and the need for programme developers in collaboration with low-income countries to address the challenge of delivering the programme in a culturally acceptable way. Mejia and colleagues argue that increasing the acceptability and 'fit' to a specific cultural context can increase the probability of uptake and successful outcomes. They also identify the need for future studies to examine the effectiveness of online interventions which offer the potential to address barriers in accessing support due to remote location.

Collectively, the results from meta-analyses across high-, middle- and low-income countries show that parenting programmes can be effective in improving the emotional and behavioural adjustment of children in addition to enhancing the psychosocial wellbeing of their parents. Further research is, however, needed to assess effectiveness of programmes for specific subgroups of children and parents (e.g. fathers, children living in adverse childhood circumstances such as living with parents with a mental disorder, parents with alcohol and drug addiction and families where serious abuse and neglect has occurred). Another limitation across all of the meta-analyses is the paucity of follow-up data available regarding the extent to which the effects of these programmes are maintained over time.

A number of reviews have identified characteristics of high-quality parenting programmes (see Box 1). Kaminski et al. (2008) synthesized results from 77 evaluations of parent training programmes aimed at enhancing children's (aged: 0–7 years) behaviour and adjustment. Programme components consistently associated with larger effects included positive parent–child interactions and emotional communication skills, teaching parents to use time out and the importance of parenting consistence and requiring parents to practice new skills with their children during parent training sessions. Programme components associated with smaller effects included teaching parents' problem-solving, teaching parents to promote children's cognitive, academic or social skills and providing other additional services.

We will now examine in detail the Triple P-Positive Parenting Programme, which adopts a public health approach to parenting, targeting entire populations for maximum effect. Triple P consists of a suite of programmes of increasing intensity within its multi-level system, which can be delivered in different formats (one-to-one, large group, small group, online) addressing the needs of parents and children aged up to 16 years.

Box 1 Characteristics of High Quality Parenting Programmes (Barlow et al. 2010; Kaminski et al. 2008; Stewart-Brown and Schrader-McMillan 2011)

- Structured programme with manual.
- Skilled workforce with good facilitation skills.
- Programme content that focuses on enhancing the overall quality of the parent–child relationship.
- Adoption of a strengths-based approach to foster skills development.
- Based on experiential learning.
- Teaching parents' skills related to emotional communication – training in active listening, teaching parents to help children identify and deal with emotions and teaching parents to reduce negative communication.
- Teaching parents to use time out effectively and consistently.
- Teaching parents to interact positively with their child – teaching parents how to demonstrate enthusiasm, how to interact on the child's level during play and how to provide appropriate activity choices.
- Providing parents with opportunity to practice new skills with their children during training session.

Practice Example: Triple P-Positive Parenting Programme (Sanders et al. 2001, 2002)

The Triple P-Positive Parenting Programme was designed as a comprehensive public health approach to parenting and family support. The Triple P system of parenting and family support aims to promote family harmony and reduce parent–child conflict by helping parents to develop a safe, nurturing environment, promote positive caring relationships with their children and develop effective, non-violent management strategies for dealing with a range of childhood behaviour problems and common developmental issues (Sanders et al. 2001). The programme, which was developed at the University of Queensland, is designed to enhance parental competency and prevent or alter dysfunctional parenting practices, thereby reducing an important set of family risk factors both for child maltreatment and for children's behavioural and emotional problems.

Programme Content

The programme draws on social learning models that highlight the reciprocal and bi-directional nature of parent–child interaction (e.g. Patterson and Reid 1984) and incorporates behaviour change techniques identified through research in child and family behaviour therapy. Triple P has multiple levels of intervention of varying degrees of intensity. All levels aim to prevent behavioural, developmental and emotional problems in children aged 0–16 years through enhancing the knowledge, skills and confidence of parents. The programme promotes; (1) enhancement of

skills, knowledge, confidence and resourcefulness of parents, (2) more nurturing, safe, engaging and non-violent environments for children, and (3) children's social, emotional, linguistic, intellectual and behavioural competencies (Sanders et al. 2003a, b, c).

Triple P incorporates five levels of intervention. The rationale for this stepped care strategy is that there are different levels of emotional and behavioural problems in children and that parents may have different needs and desires regarding the type, intensity and mode of assistance they require (Sanders et al. 1999).

- Level 1 is a form of universal prevention and it delivers psychoeducational information on parenting skills to interested parents. Universal Triple P includes use of radio, local newspapers, newsletters at school, mass mailings to family households, presence at community events and website information.
- Level 2 is a brief/'light touch' intervention providing one-time assistance to parents who are generally coping well but have some concerns about their child's behaviour or development. It is available for parents of children from birth to 12 years and for parents of teenagers.
- Level 3 is a four-session intervention, addressing the needs of children with mild to moderate behavioural difficulties and includes active skills training for parents. It is available for parents of children from birth to 12 years and for parents of teenagers. It can be delivered as a brief face-to-face or telephone intervention with approximately four consultations lasting between 15 and 30 min. Alternatively, 2-h small group sessions addressing a specific problem behaviour or issue can be provided (e.g. dealing with disobedience, managing fighting, developing good bedtime routines). Parents are taught a variety of child management skills and are trained to apply these skills both at home and in the community.
- Level 4 is an intensive 8–10 session parent training programme for children with more severe behavioural difficulties or who are at risk of developing such problems, which can be offered either individually or in a group of parents. Parents are taught a variety of child management skills. There are three delivery formats at Level 4:
  - Standard Triple P is an individual 10-session programme for parents who require intensive support.
  - Group Triple P is an eight-session programme conducted in groups of 10–12 parents with four 15–30-min follow-up telephone sessions provided as additional support.
  - Triple P Online is a comprehensive, eight-session web-based programme that guides parents through Triple P's 17 core parenting skills.
  - Self-directed Triple is a 10-week self-help programme for parents and may be augmented by weekly 15–30 min telephone consultations.
- Level 5 is an enhanced behavioural family intervention (BFI) programme for families in which parenting difficulties are complicated by other sources of family distress (e.g. marital conflict, parental depression or high levels of stress). Parents must complete a Level 4 Standard or Group programme before a Level 5 course (Sanders et al. 1999).

In addition to the five levels, there are a number of specialist programmes including:

- Stepping Stones Triple P – for parents of pre-adolescent children who have a disability.
- Family Transitions – individual or group sessions for parents whose separation or divorce is complicating their parenting.
- Lifestyle Triple P – a ten session group programme with four telephone support calls for parents of overweight children age 5–10 years.
- Indigenous Triple P – allows providers to tailor their delivery of the programmes to suit Indigenous families in Australia.

The Triple P system meets the standards of evidence criteria for dissemination (Society for Prevention Research 2004) including: substantial evidence of efficacy and effectiveness; the ability to go to scale, including professionally developed resource materials and a standardized training and accreditation process for service providers; clear and readily available cost information relating to programme cost-effectiveness; availability of evaluation tools for providers and identification of the conditions necessary to promote programme sustainability and quality assurance (Society for Prevention Research 2004). Triple P is being implemented in more than 25 countries globally and has been shown to work across diverse cultural and socio-economic groups. It has been translated into 21 languages other than English. Over 75,000 practitioners have been trained in its delivery and approximately four million children and their families have received the programme.

Evaluation Findings

The evidence base for Triple P is extensive. Starting in the early 1980s a number of controlled single case studies were conducted. Subsequently, small-scale randomized controlled trials were carried out followed by large-scale population level evaluation of Triple P as a multilevel system in communities. The programme of research has shown successful outcomes with a number of populations and problem areas, with significant improvements noted on observed and parent-reported child behaviour problems, parental adjustment and parenting practices (e.g. Bor et al. 2002; Sanders et al. 2000; Sanders and McFarland 2000). Several effectiveness and dissemination studies have been conducted on Triple P demonstrating portability and broad utility in multiple settings (Sanders et al. 2003a, b; Turner and Sanders 2006; Zubrick et al. 2005).

A number of meta-analyses have evaluated Triple P reporting medium to large effect sizes on child and parent outcomes (de Graaf et al. 2008; Fletcher et al. 2011; Nowak and Heinrichs 2008; Sanders et al. 2014; Tellegen and Sanders 2013; Thomas and Zimmer-Gembeck 2007; Wilson et al. 2012). A meta-analysis carried out by Sanders et al. (2014) identified 101 studies (including 62 RCTs), comprising 16,099 families, conducted over a 33-year period. Combining data from all levels of Triple P, significant short-term medium effects were identified for children's social, emotional and behavioural outcomes ($d = 0.47$); parenting practices ($d = 0.58$) and parenting satisfaction and efficacy ($d = 0.51$). Significant small to medium effects

were also found for parental adjustment (d = 0.34) and parental relationships (d = 0.23). Regarding observational data of child and parent interactions, significant effects were found at short-term for child observational data (d = 0.50) but not for parent observational data (d = 0.03). At follow-up, significant effects were found for all outcomes including parent observational data (d = 0.25). Targeted and treatment approaches were associated with larger effect sizes than universal studies. However, all three types of study approach produced significant effect sizes indicating that Triple P has value both as a universal prevention programme and as a treatment programme. In terms of delivery format, online Triple P had the largest effect size for child social, emotional and behavioural outcomes and online and group format had the largest effect sizes for parental relationships.

Programme Implementation Features

Research on the implementation of Triple P has identified the following key features of the planning and implementation of the programme (Sanders et al. 2002; Sanders 2003).

Model based on strong theoretical foundation: The Triple P system draws on well-established theories of human development and behaviour change including (Sanders 2003):

- Social learning models of parent–child interaction that highlight the reciprocal and bi-directional nature of parent–child interactions (e.g. Patterson 1982).
- Research in child and family behaviour therapy that has identified behaviour change techniques (Sanders 1996).
- Developmental research on parenting in everyday contexts, which has identified children's competencies in naturally occurring situations (Hart and Risley 1995).
- Research from the field of developmental psychopathology which identifies specific risk and protective factors linked to the development of psychopathology in children (Emery 1982; Grych and Fincham 1990; Rutter 1985).
- Social information processing models that highlight the important role of parental cognitions such as attributions, expectancies and beliefs as factors that contribute to parental self-efficacy, decision making and behavioural intentions (e.g. Bandura 1977, 1989, 1995).
- Population health research on changing health risk behaviours among the population that has been applied within a mental health framework (e.g. Becker et al. 1992).

System level approach: A unique feature of Triple P is that rather than being a single programme, it is a multilevel system of parenting interventions with five levels of intervention on a tiered continuum of increasing intensity for parents of children from birth to age 16. The Triple P model assumes that the differing needs of parents will require differing levels of support. The multilevel model has considerable flexibility and enables parents to participate in the programme at different levels of intensity depending on the parent's assessed need (e.g. parenting concern alone versus parenting concerns plus marital conflict) and parental availability. Many of the issues that are relevant to parents (e.g. parental consistency, having engaging and supervised activities for children, positive attention) are depicted

across the different intervention levels. However, the intensity of intervention support varies, for example, the number of sessions required, amount of practice, level of practitioner support, such as, a tip sheet plus video demonstrating the strategy versus a tip sheet plus video plus behavioural rehearsal and coaching with a practitioner (Sanders et al. 2002).

Structured training and manual: A standardized training programme has been developed for each level of the intervention. This ensures that at the first point of exposure practitioners throughout the world receive the same training experience (Sanders et al. 2002). High-quality training materials, practitioner manual and parent materials have been developed to ensure that the programme is easy to follow, accessible and culturally appropriate. Each manual for Triple P provides detailed descriptions of programme objectives, session content and process issues that can arise in delivering the programme. Each training course for practitioners involves the completion of pre-training reading, attendance at a training programme and fulfilment of accreditation requirements. Accreditation as a Triple P provider requires practitioners to demonstrate a set of core competencies defined for each level of the programme. Practitioners participating in Triple P are encouraged to establish peer support/supervision networks to review cases and to prepare for the accreditation process (Sanders 2003).

Interagency collaboration: A core element of the population-based dissemination of the Triple P system involves the engagement, training and support of a broad array of service providers from several disciplines and settings including; family support services, social services (family services, social workers), preschool and child-care settings, elementary schools, non-governmental organizations (e.g. early childhood NGOs, child-abuse prevention NGOs), private sector practitioners, health centres (primary healthcare providers) and other community entities having direct contact with parents and families (Sanders 2011). Implementation of the Triple P system depends on coordination and cooperation across the range of service providers and must be made evident from the outset to ensure integration into the current health system.

Self-regulation and parental competence: Another core element of the Triple P approach is the emphasis on developing parental competencies that support them in becoming independent problem solvers. This includes teaching parents how to select developmentally appropriate goals, monitor their child's or their own behaviour, choose an appropriate method for intervention for a particular problem, implement the solution, self-monitor their implementation of solutions via checklists relating to areas of concern and to identify strengths or limitations in their performance and set future goals for action (Sanders 2003).

Active skills training: The five core principles of positive parenting that are invoked throughout the Triple P system to promote social competence and emotional self-regulation in children are:

1. Ensuring a safe, engaging environment.
2. Promoting a positive learning environment.
3. Using assertive discipline.

4. Maintaining reasonable expectations.
5. Taking care of oneself as a parent.

The emphasis is on parents learning how to apply these skills to different behavioural, emotional and developmental issues ranging from common child rearing challenges (e.g. toilet training, mealtime behaviour, bedtime and behaviour in public) to more intense challenges (e.g. child aggressive behaviour, fears and anxiety and attention deficit hyperactivity disorder (ADHS) difficulties). At each level of intervention, active skills training methods are used to promote skills acquisition. For example, in Universal Triple P, media strategies are used that involve the realistic depiction of possible solutions to commonly encountered parenting situations (e.g. bedtime situations). These potential solutions can be illustrated through various mediums including television programmes, community service announcements, newspaper columns and advertising. In more intensive levels of intervention, for example, Level 3 or 4 or 5, information is supplemented by the use of active skills training methods that include modelling, rehearsal, feedback and between session practice tasks. Segments of videotapes can also be used to demonstrate positive parenting skills. Several generalization enhancement strategies are incorporated into the training sessions to promote the transfer of parenting skills across settings, siblings and time. Practice sessions can be conducted at home or in the clinic during which parents self-select goals to practice, are observed interacting with their child and implementing parenting skills, and subsequently review their performance and receive feedback from the practitioner (Sanders et al. 2002).

Culturally appropriate: Triple P has been shown to be effective and acceptable to parents in a range of cultural contexts. These include trials with parents in Hong Kong, Japan, Germany, Australia and New Zealand. Sanders (2008) reported on the range strategies that have been employed to ensure cultural relevance of Triple P including; soliciting consumer opinion about the parent strategies advocated; conducting focus groups with parents and service providers to identify key concerns and issues relevant to programme implementation with specific ethnic groups; translating materials, re-shooting video materials to ensure that indigenous families are included; using voice-synchronized dubbing of selected video material and conducing outcome research with different ethnic groups to examine the efficacy of the culturally adapted procedures.

Key Recommendations for Replication

Workplace support: A survey of over 1000 professionals completing training in Primary Care Triple P identified a number of barriers to delivering the programme following training. Many of the barriers related to the work environment such as support from management, access to supervision and ability to schedule after hours appointments (Turner 2003). It is recommended that support beyond professional training is provided to agencies adopting the programme. This includes policy briefings and orientation for administrators, supervisors or mangers about the programme and the training and accreditation procedures. Triple P also provides procedural guidelines, performance targets and back-up consultative advice to assist sites to identify and overcome any barriers to implementation (Turner and Sanders 2006).

Promotion of practitioner self-efficacy: The training process adopted in Triple P dissemination focuses on the development of practitioner self-efficacy. This is fostered by encouraging practitioners to take personal responsibility for their learning, which is favoured over more directive training methods and feedback from others. Practitioners receive support in fine-tuning their skills and in promoting self-efficacy. It is hypothesized that the joint focus on theory, practical skills training and personal responsibility is responsible for the increased confidence practitioners report in their parent consultation skills (Turner 2003).

Supervision: Effective supervision of staff involved in delivering Triple P includes both peer support and mentoring of practitioners who are new to the programme. Following training, practitioners are encouraged to establish or join peer support/supervision networks to prepare for the accreditation process. In the longer term, ongoing peer support is recommended to facilitate reviews of case management, continue skills development, prevent drift from evidence-based protocols and foster support from colleagues to prevent burnout (Turner and Sanders 2006).

System integration: Triple P not being integrated with practitioners' caseloads or other responsibilities at work was identified as a significant barrier to delivering the programme following training (Turner 2003). This highlights the importance of prior examination of the elements necessary to support programme delivery as well as the fit of the programme with the organization and with the practitioner's duties before a decision is made to adopt the programme.

To date, the scaling up of evidence-based parenting interventions so that they are more widely available, especially to families who may need them most, remains a challenge. Although results from experimental studies have demonstrated improved outcomes for children and parents who participate in such programmes, there is little evidence that if implemented at scale, these programmes will lead to population wide improvements in mental health, health, education and social outcomes. Like Triple P, the Incredible Years programmes is an example of a series of evidence-based programmes that have been implemented at scale across high-, middle-, and low-income countries in six continents. The Incredible Years programmes (Webster-Stratton 2011) comprise a set of multifaceted and developmentally based curricula for parents, teachers and children that aim to promote emotional and social competence and prevent, reduce and treat aggression and emotional problems in young children. The parenting programmes span the age range of 0–12 years. The child and teacher programmes span the age range of 3–8 years. The BASIC parenting training has five curricula (Baby Programme (8–9 sessions), Toddler Programme (12 sessions), Preschool or Early Childhood Programme 18–20 sessions and Early School-Age Programme or Preadolescent Programme (12–16 sessions). The ADVANCE parent programme (9–12 sessions) focuses on more interpersonal skills, anger and depression management and problem-solving and can follow the BASIC programme for high risk populations and families with diagnosed children.

Incredible Years BASIC Parenting was implemented in Wales in 1999 as part of the UK government's Sure Start initiative. Similar to the HeadStart programme in the Unites States, Sure Start aims to give children the best possible start in life through improvements in child care, early education and family support. Sure Start was launched as an area-based initiative in England in 1998 with a particular focus on the most disadvantaged families in order to reduce inequalities in child development and school readiness. Slightly different versions of the initiative were also developed in Wales, Scotland and Northern Ireland. The next case study examines the dissemination of the Incredible Years Basic Parenting Programme in Wales and identifies factors that supported the successful scale-up and sustainability of the programme at a country level. Following that we then examine the Parenting for Lifelong Health Programme, which consists of a suite of parenting programmes for low-resource settings. This case study provides an important insight into the development of a culturally adaptable suite of parenting programmes that are tailored to local contexts in low-resource settings and the factors that ensure their successful development and implementation.

Case Study: Incredible Years – Disseminating the Incredible Years® Basic Parenting Programme in Wales

Judy Hutchings · Margiad Williams
Centre for Evidence-based Early Intervention, Bangor University, Bangor, UK

Background

The Incredible Years® (IY) programmes (www.incredibleyears.com) have been developed and researched for over 30 years with the goal to prevent or reduce antisocial child behaviour. There are programmes for parents, children and teachers but the parent programmes have been most widely disseminated and have strong international evidence for both prevention and treatment of conduct disorder and related difficulties (Hutchings et al. 2007; Leijten et al. 2017; McGilloway et al. 2012). The group-based basic parent programme has been implemented in early intervention services in high-risk communities and is the subject of this case study. Participants attend groups of up to 12 parents and learn to use social learning theory principles, have role-play practice to rehearse key skills, learn to set and achieve realistic goals and are given home activities (Hutchings et al. 2004). The programme is equally effective with families experiencing disadvantaging circumstances (Gardner et al. 2010). Three factors appear to contribute: (1) content based on social learning theory (2) collaborative delivery process that helps to empower parents to achieve their own

goals and (3) ensuring access for low-income people, including creches, transport and meals. The basic programme has been widely disseminated, including in over 10 European countries and been the subject of rigorous independent RCTs in seven European countries and elsewhere.

This case study describes the development and dissemination of the IY basic parent programme in high-risk Sure Start communities across Wales.

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

1. From 1999, government-funded early intervention 'Sure Start' services were being set up across the UK to address the needs of families of preschool children at risk of poor outcomes and this included parenting support.
2. The first author, an NHS consultant clinical psychologist and researcher, reviewed existing programmes for the prevention of violence in young children using systematic reviews and the Blueprints for Violence Prevention classification. She identified the IY basic parent programme as both effective and as having the necessary tools for reliable replication (training, supervision, resources for leaders and parents). She trained to deliver the programme, in 1999, and quickly qualified to undertake local training and supervision and became the local programme champion.
3. The next step was to meet newly appointed Sure Start service managers to establish their needs. Evidence of effective outcome was required of them; however, there was no specific guidance on which programmes to deliver. Managers agreed to allow their staff to train and deliver the programme with local supervision. A survey was undertaken to obtain feedback on leader experience. Leaders valued the programme and the supervision and saw important changes in families. This established programme acceptability with both parents and group leaders but leaders also reported lack of time and other resources needed to deliver it well.
4. The survey results were shared with managers who agreed to collaborate in seeking funds for a randomized controlled trial of the programme with parents of targeted high risk 3- and 4-year-old children. It was agreed that, if the research was funded, managers would release staff for a day and a half each week and provide creches and the grant would fund parent resources, supervision and other costs including meals and transport. The first author's university research post provided the base for the successful Health Foundation funded grant for a trial in 11 local Sure Start Centres.
5. Recruitment: Local Health Visitors (public health nurses with responsibility for preschool children) identified and recruited parents who reported their children

as being within the clinical range for behavioural problems on the Eyberg Child Behaviour Inventory (Eyberg et al. 1980). Parents were encouraged to join the trial on the basis that they had a 'difficult to parent' child and that these children required special parenting. This resulted in recruitment of 90% of eligible parents.

6. Ensuring implementation fidelity: Despite evidence-based programmes being chosen, service providers often fail to replicate the results of programme developers due to failure to deliver the programme with fidelity. This trial incorporated all of the necessary fidelity criteria. Leaders had sufficient time to deliver with fidelity – in return for training, supervision and outcome evidence. All leaders had basic training and prior experience of programme delivery. They received all necessary resources, including leader manuals, parent handouts and books and support for the costs of transport, creches and lunches.
7. Supervision: The first author provided 3 h of weekly group leader supervision to which leaders brought a videotape of their most recent session for review. Staff had time to prepare for, and review, sessions for supervision, keep records of material covered, collect weekly parent evaluations, make mid-week parent phone calls and follow-up parents who missed sessions. Twenty-two of twenty-three group leaders achieved the accreditation standard.
8. Outcomes: This was the first UK-based community study providing rigorous evidence of effectiveness of an evidence-based parenting programme delivered with fidelity by regular Sure Start staff. Moreover, results showed impact on child challenging behaviour and ADHD symptoms, parenting skills, parental mental health and sibling behaviour and were sustained over time (Bywater et al. 2009; Jones et al. 2008).
9. Impact of the trial: The short-term impact was that the Welsh Government funded training, supervision and resources for staff from all 22 Welsh Local Authorities for a 7-year period, in their Parenting Action Plan for Wales (Welsh Assembly Government 2005), ensuring that the programme became widely disseminated. The results prompted firmer guidance on the need for evidence-based programmes in Wales and subsequently England (Social Exclusion Task Force 2006) with both Governments now specifying the use of programmes with evidence. They also influenced the establishment of the Government funded Early Intervention Foundation to evaluate and disseminate programme information.

Implementation Challenges in the Course of Delivery

Selecting an evidence-based programme is the first step. It must then be delivered with fidelity, as happened during the research trial, but the challenge is to maintain this in regular service provision.

Service managers and politicians can change regularly so keeping people informed is an ongoing task. Our dissemination strategy includes annual conferences in North and South Wales and an annual newsletter that reports research findings and showcases the work of service providers. Our publication strategy targets both academic and professional journals. We present annual awards to service providers that provide good role models.

Welsh Government funding provided the resources for initial wide-scale roll-out of the programme but the Centre at Bangor has maintained a monitoring role, including regular surveys of service providers that have again suggested lack of adequate time and resources. Survey results are fed back to managers and Welsh Government funded training was extended to include manager fidelity and evaluation workshops.

The ever-present risk of diluting intervention effectiveness has to be addressed and resourcing personnel with responsibility for maintaining fidelity standards is crucial. There are now three trainers in Wales and several people have been trained to provide local supervision. Not all authorities use this programme, and some continue to use home grown or other programmes that lack evidence, but we now have several centres of excellence in Wales that provide role models for other service providers. Alongside this, the culture has changed and there is better understanding of the need to deliver programmes and strategies that work and with fidelity.

Key Recommendations for Replication

When introducing a new programme, especially one developed in a different culture, the first step is to ensure that it has evidence and tools for effective replication. Next, it needs piloting to test its feasibility and acceptability in the new setting and service managers need to understand evidence and fidelity.

Once piloted, a rigorous research trial is needed to see whether the programme is equally effective in the new situation, requiring a programme champion to take the lead in ensuring replication with fidelity. Results need to be disseminated widely and the challenge of ensuring that roll-out maintains fidelity needs constant attention.

To achieve good outcomes, authorities need to fund a staff member to lead programme implementation who understands social learning theory and collaborative process, has experience of delivering the programme and has supervision skills. Unless someone has designated responsibility, effective embedding of evidence-based programmes will not happen. The Welsh Government strategy, to develop skills in delivering this programme across Wales, recognized that it would

take time for all of the 22 Authorities in Wales to have accredited leaders to take a lead in ensuring effective implementation with high-risk families in their localities.

Future Directions for Application of the Intervention

The programme continues to be implemented across Wales in early intervention settings and we have used a similar process to establish other IY parenting programmes including the baby, toddler, school readiness and autism and language delay programmes. We have also tested the programmes with different populations, including with foster carers and nursery staff and we continued to inform key policy makers (see further details of publications at: https://www.bangor.ac.uk/psychology/cebei/publications.php.en). Alongside this, also with grant funding and Welsh Government support, the IY child and teacher programmes have been developed using a similar process (Hutchings and Williams 2017).

Work is ongoing to develop supervisors and mentors to train and support front-line service providers and test programmes with new populations and different age groups. The process that embedded the IY basic parent programme in Wales addressed issues that all programme implementers should consider.

Conclusion

Sure Start services, targeting high-risk disadvantaged communities, successfully delivered effective parenting support that was rigorously evaluated and achieved outcomes as successful with hard-to-reach families as those of the programme developer. However, there are still many challenges ahead to ensure that local services achieve and maintain effective implementation. The Sure Start project provided a demonstration of how to do this (Hutchings et al. 2007). Those services that participated in our research trial, over 15 years ago, continue to deliver the programme, in many cases with the same group leaders that delivered the programme as part of the research trial.

The key factor that contributed to embedding the programme more broadly across Wales was the Welsh Government involvement in programme dissemination. The trial results just preceded the Welsh Government Parenting Action Plan for Wales (2005) and resulted in 7 years of funding to give services in all 22 Local Authorities an opportunity to have staff and managers trained and resourced. Governments in England and Wales have continued to fund the IY programmes through a series of initiatives.

Case Study: Parenting for Lifelong Health Programmes – Implementing the Parenting for Lifelong Health programmes – Lessons Learned from Low-Resource Settings

Inge Wessels · Catherine L. Ward
Department of Psychology, University of Cape Town, Cape Town, South Africa

Anna Booij · Nomagugu Masuku-Mukadah
Clowns Without Borders South Africa, Cape Town, South Africa

Lucie Cluver
Department of Social Policy and Intervention, University of Oxford, Oxford, UK

Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa

Peter Cooper · Lynne Murray
Department of Psychology, University of Reading, Reading, UK

Frances Gardner
Department of Social Policy and Intervention, University of Oxford, Oxford, UK

Judy Hutchings
Centre for Evidence-based Early Intervention, Bangor University, Bangor, UK

David Jeffery
Mikhulu Trust, Cape Town, South Africa

Jamie Lachman
Clowns Without Borders South Africa, Cape Town, South Africa

Department of Social Policy and Intervention, University of Oxford, Oxford, UK

Social Policy and Public Health Sciences Unit, University of Glasgow, Glasgow, UK

Mark Tomlinson
Department of Psychology, Stellenbosch University, Stellenbosch, South Africa

Background

Evidence-based parenting interventions have been shown to reduce risk for child maltreatment (Lundahl et al. 2006). Of concern is that most of these interventions have been developed and implemented in high-income countries (HICs), with few having been evaluated in low- and middle-income countries (LMICs) where the need for such programmes is especially great in relation to higher levels of child protection concerns (Knerr et al. 2013; Mejia et al. 2012). Governments and

non-governmental organizations (NGOs) in many LMICs, as well as international organizations such as UNICEF, the World Health Organization (WHO) and the Global Partnership to End Violence Against Children, have expressed interest in expanding the availability of evidence-based parenting interventions to improve child wellbeing and reduce child maltreatment.

While there is some evidence that programmes from HICs can be transported across countries, even to those with different cultures and contexts (Gardner et al. 2016), these programmes are often too expensive to be implemented at scale in LMICs (Mikton 2012). In response to this need, Parenting for Lifelong Health (PLH) was initiated. PLH is a suite of culturally adaptable, not-for-profit and rigorously tested parenting programmes designed to enhance parenting, promote child development, reduce risk factors for violence and prevent violence for low-resource settings. PLH represents the coming together of research, policy and practice. Researchers from South Africa (Universities of Cape Town and Oxford) and the United Kingdom (Universities of Oxford, Bangor, Glasgow and Reading) had identified a need to expand the evidence on the effectiveness of parenting programmes on reducing harsh parenting and improving child wellbeing in South Africa. At the same time, the WHO and UNICEF were engaging with policymakers and practitioners in LMICs around the world regarding the potential of using parenting programmes to prevent child mental and physical health problems. Furthermore, NGOs in South Africa, such as Clowns Without Borders South Africa (CWBSA) and the Mikhulu Trust, were gradually realizing that they needed to start rigorously testing the family programmes they were delivering to beneficiaries. In 2013, individuals from these entities came together for initial meetings in Oxford and Cape Town to explore possibilities of working in collaboration to address these issues, and thus, PLH was born.

The PLH suite comprises four programmes, spanning the age range of 0–18 years. The Mikhulu Trust (http://www.mikhulutrust.org/) is the NGO implementing partner for the programmes for babies and toddlers, while CWBSA (http://www.cwbsa.org/) focuses on the programmes for young children and adolescents.

PLH for Babies

This is a 16-session home-based parenting intervention for mothers, from late pregnancy until 6 months postpartum. In the context of providing mothers with emotional support, the programme focuses on enhancing awareness of the developing social capacities and individual sensitivities of infants.

PLH for Toddlers

This is an eight-session parenting programme involving training in dialogic reading skills, delivered to groups of four to six parents. There are programmes for parents of 12- to 20-months-olds, parents of 20- to 30-month-olds, and parents of 30- to

60-month-olds. The group sessions involve presentation of key shared-reading principles, supported by demonstration video clips and one-to-one support of group members by the facilitator.

PLH for Young Children

This is a 12-session group-based parenting intervention for parents of 2- to 9-year-olds. This programme focuses primarily on increasing positive parenting, reducing harsh parenting and reducing child behaviour problems. Home visits can be provided to parents who miss sessions or need additional parenting support.

PLH for Adolescents

This is a 14-session group-based parenting intervention for parents and their 10- to 18-year-olds. It uses evidence-based parenting principles as building blocks for parent–teen communication, and parent–teen problem-solving for risks inside and outside the home. As with PLH for Young Children, home visits can be provided when needed.

PLH for Babies is based on attachment theory (Bowlby 2008), while PLH for Toddlers is based on Vygotsky's theory of cognitive development (Vygotsky 1978). PLH for Young Children and PLH for Adolescents are informed by social learning theory and behaviour management principles (Bandura 1969). Programme principles are explained in manuals written in language accessible to non-specialists. The programmes are designed to be delivered using low-cost materials by paraprofessional staff (community health workers) – an approach that is essential within low-resourced settings where there is limited availability of professionally qualified personnel.

Initial development and testing of the PLH programmes through randomized controlled trials has taken place in South Africa and shows promising results (e.g. Cooper et al. 2014, 2009; Cluver et al. 2016; Murray et al. 2016; Vally et al. 2015; Lachman et al. 2017). Programmes are at various stages of development, evaluation and dissemination, but all are being further developed and tested in other LMICs. The PLH programmes for young children and teens are currently being implemented on a large scale in numerous low- and middle-income countries – it is estimated that they will be delivered to 500,000 participating families by 2020. Major partners include national governments, UNICEF, USAID, 4Children, Catholic Relief Services, World Education's Bantwana Initiative and Pact.

The PLH research and evaluation partners have learned several key lessons during the initial trials, from the demand for our programmes, and through working with partners at UNICEF and WHO. Typically, before an intervention can be disseminated widely, there must be evidence that it meets rigorous standards of

effectiveness as outlined by the Society for Prevention Research (Gottfredson et al. 2015). However, the team has decided that the need to increase the evidence base for these programmes must be held alongside the urgent need for implementation, rather than being completed ahead of it. Randomized controlled trials (RCTs) are prioritized to build the evidence, with trials currently being conducted in El Salvador for PLH for Babies; Brazil, Lesotho, South Africa, the UK and the USA for PLH for Toddlers; and the Philippines, Thailand, Moldova, Macedonia and Romania for PLH for Young Children. Also, routine monitoring and evaluation data across implementation sites will be collected to build evidence on issues related to fidelity and engagement so that we can examine how programmes might be delivered most effectively. This case study highlights some of the lessons learned about key factors associated with successful delivery of the PLH programmes.

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

Tailoring Programmes for Local Contexts The initial prototype programmes were developed and tested in South Africa. When there is interest from another country, two different types of adaptation are considered depending on the local context and population targeted – surface adaptations and more in-depth adaptations. Surface adaptations enable the programme to be culturally appropriate and relevant for parents in the new context. These adjustments include the translation of materials into local languages, re-drawing illustrated stories or creating new videos that depict typical families in the delivery context, and revising role-play scenarios. In some contexts, PLH has also adapted programmes to include additional content, for example, regarding HIV-prevention. More in-depth adaptation is conducted when larger structural or content-related changes are made, such as adapting the programme for children being reintegrated from residential care into families in Uganda. When core elements are changed, the intervention is fundamentally different and so must be tested again to determine efficacy (Barrera et al. 2013).

Comprehensive Training and Supervision Training and supervision are likely to be associated with successful and sustainable delivery of the PLH programmes. PLH implementing partners normally provide initial technical assistance to organizations in order to build local capacity to implement the PLH programmes. This includes intensive training for personnel who deliver the programme as well as for those who train and support facilitators. Certified PLH trainers deliver a 3- to 5-day initial facilitator training workshop for front-line implementers who are recruited either from within partner organizations' existing staff or from the target community. Prospective facilitators must be literate and fluent in the local language, with prior

knowledge and experience in child development and working with groups preferred. Only facilitators who have been through the full training process and certified as facilitators are eligible to become coaches for PLH 2–18 and trainers for PLH 0–2. For PLH 2–18, and only certified coaches are eligible to become trainers. PLH is also committed to building in-country and organizational capacity to train and deliver the programmes independently.

Monitoring and Evaluating Process and Outcomes As the programmes are being disseminated, PLH has begun to develop strategies to support facilitators in maintaining fidelity to the original intervention content and delivery style, under real-world conditions. While effective training and ongoing supervision are essential elements in achieving this, manualized delivery also plays an important function. All of the PLH interventions include manuals for the facilitators. In addition, CWBSA has created tools for facilitators so that implementation issues (e.g. difficulty with certain content) can be documented and reviewed by their coaches.

CWBSA and the Mikhulu Trust have also developed tools for partners to use to monitor outcomes. Both organizations work with partners to integrate these tools within existing assessment structures to ensure the relevance and sustainability of the data collection system.

Strong Partnerships Large-scale delivery of the programmes, especially within low-resource settings, would not be possible without strong partnerships that involve efficient and regular communication, sustainable allocation of administrative and logistical support, and collaborative problem-solving. The dedication of time and effort to implementation preparation is essential when scaling up the programmes, to ensure clear expectations, division of tasks and constructive collaboration between the multiple local implementing partners, NGOs, and donors that may be involved.

Implementation Challenges in the Course of Delivery

Implementation Fidelity Although the programmes are manualized and supported with comprehensive training and supervision, it is still a challenge to ensure that facilitators are delivering the programme competently with fidelity. The Mikhulu Trust and CWBSA recommend that trainers or coaches (delivery supervisors) conduct field visits to observe delivery, identify possible deviations from the manual, and help improve the quality of delivery by facilitators. PLH also includes a certification process that includes video or live assessments of programme delivery to ensure that facilitators master core competencies before increasing their responsibilities.

Attendance Beneficiary engagement in programming varies considerably from context to context (and from programme to programme – for example, PLH for Teens engages caregivers as well as teens), and there have been situations in which attendance has been a challenge. A study on parental engagement in PLH for Young Children during an RCT of the intervention in Cape Town identified numerous barriers to enrolment and attendance in the programme (Wessels et al. 2016). These included alcohol abuse, financial constraints and a lack of readiness to change. PLH for Babies, Young Children, and Adolescents involve pre-programme home visits, which not only provide an opportunity to introduce the programme but also to discuss and find solutions to possible barriers to enrolment and attendance.

Monitoring of attendance is also essential so that service providers can respond to fluctuations in participation. Several strategies have appeared to be effective in increasing attendance at the PLH programmes. These include sending text messages to boost engagement and remind beneficiaries about the next session, providing transport allowance (although it is encouraged that programme venues are within walking distance of participants' homes) as well as refreshments, and letting beneficiaries know that they will receive a certificate for completing all sessions. With PLH for Young Children and Adolescents, home visits can be provided to parents who miss sessions or need additional parenting support.

Integration of Programming into Existing Service Delivery For sustainability, it is recommended that programming is integrated into existing service delivery systems. This complex process requires assessment by partner organizations, with support from the training organization, of what the implementation capacity and buy-in is among managers and first line service providers, and how the programmes can be integrated into existing implementation and supervision structures. It is important for implementing agencies to reflect on the amount of work involved in delivering the programme, and consider the schedules of those staff members who will be involved with implementation. Also, it is recommended that implementing staff are(semi)-permanent employees within implementing agencies to ensure sustainable programme delivery and scale-up, as facilitators may ultimately become trainers (a one-and-a-half-year process depending on whether they demonstrate competency at each level of certification); this process helps build institutional capacity beyond the immediate assistance from CWBSA and the Mikhulu Trust.

It is also essential that community-based organizations delivering the programme are included in the planning stages of programme rollout and are committed to its success. Conducting a project preparation meeting with all stakeholders in which the intervention and the implementation plan are described is an essential strategy. Also, conducting an implementation readiness assessment with each organization that will be trained to deliver the programme will also enable organizational capacity to be assessed.

Key Recommendations for Replication

Organizations or governments that are interested in implementing the PLH suite in their own context should make contact with either the Mikhulu Trust or CWBSA. While the PLH training materials are made available free of charge, it is essential that proper training, as well as support around adaptation and implementation, is provided by the PLH implementing partners before programme delivery. Providing adequate training and support may increase the likelihood of locally appropriate programmes being delivered with fidelity and so being more likely to achieve their desired goals.

Future Directions for Application of the PLH Programmes

As interest in the programmes continues to grow, monitoring and evaluation data are being collected to inform our understanding of programme effectiveness and delivery. Researchers involved with PLH plan to pool the data from the different countries in which PLH programmes are being implemented into a single dataset. This multi-country data will provide an opportunity to examine impact at scale and whether there are differential effects across contexts and populations, particularly for highly vulnerable families. It will also allow for the exploration of process-related issues and how these may differ from context to context. The evidence-base for the PLH programmes is also being developed through ongoing randomized controlled trials as well as trials that use a rigorous quasi-experimental design. By 2020, the PLH team hopes to have moved the interventions from being evidence-informed to evidence-based, and have them widely available to all LMICs.

Preschool Programmes

Early childhood or preschool education programmes aim to provide children under 5 years with the knowledge, skills and social competence required for normal development and successful adjustment in school. Preschool programmes promote cognitive, social and emotional skills that enhance school readiness and promote better school adjustment and performance (Anderson et al. 2003). School readiness is important as a foundation for a successful education career and is also important in preventing the consequences of early academic failure and school behavioural problems such as school drop-out, delinquency, unemployment and psychological and physical morbidity in young adulthood (Hertzman and Wiens 1996). Researchers have found that for every dollar invested in preschool care, between $4 and $8 is saved in later social service costs to society (Barnett 2007; Karoly and Bigelow 2005). An OECD report (2011) cites PISA (Programme for International Student Assessment) results reporting that 15-year-olds who had attended pre-primary

education outperformed students who had not by about a year of achievement. Studies have indicated that benefits are greater for high-quality provision (Morris et al. 2017) and are in general equal for boys and girls (Magnuson et al. 2016).

The number of children attending early childhood education has grown rapidly in recent years. Early childhood education has been used as an intervention strategy to improve the development of specific at-risk groups, particularly children from low-income families who often experience particular difficulties at school (Schindler et al. 2015). Randomized control trials of early childhood programmes have reported that high-quality early years programmes have the capacity to significantly improve child health and education outcomes for disadvantaged children, in both cognitive and non-cognitive domains (Karoly and Bigelow 2005; Sylva et al. 2004). International evidence, however, reveals that in many countries, children from low-income families are less likely to attend high quality early education programmes (Corak et al. 2012). It is estimated that if all low-income children were to be enrolled in high-quality early education programmes, such reforms could close the gap in achievement by as much as 20–50% (Corak et al. 2012).

In the UK, the Study of Early Education and Development (SEED) was carried out to explore early years provision and its potential to improve outcomes for children and families. As part of this study, Callanan et al. (2017) conducted 16 case studies of high-quality early years settings in order to identify features of good practice. Key findings from this study include:

Good practice in relation to *Curriculum Planning* included approaches that are:

- Tailored to individual needs.
- Capitalized on children's interests in order to achieve learning outcomes.
- Informed by on-going assessment.
- Differentiated by age and stage of development.

Strategies to support children's *Learning and Development* included:

- Creating a language-rich environment through the use of songs, nursery rhymes and stories.
- Staff modelling prosocial behaviour.
- Small group activities that supported children to work together.
- A consistent approach to behaviour management.
- High-quality adult–child interaction and encouragement of home learning.
- Strong relationship with parents.

Characteristics of effective *Leadership*:

- Having a clear vision for the setting.
- Good professional knowledge.
- Value and foster team working.
- Effective engagement with the wider early years sector.
- Foster good relationships with parents.
- Prioritize staff continuing professional development.

A number of evidence-based preschool programmes are known to have achieved impressive long-term results. The Carolina Abecedarian Project is an example of preschool programme that provided high quality, developmentally appropriate childcare to high risk children in the USA (Ramey and Campbell 1984). The programme, which operated between 1972 and 1985 in North Carolina, provided educational child care and high-quality preschool from age 0–5 years to children from very disadvantaged backgrounds and underwent numerous assessments of its long-term effects on participants. The child care and preschool were provided on a full-day year-round basis, had a low teacher–child ratio and used a systematic curriculum of educational games emphasizing language development and cognitive skills. Results from a randomized control trial of 111 infants averaging 4.4 months indicated a significant improvement in participants' intellectual performance and school achievement. Longitudinal results from participants at 8, 12, 15, 18 and 21 years revealed that fewer programme participants repeated a grade or required special services or became teen parents and more of them graduated from high school and more attended university (Campbell et al. 2001). Economic analysis of the Abecedarian Project found that (in 2011 dollars) the programme cost $16,530 per child per year and yielded benefits to society of $3.78 per dollar invested (Masse and Barnett 2002).

The characteristics of high-quality preschool programmes are outlined in Box 2. A number of preschool interventions have also been successfully implemented in LIMCs. A rapid review of mental health promotion interventions implemented in

Box 2 Characteristics of High-Quality Preschool Programmes (Britto et al. 2017; Ackerman and Barnett 2006; Callanan et al. 2017)

- Curriculum planning that is informed by ongoing assessment and capitalized on children's interests.
- Developmentally appropriate curriculum tailored to individual needs.
- Staff modelling prosocial behaviour.
- Use of small group activities and self-directed activities with peers.
- Consistent approach to behaviour management.
- Language-rich environment.
- Warm and positive relationship between staff and children.
- Low children to staff ratio so teachers can engage in stimulating, responsive and supportive interactions and provide more individualized attention.
- Systematic efforts to involve parents in children's education.
- Effective leadership with strong organizational skills, good professional knowledge, ability to engage effectively with parents and wider early years sectors.
- Provision of continuing professional development for staff.
- Evaluation procedures that are developmentally appropriate.

LMICs identified four preschool interventions (Barry et al. 2011). In Jamaica, the Incredible Years teacher training interventions were adapted and implemented with children attending preschool (Baker-Henningham et al. 2009). The Wawa Wasi Programme was implemented in Peru with mother–carers taking care of up to eight children from the community whilst mothers of the children attend work (Cueto et al. 2009). The Turkish Early Enrichment Project examined the effectiveness of two different types of early enrichment (home-based and centre-based preschool) on children age between three and 5 years of age in Turkey. In Bangladesh a half-day preschool education programme provided to children aged between 4.5 and 6.5 years 6 days a week (Aboud 2006). Evaluations of these interventions reported improvements in children's social and emotional skills (Aboud 2006; Baker-Henningham et al. 2009; Cueto et al. 2009), behaviour, school readiness and relationship with between teachers and parents (Baker-Henningham et al. 2009).

The High/Scope Perry Preschool is another example of a community-based preschool education intervention designed to promote intellectual and social development in children aged 3 and 4 years from disadvantaged backgrounds (Schweinhart and Weikart 1988). Based on more than 40 years of scientific research, it is an educational approach which is largely based on Piaget's interactional theory of child development. The curriculum provides teachers with a framework for daily routine, classroom and playground organization and teacher–child interaction, all designed to create a warm, supportive learning environment. Children attend 3-h classes on weekday mornings 5 days a week for 7 months a year. Once a week, the teacher visits the home to support parental engagement in children's learning. HighScope Perry Preschool was initiated in 1962 in Michigan, USA. A randomized control trial involving 123 'high risk' African-American children aged 3 or 4 years was carried out and these study participants were monitored for over 40 years. Children attending the High/Scope Perry Preschool scored significantly higher than control group children on standardized aptitude tests administered in the preschool years and demonstrated significantly higher vocabulary skills 2 years beyond preschool (Berruta-Clement et al. 1984). At age 14, children who attended High/Scope Perry Preschool were less likely to be placed in special education programmes, showed a significant decrease in delinquent behaviour and had significantly higher grade point averages and were more likely to graduate from high school (Schweinhart et al. 1980, 1986). At age 27, High/Scope Perry Preschool children had significantly better educational outcomes, averaged significantly fewer lifetime criminal arrests and had higher mean monthly earnings (Schweinhart and Weikart 1997). Analysis from ages 19–40 found that the intervention mostly helped education and early employment of women (ages 19 and 27) and later-life income, employment and criminal activity of men (ages 27 and 40) (Heckman et al. 2010). Economic analysis conducted by Schweinhart et al. (2005) found that the economic return to society of the programme was $16,14 per dollar invested.

The High/Scope curriculum is implemented internationally, including in countries such as Canada, Chile, the Netherlands, Korea, Ireland, Indonesia, China, Portugal, South Africa and Mexico. The curriculum is also used in Head Start

programmes in the USA. Head Start has been referred to in the USA as the nation's 'premier' federally sponsored early childhood education programme, developed to reduce socio-economic disparities in school readiness (Bierman et al. 2008a, b). It was designed to enrich early learning opportunities and promote school readiness among children growing up in poverty. A primary goal was to reduce educational disparities associated with socioeconomic status (Zhai et al. 2011). Evaluations of Head Start, using randomized control trials or quasi-experimental methods indicate benefits for children attending Head Start compared with children attending other preschools or receiving alternative forms of care. The effect sizes for social competence and learning behaviours at the end of the Head Start are, however, generally small, in the range of 0.14–0.16. In addition, the effects were shown to dissipate in the early elementary years (McKey 1985). Results from the Family and Children Experiences Survey (FACES) evaluation suggest that while children attending Head Start gain some specific social and cognitive skills, the majority of participants enter school below the national norms in terms of overall achievement levels (US Dept of Health and Human Services 2001; Zill et al. 2003).

Over the last decade, a number of interventions aimed at enhancing preschool children's social and emotional skill development have been developed and evaluated. In reviewing the evidence on social and emotional learning practices within early childhood education, Schindler et al. (2015) examined the effects of three levels of practice with different levels of intensity and specificity. Results indicated that programmes with a clear, but broad, focus on social and emotional development (Level 2 programmes) were significantly more effective at reducing externalizing problems than programmes without a clear focus on social and emotional development (Level 1 programmes). Level 3 programmes or those that more intensively targeted children's social and emotional development were associated with additional significant reductions in externalizing behaviour problems relative to Level 2 programmes. Head Start REDI programme is an example of a Level 3 programme that intensively targets children's social and emotional development. It is designed as a social, emotional and language/literacy enrichment intervention, which can be integrated into the existing framework of Head Start classroom programmes that are already using the High/Scope or Creative Curriculum. This programme will now be examined in detail.

Practice Example: Head Start REDI (Bierman et al. 2008a, b)

The Head Start-REDI (research-based, developmentally informed) programme is designed to enrich and complement the broad education programming provided by High/Scope or Creative Curriculum by developing teachers' capacities to utilize research-based practices in supporting the development of both social-emotional competencies and language/emergent literacy skills (Bierman et al. 2008a). Language skills and social-emotional competencies are promoted because they provide support for effective school engagement, they facilitate the child's ability to

follow classroom rules, cope actively with learning challenges and relate to teachers and peers (McClelland et al. 2006).

Programme Content

The intervention is delivered by classroom teachers and includes curriculum-based lessons, centre-based extension activities, teacher training and weekly classroom coaching in 'teaching strategies' to use throughout the day (Domitrovich et al. 2010). The social-emotional component of Head Start REDI utilizes the 33 session PATHS Preschool curriculum (Domitrovich et al. 2007). The curriculum targets four domains: (1) prosocial friendship skills (2) emotional understanding and emotional expression skills (3) self-control and (4) problem-solving skills, including interpersonal negotiation and conflict resolution skills. The curriculum is divided into 33 lessons that are delivered by teachers once per week during circle time. These lessons include modelling stories and discussions and use of puppet characters, photographs and teacher role-play demonstration. Each lesson includes extension activities (e.g. cooperative projects and games) that provide children with opportunities to practice the target skills with teacher support. Generalized teaching strategies are encouraged with mentoring: including positive classroom management, use of specific teacher praise and support, emotion coaching, induction strategies to promote appropriate self-control (Bierman et al. 2008a).

The cognitive component of the programme addresses four language and emergent literacy skills: (1) vocabulary (2) syntax (3) phonological awareness and (4) print awareness. In addition to the curriculum components, teachers receive mentoring in the use of 'language coaching' strategies, including vocabulary support, expansions and grammatical recasts and decontextualized talk to provide a general scaffold for language development in the classroom. The overall goal is to improve teachers' strategic use of language in ways that support the development of children's oral language skills, including vocabulary, narrative and syntax (Bierman et al. 2008a).

Teachers receive detailed manuals and kits containing all materials needed to implement the intervention. A 3-day professional training is provided with a booster training session carried out half way through the first year of implementation. Three take-home packets are mailed to parents during the course of the year, each containing a modelling videotape, with parent tips and learning activities to use at home. In addition, the PATHS curriculum includes handouts for parents, with suggestions for home activities. Head Start REDI-Parent programme (REDI-P) provides additional home visits for Head Start parents, enriching these visits with evidence-based learning activities and support strategies. Parents receive 10 home visits during the sprint of the Head Start pre-kindergarten year and six booster sessions after the start of kindergarten. Parents receive additional encouragement in these home visits to utilize materials and learn strategies that extend the benefits of the Head Start REDI programme in the home. (Bierman et al. 2014).

Evaluation Findings

An evaluation of Head Start REDI was carried out using a randomized control trial involving 25 centres with 44 classrooms ($N = 356$ children aged 4 years of age) in the USA (Bierman et al. 2008b, 2014; Nix et al. 2013, 2016). Centres were

randomly assigned to REDI or the usual practice of Head Start and were assessed at pre-, post-intervention, 1-year follow-up and annually up to 4 years after the intervention. Results from observer ratings at post-intervention indicated significant and moderate to large improvements in teacher language use ($d = 0.67–0.72$) and positive classroom management practices, including positive emotional climate ($d = 0.42$) and positive discipline ($d = 0.66$) compared to usual practice classrooms. Positive intervention effects were also evident on child outcomes across both social emotional and cognitive domains. Significant intervention effects were evident on improved emotional knowledge and social problem-solving skills ($d = 0.21–0.035$), decreased aggression ($d = 0.28$) and improved learning engagement based on observer ratings ($d = 0.29$). Head-Start REDI classrooms also out-performed children in usual practice classrooms in areas of vocabulary acquisition ($d = 0.15$), phonological sensitivity ($d = 0.35–0.39$) and print awareness ($d = 0.16$). Moderator analysis revealed that the intervention effects were amplified in schools that served many low-achieving students when compared with schools with few low-achieving students. Examining the impact of Head Start REDI after children's transition to kindergarten, Bierman et al. (2014) identified sustained intervention effects on social problem-solving ($d = 0.38$), teacher ratings of aggression ($d = -0.26$), teacher ratings of learning engagement ($d = 0.27$) and phonemic decoding ($d = 0.27$). Nix et al. (2016) examined the long-term impact of Head Start REDI at 4-year follow-up. Children in the intervention group showed more positive trajectories for several measures of socio-emotional functioning including social competence, aggressive-oppositional behaviour, peer rejection, attention problems, student–teacher closeness and learning behaviour. These findings suggest that Head Start REDI can have lasting benefits for children's social and emotional functioning.

Programme Implementation Features

Evidence-based teaching curriculum components: The programme utilizes a research-based curriculum with the goal of enriching impact on the preschool acquisition of social-emotional skills and literacy skills central to later success (Domitrovich et al. 2009). These components are designed to be integrated with curricula already being used in HeadStart centres including the High Scope curriculum or Creative curriculum. The curriculum components are reinforced with the use of generalized teaching strategies including positive classroom management, use of specific teacher praise and support, emotion coaching, induction strategies to promote appropriate self-control (Bierman et al. 2008a). Teachers are trained in the use of these teaching strategies as part of their everyday naturally occurring interactions with children in the classroom.

Activity-based learning: Throughout the programme, children are engaged in activity-based learning. The lessons include modelling stories, discussions, utilizing puppet characters, photographs and teacher role-play demonstrations. To help children gain emotional understanding, the programme includes lessons that present photographs and stories to illustrate different feelings and associated causes. Teachers are encouraged to model and reflect emotions (emotion coaching) and children are encouraged to use small illustrating emotions (e.g. feelings faces) to

assist them in describing their own feelings and recognizing the feelings of others (Nix et al. 2013). Use of active forms of learning has been identified as an important characteristic of social and emotional skill-based interventions (Durlak et al. 2011).

Integration of social-emotional skills development with literacy: In the HeadStart REDI programme, the language and understanding of emotions are reinforced in the reading stories that are selected to work alongside the PATHS content. The capacity to use language to describe internal affective states allows children to redirect emotional arousal into adaptive activity and thus inhibits reactive aggressive behaviour. The capacity to share feelings verbally allows children to better understand the feelings of others, fostering interpersonal sensitivity and peaceful conflict management (Domitrovich et al. 2007).

Sustained professional development: In addition to the teachers receiving comprehensive training prior to implementing the programme, teachers receive weekly mentoring support. This support is intended to enhance the quality of implementation through modelling, coaching and providing ongoing feedback. REDI trainers use an array of methods to support teacher skill development including in-vivo and videotaped modelling, reflection exercises and specific problem-solving techniques. The trainers provide teachers with feedback on positive teaching practices and provide suggestions for improvements or solutions to challenges encountered. These sessions are designed to be supportive rather than evaluative.

Recommendations for Replication

Principal support: In assessing factors associated with sustained programme use of Head Start REDI, Sanford DeRousie and Bierman (2012) identified teachers' perceptions that programme administrators required teachers to continue using Head Start REDI as a particularly notable factor. Similar to evidence from other school-based interventions, strong commitment by supervisory and programme directors has been identified as critical to high- quality implementation and programme sustainability. A strong leader who advocates using evidence-based practices within a school can have a significant impact on the successful implementation of interventions (Gottfredson and Gottfredson 2002). In addition to endorsing the intervention, effective leadership provides the oversight and accountability that are necessary to maintain focus and ensure follow-through.

Teachers' openness to training and support: Domitrovich et al. (2009) identified teachers' openness to training and mentoring support as an important factor in implementing the programme with high quality and fidelity. This finding highlights the importance of teachers' perceptions of and attitudes towards the intervention and support. Research has identified this as one of the most important individual-level factors that impact on implementation quality. Teachers' perceptions that the intervention is a useful strategy for addressing a local problem, that the programme is better than current practice and that the programme is compatible with the values, needs, mission and experiences of the institution are all critical to teacher buy-in.

Teacher professional characteristics: In examining factors critical to programme implementation, Domitrovich et al. (2009) identified strong and statistically significant associations between pre-intervention teaching quality (especially emotional support, classroom management, positive discipline, instructional support

and the use of questions) and sustained implementation of the curriculum components. These results suggest that teachers who, prior to their involvement with Head Start REDI, were able to manage their classroom effectively with warm support and positive discipline were more likely to implement the programme with high quality and sustain it when compared with teachers with lower ratings in these areas. Domitrovich et al. (2009) suggest an adaptive approach to the delivery of professional development support. This approach adapts the intensity of coaching during implementation with the provision of more intensive coaching to less competent teachers, allowing them to strengthen their teaching skills through their participation in the professional development.

High-quality implementation: Initial implementation quality during the inaugural year of Head Start REDI emerged as a significant predictor of subsequent implementation quality (Domitrovich et al. 2009). These results suggest that sustainability requires more focussed attention in programme planning in order to promote the high-quality sustained use of evidence-based curriculum components and teaching practices. It is thus important for schools looking to implement and sustain evidence-based practices to pay close attention to quality of implementation if the programme is to be sustained with quality over time.

Conclusions

This chapter has examined a number of interventions that promote the mental health and wellbeing of young children and their parents. There is substantial evidence to indicate that high-quality comprehensive programmes carried out in collaboration with families, schools and communities can produce lasting positive benefits for young people and their parents. When these programmes are implemented effectively they lead to improvements not only in the mental health of children and their parents but also improved social functioning, academic and work performance and general health behaviour. The effects are especially evident in relation to the most vulnerable families from disadvantaged backgrounds and, therefore, investment in such initiatives is well spent and cost effective. Based on existing research and the programmes reviewed in this chapter, a number of generic principles underpinning good practice and successful programme implementation in working with families and young children will be outlined.

Pre-programme Planning and Programme Selection

- Undertake a needs assessment to establish the characteristics and wishes of the population who are intended to receive the interventions; assess the social context and family circumstances and ensure that interventions are matched to participants' needs.
- Select interventions based on a strong theoretical framework.
- Interventions should be structured with a manual or curriculum that provides appropriate engaging activities focussed explicitly on identified outcomes.

Characteristics of Effective Programmes

- Effective parenting interventions are characterized by staff members establishing a trusting relationship with caregivers and supporting them in their ability to engage in successful parenting.
- Programmes should to be delivered in non-stigmatizing way. Service providers need to be sensitive to the cultural and social traditions of the participants such as family structures, local neighbourhood attitudes, power relations, poverty and the politics of welfare services.
- Interventions that facilitate active modelling and practice for parents have been shown to lead to greater child outcomes.
- Understanding the level of risk of children and their parents and developing shared understanding of goals is likely to be more important than any specific perspective.
- Provide staff training and support for programme providers. A skilled workforce is important for effective programme delivery employing a structured and systematic approach, good facilitation skills and an empowering and strength-based approach.
- Ensure the interventions are accessible to children and families; offer incentives such as meals or free transport and aim to reduce barriers to access by means of flexible settings or hours.
- Preschools programmes that provide more intensive, parent-focussed activities have been shown to achieve greater impact on children's development than those that engage with parents less frequently.

Monitoring and Evaluation

- Conduct early intervention evaluation research to improve the programme quality and implementation. Carefully monitor and document activities during the programme planning and implementation phases and collect process evaluation data so that more informed judgements can be made about which elements are contributing or detracting from the positive outcomes.
- Prepare for policy recommendations by incorporating accountability and cost analysis into intervention programmes.
- Several studies have been found to have sleeper effects, which suggest that a positive outcome will only become apparent at a later stage. Plan for longitudinal follow-up to capture positive intervention effects.

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Part V
Mental Health Promotion in Schools

Promoting Children's and Young People's Mental Health in Schools

Aleisha M. Clarke

Introduction

Schools have been identified as one of the most important settings for promoting the mental health of young people (Durlak et al. 2015; OECD 2015; WHO 1998; Zins et al. 2004). The school setting provides an opportunity to reach many young people during their formative years of cognitive, emotional and social development. As most young people spend a significant proportion of their time in school, there are few other settings where large numbers of young people can be reached. The school environment is not only a place of learning, it is also an important source of friends, social networks and adult role models. As such, schools provide a socializing context that has a significant influence on the development of young people. The importance of the school as a setting for mental health promotion is reflected in the increasing number of programmes that successfully promote academic, social and emotional competence and significantly reduce a range of negative health and social outcomes (Durlak et al. 2011; Sklad et al. 2012; Taylor et al. 2017; Weare and Nind 2011).

A variety of terms have been used to describe school-based interventions, depending on the disciplinary tradition. Examples of such terms include *Non-cognitive skills, Emotional literacy*, *Social and emotional learning, Positive youth development, Positive psychology, Mental fitness, Resilience, Strengths-based approaches, Life skills, Psychological wellbeing, Character education*. Over the last three decades the concept of *Social and Emotional Learning* (SEL) has served as an umbrella framework for a range of approaches aimed at promoting children's and young people's mental health and well-being. Elias et al. (1997) defined *social and emotional learning* as the process of acquiring and effectively applying the knowledge, attitudes and skills necessary to understand and manage emotions, set

A. M. Clarke (✉)
Child Mental Health & Wellbeing, Early Intervention Foundation, London, UK
e-mail: aleisha.clarke@eif.org.uk

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and achieve positive goals, appreciate the perspective of others, establish and maintain positive relationships, make responsible decisions and handle interpersonal situations constructively. SEL consists of five interrelated sets of cognitive, affective and behavioural competencies: self-awareness, self-management, social awareness, relationship skills and responsible decision making. Children who are proficient in core SEL competences are able to integrate thinking and behaving to master important tasks in school and life (Zins et al. 2004). Most SEL programmes are based on social learning theory (Bandura 1977) and use cognitive–behavioural methods for skill development, as they assume that fostering the development of the five core competencies will coincide with attitudinal changes and lead to increased positive social behaviour, decreased problematic behaviours and emotional distress and improved student achievement (Durlak et al. 2015). A growing body of research suggests that these core skills are malleable and can be effectively taught using a variety of approaches and formats. Schools have a critical role to play in both developing these skills in young people and increasing access to opportunities that will enable the development of these skills (McNeil et al. 2012).

The range of approaches or strategies for promoting mental health in the school setting can be divided into three main groupings:

1. Whole-school interventions—these interventions aim to create supportive context within the school as a whole and involve coordinated action between three components: (1) curriculum teaching and learning, (2) school ethos and environment and (3) family and community partnerships.
2. Universal classroom skills-based interventions—the teaching of skills to all students in the classroom aimed at enhancing their mental health and well-being through a developmentally appropriate curriculum
3. Targeted interventions—interventions for students at higher risk aimed at strengthening their coping skills and reducing the risk of negative mental health outcomes.

This chapter focuses on interventions that adopt a whole-school approach to implementing mental health promotion. Chapter "Implementing Universal and Targeted Mental Health Promotion Interventions in Schools" will examine universal classroom skills-based interventions and targeted interventions.

Rationale for Promoting Mental Health in Schools

There is a growing consensus among policy makers, teachers and parents internationally on the need to develop the 'whole child' with a balanced set of cognitive, social and emotional skills, so that children and young people can better face the challenges of the twenty-first century (Domitrovich et al. 2017; Jones and Bouffard 2012). There is increasing recognition of the importance of building academic success on social and emotional competence and the role of schools in supporting young people to achieve positive outcomes in school, work and life more generally

(Barry et al. 2017; Durlak et al. 2015; OECD 2015). Not only are skills such as critical thinking, problem-solving, creativity, communication and responsible thinking necessary in a global society but extensive developmental research indicates that effective mastery of social and emotional skills supports the achievement of positive life outcomes, including educational attainment, employment and health, whereas failure to achieve competence in these areas can lead to a variety of personal, social and academic difficulties (Durlak et al. 2011; Epstein et al. 2000; Guerra and Bradshaw 2008; OECD 2015; Trentacosta and Fine 2010).

The increasingly complex global economic, social and cultural climate presents significant challenges for young people, including increases in youth unemployment, migration, rising levels of mental health problems and youth suicide (Thomson et al. 2014; Patel et al. 2007). Research indicates that half of lifetime mental disorders have arisen by the age of 14 years (Kessler et al. 2005; Kim-Cohen et al. 2003). Mental and behavioural disorders during childhood and adolescence also lead to higher rates of adult mental disorders (Colman et al. 2009; Fergusson et al. 2005). Data from New Zealand and the USA reveal rates of 50% incidence of a mental disorder between ages 12 and 25 years and 40% 12-month prevalence between ages 13 and 18 years (Gibb et al. 2010; Kessler et al. 2012). A World Health Organization (WHO) report (WHO 2014) on suicidal behaviour reveals that suicide is the second leading cause of death in the age range 15–29 years worldwide. Disadvantaged minority and migrant youth are affected disproportionally with poorer mental health outcomes and higher rates of youth unemployment and early school leaving, being almost double that of non-migrant youth (Montgomery 2011; Patel et al. 2007).

Schools are seen as a key setting, along with the home and the community, in addressing these issues and promoting positive youth development. There is an intrinsic connection between mental health and education. The WHO (2005) identifies a number of protective factors for youth mental health pertaining to education, including opportunities for involvement in school life, positive reinforcement from academic achievement and identity with a school or need for educational attainment. On the other side, poor performance and achievement in school are recognized as risk factors for a range of social and health problems such as substance misuse, unwanted teenage pregnancy, conduct problems and involvement in crime (Greenberg et al. 2001). Schools, therefore, have an important role in strengthening young people's mental health and their ability to cope with change, challenges and stress.

Evidence of Effectiveness

There is substantial international evidence that well-designed, well-implemented, teacher-taught mental health promotion interventions can produce long-term benefits for children and young people, including emotional and social functioning, behaviour and academic performance (Barry et al. 2013; Clarke et al. 2015; Durlak et al. 2011; Sklad et al. 2012; Taylor et al. 2017; Ttofi et al. 2011; Weare and

Nind 2011). A meta-analysis by Durlak et al. (2011) examined the impact of 213 universal school-based interventions. The review findings showed that compared to students in the control group, children and young people participating in social and emotional learning programmes demonstrated improvements in multiple areas including enhanced social and emotional skills (mean ES = 0.57); improved attitudes towards self, school and others (mean ES = 0.23); enhanced positive social behaviour (mean ES = 0.24); reduced conduct problems including misbehaviour and aggression (mean ES = 0.22); and reduced emotional distress including stress and depression (mean ES = 0.24). This review also found that in addition to improving students' social and emotional skills, these programmes significantly improved children's academic performance (mean ES = 0.27), yielding an average gain in academic test scores of 11–17 percentile points. These latter results indicate that SEL programmes do not come at the expense of performance in core academic skills, but can enhance achievement. Furthermore, programmes were effective regardless of the students' age, the geographical setting (urban, rural or suburban) or the ethnic composition of the student body.

A meta-analysis of the follow-up effects from 82 of the interventions reviewed by Durlak et al. (2011) was carried out by Taylor et al. (2017). This meta-analysis involved 97,406 students. The results indicate the continued positive benefit of social and emotional learning interventions on student outcomes collected on average, from 1 year and up to 3.75 years following programme participation. Follow-up outcomes demonstrated sustained improvements in participants' social–emotional skills (mean ES = 0.17), attitudes (mean ES = 0.17), emotional distress (mean ES = 0.12), drug use (mean ES = 0.12) and academic performance (mean ES = 0.22). Similar to results from Durlak et al. (2011), benefits were similar regardless of students' race, socioeconomic background or school location.

Another meta-analysis (Sklad et al. 2012) of universal school-based SEL programmes has replicated the positive effects reported by Durlak et al. (2011). This meta-analysis, which limited its review to evaluations post-2005, found overall beneficial effects in all seven categories of outcomes: social skills, prosocial behaviour, positive self-image, mental health, antisocial behaviour, substance misuse and academic achievement. The largest post-intervention effects were found for social and emotional learning, positive self-image and prosocial behaviour, followed by academic achievement and antisocial behaviour. Immediate effects were generally stronger than those at follow-up, but significant effects persisted in all categories. Comparing programmes in the USA to those implemented in other countries, Sklad and colleagues found that effect sizes were similar across all countries, suggesting that SEL programmes are relevant for children in different cultural contexts.

In a review of 52 systematic reviews of social and emotional skills-based interventions implemented in schools internationally, Weare and Nind (2011) concluded that interventions had wide-ranging beneficial effects on children and young people, on classrooms, families and communities. The impact of interventions, the majority of which were universal, on social and emotional skills and competencies was reported to be moderate to strong. Impacts on commitment to schooling and academic achievements were small to moderate and moderate effects were reported for

impacts on family and classroom environments. In Canada, a similar review of reviews was carried out in 2012 and the findings echo those of previous reviews. A review of 94 systematic reviews and meta-analyses, carried out by the Directions Evidence and Policy Research Group, found that universal, school-based SEL programmes are associated with enhanced prosocial skills, self-concept and academic achievement (Mental Health Commission of Canada 2013). The review further states that the best outcomes derive from teaching skills systematically in a class-wide manner, with opportunities for practice and collaboration, ideally conducted within a whole-school approach to mental health promotion.

Evidence on the effectiveness of whole-school social and emotional learning interventions is also emerging. A meta-analysis of 45 studies evaluating 30 whole-school social and emotional learning interventions indicated a significant positive effect on participants' social and emotional skills (mean ES = 0.22), behavioural adjustment (mean ES = 0.13) and internalising symptoms (mean ES = 0.11) (Goldberg et al. 2018). Moderator analysis revealed that these whole-school interventions were successful at all education levels (primary and secondary school). In addition, there was no difference in the effect size of interventions that were aimed at enhancing students' social and emotional skills and interventions aimed at preventing bullying. Results from this meta-analysis are supported by previous reviews which identify the adoption of a whole-school approach as being more effective than classroom-based interventions in producing sustainable change (e.g. Adi et al. 2007; Weare and Nind 2011). Whilst other reviews suggest that whole-school approaches are failing to show impact, authors attribute this to a lack of consistent and rigorous implementation, which leads to diluted impact (e.g. Durlak et al. 2011).

Positive findings also emerge from a review of the evidence from low- and middle-income countries (LMICs) (Barry et al. 2013). Fourteen studies of school-based interventions implemented in eight LMICs were reviewed, seven of which included interventions for children living in areas of armed conflict and six interventions of multicomponent life skills and resilience training. Results from this systematic review indicate that interventions promoting the mental health of young people can be implemented effectively in the school setting in LMICs with moderate to strong evidence of their impact on both positive and negative mental health outcomes. There was a paucity of evidence, however, relating to interventions for younger children in LMIC primary schools.

Evidence regarding the economic case for investing in school-based mental health promotion interventions is also emerging (Belfield et al. 2015; Knapp et al. 2011). Belfield et al. (2015) report an average return on investment for SEL programmes of $11 for every dollar invested, while McDaid and Park (2011) report a ratio of 25:1 for high-quality programmes that impact on young people's mental health and well-being. Knapp et al. (2011) also report that school-based interventions are cost-saving for the public sector based on cost–benefit analyses in the UK with savings accruing in relation to reduced crime and improved education and employment outcomes. Improved outcomes in relation to earning power as an adult have also been reported for children who received social and emotional skills programmes (Heckman 2006).

Implementing School-Based Programmes

As knowledge about effective school-based interventions has grown, a science of implementation has been developed to guide research and practice. As outlined in Chapter "Implementation Processes and Strategies for Mental Health Promotion", implementation has been defined as 'efforts designed to get evidence-based programs or practices of known dimensions into use via effective change strategies' (Damschroder and Hagedorn 2011, p. 195) or put more simply as 'the way a programme is put into practice and delivered to participants' (Durlak 2016, p. 334). Implementation research is concerned with the central issues of 'what' is to be implemented, 'how intervention tasks/activities will be carried out, and 'who' shall carry out the work of implementation.

The implementation of effective, feasible and sustainable school-based interventions that promote children's and young people's mental health is identified as a key challenge. Building on the extant evidence base, derived mainly from US research studies, evidence-based school interventions need to be implemented and brought to scale across different cultural settings and with diverse groups of children and youth. This translation of evidence into real-world practice requires an increased focus on developing structural mechanisms and capacity in local contexts that will support high-quality implementation of the most effective approaches. The adoption of evidence-based programmes in school presents significant challenges, especially in low resource settings, as many interventions developed under well-resourced and highly controlled conditions are not easily implemented in settings where there is a lack of supportive structures and limited capacity (Jones and Bouffard 2012). Schools may be presented with an array of different student issues and problems that need to be addressed such as bullying, substance misuse and antisocial behaviour, making it difficult to make decisions concerning which interventions are likely to be most effective. In addition, there is often insufficient guidance and support provided for the effective implementation of interventions in school settings. Common concerns include lack of funds, time constraints, lack of perceived need for mental health interventions and lack of teaching expertise. Therefore, although school-based programmes can achieve significant and sustained impacts on children's and young people's lives, the majority of evidence-based programmes have not been adopted or scaled up at a country level.

Findings from implementation science have confirmed that one of the most important factors affecting programme outcomes is quality of implementation, with effect sizes reported as being two or three times higher when interventions are carefully implemented with high quality (Durlak and DuPre 2008). In their meta-analysis of social and emotional skills-based interventions, Durlak et al. (2011) found that implementation quality was positively associated with student outcomes among teachers who effectively taught and integrated the programmes into their teaching practices. Of the studies that reported implementation data (57%), students who received programmes that were implemented with high quality demonstrated academic gains that were twice as high (mean ES 0.31) as students that received

programmes that experienced implementation problems (mean ES 0.14). Similar results were reported for a reduction in conduct problems (mean ES of 0.27 vs. 0.15) and emotional distress (mean ES 0.35 vs. 0.15). Durlak et al. (2011) reported that school programmes with good-quality implementation were characterized by high levels of intensity, consistency, clarity and programme fidelity being favoured over loose guidelines and broad-based principles. These results support findings from an early review by Domitrovich and Greenberg (2000), which identified that students were more likely to benefit from programmes in which their school provided training to staff and fully implemented the curriculum.

Whilst comprehensive evaluations of the implementation of interventions adopting a whole-school approach to promoting children's mental health and well-being are quite rare, as they are methodologically more complex, findings from the UK and Australia reveal important insights into the importance of programme implementation. Banerjee et al. (2014) reported that higher quality implementation of Social and Emotional Aspects of Learning (SEAL)—a national SEL initiative in primary and secondary schools in the UK—produced an enhanced school ethos, which in turn led to a range of positive outcomes for students, including better behaviour, lower rates of absenteeism and higher academic attainment. A report by Lendrum et al. (2013) of SEAL in secondary schools found that the lack of buy-in from staff, perceived need for the programme, teachers' sense of self-efficacy and insufficient staff training were all related to variability in level of implementation. An evaluation of KidsMatter whole-school framework for primary schools in Australia showed that the level of programme implementation was significantly associated with academic outcomes, with the difference in students' academic performance between high- and low-implementation schools being equivalent to 6 months of schooling (Dix et al. 2012; Slee et al. 2009). Improvements in children's social and emotional competencies were also found to be significantly related to level of implementation, with no significant changes being found for students in low-implementing schools.

These studies highlight the importance of quality of implementation in achieving positive outcomes. Implementation of school-based programmes is, however, challenging. Schools are dynamic, complex, multilevel systems with numerous factors that can influence implementation (Barry et al. 2005; Dooris and Barry 2013). Research suggests that implementation represents a complex interaction between characteristics of the implementer, implementing organization, intervention activities, participants and the specific context (Chen 1998; Durlak and DuPre 2008; Greenberg et al. 2005; Greenhalgh et al. 2004). The literature has identified more than 20 factors that can affect the process of implementation and these exist at multiple ecological levels (Domitrovich et al. 2008; Durlak 2016; Durlak and DuPre 2008; Fixsen et al. 2005). The factors are presented in Box 1 below.

Several implementation frameworks have been developed, which provide conceptual models of the factors that are important for quality implementation (e.g. Fixsen et al. 2005; Meyers et al. 2012). Guided by the implementation for whole-school programmes, Samdal and Rowling (2011) conducted a narrative synthesis of documents describing implementation of health promoting school approaches and

Box 1: Factors that Affect Programme Implementation (Adapted From Durlak and DuPre 2008)

1. Community level
   (a) Scientific theory and research
   (b) Political pressures
   (c) Availability of funding
   (d) Educational policies and mandates
2. Practitioner characteristics
   (a) Perceived need and relevance of the programme
   (b) Perceived benefits of innovation
   (c) Self-efficacy and confidence in implementing the programme
   (d) Possession of sufficient skills necessary for implementation
3. Characteristics of the programme
   (a) How compatible it is with the school's mission, priorities and values
   (b) Adaptability: what modifications are possible to fit local needs and preferences
4. Factors relevant to the school or district: organizational capacity
   (a) General organizational factors

   Positive work climate
   Organizational openness to change
   Ability to integrate new programming into existing practices and routines
   Shared vision, consensus and staff buy-in

   (b) Specific practices and processes

   Shared decision making and effective collaboration among stakeholders
   Coordination and partnership with other agencies as needed
   Frequent and open communication among participants and stakeholders
   Procedures conducive to strategic planning and task coordination

   (c) Specific staffing considerations

   Effective leadership
   Programme champions (internal advocate)
   Effective management, administrative and supervisory support
5. Factors related to professional development services
   (a) Successful training of implementers
   (b) Ongoing technical assistance to maintain staff motivation and skills

identified eight components that are critical to high-quality implementation. These components include:

1. *Preparing and planning for school development*: Building readiness and commitment for change among all relevant stakeholders is key to a successful implementation process. Building readiness stimulates shared values and a belief that such an initiative is important for student development and learning and will also positively influence the organizational climate of the school. Preparing for change and development requires a focus on planning models, identifying clear aims and priorities, assessing the programme fit in relation to existing needs, resources and organizational capacity of the school. Consulting with all stakeholders is essential. Establishing a coordination team to support planning, implementation and collaboration with school leadership is also an important step in this phase.
2. *Policy and institutional anchoring*: The inclusion of concrete actions in the school policy plan ensures that priority will be given from the school leader in terms of facilitation and resource allocation. In addition, the statements in the policy document commit all stakeholders to work towards achieving the aims stated.
3. *Professional development and learning*: Teachers are the core change agents and their competence and understanding of what to achieve and how to achieve are critical to the successful implementation of the intervention. Professional development and learning are essential for developing necessary understanding, motivation, and skills as well as generating positive attitudes and competence for undertaking organizational change processes.
4. *Leadership and management practices:* The primary function of leadership is to stimulate readiness and motivation for change as well as building ownership in the school community and anchoring the activities to the school vision through feedback, encouragement and expectations to implement actions. School principals play a crucial role in motivating teacher buy-in and putting in place practices and structures that can facilitate organizational development and change, including resource allocation for professional development.
5. *Relational and organizational support context*: This includes the development of structures, strategies and practices which facilitate smooth and efficient implementation of actions and activities. Organizational structures include timetabling, physical environment and fiscal resources. Close collaboration with school leadership is vital as the school leader is in control of both the resources and structures.
6. *Student participation*: Student participation is both a means and a goal to maximize motivation for health and learning. Teacher support of student participation in decisions is found to empower students to achieve learning goals and develop self-reliance in their thinking.
7. *Partnerships and networking*: Active parental involvement can facilitate parental support for values and actions in the school. Involvement of relevant collaborators may stimulate action and commitment through complementary expertise and expectations.

8. *Sustainability*: Based on findings from the programme evaluation, decisions need to be made about the programme in terms of its overall quality, viability and sustainability. Programme sustainability is dependent on a continued focus on conditions that facilitate and ensure implementation of agreed actions for change. Integration of the programme into the school structure is an important part of its sustainability.

The components identified by Samdal and Rowling (2011) have particular relevance for mental health promotion as they identify the range of factors operating at the level of the intervention, providers, community, delivery system and support system which are specific to the local context. These components provide a critical framework or 'science of delivery' to guide the whole-school implementation of mental health promotion in schools.

A Whole-School Approach to Implementing Mental Health Promotion

Whole-School Approach

A whole-school approach defines the entire school community as the unit of change and aims to integrate mental health promotion into daily interactions and practices using collaborative efforts that include all staff, teachers, families and children (Oberle et al. 2016). The school-wide approach attempts to shape the whole-school context, including the school's organization, management structures, relationships and physical environment as well as the curriculum and pedagogic practices (Weare and Markham 2005). This systematic approach moves schools away from piecemeal and fragmented approaches to one that is comprehensive and coordinated in both planning and implementation (Greenberg et al. 2005).

The WHO Health Promoting Schools initiative (WHO 1998) resulted in a shift from a focus on curriculum- and knowledge-based approaches to more comprehensive programmes which seek to promote generic life skills through curriculum teaching in combination with a supportive school environment that fosters positive development and a sense of connectedness with family, community and broader social context. The framework involves coordinated action between three components: (1) curriculum, teaching and learning; (2) school ethos and environment and (3) partnerships and services. The Health Promoting Schools model is considered a process that develops and evolves in line with the ever-changing life of the school. It gives emphasis to the involvement of the stakeholders in the school (students, teachers, parents, community members) in identifying needs as well as in implementing actions to meet these needs. It is a dynamic concept underpinned by reflective planning and a learning cycle that supports ongoing development and growth. The whole-school approach to health promotion has as a common base a contextual or socioecological approach to health (Samdal and Rowling 2012).

Regarding the core components of a whole-school approach, effective curriculum teaching and learning involves teaching skills through the implementation of evidence-based programmes as well as modelling social–emotional competence, fostering skills during everyday classroom situations and providing continuous and consistent opportunities to practise social and emotional skills safely (Oberle et al. 2016). At the school level, skills are reinforced in non-curriculum-based ways through policies, practices and structures that are designed to promote a positive school climate and a culture that helps children to develop across academic, personal and social domains (Jones and Bouffard 2012; Meyers et al. 2015). Such practices and policies can include the following elements:

- Developing a school vision
- Formulating school policies and a code of conduct that specifies social, emotional and behavioural norms, values and expectations for students and staff at school
- Anti-bullying and violence prevention guidelines
- Strategies to promote positive staff–pupil relations
- Professional development and learning opportunities
- Student participation
- Strategies to notice and reinforce positive behaviours among staff and students outside of the classroom
- Partnerships and networking

Family and community partnerships involve extending learning to the home and community context. Embedding families within a whole-school approach reinforces the complementary roles of families and educators and extends opportunities for learning across the two contexts in which children spend most of their time. Community partners provide links with external support and mental health services in the community, thereby ensuring there is access to services for students needing additional support.

Reviewers of the evidence to date conclude that taking a whole-school approach, which embraces change to the school environment as well as the curriculum and involving parents, families and the community, is more likely to be effective than individual classroom-based interventions, resulting in enduring positive change (Adi et al. 2007; Jané-Llopis et al. 2005; Tennant et al. 2007; Weare and Nind 2011; Wells et al. 2003). Goldberg et al. (2018) conducted a meta-analysis of whole-school interventions aimed at enhancing children's and young people's social and emotional skills. Results from 45 studies evaluating 30 whole-school interventions indicated a significant improvement in students' social and emotional skills (mean ES = 0.29), behavioural adjustment (mean ES = 0.23) and internalizing symptoms (mean ES = 0.11). Moderator analysis revealed that these whole-school interventions were successful at all education levels (primary and secondary). Studies from the United States reported significantly higher effect sizes than non-US studies. These results are in line with findings from Weare and Nind's (2011) review of social and emotional skills-based interventions. Weare and Nind suggested that some European and Australian whole-school models are failing to show impact as a

result of their 'bottom-up' flexible approach to skill development, which is in contrast to the US style of prescriptive training, intensive curriculum and strict requirements for programme fidelity. Weare and Nind recommend the balancing of the two styles combining the flexible, principle-based approach with more prescriptive elements including specific implementation guidelines. Similarly, Samdal and Rowling (2012) call for greater attention to the implementation of whole-school approaches with greater clarity around the operationalization of what is to be implemented and how it should be implemented in order to achieve optimum results.

Several countries have launched national initiatives for school-wide mental health promotion. In Australia, for example, KidsMatter Primary is a mental health and well-being whole-school framework that supports primary schools in implementing social and emotional learning school-wide (Dix et al. 2012). Through KidsMatter Primary, schools undertake a 2- to 3-year cyclical process where they plan and take action to (1) promote social and emotional learning; (2) work authentically with parents, carers and families; and (3) provide support for students who may be experiencing mental health difficulties. At secondary level, MindMatters provides whole-school education resources, curriculum and professional development aimed at improving the mental health and well-being of young people (Wyn et al. 2000). In the USA, School Wide Positive Behaviour Support (SWPBS) (Lewis et al. 2010) is a multicomponent, multitiered approach to improving behaviour and developing a school-wide environment that is safe. The whole-school framework centres around (1) defining and teaching core behavioural expectations, (2) acknowledging and rewarding appropriate behaviour and (3) establishing a consistent continuum of consequences for problem behaviour. This framework has been adapted for implementation in Norway (PALS), which works at universal, selective and indicated prevention levels (Ogden et al. 2012). In the UK, the SEAL programme was developed as a whole-school framework to support the social and emotional skill development of children and young people. The resources include a curriculum element which is designed to support both universal and targeted work, whole-school materials including resources relating to staff development, school organization, management and leadership and school ethos (Hallam 2009; Banerjee et al. 2014).

We will now examine an evidence-based whole-school intervention for students in primary and lower secondary school. Positive Action is a theory-driven, research-based intervention that contains components for all parts of the school, family and community. The programme works on many levels of the school from the individual to the classroom to the entire school system.

Practice Example: Positive Action (Flay and Allred 2010)

Positive Action is a whole-school intervention that aims to increase positive behaviour, reduce negative behaviour and improve social and emotional learning and school climate for children and young people aged between 4 and 15 years. The

programme was developed in the USA in 1977 and has since been revised as a result of process and outcome evaluations.

Programme Content

The programme is grounded in theories of self-concept and it is also consistent with social–ecological theories of health behaviours (Flay and Allred 2010; Flay et al. 1994). The theory assumes that individuals will use a range of cognitive, affective and behavioural strategies to help acquire and sustain feelings of worth (Lewis et al. 2013). The intervention is designed to create a cycle of reinforcement in which positive thoughts lead to positive behaviours that generate positive feelings about self, which, in turn, lead to more positive thoughts and behaviours (Washburn et al. 2011). Young people who behave in a positive manner are likely to refrain from engaging in negative behaviours, suggesting that Positive Action also functions to decrease harmful behaviours such as aggression. Furthermore, young people's self-esteem also functions to combat poor mental health such as symptoms of anxiety and depression (Guo et al. 2015).

Positive Action includes a classroom-based curriculum from K to Grade 12 (age 5–18 years). Grade K–6 includes 140 lessons per grade (15–20 min each taught four times per week) and Grade 7–12 includes 70 lessons per grade (20 min each, taught two times per week). Lessons for each grade are scripted and age appropriate.

The core curriculum consists of six units that form the foundation for the programme. These units integrate and align the school, home and community programmes to create a consistent and unified programme. The first unit begins with the philosophy and the Thoughts–Actions–Feelings circle. Units 2 through 6 explain key positive actions for the whole self, including physical, intellectual, social and emotional aspects of the whole self.

- Unit 1: Self Concept—programme starts with helping students to identify themselves and understand their self-concept. Students are taught the 'Thought–Action–Feelings' (TAF) circle upon which the content of the curriculum is based. The TAF circle teaches students that their thoughts influence their actions, and their actions influence their feelings about themselves.
- Unit 2: Positive Actions for Body and Mind—students are taught about nutrition, exercise, sleep, hygiene and creative thinking skills
- Unit 3: Managing Yourself Responsible—students are taught to manage their personal resources like time, energy, thoughts, actions, feelings, money, talents and possessions
- Unit 4: Treating others the way you like to be treated—students are taught positive social skills through skills practice
- Unit 5: Telling Yourself the Truth—students are taught to be honest with themselves and others by taking responsibility, learning how to be truthful, admitting to mistakes, not blaming others, knowing their own strengths and weaknesses and following through on commitments.
- Unit 6: Improving Yourself Continuously—students are taught how to set and achieve goals and learn how to apply positive action in all areas of their life by having the courage to try turning problems into opportunities, persisting and keeping an open mind to broaden their horizons.

In addition to the core curriculum, the programme also includes activities aimed at enhancing the school-wide climate as well as teacher, counsellor, family and community training. The school climate programme is designed to reinforce the classroom curriculum through coordinating the efforts of the entire school in the practice and reinforcement of positive actions. The school principal and Positive Action Committee administer this component with representatives from the teaching staff, support staff, parents, students and community members. The principal is responsible for (1) initiating the adoption process, (2) appointing a PA coordinator and PA committee and (3) coordinating training and professional development workshops. A variety of materials are provided to encourage the dissemination of key concepts throughout the school, including words-of-the-week, stickers, tokens, posters, music, CDs, certificates, balloons and 'ICU doing something positive' boxes. Principals are also provided with newsletter templates and information on conducting assemblies and celebrations for Positive Action. A Counsellor's Kit is also provided for additional counselling session with individual, small groups and families.

The Positive Action Family Kit contains 42 lessons for parents to use at home. The Family Classes Kit teaches parents how to use the Family Kit at home. There is also a separate Parent Classes Kit, which is designed to encourage parents to become more involved with the school through participation on the Positive Action Committee, attending Positive Action assemblies and through volunteer work.

A community programme outlines projects which can be done by subgroups of the community, such as community leaders, public servants, media, social service workers and business leaders. It is recommended that communities form a committee to undertake this part of the programme. The Positive Action Community Committee is responsible for promoting positive activities in each subgroup as well as through community-wide events. The programme provides a Community Kit which describes how to organize the steering committee representing various groups in the community, school and families.

Evaluation Findings

Two large randomized control trials have been conducted in the USA (Chicago and Hawaii). The Chicago trial examined the impact of Positive Action on indicators of youth development among low-income ethnic minority youth attending 14 urban schools in Chicago. This study used a matched-pair cluster randomized controlled design. Students (N = 1170) were followed from Grade 3 (8 years) to Grade 8 (14 years). Students in schools that implemented the PA programme reported significantly higher social–emotional and character development scores at Grade 5 and Grade 8. Students were also less likely to report holding normative beliefs supporting aggressive behaviours and engaging in violence-related behaviours and bullying. Students in the intervention schools reported significantly less lifetime prevalence of substance use (ever and more than once) at Grade 8. In addition to preventing negative outcomes, there was a significant improvement in positive youth development, including increased self-concept, peer affiliations, ethics and social skills. It was also reported that students had more favourable changes in positive affect, life satisfaction, and lower levels of depression and anxiety (Lewis et al.

2013). School-wide findings indicated positive programme effects on both disciplinary referrals and suspensions (Lewis et al. 2013). Bavarian et al. (2013) reported that teachers in the intervention group rated their students as achieving greater growth in academic motivation and academic ability. Furthermore, all students showed an increase in maths scores relative to their counterparts in the control schools, and intervention schools also showed significant positive effects on reading for African American boys (Bavarian et al. 2013).

Another matched pair cluster randomized controlled trial was carried out in 20 primary schools in Hawaii ($N = 544$ students). The study sample consisted of two cohorts of students (Grades 1 and 2 at pretest through to Grades 5 and 6 by wave 5 follow-up). The two cohorts were surveyed in the spring of each year. After 3 years of programme implementation, results indicated significant school-wide reductions in grade retention, suspensions and absenteeism and school-wide improvements in reading and maths proficiency relative to control schools. These results were maintained at 1-year follow-up (Snyder et al. 2010). Significant improvements were also found among Positive Action schools in school quality 1-year post-trial, compared to control schools. Teachers, parents and student reports on individual school quality indicators showed significant improvements in student safety and well-being, involvement, satisfaction, quality student report, standards-based learning, professionalism and system capacity and coordinated team work. In addition, participants in the fifth grade were significantly less likely than controls to have engaged in self-reported substance use, violence and sexual activity (Beets et al. 2009).

An independent evaluation of Positive Action was carried out in North Carolina. Results from this study, which included ethnically diverse middle-school youth (age 11–13) located in two violent, low-income rural counties ($N = 1246$), indicate that the programme had a significant positive effect on participants' self-esteem and school hassles (verbal and physical harassment endured at school). Whilst the programme resulted in a decrease in aggressive behaviour, this finding was not statistically significant (Guo et al. 2015).

Programme Implementation Features

Whilst the majority of Positive Action's research publications have focused on programme impact, the following key features of planning and implementation have been identified:

A whole-school model based on theoretical foundations: This theory-based programme attempts to improve children's and young people's outcomes through the adoption of a holistic approach to social and emotional learning, which includes addressing the school environment, teacher–student relations, parent and community involvement, instructional practices and development of the self-concept of all stakeholders (students, teachers, parents and community members). The teacher training promotes more effective implementation of the classroom curriculum and also contributes to greater integration of social and emotional skills-based activities into classroom management and instructional strategies, as well as parent–teacher relations. The classroom curriculum contributes to greater amounts and quality of dedicated classroom instruction in social and emotional learning. The school climate components lead to changes in school-wide activities such as reinforcement

and recognition of positive behaviours demonstrated by students, as well as assemblies and other events focused on social and emotional learning. The family involvement component leads to changes in opportunities for family involvement with the school, as well as positive increases in discussion and utilization of social and emotional skills in school–parent and parent–child relations (Flay and Allred 2010).

Comprehensive staff training: All staff are trained in the basic elements of the Positive Action programme, the curriculum, climate development, family/parent and community components. Additional training can also be provided in relation to improving specific segments of a school's programme, for example, classroom management, school-wide climate development, intrinsic motivation, encouraging parent and community involvement. The recommended length of a training session varies by the size of the implementation site and the number of participants. There are several options available, including online webinar, on-site orientation and on-site training of trainers.

Programme fidelity: Delivering the programme with fidelity has been shown to produce stronger programme outcomes (Smokowski et al. 2016). A number of factors influencing teacher adherence to the programme have been identified including the extent to which teachers receive support from their principal and collaborate with and receive support from other teachers when implementing the programme, teachers' own attitudes and beliefs regarding the need for schools to implement the programme, and the perceived likely effectiveness of the programme (Beets et al. 2009). Addressing these issues as part of teacher training and the provision of ongoing support is important in ensuring high-quality implementation of the programme.

Programme adaptation: Positive Action provides clear guidelines on aspects of the programme that can be adapted/localized to suit the needs of the school or area. Examples include changing the names of the characters and setting of the stories and the cultural references in the stories. Aspects of the programme that cannot be adapted include key concepts, teaching methodologies and strategies used in the lessons. Teachers are encouraged to use their own words when delivering a lesson, share personal experiences and use humour and model positive actions themselves.

Recommendations for Replication

In order to achieve the maximum results with Positive Action, the following steps have been recommended (https://www.positiveaction.net/support/best-practices):

Plan: The scope of the work should be a collaborative effort which includes all parties involved in implementing the programme. It is recommended to establish a project coordinator and the Coordinating Committee whose role is to support the implementation of the programme across the school. A schedule for communication between the core team and all key stakeholders (teachers, parents, community members) should be established and maintained. It is also necessary to jointly agree upon a timeline and schedule.

Prepare: The Coordinating Committee should determine the type of training that is required and arrange it accordingly. It is recommended that programme materials

are ordered in advance of the training to allow staff to familiarize themselves with the Kits before the training.

Implement: Positive Action lessons should be taught in the morning and the concepts taught in the lesson should be reinforced throughout the day. Teachers are encouraged to think about ways to review each lesson in detail before implementing it, explore the materials that accompany the lesson and to think about ways to adapt and localize the lessons to fit the context of the class. Key ground rules to be established with class members include the following: Keep lessons positive; Respect confidentiality; Be respectful and kind; Practice and reinforce the positive actions. The Coordinating Committee is urged to hold meetings on an ongoing basis to address issues with implementation as they arise and to plan for embedding the programme within school practice.

Assess: Schools are encouraged to monitor programme fidelity and to utilize these data to review programme achievements and progress towards desired goals and objectives. The data can also be used to identify areas requiring modification.

Further details about the programme are available at https://www.blueprintsprograms.org/factsheet/positive-action

A Whole School Approach to Bullying in Schools

A whole-school approach has also been used to effectively address particular issues such as bullying. KiVa is an example of a comprehensive anti-bullying whole-school intervention. It is a theory-based programme, employing social–cognitive theory (Bandura 1989) as a framework for understanding the process of social behaviour. The programme is also based on studies of the social standing of aggressive children, and bullies in particular, and on participant roles in bullying (Kärnä et al. 2013). KiVa shares some features with the evidence-based Olweus bulling prevention programme (Olweus 1991). The Olweus programme adopts a systemic, school-wide strategy that utilizes intervention curricula and activities across the entire school community (students, teachers, parents, staff). This has been evaluated in Norway and the USA, with more consistent positive intervention effects having been reported from Norway (Olweus and Limber 2010). Similar to the Olweus programme, KiVa is a multilevel, multicomponent programme designed to reduce and prevent school bullying. The programme consists of (1) 20 h of universal curriculum to increase anti-bullying attitudes and defending behaviours and self-efficacy among bystanders, (2) indicated intervention for addressing identified cases of bullying, (3) information for parents and (4) materials reminding both students and school personnel of KiVa (posters, highly visible vests to be worn by lunch break supervisors). Activities include classroom discussion, group work, video, role-playing and an interactive computer game. Both programmes include actions at the level of individual students, classrooms and schools and both tackle acute bullying cases through discussions with the students involved.

KiVa consists of three units. Unit 1 is designed for children aged 6–9 years, Unit 2 is suitable for children aged 10–12 years and Unit 3 is designed for children aged 13–16 years in middle school/lower secondary school. Unit 1 consists of ten double lessons for students (2 × 45 min each). At the whole-school level, a number of elements have been included, which have been associated with reductions in bullying, victimization or both (Farrington and Ttofi 2009), including a whole-school anti-bullying policy, school conferences, whole-school teacher training, improved playground supervision with teachers wearing highly visible vests reminding both students and school personnel of KiVa. At the classroom level, universal actions consist of student lessons which focus on increasing anti-bullying attitudes and defending behaviours and self-efficacy among bystanders. The student lessons include discussion, group work, role play exercises and short films about bullying. The topics cover a variety of issues related to (1) group interaction and group pressure, (2) the mechanisms and consequences of bullying, (3) different forms of bullying and how it is influenced by the bystanders and (4) what the students can do together in order to counteract bullying and support the victimized peers.

A unique feature of KiVa is the virtual learning environment (an anti-bullying computer game for primary school students, and an Internet forum 'KiVa Street' for secondary students). At primary level, the anti-bullying computer game is played during and between the student lessons. The topics in the game are closely connected to matters presented in the corresponding student lessons. By playing the game, students acquire new information and test their existing knowledge about bullying and learn new skills to act in constructive ways in bullying situations. At second level, the Internet forum consists of different places that students can visit, for example, library to find out information about bullying and motive theatre to watch films about bulling. In all grade levels, schools are provided with presentation graphics that they can use to introduce the programme to whole-school personnel and to parents. Parents also receive a guide that includes information about bullying and advice about what parents can do to prevent and reduce the problem. The indicated actions involve discussions with victims and bullies, as well as with selected prosocial classmates who are challenged to support the victimized classmate. The discussions with the bullies and victims are effectuated by a team of three teachers or other school personnel, along with the class teacher. The classroom teacher organizes a separate meeting with the potential supporters of the bullying victim.

The KiVa programme was first evaluated in a randomized controlled trial involving 234 schools in Finland. Results from this study indicated a significant reduction in bullying and victimization. The odds of being a victim or being a bully were 1.3 times higher for a control school student than for a KiVa school student. The programme was also found to reduce bystander negative behaviours (assisting and reinforcing bullying) and increased their self-efficacy to support and defend the victimized peers (Kärnä et al. 2011). The programme's effects have been found to generalize to multiple forms of victimization (Salmivalli et al. 2011). In addition, reductions in victimization in KiVa schools have been reported to predict

improvements in depression, anxiety and negative peer perception (Williford et al. 2012). Furthermore, the KiVa programme has increased school liking, academic motivation and self-reported academic achievement (Salmivalli et al. 2011). Largest effects have been found in primary school and the smallest effects were found in the lower secondary grade level (Kärnä et al. 2011). KiVa has been brought to scale in Finland and is also being implemented in many countries such as Estonia, Italy, the Netherlands, New Zealand, the USA and Wales.

The implementation of a whole-school approach to supporting children's and young people's mental health and well-being has been adopted in several countries. The whole-school approach provides an important framework for creating supportive school environments for the development of social and emotional well-being for all students in school. MindMatters is an example of a whole-school approach to supporting young people's mental health that has been implemented at a country level in Australian secondary schools. The complexity of the whole-school approach can make implementation challenging. Putting school-wide mental health promotion into action requires a supportive education system that allocates the necessary infrastructure and capacity to conduct a coordinated set of activities across classroom, school environment and community level (Oberle et al. 2016). The use of multiple strategies on multiple levels makes it difficult to implement, integrate and sustain over time. The next case study describes the development and evaluation of MindMatters in Australia and illustrates the process involved in national level implementation and the challenges of sustainability. Following that, another case study provides an account of the adaptation of a whole-school approach, the Gatehouse Project, for implementation in Pakistan. The Gatehouse Project (Patton et al. 2006) was developed in Australia and builds on the Health Promoting Schools Framework addressing adolescents' emotional well-being and health risk behaviours. The case study illustrates the adaptation of the programme from the perspective of a participating school in Islamabad.

Case Study: MindMatters: Case Study of Developing the First National School Mental Health Promotion Programme in Australia

Louise Rowling
Sydney School of Education and Social Work, University of Sydney, Camperdown, NSW, Australia

Background

This case study reports 16 years of trial, development and evaluation of MindMatters (MM) in Australian high schools. Combined with the last 4 years' developments, it offers a unique insight into the challenges, barriers and actions that contribute to

sustainability in school mental health promotion, prevention and early intervention. A number of interwoven issues have emerged. They have global applicability and point to strategies that enhance sustainability. The issues are:

- The challenges of the health/education sectors' nexus
- The impact of ideological disciplinary orientation (language and concepts)
- Application of evidence-based implementation at all levels
- The importance of readiness and active engagement of school communities

In 1995/1996, as part of the First National Mental Health Plan (Australian Health Ministers 1992), the Australian Commonwealth Department of Health funded research to identify the readiness of schools to adopt mental health promotion programmes. Lack of teacher confidence to teach about mental health, lack of appropriate classroom curriculum resources, the crowded curriculum with health being a low priority, teacher stress and low morale and stigma associated with the term mental health were found to be important influencing factors (Wyn et al. 2000).

MindMatters was underpinned by research-based conceptual frameworks (Wyn et al. 2000) that schools could use to promote mental health. It built on educational research regarding effective school programme implementation and was grounded in the research and understanding that the professional development of teachers is fundamental to the success of any health/educational innovation. The approach taken by MindMatters focused on protective factors that promoted connectedness, recognized the importance of the organizational structures, the social environment, and the individual within this context. MindMatters can be distinguished from prior single topic health education projects because it places mental health within the core educational business of schools rather than identifying it as a health topic (Murphy et al. 2017). It also provided a framework for the selective inclusion of other targeted programmes and initiatives that address specific aspects of mental health and mental ill-health. The MindMatters approach marked a significant shift away from mental health interventions that emphasized individual deficits of young people and individually focused behavioural change models.

Programme Implementation

The unique approach in MindMatters provided a guided, structured strategy for generating health-promoting schools which promote young people's mental health and well-being through all dimensions of the school environment. It is a universal approach using the school as a setting for intervention rather than a site where an intervention occurs. The 'content' of MindMatters in the first portfolio in 2000 consisted of materials for review and planning for school improvement for mental health. This included practical tools for auditing, planning and managing mental health, and it was aimed at school principals and teachers in positions of leadership. Curriculum and whole-school change strategies for selected topics such as bullying and harassment, resilience, stress and coping, help-seeking, loss and grief, and mental ill-health were other elements. All these materials were available on the

MindMatters website (www.curriculum.edu.au/mindmatters). Community Matters was added in 2002 to provide for the community context, specific groups of students with high needs, and gathering the student voice.

The pilot was conducted in 24 schools across Australia during 1998. The evidence from the pilot project demonstrated that the process and the materials worked in vastly different school contexts, thus maximizing the conditions for transferability to diverse school settings around Australia. The pilot identified quality practice criteria involving:

- The need for attention to professional development for teachers because of stigma and fear; the perception that mental health is not the core business of schools; and the uncertainty about what constitutes good teaching practice in relation to mental health promotion
- Careful use of language because of misinterpretation of mental health as mental ill-health and because of the importance of forming links to the school's core business around student welfare and pastoral care
- The development of materials and processes that match school practice conditions that are realistic and sustainable
- Collaborative practices within the schools and between schools, agencies and parents
- The importance of developing and enhancing leadership for mental health at various levels within the school community
- Contact with other schools engaged in similar work and allocation of a budget
- The acknowledgement of the critical role of the local school context including building on initiatives already underway in the school or linking with other school priorities

Different perspectives for evaluating school mental health promotion programmes were identified (Hazell et al. 2002). From a cross-disciplinary perspective, assessing the educational evidence about policy, teacher professional development and changed school practices may not be evidence the health sector recognizes as legitimate. However, education systems and school staff can be more interested in these educational outcomes than mental health per se. What was required was acceptance of outcomes that matched the priorities of both sectors.

The National Implementation Study of MindMatters[1]

Following these successful pilot studies, materials were distributed free to all secondary schools in Australia. The government also funded teachers to attend national workshops. The schools' contributions were paying for replacement teachers.

[1] This section is based on the Evaluation Report, Hazell et al. (2005) (used with permission), in Rowling and Hazell (2014).

Methodology and Results

An implementation study was conducted over 4 years by the Hunter Institute for Mental Health (Newcastle, Australia). It monitored how schools undertook a whole-school approach for mental health promotion using MindMatters materials and the professional development training. Schools were selected at random from a national list. The assessment of the impact of MindMatters used a quasi-experimental design, in which students at 3-year follow-ups were considered the 'exposed group' as they were exposed to curriculum and other changes as a result of their school's adoption of MindMatters. Their scores on questionnaires measuring positive outcomes were compared with those of students in the same year-group at baseline, who were considered the 'unexposed group.' For example, male students in year 9 in 2005 (exposed) were compared with males in year 9 in 2002 (unexposed). Hence the latter group acted as a within-school comparison group, as a partial control for other school-based variables that could have contributed to changes in the evaluation variables of interest. Of the 15 schools that participated in the case studies, 10 completed student questionnaires at baseline and at annual follow-up for 3 years.

Indicators of resilience from the key subscales in the 'Resilience' module of the Californian Healthy Kids Survey (Constantine et al. 1999; http://chks.wested.org/) were selected as likely indicators of changes that might be attributed to MindMatters. These were the 'School attachment', the 'Autonomy experience', the 'Self-esteem', and 'Effective help-seeking' subscales.

Given the differences between schools in terms of their characteristics and demographics, and the differences in the ways MindMatters was implemented, firm conclusions about patterns of change across schools are difficult to extract and equally difficult to attribute solely to the implementation of MindMatters. As each school demonstrated a different baseline condition and unique pattern of adoption of MindMatters, these comparisons are most meaningfully interpreted at the individual school level.

Results

School attachment: In examining the patterns of change across all of the schools (year levels 7–11), there is a general trend for males and females in years 10 and 11 to show increased scores for 'School attachment' at 3-year follow-up relative to baseline. 'School attachment' scores for all-year 11 males were statistically significantly higher at 3-year follow-up, compared to baseline, albeit that these increases were only 'a little higher'.

Autonomy experience: An overall pattern of improvement in 'Autonomy experience' scores emerged at the end of 3 years compared to baseline. Five of the 15 schools showed at least 1year-group where the mean score at the end of the evaluation was significantly higher than that for students of the same year-group at the beginning.

For all males in years 9 and 10, and all females in year 10 there were small but statistically significant improvements in 'Autonomy experience'. However, when all data were combined across schools and year-groups, the difference between baseline and follow-up did not reach statistical significance.

Self-esteem: No consistent pattern of responses at follow-up (relative to baseline) was found on the 'Self-esteem' subscale for males or females, or across the year levels.

Effective help-seeking: An overall pattern of improvement emerged in 'Effective help-seeking' scores at the end of 3 years compared to baseline. In particular, three schools showed at least 1 year-group where the mean score at the end of the evaluation was significantly higher than that for students of the same year-group at the beginning. Importantly, no schools reported reduced 'Effective help-seeking' scores between baseline and follow-up questionnaires that were statistically significant.

Given the process and selection criteria outlined above, the case study schools can be considered reasonably representative of schools that are implementing the MindMatters programme in Australia. However, there are some limits to the conclusions that can be made about the data collected. It is possible that a level of response bias might have occurred. MindMatters schools were more likely to respond than those whose schools were not. Additionally, as the sample schools were spread across the country, limited funding precluded evaluators visiting schools to collect data on the three occasions. Schools took responsibility for this. Given the complexity of schools, positive or negative changes in the indicators cannot be attributed simply to the school's use of MindMatters. The findings that emerge from the statistical analysis of the measures used in this study (based on the Californian Healthy Kids Survey) should be interpreted with these limitations in mind.

Implementation Outcomes

In terms of implementation outcomes of the 15 case study schools that commenced using MindMatters in 2001 or 2002, 13 were continuing to implement the initiative after 3 years. Based on information provided by surveyed participants, it is estimated that 35% of schools that attended professional development workshops and decided to use the MindMatters resources utilized a whole-school approach to implementing the initiative, developing policies, structures, procedures, and curriculum around supporting the mental health of students and staff. There was evidence to suggest that teacher responses to bullying had improved. There was some evidence that students who participated in the skills-building activities felt more confident about their ability to deal with mental health issues and were more comfortable talking about them. One of the key findings of the audit conducted in 1996 was the low confidence level of teachers in the area of students' mental health. This benchmark was improved. Teachers reported that the initiative gave them the confidence and skills to better support and understand the needs of students, and to identify those children who may need additional support.

Regarding the outcomes for the students, there was an overall pattern of improvement in school attachment, autonomy experience and effective help-seeking. There was no documented improvement or worsening in self-esteem, and seven out of the ten schools generally showed patterns of improvement.

Key Recommendations for Continuation and Replication

- The approach to mental health promotion needs to be undertaken using education systems, processes and language in the training and in the dissemination.
- Training needs to reflect and model the actual nature of the material being promoted.
- The teacher emerges as a key to the success of a school mental health promotion initiative.
- Training needs to respect the professionalism of teachers providing development in educational terms as well as acknowledging them as an individual in a worksite.
- Funding bodies need to make investments over time and understand how the dissemination occurs within an individual school and across states and sectors.
- Coordinated multilevel training needs to occur that includes teachers, principals, year-level coordinators as well as mental health workers linked to the school.
- Transference to other countries (e.g. Germany) has involved an incorporation of that country's relevant cultural context.

Current Developments

In 2013, a new agency gained the contract to re-develop MindMatters. The redevelopment involved modifying the MindMatters models for delivery online, using components that aligned with the KidsMatter Primary and Early Childhood programmes (https://www.kidsmatter.edu.au/). It was introduced after piloting in 2014. This move was part of the government's drawing together of mental health funded activities.

The KidsMatter Primary and Early Childhood programmes' framework components are:

- Positive school community
- Social and emotional learning for students
- Working with parents and carers
- Helping children with mental health difficulties

The original components in use for MindMatters framework were quite different:

- Curriculum, teaching and learning
- School ethos and environment
- Partnerships and services

The protective factors that shaped MindMatters promoted connectedness, recognized the role of the organizational structures, the social environment and the individual within this context. In the newly developed MindMatters framework the components are positive school community, student skills for resilience, parents and families and support for students experiencing mental health difficulties. This conceptualization is considerably more content focused on individual students than the original approach, due to the targeted focus of the new providers. This shift in focus has positives and negatives. First, evaluations have the potential to be more focused on student outcomes, which is very positive. However, this targeted focus on student outcomes without knowledge of the context may result in false outcomes being identified. Second, a negative—there is a significant change in implementation, with multiple materials available via online, 'blended professional learning', but with fewer implementation support options.

What Lessons Have Been Learnt and What Needs to Be Learnt?

A recent review of the world's largest school-based mental health programmes (Murphy et al. 2017) commented on the important role of implementation science into the future: 'We can now pay greater attention to assessing the processes and practices of implementation that are associated with successful, widely disseminated, and sustainable programs, and also to program limitations and liabilities that may impede adoption' (p. 227). In their review description of MindMatters, Murphy et al. (2017) highlighted the MindMatters concept of 'continuous support' meaning the programme was implemented by integration into the framework of the existing curriculum and environment, rather than added as a new protocol. Teachers were trained to follow age-appropriate programme concepts, for the entire length of time children are in the school setting (p. 224).

An important focus for national implementation in any country is the linking of new approaches and content to existing educational policy. For Australian educators, the new national curriculum documents for Foundation to Year 10 Australian Curriculum Assessment and Reporting Authority (https://www.australiancurriculum.edu.au/f-10-curriculum/health-and-physical-education/structure/) clearly recognize the importance of action for schools at many levels—classroom teacher, parent, leadership and community. It also recognizes the need for adolescents to be health literate. The focus on health literacy, as highlighted in the Australian National Curriculum, can include a focus on adolescent learning, health literate organizations and critical health literacy (Peralta et al. 2017). It is not a sole focus on medical literacy, but includes skills such as critical solutions-based thinking and capability development for now and into the future (Peralta et al. 2017).

Conclusion

This case study provides globally applicable evidence for quality implementation in school mental health. It emphasizes issues such as high engagement of educational systems and school personnel. It stresses the crucial role of teacher professional development in schools, particularly with sensitive topics such as mental ill-health, loss and grief. Additionally, quality materials, based on theory, knowledge and praxis drawn from school implementation, supports sustainability.

Case Study: Implementation of a Whole-School Approach in Pakistan

Rachel Jenkins
Institute of Psychiatry, Kings College London, London, UK

Asima Khan
Department of Psychiatry, Punjab Institute of Medical Sciences, Jalandhar, Punjab, India

Background

The whole-school approach to building resilience in children was first developed in Australia. In line with the Health Promoting Schools framework, the Gatehouse Project includes both whole-school and individual components to promote the emotional and behavioural well-being of young people in secondary schools (Bond et al. 2004; Butler et al. 2002). It aims to build and strengthen security and trust; skills, communication, social connectedness; and a sense of positive regard through valued participation in school life. It takes a systematic approach to considering how this can be achieved in individual schools through the classroom context and curriculum, the overall context and organization of the school as a whole, and through the school's links with parents and the wider community. Key elements of this whole-school approach include the establishment of a school-based health team, identification of risk and protective factors in the school environment and using these data to implement effective strategies to address these issues. Through the adoption of a holistic approach, the Gatehouse Project aims to build resilience in schoolchildren, reduce risk factors and address school problems of bullying, violence, low achievement, truancy etc. (Bond et al. 2004; Butler et al. 2002). Results from a cluster randomized control trial involving 26 schools in Australia indicate significant improvements in student health risk behaviours (Bond et al. 2004).

Whilst the teaching materials for the Gatehouse Project were originally developed for Australia, they were subsequently adapted for Pakistan as part of a British Council-funded collaborative project between Kings College London and Punjab Institute of Medical Sciences (PIMS), Islamabad (Khan et al. 2013). This case study reports on the progress made in one school, namely City School, Islamabad, after one of its teachers attended one of the Whole School Approach workshops in Islamabad. City School, Islamabad, takes in pupils from age 5 to 17 years, and is part of a private school network of more than 185 schools in 52 cities. The curriculum is derived from the UK national curriculum, and guides students towards the Cambridge International Examinations.

Implementation of Whole-School Approach in Pakistan

The materials from the Gatehouse Project were formed into a 4-day workshop which consisted of six modules altogether. Three modules were centred around the whole-school approach (Gatehouse Project), one module focused on mental disorders in childhood, one module on cognitive–behavioural therapy and one module on mindfulness. Theoretical sessions were interspersed with discussions, small group work and role plays. Participants in the workshops were class teachers, subject teachers, school doctors, school counsellors, head of institutes, college lecturers and educationists from Punjab, Capital territory, Swat, Khyber Pakhtunkhwa, the Federally Administered Tribal Areas, Azad Jammu and Kashmir and Sindh.

Following the workshops, participants were asked to return to their places of work, whether schools or colleges of education, and stimulate the formation of a representative team led by the organizational head, to review their organization's policies, programmes and practices. Participants were asked to identify priority areas for reducing risk factors and enhancing protective factors for positive health and educational outcomes, by focusing on the classroom environment, the curriculum, the school environment, and the links between school and its surrounding community.

The specific social and emotional programmes used in the school were based on values-based education which emphasizes a sense of responsibility, affection, respect, friendship, connectedness, encouragement through appreciation, unity, hope, tolerance, protection, trustworthiness and capacity to speak and act. (http://valuesbasededucation.com/images/PDF_material/Values_Introduction_for__Website.pdf) Students are taught about:

- Being honest, which will provide benefit at each stage of life
- The importance of hard work
- Team building for enhancing concepts of teamwork and collaboration
- Developing empathetic skills as an important human characteristic

Teachers are encouraged to promote a positive environment where students feel secure. This is done by:

- Listening to students and showing them that they are cared for and are safe
- Respecting the privacy of students when they share problems
- Involving students in decision making
- Modelling praise and appreciation for developing self-esteem and positive self-image

Collectively, the values promoted in the programme not only promote academic achievement in students but also develop long-lasting interpersonal skills. The values are positively modelled by teachers and school staff to support the development of interpersonal skills and emotional intelligence, avoid confrontational situations, and promote a safe and caring environment throughout the school that is fully inclusive. Thus these values support the development of the whole child as a reflective learner as well as the promotion of quality teaching and learning.

Following the training of one teacher from City School in 2012, the whole-school approach was initiated in City School by a team consisting of the principal, vice principal, school coordinator, school psychologist and class teachers, who conducted training workshops for teachers and other staff members. During the training workshops for teachers, the teachers identified psychological issues in their students that they were not able to manage themselves, and this triggered a number of referrals for professional assistance. Other staff trained included administrators, guards, gardeners, van drivers, van conductors, peons and sanitary workers. The training emphasized the importance of adopting a whole-school approach, not just in terms of formal classroom teaching but throughout all aspects of the school environment. The objective of the training was to achieve planned, holistic and sustained change in the everyday practices of the school, not just in the individual behavioural change of students.

Evaluation

The administrative authority at the school was responsible for evaluating and measuring the outcomes of implementing the programme. The measures were done at the individual level, at the classroom level, and on the whole-school level. Training outcomes were evaluated every 2 months by the school coordinator from the City School and an associate clinical psychologist, working under the supervision of the Chair of Psychiatry Department, at the Pakistan Institute of Medical Sciences, Islamabad, Pakistan. The overall analysis revealed a number of positive outcomes, including a positive school culture, secure classroom and school environments, capacity building in making and implementing school policies, and partnerships between students, parents, teachers and community representatives.

Intervention Implementation and Recommendations

Factors That Supported Implementation

Key factors that made implementation possible included:

- Attendance at the initial training workshop
- Commitment from the senior leadership of the school
- The decision to blend the whole-school approach with another related approach that was already under consideration at the school, namely becoming a Values-based Education Model School, rather than to view them as separate and possibly competing initiatives
- The identification of key champions and promoters of the whole-school approach, who could provide guidance and support to all school staff in implementing the programme

The process of implementation of the whole-school approach has encouraged the teachers to identify and manage the range of individual and collective issues presented by students and to provide support to every child. A whole-school approach recognizes that all aspects of the school community can impact upon students' health and well-being and are interlinked. Previously, the school had only been considered as an institute of academic development for students, but after integrating the whole-school approach into the daily life of the school, the social and emotional development of the students was also given importance. Implementing a friendly and supportive environment within the school, in integrated, holistic and strategic ways, enhanced trust, communication and connectedness, which boosted confidence in the students, especially those who had hitherto been socially isolated. Students are now willing to approach teachers if they have emotional or academic concerns, and indeed teachers will also approach students if they become aware of emotional or academic concerns. As well as this individual attention to each student, the whole-school approach also works on the whole-school environment, in integrated, holistic and strategic ways that change both individual and collective behaviour and the learning experience. Students have developed a better understanding of how they learn, and are better able to identify any learning issues causing difficulties, and work with teachers to address them. Students have also developed greater self-confidence both within and outside the classroom. They have become more confident in expressing their opinions, knowing that they will be supported by their classmates and their teachers.

Implementation Challenges

The main challenge was the initial uncertainty about the programme that it would not be possible to build up an implementation team, and that other teaching staff would feel too busy to collaborate. In practice, 100% commitment from everyone at the school has been achieved.

Key Recommendations for Replication

- A whole-school approach means that everyone in the school feels safe and included, irrespective of their ability, disability, language, cultural background, sexual orientation, gender identity, gender expression or age. Based on our experience, we recommend other schools to implement a whole-school approach to supporting and caring for staff and students, creating a respectful and safe learning environment that respects diversity and nurtures a sense of connectedness and belonging and a positive self-regard.
- The programme should be based on implementable strategies and practices that suit the particular school context and needs. Thus, it is helpful to conduct a baseline situation appraisal in the school to understand the context, needs and priorities of the students and staff, and then to plan appropriate interventions within the framework of a whole-school approach.
- Timetabling for implementation needs to be taken into consideration so that the programme can be implemented over an academic year and sustained as part of a long-term plan.
- Monitoring the success or failure should be done periodically to ensure that the strategy is making a positive difference in the learning environment.
- Students should be involved in active learning and provided with opportunities for practicing social and emotional skills.
- It is helpful to promote whole-school activities that will promote positive mental health.
- It is important to involve all school stakeholders, including all school staff, students, parents and community leaders.

Future Directions for Application of the Intervention

The federal Ministry of Education and Minister of Capital Administrative Division adopted this programme in 2016 and is planning to extend the whole-school approach to all schools and colleges, whether public or private, across the country, subject to national funding.

Conclusions

Promoting children's and young people's mental health and well-being is essential to their positive development, enabling them to achieve positive outcomes in school, work and life more generally. A substantive body of international evidence indicates that the development of social and emotional competencies through well-implemented, evidence-based school programmes can positively impact children's and young people's social, emotional, behavioural and academic outcomes. The implementation of these programmes is not without its challenges. Durlak et al.

(2011) recommend that effective programmes adopt the following characteristics: *Sequenced* set of activities, *Active* forms of learning, *Focused* and *Explicit* in the skills they target (SAFE practices). Furthermore, implementation research recommends an increased focus on developing structural mechanisms and capacity in local contexts that will support high-quality implementation.

This chapter examined the adoption of a whole-school approach to supporting children and young people's mental health and well-being. A whole-school approach aims to integrate skill development into daily interactions and practices using collaborative efforts that include all staff, teachers, families and children. A whole-school approach involves coordinated action between three interrelated components: (1) curriculum teaching and learning, (2) school ethos and environment and (3) family and community partnership. Several countries have launched national initiatives that adopt a school-wide approach to promoting children's and young people's mental health promotion and well-being and reducing behavioural problems such as bullying. Based on the research evidence and interventions reviewed in this chapter, the following key characteristics of successful whole-school interventions have been identified (Meyers et al. 2015; Oberle et al. 2016; Samdal and Rowling 2011; Wyn et al. 2000):

- *A shared vision is established among all stakeholders within the school.* The implementation of a whole-school approach is most successful and effective when all key stakeholders share a vision for practice, identify clear aims and priorities and develop and plan to achieve the outcomes based on the school's priorities. Establishing a coordination team to support planning, implementation and collaboration with school leadership is important in the preparation and planning stage.
- *The needs and available resources for school-wide implementation are accessed.* It is important to take into account the resources that are currently available within the school in terms of current practice supporting students' mental health and well-being in addition to the needs of students and staff. The needs and resource assessment should be comprehensive and examine what is taking place and what is needed at the classroom, school, family and community level.
- *Ongoing and embedded professional development is provided.* Professional development and learning are essential for developing necessary understanding, motivation and skills as well as generating positive attitudes and competence for undertaking whole-school change. Professional development should take into account the needs of all school staff, including the school leader, teachers, resource assistants etc.
- *Social and emotional skill development is embedded into everyday practice.* A whole-school approach to mental health promotion is most effective and most likely to be effective when it is integrated into the core functioning of the school (Jones and Bouffard 2012). This includes the teaching of skills through evidence-based interventions as well as through teacher modelling and infusing skill development into existing classroom curriculum. At the school level, it includes the promotion of a positive school climate and culture through whole-school

practices and policies, the development of positive staff–pupil relations and a focus on general well-being prosocial behaviour throughout the school. At community level, it includes the reinforcement of skills and learning through home activities with parents and developing community partners to apply these skills in various practical situations including afterschool and community programmes.

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Implementing Universal and Targeted Mental Health Promotion Interventions in Schools

Aleisha M. Clarke

Introduction

A broad range of skills, including cognitive, social and emotional skills, are needed by children and young people to support their development and success in life. Educational curricula are increasingly incorporating a more holistic focus on young people's social and emotional skills alongside their cognitive development in the school curriculum (Barry et al. 2017; OECD 2015). As outlined in the previous chapter, there is a significant body of international evidence to indicate that school-based interventions supporting social and emotional skill development lead to significant improvements across a range of social and emotional well-being outcomes including targeted social and emotional skills, self-confidence, attitudes towards self, others and school and enhanced positive social behaviours (Durlak et al. 2011; Goldberg et al. 2018; Sklad et al. 2012; Taylor et al. 2017; Weare and Nind 2011). Positive effects are also evident in reducing problem behaviours including the prevention of bullying, conflict, aggression and substance misuse and reducing mental health problems such as anxiety and depression (Adi et al. 2007; Durlak et al. 2011; Sklad et al. 2012; Weare and Nind 2011). Research has also shown the significant positive impact of these programmes on academic outcomes (Durlak et al. 2011; Sklad et al. 2012; Taylor et al. 2017).

There are a number of approaches to implementing mental health promotion in schools. Universal classroom-based interventions focus on the teaching of skills to all students in the classroom through the use of a structured curriculum. The skills that are taught can include understanding and managing feelings, problem solving, coping and conflict management/resolution. Targeted interventions are aimed at students at higher risk of mental health problems, including anxiety and depression. These interventions are designed to strengthen students' coping skills and reduce

A. M. Clarke (✉)
Child Mental Health & Wellbeing, Early Intervention Foundation, London, UK
e-mail: aleisha.clarke@eif.org.uk

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Box 1 Evidence-Based Repositories for School Interventions
- Blueprints for Healthy Youth Development (USA)
- Early Intervention Foundation Guidebook (UK)
- What Works Clearinghouse (USA)
- 2013 CASEL Guide Preschool and Elementary School Edition (USA)
- 2015 CASEL Guide Middle and High School Edition (USA)

the risk of negative mental health outcomes. They are often delivered in a group format or on a one-to-one basis.

Databases of school interventions have been made available to assist educators in making evidence-based decisions about an appropriate programme or strategy for their school. These databases utilize a systematic assessment process to evaluate the quality of school-based interventions and their evidence. Examples of these databases are provided in Box 1.

Universal Classroom Skill-Based Interventions

Universal classroom skill-based interventions are designed to teach and model skills such as emotional identification and regulation, effective communication, problem-solving, relationship and coping skills. Teachers are generally trained to deliver explicit lessons that teach these skills. Effective implementation of these interventions involves teaching and modelling skills, providing opportunities for students to practice these skills and giving them opportunities to apply the skills in various situations (Collaborative for Academic, Social and Emotional Learning (CASEL) 2013, 2015). Interactive teaching methods such as role playing, rehearsal, modelling and peer instruction are used to build and reinforce skill development.

Several reviews have identified characteristics of effective universal classroom skill-based interventions. Key characteristics include:

- Programmes with a strong theory base and well-designed goals
- A focus on teaching skills that enhance social and emotional competencies
- Use of competence enhancement strategies and empowering approaches including interactive teaching methods
- Starting early with the youngest and continuing through the school grades
- The provision of explicit implementation guidelines through teacher training and a programme manual (Adi et al. 2007; Clarke et al. 2015b; Weare and Nind 2011).

Durlak et al. (2011) found that the most effective programmes were those that incorporated four elements represented by the acronym SAFE (1) **S**equenced activities that are led in a coordinated, connected way to the development of skills (2) **A**ctive forms of learning (3) **F**ocussed on developing one or more skill (4) **E**xplicit about targeting specific skills.

Some classroom-based programmes teach social and emotional skills directly with some addressing specific skills or topics such as resilience, social skills training and mindfulness. Other programmes address the prevention of problem behaviours through social and emotional skill development, for example, bullying and violence prevention and behaviour management. For a detailed list of evidence-based programmes, please refer to one of the evidence-based repositories listed in Box 1.

Second Step is an example of a universal, classroom-based programme aimed at enhancing children's (aged 5–14 years) social and emotional competencies. The programme, which was developed in the United States, is designed to increase school success and decrease problem behaviours by promoting social emotional competence and cognitive skills training (Committee for Children 2013). The curriculum emphasizes skills that strengthen students' ability to learn, have empathy, manage emotions and solve problems. Each grade includes a total of 22 lessons that are organized into four units: (1) Skills for learning (2) Empathy (3) Emotional management and (4) Problem-solving. The mechanisms that support programme effectiveness are prepared scripts and lessons, stories with discussion, practice activities to reinforce new skills, DVDs that illustrate particular skills, brain builder games designed to increase executive function skill and selected books—all of which are organized around a single topic each week. Second Step also has a home-based component. The programme has been adapted and implemented in over 70 countries. Results from several randomized controlled trials of Second Step indicate improvements in children's interpersonal skills (reduced aggression, improved social behaviour) and a reduction in both internalizing and externalizing behaviours (Frey et al. 2005; Schick and Cierpka 2005).

Interventions including RULER (Brackett et al. 2012) and 4R's are examples of universal programmes that integrate social and emotional learning into the academic curriculum. The 4R's (Reading, Writing, Respect and Resolution) embeds social and emotional skill development into language arts curriculum for children in pre-kindergarten through grade 8 (Brown et al. 2010). It stands out from other classroom-based interventions in that the intent is for students to learn social and emotional skills through a sequence of literacy lessons. Each grade has approximately 35 lessons which are taught weekly over the school year. The 4R's curriculum uses children's literature as a springboard. In weekly lessons, teachers engage students in reading, writing, discussion and skills practice aimed at fostering children's emotional regulation skills, communication skills, problem-solving and conflict management skills. Results from a randomized controlled trial of 4R's in the United States showed that third-grade teachers trained to integrate language arts learning with SEL learning had improved the quality of classroom interactions (i.e. instructional and emotional support), after researchers accounted for teachers' social and emotional functioning (Brown et al. 2010).

The Mindfulness in Schools Programme (MiSP) is an example of a universal social and emotional skill-based intervention adopting a more specific intervention approach with a focus on mindfulness. MiSP integrates meditation-oriented practice into classroom life for young people in secondary schools (Huppert and Johnson

2010). The programme was developed in the United Kingdom and aims to teach mindfulness as a way of working with everyday stressors and experiences. The curriculum is a set of nine scripted lessons tailored to secondary schools, supported by tailored teacher training. The curriculum is drawn from mindfulness traditions, including mindfulness-based stress reduction and mindfulness-based cognitive therapy. The curriculum was designed in line with key principles that were identified in reviews as being important for the effectiveness of school-based programmes promoting mental health and well-being. These principles include explicitly teaching skills, adapting components to suit young people, using a range of age-appropriate, interactive and experiential teaching methods, intensive teacher education and programme implementation that pays close attention to fidelity, in this case supported by a manual and script (Durlak and DuPre 2008; Weare and Nind 2011). A feasibility study examining the acceptability and efficacy of MiSP was carried out in the United Kingdom with young people aged 12–16 in 12 secondary schools (Kuyken et al. 2013). Results from this quasi-experimental study indicated a significant reduction in self-reported depressive symptoms at post-intervention and at 3-month follow-up, reduced stress and enhanced well-being at 3-month follow-up. The degree to which students in the intervention group practiced the mindfulness skills was associated with improved well-being and reduced stress at 3-month follow-up.

The 'Life Skills Training' (LST) programme is an example of a classroom-based universal prevention programme designed to provide general life skills training based on social and emotional learning which is primarily aimed at preventing substance misuse including tobacco and marijuana (Botvin et al. 1980). This programme is included as a *Model Plus* programme in the Blueprints for Healthy Youth Development series. LST is delivered to students aged 12–14 years and provides them with personal self-management skill, social skills, drug-related information and prevention skills, for example, resisting drug use influences. LST contains 30 sessions to be taught over 3 years (15, 10 and 5 sessions), and additional violence prevention lessons are also available each year (3, 2 and 2 sessions). Three major programme components teach students the following skills: (1) personal self-management skills (2) social skills and (3) information and resistance skills specifically related to drug use. Skills are taught using instruction, demonstration, feedback reinforcement and practice. The LST programme has been implemented across the United States and replicated in 40 countries and has been evaluated in 35 cohorts of students over the past 30 years. Across several studies, the intervention group showed significantly greater improvement than the control group on life skills knowledge. Early evaluations of LST by its developers report reductions in alcohol, cigarette and marijuana intake among young people by 50–70% (Botvin et al. 1980, 1995, 1990, 1997). Six-year follow-up data revealed that the positive effects on reducing smoking and heavy alcohol consumption have been sustained through to the end of secondary school (Botvin et al. 2001a, b; Spoth et al. 2008). More recent studies of LST have examined its effectiveness on HIV/AIDS risk behaviours, risky driving, and violence and delinquency. Results indicate a 32% reduction in delinquency and 26% reduction in high-frequency fighting (Botvin et al. 2006). Six-year

follow-up results showed reduced driving violations (Griffin et al. 2004), while 10-year follow-up results showed significant long-term LST prevention effects for HIV risk behaviours (Griffin et al. 2006).

The 'Promoting Alternative Thinking Strategies' (PATHS) programme is an example of a well-evidenced school-based social and emotional learning intervention that targets a broad set of social and emotional learning goals. PATHS, which is recognized as a *Model* programme in Blueprints for Healthy Youth Development, will now be examined in detail.

Practice Example: Promoting Alternative Thinking Strategies (Greenberg and Kusché 2006; Greenberg et al. 1995)

The PATHS programme is designed for use with preschool children (PATHS Preschool) and primary school children (PATHS). The intervention aims to enhance areas of social-emotional development and is based on the affective–behavioural–cognitive dynamic model of development (Greenberg and Kusché 2006), which places primary importance on the developmental integration of emotion, language, behaviour and cognitive understanding as they relate to social and emotional competence (Domitrovich et al. 2010). The programme was developed in the United States (1980s) and has been taught for over 30 years. PATHS has been adopted in 25 different countries including Australia, Canada, Germany, Ireland, New Zealand, Norway, the Netherlands, South Africa and the United Kingdom.

Programme Content

The PATHS curriculum for primary school children teaches skills in five conceptual domains: (1) self-control (2) emotional understanding (3) positive self-esteem (4) relationships (5) interpersonal problem solving. The intervention is designed for use by regular classroom teachers. Teachers receive 14 h of programme training and booster training is also recommended. Lessons are sequenced according to increasing developmental difficulty and are designed for implementation in approximately 20–30 min sessions 2–3 times/week. The curriculum provides detailed lesson plans, exact scripts, suggested guidelines and general and specific objectives for each lesson. Lessons are interactive and include such activities as dialoguing, role playing, storytelling, group discussion and games. In addition to formal lessons, PATHS includes strategies that can be used throughout the day by teachers to generalize the core concepts and promote a climate that fosters social-emotional learning. Parental involvement is incorporated through home assignments, handouts and letters.

Evaluation Findings

A number of trials of the PATHS curriculum with regular and special education children have been conducted since 1983. Results from these trials have shown that the use of PATHS is associated with positive outcomes for students, including significantly improved social cognitions and more socially competent behaviours

(Greenberg et al. 1995; Kam et al. 2004; Riggs et al. 2006). Findings indicated significant reductions in both internalizing and externalizing behaviours at one year post-intervention (Kam et al. 2004; Riggs et al. 2006). Further evidence of the efficacy of PATHS comes from a large, multi-site trial, which included 198 intervention and 180 comparison classrooms from schools within high-risk neighbourhoods in the USA (Conduct Problems Prevention Research Group 1999). In the intervention schools, first-grade teachers delivered a 57-lesson version of PATHS. At the end of Grade 1, children in the PATHS classrooms had lower aggressive behaviour scores than those in the control classrooms. A significant intervention effect was also observed on children's hyperactive /disruptive behaviour. Longitudinal analyses comparing students who had received 3 years of the PATHS curriculum with students in control schools demonstrated significantly lower rates of aggressive behaviour, inattention and poor academic behaviour and higher rates of prosocial behaviour (Conduct Problems Prevention Research Group 2010).

Independent replications of PATHS have also reported positive changes in children's behaviour. A trial in the USA across 14 elementary schools reported significant changes in children's social information processing, student aggression, conduct problems and acting-out behaviour, all favouring PATHS students (Crean and Johnson 2013). Improvements in children's emotional understanding, social competence, attention and behaviour problems were also reported in trials in the United Kingdom, Germany and the Netherlands (Hacker et al. 2007; Hindley and Reed 1999; Louwe et al. 2007). However, results from other independent replications have not been as positive. A cluster randomized controlled trial was carried out in 56 schools ($N = 5074$ pupils aged 7–9 years) in the UK (Berry et al. 2016). Results indicated early improvements in learning behaviours, aggression, hyperactivity and peer problems, but these results were not sustained at 1- or 2-year follow-up. In addition, results favouring the control group were also identified, including a significant reduction in the control group's emotional symptoms and peer problems and at-risk children's cooperation and conduct problems. A cluster randomized controlled trial carried out in Switzerland in 56 schools ($N = 1675$ pupils) reported reduced aggression among all children and reduced impulsive behaviour among children with high initial levels of impulsive behaviour (Malti et al. 2011). Novak et al. (2017) reported few changes in behaviour across the sample as a whole ($N = 568$ children) in Croatia; however, this study identified improvements in behaviour among lower risk children. Another trial in the Netherlands reported low levels of programme implementation and no intervention effects on problem behaviour or social and emotional skills. These studies highlight the challenges in implementing an evidence-based intervention within new cultures and contexts and the importance of studying the process of implementation of interventions in more naturalistic settings across different countries and settings. Large-scale field trials are needed to provide information on the implementation supports required to obtain intervention effects that are replicable across diverse educational systems and country contexts.

Programme Implementation Features

Theoretical framework: The PATHS programme is based on an Affective–Behavioural–Cognitive–Dynamic (ABCD) model of development (Greenberg et al. 1995) that emphasizes the importance of the developmental integration of affect (and emotional language), behaviour and cognitive understanding within the dynamic structure of the individual personality. The relationships among the affective, cognitive and behavioural domains are considered critical for socially competent behaviour and positive peer relations (Elias et al. 1997). In developing PATHS, a number of factors were identified that were deemed critical for effective school-based social and emotional learning curricula, these included:

- An integration of a variety of promising developmental theories
- Lessons are implemented across multiple grades
- A strong focus on the role of emotions and emotional development
- Generalization of skills to everyday situations
- Ongoing training and support for implementation
- Multiple measures of both process and outcomes for assessing programme effectiveness (Kusché and Greenberg 2012)

Throughout the lessons, a critical focus of PATHS involves facilitating the dynamic relationship between cognitive-affective understanding and real-life situations. Specific strategies used to accomplish programme goals include: lessons taught at least twice weekly, use of compliments throughout lessons, activity-based learning, use of feeling face chart and cards for emotional awareness, skill practice, visual reminders and cues to promote skill use, dialoguing in problem situations, integration with base curriculum and use of take-home activities (Kusché and Greenberg 2012).

Programme model: The PATHS curriculum programme model requires teachers to administer a set of core lessons at least two times per week for 15–20 min and to engage in a number of behaviours designated to generalize the curriculum components throughout the class day. Each unit of PATHS focuses on one or more skill domains (e.g. emotional recognition, friendship, self-control and problem solving). Each new unit builds hierarchically upon and synthesizes the learning which preceded it. PATHS lessons follow lesson objectives and provide scripts to facilitate instruction, but teachers have flexibility in adapting these for their particular classroom needs (Kusché and Greenberg 2012).

Active engagement of pupils: Students are more likely to be interested in PATHS and to internalize the curriculum when teachers present the lessons in an engaging manner and generalize the core concepts throughout the day (Kusché and Greenberg 2012). Kam et al. (2003) identified that the quality of teacher implementation at the classroom level was a critical factor in determining the success of the programme on child outcomes.

Staff training: Whole staff training (teacher and school personnel, including the principal) is strongly recommended. The training model involves a two-day training session before school begins and a one-day booster session halfway through the

school year. The materials that PATHS trainers use are standardized to ensure a high level of quality and consistence of training delivery. The materials include guidelines about how to establish positive working relationships with attendees and strategies on how to manage common problems that may arise during the workshop (Kusché and Greenberg 2012).

Recommendations for Replication

Principal support: The programme developers stress that a committed school principal is essential for successful implementation. The principal's endorsement of the programme and attendance at training is viewed as a critical prerequisite for programme success. In their examination of factors influencing implementation, Kam et al. (2003) reported that school principal support for PATHS directly affected a reduction in student aggression, behaviour dysregulation and an increase in social emotional competence and on-task behaviours.

School coordinator: Schools are encouraged to identify a PATHS coordinator to serve as a liaison between the developers and the school staff. This individual provides ongoing support to teachers and maintains contact with the programme developers, seeking advice when needed (e.g. identifying critical elements of the programme as well as components that are appropriate for adaptation to fit local needs and resources) and planning future training for staff.

Family participation: The engagement of parents is identified as an important aspect of PATHS. Schools are advised to involve parents in the decision-making process and programme activities. Parents are provided with information, activities and instructions that enable them to support the skills their children who are learning in school.

Monitoring implementation: To assess the programme model, the developers request that teachers and PATHS coordinators monitor: (1) whether the core content of each lesson and the curriculum as a whole are being covered (2) how often lessons are conducted and (3) the overall number of lessons administered. This implementation information is then used to make decisions about the programme and about ways to maintain and improve its overall quality (Kusché and Greenberg 2012).

Additional information about the programme is available at: https://www.blueprintsprograms.org/factsheet/promoting-alternative-thinking-strategies-paths

In order to address multiple risk and protective factors for aggressive and disruptive behaviour problems, the PATHS programme has been integrated with the PAX Good Behavior Game to create the PATHS to PAX model (Domitrovich et al. 2010). PAX Good Behavior Game is an evidence-based classroom behaviour management strategy that teachers use alongside a school's standard curriculum (Embry 2002). The PATHS to PAX model leverages the most effective structural and content components from the two interventions, targeting teachers' classroom management style through the PAX Good Behavior Game as well as children's social emotional skills through PATHS. The integrated model is not simply the sum of two interventions, rather it is the blending of overlapping components that underlie each model (Domitrovich et al. 2010). A randomized controlled trial across 27 schools in the

USA compared the PAX Good Behavior Game with the integrated model of PATHS to PAX. Results indicated that the PATHS to PAX condition generally demonstrated the most benefits to teachers. The findings suggest that school-based prevention programmes can have a positive impact on teachers' beliefs and perceptions, particularly when the programme includes a social–emotional component (Domitrovich et al. 2016).

We will now examine a case study on Zippy's Friends, a universal classroom-based intervention aimed at enhancing children's social, emotional and coping skills. This programme, which was developed in the UK, has reached over 1.5 million children since its launch in 2001 and is running in over 30 countries around the world. Zippy's Friends has been translated into multiple languages and the same programme is being delivered in cultures as diverse as Brazil, China, Norway, Russia, Haiti and India. This case study provides an insight into the implementation and scale-up of Zippy's Friends as a universal school-based intervention at a national level in Lithuania. Key factors supporting the scale-up of the programme are highlighted, including programme planning, local and regional support of the programme and the provision of ongoing support to teachers.

Case Study: Zippy's Friends—Implementation and Scale-Up of Zippy's Friends in Lithuania

Ona Monkevičienė
Department of Childhood Studies, Lithuania University of Educational Sciences, Vilnius, Lithuania

Caroline Egar
Partnership for Children, Kingston upon Thames, UK

Background

Zippy's Friends is a mental health promotion programme for 5–7-year-old children. It develops children's coping and social skills through teaching them to choose helpful strategies to deal with everyday difficulties. The programme's development is based on the research of Lazarus and Folkman (1984), which showed that even young children could learn positive coping strategies, and that the more strategies they could call on in any situation, the better able they would be to cope. Learning effective coping strategies, being able to deal with difficulties and improving one's social skills will in turn enhance children's self-esteem, resilience and general well-being.

The programme is usually run over one school year and consists of 24 story-based sessions divided into six modules, covering feelings, communication, friendship, conflict, change and loss and looking to the future. Through simple and enjoyable activities, children learn how to develop their own solutions to problems. Teachers

must attend a training course in order to receive the programme materials and deliver the programme, and are supported by a local coordinator who organizes follow-up and support meetings.

Zippy's Friends was originally developed as *Reaching Young Europe* in 1997–2001 by Befrienders International, an umbrella organization for suicide prevention agencies around the world, but since then it has been managed by Partnership for Children, a UK-based non-profit organization, which licenses partner agencies to run the programme elsewhere.

Zippy's Friends was conceived from the start as an international programme that could be run with children from all backgrounds and cultures, and this has proved to be the case. From its launch in 2001, after successful piloting in Lithuania and Denmark, it has spread to over 30 countries around the world, and reached over 1.5 million children. It is run in countries as diverse as Argentina and China, USA and India, Russia and Mauritius. For children of this age, the themes are universal, and exactly the same programme is run effectively across this diverse range of cultures. Different countries can also apply the learning from the programme to their own local issues. In China, it helps children from single-child families to learn cooperation and consideration of others; in Mauritius, children learn to cope with issues of domestic violence; in India, the programme is seen as reducing inter-faith conflict.

Zippy's Friends has been regularly revised and developed to include home activities and parent group resources, an adapted version for children with special needs, and a follow-up programme, *Apple's Friends*, for 7–9-year old. In due course, Partnership for Children will produce resources to cover the 3–12 age range, with additional materials for teachers and the wider school community, to encourage a whole school approach to mental health promotion.

Evaluation

To date the programme has been evaluated using a cluster randomized control trial in Norway ($N = 1438$ students) (Holen et al. 2012); and Ireland ($N = 766$ students) (Clarke et al. 2014); and quasi-experimental trials in Denmark and Lithuania ($N = 418$ students) (Mishara and Ystgaard 2006); Lithuania ($N = 246$ students) Monkevičienė et al. 2006); and Canada ($N = 613$ students) (Dufour et al. 2011). Key findings from these studies highlight the significant positive effects of the programme on children's coping skills (Holen et al. 2012; Mishara and Ystgaard 2006), emotional literacy skills (Clarke et al. 2014; Mishara and Ystgaard 2006), social skills (Clarke et al. 2014; Mishara and Ystgaard 2006), externalizing behaviour (Mishara and Ystgaard 2006), improved autonomy (Dufour et al. 2011), improved behavioural and emotional adaptation to schools (Monkevičienė et al. 2006) and reduced mental health difficulties in daily life (Holen et al. 2012). Broader findings from the study conducted in Norway included improved social climate in the classroom, reduced bullying and improved academic skills (Holen et al. 2013).

National Case Study: Lithuania

Lithuania was one of the first pilot countries for *Zippy's Friends*. Befrienders International had good contacts there, and the country's education system was highly centralized and not long out of communist control, contrasted with the highly individualistic system operating in Denmark, the other pilot setting for the programme. At that time, there was very little awareness of the need for children's mental health promotion in Lithuania, and no such programmes were running in schools. An evaluation study using a quasi-experimental design was conducted in 1999–2000 (Mishara and Ystgaard 2006) and revealed significant positive effects on children's coping abilities, an increase in social skills and empathy, and a decrease in behaviour problems. Furthermore, teachers enjoyed teaching the programme, and reported that it helped them to cope better with their own problems. As a result, the Lithuanian Ministry of Education approved the programme, and the programme was launched in the capital, Vilnius, before expanding across the country.

Two further evaluation studies were conducted on *Zippy's Friends* in Lithuania. Children who took part in the programme in the pilot year were followed up 1 year later, and it was found that improvements in social and coping skills, and decreases in problem behaviours, had been maintained. A later study with over 240 children examined whether taking part in *Zippy's Friends* significantly helped children in the transition from preschool to primary school (which in Lithuania takes place at age 7). The findings showed that the experimental group adapted better to school, both behaviourally and emotionally; had more positive reactions to the new school environment; and used more appropriate and more diversified coping strategies, when compared with the control group (Monkevičienė et al. 2006).

Such has been the success of the programme in Lithuania that it is now implemented across all ten counties of the country in nearly 600 educational institutions, of which three-quarters are preschools. Children in Lithuania start primary school at the age of seven, so children take part in *Zippy's Friends* in either the last year of preschool or the first year of primary school.

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

At the outset, the programme was presented to the national institution responsible for the development of the country's education strategy and to authoritative scholars in the field of preschool education. They positively assessed the programme and its theoretical basis. The programme was presented at the Ministry of Education and Science, which confirmed it as suitable for implementation in the country's educational institutions. A local expert group of psychologists and educationalists was set up to maintain and develop the quality of the programme and train programme trainers.

Programme Development: Planning and Implementation

- *An NGO was established* for the implementation and development of the programme, with three full-time staff, who seek financial and voluntary support for the national programme, with strategy set by a professional Board.
- At the start, a *large number of trainers* (mostly educational psychologists) were trained by the expert group, who then trained, monitored and advised teachers.
- *The expansion of the programme* was started gradually, from one county in 2000 to all ten by 2006.
- *The support of the local education department* is a crucial factor for teachers when they choose which programmes to implement, so the departments were approached first when introducing the programme in a new county, through letters, phone calls and presentations. Once the programme was up and running in an area, the local education department was kept informed about how and where it was running, programme news and events in the district.
- *Zippy's Friends methodology centres*, based in participating educational institutions, were opened throughout the country, to support the programme locally with seminars and related events, store sets of materials and other publications, and represent the programme in the county and at national events. The centres participate on a voluntary basis and they are seen as a prestigious addition to an institution.
- A few years into the programme's expansion, a *volunteer group* of active, well-informed teachers was invited to become *trainers' assistants*. Every few years, training courses are organized for them to increase their qualifications and discuss potential improvements in programme implementation. The volunteer group organizes various programme events such as teacher clubs. They help in conducting seminars, distribute, collect and manage and store the programme's material sets, information booklets etc and advise first time teachers on implementing the programme.
- *The programme's methodological, informational and teaching materials* are constantly updated and supplemented and have been translated into Polish and Russian, the most widely spoken minority languages.
- In order to maintain the quality of the programme and the qualification of participating teachers, the programme coordinator organizes *qualification development seminars* for teachers. There have been three seminar cycles so far, encompassing two to three counties a year, for teachers who have taught the programme for at least 2 years. A booklet covering the seminar themes is produced beforehand. The seminars use lectures, questionnaires, discussion and practical sessions, and cover topics suggested by the teachers themselves, including: using *Zippy's Friends* to prevent bullying and violence; using the programme to help children in difficult situations; developing children's coping abilities; balancing the needs of the family and the child; reflection on teachers' own work. An important part of each seminar is letting teachers share their joys, worries and difficulties in implementing *Zippy's Friends*, discussing common issues and finding solutions together. In addition to this, teachers hear about *Zippy's Friends* news from the

country and around the world, sharing good experiences from the programme's implementers. A methodological publication covering the seminar theme is produced for each seminar.

- The programme coordinator (with partners or on their own), with the help of methodological centres and volunteer teachers, regularly organizes *programme events*: international, national or county-wide—conferences, round-table discussions, commemorative events for programme anniversaries etc. These events help teachers to feel engaged with the programme and they value taking part.
- The NGO coordinating the programme is a member of several *Lithuanian NGO coalitions* active in mental health and children's rights fields. This strengthens the programme implementer's prestige.
- The *financial sustainability* of the programme has always been an important issue. The programme's funds come from various sources: support from the general sponsor, a supermarket chain, programme services ordered and paid for by the Ministry of Education and Science, programme participants' fees, financing from project-based work and support from private individuals. In the 18 years of implementation, the programme has experienced periods of varying financial stability but has managed to survive thanks to the mix of income streams.

Implementation Challenges and Experiences that Arose in the Course of Delivery

- The introduction of the programme in Lithuania in 2000 was met with *diverging views* from specialists in the fields of education and psychology, school heads and teachers themselves: some thought that the children were too young to take part in the programme (especially 5–6-year old) and that it would be impossible for them to talk about emotions or develop their emotional skills and therefore, the programme would be ineffective. The results of the pilot evaluation showed that these concerns were groundless. Others, on the contrary, were impressed by the novelty of this idea within the context of Lithuania's educational system of that time and engaged with it enthusiastically.
- Even now *Zippy's Friends doesn't have any comprehensive alternative* in Lithuania because there is no other such programme for pre-school children that is so well-prepared, scientifically researched and proven to be effective.
- If there is no support for the programme from *local/regional municipality education departments,* educational institutions don't adopt the programme and only a few teachers will choose to implement it. In order to obtain support from the relevant authorities, it is essential to hold an introductory event, informing senior staff and decision-makers about the programme, and to keep them in touch with developments once the programme is established. Keeping them up to date with local and national programme events, about which local schools are running the programme and their contribution to it, help to keep the relevant authorities involved and supportive.

- It is difficult to fit the programme into the *intensive curriculum* that primary schools have, while preschool education institutions, children's care homes and day care centres happily adopt the programme into their less rigid curriculum.
- It is difficult to engage *parents* with the programme. Only a few of them actively participate in programme events which are offered to them.
- The implementation of the programme can become much cheaper if its coordinator has *volunteers*—both individuals and institutions.

Key Recommendations for Replication

- *Implementation should begin with a small pilot programme*—that is, only implemented in a small number of institutions while communicating regularly with programme trainers, heads of educational institutions, teachers and parents. This helps to identify any problems before they become widespread.
- *Obtain approval for the programme from the top* (e.g. the Ministry of Education) and promote this fact to regional authorities and schools.
- *Support from the local/regional municipality's education department* is crucial; in our experience, it is even more important than the support of the ministry or other institutions forming the country's education strategy.
- *The programme should be run in settings that have sufficient time to run all the sessions.* In institutions with a very intensive curriculum, teachers may have difficulty finding time to implement a new programme.
- *Keep teachers feeling involved in the programme.* This can be achieved through conferences and other meetings between teachers and trainers where they can share experience and discuss best practice.
- *Monitor the teachers through surveys* and seek their feedback.
- *Maintain the quality and reputation of the programme* through programme development and ongoing training of teachers.
- *Share best practice and learn from implementing partners in other countries*—this provides fresh insights and motivation to continue developing and expanding the national programme. This is achieved by maintaining regular communication with Partnership for Children and participating in their International Workshops.

Future Directions for Application of the Intervention

The adapted materials for children with special educational needs (SEN) will be introduced. No such programme has been available for such children in Lithuania up until now, and we hope to expand it across the country in the future. In the near future, we would like to increase the involvement of parents in the programme with parents' seminars and a lecture series on topics that interest them. We are also planning to organize a qualification development seminar for teachers, the fourth in this series. We plan jointly with programme experts and other education professionals to prepare supplementary materials to *Zippy's Friends*, which will employ a whole school approach.

Next, we examine a universal classroom-based intervention for young people in the senior end of secondary school (aged 15–17 years). The MindOut Programme is an example of the development of a common elements approach to social and emotional learning (Barry et al. 2017). A number of authors have discussed the need to move from discrete packaged interventions to the development of more accessible and feasible programmes that can be integrated into system level practices in a more sustainable manner (Jones and Bouffard 2012; Jones et al. 2017; Barry et al. 2017). One approach is to identify the most essential components across effective promotion and prevention interventions that can address core skills that are appropriate for all youth (e.g. problem-solving, emotion regulation and communication skills) and exhibit the potential for greatest impact (Boustani et al. 2015; Jones and Bouffard 2012). This 'common elements' approach provides an alternative paradigm for evidence-based practice by providing a common set of core strategies that can be applied across a number of domains and their implementation can be tailored on a modular basis to match specific needs and maximize efficiency in improving outcomes in everyday practices.

The adoption of a common elements approach to child mental health treatment shows promising results with clinical trials indicating that the modular approach outperforms both usual care and standard evidence-based treatment (Chorpita et al. 2013; Weisz et al. 2012). Similar innovative work in identifying evidence-based strategies is currently being carried out on social and emotional learning interventions in the USA (Jones et al. 2017). Identifying a set of low-burden strategies, that have the potential to be adopted and utilized in a sustained, integrated and effective way, is likely to be useful in addressing a variety of challenges including, the training of teachers in broader strategies that can applied to everyday contexts, the application of strategies across multiple settings including school, home and community and the need for low cost evidence-based resources in LMICs.

The MindOut programme, which we will now examine, was developed in Ireland in 2004 and in 2016 was re-developed using a common elements approach. This case study provides an insight into the programme's redevelopment, factors that have contributed to its successful implementation in Irish secondary schools and recommendations to strengthen its future implementation.

Case Study: MindOut Programme—Implementation of the MindOut Programme in Irish Post-Primary Schools

Anne Sheridan
Health Service Executive West, Letterkenny, Co Donegal, Ireland

Katherine Dowling · Margaret M. Barry
Health Promotion Research Centre, National University of Ireland Galway, Galway, Ireland

Background

MindOut is a social and emotional well-being programme for senior level students aged 15–18 years in Irish post-primary schools (Dowling et al. 2016). The programme aims to strengthen young people's social and emotional skills and competencies for healthy development. MindOut is a revised version of an original programme developed in 2004 by the Health Promotion Research Centre, National University of Ireland Galway and the Health Promotion and Improvement Department, Health Service Executive (Byrne et al. 2004, 2005). The revised programme was informed by advice and input from a National Advisory Group, which included representation from teachers, the Health Promotion and Improvement Service, National Educational Psychology Service, Child and Adolescent Mental Health Service and Jigsaw Youth Mental Health Service. The programme is available to post-primary schools across the Republic of Ireland and is intended to be delivered through the national Social, Personal and Health Education (SPHE) curriculum. The SPHE curriculum supports the personal development and the health and well-being of students and is currently a mandatory subject for all primary and junior level (12–15-year old) secondary school students. 'Wellbeing' is a mandatory part of SPHE within the junior cycle curriculum (12–15 years), although this is not so at senior cycle level (15–18 years). At senior cycle, SPHE is in place but while its implementation is encouraged in schools, the programme is not mandatory. Guidelines and policy documents (e.g. 'Well-being in Post-Primary Schools - Guidelines for Mental Health Promotion and Suicide Prevention' (DES 2013), do, however, support the introduction of well-being programmes and practices within the context of the senior cycle.

The re-development of MindOut involved an extensive review of international evidence-based interventions, drawing on the findings from syntheses of the evidence on school-based SEL programmes (Barry and Dowling 2015; Clarke et al. 2015b). Details of the main evidence-based programmes developed for adolescents were extracted to determine their core components. Following the initial review of the content of the relevant programmes, the common practice elements that were most frequently used across the interventions were identified. Examples of common practice elements included recognizing and managing emotions, managing thoughts, positive thinking and coping skills. The most frequently used common instructional elements across the reviewed programmes included collaborative learning such as group work, group discussion, reflection, use of games, scenarios and worksheets for structured activities, followed by role play. In addition to a review of the literature, consultations were carried out with representatives from education, health promotion, educational psychology and mental health services. Importantly, feedback was also sought directly from teachers and students who were familiar with the original programme. Young people were also directly engaged in developing the new programme, including writing scenarios and reviewing the appropriateness of the language and content of the programme materials. Piloting of the final draft of the re-developed programme was carried out in a number of schools across the

country (Dowling et al. 2016) and this also provided vital feedback on elements of the content, user friendliness and the applicability of the programme sessions to young people. Therefore, the contribution of teachers and young people was a core feature of the re-development of the MindOut.

The MindOut Programme is based on the framework developed by the Collaborative for Academic, Social and Emotional Learning (CASEL) and is centred around the five core competencies for social and emotional learning (Collaborative for Academic, Social and Emotional Learning (CASEL) 2003), as outlined earlier in this chapter.

The MindOut programme consists of an introductory session and 12 classroom-based sessions to be delivered consecutively over a 12-week period. Session topics include:

Introductory Session—Minding Your Mental Health

1. Boosting Self-Esteem and Confidence
2. Dealing with Emotions
3. Challenging Thoughts
4. Coping with Challenges
5. Support from Others
6. Walking in Someone Else's Shoes
7. Managing Conflict
8. Connecting with Others
9. Giving and Getting Help
10. Making Decisions
11. Happiness and Well-being
12. Review Session

Interactive teaching strategies include collaborative learning, group discussion, structured games, role play and multi-media resources. The Teacher Manual (Dowling et al. 2017a) includes a detailed step-by-step guide to each session, the preparation needed, as well as guidelines for dealing with difficult situations such as student disclosure, and suggestions for 'whole school activities'. Each session includes 'Practice at Home' activities for students to practise the skill learnt in the session and a 'Teacher Reflection' section to encourage teachers to strengthen their own social and emotional skills. A programme USB includes supplementary resources—PowerPoint slides to assist classroom delivery, relevant video links and whole school resources for teachers. A draft letter for parents is also provided to support teachers informing parents about the programme.

An evaluation study of programme implementation, employing a cluster randomized controlled design, is currently being completed. This study involves collecting data from 497 students, aged 15–18 years, from 32 designated disadvantaged post-primary schools in Ireland before, during and up to 12 months after implementation of MindOut (Dowling and Barry 2017). This study assesses the impact of the MindOut programme on students' social and emotional well-being, academic performance and mental health outcomes and examines the process of implementation

and its influence on programme outcomes. Early stage evaluation findings indicate that there was a significant improvement for intervention schools in terms of students' social emotional skills and mental health and well-being (Dowling and Barry 2017). Results also indicate that the quality of implementation influenced outcomes, as schools with high levels of implementation showed more significant improvements in student outcomes compared to schools where levels of implementation were low. A more detailed analysis of the findings is underway, which will include evaluation of the longer-term impacts of the programme at 12-month follow-up.

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

A number of key factors have contributed to the success of the MindOut Programme and include:

- *A comprehensive programme resource*: Teachers appreciate a programme that is evidence-based, comprehensive, well designed, user friendly, and includes all the resources required to implement the programme.
- *Previous experience with the original MindOut Programme*: Teachers found the original programme accessible, effective and engaging for students and they enjoyed facilitating the programme. Although it was quite dated, as it was developed in 2004, teachers continued to implement the original version up until the new version of MindOut was available. Aside from the perceived benefits for students, teachers also reported that the programme enhanced pupil–teacher relationships.
- *Responding to need*: There has been an increasing interest in issues relating to youth mental health and well-being within the school community in recent years. Levels of anxiety among students of all ages, particularly senior cycle students, have been identified as a major concern within schools. The MindOut programme includes scenarios, which were developed by young people themselves, depicting typical real life situations that young people experience. This means that the programme content resonates with young people's experience and lives today and that the skills development is applicable to real-life situations.
- *Evaluation results*: Being able to demonstrate the benefits of the MindOut programme is important in instilling confidence and motivation in teachers. Early findings from the evaluation study provide evidence of the positive impact of the programme for students. This is crucial in dispelling concerns and allaying fears that teachers may have about programmes that encourage young people to talk about mental health and well-being issues. The finding of the association between level of programme implementation and outcomes for students promotes a strong message to teachers to deliver the programme as comprehensively as possible.

- *Variety of interactive teaching methodologies*: The programme is grounded in experiential teaching strategies such as small and large group discussion, reflection, role play, team challenges, videos and practice of relaxation and breathing exercises, all of which help maintain student interest and promote active engagement.
- *Teacher training and follow-up*: This is a crucial element of successful implementation and is provided nationally by Health Promotion Officers from the Health Service Executive. The MindOut Programme is only available to teachers who participate in a one-day training course. Training provides an opportunity for teachers to explore their own attitudes to mental health and well-being as well as their beliefs about the value of such a programme. The training session provides an overview of the programme, its aims and scope, and offers teachers the opportunity to experience and practise some of the lesson activities. The training builds the confidence of teachers to implement the programme and to deal with any issues that may arise in the classroom. It also outlines the implementation support available. A further half-day meeting is offered to teachers to review how the programme is working in their school and provides an opportunity to address any issues arising and to reinforce the importance of completing the programme. Challenges encountered by teachers can be built in to the design of future teacher training so that the experience of teachers continues to inform the training and support being offered.
- *The partnership between the Health Service (HSE) and the Department of Education & Skills (DES)*: There is a positive relationship at national level between the HSE and the DES. This partnership provides a forum for both departments to collectively consider the health and well-being of students at all levels of the education system. As well as encouraging schools to become more health promoting (through the World Health Organization (1998) Health Promoting School (HPS) approach), the HSE has a positive reputation for the delivery of quality teacher training and the development of health- and well-being-related programmes and resources. Through the partnership arrangement, the DES provides substitution cover for teachers to attend a wide variety of HSE teacher in-service training courses. The fact that a National Lead within the HSE, Health and Wellbeing Division has overall responsibility for school-based health promotion and that a number of regional Leads are also in place provides an opportunity for a strategic and co-ordinated response to schools.
- *Support from the School Principal*: An important factor in successful implementation is the leadership provided by the School Principal. This extends to supporting the individual teachers but also in recognizing and promoting the value of social and emotional learning alongside the academic curriculum. The Principal also influences time-tabling and teacher selection. Ideally teachers should self-select where they have had some prior experience of interactive teaching methodologies such as facilitation and the delivery of SPHE curriculum.

Implementation Challenges and Experiences that Arose in the Course of Delivery

There are a number of implementation challenges in delivering the MindOut Programme in Irish schools. These include:

- *No mandatory 'Wellbeing' curriculum*: Although 'Wellbeing' is a core mandatory part of the Junior Cycle Curriculum, it is not so at Senior Cycle. A Senior Cycle SPHE curriculum is in place but while schools are encouraged to implement it, this is not mandatory. This places significantly more individual responsibility on schools to implement a programme such as MindOut. There is an already crowded timetable with a focus on academic subjects as students prepare for a significant national examination at the end of their post-primary school education—the Leaving Certificate. However, the Transition Year programme, a non-academic year for students transitioning from Junior Cycle to Senior Cycle, provides an easier fit for the programme. Each school develops its own individual Transition Year programme and this is an opportunity to embed MindOut. However, places are often limited for this year and as it is an optional year, not all students avail of this programme. This lack of a supportive infrastructure within the school timetable makes the integration of programmes such as MindOut as part of the core mission of the school more difficult.
- *Demand for the programme*: Although the MindOut Programme is in an early stage of implementation, the interest from schools has been very strong. Meeting this demand will involve the provision of additional teacher training sessions and implementation support and a further commitment from the DES and HSE to provide the additional resources required.
- *Selection of teachers*: Teachers with prior experience in facilitation and delivering SPHE programmes, and who have an interest in mental health and wellbeing, are ideally placed to implement MindOut. However, due to staffing issues it can sometimes become the responsibility of less experienced teachers with little or no experience of delivering SPHE.
- *On-going implementation support*: Whilst initial training is important, further support is needed for teachers to deliver the programme and ensure quality implementation. This can be provided in several ways. A supportive follow-up phone call and the provision of a follow-up meeting for teachers can help to sustain the motivation of teachers. The opportunity for peer support is also an important element of such meetings. Teachers are able to hear how others are managing and to problem-solve the issues that are arising. The availability of this support from the HSE is limited as increasing workloads and limited resources impact the level of implementation support available in practice.

Recommendations to Strengthen the Future Implementation of MindOut

- *Promotion of MindOut at key education fora*: This includes, for example, National Assistant, Principals and Deputies (NAPD), Inspectorate and Guidance Counsellors national meetings and conferences. These are key platforms to

engage with the management and other key stakeholders at national and regional levels and highlight the importance of their support and leadership. Published articles and promotional advertisements for MindOut in Principal and Teacher Union publications, which include teacher and student experiences, will also ensure a wider reach within the education community. The evaluation research findings provide a strong basis for such publications and presentations.

- *Continued engagement with the DES*: Substitution for training and for follow-up meetings, provided by the DES, is critical to supporting the ongoing implementation of MindOut. This supports mainstreaming the programme as a valued part of the education curriculum and puts it on a par with other training supported by the DES. Forging links with the Professional Development Service for Teachers (PDST) will further integrate MindOut within the support and professional development provided for teachers.
- *Implementation support from the HSE*: The fact that there is a rigorous evaluation of the implementation process and outcomes being conducted in Irish schools, with early findings showing that positive outcomes for students are affected by the quality of implementation, highlights the importance of continuing to provide implementation support beyond the training of teachers. Monitoring the quality of implementation is a challenge, but just as important as learning about the challenges, is identifying the enablers for quality programme implementation so that this can inform teacher training and further support meetings.

Key Recommendations for Replication

The overall recommendation is that social and emotional well-being programmes within schools require a sustained level of implementation support to ensure best outcomes for young people. Key elements of implementation support include:

- *User friendly programme resource*: A comprehensive teacher manual, which is well designed, user friendly and grounded in evidence of effectiveness, is very well received and appreciated by teachers.
- *Quality teacher training*: Building an understanding of social and emotional skills and their importance as well as the methodologies for programme delivery are critical components of training required to implement such programmes. Training focuses as much on the 'how' as the 'what' and emphasizes the importance of teacher self-awareness and the relationships developed with students.
- *On-going support and follow-up*: Providing support, through phone calls, teacher cluster meetings and school visits helps sustain individual teachers as well as providing an opportunity to garner support for the ongoing implementation of the programme within the school.
- *Support from the partnership with the education sector*: Where the programme is provided by an outside agency such as the health service, the approval and support from the education sector are essential to successful implementation. This provides reassurance to schools and recognition of the programme as being worthwhile.

Future Directions for MindOut

Following a Ministerial launch, the continued scale-up of the MindOut Programme across the Republic of Ireland is planned. The demand for the programme is high and the challenge is to meet the demand for teacher training across the country. As implementation of the revised programme is at an early stage, demand is likely to increase substantially as awareness of the programme grows. This will mean continuing support from additional resources from the Department of Education (substitution cover) and from the Health Service Executive (Health Promotion Officers to provide training and support). Teachers have already identified the need for MindOut for Parents so that they can support the development of social and emotional skills of their young people. This could be a further development of the programme in the future.

The MindOut Youth Programme (Dowling et al. 2017b) has been further adapted for out-of-school settings including 'Youthreach Centres' attended by young people who have dropped out of mainstream education. This version of the MindOut programme is presented as a modular-based resource which can be tailored to suit the needs of the individual group. Training and implementation support will be necessary to support the success of the programme in youth settings. This will be provided by the National Youth Council of Ireland and the Health Promotion and Improvement Department of the Health Service.

Targeted Interventions

A number of school-based programmes have been designed for students who have an increased risk profile for developing mental health problems and mental disorders such as depression and anxiety, due to familial risk or poverty (selected prevention), or who have early signs and symptoms (indicated prevention) (Werner-Seidler et al. 2017). School-based prevention programmes integrated into the school day alleviate many typical barriers to accessing support including time, location and cost (Barrett and Pahl 2006). Interventions for preventing depression are usually based on cognitive-behavioural therapy (Calear and Christensen 2010; Neil and Christensen 2009), with other approaches such as interpersonal therapy (Horowitz et al. 2007), being less common. These programmes usually involve teacher training and parent involvement. Findings from systematic reviews of the literature indicate that school-based depression prevention programmes that use a targeted approach and are delivered by mental health professionals show larger effect sizes than universal interventions delivered by teachers (Calear and Christensen 2010; Werner-Seidler et al. 2017). However, for anxiety prevention comparable effect sizes are reported for universal and targeted programmes, regardless of the programme deliverer (Neil and Christensen 2009; Werner-Seidler et al. 2017).

Depression and Anxiety Prevention

The Coping with Stress Course (CWS) is an example of a cognitive mood management programme which aims to prevent the development of depression in students (aged 15–16 years) with elevated risk of clinical depression (Clarke et al. 1995) (see chapter "Implementing Mental Health Promotion in Primary Care" which describes the original Muñoz depression prevention programme from which CWS for adolescents has been adapted). The programme involves cognitive restructuring techniques in which participants learn to identify and challenge negative or irrational thoughts that may contribute to the development of future mood disorders such as depression. The programme consists of fifteen 45–60 min sessions and is delivered in a group setting with six to ten adolescents. Separate parent information meetings at the beginning, middle and end of the course are optional. During these meetings, parents are informed about the general topics discussed, the skills taught in the adolescent groups and the rationale for use of the selected techniques. Groups are led by specially trained school psychologists and counsellors. Therapists are provided with 40 h of training before beginning the group sessions. Results from a randomized control trial with 150 students with elevated depressive symptoms indicated reduced rates for affective disorder (15% intervention compared with 26% control group). There were also significantly fewer cases of either major depression or dysthymia for the intervention group compared with the control group (Clarke et al. 1995). A second randomized control trial with 94 adolescents with medium severity depression reported significant improvements in the intervention group's self-reported and interviewer-rated depression and interviewer-rated affective disorder when compared with the control group (Clarke et al. 2001).

The Coping with Stress Course is a direct descendant of the Adolescent Coping with Depression Course, a cognitive behavioural treatment for adolescent depression (Clarke et al. 1999). Another related intervention is the Blues Programme which is based on the Adolescent Coping with Depression programme. It is a 6-week group intervention focussed on reducing negative conditions and increasing participant involvement in pleasant activities in an effort to prevent the onset and persistence of depression in at-risk youth with depressive symptoms. Results from a randomized control trial with 341 high-risk adolescents showed significant reductions in depressive symptoms at post-test and up to 2-year follow-up (Stice et al. 2010, 2008). Reduced substance use was also noted as a secondary benefit at 2-year follow-up (Rohde et al. 2014). Significantly lower rates of onset of major depression disorder were also recorded at 2-year follow-up (Rohde et al. 2015).

The Penn Resiliency Programme is an example of a group-based programme for preventing depression and anxiety in adolescents (10–15 years). The programme is delivered by two group leaders including teachers, school counsellors, research assistants and trainees (30 h/6 days training). The programme is based on cognitive-behavioural techniques and social problem solving. Twelve sessions are delivered to groups of 9–14 students. Students learn about: (1) the link between beliefs, feelings and behaviours (2) cognitive styles, including pessimistic explanatory styles and (3)

cognitive restructuring skills, including how to challenge negative thinking by evaluating the accuracy of beliefs and generating alternative interpretations. Students also learn a variety of techniques for coping and problem solving (Gillham et al. 2007). Topics covered include peer pressure, communication, friendships, family conflict, setting and achieving goals, self-esteem and body image. Each session includes structured activities, role-playing and guided discussion. A meta-analysis of 17 controlled evaluations of the Penn Resiliency Programme found evidence that it significantly reduces depressive symptoms through to at least 1 year post-intervention. Subgroup analyses showed that the programme's effects were significant among studies using both targeted and universal approaches, when group leaders were research team members and community providers, among participants with both low and elevated baseline symptoms, and among boys and girls (Brunwasser et al. 2009). Evaluations of the programme as a universal classroom-based intervention in the Netherlands (OpVolle Kracht) and the UK (The UK Resilience Programme), however, revealed no significant effect in reducing anxiety or depressive symptoms (Challen et al. 2014; Kindt et al. 2014, 2016).

FRIENDS is an Australian cognitive-behaviour therapy programme designed to promote emotional resilience and teach students ways to cope with their anxiety. This programme can be delivered universally or in a targeted manner to at-risk youth. When delivered as a targeted intervention, it can be taught individually or in a group setting. The intervention teaches problem-solving skills as a way to cope with and manage anxiety, drawing from cognitive behavioural therapy and positive psychology approaches. The programme has been adapted into four developmentally sensitive programmes: Fun FRIENDS (4–7 years); FRIENDS for Life (8–11 years); My FRIENDS Youth (12–15 years) and Adult Resilience for Life (16 years and over). The programmes are typically delivered over ten ×70 min sessions with two booster sessions. Two information sessions are delivered to parents to provide strategies for enhancing resilience at home, reinforcing programme strategies and behaviour management techniques. The programme has been implemented internationally including in Australia, Brazil, Canada, Finland, New Hong Kong, Ireland, Japan, Mexico, Norway, Peru, Portugal, the Netherlands, New Zealand, Singapore and the UK.

Nine experimental studies from seven different countries and one meta-analysis (Maggin and Johnson 2014) evaluating the effectiveness of FRIENDS have been carried out. The findings from the meta-analysis indicate that FRIENDS resulted in reduced anxiety in low-risk students with improvements maintained at 1-year follow-up. However, no immediate effects for students at elevated risk at post-intervention were detected. Maggin and Johnson (2014) draw attention to the methodological weaknesses in evaluation studies. In addition to reductions in anxiety, individual studies have reported improvements in self-esteem and coping strategies (Stopa et al. 2010) and perfectionism (Essau et al. 2012). Greater reductions in anxiety in girls than boys were detected in two studies (Kösters et al. 2015; Matsumoto and Shimizu 2016).

Suicide Prevention Interventions

Internationally, suicide is one of the three leading causes of death in young people (Nock et al. 2008; Wasserman et al. 2005). In Europe, the lifetime self-reported prevalence of suicide attempts in adolescents in 4.2%. Similarly, in the USA, lifetime prevalence for this age group is 4.1% (Carli et al. 2014). Suicide prevention interventions are a commonly used prevention measure incorporated into secondary schools. The general aims of these programmes are to: (1) raise awareness about suicide among students (2) educate students to recognize possible signs of suicidal behaviour for one's own safety and that of others (3) improve skills for reducing risk factors and improving protective factors for suicide (4) provide students with information about school and community resources available for providing assistance (Cusimano and Sameem 2011; Surgenor et al. 2016). These programmes generally consist of 3–5 days of in-class instruction utilizing a variety of educational modalities including videos and presentations. Other interventions include gatekeeper training for school staff, screening interventions and peer leadership programmes (Surgenor et al. 2016). Several programmes include aspects of more than one of these approaches.

There is emerging evidence that curriculum-based suicide prevention may be more effective than gatekeeper training or screening programmes. In the SEYLE multi-country trial in Europe, three different types of suicide prevention approaches were evaluated among 11,110 students from 168 schools across ten European countries (Wasserman et al. 2015). The three programmes included: (1) Question, Persuade and Refer—a gatekeeper training for school staff (2) Youth Aware of Mental Health Programme (YAM)—a curriculum-based programme aiming to raise mental health awareness and (3) ProfScreen, a screening programme that uses mental health professionals. Results from the evaluation of all three approaches revealed that YAM (described below) was the approach that showed significant positive effects on suicidal behaviour with suicide attempts and suicidal ideation reduced by 50% at 1-year follow-up (Wasserman et al. 2015). Reviews of the literature have reported that school-based psychosocial suicide prevention interventions, including awareness raising, skill-based and social support programmes, show promise in reducing suicidal tendencies, risk factors for suicide and knowledge, attitudes and help-seeking behaviour (Calear et al. 2016; Cusimano and Sameem 2011). However, few school-based studies show effects on actual suicide rates with the exception of YAM (Wasserman et al. 2015).

Youth Aware of Mental Health (YAM) is a curriculum-based suicide prevention programme for youth aged 14–16 years. The programme aims to raise mental health awareness about risk and protective factors for suicide and enhance young people's skills to deal with adverse life events, stress and suicidal behaviours. The programme consists of five sessions with three role play workshops at the core. Youth are considered experts in their own mental health and their voices and experiences

are central to the programme. Youth take part in role plays and reflections providing the opportunity to act out and discuss a variety of feelings, solutions and outcomes. The following six topics are addressed as part of the programme: (1) Awareness about mental health (2) Self-help advice (3) Stress and crisis (4) Depression and suicidal thoughts (5) Helping a troubled friend (6) Getting advice—who to contact. The programme can be delivered by teachers who have completed YAM training (4–5 days). To date, the programme has been delivered in several European countries including Austria, Estonia, France, Germany, Hungary, Iceland, Italy, Romania, Slovenia and Spain. Results from a randomized controlled trial with 11,110 students from 168 schools across ten European countries showed significant improvements in adolescent mental health with the YAM programme compared to the other two interventions (gatekeeper training and screening) and the control group, by effectively reducing depression, incident suicide attempts, incident severe suicidal ideation and suicide plans at 1 year post-implementation (Wasserman et al. 2015).

Signs of Suicide (SOS) is another suicide prevention programme for young people aged 11–17 years, which incorporates two suicide prevention strategies into a single programme. SOS combines curricula to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors associated with suicidal behaviour. Results from a randomized controlled trial with 2100 students from three high schools in the USA indicated significantly lower rates of suicide attempts and greater knowledge and more adaptive attitudes about depression and suicide among participants in the intervention group when compared with the control group (Aseltine Jr and DeMartino 2004).

Findings on the effectiveness of gatekeeper training interventions have been mixed, with some programmes showing improvements in gatekeeper knowledge and attitudes, but not in young people's suicidal behaviours (Surgenor et al. 2016). Few existing studies evaluate the effectiveness of peer leadership programmes, with some studies showing positive effects on perceptions of adult support for suicidal youth, the acceptability of seeking help and the adaptive norms in relation to suicide (Wyman et al. 2010).

In line with the WHO's model for school mental health promotion (World Health Organization 1998), it appears from current evidence that the best informed approach is to deliver suicide prevention programmes in the context of universal provision (Support for All) with the need for additional support for those at risk of developing or already showing signs of mental health difficulties (Support for Some) and the provision of specialist support for students with more complex problems (Support for a Few). There is some evidence that universal programmes that teach social and emotional skills may reduce suicidal ideation (Gravesteijn et al. 2011), by increasing protective factors such as self-esteem (Luthar and Cicchetti 2000; Masten and Powell 2003), self-efficacy (Masten and Powell 2003), social support (Thompson et al. 2000) and emotional regulation skills (Mezzich et al. 1997; Tarter et al. 2004), and thus would strengthen the impact of more targeted suicide prevention approaches such as YAM.

In addition to school-based interventions, there is a recognized need for complementary interventions which involve family members and local communities as well as a broad range of health and welfare services. The school can be an important link in ensuring awareness of, and access to appropriate sources of support and professional help for young people when needed. Linkage between schools and outside agencies is an important feature of the health promoting schools initiative and the development of a partnership approach, where better integration of the health services with everyday life of the school, is encouraged.

Digital Interventions

The use of information communication technologies (ICT) for youth mental health promotion and prevention has grown significantly. The potential that online mental health interventions hold include direct, convenient access to resources that one might not otherwise have. Online interventions provide a cost-effective and accessible means of accessing services, especially for hard-to-reach young people, such as those living in isolated areas, marginalized youth and those less likely to present for face-to-face services. Furthermore, computerized mental health programmes can offer anonymity, which may alleviate some of the stigma and barriers related to help-seeking (Barak and Grohol 2011; Bennett-Levy et al. 2010). The use of technology for mental health promotion seems particularly promising with young people, who are technology natives and already use technology to access mental health information (Burns et al. 2016; MacDonell and Prinz 2017). Computerized interventions can be delivered in multiple settings including the school setting as universal programmes (e.g. Calear et al. 2009), in primary care as targeted interventions (Van Voorhees et al. 2009) and as self-directed programmes completed from home (Kenardy et al. 2003).

There is a growing evidence base indicating the potential of computerized mental health interventions in improving mental health and well-being in youth. Computerized cognitive behaviour therapy (cCBT) interventions for depression and anxiety prevention have been shown to significantly reduce symptoms of anxiety and depression in adolescents (Ebert et al. 2015; Pennant et al. 2015; Stasiak et al. 2016). These interventions have been delivered successfully in a targeted and universal manner (Calear et al. 2009; Merry et al. 2012a, b). There is less robust evidence for positive computerized mental health promotion interventions focussing on areas such as positive psychology, stress management and relationship skills training (Baños et al. 2017; Clarke et al. 2015a). However, promising results have been reported in terms of increased mental health literacy, psychological well-being and support-seeking behaviour (Clarke et al. 2015a).

Low engagement and high dropout rates with computerized programmes are common (Christensen et al. 2011). Although computerized interventions in theory need limited input from programme moderators, supported delivery has been linked

to better engagement rates and outcomes (Clarke et al. 2015a; Sethi et al. 2010). This calls for further training for programme deliverers, such as teachers, youth workers and psychologists, in implementing computerized programmes (Clarke et al. 2015a). Future research comparing and contrasting different types of support to accompany online interventions could help in understanding the minimum level of support required to maximize positive gains. The use of persuasive technologies (Oinas-Kukkonen and Harjumaa 2009), including features such as tracking progress, personalized feedback, tailored content and using aspects of gaming (Fleming et al. 2016), shows promise and requires further investigation in order to determine the components of online interventions that support the achievement of positive outcomes. In addition, further research is required to examine the use of digital interventions with youth from diverse demographic backgrounds, the effectiveness of digital intervention in real-world settings and their long-term effects (Clarke et al. 2015a; Kuosmanen et al. 2017a, 2018; Stasiak et al. 2016). Stern et al. (2015) make a number of recommendations in relation to advancing the potential of technology to further support children and young people's mental health: (1) integrate research on technology into future programme evaluations (2) look at existing mobile technologies, video games, apps outside of mental health and well-being for inspiration (3) form strategic partnerships between technology centres and research institutes (4) use technology to develop more effective communication and delivery methods and (5) address important ethical concerns including evaluating any potential negative as well as positive impacts technology may have on young people.

MoodGYM is an example of a cCBT programme for the prevention of depression and anxiety. It was developed in Australia and was originally developed for adolescents but has been used with university students and adults. The online programme aims to change dysfunctional thoughts and beliefs, improve self-esteem and interpersonal relationships and teach problem-solving skills and relaxation (Groves et al. 2003). The programme consists of 5 weekly modules (20–45 min) which consist of information, animated demonstrations, quizzes and homework exercises. At the beginning of each module, students complete an anxiety and depression assessment. MoodGYM has been delivered in the school setting supervised by teachers.

A number of evaluations have been carried out with different users in different settings, including male and female participants in secondary school, website users and college students with elevated distress. Results from these studies suggest that this programme is effective when implemented as a universal intervention in secondary school and when implemented with university students with elevated psychological distress. One study reported significantly lower levels of anxiety at post-intervention and 6-month follow-up, and significantly lower levels of depression in males (Calear et al. 2009, 2013). Higher adherence was linked to better outcomes. Two other RCTs examined the effectiveness of MoodGYM when delivered in single sex schools. Significant small effects on depression, attributional style and self-esteem were reported for males completing three or more modules

(O'Kearney et al. 2006), and a significant moderate effect on reduction of depression was reported for females at 20-week follow-up, with those with higher baseline symptoms showing greater improvement (O'Kearney et al. 2009). Another study, which compared and contrasted the effect of MoodGYM online with (1) face-to-face therapy and (2) face-to-face therapy and MoodGYM combined, found that face-to-face in conjunction with MoodGYM was more effective in reducing university students' depression, anxiety, distress, frequency of automatic negative thought than therapy received through stand-alone MoodGYM (Sethi et al. 2010). There is also evidence from these studies that completion of fewer modules was associated with higher depression scores at baseline. This finding reinforces the need for more structured delivery of these programmes in the context of additional support (either face-to-face or web-based support) being made available, especially for young people with low levels of literacy, low levels of attention or increased risk on mental health problems. Continued research aimed at testing and uncovering new methods of support will be important for optimizing the effectiveness of these interventions.

Another example of the use of digital interventions is *The Guide* (Kutcher 2009), a mental health literacy curriculum designed for use in post-primary schools. This web-based resource was developed by mental health and educational experts in Canada in recognition of the increasing awareness of the importance of mental health literacy as a necessary foundation for improving health and well-being. *The Guide* contains a teacher self-assessment tool, a teacher self-study module, a student evaluation tool and six classroom ready modules. The modules include learning objectives, lesson plans, classroom-based activities and teaching resources such as animated videos, PowerPoint presentations, links to online mental health resources. The six modules include the stigma of mental illness, understanding mental health and wellness, understanding mental disorders and their treatments, experiences of mental illness, seeking help and finding support and the importance of positive mental health. The approach differs from other types of interventions that use mental health experts in programme delivery. *The Guide* is implemented by trained classroom teachers over 10–12 h. Research has demonstrated that implementation of the resource significantly improved students' mental health knowledge and attitudes and that these positive results were sustained over time (McLuckie et al. 2014). The resource has also been adapted for implementation in Tanzania and the United Kindgom.

SPARX is an online cCBT intervention for adolescents. The programme was developed in New Zealand as a self-help treatment intervention for adolescents but was adapted for universal use (SPARX-R) (Fleming et al. 2012b). The programme has also been implemented and evaluated with vulnerable youth in the alternative education setting in Ireland (Kuosmanen et al. 2017a, 2018). The following case study describes the development and implementation of SPARX. It illustrates the potential of online technologies and a number of considerations concerning the development of a digital resource to support young people's mental health.

Case Study: Implementation of SPARX Computerized Cognitive-Behavioural Therapy Programme for Adolescents in New Zealand

Theresa Fleming
Department of Psychological Medicine, University of Auckland, Auckland, New Zealand

School of Health, Victoria University of Wellington, Wellington, New Zealand

Mathijs F. G. Lucassen
Department of Psychological Medicine, University of Auckland, Auckland, New Zealand

School of Health, Wellbeing and Social Care, The Open University, Milton Keynes, UK

Tuuli Kuosmanen
Health Promotion Research Centre, National University of Ireland Galway, Galway, Ireland

Background

SPARX is an evidence-based computerized mental health intervention for teenagers. It was developed in New Zealand and has been shown to be effective for symptoms of depression and anxiety. It is now publicly available in New Zealand, funded though the Ministry of Health. New versions are being developed and tested in New Zealand and elsewhere.

Developing SPARX

Computerized therapies have been shown to be effective (Richards and Richardson 2012; Roger et al. 2017), but almost all of these were created for adults and many used a text-focussed, workbook style format. The research team in Auckland utilized a co-design approach to develop a youth-focussed intervention with young people, experienced clinicians and therapists, cultural advisors, learning and behaviour change experts and a computer games development company—Metia Interactive. Content was based on cognitive-behavioural therapy (CBT) and used strategies from computer games and storytelling.

The resulting intervention, SPARX, had seven modules, each taking about half an hour. The content included key skills such as relaxation, emotion regulation, activity scheduling, problem-solving, recognizing cognitive distortions, cognitive restructuring and communication skills. These were taught using a 'bicentric frame of reference' (Salzman et al. 1999): a virtual guide welcomes users to each level and lets them in to the 'game world' where they complete challenges to 'restore the balance' in a fantasy environment. At the end of each level, users return to the guide to reflect on their learning and consider how to apply this in their own lives.

This approach makes use of the playful learning opportunities afforded by gamified computer programmes, along with structured and explicit learning which is important for behaviour change. For instance, in the 'Ice Province', users need to move quickly to avoid being frozen and must communicate assertively to enlist the help of other characters. When they return to the guide, they answer questions and complete activities, as if with a teacher or therapist. They also set themselves a homework challenge, which is reviewed in the following session. Similarly, in the 'Mountain Province', users must free a character who is being attacked by negative automatic thoughts and they must try out ways to climb a mountain without knowing which strategies will work. As they try each strategy, the steps of a problem-solving approach ('Say what the problem is', 'Think of solutions…') are revealed. Again, at the end of game-play, users explore with the guide how they can use these skills.

SPARX was initially developed as a stand-alone self-help programme, rather than requiring a specialist referral and/or ongoing individual support, in order to allow young people to access it anonymously, and to ensure that it could be scaled-up at low cost.

Developing the Evidence

A randomized controlled trial of SPARX was carried out. The sample comprised 187 adolescents seeking help for low mood or depression from school guidance counsellors or primary health care providers. SPARX was shown to be appealing to young people and not inferior to 'treatment as usual' (comprising primarily face-to-face therapy delivered by trained counsellors and clinical psychologists) for depression and anxiety (Merry et al. 2012a, b). Further studies found SPARX to be promising or effective, as well as appealing in smaller studies focussed on underserved populations including:

- Māori taitamariki (indigenous young people) (Shepherd et al. 2015);
- Young people (13–16-year old) excluded from mainstream schooling (Alternative Education in New Zealand) (Fleming et al. 2012a);
- Sexual minority youth using Rainbow SPARX (an adapted version of the programme) (Lucassen, Hatcher, et al. 2015; Lucassen, Merry, et al. 2015).

Treatment or Mental Health Promotion

SPARX was developed as a treatment or therapy. However, young people in alternative education settings and youth service providers advised that it would be preferable to offer this universally, at least in settings where many youth face significant challenges (Fleming and Merry 2013; Fleming et al. 2016). This was based on the idea that the skills involved are useful to all, and that stigma and lack of recognition of mental health needs might stop young people getting help. Hence, we developed a revised version, SPARX-R, for universal use. SPARX content was reviewed with young people, the development team and clinical advisors.

We found the activities within SPARX, with their focus on skills such as relaxation, communication and activity scheduling, were relevant for both treatment and for mental health promotion. Other activities, such as identifying and adjusting negative thoughts and developing positive thoughts, were retained as these were thought to be useful for the prevention of symptoms, as well as for treatment. The wording regarding the rationale 'for dealing with depression' was altered to more general wording which would remain relevant to, but not be limited to, those who were distressed.

The first version of SPARX-R retained screening for low mood and self-harm at the start of each module and was tested in a pilot study with 15–20-year old in Irish Alternative Education Centres (Kuosmanen et al. 2017b). This version of SPARX-R was found to have a positive impact on participants' emotion regulation skills. However, high drop-out and low engagement were reported. Student and staff feedback suggested that technical problems and the repeated screening of low mood and self-harm were off-putting. They suggested that SPARX-R could be complemented with face-to-face support and group discussion (Kuosmanen et al. 2018). An updated version of SPARX-R, with reduced mood screening and improved technical performance, has been tested in a large cluster randomized trial in Australia and has been shown to be effective as a universal intervention for the prevention of depression among final-year high school students (Perry et al. 2017).

Intervention Implementation and Recommendations

Key Success Factors of the Intervention

SPARX became freely available in 2014 to anyone with a New Zealand IP address. People of any age could access it directly without a referral. This was a significant development. For the first time, New Zealanders could access a scientifically tested, youth-targeted, free, computerized therapy programme at any time. Key factors that made this possible include the following:

Funder interest: Funder interest was necessary for implementation. Several factors were critical for this. In particular, SPARX addressed a priority issue, adolescent depression, at a time when the funder also wished to do so. Secondly, SPARX was evidence-based; without being found to be effective and acceptable, it would not have been funded. Thirdly, implementation readiness was important, specifically that SPARX could be made publicly available very soon after a funding decision was made.

Rapid updates: A rapid and intensive process developed SPARX from a CD-ROM research prototype to a secure and reliable web platform for national implementation. Ongoing updates have also been needed. For example, updates were required to avoid technical glitches due to developments in commonly used internet browsers. Furthermore, public expectations of computer software and games continue to develop, and without updates, a programme looks aged and operability may suffer. The game-like format of SPARX was important for engaging young people.

However, this also meant that updates were more costly than would otherwise have been the case.

Establishing safe implementation with little precedent: Delivering a self-help intervention publicly, and in the face of limited precedents, required steps to ensure safety. We established governance groups to help ensure that robust and transparent quality processes were used. A screening questionnaire was embedded at the start, mid-way and as part of the final modules. This enabled the provision of personalized feedback directly to the user, including suggestions for further help where there were high needs or no improvement. Routine data collection processes were established to monitor nationwide use, safety and outcomes. Community agencies were contracted and trained to provide telephone and text-based support for users seeking additional help.

Promotion: Computerized interventions are relatively new and, without promotion of the programmes, people may not be aware of them or may not consider them to be relevant. Data monitoring has shown that SPARX uptake increased at times and in regions where there was promotion. Most effective was national television news coverage. Social media promotion and internet browser AdWords have also been important for youth engagement, as have talks and presentations to schools, health services and communities.

Key Recommendations for Replication

Digital interventions are important as these can be enormously scalable and offer improved mental health and well-being at people's finger-tips. However, these must be safe, reliable and appealing. They must also engage sufficient numbers of users to make the development and delivery of them economically viable (Fleming et al. 2016a, b). For successful development and implementation of digital interventions, we recommend:

- Early, high-quality engagement with target users, stakeholders, policy-makers and decision-makers in order to understand their needs and priorities.
- Robust scientific testing. For some funders at least, it is important that effectiveness and perhaps local acceptability are demonstrated.
- Build for engagement. Pure self-help interventions are cheaper to implement than those which require personal support; however, user engagement can be challenging. Opportunities to enhance this include factors which can be built into digital tools, such as high-quality IT experiences and the use of persuasive design, telepresence and gamification (Fleming et al. 2016a, b). Factors outside of the programmes are also important, for example, supported implementation via schools or health organizations.
- Rapid testing, implementation and updates. If interventions are to be appealing in the fast-developing digital environment, and then testing, dissemination of

results and implementation of findings must be timely. Constant updates and revisions are required.
- Offer promotion and training for personnel such as counsellors and health care providers.
- Collaborate—partnerships are essential for developing engaging interventions, credible evaluation, safe and reliable delivery, user support and promotion.

Future Directions for the Intervention

At the time of writing, SPARX has been available in New Zealand for over 3 years. An adapted version of SPARX is available in Japan and SPARX has been and is being tested in a range of contexts (e.g. with Inuit youth from Nunavut) (Khourochvili et al. 2016). In addition, the SPARX team is involved in the development of new digital interventions to respond to rapidly changing patterns of internet use.

Conclusions

The school is a unique setting within which children and young people's mental health and well-being being can be promoted and critical skills for school, work and life can be taught and learned. A range of school-based social, emotional and behavioural interventions have been shown to lead to significant improvements in children and young people's mental health, social functioning, academic performance and positive health behaviours. In this chapter, we examined a number of approaches to implementing mental health promotion in schools including universal classroom skill-based interventions, targeted interventions for anxiety and depression, suicide prevention interventions and digital interventions. Based on the research evidence and the programmes reviewed in this chapter, the following characteristics of successful school-based interventions have been identified:

Theory-Based Interventions
Programmes need to be grounded on sound theoretical theories of child development and learning. Interventions guided by a strong theoretical base have been found to lead to improved outcomes.

Adopting a Social Competence Approach
Reviewers of the evidence endorse the teaching of skills (as opposed to knowledge only), in particular, the use of programme strategies that promote cognitive, affective and behavioural competencies rather than a focus on the prevention of specific problem behaviours (Clarke et al. 2015b; Greenberg et al. 2001; Weare and Nind 2011).

SAFE Practices
Four core practices have been identified which tend to make social and emotional learning more effective (Durlak et al. 2011)

- *S*equenced activities that lead in a coordinated, connected way to the development of skills
- *A*ctive forms of learning—use of dynamic, varied forms of learning that are engaging and allow students opportunities to practice and learn new skills in real-world situations
- *F*ocussed on developing one or more skills
- *E*xplicit about targeting social and emotional skills rather than positive development in general.

Interventions Over Multiple Years

There is increasing evidence that once-off or short-term interventions are not likely to produce long-term effects (Weare and Nind 2011). Evidence indicates that it is best to start early and to intervene over multiple years. In general, interventions need substantial time and regular practice to produce benefits.

Adopting a Whole School Approach

Reviewers of the evidence to date conclude that the curriculum alone is not enough and that for optimal impact, curriculum work needs to be embedded within a whole school approach which embraces change to the school environment as well as the curriculum and involves parents, families and the local community (Clarke et al. 2015b; Goldberg et al. 2018; Jané-Llopis et al. 2005; Oberle et al. 2016; Tennant et al. 2007; Ttofi et al. 2011; Weare and Nind 2011; Wells et al. 2003). However, for whole school approaches to show impact, there needs to be consistent and rigorous implementation to ensure that these approaches do not become too diluted and lack impact (Durlak et al. 2011; Wilson and Lipsey 2007). Adopting a whole school approach requires a comprehensive and co-ordinated approach to implementation with appropriate leadership, staff training, close adherence to guidelines and careful evaluation and monitoring.

High-Quality Implementation

The level and quality of programme planning and delivery are influenced by contextual factors in the school setting and the presence of a supportive implementation system. This includes the level of engagement and cooperation from students, teachers, and parents, support from the school organization and management, teacher training and provision of support resources, quality of materials and the overall readiness of the school to implement the programme.

Teacher training is highlighted as being critical for effective high-quality programme delivery. High-quality training and technical assistance for teachers include:

- Materials such as standardized manuals, lesson plans
- A standard, replicable training format and a team of qualified trainers
- Initial training on the programme's theory, design, activities and expected outcomes
- Ongoing training and support, including follow-up training, coaching, feedback and implementation support
- A coherent and systematic approach
- Grounding in research-based practices.

System Wide Support

Implementation studies on SEL have demonstrated that the quality of SEL in classrooms is influenced by characteristics at the classroom level, the school level and also characteristics at the broader system level. Fostering the healthy development of children and young people necessitates supportive policy and the active participation of stakeholders from the education and health sectors in supporting best practice. The creation of partnerships between health and education sectors is necessary to create a climate of shared communication, resources, accountability and collaboration and ensures the sustainability of high-quality programmes.

Evaluation

The incorporation of systematic evaluation methods contributes to the ongoing improvement and sustainability of school-based mental health promotion programmes. The multifaceted nature of the majority of school programmes calls for research approaches that take into account the contextual and dynamic nature of the school as a setting (Barry et al. 2005; Dooris and Barry 2013). The evaluation of whole school approaches requires careful documentation of actual programme implementation, assessing the role of contextual factors in facilitating effective delivery, and measuring multiple immediate and long-term programme outcomes using a range of methodologies that can capture the dynamic implementation process and the diverse outcomes of interventions in complex settings.

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Part VI
Promoting Mental Health in the Workplace

Promoting Mentally Healthy Workplaces

Margaret M. Barry

Introduction

The workplace is a key setting for promoting the mental health of the adult population as many people spend a large proportion of their time at work. In addition to being a source of income, the importance of work in terms of role fulfilment, self-identify and participation in society is well recognized. Mental health promotion in the workplace has a wide range of social and health benefits and can also contribute to improved productivity. The promotion of employee well-being leads to greater work and life satisfaction, and reduced work stress with resultant increases in the productivity and profitability of organizations (Leka and Jain 2017). The creation of mentally healthy workplaces entails more than providing a physically safe working environment. A mentally healthy workplace involves creating an environment that is supportive of the psychosocial aspects of work, recognizing the potential of the workplace to promote workers' mental health and well-being, and reduce the negative impacts of work-related stress. Many of the factors that influence the positive health and well-being of workers relate to the psychosocial environment at work, such as the organizational ethos and climate, style of management, working culture (attitudes, values, beliefs), communication and levels of social support, as well as working conditions and job security. A positive social climate, good team work, supportive management structures with clear roles and responsibilities, and good opportunities for job development, have been found to be supportive of positive health and reduced work-related stress (Michie 2002). A culture of participation, equality and fairness, based on open communication, inclusion, diversity and involving people in decisions, is protective of positive mental health, especially in dealing with organizational change (Harvey et al. 2014). On the other hand, long

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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working hours, work overload, lack of control over work and low participation in decision-making are associated with negative mental health and absenteeism. An organizational culture of high demand and low job control, together with an unsupportive and poor management style, can have serious negative impact on workers' mental health. The original Whitehall II study drew attention to the impact of factors such as low job control, high job demand and low social support at work in influencing the physical and mental health of workers (Stansfeld et al. 1999). In a meta-analytic review of the factors influencing the psychosocial work environment and its impact on mental health, Stansfeld and Candy (2006) also report that psychological demands, low decision latitude, job strain and insecurity, low social support and an imbalance in effort and reward were found to be associated with an increased risk of mental disorder in both men and women.

Promoting employees' well-being and mental health involves addressing these psychosocial factors in the workplace and their interactions, which necessitates bringing about positive changes at both the individual and organizational level. Many interventions have focussed on individual change without consideration of the broader organizational context (Probst 2013). A comprehensive ecological approach is needed for workplace interventions to be successful and requires multiple interventions aimed at different levels of practice, such as the individual, work group, department and the organization as a whole (Harvey et al. 2014; Israel et al. 1996). Therefore, a comprehensive approach to promoting mental health at work includes addressing the mental health of the organization itself as well as that of the individual employees. The gain to both individuals and the organization is reflected in reduced absenteeism, improved well-being and productivity.

This chapter examines the importance of mental health and well-being in the workplace and considers strategies and interventions for creating mentally healthy workplaces. International frameworks and models for mental health promotion in the workplace are described, including the use of legislation, national policies, regulations and standards. The issue of work-related stress is addressed and theory and research on the main sources of stress are outlined. The importance of job control, effort-reward imbalance and social support in the workplace are considered together with the need to address job security, good working conditions, work-life balance, bullying and ill-treatment at work and other psychosocial risks. A range of individual and organizational level strategies for protecting employees' mental health and reducing the negative impact of stress are examined, including an overview of psychosocial risk management approaches. Following this, practical examples of comprehensive organizational strategies for promoting employees' mental health and well-being are presented.

Rationale for Promoting Mental Health in the Workplace

The workplace is one of the key environments that affects our mental health and well-being and there is a growing awareness of the role of work in promoting mental health. Work is seen as an important source, not only of financial security but

also of personal identity, self-esteem, time structure, social recognition, relationships and participation in a collective effort that contributes to society (Waddell and Burton 2006). Work can, however, also have negative effects on mental health, for example, through the impact of work-related stress (job insecurity, workload, lack of control, effort reward imbalance and family-work conflict) and physical and psychosocial work environments that pose a risk to the mental health of employees (physical and psychosocial hazards, poor working conditions, bullying, discrimination, negative management practices, lack of support).

Investing in the mental health of the workforce is increasingly being recognized as being good for workers and for business. Promoting workers' mental health and well-being leads to increased commitment and job satisfaction, improved productivity and performance, staff retention and reduced absenteeism (Health and Safety Executive 2009; WHO and Burton 2010; World Economic Forum 2016). The impact of mental health problems has serious consequences for the individual employee and also for the productivity of the organization (see Box 1). Mental health problems are the leading cause of sickness absence and long-term work incapacity in most developed countries (Joyce et al. 2016). The Health and Safety Executive (2017) in the UK reported that 12.5 million working days were lost in 2016/17 due to work-related stress, depression or anxiety (an average of 23.8 days per case). Depression and anxiety were found to account for 40% of all work-related ill-health and 49% of all working days lost due to ill-health. The effects of stress and mental health problems in the workplace at an individual level (absenteeism or presenteeism) can also have collective and organizational consequences. This can lead to the absence or disengagement of the individual, work performance deterioration, which can then have an impact on the company's economic performance and relations between management and workers. This in turn can lead to stress and mental health consequences for other employees, which could then exacerbate the problem even further (Sahler et al. 2009). Economic analyses show that the costs associated with mental health problems, such as depression, are significant for

Box 1 Consequences of Mental Health Problems at Work (WHO 2000):

- Absenteeism – increase in sickness rates, particularly short periods of absence, depression, stress and burnout, physical health problems such as heart disease, backache, high blood pressure, ulcers, and sleeping problems.
- Work Performance – reduced productivity and output, increased error rates and accidents, poor decision-making, planning and control.
- Staff attitude and motivation such as burnout, loss of motivation and commitment, poor timekeeping, long hours with diminishing returns, labour turnover.
- Relationships at work – tension and conflict between colleagues, poor relationships with clients and increase in disciplinary problems.

workplaces due to loss in productivity, reduced performance or presenteeism, absenteeism, increased staff turnover, early retirement and health care costs. A World Economic Forum and Harvard School of Public Health study estimated that the cumulative impact of mental disorders globally in terms of lost economic output will amount to $16.3 trillion between 2011 and 2030, with estimates for countries like India and China ranging from $1.03 trillion to $4.5 trillion respectively (World Economic Forum 2016).

While mental health problems such as depression can be treated and in many cases can also be prevented, they may go unrecognized in the workplace and remain untreated, with consequent costs to the individual, employers and society. Mental health promotion in the workplace can lead to positive outcomes for both the individual employees and the organization as whole, with reduced levels of absenteeism and presenteeism, increased productivity and job satisfaction, and improved mental health and well-being. There is, therefore, a good economic case for investing in the mental health of the workforce (Goetzel et al. 2002; Knapp et al. 2011; World Economic Forum 2016).

Alongside the economic case, there is also a strong legal and moral case for workplaces to promote the mental health and well-being of their workforce. According to the principles of the United Nations (UN), the World Health Organization (WHO) and the International Labour Organization (ILO), every citizen of the world has a right to a safe, healthy and fair workplace (UN). The ILO advocates that the protection of workers against sickness, disease and injury resulting from their employment is not only a labour right but is a fundamental human right, a statement which is also clearly reflected in the constitution of the organization. The ILO develops international labour standards in occupational health and safety to guide governments in setting national laws and regulations and enforcing their application in workplaces. Working with national authorities, frameworks are developed to improve working conditions and occupational health and safety standards, putting in place national systems, legislative frameworks, policies and programmes to deliver occupational health services and workplace health promotion. Therefore, governments, organizations and employers have a legal and moral responsibility to protect the health and well-being of workers, including their mental health and well-being, and ensure just and favourable conditions of employment.

Access to employment is a major determinant of health equity and of mental health (Commission on Social Determinants of Health 2008; World Health Organization and Calouste Gulbenkian Foundation 2014) and is, therefore, a critical factor in determining population mental health and well-being. The WHO Comprehensive Mental Health Action Plan 2013–2020 clearly endorses the importance of safe and supportive working conditions, with attention to work organizational improvements, training on mental health for managers, the provision of evidence-based stress management courses and workplace wellness programmes and tackling discrimination (World Health Organization 2013). The global plan also supports work participation and return-to-work programmes for people with mental health disorders.

Traditionally, however, many workplace health regulations and initiatives have placed more emphasis on physical health and safety issues in the workplace than on mental health. Definitions of workplace health have evolved to a certain degree in the past number of years to include a greater focus on issues such as healthy lifestyle practices, psychosocial factors and community links (WHO and Burton 2010). The promotion of mental health is relevant to many aspects of employment including health and safety, equal opportunities, bullying and harassment and work-life balance initiatives. However, relatively few health and safety policies in the workplace have explicitly addressed the promotion of mental health and the prevention of mental health problems such as depression.

The WHO 'Mental Health and Work: Impact, issues and good practices' (2000) report advocated three main issues that employers need to address to promote the mental health of their employees. These include:

- Recognition and awareness of mental health as a legitimate concern of organizations. As disability and absenteeism costs increase in the workplace, employers are faced with the challenge of developing policies and effective strategies to address these issues.
- Effective implementation of workplace policies and anti-discrimination provisions. This requires that human resource managers appreciate the full implications of existing legislation and the enforcement of anti-discrimination legislation regarding the employment of people with mental health problems.
- Understanding the need for early intervention and assistance programmes to meet employees' mental health needs, as well as reintegrating employees back into the work environment.

Addressing each of these issues requires a comprehensive approach that takes account of the wide range of risk and protective factors that determine mental health in the workplace. A review by Harvey et al. (2014) identified a number of evidence-based risk and protective factors in the workplace that operate at the level of the individual, work teams/groups and at the organization as a whole, including the following:

- Design of the job – demands of the job, control in the work environment, resources provided, the level of work engagement, characteristics of the job and potential exposure to trauma.
- Team/group factors – support from colleagues and managers, the quality of interpersonal relationships, effective leadership and availability of management training.
- Organizational factors – changes to the organization, support from the organization as a whole, recognizing and rewarding work, how justice is perceived in an organization, a psychological safety climate, positive organizational climate and a safe physical environment.
- Home-work conflict – the degree to which the conflicting demands from home, including significant life events, interfere with work.

- Individual biopsychosocial factors – genetics, personality, early life events, cognitive and behavioural patterns, mental health history, lifestyle factors and coping style.

As these factors interact in complex ways, Harvey et al. (2014) point out that focussing on any one single risk or protective factor is unlikely to create a mentally healthy workplace. Strategies are needed that will influence factors at the individual, team and organizational system level.

A strategic and coordinated approach to promoting employees' mental health is recommended, including adopting a comprehensive organization-wide approach, working in partnership with key stakeholders in integrating mental health in all workplace policies and practices concerning managing people, employment rights and working conditions (NICE 2009). In order to create mentally healthy workplaces, strategies are needed to effect change at the level of the individual and the organization as a whole. Mental health promotion strategies need to take into account the nature of the work, the workforce and the characteristics of the organization (NICE 2009), as different approaches may be needed by different sized workplaces (e.g. micro (1–9 employees), small (10–49) and medium-sized (50–249) businesses) and employee groups (e.g. specific occupational groups, part-time workers, shift workers and migrant workers).

Reviews of the evidence suggest that an effective workplace health improvement policy should include; promoting the mental health and well-being of all staff, offering support and assistance to workers experiencing mental health problems in the workplace, and adopting a positive approach to employing workers with a history of mental health problems (Harvey et al. 2014). Building on this, the Joint Action on Mental Health and Well-Being (European Union 2015, p. 62) recommends that companies promote the mental health of their employees through a combination of measures that: (1) promote resources for positive mental health (such as high levels of autonomy, social support and employee focussed management); (2) reduce or eliminate stress (taking into account the working environment, workflow, the quality of cooperation in the workplace and the relationship between personal effort and recognition received); (3) support employees with mental disorders in their working life and their care and re-integration into the workplace. Each of these aspects of mental health promotion in the workplace are addressed and details of intervention programmes examined.

Implementing Mental Health Promotion in the Workplace

Frameworks for Workplace Mental Health Promotion: Policy, Legislation and Regulations

Policy frameworks, including legislation and regulations, play a critically important role in supporting workplace mental health promotion initiatives. Resolutions passed by the WHO World Health Assembly to address the health and safety of

workers include, the Global Strategy on Occupational Health for All, endorsed in 1996, and the Global Plan of Action on Workers' Health 2008–2017, endorsed in 2007. The Stresa Declaration on Workers' Health (2006), the ILO Promotional Framework for Occupational Health and Safety Convention (ILO Convention 187) (2006) and the Bangkok Charter for Health Promotion in a Globalized World (WHO 2005) also provide important entry points for mental health promotion. The Global Plan of Action on Workers' Health set out five key objectives to:

- Devise and implement policy instruments on workers' health.
- Protect and promote health at the workplace.
- Promote the performance of and access to occupational health services.
- Provide and communicate evidence for action and practice.
- Incorporate workers' health into other policies.

Building on these core objectives, the WHO Healthy Workplace Framework and Model (WHO and Burton 2010) provides a global framework for action for employers, workers, policy makers and practitioners, with practical evidence-based guidance which can be adapted for different sectors, enterprises, countries and cultures. The WHO Healthy Workplaces Model (WHO and Burton 2010) addresses the importance of psychosocial risks in the workplace and their strong association with poor mental health. The overriding importance of workplace policies and legislation is emphasized together with the engagement of all relevant stakeholders in integrating mental health promotion and mental ill-health prevention in workplace health promotion and occupational health and safety measures. Four domains of action that affect the physical and mental health, safety and well-being of workers are identified; the physical work environment (structure, air, machines, furniture, chemicals, materials, products and processes), the psychosocial work environment (the organization of work and the organizational culture and daily practices), personal health resources (supportive health practices, health services, information and resources) and enterprise community involvement (activities, expertise and resources provided to the local and global communities within which the organization operates). To address these four domains, the model endorses a continual improvement approach based on effective leadership and the engagement of workers and all relevant stakeholders and employs a structured process of implementation. The Healthy Workplace Model is based on core values and ethics and proposes an iterative action cycle that continuously plans, acts, reviews and improves on the activities of the programme. Key stages of the action cycle include:

- Mobilize commitment of all the key stakeholders.
- Assemble a Healthy Workplace Team who will work on implementing change in the workplace.
- Assess the current situation (identify needs, assets, deficits and opportunities) and future desired conditions and outcomes.
- Prioritize areas for action based on the need's assessment.
- Plan for action for specific initiatives and programmes over the medium to long-term.

- Do the planned actions identifying clear responsibilities and support for specific programmes.
- Evaluate the process and outcomes of the implemented actions.
- Improve the programme based on the evaluation findings and institute changes and new actions as required.

The model and cycle can be implemented across different sized organizations in diverse country contexts and adapted accordingly based on levels of resources and implementation readiness.

The World Economic Forum (2016) has also produced a seven-step guide for workplaces in developing a mentally healthy organization, including a number of practical examples and resources which can be used in undertaking concrete actions. In terms of good practices, compliance with legal and social responsibility obligations, supported by the presence of national standards and employee well-being programmes, have been identified as key drivers across countries (Sivris and Leka 2015). In addition, barriers such as knowledge deficiency, financial constraints, cultural gaps, time pressure and fear are also identified as critical issues to be addressed.

Within the European context, regulatory frameworks such as the 1989 EU Framework Directive on Health and Safety (89/391/EEC) recommend a holistic approach towards health promotion at work, encompassing both the psychological and physical health aspects of occupational health and safety policy. This directive makes it mandatory for organizations with the EU Member States to assess the health and safety risks to its workers and employers are obliged to provide protective and preventive services, full information on health and safety issues and consultation and participation rights to workers on matters affecting workplace health and safety. While the directive does not specifically include the terms ‘psychosocial risk’ or ‘work related stress’ (Wynne et al. 2014), it provides an indirect provision for these concepts, for example, by requiring employers to adapt the work to the individual and dictating that vulnerable groups should be protected from the risks in the working environment that affect them (Leka et al. 2015). The 2001 European Council conclusions on combating stress and depression (Official Journal of the European Community 2002/C6/09.01) and the Communication on Health and Safety at Work (Commission of the European Communities 2002), also emphasized the importance of good working conditions, social relations and the promotion of well-being at work. In addition, regulatory policies in relation to sexual harassment, bullying and discrimination in the workplace, when implemented effectively, can impact positively on mental health, as can employment laws regarding equality, health and safety, maternal and parental leave and flexible working (Jané-Llopis et al. 2005). Framework agreements have also been concluded by the European Social Partners including agreements on work-related stress in 2004 and on harassment and violence at work in 2007.

Since its foundation in 1996, the European Network for Workplace Health Promotion (ENWHP) has promoted workplace health promotion in Europe undertaking a series of initiatives to advance practice in this field. The Luxembourg Declaration on Workplace Health Promotion (ENWHP 1997) advocated improving

work organization and the working environment, promoting active participation and personal development in the workplace. Mental health promotion was seen as being an integral part of this initiative. In 2010, the focus on mental health and well-being was brought to the fore in the Edinburgh Declaration on the Promotion of Workplace Mental Health and Wellbeing (ENWHP 2010), and the production of a guide for employers (ENWHP 2011), which outlines a series of practical approaches for improving mental health in the workplace. These are outlined below in Box 2.

Building on these developments, the European Pact for Mental Health and Well-Being (European Union 2008) also recommended that employers need to promote the mental health needs of their employees, identifying three main issues:

- Improve work organization, organizational cultures and leadership practices to promote mental well-being at work, including the reconciliation of work and family life.
- Implement mental health and well-being programmes with risk assessment prevention programmes for situations that can cause adverse effects on the mental health of workers (stress, abusive behaviour such as violence or harassment at work, alcohol, drugs) and early intervention schemes at workplaces.
- Provide measures to support the recruitment, retention or rehabilitation and return to work of people with mental health problems or disorders.

In addition to factors within the workplace, external socio-economic factors also play an important role in influencing work conditions and their impact on workers' mental health. The nature of work is changing and while globalization

Box 2 Edinburgh Declaration on the Promotion of Workplace Mental Health and Well-Being (Adapted from ENWHP 2010)

- Encouraging employers to provide meaningful and stimulating work opportunities and supportive work organization for their employees.
- Providing opportunities for employee skill development including self-confidence and social competence.
- Promoting greater employee participation in decision making.
- Recognizing the key role of managers in supporting staff.
- Creating a positive working environment and setting clear job roles and expectations.
- Reducing sources of stress in the work environment, and developing resilience to stress by promoting coping strategies.
- Encouraging a culture of enterprise, participation, equity and fairness and challenging stigma and discrimination in the workplace.
- Supporting, retaining and employing people with mental health problems.
- Developing and implementing strong policies on mental health and well-being at work.
- Monitoring the impact of these policies and interventions.

and technological advances in the workplace have had some positive impacts, the subsequent changes in workplace practices and structures, both micro and macro, have led to increasing levels of stress in workplaces globally. This can be attributed to factors such as the continuous and rapid introduction of new technologies, workplace re-organization and restructuring, downsizing and layoffs, increasing levels of competitiveness, higher job demands and workloads, greater prevalence of part-time and temporary contracts and less stable boundaries between work and home life (International Labour Organization 2016). The composition of the workforce is also changing with a higher percentage of women, older workers and migrant workers. While for some migrant workers their situation may improve as a result of migration, many face very uncertain and challenging working and living conditions, with lack of access to health and social protection systems. Some workers in low and middle-income countries may also experience high levels of job insecurity and lack of health and safety protection as result of working within the informal economy.

Policies, regulations and national health and safety systems play a critical role in safeguarding the health and welfare of all workers, including those that protect employees against discrimination based on age, gender, ethnicity, race, sexual orientation and disability together with anti-bullying and sexual harassment policies. Management standards, such as the Health and Safety management standards developed in the UK for work-related stress (Health and Safety Executive 2009) and the Canadian National Standards for Psychological Health and Safety in the Workplace Canada (Mental Health Commission 2013), provide a structured approach for workplaces in adopting good management practices to address work-related stress and promote and protect employee mental health and well-being. Mental health promotion can be incorporated into occupational health services, workplace health promotion and psychosocial risk management practice, which are underpinned by legislation in many countries. The presence of supportive policy frameworks for mental health promotion and protection at work considerably enhance the success of such initiatives (Sivris and Leka 2015). Corporate social responsibility efforts also provide important opportunities to integrate workplace mental health promotion within the organization's ethos and culture, through promoting ethical business and working conditions, a culture of equity, trust and respect and supporting employee well-being and that of the wider community. Pioneered by companies such as Johnson and Johnson in the USA, corporate social responsibility can act as a foundation for good workplace health promotion practice and contribute to business success and reduced health risks for workers (Johnson and Johnson 2017).

The development of occupational health services and the provision of employee assistance programmes (EAPs) and workplace counselling play an important role in supporting mental health promoting initiatives. Traditionally, EAPs were established to assist employees with alcohol and drug addiction problems; however, they have broadened their scope to also include personal and work-related difficulties. EAP services may include on-site and telephone counselling or referrals to appropriate agencies for additional support. A review of counselling interventions in the workplace by the British Association of Counselling and Psychotherapy in the UK,

reported positive benefits including reduced symptoms of stress, anxiety and depression (McLeod 2008). However, as quality of provision may vary across EAPs, having appropriately qualified staff and employing evidence-based approaches are important aspects of an EAP service for positive outcomes to be achieved (Harvey et al. 2014).

The low participation of small and medium-sized enterprises (SMEs) in health promotion and occupational health services has been highlighted as an area of concern. SMEs account for a major proportion of EU businesses, for example, with some 40% of companies employing less than ten people. Clearly, different approaches need to be adopted in meeting the needs of such smaller companies, as access to specific occupational health services or programmes may be more difficult, not least due to the financial costs (Hasle and Limborg 2006). A number of countries have instituted group practice models where there is shared resourcing of specific services for employees and employers of SMEs. Digital services such on online supports are also emerging as an important resource for SMEs. The provision of outreach occupational health and health promotion services to specific employee groups, such as those engaged in the construction industry and agri sector, have also been developed to meet these needs.

Addressing Stress in the Workplace

Occupational stress is of increasing importance due to structural changes in the working environment. Globalization of the world economy has impacted on job restructuring with more contract work, greater workload demands and higher job insecurity. Employees are faced with greater demands, which contribute to higher stress levels and adverse health outcomes. Job stress has been defined by the National Institute of Occupational Safety and Health in the USA as the 'harmful physical and emotional responses that occur when job requirements do not match the worker's capabilities, resources and needs' (Sauter et al. 1999). Work-related stress affects not only the employee, but also their families, employers and the wider economy (Russell et al. 2016). According to Leka et al. (2011) nearly one in three European workers report that they are adversely affected by stress in the workplace. In the original 15 Member States of the European Union, the overall cost of stress in the workplace was estimated to be between 3% and 4% of GNP (Leka et al. 2011). In their report on stress at work in the United Kingdom, Chandola (2010) estimated that the annual cost of stress in the workplace to be between 0.5% and 1.2% of UK GDP (£7 and £13 billion).

According to the ILO (2016, p. 9–10) unhealthy psychosocial environments and stress in the workplace are associated with:

- Absenteeism and presenteeism.
- Reduced motivation, satisfaction and commitment amongst employees.
- Increased staff turnover and intentions to quit the job.
- Reduced efficiency and accuracy in performance among employees.

The ILO (2016) identify the following mental health and behavioural problems which can result from workplace stress: depression and anxiety, sleep disorders, burnout, suicide, alcohol and drug abuse, smoking, unhealthy diet and lack of physical activity. The Health and Safety Executive (HSE) in the UK (2017) identifies the main causes of work-related stress, depression and anxiety amongst employees as; workload pressures, including tight deadlines and too much responsibility (44%), a lack of managerial support (14%), violence and threats of bullying (13%) and change in the workplace (8%).

There is also concern about the increased risk of work-related illness in low and middle-income countries (LMICs) that have experienced rapid industrialization. While many countries have minimum standards for health and safety related to the physical aspects of the workplace, there is no specific legislation addressing the psychological or mental health aspects of the work environment, including the impact of job stress in many countries. The desire for short-term financial gains often leads to the prevalence of poor working conditions, putting many children and adults at risk in LMIC workplaces (WHO and Burton 2010). However, available data only reflects the problem in officially registered workplaces, as in many countries workers are employed in more unofficial circumstances where there may be no record of work-related injuries or illnesses.

Sources of Stress at Work

A range of factors operating at the individual, group and organizational-level contribute to stress in the workplace. An overview of research on addressing a number of these factors will now be provided.

Effort-reward imbalance: The concept of effort-reward imbalance focuses on the links between effort performed in work tasks and rewards such as money, esteem, career opportunities and job security. The model of effort-reward imbalance (Siegrist et al. 1986; Siegrist 1996) suggests that a lack of reciprocity between costs and gains can contribute to higher levels of stress and strain. In other words, having a demanding but unstable job and achieving a high level of performance without being offered any promotion prospects, are examples of high cost-low gain conditions at work. Exposure to an imbalance of effort and reward in the workplace can lead to an increase risk of depression and stress-related disorders (Nieuwenhuijsen et al. 2010; Rugulies et al. 2017). This model clearly highlights the importance of structural factors such as the influence of macroeconomic labour market conditions and employment policies, and addresses more directly issues of salaries, career opportunities and job security (Marmot et al. 1999). The model may be applied to a range of occupational settings, especially to groups of workers experiencing segmentation of the labour market, structural unemployment, occupational mobility, underemployment and rapid socioeconomic change. Policy initiatives, legislation and regulatory mechanisms are required to safeguard the rights of workers against the negative impact of effort-reward imbalance, especially among vulnerable groups of workers such as migrant and contract workers.

Level of job control: The control-demand model of work-related stress (Karasek 1990; Karasek and Theorell 1990) addresses the important relationship between the level of job demand and degree of control over work in determining work-related strain and risks to health and provides a useful framework for interventions. The model predicts that when job demands are high and levels of control and decision-making latitude are low, work strain is more likely to be result. However, high job demands combined with high levels of control are less likely to lead to work strain and are more conducive to positive achievement. Research on the model indicates that level of control is the more important predictor of the two (Johnson et al. 1996; Siegrist et al. 2014). The model has also been extended to include social support at work as an important moderator of the negative effects of high strain jobs (Harvey et al. 2017).

Psychological and social support: Psychological and social support comprises all supportive social interactions available at work, either with co-workers or supervisors. It refers to the degree of social and emotional integration and trust among co-workers and supervisors. It refers also to the level of help and assistance provided by others when one is performing tasks. Equally important are the workers' perceptions and awareness of organizational support. When workers perceive organizational support, it means they believe their organization values their contributions, is committed to ensuring their psychological well-being, and provides meaningful support if this well-being is compromised.

Social support plays a critical role in protecting mental health in the workplace and reducing the negative impact of a stressful working environment. There are a number of strategies for increasing the social support available to an employee. These include:

- Support groups which introduce new additional supporters have been implemented widely, particular with people undergoing a life transition or undertaking behaviour change.
- Enhancing existing relationships by providing training to the employee in the knowledge and skills necessary for maintaining and mobilizing social support. This type of intervention has been used widely in the human services, but is dependent on the co-operation of co-workers and other members of the network in modifying social interactions.
- Enhancing existing relationships by training members of the employees' social network in ways to be more supportive. This approach targets network members, particularly those that have a key role to play in the work context.

While different occupational groups may differ in the nature of their work environments, Tennant (2001) reports that the social environment, especially conflict in relationships or poor social support, appear to predict depression and burnout in most groups.

Social support at work can be protective of the negative impact of job demands and can have a positive effect on workers' health and well-being (Stansfeld et al. 2000).

Stress is more prevalent in public service industries, such as education, human health and social care work activities and public administration and defence (Health and Safety Executive 2017). Occupational stress is recognized as a major problem for the 'caring professions' such as teachers, doctors, nurses, youth workers, social and health workers. Client-related stressors have emerged as reasonably consistent stressors in the caring professions. For example, the need for support systems for professionals working in the mental health area have been highlighted by Holloway et al. (2000) and Edwards and Burnard (2003) in relation to psychiatrists and mental health nurses respectively. Additional stressors in the caring professions can include exposure to high levels of trauma and death, emergency situations and also fears around complaints and litigation. Challenging the impacts of stress for those working in these areas can be in the form of increasing personal coping resources, such as self-esteem and problem-solving skills, as well as social support from colleagues in the surrounding organization (Heaney et al. 1995a). Increasing the amount of social support available to employees can help an employee modify a stressful situation, develop a new perspective on a stressful situation and decrease the emotional upset associated with a problematic situation.

The Caregiver Support Programme (CSP) is an example of a programme that effectively increases the ability of teams of caregivers to mobilize socially supportive behaviour and problem-solving techniques (Heaney et al. 1995a, b; Price and Kompier 2006). The programme had two main objectives that pertain to the quality of work relationships; to teach employees about (1) the helping potential of support systems and to build skills in mobilizing this support from others in the workplace and (2) about participatory problem-solving approaches and to build these approaches into work team meetings. Findings from a large scale randomized controlled study, in which group homes were randomly assigned to receive the programme or be in the control group, indicated that the CSP intervention resulted in increased perceived social support, interpersonal skills, group problem-solving, positive work team functioning, job satisfaction, and employee mental health among those employees who attended at least five of the six CSP sessions (Israel et al. 1996). For CSP to have been really effective, participants must have been able to use their new skills and knowledge back in the group homes. Results of the programme evaluation showed that participants reported higher levels of supervisory support, had more contact with co-workers, had a greater ability to handle disagreements and overload at work and a better work team climate compared to the control groups (Heaney et al. 1995a).

Work-life balance: A demanding workload can result in work-life conflict with subsequent negative effects on health and well-being (Commission on Social Determinants of Health (CSDH) 2008). On the other hand, a good work-life balance is positively associated with satisfaction with working conditions (Eurofound 2017). The CSDH (2008) state that working conditions which promote health equity require, amongst other variables, a healthy work-life balance. According to the sixth European Working Conditions Survey conducted in 2015 (Eurofound 2017), 18% of workers reported a poor work-life balance. Interestingly, a greater number (23%) of workers whose main jobs involves working with computers, laptops and

smartphones reported issues with their work-life balance. Workers who feel insecure in their jobs and those working long hours are also less likely to have a good work-life balance.

Supports and interventions to support work-life balance include legislation and national polices concerning statutory leave entitlements and organizational policies and practices that provide for flexible working arrangements. These include statutory maternity, parental and paternity leave options, job-share arrangements, flexible working and part-time work options. The evidence on the impact of such provisions is broadly positive with improvements found in relation to improved balance between work and personal life, increased job satisfaction and improved health and well-being (Brough and O'Driscoll 2010; Skinner and Chapman 2013; Joyce et al. 2010). A systematic review of flexible working conditions and their effects on employee health and well-being by Joyce et al. (2010) found that flexibility in working patterns that give the employee more control is more likely to have more positive effects on health and well-being. This review also reported that while interventions focussing on temporal flexibility (self-scheduling of shifts) resulted in significant improvements in employee health and well-being, the effects of contractual flexibility (e.g. in employment contracts) on employee health and well-being was reported as either equivocal or negative. Therefore, flexible working arrangements are more beneficial where employees have more control. It should also be noted that work-life balance provisions beyond statutory entitlements are discretionary and may, therefore not be available in some workplaces. Hodgins et al. (2016) also point out that even where flexible work arrangements are available they may not be taken up due to factors that limit their implementation in practice. Elements of work-life culture can have an impact on the extent and pattern of take-up and are influenced by factors such as; levels of managerial support, perceptions of career consequences, organizational time expectations, gendered nature of policy utilization, and co-workers support (McDonald et al. 2005). For example, a gendered pattern of uptake has been documented in the literature with women being more likely to avail of leave, flexible and part-time work arrangements. Therefore, a supportive work-life culture and positive organizational ethos is critical to ensuring that work-life balance strategies are fairly implemented and taken-up. The introduction of workplace award schemes in some countries (e.g. 'Great Place to Work Awards' in the USA) has also played an important role in recognizing and supporting positive organizational practices that support work-life balance initiatives outside of minimal statutory requirements.

Ill-treatment and bullying at work: There are various forms of ill-treatment that may be experienced by employees in the workplace. These can include harassment, violence, conflict, abusive behaviours, incivility and disrespectful treatment. Workplace bullying is one of the more frequently cited examples of ill-treatment at work. Bullying can be described as repeated, unreasonable behaviour targeting employee or employees in the workplace (European Agency for Safety and Health at Work 2002). Einarsen et al. (2011) provide the following definition: 'Bullying at work is about repeated actions and practices that are directed against one or more workers; that are unwanted by the victim; that may be carried out deliberately or

unconsciously, but clearly cause humiliation, offence, and distress; and may interfere with work performance and/or cause an unpleasant working environment'. (p. 9). Bullying is, therefore, characterized by its frequency (persistent and over a period of time), inappropriate behaviours and actions, intent by the perpetrator, can be physical, psychological, emotional or sexual and usually occurs where there is a power imbalance between perpetrator and victim. The effects on the victim can be physiological (stress response, impact on sleep), psychological (anxiety, depression and other mental health problems, reduced confidence and self-esteem, decreased job satisfaction, motivation and burnout), and result in behavioural problems including sick leave, leaving work, coping mechanisms such as alcohol and substance misuse, and in some cases can lead to suicidal behaviour The effects on organizations can include increased absenteeism and labour turnover, lower morale and productivity and poor relationships in the workplace. According to the sixth European Working Conditions Survey conducted in 2015 (Eurofound 2017), approximately 16% of workers in the 28 European Union member states reported exposure to adverse social behaviour. Within the previous month, 12% reported exposure to verbal abuse, 6% to humiliating behaviours, 4% to threats of some kind and 2% reported exposure to unwanted attention. Over the course of the previous 12 months, 5% reported exposure to bullying and harassment, 2% to physical violence and 1% to sexual harassment.

Although frequently viewed as being a personal or interpersonal problem, bullying is also influenced by organizational factors such as workplace culture and climate, which may foster a tolerance of bullying and other forms of ill-treatment and an unwillingness to address these problems. Anti-bullying policies play an important role in securing a commitment from employers to be proactive in preventing bullying and having clear procedures for managing cases when they occur. It is recognized that training for managers may be required in implementing such policies successfully, including raising awareness of the issue, the policy and the reporting processes involved. There is a relative paucity of research on anti-bullying interventions in the workplace. However, there is some evidence to suggest that both organizational and individual level approaches are required. Systematic reviews of the literature by Hodgins et al. (2014) and Gillen et al. (2017) report a relatively small number of controlled studies in this area and an even smaller number demonstrating evidence of effectiveness. Both reviews highlighted the positive impact of the Civility, Respect, and Engagement in the Workforce (CREW) intervention (Leiter et al. 2011). This multi-component intervention takes an organizational approach to creating a culture of respect at work that promotes and improves civility. Rooted in organizational development, change is targeted at the level of the individual, work group, management and organizational culture. The positive findings on the impact of the CREW intervention for health care workers relate only to civility and incivility and an evaluation of related impacts on bullying behaviours have not been reported. Unlike, for example, studies on bullying prevention in the school setting (see Chapter 'Promoting Children's and Young People's Mental Health in Schools'), there is a paucity of research on bullying interventions in the workplace and reviewers of the evidence have commented on the need to strengthen

the quality of research in order to inform the design of more effective comprehensive interventions in the workplace setting.

Psychosocial Risk Management

Health and safety in the workplace has traditionally been addressed by employing a risk management approach. This process usually involves a stepped approach whereby hazards are identified, the risks from these hazards are assessed, control measures are put in place and these are reviewed and revised as required to eliminate the risk. This approach has also been applied in managing psychosocial risks in the workplace, with examples, among others, the Management Standards on Work-related Stress in the UK, SME Vital in Switzerland, Health Circles in Germany and Work Positive in Ireland.

It is recognized that psychosocial risks in the workplace include a wide range of factors operating at multiple levels. Leka and Cox (2008) documented a number of key work-related psychological hazards, which are outlined in Box 3 above, that influence employees' mental health, psychological safety and productivity in the workplace.

Box 3 Work-Related Psychological Factors (Adapted from Leka and Cox 2008)

Job content	Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high uncertainty, continuous exposure to people through work.
Workload and work pace	Work overload or underload, machine pacing, high levels of time pressure, continuously subject to deadlines.
Work schedule	Shift working, night shifts, inflexible work schedules, unpredictable hours, long or unsociable hours.
Control	Low participation in decision making, lack of control over workload, pacing etc.
Environment and equipment	Inadequate equipment availability, suitability or maintenance; poor environment conditions such as lack of space, poor lighting, excessive noise.
Organizational culture and function	Poor communication, low levels of support for problem solving and personal development, lack of definition of, or agreement of, organizational objectives.
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors or co-workers, interpersonal conflict, lack of social support.
Role in organization	Role ambiguity, role conflict and responsibility for people.
Career development	Career stagnation and uncertainty, under promotion or over promotion, poor pay, job insecurity, low social value at work.
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems.

Based on a review of the risk management process and best practices, Leka et al. (2011) describe the development of a European framework for psychosocial risk management PRIMA-EF, which was designed to harmonize psychological risk management practices in Europe The PRIMA-EF framework (Leka and Cox 2008) has also served as a guidance tool for the development of further methods, including the development of management standards for psychological risk management.

An example of management standards that have been developed for addressing workplace psychosocial risks is the National Standard of Canada for Psychological Health and Safety in the Workplace (Mental Health Commission 2013), which outlines voluntary guidelines, tools and resources for promoting mental health and preventing psychological harm in workplaces. The Standard describes psychological safety as a concept that connects the dynamics of the workplace to the health, resilience and well-being of the individual and society at large. This voluntary Standard provides a framework and a systematic approach to developing, implementing and sustaining a psychologically healthy work environment. The UK Management Standards (Health and Safety Executive 2009) on work-related stress also provide guidelines to help detect, prevent and manage stress and mental health in the workplace (Memish et al. 2017). The UK Management Standards address six key areas that are associated with poor mental health and well-being, lower productivity and increased sickness absence. The Standards aim to ensure that each of the following six areas are addressed and that systems are in place to address any individual concerns relating to:

- Demands – employees indicate that they are able to cope with the demands of their jobs (such as workload, work patterns and the work environment)
- Control – employees indicate that they are able to have a say about the way they do their work
- Support – employees indicate that they receive adequate information and support from their colleagues and superiors
- Relationships – employees indicate that they are not subjected to unacceptable behaviours, such as bullying at work
- Role – employees indicate that they understand their role and responsibilities within the organization
- Change – employees indicate that the organization engages them frequently when undergoing an organizational change. (Health and Safety Executive 2009)

The Management Standards approach entails undertaking risk assessments to determine the nature and level of risks in the workplace together with the development and implementation of control measures to reduce such risks. Adopting the ‘Five steps to risk assessment model’, management and staff work together to: (1) identify the stress risk factors (2) decide who might be harmed and how—gather data (3) evaluate the risks—explore problems and develop solutions (4) record findings—develop and implement action plans (5) monitor and review action plans and assess effectiveness. The risk assessment process is meant to be undertaken in partnership

with key stakeholders, facilitating the participation of employees in identifying and deciding on the improvements and actions that need to be taken. The Canadian Psychological Health and Safety Management System (Mental Health Commission 2013) also emphasizes the importance of organizational level commitment, leadership in influencing organizational culture, practices and performance and the participation of all stakeholders, including employees and their representatives, with a shared interest in ensuring a psychologically safe working environment.

The assessment of psychosocial factors relating to health has not, however, received the same attention as traditional physical hazards. Therefore, professional training is required to enable managers and inspectors to undertake risk assessments on the psychosocial factors in the workplace that pertain to workers' mental health. An example of a management training programme developed to manage psychosocial risks in the workplace, including work-life balance, is Siemens 'Life in Balance Programme'. First implemented in Belgium in 2013, this programme sought to develop a sustainable way to promote positive mental health in the workplace that would not only benefit the employees but also the company, by producing a sustainable, healthy and motivated working environment, addressing their corporate social responsibility and improving brand image and public reputation. In order to make this programme successful, top management were recognized as key stakeholders, a clear long-term strategy and approved budget was secured and the programme was customized to the needs of the employees. To analyse and manage risks the company ran a well-being enquiry 'Are you Fit@Work at Siemens' and in Belgium, feedback from this assessment indicated that there were high levels of stress and stigma towards the topic of mental health and well-being. The programme was developed in order to address these key issues focussing on six core areas; building awareness (through talks, videos and establishing a positive mental health social media network for staff members), leadership involvement (integration of health topics into management meetings and health management training for company managers), risk analysis and measure definition, communication (the Siemens social network of employees, health experts and voluntary members), training (stress management to both managers and personnel) and employee assistance through the company's Employee Assistance Programme (EAP), which offers both face-to-face and telephone counselling and highlights internal and external persons of trust. Implementation of the programme in Belgium has produced some promising results and secured the 'Employer of the Year Award' for the company in 2014. Absentee rates were reported as decreasing by 26% in a year with 65% stress enquiry utilization. Stress management training has had an 80% take-up amongst staff and a 40% increase rating in company culture with 75% of employee suggestions being realized. Around 70% of managers attended stress management, and 46 voluntary workers became trained coaches and ambassadors for well-being within the company in order to ensure health and well-being are kept current within daily company procedures. The Belgium Balance in Life programme has since been transferred to other business units in other countries and modified to

fit their perspective environments. Programme details can be retrieved from the EU Mental Health Compass Database of Policies and Good Practice, accessible at: https://webgate.ec.europa.eu/sanco_mental_health/public/GOOD_PRACTICE/1328/show.html

Evidence-Based Intervention Approaches in the Workplace

While the factors that influence mental health in the workplace have been reasonably well researched, there are gaps in the evidence base concerning the most effective and sustainable intervention approaches that can adopted to address these issues. A lack of robust interventions studies on workplace mental health promotion and prevention interventions, particularly at the organizational level, limit the conclusions that can be drawn with regard to the most effective and cost-effective evidence-based approaches. Acknowledging this, however, it can be concluded from the available evidence that a comprehensive and integrated approach is required, combining both individual and organizational level interventions, for promoting and maintaining mental health at work.

To address and manage workplace stress three main types of interventions can be identified (Leka and Cox 2008):

1. Primary interventions – concerned with organizational and structural change and actions to modify or eliminate sources of stress inherent in the work environment.
2. Secondary interventions – concerned with early detection and management of stress by increasing awareness and improving the stress management skills of the individual worker through training and activities. Health promotion programmes such as physical fitness and lifestyle modification programmes are also included in this category.
3. Tertiary interventions – refer to the treatment, rehabilitation and recovery process for individuals who are stressed or have experienced ill-health as a result of stress. These interventions include counselling services and supports provided, for example, through employee assistance programmes. Comprehensive systems and procedures to support the rehabilitation and return to work of employees who have experienced stress-related problems is another aspect of tertiary interventions.

Examining the range of intervention studies that have focussed on the psychosocial work environment, it is clear, however, that primary interventions addressing the organization of work or organized culture are much fewer in number and more limited than those focussing on secondary or tertiary health and safety interventions (WHO and Burton 2010). We will now examine a range of individual and organizational level approaches (see Box 4) that have been developed and evaluated in addressing workplace stress and promoting mental health and well-being at work.

Box 4 Strategies for Reducing Workplace Stress and Promoting Mental Health (Adapted from Elkin and Rosch 1990 and the European Network for Workplace Health Promotion 2011)

- Establish fair employment policies.
- Reorganize poor working practices, re-design the task and work environment.
- Increase control over work, establish flexible work schedules.
- Encourage participative management, include employees in decision-making and problem-solving processes.
- Balance efforts and rewards.
- Build cohesive teams, improving communication and feedback.
- Clear roles and expectations.
- Encouraging and strengthening social support.
- Further training, qualifications and career development.

Individual Focussed Approaches

Strategies to deal with work stress may be directed at the individual employee or may be focussed on the organizational characteristics of the workplace. The individual employee focussed interventions tend to be directed at enhancing coping capacity usually through the use of stress management training. These interventions include cognitive-behavioural approaches such as stress inoculation training, relaxation techniques, social skills training, social support, training in time management and encouraging staff to enhance the balance between work and home life. By training effective coping skills before stress exposure, the objective is to prepare the individual to respond more favourably to negative stress event and reduce the psychological impact. The evidence is somewhat mixed on the effectiveness of these approaches in reducing negative mental health outcomes in the workplace (van der Klink et al. 2001; Graveling et al. 2008; Richardson and Rothstein 2008; Marine et al. 2006; Bagnall et al. 2016).

Evidence on individual stress management suggest that approaches such as Stress Inoculation Training, based on Meichenbaum's model, can have positive effects (Czabała et al. 2011). However, while there is evidence of potential small to moderate effect sizes, for example, on reducing anxiety and depressive symptoms and burnout in the short-term, the longer-term impact remains unclear (Graveling et al. 2008; Bhui et al. 2012; Bagnall et al. 2016). An increasing interest in mindfulness-based interventions in workplaces is also evident, not only for staff experiencing stress but also as a means of improving well-being and enhancing resilience against stress and burnout. A systematic review of 153 studies by Lomas et al. (2017) found that mindfulness generally had a positive effect on reducing

stress, improving job satisfaction and job performance. However, the outcomes related to burnout and depression were less clear and the quality of the studies was inconsistent. Overall, the research to date indicates that cognitive behavioural interventions produce the best results at the individual level (Richardson and Rothstein 2008; van der Klink et al. 2001; Marine et al. 2006; Bhui et al. 2012; Tan et al. 2014; Bagnall et al. 2016).

Likewise, lifestyle and workplace health promotion interventions such as physical exercise appear to be effective in reducing anxiety, depression and psychosomatic distress. Sensors and apps for monitoring stress and health behaviours such as physical activity have been developed to support intervention delivery; however, there have been few robust evaluations of these approaches. Organizational programmes focussing on physical activity have also shown a reduction in absenteeism (Bhui et al. 2012). While such interventions may lead to better coping, they do not necessarily alter the link between the stressor and the experience of psychological strain. As a result, it is difficult to sustain the benefits of such programmes if the work environment or source of the stress remains unchanged. In general, stress management approaches that focus on changing the individual's capacity to deal with stress without changing the source of the stress, are of limited effectiveness. Management tend to have a preference for supporting individual-level interventions rather than addressing issues concerning power and organizational change (Nytrø et al. 2000). However, it is now clearly recognized in workplace health promotion practice that there is a need for comprehensive interventions that will target individual and organizational issues in the workplace and recognize the need for organizational and social change to reduce stressors that are beyond the individual's control (Hodgins et al. 2016).

Organizational Approaches

Organizational approaches refer to interventions that change work organization and environmental features in an effort to reduce work-related stress. Organizational interventions can include many types, ranging from structural changes such as staffing levels, work schedules, job structure and the physical environment to psychosocial changes such as social support, increased participation and control over work, management style and culture. Many work re-organization interventions have focussed on promoting well-being by enhancing job control, enhancing choice in one's work and a sense of autonomy. Job control has been found to be a significant mediator of change in work re-organization interventions for stress reduction (Bond and Bunce 2001). Task restructuring as part of workplace reorganization that increases demand and decreases control can have a detrimental effect on employees' health and well-being (Bambara et al. 2007).

Comprehensive intervention approaches need to address the sources of stress at work, including those focussing on the following aspects of work:

- Role characteristics – clarity of role and workload.
- Interpersonal relationships-improving communication systems within the workplace.
- Organizational structures and climate – encouraging participation in decision-making, ensuring appropriate pay, security and recognition.
- Human resource management – effective mechanisms for recruitment, supervision, appraisal and performance management, employee assistance programmes, work-life balance initiatives.
- Physical aspects of the work environment-ergonomic improvements, noise reduction, safety protection.
- Changes to management style that have been shown to have a positive effect include: redressing effort-reward imbalance, improving communications and staff involvement.
- Enhancing social support, especially from mangers to staff.
- Increasing job control and decision-making latitude.
- Assessing job demands.

Successful organizational level interventions focussing on employee health outcomes are more likely to be comprehensive in nature, focussing on material, organizational and time-related conditions simultaneously (Montano et al. 2014). Reviews have shown that the majority of interventions on stress management in the workplace have focussed on the individual level (LaMontagne et al. 2007; Giga et al. 2003). In reality, few interventions have been developed to address the environmental and organizational impacts on mental health in the workplace (Leka et al. 2015).

Nytrø et al. (2000) identified the following key factors for the successful implementation of occupational stress interventions:

- Integrate interventions into the organization by including unions, interaction with other ongoing projects, establishing communication structures and implementation plans.
- Opportunities for multi-level participation and negotiation in the design of interventions – taking into account the perspectives of different stakeholders in an organization – and engage the co-operation of employees, unions, management with the management's leadership style being an important predictor of success.
- In the process of change, employees should be encouraged to act as change agents and be assisted in removing the sources of excessive stress.
- Intervention programmes provide an opportunity to educate managers and employers about the contributors to stress in the workplace for all involved and to consider the importance of power and organization change in effective stress reduction.
- Assess the context and readiness of an organization to participate.

- Identify and make visible the needs and incentives for change in an organization and provide time for stakeholders to reflect on positive and negative outcomes.
- Garner commitment to the intervention by sharing information regarding development and implementation of the programme.
- Define roles and responsibilities before and during the intervention, such as the roles of expert, advocate, enabler and the change facilitator.
- Communication and trust—if positive change is to occur it is vital that there is ongoing communication between all involved, that trust is established and fostered and that lessons are learned from successful and unsuccessful interventions.
- Create a social climate of learning from failure as well as success. While there is a tendency to learn from success, growth in an organization can also be facilitated by prevention of repeated mistakes and it is, therefore, recommended to document failures so that future change projects can benefit from the past.

Based on an analysis of systematic approaches to organizational health and well-being interventions from four European countries, Nielsen et al. (2010) identified five key phases that are consistent across all approaches, with each phase sharing a number of core elements:

- Preparation: establishment of a steering group, employee readiness for change, organizational readiness for change, senior management support, organizational maturity, communication, drivers of change.
- Screening: selection of methods, audit of existing systems, feedback.
- Action Planning: developing activities.
- Implementation: monitoring, drivers of change (middle managers), communication.
- Evaluation: communication, effect evaluation (different levels), process evaluation (documentation), process (emergent variability).

A comprehensive approach to the prevention of psychosocial risks and awareness of their impact on workers' health is still not appropriately addressed in the majority of workplaces (ILO 2016). Montano et al. (2014) reported that in order to increase the likelihood of more beneficial organizational interventions in the future, commonly reported barriers in the implementation process, such as organizational commitment and lack of training, should be addressed in the development phase of the interventions.

We will now examine the internationally developed SOLVE Programme as an example of training programme developed to support workplaces in integrating mental health promotion as an integral component of occupational health and safety policies. Although not subject to critical evaluation to date, SOLVE provides an interesting and potentially useful example of a training programme addressing stress and psychosocial problems in the workplace with cross-cultural application in LMICs. Following this, a case study is presented on developing and implementing a comprehensive approach to promoting mental health in the workplace, based on the model developed by British Telecom.

Practice Example: The SOLVE Training Programme (International Labour Organization)

The SOLVE training programme was developed by the International Labour Organization (ILO) as a means of integrating health promotion into occupational safety and health policies through action at an organizational level. The programme addresses psychosocial risks and the promotion of health and well-being at work with the aim of reducing the incidence of job-related stress and economic, workplace violence, tobacco use, drug and alcohol misuse and HIV/AIDS. SOLVE advocates that health promotion measures are incorporated into the organization's policy and that a comprehensive occupational safety and health management system should include the assessment and control of psychosocial risks to properly manage their impact in a similar manner to how other hazards and risks are managed. SOLVE uses the social dialogue approach to promote the implementation of successful workplace and community initiatives with the involvement of employers, workers, governments, public services and NGOs.

The SOLVE training package is designed for HR managers, trade unions, employers' associations, OSH professionals and national institutions responsible for the health and well-being of workers. The intervention has been implemented in several countries around the world, specifically targeting resource-poor countries in Africa and Southeast Asia that have been affected by the AIDS epidemic (e.g. Kenya, Namibia, Zambia, South Africa, Swaziland, Thailand, Malaysia, India and China).

The Programme

SOLVE focuses on nine areas including work-related stressors, alcohol and drug misuse, violence, HIV/AIDs prevention, tobacco-free workplaces, nutrition, healthy sleep and physical activity. This programme recognizes the interdependent relationship between psychosocial factors and health-related behaviours and how they affect both employee performance and the overall environment of the workplace.

The intervention begins with a 32 h policy development course and is followed by 18 months of intensive training to educate employees about the causes, consequences and methods of prevention for each of the SOLVE domains (stress, tobacco, alcohol and drugs, HIV/AIDS and violence etc.). The SOLVE programme is run by the ILO's International Training Centre in Turin, Italy and employs a 'train the trainers' approach. It is designed as a 40 h interactive programme suitable for managers, occupational health workers, human resource directors, policy and decision-makers, workers representatives, university and training organizations amongst others. SOLVE recognizes that every organization is different and so one size does not fit all. Thus, this programme provides the skills and tools necessary for these leaders to design their own individual policy for health promotion and psychosocial risk prevention. It is an interactive programme in which participants will work through simulated scenarios, analyse case studies, design policies and develop action plans. Upon completion of the course, participants will have an understanding of the nature and impact of work-related stress, workplace violence and HIV/AID as well as unhealthy lifestyle habits such as smoking, alcohol and drug abuse, poor exercise,

inadequate sleep and nutrition. They will also be made aware of the interrelationships of these health risks and be able to identify the appropriate measures to both address and prevent them, not only for the individual but at an organizational level. Furthermore, they will be trained to develop a policy statement underpinning the company's strategy to counter these problems, followed by a management model for action.

Evaluation

A preliminary evaluation of the original SOLVE training programme showed promising results in its ability to provide primary prevention and promotion strategies through integrated workplace health and well-being policies. Probst et al. 2008 examined the effectiveness of SOLVE across seven countries; Belgium, Canada, India, Sri Lanka, Malaysia, Namibia and South Africa (N = 268 individuals). The results indicate that the intervention led to significant improvements in participants' knowledge about HIV/AIDS, job stress, workplace violence, tobacco use and drug and alcohol misuse. The training resulted in equivalent knowledge gains regardless of the country in which the training was taking place or the specific course attended, thus demonstrating the generalizability of the outcomes in multiple contexts. The results of this study suggest that SOLVE may be effective in improving employee knowledge regarding the causes, consequences and methods of prevention for several major psychosocial workplace issues. However, further more rigorous studies need to be carried out to determine the effectiveness and sustainability of SOLVE in LMICs. Since the development of the updated SOLVE training packaging in 2012, no further evaluations have been carried out. Thus, this programme gives promising results as a method of good practice, however, further more robust research is needed to determine its overall effectiveness.

Further details of the programme, including training resources are available at: http://www.ilo.org/safework/info/instr/WCMS_178438/lang%2D%2Den/index.htm

Case Study: British Telecom's Approach to Mental Health in the Workplace

Catherine Kilfedder
Head of Wellbeing (Dec 2006–Sept 2017), BT, London, UK

Background

British Telecom (BT) is one of the world's leading providers of communications solutions and services, operating in 170 countries and employing around 101,000 people, of whom some 80% are located in the United Kingdom. The company seeks to promote the well-being of its people for their benefit and that of BT's customers and shareholders. BT takes a 'whole person' approach to well-being focussing on

four key driver areas of Health (which includes both physical and mental health), Security, Relationships and Purpose. In common with many other organizations, mental health is one of the growing risks at BT accounting for 23% of all sickness absence. Mental health problems are a significant cause of time away from work and addressing it in the right way helps to drive down costs associated with mental-health-related absenteeism, and reduced productivity, and is perceived to further BT's corporate social responsibility credentials.

The Mental Health Framework

BT's Mental Health framework consists of three phases:

- Proactively promoting good mental health and reducing risks to mental well-being at source through workplace and job design.
- Identifying early signs of mental ill-health and supporting individuals to address any work or non-work pressures.
- Helping people experiencing mental ill-health to cope and recover.

A mental health 'toolkit' which captures all the key resources, escalating in sophistication, in a simple, downloadable document supports the framework. This and all the other well-being resources are hosted on a dedicated Health, Safety and Wellbeing intranet site. BT runs a Mental Health campaign every year around World Mental Health Day. Positive Mentality in 2007/8 was a full 16 week programme with modules designed to raise awareness of mental health issues, tackle stigma and promote mental well-being. It dealt with the link between physical and mental health, lifestyle issues and support and relationships. The aim was to address mental resilience issues rather than simply focus on mental ill-health, although some material was included on how to deal with problems if they arose. Quizzes were used to test participant understanding of the material.

Two of the more recent additions to the toolkit include a mental health service (to complement the employee assistance programme) and resilience training. The mental health service is based on the model developed for musculo-skeletal disorders and delivers cognitive behavioural therapy (CBT) for common mental health problems. The service and its musculo-skeletal counterpart are funded through an insured solution in order to remove the risk of cost volatility and short-term budgetary pressures at business unit level. This approach also improves visibility of costs and provides economies of scale, strengthening the business case for rehabilitation. Management at a central level by Group Risk, advised by in-house specialists, has also helped drive innovation and efficiencies. The Resilience training portfolio consists of a 2 day course for people managers (developed with the support of Action for Happiness, part of the Young Foundation charity), a 1 day course for all BT people, and an online offering. The aim is to provide our people with the knowledge and skills to build their own resilience as well as promoting that of any they manage, thereby enhancing well-being, engagement and performance. Root cause analysis of a recent upturn in mental health cases in some parts of the company has shown

that serial major change programmes have been a driver. Interventions have, therefore, focussed on healthy change management through the integration of core principles and practices into pan-BT change methodologies and training. Management and leadership training programmes promote a style that takes proper account of the perceptions of the people impacted by change.

Evaluation: Benefits So Far

Management information is collected from a variety of sources (e.g. sickness absence database, occupational health returns, EAP feedback, anonymized and grouped STREAM[1] results and Your Say reports[2]) and is presented as a mental health dashboard updated monthly and supplemented by a commentary from Head of Wellbeing. This approach targets areas for attention within the business and ensures resources are directed to where they are likely to achieve the greatest impact. The demographics and the commercial challenges faced vary considerably between business units and issues alter over time. Quantifiable benefits are often difficult to demonstrate in the short-term as impact really depends on a comprehensive, integrated longer-term approach. Based on data derived from internally driven metrics (for example: http://www.btplc.com/Purposefulbusiness/Deliveringourpurpose/index.htm), key impacts include:

- BT's mental health-related sick absence rate decreased by 12% between June 2016 and June 2017 alongside maintenance of employee engagement levels.
- BT's well-being outcome question in Your Say improved from a baseline of 66% favourable in January 2017 to 67% in June 2017. Incremental changes are significant when considered in the context of reflecting the entire workforce.
- An evaluation of BT's 'Work Fit – Positive Mentality' mental health promotion campaign showed:
  - 68% learned something new about ways to look after their mental health
  - 56% tried some of the recommendations and continued to practise them at the time of the survey
  - 51% of those who had made changes had noticed improvements in their mental health and well-being.

The programme demonstrated how regular exercise, healthy eating, relaxation techniques and even the support of friends and family can help to ward off depression, stress and anxiety. It also aimed to educate employees to help reduce the stigma of mental ill-health and promote the range of support services the company provides.

[1] STREAM is BT's online Stress Risk Assessment and Management tool.

[2] Your Say is BT's company-wide engagement survey within which has embedded a Wellbeing outcome question.

- BT considers that looking after the well-being of their people is a 'win-win' with employee surveys showing that 81% 'agreed' or 'strongly agreed' that the opportunity to participate in health promotion campaigns made them feel that BT cared about their health, 58% reported that it made them feel valued as an employee, and 64% indicated that it made them feel proud to work for BT.
- The company funded mental rehabilitation service has delivered significant improvements in clinical outcomes among those using the service. Critically, from a business perspective, it has also proved effective in getting people back to work safely with 92% returning to their own role on full duties after intervention.

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

Strategic approach: BT considers it important to engage people at every level, from the shop floor to the boardroom, to view people with mental health issues in the same way as for any physical condition. Their approach is to facilitate self-help within an organizational framework that manages both physical and psychological risks. That means shifting mindsets from command and control to empowerment with mutual support and high-quality specialist back-up when needed. Personal responsibility for lifestyle changes is coupled with a recognition of the corporate duty to organize work in a way that avoids harm.

Infrastructure and governance: Leadership is key and the commitment to well-being is promoted from the main Board through operational management to every part of the business. Each division has a senior executive who champions the agenda on behalf of their Chief Executive and those champions meet regularly to share ideas and exchange best practice. Divisional action plans are refreshed annually to align with business objectives and the overall Group strategy. Support is provided by a small group of health, safety and well-being specialists who quality assure activities, stimulate innovation and ensure that an evidence-based approach is adopted. Well-being leads in each line of business tailor the messages about the importance of health issues and cascade them to the workforce to raise awareness. For instance, the Consumer business use their radio channel and the plasma screens in their contact centres, and the Openreach business use their in-house magazine. The Communication Workers Union (CWU) and Prospect have an agreement with BT which covers the role of health and safety representatives, formalizes arrangements for training, and fosters co-operation between management and employee representatives. Their partnership with management enables health and safety issues to be addressed in a non-political and non-confrontational manner. For example, BT's health and safety representatives worked with managers to form and promote a strategy on tackling health issues entitled 'Work Fit'. Dr. Catherine Kilfedder, BT's Head of Wellbeing (up to September 2017), said: '*On the health and wellbeing*

side, all the evidence suggests that a participative approach, a not 'done to' but 'done with' approach, is most effective.'

All of our health promotion initiatives are developed in conjunction with the CWU and Prospect, often in partnership with a relevant non-governmental organization (NGO), then cascaded through our lines of business by the wellbeing and communications leads. Where possible, we try to identify a senior business champion who will provide high-level visibility and promotion for these initiatives.

We think it is important to identify and utilise your 'champions', those with interest and enthusiasm for the area.

Implementation Challenges and Experiences that Arose in the Course of Delivery

One of the continuing challenges for BT is to ensure that any well-being and mental health content is globally applicable. This is not just in relation to language but also in terms of the legal and regulatory framework and cultural context. Given the diverse nature of the BT workforce, communications needed to be tailored and delivered using local channels rather than solely relying on group level push out. BT has learned that programmes need to be continually re-profiled and refreshed as individuals tend to pay most attention at their point of need rather than in preparation for a time when they may need to call on information or services. Simplicity is also key, as unless advice and tools are practical and easy to use they will gather dust on the shelf.

Key Recommendations for Replication

Each organization is different in terms of its market sector, workforce demographics and stage of evolution in terms of the broader well-being agenda. It is, therefore, crucial for mental health interventions to be tailored rather than attempting direct 'lift and shift' implementation. There are, however, some generalizable ingredients for success, namely:

- Embed mental health interventions into your business and wider well-being strategies. Without this they risk being seen as isolated 'nice to haves' rather than core, integrated activities.
- Ensure that there is visible, senior support and sponsorship of the wider well-being agenda, including for mental health. Traction can be limited in the absence of this.
- Manage and support people across the full spectrum of mental health and ill-health. The latter can range from the widely prevalent 'common mental health problems'—such as anxiety or depression—to the more severe and enduring psychiatric illnesses like bipolar disorder.

- Offer a range of delivery and intervention modalities such as self-help, line management and peer group support, external services such as EAP and cognitive behavioural therapy (CBT).
- Monitor mental health metrics regularly to target areas for intervention, measure progress and identify signs of deterioration so that these can be addressed at an early stage.

Future Directions for Application of the Intervention

In 2016, BT reviewed its Wellbeing framework in the context of emerging evidence and world-class thinking. Key drivers of Health (particularly mental health), Security, Relationships and Purpose were identified and a gap analysis of information, products and services undertaken. This provides the blueprint for developments over the next few years.

To track progress, a new question has been incorporated into the twice yearly employee survey asking about overall life satisfaction. Further work is underway to integrate the principles and associated behaviours into *Management Essentials* training (which focuses on the direct impact people managers have on how their teams feel about their jobs, the organization and customers with a suite of tools, videos and training modules to help managers get things done in the right way) and *Connected Leaders*, BTs Leadership Development Programme (which emphasizes the crucial role of leaders in creating the right culture and role modelling the right behaviours throughout the employee lifecycle).

Our Resources

BT has a wide range of resources to support mental health and well-being that are held on the company's intranet and can be accessed by direct contact with the well-being leads. Examples include:

- *Managing pressure*: An online resource designed to help people understand, manage and cope more effectively with stressful situations. It covers the distinction between pressure and stress, coping techniques and sources of support.
- *Work Fit:* Conceived in 2004 as a joint initiative with the BT unions, the CWU and Prospect, it aims to promote small behavioural changes which, if sustained, will have a long-term impact on well-being. Each year BT runs an initiative for World Mental Health day – in October 2015, they partnered with MIND and Time to Change to launch their own 'Time to Talk' micro-volunteering opportunity.
- *Managing mental health:* A one-day workshop for people managers based on the Mental Health First Aid movement from Australia that focuses on increasing the awareness and understanding of common mental health problems and enhancing confidence in dealing with such problems in the workplace.

- *Dealing with distress:* A resource pack outlining the key issues for managers to be aware of when dealing with people in distress. The information emphasizes acting on early warning signs, particularly where there is a perceived risk of self-harm, with appropriate support.
- *Mental health dashboard:* A monthly synthesis of data drawn from a number of sources to identify current status and trends in mental health-related problems in all of BT's lines of business.
- *Passport:* A document that can be completed by individuals with potentially long-term or recurring health issues, or demanding personal circumstances such as caring responsibilities, and agreed with their manager to facilitate management of the individual at work. This can then be carried forward into other roles with a new manager with the consent of the individual concerned.
- *Open Minds: Heads First:* A purpose designed downloadable guide on mental health issues for both employees and managers with practical advice and direction to appropriate resources. The guide covers the continuum of mental health issues from the early signs of distress to severe and enduring mental ill health.
- *Employee assistance programme:* A self-referral service consisting of both counselling and advice lines, akin to the Citizens Advice Bureau, which is available 24/7.
- *Employee assistance management:* A team of trained counsellors available to line managers and HR to provide support in difficult people situations.
- *Well-being, mental health and resilience toolkits:* Short downloadable guides to the key well-being, mental health and resilience resources.
- *Resilience training:* A portfolio of 2 day, 1 day and online training resources for people managers and individuals. The aim is to provide knowledge and skills to build personal and team resilience thereby enhancing well-being, engagement and performance.
- *Healthy change:* A set of collateral focussed on creating 'good' work through change, mitigating the potential negative effects, providing support to people and managers, as well as measuring and monitoring any people impacts.

Further details are also accessible from British Telecom's Delivering Our Purpose report (2016/17) at: https://www.btplc.com/Purposefulbusiness/Deliveringourpurpose/index.htm

Conclusions

This chapter reviewed the factors that influence mental health in the workplace and the range of intervention approaches that can be adopted to protect and promote employee mental health and well-being. While it is acknowledged that the evidence base needs to be strengthened in determining the most effective interventions for mental health promotion in the workplace, it can be concluded from the available evidence that a comprehensive and integrated approach, which combines both individual and organizational level interventions, is more likely to be effective. Effective

workplace approaches address the physical, environmental and psychosocial factors influencing mental health in the workplace, they strengthen modifying factors such as management practices, social support, control over decision-making and effort-reward balance, and provide skills and competences for addressing short-term and long-term responses to work-related stress. Despite the lack of robust evaluation studies, especially in relation to organizational level interventions and comprehensive approaches, the following generic principles of good practice for workplace mental health promotion can be identified based on the research and interventions outlined in this chapter:

- Supportive policy: workplace policy, legislation and regulations have a critical role to play in protecting and supporting mental health in the workplace. This includes integrating mental health promotion into the delivery of Health and Safety, and workplace health promotion initiatives, including the implementation of management standards and policies for addressing the sources of work stress such as overwork, job insecurity, bullying, harassment and work-life conflict.
- Supportive psychosocial structures: management and environmental structures need to be put in place in order to support good communication and social support among staff.
- Comprehensive theory-based interventions: using a theoretical model will inform the development of a comprehensive ecological approach combining individual and organizational factors in addressing the complex relationships between work, stress and mental health.
- A holistic health focus: promote good mental well-being by designing work processes and workplaces that promote and protect both the physical and mental health of employees.
- Managing change: reduce feelings of job insecurity and fear of the future by encouraging transparent organizational processes, which engage employees' in decision-making and as active partners in the change process.
- Tailor intervention programmes to the needs of the particular worksite: assess the needs and resources within the organization in relation to different types of stressors, modifying factors and responses.
- Adopt participatory approaches: involve key stakeholders at each stage of programme planning, implementation and evaluation. It is important to take account of the viewpoints of different stakeholders in the organization in designing an intervention. Incorporate a joint employee, union and management committee as a key component of interventions with the role of top management and union representatives being crucial in ensuring that all participate.
- Establish an organizational infrastructure: comprehensive interventions require a mechanism for integrating the change process at the different systems levels. This may involve setting up a Steering Group or some other organizing structure within the workplace to initiate organizational change. Such a structure needs to foster open communication and shared decision-making and clarify key roles and responsibilities for participant members. Different interventions require dif-

ferent roles, with each role requiring different skills, such as the role of expert, advocate, enabler and the change facilitator. Clarification of structures, roles and responsibilities is critical to good intervention planning and delivery.

- Evaluate programme outcomes and process: monitor and evaluate the implementation and effectiveness of workplace interventions particularly with regard to their cost-benefit. Document programme impact in terms of indicators of employee well-being, reduced stress, absenteeism and improved productivity and job satisfaction.
- Sustainability: comprehensive interventions that are of longer duration and are tailor-made for specific employee groups tend to be more effective. Sustaining such programmes in the long-term requires the support of senior management so that ideally, they become an integral part of the organizational culture and management practices.

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Addressing Mental Health Problems at Work

Margaret M. Barry

Introduction

Common mental health problems, such as depression and anxiety, are the leading cause of sickness absence and long-term work disability in most developed countries (Joyce et al. 2016). Psychosocial risk factors in the workplace have been found to increase the risk of anxiety, depression and burnout (Jané-Llopis and Anderson 2005; Joyce et al. 2016; Harvey et al. 2017). The mental health impacts are significant because mental health problems occur frequently and they often go unrecognized and untreated. According to the World Health Organization, 8% of depression disorders across the globe can be attributed to risk factors in the workplace (WHO and Burton 2010). Unrecognized mental health problems at work, such as depression and anxiety, contribute to reduced productivity, low job satisfaction, absence from work and increased health care costs (Tennant 2001; World Economic Forum 2016; WHO 2010). Both exposure to specific acute stressful experiences or trauma at work and long-term exposure to stressful occupational factors can contribute to psychological disorders such as anxiety and depression, burnout (state of physical, emotional and mental exhaustion) and substance misuse (Teannant 2001). Harvey et al. (2017) in their systematic review reported that three broad categories of work-related factors were found to contribute to the development of depression and/or anxiety: imbalanced job design, occupational uncertainty and lack of value and respect in the workplace.

M. M. Barry (✉)
WHO Collaborating Centre for Health Promotion Research,
National University of Ireland Galway, Galway, Ireland
e-mail: margaret.barry@nuigalway.ie

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Cognitive Behaviour Therapy Approaches

As indicated in Chapter 'Promoting Mentally Healthy Workplaces', cognitive behavioural interventions have produced the best results at the individual level on reducing anxiety, depression and burnout, especially in the short term. Cognitive behaviour therapy (CBT) approaches explore the link between an individual's emotions or affect, cognitions (thoughts, beliefs and perceptions) and behaviours and aims to improve mental health by changing unhelpful and distorted cognitions and behaviours, improving emotional regulation and personal coping strategies. Tan et al. (2014) conducted a systematic review and meta-analysis of universal interventions in the workplace focussing on depression. Nine randomized control trials were included in the study, five of which were based on CBT, two were focussed on mental health literacy, one was an exercise intervention and one was a team-based participatory intervention. The overall effects, while positive, were small. The CBT interventions, when analysed separately, produced stronger evidence. In their review of workplace interventions for common mental disorders, Joyce et al. (2016) found moderate evidence for primary interventions focussing on enhancing employee control and physical activity; however, the impact on work-related outcomes such as sickness absence was found to require further research. Similar to Tan et al. (2014), they reported stronger evidence for individual CBT-based interventions. Bhui et al. (2012) studied the evidence of stress management on anxiety, depression and absenteeism. While pointing out the gaps in the evidence, they found positive results for CBT at an individual level and for physical activity interventions in reducing absenteeism. Hill et al. (2007) also report evidence for the effectiveness of CBT and multimodal approaches in reducing psychological ill health; however, the evidence was more mixed in relation to organizational interventions. Most of the evidence reviews report a lack of focus on the role of organizations, mixed findings in relation to the impact on work-related outcomes and a lack of process evaluation in the majority of studies conducted to date.

Improving Awareness and Addressing Stigma

Despite the prevalence of common mental health problems, many employees are reluctant to disclose their difficulties at work or to seek help due to factors such as lack of awareness, stigma and fear of possible negative consequences for their careers and future employment. The workplace can play an important role in facilitating help seeking and early intervention for common mental health problems. There is some evidence to suggest that workplace screening for depression followed by outreach intervention and care management can have positive effects on clinical and work productivity outcomes (Wang et al. 2007). Follow-up telephone interventions, for example, were found to facilitate access to treatment (both psychotherapy and anti-depressant medication), to help monitor progress and to support adherence

to treatment. Such interventions were found to reduce depression levels at 1-year follow-up and lead to greater job retention and more hours worked.

This proactive model of early intervention in the workplace that provides screening followed by care management, usually involving CBT, for those found to be either experiencing or at risk of developing depression and anxiety disorders has been replicated in other countries, with research reporting it to be effective in reducing depression and productivity losses in workplaces. Economic analyses of workplace screening and care management for depression and anxiety disorders at work have been shown to deliver cost benefits for organizations, leading to improved employee mental health and wellbeing and productivity, with the costs of the intervention outweighed by the gains to business due to a reduction in presenteeism and absenteeism (McDaid et al. 2011; Whiteford et al. 2005). Godard et al. (2006) also report that a structured intervention implemented in the medical centres of a large company, which combines detection with provision of information on professional help sources, can have a positive effect for employees with anxiety and depression and help to prevent relapses. It is important to note that these positive effects for screening are found only when it is combined with tailored follow-up and care management. The use of screening without effective follow-up support and treatment is not recommended as it may increase stigmatization for the individual employees concerned and lead to increased distress. Computerized CBT courses and online supports have also been introduced in workplaces with the advantage of being potentially easier to access and cheaper to deliver and also less stigmatizing. A meta-analysis of the evidence supports the view that Internet-based psychological interventions can facilitate greater access and be effective in increasing psychological wellbeing and work effectiveness (Carolan et al. 2017).

In managing mental health problems in the workplace, the issue of stigma and lack of recognition of mental health problems needs to be addressed, in order to ensure that appropriate supports are provided and that employees are enabled to avail of them when needed. Mental health literacy and the stigma surrounding mental ill health are addressed more fully in Chapter ‘Implementing Mental Health Promotion Approaches in Mental Health Services’, including an overview of awareness raising and stigma reduction approaches. In terms of the workplace, examples that have been applied in practice include the Australian developed Mental Health First Aid, which aims to educate employees in identifying the early signs and symptoms of mental disorders and how they can assist others experiencing mental health problems. Some positive results have been found when applied in Australian workplaces, leading to improved mental health knowledge, less stigmatizing attitudes and improved confidence and help provided to others (Kitchener and Jorm 2004). See further details of Mental Health First Aid in Chapter ‘Implementing Mental Health Promotion Approaches in Mental Health Services’. The active promotion of mental health awareness and supports in the workplace need to be embedded within the workplace culture and management practices so that employees are supported to discuss their mental health concerns and all key stakeholders are committed to implementing evidence-based policies and interventions that support employees with mental health problems and disorders.

The Australian organization *beyondblue* has developed national training programmes and initiatives specifically for workplaces. The multicomponent Workplace and Workforce programme included engagement and partnership activities with workplaces, the National Workplace Program, eLearning resources, Doctors' Mental Health Program, specific targeting of SMEs, return-to-work guidelines and evidence-based research. In 2014, the national programme evolved into the Heads Up intervention, developed by *beyondblue* and the Mentally Healthy Workplace Alliance in collaboration with business, government and the mental health sector. Heads Up aims to increase the knowledge and skills of staff, managers and human resources personnel in addressing mental health in the workplace. This initiative uses an evidence-based approach and focusses on the following:

- Increasing the awareness and understanding of anxiety, depression and suicide in the workplace.
- Having a conversation with someone you are concerned about.
- Building confidence to support a colleague or employee who may be experiencing anxiety and depression.
- Supporting recovery at work.
- Creating a mentally healthy workplace.

(*beyondblue* 2015)

The programme is delivered through a series of workshops, which are developed to accommodate different levels in an organization, from management level through to all staff. Practical tools and resources are provided to assist in creating a mentally healthy workplace and addressing mental health in relation to increasing awareness and understanding within organizations and strategies for employees, managers and HR professionals (*beyondblue* 2015). Heads Up has a dedicated website, which has free tools to assist organizations improve mental health in the workplace, and a marketing campaign to encourage organizational leaders to take action on promoting mentally healthy workplace environments. Heads Up also provides engagement and partnership activities for business groups, industry and other stakeholder groups. Evaluation of the *beyondblue* workplace programme and the Heads Up initiative shows some promising indicators in terms of marketing the initiatives to workplace leaders, with positive responses to the website and use of the online tools, the take-up of new practices across a range of workplaces and reduced levels of stigma and discriminatory attitudes among workplaces registered with Heads Up (O'Donoghue et al. 2015).

Unemployment and Mental Health

In recent times employment has become more precarious for many people, particularly with respect to global economic crises and recessions and the subsequent increase in levels of unemployment, job insecurity and financial insecurity. Across countries in the European Union, 16% of workers report feeling that they could lose

their job in the next 6 months (Eurofound 2017). Job insecurity has been shown to have negative consequences for employee mental health and wellbeing (International Labour Organization 2016; De Witte et al. 2016; Silla et al. 2009) and can be as detrimental as the effects of unemployment (Griep et al. 2016).

The negative impact of unemployment on health is well-documented (Dooley et al. 1996; Paul and Moser 2009; Goldman-Mellor et al. 2010; Pharr et al. 2012). Unemployed people have poorer physical and mental health and higher rates of mortality (Gerdtham and Johannesson 2003). There is a strong association between worklessness and poor health. This may be partly a health selection effect, but it is also to a large extent cause and effect as there is strong evidence that unemployment is generally harmful to health, leading to:

- Higher mortality.
- Poorer general health, long-standing illness, limiting long-standing illness.
- Poorer mental health, psychological distress, minor psychological/psychiatric morbidity.
- Higher medical consultation, medication consumption and hospital admission rates.

(Waddell and Burton 2006, p. viii)

Unemployed people report experiencing higher levels of anxiety, depression, uncertainty about the future, anger, shame and loss of self-esteem following job loss (Breslin and Mustard 2003). The duration of unemployment also tends to have a cumulative effect in that those who are unemployed longer report the greatest level of psychological distress (Milner et al. 2014). An association between unemployment and suicide has been found in a number of studies (Gerdtham and Johannesson 2003; Johansson and Sundquist 1997). Blakely et al. (2003), based on analysis of data from the New Zealand census over a 3-year period, found that being unemployed was associated with a two- to threefold increase in relative risk of death by suicide compared with being employed. However, in determining the direction of causality, the role of mental health problems in both suicide and unemployment needs to be taken into account (Milner et al. 2014).

Social protection and social security systems provide an important safeguard to ensure the provision of basic financial security and health services for those who are unemployed. Under the 2008 UN Declaration on Human Rights, countries are obliged to put in place adequate systems to ensure the right to social security; however, this provision is far from universally available. The concept of a 'social protection floor' was adopted by the ILO in 2016, providing an internationally agreed basis for the provision of appropriate social protection systems at the national level, including income security and rehabilitative measures to enable workers to access supports and rejoin the workforce. Social protection interventions such as Active Labour Markets Policies (ALMPs) and welfare-to-work policies have been widely used across OECD countries to increase employability through improving skills and experiences that may lead to employment and reduce the risk of further unemployment. ALMPs include activities such as job search assistance, training and wage and unemployment subsidies. In reviewing the evidence on the impact of such

approaches, Coutts et al. (2014) report that participation in ALMPs has been found to lead to: a range of positive outcomes such as reduced psychological distress and depression, increased subjective wellbeing, higher levels of control, improvements in motivation and self-esteem and improved social support.

Social protection policies such as ALMPs and welfare-to-work interventions have been found to protect health and mitigate the negative effects of unemployment on health and wellbeing in times of economic downturn and rising unemployment (Stuckler et al. 2009, 2011). In an analysis of a large data set from 26 European Union countries over the period 1970–2007, Stuckler et al. (2009) found that every 1% increase in unemployment was associated with a 0.79% rise in suicides at ages younger than 65 years. This study also reported that the presence of strong social welfare policies and investments in ALMPs appeared to offer protection against the negative impact of unemployment on mental health. In countries where there was relatively less spending on ALMPs, a direct correlation was found between increases in unemployment and short-term increases in suicide rates, whereas in countries where they were strong social protection systems, the rise in unemployment was not found to be associated with a rise in suicide rates.

A number of specific interventions have been developed with the aim of improving the mental health of those who are unemployed and improving their chances of finding a job (Price and Kompier 2006). Re-employment, particularly in good-quality jobs, has been shown to one of the most effective ways of promoting the mental health of the unemployed (Schuring et al. 2010). An example of a large-scale intervention designed to assist job search through enhancing self-efficacy is the Jobs programme, which has been developed and successfully implemented across a number of different countries. Details of the programme and its adaptation across cultures will now be examined.

Practice Example: The JOBS Programme (Caplan et al. 1989; Price and Vinokur 1995a, b; Vinokur et al. 2000)

The JOBS Intervention Project, developed by researchers at the University of Michigan (Caplan et al. 1989; Vinokur and Schul 1997), was designed as a preventive intervention for unemployed workers. This intervention targets job loss as one of most consistent antecedents of depression and aims at providing job-seeking skills to promote re-employment and to combat feeling of anxiety, helplessness and depression among the unemployed. The intervention goals are to prevent the deterioration in mental health of unemployed workers, which often results from job loss and prolonged unemployment, and to promote high-quality re-employment. While the intervention is aimed specifically at enhancing job search skills, it also incorporates several mental health promotion elements such as enhancing participants'

self-esteem and sense of control, job search self-efficacy and inoculation against setbacks.

A programme of research at the Institute for Social Research at the University of Michigan produced detailed information on the problems facing unemployed persons and their families, particularly those associated with job search (Caplan et al. 1989), economic hardship (Vinokur et al. 1991a, b) and family difficulties (Howe et al. 1995; Price et al. 1998). After a series of studies documenting these problems and analysing the needs of unemployed workers and their families, the Michigan Prevention Research Center (MPRC) developed and evaluated the JOBS programme to aid unemployed workers to effectively seek re-employment and cope with the multiple challenges and stresses of unemployment and job search (Caplan et al. 1997; Price and Vinokur 1995a, b).

The JOBS programme has been evaluated and replicated in randomized control trials involving thousands of unemployed workers and their partners (Caplan et al. 1989; Vinokur et al. 1995). The programme returns unemployed workers to new jobs more quickly, produces re-employment in jobs that pay more (Vinokur et al. 1991a, b) and reduces mental health problems associated with prolonged unemployment (Vinokur et al. 1995), particularly among those most vulnerable to mental health problems (Price et al. 1992). In addition, the programme has been shown to inoculate workers against the adverse effects of subsequent job loss (Vinokur and Schul 1997). The JOBS programme also inoculates participants against subsequent job-loss setbacks because they gain an enhanced sense of mastery over the challenges of job search (Vinokur and Schul 1997).

Programme Content

The intervention consists of five intensive and active half-day workshops held over a 1–2-week period. The intervention, in the form of training seminars, applies problem-solving and decision-making group processes, inoculation against setbacks and social support together with learning and participatory job search skills. Pairs of male and female trainers work with groups of 12–22 people. The programme aims to:

- Enhance the job seeking skills of participants.
- Increase the self-esteem, confidence and motivation of the participants in their job search.
- Fortify resistance and persistence in the face of setbacks and barriers.
- Use confidence and skills to achieve re-employment in stable settings.
- Extend the benefits to the family of the job seeker.

The essential components of the programme model include:

- Content that focuses on the enhancement of job search skills.
- Delivery format with two trainers conducting a workshop.
- Delivery process of training that maximizes active learning processes, as opposed to didactic passive learning.

The JOBS Manual for Teaching People Successful Job Search Strategies (updated version by Curran et al. 1999) is a structured guide that describes the steps necessary for setting up and implementing the programme: the process of hiring trainers, the training period for the trainers and the intervention seminars.

Programme Evaluation

The intervention was originally tested through two large randomized field studies, JOBS I and JOBS II, conducted with recently unemployed people (Caplan et al. 1989; Vinokur et al. 1995, 2000). With a follow-up period of 2.5 years post-intervention, the programme has produced impressive results indicating that participants in the intervention group achieved significantly better employment outcomes in terms of better quality and higher-paying jobs and also improved their mental health through enhanced role and emotional functioning and reduced depressive symptoms. Using prospective screening, JOBS II also indicated increased benefits to high-risk participants in reducing depression symptoms. In particular, programme participants in comparison to the control group showed the following:

- Higher confidence in job-seeking ability.
- Greater sense of self-efficacy.
- Lower levels of depression.
- Found re-employment sooner (53% intervention vs. 29% control).
- Higher quality and better paid jobs at 2.5 years follow-up.
- Intervention particularly beneficial to participants at high risk of depression.
- Lower incidence and prevalence of depression at 2.5 years.

Vinokur and Schul (1997) analysed the programme's outcomes to establish the mechanisms though which this intervention produced its significant effects. Enhanced sense of mastery and inoculation against setbacks emerged as significant mediators of the intervention effects on re-employment, financial strain and depression symptoms, particularly so for the high-risk group. Choi et al. (2003) also examined the supportive and skill-building group process of the programme and found that the participants' improvements in self-efficacy were a critical factor for successful job-search outcomes. The programme has demonstrated that it clearly yields mental health benefits, economic benefits and benefits for those who would be most disadvantaged by job loss. Benefit-cost analyses show that the Jobs programme brought a threefold return on investment after 2.5 years and projected more than a tenfold return after 5 years, due to increased employment, higher earning outcomes and reduced health service and welfare costs (Caplan et al. 1997; Vinokur et al. 1991a, b). The JOBS programme, therefore, promotes positive mental health for unemployed workers, prevents the onset of depression among those at highest risk and is cost-effective in terms of increased economic benefits for participants and the State.

Replication of the Programme

The Michigan Prevention Research Center (MPRC) has worked collaboratively with practitioners in replicating the JOBS programme in many different countries. This takes the form of provision of the programme intervention, training the trainers

and data-collection instruments for the evaluation. This programme has been disseminated in other countries outside the United States including China, Korea and Finland (Vuori et al. 2002) and has also been implemented in the Netherlands and Ireland.

In Finland, the JOBS programme was adapted as the Työhön Program and was scaled up successfully at a national level by the Finnish Institute of Occupational Health in collaboration with the Ministry of Labour. At the 6-month follow-up, the Työhön Program significantly increased the quality of re-employment in terms of permanence of the attained jobs, especially for those at risk of long-term unemployment. The Työhön intervention also significantly decreased symptoms of distress (Vuori et al. 2002). At the 2-year follow-up, the Työhön intervention significantly increased active participation in the labour market, with programme participants being either employed or participating in vocational training. The intervention also significantly decreased symptoms of depression and increased self-esteem (Vuori and Silvonen 2005). Research also found that the programme was effective by improving job-seeker motivation and preparation for job searching (Vuori and Vinokur 2005).

In Ireland, the JOBS programme was adapted as the Winning New Jobs (WNJ) programme and was implemented on a cross-border basis in Northern Ireland and the Republic of Ireland in collaboration with local training and employment and health agencies in the border region. WNJ was delivered to a mixed profile of participants, including those who were long-term unemployed and mental health service users who were deemed to be job ready. An evaluation from a quasi-experimental trial showed that the programme produced positive long-term results, particularly with regard to re-employment. Specifically, 47.7% of the intervention group were employed compared to 16.8% of the comparison group at the 1-year follow-up. WNJ also had a positive effect in reducing economic hardship and enhancing inoculation against setbacks for programme participants (Reynolds et al. 2010).

In Finland, the programme has also been adapted to promote career management and mental health for those encountering critical transitions and challenges in the work life course. Young people entering the workforce after finishing school or college and older workers who do not wish to finish employment at the traditional retirement age are an example of two groups at such transitional periods. The JOBS programme has been adapted by the Finnish Institute of Occupational Health for implementation at both of these transitional points: for adolescents making the transition from school to work and for those in the workplace who are approaching retirement. The School-to-Work (STW) Program was developed to enhance readiness for employment among graduates of vocational schools in Finland. The key implementation features of the original JOBS programme were utilized together with the programme adaptation for delivery in the vocational college setting. The STW was developed to address the key challenges faced by young people in making the transition from school/college to good-quality work, i.e. finding employment that fits with their educational background and career plans and fitting in socially in their workplace to allow themselves to make their first job as secure as possible while also pursuing future career opportunities (Nykänen et al. 2014).

A randomized experimental field trial (Koivisto et al. 2007) of 17- to 25-year-olds making the transition from vocational college to work found that the participants in the programme were 1.7 times more likely to be employed in the 6 months after they had completed their education and were more likely to be in a job corresponding to their education and personal career plans. The programme also had beneficial mental health effects including a significant preventive effect on psychological distress and depression symptoms among those initially at risk of depression (Koivisto et al. 2007). A case study on the adaptation of the JOBS programme for people approaching retirement in Finland will now be presented.

Case Study: Promoting Career Management and Mental Health: Towards Successful Seniority Programme

Jukka Vuori · Salla Toppinen-Tanner · Mikko Nykänen
Finnish Institute of Occupational Health, Helsinki, Finland

Richard H. Price
University of Michigan, Ann Arbor, MI, USA

Background

The Finnish Institute of Occupational Health (FIOH) has developed a series of preventive programmes to address the challenges of the work life course of employees. This developmental work is based on the original work undertaken at the Michigan Prevention Research Center (MPRC) with the JOBS model in the field of unemployment and mental health, as outlined earlier (Price and Vinokur 1995a, b; Vuori and Price 2015).

At FIOH the initial success of the adapted JOBS model in the 1990s in Finland first led to a new application for vocational school graduates who often have difficulties during the transition to working life. Later on, based on the general group training principles of MPRC (Vuori et al. 2005), FIOH has developed a variety of programmes aimed at promoting career management and mental health for a host of critical transitions and challenges throughout the work life course. These transitions include choosing between vocational and academic study track after basic education, returning to work after family leave, managing mid-career changes, managing mental health-related early retirement and managing late career and retirement. In this case study, we present one of these programmes, namely, the Towards Successful Seniority (TSS) programme.

The TSS programme was developed at FIOH to enhance career management, mental health and job retention in work (Vuori et al. 2014). The proximal aim of the training programme is to enhance participating employees' career management preparedness, and the aim for more distal effects of the programme is to

decrease disabilities and long-term sickness absences due to mental health reasons at work. It also helps employees with high mental strain to cope with the demands of work. The central idea is to intervene early when employees are expressing early signs of symptoms or lack of work motivation, which could lead into more severe disability or lack of productivity in the long run. These kinds of situations may happen to anyone at certain points during one's life course and working career. Early prevention is beneficial also for the organizations, because with smaller investments, they may maintain a healthier personnel and reduce turnover and costs related to disability (Iijima et al. 2013; ISSA 2011).

The Programme

The programme consists of 4 half-day workshops held over a 2-week period with a focus on identifying personal skills and strengths; increasing self-esteem, confidence and the work-and career-related motivation of participants; and improving skills for self-care and building social support networks. During the workshops participants also practise assertiveness, change management and inoculation against career setbacks. The TSS programme is delivered by two trainers to employees or supervisors of a workplace. The groups consist of 12–20 participants. We recommend a two-trainer model where one of the trainers comes from the human resources management and the other from the occupational health services, when it is possible. Trainers facilitate the group by discussions, modelling and role playing and encouraging active participation from all participants. They give positive feedback and encourage disclosure and sharing of information between the participants.

Evaluation

The efficacy of the programme was tested in a randomly assigned field trial in 17 work organizations across the public and private sectors in Finland. The majority of the organizations reported significant organizational changes, such as organizational restructuring during the study period (Vuori et al. 2012). A total of 718 eligible individuals from these organizations participated in the study. The trial demonstrated that participation in the workshops had a significant beneficial effect on career management preparedness (Vuori et al. 2012). The results also showed how improved preparedness for career management led to an increase in intrinsic work-goal motivation (Salmela-Aro et al. 2012).

In the long term, at the 7-month follow-up, participation in the workshops had significantly decreased depressive symptoms, increased work ability-related mental resources and decreased intentions to retire early. This is important, since it has been demonstrated how depressive symptoms can gradually accumulate into full-blown depression (van de Leemput et al. 2013). Moreover, the intervention also

seemed to show beneficial effects on work engagement in the 7-month follow-up. Participants with an elevated level of depression or exhaustion at baseline benefited more from the workshops than those with lower levels of depressive symptoms (Vuori et al. 2012). Causal analyses (Baron and Kenny 1986; Preacher and Hayes 2008) demonstrated how the proximal increase in career management preparedness among the participants just after the workshop mediated the longer-term beneficial mental health and career effects.

Moreover, the programme proved successful as a form of selective preventive intervention against depression among those who suffered from job stress at baseline (Ahola et al. 2012). This important finding demonstrates that the adverse effects of job strain on depression, weak productivity and work disability can be combated within organizations, through training and collaboration. Further analyses, after merging the intervention study data on an individual level with register-based data of the participating organizations on sickness absences, showed that the intervention also was effective in decreasing the number of long-term sickness absences, especially among those employees with many long long-term absences (Toppinen-Tanner et al. 2016).

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

The pressure for longer careers at workplaces had become generally acknowledged in Finland already during the 1990s, but workplaces lacked preventive tools for supporting longer careers. The motivation for prevention was clear, as the workplaces are made responsible for disability costs of their previous employees. In Finland, occupational rehabilitation was generally used for early prevention of work disability due to mental health problems, especially job strain and burnout. Occupational rehabilitation was financed and organized by the Social Insurance Institution (KELA). When the early signs of risk for disability were spotted at the workplace, occupational health services and human resources of the workplace could apply for occupational rehabilitation for an employee. Usually this was arranged outside the workplace in a rehabilitation institution where employees took part in several kinds of recuperation activities and psychological consultation.

At the same time, there were critical opinions against this kind of rehabilitation for having not shown long-term beneficial effects on employee wellbeing. This was mostly because the activities were organized outside the workplace context and the positive development at the rehabilitation institutions did not seem to transfer and be maintained at the workplace. Due to the timely topic of longer careers and the needs of the companies to actively prevent work disabilities even earlier than actual rehabilitation was needed, recruiting of the organizations for our research project was relatively easy.

Implementation Challenges and Experiences that Arose in the Course of Delivery

The development and testing of the programme was sponsored by the Work Environment Fund, the State Treasury and the FIOH. During the field test period, the positive experiences of the participating workplaces spread, and other organizations became interested in the programme. Also the majority of the participating companies were interested in continuing and disseminating the programme based on their own positive experiences on the effects of the programme both on participating employees and their trainers. The programme also won the first prize (tie) of the Best Intervention Competition of the Work, Stress and Health Conference arranged by APA/NIOSH in 2008.

The programme delivery was first based on the field experiment and developmental phase of the method but also on the multidisciplinary expert group participating in the development of the programme prototype. The group included experts with connections to, e.g. governmental mental health programmes MASTO and the European Network for Mental Health Promotion http://www.mentalhealthpromotion.net/?i=portal.en.

Some of the organizations taking part in the field experiment also wanted to provide them to their clients. Several of the participating organizations included the programme in their own activities as a central part of developing mental health support for their own personnel. For instance, a large geographically dispersed governmental organization wanted training for their trainers nationwide in order to organize workshops for local personnel for supporting their organizational merger and adjustment to a new organizational culture.

The efficacy results regarding the effects of the STT programme were presented in many seminars and mental health conferences and meetings, often together with case presentations from the organizations which took part in the field experiment phase. The dissemination was further strengthened by the results of the field experiment, which showed the beneficial effects of the programme on mental health and work career.

However, almost immediately after the field phase and the publication of the method for the general public in 2008, the economic recession started and had a marked effect on the willingness of organizations to invest in preventive programmes. This was evident especially with programmes focussing on building resources and not directly dealing with the treatment of disorders.

During this time of economic constraints in work organizations, lack of resources for consultant services and researchers moving into other new areas at FIOH meant that, albeit dissemination activities of the programme were steady, they were occasionally less intensive. After a positive change in the economic situation of organizations since the mid-2010s, there has again been a marked increase in the interest in the programme. A cooperation agreement has been made with a large insurance company on disseminating the programme in order to maintain the work ability of aging employees.

So far about 200 trainers have been trained and almost 600 Trainer's Manuals and 4000 Participant Workbooks have been distributed. One indication of the positive experiences of the users is that many of the organizations participating in the research and development phase actually continued using the method even during the economically tighter times, and some of them have also applied the method to new target groups, such as returners from long sickness absences, occupational groups with highest risk for absences and turnover, young employees with high job strain and aging employees approaching retirement age. FIOH has also organized training for the trainers and transfer of know-how to other countries, such as Brazil and the Czech Republic. With the support of FIOH, they have translated the programme into their own language and are using the programme in their own language area.

Key Recommendations for Replication

The trainer and participant manuals related to the delivery of the programme are designed to be user-friendly and of high-quality material. We recommend using the available Trainer Manuals and Participant Workbooks, which can be found in English and in Finnish in https://ttl.pikakirjakauppa.fi/tuoteryhma/publications_in_english/1754380. The participant's workbook is also available in Swedish on request from FIOH. Training for the trainers is organized by FIOH on a yearly basis as part of FIOH training or on request from customers.

The primary vehicle for disseminating the programme is using the thorough training process of new trainers by a skilled and experienced master trainer. The master trainer is a key figure in the implementation and dissemination process of the entire programme. She/he could also initiate web-based trainer networks for exchange of experiences and provide continuing learning and quality control. The trainers of the Finnish workplaces are trained at FIOH. Trainer training is organized by two experienced trainers, and it lasts for 3 days. During the first 2 days, the trainers learn the method by doing hands-on exercises from the programme. Information on the principles and the effects of the method are also given during the training. The master trainers make sure that everyone understands the training principles and the necessity for implementing the programme as intended, and has plans for implementing the programme after the training. The participants are instructed to organize a pilot group in their own organization or for their clients and to write and return a reflection diary on their experiences from the pilot group before the third day of the training. During the third day, these experiences are shared among participants, and solutions are produced focussing on some key aspects of the training, such as the role of the trainer in the group situation, challenging groups and situations, challenges related to practical issues, etc. Depending on the background of the trainers, the principles of the training may be repeated again, if adopting the facilitator role feels difficult for the trainers.

Strong leadership support for the implementation of the TSS programme is crucial for the success of dissemination in work organizations. At the workplace level, the method should be incorporated in the organizations' prevention or promotion processes, whenever possible. Internal marketing is focal for the programme to succeed. Also the commitment of the trained trainers and their availability is important. The dissemination of the programme can be greatly enhanced by increasing public awareness of the programme and lobbying of the service providers and politicians.

Carrying through successful dissemination may mean that several cooperation networks are established and maintained, including organizations with a potential for system-wide dissemination, such as occupational health service firms, insurance companies, consultant firms and other organizations. Partners have to be well-motivated to implement the method, and it is of substantial advantage if partners have an obvious need for the programme or if the programme benefits them directly through, for example, diminished costs or increased productivity. This might concern their own personnel or the personnel of their clients.

In Finland, many large-scale organizations with well-organized human resources experts and occupational health services have been interested in training trainers, who then can implement preventive workshops in their own organization. These workshops can be implemented within, e.g. training programmes and processes or models for early intervention or programmes for employees at different ages with no need of external on-site support. In smaller organizations with no human resources function, implementation of the workshops may need external support. There are consultants who provide implementation of workshops for organizations directly. FIOH consultants have organized workshops for the workplaces on request since the publication of the programme, and FIOH organizes training for the trainers on a continuous basis.

Future Directions for Application of the Intervention

The STT programme has provided a fertile starting point for other preventive work life programmes. FIOH is developing new evidence-based programmes and services related to STT, including the Work Engagement for Seniority programme for preventing ageism and promoting work engagement among senior employees and the From Family Leave to Work, an extension of STT programme, for employees returning from family leave to work. Moreover, a programme based on STT for supporting career changes among mid-aged employees is under development at FIOH.

Supported Employment and Mental Health

Employment is important in maintaining mental health by contributing to one's sense of identity, but it can be especially important in promoting the recovery of those who experience mental health problems (Boardman 2003). Work and paid

employment plays a central role in the lives of all people and is fundamental to mental health recovery (Chen et al. 2016). Recovery from mental ill health is a personal journey distinguished by a greater participation in usual everyday activities, including employment (Drake and Whitley 2014). A more detailed account of recovery approaches can be found in Chapter 'Reorienting Mental Health Services to Mental Health Promotion'. Strickler et al. (2009) followed a cohort of 120 people with severe mental health disorders over a 16-year period and reported that those who worked consistently in that period reported a number of material, cognitive, structural and mood benefits.

Once an employee is absent with mental health problems for more than 3 months, the likelihood is very high that the absence will last more than 1 year, and if the absence is longer than 1 year, there is a less than 1% chance of the employee returning to work (WHO 2000). Targeted interventions and supports are, therefore, required to facilitate return to work after treatment for mental health problems. An early return to work can be facilitated by accommodating a gradual return to work in negotiation with the employee, allowing for flexible arrangements such as part-time work, flexitime and temporarily changed duties that involve less job-related stress. As far as possible, keeping people in work will help a return to normal life and reduce the likelihood of social exclusion.

There are numerous arguments for promoting employment for those with mental health problems. To date the majority of mental health service users themselves have stated that they want the opportunity to be involved and be a member of the workforce (Secker et al. 2001; Suijkerbuijk et al. 2017). This is supported by human rights declarations which state that 'everyone has the right to work' (United Nations 1948). Article 27 of the UN Convention on the Rights of Persons with Disabilities (CRPD) clearly recognizes that every person with a disability has the right to work, should be treated equally and not be discriminated against and should be provided with support in the workplace. The CRPD provides a legally binding global framework for promoting the rights of people with disabilities, including those with psychosocial disabilities. There are also social and health benefits for all stakeholders involved. Employment can provide monetary gains for an employer and employee but also material benefits for society in the form of economic productivity. Similarly, as more people are involved in employment, social security payments are not being paid out and can, therefore, be channelled into further service and initiative development. It appears that preventing employed people who develop mental health problems from losing their jobs would significantly reduce both the economic costs of increased welfare benefits and the negative psychosocial impact of experiencing social exclusion (Huxley and Thornicroft 2003). The combination of having a mental disorder as well as experiencing discrimination has negative effects on interpersonal relationships. For the worker or employee with a mental health problem or disorder, the benefits of social interaction, activity and a sense of personal achievement that are associated with a workplace environment can all contribute to improved health outcomes.

In a qualitative meta-synthesis of mental health service users' views on finding and sustaining employment, Fossey and Harvey (2010) reported a number of benefits to being employed: remuneration, greater autonomy, status and acceptance within society, structured use of time, a sense of purpose or focus, feeling productive and useful to others, affirmation of ability and opportunities for social contact and personal development. While people with a mental disorder have expressed their desire to work, the existing high rates of unemployment among this population group suggest that there are employment barriers for this group and that the opportunities that do exist may not be appropriate to their needs. Researchers have also reported large discrepancies between the number of people with mental health disorders who would like to be in employment and those who have access to supported employment (Marshall et al. 2014; Drake et al. 2012).

Numerous barriers can contribute to the low uptake of employment opportunities (Boardman 2003). These include: lack of choice in employment services and providers, inadequate work opportunities, complexity of the existing work incentive schemes, financial penalties of working, loss of health benefits, the discriminatory attitudes of employers, low expectations of health professionals and ineffective models of supported employment (Centre for Mental Health 2013; WHO 2000). Because of stigmatization and discrimination, many people with mental disorders find their economic, social and cultural rights curtailed, including the rights to work (WHO 2013). Discrimination can be related to the degree of societal stigma and social exclusion that are demonstrated towards people with a mental disorder (see Chapter 'Implementing Mental Health Promotion Approaches in Mental Health Services' for further details). Many other representatives of society, such as health professionals and GPs, can also underestimate the capabilities of people with a mental disorder in terms of work and employment.

The opportunity to participate in work and employment contributes to the rehabilitation and integration of individuals with serious mental health problems into mainstream society. To achieve this, the attitudes and structures in mainstream society that exclude people with a mental disorder from participating in everyday life need to be reorientated.

Supported Employment Work Schemes

The reform of mental health services in many countries has led to the increased emphasis on community mental health services. However, the importance of work schemes as part of the range of community services to be provided has not been emphasized routinely and thus has resulted in this population group being neglected with regard to integration into society through the medium of the workplace. New opportunities can be offered to develop and mainstream supported employment work schemes, which to date have been run mainly by nonstatutory agencies. The following gives a brief overview of the types of programmes that can guide different services.

There are a number of different types of programmes designed to enable individuals with severe mental disorders to return to employment. Some work schemes offer a period of preparation before placing clients in competitive work, but more recently clients are placed in competitive work immediately while getting 'on-the-job' support. Employing the framework by Suijkerbuijk et al. (2017), a range of specific approaches will now be described.

Prevocational Training

Prevocational training is a stepwise approach in which people with severe mental health disorders are provided with a period of preparation before undertaking competitive employment. Training is provided in generic work skills and personal development modules such as assertiveness and stress management. In some cases there are also specific training programmes that focus on social and cognitive skills (Suijkerbuijk et al. 2017).

Transitional Employment

This model includes the provision of protected employment opportunities for people with disabilities, including sheltered workshops, social firms and cooperatives.

- Sheltered workshops and employment provide a segregated working environment for people with a physical or mental disability and are beneficial as an introduction to a work situation for those who find open employment difficult. However, it does not provide employment in the open market and as a result tends to demonstrate low levels of worker movement and may not be commercially viable.
- Social firms are small- to medium-sized firms or semi-commercial businesses, which have been developed, usually with state support, with the main purpose of providing employment to people with a disability. In social firms people with disabilities work side by side with non-disabled workers and are paid regular wages and work on the basis of a regular work contract. The required support, however, is provided to workers as needed, and an important characteristic of the work environment is the empowering atmosphere for employees with disabilities. A flexible approach is adopted, and there is an emphasis on the potential and abilities of the worker rather than on potential problems and barriers. People with mental ill health experience social enterprises as providing a flexible environment that promotes feelings of belonging, success, competence and individuality (Svanberg et al. 2010).
- Social co-operatives share the same philosophy as the social firm and provide a protected workplace for persons with disabilities. The social co-operatives function independently from the mental health services but maintain a close working liaison with them.

Supported Employment

The development of supported employment for people with a mental disorder in the early 1980s indicated an important shift in rehabilitation services. Supported employment places individuals into competitive employment without prevocational training. An employee is hired and is entitled to the full company benefits. On-the-job support is given to the employee via trained job coaches (Becker et al. 1994) as well as support given to the employer, which ensures programme success. The core principles of supported employment are that the employment services are based on the client's preferences and choices, with continuous assessment and indefinite follow-up support. Rehabilitation is seen as a core component of treatment rather than a separate service, with clients expected to obtain jobs directly and contribute to the community (Boardman 2003). There are a number of different models of supported employment which include:

- Individual Placement and Support: The most widely utilized model of supported employment is individual placement and support (IPS) (Drake et al. 2012). IPS is based on eight principles: eligibility based on client choice, focus on competitive employment, integration of mental health and employment services, attention to client preferences, work incentives planning, rapid job search, systematic job development and individualized job supports (Drake et al. 2012, p. 32). In IPS programmes, support is initially provided in looking for employment, and once employment has been attained, support is provided for as long as necessary on the job. The majority of implementation and research of IPS programmes has taken place in the United States (Gilbert et al. 2013).
- Augmented Supported Employment: Additional interventions, such as skills training or cognitive training, may also be included with supported employment, in order to enhance employment outcomes. These combined approaches have been described as augmented supported employment (Suijkerbuijk et al. 2017).

Evidence

Evaluation studies have been undertaken to determine if the characteristics of different work schemes influence the degree of success people with mental disorders have in obtaining and maintaining competitive employment. Experimental studies show that there is little evidence to support the view that prevocational training is more effective in helping clients to obtain competitive employment. Research by Crowther et al. (2003) shows that a higher number of clients who were placed immediately in supported employment remained employed, earned more money and worked more hours than those who received prevocational training. Evidence reviews indicate that supported employment, in particular IPS programmes, have a stronger effect on employment outcomes than prevocational training (Crowther et al. 2003; Twamley et al. 2003; Lelliot et al. 2008; Mueser and McGurk 2014).

In a meta-analysis involving 48 randomized controlled trials with 8743 participants, Suijkerbuijk et al. (2017) compared the effectiveness of the different types of vocational rehabilitation models, as outlined above, to facilitate competitive employment.

in adults with severe mental disorders. They reported that supported employment and augmented supported employment are more effective in obtaining and maintaining competitive employment compared to prevocational training, transitional employment or psychiatric care only. They also reported that augmented supported employment showed slightly better results than supported employment on its own.

Campbell et al. (2009) report that IPS programmes result in superior competitive employment outcomes for persons with severe mental disorders than vocational programmes regardless of participants' demographic, clinical and employment backgrounds. It is important to note, however, that there will be clients who may not be suitable to participate in immediate supported employment due to the nature of their disorder and the extent of their present capabilities. As an example, in such cases social firms could be a beneficial addition to IPS programmes, as it would enable the participation of individuals across the full spectrum of mental health disorder (Gilbert et al. 2013).

Next we will describe the Clubhouse model, an intervention model that assists people with serious mental disorders in returning to work and has been replicated successfully in many countries around the world. The Clubhouse programme has developed its own set of standards, training processes and fidelity instruments, as well as a programme of research that examines the evidence base for this intervention approach.

Practice Example: The Clubhouse Model Programme (Boardman 2003)

The Clubhouse model is a facility-based intervention designed to offer people with a serious mental disorder membership in a mutually supportive and empowering community. The programme consists of 'clubhouses' where members receive support and services, with the goal of returning to the workplace as productive employees. The Clubhouse approach is based on the principles of meaningful activity and psychosocial rehabilitation, with work being the central factor in its operation (Boardman 2003). The Clubhouse movement arose in the 1950s and proposed that better employment opportunities could be achieved by fostering mental health service users' autonomy in a nonpsychiatric setting. The Fountain House Clubhouse, established in New York city in 1948, represents the original North American application of this rehabilitation approach in which vocational, communal and social services are offered under one roof.

The Programme

The Clubhouse is a building run by clients and staff along egalitarian lines, where clients meet for social activity, mutual support and graded work experience. Membership is voluntary to anyone with a history of mental disorder, unless that person poses a significant threat to the general safety of the Clubhouse community. The Clubhouse programme is designed to help people stay out of hospital while achieving social, financial, educational and vocational goals. The Clubhouse guarantees for members a place to come to and a right to meaningful work, respectful relationships and a place to which they can return. The model is based on a set of basic principles that include a belief that every member has individual strengths to recover from the effects of their mental disorder and to lead a meaningful and satisfying life, and that work and work-related relationships are a critical part of this process. The model includes the delivery of a range of supports tailored to members' needs, including housing, educational, health promotion and employment supports such as transitional employment (TE), supported employment (SE) and independent employment (IE). The Clubhouse programmes involve a period of preparation before clients attempt to return to competitive employment. A Clubhouse in a community seeks to remove the social barriers of stigma and isolation, with membership of a Clubhouse addressing issues such as low self-esteem, low motivation and social isolation that are often experienced by people living with a mental disorder. Participation in a Clubhouse can promote social inclusion and thus facilitates people to lead a more productive and meaningful life within the community. The model is consistent with the recovery approach, with an emphasis on choice, self-determination and community integration. Clients belong to a Clubhouse of their own free will and membership is lifelong. There are over 326 clubhouses in 33 countries worldwide (McKay et al. 2018) affiliated to the International Center for Clubhouse Development (ICCD). The ICCD maintains a well-documented training process and a set of standards that form the basis for a certification process. All certified Clubhouses provide comprehensive case management by trained staff and other community support services, including supported education, supported housing, mobile outreach, medication oversight and supported employment, all of which are designed to integrate members into the wider community outside the Clubhouse. Regardless of how little or how often a member chooses to use a Clubhouse, all ICCD Clubhouses remain a lifetime source of practical support and companionship.

Evaluation

The Clubhouse model has been the subject of an active, international dissemination effort including the development of rigorous quality standards and an international training and certification process. These efforts appear to have standardized the range of programmes that identify themselves as Clubhouses and has informed the development and refinement of standards. The Program for Clubhouse Research, which was established in 2000, has examined the evidence base for the Clubhouse

model and documented the outcomes for members participating in Clubhouse programmes (McKay et al. 2005). The evidence examined includes findings from multiple and single randomized clinical trials, observational studies, expert consensus and anecdotal evidence.

McKay et al. (2018) undertook a systematic review of the evidence on the effectiveness of the Clubhouse model from 52 studies, 14 of which were randomized controlled trials, published between 1948 and 2015. This comprehensive review included studies that reported on six key outcomes: employment, quality of life/satisfaction, hospitalization, social relationships/social inclusion, education and health promotion activities. McKay et al. (2018) reported that the evidence from randomized control trials support the effectiveness of the Clubhouse model in promoting employment, reducing hospitalization and improving quality of life. Evidence from quasi-experimental and observational studies were found to also support the programme's effectiveness in the education and social domains.

With regard to employment outcomes, ten RCTs reported positive findings with Clubhouse members transitioning between the different types of employment programmes offered (TE, SE, IE) and obtaining employment as quickly as those in receipt of employment services from other models such as the Program of Assertive Community Treatment (PACT). A multisite RCT study of supported employment, called the Employment Intervention Demonstration Program (Macias et al. 2006), compared the Clubhouse model with PACT. This study reported that while there were no significant differences in the number of participants from both programmes who achieved competitive work, there was a higher attrition rate for Clubhouse participants, where participation is voluntary; however, they were employed for longer, worked more hours, earned more and had significantly higher hourly wages than the PACT participants (Macias et al. 2006). Based on an analysis of the same data set focussing on study participants in competitive employment, Shonebaum et al. (2006) reported that participation in Clubhouse Work-Ordered Day prior to competitive employment was significantly associated with greater employment duration per employment cycle. McKay et al. (2005) examined employment outcomes across transitional, supported and independent employment positions in 17 Clubhouses between 1998 and 2001. This study found that individuals with longer Clubhouse memberships tended to work longer and had higher job earnings than those with shorter membership. Masso et al. (2001) also examined the effect of attendance rates of one Clubhouse model, Connections Clubhouse, on 117 randomly selected members on their employment status and their rates of hospitalization. Results of the study showed that individuals with a high rate of attendance at the Clubhouse had higher rates of employment attainment and more advanced employment status and lower rate of hospitalization than for members with low rates of attendance.

In relation to hospitalization, findings from a number of clinical trials show a positive impact on reduced or delayed re-hospitalization and reduced costs. The outcomes include a decline in rates of readmission and/or reduced lengths of hospital stay for Clubhouse participants. McKay et al. (2007) analysed Clubhouse costs using data from Clubhouse programmes in 12 countries. The total programme

costs per year varied according to country location with an average cost of $408,082 for the year 2000 (ranging from $40,145 to $1,461,100). Although not employing a detailed cost-effectiveness or cost-benefit analysis, they reported that the programme was relatively inexpensive compared to other integrated service delivery models, e.g. the annual costs per person were half the cost of services provided by Community Mental Health Centers and one-third the cost of IPS models. At the time, the average cost per member per year was reported as $3203, and the mean cost per visit was $27.12. In view of these findings, furthermore rigorous economic analyses are needed to examine the economic benefits arising from the Clubhouse programme in terms of reduced hospitalization and treatment costs and contributions from taxable income.

Positive findings are also reported for quality of life outcomes with one RCT by Gold et al. (2016) reporting that over 24 months of study participation, competitively employed Clubhouse participants reported greater global quality of life improvement, particularly with the social and financial aspects of their lives, as well as greater self-esteem and service satisfaction, compared to competitively employed PACT participants. Findings from a systematic review by Battin et al. (2016) also support the programme's impact on increased quality of life and satisfaction level for Clubhouse members (Battin et al. 2016).

Overall, reviewers of the evidence have concluded that more reliable and comparable studies are needed to provide more definitive evidence on the effectiveness of the Clubhouse model. The reviewers also raise the question as to whether it is more appropriate to speak of evidence for the model as a whole or evidence for specific programmes or elements within the model (Battin et al. 2016). If the latter approach is adopted, then the evidence for the relative effectiveness of specific practices or interventions employed within the Clubhouse model could be usefully tested and compared.

Programme Implementation Features

The programme implementation features, which are the unique elements to the success of this programme, are a compilation of the factors that can be found in the International Standards for Clubhouse Programmes (ICCD 2015). The principles discussed in the standards are at the heart of the Clubhouse community's success in helping people with mental disorders to stay out of hospital while achieving social, financial and vocational goals (ICCD 2015). Every 2 years these principle as standards are reviewed by the worldwide Clubhouse community and amended as necessary. However, the programme's main implementation features remain the same (Corcoran and McKay 2013) and are as follows:

- *Strengths-based approach membership and active participation*: The Clubhouse model focuses on the strengths and talents of people recovering from a mental disorder. The needs of the client are taken as a starting point in the daily activity. Members are expected to run their Clubhouses by taking on essential tasks and participating in every task. Members participate in planning, decision-making and carrying out activities. Staff often act as initiators of the activity but, like the members, participate in every task. Clubhouse members participate in all the

tasks of the daily running of the club, such as cooking, cleaning, maintenance, administrative duties, guidance of new members, etc. Beard et al. (1982) hypothesized that members benefited from participation in the Clubhouse because they felt needed for its successful functioning. When a Clubhouse is doing well, credit must be given to the membership upon whom the Clubhouse is dependant. This reverses the typical provider-recipient role in mental health services and sends a clear message to the members that they are competent and capable.

- *Work-Ordered Day*: Work-Ordered Day is at the heart of the Clubhouse practice and functions more as a catalyst for recovery rather than a full-time activity for its members (Johnsen et al. 2002, 2004). Regular participation in the work-ordered day promotes the development of new habits, routine and social roles which increase a number of competencies and skills, both work- and life related, such as occupational performance skills and functional independence (Gregitis et al. 2010). Clubhouse members join work crews to take responsibility for managing, maintaining and contributing to the clubhouse, with members and staff working side by side in a 9-to-5 work setting to perform voluntary work essential to the clubhouse. The work-ordered day engages members and staff together in the running of the clubhouse: administration, staff evaluation, training, research and clubhouse evaluation.
- *Employment*: The Clubhouse enables its members to participate in paid work through the use of three different programmes that assist members in making the transition back into the workplace: transitional employment, supported employment and independent employment. The desire to work is the most important factor determining placement opportunity.
  - Transitional employment (TE) refers to the placement of clients in a series of paid but temporary jobs controlled by the Clubhouse, which is based on agreements made between the clubhouse and the employers. TE aims to narrow the gap between the daily programme of the club and paid work in the open labour market by helping members develop the skills and confidence required to cope with competitive employment. Clubhouse staff coach members for the work and support him/her during employment. The Clubhouse guarantees the employer daily staffing for the employment position, so in case of illness or other problems, another club member or staff employee can act as a substitute. Failure at work is regarded as a natural part of the process and does not hinder a new attempt. Employment is usually part-time and lasts between 6 and 9 months. There are no rigid guidelines for length of time on work crews; however, clients are discouraged from seeking competitive employment until they have achieved success in TE and are free to return to work crews at any time.
  - In the independent employment (IE) programme, members with prior work experience, and/or job-related education, skills and abilities as well as those who have completed a number of TE placements, are encouraged to seek their own job. Clubhouses independent employment unit helps members prepare resumes and coaches them in job search and interview techniques. Unlike TE

and supported employment, members go on competitive interviews to get jobs. They can continue to use the services and support of the Clubhouse while they work such as advocacy regarding entitlements and assistance with housing, clinical, legal, financial and personal issues (ICCD 2015).

– Supported employment (SE) combines aspects of both TE and IE, but the employment positions are not time limited and belong to the members themselves. The main goal is to provide ongoing support to members who have permanent jobs of their own and to ease their integration into long-term employment.

Community participation: The Clubhouse model, with its focus on the normalizing function of community employment and on giving all members a chance to work regardless of psychiatric history, allows the integration and inclusion of members into society and goes some way to challenging some of the myths associated with mental disorders. The Clubhouse system can empower members to grow as individuals and to actively participate as members of a community (Gregitis et al. 2010).

Provision of other support services: The Clubhouse can also provide or support members in seeking adult education to develop their own personal skills. Similarly, information and support are given in relation to housing issues, substance misuse and wellness activities.

Recommendations for Replication

When considering recommendations for replicating the Clubhouse model, it is helpful to be aware of the circumstances of expansion for the model programme. In 1977 the founding establishment, Fountain House, was awarded a non-governmental financial grant to establish a national training programme on the Clubhouse model and thus began the process of replicating the model on a national and international basis. In 1987, the National Clubhouse Expansion Project was founded and developed the International Standard for Clubhouse Programmes (ICCD 2005). The success of the model's replication on a worldwide basis demonstrated that the Clubhouse culture and practice transcended national, ethnic and cultural boundaries, as it is based on universal human values (ICCD 2005). It was then highlighted that the work of the National Clubhouse Expansion Project needed to continue but now at an international level. Funded by dues from member Clubhouses and other sources, the International Center for Clubhouse Development (ICCD) was developed. This centre provides Clubhouse consultation and certification nationally and internationally. The centre produces the International Clubhouse Standards, which are a set of best practices and guidelines that define the Clubhouse model of rehabilitation and ensure the quality of services provided within the clubhouse. The ICCD website (www.iccd.org) provides an in-depth source of information on the centre and the participating Clubhouses and provides links and contact e-mail addresses for all the Clubhouses internationally, with clubhouses existing in most parts of the world: Albania, Australia, Estonia, Germany, Finland, Japan, Pakistan, Russia, the Republic of Ireland, the Republic of Korea, South Africa, the United Kingdom and the United States, to name but a few. This ease of access to information and contacts, combined with detailed standards for

Clubhouse programmes, has contributed to the success of this model in being replicated. In analysing the factors that influenced the sustainability of Clubhouses, Gorman et al. (2016) reported that Clubhouses stayed open significantly longer if they had received full accreditation, had more administrative autonomy and received funding from multiple rather than sole sources. The Clubhouse management structure was found to have substantial impacts on programme sustainability, whereas Clubhouse size and budget size did not.

When considering replicating the model, it is recommended to adhere to the core programme implementation features so as to remain faithful to the original model. Two fidelity instruments – the Clubhouse Fidelity Index and the Clubhouse Research and Evaluation Screening Survey – have been developed to assist in assessing adherence to the Clubhouse model (McKay et al. 2018). It is possible to convert from an existing model of rehabilitation into the Clubhouse approach. The following recommendations for new Clubhouse developments are highlighted.

- *Establish a Clubhouse community and working group*: The Clubhouse model is based on a community of people and is so before it is a building or a programme. Therefore, it is necessary to bring people together and to develop relationships between members and staff who will be working there each day. This will contribute to the implementation feature of membership and active participation. The Clubhouse working group is comprised of stakeholders representing different interests, such as service users, their families, professionals, politicians and community leaders. This group initiates the Clubhouses activity profile and also provides initial education and support, as well as identifying employers for members' employment placement. This group will also be responsible for organizing the education of the local community as to what a Clubhouse is all about, possibly via seminars, Clubhouse literature and tours of other Clubhouses. A director for the Clubhouse can then be hired by the working group to continue overseeing the programme.
- *Clubhouse training*: It is important that all involved in the Clubhouse are knowledgeable on this approach to psychiatric rehabilitation. Some existing Clubhouses are certified as training facilities whereby the members and staff of new Clubhouses can spend a period of time in training before they develop their new Clubhouse.
- *Funding*: Funding will need to be secured to assist in the community start-up and training, and in obtaining an actual location for the Clubhouse building. Funding sources may include local and national government and public or social service agencies. It may be useful to involve representatives from government agencies and organizations that receive funds in the working group.
- *Clubhouse employment employers*: Another important role of the working group is to identify employers for transitional employment placements. The attitude of the work community to people with mental health problems may well be influenced by prejudice and a fear of diversity and unpredictability as well as an element of curiosity. Initiating contact with employers directly rather than random mailing of literature can greatly develop the Clubhouse-employer relationship.

Clubhouses that develop such placements early in the programme development experience more success than those that do not. Successful employment programmes can attract new members to the clubhouse, as well as additional funding from government and private organizations.

- *Clubhouse members' personal preference*: It is recommended that special attention be paid to the preferences and competencies of Clubhouse members in establishing work arrangements. During the planning stage, resources should be used not only to organize the work tasks but also to prepare each member to meet the tangible circumstances at work and the situational aspects of coping with work. Instead of individualizing problems and focussing on assessment, the competencies and capabilities of each member in relation to work situations and the organization of work tasks should be considered at the planning stage. This will ensure a smoother transition from the Work-Ordered Day to the TE placement.

Conclusions

Effectively addressing and managing mental health problems at work can lead to positive outcomes for both individual employees and the organization as whole, with reduced absenteeism and presenteeism, improved mental health and wellbeing, increased productivity, improved job satisfaction and reduced health care costs. Likewise, interventions for managing and supporting employment transition such as entering work, finding a job, going back to work, and the reintegration of employees with mental disorders lead to improved mental health and wellbeing for workers and more productive and equitable work environments.

Workplace mental health promotion involves providing a continuum of interventions and supports from those that seek to create a mentally healthy working environment, promoting the mental health and wellbeing of individual employees, reducing the negative impacts of work-related stress, to supporting workers experiencing mental health problems and their retention in the workforce. As outlined in this chapter and the previous one, a comprehensive approach is needed for workplace mental health promotion interventions to be successful and requires integrated interventions, combining both individual and organizational-level approaches that address the individual worker or work group and the organization as a whole. Supportive workplace policies, legislation and regulations have a critical role to play in protecting and supporting mental health in the workplace, including protecting the rights of workers with mental disorders and their access to employment. Alongside tailored evidence-based interventions, supportive organizational structures and management practices are critical to ensuring that the promotion of mental health and prevention of mental health problems at work are explicitly addressed and that change processes are integrated throughout the different systems levels of the workplace.

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Part VII
Mental Health Promotion in Primary Care

Implementing Mental Health Promotion in Primary Care

Inge Petersen

Introduction

Primary care is people's first point of contact with health services and, therefore, provides an important platform for the provision of mental health services, including mental health promotion interventions. The Alma-Ata Declaration defines primary health care as a universally accessible service that is comprehensive, integrated and inter-sectoral, includes community participation, and is concerned with prevention and health promotion in addition to treatment (WHO 1978). Given that health encompasses physical, mental and social wellbeing (see WHO definition outlined in Chapter 'Concepts and Principles of Mental Health Promotion'), primary care has an important role to play in strengthening both the physical and mental health of individuals, families and communities, as well as in recognizing the importance of mental health to overall health and wellbeing (Jenkins and Üstün 1998).

Notwithstanding the rising burden of mental disorders, with depression predicted to be the second leading burden of disease (in disability adjusted life years) in 2030 (World Federation for Mental Health 2012), mental health is relatively neglected in the delivery of primary care services in many countries, with the main focus being on physical health. In particular, mental health problems frequently go unrecognized in low- and middle-income countries (LMICs) where a significant number of people with mental disorders remain untreated. World Mental Health Survey data for 17 countries (including a range of LMICs) reveals a 12-month service use ranging from 1.6% in Nigeria to 17.9% in the USA (Wang et al. 2007).

Given that primary health care interventions are delivered from the population, community and health care platforms, the case studies provided in this chapter straddle these different platforms. Examples of population-level interventions entail

I. Petersen (✉)
University of KwaZulu-Natal, Durban, South Africa
e-mail: peterseni@ukzn.ac.za

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mass awareness campaigns to improve mental health literacy as well as micronutrient supplementation and immunization programmes to promote optimal foetal development during the prenatal period. Community-level interventions include community programmes that are health promoting, such as social prescribing and home visitation programmes. Examples at the community level thus overlap with examples of mental health promotion interventions already outlined in chapter 'Implementing Community-Based Mental Health Promotion Strategies'. Examples of interventions delivered from the health care platform include specific interventions shown to prevent exacerbation of the early signs of mental disorders, particularly in adolescents and adults.

Rationale for Mental Health Promotion in Primary Care

First and foremost, the promotion of mental health as part of primary health care activities is central to the attainment of the broad vision of primary health care as contained within the Alma-Ata Declaration. This understands health holistically as including mental and social wellbeing, in addition to physical health (World Health Organization 2008).

Second, mental health promotion as part of primary health care is important to assist in the promotion of physical health. Mental disorders are two to five times more prevalent in people with chronic physical health conditions than the rest of the population (Ciesla and Roberts 2001; Lonnroth et al. 2008; Moussavi et al. 2007; Neuman et al. 2012). The relationship between mental and physical health is bidirectional. Physical ill health increases risk for mental disorders through direct effects on the brain (e.g. HIV), as well as the psychological burden of dealing with a physical illness (Prince et al. 2007). Poor mental health, on the other hand, increases the risk for physical illness, being associated with between 1.5% and 13.3% of chronic physical condition onsets (Scott et al. 2016). Promoting mental health is thus important for enhancing overall health and the reduction of physical health problems. In the current context of the rising global epidemic of chronic non-communicable diseases (NCDs) such as diabetes, hypertension and cancers, the importance of the promotion of mental health as part of primary health care is amplified.

Third, as a setting, primary health care services have the advantage of being accessible and delivered by health workers who know the local community, thus enhancing early identification and access to prevention programmes and care pathways (World Health Organization 2008). Primary health care services encompass both facility-based services as well as community outreach services that provide coordinating links to the community and school settings. Community outreach workers and primary health care providers are well-placed to identify high-risk populations such as people living in deprived areas, families under stress, first-time mothers, lone parents, carers and older people living alone. Such populations include people with preclinical symptoms of mental disorders, who could benefit from mental health promotion programmes such as self-help or peer support groups.

These outreach workers are also well-positioned to coordinate and signpost service users to social services and supports from across a range of disciplines, agencies and sectors in the local community.

Primary health care, with its links into the community, thus provides an important setting for identification of populations at risk, early identification of mental health problems, the prevention of onset of mental disorders and subsequent episodes as well as the promotion of physical and mental health wellbeing of local communities. As a gateway to services, primary care also provides a networking function, providing referral pathways to more intensive health care and community-level services, including social and community services, education, welfare, housing and employment services.

A collaborative approach has been identified as best practice for the management of mental disorders at primary health care level (Shidhaye et al. 2016); this is essentially a multidisciplinary approach involving sharing of tasks between specialists, generalists and community members, as well as with other resources, such as social service organizations and non-governmental organizations. A case manager who makes the referrals and monitors a person's progress is central to this approach and is ideally located at the primary care level. The collaborative care model has been implemented widely in high-income countries as well as some low- and middle-income countries—see the WHO report on integrating mental health into primary health care (World Health Organization 2008). There is good evidence that this approach improves both mental and physical health outcomes in people having comorbid mental and physical conditions, as well as promoting better quality of life and greater satisfaction with care received; an example is TeamCare in the USA (Katon et al. 2010; McGregor et al. 2011). The primary care setting thus offers an opportunity to play an important coordinating role across a range of disciplines and sectors; this is necessary for promotion and prevention, given the well-known social determinants of mental health (Patel et al. 2010a).

Stepped-up care is an efficiency model which is promoted for resource-scarce contexts, where patients with milder symptoms are started on low-intensity, low-cost interventions including self-help and peer/lay health worker-delivered interventions that progress to more high-intensity, high-cost interventions, should symptoms worsen or not improve. There have been a number of trials showing the effectiveness of this approach for improving mental health outcomes in primary health care (Araya et al. 2003; Patel et al. 2010b).

Box 1 The Importance of Primary Health Care as a Setting for Mental Health Promotion (Adapted from Barry and Jenkins 2007)

- Accessible community-based service
- Provision of comprehensive and continuous care from the cradle to the grave
- Non-stigmatizing service
- Multidisciplinary team coordinating service provision between health, social services, community and self-help groups

(continued)

Box 1 (continued)
- Gateway for specialist services
- Referral to other support agencies and services
- Provision of holistic care recognizing the links between physical and mental health care
- Knowledge of the social milieu of clients and their circumstances
- Greater possibilities for inter-sectoral collaboration in the local community

Implementing Mental Health Promotion in Primary Care

The previous section showed how primary care is an important setting for the delivery of mental health promotion interventions, which in turn can help improve physical health and wellbeing across the lifespan which are important for overall population health (Katon et al. 2010; Marmot 2015; McGregor et al. 2011). Integrated primary mental health care is endorsed by the World Health Organization as the most efficient mechanism to increase access to mental health care services (World Health Organization 2013) and is central to many regional- and country-level mental health policies.

However, there are a number of barriers to the identification and management of mental health problems in primary health care in high- as well as low- and middle-income countries. These include a lack of orientation among primary health care providers to holistic person-centred care that includes mental health; mental health stigma on the part of health care providers and patients, which hinders help seeking; the perception that mental health care is time-consuming and additional work; and a lack of pre-service and in-service training and specialists to provide support, particularly in low- and middle-income countries (Petersen et al. 2017; World Health Organization 2008).

In order to address the lack of pre-service and in-service training, the World Health Organization introduced the Mental Health Gap Action Programme (mhGAP), with the *mhGAP Intervention Guide* providing evidence-based clinical practice guidelines for non-specialists, for mental health promotion and for the prevention and management of priority mental, neurological and substance use disorders (World Health Organization 2016). Since the first version was introduced in 2010, these guidelines have been adopted by over 90 countries and include psycho-educational material for all mental disorders, as well as guidelines for mental health promotion for different priority conditions (World Health Organization 2016).

Using a life course approach, as described earlier in chapter ‘Concepts and Principles of Mental Health Promotion’, we explore in greater detail many of the evidence-based interventions for mental health promotion and prevention contained within the mhGAP guidelines, which can be delivered from the primary care setting.

The Prenatal and Infancy Period (0–2 years)

As discussed in chapter 'Promoting the Mental Health of Children and Families in the Early Years', the prenatal and infancy period is a particularly important period for laying the foundation for healthy growth and development across the lifespan, with poor early childhood development being responsible for lowered longevity, poorer health outcomes and lowered human potential. It is thus a critical period for intervening for the promotion of the future general health and wellbeing of the developing child (Dawes and Richter 2010). In relation to mental health specifically, and in light of heightened neural plasticity, it is a particularly vulnerable period for environmental assaults that can negatively affect neurocognitive and socio-emotional development, leading to potential deficits in these areas (Dawes and Richter 2010).

Given that prenatal and postnatal care takes place in primary health care, it provides an important setting for the provision of mental health promotion activities during this critical and vulnerable period. In particular, the following population-level primary health care interventions are highlighted as important:

1. The provision of micronutrient supplementation of iodine and folic acid and protein nutrition supplementation for at-risk populations
2. Prenatal immunization and treatment programmes for diseases that can have an impact on brain development such as influenza, rubella and toxoplasmosis and the human immunodeficiency virus (HIV)
3. Health education to raise awareness of the negative impact of exposure to toxins (such as lead, arsenic, pesticides, tobacco smoke and alcohol) on the developing brain
4. Ensuring adequate obstetric care to prevent birth trauma (Petersen et al. 2014)

During the postnatal period, maternal depression can have a negative impact on the developing child's socio-emotional development as a result of an impaired mother-child attachment relationship. It can also impair cognitive development as a result of lack of psychosocial stimulation associated with poor maternal responsiveness (Canadian Paediatric Society 2004). Given that mothers visit clinics for pre- and postnatal care and immunization programmes, it provides a convenient setting for screening and providing interventions for maternal depression. There is now robust evidence of the impact of interventions to combat maternal depression from high- and low- and middle-income countries (Patel et al. 2016a, b; Rahman et al. 2008).

One of the first controlled trials of an intervention aimed at demonstrating the effectiveness of a psychosocial intervention for reducing maternal depressive symptoms in a primary health care setting was conducted by Elliott et al. (1988). The programme targeted first- and second-time mothers who had similar expected delivery dates and were identified as vulnerable to depression. Recruited participants were allocated either to the preventive intervention (n = 47) or control group (n = 52). The prevention intervention included the following components:

1. Monthly emotional support group sessions from 4 months of pregnancy through to 6 months postnatally (duration 11 months)

2. The inclusion of an educational component covering at least three aspects: postnatal depression, the common 'realities' of life with a newborn and ways of preparing for the new or changed job of parenting
3. The provision of information on, or referral to, relevant local and national organizations

Women were assessed at 3 months postnatally. Using intention-to-treat analysis, differences in the diagnosis of depression using the Present State Examination for both groups was statistically significant for first-time mothers, with mothers in the control group more likely to be depressed (Elliott et al. 2000).

A more recent evidence-based intervention for maternal depression from a LMIC is the Thinking Healthy Programme, developed and evaluated in Pakistan (Rahman et al. 2008), which has been adopted by the World Health Organization as best practice. Female health workers who conduct home visits were trained to deliver a cognitive-behavioural therapy intervention to women identified as having depression in their third trimester. Counselling was provided weekly during the last month of pregnancy, three sessions were provided in the first postnatal month and sessions were once per month for 9 months thereafter (Rahman et al. 2008). At 6-month follow-up, mothers in the intervention group were significantly less likely to be depressed compared to those in the control group, and these effects were sustained at 12 months (Rahman et al. 2008). For more information visit www.who.int/mental_health/maternal-child/thinking_healthy/en/.

However, given evidence that maternal depression interventions alone do not improve child health outcomes (Gunlicks and Weissman 2008), the need for more broad-based mental health promotion interventions that address some of the social determinants of poor maternal mental health is becoming increasingly evident. Such interventions include those that address environmental risks for poor child outcomes in scarce-resource contexts, as well as parenting skills to promote attachment and psychosocial stimulation. Parenting programmes during infancy have been identified as good practice by the Disease Control Priorities working group on mental, neurological and substance use disorders (Patel et al. 2016a, b). Classic examples of such programmes from high-income countries include the Newpin (New Parent Infant Network) and Home-Start programmes. Newpin is a voluntary network based in the United Kingdom, where volunteer befrienders work with parents in providing training and therapy to promote personal development and self-esteem. Evaluations of the outcomes of the Newpin programme in the United Kingdom showed improvements in self-esteem and reductions in depression and social isolation for both volunteers and referred women with young children from disadvantaged backgrounds (Pound and Mills 1985; Cox et al. 1991). Research on the delivery of Newpin in Australia also reports improved self-esteem and confidence in mothers and reduced problem behaviours in children for families attending for at least 6 months (Mondy and Plath 2001).

Similarly, Home-Start is also run by a voluntary sector group, which organizers volunteers, usually mothers themselves, who visit people's homes and provide emotional support to families under stress. Home-Start parent volunteers offer regular

support, friendship and practical help to families by visiting them in their own home, helping to prevent family crises and breakdown and emphasizing the pleasure of family life. A cluster randomized trial of Home-Start found a greater reduction in parental stress at follow-up in mothers exposed to the programme compared to unexposed mothers; this was when infants were 12 months of age (Barnes et al. 2006). While Home-Start originated in the United Kingdom, it has been adopted by other countries, including Israel, Ireland, Norway, Russia, Hungary, the Republic of South Africa, Australia, Canada and the Netherlands

In addition to this short-term evidence of the positive effects of home visitation programmes targeting the pre- and postnatal period in at-risk mothers, there is also evidence of the long-term positive impacts on the mental wellbeing of mothers and their children. The Prenatal and Infancy Home Visitation Programme in the USA, also known as the Nurse-Family Partnership, is one of the most replicated programmes, showing not only improved developmental outcomes in the short term but better social and behavioural outcomes of child participants in the long term (NHS Centre for Reviews and Dissemination 1997; Olds et al. 1997). Further details of this intervention, as well as examples of other family strengthening interventions, can be found in chapter 'Promoting the Mental Health of Children and Families in the Early Years'.

While these studies cited are from high-income countries, there is also increasing evidence from low- and middle-income countries of the short- and long-term impact of home visitation programmes that encourage maternal responsiveness. A classic example is from a study in Jamaica which demonstrated the long-term positive impact of a home-based stimulation programme on growth-stunted children.

The Jamaican Early Childhood Home Visiting Intervention

The Jamaican psychosocial stimulation programme was delivered by community health workers (CHWs) who attended a 4-week training in child development and in a psychosocial stimulation programme which comprised 1-h home visits with mother and child. Here the CHWs made use of a structured curriculum to empower mothers to promote their children's development through play and to improve mother-child interaction. CHWs demonstrated play techniques and encouraged mothers to talk to their children and to use praise and reinforcement over physical punishment. Mothers were encouraged to continue with play activities between visits (Walker et al. 2011).

The study initially identified 129 growth-stunted children aged 9–24 months who were followed up at various time points, with the final follow-up period at 22 years comprising 105 of the original sample. Participants were identified through a house-to-house survey of poor communities in Kingston, Jamaica. Children were randomly assigned to one of four cohorts: the control group ($n = 33$), a group receiving nutritional supplementation ($n = 32$), a group receiving the psychosocial stimulation programme ($n = 32$) and a group receiving the nutritional supplementation as well

as the psychosocial stimulation programme (n = 32). The control cohort received only illness information. The nutritional supplementation comprised 1 kilogram of milk-based formula weekly.

After 2 years, both the nutritional supplementation and psychosocial interventions showed independent benefits to the children's development. At 7 years, each intervention was shown to have a small benefit on cognitive development but not growth. At 11 and 17 years, children exposed to the psychosocial stimulation intervention were shown to have benefitted in terms of cognition, while those exposed to the nutritional supplementation no longer showed any benefit. At 17 years, the stimulation intervention also showed a benefit on psychosocial functioning, and at 22 years, participants exposed to the stimulation intervention showed a benefit in terms of reduced involvement in fights and serious violent behaviour than did participants who did not receive the stimulation intervention. They also had higher adult IQ, higher educational attainment (achievement, grade level attained and secondary examinations), better general knowledge and fewer symptoms of depression and social inhibition (Walker et al. 2011).

The findings showed that early child psychosocial stimulation programmes can assist children to optimize their developmental potential in the long term. While there has been no direct replication of this study to date, similar studies have been developed in other LMICs, for example, to determine the effects of psychosocial stimulation on the growth and development of severely malnourished children in Bangladesh. The results of this study indicated that psychosocial stimulation had a significant effect on improving mental development and growth in weight compared to those who did not receive psychosocial stimulation (Nahar et al. 2012).

The Philani Mentor Mothers Project in the Western Cape Province of South Africa provides a case study of a broad-based home visitation programme from a low- and middle-income country. Community health workers (CHWs), who are called mentor mothers and who are selected on the basis that they come from the same communities and have thriving children, visit other mothers in their homes and provide support to promote optimal infant and child nutritional status and development, referral pathways and ongoing social support.

Case Study: Mentor Mothers: Helping by Proxy: Improving Maternal Mental Health During the Course of a Generalist Health Promotion and Prevention Intervention in South Africa

Mark Tomlinson · Xanthe Hunt
Department of Psychology, Stellenbosch University, Stellenbosch, South Africa

Mary Jane Rotheram-Borus
Semel Institute and the Department of Psychiatry, University of California, Los Angeles, CA, USA

Background

Pregnant women in South African townships face multiple health risks, both personally and for their infants. Children face innumerable challenges to their development and wellbeing, including HIV, low birth weight, malnutrition and widespread violence (Rotheram-Borus et al. 2015a, b; Sherr et al. 2017). Concurrently, mothers' wellbeing is threatened by alcohol use, intimate partner violence and depressed mood (Tsai et al. 2016b). Given widespread poverty and unemployment, and infrastructural constraints, existing clinic-based services are beset with significant barriers to access and utilization, as well as substantial human resource limitations. In response to these challenges, community health workers (CHWs) have been deployed to provide services to poor communities to complement professional care. Community health workers are trained to address the high prevalence of local health conditions (HIV, TB, malnutrition); screen, assess and refer patients; educate people in prevention and health promotion; provide psychosocial and adherence support to the ill; and advocate for health within communities. Their deployment, thus far, has largely centred on single health challenges (e.g. HIV, infant birth weight).

Home-visiting programmes in the USA (such as the Prenatal and Infancy Home Visitation Programme of Olds and Colleagues) have found positive impacts on both short- and long-term health and socio-emotional development outcomes for both mothers and children (Olds et al. 2007, 2014). One model through which the health challenges, such as those encountered in LMICs, can be universally addressed is through the deployment of generalist health workers. Philani is a non-government organization (NGO), operating in 150 township neighbourhoods in South Africa, which has successfully deployed a cadre of such workers. Their interventions initially focussed on improving children's nutritional status. However, the modified intervention incorporates stimulation, HIV prevention and violence prevention intervention components.

Philani identifies potential neighbourhood CHWs on the basis of being 'positive peer deviants': mothers living in target neighbourhoods who are positive role models and are thriving in the face of challenges and risk. These women are then trained to make home visits to intervention mothers to monitor and support infant and child nutrition, health and development, to refer mothers to clinic care and to provide social support to the women with whom they work. Philani's use of home-visiting and the positive peer deviant model of CHW selection have proven vital to their success. The rationale for these strategies is expanded upon presently.

In 2009, researchers from Stellenbosch University and the University of California, Los Angeles, in partnership with a local non-governmental organization (NGO), the Philani Nutrition Programme, began evaluating a CHW-delivered generalist intervention in the Western Cape. Our team conducted a cluster randomized controlled trial to test the effectiveness of the model, as implemented by Philani, in improving maternal and child health. We were interested in the impact of a 'real world', community-based, generalist early intervention using CHWs to track maternal and child health and child development. The intervention used pragmatic models of problem-solving and cognitive-behavioural techniques but was not explicitly a

mental health promotion or prevention intervention. Rather, training for mentor mothers focussed on prevention of mother-to-child transmission (PMTCT) of HIV, reducing alcohol use across the perinatal period, self-care and social support, accessing the child support grant, nutrition and exclusive breastfeeding.

We assessed the impact of the intervention on mothers and children antenatally and at 6 months, 18 months, and 36 months postpartum. We have published primary and secondary outcomes, including infant birth weight (Rotheram-Borus et al. 2014; Tomlinson et al. 2014), breastfeeding (Le Roux et al. 2013; Rotheram-Borus et al. 2014), alcohol use among mothers (O'Connor et al. 2011, 2014; Rotheram-Borus et al. 2011, 2015a; Tomlinson et al. 2014; Tsai et al. 2016a), PMTCT (Rotheram-Borus et al. 2014), ARV adherence (Rotheram-Borus et al. 2015a, b), child health (Le Roux et al. 2013; O'Connor et al. 2014; Rotheram-Borus et al. 2014; Tomlinson et al. 2014, 2015, 2016; Tsai et al. 2016a) and child cognitive ability (Rotheram-Borus et al. 2014).

However, and of relevance to the remainder of the present discussion, our intervention also positively impacted maternal mood (Tomlinson et al. 2016). Recipients of the home-visiting intervention had improved maternal emotional health 36 months after their children were born, despite the fact that the intervention did not target maternal depression or maternal emotional health. Further, by improving mothers' social support, as well as addressing their alcohol use and other sequelae of depression, the intervention seemed to reduce the impact of maternal depression on the child. We have shown how the children of pregnant women with depressed mood who received home visits from mentor mothers were significantly taller at 6 months of age and had higher scores on a measure of child cognitive development at 18 months of age, compared to the children of pregnant women with depressed mood in the control condition, even when maternal depressed mood was not reduced (Sherr et al. 2017; Tomlinson et al. 2015). The capacity of a broad-based intervention to alleviate maternal emotional distress, even when not setting out to do so, has important implications for our thinking about mental health promotion and prevention in LMICs.

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

During the course of the study and subsequently, it became apparent that certain features of the intervention and its delivery facilitated its effectiveness and made apparent its sustainability and scalability as a model. We reflect on those relevant to the intervention in general first and those specific to its unexpected impacts on maternal health thereafter. We also include key lessons learned for adoption and scale-up in other scarce resource contexts.

Investing in the Capacity of Community Health Workers CHWs, like all paraprofessional health workers, may enter a given project with limited experience in health promotion and prevention. The importance of thorough training and capacity building, and continuous skills development, is critical. Not only will investing in CHWs ensure greater fidelity to an evidence-based intervention, but—given recent research into employing paraprofessional staff—it may mitigate staff turnover, ensure project longevity and improve community investment in the programme (Tomlinson et al. 2017). In terms of capacity building, CHWs should be trained to deal with multiple health risks and target multiple health behaviours, and a siloed approach to human wellbeing should be avoided. In the case of Philani, mentor mothers were trained to address the maternal-child dyad as a unit and be cognizant of the interrelationships between different health risks and protective factors.

Concerning ongoing skills development, proper training and skills development may encourage an additional level of investment by CHWs involved in long-term programmes. It is our experience that CHWs should be adequately remunerated (and not employed as volunteers), training and investment in staff provide an additional incentive for staff to remain involved in the programme for its full duration.

Working with Established Partners It is of substantial benefit for long-term interventions to work with NGOs and CBOs who already have established networks within communities and a good rapport with community members. Philani has a 30-year history of successful and sustainable home-based support for pregnant women and their children (Rotheram-Borus et al. 2011). In terms of intervention delivery, this facilitates mentor mother recruitment and participant retention and ensures community buy-in. Further, working with a partner with existing relationships with community structures may aid in referral processes for participants in need (for instance, knowing which mental health services are preferred and trusted by community members and which are seen as stigmatizing and would thus not be used).

Monitoring In the Philani study, implementation was routinely monitored, and mentor mothers were supervised both in person and remotely using mobile phones (Tomlinson et al. 2013). In the past, the effectiveness of CHW models of intervention has been questionable partly due to issues around inconsistency in training, monitoring and supervision (Haines et al. 2007; Tomlinson 2010). Consistent monitoring and evaluation, however, are imperative if claims are to be made about a programme and its effectiveness. Providing consistent monitoring in such a large project as Philani has shown the feasibility of doing so, even when bringing such interventions to scale.

Drawing on Community Resources Using CHWs who are local to the intervention area and positive peer deviants was an innovation in the Philani model and one which bears replication. Typically, home-visiting interventions focus on training professional workers or general CHWs (Flay et al. 2005). In the Philani model, CHWs who were positive peer deviants were selected (Berggren and Wray 2002);

these were women who showed promise in pragmatic problem-solving and had good social skills (Rotheram-Borus et al. 2014). Not only were such women able to provide role models to women in their communities, but they were also capable of leveraging their knowledge of unique contextual issues to provide the intervention mothers with a form of social support the likes of which would perhaps be unattainable by a 'foreign' health worker. Given the importance of social support in alleviating emotional distress (Cohen and Wills 1985; Lin et al. 2013), it is very possible that this feature of the Philani model was at least in part responsible for some of the improvements in maternal mental health over the study period.

Home Visiting as Non-stigmatizing Intervention Universal home visiting is recognized to be a non-stigmatizing mode of intervention (Nievar et al. 2010). Indeed, such universal services are attractive due to the lack of stigma attached to them. If all pregnant women, for instance, are being enrolled into a programme, then individuals who are receiving support for mental health or HIV do not stand out. The combination of education and authority, which social workers or more formal health professionals may carry, can lead to their presence being seen as stigmatizing (Nievar et al. 2010). It is possible that mental health improvements seen among participant mothers would not have been observed had the presence of the intervention been perceived as stigmatizing. Instead, given that it was a nonthreatening mode of delivery, it is possible that mothers' engagement in the programme was more durable, and they felt greater investment, and less stigma, as a part of a community of women all receiving an intervention, rather than as a single case being sought out for 'help'.

CHW Training in Behaviour Change Of equal importance to their knowledge of the intervention's approach and content was the fact that the mentor mothers were trained in foundational skills to support behavioural change. Without the necessary skills to facilitate the process of behaviour change, health promotion educational interventions are unlikely to be effective. In the Philani model, CHWs were taught basic cognitive-behavioural approaches (Le Roux et al. 2013; Rotheram-Borus et al. 2014). This, coupled with an emphasis on pragmatic problem-solving, meant that mentor mothers were well-equipped to assist participants in addressing the challenges of daily life. Past research (Bell and D'Zurilla 2009; Dowrick et al. 2000) has shown that equipping individuals with problem-solving skills may be an effective way of scaffolding their own coping with moderate distress. This, coupled with the social support provided by the mentor mothers, could have led to the intervention's positive impact on maternal mental health.

Challenges Faced

Despite the effectiveness of this model, and Philani's implementation of it, certain challenges were faced during the course of delivery. These are worth bearing in mind when conceptualizing and implementing future work of this nature. Firstly,

the attrition rate among mentor mothers was relatively high. Given funding constraints, mentor mothers were paid only a stipend for their work. As the mothers themselves were often from poor households, when they found higher-paying employment opportunities, they resigned from Philani. Secondly, and also related to funding, there is a need for intervention work such as this for children and adolescents across the life course. As it stands, Philani is only mandated and funded to serve children in the early years and their mothers. Stable funding sources for continuous intervention over the course of development are necessary. Finally, it was very difficult for the mentor mothers to access male partners of intervention women involved in the project. As such, the intervention aims were seldom communicated to men. Given the relative social and economic power of men in the communities in which Philani works, future intervention work needs to find ways of engaging male partners in health promotion work.

Key Recommendations for Replication

Despite the fact that benefit was derived by participating mothers in relation to their emotional wellbeing, the fact remains that the intervention was not specifically developed to address mental health issues. Given the apparent need for such services, future interventions should clearly incorporate a mental health promotion component. Our key recommendations for replication of such broad-based generalist interventions are twofold.

Need for Strengthened Referral Pathways

While trained generalist CHWs conducting home visits can impact upon a broad range of maternal and child health outcomes, they are not equipped to address severe psychosocial problems. Thus, incorporating reliable referral systems into such a model of intervention would be an important consideration for future intervention efforts. Women who are in distress may then be referred ‘up’ a tier (stepped-care model) to a more specialized service.

Incorporate Mental Health Promotion Intervention

Given the fact that this model relies on selecting CHWs who have good social, communication and problem-solving skills, the possibility for incorporating a mental health promotion element into the existing Philani framework (or similar ones) is promising. Women already working as successful role models and supports within the community could well be trained to deliver a manualized CBT-style intervention for women who show signs of emotional distress (although, as noted, women in severe distress will require more sustained, targeted support).

Key Lessons Learned for Adoption and Scale-up in Scarce Resource Contexts

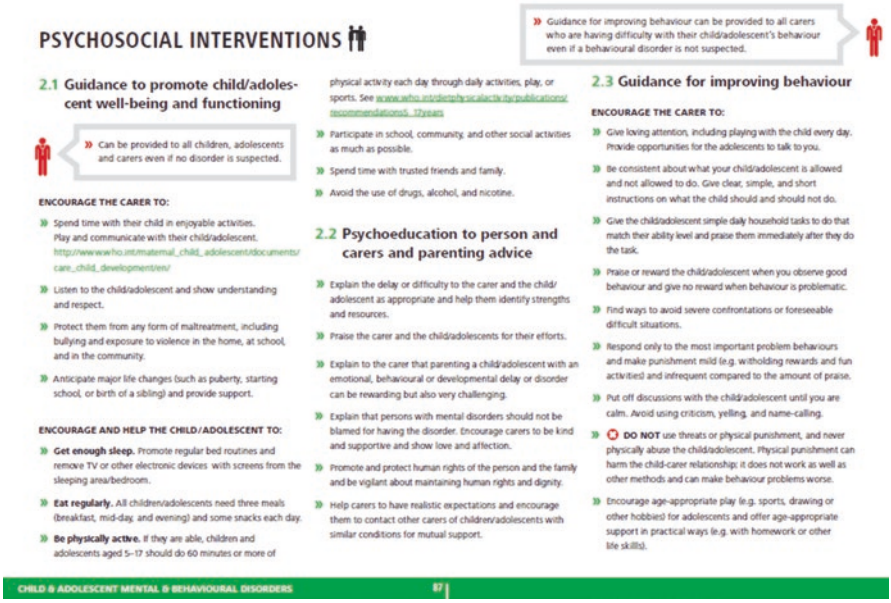
- Low- and middle-income countries need horizontally integrated generalist interventions.
- Interventions need to address concurrent and intersecting health challenges, such as alcohol abuse, poor mental health and malnutrition.
- Prevention should target the major health risks in local communities.
- Generalist programmes potentially have multiple benefits, even in domains not specifically addressed by the intervention.

Future Directions for Application of the Intervention

The Philani model is easily scalable. However, with adaptation (including the above-mentioned points regarding mental health), the model could provide additional benefit to the communities in which it is implemented. Finally, the Philani model is currently being implemented in rural Eastern Cape, Swaziland and Ethiopia, and preliminary planning for dissemination to Namibia and Lesotho is currently under way.

Childhood

During childhood, the preschool and school settings become more important for the delivery of mental health promotion interventions than the primary care setting, given that this age group is generally at school. Guidelines to promote mental health and wellbeing of children and adolescents are, however, provided in the *mhGAP Intervention Guide* for health care providers in general health care platforms including primary health care (see Fig. 1). Much of the guidance provided involves advice and information for carers. This advice can be substantially bolstered by 'social prescribing' which refers to providing practical information, advice and networking of service users to resources within the community that can assist with social issues such as poverty and abuse, as well as programmes that are health promoting such as parenting and exercise programmes (Bickerdike et al. 2017). Of particular importance during childhood are parenting programmes that support the development of caregiver warmth and support, and developmentally appropriate monitoring and control, in order to promote authoritative parenting styles that can help mediate exposure to stressful events. While there are examples of parenting programmes being provided from the primary health care platform (an example being the VUKA family programme which is an adaptation of the CHAMP programme described in detail in chapter 'Implementing Community-Based Mental Health Promotion



PSYCHOSOCIAL INTERVENTIONS

» Guidance for improving behaviour can be provided to all carers who are having difficulty with their child/adolescent's behaviour even if a behavioural disorder is not suspected.

2.1 Guidance to promote child/adolescent well-being and functioning

» Can be provided to all children, adolescents and carers even if no disorder is suspected.

ENCOURAGE THE CARER TO:

» Spend time with their child in enjoyable activities. Play and communicate with their child/adolescent. http://www.who.int/maternal_child_adolescent/documents/care_child_development/en/

» Listen to the child/adolescent and show understanding and respect.

» Protect them from any form of maltreatment, including bullying and exposure to violence in the home, at school, and in the community.

» Anticipate major life changes (such as puberty, starting school, or birth of a sibling) and provide support.

ENCOURAGE AND HELP THE CHILD/ADOLESCENT TO:

» **Get enough sleep.** Promote regular bed routines and remove TV or other electronic devices with screens from the sleeping area/bedroom.

» **Eat regularly.** All children/adolescents need three meals (breakfast, mid-day, and evening) and some snacks each day.

» **Be physically active.** If they are able, children and adolescents aged 5–17 should do 60 minutes or more of physical activity each day through daily activities, play, or sports. See www.who.int/dietphysicalactivity/publications/recommendations5_17years

» Participate in school, community, and other social activities as much as possible.

» Spend time with trusted friends and family.

» Avoid the use of drugs, alcohol, and nicotine.

2.2 Psychoeducation to person and carers and parenting advice

» Explain the delay or difficulty to the carer and the child/adolescent as appropriate and help them identify strengths and resources.

» Praise the carer and the child/adolescents for their efforts.

» Explain to the carer that parenting a child/adolescent with an emotional, behavioural or developmental delay or disorder can be rewarding but also very challenging.

» Explain that persons with mental disorders should not be blamed for having the disorder. Encourage carers to be kind and supportive and show love and affection.

» Promote and protect human rights of the person and the family and be vigilant about maintaining human rights and dignity.

» Help carers to have realistic expectations and encourage them to contact other carers of children/adolescents with similar conditions for mutual support.

2.3 Guidance for improving behaviour

ENCOURAGE THE CARER TO:

» Give loving attention, including playing with the child every day. Provide opportunities for the adolescents to talk to you.

» Be consistent about what your child/adolescent is allowed and not allowed to do. Give clear, simple, and short instructions on what the child should and should not do.

» Give the child/adolescent simple daily household tasks to do that match their ability level and praise them immediately after they do the task.

» Praise or reward the child/adolescent when you observe good behaviour and give no reward when behaviour is problematic.

» Find ways to avoid severe confrontations or foreseeable difficult situations.

» Respond only to the most important problem behaviours and make punishment mild (e.g. withholding rewards and fun activities) and infrequent compared to the amount of praise.

» Put off discussions with the child/adolescent until you are calm. Avoid using criticism, yelling, and name-calling.

» **DO NOT** use threats or physical punishment, and never physically abuse the child/adolescent. Physical punishment can harm the child-carer relationship; it does not work as well as other methods and can make behaviour problems worse.

» Encourage age-appropriate play (e.g. sports, drawing or other hobbies) for adolescents and offer age-appropriate support in practical ways (e.g. with homework or other life skills).

CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS 87

Fig. 1 Mental health promotion guidelines for children and adolescents from the *mhGAP Intervention Guide* (From *mhGAP Intervention Guide*, Version 2.0. World Health Organization (WHO), p. 87. Reprinted with permission of the World Health Organization)

Strategies'), these programmes are generally located within the school or community setting.

Social prescribing recognizes the social, economic and environmental determinants of people's health and the need for a holistic approach to health care that empowers service users to be more in control of their health and wellbeing. It operates alongside traditional medical and psychological treatments in primary health care settings and provides primary care practitioners with a non-medical referral option to community services and programmes. Social prescribing may involve practical advice and linking a person to a number of community activities such as gardening groups, befriending programmes, sports activities, art programmes and so on. People who may benefit from social prescribing include those who are socially isolated and have mental health problems, as well as socio-economically disadvantaged groups (Bickerdike et al. 2017).

However, the evidence base of the effectiveness of social prescribing on improving health and wellbeing is still in its infancy, with a recent systematic review highlighting that most of the existing evidence is of low quality (Bickerdike et al. 2017). Notwithstanding the need for more robust evidence on the effectiveness of social prescribing on health and wellbeing, promising evidence is emerging as is exemplified in the case study of social prescribing by general practitioners in Sheffield in the United Kingdom.

Case Study: City of Sheffield Social Prescribing Model: 'People Keeping Well Programme'

Lorraine Jubb
People Keeping Well, Sheffield City Council, Sheffield, UK

Steve Thomas
NHS Sheffield Clinical Commissioning Group, Sheffield. UK

Background

> Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing. (Centre for Reviews and Dissemination 2015, p. 2)

Most people are 'social prescribing' for themselves and others already, identifying things and doing things that they need to do to stay healthy and well and helping others to do the same. However, *some* people, *some of the time*, need a bit of extra support. For example, they might face a range of challenges that have got on top of them and have support needs that exceed the capabilities of their family or social networks. Indeed, they may distinctly lack family support and other social networks and be in a position of isolation, loneliness, financial difficulties and experiencing the challenges of living with physical illness or having long-term conditions that place them at increasing risk of poor mental health. Examples include people who

- Have experienced a recent bereavement or relationship breakdown, which has led to them withdrawing from social networks and becoming depressed and isolated
- Have had a deterioration in their physical or mental health that is affecting their ability to do the things they used to do to stay well
- Have just moved into a community where they have no support network—perhaps being unaware that there are things going on in the community that would be right up their street (literally and figuratively)
- Are struggling to find the time or the money to do things they used to do because they are spending more time looking after a partner or loved one

Without support, the health and wellbeing of some people in situations like these deteriorate, and they increasingly depend on public services, for example, by turning up frequently at the general practitioner (GP), falling behind on their rent, struggling to get the kids to school, being referred for a social care assessment or being admitted to the hospital with medical issues resulting from self-neglect or an unchecked health issue. The social prescribing model is summarized in Fig. 2.

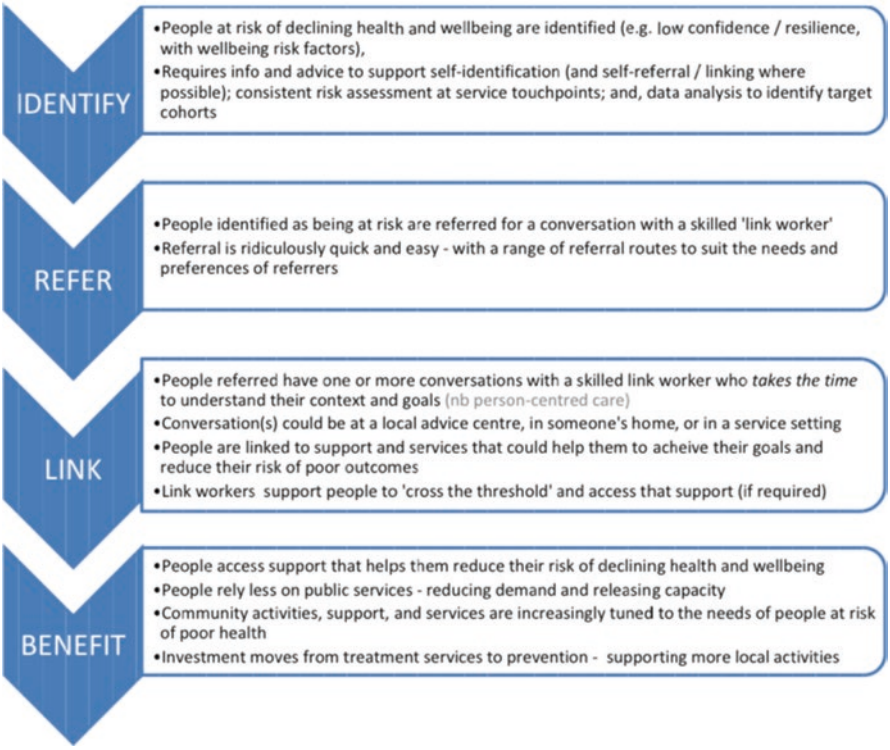


Fig. 2 Social prescribing model. Authors' compilation, reprinted with their permission

The 'People Keeping Well Programme' is a social prescribing initiative established by the Sheffield City Council. A key aim of the initiative was to assist people in their own homes at the earliest time of need, with the main objective being to avoid unnecessary hospital admissions and to prevent deterioration. Therefore, statutory services and long-term social care packages may not be required, and health and wellbeing are improved while also saving the local authority and the NHS money (Harris et al. 2017).

The application of social prescribing in the city of Sheffield originally involved the placement of community support workers (CSWs) in GP practices. In effect, CSWs provide a referral resource for GPs, other primary care staff and for self-referrals. While an electronic referral system between GPs and CSWs was established, a flexible approach to referrals was applied to maximize potential referrals. The social prescribing service in Sheffield attended to patients' non-medical needs through (1) linking people to appropriate support and care—assisting individuals to navigate the system and ensuring that they received the appropriate support and interventions for their particular needs; and (2) referring them to health trainers who support people, on a one-to-one basis, around changing or leading a healthy lifestyle. These health trainers support people to set their own lifestyle goals for chang-

ing their behaviour and engage with them over a period of 6–8 weeks to achieve this personal health plan to improve their health and wellbeing.

Since the inception of the service, referral sources have spread beyond the health sector with increasing word-of-mouth referrals. This is a result of beneficiaries of the programme having positive experiences with the service, to the point where they informally recommend it to others (Harris et al. 2017).

Evaluation

Data collected from thousands of social prescriptions in Sheffield show that over a 3-year period (April 2015–March 2017), 11,350 people were visited by CSWs and provided with 'linking' conversations to improve their wellbeing (Harris et al. 2017). Actions taken by CSWs are depicted in Fig. 3.

The evaluation of the People Keeping Well Programme in Sheffield showed that, through the provision of peer support, CSWs promoted health literacy. This is important given that getting connected to services is heavily dependent on health literacy, specifically the ability to use information to improve health. However, it was found that just providing information and signposting to services was insufficient,and that long-term support is important to help clients access, understand and appraise information and to use support to improve health (Harris et al. 2017).

Further, the evaluation found that the programme was successful in identifying and supporting people who were at risk for mental ill health, as well as those having physical conditions related to avoidable admissions, thus reducing their risk for developing mental and physical ill health. There was, however, insufficient evidence that the programme reduced avoidable use of secondary care (Harris et al. 2017).

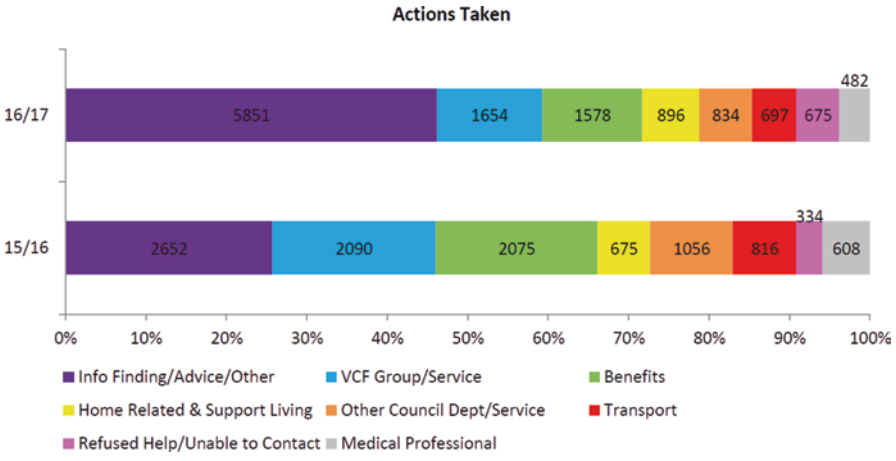


Fig. 3 Actions taken by community support workers (CSWs). From Harris et al. (2017), reproduced with permission

Intervention Implementation and Recommendations

Key factors that made the interventions possible include:

- The need for a culture shift towards person-centred care was key in order for GPs to view a person's problem holistically. Conversations and awareness raising are key to promoting this shift. A feedback loop showing evidence of success has also been found to be helpful in convincing GPs of the usefulness of social prescribing. If they have a patient who has been turning up every week or being regularly admitted to hospital and this pattern changes, buy-in is more likely to be achieved.
- 'Value-based recruitment' was used to identify potential CSWs whose values were congruent with the programme.
- Training of staff to recognize early signs of mental health issues and to have 'healthy conversations'.
- Data-sharing agreements that enable CSWs to access patient records from every practice, as well as patients' social care records.
- Risk stratification—this involves a shift from a reactive to proactive approach to identify not only those already known but to identify those at risk of developing low-level mental health issues so that support can be proactive rather than reactive.

Implementation Challenges

- Implementation was not smooth or even, as aspects were tried out on a small scale over short periods of time and, therefore, not given long enough for change to take place or impact to be measured effectively.
- Trying to establish data-sharing agreements with each individual GP practice took a great deal of time and was often used as a barrier to engagement. Lack of a single patient/customer record meant that follow-up was piecemeal and reliant on frustrating paperwork or time-consuming 'catch-up' conversations. However, the latter could be viewed as advantageous from other perspectives, for example, developing/strengthening links with the worker.
- As many of the low-level interventions were based around reconnecting people with local community support and information, this often left the referrer not knowing if the intervention had the desired outcome until the next appointment (if there is one), which could be weeks or months away and with a different GP.
- Stigma around recognizing and feeling able to talk about emerging mental health issues acted as an impediment to engaging with these issues.
- A lack of continuity of care with patients not always seeing the same GP resulted in GPs not being able to detect subtle changes (both positive and negative) in patient functioning; in addition, patients did not have a consistent form of support in relation to their GP, and there were unnecessary referrals into 'case-managed' services.

Recommendations for Replication and Future Directions

Future replication efforts should ensure that the intervention is co-produced and developed collaboratively with the community in the locality where it is intended to be introduced. Workshops should be held with community groups based in the area, as well as with GP practices, so as to ensure that these stakeholder groups work together to develop an operational framework to guide how the intervention will work on the ground. Further, it is recommended that one works initially with early adopters to get the programme going, as well as investing in 'front-of-house' staff such as receptionists, GP practice managers, practice nurses and so on. They need to know how to have healthy conversations and, more importantly, see this as an integral part of their role. In addition, ensuring an effective feedback loop that provides GPs and other people making referrals with feedback on patient progress is important to promote buy-in and support for the programme.

A further important consideration for replication is that social prescribing infrastructure is not 'free', as there are substantial infrastructure costs. The workers who connect people to activities and interventions need to be paid, well-trained and managed, able to access and be trusted by health and care users and supported with phones, technology and transport. This requires investment in the programme on the part of government and local authorities; however, projects such as social prescribing are usually the first to be cut when these funding bodies are faced with financial difficulties.

Adolescence and Adulthood

During adolescence and adulthood, primary health care provides an opportune setting for the identification of, and early interventions for, incipient severe mental disorders as well as common mental disorders such as anxiety and depression. Early identification of these disorders is important to reduce human misery and suffering, as well as reduce health care costs associated with increased severity and duration of these conditions. It is, however, also important for the promotion of overall health, given that common mental disorders are strongly associated with the onset of chronic physical NCDs (Scott et al. 2016), which are now the leading burden of illness in high-income countries and rapidly advancing in low- and middle-income countries.

Depression is particularly concerning, as it peaks during early adulthood and is responsible for a disproportionately high burden of mental, neurological and substance abuse disability-adjusted life years (DALYs) (24.5%) (Whiteford et al. 2015). Further, depression is also associated with increased risk for the onset of NCDs, particularly diabetes and cardiovascular conditions, while it also exacerbates the course and health outcomes of individuals with NCDs and other diseases such as HIV. In terms of the latter, this is a product of the negative interactive effect of

depression on the endocrine and immune system, as well as its role in reducing treatment adherence (World Health Organization 2014).

Depression is also recognized as a precursor to suicide in both adolescents and adults; therefore, interventions designed to promote improved emotional functioning and depression prevention have the potential to make a significant impact on suicide prevention (Gould et al. 2003; Hawton et al. 2013). The onset of depression and its recurrence are influenced by a range of modifiable risk and protective factors at different stages of the lifespan. Identified risk factors include parental depression, inadequate parenting, child abuse and neglect, stressful life events and bullying (Hosman and Jané-Llopis 2005). Protective factors include sense of control, self-efficacy, stress resistance, emotional regulation, social support and exercise.

With regard to exercise, Daley (2002) notes that a number of studies have demonstrated a positive relationship between exercise and mental health in people with clinical depression, with more recent robust evidence of the role of physical fitness in moderating the impact of psychosocial stress on health (Wood et al. 2017). An example of a community-based exercise programme is provided by the Green Gym project in the United Kingdom; primary care users could be networked to this through social prescribing (described in the previous section). This initiative was a joint venture between a local health authority and the British Trust for Conservation Volunteers (BTCV), established to encourage the local community to improve their health and environment through participation in conservation activities. Participants were offered the opportunity to take part in practical conservation activities such as planting hedges, creating wildlife gardens or improving footpaths in order to improve the local environment. These activities promoted physical activity, as well as social interaction. Local evaluations of the Green Gym initiative point to a number of physical and mental health benefits for participants (British Trust for Conservation Volunteers (BTVC) 1999, 2001).

In addition to mental health promotion interventions for depression, early identification and treatment of depression can assist in reducing the incidence, severity and recurring episodes of these disorders (Muñoz 1998; Petersen et al. 2014). There is evidence of the effectiveness of prevention programmes in reducing depressive symptoms and suicide in people screened as being at risk of developing major depressive episodes. By way of example, from 1983 to 1984, the Swedish Committee for the Prevention and Treatment of Depression launched an educational programme on the diagnosis and treatment of depressive disorders for all GPs on the island of Gotland (Rutz et al. 1995). The proportion of depressive suicides was found to be significantly lower after the training interventions, with savings to society predicted as a result of reduced sick leave and inpatient care, drug prescriptions and frequency of suicide (Rihmer et al. 1995; Rutz et al. 1995).

Evidence-based interventions that are effective for people with preclinical signs of depression and anxiety include cognitive-behavioural therapy (CBT) which, used as a prevention strategy, helps promote more adaptive coping strategies for stressful life events. Interpersonal therapy (IPT) has also been found helpful for strengthening social support and problem management strategies in people with preclinical signs of depression (Cuijpers et al. 2008).

The San Francisco Depression Prevention Research programme is an example of one of the first evidence-based mood management programmes in primary health care. There have since been a number of programmes modelled on the San Francisco Depression Prevention programme, such as the beyondblue guide for the management of depression in primary care, developed for primary practitioners in Australia (https://www.beyondblue.org.au/). Beyondblue is a national non-government organization in Australia, originally started in 2000 to raise awareness and reduce stigma associated with depression, improve early help-seeking and services, as well as support research on how to reduce the incidence of depression. It has since broadened its scope to promote good mental health through multiple platforms and linking across multiple sectors to improve the lives of individuals, families and communities affected by depression, anxiety and suicide. For more information visit https://www.beyondblue.org.au/.

Practice Example: The San Francisco Depression Prevention Research Project (Muñoz 1997; Muñoz and Ying 1993)

Background

The San Francisco Depression Prevention Research programme developed and evaluated strategies for mood management in order to promote healthy emotional functioning and reduce risk for developing clinical depression in poor, ethnic minority patients attending primary care clinics in San Francisco (Muñoz et al. 1987, 1995). The intervention, which adopted a group-based educational format using cognitive-behavioural techniques, was evaluated through a randomized controlled trial. The final sample of 150 participants was 24% African American, 24% Latino, 36% White, 10% Asian and 5% Native American (Muñoz and Ying 1993). Of the 150 randomized participants, 139 were followed up at 1 year (Muñoz and Ying 1993). Depressive symptoms, measured by the Beck Depression Inventory, were significantly lower in the intervention arm compared to the control condition, with the decline in depressive levels in the intervention group found to be significantly mediated by changes in activity levels and the frequency of negative thinking (Muñoz and Ying 1993).

Programme Content

The project focussed on low-income primary care patients from ethnic minority groups attending public sector clinics in the San Francisco area. This target group had high-risk markers of poverty and self-perceived health problems. The programme aimed to reduce the risk of clinical depression by teaching participants methods of mood management based on a social learning approach and cognitive-behavioural theory, using the *Control Your Depression* book by Lewinsohn et al. (1978, 1986). The programme consisted of eight weekly 2-h sessions with

no more than ten participants per group. The order of group sessions was as follows:

1. Introduction
2. How activities affect mood
3. Increasing pleasant activities
4. How thoughts influence mood
5. Learning to change thoughts
6. How contacts with people affect mood
7. Increasing interpersonal activities
8. Planning for the future.

Participants were taught by trained programme implementers to identify their mood states and to learn to keep track of how specific thoughts, levels of pleasant activities and interpersonal contact either improved or worsened their mood. Programme materials included homework forms on which the participant could document daily mood levels, frequencies of mood-related thoughts, activities and contacts with people. These forms were reviewed in the groups to illustrate the relationships among these events. Once these mood states were identified, students were then encouraged to identify and increase those thoughts, activities and interpersonal contact with others that led to positive mood states.

Programme Implementation Features

Adopting a mood management approach: The programme was designed to provide an educational intervention that would not require individuals to take on the role of a 'patient'. Rather, the participants were involved as students learning about mood management skills. The view of depression, as beginning with a problem in emotion regulation, then becoming an unhealthy mood state and eventually becoming a major depression disorder, formed the framework on which the intervention was based. This led to a focus on averting problems in emotion regulation, as well as identifying individuals with unhealthy mood states and providing them with methods to strengthen their emotion regulation capacity. Such an approach, which may be perceived as more positively focussed and less stigmatizing, has widespread applicability in general community, schools and primary health service settings.

A theory-based intervention approach: The social learning and cognitive-behavioural frameworks were utilized in this intervention due to the effectiveness of this combined approach in improving mood states and reducing levels of depression in comparison with anti-depressant medication in clinical populations (Lewinsohn 1975; Beck et al. 1979). The theory underlying these treatment approaches was applied to promotion and prevention of depression. This theoretical approach posits that specific thoughts and behaviours may increase or decrease the likelihood of depressed mood, which in turn, increases the likelihood that depressive thinking and behaviour will occur. Participants were encouraged to identify and modify the

thoughts and behaviours that led to depressive mood states, thereby reducing the likelihood of these states, as well as the likelihood of experiencing a clinical depressive episode.

A group-based format: The group-based approach provided individuals with an opportunity to practice and role-play new skills and techniques acquired in the sessions. There was also an opportunity to use the dynamics of the group as a support to assist with learning and modelling of skills. A group intervention was also more cost-effective in that one teacher/facilitator could impact on as many as ten people, thus making it more economically efficient than one-on-one approaches.

Adoption of a task-sharing approach: The programme was provided by facilitators who were not necessarily mental health professionals but were trained to teach the techniques and methods of the programme. This enabled a wider reach to the target population, especially in resource-scarce contexts. However, it is essential that the facilitators are competent and provided with supervision.

Fidelity to the programme: While it was recognized that the programme would need to be adapted to be more appropriate for different cultural and contextual settings, adherence to the basic principles and structure of the programme is regarded as being critical to effective delivery.

Dissemination and Replication

Subsequent to this initial study, there have been further developments and adaptations of the programme. Muñoz has since manualized the programme and widely disseminated manuals for use for various racial/ethnic groups, such as the *Individual Therapy Manual for Cognitive-Behavioural Treatment of Depression*, *Group Therapy Manual for Cognitive-Behavioural Treatment of Depression* and *San Francisco General Prevention and Treatment Manuals* (Muñoz and Mendelson 2005). The programme also provided the framework for the development of a psycho-educational intervention for low-income women in primary health and mental health settings in Mexico City who displayed depressive symptoms (Lara et al. 2003).

Based on the same principles as the Muñoz programme, Clarke et al. (1995) developed and implemented a 'Coping with Depression Course' with adolescents in Oregon, USA. The course consisted of fifteen 45-min group sessions in which at-risk adolescents were taught cognitive techniques to identify and challenge negative thoughts that may contribute to future development of depression. Employing cartoons, role-play and group discussions, adolescent participants were trained in cognitive restructuring skills to enable them to identify and reduce negative cognitions and thereby reduce the risk of depression. A randomized control trial demonstrated significantly lower depression incidence rates of affective disorders in the intervention group compared to the control group (Clarke et al. 1995, 1999). (Further details of depression prevention programmes for adolescents may be found in chapter 'Implementing Universal and Targeted Mental Health Promotion Interventions in Schools'.)

A further adaption of the mood management approach targeted the prevention of major depressive episodes in pregnant women—the Mamás y Bebés/Mothers and

Babies: Mood and Health Project (Le et al. 2004). A randomized control trial found a lower depressive incidence rate (14.3%) in the group exposed to the intervention compared to the comparison group (25%), although this was not statistically significant. Building further on this project, Barrera et al. (2015) are adapting the intervention to be delivered from an internet web-based platform with increasing evidence of the effectiveness of web-based psychotherapeutic interventions described in the chapter "Implementing Universal and Targetted Mental Health Promotion Interventions in Schools".

Moving to low- and middle-income countries, while there is evidence from controlled trials of the effectiveness of task-shared interventions for depression, where specialist tasks are shared with general health care providers (Patel et al. 2010a, b; Patel et al. 2017; Rahman et al. 2008), one of the first evidence-based mood management programmes, which is being scaled-up in a low- and middle-income country, is that of the Friendship Bench in Zimbabwe. The Friendship Bench is a task-shared intervention at primary health care facilities, where people screened for depressive symptoms are offered counselling by trained lay health workers. To date, it has been scaled up to 70 facilities in 3 cities in Zimbabwe.

Case Study: The Friendship Bench, Zimbabwe

Dixon Chibanda
University of Zimbabwe Clinical Research Centre, Harare, Zimbabwe

Background

The Friendship Bench is a brief psychological intervention delivered by trained lay health workers (LHWs) employed by the city of Harare's health department. The intervention is based on problem-solving therapy (PST) (Chibanda et al. 2011), which is delivered on a park bench in six sessions lasting between 45 and 60 min. Indigenous terms such as: *kuvhurapfungwa* (opening the mind), *kusimudzira* (uplifting) and *kusimbisa* (strengthening) are the key terms used within the context of a traditional PST approach (Abas et al. 2016; Chibanda et al. 2016b). There are over 200 lay health workers (LHWs) currently employed by the 52 clinics in Harare.

The programme was first piloted in 2006 (Chibanda et al. 2011), in response to the high rate of common mental disorders (CMD) observed among people utilizing primary health care facilities in the city. The initiative was later successfully scaled-up to over 70 primary health care facilities in 3 cities in 2015 (Chibanda et al. 2016c). Key source references related to this initiative include a cluster randomized controlled trial (RCT), which showed effectiveness of the approach after a 6-month

follow-up (Chibanda et al. 2016d), validation of culturally appropriate screening tools (Chibanda et al. 2016a), a series of qualitative studies highlighting the experience of both the grandmothers (delivering agent) and clients (Chibanda et al. 2016b, 2017) and a strategy for the evaluation and scale-up of the programme (Chibanda et al. 2016b, c). The mental health landscape and context in the country is described in a national mental health systems analysis (Kidia et al. 2017).

Intervention Implementation and Recommendations

The success of the Friendship Bench was attributed to three key factors that made the intervention possible and ensured its successful planning and delivery. These emerged in the early 2000s and included the need to

- *Address the high burden of psychological morbidity at primary health care level*: Although documented in the early 1990s (Patel et al. 1995, 1997), this need became conspicuous after a government-sponsored clean-up programme (https://en.wikipedia.org/wiki/Operation_Murambatsvina), which left over 300,000 people homeless in 2005. At the time, mental health services were primarily restricted to tertiary facilities, which focussed on acute conditions such as psychosis, epilepsy and severe depression. The government clean-up operation, strongly condemned both locally and internationally, had a negative psychological impact on thousands of people and provided a window of opportunity to address mental health issues at community level.
- *Use non-professionals to fill the gap left by thousands of Zimbabwean health professionals who left the country*: Non-professionals or community health workers had been used extensively in non-mental health work such as in the directly observed treatment (DOT) for TB and community awareness of disease outbreaks such as cholera but never for mental health care. Engaging LHWs was seen as an attractive option which offered minimal financial risks and did not interfere with routine clinic work carried out by nursing staff and doctors at the primary care level. Furthermore, the idea of a mental health programme embedded in the clinics was seen as something that could eventually improve outcomes of non-mental health-related conditions such as HIV, hypertension and diabetes, while the use of an existing cadre already employed by the health department (i.e. LHWs) was further seen as a cost-cutting initiative.
- *Address mental health issues among patients utilizing HIV/AIDS and maternal and child health care services at primary health care facilities*: The Friendship Bench was consistently presented as a programme that would augment existing public health initiatives. This key selling point of the Friendship Bench was found to be attractive by the community and key stakeholders, which included the director of city health services and the Ministry of Health. The idea of providing therapy on a bench—the Friendship Bench—also removed an element of competing needs, which is often used as an excuse to sideline mental health

services and care packages in favour of HIV/AIDS, maternal and child health and immunization programmes. In addition to these factors, an emphasis on providing empirical evidence to justify the Friendship Bench approach was critical. This evidence was gathered systematically over time, with initial research showing the feasibility and acceptability of the approach (Chibanda et al. 2011, 2014). A deliberate and consistent strategy to present data emerging from the programme to policy-makers, academics, communities and user groups contributed to the success and sustainability of the programme, particularly during the planning of the evaluation and scale-up (Chibanda et al. 2016b, c). Furthermore, providing an opportunity for senior policy-makers to present about the Friendship Bench at key international platforms over the years, such as the WHO mHGAP meetings, strengthened stakeholder buy-in. A clearly defined public engagement strategy, which included social media, radio/TV appearances and publications of 'op-eds', further increased visibility of the programme.

Implementation Challenges

The implementation of the Friendship Bench was rooted in a rigorously designed cluster randomized controlled trial (Chibanda et al. 2016d), which was followed by a well-defined scale-up strategy endorsed by key stakeholders including the Ministry of Health, city health services, academic institutions, user groups and NGOs (Chibanda et al. 2016b, c). Despite this well-planned approach, several challenges emerged which included the absence of a strategy on the following:

- *How to maintain fidelity among the newly trained 400 LHWs delivering the programme*: During the formative stage, five cross-cutting issues were identified as critical and needing to be addressed for a successful scale-up (Chibanda et al. 2015). These included the lack of training in mental health, unavailability of psychiatric drugs, depleted clinical staff levels, unavailability of time for counselling and poor and unreliable referral systems for people suffering with depression. Consensus was reached by stakeholders on supervision and support structures to address these cross-cutting issues described above, and funding was successfully secured for the scale-up (Chibanda et al. 2016c). However, a major limitation to the strategy was the absence of a protocol and standard operating procedures (SOP) to ensure fidelity. Following a needs assessment of the different clinics, which focussed on challenges faced by clinic staff in integrating mental health care at primary care level and ensuring fidelity (Chibanda et al. 2016c), a fidelity checklist was developed which included random audio recording of sessions, client exit questionnaires and peer group support to discuss difficult cases with LHWs. Although these strategies have been implemented in most clinics, there is still a need to examine factors that make certain communities perform better than others in implementation of the Friendship Bench.

- *How to address comorbidity when LHWs on the Friendship Bench were primarily trained to only manage common mental disorders (CMDs)*: With the popularity of the Friendship Bench, an upsurge of patients requiring mental health services that are beyond the scope of the LHWs has emerged. Conditions such as substance use, epilepsy and psychosis have been referred to the Friendship Bench. Although LHWs are trained to refer to tertiary facilities, patients and their families are often reluctant to be referred beyond their community. In response to this, a more trans-diagnostic approach (Upthegrove et al. 2017) is being included in future development of the Friendship Bench. This approach focuses on similar aetiological and maintenance processes that underlie psychopathology (Newby et al. 2015) and is consistent with the Research Domain Criteria (RDoC) (Krueger and DeYoung 2016; Yager and Feinstein 2017). This approach, also described as a common elements approach, seeks to empower LHWs with the capacity to use an internal stepped-care approach where LHWs refer to each other within a closed system with minimal use of external referral (Murray et al. 2014)
- *How to manage the large number of people needing services*: The original cohort of 400 LHWs trained to deliver the problem-solving therapy (Chibanda et al. 2011) of the Friendship Bench intervention has not been able to deal with the demand for services. In response to this demand, a group therapy approach (Chibanda et al. 2014) has been considered for certain key populations such as pregnant women, young people living with HIV and commercial sex workers.

Key Recommendations for Replication

A three-pronged approach consisting of community engagement, use of evidence-based treatments and a government-endorsed scale-up plan was critical in the scale-up of the Friendship Bench in Zimbabwe (Chibanda 2017). While this approach has worked, it faced challenges in ensuring fidelity, addressing comorbidity and meeting population demand. Other generic and contextual factors such as the core competencies of delivering agents (Collins et al. 2015), and the support and sustainability of the initiative, should be considered for successful replication of this approach (Chibanda et al. 2016c).

Despite the challenges, the three most important ingredients for successful replication and scale-up of the Friendship Bench approach should include

1. Integration in an existing health care system.
2. The delivering agents should be part of an existing health care system and supported by the government.
3. A supervision system that is sustainable.

While all three ingredients are present within the existing Friendship Bench model, the third component has been challenging to sustain, largely due to the high turnover of senior staff within the city health department, as well as an absence of ongoing formal training, supervision and mentoring for both LHWs and nursing staff that is embedded within the primary care system.

Future Directions for Application of the Intervention

As the Friendship Bench expands to rural Zimbabwe and considerations for scale-up outside Zimbabwe are discussed, there will be a need to focus more on a common elements approach (Murray et al. 2014), which enables LHWs to address a number of conditions using an internal stepped-care approach as described above (Murray et al. 2011). Building capacity to put in place sustainable training, supervision and mentoring strategies will be a key element to ensure continued growth of the programme.

The mental health of young people will be of particular importance within this context because young people face different challenges and most mental disorders start during this period (Patel et al. 2007). Emphasis on young people living with HIV will be critical because they have poor HIV-related outcomes, higher mortality (Makadzange et al. 2015) and double the adult rates of CMD (Mavhu et al. 2013), with comorbidity of CMD and substance use often described as the norm (Quello et al. 2005).

Future Directions for Adolescent and Adult Mental Health Promotion Interventions

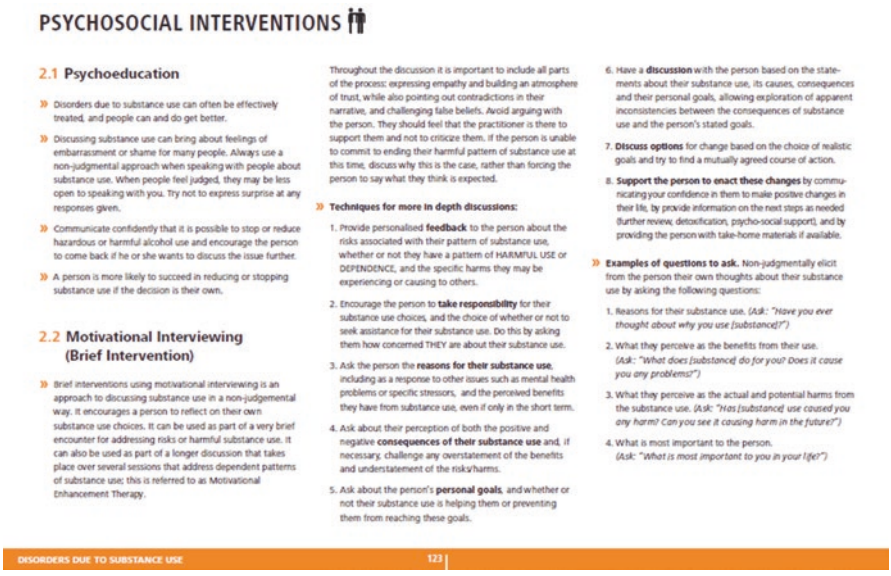
In the age of information technology and the Internet, there is increasing evidence of the effectiveness of supported and unsupported internet web-based psychotherapy for reducing depressive and anxiety symptoms (Andersson and Cuijpers 2009). The Internet provides a convenient, efficient and low-cost platform for the scaling-up of evidence-based mood prevention programmes (2010). MoodGYM is an example of a widely used web-based psychological therapy programme using CBT principles. It has more than 700,000 registered users globally (www.mhinnovation.net/innovations/moodgym) and has proven effective at treating mild and moderate depression and anxiety and in promoting mental wellbeing (Powell et al. 2013). While these studies have been mainly conducted with users from high-income countries, with greater Internet access in low- and middle-income countries, such technologies provide leapfrogging opportunities to increase access to such interventions for people in these countries, where specialist and generalist human resources are scarce (Patel et al. 2016a, b).

SPARX is a classic example of an evidence-based online CBT programme for adolescents with depressive and anxiety symptoms that has been scaled-up in New Zealand with the support of the Department of Health (see case study on implementation of the SPARX computerized cognitive behavioural programme in chapter ‘Implementing Universal and Targeted Mental Health Promotion Interventions in Schools’).

In addition to depression, alcohol misuse is another cause for concern given that it comprises the highest burden of substance use disorders globally (Whiteford et al. 2015). Alcohol misuse is also associated with the onset of a number of mental and

physical NCDs (Scott et al. 2016), such as depression, cardiovascular disease, diabetes and cirrhosis of the liver. It is also associated with increased risk of contracting HIV and tuberculosis, as well as accidental/intentional injuries that could result in death (Rehm et al. 2006, 2009).

Screening and brief interventions (SBIs) for alcohol misuse provided by primary health care providers have been found to be effective in reducing hazardous and harmful drinking and in reducing the onset of alcohol use disorders in adults and, in particular, among pregnant women (Botelho et al. 2011; Patel et al. 2016a, b). These interventions involve screening to detect individuals drinking hazardous or harmful amounts of alcohol, as well as the delivery of a brief intervention using motivational interviewing techniques to reduce alcohol consumption. Motivational interviewing is a counselling method that evolved from a client-centred approach and typically involves motivating people to change behaviours that are not health enhancing (Miller and Rollnick 1991). In the case of alcohol misuse, the health care practitioner provides information on the risks of alcohol misuse and encourages the person, in a non-judgemental way, to reflect on their alcohol use and ways in which they could reduce consumption. The *mhGAP Intervention Guide* provides guidelines for brief motivational interviewing for substance use disorders as an example (Fig. 4).



PSYCHOSOCIAL INTERVENTIONS

2.1 Psychoeducation

» Disorders due to substance use can often be effectively treated, and people can and do get better.

» Discussing substance use can bring about feelings of embarrassment or shame for many people. Always use a non-judgmental approach when speaking with people about substance use. When people feel judged, they may be less open to speaking with you. Try not to express surprise at any responses given.

» Communicate confidently that it is possible to stop or reduce hazardous or harmful alcohol use and encourage the person to come back if he or she wants to discuss the issue further.

» A person is more likely to succeed in reducing or stopping substance use if the decision is their own.

2.2 Motivational Interviewing (Brief Intervention)

» Brief interventions using motivational interviewing is an approach to discussing substance use in a non-judgemental way. It encourages a person to reflect on their own substance use choices. It can be used as part of a very brief encounter for addressing risks or harmful substance use. It can also be used as part of a longer discussion that takes place over several sessions that address dependent patterns of substance use; this is referred to as Motivational Enhancement Therapy.

Throughout the discussion it is important to include all parts of the process: expressing empathy and building an atmosphere of trust, while also pointing out contradictions in their narrative, and challenging false beliefs. Avoid arguing with the person. They should feel that the practitioner is there to support them and not to criticize them. If the person is unable to commit to ending their harmful pattern of substance use at this time, discuss why this is the case, rather than forcing the person to say what they think is expected.

» **Techniques for more in depth discussions:**

1. Provide personalised **feedback** to the person about the risks associated with their pattern of substance use, whether or not they have a pattern of HARMFUL USE or DEPENDENCE, and the specific harms they may be experiencing or causing to others.
2. Encourage the person to **take responsibility** for their substance use choices, and the choice of whether or not to seek assistance for their substance use. Do this by asking them how concerned THEY are about their substance use.
3. Ask the person the **reasons for their substance use**, including as a response to other issues such as mental health problems or specific stressors, and the perceived benefits they have from substance use, even if only in the short term.
4. Ask about their perception of both the positive and negative **consequences of their substance use** and, if necessary, challenge any overstatement of the benefits and understatement of the risks/harms.
5. Ask about the person's **personal goals**, and whether or not their substance use is helping them or preventing them from reaching these goals.
6. Have a **discussion** with the person based on the statements about their substance use, its causes, consequences and their personal goals, allowing exploration of apparent inconsistencies between the consequences of substance use and the person's stated goals.
7. **Discuss options** for change based on the choice of realistic goals and try to find a mutually agreed course of action.
8. **Support the person to enact these changes** by communicating your confidence in them to make positive changes in their life, by provide information on the next steps as needed (further review, detoxification, psycho-social support), and by providing the person with take-home materials if available.

» **Examples of questions to ask.** Non-judgmentally elicit from the person their own thoughts about their substance use by asking the following questions:

1. Reasons for their substance use. (*Ask: "Have you ever thought about why you use [substance]?"*)
2. What they perceive as the benefits from their use. (*Ask: "What does [substance] do for you? Does it cause you any problems?"*)
3. What they perceive as the actual and potential harms from the substance use. (*Ask: "Has [substance] use caused you any harm? Can you see it causing harm in the future?"*)
4. What is most important to the person. (*Ask: "What is most important to you in your life?"*)

DISORDERS DUE TO SUBSTANCE USE 123

Fig. 4 mhGAP guidelines for brief motivational interviewing to reduce substance use in patients (From *mhGAP Intervention Guide*, Version 2.0. World Health Organization (WHO), p. 123. Reprinted with permission of the World Health Organization)

Older Adults

In older adults, typically regarded as being over 65 years, risk for dementia is of particular concern. This encompasses Alzheimer's disease as well as vascular dementia, among other forms, and affects cognitive abilities including memory, behaviour and functionality. It is estimated that 47 million people worldwide were living with dementia in 2015, with a sizable proportion (60%) being from low- and middle-income countries, with this figure expected to triple by 2050 (Livingston et al. 2017). Modifiable risk factors for dementia in older people include adult lifestyle factors that are associated with NCDs (particularly hypertension, type II diabetes and hypercholesterolemia) and also include physical inactivity, obesity associated with unhealthy diet, tobacco use and harmful alcohol use. In addition, midlife depression, low educational attainment, social isolation and cognitive inactivity are also associated with increased risk for dementia (Livingston et al. 2017).

mhGAP provides guidelines for the early recognition of signs of dementia, the provision of psycho-education, management of psychological and behavioural symptoms, the promotion of functioning in activities of daily living, interventions to improve cognitive support and carer support. Mental health promotion activities to reduce risk for the onset of dementia in later adulthood include adequate management of depression and non-communicable diseases, especially diabetes and hypertension, during middle age and in older people, general health promotion programmes to promote healthy adult lifestyles, the promotion of social engagement activities among older people who may be socially isolated and the promotion of cognitively stimulating activities and continued learning as a person ages (World Health Organization 2017).

The early dementia prevention programme in Singapore provides an example of a multipronged intervention for dementia and late life depression, involving community nurses inviting residents aged 60 and above to be screened for depression, mild cognitive impairment and dementia by a team of professionals. In addition to diagnoses being formally communicated to participants' doctors for medical treatment, participants are invited to free psychosocial interventions. These include group activities that expose participants to health education on the need to keep chronic NCDs such as diabetes and hypertension in check, as well as other activities such as art therapy, Tai chi exercise, mindfulness practice or music reminiscence (where participants share the memory behind their music choice) (Wu et al. 2014). An observational study of 210 elderly Chinese people screened as having mild depressive symptoms found a significant improvement in mood on the Zung Self-Rating Depression Scale after 3 months on the programme, with no significant differences between the groups exposed to the different modalities of therapy (Kua et al. 2013). For more information see http://nusmedicine.nus.edu.sg/pcm/research-2/research-programmes/dementia-prevention-programme-dpp/.

Conclusions

Mental health promotion in primary care settings is fundamental to the vision of primary health care as contained in the Alma-Ata Declaration of 1978 (World Health Organization 1978). As the first point of contact a person has with the health system, it provides an opportune setting for identifying and supporting people at risk of developing mental disorders and for the implementation of mental health promotion and prevention interventions. Further, the extension of primary care into the community via outreach programmes expands its reach beyond primary health care facilities, providing opportunities for the delivery of interventions better suited to being provided in people's homes and in the community, as exemplified by the Philani mentor mothers' programme.

The global trend towards integration of mental health into primary health care, supported by the World Health Organization's mhGAP programme, provides an important opportunity to strengthen mental health promotion interventions in primary care, which includes linking service users to other sectors, as well as evidence-based mental health promotion interventions that may be available in the community.

This chapter has provided examples of evidence-based mental health promotion programmes that have been delivered from the primary care setting. While these may be more readily available in high-income countries, there is a need to promote such interventions in low- and middle-income countries, where the focus to date has been on the provision of treatment services. While this focus is not surprising given the large treatment gap experienced in these contexts (Wang et al. 2007), treatment alone is unlikely to close the ever-growing burden of unmet need as the prevalence of mental disorders increases globally (Patel et al. 2016a, b). For this, efforts to increase access to treatment need to be accompanied by mental health promotion and prevention interventions across the lifespan.

Based on the research evidence and the interventions examined in this chapter, the following characteristics of successful mental health promotion programmes in the primary health care setting have been identified to guide effective practice:

- Programmes that adopt a competence enhancement and empowering approach—working in partnership with families and the local community.
- Programmes and initiatives that strive towards adopting an ecological approach—seeing the child or adult as a member of a family and the family as a member of the community, engendering a better appreciation of how circumstances affect both the parents' and children's development capacities.
- Home-visiting programmes that seek to address a broad spectrum of family needs are more effective than single-focus programmes.
- Programmes developed for at-risk populations, to ensure greater efficiency with scarce resources, focussing on families with a high level of need such as unsupported and young families, families living in poverty and those having children with a high level of need.
- Sustained high quality and continuity of input are important so that a relationship of trust and mutual respect is established.

- Interventions based on inter-agency and cross-sectoral community work, facilitating access to integrated health, education and social services.
- Programmes that critically monitor their implementation in context and assess how programme delivery is affected by, and how it can positively influence, formal and informal family services and supports.
- Programmes delivered in a non-stigmatizing and accessible manner, reaching those most in need.
- Programmes integrating mental and physical health goals, such as exercise programmes, are important for the promotion of overall health.
- Programmes delivered by skilled and trained staff orientated to recognize and respond to the mental health needs of the local community.

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Part VIII
Mental Health Promotion Within Mental Health Services

Re-orienting Mental Health Services to Mental Health Promotion

Rachel Jenkins

Introduction

The re-orientation of mental health services to mental health promotion carries with it the promise of dramatic changes in the culture of service provision and in attitudes towards mental disorders and mental health service users (McGorry 2000; WHO Global Mental Health Action Plan 2013–2020). Programmes that promote recovery and strengthen opportunities for user empowerment, together with initiatives to reduce the stigma and discrimination associated with mental disorder, have a key role in promoting the mental health of service users. It is now appreciated that mental health promotion is just as valuable for people with mental disorder as for the general population. This is strongly backed up by the research evidence, which indicates that positive mental health is a separate dimension to mental ill-health, and hence there is a scientific rationale to the view that efforts can be made to boost a person's positive mental health at the same time as managing the person's mental ill-health (Keyes 2002; Beddington et al. 2008; Weich et al. 2011).

The various dimensions of mental health promotion include the enhancement of the perceived value of positive mental health for mental health service users and staff, education of both patients and staff about the importance of mental health promotion, the inclusion of mental health promotion within care management plans, and the inclusion of mental health promotion within service structures and organizations. Therefore, mental health service users will benefit from many of the interventions and approaches discussed in previous chapters, e.g. empowerment and competence enhancement approaches, exercise programmes, community participation, social support and employment programmes. In addition, there are specific

R. Jenkins (✉)
King's College London, London, UK
e-mail: rachel@olan.org

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quality of life issues for mental health service users and their families in terms of living and coping with long-term mental disorder, which will require targeted interventions in order to meet people's needs.

Rationale for Promoting Mental Health Promotion Within Mental Health Services

Background

Mental health promotion is concerned with achieving positive mental health and quality of life. For much of the history of mental health promotion, efforts to promote mental health have been largely focussed on the general population and on non-health sectors. However, just as primary health care is a key opportunity for mental health promotion (see Chapter 'Implementing Mental Health Promotion in Primary Care'), it is now also increasingly understood that mental health promotion is as crucial for people engaged with specialist mental health services as it is for the general population. There have been at least three historical trends that have influenced this view. Firstly, the gradual shift to community-based care from the institutional care that had developed during the eighteenth century, and continued uncontested and unabated until half way through the twentieth century when evidence started to emerge of its harmful effects on social skills and cognition. Secondly, the emergence of the recovery movement that aims to empower people with mental disorder. Thirdly, the recent inclusion of mental health in international development goals, now termed the Sustainable Development Goals (United Nations: Economic and Social Council 2005).

Shift in Service Delivery

The first of the three key trends mentioned above, which influence both the rationale and the context to mental health promotion in specialist services, is the shift in service delivery away from assessment, management and long-term care in large institutions, often a long way from home, towards more local comprehensive, community-based mental health care. This shift to community-based care brings an emphasis on care being delivered as close to home as possible, with smaller and more local provision of inpatient services. Such reform processes have been outlined in a variety of low and middle income countries in eastern Europe, the Middle East (Jenkins et al. 2010) and Africa (Mbatia and Jenkins 2010; Kiima and Jenkins 2010). For example, in Russia, a collaborative reform project comprised situation appraisal to inform planning; sustained policy dialogue at federal and regional levels to catalyse change; introduction of multidisciplinary and intersectoral working at all levels; skills-based training for professionals at primary care level, specialist

level and in other sectors; and support for non-governmental organizations (NGOs) to develop new care models (Jenkins et al. 2007, 2009, 2010). In Egypt, mental health has been integrated into general health sector reforms, while in Africa more broadly the shift has been especially to integrate mental health into primary care, supported by local decentralized district mental health services (Mbatia and Jenkins 2010; Kiima and Jenkins 2010; Jenkins et al. 2011).

This global shift from large-scale institutions where people spend long periods of time to community oriented mental health service provision provides increasing opportunities for mental health promotion by ensuring that both the way in which services are provided and the environment in which they are delivered contribute to improving the health of the 'whole' individual rather than just treating the mental disorder. The second objective of the WHO Mental Health Action Plan 2013–2020 centres around providing comprehensive, integrated and responsive mental health and social care services in community-based settings (World Health Organization 2013). Adopting a mental health promotion perspective highlights the need for a more comprehensive approach to service delivery addressing the full range of needs of service users and their families within a comprehensive, integrated and positive model of care that addresses mental health promotion, prevention, assessment, treatment, rehabilitation and prevention of mortality. Mental health promotion within the mental health services adopts a holistic approach towards mental health, taking into account people's mental, physical, emotional, spiritual, social, educational, employment and other practical needs in order to promote improved quality of life.

The Recovery Approach

The second historical trend has arisen in the context of a shift to a more holistic, socially inclusive approach and is termed the recovery approach, which has become a pervasive concept in specialist mental health services. The recovery approach aims to empower individuals with mental disorder and enable them to be agents of change rather than passive recipients of care.

The recovery approach has emphasized the individual and personal journey towards regaining a meaningful life and becoming more resilient, involving the development of hope, a sense of personal security, a sense of self, supportive relationships, empowerment, social inclusion, coping skills and meaning to life (American Psychological Association 2012; Elm et al. 2016). The recovery approach sees symptoms as a continuum of the norm rather than as a 'sane-insane' dichotomy. Indeed the epidemiological study of the distribution of symptoms in the general population supports this view that symptom distribution is on a continuum rather than as discontinuous in the general population (Johns et al. 2004). The recovery approach gained impetus as a social movement due to a perceived failure by services and/or wider society to adequately support social inclusion. A number of features or signs of recovery have been proposed and categorized under the concept of CHIME, which is an abbreviation of Connectedness, Hope and optimism, Identity, Meaning and purpose and Empowerment (Leamy et al. 2011).

A common aspect of recovery is considered to be the presence of others who believe in the person's potential to recover, and who stand by them. While mental health professionals can offer a particular limited kind of relationship and help foster hope, relationships with friends, family and the community are considered to often be of wider and longer-term importance (Repper and Perkins 2006). Others who have experienced similar difficulties, who may be on a journey of recovery, and those who share the same values and outlooks more generally (not just in the area of mental health) may also be particularly important. It is thought that one-way relationships based on being helped can actually be devaluing and that reciprocal relationships and mutual support networks can be of more value to self-esteem and recovery.

Community-Based Rehabilitation

Community-based rehabilitation (CBR) is also relevant to recovery (World Health Organization 2010). It was introduced by WHO following the Alma-Ata Declaration (WHO 1978).

In the beginning, CBR was primarily an approach to bring primary health care and rehabilitation services closer to people with disabilities, especially in low and middle-income countries (LMICs). But gradually, it adopted a more multisectoral approach. In 2003, the Helsinki International Conference (WHO 2003) highlighted the need for CBR programmes to focus on reducing poverty, promoting community involvement and ownership, scaling up programmes and using evidence-based practice in LMICs, in order to implement the convention. Consequently, CBR has been redefined as 'a strategy within general community development for the rehabilitation, poverty reduction, equalization of opportunities and social inclusion of all people with disabilities' (International Labour Office 2008, p. 6), and it has broadly been recognized that mental, neurological and substance use (MNS) disorders should be mainstreamed within CBR to promote and protect the rights of people with mental health problems and disorders, support their recovery and facilitate their participation and inclusion in their families and communities (WHO, UNESCO, ILO and International Disability Development Consortium 2010). In addition, CBR contributes to the prevention of mental health problems and promotes mental health for all community members. Thus, while initially a strategy to increase access to rehabilitation services in resource-constrained settings, CBR is now a multisectoral approach working to improve the equalization of opportunities and social inclusion of people with disabilities while combating the perpetual cycle of poverty and disability. CBR is implemented through the combined efforts of people with disabilities, their families and communities, and relevant government and non-government health, education, vocational, social and other services. Guidelines for its implementation have been produced by WHO in 2010, and the CBR matrix is a helpful adjunct to consideration of the different issues relevant to social inclusion for people with disabilities (http://www.who.int/disabilities/cbr/cbr_matrix_11.10.pdf?ua=1).

The Sustainable Development Goals

The third trend is the international focus on the Sustainable Development Goals, which include mental health both explicitly in SDG 3, and implicitly in other relevant goals, and these are described more fully in Chapter 'Promoting Mentally Healthy Workplaces'. Suffice it here to say that in the Agenda 2030 for Sustainable Development, population mental health has been recognized as a critical element of sustainable development.

The rationale for inclusion of mental health within the SDGs derives from the recognition that mental disorders are the leading cause of the non-fatal disease burden globally and contribute significantly to premature mortality from NCDs due to suicide, trauma and accidents and the comorbidity between mental ill-health, physical illness and substance misuse (see Chapter 'Reframing the Challenge of Promoting Population Mental Health'). Apart from the development goals that make specific reference to mental health such as, SDG 3.4, 3.5 and 3.8, goals 4, 8, 10 and 11 also include specific reference to the inclusion of people with disabilities. To achieve progress on these goals will require intersectoral action on integrating mental health within the broader global health and development agenda including, mainstreaming mental health within national health and development policies and strengthening mental health systems. As highlighted in Chapter 'Reframing the Challenge of Promoting Population Mental Health', progress on the SDGs related to poverty reduction, gender equality, economic development and reducing social inequities will contribute greatly to mental health promotion as mental health is strongly influenced by levels of poverty, financial hardship and debt, education and low productivity. Likewise, the development of mental health systems with more effective treatment, prevention and promotion interventions will contribute to reducing premature mortality from NCDs.

There is, therefore, a strong case for the inclusion of mental health promotion within mental services to address the heavy burden of mental disorders, the immense exclusion suffered by people with a mental disorder, the impact of mental disorders on physical health and the fact that mental health promotion measures have an effective role to play in improving the social functioning and quality of life of people with mental disorder. Each of these aspects will now be considered.

The Burden of Mental Disorders

The SDGs have been underpinned by a growing understanding of the measurement of the Global Burden of Disease (see Chapter 'Reframing the Challenge of Promoting Population Mental Health'). Metrics have been devised to measure the global burden attributable to each disease. These metrics comprise the Disability Adjusted Life Year (DALY), Years of Life Lost (YLL) through premature mortality from a disease and Years of Life lived with a Disability (YLD) through disability accompanying a particular disease. Overall, mortality is declining faster than both disease prevalence and disability. Mental, neurological and substance misuse

(MNS) disorders account for 10.4% of global disability-adjusted life years (DALYs), 2.3% of global years of life lost due to premature mortality (YLLs) and 28.5% of YLDs. In addition, MNS disorders account for four out of the ten leading causes of disability, with depression being the most disabling disorder worldwide measured in YLDs (Whiteford et al. 2013). By 2030, depression is expected to be the leading cause of disability in high-income countries (HICs), the second leading cause of disability after HIV/AIDS in middle-income countries (MICs) and the third leading cause of disability after HIV/AIDS and perinatal conditions in low-income countries (LICs) (Whiteford et al. 2013). Indeed the global burden of mental disorders is underestimated in these calculations (Vigo et al. 2016). Thus, people are living longer, but with more diseases and disability. There is a major transition from prevalence of communicable diseases to non-communicable diseases, for which health systems are inadequately prepared (Atun 2015), and there is a need for a comprehensive coordinated response from health and social sectors at the country level (World Health Organization 2011).

Thus, the burden arises from the combination of prevalence, disability and chronicity of the disorders, as well as their contribution to premature mortality. Some mental disorders may last a long time. Studies carried out since the 1950s have given a general indication that most people with nonpsychotic mental disorders, such as depression and anxiety, recover with treatment, and that at least a third of those with psychosis recover fully, another third pursue a relapsing course which can be greatly improved by consistent management and the deterioration in the remaining third can be arrested by multidimensional management (Harding et al. 1987; Harrison et al. 2001). However, precise proportions depend on the selection criteria and outcome measures used. Smith et al. (2010) found that approximately three quarters of people with schizophrenia have ongoing disability with relapses (Smith et al. 2010). When people with a first episode of psychosis are followed up, a good long-term outcome occurs in 42% of cases, an intermediate outcome in 35% of cases and a poor outcome in 27% of cases (Menezes et al. 2006). After long-term follow-up, half of people with schizophrenia have a favourable outcome, while 16% have a delayed recovery after an early unremitting course. It was found that the course in the first two years predicted the long-term course and early social intervention was related to a better outcome (Harrison et al. 2001). A clinical study using strict recovery criteria (concurrent remission of positive and negative symptoms and adequate social and vocational functioning continuously for two years) found a recovery rate of 14% within the first five years (Robinson et al. 2004). A 5-year community study found that 62% showed overall improvement on a composite measure of clinical and functional outcomes (Harvey et al. 2007).

These statistics highlight the major contribution made by mental disorders to the overall disease burden in the world and are one of the reasons why it is crucial to expend effort on boosting good mental health, preventing mental disorder, developing services for effective treatment and encouraging recovery. Further reasons for action are described below, namely the impact of mental disorders on physical health, social functioning and social exclusion.

Impact on Physical Health

People with severe mental disorders have been identified as being one of the most excluded and vulnerable population groups, with poorer physical health and significantly raised standardized mortality ratios (SMRs) than the general population (Hoang et al. 2013; Saha et al. 2007). Some of these increased health risks include cardiovascular disease, respiratory infections, diabetes, hepatitis C, obesity, malignancy and trauma (Beary et al. 2012). Medications used to treat mental disorders often affect appetite and gastrointestinal function, as well as altering the absorption and metabolism of nutrients. Excessive weight gain occurs in up to half of all patients prescribed anti-psychotic drugs and in some cases is associated with the development of Type II diabetes (INDI 2000). Research has also shown that the prevalence of smoking is significantly higher among people with mental disorders than the general population and smoking is a leading contributor to early mortality in this population (Tam et al. 2016).

Some of the symptoms associated with mental disorders, such as schizophrenia, may exacerbate or contribute to physical health problems. For example, people with schizophrenia are less likely than healthy controls to report physical symptoms spontaneously. This may be due to cognitive impairment, social isolation and suspicion, which may contribute to patients not seeking care or adhering to treatment. Health professionals have been shown to have stigmatizing attitudes towards people with mental disorder which impacts on their care (Reavley et al. 2014; Stuber et al. 2014), and they are, therefore, less likely to be offered annual health checks and health promotion interventions. Clearly, there is a need to ensure the provision of routine health promotion and prevention services to mental health service users as this could make a significant contribution to their general health.

Impact on Social Functioning

With the move to community-based care, there has been increasing emphasis on the impact of service provision on the quality of life of mental health service users (Katschnig et al. 2006). The quality of life literature has drawn attention to the need for services to ensure the adequate provision of resources for living, i.e. housing, financial and social support, leisure and employment opportunities. The focus on quality of life has also highlighted the importance of the individual service user's perspective including their sense of efficacy and control over their lives, and their ability to fulfil their roles and identities as community members (Zissi and Barry 2006). The focus of services, therefore, extends beyond clinical treatment to consider the needs of the whole person in their social context. This has brought a shift to psychosocial models of intervention designed to build service users' capacities and their personal and social resources for living. Together with supports for economic independence and empowerment (Laugharne and Priebe 2006), psychosocial programmes have been shown to have a positive effect on sense of control and quality of life. Therefore, mental health promotion interventions which

build on the strengths and capacities of service users and their families, and encourage greater participation and expectations of positive outcomes and recovery, are also likely to contribute to overall subjective well-being and improved mental health.

Social Exclusion

People with mental disorders consistently identify stigma, discrimination and social exclusion as major barriers to their health, well-being and quality of life (Read et al. 2006). Exclusion from employment opportunities, good quality housing, social participation and lack of control and influence in how services are designed and delivered have been identified as contributing to the sense of isolation experienced by people with mental health problems (Bates 2002). Clement et al. (2015) found that stigma and discrimination are barriers to help-seeking and lead to employment discrimination. Identified barriers to help-seeking included the use of stereotypes such as 'weakness' and 'craziness'; social judgement and rejection of people with mental health problems; and shame/embarrassment. Disclosure issues were found to be a particular concern, and interventions to aid decision-making around disclosure may be warranted. Employment is important both in maintaining mental health and in promoting the recovery of those who have experienced mental health problems. As already outlined in Chapter 'Addressing Mental Health Problems at Work', work is crucial for people with mental health problems in that it provides structure, a sense of purpose and identity, and a sense of achievement, as well as a source of income. Unemployment aggravates the social exclusion already experienced by those with mental health problems and can lead to poverty, unmanageable debt, crime and homelessness. Indeed, a two way relationship exists between mental disorders and socioeconomic status so that mental disorders lead to reduced income and employment, which entrenches poverty and in turn increases the risk of mental disorder (WHO and Calouste Gulbekian Foundation 2014). As Rankin (2005) put it '*Mental health problems are written like invisible ink on social problems such as poverty, worklessness and social exclusion*.'(p. 10).

International Legal Context

The UN Convention on the Rights of Persons with Disabilities (CRPD) enshrined in international law the shift to community services and the right of a person with disabilities (a term which expressly includes mental disabilities) to integration into the community (United Nations 2006). Domestic mental health legislation in individual countries is crucial to safeguard the rights of people with mental disorders, including their right to access appropriate services and supports (Bartlett et al. 2011). The CRPD has been followed by a report from the United Nations Human Rights Council which argues for the right of everyone to the highest standard of mental health (The 2017 Annual Report by the Special Rapporteur to the UN Human Rights

Council, on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21). It complements the report presented by the Office of the High Commissioner for Human Rights in March 2018 (A/HRC/34/32), mandated by Resolution 32/18 (http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx). The 2017 report states that 'For care to comply with the right to health, it must embrace a broad package of integrated and coordinated services for promotion, prevention, treatment, rehabilitation, care and recovery.' (paragraph 55). It also argues that 'the right to health requires that mental health care be brought closer to primary care and general medicine, integrating mental with physical health' (paragraph 78). It follows that specialist mental health services need to ensure close links with primary care and general health care for their clients. The right to health also applies to people in prisons (United Nations 2005) where mental health promotion can also be included. Efforts have been made to produce mental health guidelines for prisons (Paton and Jenkins 2002), but implementation is hampered in prison environments where staffing is highly stretched, and resources for staff training are restricted.

Recovery and Mental Health Promotion

Concept of the Recovery Approach

The move towards community care and the delivery of community-based services has highlighted the importance of meeting the broader needs of mental health service users in the context of their social environments. The consensus is that mental health services, as well as being evidence-based, should reflect the life goal of service users so that as well as focussing on symptom reduction, services also help people to attain independence, employment, satisfying relationships and quality of life (Slade et al. 2008). This approach underpins the concept of recovery, as outlined in the introduction above. Recovery was originally described as involving the development of new meanings and purpose in one's life as the person grows beyond the effects of the mental disorder (Anthony 1993). The recovery model stresses the importance of empowerment and self-directedness and emphasizes that the person who has the condition must be given in large part responsibility for, and control of, the recovery process (Frese et al. 2001). Mental health services embracing this approach are designed to be empowering for service users and stress values such as healing, hope, social connectedness, human rights and recovery-oriented services (Jacobson and Greeley 2001). The recovery movement has spread rapidly, and there are now many examples of models of service delivery based on holistic recovery models, i.e. those which address the physical, mental, emotional and spiritual aspects of people within their social setting. Such holistic recovery models recognize the importance of social needs such as appropriate housing, employment, leisure opportunities, freedom from discrimination and the need for social networks and support. For example, Hergerl et al. (2016) describe a four-level intervention concept

comprising training and support of primary care providers (level 1), a professional public relations campaign (level 2), training of community facilitators (teacher, priests, geriatric caregivers, pharmacists, journalists) (level 3) and support for self-help of patients with depression, and for their relatives (level 4). They studied implementation in four intervention and four control regions from four European countries, and found that strong synergistic as well as catalytic effects were identified as a result of being active simultaneously at four different levels.

Act-Belong-Commit in Recovery

Act-Belong-Commit in Recovery is an example of an initiative developed in Australia that aims to enhance recovery and prevent relapse by empowering individuals recovering from mental ill-health to get physically, spiritually, socially and mentally active in ways that increase their sense of belonging to the communities in which they live, work, play and recover; and that involve commitments to causes or challenges that provide meaning and purpose in their lives (Donovan et al. 2003, 2007). Based on the Act-Belong-Commit community-wide campaign (see case study in Chapter 'Implementing Community-based Mental Health Promotion Strategies' for further information), which emphasizes the importance of being proactive in looking after mental health and well-being, the Act-Belong-Commit in Recovery project extends this approach into the recovery setting where people living with mental disorders are empowered by the campaign to take steps of their own to enhance their mental health and well-being. The campaign is viewed 'as for everyone' and does not require divulgence of mental ill-health to be able to participate (Donovan et al. 2016). Thus the campaign has a destigmatizing effect, whilst promoting mental health and well-being (Donovan et al. 2016) and results in lower levels of anxiety and depression in older adults (Santini et al. 2017).

The Act-Belong-Commit in Recovery project seeks to build the capacity of the mental health workforce to support and mentor service users to engage in mentally healthy activities to aid in their recovery on discharge. Workshops are targeted to mental health professionals and other support workers to introduce the fundamental principles of the Act-Belong-Commit message, the evidence base for the campaign and the various components of the campaign. These include assesment tools and resources, and, in particular, the structure and content of the Act-Belong-Commit self-help *Guide to Keeping Mentally Healthy*, and how the Guide can be used as a positive framework to support service users in the recovery process. Attendees are also encouraged to educate their colleagues on Act-Belong-Commit and the *Guide to Keeping Mentally Healthy*. The *Guide to Keeping Mentally Healthy* was developed as a tool for individuals seeking ways to enhance and protect their mental health and well-being and engage in mentally health behaviours, and can also be used by health professionals to counsel their clients about keeping mentally healthy.

Act-Belong-Commit in Recovery has empowered people living with mental disorders to get active, engage in the community and find meaningful things to do. However, it is not appropriate at all stages of recovery, specifically people who are

acutely unwell or receiving inpatient care. There needs to be an emphasis on supporting health professionals to identify the most appropriate stages of recovery and when to introduce the Act-Belong-Commit message. Motivation of clients is crucial and resources were created, such as pledge cards and weekly planners, to address this, along with motivational interviewing techniques to assist in translating campaign messages into action. The use of a self-assessment tool and self-help guide allows for customization of the Act-Belong-Commit behavioural domains. Thus, the self-assessment results should be discussed with individual clients, followed by encouragement to complete the guide, make a pledge and follow through with plans to engage in mentally healthy behaviour. These results should be reviewed regularly to track progress and identify new needs (Anwar McHenry et al. 2017). The campaign places emphasis on keeping or becoming more mentally healthy, which has inherently positive connotations, and applies whether or not one has a diagnosed mental disorder. It can improve quality of life, mental health and well-being when delivered at an approriate stage of recovery, and as a complement to, not a replacement for, medication of psychotherapy treatment. The Recovery project seeks to ensure that people with mental disorder and their health professionals are aware that major life changes are not necessary for the programme to be effective, that minimal social activity can be maintained simply by encouraging individuals to smile or say hello to neighbours or customer service staff and that there are benefits from simply being exposed to other people at community events, or engaging in very simple random acts of kindness. Support is provided to reduce barriers to engagement, such as shyness. Initiatives such as Act-Belong-Commit are a useful complement for people in recovery from mental ill-health as the programme promotes self-management of mental health and well-being by empowering and encouraging people with a diagnosed mental disorder to take action over their own recovery, alleviate symptoms and implement solutions for themselves.

Service User and Caregiver Involvement

Service user and caregiver involvement in policy making, research and service development is now seen as an integral part of mental health system strengthening, so that in many countries the user and survivor movements play an important role in service planning and delivery and bring a focus on empowering service users to engage in recovery through increased participation in self-help groups and in their own care plans. There is increasing recognition of the role of self-help groups, through providing natural support networks and mutual help between people experiencing the same problems, in facilitating the recovery process. Semrau et al. (2016) have examined the evidence for service user and carer involvment in policy making, research and mental health service development in low and middle income countries, and found that although there were examples of service user and caregiver involvement in mental health system strengthening in numerous countries, there was a lack of high-quality research and a weak

evidence base for the work that was being conducted across countries. However, there was some emerging research on the development of policies and strategies, including advocacy work, and to a lesser extent the development of services, service monitoring and evaluation, with most service user involvement having taken place within advocacy and service delivery. Research was scarce within the other health system strengthening areas.

Dahlqvist Jönsson et al. (2015) explored users' experiences of participation in decisions in mental health services in Sweden, and the kinds of support that may promote participation. This study highlighted the desire of users to participate more actively in decision-making and demonstrates that people with severe mental disorders struggle to be seen as competent and equal partners in decision-making situations. Those interviewed did not feel that their strengths, abilities and needs were being recognized, which resulted in a feeling of being omitted from involvement in decision-making situations. The core category that emerged in the analysis was the 'struggle to be perceived as a competent and equal person', while three related categories, including being the underdog, being controlled and being omitted, described the difficulties of participating in decisions. The service users considered the following would be helpful in promoting participation in decision-making, namely, having personal support, access to knowledge, being involved in a dialogue and clarity about responsibilities. The authors comment that mental health nurses can play an essential role in developing and implementing shared decision-making as a tool to promote recovery-oriented mental health services.

Another important aspect of user involvement is in mental health professional training, by involving the users of mental health services in designing a curriculum, because the vast majority of curriculum planning and delivery occurs in the absence of consultation with service users. Higgins et al. (2011) present the findings of a study of service user involvement in the education and training of professionals working in mental health services in Ireland. Findings from this study indicate that in the vast majority of courses, curricula are planned and delivered without consultation or input from service users. Currently the scope of service user involvement is on teaching, with little involvement in curriculum development, student assessment and student selection. However, there is evidence that this is changing, with many respondents indicating an eagerness to move this agenda forward.

The Self-Help Model

The self-help model recognizes and values the experiences of service users in living with and understanding their mental disorder and how this can contribute to helping others in the process of recovery. For example, groups for people who hear voices and self-help organizations such as the International Voices Network show how people are able to help each other and advocate on each other's behalf. Self-help groups and organizations have a key part to play in advocating for users' rights and the provision of user-focussed services, which promote the recovery, quality of life and mental health of service users. McGorry et al. (2013) describe designing youth

mental health services, oriented to the community, using peer involvement and tailoring level of supportive interventions to severity of disorders, using examples from Australia, Ireland and England. The ability to make choices about services and how best they should be delivered, together with taking control of their own lives, has been highlighted by service users as being critical to their recovery (Frese et al. 2001). Service users value both more autonomy for themselves and also more influence in relation to policy making, service delivery and research.

Integrated Care

A related issue to that of encouraging user and carer involvement is that of integrating care across the different levels of the service and different service stakeholders. The concept of integrated care has been defined as a practice that aims 'To create connectivity, alignment and collaboration between the cure and the care sectors … to enhance quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings' (Kodner and Spreeuwenberg 2002, p. 3). It particularly involves integration between primary and secondary care (Nicholson et al. 2013; Valentijn et al. 2013) and also includes concepts of patient-centred care, inter-professional working, shared decision-making, integrated delivery networks and different levels of clinical, organizational and normative integration (Tremblay et al. 2017). Tremblay et al. (2017) describe the essential features of a Canadian programme to forge connections between the different stakeholders in the mental health community and institutional network to 'allow them to exchange ideas and opinions as well as share information regarding organizational and systematic work values and philosophies in order to promote integrated care - in particular normative integration and greater involvement of users and carers in the organizational and planning of services' (p. 7). The essential features of this programme included a small number of participants, at least half of whom were users and carers, the absence of hierarchical relations between the participants, direct contact between mental health workers, users and carers, and precise group rules that promote respect, creating a forum for free speech and dialogue and fostering effective communication between different stakeholders to develop a holistic view of services and shared values. Despite the potential of shared decision-making to impact service users' knowledge and positively influence their experience of decisional conflict, there is a lack of qualitative research on how participation in decision-making is promoted from the perspective of mental health service users.

The Balanced Care Model (BCM) refers both to a balance between hospital and community care and to a balance between all of the service components (e.g. clinical teams) that are present in any system, whether this is in low-, medium- or high-resource settings. The BCM, therefore, indicates that a comprehensive mental health system includes both community-based and hospital-based components of care. The extent of the provision will depend on human and financial resource availability.

An example of a collaborative community-based mental health service is that of the Burans programme in India, which is described in the case study below.

Case Study: Burans—A Community Mental Health Programme in Uttarakhand, North India

Michelle Kermode
Nossal Institute for Global Health, University of Melbourne,
Melbourne, VIC, Australia

Kaaren Mathias
Emmanuel Hospital Association, India, Mental Health in India,
New Delhi, India

Background

Government investment in health in India is very low, and only a small proportion of the health budget is allocated to mental health. Most people experiencing mental ill-health in India are cared for by their families without access to effective treatments, and some are even hidden away for years. Misunderstanding about mental health and illness is widespread, as is associated stigma and discrimination targeting affected people and families (Kermode et al. 2009, 2010; Mathias et al. 2015a, b). Mental health care of varying quality is provided by the public, private and traditional healing sectors in India. The availability of bio-medical psychiatric care is limited and often of poor quality. It tends to be institutional rather than community-based, and inappropriate and overuse of medication and ECT is prevalent. Psychiatrists are small in number and mostly practice in large towns and cities. Psychiatric consultations in the public sector often last for minutes at best, so assessment is inadequate, and psychosocial therapies are largely unavailable. Around 90% of people living in rural areas have no access to psychiatric services. However, there is increasing recognition of the importance of mental health by government policy makers, and NGOs are becoming increasingly involved in mental health promotion and care in the community (Parasuraman and Gopikumar 2013; Sarin and Jain 2013).

The Burans Project

The North Indian state of Uttarakhand has a population of approximately 10 million, with 40% living below the poverty line (*cf* 27% for India). As of late 2017, there were only nine government psychiatrists for the entire state, four of whom lived in the capital city of Dehradun. Additionally, there were a handful of private psychiatrists. The one state psychiatric hospital can accommodate only 50 inpatients, and very few community-based care options are available. The Burans project evolved in response to this significant gap in community-based mental health care in Uttarakhand. It is named after the red rhododendron flower that spreads colour and hope around the hillsides of Uttarakhand each spring. In July 2014, the Burans team

conducted a cross-sectional survey of 960 people in Dehradun district, Uttarakhand to assess the prevalence of depression (using the Patient Health Questionnaire-9 (PHQ-9) screening tool) and the related treatment gap. The prevalence of depression was 6%, and people of oppressed castes, lower educational status, poor housing and with recent debt were two to three times more likely to be depressed. There was a 100% treatment gap for counselling, the recommended first line treatment of depression (National Institute for Health and Care Excellence 2011) and only 3.6% of those identified with depression had been prescribed anti-depressants (Mathias et al. 2015a, b).

The Burans project commenced in June 2014 and is a partnership between the Emmanuel Hospital Association (EHA) and the Community Health Global Network. Burans has an integrated focus on mental health promotion, prevention, treatment and rehabilitation, and has the following vision:

> Communities in Dehradun district of Uttarakhand welcome all people including those who have mental distress, and have the knowledge and skills to be mentally healthy. People with mental health problems participate in family and community life, and are supported by resources, care and skills to live life to the full.

Burans implements a range of strategies to realize this vision including:

- Advocacy to build community awareness of mental health to increase recognition of mental health problems.
- Training and support to strengthen the local capacity of government services, community workers and NGOs to recognize, diagnose, treat and support people with mental health problems.
- Provision of community-based rehabilitation to enable people with mental ill-health to lead full lives by promoting social and financial inclusion, civic participation and the Convention on the Rights of Persons with Disabilities.
- Meaningful inclusion of people who have experienced mental ill-health who are recognized as ‘Experts by Experience’. People experiencing mental health problems are supported to seek care, identify their own pathways to recovery, participate in public advocacy and access entitlements.
- Building resilience among young people both in and out of school.

Intervention Implementation and Recommendations

Key Factors to Ensure Successful Planning and Delivery of Burans

Several start-up activities informed the original design of the Burans model, which has been adapted to the local context and needs over time. As well as project implementation through EHA teams in Mussoorie and Kanwali road, Burans auspices and supports local partners in Sahaspur (HOPE) and Majra (OPEN). Start-up activities included the following:

- Mapping local communities and services
- Identifying and training partner NGOs
- Building relationships with communities, religious leaders and government agencies
- Developing culturally appropriate IEC materials
- Recruiting and training staff
- Establishing a system of governance and accountability

Carefully nurtured partnerships are key to the success of Burans. The organization works with a range of identified 'boundary partners' including: people with psychosocial disability; their caregivers; community leaders; government community workers (ASHA and AWW)[1]; government health service providers and young people.

The Burans Staff: Burans has four different geographically based teams that each consist of one project officer and four community workers, who each care for about 25 clients and their families. The community workers are trained using a purpose designed manual (An Introduction to Mental Health: Facilitators manual for training community health workers in India), and their practice is supported by the Project Burans Community Worker Toolkit—both of these manuals are freely available on the web in both English and Hindi.[2] The coordination office of Burans employs a project director, field coordinator, monitoring and evaluation officer, and an administrative assistant. The organization is also supported by a range of international volunteers with varied skill sets. As of late 2017, the Burans project has registered >650 people with mental health problems (73% are women). The Burans team has been invited by the Government of Uttarakhand to train staff in primary health care centres, community health centres and the state mental hospital in counselling and rehabilitation for people with mental ill-health. Burans staff actively mobilize local communities on World Mental Health Day and skilfully use the media for advocacy and awareness raising. As with many mental health projects, funding for Burans is a struggle, and comes mostly from philanthropic donations and small grants.

[1] ASHA are Accredited Social Health Activists, and AWW are Anganwadi Workers who focus on the health of babies and young children

[2] https://projectburans.wixsite.com/burans.

Burans capacity to innovate: Burans has developed a number of innovative approaches to ensure that all activities are appropriate for the local context. These include: a contextually adapted approach to identifying people experiencing mental health problems and facilitating their access to care; locally designed, structured care plans; a checklist to guide the first six client visits; ongoing input and support of an Experts by Experience advisory group; a sports initiative with a focus on participation by women with mental ill-health and the Nae Disha programme to strengthen emotional resilience in young people.

Identifying and helping people in need: The Burans approach to identifying people with mental ill-health in the community, and facilitating access to care for them, involves a methodically stepped process. When entering a new community, the Burans teams begin by promoting awareness of mental health and mental ill-health through formal and informal community meetings, and by training government workers such as ASHA and AWW. During this process people are encouraged to refer anyone who may possibly be experiencing a mental ill-health to the Burans team. The team members then visit affected households to build a therapeutic relationship with families, and to assess potentially unwell family members. The Burans team are trained to administer the Hindi version of the WHO Self-Report Questionnaire (SRQ20) to screen for common mental health problems such as anxiety and depression. This scale has been validated in Indian populations (Patel et al. 2008), with a cut-off score of ≥12 determined, among people attending primary care in India, as correctly identifying 89% of participants who had mental distress (Patel et al. 2008). Those who score ≥12 on the SRQ20 are invited to register with Burans. Registered clients are visited weekly for one month, and 2–4 times per month thereafter. Access to psychiatric treatment at government health facilities is facilitated for: those who score >15 on the SRQ20; those who scored 12–15 but have not responded to psychosocial interventions after six weeks; and anyone with symptoms of psychosis. If the unwell person and his or her family members agree to attend health services, a Burans team member will usually accompany them for the first few visits. Evidence-based psychosocial interventions guided by individual care and recovery plans are provided by the Burans team members. These interventions include counselling, with a focus on motivation and problem solving, and promotion of five steps for well-being that aim to create opportunities for social connection, mindfulness, contributing to the well-being of others, physical activity and gratefulness.

The first six visits checklist: This is a tool used by the client, caregiver and community worker in order to progressively build skills and knowledge in mental health through regular visits by the Burans team. It includes facilitating access to professional mental health care if this is indicated. After an initial registration and assessment visit, the checklist guides the community worker to follow through a four-step process of ‘Ask and listen’, ‘Praise and speak’, ‘Write’ and ‘Agreed home work’. In step one, ‘Ask and listen’, the community worker asks the client about progress on a self-selected area of focus, such as increasing social connections with neighbours or taking the children to school, and actively listens to both the client and caregiver. In the second step, ‘Praise and speak’, the community worker appreciates progress

and then provides a brief mental health knowledge and skill-building teaching session focussing on areas such as identifying and managing side effects of medication and recognizing and responding to worsening depression. In the 'Write' section, a two to three-sentence agreed upon summary of the progress to date and subsequent actions are noted. In the fourth step, 'Agreed homework', the client and caregiver agree on an aspect of recovery for focussed attention between now and the next visit. The areas that have progressed provide the client with hope and encouragement. Following completion of six visits, the community worker repeats assessment of the client, and together with the client and caregiver, decides whether ongoing support is still needed.

The Nae Disha Programme: Nae Disha (new pathways) is designed to build youth resilience and has been implemented by the Burans staff in schools, and with out-of-school youth. It covers a range of areas including building self-esteem, managing strong emotions, understanding our differences, mental health, coping with tension, bouncing back after adversity, communicating confidently, responding to bullying, creating change, maintaining relationships, saying no to tobacco and alcohol and protecting ourselves.

Burans contribution to evidence: The Burans project also actively engages in generating evidence for practice by involvement in a number of research projects. For example, a recent study used a realist evaluation approach to assess how the Burans project builds community mental health competency in the domains of knowledge, safe social spaces and partnerships for action, describing the mechanisms and contextual factors that contribute to this (Mathias et al. 2017). This case study used predominantly qualitative methods including focus group discussions, participant observation and document reviews of monthly reports on changes in behaviour, attitudes and relationships among stakeholder groups. Data analysis involved thematic analysis of three domains: knowledge, safe social spaces and partnerships for action. By exploring thematic patterns within each domain, we were able to infer the mechanisms and contextual elements contributing to outcomes.

Community knowledge of mental health was effectively increased by allowing communities to absorb new understanding into pre-existing social and cultural constructs. Non-hierarchical informal community conversations rather than didactic teaching allowed 'organic' integration of unfamiliar biomedical knowledge into local explanatory frameworks. People with psycho-social disability (PPSD) and caregivers found increased social support and inclusion by participating in groups. Building skills in respectful communication through role-plays and reflexive discussion increased the receptivity of social environments to PPSD participation, thereby creating safe social spaces. Facilitating social networks through group formation increased women's capacity for collective action to promote mental health. In summary, locally appropriate methods contributed meaningfully to learning, stigma reduction and help seeking. However, achieving social change in this complex setting was often patchy and slow.

Implementation Challenges

Communicating nuanced messages about mental health such as 'not all people with mental health problems need medications but the first step for most people is to start with talking therapy' was challenging for community health staff. Training, role plays and regular observation with feedback were required to supporting effective communication of these health messages. Initial efforts to build community knowledge and awareness in mental health were primarily among community members, but this had limited impact. In the second year of implementation, we focussed on promoting mental health awareness among community leaders such as the head of the Sikh *gurudwara* (temple) and local political leaders such as *panchayat* (village council) members, who then propagated the messages more widely with greater social receptivity.

Deeply embedded social hierarchies of class, caste and gender complicated efforts to increase social inclusion for people with mental health problems. Initial conversations focussing on reduction of stigma and discrimination for those with mental health problems stalled. Subsequently, we sought to address social inclusion through community conversations about forms of exclusion and inclusion more broadly, and this led to dialogue and 'islands of inclusion' for people with mental health problems in communities. There is still a long way to go before communities are universally welcoming and safe social spaces for all.

Availability and affordability of psychotropic medications was a significant challenge with essential medicines frequently out of stock at Government services and private providers, or else too costly for most families. Community members accompanied Burans team members as we embarked on an approach of escalating advocacy to community health centre doctors, Government psychiatrists and pharmacists, right up to the Director General of Health for the state to discuss the lack of access to medicines and in most instances the Government services responded to increase access to these required medicines.

Key Recommendations for Replication

- Developing the skills of community-based lay mental health workers requires a lot of support including weekly or fortnightly training and creation of opportunities for discussion and reflection; and a focus on building skills such as active listening in community organizations, which is optimally facilitated by use of role plays and structured feedback.
- Supporting mental health knowledge building in communities requires an approach that facilitates conversations using peer-to-peer methods. It is important to convey messages that are nuanced and not over-simplified, and should actively involve key community leaders including religious leaders. Building on existing relationships with Government community workers is an effective way of amplifying the spread of information about mental health.

- Increasing social inclusion for people with mental health problems is facilitated by formation of facilitated groups that foster relationship development and establishment of new social networks; providing opportunities that stimulate awareness raising of social hierarchies including those related to gender, caste and class; increasing inclusion and participation among sub-groups in the community such as Disabled Persons Groups and organizations; generation of collective actions that promote social support for each other and advocacy.
- Increasing access to care for people with mental health problems is facilitated by actively advocating with service providers, programme implementers and policy makers for the removal of access barriers; and involving people with mental health problems and non-government organization team members familiar with service specifications of the national district health plan in advocacy efforts.

The Future of Burans

The Burans Advisory Group has representation from people who have experienced mental health problems, caregivers, mental health professionals (a psychiatrist and a mental health nurse), community health and development professionals, community health workers and academics. The group meets twice each year to review progress, discuss successes and challenges, and identify ways forward. With the future in mind, the Burans team is planning interventions to address gender and family violence intersections with mental health; strengthen mental health systems; amplify the consumer voice; promote financial inclusion for people with mental ill-health; enhance social inclusion for young people and further build capacities of boundary partners through training, mentoring and provision of technical support.

Conclusions

Mental health promotion is as crucial for people engaged with specialist mental health services as it is for the general population. A mental health promoting approach requires that services are extended beyond clinical treatment of the condition or illness to consider the broader psychosocial needs of clients and their families and seeks to enhance capacity and the prospects of positive recovery. Models of service delivery based on holistic recovery, service user and caregiver involvement, and integrated care provide increased opportunity for integrating mental health promotion as a core element of service delivery. Mental health promotion approaches which build on the strengths and capacities of service users and their families and encourage greater participation in the recovery process and service delivery have a critical role to play in ensuring that the way services are provided contribute to improving the mental health and well-being of the whole person and consequently to improved service outcomes.

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Implementing Mental Health Promotion Approaches in Mental Health Services

Rachel Jenkins

Introduction

Having outlined the rationale and context for re-orienting mental heath services to mental health promotion in Chapter 'Re-orienting Mental Health Services to Mental Health Promotion', this chapter considers specific mental health promotion approaches and programmes that have been implemented and evaluated within the context of mental health services. People with mental disorders can face a heavy burden, comprised not only of their symptoms, duration, severity, and accompanying disability but also of stigma and discrimination. Therefore, this chapter describes mental health promotion inititatives to address stigma and improve mental health literacy, to prevent illness and to reduce its duration, severity and disability. Programmes focusing on supporting carers are also addressed including psychoeducational interventions that improve knowledge about coping strategies and resources that can improve the care giving experience and lead to improved carer mental health and well-being. Psychosocial rehabilitation supports are also addressed as an essential component of person-centred, recovery-oriented services that enhance the capacity of people living with mental disorders to access community resources and live successfully in environments of their choice and improve their well-being and quality of life. Practical examples and case studies are provided that illustrate the implementation of these initiatives in different countries globally.

R. Jenkins (✉)
King's College London, London, UK
e-mail: rachel@olan.org

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Addressing Stigma

Stigma Reduction

The World Health Report (2001) highlighted that the single most important barrier to overcome in the community is the stigma and discrimination associated with mental disorder and people who experience mental health difficulties. People with mental health problems and disorders consistently identify stigma, discrimination and exclusion as major barriers to their health and quality of life (Dunn 1999). Tackling stigma and raising greater public awareness requires public education and focussed intervention approaches. Gale et al. (2004), in a scoping review on mental health anti-stigma and discrimination, provide an overview of a range of effective approaches to challenging the stigma and discrimination that is associated with mental health problems in England. This report identified six key principles that should underpin effective programmes:

- Users and carers are involved throughout the design, delivery, monitoring and evaluation of programmes.
- Programmes should be appropriately monitored and evaluated.
- National programmes supported by local activity demonstrate the most potent combination for efficacy.
- Programmes should address behaviour change with a range of approaches.
- Clear consistent messages are delivered in targeted ways to specific audiences.
- Long-term planning and funding underpins programme sustainability.

There is a large body of research on the nature and extent of stigma and discrimination that impacts on access to mental health services. A review by Clement et al. (2015) found that barriers to help-seeking included stereotypes (particularly weakness and 'craziness'); social judgement and rejection of people with mental health problems; employment discrimination and shame/embarrassment. Disclosure issues were found to be a particular concern, and interventions to aid decision-making around disclosure may be warranted.

Awareness raising and de-stigmatization have a significant role to play in mental health promotion programmes. Socially shared beliefs and perceptions influence how mental health is interpreted and dealt with in the context of community life (Corrigan et al. 2014). Chronister et al. (2013) investigated the mediating properties of different types of coping orientation and social support on the relationship between societal stigma, internalized stigma (learned discriminatory attitudes applied by the person to him or herself), mental health recovery and quality of life among people with severe mental disorders. The study found moderate to high levels of societal stigma, internalized stigma in the sample as a whole and low levels of social support. The authors showed that the styles of coping used to deal with stigma (e.g. concealment of mental disorder to avoid rejection and withdrawal or avoidance as a means of self-protection from stigma) and levels of emotional and tangible support mediate the effect of societal stigma on internalized stigma and recovery.

Those who were more likely to conceal and/or use withdrawal coping were more likely to internalize stigma to a greater extent and have poorer recovery. The study also found that the use of coping styles that involved actively responding to stigma, e.g. through challenging others by pointing out stigmatizing behaviours and/or educating others about mental disorder in order to reduce rejection, were found to be positively linked to recovery. Low levels of social support and coping were associated with higher levels of societal and internalized stigma and lower levels of recovery and quality of life. The authors concluded that social support and coping should be incorporated into treatment to reduce the negative effects of stigma.

A number of key approaches and strategies for effective and sustained stigma reduction have been identified, including educational campaigns, whether local or national, social contact, peer interventions and protest movements (Thornicroft and Tansella 2013), and examples of these will now be described

Public Awareness Campaigns

Campaigns or mass media interventions, particularly if they are supported by local community action, can have a significant impact on knowledge, attitudes and behavioural intentions. Such interventions can be used to increase understanding, reduce stigma and increase knowledge of coping and sources of support. In other words, they have the potential to impact positively on mental health literacy at the wider community level. Challenging stigma and promoting increased awareness of, and positive attitudes towards, mental health issues have been addressed through international campaigns for over three decades: e.g. World Mental Health Day and the World Psychiatric Association's campaign 'Open the Doors' (Sartorius 1997; www.openthedoors.com); national campaigns like 'Changing minds—every family in the land' by the Royal College of Psychiatrists in the UK; the You in Mind (Barker et al. 1993; Hersey et al. 1984); the Norwegian Mental Health Campaign (Sogaard and Fonnebo 1995); the Mind Out for Mental Health campaigns in England (www.nimhe.org.uk/stigmaanddisc); the Scottish 'See Me' campaign (www.seemescotland.org); the Stamp Out Stigma in the USA (www.community-2.webtv.net/stigmanet), Opening Minds, the Mental Health Commission of Canada anti-stigma initiative (https://www.mentalhealthcommission.ca/English/opening-minds) and the 'Like Minds, Like Mine' campaign in New Zealand (www.likeminds.govt.nz). More recent national and European campaigns include 'Each of Us' (https://eachofus.eu), which arose from the Anti Stigma Programme European Network; England's Time to Change (England 2018), which is a movement of people changing how we all think and act about mental health problems (https://www.time-to-change.org.uk/about-us); and Ireland's 'Ireland's See Change' (Ireland-See Change 2018), which is an alliance of organizations working together through the National Stigma Reduction Partnership to bring about positive change in public attitudes and behaviour towards people with mental health problems (http://www.seechange.ie/).

European anti-stigma campaigns have been reviewed by Quinn et al. (2014), who identified 26 programmes across 18 EU countries. Most were universal and targeted the whole population, while many also targeted specific population groups or settings, such as young people or health professionals. The most common programme aim was improving literacy, although reducing stigmatizing attitudes and discriminatory behaviour and promoting help-seeking were also common. Most programmes originated from professional bodies, or as grassroots initiatives from service user groups/NGOs (eg. Mental Health Europe 2018), rather than as part of national and local policy.

See Me Campaign

'See Me', the national Scottish campaign against the stigma and discrimination associated with mental ill-health, was launched in 2002. The campaign was funded as part of the Scottish Executive National Programme for Improving Mental Health and Well-being, but managed by an alliance of five mental health organizations. The campaign's activities have included national-level publicity campaigns targeted at the general population, targeted publicity campaigns aimed at specific groups or environments, work with the media and support for local activities. The campaign initially took a general population approach, informed by the model of a journey from raising awareness to changing attitudes and then to changes in behaviours. This model was underpinned by the view that it takes a generation to effect change. To begin this change process, the campaign used social marketing techniques coupled with a community development approach.

Drawing on these approaches, 'See Me' developed high-level national campaigns targeted at the general public, workplaces and young people, as well as a number of other mechanisms for raising awareness of stigma. These included developing a pool of volunteers trained to talk to the media about their own experiences, Stigma Stop Watch, which enabled people to draw the campaign's attention to negative (and positive) representations of mental health issues in the media, and the development of media guidelines and fact sheets. In addition, the campaign sought to link and work with local areas to support local level activities. Branding these local and national level activities under the 'See Me' banner was felt to be important for maximizing impact.

An independent evaluation of the inception and the first four years of 'See Me' was commissioned by the then Scottish Executive in 2006. The aims of the evaluation were to co-ordinate a detailed account of the development and activities of 'See Me', to determine the extent to which the campaign had met its own strategic objectives and make recommendations for future work in Scotland to address the stigma and discrimination experienced by people with mental health problems.

'See Me' was evaluated against each of its main objectives using both data from national surveys and surveys commissioned by 'See Me' (Scottish Executive 2009). In relation to its first objective, namely *to tackle stigma and discrimination*, national

surveys and surveys commissioned by 'See Me' over the period 2002–2006 revealed positive shifts in mental health awareness and in expressed attitudes towards people with mental health problems, as well as growing recognition of the 'See Me' brand name. Awareness was particularly high among people with direct experience of mental health problems. The number of other parallel initiatives over this period makes it difficult to estimate the specific contribution of 'See Me'. Nonetheless, the perception among those interviewed as part of the evaluation was that the campaign had contributed to increased mental health awareness at individual and organizational levels. The campaign was also felt to have 'galvanized' the mental health community in Scotland. Interviewees also raised a number of issues that may have implications for ongoing work to tackle the stigma and discrimination experienced by people with mental health problems. These included: whether the quality of the campaign may have had the unintended consequence of deferring responsibility for anti-stigma work to 'See Me', rather than embedding it within agencies and organizations; to what extent the campaign had been able to reach beyond the environments of the already willing or sensitized; although the campaign sought to be inclusive, whether a 'general population' approach can be sensitive to the diversity of the population, including people who may be subject to multiple sources of discrimination; and whether a public relations campaign alone could lead to a deeper understanding of the issues. In relation to the second objective, *to challenge individual incidents of stigma and discrimination*, in terms of media reporting, the campaign, including the work of the media volunteers, was felt to have had an important role in creating an environment in which it was becoming increasingly unacceptable to use derogatory terms or negative story lines. In relation to the third objective, *to involve people in anti-stigma activities across Scotland at national and local levels and across sectors and communities of interest*, the campaign was considered to have encouraged a breadth of local activity by adopting an 'open door' approach, developing contacts where there was already a degree of commitment or interest, but that the campaign's reach did not extend to some of the more intractable environments. In relation to the fourth objective, *to ensure that the voices and experiences of people with mental health problems and their carers are heard*, whether as media volunteers and/or as participants in campaign design and implementation, 'See Me' sought to involve users and carers at national level, but involvement at local levels was more variable. In relation to the fifth objective, *to promote a culture of learning and evaluation through all its work, so that effectiveness can be demonstrated and lessons shared*, 'See Me' had a strong national within-campaign culture of research and evaluation. This included pre-campaign strand research and post-campaign strand evaluations of reach and recall. However, there was less evidence of this culture having extended to local areas.

See Me still continues as a sustained national campaign with significant local reach and involvement (further details at: https://www.seemescotland.org/about-see-me/).

Another example is Canada's 'In One Voice' campaign, which in contrast was a brief social media intervention. This campaign featured a prominent male sports

figure talking about mental health issues and used online social media. It was evaluated by a successive independent samples design to assess market penetration and attitudinal changes among the young people (Livingstone et al. 2013). Two samples of respondents completed an online questionnaire either immediately before or two months after the campaign launch. Website analytics determined changes in activity levels of a youth-focussed mental health website (www.mindcheck.ca). The evaluation study found that one-quarter (24.8%, $n = 100$) of the respondents remembered the campaign. The proportion of respondents who were aware of the website increased significantly from 6.0% before to 15.6% after the campaign. Average overall scores on standardized measures of personal stigma and social distance were not significantly different before and after the campaign. Attitudes towards mental health issues were statistically similar between respondents who were or were not exposed to the campaign. Those who were exposed to the campaign were significantly more likely to talk about and seek information relating to mental health issues. The authors of the evaluation concluded that the proximal outcomes of the campaign to increase awareness and use of the website were achieved. The distal outcome of the campaign to improve attitudes towards mental health issues was not successfully achieved. Thus, the brief social media campaign improved mental health literacy outcomes but had limited effect on personal stigma and social distance (Livingstone et al. 2013).

Educational Campaigns

Evidence is mixed on the effectiveness of educational interventions in changing public stigma in a significant sustained way (Corrigan 2012, 2015; Griffiths et al. 2014), and certainly brief media anti-stigma and mental health literacy campaigns do not result in significant and lasting change (Livingstone et al. 2013). Age is a crucial variable, and adolescents have been found to be more responsive to educational interventions than adults (Corrigan et al. 2012). However, although educational campaigns are generally aimed at combating public stigma, educational interventions have also been found to be effective in reducing self-stigma, improving stress management and boosting self-esteem when delivered as a component of cognitive and behavioural therapy (Cook et al. 2014). It is important to note that while educational campaigns that gave information about the genetic origins of schizophrenia did indeed reduce the blame applied by the general public to people with schizophrenia, it had the unintended consequence of increasing the perception of a low chance of recovery both in mental health service users themselves and the public, and made the general public less likely to want to interact with a person with schizophrenia. Basic health education to improve mental health literacy may be effective in reducing stigma in school-age children, but the curriculum needs to be recovery-focussed if it is not to increase self-stigma, and needs to be developmentally and cognitively tailored to different age groups (Wei et al. 2013). An example of a mental health literacy programme is Mental Health First Aid, which is described here.

Practice Example: Mental Health First Aid—Improving Mental Health Literacy (Kitchener and Jorm 2002; Jorm and Kitchener 2011)

Mental Health First Aid (MHFA) is an early intervention, skills-based training programme aimed at non-clinicians and designed to increase understanding of mental health, while providing skills to manage crisis situations. Internationally, 'first aid' is a well-recognized term practised, appreciated and understood by the general public in relation to physical health. After research into lay people's mental health literacy in the 1990s in Australia, a MHFA training programme was developed in 2001 that was modelled on traditional physical first aid (Jorm and Kitchener 2011). The definition these researchers developed for mental health literacy included knowledge and beliefs about mental disorders and their recognition, management and prevention (Jorm 2012). In particular, because of their intention to raise awareness, MHFA courses are intended to help members of the public interact with vulnerable people more sensitively and helpfully.

The Programme

Mental Health First Aid (MHFA) is an intensive educational and skill development programme designed to equip individuals to recognize the signs, symptoms and risk factors of mental disorder and substance use disorders and to provide immediate support and assistance via both professional and self help resources (Kitchener and Jorm 2008). It also aims to increase their confidence and likelihood to help an individual in distress, and to improve increased mental wellness in the people who undertake the programme. A wide variety of courses have been developed in different countries for different age groups. The content covers a range of common disorders e.g. depression and suicidal behaviour, anxiety, substance use and psychotic disorders. The rationale is that knowledge, skills and helping behaviour of participants will be enhanced, and symptoms of mental disorders will be less likely to be misinterpreted.

MHFA is an intensive education and skill development programme which parallels the format of standard first aid courses. The format consists of didactic teaching approaches utilizing lecture style presentation, small and large group discussions, the use of audio visual tools and practical exercises where a framework for action is applied to case studies. This approach was chosen because the general population was considered to be familiar with the format of standard physical first aid courses in terms of their content, learning and delivery expectations and accessibility

The content of the course provides a framework for assisting people experiencing or in the early stages of developing mental ill-health. Following the National Survey of Health and Well-being in Australia, the areas covered in MHFA were selected to address those mental health problems that are the most prevalent within the community. The areas addressed within the course are:

- Depression, including suicidal ideation and self-harm
- Anxiety-related disorders including panic attacks, acute stress reaction, post traumatic stress reactions

- Psychosis focussing on schizophrenia and bipolar disorder
- Substance misuse and its impact on mental health
- Communication with adolescents
- Helping the confused older person.

Participants learn the signs and symptoms of the various disorders, risk factors associated with their onset, where and how to get assistance and evidence-based techniques to assist. Each participant receives a manual written to reflect the content of the course (Kitchener and Jorm 2002). The central action plan that is utilized for all the presented mental health conditions consists of a five-step plan for approaching and delivering assistance. The five steps, referred to by the mnemonic 'ALGEE', are:

1. **A**ssess the risk of suicide or harm
2. **L**isten non-judgementally
3. **G**ive reassurance and information
4. **E**ncourage the person to get appropriate professional help
5. **E**ncourage self-help strategies.

Guidelines are available from: www.mhfa.com.au/cms/mental-health-first-aid-guidelines-project/, and a range of procedures have been implemented for quality control of course delivery, including selection, training and continuing education of instructors, quality and up-to-date manuals and teaching materials, and standardized participant feedback forms.

People trained as course facilitators are selected for training on the basis of their capacity to deliver the course appropriately. Most are social care or allied health professionals, and all have experience in the area of mental health. Once accepted as having the pre-requisites to be a facilitator, individuals attend a five day 'train the trainer' course where the course content and delivery methods are honed. Facilitators are required to attend refresher courses every three years and must deliver a minimum of three courses per year to maintain their facilitator status. Courses can be conducted for groups with similar interests (such as on worksites) or in mixed environments such as for community groups.

The authors of MHFA have been keen to ensure that the course is taken up widely, and to facilitate this, they have encouraged its modification to meet the needs of particular target populations. Permitted modifications are to the emphasis on the elements within the course, and to the modes of delivery, but not to essential content. Where adaptations have occurred to meet the needs of specific target groups or populations, the course authors have maintained a quality assurance role to ensure the integrity of the course. To date, there are courses focussing on the mental health needs of youth, Aboriginal and Torres Strait Islander populations and in the Vietnamese, Finnish and Cantonese languages. There is also a computer-based learning version of the course available. The course materials and statistics have been adapted for delivery in Singapore, Hong Kong, Finland, Canada, Wales, England, South Africa, Sri Lanka, the USA and Scotland. A tailored course for the border regions of the Republic and Northern Ireland was piloted in 2007 using local area data. In 2009 an adapted course was launched for delivery in Northern Ireland (Kitchener and Jorm 2008).

Evaluation

Jorm et al. 2004 evaluated the effects of a 9 h MHFA training on knowledge, attitudes and helping behaviour using an experimental design in a rural environment. They undertook a randomized controlled trial using a five months waiting list as the control group and found improved recognition of disorders, increased agreement with health professionals regarding options, decreased social distance, increased confidence in providing help and increase in help provided in the trained group compared with the controls. A subsequent meta-analysis of MHFA by Hadlaczky et al. (2014) identified 15 studies that conducted a quantitative evaluation of the standard adult or youth version of MHFA (three of the 15 studies included the youth version). The majority of studies in the meta-analysis focussed on outcomes among individuals trained in MHFA (i.e. MHFAiders) and found reasonably strong evidence that individuals trained in MHFA experience improvements in knowledge, attitudes and help-provision behaviours. Since this review was conducted, more new trials have been published evaluating the programme, and a further meta-analysis has been undertaken to include these new studies, evaluate the full range of training outcomes, examine the persistence of effects and to further explore whether effects vary according to study characteristics (Morgan et al. 2018). This time, a total of 18 trials (5936 participants) were included, and it was found that MHFA training led to improved mental health first aid knowledge (ds 0.31–0.72), recognition of mental disorders (ds 0.22–0.52) and beliefs about effective treatments (ds 0.19–0.45). There were also small reductions in stigma (ds 0.08–0.14). Improvements were also observed in confidence in helping a person with a mental health problem (ds 0.21–0.58) and intentions to provide first aid (ds 0.26–0.75). There were small improvements in the amount of help provided to a person with a mental health problem at follow-up (d = 0.23) but changes in the quality of behaviours offered were unclear. Thus, to summarize, the outcomes were generally small-to-moderate post-training and up to six months later, with outcomes up to 12-months later unclear.

One key limitation of nearly all MHFA studies is the lack of data on potential recipients of MHFA, that is, individuals who are at risk of or experiencing mental disorder and who may or may not receive help from a trained MHF Aider. Wong et al. (2015) conducted a further review and found three studies which examine the impact of training on potential recipients of MHFA. All three studies had fairly strong designs, including control groups and longer-term follow-up assessments. In addition to assessing potential aid recipients' mental health knowledge, stigma and treatment efficacy beliefs, these studies also measured their help-seeking intentions, help sought/received or both. These studies demonstrated little support so far for MHFA's effectiveness with respect to potential aid recipients. Specifically, Jorm et al. (2010) found no significant differences between students at schools where staff were trained as MHFAiders versus students at waitlist control schools on any of the outcomes except help received. Although students at MHFA intervention schools were more likely to report having received help, this was only in the form of receiving information about mental health problems from a teacher via a class lesson, written materials or reference to a website. No significant effects were found for other student outcomes, such as talking with school staff about a mental health problem or having staff members spend time listening to their problem, help them

calm down, talk about suicidal thoughts or recommend professional help—all specific parts of providing MHFA to an individual in distress. Similarly, Pierce et al. (2010) reported no significant differences between football players in leagues where coaches received MHFA training and football players in another league not exposed to MHFA training. However, only stigma and help-seeking intentions were assessed. Finally, Lipson et al. (2014) also reported no significant differences when comparing students in residence halls in which resident advisors were trained as MHFAiders versus the control condition.

Reavley et al. (2014a, b) tested the effects of a multi-component, campus-wide intervention in which MHFA training was made available to students, along with a mental health promotion campaign that involved social media messaging, online resources, email communications, special campus events, fact-sheets/booklets, posters on campus and awareness-raising events. No significant differences were found between students at intervention and control campuses with the exception of help-seeking intentions. Students at intervention campuses were significantly more likely to report that they would obtain drug and alcohol services for an alcohol problem.

Nonetheless, training young adults on how to effectively link peers to needed mental health treatment appears to be an important point of intervention. In a study conducted with a representative sample of California residents by Collins et al. (2014), young adults (ages 18–29) were more likely to report recent contact with someone who has a mental health problem compared with older adults (ages 30 and older). Moreover, even though young adults had positive attitudes towards people experiencing mental health problems, they were less likely than older adults to report providing assistance with obtaining professional help.

While there are no data to suggest that MHFA results in increased support among those in distress, definitive conclusions about the lack of impact on individuals who may be at risk for or are experiencing mental disorder cannot be made. Detecting shifts among potential recipients of MHFA can be challenging and may require tracking very large samples with substantial levels of mental health risk over a long period. For example, in a population where one in four may experience mental disorders within a one-year period, only a quarter of the sample would be relevant for looking at outcomes such as whether MHFA assistance was received and referral to professional treatment was provided. Further, the ability to detect shifts may also be difficult if the number of people trained in MHFA relative to the number of people at risk is small, that is, if the penetration rate is low. For instance, evidence of effectiveness might be missed even if every person trained in MHFA helps at least one person over the course of a year, given that the overall effect on the at-risk population (the one in four who may experience a mental disorder) could be very small.

The lack of significant effects among potential recipients of MHFA could also be related to other factors. The quality of help provision by MHFAiders has not been as rigorously evaluated as other outcomes. Many of the studies assess help provision by asking MHFAiders whether they provided help to individuals with mental health problems. Few studies extend beyond this to assess whether actual

encouragement of professional treatment was provided. It is possible that effects are not detected among potential MHFA recipients because MHFAiders may not be administering all of the MHFA actions, which include encouraging appropriate professional treatment. For example, Jorm et al. (2010) assessed specific MHFA actions and found that teachers trained in MHFA were no more likely to encourage professional treatment than teachers who had not received training. Similarly, Lipson et al. (2014) found no significant differences in rates of referring students to professional counselling between resident advisors who had or had not received MHFA training. Thus, the nature and type of support provided by MHFAiders may play a role in whether there is an impact on not only potential recipients' help-seeking behaviours, but also their mental health knowledge, stigma and treatment efficacy beliefs. Further study is needed to examine the quality of help provided by MHFAiders and whether more intense training or additional coaching is warranted.

Social Contact Interventions

Social contact interventions aim to overcome the impersonal divide between people with mental disorder and the general public, by people with lived experience of mental disorder interacting with the general public to describe their challenges and success stories. As well as reducing public stigma, this approach has also been shown to benefit self-stigma by boosting self-esteem and empowerment (Corrigan et al. 2013). Online interaction is particularly appealing for young people (Suzuki and Calzo 2004; Webb et al. 2008).

One method of delivering contact-based interventions on a daily basis is through the use of peer service providers who are people with lived experience who work as integrated health care team members to encourage the provision of nonjudgemental, nondiscriminatory services while openly identifying their own personal experiences. This helps the identification of problems and coping strategies (Corrigan and Phelan 2004), helps to sustain long-term take up of treatment, employment opportunities, as well as benefiting peer recovery as well (Gates and Akabas 2007). In the US, peer support services are becoming professionalized with the introduction of uniform standards for training and practice (Chinman et al. 2014).

Stigma Reduction Training Programmes for Staff

Stigma reduction training programmes for health service staff, which involve users in the delivery of the programme, hold promise as an effective means of addressing stigma among front line health and welfare staff who interact with mental health service users. For example, the Acceptance project in Ontario aims to reduce stigma and discrimination towards mental disorders and substance use problems among

community health centre (CHC) staff. CHCs are an optimal setting for projects aimed at reducing stigma as they cater to a diverse population, which often includes the most vulnerable and marginalized groups. CHCs offer a wide range of services and programmes such as medical, dental, counselling/social work, nutrition and recreation programmes. An anti-stigma intervention was developed for primary care staff, with inputs from staff and service users at three CHCs in Toronto. An evaluation was conducted whereby six CHCs were randomly assigned to receive the intervention over the course of three years and three CHCs were in the control group and did not receive the intervention (Lentinello 2017). The aim of the study was to determine the effects of the intervention on stigmatizing attitudes and behaviours towards clients with mental health and substance use problems. Each CHC in the intervention group had three to five staff members who acted as champions of the project. Their role was primarily to support and encourage participation in the project and raise awareness about stigma within their CHC. Four training sessions were held for all staff members in the intervention group. The sessions included academic facilitators as well as a person with lived experience. Topics included (but were not limited to) concepts of stigma, social location (a person's place in society defined by characteristics such as gender, ethnicity or religion); intersecting stigma (the process of many identities such as sexual orientation or ethnicity being stigmatized at the same time) and the importance of staff taking time for self-care and reflection. Staff in the intervention CHCs created posters to raise awareness about mental health and stigma among clients and staff. Through discussions with staff, it was determined that the posters would include an image of a CHC client with lived experience as well as a quote indicating how the CHC had helped them. The posters were displayed in various areas of the CHCs. The champions and project team members also created a logo and corresponding tagline, which were displayed on items such as pens and buttons. The logo consists of two people embracing, to emphasize the idea of acceptance.

The researchers analysed some of the CHC's policies and procedures to find out if they reflected anti-stigma practices and protocols. The analysis tool allowed the project team to highlight areas that required attention. CHC senior management then reviewed the analysis and agreed to implement the changes in their policies and guidelines. The final component of the intervention was the recovery-based arts programme. For this element, staff members and clients participated in a 10-week art class taught by a staff facilitator and an artist. Each week the class focussed on a theme related to the experience of stigma. The classes consisted of ten clients with lived experience and three staff members. To create a safe and trusting environment, the same 13 people would participate in the class each week. At the end of the 10 weeks, an art show was held, and all CHC staff members were asked to attend. Participants were encouraged to speak about their work and what it was like to be in the programme. The goal was to allow staff and clients to learn about each other on a deeper level and to create art as a way of expressing and understanding stigma.

The programme was evaluated by questionnaire at successive time points. Staff members from each CHC and clients were asked to complete a questionnaire at four different time points during the three-year project period and participated in inter-

views to measure stigmatizing attitudes and behaviours. In total, 392 staff and 89 clients completed the surveys, and 18 staff and 25 clients participated in interviews. Two of the scales that staff completed (Opening Minds Scale for Health Care Providers and the Mental Illness: Clinicians Attitudes Scale) found significant differences between the intervention and control CHCs. Staff members who received the intervention had significantly greater reductions in stigma compared to the controls. The control group scores essentially stayed the same throughout the study period, with little change in the way staff treated clients with mental health and/or substance use problems. Client data were harder to analyse because it was a small group, and therefore, it was difficult to draw conclusions from the results. But the results did suggest there were greater reductions in stigma at the intervention sites than at the control sites. In follow-up meetings, staff members from the intervention sites reported that the initiative had changed and would continue to change their practice. One of the biggest changes they reported was to self-care. After they received the intervention, providers reported that they were having more discussions about mental health and substance use, and more of them said they talked about their own health and about taking steps to improve their well-being. Such discussions with colleagues humanize the experience of living with a mental health or substance use problem (Lentinello 2017).

Protest Strategies

Protest strategies are formal objections to negative representations of people with mental disorder and are carried out by people who have experienced discrimination or by advocates on their behalf, and typically employ letter writing, product boycotts or public demonstrations (Arboleda-Flórez and Stuart 2012). Target groups for protest campaigns are opinion leaders such as politicans, journalists or community officials. The goal may be to suppress negative attitudes or to achieve legislative reform such as protect rights, increase access to social resources or reduce inequalities. Protest is the least studied (Griffiths et al. 2014). Unfortunately, while protest may have some positive outcomes, it may also trigger a rebound effect in which negative public opinion is strengthened as a result of the protest (Corrigan et al. 2001). There are calls for health professionals to take up advocacy blogging online to educate the public about mental health conditions and counter stigmatizing stereotypes.

Legislative and Policy Change

Finally, legislative and policy change can be used to protect and normalise stigmatized groups. Such legislation can address discrimination in education, employment, housing, disability benefits and access to health insurance, health care and

access to medicines (Stuart et al. 2012; Mental Health Commission of Canada (2013) The importance of such legislative and policy support is discussed further in Chapters 'Reframing the Challenge of Promoting Population Mental Health' and 'Addressing Mental Health Problems at Work'.

Evidence-Based Interventions in Mental Health Services

Prevention of Depression

Prevention of depression is important, not only for the general population but especially for people who already have a serious mental disorder of some other kind, such as a chronic psychotic disorder. People with a chronic psychotic disorder have a greatly increased risk of suicide, partly because depression accompanying psychosis is often under recognized and undertreated. Psychological interventions such as cognitive behaviour therapy and interpersonal psychotherapy have been found to be effective in the prevention of depression (van Zoonen et al. 2014). While prevention of depression is, therefore, feasible and effective, it is nonetheless in practice difficult to deliver to large populations due to limited health care resources in routine practice. This difficulty could potentially be overcome by providing internet and mobile-based interventions, which would then be free of the constraints of travel and time. The different types of technical possibilities for the delivery of preventive interventions include interactive self-help lessons, email, chat or video sessions, virtual reality for exposure interventions, serious games in which psychological strategies are trained in the context of a computer game and the use of automated memory, feedback and reinforcement interventions. Such reinforcement may be achieved through the use of apps, emails, text messages or short prompts which support the participant in incorporating intervention content into everyday life. Sensors and apps for monitoring health behaviour such as physical activity can be used to support the learning process (e.g. the online gaming programme SPARX-R with adolescents—see Chapter 'Implementing Universal and Targeted Mental Health Promotion Interventions in Schools'). There have been few robust evaluations of these approaches, and there is consistent evidence only for indicated prevention of depression (i.e. prevention for people who already have early symptoms of actual depression). The existing evidence supports using internet-based cognitive behavioural programmes (Ebert et al. 2017). One potential next step for research is to repeat the internet and mobile-based studies while tailoring the content of the intervention to the individual participant rather than giving all participants the same intervention.

In discussing the implementation of evidence-based practices in routine mental health service settings, NICE (2014) set out the key interventions that lead to better outcomes and quality of life for people with severe mental disorders. The Guideline (https://www.nice.org.uk/Guidance/CG178) includes recommendations

on recognition and prevention of psychosis, early intervention for a first episode of psychosis, treatment of people with an acute episode of psychosis or schizophrenia, including psychological interventions, prescription of medicines within specific parameters, promotion of recovery and long-term care, prevention and treatment of physical health problems and continuing to check for physical health problems, and support for carers. The WHO mhGAP psychosis intervention guide (http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf) recommends education to the person and carers about psychosis and its treatment, antipsychotic medication, psychological and social interventions, such as family therapy or social skills therapy, rehabilitation, regular follow-up and the maintenance of realistic hope and optimism.

Mental Health Promotion as Part of Early Intervention Services for Young People with Psychotic Symptoms

The re-orientation of mental health services to include the value of early intervention was proposed by McGorry (2005) as one of the key priorities in international mental health. McGorry (2000) made the case for the integration of efforts to improve positive mental health within preventive interventions in mental health services and points to the benefits in terms of nurturing a more positive approach to service provision. Early intervention strategies in first-episode psychosis seek to reduce the duration of untreated psychosis, provide comprehensive early treatment of the first episode of psychosis, reduce the duration of active psychosis and promote recovery, community involvement and quality of life (McGorry et al. 1999). Bertolote and McGorry (2005) argued that the provision of prompt and effective interventions for young people with early psychosis, for their families and carers, will promote recovery, equity and self-sufficiency and will facilitate the uptake of social, educational and employment opportunities, thereby promoting the individual's rights to citizenship and social inclusion. The early intervention paradigm builds on the strengths and qualities of young people with a psychosis and their families, and encourages greater optimism and expectations of positive outcomes and recovery. McGorry (2000) stresses that recovery rather than rehabilitation is the goal of early intervention approaches and that quality of life in a positive sense, not merely the abolition of symptoms in the shortest possible time, should be constantly focussed upon.

There is now promising evidence that early intervention approaches are more effective than standard clinical care (McGorry et al. 2002; Alvarez-Jimenez et al. 2014; Poon et al. 2017) and a number of interventions have demonstrated efficacy in the management of early psychosis leading to improved outcomes. The headspace case study showcases such an approach, which also exemplifies a number of themes, including addressing stigma to enable young people to access services, and early holistic intervention designed to achieve recovery.

Case Study: Headspace: Australia's National Youth Mental Health Foundation

Debra J. Rickwood
Faculty of Health University of Canberra and Chief Scientific Advisor to Headspace National Youth Mental Health Foundation Canberra, ACT, Australia

Background

headspace National Mental Health Foundation was initiated by the Australian Government in 2006 to reorient the mental health care system to meet the needs of adolescents and young adults aged 12–25 years (McGorry et al. 2007). The headspace centres have been progressively implemented, starting with an original ten and upscaling to 110 centres across Australia in 2017. A headspace centre is a youth-friendly, non-stigmatizing, easy to access, early intervention, primary care facility providing four core service streams: mental health, alcohol and other drug, physical and sexual health, and vocational support. These holistically address young people's health needs, prioritizing mental health as the major health issue for this age group. Centres are focussed on early presentations for those at risk of mental health problems and with emerging mental disorder, but operate an inclusive access policy to ensure young people are not turned away. The aim is to break down the barriers to young people seeking help for mental health problems and ensure that they receive an early and effective response to their issues to get them back on track to living a healthy, happy and productive life.

Recognizing the critical role of reducing stigma and increasing mental health literacy, headspace has also invested in stigma reduction and mental health literacy initiatives. These include national and local media campaigns, such as the 'Big problems start small' posters in bus shelters, 'We've got your back' poster series, headspace Day, a Father's campaign to encourage fathers to talk to their sons about mental health and a 'Yarnsafe' campaign co-designed by and for Aboriginal and Torres Strait young people. Alongside national campaigns, headspace centres are funded for a community awareness position, to engage with the local community around mental health promotion and mental health literacy.

The headspace centre platform has been used to expand support for young people's mental health. It has been augmented by eheadspace, which provides online (via e-chat), phone and text counselling, to increase the reach of headspace to young people who can't or are reluctant to seek face-to-face services (Rickwood et al. 2016). A programme to support schools cope with suicide commenced in 2011 (Rickwood et al. 2017). Most recently, early psychosis services have been added to headspace centres in key population areas. headspace has become a well-recognized 'brand' upon which to build new programmes for a reoriented youth mental health system.

Intervention Implementation and Recommendations

Key Factors that Made the Intervention Possible and Ensured its Successful Planning and Delivery

Many key factors have enabled the successful implementation of headspace. Fundamental has been recognition of the need for such services by all sides of government, and subsequent bipartisan government support. Similarly, communities have been vigorous advocates—every community wants their own headspace centre, reflecting the large unmet and increasingly recognized need for youth mental health.

In addition, headspace has focussed on building a strong and consistent, highly recognized, national 'brand', which is unusual in the mental health services sector. This was deemed essential to raise awareness among young people, and their families and friends, about where to go to get youth-appropriate, non-judgemental, evidence-informed support. Brand recognition and credibility have been critical to raising awareness, reducing stigma and pointing young people in the right direction to seek help.

Youth participation underpins headspace at all levels. The headspace model requires every centre to prioritize youth participation in its governance and service development, as well as in each young person's individual treatment plan. A local Youth Reference Group is supported by each centre, and headspace National hosts the headspace Youth National Reference Group—hYNRG. Fundamental to the success of headspace has been guidance from young people about their priorities and co-design to develop youth-appropriate programmes and initiatives.

The headspace centres are embedded within their local communities and draw from and build upon community capacity. Centres are set up by a consortium of local service providers, with the aim of integrating and enhancing local partnerships and collaboration. This enables centres to be responsive to local population needs, which vary markedly across the vast expanse of Australia, comprising major cities, regional areas, and rural and remote communities. The growing headspace network has been a major strength, with staff across Australia identifying with the initiative and being passionate about providing an inclusive, early intervention, youth mental health approach. The network is facilitated by regular communication channels, including a national forum, and an education and training platform that helps translate evidence into practice from research, evaluation and practice-based learning.

Evaluation has been built into headspace from the start. The centre initiative has had two external evaluations undertaken, and there is ongoing internal evaluation and monitoring of all headspace programmes. The second external evaluation concluded that centres are accessible to a diverse group of young people whose need for mental health care is evidenced by high levels of psychological distress (Hilferty et al. 2015). It also found a small positive improvement in outcomes for young

people accessing headspace centres compared with a similar group of help-seeking young people, with a greater reduction in psychological distress. Suicidal thoughts and days out of role and days cut back were also significantly reduced for headspace clients. Similarly, internal evaluations report that 60% of young people accessing centres improve in either psychological distress or psychosocial functioning (Rickwood et al. 2015a). Notably, headspace has been a pioneer in collecting and sharing data on its progress. A national data warehouse has been developed that stores data collected directly from young people and their service providers at each occasion of service. This information is used in multiple ways to improve the quality of services for young people: it is available to clinicians to help inform their treatment planning, provided to centre managers and lead agencies for service planning and development and, more recently, summarized for Primary Health Networks for regional planning across Australia. The data are used to inform headspace National of trends, including strengths and gaps, as well as to describe progress of the initiative to its many interested stakeholders (i.e. Rickwood et al. 2014, 2015b).

Implementation Challenges and Experiences that Arose in the Course of Delivery

headspace has certainly experienced many challenges and has had to become resilient to pursue its change agenda. Notably, a significant challenge is workforce capacity, particularly in regional and rural areas (Carbone et al. 2011), which limits the ability of centres to deliver the four core streams and to meet high demand. Workforce shortages are endemic for many health professions, and especially the mental health workforce, particularly outside large metropolitan areas.

Short government funding cycles have exacerbated workforce issues. headspace National and the centres have been funded in a series of funding cycles, consistent with government forward planning. This creates substantial uncertainty towards the end of a funding cycle, making recruitment of new staff difficult and attrition likely as staff become concerned about job security. This issue plagues all non-recurrent government-funded initiatives and has real implications for the implementation, upscaling and sustainability.

High demand has become an increasing challenge. The extensive need for youth mental health care, and the inclusive access policy of headspace centres, means that centres quickly reach capacity once opened. Waiting lists can become longer than is appropriate for an early intervention approach; headspace prioritizes young people accessing services as quickly and easily as possible to reduce help-seeking barriers. Innovative ways to meet demand are being developed, including more efficient intake and assessment processes (Bradford and Rickwood 2014), group-based programmes, and guided self-help and internet-based support.

Funding gaps still exist in the service delivery model, and further advocacy and innovation is required to redress these. Vocational support, in particular, does not have an identified funding stream. This reflects traditional mental health service

approaches that do not acknowledge the critical socio-economic factors that impact on mental health. Funding streams that support holistic care models for mental health are still not available, partly due to continuing sectoral funding silos. Funding also needs to keep pace with Consumer Price Index increases.

Headspace centres aim to fill a gap in the mental health service system to enable young people to seek and receive appropriate support and treatment at the early signs of mental health problems, long before health needs reach a crisis point or long-term and complex issues have set in. However, it has become evident that while focussing on emerging mental health issues for young people with mild and moderate impact presentations is critical, there is another major gap in the service system for those with more severe presentations. Young people with more complex, acute and severe issues are still locked out of the mental health system, and fall through the gaps. While it is important that the headspace focus remains on early presentations, there is a need to augment the model to be able to respond to young people with more severe conditions, and integration with public and tertiary mental health services is a continual work-in-progress.

Key Recommendations for Replication

headspace-like approaches are being implemented across the world (McGorry et al. 2013). In Ireland, Jigsaw was among the pioneers along with headspace and is being upscaled, and Canada, France and New Zealand are some of the other countries that have implemented similar youth mental health initiatives (Hetrick et al. 2017). A growing world-wide recognition of the need to focus on early intervention in youth mental health as an investment for the future is a significant achievement for mental health promotion.

Replication requires clear articulation of the approach to ensure fidelity, but with flexibility to adapt to local parameters. Best practice models and critical elements for success are increasingly being articulated, including through international collaborations such as those supported by the International Association of Youth Mental Health.

The best advocates for replication are young people themselves, and their families and communities. Strong and vocal local advocacy of the need for such approaches, and youth and community participation at all phases of the implementation process, are key. Notably, the stories of young people and their families and friends are compelling supportive arguments. We know that every person in every community is touched by mental ill-health; the real-life stories of struggle and success by young people and their families are the justification for investment in youth mental health.

Investment from government and other funding streams, including potentially health insurance and the corporate sector, is critical to enable sustainable services. Convincing funders of the imperative to invest in such service reorientation is an ongoing task. Critically, investment needs to be long term; the days of short-term,

non-sustainable, pilot programmes must be gone. Real change that can produce genuine outcomes for young people requires sustained investment, and time to be fully implemented and able to demonstrate achievements.

Future Directions for Application of the Intervention

The future for headspace, and other international equivalents, is very positive. The evident need for such initiatives is well-accepted, and effective intervention models have been established and are being expanded through innovation, practice-based learning and a growing national and international evidence base (McGorry et al. 2014). Future directions for headspace include a focus on ways to extend reach to ensure that all young Australians have access to appropriate services. This includes developing, implementing and evaluating model adaptations that meet the needs of regional and remote communities, and young people from harder to reach population groups, including young people who are Aboriginal and Torres Strait Islander, and those from culturally and linguistically diverse backgrounds.

Elements of the model that are less well-implemented will be a priority. These include vocational support to ensure young people are fully engaged with work and study opportunities, and alcohol and other drug services, where effective early intervention and integrated approaches require further development.

A significant direction will be expansion of the headspace platform to extend further across the continuum of care, to meet the needs of young people with more severe disorders and complex presentations, while still retaining a youth-friendly, non-judgemental, non-stigmatizing, early intervention, and easy to access, open-door approach.

The heavy disease burden of mental ill-health on young people will only be redressed with a sustained focus on early access and early intervention. The risks to and early signs of mental ill-health must be responded to effectively to enable young people to transition through the critical and vulnerable lifestages of adolescence and emerging adulthood. Our mental health intervention system must be mental health promoting—holistic, strengths-based, optimistic, evidence-informed, sustainable and fully informed by youth participation. For headspace, this will continue to be facilitated through a strong national network and brand, community advocacy and sustained commitment at all levels of government.

Support Programmes for Carers

Carers play a critical role in the care and recovery of people with long-term physical and/or mental disorders, and the impact of caring for a family member or relative on the mental health of carers is widely acknowledged. Researchers have documented the burden that the caring role imposes on relatives and the nature and extent of the areas affected. As Kuipers and Raune (2000) point out, carers may not choose their

role. Instead, they find that they become carers, due to the long-term illness of a family member. Carers may find themselves providing care with few supports, no specialist knowledge and no perceived support from services.

Caregivers tend to focus on the needs of those they take care of and, therefore, may neglect their own health needs, especially their psychological or emotional health which is the area of a caregiver's daily life that is most affected by providing home care (Gray 2003). The burden of caring can include clinically significant levels of distress in the care givers themselves, so that in comparison to the general population, primary caregivers are more frequently depressed and anxious, are more likely to use psychotropic medications and can exhibit more symptoms of psychological distress (Toseland and Smith 2001; Zarit and Zarit 1998). Carers' perceived burden and appraisal about their ability to manage the caring for a loved one with psychosis are well established as being highly correlated with their well-being and morbidities (Guerriero Austrom et al. 2015; Smith et al. 2014; Kuipers 2010). Poorer care giver well-being affects propensity to provide adequate support, which in turn influences patients' prognosis and relapse rates (Kuipers et al. 2010). Carers may also suffer from reduced social networks and are likely to feel a sense of emotional loss and isolation (Gray 2003). Various methods have been devised to support carers. These usually include giving information about a condition and its management, and is termed psychoeducation, which will now be described.

Psychoeducational Interventions

Psychoeducation is commonly delivered via individual or group programmes and involves clinicians taking on the role of information provider and client and family carers as participants (Sin et al. 2015; Sin and Norman 2013). More recently, interventions delivered via eHealth (internet based) or mHealth (using mobile apps) have also gathered increasing interest and use, augmenting face-to-face formats (Alvarez-Jiminez et al. 2014). Multicomponent programmes which comprise peer support and discussion with others in a similar position, information about coping strategies and problem-solving techniques for common illness management or care related issues have become increasingly popular (Gilliard et al. 2015). Involvement of family carers in psychoeducational interventions, with or without clients present, has been identified as a pivotal mechanism for promoting patients' outcomes (NICE 2010; Yesufu-Udechuku et al. 2015). In general, it is hypothesized that the effectiveness of psychoeducation is contingent on carers' knowledge about psychosis, their cognitive appraisal about the caring situation and subsequently their perceived burden and self-efficacy in coping with the caring (Birchwood et al. 1992). Therefore, involvement of family carers in psychoeducational interventions has been identified as a key mechanism for improving client outcomes, but there has been little research on whether such involvement actually benefits the carers themselves. It has been hypothesied that psychoeducation can improve carers' knowledge about psychosis and related care giving issues. Improved knowledge about coping strategies and

resources can lead to a more positive appraisal of their care giving experiences as well as carers' own self-efficacy in coping with the demands. This may reduce perceived burden and hence benefit carer well-being, health and quality of life (Kuipers et al. 2010).

Sin et al. (2017) conducted a systematic review and meta-analysis of the effectiveness of psychoeducational interventions for family carers of people with psychosis in a wide range of countries in Europe (Italy, Denmark, Spain, Portugal, UK), Australasia (Hong Kong, China and Australia), the Middle East (Turkey, Iran, Jordan) and the Americas (Canada, US and Chile). Some studies targeted carers of people with first episodes of psychosis while others focussed on carers of people with long-term psychotic disorder. Only one RCT examined carers' quality of life as an outcome when comparing psychoeducation with usual care and found no significant difference between groups. Four RCTs examined carer stress levels and again found no significant difference between groups. The seven RCTs that examined carers' overall health and disability scores did find a small but significant effect of the psychoeducation intervention for carers, and two studies examined carer depression and also found a significant positive effect on carer depression. Findings from five RCTs also reported that psychoeducation did not significantly enhance carers' positive caregiving experiences. Ten RCTs included caregiving-related burden, and the meta-analysis showed that psychoeducation does reduce carers' perceived burden. The authors concluded that psychoeducation is beneficial for enhancing carers' knowledge about mental health, perception of burden and emotional support. Better understanding of treatment mediators and moderators may inform optimal design of psychoeducational interventions, targeting both clients' and cares' outcomes. Additionally, while improving caregiving capacity is of pivotal importance for clients' outcomes, carers' needs in terms of their own health and well-being should be better understood and subsequently addressed.

Joling et al. (2017) conducted a Delphi consensus study of the essential features of resilience for informal caregivers of people living with dementia and sets out the important factors of building carer resilience (feeling competent, supported, coping mechanisms etc.) that can be used as outcomes for intervention development.

There have also been studies of psychoeducation for carers in different environments, e.g. the hospice setting (Price and Lucas 2016), where providing carer support networks had positive results on carers' mental well-being. Another key setting is that of homes for people with dementia, whether their own homes or collective settings.

The DEMentia Digital Interactive Social Chart (DEM-DISC) is an interactive computerized technology tool to support customized disease management in dementia (van Mierlo et al. 2015). A study employing a cluster randomized controlled trial found that informal caregivers who used DEM-DISC for twelve months reported an increased sense of competence than controls. A subgroup of users who frequently accessed DEM-DISC reported more met needs after six months than controls. Overall, informal caregivers and case managers judged DEM-DISC as easy to learn and user-friendly. This study demonstrates that using DEM-DISC had a positive effect on the sense of competence and experienced (met) needs of

informal carers, which shows the importance of user-friendly ICT solutions to assist carers in finding appropriate care services tailored to their specific situation and needs.

Psychosocial Rehabilitation and Psychoeducation in LMICs

Psychosocial rehabilitation (PSR) has been defined by the Psychiatric Rehabilitation Association in the USA and the Psychosocial Rehabilitation /Réadaptation Psychosocial (PSR/RPS) Canada as promoting recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychosocial rehabilitation services and supports focus on helping individuals develop skills and access resources needed to increase their capacity to live successfully in the living, working, learning and social environments of their choice and include a wide continuum of services and supports. PSR operates in the key life domains of employment, education, leisure, wellness and basic living skills as well as family involvement, peer support and peer delivered services. Services are collaborative, person-directed, individualized and recovery-oriented.

PSR builds upon the assessed strengths of persons rather than their deficits and problems, using the assessment of a person's strengths as the basis for individualized goal setting and recovery. PSR assists individuals to re-discover skills, build new skills and access community resources needed to live successfully and with a self-identified quality of life, with the client setting their goals rather than goals being set by others. In this way, PSR supports people to have a meaningful life focus on the determinants of good mental health, including employment, education, social supports, basic living skills, leisure and wellness. PSR approaches generally place persons in their chosen goal settings such as jobs and housing and then train and support them in those settings. Similarly, other training, such as social skills training, takes place in the person's natural environments.

Psychosocial rehabilitation is, therefore, an essential component in the management of mental disorders such as schizophrenia and is a core part of treatment, alongside psychological treatments and medication, contributing to the overall process of recovery. In high-income countries, psychosocial rehabilitation has been developed and delivered to clients who have been assessed by specialist teams at district and regional levels, but in LMICs the general scarcity of human resource poses specific challenges to the delivery of rehabilitation. This is because, given the prevalence of mental disorders in the general population, each primary care centre of approximately 10,000 population will have several hundred clients needing support and rehabilitation, and so it is clear that only a tiny proportion of the several hundred from each primary care centre can be referred for assessment to the district level of 250,000 population where only one or two mental health specialists may be available. This means that for systematic population coverage, psychosocial rehabilitation will need to be developed and delivered at the primary care level, in collaboration with local communities, with community health workers and NGOs if available.

Nonetheless, standalone psychosocial rehabilitation projects do exist in LMICs, and have been reviewed by Rangaswamy and Sujit (2012). Many such projects are run by NGOs such as the Schizophrenia Research Foundation of India, the Richmond Fellowship in India, Fountain House in Pakistan and Sahanaya in Sri Lanka. Unfortuantely, there is little research to date on their activities. Disasters are followed by global donations of funds, some of which may be used for psychosocial interventions, and Rangaswamy and Sujit in their review of psychosocial rehabilitation, therefore, include the psychosocial response to the Asian tsunami of 2004. This psychosocial response to the Tsunami was designed to provide basic mental health services to affected communities, and aim to restore security, independence, and dignity to individuals, promote community resilience and prevent psychiatric morbidity and further social disruption. They do not give specific descriptions of interventions for psychosocial rehabilitation of those tsunami survivors who had schizophrenia.

A number of projects described by Rangaswamy and Sujit have used nurses or community health workers to conduct home-based care for people with schizophrenia, including supporting carers. Some countries have built on the CBR movement to incorporate CBR into the community mental health programme, and the Burans project, as described earlier, is relevant here. Raja et al. (2009) described efforts to integrate CMD into mental health services in Sri Lanka and India. The study suggested many benefits of integration and several indicators of readiness: willingness to work with people with mental disorders, a basic understanding of the concepts of mental health and mental ill-health, a match of context and strategy between current CBR activities and proposed mental health service activities, stability of basic resources and infrastructure within the organization. A major finding of the study was the need for training in the practical aspects of integration of mental health interventions with CBR.

Pakistan has made extensive efforts over decades to integrate mental health into primary care and to deliver psychosocial rehabilitation at that level, but resources remain challenging. Close participation of families, community members and local health providers, in concert with continuous treatment, form the foundation of community-based care and rehabilitation. Activities to facilitate economic and social rehabilitation (Chatterjee et al. 2003), such as supported housing for people with severe mental disorders (Chilvers et al. 2006) and vocational rehabilitation (Crowther et al. 2001), are effective in promoting rehabilitation of people with severe mental disorders.

Longitudinal studies from India observed that community-based rehabilitation for people with psychotic disorders had a beneficial impact on disability (Chatterjee et al. 2009). Results from a clinical trial in India suggest that community-based care, along with facility-based care, was more effective than facility-based care alone for reducing disability and symptoms due to psychoses (Chatterjee et al. 2014). However, the intervention relied on more support from psychiatrists than would be generally available in LMICs where mental health specialists are extremely scarce, and therefore, further research is needed to study interventions compatible with the general human resource availability in LMICs (Gupta and Srinivsamurthy 2014).

Conclusions

Mental health services operate in a wide variety of settings, including hospitals, community mental health services, prisons, schools and universities, and even workplaces. In this chapter we have focussed mainly on community-based services and hospitals. Based on the research evidence and programmes reviewed in this chapter, the characteristics of successful mental health promotion programmes within mental health services include:

- Comprehensive multicomponent interventions that encompass service users/clients families, service providers, service managers and communities
- Use of multiple methods of education, empowerment, destigmatization, liaison, early intervention and recovery models
- Operation in multiple settings, including where the target audience are normally found, i.e. in homes, communities and workplaces, rather than in health service settings alone
- Adoption of inclusive and equity-focussed models of planning and implementation, involving service users, families and staff
- Detailed needs assessment, which includes the perspective of the service user and their families and considers their social context
- Services which respect the rights of clients and adopt a positive, enhancing approach to all aspects of service delivery
- Provision of professional development and training for mental health service staff in implementing a mental health approach to service delivery.

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Index

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