Promoting Mental Health: From Theory To Best Practice

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Abstract

Health is not just a biological matter (in the sense of the absence of illness) but also a social phenomenon, since it incorporates the quality of relations individuals have with each other and with their environment. The importance of mental health, its interdependence on physical health and the burden that mental disorders cause on a personal, family and social level have gained increasing recognition both by the relevant policymakers and by the general public.

Mental health is defined as the state of emotional well-being which prompts individuals to recognise their skills, to effectively deal with stressful life situations, to work to produce results and to contribute to the society in which they live. In our times, man appears to be particularly vulnerable in terms of mental health, and the frequency with which mental disorders are appearing is constantly on the rise. Both promoting health and preventing illness seek to ensure the common goal of maintaining and improving health.

Late diagnosis of mental problems in the young can very likely lead to serious mental illnesses in adult life with long-term effects. The World Health Organisation (WHO) has highlighted the importance of promoting mental health and prevention in children and adolescents and urges governments worldwide to include mental health as a key part of their primary healthcare. However, there is nonetheless an immense gap between needs and resource availability. However, in all European Union countries, there is some activity in terms of mental health

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prevention and promotion. The availability of the practices, resources and infrastructure which has been developed varies from country to country reflecting different situations in healthcare systems, political history and traditions and their understanding of both mental and public health.

A literature review highlights examples of best practices and evaluation of the effectiveness of measures to promote mental health among individuals of school age, since it recognises that education contributes to the prevention of the onset of mental illnesses.

The *programme to promote mental health in children and adolescents in selected areas of Greece* ran for the period 2011–2013. It was financed by the Stavros Niarchos Foundation and implemented by the Association for Regional Development and Mental Health on the islands of the NE and Western Cyclades. The measure sought to ensure primary protection of the mental health of children and adolescents. It included awareness-raising and counselling groups for parents of children in each age group, awareness-raising and counselling groups for adolescents about mental health issues and awareness-raising and support groups for teachers in preschool, primary and secondary education.

The awareness-raising groups performed an educational support role. The principles of assertive-experiential learning were chosen for the methodological approach. The results were particularly encouraging in all sectors of intervention. The chapter highlights the epistemological and social need for holistic interventions on interactive local systems, to ensure the best outcome of programmes to promote mental health.

7.1 Introduction

Health is a wide-ranging concept which can include positive, negative, functional and experiential definitions. The historic definition of health as the absence of illness is clearly an example of a negative definition. On the contrary, an example of a positive definition is the one from the WHO (1948) which states that health is a complete state of physical, mental and social well-being. A functional definition would refer to the ability to participate in normal social roles while an experiential definition would take into account one's sense of self (Kelman 1975).

Consequently, health is not just a biological but also a social phenomenon, since it incorporates the quality of relations individuals have with each other and with their environment (Tountas 2001). It can be depicted as a complex model which reflects the physical, mental and social dimension of well-being and illness.

The importance of mental health, its interdependence on physical health and the burden that mental disorders cause on a personal, family and social level have gained increasing recognition both by the relevant policymakers and by the general

public. According to the Mental Health Declaration for Europe, "mental health -representing a state wellbeing in which the individual realises his own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his community- has been recognised as fundamental to quality of life, enhances social cohesion, enhances peace and stability in the environment and contributes to the economic development of societies" (Jané-Llopis and Anderson 2006).

7.2 Concepts and Definitions: Historical Background

According to the World Health Organisation (WHO 2003a), mental health is defined as the state of emotional well-being which prompts individuals to recognise their skills, to effectively deal with stressful life situations, to work to produce results and to contribute to the society in which they live.

In our times, man appears to be particularly vulnerable in terms of mental health, and the frequency with which mental disorders are appearing is constantly on the rise. According to a recent health report, in the USA one in five Americans suffers every year from a diagnosable mental disorder, while 50 % of the American population will present such a disorder during their life time (Sultz and Young 2010). It also mentions that one in ten people will become ill with depression at some time in their life. It is estimated that around 6 % of the general population suffers from depression, in other words around 350 million people on the planet, 550,000 of whom are in Greece (Skevington and O' Connell 2004). One should not ignore the fact that mental disorder, which reflects a social pathology and is the result of the interactions of the psychobiological substrate with the natural environment, increases in periods of economic recession and social crisis, like the one we are currently experiencing.

According to research carried out in all EU countries (Wittchen et al. 2011), 38 % of the population (including those in childhood) are estimated as presenting some mental disorder every year. As far as adolescents are concerned, around one in five has been diagnosed with some form of mental disorder. It is no coincidence that mental disorders appear for the first time in adolescence or in early adult life (WHO 2009) since they may be an early sign of the appearance of mental disorders in adult life. According to the results of one study, 75 % of individuals with a diagnosed mental disorder at the age of 26 had been diagnosed for the first time during adolescence (WHO 2005). Around the world, almost 20 % of children and adolescents suffer from some mental illness, which degrades their quality of life, while also raising social and economic barriers for them. WHO surveys argue that mental illnesses and their symptoms are accompanied by mental, social and economic burdens of a scale of € 240 billion in the EU. In Europe 20 % of children and adolescents face developmental, mood-affective and behavioural disorders, while 4 % of children aged 12–17 years old suffer from depression (SOU Report 2006).

According to more recent epidemiological data (Mavreas et al. 2010), one in six Greeks aged 18–70 have developed clinically significant psychopathology and 1 in 12 (600,000) have serious psychopathology. International data showing that in Greece 75 % of the population with some form of psychopathology do not receive any treatment for their problem have been confirmed. In addition, the suicide rate has risen from 2.8 per 100,000 in 2008 to 5.2 in 2010 (Giotakos et al. 2011). As far as adolescents are concerned, research data confirm that mental disorders, dominated by depression, affect 3–8 % of the population and are directly related with negative health behaviours such as smoking, use of psychotropic substances and alcohol abuse and with reduce performance at school, poor social relations, bullying, high-risk sexual behaviour and even suicidal tendencies (Giannakopoulos et al. 2009). A study conducted on Greek adolescents found that the rate of attempted suicide in 2007 was 13.4 % of the population (Kokkevi et al. 2010).

7.3 Promoting Health and Preventing Illness

During the 1980s, and on November 21, 1986, in particular, the first international conference to promote health was held in Ottawa, Canada, under the aegis of the WHO, where the charter to develop actions to achieve health for all from 2000 onwards was presented. At that conference, a wide-ranging definition of health promotion was presented and then adopted:

> Health promotion is the process of enabling people to increase control over, and to improve, their health. A necessary tool in health promotion is health education, which is can be defined as a process which helps individuals take decisions, adopt behaviours and act in accordance with the need to safeguard and promote their own health. (Tountas 1994)

Health promotion includes all aspects which affect the individuals' choices about his behaviour such as values, beliefs, attitudes and incentives which prompt them towards a special form of health behaviour. In addition, it recognises that individuals do not make choices on their own but based on interactions with their environment (family, friends, social and community milieu, economic and political environment). Consequently, health promotion requires an exploration of the methods used by social policy such as laws and regulations about how the state operates, and social structures can change or support the positive dimension of health. Health promotion activities seek to support individuals and their social environments, to organise and set priorities and take action on health issues in line with social needs (Whitehead 2004).

On the other hand, illness is defined as an interruption or irregularity in bodily functions which causes pain or weakness. Anything that negatively affects the

physical functionality of the body can be considered to be an illness. Although most people do not try to get ill, they do adopt day-to-day habits which are harmful to health, such as smoking or not exercising.

Illness prevention relates to any attempt to stop the onset of a specific illness or condition, such as heart conditions, diabetes or cancer, for example (Breslow 1999). In addition, prevention can include identifying illnesses during their early-onset phase. Such types of prevention are considered to be more effective than any other health promotion or behavioural strategy.

Both promoting health and preventing illness seek to ensure the common goal of maintaining and improving health. The difference lies in the fact that health promotion activities can be more general and seek to improve the individual's overall well-being. Illness prevention, on the other hand, focuses on preventing a specific disease. Moreover, health promotion arises from the needs and priorities of each distinct community, while illness prevention will most likely be based more on general data which show the importance of a health problem in the community such as depression levels in the elderly, for example.

7.4 The Importance of Promoting Mental Health

Late diagnosis of mental problems in the young can very likely lead to serious mental illnesses in adult life with long-term effects. Moreover, disorders that have not been identified and treated can seriously reduce the abilities of adolescents in becoming productive members of society and can lead to high levels of crime, major family conflicts, destructive substance abuse, low self-esteem and alcoholism (ASTHO 2002; WHO 2003b). The current socioeconomic crisis, the high demands of modern life, the incomplete parenting, changes in the family structure, dysfunctional interpersonal relations and new demands on adolescents have made it essential to identify mental health problems among adolescents in good time and provide them with support (Patel et al. 2007). However, for that to happen, one must first fully understand and approximate the environment of adolescents in terms of family and school, since mental health problems which prevent functionality are reflected in their reactions to social/environmental stressors (Appleton and Hammond-Roley 2000).

The World Health Organisation (WHO) has highlighted the importance of promoting mental health and prevention in children and adolescents and urges governments worldwide to include mental health as a key part of their primary healthcare (WHO 2004, 2011). However, there is nonetheless an immense gap between needs and resource availability (Keiling et al. 2011). However, in all European Union countries, there is some activity in terms of mental health prevention and promotion. The availability of the practices, resources and infrastructure which has been developed varies from country to country reflecting different situations in healthcare

systems, political history and traditions and their understanding of both mental and public health.

7.5 Best Practices for Promoting Mental Health: International Standards

A literature review highlights examples of best practices and evaluation of the effectiveness of measures to promote mental health among individuals of school age, since it recognises that education contributes to the prevention of the onset of mental illnesses. In fact, programmes that are implemented in schools that focused on promoting general psychological skills (coping skills) for adolescents appear to be more effective than those which focus on specific problematic forms of behaviour (Mentality 2003). This approach includes interactive and participative methodologies, which have been confirmed as being more effective (Tobler et al. 2000).

After running the Responding in Peaceful and Positive Ways (RIPP) programme on 600 adolescents to develop socio-cognitive skills to promote non-violent conflict resolution and positive communication among them and teachers and parents, it appears that the participants acquired important knowledge about how to effectively communicate, manage anger, be empathic and control urges (Farrell et al. 2001).

The interpersonal cognitive problem-solving programme (ICPS) appeared to be equally important. It was run by teachers in the classroom to train adolescents about effective thinking, listening and interpersonal skills for solving problems using techniques such as dialogue, role playing, team spirit and relaxation (Shure and Spivack 1988). The participants appeared to significantly improve their cognitive conflict resolution skills and inhibitions, and spontaneity was significantly reduced. The intervention had a major effect on the role of teachers and also contributed to a reduction in psychological distress.

The Promoting Alternative Thinking Strategies (PATHS) programme was aimed at educating adolescents within structured groups to recognise, understand and self-regulate their emotions (Greenberg and Kusche 1998). For more positive results, printed materials were provided to teachers and parents about how to manage adolescents. The results of the programme confirm improve self-efficacy and positive mental health among the adolescents.

Hains and Ellmann (1994) designed an intervention programme for adolescents to reduce negative emotional arousal and other psychological consequences of stress. The adolescents participated in 13 groups overall which were briefed about stress and its harmful effects of health and were trained in stress management and problem-solving techniques. After the end of the intervention,

stress levels reduced but not to such an important degree as the improvement in their attitude towards seeking health from mental health specialists. The awareness-raising and information campaign applied to 472 adolescents in England contributed significantly to the reduction in stigma about mental illness (Pinfold et al. 2003).

The WHO has shown the importance of integrating health services into the context of the school environment, which to a large extent is based on training the trainers (WHO 2010). Job satisfaction has been shown by many studies to positively affect teachers' ability to manage stress (Bindhu and Sudheeshkumar 2006) while fostering self-efficacy and positive health among teachers who protect both their own professional commitment and the mental balance of adolescents (Brouwers and Tomic 2000).

In one programme to promote mental health in the school environment run for adolescents, parents and teachers (Webster-Stratton and Hammond 2001), the results were positive for all three target populations: after counselling groups, parents appear to have lower levels of negative parenting and higher levels of positive parenting. Moreover, the ties between school and family and the partnership between teachers and parents improved, behavioural problems of children at home and school declined and the role of teachers and how they managed classes were improved.

In another interventionist programme to bolster the educational role and well-being of teachers (Wyn et al. 2000), the latter participated in a total of ten group sessions lasting 30 h which included experiential exercises such as exchanging professional experiences with colleagues, recognising specific stressors and potential coping strategies, using alternative ways of thinking and analysing specific methods for dealing with unruly students in the classroom. After the end of the programme, teachers noted a drop in psychological distress, improved social relations with each other and a drop in levels of burnout.

Another programme for parents and teachers of primary school pupils used teach learning methods to prevent early aggression in children and prepare them for higher school classes (Hawkins et al. 1991). At the end of the programme, teachers acquired stronger skills for teaching social skills to children and more effective knowledge dissemination methods. For their part, parents improved communication skills with their children, learned how to implement home discipline techniques and increased their knowledge about adolescent issues.

In 2008 the WHO in partnership with the International Association for Child and Adolescent Psychiatry organised an interventionist programme for adolescents, parents and teachers and government bodies to provide information and raise awareness about mental health issues faced by children and adolescents (Hoven et al. 2008) in nine countries. Positive changes were recorded in terms of the knowledge acquired by all participants, while the stigma attached to

mental illness dropped and mental health issues were integrated into public debates and media coverage.

7.6 Best Practices in Greece

Programme to Promote Mental Health in Children and Adolescents

The programme to promote mental health in children and adolescents in selected areas of Greece ran for the period 2011–2013. It was financed by the Stavros Niarchos Foundation and implemented by the Association for Regional Development and Mental Health on the islands of the NE and Western Cyclades, where two mobile mental health units have been in operation for the last 10 years. These island areas are remote, meaning that social services either operate below capacity or do not exist at all, and the problems frequently encountered by health services make it difficult if not impossible to prevent and deal with mental health problems.

The intervention was aimed at primary protection of the mental health of children and adolescents and consisted of three levels, to support adolescents and children within frameworks which are important for their development: (a) interventions for the adolescents themselves, (b) interventions at school by working with teachers and (c) interventions in the family. The programme was designed as follows:

(a) Awareness-raising and counselling groups for parents of children in each age group (parents of children of preadolescent and of adolescent age). The main goal of the parents' intervention group was to improve positive mental health and reduce mental distress (by focusing on promotion and prevention, respectively). In addition, specific goals of the intervention were to reduce parental stress, to cultivate coping skills, to expand social networks and to improve attitudes towards mental health professionals and the idea of seeking out help for psychological difficulties.
(b) Awareness-raising and counselling groups for adolescents about mental health issues and theatrical play meetings, where the central goal was to improve positive mental health and reduce mental disorders. Secondary goals included improving the degree of self-efficacy, cultivating coping skills and improving attitudes towards mental health professionals and the idea of seeking out help for psychological difficulties.
(c) Awareness-raising and support groups for teachers in preschool, primary and secondary education. The main goal of this intervention was to improve the ability of teachers to identify mental stress in children and adolescents and to improve their professional self-efficacy. Secondary goals included learning coping skills and expanding social networks.

Planning the Intervention

The plan was that teacher and parent groups would attend nine 2-h long meetings and adolescents would attend 18 meetings with two facilitators in each group (expert mental health trainers specialised in group work). The groups were to meet every 15 days. Each of the meetings per group sought to address specific issues and cover a particular topic. A manual was drawn up for each group meeting which consisted of two parts: (a) a seminar-like presentation on the topic presented using interactive media and (b) an experiential part to ensure deeper assimilation of the topic through experience.

Preparing the manuals was the tool and joint basis for the interventions. The content and subject matter was determined by an informal exploration of needs done by a focus group of school advisors and educational bodies during the preparatory phase. Members of the teams across the entire programme were also asked at the first meeting as part of a brainstorming exercise. The final subject matter was approved by the editorial committee, having taken into account the information generated by the focus groups. The manuals were written by committees of group facilitators appointed depending on the area of specialisation each one had. The editorial team then edited the texts. Each manual was different and aimed at a specific target group. Depending on the subject examined, the epistemological focus of the manual differed (psychoanalytical, systemic, cognitive-behavioural).

The content of the manuals was revised during the programme in line with the intervention's quality control process. The diaries designed as part of the programme's internal evaluation process to be filled out by the group therapists with information about the process indicators for each meeting (a) ensured the uniformity of the intervention at different stages of the programme and (b) allowed one to identify weaknesses in the meetings and correct them later (such as subject matter might have needed to be explored in more detail or required more time or fewer experiential exercises may have been needed).

Methodology: Awareness-Raising and Counselling Groups: Assertive, Experiential Learning

The awareness-raising groups performed an educational support role. Their primary target was to create a framework to activate the individual as a "whole" (Senge et al. 2008). Implementing the project utilised key principles of group dynamics, such as interaction, building a team spirit, developing social networking, creating familiarity, developing communication and cooperation skills, expressing emotions and connecting to personal meaning (Navridis 2005). Consequently, the educational process also aided the personal growth of those who participated.

The principles of experiential learning were chosen for the methodological approach. As stated above, the structured group interventions followed a manual

which included presentations and experiential techniques, such as how to present the topic of small groups, role play games, case studies, simulations (goldfish bowls), communication exercises and use of the group as a forum for social learning about the target group. The approach was experiential and integrated the concept of assertive learning and was aimed at the ability of participants to learn through experience.

Yalom (1995) states that the group process on its own has an experiential character. In addition, experiential learning places emphasis on the important role played by experience in the learning process and provides intellectual and emotional stimulation seeking to integrate intellectual and emotional processes (Evans 1994). At the same time, it is based on initiative and assertive involvement of the individual, which gives the chance to act and take responsibility for the process (Mulligan 1993) and covers a longer time period since it mobilises the individual as a "whole". Learning is in depth and can help the individual grow, affecting his attitudes and personality.

Results

A multifaceted approach was used to evaluate the programme in an attempt to remain in keeping with the complexity of the programme itself and each such mental health prevention and promotion programme. In particular, indicators relating to structure, procedure and outcomes of the programme were included, and information was collected in various ways relating to the outcome indicators: number of referrals to mobile units, use of self-reporting scales, questions to subjects benefiting from the programme, focus groups and open-ended questions about satisfaction with the programme. A brief presentation of the results is set out below.

Overall 1,259 received services as part of the programme over 2 years, and 66 individuals (teachers in the second round) participated in the programme in both years. One thousand and twenty-three people received programme services in the Cyclades, 140 in Evia and 96 in the northern suburbs of Athens. In each target group, the figures for those who received services were 585 teachers, 513 parents and 161 adolescents. The lower number of adolescents compared to other groups can be explained by the difficulty in approaching and retaining the specific population group in long-term, stable prevention measures, especially when the programme is run outside of school hours.

As far as referrals to mobile units are concerned, there was a significant increase which reflects the positive impact of the specific programme on the local communities in the Cyclades where it was run. In the first year, 23 % of referrals to paedo-psychiatric services offered by the mobile unit came from the programme while the corresponding figure for adult services was 16 %. In the second year, 29 % of referrals to paedo-psychiatric services came from the programme and 17 % of referrals for adult services.

As far as adolescents are concerned, the interventions generated the following statistically significant differences compared to the scales before and after the intervention:

Improved self-efficacy (theatrical games and counselling groups)
Reduced symptoms of stress (theatrical games)
Reduced social dysfunction (counselling groups)
Increased use of emotional and practical support as coping strategies (counselling groups)
Reduced mental stress in general (theatrical games)

Adolescents considered that the interventions helped them improve self-confidence, learn more about themselves, become able to express their thoughts and emotions without problems, make new friends and seek out help if they needed it. The interventions do not appear to have improved their positive mental health (mental well-being) but that change may require time to take place.

As far as parents were concerned, the intervention succeeded in large part in its individual goals as is clear from the statistically significant changes noted between the two points in time when the evaluation tools were used (before and after the intervention). The following findings were recorded:

A reduction in psychological distress (psychopathologies of a neurotic type using the GHQ scale)
Improved positive mental health
Reduced parental stress
Expanded social networks
More frequent use of coping skills

As far as teachers are concerned, the internal evaluation and quality control processes resulted in the targets for the specific intervention being redefined as well as in a change in methodology from year 1 to year 2. The lack of a statistically significant impact of the intervention in year 1, the focus groups with group facilitators and a supervisor and the focus groups with the teachers themselves held at the end of year 1 led to a change in focus. During year 1 the intervention primarily related to emotional difficulties faced by teachers themselves and to raising of awareness about mental health issues. In year 2, however, the intervention focused on issues such as identifying mental disorders, managing difficulties in the classroom and fostering the role of the teacher so that he/she could provide effective, real support to students.

The evaluation of that year, which also included teachers who had taken part in year 1 and some who had taken part in year 2 (deeper examination of issues and focus of specific school-based issues), showed that during year 1, teachers had learned about mental health issues and awareness of them had increased, while in

year 2 they were given the opportunity to use that knowledge, to better organise and manage their own issues in terms of their tendency towards emotional over-involvement and their position in relation to the student, parent, colleagues and headmaster.

The intervention led to better identification and recognition of mental health issues among students, greater professional self-efficacy, better social networking and cultivation of better coping skills.

The programme's successes include the involvement and high response rate among local communities which were helped in actively participating in all stages of programme implementation. All procedures were made easier, since facilities were provided for the interventions, thereby raising awareness and informing the population and using the local process to spread news about the programme. For the purposes of the programme, psychometric tools were translated and localised for the Greek population, which can now be used to conduct other research into related topics, and the scientific process used to document the manuals means they can now be used for other mental health working groups, agencies and organisations.

Consequently, the programme's contribution and effectiveness was evaluated on many levels, since the programme itself appears to have benefited the attendees, local communities, mental health services in the local area, mental health professionals and the scientific community in general.

7.7 Discussion

The literature and history of psychiatric reform in Greece shows that the reform process was not accompanied by programmes of this sort which would have improved primary prevention in the population against mental illnesses. Even agencies which could have presented examples of good social psychiatry did not adopt a structured programme to promote mental health.

The programme we implemented had positive effects on local communities, as we mentioned, but also had specific constraints and limits. In many cases we have seen islands of psychiatric reform collapse in the past because of lack of resources and because of the medical focus of the culture within agencies/services, professionals and the wider healthcare system. (See the chapters on psychiatric reform in Europe and Greece.) Reality has taught us that certain synergies are needed at institutional level to run programmes of this kind and that networks of services (networking) are needed to (a) ensure that reform is not put at more risk and (b) ensure that it does not remain suspended in mid-air. Moreover, one disadvantage of the situation in Greece is that mental health promotion and health education are not taught in educational institutes, except in some isolated postgraduate courses. Professionals therefore lack the ability to acquire the necessary tools and skills for the relevant practices.

Talking about local communities, it is essential to stress the multifaceted aspect of interventions of this kind, as well as the complex interactions between the individual, family, wider community (local authorities, services, agencies) and the

wider framework to which the community belongs. Fritjof Capra, an important systems theorist, highlighted the idea of the web of life. For major social issues such as health, he refers to direct connections and interactions with living systems: individuals, social systems and ecosystems (Capra 1997, 2004). The concept of the web of life in the humanities demonstrates the use of network networks at all system levels. It is a dynamic process with numerous individual levels, which are both affected and affect the system. We can identify the benefits of an intervention on all the levels referred to but contrariwise the fact that the same benefits may also be needed to affect the culture of the scientific sector, to shape policy, and the content of interventions. Living systems respond to the effects they are subject to from their environment by making structural changes (Bateson 1979; Maturana and Varela 1987).

At the same time, the concept of interdependence of all phenomena allows us to understand the multiplier effect of positive results on the members of a community, and outside of it, by connecting the local with the global. Modern theories of networks talk about the "human superorganism" where local contributions to the human social network can have global consequences (Christakis and Fowler 2010). Consequently, interventions to promote mental health need to take these fundamental changes in the theory of humanities and the connections between phenomena which were until now treated as "separate" into account and must approach the individual from a holistic scientific perspective.

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