

(targeted to subgroups of the population with risks significantly above average, e.g. family support for young, poor, first pregnancy mothers) or *indicated* (targeted at high-risk individuals with minimal but detectable symptoms, e.g. screening and early treatment for symptoms of depression and dementia). The approach to gathering evidence is influenced by recognising that (1) the evidence for direct causal pathways is generally strongest for the most immediate influences on health or disease; (2) most health states have multiple causes interacting over time (Desjarlais et al. 1995); and (3) important factors such as family environment or child abuse and neglect will influence the level of physical and mental health as well as the risk for several types of illness in later life. Other life events and circumstances will interact favourably or unfavourably to contribute to health and resilience or the development of illness.

Mental health promotion has been seen to ask for peace, social justice, decent housing, education, and employment. The call for intersectoral action has sometimes been diffuse (Kreitman 1990). Specific evidence-based proposals with measurable outcomes are required. However, asking individual health promotion projects to demonstrate long-term changes in ill-health, productivity, or quality of life is often unrealistic and unnecessary. What is required instead is a marshalling of the evidence linking mental health with its critical determinants (aetiological research), and programme design and evaluation to demonstrate changes in the same determining or mediating variables. Programmes and policies can aspire, in other words, to produce changes in indicators of economic participation, levels of discrimination, or social connectedness. Identifying and documenting the mental health benefits of these changes, and developing indicators of these determinants, are complementary areas of work needing further support. An evidence base for mental health promotion does exist but it needs boosting with aetiological research and programme and policy evaluation.

This Part of the Summary Report moves on to consider the nature, collection, assessment, and use of the evidence for mental health promotion in various settings and population groups, and by various means. It concludes by considering the way forward in generating further evidence.

## Evidence and its use in mental health promotion

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### Linking research with practice and policy

Important advances in establishing a sound evidence base for mental health promotion have occurred in recent years. Consensus exists on clusters of known risk and protective factors for mental health and there is evidence that interventions can reduce identified risk factors and enhance known protective factors (Mrazek & Haggerty 1994). The International Union for Health Promotion and Education (IUHPE) report for the European Commission endorses that mental health promotion programmes work and that there are a number of evidence-based programmes to inform mental health promotion practice (IUHPE 2000). The accumulating evidence demonstrates the feasibility of implementing effective mental health promotion programmes across a range of diverse population groups and settings (see Hosman & Jané-Llopis in press).

An important challenge is to strengthen the evidence base in order to inform practice and policy globally. While researchers are more likely to be concerned with the quality of the evidence, its methodological rigour, and its contribution to knowledge, different stakeholders in the area may bring other perspectives to bear on the types of evidence needed. As described by Nutbeam

(2000), policy-makers are likely to be concerned with the need to justify the allocation of resources and demonstrate added-value, practitioners need to have confidence in the likely success of implementing interventions, and the people who are to benefit need to see that both the programme and the process of implementation are participatory and relevant to their needs. Another major task is to promote the application of existing evidence into good practice on the ground, particularly in disadvantaged and low-income countries and settings. This entails identifying programmes that are effective, feasible, and sustainable across diverse cultural contexts and settings. The challenge is therefore 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.

### **Shifting to positive mental health**

Mental health promotion reconceptualizes mental health in positive rather than in negative terms. This shift in focus to positive indicators of well-being calls for methodological refinement in establishing positive indicators of mental health outcomes. This shift also calls for a focus on research methods that will document the process, as well as the outcomes, of enabling positive mental health and identify the necessary conditions for successful implementation.

### **Identifying effective programme implementation**

The systematic study of programme implementation has been relatively neglected. The challenge has been identified as using evaluation methods and approaches that are congruent with the principles of mental health promotion practice (Labonté & Robertson 1996), which cross methodological boundaries, and which evaluate initiatives in terms of their process as well as their outcomes (WHO 1998b). The notion that there is a hierarchy of evidence, particularly one that focuses almost exclusively on evaluation outcomes from expensive randomized controlled trials (RCTs), restricts the current body of evidence to that research conducted mainly in high-income countries. A continuum of approaches is needed ranging from RCTs to more qualitative process-oriented methods such as the use of case studies, narrative analyses correlational studies, interviews, surveys, and ethnographic studies (McQueen & Anderson 2001).

Implementation research is critical to the understanding of how and under what conditions programmes may be effective. Collections of this kind of data will contribute to advancing knowledge on best practice in real settings.

### **Applying the evidence to low-income countries**

The evidence debate needs to extend beyond a concern with the quality of research design to focus more directly on the quality of the interventions and their wider practice and policy implications. Currently the evidence debate has taken place in the English language literature within a Euro-American context: "evidence is least available from areas that have the maximum need, that is developing countries and areas affected by conflicts" (WHO 2002, p. 27).

The development of user-friendly information systems and databases is required in order to make the evidence accessible to practitioners and policy-makers. In particular, there is an urgent need to identify effective programmes that are transferable and sustainable in settings such as schools and communities. In this respect, it may be useful to explore the application of programmes based on community development and empowerment methods, such as the community mothers pro-

gramme (Johnson et al. 1993, 2000) and the widow-to-widow peer support programme (Silverman 1988). These programmes, among others, have been shown to be highly effective, low-cost, replicable programmes successfully implemented and sustained by nonprofessional community members in disadvantaged community settings. The implementation of school-based programmes for young people also appears to be a key area for development in low-income countries.

In the absence of large resources, the challenge in many countries is to document innovative forms of practice and to bring them to the attention of others. Documentation, even newsletters and brochures, may be lacking. A lack of documentary evidence does not mean that there is not good practice, however. Dissemination research to examine how existing evidence can be applied across diverse cultural settings is necessary.

International cooperation is necessary to assist low-income countries by means of technical support in publishing guidelines for effective implementation of low-cost, sustainable programmes. The ultimate test of the evidence base is how it can be used effectively to inform practice and policy globally that will reduce inequalities and bring about improved mental health for individuals, families, and communities in most need.

## Social determinants of mental health

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The socioeconomic determinants of health have been well studied. In brief, people who are more socially isolated and people who are disadvantaged have poorer health than others (House, Landis & Umberson 1988). More socially cohesive societies are healthier, with lower mortality (Kawachi & Kennedy 1997). Many studies have shown the powerful health associations of social connectedness (Putnam 2001). The evidence on the personal, social, and environmental factors associated with mental health and mental illness has been reviewed by a number of authors (e.g. HEA 1997; Lahtinen et al. 1999; Wilkinson & Marmot 1998; Eaton & Harrison 1998; Hosman & Llopis 2004; Patel & Kleinman 2003).

Concurrent with 20th century advances in learning from the brain sciences and neuroscience, there has been an evolution of ideas about the social determinants of mental health and mental disorders. At the beginning of the 21st century, we have returned to a position of widespread enthusiasm about our genetic endowment and the social shaping of its expression. At present, the predominant motif is not from eugenics as practiced at the population level via the now-rejected modes of ethnic cleansing and selective sterilization. Instead, a prevailing motif is that gene expression can be shaped by exogenous agents and may be shaped by social experience.

It will be important for the lay public and for societal leaders to grasp these ideas as they emerge and are developed during the 21st century. Choices about the societal response depend in part upon our capacities to predict the occurrence of harm or benefit and in part upon our benefit–risk analysis with respect to deployment of resources. In this context, the accuracy of our predictions is disclosed in the evidence and is more or less objective, but the benefit–risk evaluation and the choice of interventions depend upon an expression of shared consensus about values.

An immediate challenge for society's leaders is to create or refine the social structures and processes we use to evaluate the available evidence and to mobilize resources to promote mental health (Jenkins 2001). New discoveries and increasingly definitive evidence about the determinants of mental health are of limited value unless there are social structures and processes to put the new discoveries and evidence into action.