

Chapter 9

The Nature of Evidence and its Use in Mental Health Promotion

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Introduction

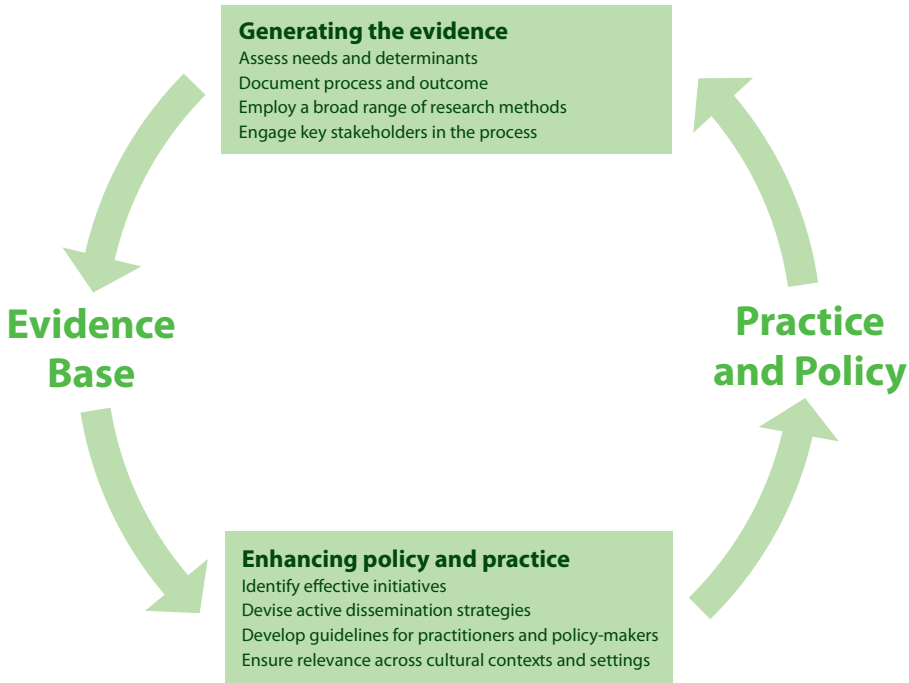
There have been important advances in establishing a sound evidence base for mental health promotion in recent years. There is consensus that there are clusters of known risk and protective factors for mental health and there is evidence that interventions can reduce identified risk factors and enhance known protective factors (Mrazek & Haggerty, 1994). An International Union for Health Promotion and Education (IUHPE) report for the European Commission in 2000 clearly endorsed that mental health promotion programmes work and that there are a number of evidence-based programmes that inform mental health promotion practice (IUHPE, 2000). This accumulating evidence demonstrates the feasibility of implementing effective mental health promotion programmes across a range of diverse population groups and settings.

An important challenge is strengthening the evidence base in order to inform best practice and policy globally. There is a need to identify gaps in, and expand, existing knowledge in order that the complexities and creativity of contemporary practice can be captured and disseminated widely. While researchers are more likely to be concerned with the quality of the evidence, its methodological rigour and contribution to the knowledge base, different stakeholders in the area may have different perspectives 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 be able to have confidence in the likely success of implementing interventions, and the potential users or 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 to 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 can make its way into the published literature and thus build on and expand the existing evidence base (see figure 9.1). 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 programme implementation across diverse cultural settings.

Evaluating the promotion of positive mental health

As discussed in earlier chapters, mental health promotion reconceptualizes mental health in positive rather than negative terms and is concerned with the delivery of effective programmes designed to reduce health inequalities in an empowering, collaborative and participatory manner. This shift in focus from negative to positive indicators of well-being calls for methodological refinement in establishing sound measures of protective factors and positive indicators of mental health outcomes. Chapter 12 of this volume provides a useful discussion of this issue and outlines a socioecological framework for developing indicators of positive mental health. A focus on positive mental health also calls for more attention to the process and principles of programme delivery. Evaluation methods are needed that focus on documenting the process, as well as the

Figure 9.1
Bridging the gap between evidence and practice



outcomes, of enabling positive mental health and identifying the intervening or mediating variables which act as key predictors of change. This leads to a focus on evaluation methods aimed at capturing the dynamics of programmes in action and identifying the critical ingredients for successful programme development, planning and implementation.

The available evidence supports the view that competence-enhancing programmes carried out in collaboration with families, schools and wider communities have the potential to produce multiple positive outcomes across social and personal health domains (Barry, 2001; Durlak & Wells, 1997; Friedli, 2003; Hosman & Jané-Llopis, 2000; Tilford, Delaney & Vogels, 1997). Most interventions have been found to have the dual effect of reducing problems and increasing competencies. However, much of the existing evidence has focused on individual-level interventions and, as highlighted in Chapter 15, there is a paucity of evidence on the effectiveness of upstream policy interventions such as improved housing, welfare, education and employment in improving mental health. There is a need to generate evidence of the effectiveness of interventions operating at different levels – individual, community and macro-level policy – in promoting positive mental health.

The evidence-based practice of health promotion is a relatively recent phenomenon, therefore strengthening the evidence base in order to inform best practice and policy is an important challenge. There is considerable debate, however, as to how this is best approached. This chapter takes a critical look at some of the key issues, challenges and opportunities in strengthening the mental health promotion evidence base.

Adopting an evidence-based approach: issues and challenges

There has been much discussion about what constitutes legitimate evidence in health promotion evaluation and how best to assemble the evidence in ways which are relevant to the complexities of contemporary practice (McQueen, 2001; Nutbeam, 1999; Tones, 1997; see also Chapter 2). As health promotion is an interdisciplinary area of practice, the challenge is to use evaluation methods and approaches that are congruent with the principles of health promotion practice (Labonté & Robertson, 1996), that cross methodological boundaries and that seek to evaluate initiatives in terms of their process as well as their outcomes. The WHO European Working Group on Health Promotion Evaluation (1998) set forth recommendations for policy-makers concerning the appropriate methods for evaluation in health promotion (see table 9.1). They point out that the use of randomized control trials (RCTs) to evaluate health promotion initiatives “is, in most cases, inappropriate, misleading and unnecessarily expensive”. While RCTs and systematic reviews are regarded as the “gold standard” in the traditional hierarchy of research designs (WHO, 2002), their application to

The Cochrane Collaboration

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The Cochrane Collaboration, an international organization of health professionals, aims to promote the preparation and use of high quality, regularly updated, systematic reviews on the effectiveness of health interventions. Cochrane reviews begin life as a registered title of a Collaborative Review Group. A protocol (a blueprint for the review) is developed, peer reviewed and published electronically on the Cochrane Library. The review is then carried out, peer reviewed and published. The authors make a commitment to update the review at least every two years and Cochrane protocols and reviews are open throughout their lifespan to comments and criticism by readers. The Health Promotion and Public Health Field (the Field) of the Collaboration is aiming to improve the quality and quantity of systematic reviews in order to develop a solid foundation of evidence relevant to core public health questions, including reviews of mental health promotion interventions and interventions with mental health outcomes. The emergence of the Campbell Collaboration, which focuses on social, education and justice interventions, also has relevance for identifying interventions that have an impact on mental health.

In October 2003, the Field completed a collaborative initiative to develop a list of priority topics for future health promotion and public health Cochrane reviews. A global taskforce including representatives from the IUHPE, WHO, Global Health Council, Global Forum for Health Research, Centers for Disease Control and Prevention and MacFarlane Burnet Institute for Medical Research and Public Health identified a list of the top 15 topics for review. Six of these 15 are directly relevant to mental health promotion and are highlighted in bold below.

Further information can be found at:

Cochrane Collaboration: www.cochrane.org

Cochrane Health Promotion and Public Health Field: www.vichealth.vic.gov.au/cochrane/

Campbell Collaboration: www.campbellcollaboration.org

Health promotion and public health field topics for review

1. **Community-building interventions (designed to build a sense of community, connectedness, cultural revival, social capital) to improve social and mental health**
2. Healthy cities, municipalities or spaces projects in reducing cardiovascular disease risk factors [Could include mental health outcomes]
3. Interventions to build capacity among health care professionals to promote health and/or
Interventions to build organizational capacity to promote health
4. **Physical exercise to improve mental health outcomes for adults** [specified to adults to avoid overlap with existing reviews focusing on children and young people]
5. Interventions utilizing marketing strategies to promote healthy behaviours in young people [focusing on tobacco, alcohol and food]
6. **Prenatal and early infancy interventions for prevention of mental disorder**
7. **Interventions using the WHO Health Promoting School framework in improving health and academic achievements among students in schools**
8. Interventions that employ a combination of environmental, social and educational strategies to prevent infectious diseases such as malaria, dengue and diarrhoea
9. Interventions addressing gender disparities in family food distribution to improve child nutrition
10. **Interventions to decrease/minimize adverse health effects of urban sprawl**
and/or Interventions to increase the supply of sidewalks and walking trails for the public
11. Interventions for healthier food choices
 - Sales promotion strategies of supermarkets to increase healthier food purchases
 - Pricing policies to increase healthy food choices
12. Transport schemes to increase use of maternal and newborn health services (with a skilled attendant), increase community support and action for maternal and newborn health populations
13. Interventions to improve nutrition of refugee populations and displaced populations
14. **Interventions that aim to reduce health risk behaviours through enhancing protective environments for adolescents**
15. Interventions focusing on adolescent girls in order to improve nutritional status of women of child-bearing age prior to first pregnancy

the field of health promotion has generated considerable debate. Such approaches restrict the current body of evidence to published research carried out mainly in high income countries.

McQueen and Anderson (2001) discuss the complexity of the debate and call for a broadening of the base of appropriate research methods in keeping with the diversity of practice in the area. They point out that researchers and practitioners in health promotion have not reached consensus on any hierarchy of evidence and that international groups have asserted that it is premature to prioritize types of evidence in a linear hierarchy. They argue for the establishment of rules of evidence that take into account the diverse, multidisciplinary and contextualized nature of health promotion practice. Different methodological approaches are required to encompass the different elements of process, impact and outcome evaluation. While outcome-focused studies may lend themselves to more quantitative approaches, process-focused 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. A useful generic framework for guiding the evaluation of health promotion initiatives has been proposed by Goodstadt and colleagues (2001). This model has its conceptual and operational roots in the Ottawa Charter (WHO, 1986) and describes a structure and logical sequence of steps that can be followed.

Flexible and creative approaches are required for mental health promotion evaluation ranging from RCTs to more qualitative process-oriented methods. This calls 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 (Barry, 2002; Friedli, 2001; Jenkins, Lehtinen & Lahtinen, 2001). This includes the use of case studies, narrative analyses, correlational studies, quasi-experimental and experimental studies, interviews and surveys, epidemiological studies, ethnographic studies and others (McQueen & Anderson, 2001). Approaches covering action research and participatory research methods also have an important role to play in developing more collaborative forms of research inquiry. These approaches seek to actively engage those most involved in and affected by the research with the researcher and the process of evidence gathering.

There is also a need to agree on quality standards and rules of evidence at each stage of the evidence building process. In this manner, research methods can be tailored to the evaluation of programmes at different stages of development and levels of implementation. As mental health promotion draws on a diverse range of disciplines, different theoretical and methodological perspectives may also be brought to bear in establishing a sound evidence base. As McQueen (2001) suggests, we need to identify the rules of different disciplines and where they fit into the process of building the evidence base in order to capitalize on the multidisciplinary nature of the field. This broad approach is the one endorsed and taken up by the IUHPE Global Programme on Health Promotion Effectiveness (Jané-Llopis, in press).

Table 9.1
Conclusions and recommendations from WHO European Working Group on Health Promotion Evaluation

Conclusions	Recommendations to policy-makers
Those who have a direct interest in a health promotion initiative should have the opportunity to participate in all stages of its planning and evaluation.	Encourage the adoption of participatory approaches to evaluation that provide meaningful opportunities for involvement by all of those with a direct interest in health promotion initiatives.
Adequate resources should be devoted to the evaluation of health promotion initiatives.	Require that a minimum of 10% of the total financial resources for a health promotion initiative be allocated to evaluation.
Health promotion initiatives should be evaluated in terms of their processes as well as their outcomes.	Ensure that a mixture of process and outcome information is used to evaluate all health promotion initiatives.
The use of RCTs to evaluate health promotion initiatives is, in most cases, inappropriate, misleading and unnecessarily expensive.	Support the use of multiple methods to evaluate health promotion initiatives. Support further research into the development of appropriate approaches to evaluating health promotion initiatives.
Expertise in the evaluation of health promotion initiatives needs to be developed and sustained.	Support the establishment of a training and education infrastructure to develop expertise in the evaluation of health promotion initiatives. Create and support opportunities for sharing information on evaluation methods used in health promotion through conferences, workshops, networks and other means.

Adapted from: WHO European Working Group on Health Promotion Evaluation, 1998

Evaluating the process of programme implementation

As already discussed, there is a need for an approach that embraces the process of programme development and implementation as well as programme outcomes and how the two areas are linked. This is essential if the area is to move to a new level of understanding and sophistication beyond the question of whether programmes work to consider what makes them work, with whom and under what circumstances. The published research studies are largely restricted to research outcomes and typically little information is provided on the process and extent of programme delivery that must occur in order for those outcomes to be produced.

Programme implementation refers to the actuality of putting a programme or intervention into practice: what the programme consists of and how it is delivered (Durlak, 1998). Details of programme implementation are typically under-reported in the published literature. As a result, there is a dearth of published information to guide practitioners and decision-makers regarding the practical aspects of programme adoption and replication. In contrast to the absence of formal measurement there is, however, a wealth of information based on practitioner experience. This is what Domitrovich and Greenberg (2000) refer to as the “wisdom literature”, a body of knowledge based on practical experience of programme delivery. There is a need for greater attention to documenting and accessing this body of knowledge in order to become better informed about the circumstances and practices that enhance programme implementation. Process evaluation techniques based on careful project description, documentation and monitoring are required to assess both the quantity and quality of programme implementation.

Although the majority of evaluation studies provide little or no data on implementation (Dane & Schneider, 1998; Durlak, 1998), it is clear from those studies that have monitored it that it is often variable and imperfect in field settings and that the level of implementation influences outcomes (Durlak, 1998; Domitrovich & Greenberg, 2000; Mihalic et al., 2002). Monitoring and documenting the process of programme implementation is critical to highlighting programme strengths and weaknesses, determining how and why programmes work, enhancing the validity of outcome evaluation and providing feedback for continuous quality improvement in programme delivery (Domitrovich & Greenberg, 2000). If programme implementation is not monitored and assessed, an outcome evaluation may be assessing a programme that differs greatly from that originally designed and planned. The collection of systematic data on programme implementation plays an essential role in advancing knowledge on best practice for replication in real world settings.

Evaluating implementation is a complex process as it entails capturing the dynamics of programmes in action and monitoring the gaps between plans and delivery. Information is needed about the specific programme components, how they are delivered and the characteristics of the contexts or settings in which they are conducted (Dane & Schneider, 1998). In addition to identifying the core components of the intervention, information is also needed on what Chen (1995) refers to as “the implementation system”. This includes the process and structure of the planning, implementation and training; the characteristics of programme implementers and participants and the nature of their relationships; and facilitating and inhibitory factors in the local context, including readiness, mobilization of support, ecological fit of the programme, cultural sensitivity and the extent of participation and collaboration with key stakeholders. Chen (1995) argues that although the intervention itself is the major change agent, the implementation system is likely to make an important contribution to programme outcomes as it provides the means and the context for the intervention. Comprehensive documentation of programme delivery provides data on the practical realities of implementation including programme modification and adaptation for the local setting.

Barry (2002) highlighted the need for a more explicit understanding of programme theory and a more systematic study of programme implementation in mental health promotion practice. Of interest is the growing emphasis on theory-driven evaluation (Chen, 1995; Goodstadt et al., 2001) and the use of evaluation logic models (Scheirer, Shediak & Cassady, 1995) in clarifying the connections between a programme’s operations and its effects. While outcome-focused evaluation provides summary information on the total effects of a programme, it does not of necessity evaluate

the intervening mechanisms responsible for the intervention's success or failure. The usefulness of the theory-driven perspective is its focus on examining the causal mechanisms underlying the change process and the relationship between the programme's conceptual theory and action theory, i.e. its translation into practice. Evaluation logic models have been used to make explicit the logic of the change processes linking programme implementation with intermediate and early outcomes. Scheirer, Shediac & Cassady (1995) illustrate the use of a chain of events research paradigm to examine the detail of actual programme delivery by tracking prospectively the sequence of programme actions influencing intended outcomes. The detailing of the programme in action permits an accurate record to be kept as it unfolds and plays a crucial role in informing the detection of intermediate-level changes which lead to ultimate programme outcomes. This form of evaluation research gives equal emphasis to process and outcome data and attempts to link the two in a logical and systematic fashion, relating variability in programme implementation with variability in outcomes. This type of logic model approach has been adopted, developed further and consistently and effectively applied in the systematic reviews of evidence carried out by the USA Community Preventive Services Task Force over the past several years (Briss et al., 2000).

The systematic study of programme implementation calls for the use of a wide range of research methods and the collection of rigorous data drawn from multiple sources. The generation of practice-based evidence and theory is an important challenge in this area and will require researchers and practitioners to work in partnership to document and analyse the implementation of mental health promotion programmes. Through the development of more collaborative and participatory evaluation methods there will be an opportunity to include the knowledge of programme implementers and participants into the evaluation process, thereby incorporating the wisdom literature into the evidence base. There is a need for analytic frameworks that integrate process and outcome data in a meaningful way so that clear statements can be made about how and why programme 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.

Widening the evidence base: applying the evidence to low income countries

While good progress is being made on building the research base of mental health promotion, there is a need to extend the evidence debate beyond an academic elite concerned with the quality of research design to focus more directly on the quality of the intervention programmes and their wider practice and policy implications. As advocated by Mittelmark (2003), it is time to draw clear messages from the existing evidence and establish guidelines based on that evidence in order to inform best practice and policy on the ground. While addressing the complex methodological issues and specifics of the evidence debate, it is critical not to lose sight of the bigger picture, which is to apply what we do know in order to inform decision-making and bring about lasting change in the broader policy context. Speller, Learmonth & Harrison (1997) highlighted that there is a tendency for researchers reviewing the evidence to focus their energies on the research and methodological issues rather than on the quality of the actual programmes being evaluated. While continuing to build on systematic reviews of specific topic areas, it is important to identify crosscutting themes and generic processes that underpin the successful implementation of mental health promotion programmes. There is a need for practice and policy guidelines based on the

existing evidence to inform practitioners and decision-makers concerning effective programme planning, delivery and evaluation and the critical factors that are needed to ensure the implementation of successful programmes. This information is beginning to emerge, and there are some useful practitioner-oriented publications, such as Price et al. (1988), the Blueprints series by Elliott (1997) and *Making it Happen* (Department of Health, 2001), all concerned with providing practical guidance on programme implementation.

There is a particularly urgent need to expand the evidence base to be more relevant to the realities of those working and living in low income countries. McQueen (2001) points out the strong cultural and geographic bias in the manner in which evidence is currently articulated and represented in the health promotion literature. The evidence debate has been mainly conducted in the English language within a European-American context and is largely the preserve of an academic elite. As McQueen points out, much of the relevant material that could broaden the discussion on evidence is unpublished. Voices from developing countries are absent as indeed are the voices of practitioners and programme users/recipients. This view is echoed in a WHO 2002 report on prevention and promotion in mental health which highlights that evidence is “least available from areas that have the maximum need, i.e. developing countries and areas affected by conflicts” (WHO, 2002, p. 27).

In many countries implementing programmes usually entails working with minimal resources, few of which can be allocated to large research programmes. Because there may not be “evidence” as represented by sophisticated outcome measures, this doesn’t mean that there is not good practice. There may indeed be many worthwhile and effective interventions taking place in developing countries; however, the documented evidence may lag behind the practice. In the absence of large grants, a key challenge is how to uncover and document good practice which is not yet disseminated in the literature. Traditional documentation is often lacking and even such rudimentary publications as newsletters and brochures may not exist. Nonetheless, intervention programmes may be known through word of mouth and other traditional ways of spreading the word about good practice in the field. The problem for those trying to assess these practices is how to bring them into view of the so-called scholarly world. That is a challenge that calls for innovative methods of discovery such as Delphi techniques among recognized health promoters who are in the field. Such a type of data gathering and the methodological rigour that it should pursue remain developmental and a task for programmes such as that of the IUHPE. In the mental health field the challenges may be even greater.

Much energy and many resources have been devoted to establishing efficacy and effectiveness trials in middle to high income countries; it is now timely to invest in dissemination research to examine how the existing evidence can be used effectively across diverse cultural settings. As discussed in Chapter 13, the development of user-friendly information systems and databases is required in order to make the evidence base accessible to practitioners and policy-makers. In particular, there is an urgent need to identify effective programmes that are transferable and sustainable in low income country 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 programme (Johnson, Howell & Molloy, 1993; Johnson et al., 2000) and the widow-to-widow peer support programme (Silverman, 1988) to name but two. These programmes, among others, have been shown to be highly effective, low-cost replicable programmes based on empowerment principles and successfully implemented

and sustained by non-professional community members in disadvantaged community settings. The implementation of school-based programmes for young people would also appear to be a key area for development in low income countries.

Mental health promotion needs to be incorporated into the wider health development agenda in order that the broader determinants of poor mental health such as poverty, social exclusion, exploitation and discrimination can be successfully addressed. The innovative Voices of the Poor study, carried out under the auspices of the Poverty Reduction Group of the World Bank (Narayan & Petesch, 2002), underscored the need to invest in poor people's assets and capabilities and to work in partnership with people living in poverty in order to develop strategies and solutions that can be locally owned and adapted.

In establishing a credible evidence base from low income countries there is a need for internationally supported dissemination research that will examine the documentation, replication and adaptation of effective programmes across diverse low income country settings. More active strategies are required for disseminating the evidence and providing technical assistance and capacity building resources for mental health promotion in low income countries. As Backer (2000) points out, dissemination entails not only distributing information about successful programmes and practices but also the provision of technical assistance and capacity building resources to enable practitioners to actually implement the programmes and the complex processes involved. This involves funding not only a particular programme but also the overall ability and resources of the organization or group needed to implement and sustain the programme in complex and challenging local contexts. Capacity building also entails increasing the organizations' ability to share new programmes 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 programmes and creative practice.

Conclusion

A key challenge in establishing the mental health promotion evidence base is how this evidence can be used to create change and bring about improved mental health for individuals, families and communities in most need. The evidence base should serve the needs of practitioners and policy-makers concerned with the practicality of implementing successful programmes that are relevant to the needs of the populations they serve. This calls for the active dissemination of validated programmes and guidelines on best practices based on efficacy, effectiveness and dissemination studies. There is a need for international cooperation in assisting low income countries with technical support and other capacity building resources, designing dissemination strategies, publishing guidelines for effective implementation of low-cost sustainable programmes and providing training in programme planning and evaluation. The ultimate test will be how the evidence base can be effectively used to inform practice and policy that reduces inequalities and brings about improved mental health, especially where it is needed most.

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