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Begründet von Günter Ammon

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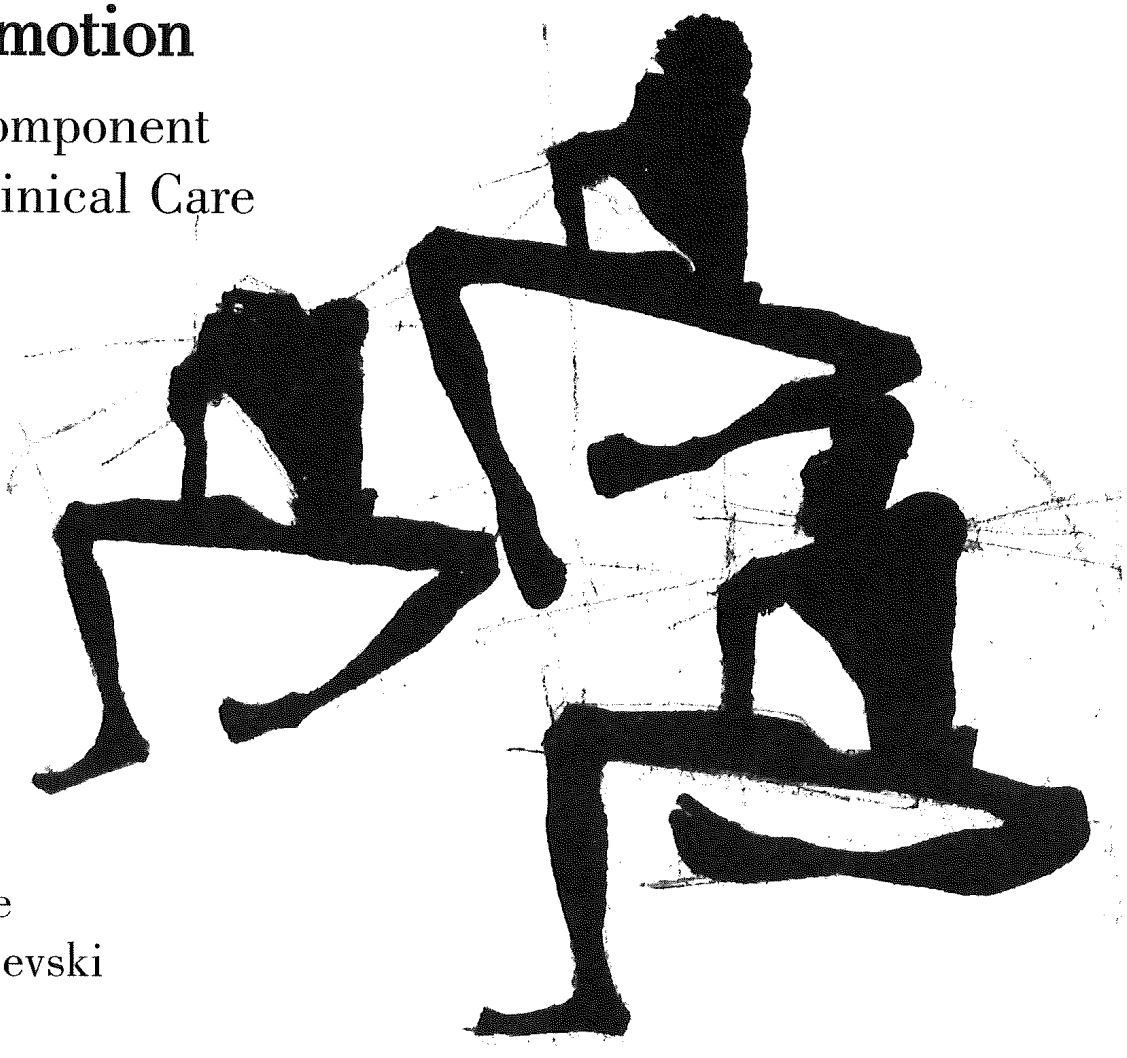
Health Promotion

An Integral Component of Effective Clinical Care



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Begründet von GÜNTER AMMON

herausgegeben von MARIA AMMON unter Mitarbeit von:

Titelbild: Egon Schiele, Komposition dreier Männerakte, 1910 (c) Leopold Museum Wien.

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Editorial

> »Health of a human being is not just a capital to be consumed, but health is present actually only there where it is created in any moment of life. If health is not created, then man is already sick.«
>
> Viktor v. Weizsäcker (1930)

Welcome to this first Special Issue on Health Promotion! We are proud to present here a set of original papers on various aspects of Health Promotion from eminent international experts in this field across the world. The papers were presented in a special symposium of the World Psychiatric Association (WPA) Section on Preventive Psychiatry, chaired by the editors of this Special Issue, at the last World Congress of WPA in Yokohama in August 2002.

During the last two decades there has been an increasing interest, active conceptualization and research efforts in prevention and health promotion involving the health and social sciences. There is a reason for this increasing need and interest. Despite of an impressive progress in etiological research and treatment of diseases, the morbidity rates and chronicity of illnesses have not decreased. It has therefore become compelling to involve in health care developments more refined prevention and health promotion perspectives. The main programatic idea of the health promotion approach is a shift from only minimizing risks and focusing on deficits towards strengthening the positive health of a person - who is an active participant and decision-maker and not just a passive recipient of care - and towards promoting an environmental context conducive to health.

In 1986, the World Health Organization (WHO) convened its 1st International Conference on Health Promotion in Ottawa. In a declaration that emerged from this conference, health promotion was founded as a far-reaching field of action, ranging from health promotive policy, environments, community actions to developing personal competences and reorienting health services (WHO, 1986). Since then, WHO has initiated innovative programs

such as Healthy Cities, Healthy Islands, Health Promoting Hospitals, Health Promoting Schools, etc. to mention just some of its initiatives (eg, Berger et al., 1999; Paulus, 1997; WHO, UNESCO & UNICEF, 1992). Currently, there is an important international publication project in preparation by WHO in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne in Australia on »Promoting Mental Health: Concepts, Evidence and Practice«. It is edited by Helen Herrman, Shekhar Saxena and Rob Moodie. (Helen Herrman and Rob Moodie are authors of an article in this Special Issue.)

In 1998, Martin Seligman, as president of the American Psychological Association, placed its congress under the motto: »Promoting strength, resilience, and health in young people«. In his greetings he said: »But 50 years of working in a medical model on personal weaknesses and the damaged brain have left mental health professions ill-equipped to do effective prevention. We need massive research on human strength and virtue.« (Seligman, 1998; see also Seligman & Peterson, 2003) It could be argued further that we also need more research on cultural, socioeconomic and ecological factors and environments which promote health and have preventive influences, as two German health promotion researchers and community psychologists emphasized recently (Röhrle & Sommer 1999).

The health promotion approach is conceptually connected closely to the »recovery approach« which is presently being adopted by many mental health systems around the world due to its positively formulated focus on healing. It includes aspects such as hope, relearned optimism, resilience, self-help activities, or supportive networks. For example, Courtenay Harding at the Institute for the Study of Human Resilience, Boston University, is investigating systematically resilience and recovery processes in mental illness (Harding, 1986). The current emphasis on positive aspects of health and recovery within the mental health field has been recently (March 2003) documented in a report of the Subcommittee on Consumer Issues by the US Presidential Commission on Mental Health with the title »Shifting to a recovery-based continuum of community care«. According to this report, a recovery-oriented mental health system embraces the following values: a) Collective and individual self-determination, b) Empowering relationships, c) Meaningful roles in society, and d) Eliminating stigma and discrimination. The report suggests building a recovery-based system, in which the mental health community must draw upon resources of people with mental illness in their communities. Meaningful

involvement of consumers in the mental health system may ensure they lead a self-determined life in the community, rather than remaining dependent on the mental health system for a lifetime.

We can say that health promotion in the context of clinical care has not yet been investigated in a systematic manner and that there is a lack of publication and research in this field. Therefore we are glad to publish in this Special Issue papers which connect health promotion with clinical care issues such as diagnosis and prevention besides conceptual, research and international collaboration topics.

Martin Anderson and Rachel Jenkins (Nottingham/London) will show that there is a rapidly increasing evidence base for the effectiveness of programmes for mental health promotion to increase psychosocial resilience in children, adolescents and adults. They propose several prevention models in which health promotion plays a central role.

Juan E. Mezzich (New York) will discuss the relevance of both illness and positive health information in the development of comprehensive diagnostic models aimed at enhancing clinical care. He will briefly outline the recently published WPA International Guidelines for Diagnostic Assessment (IGDA) as a useful diagnostic model for the assessment of clinical disorders, contextual factors as well as positive health aspects, all within an interactive process engaging clinicians, patients and families.

Margit Schmolke (New York/Munich) will summarize some basic conceptual elements and research methods being employed in health promotion as compared to traditional clinical research. Selected research results will illustrate the relevance of such a health promotion approach to clinical care and non-clinical environments in the community.

Helen Herrman and her co-authors from Melbourne provide a congent introduction into their innovative and comprehensive VicHealth project on mental health promotion. Their framework for action includes gathering local evidence about mental health and disorders in the community, the relationship to key socioeconomic variables, intersectoral partnerships and project development.

Michael Murray and John Orley (London) focus on the need of effective collaboration on health promotion across cultural, professional and international barriers. They discuss organizational, strategic and professional issues to be addressed by leading agencies such as WHO, WPA, and WFMH to create effective partnerships.

Finally, the Section Committee on Preventive Psychiatry of the World Psychiatric Association, chaired by Dusica Lecic-Tosevksi (Belgrade), will present a Consensus Statement on Psychiatric Prevention recently endorsed by the WPA General Assembly in Yokohama. Health promotion interventions play clearly a central role in current concepts of psychiatric prevention. However, a word of caution is pertinent at the end with reference to the difficulty to carry out prevention and health promotion in countries with socioeconomic problems or living in conditions of violence, war or sanctions. Unless support is given to those countries »modern psychiatry and international organizations will remain elitistic and their accepted goals and intentions only declarations without a wider impact«. The Consensus Statement ends addressing WPA Task Forces and Sections who could play a major role in helping Member Societies in sharing effective models of prevention, adjusted to specific needs of each population, as well as by providing teaching material and advocacy.

We would like to thank the participating authors for their important contributions to this Special Issue and we wish researchers and clinicians may feel inspired and encouraged to complement their knowledge base with a health promotion component and its creative ingredients of hope and positive health.

Margit Schmolke and Dusica Lecic-Tosevski

Editorial

> »Die Gesundheit eines Menschen ist eben nicht ein Kapital, das man aufzehren kann, sondern sie ist überhaupt nur dort vorhanden, wo sie in jedem Augenblick des Lebens erzeugt wird. Wird sie nicht erzeugt, dann ist der Mensch bereits krank.«
>
> (Viktor von Weizsäcker, 1930)

Willkommen zum ersten Spezialheft zum Thema Gesundheitsförderung! Wir sind stolz, in diesem Heft eine Zusammenstellung von Originalmanuskripten von eminenten internationalen Experten zu verschiedenen Aspekten der Gesundheitsförderung zu veröffentlichen. Die Beiträge wurden in einem Symposium der Sektion »Präventive Psychiatrie« der Weltgesellschaft für Psychiatrie (WPA) auf ihrem letzten Weltkongress in Yokohama im August 2002 vorgetragen. Das Symposium wurde von den Herausgeberinnen dieses Spezialheftes organisiert.

Während der letzten zwei Jahrzehnte sind ein steigendes Interesse und aktive Bemühungen um eine Konzeptualisierung und Erforschung im Bereich Prävention und Gesundheitsförderung deutlich geworden, an denen Gesundheits- und Sozialwissenschaftler beteiligt sind. Es gibt einen Grund für dieses wachsende Interesse an diesem Thema. Trotz beeindruckender Fortschritte in der Ätiologieforschung und in der Krankheitsbehandlung haben sich die Morbiditätsraten und die Chronifizierung von Krankheiten nicht vermindert. Es ist daher zwingend geworden, verstärkt Perspektiven der Prävention und Gesundheitsförderung in die Gesundheitsversorgung einzuführen. Die zentrale programmatische Idee des Gesundheitsförderungs-Ansatzes ist ein Perspektivenwechsel von einer lediglichen Risikoreduzierung und Defizitfokusierung in Richtung einer Stärkung der positiven Gesundheit eines Menschen und der Förderung eines umweltbezogenen Kontextes, der für die Gesundheit günstig ist. Dabei ist der Einzelne ein aktiver Teilnehmer, der Entscheidungen trifft und nicht nur ein passiver Empfänger von Hilfeleistungen.

1986 veranstaltete die Weltgesundheitsorganisation (WHO) in Ottawa ihre erste internationale Tagung zur Gesundheitsförderung. Daraus resultierte eine Deklaration, in welcher die Gesundheitsförderung als ein weitreichendes Aktionsfeld begründet wurde. Dieses Feld reicht von gesundheitsfördernder Politik, Umwelt, Aktionen in der Gemeinde bis hin zur Entwicklung von persönlichen Kompetenzen und Reorientierung der Gesundheitsdienste (WHO, 1986). Seitdem hat die WHO innovative Programme ins Leben gerufen, wie z.B. Gesunde Städte, Gesunde Inseln, Gesundheitsfördernde Krankenhäuser und Schulen, um nur einige zu nennen (vgl. Berger et al., 1999; Paulus, 1997; WHO, UNESCO & UNICEF, 1992). Zur Zeit wird ein bedeutsames internationales Buchprojekt von der WHO vorbereitet in Zusammenarbeit mit der Victorian Health Promotion Foundation und der Universität Melbourne in Australien zu dem Thema »Förderung von psychischer Gesundheit: Konzepte, Evidenz und Praxis«. Die Herausgeber sind Helen Herrman, Shekhar Saxena und Rob Moodie. (Helen Herrman und Rob Moodie sind Autoren eines Beitrages in diesem Spezialheft.)

Martin Seligman gab im Jahre 1998 als Präsident der Amerikanischen Psychologenvereinigung ihrem Kongress das Motto: »Förderung von Stärke, Resilienz und Gesundheit von jungen Menschen«. In seiner Eröffnungsansprache sagte er: »Aber 50 Jahre Arbeit mit einem medizinischen Modell der individuellen Schwächen und des beschädigten Gehirns hat das psychiatrische Berufsfeld schlecht ausgerüstet zurückgelassen für eine effektive Präventionsarbeit. Wir benötigen eine massive Forschung über die menschlichen Stärken und Tugenden.« (Seligman, 1998; vgl. auch Seligman & Peterson, 2003) Weiter könnte argumentiert werden, dass wir auch mehr Forschung brauchen über kulturelle, sozioökonomische und ökologische Faktoren und Kontextbedingungen, die gesundheitsförderlich sind und präventive Einflüsse haben - wie zwei deutsche Forscher auf dem Gebiet der Gesundheitsförderung und der Gemeindepsychologie kürzlich betont haben (Röhrle & Sommer, 1999).

Der Ansatz der Gesundheitsförderung ist konzeptionell eng verbunden mit dem »recovery«-Ansatz (recovery bedeutet etwa Erholung oder Wiederherstellung), der gegenwärtig von vielen psychiatrischen Gesundheitssystemen weltweit übernommen wird wegen seines positiv formulierten Fokus auf Heilung. Dieser Ansatz beinhaltet Aspekte wie Hoffnung, wiedererlernter Optimismus, Resilienz, Selbsthilfe-Aktivitäten oder unterstützende Netzwerke. Zum Beispiel ist Courtenay Harding am Institut zum Studium der

menschlichen Resilienz der Universität Boston (USA) dabei, Prozesse der Resilienz und Wiederherstellung nach psychischer Krankheit systematisch zu untersuchen (Harding, 1986). Die derzeitige Betonung der positiven Aspekte von Gesundheit und »recovery« innerhalb der Psychiatrie ist aktuell dokumentiert in einem Bericht des Subkommittees von Nutzer- bzw. Betroffenenanliegen von der US-Präsidenten-Kommission zur Psychiatrie. Der Bericht hat den Titel »Wandel zu einem recovery-orientierten psychiatrischen Gesundheitssystem« und enthält folgende Werthaltungen: a) Kollektive und individuelle Selbstbestimmung, b) Befähigende soziale Beziehungen, c) Bedeutsame Rollen in der Gesellschaft und d) Beseitigung von Stigma und Diskriminierung. Der Bericht schlägt ein recovery-orientiertes System vor, in dem die psychiatrisch Tätigen die Ressourcen der Menschen mit psychischer Krankheit in der Gemeinschaft heranziehen soll. Eine sinnvolle Einbeziehung der Nutzer in das psychiatrische Gesundheitssystem könnte sicherstellen, dass sie ein selbstbestimmtes Leben in der Gemeinde leben statt auf Lebenszeit abhängig zu bleiben von dem psychiatrischen Versorgungssystem.

Wir können feststellen, dass Gesundheitsförderung im Kontext der klinischen Versorgung bisher noch nicht ausreichend systematisch untersucht worden ist und dass ein Mangel an Veröffentlichungen und Forschungsaktivitäten auf diesem Gebiet zu verzeichnen ist. Daher freuen wir uns, dass in diesem Spezialheft Beiträge publiziert werden, die die Gesundheitsförderung mit klinischen Inhalten verknüpfen, wie z.B. Diagnostik und Prävention neben Themen zur Konzeption, Forschung und internationaller Zusammenarbeit.

Martin Anderson und Rachel Jenkins (Nottingham/London) zeigen in ihrem Artikel auf, dass es eine stark anwachsende Basis von Nachweisen gibt für die Effizienz von Programmen der psychischen Gesundheitsförderung, welche die Aufgabe haben, die psychosoziale Resilienz bei Kindern, Jugendlichen und Erwachsenen zu stärken. Sie schlagen verschiedene Modelle der Prävention vor, in denen die Gesundheitsförderung eine zentrale Rolle spielt.

Juan E. Mezzich (New York) diskutiert die Bedeutsamkeit sowohl von Krankheitsdaten als auch von Informationen zur positiven Gesundheit für die Entwicklung von umfassenden diagnostischen Modellen, die das Ziel haben, die klinische Versorgung qualitativ zu verbessern. Er skizziert in seinem Beitrag die kürzlich erschienenen Internationalen Richtlinien zur Diagnostischen

Erhebung (IGDA) als ein nützliches diagnostisches Modell zur Erhebung von klinischen Störungen, Kontextfaktoren sowie Aspekten von positiver Gesundheit. Diese Informationen werden erhoben im Rahmen eines interaktiven Prozesses, an dem Kliniker, Patienten und Angehörige beteiligt sind.

Margit Schmolke (New York/München) fasst einige grundlegende konzeptionelle Elemente und Forschungsmethoden zusammen, die im Rahmen der Gesundheitsförderung angewandt werden und vergleicht diese mit traditionellen Methoden in der klinischen Forschung. Ausgewählte Forschungsergebnisse illustrieren die Bedeutsamkeit des Gesundheitsförderungs-Ansatzes für die klinische Versorgung und für nicht-klinische Kontexte innerhalb der Gemeinde.

Helen Herrman und ihre Co-Autoren aus Melbourne liefern einen detaillierten Einblick in ihr innovatives und umfassendes VicHealth-Projekt in Australien zur psychischen Gesundheitsförderung. Der Handlungsrahmen ihres Projektes umfasst folgende Aspekte: Sammeln lokaler Nachweise über psychische Gesundheit und Störungen in der Gemeinde, die Beziehung zwischen Gesundheitsparametern und zentralen sozioökonomischen Variablen, intersektorale Partnerschaften und Informationen zur Projektentwicklung.

Michael Murray und John Orley (London) betonen in ihrem Beitrag die Notwendigkeit von effizienter Zusammenarbeit auf dem Gebiet der Gesundheitsförderung und die Überwindung von kulturellen, professionellen und internationalen Barrieren. Sie diskutieren organisationale, strategische und professionelle Fragen, die von führenden internationalen Organisationen wie z.B. der Weltgesundheitsorganisation (WHO), Weltgesellschaft für Psychiatrie (WPA) und Weltföderation für psychische Gesundheit (WFMH) thematisiert werden sollten, um effektive Partnerschaften zu fördern.

Schliesslich stellt das Kommittee der Sektion für Präventive Psychiatrie der Weltgesellschaft für Psychiatrie (WPA), geleitet von Dusica Lecic-Tosevski (Belgrad), eine Konsensuserklärung zur psychiatrischen Prävention vor, die kürzlich auf der WPA-Generalversammlung in Yokohama verabschiedet wurde. In dieser Erklärung wird deutlich, dass Interventionen der Gesundheitsförderung einen zentralen Stellenwert in aktuellen Präventionskonzepten der Psychiatrie einnehmen. Allerdings wird am Ende der Erklärung zur Vorsicht gemahnt hinsichtlich der Schwierigkeiten, die bestehen bei der Umsetzung von Prävention und Gesundheitsförderung in Ländern mit

gravierenden sozioökonomischen Problemen oder Lebensbedingungen mit Gewalt, Krieg oder Sanktionen. Wenn solche Ländern keine Unterstützung erhalten, dann »werden die moderne Psychiatrie und internationale Organisationen elitär bleiben und ihre erklärten Ziele und Absichten lediglich Erklärungen ohne irgendeinen grösseren Einfluss«. Die Konsensuserklärung endet damit, sich an Arbeitsgruppen und Sektionen der WPA zu richten, die eine zentrale Rolle dabei spielen könnten, Mitgliederorganisationen zu helfen bei der Entwicklung von gemeinsamen effektiven Präventionsmodellen, die den spezifischen Bedürfnissen der jeweiligen Bevölkerung entsprechen, und bei der Bereitstellung von Lehrmaterial und Beratung.

Wir möchten allen beteiligten Autoren danken für ihre wichtigen Beiträge in diesem Spezialheft und wünschen den Forschern und klinisch Tätigen, dass sie sich inspiriert und ermutigt fühlen, ihr Wissen zu ergänzen um die verschiedenen Komponenten der Gesundheitsförderung und ihrer kreativen »Zutaten«, bestehend aus Hoffnung und positiver Gesundheit.

Margit Schmolke und Dusica Lecic-Tosevski

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Mental Health Promotion and Prevention

Martin Anderson (Nottingham)[1], Rachel Jenkins (London)[2]

This paper aims to offer a contemporary overview of mental health promotion and prevention. Fundamental issues in the field are considered and four possible models of mental health promotion are suggested. It is argued that we cannot disconnect the »mental« from everything else in our experience and environment if such models are to succeed. Stigmatization of mental health problems remains in many societies. The key to effective mental health promotion is an integrated effort in tackling stigma at all levels. Widespread changes in the structure and delivery of mental health services have brought about a significant shift in the role of the service user. A pivotal way forward will be to ensure that people who experience mental health problems are included in defining, planning, creating and implementing strategies for mental health promotion and prevention.

Introduction

Mental health problems are one of the leading causes of morbidity and disability. They bring distress to individuals and families, constituting a substantial and costly health burden (JENKINS, 1994). Mental well being and the promotion of mental health is becoming a key area in many national health strategies (Department of Health, 2001, World Health Organization, 2001). A balanced approach to promoting mental health, preventing mental illness and caring for those experiencing mental health problems is recommended by experts and governments in a number of countries (Health Education Authority, 1997). Some view prevention to be possible and promotion is seen as diffuse and inexact (KREITMAN, 1989; HERRMAN, 2001). However, stigma continues to surround mental illness. Indeed, it could be argued that »previous hospitalization« for people experiencing mental health problems continues to have a considerable impact on their lives. The high social distance created by the public perceiving former »patients« to be dangerous and low social distance among the public who do not see patients as a threat may well still coexist (LINK et al., 1987). So while mental illness and health are now steadily entering the international public health agenda, stigma, poor understanding of mental illness and ambiguity over the nature health promotion remain as barriers.

Despite such obstacles the Ottawa Charter of 1986 still holds promise. In the charter health promotion was understood as returning health related power, knowledge, skills and other resources to people, community, families and individuals (ICHP, 1987). This was and is a revolutionary concept in an era of exponentially increasing understanding of the human genome and rapid development of medical technology. The Ottawa Charter and its elaboration of the concept of health promotion draws attention to health determinants that are beyond individual, behavioural or social factors, and which are located in all dimensions of the micro and macro environment of people. Indeed, it made health promotion a revolutionary concept (WHO, 1985). Caring, holism and ecology were named as essential approaches within the five main strategies for action:

- building healthy policy,
- creating supportive environments,
- strengthening of community action,
- development of personal skills, and
- reorienting health services.

Despite its long life span, the Ottawa Charter is frequently referred to in publications on mental health promotion and governments use it as a foundation for strategies. It therefore remains a basic source of inspiration for general health promotion and for a variety of health policy documents. It is also very relevant for mental health promotion, partly because of its key political significance, and partly because of the close relationship between physical and mental health (WHO, 1985; ICHP, 1987; TUDOR, 1996).

Taking the Ottawa Charter as the bedrock in the field, this paper aims to offer a brief account of the nature of mental health promotion and prevention. The paper addresses the nature of healthy public policies and stages of intervention, alongside levels of prevention. The goals and approach of mental health strategies are indicated and specific entry points for mental health promotion are identified. Four models for mental health promotion and prevention are proposed in the light of evidence-based interventions and programmes. Finally, the paper discusses some of these aspects and argues that mental health promotion and prevention should be based on anti-stigmatization and clear lines of user involvement. In the first instance

however, we consider the struggle to find an adequate definition of »mental health problems«, which is arguably at the root of the debate surrounding mental health promotion and prevention of mental illness.

Mental Health Problems

TUDOR (1996) argues that over last two centuries many people have attempted to move psychiatry out of scientific objectivity and move towards a definition of mental illness. The predominantly positivist nature of psychiatry and classifications of mental illness have led to the construction of clinical models of pathology. Subsequently, we as mental health professionals frame mental illness in the context of »normality« and use statistical evidence to categorize mental illness in the Diagnostic Statistical Manual and International Classification of Disorders (WHO, 1992; APA, 2000). The result is a set of diagnostic areas that are used to identify/name mental health problems. These can be summarized as:

- Psychological distress connected to life experiences, situations, events and troubles
- Common mental disorders (eg depression, anxiety)
- Severe mental disorders with disturbances in perception, beliefs and thought processes (psychoses)
- Substance abuse disorders (excess consumption and dependency on alcohol, drugs, tobacco)
- Abnormal personality traits which are handicapping to the individual and or to others
- Progressive organic diseases of the brain

However, over the past 40 years anti-psychiatry along with the development of labelling theory engendered an opportunity to shift from the use of terms or classifications that, some argue, have stigmatized and generated prejudice (LAING & ESTERSON, 1967; SZASZ, 1973; LINK et al., 1987). Today, the progression of user involvement in psychiatry has added to the blurring of definitions with the justified aim of de-stigmatizing mental illness, but more importantly to gain people dignity and to give them a voice (RODGERS & PILGRIM, 1991; EDWARDS, 2000).

SEEDHOUSE (2002) recognizes the confusion and difficulties in gaining an adequate definition of mental health and »mental well-being«. He maintains that the fundamental problem with attempting to define mental health and illness is that it simply reinforces the way »mental« appears to us. Efforts to define mental health have become a process of classifying and if the definer merely accepts the way things seem (that the mental world is disconnected) they are then automatically obliged to disconnect the mental from everything else. SEEDHOUSE's arguments are important to the present overview of mental health promotion and prevention. That is, whatever approach or model, policy and subsequent practice cannot be suggested purely on the basis of a set of categories of mental health problems (despite the fact that we all tend to use and refer to »disorders«). More important is the view that our mental experiences cannot be separated (or disconnected as SEEDHOUSE would argue) from our physical experiences, feelings, thoughts and behaviours.

With this viewpoint in mind, mental health promotion in today's world is concerned with generating »positive mental health«. Policy and practice has to be based on the objective of gaining a positive sense of well being. But instead of demarcating a person's experience in definitions of »possible« mental diseases, people should think of the world as an interconnected entity (SEEDHOUSE, 2002). In this way people can move towards using individual resources including self-esteem, optimism and a sense of mastery and coherence. People can find the ability to initiate, develop and sustain mutually satisfying relationships, and to cope with adversities. Therefore, an effective mental health promotion approach utilises strategies that foster supportive environments and individual resilience (RAEBURN & ROOTMAN, 1998). However, underlying this requirement there needs to be effective and healthy public policies.

Healthy Public Policies

The Ottawa Charter refers to all public policies, irrespective of whether they overtly concern health, social, environmental or economic issues not just to health (or mental health) policies (WHO, 1985). Further to this, there are two underlying concepts: firstly, the association of most societal structures and actions with health and, secondly the concept of advocacy, in order to make this association known, recognized and used for the benefit of health. Mental health still has a secondary role compared to general health in health policies,

not to speak of other socio-economic policies, even in developed countries. In addition, mental health remains mostly isolated politically, theoretically, organisationally, and professionally. Therefore, perhaps the most essential task of mental health promotion (policy) is advocacy which aims to enhance the visibility and value of mental health at the level of societies, sections of societies and individuals (TUDOR, 1996; EDWARDS, 2000). The objectives include reintegrating mental health into general and public health, and strengthening societal action conducive to mental health.

HERRMAN (2001) maintains that there is a strong evidence base identifying personal, social and environmental factors promoting mental health. These cluster around three distinct themes (LEHTINEN et al., 1997):

1. The development and maintenance of healthy communities. These might include communities provision of social protection (safe and secure environment), good housing, positive education, employment and good working arrangements. These are examples of policies that are directly associated with social integration with a supportive political infrastructure. This would offer people knowledge, skills, and a lifelong stream of experiences, providing a social framework for life.

2. An individuals ability to deal with the social world through skills such as participating, tolerating diversity and mutual responsibility. This is linked to positive experiences of early bonding, attachment, relationships, communication and acceptance. These are important factors as there is evidence for focusing on people who are at a high risk of developing mental health problems. Children who are living in poverty, who show behavioural difficulties, experiencing parental separation and divorce or who are within families experiencing bereavement are at particular risk (NHSCR, 1997).

3. An individuals ability to deal with thoughts and feelings and the maintenance of life and emotional resilience. This is associated with physical health, self esteem, ability to manage conflict, and the ability to learn.

The development of such individual, social and environmental qualities have to be an integral part of mental health promotion and prevention. Such activity in mental health promotion is often socio-political, i.e. reducing unemployment, improving schooling and housing, combating stigma and discrimination (HERRMAN, 2001). Involved in this work will be politicians, educators, housing officers, voluntary agencies and ultimately service users themselves. Mental health »professionals« need to be ready to update and remind these key players of evidence supporting the main variables (GOLDBERG, 1998).

Stages of Intervention

When we move to discuss prevention we come across stages of intervention - these are seen being useful in the prevention of »mental illness« particularly when we are aware of and have evidence of causation. Primary prevention involves the reduction of incidence (rate of occurrence of new cases in community) and is directed at people who are without illness, but who may be at risk (eg, children in poverty, adults who are unemployed) (NHSCR, 1997). Secondary prevention involves reducing prevalence by reducing duration of illness. This is directed at people who show early signs of disorder and aims to shorten duration of disorder by early and prompt intervention (Department of Health, 1999). The aim is also to prevent chronic morbidity, disability and mortality. Finally, tertiary prevention includes the reduction of severity and disability associated with a particular disorder. People who are experiencing a disorder are targeted with the objective of lifting the level of disability by effective rehabilitation (DoH, 1994; TUDOR, 1996).

In addition to the traditional approaches outlined above it is possible to consider universal/indicated prevention and selective prevention. Universal prevention is essentially seen as desirable for everyone, clearly the benefits outweigh costs and risks, e.g. seat belts, safe drinking, good nutrition, reduction of tobacco, education. In England a good example of a universal strategy within mental health has been the »Defeat the Depression Campaign« (Jenkins 1998). Indicated prevention is appropriate for a tightly defined group who are at considerably increased risk, e.g. children exposed to major trauma. Selective prevention is suitable for subgroups whose risk of illness is above normal, e.g. pregnant women, teenage mothers, socially isolated older persons. Early diagnosis and the treatment of high-risk groups are two strategies implemented in other areas of healthcare (HERRMAN, 2001). Such strategies are

important in preventing and treating a selection of identified disorders, for example: breast cancer, depression. In primary care preventative interventions may help groups of people at high risk of depression (male, socially isolated) or those drinking high levels of alcohol. Health, mental health and social service professionals offering education, support and counselling are essential to the prevention of episodes of ill-health (GOLDBERG, 1998; HERRMAN, 2001).

However, if one concentrates on high risk groups, the prevention pay off or return is probably greater if one concentrates on high risk situations, since these are more likely to be closely followed by illness in the short term, than if one concentrates on high risk populations who may not develop the illness in any case for many years (JENKINS, 1998). Thus, close attention has to be paid to the micro and macro levels of prevention.

Microlevel and Macrolevel Prevention

In general there are more practical opportunities for prevention in the domain of precipitation, rather than predisposing factors. It is also easier to identify those in high-risk situations for the purposes of the preventative interventions rather than those in high-risk populations. Traditional ways of implementing mental health promotion concentrate on the individuals and their immediate surroundings, for example the family, at the microlevel e.g., education about parenting to reduce damaging parenting, marital therapy to reduce divorce. The real challenge for the promotion of mental health is to recognise factors at the macrolevel for example policies on social inclusion and employment. The problem is that the macrolevel has been avoided because of the difficulty of these influencing factors (social discrimination, poverty, unemployment). The argument here is to focus on such forces that affect mental health, and to develop interventions to modify them, and indicators to evaluate both their impact and outcome (CATALANO AND DOOLEY, 1980; JENKINS, 1998).

Goals and Approaches of Mental Health Promotion

While there is evidently a need for mental health promotion to be directed towards those concepts at a macrolevel it is also important for politicians, governments, educators, health professionals and service users to set out clear goals and approaches of mental health promotion. These will involve the need to:

- Enhance the value and visibility of mental health at national, local and individual levels.
- Protect, maintain and improve mental health.

Approaches of mental health promotion are:

- Participation and empowerment (RAEBURN & ROOTMAN, 1998; TONES & TILFORD, 2003)
- Intersectoral cooperation
- Multilevel action (whole society, community, social group, risk group, individual)
- Variety of approaches, methods and tools

These goals and approaches have to be considered in the planning and delivery of mental health promotion but will be dynamic and changing (JENKINS, 1995).

Mental Health Promotion - Entry Points

Mental health as a key health area has become one of a number of healthcare priorities, jockeying for action. TANNAHILL (2003) has recently offered possible orientations for health promotion. Mental health promotion arises out of what constitutes the bigger picture i.e., »health promotion«. The bigger picture of health promotion encompasses efforts to promote quality of life, social cohesion in communities, the protection of health through overlapping polices and strategies on social justice and inclusion, education, employment etc as we have seen (WHO, 1985; TANNAHILL, 2003). Perceiving mental health promotion as part of this »bigger picture« is important. So as for any health promotion strategies, mental health promotion has specific entry points, these can be summarized as follows:

- Target groups (eg, age, gender, occupation, specific risk factor)
- Settings (eg, school, workplace, prisons, health sector, social sector, urban, rural, media)
- Levels (i.e., person/individuals, local communities, national, international - reducing barriers to mental health) (DoH, 2001)
- Public health level (policy, disease programme, service, intervention)

Four Models of Mental Health Promotion and Prevention

Once the points of entry in mental health promotion can be established it is possible to offer specific models of mental health promotion and prevention, integrating a number of the factors discussed. Four such models can be suggested:

Model 1: Health promotion = universal prevention strategies.
Primary prevention = selective and indicated strategies.

Model 2: Primary prevention:

- Universal strategies
- Educational strategies = health promotion
- Selective strategies
- Indicated measures

Model 3: Mental health promotion:

- Increasing positive mental health
- Primary prevention
- Secondary prevention
- Tertiary prevention

Model 4: Primary prevention (to stop illness from occurring)

- Macro-level and micro level strategies
- Education and clinical strategies
- Proactive strategies
- Universal, selective and indicated strategies

In contrast, there is less confusion about the definitions of secondary prevention (to detect and treat existing illness as soon as possible) and tertiary prevention (to reduce chronic disability and avoid long term disabilities).

Evidence for Mental Health Promotion Interventions and Programmes

The development of mental health promotion interventions and programmes (and ultimately the model selected) has to be grounded in relevant evidence. Indeed, there is a continued need for integrated research that can add to the established research base (HERRMAN, 2001). There is empirical evidence from studies involving high risk and vulnerable groups (e.g., children from broken homes, unemployed adults) that mental health promotion interventions can: increase problem-solving skills (HEANEY et al., 1995); reduce stress and build conflict management skills (CLARKE et al., 1995); provide social support and so reduce depression (PRICE et al., 1992); increase school performance via mental health promotion in a school environment (EMSHOF, 1990); cognitive restructuring to build self esteem in teenagers (HORAN, 1996) and resilience in children of divorced parents (PEDRO-CARROLL & COWAN, 1985).

Further to this there is empirical evidence that mental health promotion programmes can: increase prosocial behaviour (TREMBLAY et al., 1991); lower child abuse and neglect (BARKER et al., 1992); reduce psychological problems in recently divorced couples (BLOOM & HODGES, 1988), and reduce depression among carers of people experiencing Alzheimer disease (MITTLEMAN et al., 1995). While there is good evidence of mental health promotion interventions and programmes in high risk groups there is still a need for reliable research underpinning practical effectiveness and cost effectiveness. Possibly the most appropriate way is through a national strategy for mental health promotion research which prioritizes specific areas (NHSCR, 1997; DoH, 2001).

Discussion

A good mental health promotion policy is based on an appropriate concept of mental health and clear goals and objectives. Capacity building for mental health is an essential part of any mental health promotion policy. Identifiable leadership in the public administration is a prerequisite of consistent implementation, and a knowledge base with good quality information, data and statistics is required for the planning and follow-up activities. It is favourable, but not vital, to have the policy recorded in a written policy document. In fact, as with any policy making, mental health promotion policy should be continuously redrafted. Special attention should in this regard be given to the communication with non-governmental organisations, communities and

people, as the most successful policies are made together with people, instead of a top-down approach (HERRMAN, 2001). The »silent voices and signs«, changes in the society and culture, which may in the long-term affect mental health, should be carefully noted and taken into account.

The most revolutionary aspect of the Ottawa Charter was that it left the medical domain outside the concept of health promotion. Instead, the idea of »returning power to people« can be understood as taking the power from medicine to be returned to people. Health services were seen as a powerful resource for health promotion, but only after a reorientation, or »conversion«from medicalisation to health. An unfortunate and unhelpful dichotomisation, often also a full separation, of the two complementary strategies followed. Despite some tension between disciplines, the trend in the field of mental health looks as if the components of mental health work - promotion, prevention, treatment and rehabilitation - are being seen as overlapping and complementary, at least to a certain degree. This is, indeed, the most essential lesson mental health promotion should learn from health promotion »the bigger picture«. The risk may be that an unnecessary waste of resources follows, if a dichotomy develops between the »soft strategies«, which have their foundation in the socio-political, socio-ecological or socio-environmental domains, and the »interventions-strategy«, based on evidence from randomised controlled trials.

Health promotion is characterised by positive approaches and messages rather than paternalistic or restrictive education strategies; that all health promotion activities should be preceded by an assessment of objective and subjective perceived needs. Health promotion activities may have many kinds of objectives; and their achievement may be measured by a variety of qualitative and quantitative indicators of input, process, process outcomes and health outcomes. The reality is that at present health promotion is defined not only as expert action on the population or specific groups, it is also about working directly with people in order to improve the populations health. Since the value basis of health promotion relates closely to seeing people as subjects of their own life, health promotion emphasises empowerment and genuine participation as fundamental approaches/characteristics of all health promotion activities (RAEBURN & ROOTMAN, 1998; TONES & TILFORD, 2003).

An overriding principle for »mental«health promotion is the argument that we cannot disconnect the mental from everything else in our experience and environment (SEEDHOUSE, 2002). Any model of mental health promotion

cannot be delivered in only the rudimentary and rigid forms such as »wear a crash helmet«, »wear a condom«. These are disconnected forms and it is easy to realize why they may not work in isolation. Mental health promotion is not just concerned with preventing mental disorders or indeed any disease - albeit these are incredibly important. Actions to promote mental health should not have to be justified as a way of reducing costs of mental illness, since positive mental health and well being alone can be seen as the most desirable ends. Yet mental health promotion does have costs. The role of the health sector in mental health promotion may not involve the investment of large amounts of resources. But the health sector can be of use by indicating actions that are needed and help by initiating such actions, monitoring and establishing quality control mechanisms. Mental health promotion is evidently about placing mental health well-being in the sphere of relevant authorities, in schools, in workplaces, etc. (ORLEY, 1998). This must involve a wide range of participants, health/social care professionals, education, justice systems, but most importantly the service users themselves and beyond that the potential service user. Therefore, while »de-stigmatisation« may be identified as a part of a mental health promotion strategy, stigma has to be tackled at all levels from the outset, as it is itself one of the greatest barriers in the development of realistic mental health promotion and prevention.

Psychische Gesundheitsförderung und Prävention

Martin Anderson (Nottingham), Rachel Jenkins (London)

Ziel der Autoren ist es, einen aktuellen Überblick über die psychische Gesundheitsförderung und Prävention zu geben. Dabei werden zentrale Anliegen auf diesem Gebiet formuliert. Die Ottawa Charter der Weltgesundheitsorganisation betont das Prinzip der Anwaltschaft bzw. Fürsprache (advocacy) in der Gesundheitsförderung. Allerdings muss von Anfang an für die psychische Gesundheitsförderung geklärt werden, wie »psychische Krankheit« verstanden wird. Es wird argumentiert, dass wir das »Psychische« nicht von allem anderen in unserer Erfahrung und Umgebung trennen können. Wir müssen versuchen, uns über diagnostische Definitionen von psychischen Gesundheitsproblemen hinauszubewegen. Dies muss berücksichtigt werden im aktuellen Verständnis von Gesundheitspolitik, Ebenen der Intervention und Prävention.

Es werden zentrale Ziele und Ansätze von psychischer Gesundheitsförderung entwickelt und vier Modelle von Gesundheitsförderung und Prävention vorgeschlagen.

Modell 1 Gesundheitsförderung = universale Präventionsstrategien
Primäre Prävention = ausgewählte und indizierte Strategien

Modell 2 Primäre Prävention:

- Universale Strategien
- Edukative Strategien = Gesundheitsförderung
- Ausgewählte Strategien
- Indizierte Massnahmen

Modell 3 Psychische Gesundheitsförderung

- Stärkung der positiven psychischen Gesundheit
- Primäre Prävention
- Sekundäre Prävention
- Tertiäre Prävention

Modell 4 Primäre Prävention
(Verhindern des Ausbruchs einer Krankheit)

- Makrolevel und Mikrolevel-Strategien
- Edukation und klinische Strategien
- Proaktive Strategien
- Universale, ausgewählte und indizierte Strategien

Im Vergleich zur primären Prävention gibt es weniger Unklarheiten bei der Definition von Sekundärer Prävention (Erkennen und Behandeln bestehender Krankheit so früh als möglich) sowie Tertiärer Prävention (Reduzierung von chronischer Behinderung und Vermeidung von Langzeit-Behinderung).

Stigmatisierung von psychischen Gesundheitsproblemen bleibt in vielen Gesellschaften nach wie vor ein Problem und stellt ein Hindernis dar. Den Schlüssel zu einer effektiven psychischen Gesundheitsförderung bildet eine gemeinsame Anstrengung, gegen das Stigma auf allen Ebenen zu kämpfen. Weitreichende Veränderungen in der Struktur von und Versorgung mit psychiatrischen Gesundheitsleistungen haben einen bedeutsamen Wandel der Rolle von Nutzern dieser Leistungen mit sich gebracht. Ein wichtiger Schritt weiter wird sein sicherzustellen, dass Menschen, die psychische Probleme erleben, einbezogen werden in die Festlegung, Planung, Entwicklung und Umsetzung von Strategien für eine psychische Gesundheitsförderung und Prävention.

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Comprehensive Diagnosis as Formulation and Process towards Health Promotion

Juan E. Mezzich (New York)*

This paper will outline two relatively recent and increasingly compelling concepts, comprehensive diagnosis and health promotion, and will articulate their relationship within the framework of clinical care. First, the nature and meaning of health promotion will be concisely considered. To this effect, it will be contrasted to prevention and its place for thorough and responsible clinical care will be pointed out. Second, the need for and the conceptualization and implications of comprehensive diagnostic models will be reviewed. Finally, the connections between comprehensive diagnosis and health promotion will be briefly explored and illustrated.

The main meanings of diagnosis emerging in recent times are to provide the informational bases for clinical care and to represent a process of engagement among patients, families and health professionals involved in clinical care. Thus, if health promotion is to be included as an integral component of clinical care, diagnosis both as a formulation and as process has a role for planning and conducting health promotion activities. To fulfill these demands, a diagnostic formulation must encompass not only syndromes and illnesses but also an indication of the patient's whole clinical condition, including positive aspects of health. Likewise, diagnosis as a process must organize and energize the various key players in the clinical setting for joint understanding of an individual's health status and joint committment to a program of clinical care. An emerging diagnostic model that may be useful for health promotion as well as for standard treatment is that at the core of the new WPA International Guidelines of Diagnostic Assessment (IGDA) (MEZZICH, BERGANZA, et al., 2003). It includes, first, a standardized multiaxial formulation composed of the following domains: I. Clinical disorders, II. Disabilities, III. Contextual factors, and IV. Quality of life. Second, it incorporates an idiographic personalized formulation integrating the perspectives of the clinician, the patient and the family on the following areas: contextualized clinical problems, patient's positive factors relevant to care, and expectations for health restoration and promotion. Such integration is to be obtained through a process of deliberate interactions among all key players.

Types and Levels of Clinical Care

1. Disease-Oriented Clinical Care

The more conventional approach to clinical care conceptualizes and organizes such care in terms of the following levels of prevention.

- Primary prevention: This involves avoiding the factors that are presumed to lead to the development of various forms of illness and disabilities.
- Secondary prevention: This involves early detection and prompt resolution of emerging pathological conditions.
- Tertiary prevention: This involves effective and encompassing treatment of well established morbid entities. This type of effort represents the bulk of clinical work in most countries and situations.
- Quaternary prevention: This refers to rehabilitation activities, efforts aimed at minimizing disabilities and other consequences of illness conditions.

2. Health-Oriented Clinical Care

Health oriented or »salutogenic« (ANTONOVSKY, 1987) clinical care focuses on lifting as much as possible the level of health status of a given person, instead of being restricted to minimizing or resolving illnesses and disabilities. These health oriented activities are now often mentioned as examples of health promotion. Characteristically, health promotion involves a creative and empowering process leading to higher stages of health status and the greater fulfillment of a person's life project. Critical players in health promotion are, first and foremost, the patient or consulting person as well as families and a broad range of health and social professionals.

3. Comparing Prevention and Health Promotion

The basic difference between these activities refers to their principal focus, pathology (vulnerabilities, illness, disabilities) versus positive health (personally and socially enriching functioning, family and community supports, and quality of life). Table 1 highlights the differences between primary prevention and health promotion, although, of course, they have overlapping characteristics as well (MEZZICH & SCHMOLKE, 1999).

Primary Prevention vs. Health Promotion	
Pathology orientation	Positive health orientation
Minimization of risk factors, disorders and disabilities	Enhancement of the health of the whole individual in his context
Avoiding problems	Activating resources
Adhering to health norms	Creating new paths to health
Expert medical teaching	Empowering social participation

Table 1:
Contrasting Primary Prevention and Health Promotion

Emerging Diagnostic Models

The conventional concept of diagnosis as merely a classification of illnesses or disorders, is being challenged by expanding the meaning of diagnosis to include both a formulation of health status and an interactional assessment process dynamically involving the participation of clinicians (with various disciplinary backgrounds), the consulting person, and his/her family and carers.

One of the emerging innovative approaches to comprehensive diagnosis is the model found at the core of the recently published Essentials of the World Psychiatric Association International Guidelines for Diagnostic Assessment (IGDA) (MEZZICH, BERGANZA, VON CRANACH et al., 2003). This comprehensive diagnostic model outlines a Standardized Multiaxial Formu-lation and an Idiographic Personalized Formulation.

The first one uses typologies and dimensions to classify and measure various aspects of the clinical condition. These include all forms of illness (Axis I), their impact on functioning, i.e. disabilities (Axis II), contextual factors (psychosocial and environmental problems) (Axis III), and quality of life (Axis IV). The first three axes basically correspond to the ICD-10 triaxial schema (JANCA et al., 1997). Axis IV is particularly innovative because of its embodying a wide concept of health (from physical wellbeing to spiritual fulfillment) and because it places the consulting person in a central and active position in the evaluation process.

The second component of the IGDA diagnostic model is the Idiographic Personalized Formulation, which describes with the nuanced power of a narrative a contextualized and interpretative presentation of clinical problems, key positive aspects or assets of the consulting person relevant to clinical care,

and a set of expectations for health restoration (resolution or amelioration of disorders) as well as for health promotion. Of critical importance is that this formulation is to be obtained through an interactive process of joint understanding and joint committment among all protagonists in clinical care.

IGDA Comprehensive Diagnostic Model

☐ STANDARDIZED MULTIAXIAL FORMULATION

I. Mental and non-mental disorders

II. Disabilities / adaptive functioning

III. Contextual factors (stressors / supports)

IV. Quality of life

☐ IDIOGRAPHIC OR PERSONALIZED FORMULATION

(Integration of clinician, patient and family perspectives)

- Contextualized clinical problems
- Positive factors or assets
- Expectations on restoration and promotion of health

Table 2:
IGDA Comprehensive Diagnostic Model

Linking Comprehensive Diagnosis to Integrated Care and Health Promotion

Comprehensive diagnosis, first, by yielding organized data on critical aspects of clinical conditions and health status may provide a rich informational basis for constructing an effective plan for clinical care, including health promotion. Second, comprehensive diagnosis as a process engaging and energizing clinicians, consulting persons and families facilitates the establishment of a social matrix propitious to the empowering and creative features of health promotion. Table 3 illustrates some of the useful connections between the informational areas of the IGDA comprehensive diagnostic model and a broad profile of health care activities.

Components of Comprehensive Diagnosis	**Illustrative Health Care Activities**
Multiaxial Formulation I. Illness (mental and non-mental) II. Disabilities III. Contextual Factors IV. Quality of life	• Early identification of illness (2nd Pv) • Skills development (4th Pv, HP) • Activating social supports (4th Pv,HP) • Spiritual counseling (HP)
Idiographic Formulation (Perspectives of clinician, patient and family, and discrepancy resolution) • Contextualized clinical problems • Positive factors or assets • Expectations on health restoration and promotion	• Affirmation of cultural identity (HP) • Engagement of special talents (HP) • Integration of services (3rd Pv, HP)

Table 3:
Illustrating the connection between comprehensive diagnosis and broadly based clinical care including health promotion

Notes: 2nd Pv = secondary prevention
3rd Pv = tertiary prevention
4th Pv = quaternary prevention
HP = health promotion.

Concluding Remarks

The innovative ferment connected to the recently emerging concepts of comprehensive diagnosis and health promotion is being anchored by and nurtured through significant international efforts. In the diagnosis field, this is illustrated by the WPA-WHO ongoing collaborative effort towards the development of new international classification and diagnostic systems (MEZZICH & ÜSTÜN, 2002). Concerning health promotion, we can note the current development of a WHO project on »Promoting Mental Health:

Concepts, Evidence and Practice« directed on behalf of WHO by HELEN HERRMAN, SHEKHAR SAXENA and ROB MOODIE. Through such efforts, a new era may be opening for more effective clinical care and public health.

Umfassende Diagnostik als Formulierung und Prozess in Richtung Gesundheitsförderung

Juan E. Mezzich (New York)

In den letzten Jahren hat sich die zentrale Bedeutung von Diagnostik in zwei Richtungen entwickelt: a) Diagnostik als Informationsbasis für die klinische Versorgung, und b) Diagnostik als Prozess, in dem sich Patienten, Familienangehörige und die an der klinischen Versorgung beteiligten Professionellen gemeinsam engagieren. Soll Gesundheitsförderung als ein integraler Bestandteil in die klinische Versorgung mit einbezogen werden, dann spielt Diagnostik sowohl als diagnostische Formulierung als auch als Prozess eine wichtige Rolle für die Planung und Durchführung von gesundheitsförderlichen Massnahmen.

Um diese Forderungen umzusetzen, hat eine diagnostische Formulierung nicht nur Syndrome und Krankheiten zu erfassen, sondern den gesamten klinischen Zustand des Patienten einschliesslich der positiven Gesundheitsaspekte. Ausserdem muss Diagnostik als ein Prozess die verschiedenen Beteiligten in das klinische Setting aktiv einbeziehen, um ein gemeinsames Verständnis des Gesundheitsstatus des Einzelnen und ein gemeinsames Behandlungsprogramm zu entwickeln.

In neuerer Zeit wurde ein diagnostisches Modell konzipiert, das auch von Nutzen sein kann für die Gesundheitsförderung sowie für die Standardbehandlung: die neuen Internationalen Richtlinien zur Diagnostischen Erhebung der World Psychiatric Association (WPA International Guidelines of Diagnostic Assessment IGDA) (MEZZICH, BERGANZA, et al., 2003). Sie umfassen erstens eine standardisierte multiaxiale Formulierung, die aus folgenden Bereichen zusammengesetzt ist:

I. Klinische Erkrankungen
II. Behinderungen
III. Kontextuelle Faktoren, und
IV. Lebensqualität

Zweitens enthalten die Richtlinien eine idiographische personorientierte Formulierung, die die Perspektiven des Klinikers, des Patienten und der Familienangehörigen auf folgenden Ebenen integrieren: kontextbezogene klinische Probleme, positive Faktoren des Patienten für die Behandlung sowie Erwartungen für die Wiederherstellung und Förderung der Gesundheit des Patienten. Eine solche Integration soll erreicht werden durch einen Prozess, in dem alle zentralen Beteiligten aktiv miteinander in Interaktion treten.

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Health Promotion and Multi-Modal Research Perspectives

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Health promotion is increasingly emerging as a focus of interest in health sciences. In order to make use of this great potential for clinical care, the various forms and strategies of health promotion must be investigated systematically and sensitively. Emerging research endeavors cover the range from ill to positive health, focusing on the person of the patient, on the perspectives of health professionals and community agents, employing a variety of research methods. This paper will briefly outline theoretical essentials of health promotion and mental health promotion and summarize basic conceptual components of health promotion research in contrast to more traditional research in clinical settings. The author pleads for integrating recovery processes into health promotion research. Selected research results (on resilience, salutogenetic factors in adolescents or schizophrenic patients) will illustrate the relevance for clinical care and, more general, for the life in communities.

Antecedents of Health Promotion

AARON ANTONOVSKY's concept of »Salutogenesis« (ANTONOVSKY, 1979, 1987), that means the »cause of health«, has become increasingly popular in health sciences in general and in health promotion in particular. A salutogenetic orientation include a) localization of a person on a health-disease-continuum, b) search for the total history of a person, not just for his/her disease, c) factors being responsible to maintain one's position or to move towards the healthy pole on the continuum, d) perception of stressors as not only being pathogenetic, e) search for factors towards an active adaptation to one's environment, and f) consideration of the deviating cases in pathogenetic studies. It has been recently suggested by KICKBUSCH (1996) that Antonovsky's concept of salutogenesis may serve WHO as a theoretical foundation of health promotion.

Long time before the health promotion approach had been articulated and conceptualized systematically, GÜNTER AMMON (1979) emphasized in his treatment concept of Dynamic Psychiatry the »alliance with the patient's healthy Ego-parts«. That means, in treatment the therapist needs to understand a patient in his/her totality including the patient's strengths, capabilities, creativity as well as his/her illness experience, symptoms and

suffering embedded in a groupdynamic and biographical context. The discovery and search for the patient's healthy Ego-parts requires from the therapist an active effort to create a real contact basis with the patient in a sensitive manner as well as openness and conceptual thinking beyond illness categories and deficits. The alliance with the patient's healthy personality parts is considered by AMMON as the foundation on which any clinical interventions may be applied. Thus, strengthening the healthy aspects in patients and support in his/her social context and integrating positive health into clinical psychiatry have always been critical elements, among others, in the concept of Dynamic Psychiatry (BURBIEL & SCHMOLKE, 2001).

Health Promotion and Mental Health Promotion

Increasing interest for health promotion has been expressed by researchers and clinicians during the last two decades across disciplines. After it has become clear that even widespread and developed psychiatric care cannot prevent chronic mental diseases, the focus has shifted towards strengthening the healthy aspects in patients and the subjective perspective of the individual on his disease, towards the whole spectrum of the disease-illness continuum, and towards the resources which may be activated within the individual itself and within the community.

Four international conferences of WHO on health promotion had been held, 1986 in Canada, 1988 in Australia, 1991 in Sweden, and 1997 in Indonesia. In the well-known Ottawa Charter (WHO, 1986) five strategies of health promotion have been conceptualized:

1. to build healthy public policy,
2. to create supportive environments,
3. to strengthen community action,
4. to develop personal skills, and
5. to reorient health services.

Accordingly, in the beginning of the 1990's WHO has initiated important programs in order to foster projects in different environments and settings, such as health-promoting cities, islands, local communities, markets, schools, workplaces, and health services. One claim within WHO is to implement strategies for health promotion throughout the life span with particular

attention to the vulnerable groups in order to decrease inequities in health. People should be at the center of health promotion actions and decision-making processes if they are to be effective. Furthermore, access to education and information is regarded as vital in achieving active participation of people and communities (WHO, 1998).

»Mental health promotion« in a WHO definition is an umbrella term that covers a variety of strategies, all aimed at having positive effects on mental health. Among them are the encouragement of individual resources and skills as well as improvements in the socio-economic environment (WHO, 1999). Mental health promotion is also strongly connected to concepts such as »recovery processes«, »sense of hope«, and »empowerment« (National Mental Health Association).

It has been recognized by top health authorities that »mental health is fundamental to general health«, as noted in the first Report of the Surgeon General on Mental Health in the United States (U.S. Department of Health and Human Services, 1999). Mental health promotion has a wide range of health and social benefits, such as improved physical health, increased emotional resilience, greater social inclusion and participation, and higher productivity (Department of Health, UK, 2001).

However, current definitions of »mental health« are considered by some authors to be inadequate for the health promotion practice. They criticize definitions in which health is simply equated with the absence of illness, or that individualized and expert-led versions exist of what is »mentally healthy«, and finally they state that the role of culture for health maintenance and promotion is neglected (SECKER, 1998).

Interdependence of Health Resources and Risk Factors

Individual, social and community ressources, such as optimism, coping competences, social support network, or access to health care play an important role in theoretical concepts of health promotion. They may also serve as «esistance resources« (ANTONOVSKY, 1987) against stressful events. Recently, research projects aim at developing of a theoretical framework in order to investigate the interdependence of health maintaining resources at one hand and pathogenetic and risk factors at the other. For example, one cannot simply say: »The more resources, the healthier the person is.« Complex processes such as perceiving and activating resources may promote or restrain

health (STRAUS & HÖFER, 2000; UDRIS ET AL., 1992). In a special context some resources with its originally positive function for the person (eg, social support) may have a demoralizing effect on health and well-being. For example, a person with low self-esteem may experience social support as demoralizing in a specific context (SCHULTE-CLOOS & BAISCH, 1996). Presently, the majority of studies focus on social and personal resources, but there are only few on physical and cultural resources which could deliver new insights into the positive conditions of health (FALTERMAIER, 2000).

Integrating Recovery Processes into Health Promotion Research

The recovery movement in mental health is part of a larger social movement of empowerment and self-determination: From traditional model of service delivery (eg, group residences, day treatment, assertive community treatment teams) to a model emphasizing psychiatric rehabilitation, including goal setting and training for consumers to assist and support other consumers which may lead to improved functioning of consumers. MICHAELA AMERING (2003) points out that efforts to establish a definition of recovery have led to discussions of related concepts such as remission, episode, relapse, chronicity, and cure as well as normal and near-normal functioning. Furthermore, she emphasizes that major advances in social and biological treatments as well as epidemiological data support efforts to urgently emancipate diagnoses such as schizophrenia from unjustified prognostic negativity.

According to the recovery and resilience researcher from Boston University COURTENAY HARDING et al. (2002), the term »recovery« is simultaneously used to describe outcomes or end points achieved by people with psychiatric disabilities, as a process experienced by people, and as an organizing vision for the mental health system. The authors express their concern that the recovery concept may become so overused and corrupted that it would become meaningless.

Recovery is a concept that resists definition and efforts to determine when it has occurred (MULLIGAN, 2003). There are no standard or universal characteristics of positive mental health and recovery processes since they are subjective and embedded in the person's life and history context. This is important for the conceptualization of qualitative research projects in health promotion. A study team directed by KEVIN ANN HUCKSHORN at the National

Technical Assistance Center of State Mental Health Planning in USA (quoted by MULLIGAN, 2003) articulated nevertheless a multifaceted definition of recovery:

»Recovery is an ongoing, dynamic, interactional process that occurs between a person's strengths, vulnerabilities, resources, and the environment. It involves a personal journey of actively self-managing psychiatric disorder while reclaiming, gaining, and maintaining a positive sense of self, roles, and life beyond the mental health system, in spite of the challenges of psychiatric disability.«

Health promotion and clinical psychiatry researchers would benefit greatly of investigating individuals' recovery processes in detail. This way, they learn about various self-help activities and regulatory mechanisms which may influence patients' recovery processes, e.g. with activities such as »telling self to calm down«, »comparing own behavior with that of others«, »keeping oneself busy«, »reading the bible« (STRAUSS, 1987; BÖKER et al., 1984).

Longitudinal studies are needed to chart recovery processes and to identify common pattern or themes among patients. Authorities in the field do not believe that recovery occurs at a given moment in time, but rather that it is a long, involved process of forward movements, regressions, and plateaus. For example, people may go through periods of organisation followed by periods of disorganisation (STRAUSS, 1987; HATFIELD & LEFLEY, 1993). Autobiographical accounts of consumers or (ex)patients provide us with an understanding of the experience of illness in general and mental illness in particular that we can get in no other ways. These accounts can be found in a broad range of publications, such as the section First Person Account in the Schizophrenia Bulletin, in self-help publications such as books, newsletters (eg, DEEGAN, 1996; LOVEJOY, 1984; National Mental Health Association).

The risk in research is that autobiographical accounts on mental disorders may be soon transformed by the particular viewpoints and conceptual frameworks about these disorders that professionals and researchers have developed in their professional socialisation. ESTROFF (1989) and STRAUSS (1989) have challenged the field by discovering and developing methods of inquiry that preserve subjectivity and protect rather than reduce experiential data.

Research Methods

Health promotion researchers strongly suggest the application of a variety of research methods due to the highly complex field of health promotion (WHO, 1998; BRITTON et al., 1998). Methodological pluralism and the integration of multidisciplinary research are regarded as not only acceptable but essential (DOWNIE et al., 1998; NUTBEAM, 1999). The tendency to strait-jacket health promotion into models of biomedical evaluation focusing on outcomes ignores the creative, developmental components of health promotion (DOWNIE et al., 1998, p. 90). The broad scope of health promotion requires in addition the assessment of the context of health and illness processes, such as the individual's biography and life style as well as the social, cultural, societal, historical and ecological context (see table 1).

Health Promotion Research Principles

- *Plurality of research methods* due to the complexity of health promotion
  (public health and epidemiological studies; longitudinal rather than cross-sectional studies; retrospective studies; standardized assessment; qualitative studies; combination of qualitative-quantitative methods)
- Assessing the *context* of health and illness
  (individual biography, life style, social, cultural, ecological, political, historical context)
- *Multidisciplinary assessment*
  (health sciences, medicine, physiology, biology, neuro-psycho-immuno-endocrinology, psychology, sociology, philosophy, anthropology, architecture, environmental sciences)

Table 1.- General health promotion research principles

Scope and assessment methods in health promotion range from public health and epidemiological, longitudinal, cross-sectional, retrospective, quantitative and qualitative studies. Health promotion researchers suggest a combination of qualitative and quantitative methods as well as process studies in networks, in contrast to isolated short-term outcome studies (usually used in clinical research), in order to assess the effects of programs and interventions in a comprehensive manner (eg, WHO, 1998; FALTERMAIER, 2000).

Evaluation Measures

Just focusing on programs' outcome is a limited approach. We have to evaluate the process itself, the immediate impact, as well as long-term effects of activities what is called »output measures« (DOWNIE et al., 1998). Output measures could be, for example, health indicators, measures of health status, quality of life scales, assessment of behavior, locus of control scales, surveys of social attitudes and values, or environmental monitoring (see Table 2).

Guide to Health Promotion Evaluation (Downie, Tannahill & Tannahill, 1998)	
Aim / Objective	**Measure / Methods**
To prevent ill-health while promoting positive health	Health indicators; Measures of health status; Quality of life scales
Change knowledge and beliefs	Health knowledge; Perceived risks
Change attitudes and values (eg, self-awareness and self-esteem)	Values clarification; Attitude scales; Self-esteem scales
Change behaviors	Assessment of behavior
Establish health-promoting environments	Environmental monitoring
Foster empowerment of individuals and communities	Locus of control; Surveys

Table 2.- Guide to Health Promotion Evaluation

Traditional objective indicators of health (eg, service utilization rates) are to be complemented by subjective indicators of health. Of particular interest are lay concepts of health and the experiencial concept of feeling ill or well whether or not a disease is present. There is currently a considerable interest towards methodologies which

- involve local people and local communities
- recognize the legitimacy of experiencial and subjective perspectives, and
- endorse a broad conceptualization of health and its determinants (DOWNIE et al., 1998).

The importance of involving local communities and consumers is now well recognized, but the views of these groups deserve much more attention than they currently receive. These views can form a valuable complementation to empirical evidence which is often partial or inconclusive.

According to BRITTON et al. (1998), randomised controlled trials ignore unique features of health promotion. The reasons are the following: Health promotion interventions often take place at a community or national level, expected proportional benefits to individuals may be small or delayed, attribution to specific interventions are not certain, and replication is limited.

The search for a »definitive study« in health promotion is illusory (NUTBEAM, 1999). Both systematic health-related outcome studies as well as a more creative, broad evaluation are necessary, especially in the mental health field. Some authors plead for culturally sensitive studies, cross-cultural adaptation and gender approach in health promotion research (eg, HAZUDA et al., 2000; WALTERS & SIMONI, 2002; PARDINI et al., 2000).

Illustrative Research Results on Positive Factors of Health

In the following, selected examples of studies on positive factors of health may be meaningful for the health promotion and mental health promotion field.

Resilience and Protective Health Factors

In prospective and longitudinal studies, such as the well-known Kauai-Study of WERNER and SMITH (1992) and the Lundby-Study of CEDERBLAD et al. (1994), the authors investigated high-risk children who managed to cope with severe stress factors in their childhood and were able to develop and maintain mental health and competences as adults. The authors found following main protective and resilience factors:

- a positive attachment to at least one primary person
- compensatory relations, an informal family and/or peer network
- structures and rules in the primary family
- internal locus of control
- at least an average intelligence
- cognitive, social, and coping competencies
- a positive self-concept
- a sense of purpose in life
- one or more reliable supportive relationships later in adulthood

Recently, researchers in the field of »resilience« have called for a shift towards a stronger inclusion of sociocultural factors (CLAUSS-EHLERS, 2002).

Salutogenetic Factors in Adolescents

HÖFER (2000) investigated in her public health research project in Germany the interdepencence of adolescents' development of identity and their »sense of coherence« - the latter is a central term in Antonovsky's concept of Salutogenesis (ANTONOVSKY, 1979). The sense of coherence is composed of three factors: a) sense of comprehensibility (eg, environmental stimuli are experienced as structured, foreseeable and explicable), b) sense of manageability (eg, confidence in one's ability to cope successfuly with stressful events due to salutary resources), and c) sense of meaningfulness (eg, demands in life are seen as challenges and worthwile to invest engagement).

The Author Documented The Following Main Results:

- Adolescents experience a positive sense of identity through experiences of acceptance and acknowledgement by and belonging to a peer group. Those adolescents have more meaningful projects than those with a low sense of coherence.

- Autonomy and self-determination is connected to a strong sense of coherence: Adolescents experience their projects and activities as self-determined and chosen by themselves.
- Adolescents with a low sense of coherence report about projects which are experienced as alienated and not self-determined (since they did not have a choice or they were persuaded by their parents). They attribute those »projects of failure« to their own lack of capability.

Personal, social and material resources of persons experiencing schizophrenia

In an own combined qualitative and quantitative research project on health protective resources of persons experiencing schizophrenia in Germany (SCHMOLKE, 2001), following main areas could be found:

Health promotive strategies and resources related to illness experience:

- Development of a subjective concept of illness
- Accepting the illness and living with it
- Feeling ill only in acute illness phases
- Increasing knowledge and capability to deal with one's illness

Personal health promotive strategies and resources:

- Need to work with consideration of one's present capabilities
- Caring for own physical needs
- Establishing of an emotional balance by multiple activities
- Attempting a self-independent style of life
- Reducing stress
- Formulating own life goals with emphasis on stability in life
- Orientation towards higher ethical values
- Emotional support through religious belief and spirituality

Social health promotive strategies and resources:

- Need to be part of the society and to be needed by others
- Emotional wellbeing by active social interactions (eg, friends, peer group)
- Supportive relationship between patient and therapist
- Need for distance to sick (peer) environment
- Protective partner relationship
- Social support through and strong bonds with family
- Sense in life through interpersonal relationships and to be important for others

Material health promotive resources:

- Housing (apartment) as meaningful life space and refuge
- Rent as important material security
- Efforts to live with limited financial resources

Practice Relevance

Research and clinical practice can be mutually enriched in the following way: Firstly, through the integration of clinicians and consumers into the conceptualization and evaluation of health promotion programs (eg, SIMPSON & HOUSE, 2002). Secondly, by the translation of health promotion research into practice. Research findings can be implemented into concrete clinical care, such as prevention, diagnosis, treatment, and rehabilitation.

Practice fields are for example:

- Resource activation in psychotherapy (eg, GRAWE et al., 1999)
- Salutogenetic approach in nursing (eg, BRIESKORN-ZINKE, 2000)
- Successful coping and resilience in the elderly (eg, FOSTER, 1997)
- Spontaneous remission and resilience in cancer patients (eg, ODA, 2001; WENZEL et al. 2002)
- Recovery orientation in the mental health system (eg, US Presidential Commission on Mental Health, 2003)
- Health promotion in specific settings such as hospitals and schools (eg, BERGER et al., 1999; WYN et al., 2000)
- Mental health promotion in the communities (eg, see paper of HERRMAN et al., 2003 in this Special Issue or www.vichealth.vic.gov.au).

Future Goals in International Health Promotion Research

In the year 2000 the Inaugural World Conference of Health Promotion took place in Atlanta, followed two years later by a second conference in London, organized by the World Federation of Mental Health and the Clifford Beers Foundation in collaboration with the Carter Center and co-sponsored by WHO. The institutional and conceptual development of these conferences and the international collaboraton among pertinent organisations are described in detail by MICHAEL MURRAY and JOHN ORLEY (2003; their paper in this Special Issue).

Following main goals for future international health promotion research, as discussed and formulated at the above mentioned two conferences (MURRAY & ORLEY, 2003), seem to be relevant:

1. Successful research projects need sustainable institutional partnerships with communities and settings. Researchers require training and education to develop such partnerships.
2. In developing evidence-based prevention and health promotion research, consideration must be given to engaging a wider role of stakeholders into the partnerships (eg, architects, environmental experts, spiritual leaders).
3. Different views on Standards of Evidence exist between global-wide organisations. There is a need for an ongoing debate between such organisations to achieve a common perspective and/or to highlight issues of difference. This discussion needs to be sensitive to different cultural and economic contexts.
4. More engagement is necessary to examine the role of assessment in promotion and prevention.
5. There is a need to develop an international network of research and development centers in prevention and promotion of mental health.
6. Accessible international databases (eg, on evidence-based interventions that work for specific populations) are a priority.

Conclusions

We need to know to what extent there is inherent in each person, however deeply buried, a natural tendency to struggle for a meaningful life. Researchers must learn to deal with the complexities and contradictions that emerge, and to live with the tensions between data and concepts, between formulations and unexpected findings (HATFIELD & LEFLEY, 1993). We can assume that clinical research and health promotion research findings would complement and enrich each other and that these findings will inform eventually the practice field.

Finally, a general and critical statement by ANTONOVSKY (1996): Health promotion programs will fail to be successful and are far from the salutogenetic idea if researchers a priori determine what is good for other people. Due to the growing attractiveness of health promotion programs, there are many studies which claim to be »salutogenetic« or »health promotive«. However, at a closer look, they still prefer concepts and methods oriented to the pathogenetic

paradigm of deficits, to the biomedical model, or to the traditional risk model (BENGEL et al., 1998). A shift in mind towards health promotion is a necessary ongoing process, and clinicians as well as researchers will definitely benefit from it.

Gesundheitsförderung und multimodale Forschungsperspektiven

Margit Schmolke (New York/Munich)

Konzepte der Gesundheitsförderung und Förderung psychischer Gesundheit
In ihrem Artikel gibt die Autorin einen knappen Überblick über die konzeptionelle Entwicklung des WHO-Ansatzes der Gesundheitsförderung und der Förderung von psychischer Gesundheit (WHO, 1986; WHO, 1999). Die Förderung von psychischer Gesundheit ist eng verbunden mit Begriffen wie »Heilungsprozess«, »Hoffnung« und »Empowerment«. Führende Gesundheitspolitiker betonen, dass »psychische Gesundheit fundamental für die allgemeine Gesundheit« und nützlich ist hinsichtlich verbesserter körperlicher Gesundheit, erhöhter emotionaler Resilienz, stärkerer sozialer Partizipation und höherer Produktivität (Department of Health, UK, 2001).

Lange bevor das Konzept der Gesundheitsförderung der WHO systematisch entwickelt wurde, hat GÜNTER AMMON (1979) in seinem Behandlungskonzept der Dynamischen Psychiatrie das Bündnis des Therapeuten mit den »gesunden Ich-Anteilen« des Patienten formuliert. Dieses Bündnis bildet die Grundlage für jegliches klinische Handeln und basiert auf einer aktiven und heilungsorientierten Einstellung des Therapeuten, der über das Denken in Krankheitskategorien und Defizitorientierung hinaus in kreativer Weise auf den Patienten eingeht.

Als ein weiterer Vorläufer der Gesundheitsförderung ist das Konzept der Salutogenese (d.h. Entstehung von Gesundheit) von AARON ANTONOVSKY (1979, 1987) zu nennen. Es umfasst im wesentlichen a) die Lokalisierung einer Person auf einem multidimensionalen Gesundheits-Krankheits-Kontinuum, b) Exploration der gesamten Geschichte einer Person und nicht nur ihrer Krankheit, c) Faktoren, die die Position auf dem Kontinuum zumindest beibehalten oder auf den gesunden Pol hin bewegen können, d) Verständnis von Stressoren als nicht nur pathogenetisch, sondern möglicherweise auch als

gesund, e) Faktoren zur aktiven Adaptation des Organismus an seine Umgebung, und f) Beachtung der abweichenden Fälle in pathogenetischen Studien.

Forschungsmethoden

In der Forschung zur Gesundheitsförderung werden protektive Ressourcen und Risikofaktoren in ihrem wechselseitigen Verhältnis erforscht und eine Rahmentheorie entwickelt (vgl. UDRIS ET AL., 1992; STRAUS & HÖFER, 2000).

Die Forschungsprinzipien in der Gesundheitsförderung beinhalten u.a.

- Pluralität der Forschungsmethoden aufgrund der Komplexität von Gesundheitsförderung (Public Health und epidemiologische Studien; Längsschnitt- vor Querschnittstudien; retrospektive Studien; standardisierte Erhebungen; qualitative Studien; Kombination von qualitativen und quantitativen Methoden)
- Untersuchung des Kontextes von Gesundheit und Krankheit (Individuelle Biographie; Lebensstil; sozialer, kultureller, ökologischer, politischer, historischer Kontext)
- Multidisziplinäre Untersuchung (Gesundheitswissenschaften, Medizin, Physiologie, Biologie, Neuropsychoimmuno-Endokrinologie, Psychologie, Soziologie, Philosophie, Anthropologie, Architektur, Umweltwissenschaft, u.a.)

In der Evaluationsforschung wird betont, dass es in der Gesundheitsförderung nicht ausreicht, sich nur an Ergebnissen von Programmen bzw. an den Wirkfaktoren zu orientieren, wie dies in der klinischen Forschung üblich ist. Wichtig sind der Prozess selbst, der unmittelbare Einfluss sowie Langzeiteffekte von gesundheitsfördernden Programmen - alle drei Aspekte werden »output« genannt (DOWNIE et al., 1998).

Einbeziehung von Heilungsfaktoren in die Gesundheitsförderungs-Forschung

Die Recovery-Bewegung ist Teil einer grösseren sozialen Bewegung, deren Hauptelemente Empowerment und Selbstbestimmung sind. Heilungsprozesse werden als höchst individuell und kontextspezifisch verstanden (vgl. MULLIGAN, 2003). Dies stellt eine Herausforderung für qualitative

Forschungsansätze dar. Die Autorin plädiert für die Einbeziehung von diesen individuellen Heilungsfaktoren in die Forschung der Gesundheitsförderung, welche in autobiographischen Berichten von Personen detailliert beschrieben werden, die eine schwere psychische Erkrankung überwunden haben (z.B. im Schizophrenia Bulletin).

Illustrative Forschungsergebnisse

Es werden kurz einige ausgewählte Forschungsresultate über positive Gesundheitsfaktoren beschrieben, die für den Bereich der Gesundheitsförderung bedeutsam sein könnten: a) Resilienz- und protektive Faktoren (WERNER & SMITH, 1992; CEDERBLAD et al., 1994), b) Salutogene Faktoren bei Jugendlichen (HÖFER, 2000), c) Gesundheitsförderliche Ressourcen bei schizophrenen Patienten (SCHMOLKE, 2001).

Zukünftige Forschungsziele

MURRAY und ORLEY (2003; in diesem Heft) beschreiben zukünftige Ziele in der Forschung zur Gesundheitsförderung, z.B. institutionelle Partnerschaften, Training von Forschern, um solche Partnerschaften zu entwickeln, Einbeziehung eines grösseren Kreises von Teilnehmern (z.B. Architekten, Umweltexperten, spirituelle Experten), globale Entwicklung einheitlicher Standards von Evidenz, Entwicklung eines internationalen Netzwerkes von Forschungszentren in Prävention und Gesundheitsförderung, Priorität von zugänglichen internationalen Datenbanken.

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International Collaborations on Mental Health Promotion: A Western Pacific Initiative

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Interventions that promote mental health at community and country levels complement early intervention and treatment in clinical care. Once mental health is seen as a legitimate part of public health, or health promotion, the public health approach becomes a useful framework to develop partnerships and interventions. VicHealth is an independent statutory authority, funded by the state government of Victoria, Australia to work in health promotion. It has begun a long-term investment in mental health promotion. The framework for action begins with gathering local evidence about mental health and its modifiable determinants such as connection to community, school, work and home, the environments in these places, and forms of discrimination and violence. Evidence is also gathered about the prevalence of mental disorders, risk behaviours, suicide, and the relationships to key socio-economic variables and economic participation. Key informants from several health and non health sectors assist in deciding the determinants on which to focus. Strategies that support each other and emphasise inter-sectoral partnerships can then be developed, including legislative reform, project development, community and organisational capacity building, communications, and research and evaluation. This work has recently been extended to a Pacific nation through invited consultation with the World Health Organization.

Introduction

The World Health Organization (WHO) famously defines health as »not merely the absence of disease or infirmity«, but rather, »a state of complete physical, mental and social well-being«. More recently it defines mental health as »a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community« (WHO, 2001a). Mental health is the foundation for well-being and effective functioning for an individual, and for a community. It is more than the absence of mental disorder.

Mental health is intimately connected with physical health, and with behaviour. Each of these is affected by community action in many spheres. Improving mental health is inevitably linked with improving health and changes in behaviour. A growing evidence base suggests complex interactions in some western societies at least between mental health and educational

achievement, work productivity, development of supporting relationships, reduction in crime rates and safe use of alcohol and drugs. Similar social and economic determinants affect these outcomes, and all share similar developmental pathways (WALKER et al., 2002). We can expect on this basis that promoting mental health should be associated with improved physical health, better educational performance of children in school, better productivity of workers in business and industry, and improved relationships within families and the broader community, as well as lower rates of some mental disorders.

The Victorian Health Promotion Foundation (VicHealth) is an independent statutory authority, established in 1987 with government funding in the state of Victoria, Australia. Its tasks are to change social, economic and physical environments so that they improve health for all Victorians, and to strengthen the skills of individuals in ways that support their efforts to achieve and maintain health. In this context it has begun a long-term investment in mental health promotion (VicHealth, 1999). The spur for this was twofold: the recognition that the social and economic costs of mental ill health are increasing; and second, the growing realisation that the unused opportunities for improving mental health most likely mean significant foregone benefits. Improving health, as well as reducing the costs of mental ill health, can only be achieved through mental health promotion and the prevention of disorders at community and country levels, alongside treatment and rehabilitation for those with mental disorders.

The burden of mental disorders remains significantly underestimated in terms of its personal, social and economic impact with mental ill health accounting for 11% of all disease burden and a major source of chronic disability worldwide (MURRAY et al., 2000). While mental disorders are common, and universal, they are more common among people with relative social disadvantage in any community (DESJARLAIS et al., 1995). The social and economic costs associated with this growing and unequal burden will not be reduced by the treatment of mental disorders alone. In addition, the unused opportunities for mental health promotion in any community remain largely unexamined.

Mental health and the risk of mental disorders in a community are each influenced for better and worse by social and economic conditions. Social changes can bring advantages such as access to education and employment. Improving the status of women and minority groups including indigenous

communities may have profound positive effects on community mental health. Individual resilience is more likely to develop in a socially inclusive, tolerant and prosperous community. On the other hand, rapid social change is associated with rising stress levels for many people, especially the poorly educated and rural and slum dwellers in many countries. Broad groups of disadvantaged people are affected by family disruption, lack of work, homelessness, exploitation, violence, abuse, and social isolation. Migrants and displaced people face more and more obstacles. Communities become less able to support each other, and crime and intolerance increase. Families are often assumed to be the primary carers for those with disorders and disabilities of all kinds, but in many cases they receive insufficient support. These adverse factors are likely associated with a decline in overall mental health, as well as increased rates of mental disorders including depression, anxiety, and alcohol and substance abuse.

Promoting mental health is relatively new as a recognised area of health promotion activity. However it is an integral part of health promotion, and innovations in health promotion theory and practice. VicHealth has developed a framework for mental health promotion to assist the understanding and development of strategies (VicHealth 1999; MOODIE et al., in press).

VicHealth's Framework to Promote Mental Health

The framework can be used to plan and introduce a range of mental health promotion activities. VicHealth developed this framework after discussion with key informants from a wide range of sectors and organizations in Victoria. The framework provides a unifying language that identifies strategies for collaborative and integrated work across sectors. It begins with the selected determinants of mental health: social inclusion (supportive relationships, involvement in group activities and civic engagement); freedom from discrimination and violence (including valuing diversity, ensuring emotional and physical security and maximizing opportunities for control over one's life); and economic participation (access to skill development, income, housing, education).

Interventions or health promoting actions that address major determinants are planned and carried out in different populations, through different settings and sectors. The effects of the interventions can be measured in terms of the intermediate outcomes (increased sense of belonging, social supports,

increased communication, safer environments, decreased discrimination). Measurable longer-term outcomes may include reduced stress, anxiety and depression, and subsequently a reduction in substance abuse, improved coping, improved physical and mental health.

Intersectoral Partnerships to Promote Mental Health

The need to give appropriate attention to promoting mental health and wellbeing in global, national, state and regional policy and practice has become evident. Advice and advocacy are needed from public health and mental health experts. Additionally, as a range of social and economic circumstances affects mental health status, so too is mental health promotion becoming recognised as being the role and responsibility of people working beyond health, across a range of sectors including employment, education, the arts, sport, transport, housing, criminal justice, welfare and the environment, as well as health care (FRIEDLI, 1999).

The focus of mental health promotion activity will depend on local opportunities, capacity and priorities. As indicated in the framework, and consistent with the theory and practice of health promotion more generally, a range of actions can promote mental health and wellbeing. These include: legislation; research, policy development; monitoring and evaluation to improve the evidence base for mental health promotion and the effectiveness of strategies; project development and funding (including access to community participation in a range of activities, such as arts and sports; organisational development to ensure that policies and procedures encourage participation and connection, ensure emotional and physical security, reduce discrimination; working with communities to build capacity to improve mental health; education and training programs for community members, ensuring there is a workforce with skills and attitudes conducive to mental health promotion activities); communicating about mental health promotion through media and other avenues; and advocating for policy development and legislative reform.

Success in any of these activities depends on the development of collaboration and partnerships with a range of agencies in the public, private and non-government sectors. Mental health promotion needs to occur in the health sector, and in sectors that influence the way people live, are educated and work (VicHealth, 1999; WALKER et al., 2002).

Determinants

Mental health and mental disorders are determined by multiple and interacting social, psychological and biological factors, just as health and illness in general (WHO, 2001; DESJARLAIS, 1995; MRAZEK et al., 1994). The determinants of mental health appear to include: social inclusion and access to social networks; stable and supporting family, social and community environments; physical and psychological security; access to meaningful employment or occupation; having a valued social position; opportunity for self determination and control of one's life; access to education, income and housing; and caring and consistent parenting. On the other hand, parental drug and alcohol abuse and family conflict and instability appear to be particular obstacles to healthy development.

As the evidence grows it suggests more and more that the pattern of these determinants is common to alcohol and drug use (RESNICK, 1997), crime (National Crime Prevention, 1999; HOMEL, 2001), and dropout from school and academic achievement. The absence of the determinants of health, and the presence of the noxious factors, also appear to have a major role in other risky behaviours such as unsafe sexual behaviour, road trauma, eating disorders and physical inactivity. Furthermore there are complex interactions between these determinants and behaviours and mental health. For example, a lack of meaningful employment may be associated with depression, and this in turn with alcohol and drug use, resulting in road trauma, the consequences of which are loss of employment and physical disability.

The VicHealth framework focuses on three of these major determinants of mental health: social connection and inclusion; freedom from discrimination and violence; and economic participation.

Social Inclusion: Concepts and Practice

Social isolation is emerging as a major risk for health - rivalling the effects of well-established risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity. Young people reporting poor social connection are between two and three times more likely to experience depressive symptoms than their peers who report the availability of confiding relationships (GLOVER et al, 1998).

Social inclusion is defined as connection (sense of belonging, participation, and reciprocity, having supportive and stable relationships) to other individuals, to networks of individuals, at the family, school, workplace and community levels, and to organisations, associations, civil structures and movements at different levels in society. It connotes inclusion, and inclusive forms of social connection, as distinct from what might be described as the »Ku Klux Klan« or »exclusive« form. ROBERT PUTNAM in his book »Bowling Alone« gives a persuasive account of the decline in social capital in the US since the 1970's (PUTNAM, 2000).

Pressures on social cohesion and increases in social exclusion will most likely continue in many parts of the world, despite progress for some, in the era of open trade and greater competition, as well as armed conflict and the spread of HIV and AIDS. International and national responses will determine the overall economic and social frameworks. However, communities and governments can act to create and improve social connection and inclusion at the local level. The overall aim is to create organisations and environments that increase opportunities for social connection and participation. This can involve civic engagement, physical activity, sports and recreation, performing and visual arts, service organisations, religious organisations and organisations focused on a period of life such as youth groups, elderly citizens groups, and parents and teachers associations.

Local government planning can create environments conducive to good mental health, using research and monitoring. A study in San Francisco illustrates the scope. Three streets in San Francisco were studied, looking at the traffic passing and the level of connectedness and safety as perceived by the residents. One (heavy street) street had approx 16,000 cars per day, one 8,000 per day and one (light street) had 2,000 per day. Those living on light street have three times as many friends among their neighbours as those on heavy street. Light street was perceived to be friendly and safe for kids, whereas on heavy street residents kept to themselves and there was little sense of community (DORA et al., 2000).

Another example indicates how communities value the development of facilities and environments that help connect people. During the redevelopment of a socially and economically deprived area in a rural Victorian town, the safety and well-being of children up to the age of 12 years was regarded as important (BEILHARZ, 1999, cited in MOODIE et al., in press). A local non-government organisation, together with the local government

authority asked what people wanted, and how they understood a safe, healthy and pleasant community to be. People in the town identified trusting relationships, communication, belonging and identity as the underlying elements needed to promote other aspects of well-being. They chose to establish a sports and recreation club and a family park to stimulate and support community activity. This community with low employment, high conflict and low levels of trust preferred a football club to welfare.

Freedom from Discrimination and Violence: Concepts and Practice

Freedom from discrimination and violence includes the reality and perception of safety, as well as self determination and control over one's life. It is defined as being free from all forms of emotional, verbal and physical violence and discrimination on the basis of gender, race, religion, creed, ethnicity, colour, sexual identity, political beliefs, health status or level of ability. Discrimination on the grounds mentioned above is one of the most enduring characteristics of humanity (MOODIE et al., in press).

The most common results of discrimination are low self-esteem, social isolation, depression and anxiety, drug and alcohol misuse and suicidal feelings (University of Surrey, 1998). Women who have experienced discrimination in the form of violence have high rates of depression, anxiety, stress, and pain syndromes, phobias, chemical dependency and poor subjective health (WHO, 2000). Despite the difficulty of methods and measurement »higher levels of self-reported experience of discrimination were associated with poorer mental health« in a review of US based studies (KRIEGER, 1999).

Legislative and policy reform and enforcement can be used to reduce discrimination in a number of areas. Examples include racial vilification legislation, sexual harassment complaint procedures, and codes of conduct as mechanisms to decrease discrimination in particular settings. Legislative reform in itself will not make substantial changes where discrimination is rife. However, combined with other strategies, the effects of legislation and regulation can be significant. Advocacy for racial tolerance legislation in Victoria recently highlighted the links between the experience of racism and poor mental health. It raised community awareness about the ill effects of racism.

Discrimination is often associated with or takes the form of bullying. In Australia and many other countries bullying has been acknowledged as a

problem in schools, in workplaces and in the armed forces, but there has been far less acknowledgment of its presence in the media (TV and radio), on sporting fields and in civil and political institutions such as state and federal parliaments. Bullying may be responsible for up to 30% of depressive symptoms among high school students in Australia, and a »reduction in bullying in schools could have a substantial impact on the emotional health of young people« (BOND et al., 2001). Strategies have been developed to change attitudes and environments in which discrimination can breed and bullying, if left unchecked, can flourish (MOODIE et al., in press).

The Gatehouse Project in Melbourne is a program funded by VicHealth, the Commonwealth Government of Australia and the Queen's Trust, aiming to improve mental health outcomes for young people at school. The strategies include staff training, curriculum development, and partnerships with sectors outside education (GLOVER et al., 1998). Evaluation of key outcomes uses measures of depression, alcohol use, deliberate self-harm and quality of life (PATTON et al., 2000).

Indigenous emotional and spiritual wellbeing programs, developed by the indigenous communities in Victoria, exemplify community capacity building. The projects are designed to increase the capacity of community leaders through leadership networks for the future, indigenous imaging projects using drama, film and visual media, and youth leadership projects.

Economic Participation: Concepts and Practice

People who are unemployed in Australia experience higher levels of depression, anxiety and distress as well as lower self-esteem and confidence (MCCLELLAND et al., 1998). A workplace survey conducted in 1998 by the Australian Council of Trade Unions indicated that the five top causes of workplace stress are lack of communication, increased workload, job insecurity, organisational change and poor work organisation (MOODIE et al., 1999).

Economic participation means access to education, employment and the money necessary to participate in community life (VicHealth, 1999). There is an established link between economic participation and physical health, and a growing interest in the link between employment, social status and mental health. An influential World Health Organization report on the social determinants of health in Europe notes that good health, including mental health,

requires lowering the levels of education failure, job insecurity, and the scale of income differences in society. Societies that enable as many as possible to participate in the social, economic and cultural life will be healthier than those where people face insecurity, exclusion and deprivation (WILKINSON et al., 1998).

While the link between unemployment, income insecurity and mental ill health is well established it is also evident that in an era characterised by downsizing, reductions in benefits, globalisation, use of temporary workers and welfare reform, there is an urgent need to document and understand the impact of these economic and social policies, and resulting work practices, on the mental health of populations and sub-populations (KAPLAN et al., 1997). It is also important that the negative impacts of contemporary workplaces, as indicated in the Australian Council of Trade Unions study, are addressed at the structural and organisational level, rather than the individual behavioural level alone (MOODIE et al., 1999).

Increasing rates of employment is not within the scope of local mental health promotion activity (although developing skills and strategies for advocacy is open to all). However it is possible to increase skills required for employment and to create opportunities for people, at the local level, to participate in meaningful paid and unpaid pursuits. Trying out new workplace processes and policies that promote mental health and wellbeing is also possible.

Developing and sustaining activity in these areas also underlines the role of different sectors at a range of different levels and the crucial role of partnerships. An example in Victoria is the development of partnerships between juvenile youth correction facilities and private industry, giving positive employment experiences to young people on release (the Whitelion Project). Employers are recruited to the scheme and offered advice on ways to support the young people. The young people gain skills and contact with mainstream society, self-confidence develops and the likelihood of re-offending is lessened. Private industry is able to contribute to the development of communities and in particular, young people. This project indicates how partnerships developed between public organisations and private industry can create opportunities to improve mental health and wellbeing (MOODIE et al., in press).

Workforce development initiatives can also contribute to awareness of the determinants of mental health and wellbeing. VicHealth is designing and offering a short course in mental health promotion to people working in a

range of diverse sectors including the arts, sports, justice, community, local government and health, to improve planning and collaboration across sectors.

Mental Health Promotion in the Pacific

An opportunity arose to extend this approach to promoting mental health to another country and to explore its application in this different environment. The country's government expressed interest and concern about the needs of people with mental disorders, the problem of suicide, and the scope for mental health promotion in the country. The government invited RM to visit as a WHO Consultant to report and advise on approaches to mental health promotion in the country. Another consultant advising on the needs of people with mental disorders followed later. The consultations were seen as complementing one another and both were seen for instance as having relevance to the problem of suicide in the country. The consultation included a series of meetings with government, non-government organisations and groups. A number of reports on mental health, youth health including a youth health survey and a country development strategy in association with UN organisations were reviewed. The consultant then participated in drafting a series of recommendations and a local framework for mental health promotion.

The country is a small nation with a population of less than 200,000 people, but a tradition of strong community structures. Local professionals have adopted the phrase »weaving mental health into the culture«. One particular problem is a high suicide rate, often involving use of the herbicide paraquat, but to date there is little analysis of the factors leading to suicide. The community has expressed interest in mental health promotion while accepting it is not a panacea. The country is undergoing an epidemiological transition from infectious and communicable disease as the major cause of morbidity, to non-communicable diseases including mental disorders and drug and alcohol abuse as significant causes of illness and death in community. Health services are provided through general hospitals and community health services in rural areas. Specific treatment and prevention of mental disorders receives relatively little support.

Organisations that should be involved in promoting mental health in the country, similar to Victoria and other places, include sports associations and clubs and arts and entertainment organisations. Activities such as singing in a choir are important to the culture and provide great stimuli to mental health.

Schools, tertiary educational institutions and churches provide other opportunities for mental health promotion of particular relevance to the country. The training of pastors and priests could enhance the influence of the churches on mental health. Women's committees have a crucial role in supporting family structures throughout the country.

Determinants of mental health important in the country include the level of income, the standard of housing and education. An urban youth study in 1994 showed that young people who were not employed or in school were in general more vulnerable to a range of problems than those in employment or studying. For example, they were at more than twice the risk of not discussing their problems with anyone, were less likely to be members of organisations, and were more likely to be smokers. It is estimated that several hundred children have special needs and many are not receiving educational opportunities, which in the long run will most probably be detrimental to their mental health. For example, over half of children with epilepsy are not at school.

Changes in the country's life and culture were described as having major effects on mental health. These are described in many ways and include differences in expectations between parents and their children, with the background of the traditional authority structures within the families and the villages and the changing role of the church. Younger people who have been abroad have sometimes developed a different view of life and of the authority patterns. Changes in physical activity patterns have been marked, along with the greater availability of processed food, the increasing use of cars and fewer children walking to school. Changes in living patterns away from open communal living, with increasing influence of TV, video, internet and the influence on such things as dress and appearance from Samoans returning from other countries. The move towards greater individualism and a focus on close rather than extended family, and urbanisation all have the effect of a possible decreasing influence of the family authority system. Along with this is the concern that inequalities in the community will increase. The system of mutual reciprocity has traditionally accompanied the family authority structures. This system of mutual reciprocity has been seen to have great benefits but also to be increasingly difficult.

Many informants felt that problems with alcohol, domestic violence, teenage pregnancy, child and sexual abuse were generally being denied as issues of consequence in contemporary life. On the other hand, the police and non-

government organisations were vocal in their concern and actively inviting discussion and development of strategies to reverse these trends. Key informants consistently raised concerns about under-age drinking, marijuana use, teenage pregnancy and suicide. This seems to be backed up by young people themselves, based on the findings of the 1994 survey.

Bullying in schools (a common and harmful form of discrimination in most countries) and harsh discipline are apparently problems in some areas at least, but remain unmeasured. There was consistent comment that people with a mental illness faced discrimination both by the general public and in service provision, including health services.

Overall, there was a high level of interest in mental health and the need for a greater focus on mental health promotion, among those interviewed. However, to date apart from the publicity surrounding suicide, mental health has been low on the agenda for the community. There were considerable concerns among the key informants about many issues associated with poor mental health, including alcohol and drug use, suicide, domestic violence and sexual abuse. Much concern was also expressed about the rapid social, economic and cultural transitions, and the effects these might be having on mental health and risk behaviours in the country. An overall mental health program in the country could encapsulate treatment, early identification and prevention of mental illness as well as promotion of mental health. The creation of a national alcohol and drug program could be integrated with this. Those in the country saw continuing external advice and support as essential, particularly where this can provide linkages to international non-governmental organisations, academic institutions and aid agencies.

Recommendations included the development of a national mental health program, basic research and surveillance to build on previous work, and legislative and regulatory reform, especially in relation to alcohol, discrimination and treatment for mental illness. They also included development of communications about the selected matters relevant to mental health, emphasising existing strengths in the community leaders, family and church. Project development, focusing on selected determinants was recommended: counselling for depression, suicide thoughts, and information about alcohol and drug use and sexuality; support for sports participation; school mental health promotion; support to special needs children attending schools; and care for the mental health of family caregivers. The recommendations noted the need for continuing outside support.

Mental Health Promotion in Victoria, The Pacific And Elsewhere

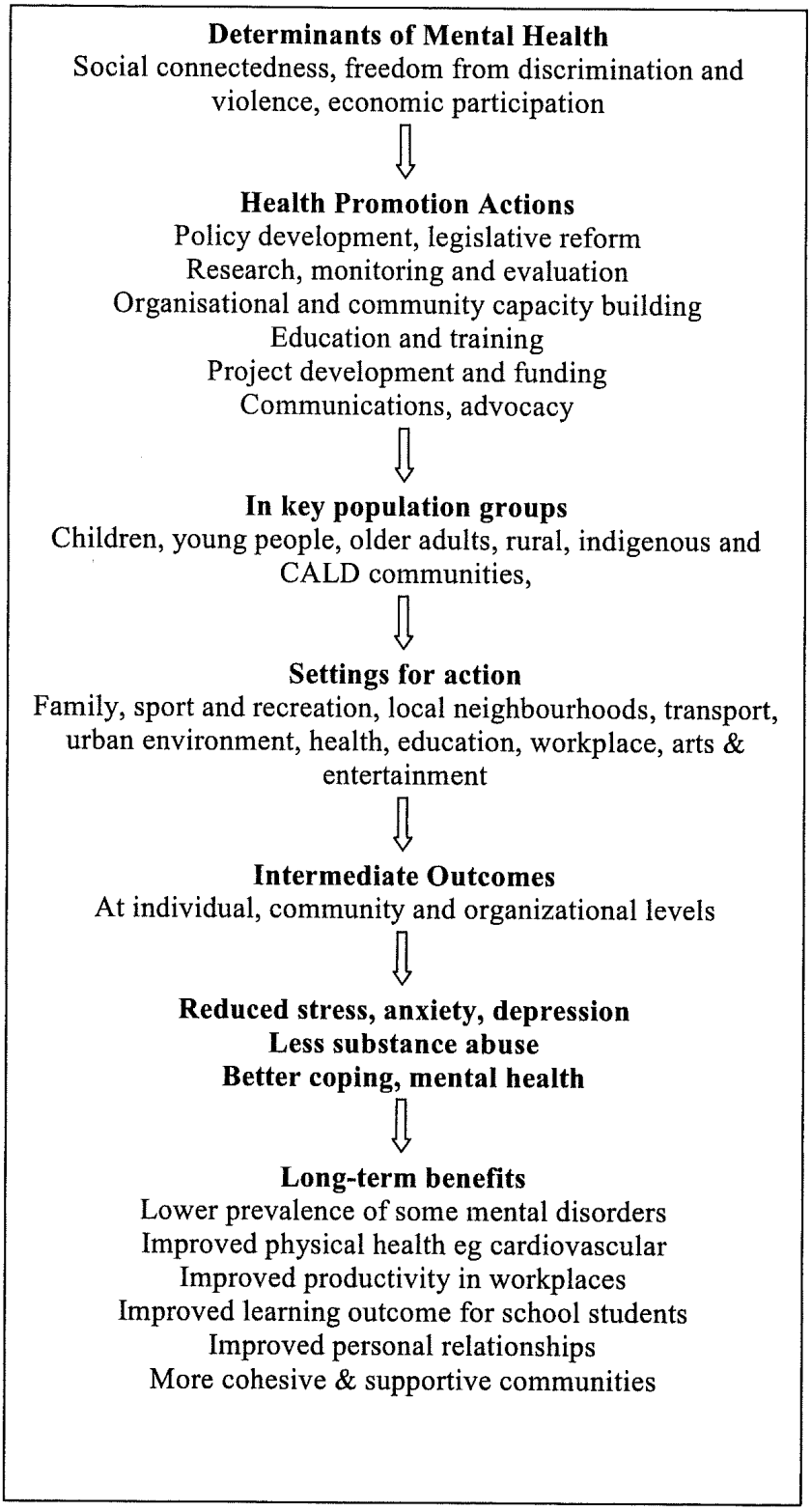
Much of the activity promoting mental health is probably happening already to varying degrees in any setting. The task is to identify, acknowledge and evaluate the role and effects of these activities, and to encourage their development. This work is required in each community. Building the global evidence base is critical and will give an invaluable basis and guidelines for local activities and studies. However, the justification and activities will be shaped by the cultural factors in each community. The work in Victoria and the Pacific gives confidence that promoting mental health occurs in the framework of public health action.

For local activities in a new setting, the first step is twofold: first, to gather local evidence about the prevalence of preventable mental disorders (depression, anxiety neuroses) and risk behaviours (eg, alcohol, marijuana, heroin, amphetamine use, road trauma) and outcomes, particularly suicide, related to mental ill health; and second, to examine the local situation with respect to the modifiable determinants of mental health such as connectedness to community, school, workplace and home, school environments and the prevalence of bullying, forms of discrimination and violence (gender, race, age). This can be done by examining local studies, if they exist and by using focus groups of key informants. Key informants should include all those sectors mentioned above that have a potential contribution to make, especially in partnerships with each other. The key informants will examine the local evidence and assist in deciding the determinants on which to focus.

Having defined the key local determinants, the next step is to identify and develop strategies that support each other such as legislative and regulatory reform, project development across appropriate sectors and focusing on selected determinants, communications, including an emphasis on existing strengths within the local community, and continuing research and evaluation to underpin the overall program. If resources are required to develop the strategies, further discussion with potential project partners could secure the resources that are needed. Also, as mental health promotion is an intersectoral activity, funding bodies responsible for the development of strategies across a variety of sectors are potential resources of support.

Mental health promotion is more than mental illness prevention, although the activities overlap, having potential outcomes in improved physical health and improved productivity as well as fewer people living with mental illness.

Mental health promotion is everyone's business. Policies and actions in education, urban environment, sports, arts, business and industry have major impacts on mental health, and many of these are potentially modifiable with local or national action.



Internationale Zusammenarbeit auf dem Gebiet der psychischen Gesundheitsförderung: Eine westpazifische Initiative

Helen Herrman, Rob Moodie, Lyn Walker, Irene Verins (Melbourne)

Interventionen mit dem Ziel, die psychische Gesundheit zu fördern, stehen in einem Ergänzungsverhältnis zu Frühintervention und Behandlung innerhalb der klinischen Versorgung. Psychische Gesundheitsförderung wird auch angestrebt durch Interventionen auf Gemeinde- und Länderebenen. Wird psychische Gesundheit erst einmal als ein legitimer Faktor innerhalb der Public Health anerkannt, dann kann der Public Health-Ansatz zu einem nützlichen Rahmen werden für die Entwicklung von Partnerschaften mit dem Ziel, psychische Gesundheit des Einzelnen und innerhalb der Gemeinde zu fördern.

VicHealth ist eine unabhängige rechtliche Organisation im australischen Staat Victoria, die von der Staatsregierung zum Zweck der Gesundheitsförderung gegründet wurde. Damit begann ein langfristig angelegtes Projekt im Bereich der psychischen Gesundheitsförderung. Der Handlungsrahmen beginnt mit dem Nachweis psychischer Gesundheit und ihren variierenden Bestimmungsstücken auf bestimmten Gebieten, wie z.B. die Verbindung zu Gemeinde, Schule, Arbeit und Zuhause, Schul- und Arbeitsumwelten sowie Formen von Diskriminierung und Gewalt. Informationen werden auch gesammelt zur Prävalenz von psychischen Störungen, Risikoverhaltensweisen, Ergebnisse von Interventionen einschließlich Suizid sowie die Beziehung zu zentralen sozioökonomischen Variablen und wirtschaftlicher Partizipation. Zentrale Informanten aus unterschiedlichen Sektoren untersuchen diese lokalen Nachweise und helfen bei der Entscheidung, auf welche Determinanten von psychischer Gesundheit in dem Projekt der Fokus gelegt wird.

Das VicHealth-Projekt konzentriert sich auf drei Hauptdeterminanten von psychischer Gesundheit (VicHealth, 1999):

1. Sozialer Anschluß und Eingebundenheit (z.B. Verbindung zu anderen Personen, zu sozialen Netzwerken auf der familiären, schulischen, Arbeitsplatz- und Gemeindeebene sowie zu Organisationen und Vereinen, zu bürgerlichen Strukturen und Bewegungen auf verschiedenen Ebenen innerhalb der Gesellschaft).

2. Freiheit von Diskriminierung und Gewalt (z.B. Realität und Wahrnehmung von Sicherheit; Selbstbestimmung und Kontrolle über das eigene Leben; Freiheit von allen Formen von Gewalt und Diskriminierung: emotional, verbal, physisch sowie bezogen auf Geschlecht, Rasse, Religion, ethnische Gruppen, Hautfarbe, sexuelle Identität, politische Überzeugungen, Gesundheitsstatus oder Behinderung).
3. Wirtschaftliche Partizipation (z.B. Zugang zu Bildung, Arbeit und Geld, was notwendig ist, um am Gemeinschaftsleben teilnehmen zu können).

Schließlich können in dem Projekt Strategien entwickelt werden, die sich gegenseitig ergänzen und den Fokus legen auf intersektorale Partnerschaften, einschließlich gesetzlich durchzuführende Reformen, Projektentwicklung, Kommunikation, Forschung und Evaluation. Diese Arbeit wurde kürzlich auf eine pazifische Nation ausgeweitet in beratender Zusammenarbeit mit der Weltgesundheitsorganisation (WHO). Informationen können nachgelesen werden auf den Webseiten www.vichealth.vic.gov.au oder auch unter www.togetherwedobetter.vic.gov.au

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Mental Health Promotion: Strengthening Global Partnerships

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The burden created by the incidence of mental disorder is not just financial but in total arises from individual suffering, disability, increased mortality, loss of economic productivity, poverty, family burden,etc. The prevalence of mental illness creates a very significant demand on the resources of states. The view that treatment alone cannot resolve the problems arising from the existing levels of mental disorder is proposed and a plea is made for further development of mental health promotion and the prevention of mental disorder programmes.
A range of existing initiatives in the field are discussed and although there is a plethora of knowledge and expertise in the field it is contended that it is not so much the lack of expertise, knowledge or even effective programmes that hindered progress (in promotion and prevention) but: the lack of shared information about ongoing research and programmes, international collaboration and co-ordination and management and planning in the development, dissemination and implementation of effective programmes.
A plea is made for the development of a world wide consortium that can act as a focal point for collaboration and co-operation between individuals, agencies and nations.

Introduction

Mental health is a complex, multi-faceted issue in which a broad range of social, political, economic and health and welfare components interact. Decisions on the resourcing of policies, priorities and programmes should be based upon evidence that recognises and addresses the complex nature of these interactions but for too long have been based upon ignorance, traditional professional practices and power and financial considerations.

However the 20th century witnessed the beginnings of a movement, driven forward by the rising social and financial costs attributable to mental illness and aimed at addressing such deficiencies. In essence, politicians began to accept that the prevalence and morbidity of mental disorders throughout the world are staggering and the suffering created for individuals and families and the social costs are immense. For example, it is estimated that some 20 per cent of the population have a mental health problem in any given year (U.S. Department of Health and Human Services, 1999, p. 46) and that around one

third of the population can expect to face an episode of mental illness during their lifetime (BLACKER & CLARE, 1987). Mental disorders are a major cause of morbidity. They account for some 14 per cent of reported days off work for illness, in the UK (Department of Health, 1994). In the Mini Finland Health Survey (LEHTINEN et al., 1989) 17 per cent of the population studied required some form of mental health care in the year of study with half requiring specialist help and six in every 1000 people having a mental disorder of a severity that warranted long-term care (CONWAY et al.,1994). The prevalence of mental illness on this scale creates a very significant demand on the resources of states. Mental health services in the UK have been estimated to make up 23 per cent of all inpatient and 25 per cent of the total pharmaceutical costs (Department of Health, 1994). The direct costs of mental health services in the USA in 1996 was $ 69 billion dollars (U.S. Department of Health and Human Services, 1999, p 609) while the indirect costs for 1990, attributable to lost productivity in the workplace, school and home, due to premature death or disability, was estimated at $ 78.6 billion (RICE & MILLER, 1996).

The burden created by the incidence of mental disorder is not just financial but in total arises from individual suffering, disability, increased mortality, loss of economic productivity, poverty, family burden - cycles of disadvantage, intellectual and emotional consequences for children (RUTTER & MADGE, 1976) and reduced access to successful health promotion, prevention and treatment programmes (JENKINS & ÜSTÜN, 1998). In addition considerable stigma is also attached to people with a severe mental illness (JENKINS, 1990).

Despite the efforts of many dedicated people there is still much to be done. Although the number of inpatients has been reduced on a worldwide basis, current epidemiological data does not show a significant increase in mental health in the community (HOSMAN, 1997), rather it is the contrary. The World Bank Report (1993), the World Mental Health Report (DESJARLAIS et al., 1995) and the Global Burden of Disease Report (MURRAY & LOPEZ, 1996) present an alarming account of the mental health status of the world population.

It is against this background that mental health promotion and the prevention of mental and behavioural disorders has become an increasingly important feature of health policy at local, national and international levels (CRAG, 1994; Department of Health, 1996; LEHTINEN et al., 1997).

Promotion/prevention is not a new concept and efforts to promote mental health have a considerable history in certain parts of the world (HOSMAN, 1997). Early in the 20th century the mental hygiene movement was successful

in putting mental health promotion on the international agenda and during the 1920's and 30's there was substantial activity to stimulate »the integration of mental health principles into the practices of social work, nursing, public health administration, education, industry and government« (BEERS, 1935) - views that are still very prevalent today. However despite the efforts of the early pioneers the movement failed to attract sufficient interest from these other groups. It was not until the 1970's, when the first evaluation studies were initiated, that concerns developed. On a much more positive note, during the last thirty years we have witnessed a significant increase in this type of cost benefit research on promotion, prevention and related fields (HOSMAN, 2000); this in turn increasing awareness and recognition of issues to be addressed.

Of course, it is accepted that mental health treatment services are needed, but alone they will never be able to meet demand. »No mass disorder afflicting mankind has ever been brought under control or eliminated by attempts at treating the afflicted individual nor by training large numbers of therapists.« (GORDON, 1983), and as succinctly outlined by U.S. Surgeon General Dr. David Satcher, »Preventing an illness from occurring is inherently better than having to treat the illness after its onset.« (U.S. Department of Health and Human Services, 1999, p 62).

After many years of a somewhat »humble« approach to mental health promotion and the prevention of mental and behavioural disorders the field is gaining momentum on government agendas. With some confidence, we can now start to see the beginnings of the recognition of this new movement. Mental health and mental illness are beginning to be seen as public health issues (U.S. Department of Health and Human Services, 1999) and a public health framework requires promotion to be an integral component of a comprehensive mental health service. »The field of prevention has now developed to the point that reduction of risk, prevention of onset, and early intervention are realistic possibilities. Scientific methodologies in prevention are increasingly sophisticated, and the results from high-quality research trials are as credible as those in other areas of biomedical and psychosocial science. There is a growing recognition that prevention does work.« (U.S. Department of Health and Human Services, 1999, pp 132-133).

The major challenge facing us is how do we best collaborate to disseminate skills, knowledge and expertise across the globe. We may choose to ration these initiatives, much as in the same way we ration other forms of health delivery. We may choose to present promotion/prevention programmes as another form

of western medicine. Alternatively there is the opportunity to recognise, »because of their positive effects in multiple sectors - education, economic and legal for example - the promotion of mental health and prevention of mental and behavioural disorders are in the shared interest of diverse groups of stakeholders. An opportunity exists to develop powerful intersectoral coalitions for promotion and prevention at global, regional, national and local levels.« (MRAZEK & HOSMAN, 2002).

This need to bring players, in the field of promotion and prevention, together has been recognised for some time and it is not so much the lack of expertise, knowledge or even effective programmes that hindered progress (in promotion and prevention) but, the lack of:

- shared information about ongoing research and programmes,
- international collaboration and co-ordination, and
- management and planning in the development, dissemination and implementation of effective programmes (HOSMAN et al., 1996).

In order to strengthen global collaboration and partnerships a number of initiatives have been undertaken. These include:

- the development, evaluation and dissemination of models of best practice (model programmes)
- a series of international meetings to discuss/share projects
- initial steps on the commissioning of a World Consortium for the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders

1. Models of good practice

Although a common feature for many years in other fields, the concept of model programmes are more recent in the field of mental health promotion and the prevention of mental and behavioural problems. However dissemination and large-scale implementation of such programmes are considered essential tools in helping to improve promotion and prevention at community level. International collaboration has been greatly extended to encourage this work and several reviews have been published and the development and dissemination of evidenced-based model programmes have

become an essential element in national prevention policies. See for example Reducing Risks of Mental Disorder (MRAZEK & HAGGERTY, 1994), Chapter Three in the Report for the European Commission by the International Union for Health Promotion and Education), and the International Classification and Registry of Preventative Trials.

There are many examples of such programmes, in different settings and addressing specific problems. There is not the opportunity to discuss all of them but perhaps a few illustrations may be helpful.

For example, a cognitive behavioural group intervention delivered to high school students identified as being at high risk for depression because of very early symptoms can prevent depressive disorders in those teens (CLARKE et al., 1995) and because there is a known link between depression and substance abuse, there is also the potential that this intervention could also contribute to the prevention of substance abuse. Drugs use can also be reduced by 44 percent in 12th graders (USA school category) by life skills training begun in the 7th grade (BOTVIN et al., 1995).

Child abuse can be reduced by 80 percent if prenatal nurse home visitations are made during the first two years of life (OLDS & KITZMAN, 1990; OLDS et al., 1997, 1986; KITZMAN et al., 1997). Child abuse has strong links to a wide range of mental health effects as well as level of educational attainment and involvement in juvenile justice.

A school-based programme designed by a psychiatrist was tested in a controlled trial and found to significantly reduce disciplinary referrals and cases of physical aggressiveness. This same programme was associated with increased scores on standardized academic achievement measures. The intervention focused on the role of the bystander and taught children how to handle bullies and gave teachers the skills to discipline children without having to resort to punishment. It did not focus on individual pathology. The intervention is now being tested in a randomized controlled study in nine elementary schools in Topeka, Kansas (TREMLOW et al., 2001).

In the area of AIDS prevention there are many effective programmes. For example, the number of adolescents engaging in unprotected sexual encounters can be reduced by 63 percent by providing behaviour skills training (ST. LAWRENCE et al., 1995). Some of the early prevention research trials that started some 15 to 20 years ago with children are now documenting long term significantly positive results on a wide range of behaviour with participants who are now approaching adulthood (OLDS et al., 1997; OLDS et al., 1998).

The prevention of depression in Hispanic low income women in public sector primary health care facilities (MUNOZ et al., 1987) is one of the earliest randomised preventive intervention trials investigated. The intervention consisted of a course in cognitive behavioural methods to gain greater control of mood, and it was successful in decreasing depressive symptoms. The protocol is now adapted for non-minority populations and is being used in both public and private settings in many parts of the world (MUNOZ, 2000).

The above demonstrates some examples of progressive work in the field of promotion/prevention but there are of course many more examples. Increasingly, research methodologies have improved; mental health outcomes are being documented; and more evidence-based promotion and prevention is ready to be moved into practice.

Even more encouragingly »public health experience has shown that when a critical mass of knowledge regarding a specific health problem accumulates and a core group of expert researchers have been identified, the time is ripe for launching a larger, coordinated research and training endeavour«. (MRAZEK & HAGGERTY, 1994) There is growing evidence to suggest that such a time may well have arrived.

In spite of these advantages mental health promotion and the prevention of mental and behavioural disorders is still not practised throughout the world. In many countries treatment services for mental disorders and resources for promotion/prevention are still almost non-existent. »It is urgent we firmly establish mental health in the world's public health agenda.« (Mrs ROSALYNN CARTER, 2000). To do this there must be the political will, but hesitancy occurs when politicians who are more often that not faced by short-term targets and overwhelming difficulties are asked to sign up to initiatives that are long-term strategies. The need to engage in applying these programmes across boundaries of country, culture and economic status is a major challenge we need to address.

2. *International meetings/co-operation to discuss/share projects*

It would be inappropriate to be too pessimistic as there are a range of initiatives that have been taken to try and bring a more international and collaborative approach to these issues. For example, during the 90's the Clifford Beers Foundation organised the series of Annual European Conferences on the Promotion of Mental Health. The meetings helped encourage further

developments and in 1997 the European Commission established the European Mental Health Promotion Network to try to enhance the implementation and dissemination of models of good practice. The Commission has continued to play a leading role in this work, throughout Europe, by encouraging international co-operation on a range of specific issues, e.g. Mental Health Promotion for Children 0 to 6 years and by making it possible on an international basis for researches, clinicians, users and practitioners to collaborate on research and dissemination of ideas and projects.

Building upon the interest generated by the European Conferences, the World Federation of Mental Health (WFMH) and the Clifford Beers Foundation planned a series of world conferences, to be held on a biennial basis. The Inaugural World Conference which was held in collaboration with the Carter Center and co-sponsored by WHO took place in Atlanta in 2000 and was followed two years later by a second one in London. In the field of scientific journals we now have the International Journal of Mental Health Promotion which is a publication with the specific remit to »co-ordinate the dissemination of new research outcomes to all those involved in policy making and the implementation of mental health promotion and the prevention of mental health disorder prevention policies«. The Journal which consistently attracts writers from across the globe is another vehicle used to increase awareness, foster understanding and promote collaboration between different players and different disciplines engaged in promotion/prevention work.

WHO has also taken a major and proactive role in promotion and prevention. For example the World Health Report 2001 was devoted to mental health and the WHO Mental Health Policy and Service Guidance Package, the WHO / VicHealth mental health promotion project and the WHO publication »Prevention and Promotion in Mental Health« (WHO, 2002) have all helped to generate further interest, research and collaboration in the field of mental health promotion and the prevention of mental and behavioural disorders.

3. *Development of the World Consortium for the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders*

In an effort to try to bring and improve co-ordination, harness resources and avoid continual reinventing of the wheel it was proposed that a World Consortium should be commissioned. The idea for such a consortium was first

discussed some five years ago when the early plans for the series of Biennial World Conferences were first discussed, the intention being that the conferences would be part of a more comprehensive programme of such a consortium and would provide the opportunity to examine the work of the consortium, report back on progress since the previous conference and set the agenda for the proceeding two years. This idea was further discussed at Atlanta and London.

The vision has generated significant interest from governmental agencies, NGO's and academic institutions who have repeatedly stressed the need for strengthening the ties and expanding collaborative actions among their organizations worldwide in order to establish better conditions to develop, disseminate and implement evidence-based prevention and promotion in mental health worldwide.

As a result of this growing interest the first meeting of a proposed World Consortium was held in Washington at the end of April 2003, to seek concrete opportunities for common actions and mutual support. The initiative is based on the belief that significant progress worldwide can only be made through more effective collaboration and partnership among relevant international organizations, making optimal use of the strengths of each participating organization. »Many of the activities we need to invest for health gain through health promotion work can only be delivered through partnerships between organisations and organisations and between organisations and communities, to make a significant contribution to the achievement of health gain for local populations. This is done by building effective partnerships....«. (SIMNETT, 1997). The meeting was attended by representatives from a range of organisations including the WFMH, Clifford Beers Foundation, VicHealth, Mental Health Foundation of New Zealand, the World Psychiatric Association, the Society for Prevention and Research, International Union of Psychological Science, Carter Center, World Bank, WHO/PAHO, Ministry for Social Affairs and Health Promotion Group of Finland, International Union for Health Promotion and Education, Centers for Disease Control and Prevention, International Network for Child and Adolescent Mental Health and Schools and Collaborative for Academic, Social and Emotional Learning. In addition there were representatives from a number of US Federal health agencies.

The aim of the meeting was to discuss how the Consortium might be best developed to promote effective partnerships between international

organizations and thereby help contribute to more effective prevention and promotion in mental health across communities, countries and regions.

Specific objectives were to:

- exchange information on each others policies and ongoing and/or planned activities
- identify concrete opportunities for successful inter-organizational collaboration, mutual support and common actions
- find a system for sustainable collaboration between international organizations

Participants stressed that in building partnerships for effective promotion andprevention there must be effective

- collaboration on the core tasks in prevention and promotion
- partnerships at each level: global, regional, national and local
- partnerships across levels (figure 1)

Figure 1: Towards effective collaboration for Prevention and Promotion

In figure 2 we can see that the meeting addressed the issue of international collaboration through the »themes« used in both Atlanta and London, i.e. analysing and examining evidence based programmes from the perspective of:

- research and development
- policy and organization
- dissemination and advocacy

- training to develop competent personnel and
- bringing this work together through effective collaboration within a partnership approach.

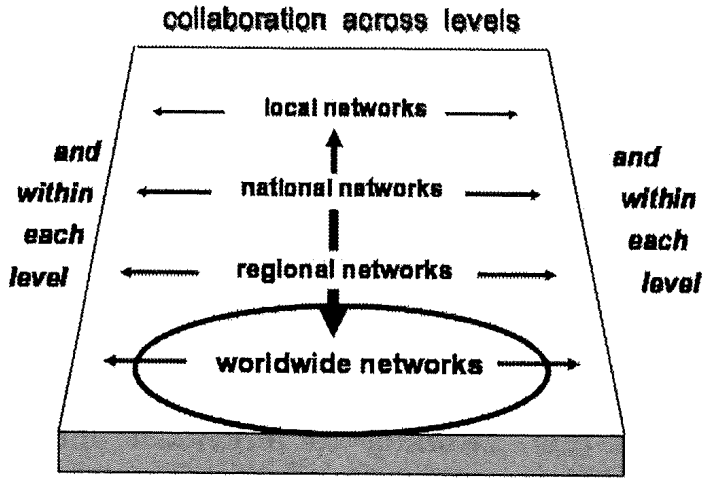

Figure 2: Building a system of effective international collaboration

The discussions raised further issues and although it is not possible to be comprehensive in this presentation, a number of relevant points are set out below:

A Need For Well-Defined and Common Concepts

It was agreed that

- there is a lack of clarity on the relationship between prevention and promotion, and on the way these concepts are used by different organizations. Further work is needed to clarify the language used.
- the conflicts and dilemmas in following prevention versus a mental health promotion approach should be articulated and addressed.

Research and Development

- Successful research projects require sustainable institutional partnerships with communities and settings. Such partnerships need to be established at the commencement of the research project. More sensitivity is needed in respect of the social context of research. Researchers require training and education to develop such partnerships.

- In developing evidence-based prevention and health promotion research consideration must be given to engaging a wider role of stakeholders into the partnerships, e.g. architects, environmental experts, spiritual leaders...Research must also focus on the impact of cultural context on risk and protective factors in mental health, promotion and prevention.

- Different views on standards of Evidence exist between global-wide organisations. There is a need for an ongoing debate between such organizations to achieve a common perspective and/or to highlight issues of difference. The discussion needs to be sensitive to different cultural and economic contexts.

- More resource is required to examine the role of assessment in promotion and prevention (i.e., attuning to individual and environmental risk differences; use of community mental health indicators; epidemiological data, surveillance systems; outcome indicators).

- There is a need to develop an International Network of Research & Development Centres in prevention and promotion of mental health.

- Accessible international databases on e.g. evidence-based interventions that work for specific populations are a priority.

Knowledge Exchange and Knowledge Utilization

- Although numerous relevant websites and electronic newsletters exist across organizations, regions and countries there is a need for better co-ordination, transparency, and accessibility while the issue of »information overload« must be addressed.

- It would be very helpful to establish a Consortium Task Force on databases and a proposal was made to set this up.

- There is the need to identify and disseminate knowledge on effective programmes and policies. In addition, attention should be directed to addressing lessons to be learned from effective interventions and their dissemination and implementation across communities, countries and cultures.

Collaboration on Effective Advocacy

- discussions on the above must pay due recognition to the different stakeholders and
- the roles and aspirations of such stakeholders.

Policy making and Organizational Structures

- The proposed consortium should work towards enhancing collaboration and synergy between the global organisations on issues of policy making in prevention and promotion.

Collaboration on Training and Developing a Competent Workforce

- that a Consortium Task Force on Training and Workforce Development be developed to identify needs across regions, countries and stakeholders, prepare an inventory of existing training programs, make information on existing programmes more accessible and stimulate initiatives to provide increased training opportunities.

Bridging the Gap between Developed and Developing Countries

- There is a need to provide guidance for research within developing countries.
- Bridging the gap between developed and developing countries in the field of promotion and prevention should be a major issue for the Consortium.

The meeting reached a series of conclusions:

Support for the Consortium

- There was unanimous support for the idea of a sustainable global consortium on mental health promotion and prevention of mental disorders.

Identity of the Consortium

- It was considered to be essential that the definition and scope of the proposed Consortium be clarified, i.e. mental health promotion and prevention of mental and behavioural disorders, including the field of substance abuse.

- Clear goals and aims for the Consortium, will be defined as will the explicit »added value« for participating organizations.
- The core tasks of the Consortium: advocacy, research across cultures, and dissemination of knowledge and training will be clarified.

Organizational Structure

- The Consortium will design a clear structure and draft a strategic plan for the next 5 years, for discussion and decision making at the next Consortium meeting.

It would be inopportune not to emphasise that the meeting recognised that discussions were only an initial step in a process to develop further interactive links and collaboration. Although the initial meeting of the proposed consortium did not have the input and participation of a number of groups and agencies whose input will be vital for the success for the consortium, nonetheless this first step marks another important stage in the move to develop a collaborative and co-operative vehicle to enhance mental health promotion and the prevention of mental disorders.

It would be both inopportune and foolish to minimise the task ahead. There is much work to be done. However, on a positive note much has been achieved and especially so over the past decade. We now have the opportunity to build upon a growing momentum. If the opportunity is not fully grasped, we will have much to regret in future years. We can choose to do nothing or recognise,

»*Because of their positive effects in multiple sectors - education, economic and legal for example - the promotion of mental health and prevention of mental and behavioural disorders are in the shared interest of diverse groups of stakeholders. An opportunity exists to develop powerful intersectoral coalitions for promotion and prevention at global, regional, national and local levels.*« (Mrazek & Hosman, 2002).

Förderung von psychischer Gesundheit: Stärkung globaler Partnerschaften

Michael Murray, John Orley (London)

Psychiatrische Gesundheitsversorgung wird seit vielen Jahren zu wenig finanziert und seit Jahren wird das Ausmass und die Prävalenz von psychischen Störungen in unseren Gemeinden unterschätzt. Die Lasten, die durch die Tatsache von psychischen Störungen verursacht werden, sind nicht nur rein finanzieller Natur, sondern entstehen aus individuellem Leiden, Behinderung, erhöhter Sterblichkeit, Verlust von wirtschaftlicher Produktivität, Armut, familiärer Belastung, Kreislauf von Benachteiligung, intellektuellen und emotionalen Konsequenzen für Kinder und vermindertem Zugang zu erfolgreichen Gesundheitsförderungs-, Präventions- und Behandlungsprogrammen. Zusätzlich haftet den Menschen mit schwerer psychischer Erkrankung ein beträchtliches Stigma an. Die Prävalenz von psychischen Erkrankungen bedeutet eine sehr hohe Anforderung an die Ressourcen der Staaten. Es wird die Auffassung vertreten, dass Behandlung alleine die Probleme nicht lösen kann, die von den existierenden psychischen Störungen herrühren. Daher plädieren die Autoren für die Weiterentwicklung von Förderungsprogrammen für psychische Gesundheit und für die Prävention psychischer Erkrankungen.

Auf diesem Hintergrund spielen Gesundheitsförderung und Prävention eine zunehmend wichtige Rolle in der Gesundheitspolitik auf lokaler, nationaler und internationaler Ebene. In den letzten Jahren gab es eine Reihe von Initiativen, die die Zusammenarbeit und Kooperation zwischen Organisationen und Individuen unterstützen, welche in den Berufsfeldern der Förderung psychischer Gesundheit und der Prävention arbeiten.

Dieser Beitrag beschreibt eine Reihe von solchen Projekten und plädiert für verstärkte Aktionen, in denen Menschen, Programme und politische Zielsetzungen zusammengebracht werden. Die Autoren betonen, daß es nicht so sehr der Mangel an Erfahrung, Wissen oder sogar effektiven Programmen ist, die den Fortschritt von Gesundheitsförderung und Prävention behindern, sondern der Mangel an:

- gesammelten Informationen über bereits bestehende Forschung und Programmen

- internationaler Zusammenarbeit und Koordination und
- Management und Planung von Entwicklung, Verbreitung und Einsatz von effektiven Programmen (HOSMAN et al., 1996).

Drei Strategien, die eingesetzt werden, um diese Prozesse zu unterstützen, werden kurz beschrieben:

1. Entwicklung, Evaluation und Verbreitung von Modellen bestmöglicher Praxis (Modellprogramme),
2. Internationale Kongresse, auf denen Projekte diskutiert bzw. gemeinsam umgesetzt werden,
3. Entwicklung des Weltkonsortiums für die Förderung von psychischer Gesundheit und Prävention von psychischen und Verhaltensstörungen.

Weitergehende Diskussionen um die Weiterentwicklung des Konsortiums sollen unterstützt werden, welches als zentrale Stelle für Zusammenarbeit und Kooperation zwischen Individuen, Agenturen und Nationen fungieren soll. Die anfängliche Arbeit an dem Aufbau eines solchen Konsortiums zeigt bereits ermutigende Ergebnisse. Um jedoch erfolgreich zu sein, sind der Input und die Unterstützung einer weit größeren Bandbreite von Organisationen und Menschen erforderlich, die auf diesem Gebiet tätig sind.

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WPA Consensus Statement on Psychiatric Prevention*

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(for the World Psychiatric Association Section Committee on Preventive Psychiatry)

Introduction

Mental illnesses are among the leading causes of disability worldwide. Therefore, psychiatrists and other mental health professionals should put all their effort to decrease the mental health »epidemic« in the society, by preventive and health promotion programs. Conventional, illness based treatment should be broadened to a comprehensive, multidimensional approach to mental health and mental disorders. This includes the enhancement of positive attitudes and reduction of prevailing skepticism regarding the possibility of prevention and cure. Combining illness-focused treatment with health promotion interventions and strengthening positive mental health such as life skills, would decrease psychological distress, enhance quality of life, i.e. self-esteem, mastery of one's life, life satisfaction, competence and psychological adjustment. It would break the spiral of stress, increase psychobiological immunity, and reduce inpatient treatment and stigmatization of people with mental illnesses.

Primary, secondary and tertiary prevention should be only parts of the whole, influencing each other, and not artificial fragments. National and international programs on the protection and promotion of mental health should be comprehensive because these activities are mutually interwoven and pervaded. It is of utmost importance for prevention, promotion and treatment to be continuously led by demystification of mental disorders, investment into healthy potentials of the population and of people at risk. This also includes the investment in healthy potentials of patients, as well as by focusing on health rather than disease.

According to current use, primary prevention can be divided into universal, selective and indicated prevention. Universal prevention refers to interventions that are targeted to the general public or to a whole population group that has

not been identified on the basis of increased risk. Selective preventive interventions are targeted to individuals or groups whose risk of developing mental or behavioural disorders is significantly higher than average, on the basis of the presence of biological, psychological or social risk factors or the absence of protective factors. Indicated prevention targets high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing a mental disorder or biological markers, indicating a predisposition for mental or behavioural disorders, but who do not meet the diagnostic criteria for such a disorder. Not all these persons at risk will actually develop a diagnosable disorder. While in none of these three categories of target persons and populations a diagnosable disorder is yet present according to the DSM-IV and ICD-10 criteria, universal, selected and indicated prevention may be considered as a subdivision of primary prevention. When early signs would be considered as subclinical symptoms, pointing at an already present disorder, indicated prevention would partly overlap with secondary prevention.

Health promotion intervention implies better understanding of the multidimensional origin of mental health and illness and acceptance of the mentally ill, both from their family and their social environment. Promotion of mental health refers to all actions specifically aimed to enhance and strengthen positive mental health. Derived from the Ottawa Charter on health promotion, mental health promotion strategies aim to enable people to increase control over their life and to improve their mental health by developing personal skills and resilience, by creating supportive environments, and by empowering people and communities. Mental health promotion aims to protect, support and sustain emotional and social well-being by promoting factors that enhance and protect mental health, while showing respect for culture, equity, social justice and personal dignity. It also includes a focus at social and economic factors and actions to defend human rights.

However, despite the dictum of conventional wisdom that prevention is better than treatment, as well as the growing body of evidence-based preventive programs that have shown their efficacy, preventive psychiatry is still neglected and marginalized. It is hoped that the WPA will contribute to the promotion and dissemination of the principles of preventive psychiatry and also to a closer international collaboration in this important field. Its activities should be closely linked with the member societies and WPA sections related to prevention, by adhering to the following:

1) Psychiatrists should be actively involved in prevention and health promotion in a multidisciplinary approach to mental health. They should collaborate with other professionals, such as developmental and clinical psychologists, gerontologists, primary care physicians and nurses. In addition to that they should also closely collaborate with people and agencies indirectly involved with mental health (e.g. universities, teachers, clergy, administrators, government, police, journalists and practically every sector of the community).

2) Member societies should influence policy makers to develop comprehensive national preventive programs that would be of benefit to patients, their families and community. Member societies should be involved in national task forces on prevention and development of systems of mental health care services, based on the concept of community care. In preparing national programs, providers, professionals and patients should co-operate.

3) There should be a continuous assessment of priority needs and a follow-up of the needs of communities regarding mental health problems. Assessment of resources at the disposal of each community in the implementation of preventive programs and mental health promotion is also needed.

4) Networks of prevention-oriented services at local and national level covering the needs of the population should be created.

5) Collaboration with other agencies is vital, including non-governmental organisations. Taking into consideration that mental health is a fundamental right, patients should be active participants in the process of prevention. The involvement of the patients is extremely important in determining mental health policy and practice.

6) Links should also be developed between national and international preventive programs. Cooperation between member societies and international exchange of information, experience and evidence-based programs and policies should be encouraged. The WPA sections related to prevention should promote international collaboration between many existing preventive associations so that the best results can be achieved and resources shared.

7) Continuous prevention education and training of the primary care staff, social services, mental health professionals and paraprofessionals should be stimulated. Special attention should be paid to the training of undergraduate and postgraduate students, where prevention of mental health problems should be part of the regular curriculum. As an example, the Core Curriculum in Psychiatry of the WPA, which includes prevention of mental disorders, may be promising in this respect. University-based, multidisciplinary training centers should shape the practitioners and future leaders in the field.

8) Special attention should be paid to dissemination of information on prevention to the individuals, families and population at large, through special programs and with the assistance of mass media.

9) Research on the efficacy of preventive programs is very important. There should be a continuing development and rapid translation into practice of the scientific evidence base for preventive programs. Both scientific research and consensual experience should guide this process. Support should be given to the development of an accessible database to disseminate available evidence-based programs and strategies, and to stimulate their worldwide implementation. Multicentric studies should be stimulated and coordinated by the member associations and the WPA.

10) Legal and other regulations should be adjusted to offer support to preventive programs and facilitate their implementation. Member societies should offer assistance in this important task.

11) Programs of prevention of mental disorders and mental health protection and promotion should be incorporated in public health policies, in programs of promotion of health in general as well as in the program of socio-economic development of a country as a whole.

Primary Prevention

Primary, secondary and tertiary prevention should be parts of a comprehensive approach to health and illness. For reasons of convenience, they are separated here.

1) It is estimated that in many countries one third to one half of all mental disorders could be averted by primary prevention measures. There is a current emphasis worldwide on universal, selective and indicated prevention, all directed at populations, groups or individuals before the occurrence of a diagnosable disorder. They are parts of primary prevention aiming at improvement of mental health of the population at large, promotion of positive mental health, and protection of sub-groups at higher risk of developing mental disorders.

2) Identification of high-risk groups should be an important aim of preventive psychiatry, as well as applying adequate strategies to these groups at all developmental stages, which should include the following: early stage care, before delivery; healthy start of life; high-quality parenting; care for the children of mentally ill or addicted parents; mental health promotion in schools; upholding of family cohesion (with close cooperation of mental health professionals and family physicians); prevention at the work place; life skill education of the population; prevention in old age, etc.

3) Extensive and rapid socio-economic changes in many countries are followed by numerous factors which can be detrimental to health in general and particularly on mental health of the population. Developing societies as well as societies in transition undergoing social and economic upheavals should be helped by developed countries in implementation of preventive programs.

4) Natural and man-made disasters are unfortunately frequent, and far from eradicated, especially the latter. Wars, terrorism, growing violence in many countries, made life of many populations extremely difficult. Experiences of psychological trauma may be deleterious to health, causing various forms of posttraumatic stress or psychosomatic disorders, and an increased morbidity in whole due to a suppressed psychobiological

immunity. If not prevented, psychosocial consequences of man-made disasters can lead to a spiral of stress and violence as well as a serious late consequence such as transgenerational transmission of trauma. Although most frequently the population at large is exposed to trauma, some population groups are particularly endangered, such as children, the elderly, incomplete families, unemployed, the poor, migrants, etc. These groups at risk require intensive programs of prevention. Therefore, a systematic education of health care workers and their associates in the field of disaster psychiatry should be given priority. There is a necessity of preparing national programs for prevention and mitigation of psychosocial consequences of disasters. This could be done in collaboration with the WHO, WPA task force on disasters and with the relevant WPA Sections.

Secondary Prevention

1) Early recognition and effective management of mental disorders, especially at the level of primary health care, is essential to prevention. Primary care physicians must be adequately trained in mental health problems. Appropriate guidelines like the WHO ICD-10 Primary Care Guidelines and other aids, including screening procedures, may be helpful in this context. Local task forces on prevention should undertake continuous education, in cooperation with universities and policy makers.

2) Treatment and prevention of many disorders (depression, eating disorders, posttraumatic stress disorder, personality disorders, substance abuse, etc.) with high public health significance, i.e. deleterious effects on the immediate (micro) and wider (macro) environment, should be part of extensive community programs.

3) Public awareness should be raised in early detection of symptoms and a need for a prompt intervention. Primary care physicians, staff of medical and other services, the individuals and their families, and community at large should be helped in learning how to recognize mental disorders.

4) Dissemination of information is useful for health promotion. The education of medical staff and nonprofessional caregivers concerning life

stresses, which are likely to act as precipitating events for relapse of mental disorders, as well as training in stress management, is of a great importance.

5) Burnout affects great percentage of mental health professionals, in both developed and developing countries, especially the latter. It affects personal well-being and professional performance. Therefore it is important to undertake preventive measures against its development, such as strategies focused on individual and organization.

6) Services should involve patients to ensure that support is relevant to their needs as they see them. Self-advocacy and self-help schemes may enable patients to help one another. Partnership in treatment, instead of passivity should be encouraged. The traditional paternalistic attitude should be overcome and sharing encouraged.

Tertiary Prevention

Objectives of tertiary prevention, or enabling patients, are extremely important and should be part of comprehensive care. WPA has set them as important priorities in many of its tasks, including a Section on Rehabilitation. According to many preventionists it should not be put on the agenda of modern prevention since it should be part of a normal psychiatric care. However, it is mentioned here for reasons of still domineering traditional views in medical circles. In addition to this, it seems that rehabilitation is still neglected, especially in developing countries.

Most mental disorders require a prompt application of rehabilitation measures from the very initiation of treatment. Rehabilitation should have highly set goals. It should increase competence of the patients and their creative reintegration into community. Families and all relevant community factors, such as decision makers, should be engaged in the successful implementation of rehabilitation. Community-based care, i.e. maintaining the patient in the most natural environment should be stimulated. Rehabilitation services, aiming at reducing disability produced by mental health disorders should be developed in adequate numbers.

Destigmatization**

Destigmatization is widely recognized as a goal and task that should be supported by all psychiatrists and other mental health professionals, including those involved in traditional treatment. Although it is currently a core topic on the international agenda of psychiatry, the implementation of destigmatization activities needs full support across regions and countries. It will take time to eradicate stigma which is attached to mental illnesses and not infrequently to psychiatry as well. Destigmatization should be an element in all phases of prevention and in all forms of psychiatric treatment and care. It should be part of special programs, covering the families, the public, and the professionals. In this important aspect of prevention, the WPA task forces and sections should be actively involved and should collaborate closely with member societies.

Concluding Comments

Over the last two decades much progress has been made in the development of knowledge on determinants of mental health and mental disorders and in the development of practice- and theory driven evidence-based preventive programs. Psychiatry has a lot to contribute to this field and should take advantage of the rapidly developing multidisciplinary field of prevention and health promotion science.

International collaboration, harmonization, integration and unification of preventive and treatment models are among the key words of contemporary psychiatry. However, these words, popular at the time of prevailing globalization are only theoretical labels for a large part of the world. "Health for All" is a wonderful dictum that is unfortunately a utopian goal for many psychiatric communities. Prevention and health promotion are most important, but complex tasks. They are difficult to carry out in many countries with more demanding priorities, determined by socioeconomic problems or adverse conditions like disasters, war, violence, or sanctions. Many of them do not have the means to obtain even the cheapest medication for individuals with mental disorders. Mental health professionals in these countries are sharing adversities with their patients. They are often burnt out, isolated and deprived of possibilities of participating at the international professional scene.

The possibility to apply preventive and health promotion models varies as a function of many factors involving economic development, professional re-

source availability, national priorities and the particular culture. Globalization should include understanding and assistance to developing countries. Unless these countries are helped, modern psychiatry and international organizations will remain elitistic and their accepted goals and intentions only declarations without a wider impact. The WPA task forces and sections could help member societies by sharing relevant and effective models of prevention adjusted to specific needs of each population, as well as by providing teaching material and advocacy.

* The basic version of this Consensus Statement was approved by the WPA General Assemblyin Yokohama, Japan, August 2002. It was lightly edited afterwards by a task force of the WPA Section on Preventive Psychiatry.

** Sometimes also referred to as quaternary prevention.

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Ankündigungen

123. Gruppendynamische Selbsterfahrung in Paestum / Süditalien

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3rd International Conference Ethics-Education in Medical Schools

Datum:	March 21 - 25, 2004
Ort:	Eilat, Israel; Hilton Queen of Sheba Hotel
Organized by:	UNESCO
Infos:	www.isas.co.il/medethics2004

1st International Conference on Psychiatry, Law and Ethics

Datum:	March 23 - 25, 2004
Ort:	Eilat, Israel; Hilton Queen of Sheba Hotel
Organized by:	WPA, Section on Psychiatry, Law and Ethics
Leiter:	Prof. A. Carmi
Infos:	ISAS International Seminars
	POB 574, Jerusalem 91004, Israel
Tel:	9 72 - 2 - 6 52 05 74
Fax:	9 72- 2- 6 52 05 58
e-mail:	seminars@isas.co.il

14. Weltkongreßder World Association for Dynamic Psychiatry WADP XXVII. Internationales Symposium der Deutschen Akademie für Psychoanalyse

Leitung:	Prof. Modest M. Kabanow M.D.; Dipl.-Psych. Dr. phil. Maria Ammon
Titel:	Trauma, Bindung und Persönlichkeit – Dynamische Aspekte
Ort:	Jaggellonian Universität Krakau, Polen
Datum:	16. - 19.3.2005
Information:	Lehr- und Forschungsinstitut der Deutschen Akademie für Psychoanalyse (DAP); c/o Dipl.-Psych. Sylvelin Römisch, Goethestr. 54, D-80336 München;
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Unsere nächste Ausgabe Heft 1/2 2004 wird unter der Herausgeberschaft des Guest Editors Dipl.Psych. Gabriele von Bülow (Berlin) erscheinen zum Thema »Dualismus und Destruktivität« mit philosophischen, soziologischen und psychoanalytischen Beiträgen namhafter Autoren.

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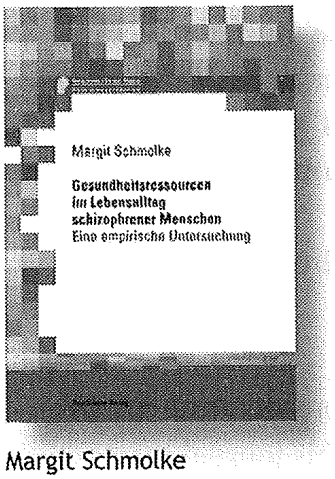
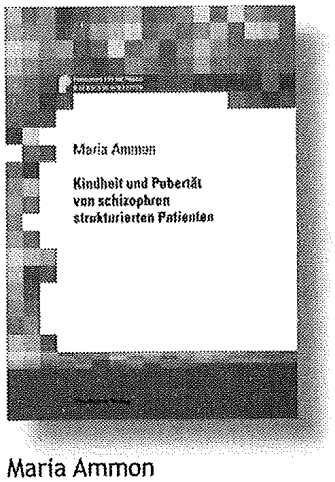


Margit Schmolke
Gesundheitsressourcen im Lebensalltag schizophrener Menschen
Eine empirische Untersuchung
ISBN 3-88414-276-3
368 Seiten,39.90 Euro

Mit den hier vorgestellten Konzepten der Gesundheitsförderung und der Salutogenese wird ein neuer Blick auf das Erleben von schizophrenen Menschen geworfen. Anhand qualitativer und quantitativer Forschungsmethoden belegt die Autorin, dass den Betroffenen eine Vielzahl von gesunden Anteilen und Ressourcen in ihrem Lebensalltag neben oder trotz ihrer Erkrankung zur Verfügung stehen und sie ihr keineswegs - wie so oft angenommen - hilflos ausgeliefert sind, sondern ihr Leben zu gestalten vermögen.
In einer Zeit, in der die Medikalisierung der Psychiatrie und Klinischen Psychologie zunehmend den klinischen Alltag bestimmt, ist ein Menschenbild, das den Patienten nicht zum bloßen Träger einer Krankheit reduziert, umso notwendiger. Dazu liefert diese Arbeit einen wichtigen Beitrag.



Maria Ammon
Kindheit und Pubertät von schizophren strukturierten Patienten
ISBN 3-88414-321-2
272 Seiten, 39.90 Euro

Vor dem Hintergrund der unterschiedlichen Hypothesen zur Pathogenese der Schizophrenie liefert Maria Ammon eine qualitative Untersuchung der frühen Lebensgeschichte von schizophren erkrankten Patienten und deren Familien.
Das Herzstück der Arbeit bilden biografische Interviews mit sechs schizophren erkrankten Menschen und ihren nächsten Bezugspersonen. Anliegen ist, das familiäre Umfeld in Bezug auf das Beziehungsgeschehen, das Erleben von wichtigen Lebensabschnitten wie Kindergartenbesuch, Schule und Pubertät und schließlich den Umgang mit Körperlichkeit, Sexualität und Emotionen aus den unterschiedlichen subjektiven Blickwinkeln abzubilden.
Im Ergebnis geht es der Autorin darum, die Erkrankung familiendynamisch zu verstehen, aber nicht, um Schuldzuweisungen vorzunehmen und etwa statt der »schizophrenogenen Mutter« die »schizophrenogene Familie« zu entwerfen, sondern die Bedingungen schizophrener Erkrankungen zu beleuchten, um Alternativen zur Prophylaxe und Hilfestellungen für die Familien zu entwickeln.

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