CHAPTER 3

Future directions in mental health promotion and public mental health

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Chapter overview

This chapter covers:
- The emergence of mental health promotion as a discipline;
- Different definitions of mental health promotion;
- Public mental health and population approaches;
- Mental health promotion and recovery.

It concludes by highlighting three key challenges for the future of mental health promotion and public mental health:
- mainstreaming;
- putting inequalities at the centre of the mental health promotion agenda;
- resisting a focus on individual interventions and solutions.

Introduction

Mental health promotion can be described very simply as: any action to improve mental health. At the same time, mental health promotion is one of the most complex and contested fields of public health. It is emerging as a topic of considerable policy and public interest, intersecting with current debates about happiness, quality of life and emotional well-being, notably of children (Huppert 2005; Friedli in press). It also prompts challenging questions about the medicalization of sadness, disappointment, anger and frustration (Horwitz and Wakefield 2007).

The literature on mental health promotion reflects broader conflicts about the meaning of mental health, the determinants of mental illness and how society should respond to people experiencing mental health problems. The theory and practice of mental health promotion
cannot be separated from how people with mental health problems have been treated, both within the community and by the medical professions and criminal justice system. People’s experiences of compulsory admission, detention, medication and other treatments, and mental health services generally, continue to be central to thinking about all aspects of mental health.

The contested nature of mental health promotion and what it means to be mentally healthy echoes similar debates on conformity and diversity within the civil rights movement, the women’s, gay and black liberation movements and the disability rights movement. While there may be broad agreement that improving mental well-being is a worthwhile goal, there is far less consensus on the ethics and potential consequences of a prevention agenda. There are concerns about wider civil liberties issues, if the goal of interventions is to eliminate all disorders of the mind, in the same way that the disability rights movement challenges attempts to eliminate all conditions that result in physical disabilities.

As the field of mental health promotion expands to include positive mental health, there are further questions about the relative contribution to mental well-being of individual psychological skills and attributes (e.g. autonomy, positive thinking, self efficacy) and the circumstances of people’s lives: housing, employment, income and status. These debates are relevant to all aspects of health and health care and raise challenging questions for the practice of nursing.

### Mental illness to mental health: the emergence of mental health promotion as a discipline

Recent years have seen a marked shift in the debates about mental health, from a predominant focus on mental illness to an analysis of the importance of mental health and well-being to overall health (Jane-Llopis and Anderson 2005; Mental Health Foundation 2005). This shift is evident across the UK and in Europe, notably in the World Health Organization (WHO) Europe Declaration4 and the European Union (EU) Green Paper on Mental Health (European Commission 2006).

This is in part a result of a growing policy acknowledgement of both the economic and public health case for a greater focus on promotion and prevention. The Wanless Report, for example, argues that the assessment of population health should move beyond morbidity and mortality data, to the inclusion of measures of positive physical and mental health. ‘A health service, not a sickness service’ has become an increasingly significant catch phrase for the direction of NHS policy (Wanless 2002, 2004). It is also related more specifically to the costs of mental illness and the limited effectiveness of treatment: it is calculated that the overall cost of mental health problems in the UK amounted to over £110 billion in 2006/7 (Friedli and Parsonage 2007).5

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4 The WHO European ministerial conference on mental health, in Helsinki in January 2005, brought together all 52 countries in the European region of the WHO. Organized in partnership with the European Union and the Council of Europe, the conference’s declaration and action plan will drive the policy agenda on mental health for the coming years (WHO 2005) http://www.euro.who.int/document/mnh/edoc07.pdf; http://www.euro.who.int/document/mnh/edoc06.pdf.

5 Northern Ireland’s share of the total is put around £3.5 billion, reflecting a prevalence rate for mental health problems which is 20-25 per cent higher than in the rest of the UK.
Although the situation across the UK varies, all four countries have a policy commitment to mental health promotion, with perhaps the most comprehensive approach in Scotland, through the National Programme for Improving Mental Health and Well-being, launched in 2001 (http://www.wellscotland.info/mentalhealth/national-programme.html). This includes an ambitious attempt to develop indicators of mental health, to complement existing indicators of mental illness. The Welsh Assembly has published its Mental Health Promotion Action Plan for Wales: consultation document (Welsh Assembly 2006), which requires each local health board to develop a mental health promotion strategy by 2007/8. Meanwhile in Northern Ireland, the Bamford Review on mental health promotion (Bamford 2004; DHSSPS 2006), states:

“We also want to see a society where everyone plays a role in and takes action to create an environment that promotes the mental health and well-being of individuals, families, organizations and communities” (DHSSPS 2006).

In England, the publication of the National Service Framework for Mental Health (DH 1999) marked a significant turning point. For the first time, health and social services were required to: ‘promote mental health for all, working with individuals, organizations and communities’ as well as to tackle the stigma, discrimination and social exclusion experienced by people with mental health problems. This commitment was reinforced in the White Paper Choosing Health (DH 2004a) and in Our Health, Our Care, Our Say:

“We will ensure that standard one of the NSF for Mental Health, which deals with mental health promotion, is fully implemented.”

“We will have delivered if we improve the mental health and well-being of the general population.” (DH 2006)

Guidance to support delivery of mental health promotion, through the development of local mental health promotion strategies, was first published in 2001 (DH 2001), although tackling discrimination and social exclusion has tended to receive a stronger focus than promoting mental health for all (Social Exclusion Unit 2004; NIMHE 2004).

Louis Appleby, National Director for Mental Health remarked on lack of progress on Standard One and in his report The National Service Framework for Mental Health: Five Years On, noted: ‘We need to broaden our focus from specialist mental health services to the mental health needs of the community as a whole’ (DH 2004b).

The launch of Making it Possible: Improving mental health and well-being in England (NIMHE 2005) can be seen as an effort to achieve this broader focus and to provide greater leadership and support for a population wide approach to improving mental health. Making it Possible sets a framework for action to:

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raise public awareness of how to look after our own mental health and other people’s;
involve all communities and organizations, across all sectors, in taking positive steps to
promote and protect mental well-being.

It argues that improving the mental health of the population will contribute to achieving a
wide range of cross-government priorities for children and adults and to meeting Public
Service Agreement (PSA) targets in health, education, neighbourhood renewal, crime,
community cohesion, sustainable development, employment, culture and sport. The
framework sets out nine priorities for action (Box 3.1).

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<tr>
<th><strong>Box 3.1 Public mental health: key areas and measures of success</strong></th>
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<td><strong>Action: marketing mental health</strong></td>
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<td>People are well informed and motivated to look after their own and others’ mental</td>
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<td>health</td>
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<td>People have positive and accepting attitudes to people with mental health problems</td>
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<td><strong>Action: equality and inclusion</strong></td>
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<td>People have access to a wide range of sources of support for emotional and</td>
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<td>psychological difficulties</td>
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<td>Reduction in inequalities in access to non-pharmacological sources of support, notably</td>
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<td>for black and minority ethnic communities and older people</td>
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<td><strong>Action: tackling violence and abuse</strong></td>
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<td>Reduction in prevalence of mental health problems</td>
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<td>Reduction in self-harming behaviour</td>
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<td><strong>Action: parents and early years</strong></td>
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<td>Parents and caregivers have the knowledge, skills and capacity to meet the emotional</td>
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<td>and social needs of infants and young children</td>
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<td>Parents and carers have access to support for themselves and their parenting roles,</td>
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<td>delivered in a way that is evidence-based and meets their needs</td>
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<td><strong>Action: schools</strong></td>
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<td>Schools achieving National Healthy Schools Status targets and delivering SEAL</td>
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<td><strong>Action: employment</strong></td>
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<td>Reduction in mental health related unemployment</td>
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<td><strong>Action: workplace</strong></td>
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<td>Workplaces adopt HSE stress management standards</td>
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<td>Support in place to enable people off work with mental health problems to return to</td>
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<td><strong>Action: communities</strong></td>
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<td>Improved quality of life and life satisfaction</td>
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<td>Increase in the proportion of local areas with a high ‘liveability’ score</td>
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<td><strong>Action: later life</strong></td>
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<td>Improved life satisfaction among older people</td>
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<td>Increased opportunities for older people to participate</td>
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(NIMHE 2005)
In the European Union, the focus on promotion and prevention has been given a strong impetus by the WHO European Mental Health Declaration and Action Plan and the positive response to the consultation for the EC Mental Health Green Paper, including a warmly supportive Resolution by the European Parliament (European Commission 2006; European Parliament 2006; Stahl et al. 2006). Two important themes emerge:

- The social and economic prosperity of Europe will depend on improving mental health and well-being.
- Promoting mental health, i.e. building communities and environments that support mental well-being, will deliver improved outcomes for people with mental health problems.

This focus on the benefits of positive mental health is matched by WHO research demonstrating the value of a focus on assets, as opposed to a deficit model and a call for more studies on the determinants of health, as distinct from studies on the determinants of illness.


"Mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens."

European Commission Social Agenda 2005–2010
http://ec.europa.eu/employment_social/social_policy_agenda/social_pol_ag_en.html

"The mental health of the European population is a resource ... to put Europe back on the path to long-term prosperity."

Defining terms: what is mental health promotion?

The difficulty of agreeing a common language and shared definitions of both mental health and mental health promotion is widely acknowledged (Tudor 1996). Mental health, mental well-being, emotional well-being, emotional literacy, well-being and quality of life may be used more or less interchangeably and/or may have very different meanings and significance in different sectors.

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8 The case for promotion and prevention has also been strengthened by the publication of two major WHO reports highlighting emerging evidence of effectiveness (WHO 2004a, 2004b).
9 WHO defines a health asset as any factor (or resource) that enhances the ability of individuals, communities, populations etc. to maintain health and well-being. Evidence shows that interventions to maximize and take advantage of health assets can counter negative social and economic determinants of health, especially among vulnerable groups. The result is improved health outcomes (http://www.euro.who.int/socialdeterminants/assets/20050623_1?language=French

Mental health promotion is an umbrella term that may include action to promote mental well-being, to prevent mental health problems and to improve quality of life for people with a mental illness diagnosis.

Mental health promotion is both any action to enhance the mental well-being of individuals, families, organizations and communities, and a set of principles which recognize that how people feel is not an abstract and elusive concept, but a significant influence on health.

(Friedli 2000)

Mental health promotion is essentially concerned with:
- how individuals, families, organizations and communities think and feel;
- the factors which influence how we think and feel, individually and collectively;
- the impact that this has on overall health and well-being (Friedli 2000).

Mental health promotion can be seen as a kind of immunization, working to strengthen the resilience of individuals, families, organizations and communities, as well as: to reduce conditions which are known to damage mental well-being in everyone, whether or not they currently have a mental health problem.

(Health Education Authority 1998)

Recognition of the socio-economic and environmental determinants of mental well-being has led to a growing emphasis on models of mental health promotion that work at different levels, for example:
- strengthening individuals – by increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills;
- strengthening communities – by increasing social support, social inclusion and participation, improving community safety, neighbourhood environments, promoting childcare and self-help networks, developing health and social services which support mental health, improving mental health within schools and workplaces, e.g. through anti-bullying strategies and mental health strategies.
- reducing structural barriers to mental health – through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable (Health Education Authority 1997; DH 2001).

Reducing structural barriers to mental health and introducing policies which protect mental well-being will benefit those who do and those who do not, currently have mental health problems, and the many people who move between periods of mental health and mental illness.

(Department of Health 2001)

One of the most significant debates about mental health promotion concerns the balance between interventions which focus on strengthening individuals and those which address the
wider determinants of mental health. It has been argued that focusing on emotional resilience or life skills, for example, may imply that people should learn to cope with deprivation and disadvantage (Secker 1998).

**Current debates: population approaches and public mental health**

Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients. Epidemiology (from epidemics) is the study of the distribution and determinants of health. Key themes in public health include addressing the root causes of illness, tackling the inequalities which are at the heart of large variations in health and public participation.

What is sometimes called the new public health is particularly concerned with the wider determinants of health and overlaps with ecological public health, which emphasizes the common ground between health and sustainable development.

Public mental health takes a population wide approach to understanding and addressing risk and protective factors for mental health:

"Public mental health, (of which mental health promotion is one element), provides a strategic and analytical framework for addressing the wider determinants of mental health, reducing the enduring inequalities in the distribution of mental distress and improving the mental health of the whole population.

(Friedli 2004: 2)"

"How people feel is not an elusive or abstract concept, but a significant public health indicator; as significant as rates of smoking, obesity and physical activity.

(DH 2001)"

A population wide approach to promoting mental health for all has been used to make the case for the benefits both of improving mental health and preventing mental health problems. In addition it has been argued, applying the principle of ‘herd immunity’, that the more people in a community (e.g. a school, workplace or neighbourhood) who have high levels of mental health (i.e. who have characteristics of emotional and social competence), the more likely it will be that those with both acute and long-term problems can be supported (Stewart-Brown 1998; Blair et al. 2003: 143).

Huppert, using the Keyes classification (languishing, moderate mental health, flourishing etc.), applies the work of Rose (1992) to argue for shifting the whole population in a positive direction (Figure 3.1):

- By reducing the mean number of psychological symptoms in the population, many more individuals would cross the threshold for flourishing.
- A small shift in the mean of symptoms or risk factors would result in a decrease in the number of people in both the languishing and mental illness tail of the distribution (Huppert and Whittington 2003; Huppert 2005).
This model has been criticized for implying that people with a mental disorder cannot also be flourishing and it is worth noting that Keyes and others have found that individuals who fit the criteria for a DSM mental disorder may have the presence of mental illness plus the absence of mental health, or in some cases may have moderate mental health or be flourishing (Gilleard et al. 2005; Keyes 2005). Nevertheless, it does demonstrate the potential of applying public health models to mental health promotion.

A UK population study in 1993 of participants in the Health and Lifestyle Survey found that the prevalence of mental disorders was directly related to the mean number of symptoms in the sub-population (excluding those with a disorder). In a seven-year longitudinal follow-up, Whittington and Huppert showed that the change in the mean number of symptoms in sub-populations (excluding those with a disorder) was highly correlated with the prevalence of disorders (Whittington and Huppert 1996). For this reason, Huppert suggests that population-level interventions to improve overall levels of mental health could have a substantial effect on reducing the prevalence of common mental health problems, as well as the benefits associated with moving people from ‘languishing’ to ‘flourishing’ (Huppert 2005).

Keyes argues that when compared with those who are flourishing, moderately mentally healthy and languishing adults have significant psychosocial impairment and poorer physical health, lower productivity and limitations in daily living (Keyes 2004, 2005). Keyes found that cardiovascular disease was lowest in adults who were the most mentally healthy, and higher among adults with major depressive episodes, minor depression and moderate mental health (Keyes 2004). This is consistent with review level evidence that CHD risk is directly related to the severity of depression: a one- to two-fold increase in CHD for minor depression and a three- to fivefold increase for major depression (Bunker et al. 2003).

In other words, intermediate levels of mental health are different from mental illness as well as from flourishing. Other research has shown that positive effect and negative effect have a degree of independence in the long term (Diener et al. 1995).

In a parallel analysis of adolescents (using measures of emotional well-being, psychological well-being and social well-being as three distinct but correlated factors), Keyes found that prevalence of conduct problems (arrests, truancy, alcohol, tobacco and marijuana use) decreased and measures of psychosocial functioning (self-determination, closeness to others and school integration) increased, as mental health increased. Based on his findings,
he argues that children without mental illness are not necessarily mentally healthy. Flourishing youth were found to be functioning better than moderately mentally healthy or languishing youth (Keyes 2006).

**What is positive mental health?**

There is ongoing debate about what might be called a ‘diagnosis of mental health’ and what constitutes the necessary or sufficient elements making up positive mental health and well-being, although there is widespread agreement that mental health is more than the absence of clinically defined mental illness (WHO 2004a, 2004b).

Broadly, the literature distinguishes between two dimensions of ‘well-being’ or ‘positive mental health’:

- *hedonic*: positive feelings or positive effect (subjective well-being);

Keyes describes the combination of positive feelings and positive functioning as ‘flourishing’, with individuals exhibiting at least seven of thirteen elements of subjective well-being described as flourishing (Keyes 2002). Others categorize the key elements slightly differently, e.g. a sense of autonomy, a sense of competence and a sense of relatedness (Ryan and Deci 2001). Lyubomirsky et al. (2005) focus on the experience of frequent positive emotion and less frequent (but not absent) negative emotion.

Clearly, how positive mental health is defined influences how it is measured. Well-being, for example, may be assessed through either subjective measures (self-assessed, e.g. responses to social survey questions on life satisfaction, quality of life, happiness etc.) and/or objective measures of factors known to influence well-being, e.g. crime, environment, housing, debt. Much of the current debate about well-being is driven by different views on the relative importance of:

- material factors (income, housing, employment);
- psycho-social factors or attributes (relationships, life satisfaction, positive effect, cognitive style);
- the influence of material inequalities on people’s subjective well-being (Wilkinson 2005; Eckersley 2006; Pickett et al. 2006).

For example, the Sustainable Development Commission proposes indicators of social well-being that include individual subjective well-being, as well as some measure of ‘fairness’ or social justice (Marks et al. 2006).

There is also growing interest in well-being generally (sometimes referred to as the ‘happiness debate’), and in how a ‘well-being focus’ might influence the future direction of UK policy on the economy, health, education, employment, culture and sustainable development (Callard and Friedli 2005; Marks et al. 2006). The UK Government’s Office of Science and Innovation is conducting a wide-ranging review of Mental Capital and Mental

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11 The terms ‘well-being’ and ‘positive mental health’ are largely synonymous in the literature and are frequently used interchangeably.

Well-being as part of its Foresight programme. DEFRA has commissioned a number of major reports on different aspects of well-being, including a review of influences on personal well-being and the relationship between sustainable development and well-being. What all these developments have in common is an interest in the relationship between positive mental health and improved outcomes across a very wide range of domains, including health, health behaviour, education, crime, relationships, employment, productivity and quality of life (Friedli in press).

Beyond stigma – the contribution of mental health promotion to the recovery agenda

Although in practice, mental health promotion interventions often focus on prevention, there is general agreement that mental health is more than the absence of mental illness:

“Everyone has mental health needs, whether or not they have a diagnosis. These needs are met, or not met, at home, in families, at work, on the streets, in schools and neighbourhoods, in prisons and hospitals – where people feel respected, included and safe, or on the margins, in fear and excluded."

(DH 2001: 28)

“Mental health is the emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others’ dignity and worth."

(HEA 1997: 7)

The definition of mental health as a ‘positive sense of well-being’ challenges the idea that mental health is the opposite of mental illness. For example, someone with a diagnosis of schizophrenia might feel supported, at ease and optimistic. They might be coping well with life and enjoying a high level of well-being. Equally, many people who are not clinically diagnosed have a poor sense of well-being (Gilleard et al. 2005).

The focus on health, rather than illness, and the view that a diagnosis is not inconsistent with mental well-being is one example of the way in which mental health promotion has been informed by, and also contributed to, ideas about recovery. Recovery has been defined as what people need in order to hold on to or regain a life that has meaning for them (Anthony 1993) and aims to enable people with mental health problems to:

- maintain existing activities and relationships;
- reduce the barriers that prevent people from accessing new things they want to do;
- gain access to the material resources and opportunities that are their right (Bates 2002; Perkins 2002; Sayce 2002).

13 www.foresight.gov.uk
14 http://www.sustainable-development.gov.uk/what/latestnews.htm#1n210906
Although the reform of mental illness services and addressing the stigma, discrimination and denial of human rights and civil liberties experienced by people with mental health problems remain central, these goals are now also being considered in the context of public mental health. This is an important development because the focus on stigma and discrimination has tended to preclude a wider debate about factors that are toxic to mental health, whether or not one has a diagnosis. We have a wealth of data on public attitudes to mental illness (Braunholtz et al. 2007), but very little on public knowledge of what harms and hinders mental well-being: the mental health equivalents of smoking and car exhaust fumes (Friedli et al. 2007).

These questions are central in considering some of the potential problems with ‘raising awareness’ campaigns, which have been at the heart of much mental health promotion activity (Gale et al. 2004). At root, these invite the public to adopt a medical explanation for their problems and to seek medical help, while also, usually through case studies or first person accounts, highlighting the consequences of the disorder: stigma and exclusion. They do not invite reflection on economic and environmental causes.

### Future opportunities and challenges

The policy environment for mental health promotion has probably never been more favourable as the potential social, economic and environmental costs of not paying greater attention to how people think, feel and relate generate greater interest and debate. Improving mental health, i.e. promoting the circumstances, skills and attributes associated with positive mental health, is now widely seen as a worthwhile goal in itself and also as:

- contributing to preventing mental illness;
- leading to better outcomes, for example in physical health, health behaviours, educational performance, employability and earnings, crime reduction (NIMHE 2005).

There is growing evidence that these beneficial outcomes are not just the result of the absence of mental illness, but are due, wholly or in some degree, to aspects of positive mental health. For example subjective well-being is associated with increased longevity, provides a similar degree of protection from coronary heart disease to giving up smoking, improves recovery and health outcomes from a range of chronic diseases and in young people, significantly influences alcohol, tobacco and cannabis use. Positive effect also predicts pro-social behaviour, e.g. participation, civic engagement and volunteering (Friedli and Parsonage 2007).

### Mainstreaming

‘Mainstreaming’ has long been a holy grail for mental health promotion: gaining cross-sector/cross-government ownership is crucial to securing the long-term investment that public mental health requires. But developments in policy and the prevailing zeitgeist suggest that this is already happening.\(^{15}\) The factors that influence how people think and feel – in

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\(^{15}\) See for example David Cameron’s speech to Google Zeitgeist Europe 2006 [http://politics.guardian.co.uk/conservatives/story/0,1780585,00.html](http://politics.guardian.co.uk/conservatives/story/0,1780585,00.html)
schools, in the workplace, in the delivery of services, in the built and natural environment and in local communities – are becoming mainstream concerns, even if they are not labelled mental health promotion. There is growing evidence of grass-roots mobilization against global and local trends that are seen as toxic to well-being, often in expressed in concerns about work-life balance, the environment, the neglect of children and older people and the anti-poverty movement (Friedli 2005).

Other issues high on the policy agenda that provide opportunities to call for greater focus on mental health promotion include alcohol, violence, parenting, worklessness, anti-social behaviour and a perceived decline in ‘respect’. These issues also provide opportunities to build partnerships with non-health sectors – probably the most pressing priority.

Putting inequalities at the centre of mental health promotion theory and practice

Poor mental health is both a cause and a consequence of the experience of social, economic and environmental inequalities (Rogers and Pilgrim 2003; Social Exclusion Unit 2004; Melzer et al. 2004). As Rogers and Pilgrim have noted in relation to the oft-cited prevalence figures for mental health problems: one in four yes, but not any one in four (Rogers and Pilgrim 2003). Mental health problems are more common in areas of deprivation and poor mental health is consistently associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events. Lone parents, those with physical illnesses and the unemployed make up 20 per cent of the population, but these three groups contribute 36 per cent of all those with neurotic disorders, 39 per cent of those with limiting disorder and 51 per cent of those with disabling mental disorders (Melzer et al. 2004).

Rogers and Pilgrim (2003) highlight three key issues in understanding the mental health impact of socio-economic inequalities:

- social divisions – mental health problems both reflect deprivation and contribute to it;
- social drift – the social and ecological impact of adversity, including the impact of physical health problems and the cycle of invisible barriers which prevent or inhibit people from benefiting from opportunities;
- social injuries – mental distress as an outcome of demoralization and despair.

A preliminary analysis by Pickett et al. (2006) suggests that higher national levels of income inequality are linked to a higher prevalence of mental illness and, in contrast with studies of physical morbidity and mortality, as countries get richer rates of mental illness increase.

Richard Wilkinson’s work analyses deprivation as a catalyst for a range of feelings which influence health through physiological responses to chronic stress, through the damaging impact of low status on social relationships and through a range of behaviours seen as a direct or indirect response to the social injuries associated with inequalities (Wilkinson 1996, 2005). More recent analysis suggests a significant relationship between inequality and levels of violence, trust and social capital (Wilkinson and Pickett 2007b). Taking the Unicef data on children’s well-being as a starting point, Wilkinson and Pickett found that adolescent pregnancy, violence, poor educational performance, mental illness and imprisonment rates were all higher in more unequal countries and states (Pickett and Wilkinson 2007). Unicef
looked at 40 indicators (for the period 2000–3) covering material well-being, family and peer relationships, health and safety, behaviour risks, education and sense of well-being. Those at the top of the list: the Netherlands, Sweden, Denmark and Finland were also those with the lowest levels of relative income poverty (Unicef 2007). In the UK, relative poverty for children has doubled since 1979. Wilkinson and Pickett argue that the Unicef data suggest that children’s responses to inequality are similar to those found in the adult population and are similarly related to the effects of social status differentiation: greater inequality heightens status competition and status insecurity (and does so across all income groups) (Pickett and Wilkinson 2007; Wilkinson and Pickett 2007a).

In this context, levels of distress among communities are understood not in terms of individual pathology but as a response to relative deprivation and social injustice, which erode emotional, spiritual and intellectual resources essential to psychological well-being: agency, trust, autonomy, self-acceptance, respect for others, hopefulness and resilience (Stewart-Brown 2002; Friedli 2003). In addition, health-damaging behaviours may be survival strategies in the face of multiple problems and despair related to occupational insecurity, poverty and exclusion. These problems impact on intimate relationships, the care of children and care of the self. The 20–25 per cent of people who are obese or continue to smoke are concentrated among the 26 per cent of the population living in poverty, measured in terms of low income and multiple deprivation of necessities (Gordon et al. 2000). This is also the population with the highest prevalence of anxiety and depression (Melzer et al. 2004). Capacity, capability and motivation to choose health are strongly influenced by mental health and well-being.

Hopelessness and a difficulty in imagining solutions (which are also risk factors for suicidal behaviour) are also factors which may have an important ecological dimension. Mistrust and powerlessness amplify the effect of neighbourhood disorder, making where you live as important for health and well-being as personal circumstances. Poor, socially disorganized neighbourhoods have higher rates of violence and strong norms of violence: risk of violence is constructed by locality. The social variables which predict suicide (which is more strongly associated with social fragmentation than with deprivation) also predict violence to others. Some research suggests clear links between economic deprivation, social disorganization, ethnic inequities and violence (Krueger et al. 2004).

Whitehead and Dahlgren (2006) argue that key inequalities in the social distribution of outcomes relate to:
- behaviour;
- health;
- consequences of illness;
- access to services.

(See also Commission on Social Determinants of Health 2007.)

A wealth of existing research exists to suggest that mental health is a significant determinant in each case, influencing:
- capacity and motivation for healthy behaviours;
- risk for physical health (e.g. coronary heart disease);
- chronic disease outcomes (e.g. diabetes);
relationship to health services, including uptake and treatment (e.g. patterns of concordance).

Although it is frequently noted that health enables a person to function as an agent and contributes to inequalities in people’s capability to function (Anand and Ravillion 1993), it is mental health that constitutes the key determinant of agency and helps to explain the relationship between low levels of mental well-being and neglect of self, neglect of others and a range of self-harming behaviours, including self sedation and self medication, e.g. through alcohol, high fat and sugar consumption.

Resisting focus on individual interventions and individual solutions

A focus on social justice may provide an important corrective to what has been seen as a growing over-emphasis on individual pathology. This takes several forms: the expansion of diagnostic categories, as more and more people are exposed to information which suggests they have a mental disorder that needs treatment. When everything from shopping to texting to shyness and lack of interest in sex becomes a site of under-diagnosis and unmet need, the scope for growth appears unlimited. Second, a focus on individual symptoms may lead to a ‘disembodied psychology’ which separates ‘what goes on inside clients’ heads’ from social structure and context (Smail 2006). The key therapeutic intervention then becomes to ‘change the way you think’ rather than to refer people to sources of help for key catalysts for psychological problems: debt, housing, benefits. As Joanna Moncrieff observes: ‘a society obsessed with its own navel’ is unlikely to be able to mount an effective challenge to complex social problems (Moncrieff 2003).

Conclusion

How things are done (values and culture) and how things are distributed (economic and fiscal policy) are probably the key domains that influence and are influenced by how people think, feel and relate (Friedli and Parsonage 2007). Mental health promotion has made and continues to make a significant contribution to our understanding of the wider determinants of mental health and the crucial relationship between social position and emotion, cognition and social function or relatedness (Singh-Manoux and Marmot 2005). Evidence to this effect needs to inform current thinking about how individuals (and children) respond to stressors and appropriate promotion, prevention and treatment strategies across the spectrum of mental health problems.

Questions for reflection and discussion

1. Do you (the reader) have a sense of your own mental health and well-being – and, in what ways do you identify, maintain, develop and promote it?
2. Think about the community in which you live and identify those aspects that have an impact on the mental health of its members.
3. What contributions can the mental health nursing profession make to develop communities and environments that support mental health and well-being?

4. What do you consider to be the key public mental health priorities for your country over the next decade and what role can you play in meeting those challenges?

Annotated bibliography

- Carlisle, Sandra (2007) Series of papers on cultural influences on mental health and well-being in Scotland. http://www.wellscotland.info/publications/consultations4.html. This series of papers provides a valuable introduction to the ‘well-being’ literature, including perspectives on culture, economics, biology and spirituality. Although written to inform debates in Scotland, they are equally relevant to a wider audience.

- Friedli, L., Oliver, C., Tidyman, M. and Ward, G. (2007) Mental Health Improvement: evidence based messages to promote mental well-being. Edinburgh: NHS Health Scotland. http://www.healthscotland.com/documents/2188.aspx. This report, commissioned by NHS Health Scotland, includes an extensive review of the strength of the evidence on what works to improve mental health (e.g. physical activity, diet, arts and creativity), as well as the views of professionals and the public to ‘positive steps’. Also included is a helpful case study from British Telecom, describing the response of employees to ‘positive mentality’, a workplace campaign designed to encourage staff to take care of their mental health.


- Wilkinson, R.G. and Pickett, K.E. (2006) Income inequality and population health: a review and explanation of the evidence. Social Science and Medicine 62: 1768–84. The extent to which it is inequality, i.e. relative deprivation that has the greatest influence on health remains hotly contested. Richard Wilkinson has made a significant contribution to the evidence and here summarizes the arguments.

- Friedli, L. and Parsonage, M. (2007) Building an Economic Case for Mental Health Promotion. Belfast: Northern Ireland Association for Mental Health. This report uses economic analysis to develop the case for greater investment in mental health promotion, outlining the cost effectiveness not only of the prevention of mental illness but also of the promotion of positive mental health. It includes a list of ‘best buy’ interventions.

References


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Nijmegen and Maastricht. Geneva: WHO.