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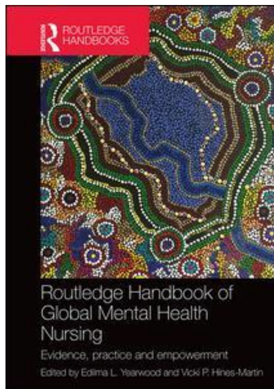

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Mental Health Promotion

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3

MENTAL HEALTH PROMOTION

Vicki P. Hines-Martin

Introduction

Mental health and illness have increasingly become a priority in global discussions because of their impact on individuals, families and communities. Mental illness or mental ill health has an impact on quality of life, lost days of productivity and economics status of citizens regardless of their setting (see Chapter 1). Current strategies to support the mental health of citizens have centered on recognition and treatment of those who are acutely ill and support for those who have persistent mental illness to attain and maintain their highest level of functioning. Conducting research and using evidence-based care strategies has been a goal to better address those who have mental health needs (WHO, 2015a).

Even as nurses and other providers strive to accomplish those goals, there is a clear recognition that resources to address the importance and enormity of this health care priority are inadequate to meet the need regardless of whether the setting is within a low-, middle-, or high-resource environment. In addition, as with other areas of health, there are many social determinants that impact health and place a variety of populations at higher risk for mental illness (see Chapter 4 on social determinants of health). Those two factors, *mental health resources* and *social determinants as a risk factor* have supported a start in the transformation of mental health care over the last 10–15 years. Also contributing to this change is the recognition that negative mental health can be mediated or prevented in many instances through proactive strategies such as targeted *mental health promotion*, *disease prevention* and *early intervention*. Mental health and how to support well-being among a variety of populations is now being viewed in the same way that other conditions such as cardiovascular disease and diabetes are being viewed. The care for populations at risk for these conditions clearly has a strong emphasis on minimizing the risks for and intervening early when beginning symptoms are identified. Central to this approach is engagement and education of individuals and populations in the process.

What is health promotion?

Health is a state of balance; an equilibrium that an individual has established within identified social and physical environments. Health allows the individual to adequately cope with demands of life while experiencing overall positive emotions and satisfaction. Within this definition is the concept of well-being (adapted from Sartorius, 2006 and Centers for Disease Control, 2013).

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The identified definition is well suited to the aims of health promotion. Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (WHO, 2015b). Health promotion and disease prevention programs focus on keeping people healthy. Health promotion engages and empowers individuals and communities to participate in healthy behaviors, and make changes that reduce the risk of developing chronic diseases and other morbidities. Early intervention is defined as the recognition of symptoms indicative of negative health concerns, problems or conditions at early onset; upon identification, facilitating the use of appropriate resources to prevent problem progression and increasing severity (Substance Abuse and Mental Health Services Administration, 2014).

For the purposes of this chapter, the term health promotion will include functions of health promotion, disease prevention and early intervention as the focus for nursing actions. The goal for health promotion is empowerment. Empowerment describes a process through which individuals, groups, organizations, or communities gain self-reliance and abilities to enhance their quality of life.

Health promotion is multifocal in its approach and targets change at the micro (individual/family) through macro (institutional and societal) levels of the environment to address modifiable risks that affect health. Usual strategies for health promotion programs include:

- *Communication* that focuses on raising awareness about healthy behaviors and engaging the public in partnership. Examples of communication strategies include lay advisory groups, public service campaigns (through a variety of media strategies), health fairs, etc.
- *Education* empowers populations toward health behavior change through increased knowledge. Examples of education strategies include peer counselors/navigators, trainings, and support groups.
- *Environmental* efforts include modifying structures or environments to make healthy decisions and resources more readily available to large populations. Examples would include conditions supporting access to clean water and non-smoking environments.
- *Policy* includes regulating or mandating activities by organizations or public agencies that encourage healthy decision-making such as immunizations.

Health promotion strategies are influenced by the approach that serves as its theoretical foundation. Effective practice depends on using theories and strategies that are appropriate to a situation. This *situation appropriateness* underlies any intervention that is culturally and socially congruent with the targeted population. There are many theories on which health promotion can be based. The following are some theories/models that focus on health promotion. The following theory/model descriptions are from the *Theory at a Glance: A Guide for Health Promotion Practice* publication (National Cancer Institute (NCI), 2005).

Individual or intrapersonal level of health promotion focuses on intrapersonal factors (those that are internal to the individual themselves). Intrapersonal factors include knowledge, attitudes, beliefs, values, self-concept, past experience, and skills.

- *The Health Belief Model (HBM)* addresses the individual's perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors influencing the decision to act (barriers, cues to action, and self-efficacy).
- *The Stages of Change (Transtheoretical) Model* describes individuals' motivation and readiness to change a behavior.

- *The Theory of Planned Behavior (TPB)* examines the relationship between an individual's beliefs, attitudes, intentions, behavior, and perceived control over that behavior.
- *The Precaution Adoption Process Model (PAPM)* names seven stages in an individual's journey from awareness to action. It begins with lack of awareness and advances through subsequent stages of becoming aware, deciding whether or not to act, acting, and maintaining the behavior.

(NCI, 2005, pp. 9–10)

Interpersonal level theory of health behavior recognizes that individuals exist within, and are influenced by, the context in which they live. The opinions, and influence of other valued people influences the individual's feelings and behavior, and the individual has a mutual effect on those people.

- *Social Cognitive Theory (SCT)* describes a dynamic, ongoing process in which personal factors, environmental factors, and human behavior exert influence upon each other. According to SCT, three main factors affect the likelihood that a person will change a health behavior: (1) self-efficacy; (2) goals; and (3) outcome expectancies.

(NCI, 2005, p. 19)

Community level models identify that social systems and their functioning affect people; and that those people can affect social systems. The focus of these models is to mobilize community members and organizations toward change that improves health. The strength of these models is community participation in identifying and implementing strategies that work in a variety of settings, such as health care institutions, schools, worksites, and in the community. Within this model, community can be a geographic area but also may be a population or group that holds a common interest, identity or shared characteristics or circumstances.

- *Community organization and other participatory models* emphasize community-driven approaches to assessing and solving health and social problems.
- *Diffusion of Innovations Theory* addresses how new ideas, products, and social practices spread within an organization, community, or society, or from one society to another.

(NCI, 2005, p. 30)

Nursing functioning is well suited to any of these models and most nurses are adept at health promotion especially as it relates to physical health conditions. However, health promotion in the area of mental health can be a challenge. The evidence for health promotion with individuals that have health concerns other than mental health is much more abundant. In addition, health promotion that may be much more readily accepted in other areas of health, may not be as acceptable when discussing mental health due to stigma. However, much can be learned from the evidence and expert opinions that are now being published in the area of mental health promotion.

What is mental health promotion?

Mental health is a "state of well-being in which the individual realizes 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 2001, p. 1). Mental health promotion

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includes "*strategies* to promote the mental well-being of those who are not at risk, those who are at increased risk and those who are suffering or recovering from mental health problems" (WHO 2004). With an understanding of the social determinants of mental health, improving and supporting mental health also requires policies and programs in government and business sectors including education, employment, law, transportation, environment, housing, and social service provision, as well as specific activities in the health field relating to the prevention and treatment of a variety of illnesses (WHO, 2014).

The mental health promotion literature has most prominently been published in relation to the life span perspective with a focus on early childhood and school-age children with the greatest growth beginning in conjunction with publication of the document *Child and Adolescent Mental Health Policies and Plans* (WHO, 2005). Research has focused on supporting adaptive, and addressing maladaptive, interactions between parents and children (Chartier *et al.*, 2015; Gyungjoo *et al.*, 2013), promotion in school and community settings even with children who are at high risk due to environmental circumstances ((Barry, Clarke, Jenkins, & Patel, 2013; Puskar *et al.*, 2006). These exemplars and other research in this area have contributed to evidence about mental health promotion strategies aimed at creating a sense of attachment and connectedness and belonging; promoting resilience and developing competencies (efficacy and coping); supporting a positive and safe school environment; teaching and reinforcing positive behaviors and decision-making; encouraging pro-social behavior; educating adult care providers about influences on child development and early symptom/problem recognition; identifying and linking school-based mental health supports; and providing access to early intervention resources for children and their families when available (Campion, Bhui & Bhugra, 2012).

Mental health promotion literature focused on other points in the life span is much less developed. Adults in the workplace are an important area for focused direction about mental health promotion. The WHO (2006) identified the following,

> Work is an essential feature of most people's adult life, and has personal, economic and social value. Work substantially contributes to a person's identity; it provides income for an individual and his or her family, and can make a person feel that he or she is playing a useful role in society. It is also an important source of social support. Participation in work also contributes to the economic and social development of communities. . . . Work is important for mental health and indeed the right to work in just and favourable conditions and with protection from unemployment is enshrined in the United Nations Universal Declaration of Human Rights (Article 23). Work produces personal and health benefits, while the absence or loss of work can potentially damage a person's mental health.
>
> *(WHO, 2005b, p. 9)*

Although WHO and other national and international organizations identify the importance of work for individuals, families and society, there is mixed evidence regarding mental health promotion interventions to assist workers with work-related stressors or interventions for individuals who are unemployed and/or experience stress due to economic pressures. Evidence to identify successful organizational changes to reduce stress for those who are employed as health care workers and teachers has not been strong according to the Cochrane Database for Systematic Reviews (Naghieh *et al.*, 2015; Ruotsalainen *et al.*, 2015). Strategies such as changing work conditions, increasing communication skills, changing work schedules, changing organizational characteristics such as providing job promotion and performance bonuses and mentoring support were used in a variety of studies. Only one study that used relaxation techniques (such

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as meditation) showed strong evidence for use as a mental health promotion strategy for professional workers (Ruotsalainen *et al.*, 2015).

The workforce literature discusses the benefits of effective interventions that reduce the strain of unemployment including counseling to improve coping skills, and improving employment opportunities for low-income groups that provide social and job seeking skills training for at-risk youth entering the workforce (Tandon *et al.*, 2015). Recent health research literature now focuses on this population but provides limited support to the benefit of mental health promotion activities in relation to the stress of unemployment. Walhlbeck and McDaid (2012), in their discussion on alleviating the mental health impact of economic crisis, identify that the impact is significant worldwide. They also identify strategies such as family and parental support, suicide prevention and first aid, and income resource information as critical strategies. Within that discussion, limited evidence is provided, however, to identify the effectiveness of these strategies. Schuring *et al.* (2009) in a study of the effectiveness of a health promotion program for long-term unemployed individuals with physical health conditions, identified that interventions that were implemented in this study resulted in no changes in perceptions of physical or mental health status among participants. In addition, scores on measures of physical and mental health showed no statistical difference after the intervention.

In addition to the populations just discussed, people with mental health conditions also experience disadvantage entering the work place, which has implications for mental health. The Bazelon Center for Mental Health Law in its 2014 report entitled *Getting to Work: Promoting Employment of People with Mental Illness* provided a synthesis of data and estimated that only 22 percent of people with serious mental illness were employed, with about half of these individuals working full-time. This number is less than one-third of those employed who did not have a serious mental health condition (Bazelon, 2014).

These numbers reflect a particularly significant problem since mental health conditions affect so many people worldwide. Individuals with mental health conditions who are employed benefit in a variety of ways. Bazelon (2014) identifies that employment fosters social acceptance and integration into the community. Individuals gain a sense of purpose, self-esteem, and self-worth. Employment reduces poverty and dependence on others, empowering people to become self-sufficient, and live independently. It improves clinical outcomes, including reducing symptoms of a person's mental illness, and lessens the need for supportive resources. The Bazelon report (Bazelon, 2014) also identifies that about one half of people with serious mental illness who participated in a national survey reported the primary barriers to employment to be stigma and discrimination, and fear of losing benefits, and approximately one quarter of those surveyed cited inadequate treatment, and lack of vocational services, which served as insurmountable barriers (Bazelon, 2014).

Evidence for workplace mental health promotion initiatives is limited and what is available must be strengthened to serve as a foundation for change. Adult functioning in relation to the workplace, mental health and mental health promotion hold great potential for clinical and organizational research, and community partnership to identify and address important areas for mental health promotion that are effective and contextually appropriate.

Mental health promotion can be initiated through the screening of at-risk populations. Evidence for the importance of mental health screening is demonstrated in this section with two populations; aging adults and high-school girls.

With the growing numbers among the aging population, mental health promotion within this group has become increasingly important. The WHO identifies that the world population of older adults will double between 2000 and 2050 and will result in approximately 2 billion people over the age of 60 (WHO, 2013). The CDC (2008) in its report of findings about the

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US aging population identifies that anxiety, severe cognitive impairment, and mood disorders are most common within this age group. "Risk factors for late-onset depression included widowhood, physical illness, low educational attainment (less than high school), impaired functional status, and heavy alcohol consumption" (CDC, 2008, p. 6). Men within this age group are more likely to commit suicide than any other population group (CDC, 2008). These conditions are under-recognized by health care professionals and have significant effects on mental and physical functioning in aging. The Hartford Institute for Geriatric Nursing identifies that

> persons drinking at (high) levels (are at risk for) negative outcomes for physical and mental health such as falls, stroke, depression, and gastrointestinal problems. Older drinkers taking prescription medications are at greater risk. Use of prescription drugs and alcohol in combination is not an uncommon occurrence.
>
> *(Naegle, 2012, p. 1)*

Recommendations by the CDC, the Hartford Institute, WHO, and other organizations focused on this population identify that mental health and substance abuse screenings are an essential part of care. Some of the recommendations about screening also provide direction on tools that can be used in any setting: for depression screening, the Patient Health Questionnaire (PHQ -9), which includes 9 questions and for alcohol abuse screening, the Short Michigan Alcoholism Screening Instrument Geriatric Version (SMAST-G), which includes 24 questions with yes/no responses. Both of these self-report instruments are easily incorporated into any health care environment and have been identified as valid in numerous studies. For more information about these screening instruments see van Steenbergen-Weijenburg *et al.* (2010); Sullivan and Fleming (1997); and Spitzer, Williams, and Kroenke (1995). Other screening measures are available for use and may be identified as more suitable based on cultural and social context.

Another at-risk population are females, especially those who live within contexts in which their roles are circumscribed and/or restricted based on their gender. These restrictions may be based on religion, culture or tradition (see Chapters 4 and 19 on social determinants of health and violence). El- Sayed Desouky, Abdellatif Ibrahem, and Salah Omar (2015) conducted a study of 1,024 Saudi adolescent girls and investigated the prevalence of psychiatric disorders (depression, anxiety, and obsessive compulsive disorder) within this population. The girls were aged 15–17 years and findings from this study identified that 54.9 percent had symptoms of anxiety, 42.9 percent had depressive symptoms, and 23.1 percent had symptoms of obsessive-compulsive disorder. There was a statistically significant co-morbidity between these conditions, meaning that many had symptoms of more than one of these disorders. Explanations for the incidence of these disorders in this sample were as follows. The author identified that some factors may be related to parental restriction of girls versus boys in regard to permissible behavior; lower expectations for girls related to competencies and achievement; and stress faced by Saudi females resulting from cultural and social factors. One important limitation of this reported study was the restriction on the researcher. As females they were not allowed to study males and therefore were unable to gather data for comparison between males and female prevalence of the identified disorders. The primary recommendation from the investigators resulting from this study is the need for mental health screenings for this population.

Increasingly the literature has identified the benefit of working with communities around mental health issues in the use of lay people in mental health promotion roles as navigators, educators and cultural experts. Patel *et al.* (2011) have been at the forefront in relation to identification and utilization of lay individuals in these capacities within communities with low resources. Although peer support has been used by many in relation to individuals with severe

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and persistent mental illness, data about mental illness resulted in increased recognition that mental health needs far exceeded the mental health resources. Patel *et al.* (2010) undertook innovative work to expand the scale of lay-worker delivered mental health resources which has served as a foundation for change in how peer support is used. Patel *et al.* (2011) identified that trained lay personnel can reduce incidence of the most prevalent mental conditions, suicide, and mental health disability days within a primary care setting. Other studies have supported the usefulness of lay workers on mental health promotion and care (Patel *et al.*, 2010; Shinde *et al.*, 2013).

As previously discussed, use of theory in health promotion strategies is well established and is beneficial in that an appropriate theory can help a health promotion strategy identify influential factors to consider and assist in making the chosen interventions situation (or culturally and socially) specific.

In their nursing intervention study of elderly Iranian women, Alaviani, Khosravan, Alami, and Moshki (2015) focused on the prevention of loneliness and social isolation and included 150 women. The study was constructed using the principles of the Pender Health Promotion model. The Health Promotion Model is a nursing model based on social cognitive theory. According to this theory, cognitive perception factors (such as perceived benefits and barriers) have influence on involvement in health promotion behaviors. In addition, the person already possesses interpersonal factors (like demographic factors, effective interpersonal factors, and behavioral factors). The theory proposes that an intervention that takes into account the interaction of all these factors can affect cognitive perception processes and result in healthier behaviors. Using this model, a quasi-experimental study employing a multi-modal intervention was used with the experimental group. Both the experimental and control groups were measured before and after the intervention period using questionnaires that measured perceived barriers, benefits, self-efficacy, and interpersonal influences on behaviors associated with loneliness and social isolation. Findings from this study indicate that there was significant decrease in perceived loneliness and improved ability to make social contact in the experimental group, which illustrated the benefit of this theory-driven mental health promotion study.

Mental health promotion, engagement and patient-centered care

The US Institute of Medicine (IOM, 2001) defines patient-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (IOM, 2001, p. 2). Patients must be viewed as persons in context within their own social worlds, and therefore listened to, informed, respected, and involved in their care and, to whatever extent possible, have their wishes adhered to as part of the health care process. The IOM proposed 10 simple rules for improved patient-centered health care delivery; the following have particular application to mental health promotion.

- Care has a focus on supporting the highest level of health possible.
- Care is adapted according to patient needs and values.
- Knowledge and information on which care is based is shared with those involved.
- Decision making about therapeutic approaches is evidence-based.
- Cooperation among providers is a priority to accomplish positive health outcomes.

(IOM, 2001, p. 2)

The ICN in its statement on the definition of nursing identifies that the profession has an inherent focus on patient- or person-centered care and the following points of emphasis were

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particularly supportive of that message. ICN states that nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well, and in all settings. Nursing includes the promotion of health, and prevention of illness. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

Both the IOM statement on patient-centered care and the ICN definition of nursing articulate the need to partner with individuals who are the focus of care (individually or collectively) to address health needs and accomplish identified health goals. The process must be one that involves mutual give and take, in context with the person's perception and circumstances, as well as active participation by all. When this process is successful, the care recipient becomes invested as a partner in the process, which is called engagement. Engagement and patient-centered care also require the collaboration of health care and non-health care personnel to fully accomplish the health care goals. Therefore, interprofessional collaboration is vital with nursing often functioning as the hub, facilitator, gatekeeper, or director of that collaboration. This function is particularly critical in the area of mental health promotion.

Literature on mental health promotion with a perspective on person-centered care, engagement and interprofessional practice illustrate the importance of these concepts on mental health outcomes.

With mental health promotion, the focus for partnerships is often communities or populations. Engagement of those populations to identify needs, strengths, and perspectives requires a consensus building process whereby mutually agreed upon priorities are identified. This process can focus on organizational coalition building (Maurer, Dardess, Carman, Frazier, & Smeeding, 2012; Ng, Fraser, Goding, Paroissien, & Ryan, 2013), or the development of appropriate mental health priorities for culturally diverse and/or at-risk populations (American Indian/Alaska Native Indian Health Services Office of Clinical and Preventive Services, 2011; Hinton, Kavanagh, Barclay, Chenhall, & Nagel, 2015). Nurses have the right and the responsibility to serve as advocates, members or leaders in policy development groups and opportunities are at many levels regardless of the setting. However, large sectors of the nursing profession are constrained in how to implement engagement by contextual factors (geography, economics, social norms, etc.). All nurses can, and do, function with individuals and families. Most importantly, Interprofessional collaboration, person-centered care and engagement can be implemented successfully with nursing as the lead in those instances.

Markle-Reid *et al.* (2014) describe a nurse-led intervention for home-based elders, which was directed at depression prevention. The 1-year project with 142 participants incorporated patient, family/supports and collaboration of a personal support worker. The intervention included education, counseling and assessment. Study findings indicated that participants had improved recognition and management of depression, increased participant physical and pleasurable activities, social support, quality of life, and ability to manage other chronic health conditions. Nursing education improved the participants' and family knowledge of the symptoms of depression, available treatments, and available community resources.

Mental health promotion and implications for nursing

The data about influences on mental health and the universal support in the literature for mental health promotion clearly identify that this care strategy should be a priority in nursing regardless of the setting or the educational level of nurses. Nursing has an advantage in that health promotion has historically been one of the essential strategies within the profession. Nurses work with populations in support of their health.

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The International Council of Nurses (ICN) has identified the priorities for nurses and mental health. ICN states that

> people worldwide suffer from mental disorders and all people are at risk of mental health problems, often due to stressful lifestyles, dysfunctional relationships, civil conflict, violence, physical illness, infection or trauma . . . Nurses are integral to holistic approaches to mental health promotion, prevention, care, treatment and rehabilitation of people living with mental health problems and support of their families and communities.
>
> *(ICN, 2008, p. 2)*

In the ICN/WHO joint statement on Developing Nursing Resources on Mental Health (2002), they identified that nurses are the largest group of health care providers in the world, and that they can serve an essential function in the provision of mental health care delivery. The statement also identifies that education is needed to help nurses better understand this rapidly developing field and their role in it. Specific recommendations were as follows:

- Increase education for nurses in the areas of
  - advocacy;
  - community mental health;
  - legal issues/human rights;
  - working with patients and their families in a variety of settings;
  - development of mental health policies;
  - public health models (for population health); and
  - promotion of mental health.
- Increase nursing involvement in the development of mental health policy by:
  - developing the vision for care delivery;
  - establishing models of care; and
  - improving consultation in policy and planning.

Nurses have been increasingly active in these areas since the 2002 statement. Nurses have added to the literature on mental health promotion by exploring mental health promotion and graduate education in multicultural settings (Khanlou, 2003), advocating for increased nursing involvement in mental health promotion (Calloway, 2007), conducting research on new approaches to mental health promotion (Alviani *et al.*, 2015; Chartier *et al.*, 2015; Melnyk *et al.*, 2015), and leading dialogue on expanded roles for the nurse and developing a vision for care delivery in this important area (Wand, 2011).

Nursing is at a pivotal point in time when there is a synergy within and across nations to view “there is no health without mental health” (WHO, 2016). Collaborative groups have developed and continue to develop focused in this area. Table 3.1 provides examples of several groups with a dedicated focus on mental health.

Mental health promotion is both old and new. Terminology and expectations evolve as health care groups better understand the importance of this area of health care provision and as health providers especially nurses better understand their role in mental health promotion. Nurses are the largest group of providers who have always seen the benefit of promoting health. It is now the time for us to communicate our strengths in this area and better focus our attention on using our expertise in supporting health through evidence-based mental health promotion.

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Table 3.1 Examples of groups with a dedicated focus on mental health

Organization	*Website (URL)*
Centre for Global Mental Health (multi-site resource)	www.centreforglobalmentalhealth.org/global-mental-health-websites
European Network for Mental Health Promotion	www.mentalhealthpromotion.net/?i=portal.en.about
Portico. Canada's mental health and addiction network	www.porticonetwork.ca/
International Council of Nurses (see mental health page)	www.icn.ch/
Mental Health America US	www.mentalhealthamerica.net/
Mental Health Information Centre (South Africa)	www.mentalhealthsa.co.za/
Pan American Health Organization (see mental health page)	www.paho.org/hq/
The WHO Pacific Islands Mental Health Network (PIMHnet)	www.who.int/mental_health/policy/pimhnet/en/
National Asian American Pacific Islander Mental Health Association US	http://naapimha.org/

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