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Promoting Positive Mental Health: Theoretical Frameworks for Practice

Introduction

This paper outlines the importance of a strong theoretical base for the development of mental health promotion practice. As an interdisciplinary area, mental health promotion derives its theoretical base from a number of diverse disciplines. The development of this area needs to be underpinned by sound conceptual and theoretical frameworks which provide coherent models for designing, conducting and evaluating programmes.

Currently, however, the area is bedevilled with debates about the distinctions between mental health promotion and the prevention of mental disorders. These two areas, while clearly overlapping, are informed by different sets of principles and hence derive from different conceptual frameworks. Mental health promotion focuses on positive mental health and its main aim is the building of strengths, competencies and resources. In contrast, prevention concerns itself primarily with specific disorders and aims to reduce the incidence, prevalence or seriousness of targeted problems: mortality, morbidity and risk behaviour outcomes. Articulated as such, these two fields have different starting points and seek to impact on different outcomes. In practice, however, there is much common ground between the two areas, particularly with regard to primary prevention and mental health promotion programmes.

This paper considers the current theoretical perspectives and research evidence underpinning both prevention and promotion programmes. Based on the strength of current evidence, a case is put forward for focusing on the enhancement of protective factors with the explicit goal of promoting positive mental health and well-being across populations. The relevance of key constructs and principles from community psychology and developmental theory are explored, in particular...
those which emphasise a socio-ecological focus and underscore the role of mediating structures in promoting psychological strengths and competencies. Building on current frameworks, an integrative approach is proposed which locates a central role for strategies promoting positive mental health within the broader spectrum of current intervention activities.

**Conceptual frameworks for promoting positive mental health and preventing mental disorders**

**Prevention frameworks**

The most widely used prevention framework in the mental health area is that put forward by Caplan (1964). This framework distinguishes between three types of prevention:

1. primary prevention aimed at reducing the incidence of mental disorders of all types in a community
2. secondary prevention aimed at reducing the prevalence of disorders by reducing duration
3. tertiary prevention aimed at reducing the impairments which may result from disorders.

Caplan’s framework proposes a continuum between prevention and treatment as part of a wider spectrum of activities designed to reduce the incidence and prevalence of disorder. However, this framework has been criticised for blurring the distinction between early treatment and prevention interventions.

A more recent prevention framework was put forward by Mrazek & Haggerty (1994) in the Institute of Medicine (IOM) report *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention*. This framework, which was originally depicted as a half circle (see Figure 1, above), places prevention activities in the wider mental health intervention spectrum of treatment, maintenance and rehabilitation. Three main categories of prevention activities are identified: universal (targeting the general population), selected (targeting high-risk groups) and indicated (targeting high-risk individuals or groups already displaying symptoms). While clearly articulating the different types of prevention, this framework does not include interventions focusing on promoting positive mental health, nor does it explicitly identify links across the different areas of prevention, treatment and rehabilitation. However, it would appear that, at least conceptually, there is quite an overlap between universal prevention activities, as outlined in the framework, and those of mental health promotion.
Mental health promotion frameworks
Adopting a health promotion framework locates mental health within a holistic definition of health and, therefore, builds on the basic tenets of health promotion as outlined in the Ottawa Charter (1986) and subsequent WHO directives.

The underlying principle of this approach is that mental health promotion is an integral part of overall health and is therefore universal and of relevance to all. The framework is developed in the context of the broad determinants of health and mental health. A good example of such an approach is that developed by the UK Health Education Authority in its Mental Health Promotion Quality Framework (1997). This framework operates within a biopsychosocial model of health, identifying vulnerability and protective factors for mental health. In particular, the framework highlights three key influences on mental health:

- healthy structures such as the economic, social and cultural framework
- citizenship, including social support, sense of social integration and inclusion
- emotional resilience encompassing self-esteem, coping, life skills and sense of control.

Both internal and external vulnerability and protective factors across these three dimensions are identified, and a quality framework for intervention programmes is outlined. This framework, therefore, views mental health promotion as an integral part of health promotion and advocates the same basic principles of practice.

An interesting population perspective on promoting positive mental health is outlined in the Australian discussion document Building Capacity to Promote the Mental Health of Australians (Health Australia Project, 1996). This model (Figure 2, above) clearly shows the relevance of mental health promotion across populations ranging from healthy populations to those with mental disorders. The framework outlines the opportunities for mental health promotion across these different population groups and articulates the diverse aims and goals of mental health promotion strategies across the different areas of practice. These range from building resilience and promoting health for healthy populations to reducing risk and early identification for high-risk groups, to treatment and optimal care for those with mental disorders. This framework covers the spectrum of promotion, prevention, treatment and rehabilitation and, although they are not explicitly identified, holds open the possibility of links across the different areas of practice.

Clearly these different prevention and promotion frameworks inform different models of practice and are underpinned by different theoretical perspectives. The conceptual approaches to prevention and promotion will now be considered. In particular, the two inter-related approaches of the risk reduction model and the
competence enhancement model will be outlined and findings from current research and sample programmes based on both these models will be explored.

Current theoretical models and practices

The risk reduction model
Recent advances in the understandings of risk and protective factors for mental health problems form the basis of the risk reduction model. Indeed, the IOM report (Mrazek & Haggerty, 1994) endorsed the risk reduction model as the best theoretical model to guide preventive interventions at this time. This model is concerned with the reduction of risk factors, for general as well as specific mental disorders, and the enhancement of protective factors. Current research indicates the presence of generic risk and protective factors that are common to many disorders and dysfunctional states. Mrazek & Haggerty suggests that, rather than attempting to identify risk factors unique to specific mental disorders,

‘there may be greater value in clarifying the role of those risk factors that appear to be common to many mental disorders, especially in view of the frequent co-morbidity of these disorders’ (p182).

Applied to prevention interventions, this model aims at reducing ‘modifiable’ risk factors and strengthening protective factors. The risk reduction model draws on the findings from aetiological and treatment research and adapts intervention techniques, such as cognitive-behavioural or social learning approaches, to the area of prevention.

Primary prevention programmes
The IOM report (Mrazek & Haggerty, 1994), which reviewed 39 prevention programmes tested by randomised trials, concluded that there is strong evidence that preventive interventions can lead to a reduction of risk factors and enhancement of protective factors associated with the first onset of substance abuse and mental health problems. However, the report found that there was minimal evidence that mental disorders have been prevented through such risk reduction. On foot of this Mrazek & Haggerty recommends that the most fruitful approach for preventive interventions may be to use a risk reduction model that includes the enhancement of protective factors and to aim at clusters or constellations of risk or protective factors. The goal of preventive interventions, therefore, becomes the reduction of risk rather than the prevention of disorders per se. Two examples of successful prevention programmes applying this approach to the area of depression will now be considered.

The San Francisco Depression Prevention Research Project (Muñoz et al, 1995; Muñoz & Ying, 1993) focuses on primary health care clients and aims at preventing new cases of depressive disorder among low-income minority groups. The theoretical and empirical base for the intervention stems from behavioural and cognitive approaches which were adapted and applied to prevent new cases of major depression and dysthymia. This programme takes the form of an educational intervention designed to teach participants methods of mood management based on modifying thinking and activity patterns. It was delivered in a small-group format consisting of eight weekly two-hour sessions, and participants were randomly assigned to the depression prevention course or to a control condition. Follow-up at six and twelve months suggests that the intervention group had significantly fewer depressive symptoms at both time points. However, due to the small number of intervention participants (N = 72), the study lacked the statistical power to show whether the onset of a first episode of depressive disorder had in fact been prevented. Nevertheless, the intervention did result in the reduction of negative thinking patterns and gave rise to positive increases in levels of pleasant and social activities, leading in turn to a reduction in depressive symptoms. The programme, therefore, does result in a reduction of risk factors and an increase in protective factors despite its methodological difficulties in demonstrating a preventive effect for new cases of depression.

The JOBS intervention project (Caplan et al, 1989; Vinokur et al, 1995; Vinokur & Schul, 1997) also focuses on depression prevention, but takes a different approach. This programme targets job loss as one of the most consistent antecedents of depression, and designs a preventive intervention targeting unemployed workers. The conceptual framework guiding the programme focuses largely on increasing protective factors through increasing the sense of mastery and the enhancement of personal control and job search self-efficacy. The intervention was originally tested through two large randomised field studies (JOBS I and JOBS II) conducted with recently unemployed people. The intervention applies problem-solving and decision-making group processes, inoculation against setbacks and social support, together with learning and participatory job search skills. With a follow-up period of two and half years post-intervention, the programme has produced impressive results, indicating that participants in the intervention group achieved significantly better
employment outcomes (better-quality and higher-paying jobs) and also improved their mental health through enhanced role and emotional functioning and reduced depressive symptoms. Using prospective screening, JOBS II also indicated increased benefits to high-risk participants in reducing depression symptoms. Vinokur & Schul (1997) analysed the programmes’ outcomes to establish the mechanisms through which this intervention produced its significant effects. Enhanced sense of mastery and inoculation against setbacks emerge as significant mediators of the intervention effects on re-employment, financial strain and depression symptoms, particularly for the high-risk group.

Commenting on the findings from the JOBS programme, Price (1998) points to the interweaving effects of the promotive and preventive aspects of the intervention, which had preventive effects for those at high risk of depression and promotive effects for those at lower risk. The JOBS programme is, therefore, a good example of an intervention that operates on both risk and protective factors simultaneously. Clearly, from the outset this programme had a strong emphasis on protective factors, as self-efficacy and sense of control were identified as integral components of the intervention.

The competence enhancement model
While the risk reduction model begins with a focus on reducing risks for mental disorders, the competence enhancement model focuses on enhancing competence and positive mental health. The competence approach signals a shift from an individual-centred, disorder-focused approach to one embracing an emphasis on psychological strengths and resilience. The goal, therefore, becomes enhancing potential rather than focusing on reducing disorders. This perspective is in keeping with the basic thrust of health promotion which clearly articulates that

‘Health promotion involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases’

(WHO, 1985 p6).

Mental health is therefore reconceptualised in positive rather than in negative terms. Mental health promotion programmes adopting a competence perspective are concerned primarily with building strengths and competencies and feelings of efficacy in diverse life areas (Weissberg et al., 1991). An enhancement model assumes that, as an individual becomes more capable and competent, their psychological well-being improves. This approach builds on the theoretical base of lifespan developmental theory and the ecological perspective of community psychology.

Cowan (1991) argues for a comprehensive lifespan approach to the promotion of wellness, one that takes into account age, situation, group and society-related determinants of and impediments to wellness. Based on current knowledge and theory, four key concepts – competence, resilience, social system modification and empowerment – are proposed to guide the promotion of psychological wellness. Cowen puts forward these constructs as providing the knowledge base to guide the formulation of programmes, policies and practices designed to promote psychological wellness. In developing this wellness perspective, community psychology applies an ecological perspective that stresses the interdependence of the individual, the family, community and society. It therefore views mental health as both a community and an individual resource. From this theoretical perspective, which draws on Lewin’s (1951) person-in-context principle, mental health is conceptualised as the interaction, over time, between person and social settings and systems, including the structure of social support and social power (Orford, 1992). This perspective clearly moves the concept of mental health beyond an individualistic focus to consider the influence of broader social, economic and political forces.

A key concept underpinning this ecological perspective is that of interdependence – the fact that behaviour is influenced by multiple interacting systems. Bronfenbrenner’s (1979) model of nested systems provides a useful set of constructs to understand these different levels. Bronfenbrenner postulates a set of nested structures, the micro-, meso-, exo- and macro-levels, to indicate the way in which systems operating at individual, family, community and broader societal levels interact with and mutually influence each other. This model points to the importance of the larger sociocultural and policy context within which individuals, group systems and social settings are embedded. The model underscores the important role of mediating structures such as schools, workplaces and communities as providing key contexts for social interventions operating from the micro- to the macro-levels.

As a multi-level construct, empowerment plays a key role in this framework as it is capable of operating at many different levels from the micro to the macro, but particularly at the level of organisations and community. Empowerment may be defined as

‘a social action process through which individuals, communities and organisations gain mastery over their lives in the context of changing their social and
political environment to improve equity and quality of life' (Rappaport, 1985; Wallerstein, 1992).

Embracing an empowerment philosophy of mental health requires that attention be focused away from an exclusive concern with individual factors to consider the interface between the individual and wider community and social forces. This points to a need to address poverty, economic and social disadvantage, social injustice and discrimination as key determinants of mental health. This approach, therefore, underscores the importance of social interventions addressing systems of socialisation, social support and control and operating at multiple levels of analysis.

**Competence enhancement programmes**

Programmes focusing explicitly on competence enhancement appear to concentrate primarily on children and adolescents. A number of recent reviews of successful interventions (Price et al, 1988; Weissberg et al, 1991; Durlak & Wells, 1997) point to strong evidence that high-quality comprehensive programmes that focus on young people and their socialising environments produce long-lasting positive effects on mental, social and behavioural development.

Durlak and Wells (1997) carried out a meta-analysis review of 177 evaluation studies of primary prevention and mental health promotion programmes for children and adolescents. The findings from this review indicate that most programmes examined achieve significant positive effects, reporting mean effect sizes of between 0.24 and 0.93. In practical terms, they report that the average participant in the intervention programmes surpassed the performance of between 59–82% of those in control groups. The positive programme effects were found to be long-lasting and to impact on functioning across multiple domains. As the authors point out, these findings compare extremely well with findings from many established medical, educational and behavioural interventions.

Weissberg and colleagues (1991) selectively review primary prevention programmes that demonstrate positive behavioural effects for young people and then describe the elements that appear critical for their success. They conclude that the critical ingredients of most effective programmes include a focus on, a) enhancing children's capacities, personal and social skills, attitudes and values and, b) creating environmental settings and resources to support the development of young people's personal social and health behaviour. For children under the age of five years, high-quality family support and early childhood programmes have produced long-term benefits. These programmes typically involve specially trained community members or professionals providing ongoing support to families during pregnancy, infancy and early childhood with the goal of empowering parents and children.

The most widely quoted programme, the High/Scope Perry Preschool Study (Schweinhart & Weikart, 1988), is a pre-school educational programme targeting intellectual and social skills to low-income 3/4-year-old African American children with below average IQ scores. The children were randomly assigned to experimental and control conditions and over a two-year period an intensive programme was delivered, consisting of structured classroom activities and weekly home visit by teachers to parents. The children were followed up through the school years right up to 28 years of age. The results from this programme are very impressive, in that programme participants in comparison to control were found not only to have higher levels of school performance, but also fewer arrests, higher rates of employment and lower use of welfare assistance. In other words, the programme resulted in multiple long-lasting positive effects across intellectual, social and mental health domains. Similar positive findings are reported by the Consortium for Longitudinal Studies (Lazar et al, 1982) which examined the long-term effects of 11 pre-school programmes on over 2,000 children from 9–19 years of age. This report suggests that, in addition to positive outcomes on academic achievement, these programmes also had the potential to influence rates of delinquency, unwanted pregnancy, welfare and employment.

For older children, the most promising strategies were found to involve comprehensive school-based, multi-component programmes that address predictors of multiple behaviours. There is good evidence in support of generic broad-based personal and social skills training programmes such as those developed by Shure and Spivack (1988) and Botvin and Tortu (1988). Even in the area of adolescent suicide prevention, Garland and Zigler (1993), in their review of current research, call for generic competence-building interventions that promote mental health rather than narrow suicide-specific programmes.

The available evidence, therefore, strongly supports the view that competence-enhancing programmes, carried out in collaboration with families, schools and wider communities, have the potential to impact on multiple positive outcomes across social and personal health domains. Interestingly, most interventions also have the dual effect of reducing problems and increasing competencies.
A compelling case for promoting positive mental health

Based on the programmes and studies reviewed in this paper, there is a compelling case for promoting positive mental health, that is, focusing on interventions that promote psychological strengths and competence. Programmes promoting positive mental health have a universal target group, they have been found to result in impressive long-lasting positive effects on multiple areas of functioning and they also have the dual effect of reducing risk. Such programmes would therefore appear to hold the greatest promise as cost-effective interventions. The strength of evidence from systematic reviews and effectiveness studies would also support this orientation.

Mrazek and Haggerty (1994) clearly conclude from their review that that there is currently little evidence that any specific mental disorder can be prevented. Tilford and colleagues (1997), in their HEA review of mental health promotion programmes, also conclude that there is no strong evidence for the superiority of programmes directed at the prevention of specific disorders over broad skills-based interventions. The complex multifactorial aetiology of many mental health problems and disorders means that it is extremely difficult to identify risk and protective factors for specific mental health problems. Likewise, there are methodological difficulties in demonstrating that a negative outcome has not occurred, ie proving that interventions do actually prevent the onset of specific mental disorders (Mrazek & Haggerty, 1994; Durlak & Wells, 1997). Given the low base-rate of diagnosed mental health problems and the episodic nature of some conditions, extremely large sizes and extensive follow-up periods are required to judge the effects of the programme. With funding and other limitations, few current programmes meet these requirements, as the majority of studies do not follow-up beyond 12 months post-intervention.

However, there is consensus that there are clusters of known risk factors and protective factors, and there is considerable evidence that interventions can reduce identified risk factors and enhance known protective factors. Hosman & Llopis (2000) in a recent report on the evidence of health promotion effectiveness from the International Union of Health Promotion and Education, finds ample evidence that mental health promotion programmes not only improve mental health and quality of life but also reduce the risk for mental disorder. The report also attests to the impact of mental health promotion programmes on the reduction of a range of social problems such as delinquency, child abuse, school drop-out, lost days from work and social inequity. Clearly, these accumulated findings endorse the value of programmes promoting positive mental health as cost-effective initiatives capable of impacting positively across multiple domains of functioning.

For these conceptual and methodological reasons, it is proposed that it may be more productive for programmes to focus on enhancing protective factors, with the explicit goal of developing competence to promote well-being, rather than preventing symptoms or the onset of disorders. Moving from disorder prevention to a competence enhancement approach requires that current frameworks accommodate this shift in emphasis to locate the promotion of positive mental health within the broader spectrum of intervention activities. With this in mind, two of the frameworks outlined earlier in this paper are re-visited and modified in order to consider how a competence enhancement perspective may be represented.

Taking the lead from Mrazek's (1998) own suggestion, that perhaps the second half of the circle depicting the mental health intervention spectrum consists of mental health promotion, the circle has been completed (Figure 3, overleaf) to include mental health promotion, indicating some core concepts by way of example (by no means exhaustive or exclusive). This amended circle depicts mental health promotion as the largest part of the circle, given its universal relevance, and indicates the unifying central area between the different interventions as that centred on strategies for promoting well-being and quality of life. Likewise, a slightly modified population perspective on opportunities for mental health promotion is depicted in Figure 4, page 33. Here the original diagram, with its layers of population targets, programme aims and outcomes, is potentially brought together at the level of conceptual approaches and strategies which seek to promote positive mental health.

Promotion, prevention, treatment and rehabilitation programmes all have at their core the overall goal of promoting well-being and quality of life. While these intervention categories clearly differ in their target populations, programme objectives, content and process, they may share many core intervention components derived from underlying theoretical constructs. For example, there is an extensive literature on the potency of core constructs such as self-efficacy, sense of control, self-esteem, social support and resilience, which have been successfully applied across the spectrum of health and mental health interventions. Clearly, there is much opportunity for shared learning
and development around the application of these constructs with different populations across the diverse areas of practice.

This shift in focus from negative to positive indicators of well-being calls for methodological refinement in developing sound measures of protective factors and positive outcomes. Evaluation methods are needed that will focus on intervening or mediating variables which act as key predictors of change. This requires that the core components of intervention strategies are clearly identified, in order that they may inform the specifica-

tion of proximal as well as distal programme objectives. The identification of such core intervention components calls for clear articulation of the underlying theories and constructs informing programme development. As Durlak & Wells (1997) points out, we need to challenge the idea that there are uniform primary prevention or mental health promotion programmes, as clearly programmes may draw from a range of different underlying theories, constructs and perspectives. Focusing on the level of developing distinct conceptual approaches and strategies for promoting positive
mental health presents an opportunity for integration and for establishing links across the spectrum of mental health interventions.

**Conclusion**

If the area of mental health promotion is to develop, based on a sound knowledge and research base, then it is critically important that appropriate theoretical frameworks, constructs and practice methods be identified. This paper argues that there is a strong case for focusing on promoting positive mental health based on core theories and constructs that have been tried and tested in the literature. Rather than deliberating on the debate between primary prevention and mental health promotion, it is now time to focus on developing clear, theory-based intervention strategies which can be carefully tailored to the needs of different population groups and settings. Focusing on the development of distinct theory-based strategies for promoting positive mental health calls for consideration of the dynamic interaction of practice and theory-based evidence. Clearly, a focus on intervention outcomes alone will not inform practice if the evidence does not point to the mediators of programme effectiveness or provide a clear indication of the critical elements of successful interventions. For an interdisciplinary area such as mental health promotion, this shift to theory-based evidence holds the greatest promise of cross-fertilisation of ideas, practices and methodologies from the wider health and mental health fields.

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