PIA SOLIN

Mental Health from the Perspective of Health Promotion Policy

ACADEMIC DISSERTATION
To be presented, with the permission of
the board of the School of Health Sciences
of the University of Tampere,
for public discussion in the Auditorium of
School of Health Sciences, Medisiinarinkatu 3,
Tampere, on October 15th, 2011, at 12 o'clock.

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ACADEMIC DISSERTATION
University of Tampere, School of Health Sciences
Finland

Supervised by
Professor Juhani Lehto
University of Tampere
Finland
Professor Pirjo Nikander
University of Tampere
Finland

Reviewed by
Docent Ville Lehtinen
University of Turku
Finland
Professor Sirpa Wrede
University of Helsinki
Finland

Distribution
Bookshop TAJU
P.O. Box 617
33014 University of Tampere
Finland

Tel. +358 40 190 9800
Fax +358 3 3551 7685
taju@uta.fi
www.uta.fi/taju
http://granum.uta.fi

Cover design by
Mikko Reinikka

Acta Universitatis Tamperensis 1642
ISBN 978-951-44-8533-6 (print)
ISSN-L 1455-1616
ISSN 1455-1616

Acta Electronica Universitatis Tamperensis 1104
ISBN 978-951-44-8534-3 (pdf)
ISSN 1456-954X
http://acta.uta.fi

Tampereen Yliopistopaino Oy – Juvenes Print
Tampere 2011

Summary

Mental health is an essential part in coping in our everyday lives. However, the area of mental health policy has not been a very popular research area until the 20th century, even though mental health promotion research is important as it focuses on an issue which is societally sensitive. Mental health is an interesting area from many perspectives. There have been difficulties in finding a unifying concept of mental health. Mental health determinants are also ambiguous as they are societal by nature. Traditionally health promotion strategies need determinants such as tobacco smoking, nutrition or exercise. Actions can easily be directed at these determinants. On the other hand, mental health policy usually concentrates on organisational care related activities.

Mental health has had a smaller role in national health programmes, in spite of continually rising publicity, the amount of human suffering and societal costs. Therefore the research began with an assumption that health promotion programmes are constructed in such a form which does not support mental health targets. Thus the hypothesis is that mental health has a defensive role in the area of health promotion.

As the research analysed the role and position of mental health in national health promotion policies, the perspective comes from the policymaking. In each part of the research, mental health is scrutinised from a different phase of the health policy cycle. Thus mental health is studied from the perspectives of problem appearance, policy formulation, policy adoption and finally policy evaluation. The research concentrates on the following main points; what kinds of arguments are used in health policy documents when mental health is discussed? What does the analysis of mental health determinants reveal from a policy perspective? How and to whom are mental health policy documents directed? What kind of a health target is mental health? The research showed that in policy documents mental health is clearly acknowledged as a problematic issue when compared to somatic health problems that the determinants of mental health situate widely in the social, socio-economic and environmental factors of health. The findings of the third study also suggested that certain documents do attempt to reach a variety of actors in the field with the use of language and discourse. When scrutinising the final phase of the policymaking cycle; evaluation of mental health targets, it was found that mental health has several

unique features which cannot be converted into simple or quantifiable targets and thus evaluated for efficiency like somatic health targets.

The data of the research consisted of national health policy documents from Finland, Sweden, England, The Netherlands, Denmark and Portugal. Several interviews with key informants from each country were also used as background material. The research methods were qualitative, consisting of content and policy analysis and analysis of interpretative repertoires. The ideology of grounded theory was also applied throughout the research.

The analysis of policy documents revealed the assumptions, attitudes and values assigned to mental health. This research aimed to draw a realistic picture of how European welfare states "speak" about mental health and its promotion. The research also sought to point out that even the most effective targets do not necessarily equal the actual needs or what is actually done. Furthermore, the many aspects why mental health, its promotion and mental health policy have been considered difficult will be discussed. Stigma, ambiguous definitions, variety of background factors and causality are only a few obstacles linked to mental health. It seems that health promotion policy has to adapt to the needs of mental health.

Tiivistelmä

Mielenterveys terveyden edistämispolitiikan näkökulmasta

Mielenterveys on olennainen osa jokapäiväisessä elämässä toimimista. Mielenterveyden edistämisen tutkimus on tärkeää, sillä se keskittyy yhteiskunnallisesti sensitiiviseen terveyden alueeseen. Siitä huolimatta mielenterveyden edistäminen tai sen politiikka ei ole ollut kovinkaan suosittu tutkimusaihe ennen 2000-luvulle tulemista.

Mielenterveys on kiinnostava aihe moni tavoin. Tätä tutkimusta ohjaa olettamus, että terveyden edistämisohjelmat jakautuvat terveyden edistämisen lähtökohtiin tavalla, jolloin niiltä osittain poikkeavat mielenterveyden tavoitteet voivat saada ohjelmista vähemmän tukea. Tutkimuksen perusolettamus on väite, että mielenterveydellä on syrjäytyvä asema terveyden edistämisen alueella. Vaikeudet määritellä mielenterveyden käsite sekä hahmottaa mielenterveyden ja kokonaisterveyden suhde ovat hankaloittaneet mielenterveyden sijoittamista terveyden edistämispolitiikkaan ja -käytäntöihin. Kansallinen mielenterveyspolitiikka keskittyykin usein organisatorisiin hoidon järjestelyihin, kun taas liittyminen somaattisen terveyden edistämisen strategioihin edellyttäisi esimerkiksi tupakan, ravitsemuksen ja liikunnan kaltaisten determinanttien tunnistamista ja toiminnan kohdistamista niihin.

Huolimatta mielenterveyden yhä kasvavasta julkisuusarvosta, inhimillisen kärsimyksen määrästä tai yhteiskunnallisista kustannuksista, sen rooli kansallisissa terveysohjelmissa on ollut verraten pieni. 2000-luvun alussa alkaneen tutkimukseni olettamuksena oli, että terveyden edistämisohjelmat ovat rakentuneet tavalla, jotka eivät välttämättä tue mielenterveystavoitteita. Siten oletuksena oli, että mielenterveyden täytyy puolustaa rooliaan terveyden edistämisen alueella.

Tutkimus analysoi mielenterveyden roolia ja asemaa kansallisissa terveyden edistämispolitiikoissa lähestymistavan liittyessä toimintapolitiikan tekemiseen. Osatutkimuksissa mielenterveyttä tarkastellaan terveyspolitiikan kehän eri vaiheissa. Siten mielenterveyttä tutkitaan ongelman ja toimintapolitiikan muodostamisen, toimintapolitiikan omaksumisen ja lopuksi arvioinnin näkökulmista. Tutkimus keskittyy seuraaviin kysymyksiin; millaisia argumentteja mielenterveydestä käytetään terveyspolitiikka-asiakirjoissa? Mitä merkitystä on

mielenterveyden taustatekijöillä mielenterveydestä politiikan näkökulmasta? Miten ja kenelle mielenterveyspolitiikka-asiakirjat on suunnattu? Millainen terveyden edistämistavoite mielenterveys on arvioinnin näkökulmasta?

Tutkimuksen aineisto sisältää kansallisia terveyspolitiikka-asiakirjoja Suomesta, Ruotsista, Englannista, Hollannista, Tanskasta ja Portugalista. Taustamateriaalina käytettiin myös useita informanttihaastatteluita kustakin maasta. Aineiston analysointimenetelmät ovat laadullisia.

Politiikka-asiakirjojen analyysi paljasti mielenterveydelle annettuja olettamuksia, asenteita ja arvoja. Niiden avulla voidaan esittää hahmotelma tavasta, jolla Eurooppalaiset hyvinvointivaltiot puhuvat mielenterveydestä ja sen edistämisestä. Tutkimus antaa myös viitteitä siitä, etteivät tehokkaatkaan tavoitteet välttämättä kohtaa todellisia tarpeita tai sitä, mitä kentällä loppujen lopuksi tehdään. Tutkimuksen yhteenvedossa keskustellaan myös niistä monista ja moninaisista tekijöistä, joiden takia mielenterveyttä, sen edistämistä ja toimintapolitiikkaa pidetään hankalana. Stigma, vaihtelevat määritelmät, taustatekijöiden moninaisuus ja niiden syy-seuraussuhteet ovat vain muutamia mielenterveyteen liitettyjä ongelmakohtia. Terveyden edistämispolitiikan tulisikin entistä tehokkaammin huomioida mielenterveyden erityisvaatimukset. Tämän tutkimuksen tulokset saattavat antaa viitteitä siitä, kuinka mielenterveyden edistämispolitiikkaa tulisi suunnitella terveyden edistämispolitiikan osana.

Acknowledgements

This has been a long journey and now is time to acknowledge those people who have been involved.

First I would like to express warm thanks to my supervisors; Professor Juhani Lehto and Professor Pirjo Nikander. I would like to thank Juhani for giving me a chance to be part of a research project and grow into the role of researcher. Your knowledge in the area of health policy has been tremendous and you have always been generous to offer it when needed. Pirjo, I am extremely grateful to have had you as my supervisor. Your wisdom in whatever area "in doing science", as well as support, always lifted my spirits when it was most needed.

The TEPOL Research Project seniors; Dr Marita Sihto, Dr Eeva Ollila and Dr Meri Koivusalo; thank you all for your advice and guidance during my first steps as a researcher. It was a pleasure to be part of TEPOL group.

My follow-up group members; Dr Eero Lahtinen and Dr Maila Upanne. I would like to thank you for your scientific knowledge. In written form it has guided me from the beginning.

Thank you to Docent Ville Lehtinen and Professor Sirpa Wrede for accepting the role of official reviewers of my work and for providing comments which were highly appreciated.

I would also like to thank the FF group, recently known as SOTEPO group, for comments, advice and support during the writing of articles.

All the fine women and men in the group of Social and Health Policy; keep up the good work. Jutta, Sari M, Liina-Kaisa and Annika – you are all great women! Especially I would like to thank Leena, who began her journey at the same time and shared the ups and downs, the tears and the laughter with me.

I would also like to thank other colleagues with whom I have worked in The School of Health Sciences – Helena, Stiina, Sari F, Ilkka, Olga and also Rita, who took me as part of other activities besides this research project.

The Mental Health Promotion Unit in THL; Eija, Kaija, Esa, Minna, Maarit, Anne, Ritva, Maritta and Heli – during the last year of this process you have been my

haven of support in both ending one journey and beginning another. I will never forget how warmly you took me as part of your team. Especially I would like to thank Eija, who as a team director, a colleague and a mentor is more than I ever could hope for.

I also thank Virginia Mattila for doing a great job in proofreading the article manuscripts and the overview as well as Aila Helin for doing the layout.

For financial support I would thank Emil Aaltonen Foundation, University of Tampere, Doctoral Programmes in Public Health (DPPH), The National Post Graduate School in Social and Health Policy, Management and Economics (SOTKA), Competitive Research Funding of the Tampere University Hospital and Ministry of Social Affairs and Health.

My friends who share my passion for equines, and those who do not, but accept me anyway. Your company has given me much welcomed break from continuous working. Special thanks to Hanna and her family, for relaxing evenings of good food, wine and company. I have always been able to have your support in what ever I did.

My sister Sini, thank for being much more than a sister. You have often acted as a voice of reason and always been ready to listen. My parents Marianne and Raimo, who co-lived this process with me.

My four-legged friends; when stressed out, you have showed me what ultimately is important; a sunny place to sleep and a pile of good hay.

My husband Tero, during this process, you have always believed in me. Without you, I would not be complete.

Ylöjärvi 27.6.2011

Pia Solin

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Abbreviations

DSM	Diagnostic and statistical manual of mental disorders
GT	Grounded theory
ICD	Statistical Classification of Diseases and Related Health Problems
RCT	Randomised controlled trial
WHO	World Health Organisation

1. Introduction

We need mental health to perceive, comprehend and interpret our surroundings, to adapt to the changing world around us and to change our comprehension when needed. It helps in our communication with others, in forming and sustaining relationships and living our daily lives. Mental health is evidently part of the wider notion of health and moreover, of our everyday living. However, a little over ten years ago mental health policy was not always a very popular research area, although recognition of the neglect of mental health is evident in health promotion and public health documents. In 1999, according to Lahtinen et al. (1999), there were no studies analysing or comparing mental health promotion policies, nor were "research projects attempting to enhance the visibility or the value of mental health" reported. They also claimed that one way of improving the situation would be to stress the importance of mental health policy surveys including interviews with key players and content and value analysis of mental health policy documents as well as analysis of the implementation mental health promotion projects and legislation related to mental health. (Lahtinen et al. 1999) Knapp et al. (2007) also argue that wider international interest in mental health issues has been missing until this century.

Before starting the research project I collected information; references, policy documents, reports, articles, etc. anything that might be usable for background information but also as data. I could easily agree about of this lack of research as well as rising interest in the area. It did make the issue more intriguing. As a novice researcher I was excited to have a chance to attend the WHO European Ministerial Conference on Mental Health in Helsinki in 2005 and be part of making mental health policy. I felt that I was witnessing something happening. During the preparation of this research project the situation may have changed somewhat, for example Finland raised mental health on the European Union agenda during its presidency (Lavikainen et al. 2000). In October 2005 the European Commission published a Green Paper on mental health and this started preparations for a mental health strategy of the European Union (Taipale & Lavikainen 2006).

Not only in the area of research, mental health also had a smaller role in national health programmes, in spite of continually rising publicity, the amount of human suffering and costs to society, mental health services were claimed to suffer from undervaluation, which may have led to a lesser role of promotion.

This may have been a correct assumption, especially if promotion was seen as a rival for services regarding attention and resources. (WHO 2003) The separation of mental health from the notion of health in general may have only highlighted its distinctiveness and this may have led to a situation where it has been excluded as a marginal area. It seems that mental health has had (and still has) problems which are difficult to locate and which undermine the chances of reaching an equal status in health promotion. The stigma of mental illness seems to be one of explanations for the problematic nature of mental health in policymaking (McSween 2002). My interest in the visibility of mental health on national health promotion programmes is based on a hypothesis that mental health and its promotion did not gain the respect that it should have. Further I will discuss many aspects why mental health, its promotion and mental health policy have been considered difficult. Stigma, ambiguous definitions, a variety of background factors and causality are only a few obstacles linked to mental health.

Policymaking is a process with various phases from problem definition to evaluation. On each phase there are certain activities to be done and thus the whole process becomes very delicate in order to be successful. (e.g. Dunn 1994; Rushefsky & Patel 1998; Van de Water & van Herten 1998) In this research project mental health is scrutinised through separate phases of the policy cycle and thus the aim is to outline the status and role of mental health in health promotion policy documents used as the research data.

This research project consists of four articles and their summary. The articles scrutinise mental health in different phases of policymaking, as a discourse and health issue. The studies analysed the role and position of mental health in national health promotion policies, the determinants of mental health and evaluation of mental health targets. It also scrutinised how and to whom mental health policy documents are directed.

The research project is based on a claim that mental health has a defensive position in the area of health promotion. If health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" and that "there is no health without mental health" (e.g. WHO 2004a) and thus it is accordingly given an equal status as a part of overall health, how is the varying or even marginal value of mental health in national health programmes to be explained? The research project also aims to paint a realistic picture of how mental health and its promotion are conceptualised in a number of European welfare states. Discourses,

as manners of speaking and arguing, in policy documents and the development of mental health policy goals and strategies reveal assumptions, attitudes and values, which are given to mental health promotion. The research project asks if efficiently designed targets and objectives meet the realistic needs or actions. Mental health promotion research is important as it focuses on an issue which is societally sensitive and insufficiently addressed by aiming to increase the discussion and the attention paid to it. The result of this research project on mental health promotion and policy may hopefully give more insight into mental health as a policy object, and thus be helpful in producing guidelines on how to plan mental health policy in the future.

Before presenting the background of the issue, opening up a few basic concepts that I will be using throughout the paper is appropriate. When *mental health* is discussed (without a reference), I refer to mental health which includes positive mental well-being, not only absence of mental illness. The term *mental health promotion* has raised a lot of differing opinions, as will be discussed later. However, I agree with Coombes & Thorogood (2003), who have described mental health promotion to be "activities such as public policy aimed at improving health, clinical interventions which aim to enable people to take more control of their health, and a variety of interventions which aim to strengthen communities and increase social capital." This definition stresses social capital as well as mental health promotion in all policies and thus suits my perspective on the issue. The term *policy* has been referred as "a purposive course of action that an individual or group consistently follows in dealing with a problem" (Anderson 2003). When discussing *mental health policy*, in its widest sense, it is understood "as an organised set of values, principles and objectives aimed at improving mental health and reducing the burden of mental disorder in a population" (WHO 2008a).

These concepts are discussed in further detail in the text as I present the various conceptualisations of mental health and mental health promotion. I will also discuss the issue in more detail from the perspective of *public health*, *promotion*, *prevention* and *mental health policy*.

2. Background

According to Lahtinen et al. (1999) when decisions are made concerning priority issues in the field of health policy they can be made by referring to the following issues; are the societal costs of the disease high enough, what is the face value of its importance or what are the specific needs of the community? If an idea is a newcomer in the field of public health it must prove not only to be evidence-based and cost-effective but also socially and culturally accepted. (Lahtinen et al. 1999) Mental health is recognised to be an economic and societal burden nationally and globally (e.g. Jenkins et al. 2002). This legitimises its place among public health priorities. However, mental health has cultural as well as social dimensions which exist, even if rarely, in somatic diseases such as AIDS. In the following chapters I will discuss the conceptual ambiguity and distinctive features of mental health, I will continue by analysing characteristics of mental health as a public health issue, in areas of prevention and promotion policy and how they affect policymaking in action.

It is claimed that "mental health is not a high-enough governmental priority to attract proper long-term planning", instead it is "a classic example of ad hoc, short-term policymaking" (Kemp 2004). Furthermore, it is said that the health sector reforms also carry several risks for mental health policy. During such reforms mental health services are at risk of marginalisation and decentralisation may lead to the fragmentation and exclusion of services for people with mental disorders. (WHO 2003) This policy fragmentation does not promote the use of the same methods in policymaking between mental and physical health as mental health already is in a subordinate position compared with physical health (Lahtinen et al. 1999). This may well be explained by the problematic nature of mental health. However, there are various other reasons for mental health policy being a sensitive process. (Jenkins et al. 2002; Rogers & Pilgrim 2001) One of these is the fact that in order to achieve the goals of public policy on mental health the involvement of various sectors is needed. Actors from the health sector alone are not sufficient. (Jenkins et al. 1998)

According to Rogers & Pilgrim (2001) current mental health policy has to control functions which were not recognised a century ago, promote well-being, reduce distress and respond to mental illness surrounded by dysfunction. The problem in this perspective seems to be that even though mental health policy has

overcome this transformation from simple “lunacy policy” to diverse mental health policies and has become closer to somatic health, it still retains special features which do not fit. Additionally, the health policy solutions offered are not always accepted by all the actors, which leaves the issue unresolved while opinions are exchanged. (Rogers & Pilgrim 2001) However, mental health policy would benefit from the development of mental health indicators and from research and development. A fine example of a community-based health promotion programme focusing on physical disease is The North Karelia Project (Pohjois-Karjala Projekti) (Puska et al. 1983). Unfortunately no reports of a similar extent in mental health promotion activities exist. According to Lahtinen et al. (1999) “this may be due, in the first place, to the secondary position of mental health compared with physical health, but also the fact that the mainstream orientation of mental health promotion has remained at the level of individuals.” Nonetheless, serious efforts have been made to enhance the value and visibility of mental health.

2.1 Conceptualising mental health

In the late 1950s Jahoda (1958) already thought that “there is hardly a term in current psychological thought as vague, elusive and ambiguous as the term mental health.” As proof of this, over half a century later, the term remains largely undefined and ambiguous. The word ‘health’ alone “represents different things to different people at different times and different situations.” (Commers 2002) So what is mental health? Is mental health sanity and if so, according to what? Or is it happiness? One may be mentally or physically ill, but content and happy in one’s life. A person may also be healthy both physically and psychologically in medical terms, but be unhappy, feel distressed or depressed. Is that person mentally healthy? From that point of view mental health can be considered something that is experienced individually but constructed collectively. Even within the field of mental health expertise; psychology, psychiatry or psychotherapy, there are various ideas of what mental health is and how it can be affected (Munk-Jorgensen 1996). Often when referring to mental health, we are concerned with mental illness instead (Tudor 1996). It is argued that from layperson to politician the concept of *psychiatry* contains variety of terms, such as; primary mental health, mental health, primary mental health

prevention, psychiatric illnesses, etc. According to Munk-Jorgensen (1996) this is the consequence when the professionals themselves have not clarified the concepts in such a way that they would be unambiguous to all including the profession itself. However, Seedhouse (1986) has suggested that the pluralist view of mental health may not be completely a hindrance, as it could also be seen as a potential.

Before discussing mental *health*, it may be relevant to briefly discuss the terms of *being* ill and *feeling* ill[1], as the two terms must be differentiated. How does one measure what one is feeling and in comparison to what? The terms disease and illness are likewise not synonymous; one may have a disease, but not feel ill. Or one may feel ill without a disease. (Downie et al. 1996) According to Downie et al. (1996) "the idea of abnormal or sick states of mind is much less obvious and a source of much more disagreement than that of abnormal bodily states." This is a result of the biological norm in the definition of the terms 'body' and 'abnormal', whereas the norm of 'mind' is either culturally relative, social or statistical. Labelling deviant behaviour as abnormal, and thus sick, is a good example. Confusion over what is considered abnormal leads to a variety of sub-terms, as abnormal states can be divided into sick desires, minority desires and immoral or illegal desires. For example, stealing is considered a desire of a minority and an illegal action, however, it is not considered as sick in general. (Downie et al. 1996) Mechanic (1999) also discusses mental illness as a form of deviant behaviour. It is deviant when the community and its culture define one's feelings or behaviours as problematic or inappropriate.

The simplest mental health model is *unipolar*, which actually refers to mental illnesses, not *health* (Herron et al. 1997; Kendell 1995). Some researchers have defined mental *health* as merely an absence of illness, and thus, the relationship between mental health and illness has been left without analysis (Secker 1998). It has also been argued that the terms 'mental health' and 'mental illness' suffer from not being viewed as separate concepts and having a strong negative connotation (Herron & Springett 1995). But do concepts used in physical ill-health apply in mental ill-health? It has also been shown that the division of physical health and mental health is artificial and a product of the western developed world. There are cultures where physical illnesses are closely connected with the emotional, social or spiritual health of an individual. (Sturgeon 2007)

1 Downie et al. (1996) refer to health in general when discussing these terms.

The bipolar model of mental health puts mental health and ill-health on the same continuum (Kendell 1995). Tudor (1996) claims that this does not further our understanding as "to define something by the absence of its opposite is simply a semantic sleight of hand and to define it by substitution is procrastination." He also points out that policies which aim to promote the mental wellbeing of the mentally ill, are very difficult with a single mental health - mental illness continuum (Tudor 1996). Instead, both mental health and ill-health should have their own continua, where the mental ill-health continuum includes the most severe mental disorders as well as symptoms of different severity and duration (Lahtinen et al. 1999).

There are several researchers who are in favour of *the two continua model* (see for example Trent 1992; Herron et al. 1997, also Downie et al. 1996). The mental health model of Keyes (2003) (Figure 1.) presents the terms of flourishing and languishing. A person is flourishing when experiencing good mental health without any symptoms of mental illness, whereas a person is languishing when experiencing poor mental health without any symptoms. The model suggests that both mental health and mental illness can vary independently and from minimal to maximal. According such a conceptualisation one may suffer from mental illness but "experience good mental health in terms of having a genuine sense of subjective well-being, and be functioning well". (Tudor 1996; Lahtinen et al. 1999)

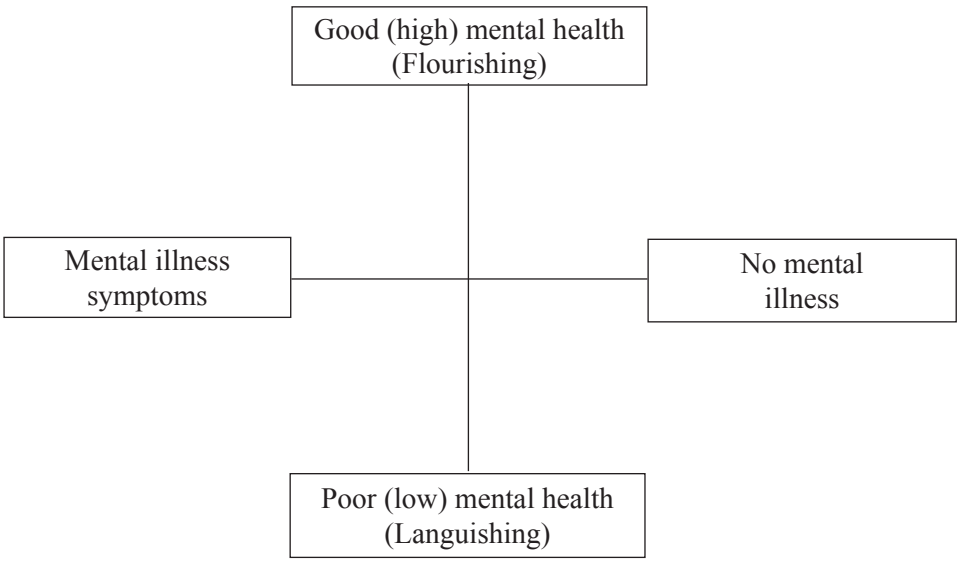

Figure 1. Mental health model (adapted from Keyes 2003).

T*he functional model of mental health* (Hosman 1997; Lahtinen et al. 1999) could also be situated on the two continua model where mental health and ill-health are separated. The term of *positive* mental health has been attached as part of this model (Sohlman 2004). It can be considered as a potential with conceptual dimensions which are divided into four groups. First, there are *individual factors and experiences*, which entail elements such as thinking, identity, self-image, coping skills and physical health. Second, there are *social support and interaction* with the surrounding elements of school, work and family but also community and environment. The third dimension, *societal structure and resources* consists of social policy, societal system, housing, etc. Finally, the last dimension; *cultural values* is mainly about mental health; how its problems, disorders and deviance are tolerated and how they stigmatise. It also entails how mental health and illness are defined socially and what appreciation is given to mental health. But it also includes what the basic societal values are, such as equality and human rights. With such an approach presented in this section, health, mental as well as somatic, seems to be "a state of equilibrium between the individual and the environment." (Lahtinen et al. 1999) This idea of mental health as a state of equilibrium between various parts can easily be related to the WHO (2001) definition. According to WHO (2001) mental health can be defined as a state of wellbeing "in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Mental health can also be seen as *a process*. It entails risk and protective factors as well as various consequences and outcomes. As a process mental health can be approached from either a positive or negative perspective. The negative approach contains psychological disorders, symptoms or problems. On the other hand, the positive approach sees mental health as a resource, which is central to our wellbeing and capacity to interact and cope with our surroundings. (Lavikainen et al. 2000)

This section has acknowledged that mental health is a heterogeneous issue which changes and transforms, while forming the basis of human wellbeing and capacity (Lavikainen et al. 2000). The term mental health is wide, as it includes a range of needs and issues that apply to a heterogeneous population (Mechanic 1995). Maybe we should talk about mental health*s* in the plural instead of the singular, as Tudor (1996) has suggested. Furthermore, Ingleby (1981) notes that conceptualising mental health is very much a political issue as it depends on our

views of what society should be like. In any case, as can be seen, the definitions of mental health and illness are currently very ambiguous and one may ask whether a unitary conceptualisation will ever be agreed on. In the next section I will move on to discuss mental health as a public health issue.

2.2 Mental health as a public health and global challenge

In this section I will scrutinise mental health as a public health issue. I will describe the nature of mental health problems as a public health challenge from the perspective of risk factors.

The burden of mental illness consists not only of suffering from the illness itself, but also of the social and economic costs affecting the individual as well as society. These include health and social service costs, lost employment and reduced productivity, the impact on families and caregivers, levels of crime and public safety, the negative impact of premature mortality. Costs that cannot be measured, such as costs of lost opportunities of individuals and families, are also part of the burden. (Jané-Llopis & Anderson 2007; also Funk et al. 2007; Jenkins et al. 2002)

It has been estimated that approximately 450 million people suffer from mental and behavioural disorders worldwide (WHO 2004b). The 'Global Burden of Disease' reported that 25 percent of all morbidity is estimated to result from psychiatric illnesses (WHO 2008b). A little over a fifth of the adults (18-65 years) living in the EU area has suffered from at least one mental health problem during the past year. This includes problems arising from substance abuse, psychoses, depression, anxiety and eating disorders. (WHO 2011) The mental ill-health of the population causes a heavy economic burden for society, depression being the heaviest. (Vieth 2009; Jenkins et al. 2002) The direct costs of schizophrenia are also estimated to be higher than the costs resulting from smoking (Lahtinen et al. 1999). The overall costs of mental health problems are calculated to be as much as 3-4 percent of GNP in EU Member States (Vieth 2009; Lavikainen et al. 2000).

There are not only the direct costs (use of services), but also indirect costs, like disability pensions and sick leaves (Lahtinen et al. 1999). According to Lavikainen et al. (2000) mental disorders are the most common cause for disability pensions in the European region. In 1990, five of the ten leading causes

of disability (years lived with a disability) were psychiatric conditions: unipolar depression, alcohol abuse, bipolar affective disorder, schizophrenia and obsessive-compulsive disorder (Jenkins 2003). Sick leaves due mental health problems and somatic disorders caused by them along with suicides and accidents have turned mental health problems into a major public health risk. Mentally disturbed people tend to have higher mortality and morbidity rates than general population (Persson et al. 2001). For example, Sohlman & Lehtinen (1999) found in their study that the mortality of psychiatric patients is higher than of general population. Poor mental health and emotional distress are risk factors for several physical illnesses such as to cardiovascular and respiratory diseases as well as malignancies (Jenkins et al. 2002; Lahtinen et al. 1999). The costs of mental health problems are very often widely spread and especially outside the health sector (Knapp et al. 2004).

There are several costs that cannot be measured in monetary terms. Suffering caused by illness itself and social consequences like shame, fear, stigma and loss of a certain social status affect not only the patient but also his or her family and relatives. The effects lead to discrimination and often transfer to the next generation. The burden of patients' families causes psychological and somatic consequences like depression and emotional exhaustion, which add to the burden caused by a straitened financial situation. (Lahtinen et al. 1999; Funk et al. 2007) If quality of life is concerned, it cannot be measured only by physiological healthiness. Mental ill-being can affect all aspects of life equally drastically.

Alleged threat of violence is a challenge which does not exist with somatic illness. There are arguments that violence is more common among those with mental health problems (e.g. Wolff 2002) However, having a mental illness is not a very good predictor of violent behaviour. Predictors such as social class, age, gender and substance abuse have been suggested to be much more valid indicators. However, the fear of risk of violence is real, even though the fear may be groundless. Still, this alleged threat may have an impact on a person as they may re-define themselves and suffer from this risky image. A threat posed to a mentally ill person from outside is much more probable. These risks include loss of freedom and access to material and social resources as well as iatrogenic risk[2]. (Pilgrim & Rogers 1996) This entails that "in addition to the obvious suffering caused by mental disorders there is a

2 Iatrogenic risk refers to a situation where something considered as treatment may cause harm to a person receiving it (Pilgrim & Rogers 1996).

hidden burden of stigma and discrimination, and human rights violations" (Funk et al. 2007).

From this perspective one can ask why public mental health has not been higher on the agenda until now. In order to achieve public policy goals on mental health (one being mental health promotion) actors solely from the health sector are not sufficient. In order to succeed, public mental health needs involvement from various sectors: social welfare, industry, employment, education, environment and housing, etc. (Jenkins et al. 1998; Jenkins 2003) The growth of ex-user groups and their involvement in the area has been an important advocate in redesigning mental health policy. The needs of the stakeholder group may also vary. Families may value adequate information as well as financial and social support while policymakers emphasise cost-effectiveness in actions. The needs of consumers may include autonomy, whereas mental health professionals stress efficiency and resources. (Funk et al. 2007) Friedli (1999) brings to the debate the concept of 'public mental health'. This 'public mental health' takes a broader view of mental health and provides a framework for talking openly about the mental health needs of the whole community.

Most countries have recognised that mental health policy (public mental health) is an important area in enhancing their economic, social and human capital (Jenkins 2003; also Jenkins & Strathdee 2000). The mental health aspect of different sectors of society becomes even more crucial when the basis of mental health/illness seems to be in the social environment of individual. Positive mental health, discussed earlier, is not only an individualistic feature; it is a resource for families and larger entities, such as societies and nations. Thus, good mental health promotes wellbeing, the ability to function and individuals' attachment to different communities and to society. As a crucial part of public health it affects productivity and the actions of society. The link between mental and physical health is undeniable. Those who have mental health problems have higher morbidity and mortality than average. (Lavikainen et al. 2000)

2.3 Measuring stigmatic mental health

In what follows, the problematic nature of mental health is further discussed through the notions of measurement and stigma. Health strategies and programmes set targets and objectives which have to be measured and evaluated. One can measure the incidence of those suffering mental illness or the use of hospital beds, but how one can measure mental *health*? The social stigma and the measurement of such stigma linked to mental health further complicate any attempt at measurement. These points are further elaborated below.

Mental health lacks indicators similar to those existing for certain somatic illnesses. Therefore evidence-based knowledge and cost-effectiveness of mental health promotion are difficult to prove to the full extent. Mental health has been a challenge for a long time, not only to define, but also to measure and classify. Various ways to apprehend abnormality and its relation to what is considered to be normal do not make the job any easier. (Tudor 1996) Conceptualising mental health can be constructed from many different perspectives; normatively, statistically, clinically, subjectively with various cultural backgrounds (Tudor 1996; Chwedorowicz 1992). The question of indicators and measuring mental health as well as estimating the burden of mental health can therefore be problematic (WHO 1999). One may ask whether the instruments are adequate or fit. Probably neither, but it could be suggested that the concepts used also affect the selection of indicators. The statistics on depression, anxiety or suicide are relatively 'easy' and have a common background with other health indicators. However, would the mental health of society need different kinds of indicators such as levels of tolerance, safety or trust, which tell how we feel about ourselves and others. That would mean creating a whole new system of mental health indicators. (Friedli 2000)

Because it is difficult to find satisfactory outcome measures for public mental health, measuring mental illness and especially prevention of suicide has become more and more used (Tyrer & Tyrer 2002), at least until something more suitable comes along. Using suicide as an indicator of mental health entails problems as it has cultural differences which affect "both for the inclination to commit suicide and for the tradition of determining the cause of death" (Persson et al. 2001). Difficulty in producing hard data about the reasons for and consequences of mental ill-health is quite universal. Suicide rates, hospital beds and availability and use of psychiatric

drugs are also used. They all measure 'result', not reasons, and in measuring mental healthiness or mental ill-health, as indicators, they are still quite inadequate.

In 1999, a two-year action project was started to establish the indicators for mental health monitoring in Europe. This common set of indicators for mental health aimed to enable the establishment of joint efforts in the field of mental health, comparison of policies and activities in different Member States as well as evaluation and dissemination of good practices. (Korkeila 2000) The following MINDFUL[3] project aimed to improve the level of mental health information. It also produced a proposal for a comprehensive mental health information system in the EU area. In this project monitoring of mental health was considered as a systematic, regularly repeated "measures of matters related to the mental health of the population." Furthermore, monitoring mental health should include repeated data collection with interpretation of the evolution of mental health and suggestions for further actions if needed. It is stressed that a comprehensive monitoring system needs to scrutinise mental health from several aspects. The definitions of positive and negative mental health are also acknowledged and it is understood that mental health problems may "exist even though the criteria for clinical disorders are not met". (Lavikainen et al. 2006) This is challenge for both measuring as well as for policymaking.

Measuring the burden of stigma remains without a proper indicator, although fighting stigma on mental health problems has been among the latest objectives of the WHO (and most European countries) and also of the EU mental health declaration. Stigma and the ensuing discrimination are part of the burden created by mental health problems. (WHO 2001; European Commission 2005) Negative opinions will indiscriminately overemphasise various social handicaps that may follow mental disorders. For example, social isolation and difficulties in employment are usual (Crisp et al. 2000). However, stigma is not merely a negative concept. If used correctly it can be an effective tool. For example, as a topic of discussion it can reduce tacit assumptions towards itself. (WHO 2001) In such a campaign it is necessary to do more than just provide information but also to attempt to reduce discrimination (Crisp et al. 2000). As the stigma of the mentally ill has its origin in the perpetrators' fear and ignorance, open discussion might dispel false beliefs and negative images (See Crisp et al. 2000). Changing public perception is a continuous process and should start from small group level, such as from neighbourhoods (Reda

3 The project MINDFUL "Mental health information and determinants for the European level".

1995). It is also important to recognise differences in opinions about different mental disorders when campaigning against stigma (See Crisp et al. 2000) Furthermore, understanding of the social determinants of illness (for example poverty and violence) may promote broader awareness of linking mind and body (Garfinkel & Goldbloom 2000).

The beginning of the development of classification systems[4] several decades ago was a huge step forward in measuring mental illness. Even earlier, over half a century ago, an epidemiological approach arose in public health, which allowed mental illness (through epidemiological data) to be studied and compared in similar ways to physical illness. (Tyrer & Tyrer 2002) It seems that the rise of epidemiology to policy on environmental issues (employment, housing, education, etc.) and through these to mental health makes another advance this century (Jenkins 2003; also Bramesfield & Wismar 2003). The difference is that earlier epidemiology showed data on mental illness and its prevalence, now, according to Jenkins (2003), it can be used through general policy for promoting and evaluating mental health.

2.4 Prevention of mental health problems

In the previous sections the various conceptualisations of mental health and also its role and magnitude as a public health issue were discussed. Those sections already underlined the common difficulties concerning mental health as a term and quantifiable burden. When discussing the term of prevention, it seems that the terms prevention and promotion often tend to overlap each other. However, most authors situate mental illness prevention as an activity under mental health promotion. In order to clarify this use of terminology, it is necessary to discuss it in more detail in order to reach a better understanding of this area before entering into a discussion of mental health promotion.

4 WHO's *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) are international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. It has a chapter of *Classification of mental and behavioural disorders*, which contains detailed classification of over 300 mental and behavioural disorders. ICD-10 was updated in 2010. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) consists all mental health disorders and lists known causes of these disorders, statistics and prognosis as well as some research concerning the optimal treatment approaches. This manual is under process for a fifth version.

There is a wide range of actions and ideas under 'mental health'; either in mental health promotion, mental illness prevention or psychiatry. Although there is a theoretical difference between mental health promotion and the prevention of psychological disorders, according to Lahtinen et al. (1999) they should not be separated, as mental health promotion does likely prevent psychological disorders. In some cases it is necessary to see these two as interrelated and overlapping activities. Jenkins (1994) has suggested several alternative relationships for prevention and promotion[5]. However, Jenkins (1994) continues, if health promotion were only a sub-strategy of primary prevention, it would reduce the role of promotion and, thus, its effectiveness.

Fundamental to prevention is to reduce "the risk of occurrence of a disease process, illness, injury, disability, handicap, or some other unwanted phenomenon or state." (Downie et al. 1996) As the public health model has traditionally been used in the prevention of mental health problems, this has meant dividing it into primary, secondary and tertiary prevention. Primary prevention is basically considered as Downie et al. (1996) presented above. It focuses on reducing the appearance of new cases (incidence) and is targeted at people with a risk of having a mental health problem. Secondary prevention aims to shorten the duration of the disorder (prevalence) with early and fast treatment. Finally tertiary prevention focuses on relieving the existing disorder and also diminishing the loss of ability to act that connects to it. (Caplan 1964)

There are also several approaches to preventive actions in general. *Universal prevention* focuses on the whole population, whereas *selective prevention* is used in population groups at higher risk. Preventive actions designed according to need are directed towards certain smaller groups, for example those who have experienced emotional stress. (Jenkins 1994) It is argued, however, that primary prevention would focus only on risk groups with interventions of selective nature and based on need, whereas promotion focuses on the whole population with universal strategies (Toews & El-Guebaly 1989). Even though there are arguments for primary

5 Jenkins (1994) sees alternative relationships for prevention and promotion. The first model construes both as separate functions having their own strategies. In the second model mental health promotion consists of increasing positive mental health as well as primary, secondary and tertiary prevention. In the third model primary prevention consists of universal, selective and indicated strategies and mental health promotion is included in the first as an educational task.

prevention and promotion to be completely different, it is easy to comprehend why these two concepts are often used synonymously.

2.5 Targeting health and mental health

In mental health policy, either the prevention of mental illness or mental health promotion need aims to guide policy actions. Setting targets is used in all policymaking to give focus and maximize recognisability (van Herten & Gunning-Schepers 2000). Health policy especially has used targets starting with the WHO Health for All strategy for the European Region which became reality by 38 targets in the 80's (WHO 1985). In this section I will briefly discuss the use of targets in overall health policy, as the issue becomes relevant in Study IV.

According to van Herten & Gunning-Schepers (2000) the idea of using targets in health policy comes from the business world. "Management by objectives" approach specifies the common goals which in turn are turned into targets and finally into focused actions. Using targets has other benefits as well; for example, targets are said to improve management as they may help decide whether "a policy is realistic in terms of strategies, timetables and resource allocation". The measurement of progress is also facilitated by explicit targets. (van Herten & Gunning-Schepers 2000)

Unfortunately most of the drawbacks of target setting can be seen in mental health policy. Difficulty in creating targets or other statistically based objectives except lowering suicide rate is common in mental health. In overall health policy formulating targets may suffer from setting only easily measurable targets while neglecting other important or new issues (Zwick 1983; Abel-Smith et al. 1995). On the other hand, excessively ambitious or varying targets may hamper the implementation phase (Koontz et al. 1986; Zwick 1983). Even though novel targets were set, evaluation may easily concentrate on those issues which are measurable (Zwick 1983) as novel targets usually need additional research and data. However, overall use of targets in health policy enables monitoring and evaluation and this in turn generates more knowledge which can be used as a base for decision-making (van Herten & Gunning-Schepers 2000).

According to Tudor (1996), mental health targets have to be not only commonly agreed upon but also compatible at international, national, regional and local levels. However, this is possible only with mutual political understanding and sufficient economic resources. Tudor (1996) argues that these are items which unfortunately are lacking in the field of mental health promotion. Furthermore, the methodological conditions of health targets should be specific, measurable, achievable, realistic and time-bound (SMART). However, without political will, commitment and courage these SMART conditions are worthless. It is argued that "due to the limited direct influence of the actions taken by the government on the health status of a population, targets should mainly focus on health determinants". (van Herten & Gunning-Schepers 2000) However, following this argument means special attention in planning mental health, as the determinants of mental health are complex, as the background factors "are associated with different aspects of mental health" (Lehtinen 2008).

2.6 Mental health as a focus of health promotion

As discussed earlier in the section on conceptualising mental health, it is a very ambiguous term. Due to methodological difficulty in both defining mental health and in outlining its relationship to health overall, situating mental health in health promotion policy has been problematic. It has also raised question of "what efficient mental health promotion is" (see Braidwood 1997; Munk-Jorgensen 1996). In this section the concept of mental health promotion is discussed from the health promotion perspective as the term has suffered from confusion and has most often been conflated with mental illness prevention. (Tudor 1996) However, before discussion these aspects, I will briefly introduce the background of the *health promotion* concept.

The term 'health promotion' appeared in its current form in 1975 in the Lalonde Report (Lalonde 1974). This report introduced at that time a novel perspective into public health policy consisting of the treatment and prevention of illness as well as the promotion of health. It also started a series of WHO initiatives (Tudor 1996). WHO has also had an important role in the formation the term of health promotion.

There are several opinions as to which actions should be included in health promotion. One view suggests that in order to enhance positive health and prevent ill-health the activities of health education, prevention and protection are connected as a model of health promotion (Tannahill 1985; Downie et al. 1996). Health promotion can also be considered as an umbrella term subsuming cure, prevention as well as policy (Tones 1990). Despite various actions under health promotion, it should be remembered that to be most effective it should enhance *all aspects* of health; physical, mental and social as well as prevent ill-health in these. The term health education then strives to do both by influencing beliefs, attitudes and behaviour (Downie et al. 1996). However, it seems that WHO with its Health for All strategy has had the main role in establishing the term of health promotion.

In 1977 at the Thirtieth World Assembly it was accepted that health for all would be the main social target of governments and WHO. The Declaration of Alma Ata in 1978 launched the strategy 'Health for All by the Year 2000' (later referred to as 'Health for All') which was later revised into 38 targets with principles of action (WHO 1985) The HFA strategy stressed equality, impact of services and policies outside the health sector, intersectoral and multidisciplinary collaboration and finally community participation. Since then, WHO has issued several statements on health promotion. (Downie et al. 1996) For example, according to the Ottawa Charter (WHO 1986) health promotion can be defined as five actions 1) building healthy public policy, 2) creating supportive environments, 3) strengthening community actions, 4) developing personal skills and 5) reorienting health services. European developments in the area of mental health were strongly influenced by the WHO and the so-called new public health movement. The WHO Health for All strategy was translated into many national health and prevention policies (Hosman 1995), for example; the Finnish Health for All by the Year 2000 and the English Health of the Nation.

In the Declaration of Alma-Ata the definition of health is described as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.." (WHO 1978; 1946). In this perspective mental well-being should be a crucial part of healthiness. This definition has been widely criticised as being static instead of dynamic, but also for being unquantifiable, perfectionist and fixed (Downie et al. 1996; Noack 1987). Even though WHO considers health as a state of being, it can, however, be understood in various other ways, for example, as a potential, a resource, a value or a status. Furthermore, it can also be considered "as

a philosophy of care (e.g. health maintenance), micro and macro politics (e.g. health priorities, health insurance) or as a system of care (health care delivery systems, national health services)". Mental health does not differ from physical health in this perspective, as it can be understood and translated similarly (Tudor 1996) and this leads to a discussion of mental health promotion.

At the beginning of the 1990's mental health promotion was a new field and a concern of various professions. Tudor (1996) argued that at that time it desperately needed "theoretical and conceptual clarity, political direction and practical detail." It was also argued that there was a certain reservation about discussing the definitions of mental health or even comprehending mental health issues. This accusation was levelled at professionals as well as the public. (Childs 1992) Furthermore, Tudor (1996) argued that even though "mental health promotion looks good on paper" specific policies directed actually to promote mental health are unfortunately few. Promoting mental health is, or at least should be, "a fundamental part of health promotion". Several authors have claimed that mental health promotion has been overlooked as an essential part of health promotion (Sturgeon 2007; Lavikainen et al. 2000; WHO 2001).

The discussion of how to conceptualise mental health has been active. Secker (1998) suggested that definitions of mental health are inadequate for health promotion practice. They "either equate health with the absence of illness or present a culturally skewed, individualized and 'expert' –led version of what it means to be mentally healthy." The problem is how to embody health promotion principles in mental health promotion practice. More suitable definitions of positive mental health for mental health promotion principles are urgently needed. Although there has been a movement from individualized, psychological definitions to a more social context with a lay perspective, more extensive research is needed. (Secker 1998) Mechanic (1989) stated that "if our goal is to develop policies with the prevention and treatment of mental illness and the facilitation of mental health, then we must clearly outline the dimensions of these concepts." A goodness-badness continuum where lay definitions are often situated makes this even more complicated. Mental illness easily characterizes the whole person even though it is only part of an individual's functioning. (Mechanic 1989)

In time mental health promotion appeared as a unifying concept bringing together a variety of fields of study. For example, it became a part of the new public health movement, as health promotion it developed both independently as well as

in interaction with it. (MacDonald & Bunton 1992) There are several definitions (e.g. Table 1.) and the World Health Organization (2001) defined mental health promotion to be an umbrella term that covers different strategies aiming at a positive effect on mental health, which have an extent and non-specific mission. The Quality Framework report of the British Health Education Authority (1997) has also defined mental health promotion to "be any action, which actively cherishes good mental health by enforcing factors which promote it and diminishing the factors which harm or weaken the psychological health of individual and societies." Thus mental health promotion increases wellbeing, relieves human suffering and diminishes mental health problems and it is also often part of mental health services. (Lavikainen et al. 2000)

Lahtinen et al. (1999) refer to mental health promotion as a set of actions aiming to 1) "enhance the value and visibility of mental health at the level of societies, sections of societies and individuals" and 2) "protect, maintain and improve mental health". They (Lahtinen et al. 1999) also note the cultural aspect of mental health and therefore its promotion has to be adjusted to cultural as well as social, gender, age-related and developmental contexts. In all, mental health promotion could be defined as a cross-disciplinary and socio-cultural effort to arrange conditions where wellbeing of individuals, groups and societies can be promoted. It is a lifelong process to create such conditions where growth of mental and physical health may be guaranteed and mental health problems diminished. (Lavikainen et al. 2000)

Even though the Health for All strategy had various targets which can be read as promotion of mental health, yet no useful practical policies were translated from them. It has been said, that "in practice, people are either promoting mental health quietly; struggling with what it really is; or claiming anything remotely to do with mental health and/or mental illness as mental health promotion." Unfortunately this variety of practices confuses the field even more. (WHO 2001) The problem seems to be how to position mental health in general health promotion policies as without knowing what makes mental health and how these parts react with "the whole of health", effective mental health promotion is not possible (Braidwood 1997; see also Munk-Jorgensen 1996). According to Jenkins et al. (2002) there is an understanding of positive efforts towards promoting good mental health as well as evidence of the effectiveness of actions towards it. One of the most important things is to acknowledge the intense bond between mental and physical health. They stress that even though treatment and prevention are valuable, excluding mental health

promotion from the overall strategy has social, economic and health disadvantages. (Jenkins et al. 2002)

Table 1. Conceptions of mental health promotion

Author	Mental health promotion
WHO (2001)	An umbrella term that covers different strategies aiming at a positive effect on mental health. It has extent and non-specific mission
Health Education Authority (1997)	Any action which actively cherishes good mental health by enforcing factors which promote it and diminishes the factors which harm or weaken the psychological health of individual and societies
Coombes & Thorogood (2003)	Includes activities such as public policy aimed at improving health, clinical interventions which aim to enable people to take more control of their health, and a variety of interventions which aim to strengthen communities and increase social capital
Lahtinen et al. (1999)	Includes enhancing the value and visibility of mental health at the level of societies, sections of societies and individuals. Also protecting, maintaining and improving mental health.
Tudor (1996)	A fundamental part of health promotion

2.7 Mental health as a part of health policy

To be acknowledged as a public health problem, any phenomenon has to be frequent, have severe consequences and be receptive to ethically acceptable solutions. Mental disorders do satisfy these criteria. However, if the issue is widened into mental *health* it immediately becomes more difficult. The concepts of mental illness, disorder, ill-health, health, well-being, positive and negative health are vague in their variety and wideness. Public health authorities have dichotomised the two and believed that effective mental health promotion or mental illness prevention is impossible. (Lahtinen et al. 1999) 'Impossible' may be a relatively strong argument, however,

I do think executing these actions need special efforts and specified means, even though Tudor (1996) argues that mental health policy consists of "macro politics, their implementation (through policy), as well as the (political) action necessary to implement policy". In this sense it seems that it does not differ from health policy in general. In this section I will discuss features of mental health as health policy objects and the uniqueness of mental health promotion and policy.

Rochefort (1997) considers that mental health policy consists of everything from prevention and treatment of mental disease to the living situations of the mentally ill. According to Fellin (1996) the problem lies on these collections of policies and programmes instead of a unified and overall set of goals. Wahlbeck (2006) adds creating knowledge and awareness raising as well as development of population-level promotion and prevention activities. Grob (1995) also states that "mental health policy arises out of the interaction of many different variables". Apart from the area's wideness (or because of it?), there are also arguments which suggest that mental health policy has chronically failed in the most developed countries (Mechanic 1999; Goodwin 1997) According to Wolff (2002) this is due to policymakers' focus on minimizing the wrong risks. She also argues that treating mental illness is not so different from treating physical illness. The feature that separates the two is the potential risk. First there is a potential risk of violence, which exists in mental illness and was discussed briefly in earlier section. Another is a political risk, which appears with the uncertainty of the effectiveness of a policy. Policymakers have to respond to public demands; however they are also responsible for the results of the actions. (Wolff 2002)

Political risks are greatest when a so-called 'single-bullet approach' is used. This term refers to a situation where a single course of action is chosen by the policymakers. Therefore politicians usually favour the so-called "shotgun effect", where mental health policy is constructed out of multiple alternative actions under the expectation that at least some of these interventions would hit the target. Even if the actions fail, one can still claim that all measures were taken. Also, the critique directed at policy may be diminished by conservative and unfortunately often inefficient plans of action (Wolff 2002), as some extent of ineffectiveness may be tolerated if the programme otherwise fits with the prevailing values or aspirations of political actors (Weiss 1993). However, it is evident that in the case of possible moral panic, politicians want to have their backs secured (Wolff 2002).

Researchers should also be familiar with the policymaking process in order to push the research results more vigorously to the attention of policymakers and thus influence the policy process. As the negotiation of political decisions is continued throughout the process of decision-making, providing information regardless of the phase of the process is important. (Whiteford 2001) However, there are several arguments that should be recognised when designing mental health policy.

First of all, according to Jenkins et al. (2002) mental health suffers from a lack of integration with overall health policy. Mental health policy is planned separately from physical health policy and due to this isolation "opportunities for concerted action favourable to both mental and physical health will be missed." Also, physical health is likely to enjoy the lion's share of the available resources. Second, when mental illnesses are recognised, policymakers usually concentrate on more severe types of diseases such as psychoses, leaving much lighter problems unnoticed. In training this leads to paying insufficient attention to symptom recognition or learning more about treatment. These activities should be available in primary care. (Jenkins et al. 2002) Third, mental health promotion is distinct from illness prevention. In contrast to prevention, promotion of mental health is based on a different set of assumptions, which focus on generating or preserving mental health. This means different policy design compared to medicine-based illness prevention. (Rogers & Pilgrim 2001) Fourth, according to Rogers & Pilgrim (2001) governmental mental health policy is generally focused on organisational arrangements, such as hospital run-down and de-institutionalisation, whereas physical health promotion strategies have been more focused on the social causes and prevention of physical ill health. This may be true, although social determinants of mental health have recently arrived on the agenda of mental health promotion. Finally, monitoring and evaluation is comparatively poor, which will affect future mental health decision making and strategy planning. One way to obtain more information is to build on the knowledge of service-users and other stakeholders. This is getting more attention; however, interaction is still quite limited. (Jenkins et al. 2002)

Planning mental health policy is also hampered with long-lasting stigma, an issue which was discussed in earlier sections. Although we have proceeded from the mediaeval demonization of madness (Rochefort 1997), there is still much progress to be achieved. However, many countries have recently recognised that mental health policy, public mental health, is an important area when enhancing their economic, social and human capital (Jenkins 2003; also Jenkins & Strathdee 2000).

According to Pilgrim & Rogers (2001) “health promotion and prevention overall have had only a limited place in health policy, this trend is even more pronounced in the area of mental health”. Traditionally the focus of health promotion policy has been predominantly on preventing physical ill-health. Unfortunately often decisions concerning mental health “are made by political actors outside the mental health community.” The problem for these actors is ignorance of mental health areas due to scarce contact with the issue. Mental health policy thus presents policymakers with an issue on which they yet have no clear view. In such a case it is easy to concentrate on more familiar issues, especially when resources are limited.

One reason why mental health issues may be unfamiliar is that the linkage between policymakers and mental health researchers and practitioners is lacking. There are several scientific publications on mental health. However they concentrate on technical or clinical perspectives and are targeted mainly at others in the field instead of at political decision-makers. On the other hand, journals that are health policy related rarely discuss mental health issues and when they do, the timing may be ill-placed with regard to policy planning. These factors may lead to a situation where policymakers have tended not to include mental health in a key policy issues. (Scallet & Havel 1995)

Apart from the slight recent recognition and the fact that lack of accurate data is said to be one of the major problems in the development of mental health policy (Kemp 1993), it has not been very popular as an object of research. The recommendation by the European Network on Mental Health Policy to gather more analysis considering mental health policies in Member States may have had a positive effect in this development (Lahtinen et al. 1999). Another critical point in successful mental health policy is the question of funding. Apart from tuned up plans, programmes and laws without sufficient financial resources the implementation is left incomplete. The analysis of mental health policy also suffers from inadequate data on expenditure on mental health. (Kemp 1993) Thus policymakers may simply be unfamiliar with mental health issues or with the effects of how mental health policy and without adequate knowledge it is difficult to make up one’s mind (Scallet & Havel 1995).

2.8 The cycle of the policy process

Mental health as a part of human health as well as a term operates in several different policies. Mental health determinants are ambiguous and thus mental health promotion policy may easily expand something that is very difficult to control (Lehtinen 2008). The ambiguous nature of mental health promotion and policy demands a certain openness to several theoretical sources and at the same time retaining a grounded theory perspective.

The word 'policy' has various uses and definitions. It is scrutinised in this study as a concept for activity in the health policy area, including decisions of government, programme design and other related processes, but it is also looked on as an outcome. (See Hogwood & Gunn 1984) This research project focuses on conceptualising mental health at policy level. A health policy programme is seen as a means for implementing and developing policy further, and thus, Kingdon and his theory on streams of change (1984) has been chosen to form a theoretical basis for the research. As the parts of the research set themselves into different phases of policy cycle, the cycle of the policy process also has an important role in the theoretical basis of the research.

In the following sections I will take a closer look at the policy process and its phases; what happens in a policy process, how policy items are turned into action and what policymaking is in reality. I will also discuss streams of policy change in greater detail.

Policy process is often described as phases in a cyclical form. The number of phases varies depending on a theory; however, the main content remains the same. Van de Water & van Herten (1998) as well as Rushefsky & Patel (1998) have one of the simplest versions of policy cycle. Their policy cycle consists of four stages. The agenda-setting process is the first step and includes the recognition of a problem and its placement on policy agenda. The second step is policy formulation and adoption, which includes consideration of available alternatives. If policy adoption succeeds it leads to policy implementation and finally to the last step of policy evaluation. As mentioned, the number of stages[6] as well as their content varies slightly depending on the authors, however most authors agree (for example Rushefsky & Patel 1998;

6 Hogwood & Gunn (1984) have distinguished nine stages for public policy framework.

Lindblom 1959; Dunn 1994) that the final stage starts the next policy cycle (Fig. 2.), thus policymaking is a continuous process.

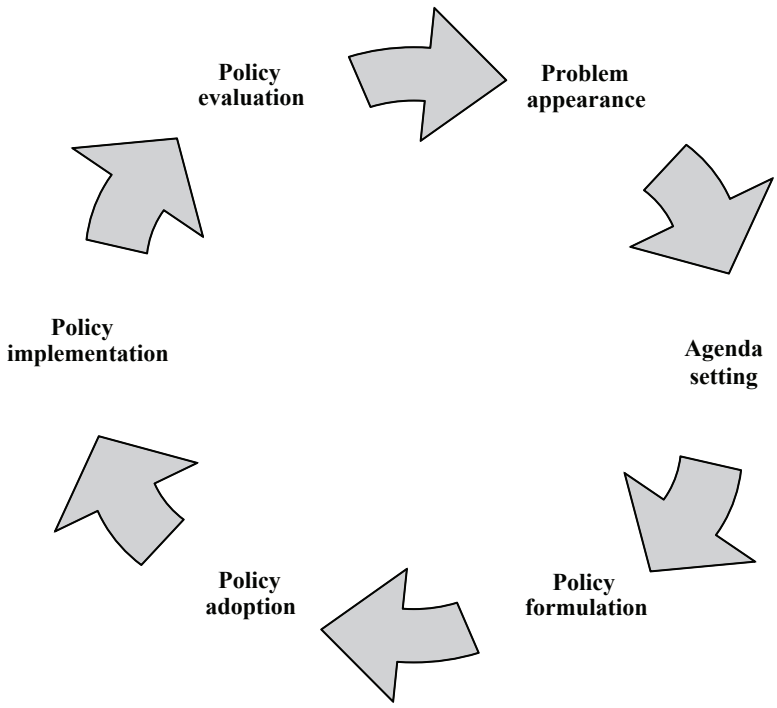

Figure 2. Policy cycle (Dunn 1994).

2.9 Streams of policy change

In this research project Kingdon's ideas of policymaking, policy change and streams were found as a theoretical point of view when policymaking was scrutinised. In the following I will present some existing ideas.

Kingdon (1984) defined three streams of policy change. The first stream or condition where agendas are influenced is *a problem stream*. A sudden crisis or unexpected event may act as an early-warning signal of an emerging problem; however, it needs an accompaniment to carry it to the policy agenda. Feedback from the public or evaluation of a programme may also be indicators of a problem.

(Kingdon 1984; Rushevsky & Patel 1998) The second is *a policy stream*, which refers to the generation of policy proposals by extending the knowledge and perspectives of a variety of the specialists in the policy area. These specialists have their pet ideas floating them around in policy communities (Kingdon 1984). The specialists interact with each other and they are also familiar with each other's ideas. The degrees of cohesiveness and fragmentation vary from one community to another and they naturally affect the policy agenda. The cohesiveness produces cohesive policy with a stable agenda while fragmentation leads to fragmented policy and agenda instability. (Kingdon 1984; Rushevsky & Patel 1998) Kingdon (1984) compares policy generation to a process of biological natural selection. Various possible ideas float around in a "policy primeval soup" where they are revised, altered and combined with each other. However, in order to become selected, an idea has to meet several criteria, such as technical feasibility or value acceptability (Kingdon 1984; Rushevsky & Patel 1998). Most of the ideas usually end up floating in the soup again. Third; *a political stream*, affects the agenda setting through processes like changes in the national mood or public opinion, movement of interest groups, election results or administration. These processes may either promote or prevent an idea's rise higher up the agenda. Turnover of key personnel will also produce new agenda items while old ones fade. The question of jurisdiction may lead to a situation where an item will be left out because everyone assumes that it does not belong to their jurisdiction. (Kingdon 1984)

Kingdon (1984) discusses the processes of policy formation from three different approaches; 1) tracing the origins of initiatives; 2) rational decisionmaking and 3) incrementalism. In the idea of the origins of initiatives is interesting as ideas can come from anywhere and there is no certain moment at which the idea started to evolve (Kingdon 1984). In rational decision-making policymakers define the goals, weigh up the alternatives to achieve them and finally choose between them. Fischer (2003) includes the economic aspect in this. After choosing between the most promising solutions, the alternative means are given a numerical value as the costs and benefits of consequences are calculated. When this "information about consequences, probabilities, and costs and benefits" is combined, the most effective and efficient possibility is chosen. However this is seldom what happens in reality, as the amount of knowledge needed for such decisions is rarely either available or adopted. Also, there are a number of actors linking in to the process simultaneously affecting its development and furthermore, the policy process rarely happens in

orderly stages. They do exist, but they do not follow each other chronologically. Therefore such a rationality described in theoretical sense is rarely executed. (Kingdon 1984)

Rational policy-making has been criticised as unrealistic or impracticable. (Hogwood & Gunn 1984) As something of a counterpart to it, an incremental approach is described. (Lindblom 1959; Hogwood & Gunn 1984; Kingdon 1984). In this approach adjustments are made in something that is already in the process and the ongoing task or programme is only slightly altered in the desired direction. There are several benefits in this approach: small adjustments do not require an excessive amount of time or manpower. Smaller steps may also be more welcomed by the actors, as they are usually easily manageable. This way policy changes very gradually, yet if drastic measures are needed, these changes may not be visible and fast enough. (Kingdon 1984) However, Lindblom (1959) has emphasised the continuous nature of policy-making; pointing out that policy "is made and remade endlessly."

As policymakers tend to favour these marginally different alternatives, only a limited numbre of new issues get on the policy agenda. This approach is called the decision–making approach. (Lindblom 1959; Rushefsky & Patel 1998) Rushefsky & Patel (1998) also introduce the pluralist and the elitist approaches. The elitist approach argues that there is a well-defined "power elite" which dominates the agenda-setting process through coordinated action. In contrast to this approach, there is the pluralist approach, which views politics as a struggle between organised groups. Not only there are different approaches to how the agenda is set, there are different kinds of *policy agendas*. *Symbolic agendas* need visible, however slight, effort from policymakers, while *resource agendas* require a substantial amount of both action and resources. It seems that it is not difficult to make a choice between the two. A symbolic agenda makes a statement policymakers want to present to the public; however, it does not spend so many resources. Furthermore, there are internal and external triggering devices which affect whether issues get on the policy agenda. Internal triggering devices consist of natural catastrophes, technological and ecological changes, etc. whereas external triggering devices are acts of war or military confrontations, innovations in weapons technology, international conflicts and so on. (Rushefsky & Patel 1998)

As mentioned, problems are recognized by the public and inside the government through unexpected crises or disasters or when the conditions are

composed to an ideal state or, for example, to another country. Furthermore, a situation becomes a problem only when it is believed that something should be done about it. Monitoring and indicators may reveal a situation which would need improvement or changes. Therefore policymakers may use indicators to either assess the magnitude of the problem or to become aware of changes in it. Sometimes these changes in indicators may be exaggerated and thus have effects on policy agenda. Uncritical use of the overall indicator also lacks a certain subtlety. (Kingdon 1984). However, not only evaluations but also public comments on an existing programme may indicate a problem and bring it to the policy agenda (Rushefsky & Patel 1998). Furthermore, when an agenda is set, political forces have also to decide when the effort is worth the costs, as it is not wise to put a lot of effort into a lost cause. (Kingdon 1984) Kingdon (1984) continues that there are parties inside as well as outside the government which have an important role in agenda setting. Pressure from outside the government consists of actions by, for example, of members of interest groups, academic researchers and consultants, the media and public opinion. Political parties are also included. Sometimes problems just fade away from the policy agenda. They drift back into the policy primeval soup[7] or they continue evolving in garbage cans[8]. Policymakers may feel that they have solved the problem by passing legislation, designing a strategy or implementing a programme.

Kingdon (1984) also presents *the garbage can model*. By this term Kingdon (1984) refers to a set of different problems and solutions and this mixture in a single "can" depends on the variety of "cans" available, labels attached, the speed garbage is collected, etc (depending who are the participants that moment, and what their interests are). Often problems and solutions do not meet. Perhaps a solution is moved to another can and the problem drifts on unsolved because there was no suitable solution available. The important point here is, and what is contradictory to rational decision-making, that often problems are found by solutions, not people. In short, "people work on problems only when a particular combination of problem, solution, and participants in a choice situation makes it possible." They do not

7 By this Kingdon (1984) refers to a term used by biologists when they refer to a process of biological natural selection and molecules floating in the "primeval soup". In the policy area this means that policy ideas float around in communities of specialists, such as researchers, policymakers, interest groups, etc. All these specialists have their own conceptions, ideas and proposals. The ideas are tried out, combined, rejected and finally those that last, as in a natural selection system, had met the certain criteria.

8 The term "garbage can" is described in more detail in the next section.

follow prescribed stages of defining a problem, finding solutions and evaluating their possible success. (Kingdon 1984) A policy window has to be opened in order to understand the policy change occurring. The policy window enables actors to push their ideas and solutions to be chosen for problem solving. Often the opening of policy windows cannot be predicted and they stay open only for a short time for policy entrepreneurs to seize the opportunity. However, sometimes, if rarely, the opening of a window may be predicted, for example during the updating of a policy or programme. The chances of a problem moving onto the policy agenda are substantially better if streams of policy change appear and are joined together. The policy window may also close very quickly for several reasons, for example, there are no available alternative solutions or there is no consensus on these. Actors may also change or feel that the problem has already been solved. (Kingdon 1984; Rushevsky & Patel 1998)

However, the opening of *the window of opportunity* for policy change itself needs the existence of the streams and even though these streams are relatively independent, occasionally they couple and thus create the greatest policy changes. The independence of the streams may cause one stream to change whether the others are ready or not. However, when they do couple their coupling leads to agenda and policy change. Furthermore, usually "the agenda is affected more by the problems and political streams, and the alternatives are affected by the policy stream". (Kingdon 1984)

There are different approaches to how policymaking proceeds. Etzioni (1967) has used the term 'mixed scanning' in trying to map the middle ground in decision-making approaches. When rationalism refers to seeking comprehensive and detailed information about the whole area, incrementalism focuses on specific and already familiar areas. A mixed scanning approach would combine the best features of both. This approach is flexible as it can adjust to changing circumstances. (Hogwood & Gunn 1984; Etzioni 1967) Hogwood & Gunn (1984) also suggest "that different policy issues require different policy-making approaches." There are issues needing pluralist, bargaining and incrementalist approaches, however there are some few special issues which need a planned and analytical approach. Is mental health such an issue? Or what kind of approach is needed in mental health?

3. Research objectives and procedures applied in the studies

The research consists of four articles and a summary. The articles scrutinise issues of mental health from the perspective of policymaking. The main research objectives can be summarised in the following:

1. How is mental health presented in national health promotion programmes and what kinds of concepts are attached to it in different policy documents?
2. Can the reason for mental health being a problematic issue in policy-making be found through the determinants of mental health?
3. How are actions suggested and specific guidelines "offered" in suicide prevention policy documents?
4. What kind of target is mental health from the perspective of evaluation?

The focus of this research is to improve the understanding of mental health as a target of political decision-making, policy actions and evaluation. As the research started with the assumption of mental health having a secondary role in comparison with physical health, I also reassess whether the assumption has been made correctly by scrutinising mental health as a policy object in various phases of policymaking. The research parts can be situated in the policy cycle (Figure 3.).

The first article focuses on what kind of a health issue mental health is, how the place of mental health is argued for in national health promotion programmes and what kind of concepts are attached to it in national health promotion strategies and programmes. This theme is situated in the phase of agenda setting. The data consisted of health promotion strategies and programmes from England, Sweden, Denmark, The Netherlands, Finland and Portugal. The data was organised with qualitative content analysis and scrutinised using the theoretical approach of grounded theory.

After a problem is recognised as something that needs action, its background factors are assessed in order to formulate a policy programme. The first article produces the position of mental health within the national comprehensive health promotion policies. The second article studies whether the reason for mental health

being a problematic issue in policy-making can be found through the determinants of mental health. This article concentrates mainly on the policy formulation phase by scrutinising what kinds of determinants are brought as a basis for choosing an item for policy programmes. It also focuses on whether mental health determinants differ from the determinants of somatic health and if so, how. The data consisted of health promotion strategies and programmes from England, Sweden, Denmark, The Netherlands, Finland and Portugal. The data was organised with qualitative content analysis and scrutinised by using theoretical approach of grounded theory.

The third article situates itself both in formulation as well as policy adoption phases as the data (the suicide prevention strategy documents), are looked at as something that is decided and written as a policy and which is ready to be acted on. The third article studied how the suggested actions and guidelines are "offered" and argued for in these policy documents. What kind of arguments can be found and to whom are these directed in the health policy documents? Suicide prevention strategies from Finland and England were used as a data. Qualitative content analysis was used to organise the data. After organising the data the analysis of interpretative repertoires was applied. Quantitative content analysis was also used to find out the number of the repertoires.

When the policy cycle approaches the end of its first round, it is time to evaluate the process so far. This is the focus of the fourth article, which aims to scrutinising the evaluation from the perspective of policy analysis. It asks the data what kind of role or status mental health has in national health programme evaluations in the perspective of health promotion policy as a whole and what are the criteria that mental health is evaluated with? The data consisted of official evaluations and scientific articles concerning the evaluation (or having an evaluative nature) of English and Finnish health promotion strategies. The data was organised with qualitative content analysis. Finally policy analysis was used with meta-evaluative approach.

In the next sections I will present the research project, the data and the research methods.

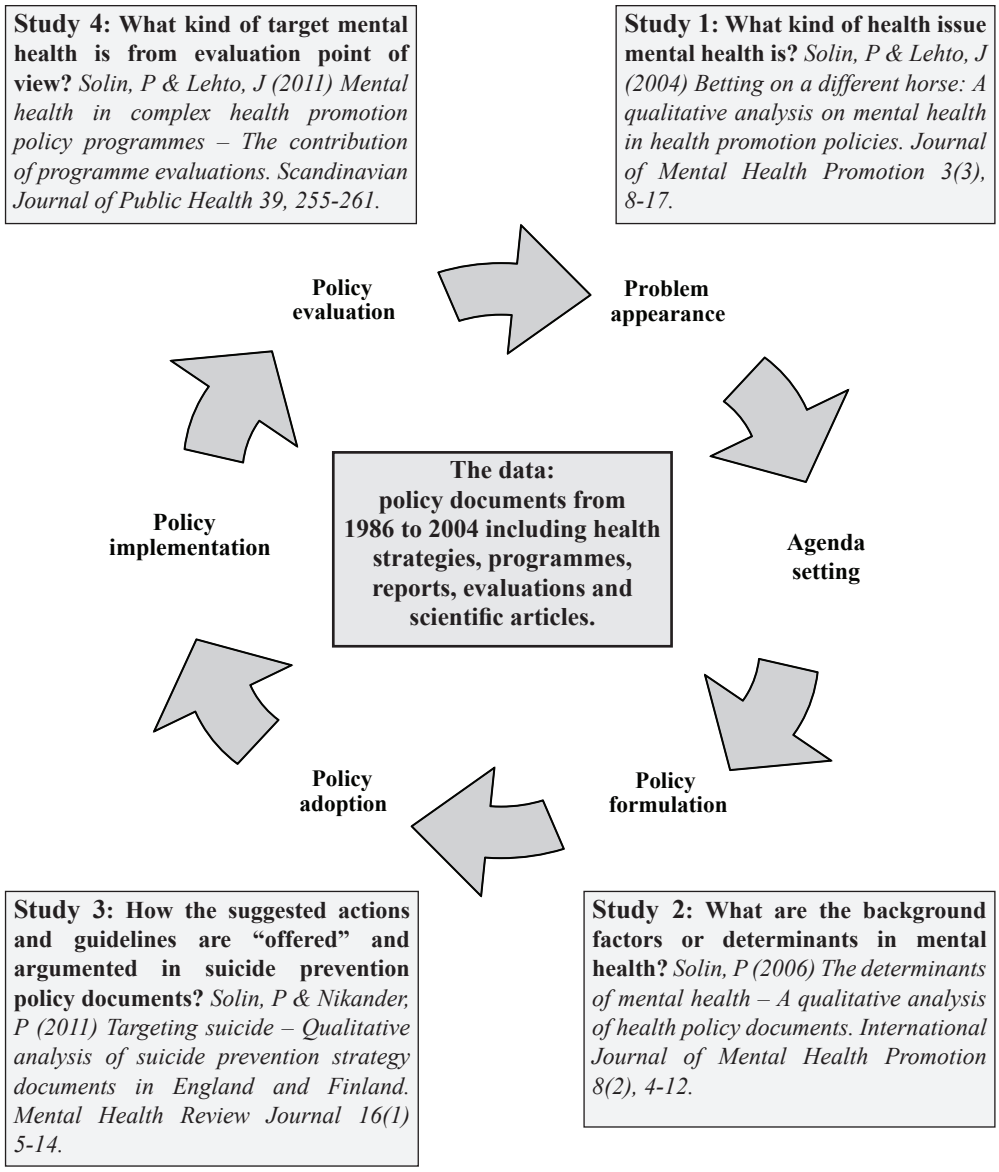

Figure 3. The research objectives situated in the policy cycle (modified from Dunn 1994).

4. Data

The data was collected during a project entitled "Finnish National Health Promotion Policy from an International Comparative Perspective", which is presented in more detail in the next section.

4.1 The research project

The project was a collaborative effort between the University of Tampere and National Research and Development Centre for Welfare and Health (STAKES). The aim of the project was to analyse and compare the Finnish health promotion policy processes, policy contents, implementation and wider contexts with Sweden, Denmark, England, the Netherlands and Portugal. The project itself is a part of a health promotion research programme (TERVE) and funded by the Academy of Finland. (Cancer Society of Finland 2005) The project was led by Professor Juhani Lehto (University of Tampere). Researchers Eeva Ollila (STAKES), Meri Koivusalo (STAKES), Marita Sihto (STAKES) and Leena Tervonen-Gonçalves (University of Tampere) and myself participated in the project.

The research material was collected from six European countries, which were chosen because they represent different kinds of European health and welfare policy systems or models[9]. They all have developed national health promotion policies, but through different policy development processes. This choice of countries allows the use in terms of the institutional context and historical development of national health promotion policy. At the same time, the countries are similar enough to Finland and they have been active enough in developing national health promotion policies so that comparison helps in identifying relevant features of the Finnish policy and there is enough relevant data to be used in the analysis.

As the project aimed to compare the policy processes, there were several focal areas among the research group, for example, equality in health or the role of church and religious actors in health promotion policy. The aim of my study was to analyse the position and role of mental health in health promotion policy.

9 The Scandinavian model of universalism and decentralisation, the corporatist Bismarckian continental model and the centralised Beveridgean model.

The appearance of the countries is not constant in all parts of the dissertation. The first two studies used material from all countries; the last two used only material from England and Finland. This choice was guided by the requirements of the research questions as well the relevance and the readability of the material without the help of translation (Finnish, English or Swedish).

4.2 Choice of data

The data consists of national health policy documents from 1986 to 2004 including health strategies, programmes, reports, evaluations and scientific articles. Interviews were also conducted in every country. The data for the whole project also included background material, documents and articles producing over 700 references. Additional data concerning especially mental health, mental health promotion and mental health policy was also collected solely for the purposes of this dissertation. This material consists of 250 references. In the following I will describe the material used in this dissertation.

In trying to conceptualize mental health in the health promotion programmes and strategies of chosen countries, the first difficulty was in deciding what parts of the data were to be studied. Finally the analysed data consisted of documents, (and their parts or words) which in my opinion were relevant to the study or linked closely to my research objectives. As mentioned previously, the language of the material was another criterion when choosing the data. In the following I will present the main data used in the research.

4.3 Interviews with informants concerned with mental health

The data collection during the years 2002-2003 included 5-8 informant interviews in each country. From these interviewees 2-3 people were selected, academics, officials, civil servants or non-governmental actors from the field of mental health promotion or mental health policy as they had knowledge on the relevant information. They were also used as guides for collecting the written material (Harrison & Deicke 2001).

The interviews in each country were conducted by at least one member of the research group. The interviews were 'unstructured' and followed the pre-prepared brief list of the main topics and themes (Seale 1998; Eskola & Suoranta 1998). The brief list was used to help the interviewer to stay focused without disturbing the flow of the discussion (Harrison & Deicke 2001). The interviews lasted from 45 minutes to 1 hour 30 minutes, they were tape-recorded and transcribed, so that limitations of memory did not impair the validity of the interviews (Harrison & Deicke 2001).

According to Harrison & Deicke (2001) "an interview is an encounter between a researcher and a respondent, where the respondent's answers provide the raw data". As mentioned, these interviews had several purposes; to lead the researcher to the key policy documents as well as to give further background information about the documents and the policy processes behind them. During the analysis they were used as background material for a better understanding of the situation in each country. As data they were used mostly in the fourth study together with other data.

4.4 Texts: health policy documents

The main data consists of health documents from England, Portugal, Denmark, Sweden, Finland and the Netherlands. The health promotion or public health strategy programme documents were translated into English, Swedish or Finnish. In these documents the analysis of the research focused on the parts where mental health and prevention of mental illnesses received a written form. However, for the purposes of the second article parts concerning cardiovascular diseases were also analysed.

Specific strategies and programmes concerning solely mental health promotion were also collected. However, they were not available from every country and they were used mainly as background material to mental health policy in written form. Suicide prevention strategies from England and Finland were used as data for the third article.

For the purposes of the fourth article evaluations and reports of the health promotion strategies and programmes of Finland and England were also analysed. The data consisted not only of official evaluations but also scientific articles, editorials and interviews which assessed or criticised those strategies or their evaluations.

5. Methods

The research presented in this dissertation is qualitative. Like all forms of analysis methods, qualitative research also has its strengths and weaknesses. Qualitative research extends the knowledge from the data from 'what' to 'why' and 'how'. It attempts to reveal the beliefs and attitudes behind individuals' actions and thoughts. On the other hand, normally the analysis allows fewer possibilities to generalise about the issue on the basis of the data. The researcher himself/herself may be seen as an obstacle. The same data may be interpreted differently depending on the researcher or the researcher may influence the data. As a qualitatively oriented researcher, I do indeed acknowledge this and the fact that this research produces one point of view, which hopefully extends our knowledge in a so far unfamiliar area. Conducting interviews and analysing written material with qualitative methods takes time and this is often criticised as the down side of qualitative methods (Harrison 2001). However, the results are often unique and could not be achieved through quantitative methods. Backman & Kyngäs (1998) have written that writing a researcher's own actions and insights may sometimes be difficult. Explaining the thinking process and formation of mental models of the issue can be seen as another downside or a challenge for qualitative researchers.

Applying several methods is seen throughout this project in theoretical approach, analysis and in the form of presentation of the results. For example, in the first and the second articles (see Solin & Lehto 2004; Solin 2006), the analysis of the data was conducted using qualitative content analysis (Berelson 1952), whereas the discussion part; the dialogue between the literature, the theory and the data followed grounded theory (Strauss 1987). Every analysis has started with qualitative content analysis in some form; at least in grouping and organizing the data. Yet the effect of grounded theory (GT) in practice was relatively small, for me GT is mainly an inspirational element of thought, which, I think, is seen throughout the research. Therefore explaining the method in detail is relevant.

5.1 Inductive orientation as a basis for research

According to Patton (1990) inductive analysis means that patterns, themes and categories of analysis emerge from the data instead of being given in previous research. The inductive approach assumes that the researcher herself makes no, or as few , presuppositions as possible about the phenomenon of interest. It is essential that the theory is formed solely from the data. The inductive approach is strong in this research. The research started with the hypothesis of mental health being in a defensive role in health promotion area, however, other presuppositions were limited. (Glaser 1978) The main idea was to have, as Strauss & Corbin (1998) stressed, a new perspective on the phenomenon.

It is a misconception to believe that grounded theory or inductively based content analysis is totally free from other influences than the data itself. The analyst does not exist without prior knowledge, which directed the researcher to the data in the first place (see Strauss 1987; Glaser & Strauss 1967). However, this does not mean that the data could not be *examined* inductively. The researcher has a responsibility to be aware of this and not to force the results artificially into any predestined form. Glaser (1978) harnesses the only deductive hint of GT as "conceptual guides as to where to go next". Thus deductive logic is only used to help further inductive research. (Glaser 1978) Eskola & Suoranta (1998) also ask if researcher is totally without an approach, how could one decide what to look for in the data.

Both qualitative content analysis and GT are basic research methods, which are suitable for analysing documents both systematically and objectively (Kyngäs & Vanhanen 1999; Tuomi & Sarajärvi 2002). In qualitative and inductively based content analysis, the method is in some perspectives very similar to GT. The theoretical sensitivity of the researcher, open coding and categorisation of the data are similar procedures in both methods. Furthermore, the formation of categories in GT as well as in qualitative content analysis needs consistent dialogue between the data and existing (or emerging) categories (Dey 1993; Glaser 1978). Both methods also require tolerance of uncertainty (Glaser 1978; Elo & Kyngäs 2008).

5.2 Grounded theory

Grounded theory was developed by Barney Glaser and Anselm Strauss. Their first collaboration; "Discovery of Grounded Theory" was published in 1967. GT, which is based on inductiveness, can be considered both as an approach and a method. Even though the method was developed from the collaboration of two colleagues, years later their paths diverged but they crossed from time to time. Glaser (1978), for example, described his book "Theoretical Sensitivity" as a "supplement to DISCOVERY". In both paths GT was developed independently further and also produced transformations and extensions; Straussian GT had branches in situational and dimensional analysis, Glaserian GT was more isolated. Over the years Glaser rejected "the search for a basic social process" as he felt it tended to "force data into a preconceived framework". Furthermore, he abandoned line-by-line coding preferring incident-by-incident coding to give the codes more congruity. (Charmaz 2009) Charmaz (2009; see also Morse 2009) applied both branches to create a constructivist GT, which she called a contemporary revision of classic GT. One of the main differences in constructivist GT compared to classic GT is that constructivists see analyses as interpretations and data as constructed instead of discovered. However, it still stresses the inductive, comparative, emergent and open-ended approach of the classic version. (Charmaz 2009)

As noted, GT, like all qualitative methods, has as many adaptations as there are researchers using it. The aims of the research, the time and place as well as the audience, also made their demands on the method[10]. GT is not only "a collection of strategies", it can be considered as a certain way of thinking. (Morse 2009; Morse et al. 2009) It can be perceived as "a general all-round method" which is moulded individually by the researcher. The all-roundness should not be considered as a somehow weakening feature of the method. If critical, one could ask if all-roundness is truly possible. However, the most important thing is to get the most out of the data (Morse et al. 2009) and it should always be concerned with the needs of the research aims and the data. Like any other method, GT also gets its share of criticism

10 My perspective is that qualitative methods should always be moulded by the researcher to meet the demands of the research objectives as well as the data. This can be seen as a positive feature of qualitative research as the suitable elements can be selected from various methods. Naturally they have to be well justified.

both among the proponents of the method and within them. It seems that the main criticism focuses on whether true inductiveness is possible.

In GT the collection of data, analysis and perceiving grounded theory happen simultaneously (Backman & Kyngäs 1998) and this directs the next phase of data collection (Glaser 1978). Glaser (1978) calls this theoretical sampling. Research functions are loose and data can consist, for example, of interviews, observations, diaries or other written documents. (Glaser, 1978; Glaser 2001; Strauss & Corbin 1998) The analysis itself is a dialogue between the data, GT, memos and the researcher (Glaser 1978; Strauss & Corbin 1998). This takes time as well as systematic and a manysided approach in data collection (Backman & Kyngäs 1998).

Analysis of the data itself is done in three stages. The first stage, which is called open coding, starts when data is collected and coded. The second stage; axial coding, happens by scrutinising the relationships between the categories. In the third and final phase of selective coding categories start to form relationships and hypotheses. (Strauss & Corbin 1998; Backman & Kyngäs 1998) It is important not to force the data into something that it is not, this means that "the categories of the theory must fit the data" (Glaser 1978). Glaser (2001) also stresses that instead of generating findings, GT "generates hypotheses about explaining the behaviour from which it was generated."

5.3 Qualitative content analysis

Content analysis can be conducted either quantitatively or qualitatively. Perhaps the better known roots are in Berelson's quantitative content analysis, even though qualitative content analysis was already used in the 18th century to analyse religious hymns. However, Berelson has been the first to define it as a scientific method. (Kyngäs & Vanhanen 1999) As a method it is often linked to communication theory and the analysis of the communication process (Polit & Beck 2004; Krippendorf 1980; Weber 1990). In communication theory every message has a sender and a recipient. Furthermore, the message is sent by a certain instrument in a certain societal context, therefore content analysis may be used to study communication for *who* is saying *what*, to *whom*, *how* and with *what effect* (Berelson 1952; Weber 1990; Polit & Beck 2004). The third part of the project concentrated on these elements.

The suicide prevention strategies were analysed aiming to specify what is said, how it is said, to whom it is directed and for what purpose.

Content analysis can also be seen as a basic analytical tool as well as a theoretical framework and it can be combined with other methods. Most qualitative methods are originally based on content analysis. As a method, qualitative content analysis is suitable for analysing documents both systematically and objectively (Kyngäs & Vanhanen 1999). It makes it possible to test the theory in order to increase the understanding of the data (Elo & Kyngäs 2008), but also to make replicable and valid conclusions, thereby "providing knowledge, new insights, a representation of facts and a practical guide to action." (Krippendorff 1980). Its strengths are in organising written material such as reports, articles or, as in this research, policy documents (Kyngäs & Vanhanen 1999). Despite its quantitative origin (Berelson, 1952), the coded data can well be analysed after quantification using qualitative procedures. The most common qualitative applications are utilised in "describing the characteristics of the content of the message" (Polit & Beck 2004). This sensitivity to content is an advantage of the method (Krippendorff 1980) as is the flexibility in designing the research (Harwood & Garry 2003).

The criticism of content analysis is directed at "the absence of a generally useful and agreed-upon classification system for categorizing and comparing diverse materials", its lack of objectivity and incompleteness as a method to produce conclusions (Polit & Hungler 1999). According to Elo & Kyngäs (2008) the disadvantage of content analysis relates to research questions which are too ambiguous or extensive. Furthermore, excessive interpretation by the researcher may compromise valid analysis. Some critics argue that conventional content analysis does not develop theory[11] (Hsieh & Shannon 2005). It has also been criticised

11 Hsieh & Shannon (2005) hold the view that conventional content analysis is too often confused with other qualitative methods, such as Grounded theory. Hsieh & Shannon point out that they are similar in their initial analytical approaches, however, conventional content analysis does not develop theory or have the ability for nuanced understanding of the phenomenon. At this point, it has to be acknowledged that Hsieh & Shannon divided content analysis into three separate approaches and their argument comes from these definitions. I have pointed out how methods, even the same ones, vary depending on their user and that there are various approaches in every qualitative method. So, even though I have emphasized the similarities of Grounded theory and inductive qualitative content analysis I do acknowledge that according to the definitions by Hsieh & Shannon the qualities of the methods are also differently defined.

for its simplicity as a technique and not being "sufficiently qualitative in nature" (Morgan 1993). The quantitative origin of content analysis may have affected this argument that it is poor in its qualitative nature as a method, however, I would not agree with the former being a negative feature, as simplicity of technique does not automatically produce simplistic results. Weber (1990) continues that if the skills of analyst are poor, the results will be simplistic with any method. Neuendorf (2002) also agrees that the complexity and usefulness of the method are totally dependent on the researcher using it. Thus its apparent simplicity may well be a challenge for the researcher. The flexibility of the method and its various and correct applications challenge researchers to judge for themselves which variations are the most appropriate for particular problems. (Elo & Kyngäs 2008) This requires an enormous amount of work during the process (Polit & Beck 2004).

As mentioned earlier, qualitative content analysis allows testing of theories, so it can be either inductive or deductive in its approach. The inductive approach is suitable for novel cases with no former studies or knowledge, or if the knowledge is fragmented (Elo & Kyngäs 2008). This approach uses open coding and creating categories in order to describe the phenomenon, increase understanding as well as to generate knowledge (Cavanagh 1997). The final task is abstraction to formulate a general description of the phenomenon (Robson 1993; Polit & Beck 2004). These phases are described in more detail in the chapter "Analysis of the data by inductive qualitative content analysis". The deductive approach[12] is most useful in when "the structure of analysis is operationalised on the basis of previous knowledge and the purpose of the study is theory testing". It uses an already existing categorization matrix into which the researcher codes her data. (Elo & Kyngäs 2008; Kyngäs & Vanhanen 1999) When in the inductive approach the analysis moves from specific to general, in the deductive approach the movement is from general to specific. Thus the purpose of the study determines which approach to use[13]. However, these two have similar preparatory phases which consist of preparation, organising and finally

12 Hsieh & Shannon (2005) divided qualitative content analysis into *conventional*, *directed* and *summative* approaches. Directed content analysis can be seen as a deductive use of theory as its aim is to validate or extent conceptually a theoretical framework. In directed content analysis an already existing theory or research can help focus the research objectives. The findings from this method provide either supporting or undermining evidence for the theory.

13 The deductive approach is used in the fourth part of the research, whereas in other parts the inductive approach is used.

reporting. The key purpose is to choose the relevant words from the text and classify them into smaller categories. (Elo & Kyngäs 2008) The first phase of the analysis; preparation, starts by selecting the unit of analysis. It may be a word, a sentence or a theme, as a unit can consist of more than one sentence (Polit & Beck 2004). In this case, dividing the unit means losing the meaning. Furthermore, during the analysis, it may happen that one unit contains several meanings (Elo & Kyngäs 2008).

Researchers may also choose whether they analyse only the manifest content or the latent content as well. Latent content consists, for example, of sighs, laughter, pauses, etc. Even though analysing hidden meanings is not unanimously agreed on (Elo & Kyngäs 2008); Robson (1993) argues that the research aim and the research questions make the decision for the researcher.

5.4 Analysis of the data by inductive qualitative content analysis

In this chapter I will briefly describe how inductive content analysis is conducted.

First the data is fragmented by the selection of the parts dealing with the interest of the research, for example, mental health, mental health problems and mental illness. During this first stage the data goes through *reduction* (Kyngäs & Vanhanen 1999). This means simplifying significant information through coding[14]. It can be done by condensing or splitting the relevant information into smaller parts (Tuomi & Sarajärvi, 2002). These parts are read several times. Finally the data consists of chapters, parts and sentences, which have been seen relevant to the research or could be linked to phenomenon in question. The basic unit for analysis is usually a sentence. Although in some cases more than one sentence may form a whole, if they cannot be separated into smaller units without losing their meaning. (Kyngäs & Vanhanen 1999) An example of reducing the data is presented in Solin & Lehto (2004).

When the reduced expressions have been divided into subcategories, preliminary descriptions of the data are made. This is the second stage of the analysis; *grouping* (Tuomi & Sarajärvi 2002; Kyngäs & Vanhanen 1999). If needed,

14 In grounded theory the literal terms are transformed (by the analyst) into the sociological constructs which give the data more depth and breadth (Strauss 1987). According to Strauss (1987), these constructs "are based on a combination of the researcher's scholarly knowledge and knowledge of the substantive field under study".

subcategories can be grouped further into upper categories. However, they may be conceptualised directly to main categories as well. An example of grouping the data is presented in Solin & Lehto (2004).

The final stage of the analysis is the *conceptualisation* of the data. Its purpose is to move on from the original information to the theoretical concepts and conclusions[15]. This was carried on as long it was possible from the point of view of the data. (Tuomi & Sarajärvi 2002; Kyngäs & Vanhanen 1999) All the main categories found from the data were now grouped under one unifying category, which answered the final research question (see an example in Solin & Lehto 2004).

5.5 Interpretative repertoires

The concept of interpretative repertoires originates from the work of Gilbert & Mulkay (1984) as they referred to the term when they discussed different ways of talking. The concept was later incorporated into the work of two social psychologists, Jonathan Potter and Margaret Wetherell (Edley 2001). Wetherell & Potter (1988) base discourse analysis on the idea "that utterances are acts and that language is functional all the time". In utilising the concept of interpretative repertoire their intention was not to blend other traditions, but instead to offer something that is lacking in others. There are "a wide variety of different analytic principles and practices" under discourse analysis[16] (Edley 2001) and in this chapter I will concentrate mainly on the idea of using and analysing interpretative repertoires.

The main concepts of discourse analysis are *function*, *construction*, *variation* and *interpretative repertoire*. By the term *function* discourse analysts mean both the intended as well as unintended consequences of one's discourse. Functions can, for example, explain, justify, excuse or blame. Sometimes the functions are obvious and

15 Even though some of the main categories may have emerged in a very early phase of the analysis, I have tried not to let them "tie" the data from producing other main categories. In this sense the analysis was either purely inductive or deductive, but a combination of both.

16 As the most common concept of discourse analysis is discourse, it may be necessary to explain how it differs from the concept of interpretative repertoire. In the repertoire the role of human agency is stressed as the user of language. Repertoires are also seen as more fragmented and smaller compared to monolithic discourse. Thus they offer speakers more variety and opportunities in constructing speech. (Edley 2001)

easy to identify, however in some cases the speaker uses such subtle choice of words or terminology that functions may be overlooked by the listener or the speaker just constructs the language from words that "seem right". Therefore functions are not usually available as such; instead they are always hypothetical interpretations of the discourse analyst and they can be "found" through a study of *variation*. Again, the use of variation is an unintentional process as people do not strategically plan their lay explanations. Identifying variation is a straightforward analytical task where a certain kind of functions leads to certain kinds of variation. Thus, language is *constructed* to achieve particular consequences. The final analytical tool is the *interpretative repertoire*, which is a summary unit, gathering "a restricted range of terms used in a specific stylistic and grammatical fashion". (Wetherell & Potter 1988; also Potter & Wetherell 1987) Repertoires can therefore be seen as the building blocks of conversation which speakers use in their language or as a register of terms and metaphors (Edley 2001; Potter & Wetherell 1987; Wetherell & Potter 1988). Edley (2001) compares the use of repertoires into a library, where linguistic material for interpretative repertoires; phrases, metaphors or figures of speech can be borrowed and thus repertoires can be formed flexibly and creatively. (Edley 2001; Wetherell & Potter, 1988)

The analysis with this method starts by executing preliminary coding in order to arrange the data in more manageable form (Wetherell & Potter 1988; Potter & Wetherell 1987). Coding in the beginning is described inclusively; it accepts borderline and anomalous cases. After this the material is repeatedly read in order to find recurring patterns or structures of particular metaphors or figures of speech. (Wetherell & Potter 1988; Edley 2001) Wetherell & Potter (1988) stress, that there is no logic or rules in this search, instead it is often "following up hunches and the development of tentative interpretative schemes, which may need to be abandoned and revised over and over again". However, this is an ability which develops with practice (Edley 2001). After time consuming analysis the patterns of different repertoires take shape. It is possible to find one or more dominant repertoires from the material. (Wetherell & Potter 1988) Several repertoires may also be used simultaneously. However, the analysis does not end up with identifying different repertoires. Instead, the analysis is continued finding the hope of finding the uses and functions of the repertoires (see Solin & Nikander 2011) as well as the problems that their existence might bring out. (Potter & Wetherell 1987) In the fourth article (Solin & Nikander 2011) the examples of repertoires taking shape from the data

and the repertoires used simultaneously are presented. Possible functions are also suggested.

Finding interpretative repertoires is time-consuming. It is also suggested that for finding universalities or broad empirical laws this is not the method, as findings are specific to a certain time, place or culture. (Wetherell & Potter 1988; Juhila 2007) On the other hand, this method brings out the subtlety and variety in the use of language and lay explanations. (Wetherell & Potter 1988) As a concrete method, interpretative repertoire analysis stresses the researcher's dedication to the data, as often only thorough familiarity with the data results in finding these elements. (Edley 2001) A reader is expected to be able to follow the path from which conclusions have been drawn. Doing this the reader is welcomed to assess the success of interpretations, evaluate the findings and even offer alternatives. (Wetherell & Potter 1988)

5.6 Policy analysis and meta-evaluation

According to Dunn (1994) policy analysis is "an intellectual and practical activity aimed at creating, critically assessing, and communicating knowledge *of* and *in* the policy-making process". Dunn divided the policy analysis process into five interdependent phases which form a complex and nonlinear cycle of intellectual activities. (Dunn 1994). The phases of policy analysis can be situated in the phases of policymaking as is demonstrated in Figure 4. (Appropriateness of policy-analytic procedures to different phases of policymaking).

In policy analysis knowledge of policymaking (processes) is created systematically and in an organised fashion by scrutinizing the causes, consequences and performance of public policies and programmes (Kraft & Furlong 2004; Dunn 1994). Policy analysis identifies and analyses five phases of the policy cycle; agenda setting, policy formulation, policy adoption[17], implementation and finally assessment, which form a nonlinear cycle of activities. (Dunn 1994) According to Dunn (1994; see also Kraft & Furlong 2004) the policy analyst may focus on or

17 In the policy process model presented in Kraft & Furlong (2004) policy adoption is replaced by policy legitimation meaning "the mobilization of political support and formal enactment of policies." It also "includes justification or rationale for the policy action."

affect one or more of these phases by communicating or critically assessing policy-relevant knowledge. Most often it is used in formulation and evaluation phases (Kraft & Furlong 2004). According to Dunn (1994) policy analysis is not only "to produce policy-relevant information that may be utilized to resolve problems in specific political settings", but "also to produce information about values and referable courses of action." Policy relevant procedures therefore consist of problem structuring, policy forecasting, recommendation, monitoring as well as evaluation.

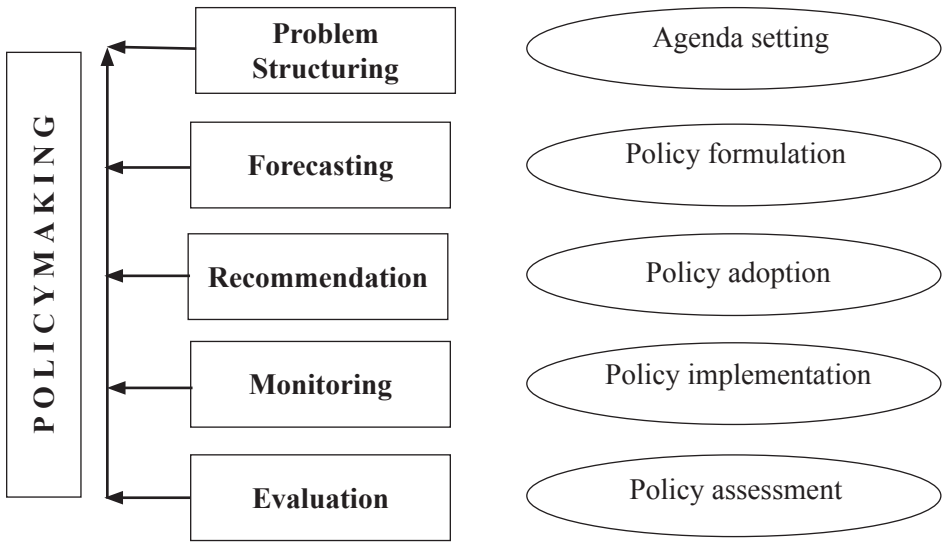

Figure 4. Appropriateness of policy-analytic procedures to different phases of policymaking (adapted from Dunn 1994). (Policy making attached from Kraft & Furlong 2004.)

Patton & Sawicki (1986) presented *descriptive* policy analysis, which refers "to either the historical analysis of past policies or the evaluation of a new policy as it is implemented." This type of analysis can be divided into types. The first is retrospective, which describes and interprets the past policies trying to answer the question "what happened?". The second is evaluative, which focuses on programme evaluation with the question of "were the purposes of the policy met?". (Patton & Sawicki 1986) Dunn (1994) also agrees that policy analysis is partly descriptive when it focuses on the "knowledge about causes and consequences of public

policies". However, policy analysis may also be seen as normative or value-critical when the value of public policies is considered through ends and means. Dunn (1994) also refers to different approaches which the policy analyst may use. *The empirical* approach focuses mainly on the causes and effects by giving descriptive and predictive information. *The valuative* approach on the other hand concentrates on valuative information. The third approach is *normative* and focuses on future actions and prescriptive types of information. Policy analysis can be conducted either before (prospective policy analysis) or after (retrospective policy analysis) the action. It can also combine the two (integrated policy analysis). The latter is the most useful type as it has all the advantages of both separate types. However. it does not possess any of their weaknesses such as the inability of prospective analysis to deliver sufficient information about the changes or the incompetence of retrospective analysis to affect policy changes while in progress. (Dunn 1994) Despite the approaches the most important task of information provision is learning more about the policy problems "since the way a problem is defined governs our ability to search out and identify appropriate solutions" (Dunn 1994).

In the fourth study (see Solin & Lehto 2011) the policy analysis concentrates on evaluation and thus it has meta-evaluative features, which means evaluating the evaluation. Vedung (2008) discusses meta-evaluation as he argues that evaluation and auditing processes may as well be assessed, for example, as policy implementation. Meta-evaluation can either concentrate on one single evaluation or be a summary of several evaluations. It can also be an evaluation of the general evaluation function. (Vedung 2008) Meta-evaluation can be exploited to check the methodological quality, readability and faithfulness to facts but also to be carried out as a summary of findings from several evaluation studies (Vedung 2008) which is attempted in the fourth study.

6. Results

6.1 What kind of a health issue is mental health from the health promotion policy perspective? (Studies I + II, IV)

The first part of the research project studied how mental health is discussed in policy documents; what are the political ways to define mental health and illness? The data revealed a variety of arguments which were used when themes concerning mental health and choosing them as health promotion targets were discussed. It was stated that mental health problems are a public health challenge, economic and societal burden, important part of overall health and that they affect quality of life and add to human burden. However, the category of *problematic issue* was the most interesting, as the others were relatively common arguments for a health issue to become a target. In this category mental health was considered problematic by definition, measurement, indicators and data as well as care. As discussed earlier, conceptualising mental health and illness is very difficult and still without a common understanding. According to WHO (1999), cultural variation will also affect the variety of definitions and these culture-related problems in defining mental health are one reason why it is difficult to estimate the extent of the burden of mental health problems.

The issue of indicators and the difficulties in measuring mental health was discussed in the data as a specific feature of mental health. This difficulty was also noted in the evaluation of the mental health targets (Study IV). The measurement of mental health was claimed to suffer from non-existent and inappropriate indicators. Data collecting in the mental health area often needs long monitoring periods as well as large financial resources. Very often suicide serves as an incorrect indicator of mental health. In addition to suicide rates, statistics on depression or anxiety are also relatively 'easy' and have a common background with other health indicators. Friedli (2000) raised the question whether the mental health of society needs different kinds of indicators such as levels of tolerance, safety or trust, which tell how we feel about ourselves and others. Tudor (1996) summarised the many ways mental health can be measured and assessed. There are indicators, for example, for coping, stress management, autonomy or self-esteem. Most of the measures were developed several decades ago. Thus they are not novel ideas and therefore claiming

that measurement of mental health has lacked proper indicators may not be correct. However, turning those elements of mental health into accepted and acknowledged targets in comparison to those of physical ones is still a challenge to be met.

The analysis of the data indicated that mental health is considered as a severe public health problem, however, it is a difficult issue to promote. It seems that such problems do not exist on a similar scale when somatic health problems are concerned. Unfortunately health policy would rather support health targets which can be unambiguously defined, have simple one-way background factors and, as discussed, are easily measurable. Mental health issues lacking such elements may cause decision-makers to ignore it (Lahtinen et al. 1999). It is also argued that the stigma of mental health problems may have an influence on how politicians react to this issue (Jenkins & al 2002; WHO 2003). Even though policymakers favour using similar policy-models for different issues, as success in one area may increase the probability of success in related areas (Kingdon 1984), the data seems to suggest that in the case of mental health a more tailored model is needed. Perhaps using indicators suggested by Friedli (2000) in designing mental health targets as well as their assessment would be welcome progress in mental health *promotion*.

6.2 How do determinants of mental health affect mental health policy? (Study II)

Rose (1993) defines the determinants of health to proximal and underlying causes from the aspect of preventive medicine. The proximal or immediate causes refer to factors such as smoking, whereas the underlying determinants are 'the causes of causes', factors which expose, for example, to unhealthy habits. The latter are often themes of social, economic and political research. Rose (1993) claims further that as the primary determinants of health are mainly economic and social, therefore the remedies should also be similar without separating the two. These aspects are worth looking at from the perspective of mental health promotion as the second part of the research concentrated on determinants of mental health[18]. I studied what kind of background factors or determinants were presented specifically for mental health in health policy documents. All the presented determinants could be divided into five

18 When I refer to determinants of mental health, I also include the determinants of mental illness in the same term.

categories 1) biological, 2) lifestyle, 3) physical environment, 4) social environment and 5) societal and economic environmental factors. The findings showed that for the determinants of mental health the documents mention social and socio-economical as well as lifestyle factors. Biological factors and physical environment were also mentioned on a few occasions.

When comparing the determinants of mental health with the determinants of cardiovascular diseases (CVDs) it was seen that they did share some of the factors. However, the determinants of CVDs were mostly lifestyle based. When these factors were scrutinized through *the model of the determinants of health* by Dahlgren & Whitehead (1991) it was seen that mental health and illness have background factors throughout the model, whereas the determinants of CVDs are situated mostly in one area. Even though mental health also has its determinants situated in the layers considered to be modified, the variety of these makes interventions challenging as these interventions should focus on several layers and need extensive resources from design to follow-up (Harding & Taylor 2002).

Dahlgren & Whitehead (1992) refer to the fact that not only are the poor sicker, but also that sick people have a tendency to become poor. Mental health determinants presented in health policy documents have a similar nature. Stress, employment situation, substance abuse, poverty and homelessness are single determinants affecting mental health which were most often mentioned in the health policy documents. These determinants have a two-way nature not only towards mental health, but also to each other, thus multiplying the risk of affecting mental health.

The study showed that the determinants of mental and somatic health are constructed differently and that the determinants have an important role. This seems to affect the design of health promotion policy. The diseases and illnesses are more familiar if their background factors are unambiguous and simple and thus the interventions for health promotion are easier. The determinants of mental health are cyclical, bidirectional and they often consist of larger elements which are difficult to grasp.

6.3 How are actions and guidelines argumented in written policy? (Study III)

The third part of the research project focused on one special issue in mental health; suicide. The study scrutinised suicide prevention strategy documents in order to find out how specific policy programmes discuss the mental health issue. The analysis found that several interpretative repertoires were used in the documents. *The political repertoire* situated itself as an umbrella concept formed from four other repertoires of *public health epidemiology*, *the everyday*, *preventive action* and *the reflective repertoire*. Each repertoire had its individual features; in language used; words, terms and phrases how suicide is discussed. These repertoires also seemed to attempt to speak to certain audiences. To explain the existences of these repertoires in the documents three separate functions were suggested. The repertoires may 1) be used as tools, 2) they may give additional information and 3) they may justify the actions proposed. The ultimate aim is to carry out the programme planned. This aim is understandable as policy documents have to reach and assure a wide readership in order to contribute to the implementation of the programme. However, one may asked whether the existence of several repertoires, manners of speaking, only confuse readers as every repertoire has a different approach. Furthermore, does it lead to a situation where each approach should have its own strategy?

This leads to taking a further look into which kind of strategies are the most effective in suicide prevention. The wide variety of suicide determinants proposes the claim that whole population strategies may have the most positive effect on lowering the suicide rate. However, those who belong to the group at highest risk are usually left outside in this strategy. Rose (1993) suggests this is a phenomenon called "the prevention paradox", which refers to "a preventive measure that brings large benefits to the community but offers little to each separate individual." Healthcare does have an important role in suicide prevention; however social policy actions focusing on diminishing the determinants of suicide may be as efficient (Anderson & Jenkins 2005). As substance abuse is often linked to mental health problems including suicide, interventions focusing on decreasing substance abuse are widely considered important means of preventing suicide (as well as mental health problems). However, Gunnell (2000) disagrees and argues that none of the single interventions have decreased the number of suicides. Suicide prevention strategies are often high-risk preventive strategies. When designed for the needs of the target

group, they are cost-effective with regard to resources. However, these strategies usually exclude those who are not at particular risk. Thus family and friends, who very often suffer from the situation, are left unnoticed in this strategy. Prevention also becomes medicalised very easily, and mental trauma from labelling and stigma are already difficult issues for those with mental health problems. There are other disadvantages in this approach as well, such as limited ability to predict the future of individuals as well as its contribution to overall control of a disease, which may be disappointingly small. (Rose 1993) Furthermore, the determinants of suicide, as in mental health, interact in complex ways and therefore they may hinder the wider effect of one specific intervention (Oakley & Potter 1997).

Choosing the right strategy is difficult not only in suicide prevention but in mental health problems in general. The variety of possible reasons was discussed in Studies I and II. Furthermore, the lack of adequate research data on the effectiveness of the actions may also be one of the hindrances. This issue is discussed in the next section addressing the evaluation of mental health targets.

6.4 What kind of a target is mental health from the perspective of evaluation? (Study IV)

In this study the analysis of the data showed that the main obstacles to executing valid evaluation were lack of time, manpower or indicators for monitoring progress. Evaluation of the progress of mental health targets seem to suffer especially from non-existent indicators. Mental health targets themselves also raised criticism as some claimed they were unclear. For example, definitions of the problem were not unanimously agreed. Weiss (1972; see also Hogwood & Gunn 1984) suggested that in certain circumstances evaluation is not worth doing. Thus even though the idea of evaluation is good, whether to use slightly more resources for valid and complete evaluation or to conduct evaluation with more modest aims should be considered. Even though in the long run the former solution would improve future action with efficiency, policy and programme decisions are too often made on the basis of other reasons than scientific evidence (Valente 2002) and thus the need for investing in a large-scale evaluation may be ignored.

Evaluation as a policymaking tool has several functions. It can be understood as part of the learning process and this distinguishes it from processes of auditing,

performance management, reporting or natural evolving. (Rowe & Taylor 2005; Van Herten & Gunning-Shepers 2000) Evaluation can be used as a tool for resource allocation and to improve the decision-making skills of professionals as well as management (Ovretveit 1996). It offers not only information about the results but proposes additional corrective actions (Van Herten & Gunning-Shepers (2000). Thus growing efficiency in these areas also leads to better informed political decisions (Ovretveit 1996). In a wider perspective evaluation should not only pinpoint the relative success of one programme but also utilise its reflections of "what kinds of things society ought to be doing". (Fischer 1997)

It should also be noted that evaluation also takes place in a political context and one has to be aware of the three following premises. Firstly, the targets of the evaluatio, the policies and strategies, are the results of political decisions. Hence everything happens in the political field. It may even be possible, that political pressures may change the perspective of evaluation in their favour. After all, they are usually only conducted to serve official ends. (Weiss 1993) Secondly, as evaluation is conducted in order to collect information for decision-making, this information naturally enters political arena where it has to compete for attention with other significant issues. Finally, it often goes unrecognized that evaluation itself has a political aspect. (Weiss 1993; Pawson & Tilley 1997) However, decision-makers unfortunately favour those results which suit their preconceptions and values (Weiss 1993). Ideally evaluation research could reveal "how much is being given up to satisfy political demands and what kinds of program effects decision-makers are settling for" (Weiss 1993).

What is often forgotten, and was also the focus of criticism in the data, is that when evaluation is planned, and this should be done at a very early stage of the policy cycle, all phases of evaluation should be negotiated with all parties to ensure that the needs of a certain programme are understood and especially how research results are presented and utilised. Evaluators should also be involved in the main decisions at a very early stage as "these may have impact on the evaluation aims and design". (Roker 2005; Schouwstra & Ellman 2006) Unfortunately scarce resources encourage collecting quick and simple results and this may affect the level of the research itself (Braverman 1989; Ovretveit 1996; Weiss 1993). Fischer (1997) notes that there are policy issues which cannot "be reduced to costs and benefits." There are inconvenient issues, such as mental health, which are valuable; however placing monetary value on them is difficult.

7. Conclusions and discussion

7.1 Assessment of methodology and research methods

As triangulation is often used to ensure more widespread results and to enhance the reliability of the research (Silverman 1993; Patton 1990), I used it in the methods as well as in some parts in analysing of the data. Numerous endnote references have often been used as background data whereas the main data has been narrower. Choosing the data was done due to the needs of the research questions as well as my ability to read and understand the documents without a use of translator. Research methods were adopted in order to get the best results from the data.

At this point it should be also noted that my intention was not to compare the countries, as the cultural differences alone would have forbidden this. Instead, the aim was to reach a deeper understanding of one side of mental health and its role in health promotion policy and to raise the issue and the results under discussion.

Arguments may be focused on the amount of the data in some parts of the research. For example, in the last two articles material from only two countries was used. However, qualitative research often focuses on small amounts of data aiming to scrutinise them thoroughly. It is argued that there are no mechanical rules for defining the size of the data as it is always dependent on each occasion and it is the researcher's responsibility to collect the data which satisfactorily answers the research question. Thus the criterion for validity is quality; the scope of conceptualising, not the quantity of the research material. The role of the researcher is also different when conducting quantitative research. The researcher has more freedom to make choices on how to conduct her research; one is even expected to be more creative with methods and writing. (Eskola & Suoranta 1998)

7.2 Mental health affecting policymaking

It is obvious that mental health is a demanding target, which, in order to be promoted, needs large amounts of resources in several phases of policymaking; detecting problem areas, deciding on targets, implementing and finally evaluating them. All these phases have their obstacles. Furthermore, deciding the value of

health, especially mental health, which is experienced and interpreted subjectively, is not an easy task (Coombes & Thorogood 2003).

The determinants of mental health are widely located in the social, socio-economic and environmental factors of health as noted in the second part of the research. Within these, several risk factors predisposing to mental health problems such as political conflicts, long-term economic problems or nature's disasters are difficult to point out. However, there is a classification of mental health factors into *individual*, *community* and *structural* factors[19]. For mental health promotion policy purposes this model may be practical as these factors affect mental health either positively or negatively and they are known to vary at different *life stages* (e.g. childhood, old age), *settings* (e.g. schools, workplaces) or *levels* (e.g. individual, community, national). This helps to focus promotion in such a way that it is not only effective but also monitor its development is easier. (Jenkins et al. 2002) From the perspective of mental health promotion, it seems that this has been more and more recognised and therefore "an understanding and commitment from stakeholders from many constituencies" is also welcomed (Sturgeon 2007). The findings of the third study did suggest that certain documents do attempt to reach a variety of actors with the use of language and discourse. In all, in health promotion policy designing targets is important; they affect the implementation and measurement of the effectiveness. Furthermore, if monitoring is poor, it cause policymaking to have poor evaluation results as a basis of further decisions.

Evaluating progress in mental health promotion is not an easy task. Mental health has several features previously discussed which cannot be converted into simple or quantifiable targets. Therefore, in a sense, it is easy to understand why suicide is often used as an indicator, as it seems to give a solid and measurable instrument to define, albeit erroneously, the state of mental health[20]. When mental health itself is evaluated, it is often done through the absence of disease or ill-health. (Jané-Llopis & Anderson 2007) However, as discussed at the beginning of

19 Individual factors may be described as such circumstances or elements which affect emotional flexibility. For example, physical illness or substance abuse are those which impair flexibility, whereas positive self-image or coping skills increase it. Community risk factors, such as cultural conflicts, discrimination or unemployment, use the capacity to build strong social networks, to be part of them or to have access to basic services. The structural factors consist, for example, of poverty, physical environment, poor education or housing.

20 It has been argued that monitoring the suicide rate does not reflect the nation's mental healthiness.

this dissertation, mental health cannot be monitored by measuring mental illness as absence of mental illness does not equal good mental health.

Unfortunately, finding measurable targets is still a problem in mental health, even though the situation was already acknowledged in the 1970's (Stevenson & Longabaugh 1980). Setting mental health targets without indicators for measuring success may promote only reluctance for action. One is also tempted to use measures which are easily available and quantifiable and these are usually not suitable for mental health targets. This may lead to missing those which are harder to get, yet perhaps more valuable (Coombes & Thorogood 2003). It has been argued that even though some mental health targets may be imperfect they should not be omitted from health promotion programmes as their omission would be even more harmful to mental health promotion (Hawton 1998). However, it is becoming increasingly evident that this step has to be taken, as mental health policy cannot function without a solid information base (Wahlbeck 2006). The fourth study clearly verified what is already known; that the channel of information from researchers to policymakers has therefore to be strengthened, otherwise the development of indicators and collection of the data are not worth doing (Jenkins et al. 2002). The information can be used in several ways besides measuring success in reaching a certain target. It can be utilised, for example, as a tool for the allocation of resources or in the evaluation of the mental health impact of other policies, and thus help political decision-making. (Korkeila 2000)

As mental health promotion is marginally funded, this may have affected the effectiveness of the development of indicators. This leads to a vicious circle of funding being limited as long as there are no efficient indicators showing improvement in mental health promotion outcomes. Kemp (1993) continued about monetary issues and argued that very often fine mental health policy statements are left without a solid funding base and therefore they become "symbolic politics" instead of actual policy. When funding is available, there are only few databases on how the money is actually spent (Kemp 1993; WHO 2008a). The indicators measuring mental health are thus not the only ones to be developed in the area of mental health policy, monitoring the allocation of monetary resources is also important.

Research results including evaluations and assessments of policy actions, may be used wrongly to mislead. Weiss (1998) proposed several forms where evaluation may only play the role of subterfuge, for example, when difficult decisions

are postponed by referring to forthcoming results from evaluation, responsibility is avoided by counting on the independent results or evaluation may be used as a cover for already made decisions. Evaluation or research findings may also be screened for only positive results, which then are brought into the focus of attention. Furthermore, sometimes funders, policymakers or those who make grants may wish evaluation to be executed. (Weiss 1998) Clearly in those cases evaluation is merely something that has to be done, not a genuine effort to improve future tasks and programmes. It has to be acknowledged that evaluation is more than gathering information. It is linked to control and the exercise of power. The information delivered may be polished to suit the plans of implementers, evaluators or the policymakers themselves. (Hogwood & Gunn 1984; Schouwstra & Ellman 2006)

Weiss (1972) pointed out that evaluation results show minor, ambiguous changes which have been "influenced by specific events of the place and the moment." This is how overall policymaking seems to operate (Lindblom 1959; Kingdon 1984). The parts of policymaking; the problems and solutions, are the already existing primeval soup. If a solution has been found successful, it is readily applied to another problem with minor modifications. Tudor (1996) has suggested that "there are no specific policies on mental health promotion. There are objectives for the promotion of mental health which are not elucidated as policy, and there are strategies which draw on implied policies. Thus for genuine policies on mental *health* promotion we need to consider the existing fields of mental health (illness) policies and health promotion policies, to redefine them, and if necessary to break out of them." The radical suggestion follows; if incremental changes or existing solutions do not seem to work, is the time for a revolutionary era in mental health policy at hand? Using Kingdon's (1984) metaphor, is it time for creating a recipe for a whole new *soup*?

7.3 Uniqueness of mental health

The aim of this research was to give more information for designing mental health policy, better execution of these and hopefully leading to better mental health of the population. This research provided insight how mental health is approached in different phases of the policy cycle, clearly pointing out the weaker areas of mental health policymaking. It showed how mental health and illness are spoken of in

different kinds of policy documents; health promotion strategies, specific prevention strategies and evaluations of those strategies. Mental health has unique features in its conceptualisation and determinants which affect designing mental health policy starting from the targets, and thus the following phases of mental health policy; implementation and evaluation.

There are differing opinions on how to design mental health promotion and policy. Some argue that positive aspects of mental health should be strengthened while diminishing the link to mental disorders (Lavikainen et al. 2000). However, most arguments agree that linking mental health promotion and mental illness prevention programmes into health programmes and implementing them together yields the most effective result. In this case "a further challenge is for mental health professionals to become more skilled in the process of advocacy in order that such evidence is used to maximum effect in ensuring that mental health promotion is recognized as an integral and central component of health promotion." (Sturgeon 2007) Stressing the link between mental and somatic health, for example via stress, loss or self-esteem help us to consider those parts of health as a whole and thus improve public health promotion (McCulloch & Boxer 1997). In the public health field there are several issues which are essential and concern mental health. This should be taken into consideration in every sector of political decisions, organisation of social and health services, as well as in strengthening and supporting networks and structures. Furthermore, every country should have its own strategic mental health policy and, most importantly, it should be attached to general health policy at every level. (Lavikainen et al. 2000)

According to WHO (2008a) 38 out of 42 its member countries in the European region had adopted mental health policies by the time of their survey in 2008. The format and content of the policies varied from separate mental health policy documents to a combination of mental health and health components. According to this survey also legislation and adoption of new strategies had also increased tremendously (WHO 2008a). Only three years earlier in the Mental Health Atlas (WHO 2005) it was stated that in many European countries' specific mental health policies with strategic goals and means to achieve them are absent or very old. It therefore seems that there has been very positive development throughout European region, even though creating mental health policy does not yet mean that the actual policy is successful (see Kemp 1993). One challenge for the future is implementation, which seems to hamper, even when there is commitment and will.

The obstacles include not only the previously mentioned inadequate funding but also a lack of skilled leaders, competent personnel, infrastructure or co-operation. (WHO 2008a) The WHO survey (2008a) acknowledges that more detailed research is needed to estimate the true value of this progress. Qualitative methods especially are needed in future research on mental health policy. If we consider them as complementary to quantitative research, not as an alternative, it is possible to obtain information which can truly have an impact on policy-making (Jenkins et al. 2007). The monitoring and assessment of this implementation process is not meant to be critical, but to provide a clear account of what and how well something has been done and whether outcomes can be considered as a result of what has been done. Another challenge consists of doing research and collecting data from the area of mental health promotion and policy. This information has to be disseminated. The researchers, policymakers, implementers as well as users in the field have to be part of collecting, changing and disseminating the knowledge in order to improve the action where needed. (Barry & Jenkins 2007)

Eisenberg (1981) argued that there is no entity of "mental illness" which could be prevented as there are various disorders with separate causes, mechanisms and outcomes. Thus, according to Eisenberg (1981), preventing mental illness as an objective is impossible. Prevention should aim at separate disorders. This raises interesting thoughts as mental health also consists of a variety of elements all with different background factors. Is mental health therefore also something that cannot be promoted as a whole, and instead we should concentrate on smaller parts of this issue? Furthermore, given the many ways of conceptualising mental health, are many current promoting actions pointless if mental health is considered a subjective feeling (see MacDonald 1993)? This is followed by many questions; who is entitled to define and prioritize them? Or how does one promote subjective feelings? MacDonald (1993) continues: "If we are to be flexible about how we describe mental health, tolerant of how others describe it, serious about the real needs that people have, accepting the likelihood of conflicts and opposition between different needs and willing to work with people to help them find balance and resolution, then mental health is perhaps much more like a journey than an arrival" and so the promotion of mental health would also be. This idea should be connected to the acceptance of mental health promotion needing several approaches instead of one.

Policymaking is value-driven. According to Noack (1987) the concept of health and those linked to it always "reflect the values, beliefs, knowledge and

practices shared by lay people, professionals and other influential groups". Choosing to promote one value means that others are downgraded because of that. What is important to some of us may not be felt similarly by others. (Sartorius 1992) Who is then the authority to decide the value of things for others? Or furthermore; how we decide the order of valuable things for ourselves? The stigma, poor evidence or problematic features presented in this research are obstacles to mental health promotion which easily affect willingness for action, even though they should be features to be overcome.

It is a fact that designing and implementing policies without evidence-based knowledge may be a waste of resources or even harmful. It is most practical to make use of existing evidence. (Jané-Llopis et al. 2010) However, it may be worth looking beyond the economic evaluations or randomised controlled trials (RCT's) and learning from those interventions which have not been RCT's or evaluated. It is argued that when evaluating interventions of mental health promotion, RCT's are not always feasible or appropriate, as e.g. finding a control group may not be possible (Jané-Llopis et al. 2010; see also Friedli & Parsonage 2009). Friedli et al. (2008) remind that "the absence of evidence is not an indication that an intervention does not work, but rather that the research has not been done".

Mental health promotion also entails influencing policymaking. The research results have to be delivered into the decision-making arena. Improvement of reporting and enhancing communication between all participants is needed (Jane-Llopis et al. 2010). However, the language of researchers differs from that of policymakers. Furthermore, policymakers use discourses which may not open up to other stakeholders. The research of policy texts is one step further to understanding the area of policymaking, and thus, better communication between all the stakeholders, as "mental health is everybody's business" (Herrman et al. 2005).

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ARTICLES

I

Solin, Pia & Lehto, Juhani (2004): Betting on a different horse: A qualitative analysis on mental health in health promotion policies. Journal of Mental Health Promotion 3(3), 8-17.

II

Solin, Pia (2006): The determinants of mental health – A qualitative analysis of health policy documents. International Journal of Mental Health Promotion 8(2), 4-12.

III

Solin, Pia & Nikander, Pirjo (2011): Targeting suicide – Qualitative analysis of suicide prevention strategy documents in England and Finland. Mental Health Review Journal 16(1), 5-14.

IV

Solin, Pia & Lehto, Juhani (2011): Mental health in complex health promotion policy programmes – The contribution of programme evaluations. Scandinavian Journal of Public Health 39, 255-261.

Principal author:
Solin, Pia M. Soc. Sc
Researcher
Tampere School of Public Health
University of Tampere

co-author:
Lehto, Juhani Ph. D
Professor of social and health policy
Tampere School of Public Health
University of Tampere

Betting on a different horse: A Qualitative analysis of mental health in health promotion policies

Abstract

The aim of this study is to analyse the position and role of mental health in health promotion policy. Policy documents from Finland, Sweden, Denmark, the Netherlands, England and Portugal indicate that, although mental health is considered a serious issue, it is problematic in policy terms. A range of arguments are put forward, making the case for the importance of mental health within the health promotion agenda, including the classification of mental illness as a public health problem, socio-economic and individual costs of mental health problems and the view that mental well-being is a crucial element of overall health. However problems of definition, measurement and a traditional focus on treatment and care continue to make mental health promotion problematic for policy makers.

Mental health promotion as an umbrella term covers different strategies aiming to produce a positive effect on mental health (WHO, 2001). However ongoing debate and methodological concerns about defining mental health and delineating the relationship between mental health and overall health have hampered efforts to position mental health in health promotion policies and have also raised questions about what constitutes 'effective mental health promotion' (Braidwood, 1997; Munk-Jorgensen, 1996).

Jenkins et al (2002) argue that mental health suffers from a lack of integration within overall health policy. Mental health policy is planned separately from physical health policy, reducing opportunities for concerted action favourable to both mental and physical health. Physical health is also likely to enjoy the lion's share of available resources (Jenkins et al, 2002). Health promotion generally has had a low status in comparison with treatment of illness. According to Rogers and Pilgrim (2001): 'Health promotion and prevention overall have had only a limited place in health policy [and] this trend is even more pronounced in the area of mental health. Traditionally the focus of health promotion policy has been predominantly on preventing physical ill health.' A further problem is that mental health promotion is distinct from illness prevention. In contrast to prevention, the promotion of mental health is based on a different set of assumptions, which focus on generating or preserving mental health. This requires different policy design to medicine-based illness prevention. Government mental health policy is generally focused on organisational arrangements for treatment and care, whereas physical health promotion strategies have been more focused on the social causes and prevention of physical ill health, although recently, across Europe, there has been a greater focus on the socio-economic determinants of mental health (Rogers & Pilgrim, 2001).

Many countries have recently recognised that mental health policy to enhance public mental health has significant potential in terms of improving their economic, social and human capital (Jenkins, 2003; Jenkins & Strathdee, 2000). However mental health policy has not been very popular as an object of research, although recognition of the neglect of mental health is evident in health promotion and public health documents: for example, in Sweden, Denmark and Finland.

According to the Danish government Health Promotion Programme of 1989, mental illness is an area that 'has been neglected and is a subject of much prejudice. It is important to work towards giving mental illness the same priority as somatic disorders and diseases' (Ministry of Health, 1992). The Swedish National Goals for Public Health document of 2000 concedes that 'mental illness presents a big challenge to Swedish society and public health' not only 'because of the size of

the problem but also because very few measures have been taken to prevent mental illness until now' (Ministry of Health and Social Affairs, 2000).

In this report, we examine the features and characteristics of mental health in health promotion policy documents and explore the role of mental health within health promotion policy.

The data

The data consist of government health promotion policy documents from Finland, Sweden, Denmark, the Netherlands, England and Portugal (table 1) between 1980 and 2003. The data were collected for the Finnish National Health Promotion Policy from an International Comparative Perspective project, funded by the Academy of Finland. Eleven documents were chosen that addressed mental health in sufficient depth to allow analysis. The analysis of the policy documents was supported by a series of expert interviews about health promotion policy in each country.

Denmark

The Health Promotion Programme of the Danish government was published in 1989.' Its overall goals are reducing the number of premature deaths and the number of people who are disabled or suffering ill health and to enable elderly people to maintain their quality of life. The programme gives priority to preventing cancer, cardiovascular disease and accidents. It also presents a framework for two potential future priority areas: diseases of the musculoskeletal system and mental illness (Ministry of Health, 1992). Healthy Throughout Life was published in 2003 and presents the targets and strategies for public health policy following closely the line established in Denmark's first overall health promotion programme of 1989. The detailed targets concern lifestyle and environmental factors (Government of Denmark, 2003).

The Netherlands

Health as a Focal Point is a Dutch memorandum for health for the year 2000, published in 1987. The memorandums general health targets are focused on improvement of quality of life for the elderly and reduction of mortality among the younger generation and new-born, with an emphasis on healthy lifestyles (Ministry of Welfare, Health and Cultural Affairs, 1987).

Portugal

The National Health Plan of Portugal gives strategic guidelines for action in 2003. The guiding principles are transparency, equity, effectiveness and efficiency (Ministry of Health, 2003).

Finland

Health for All by the Year 2000 is a long-term action plan for the Finnish health policy published in 1986. Finland's Health for All policy has four general objectives: more years to life, more health in life, more life in years and reducing health differences among the population (Ministry of Social Affairs and Health, 1986). In 1993 this programme was renewed, with parallel objectives (Ministry of Social Affairs and Health, 1993).

England

England's action plan Saving Lives: Our Healthier Nation2 sets out four priority areas with targets to be reached by the year 2010: cancer, coronary heart disease and stroke, accidents and mental illness, which are seen as 'the four big killers' (Secretary of State for Health, 1999).

Sweden

Sweden's Health on Equal Terms3 document was published in 2000. The tide describes the basic principle of the document, which sets out 18 national goals and a number of sub-goals and indicators. Fourteen of the goals concern determining factors for health and the remaining four focus on the quality of the infrastructure for work in the field of public health (Ministry of Healdi and Social Affairs, 2000a; 2000b).

Analysis of the data

The data were analysed to consider what concepts and phenomena are included in or relate to mental health and how national health promotion programmes present a case for addressing mental health. References to mental health were examined in the context of the whole document and selected references scrutinised more closely within their own context. The basic unit of analysis was a sentence, unless a small unit could not be separated into smaller units without losing its meaning (Berelson, 1952).

The units were analysed applying qualitative content analysis in three stages. In the first stage the data underwent reduction (figure 1). This means simplifying significant information through coding. In grounded theory the literal terms are transformed (by the analyst) into sociological constructs that give the data more depth and breadth (Strauss, 1987).

During the first stage the original expressions were reduced to a simpler and more illustrative form. For example, the expression 'mental illness presents a big challenge to (...) society and public health was reduced to 'public health challenge'.

In the second stage of the analysis, the reduced expressions were separated into subcategories, after which they were conceptualised directly to the main categories (figure 2). The final stage of the analysis was the conceptualisation of the data (figure 3.) in order to arrive at the theoretical concepts and conclusions (Berelson, 1952). This was carried on as long as possible from the point of view of the data (Dey, 1993). All the main categories found in the data were grouped under one unifying category to answer the research question about the arguments and concepts attached to mental health.

Results

Five main categories were used in locating and arguing for the inclusion of mental health in government policy documents. The main categories were:

* public health challenge

* economic and societal burden

* quality of life and social burden

* part of overall health and

* problematic issue (table 1).

Public health challenge

All the documents analysed (table 1) mentioned the public health challenge as an argument for promoting mental health and preventing mental illness. It is cited as a future priority and its role as a public health threat is underpinned by statistics and the growing incidence of mental illness.

In the Swedish policy it is argued that mentally ill people have a higher mortality and morbidity rate than the general population (Persson et al, 2001). Finland's health programme considers mental health problems to be one of the significant challenges for Finnish health policy in the future (Ministry of Social Affairs and Health, 1986).

Economic and societal burden

Six of the documents, from Denmark, Sweden, England and Finland (Government of Denmark, 2003; Ministry of Health, 1992; Ministry of Health and Social Affairs, 2000a, 2000b; Secretary of State for Health, 1998, 1999; Ministry of Social Affairs and Health, 1986) mention that mental health problems present a heavy economical and societal burden. This situation was described by the simple statement: 'Mental illness has a high economic cost' (secretary of State for Health, 1999) or, more precisely: 'Mental disorders account for one fifth of all bed days and one third of all health-related anticipatory pensions' (Government of Denmark, 2003).

Part of overall health

The Portuguese National Health Plan argues that mental health is something that 'goes through all the human health problems' (Ministry of Health, 2003). Sweden's Health on Equal Terms recognises that mental health is part of overall health and also a part of an individual's personality (Ministry of Health and Social Affairs, 2000). Documents using this argument seem to emphasise that mental health has an equal position with physical health and that they affect each other. The documents emphasising this argument in mental health adhere closely to the line of WHO (2003), which also declares that the relationship between physical and mental health is complex and interactive.

Quality of life and human burden

Denmark, the Netherlands, Sweden, England and Finland (Ministry of Health, 1992; Ministry of Welfare, Health and Cultural Affairs, 1987; Ministry of Health and Social Affairs, 200Oa; 200Ob; secretary of State for Health, 1998; 1999; Ministry of Social Affairs and Health, 1986) state that mental health problems cause individual suffering, disability and reduction in quality of life, arguing that quality of life cannot be measured by physiological health alone. England's Saving Lives states: 'People with mental illness may suffer considerable fear, mental pain and distress, sometimes for many years, taking considerable toll on themselves and their families' (secretary of State for Health, 1999). Other social consequences mentioned include stigma and social exclusion, which can negatively affect the individual's relationship with the outside world (secretary of State for Health, 1999). In addition, social attitudes may hinder recovery (Ministry of Welfare, Health and Cultural Affairs, 1987).

Problematic issues

The first four categories are fairly conventional ways to describe a health problem and emphasise its importance (Lahtinen et al, 1999; WHO, 2003). Of special interest is the focus on the fifth category: the problematic issue. This is a core category that, according to Strauss (1987), 'is central to the

integration of the theory'. This category was selected for closer analysis and four subcategories (table 2) were found.

Mental health is presented as a problematic issue in number of ways (table 2), notwithstanding the importance attached to it for all the reasons outlined above. One of the major reasons for mental health being seen as problematic and difficult for mental health promotion policy is that mental ill health has a wide and complex range of determinants. These are identified as stress, poor living conditions, surroundings or social environment, financial situation or unhealthy lifestyle, including smoking and substance abuse. In the absence of robust indicators of mental health, the impact and the direct causation of the determinants cannot be as accurately estimated as they can for physical health.

Problem of definition

The Health Promotion Programme of the government of Denmark considers the concept of 'mental illness' as an umbrella term extending from classical mental disorders to substance abuse and reduction in quality of life resulting from lack of mental well-being (Ministry of Health, 1992). The Swedish document (Swedish version) admits at the start that it has not been possible to find a consistent definition of mental health (Ministry of Health and Social Affairs, 1999).

Problem of measurement, indicators and data collection

Measurement, indicators and data collection are identified as key problems. The Danish Health Promotion Programme states: 'Knowledge of the very complex causes of mental illness is inadequate' (Ministry of Health, 1992). This lack of knowledge is seen to result directly from a lack of reliable, robust and valid indicators of mental health. The problem of indicators, measurement and data is described in four other documents. For example, the Portuguese Health Plan states: '... there does not exist a system of health indicators that makes it possible to understand the extent of this problem ...' (Ministry of Health, 2003). Finland's Health for All by the Year 2000 points out that, even though measurement of the phenomenon is difficult, it does not make it any less important (Ministry of Social Affairs and Health, 1986).

Difficulties in producing hard data about the determinants and consequences of mental ill health are consistently mentioned. It is believed that the vague concept of mental health makes it difficult to define accurately what should be done (interventions) or to set measurable targets (outcomes) (Friedli, 1999). Suicide rates, hospital beds and availability and use of psychiatric drugs measure treatment outcomes, not the mental well-being of the population.

Problem of care

According to Lahtinen et al (1999) there is a common misconception that mental health cannot be protected or promoted and that mental illness cannot be prevented effectively. In our data this problem seems to be most obvious on the borderline between primary health care and mental health care. It is suggested that a great number of people experiencing mental health problems could be treated in primary care, but that lack of capacity makes this difficult. In some cases, the problem of treatment is seen to be a result of recently discovered new risk groups. As risk groups increase and diversify, mental health care is not able to keep up with the new demands.

Discussion

Lahtinen et al (1999), in their analysis of the position of mental health in Europe, have argued that mental health has not achieved equal recognition with physical health among decision makers. This may in part be explained by the problematic nature of mental health described above. A further factor is the marginal status of mental health services, which may lead to a reluctance to focus on promotion/prevention if this is seen to detract attention and resources from improving services. In most countries mental health services are underfunded relative to other services (WHO, 2003) and, as previously stated, mental health already has a secondary position compared with physical health (Lahtinen et al, 1999).

Some commentators have seen the inequalities agenda as providing a valuable opportunity for addressing public mental health. Describing developments in the UK, Rogers and Pilgrim (2001) argue that: 'Mental health promotion and prevention now form an explicit part of a wider government strategy for addressing inequalities in mental health status and access to resources and services.' According to Dekker (2000), the equity programme of the Netherlands has been a successful spin-off of health policy. We may, however, ask whether addressing inequalities really creates a better opportunity for mental health to enter the policy agenda. As minorities of different social and cultural groups are placed on the margin of society, there may not be modes for action available. Inequality may just be another stigmatised problem instead of being a suitable policy window (Mackenbach et al, 2000).

The recognition that primary care has a growing role in recognising and treating mental health problems (Jenkins et al, 2002) is a further factor in extending the boundaries of mental health policy although, as Etheredge (2002) points out, in the case of mental health financial incentives tend to be attached to treatment rather than promotion/prevention: 'Misunderstanding that most mental

illnesses cannot be treated effectively may come from the point that policies limit reimbursement [to] mental health care.'

Designing mental health promotion policy also requires the existence of agreed indicators - both to assess the mental health, as opposed to the mental illness, of the population and to measure the success of interventions. Developing mental health indicators generally means using subjective measures, which are based on judgements made by, for example, the target group, patient, family or project worker, about well-being and quality of life. These are distinct from the traditional clinical indicators that are used to establish a diagnosis (eg. symptoms that indicate schizophrenia or bipolar disorder) or levels of morbidity in a population (eg. blood pressure or cholesterol levels) (Friedli et al 2004).

Mauthner and Platt (1998) reviewed 23 different scales for measuring positive mental health, well-being, quality of life and social functioning and identified a number of well-validated instruments that include questions designed to identify aspects of positive mental health in individuals (Mauthner & Platt, 1998; Steward-Brown, 2002). Research into quality of life and social capital has also been seen as a useful source of mental well-being indicators (Scottish Executive, 2003; Chanan & Humm, 2003; Morgan & Swann, 2004). WHO has conducted a major international study into quality of life (WHOQOL, 1996), which identifies six broad domains: physical, psychological, level of independence, social relationships, environment and personal beliefs/spirituality. However, it remains to be seen to what extent these developments in defining 'well-being' indicators will assist in addressing the concerns of policy makers regarding data and measurement (Friedli et al, 2004).

Conclusions

'Health' is a concept which represents different things to different people at different times in different situations' (Commers, 2002), and mental health is an even more complex concept. The idea of a sick or abnormal state of mind is much more contested that that of an abnormal bodily state (Downie et al, 1996), although there are parallels in the concerns raised by the disability rights movement. Broadly, however, a body that is ill can be defined by objective biological norms, whereas norms of mind are culturally relative or socially constructed (Downie et al, 1996). According to seeker (1998), current definitions of mental health are inadequate for health promotion practice because they 'either equate health with the absence of illness or present a culturally skewed, individualised and "expert"-led version of what it means to be mentally healthy. If successfully defining the whole concept of mental health is almost impossible, it is difficult to see how mental health promotion could be implemented. The conceptual vagueness' described by Rogers and

Pilgrim (2001) may well be the sticking point when it comes to designing mental health promotion policy.

The aim of this study was to analyse the characteristics and role of mental health in health promotion policy documents. The analysis indicates that mental health is considered a serious and seriously taken issue, which should not be overlooked. Various arguments are used for mental health to be included or integrated within health promotion programmes. These include mental illness being a public health problem, the economic as well as societal and individual burden of mental illness and the view that mental health is a crucial part of overall health.

A further finding is that mental health is considered a problematic issue, for reasons to do with definition, in the case of measurement or care-related issues. These make it a problematic issue for public health policy-making. These problems are seen as smaller or non-existent in the case of somatic health.

Kingdon (1984) argues that opening the window of opportunity for policy change requires three conditions. First, there should be a common recognition of the problem that will be addressed by a new policy. Our analysis indicates that mental illness and mental health are recognised as a neglected area that should be addressed. second, an appropriate policy model that is supported by experts influential in the given policy area should be available. For mental health, the policy model would demand the kind of definitions, determinants, indicators and measurable targets that are available, for example, for cancer, cardiovascular disease and communicable diseases.

The third condition needed is a supportive 'politics stream'. Here we cannot base our conclusion on the analysis of the documents, but it is often argued Qenkins et al 2002; WHO, 2003) that the whole domain of mental health carries with it a strong stigma that still prevents politicians from joining in the advocacy for mental health policies. Even if this were not true, the weakness of mental health in the policy stream' and its mismatch with the dominant public health policy model that is central in formulating governmental health promotion policies would mean that mental health is pushed into a defensive role in these arenas.

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Figure 1. Extract from reducing the data

1) **<u>Reducing the data</u>** (Reducing/simplifying of the data was guided by the following research questions: What concepts and phenomena are included when discussing mental health? How it is argued?)

<u>Original expressions</u>	**<u>Reduced expressions</u>**
"Mental illness presents a big challenge to (--) society and public health"	- public health challenge - societal challenge
"Without good mental health, people can be unable to fulfil their full potential or play an active part in everyday life"	- crucial part of human life at individual and social level
"..there will be little advancement in finding causes of and treating the most important mental diseases…"	- difficult to find determinants - the problem of treatment
- the magnitude of the phenomenon	
"although this situation is relevant, there does not exist national data…"	- data on the phenomenon is not available
"…mental illness cause much suffering and reduce people's quality of life"	- reason for human suffering
"Various attempts to define mental health have been made, but no common definition has been found"[1]	- attempts at definition - no universal definition exists yet

"Mental health is as important to an individual as good physical health"	- equally important as physical health
"Even though the phenomenon is difficult to measure, it does not make it any less important"[2]	- difficult to measure
"..the phenomena and problems of psychological coping, mental health and activeness, social relationships and interaction will be highlighted in the future health policy"[3]	- political challenge

Figure 2. Extract from grouping the data

2) Grouping the data

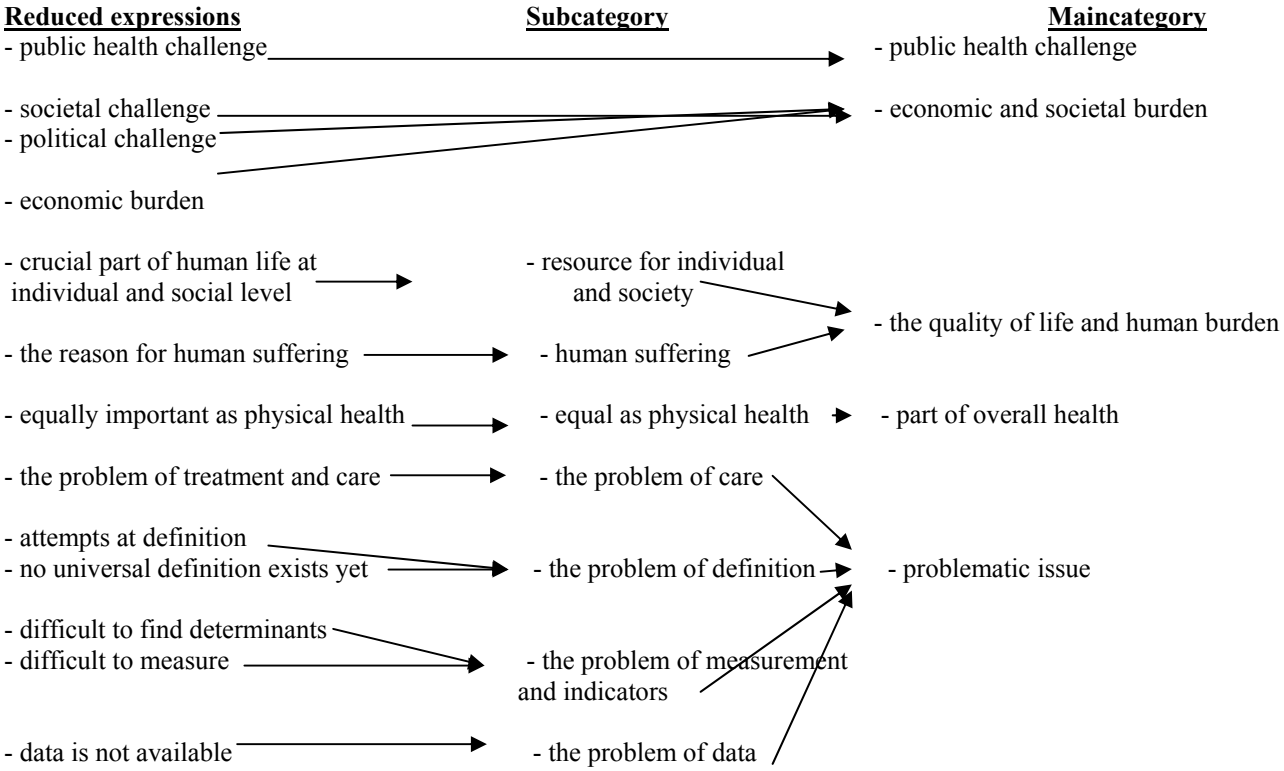
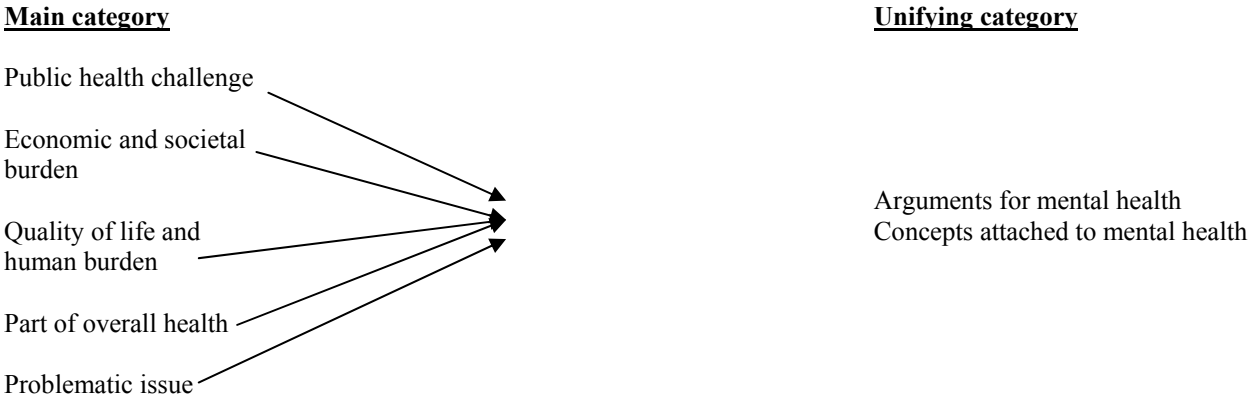


Figure 3. Extract from conceptualising the data

3) Conceptualising the data



F E A T U R E

Pia Crista Milana Solin

Researcher, Tampere School of Public Health, Finland

The Determinants of Mental Health: A Qualitative Analysis of Health Policy Documents

Keywords: determinant; mental health; policy

Introduction

It has been claimed that mental health promotion requires different policy design from medicine-based illness prevention. This is partly because of a different set of assumptions behind the mental health promotion 'ethos' (Rogers & Pilgrim, 2001). Mental health has been recognised as a serious public health issue, and one to be taken seriously in health promotion programmes. However, the complex nature of mental health seems to make it difficult for policy development. This does not mean that mental health is not prioritised, only that including mental health in a comprehensive health promotion policy tends to require definitions, determinants, indicators and measurable targets similar to those for major somatic illnesses such as cancer and cardiovascular diseases (CVD). In short, it would mean making an effort to examine the health promotion policy paradigm from the mental health perspective (Solin & Lehto, 2004)

A B S T R A C T

This paper reports on an exploratory analysis of the determinants of mental health in health policy documents from Finland, Sweden, Denmark, The Netherlands, England and Portugal during 1985–2004. Similarities and differences in mental and somatic health were examined, using qualitative content analysis. The results of the analysis are compared with some frequently applied health determinant conceptualisations and with the conclusions of previous research. The paper concludes by pointing out that the determinants of mental and somatic health are constructed differently, which seems to affect the design of health promotion policy.

According to Ziglio *et al* (2000), since the Ottawa Charter in 1986 knowledge of health determinants has increased rapidly. For example, there has been active research on the determinants of self-reported mental health, mainly in sociology, psychology and public health (Andrés, 2004). Although this progress has been very welcome, much remains to be done, especially in health policy research; for example, the relationships and measurements between different determinants need more research (Ziglio *et al*, 2000). There is a growing gap between the common understanding of health determinants and priorities in health policy for providing health care. Conceptualisation of the determinants of health rests on either imperfect and obsolete models or intellectual frames of reference, which exclude otherwise valid data from consideration as it does not fit pre-defined categories (Evans & Stoddart, 1990). This is true of health promotion as a whole, including all aspects of health. Looking only at determinants of mental health, the picture becomes even more confused, as the issue of mental health in the health promotion area is more

complex than is somatic health (Solin & Lehto, 2004); the causal pathways are usually considered to be easier to identify in physical illnesses (Rogers & Pilgrim, 2001).

The aim of this article is to provide an exploratory analysis of the determinants of mental health presented in various health promotion documents, and of how they are used. The first part of the results presents the outcomes of the content analysis, and the second part of the results focuses on the conceptual analysis conducted with grounded theory. Finally, the article relates the different aspects of mental health determinants to health policy planning and making.

Data and analysis

In this report, health promotion and health policy documents from Finland (1986, 1993, 2001), Sweden (2000), Denmark (1992, 2000, 2003), The Netherlands (1987, 1992, 1996, 2004), England (1999) and Portugal (1999, 2003) are analysed. The data is described in more detail in Solin & Lehto (2004). The analysis focuses on the determinants of mental health, which are also compared with the determinants of somatic health to ascertain their similarities or differences.

The first part of the analysis of the documents was conducted with qualitative content analysis (Berelson, 1952) and procedures developed in grounded theory (Glaser & Strauss, 1967). At the start of the analysis, the data was organised into smaller units and then categorised by qualitative content analysis. After organising the data, the methods of grounded theory were introduced for a more sensitive perspective on the data. Both qualitative content analysis and grounded theory are basic research methods suitable for analysing documents systematically and objectively (Berelson, 1952; Glaser & Strauss, 1967). In qualitative and inductively orientated content analysis, the methods adhere closely to grounded theory. The theoretical sensitivity of the researcher, open coding and categorisation of the data are procedures similar in both methods, and the axial coding of grounded theory can be seen as the first framing of the content analysis.

In qualitative content analysis (Berelson, 1952) the data was fragmented by selection of the parts dealing with mental health determinants or factors influencing mental health. In the later stage, the same procedure was carried out for somatic health determinants. These selected parts of the data were read several times, and finally the data consisted of chapters, parts and sentences where all the determinants for both mental and somatic health introduced in the policy documents were pointed out.

The second step was to relate the observations to the conceptual models of health promotion. This conceptual analysis follows grounded theory, as conceptualisation of the data is the core process of GT (Glaser, 2001; Strauss, 1987). In grounded theory the aim is to describe realistically the area of research, and to link it to current theoretical concepts, by offering insight, enhancing understanding and providing meaningful guidance to action (Strauss & Corbin, 1998).

Comparison between the documents and countries is difficult, because the categorisations of the determinants vary and the same terms may cover factors that vary between documents. The issues considered important in each document may also vary. It is important to note, too, that different categorisations of health determinants have been created for different purposes and from different perspectives.

The policy documents use either 'determinant' or 'factor' in discussing the prerequisites of mental health. Factors can be described as either protective or risky. Protective factors maintain 'mental well-being', whereas risk factors may undermine 'mental stability'. The term 'determinant' includes both positive and negative conditions underlying mental states, which may be affected directly for health promotion purposes. Although the terms 'determinant' and 'risk factor' have slight differences, they are mixed in the data and therefore treated as synonyms in the content analysis.

Results 1: content analysis of the documents

Following content analysis, the factors affecting mental as well as somatic health could be divided into five common categories. **Biological factors** are fixed, such as genes, sex and age, whereas **lifestyle factors** are considered to be decisions made principally by an individual, for example physical activity, consumption of alcohol, tobacco or unhealthy food. Themes related to town planning, green surroundings or living conditions and environment, including chemical, biological and radioactive risks in water, air and residues, form the category of **physical environment**. **Social environment** refers to social networks and interaction with family, friends and work colleagues, and the individual's feelings of social exclusion and loneliness. Changes in the structure of society, demography and financial circumstances are examples of **societal and economic environment** affecting health.

The documents stress different factors as determinants of health (either somatic or mental) – ***Tables 1*** and ***2***, overleaf. There are differences not only between the countries, but also between documents in the same country. For

TABLE 1 *Determinants of Mental Health*

Documents analysed	Biological factors	Social environment	Societal and economic environment	Lifestyle	Physical environment	Physical morbidity
The Health Promotion Programme Denmark 1992		✖	✖	✖	✖	
The Danish Government Programme on Public Health and Health Promotion Denmark 2000						
Healthy Throughout Life Denmark 2003	✖	✖	✖	✖		
Health a Commitment Portugal 1999						
Contributions to the National Health Plan Portugal 2003				✖		
Health as a Focal Point The Netherlands 1987	✖	✖	✖			
A Strategy for Health The Netherlands 1992			✖	✖	✖	
Healthy and Sound The Netherlands 1996		✖		✖		
Living Longer in Good Health The Netherlands 2004	✖	✖	✖	✖	✖	
Health on Equal Terms Sweden 2000	✖	✖	✖	✖	✖	✖
Saving Lives: Our Healthier Nation England 1999			✖	✖	✖	
Health for All by the Year 2000 Finland 1986		✖	✖	✖		
Health for All by the Year 2000. Renewed Collaboration Programme Finland 1993						
Valtioneuvoston periaatepäätös Terveys 2015 – kansanterveysohjelmasta Finland 2001		✖	✖			

TABLE 2 *Determinants of SomaticHealth*

Documents analysed	Biological factors	Social environment	Societal and economic environment	Lifestyle	Physical environment	Mental illness
The Health Promotion Programme Denmark 1992		✖	✖	✖	✖	✖
The Danish Government Programme on Public Health and Health Promotion Denmark 2000		✖	✖	✖	✖	
Healthy Throughout Life Denmark 2003		✖	✖	✖	✖	
Health a Commitment Portugal 1999				✖		
Contributions to the National Health Plan Portugal 2003		✖	✖	✖	✖	✖
Health as a Focal Point The Netherlands 1987	✖		✖	✖	✖	
A Strategy for Health The Netherlands 1992	✖			✖	✖	
Healthy and Sound The Netherlands 1996				✖		
Living Longer in Good Health The Netherlands 2004						
Health on Equal Terms Sweden 2000		✖	✖	✖	✖	✖
Saving Lives: Our Healthier Nation England 1999		✖	✖	✖	✖	✖
Health for All by the Year 2000 Finland 1986				✖	✖	
Health for All by the Year 2000. Renewed Collaboration Programme Finland 1993				✖		
Valtioneuvoston periaatepäätös Terveys 2015 – kansanterveysohjelmasta Finland 2001						

example, Danish (1992, 2003), Dutch (1987, 1992, 1996, 2004), Swedish (2000), English (1999) and Finnish (1986, 2001) documents stress either societal and economic or social environment (or both) as a factor affecting mental health. Lifestyle as a determinant of mental health is mentioned in nine documents (Danish 1992, 2003; Portugal, 2003; Dutch, 1992, 1996, 2004; Swedish, 2000; English, 1999; Finnish, 1986).

The documents also mention two determinants of mental health which are generally closely linked to somatic health: biological factors (Denmark, 2003; The Netherlands, 1987, 2004; Sweden, 2000) and lifestyle (Denmark, 1992, 2003; Portugal, 2003; The Netherlands, 1992, 1996; 2004; Sweden, 2000; England, 1999; Finland, 1986). However, the most interesting finding is that mental health in four documents occurs as a determinant of somatic

health (***Table 2***), whereas somatic health is defined only once as a determinant of mental health (***Table 1***). A good example can be seen in a quotation from the Dutch document (2004) stressing the importance of mental well-being for physical health:

> *There is a clear connection between physical and mental health. Prevention of psychological problems is therefore extremely important for proper physical health.*

The documents locate the main determinants of somatic health in lifestyle (Denmark, 1992, 2000, 2003; Portugal, 1999, 2003; The Netherlands, 1987, 1992, 1996; Sweden, 2000; England, 1999; Finland, 1986, 1993) and physical environment (Denmark, 1992, 2000, 2003; Portugal, 2003; The Netherlands, 1987, 1992; Sweden, 2000; England, 1999; Finland, 1986). Societal and economic environment is also mentioned as a determinant in seven of the documents studied (Denmark, 1992, 2000, 2003; Portugal, 2003; The Netherlands, 1987; Sweden, 2000; England, 1999).

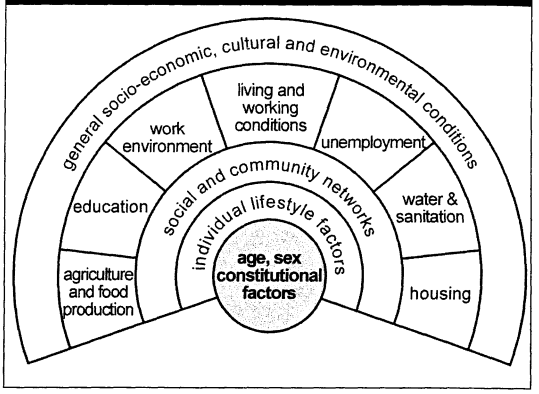
Results 2: conceptual analysis of the data

Dahlgren and Whitehead (1991) modified a multi-layered model (***Figure 1***, below) for the determinants of health in a discussion paper which was used as a base for the World Health Organisation's report in 1992. This model is widely recognised for its interpretation of how an individual's health is shaped by personal, social, cultural and environmental factors. At the centre of the model are the fixed factors, which cannot be affected. 'The layers of influence' surrounding the fixed factors are considered to be modifiable (Harding & Taylor, 2002). This social model of health has been used frequently in various types of health document (for example the Acheson Report in 1998) discussing health inequalities and their interaction. For example, individual lifestyle factors such as smoking or diet often correlate with social or economic status. The layer of social and community networks:

> *has the potential to sustain the health of an individual in otherwise unfavourable conditions.*

With the next layers, from areas such as work and environment to general socio-economic, cultural and environmental conditions, they form a group of wider determinants (of health inequalities) (DoH, 1998, 2002) It has been suggested that mental health could profit from the inequalities agenda (Rogers & Pilgrim, 2001), as these two issues share

FIGURE 1 ***Model of Determinants of Health***



Source: Dahlgren & Whitehead (1991)

the features of marginalisation and stigmatisation (Mackenbach *et al*, 2000; Solin & Lehto, 2004).

Rose (1993) divides determinants of health into proximal and underlying causes. Proximal causes are factors such as smoking or substance abuse, and underlying determinants are 'the causes of causes', factors that expose people to such unhealthy habits. Rose also claims that the primary determinants of health are mainly economic and social, and so the remedies should be similar for both mental and somatic illness. Socio-economic factors do indeed affect the risk of both CVD and mental illness, but the documents present the effects rather differently. In the case of CVD many of the documents claim that these factors affect people via their lifestyles, which is evinced as an argument for presenting lifestyle factors as the most visible determinants of CVD. With regard to mental health, the connection between socio-economic circumstances and mental well-being is presented as more direct. Emphasis on the lifestyles of individuals seems to undermine the position of mental health and its social determinants.

A distinctive point about mental health problems is that no-one has ever proved them to be contagious, even though they are treated as if they were (Jodelet, 1991). This may well be the case with the determinants of mental health as well, since they are treated similarly to the determinants of somatic health. According to Jenkins *et al* (2002), the unique nature of mental health follows from its determinants. For example, several risk factors predisposing people to mental health problems, such as political conflicts, long-term economic problems or natural disasters, are difficult to identify. It is also noteworthy in Jenkins and colleagues' work that factors affecting mental health (either positively or negatively) vary between life stages, settings

or levels. For purposes of mental health promotion policy, this model may offer a practical viewpoint to take into consideration.

Lahtinen and colleagues (1999) have defined the conceptual dimensions of positive mental health as individual factors and experiences, social interaction, societal structures, and resources and cultural values. These dimensions of positive mental health have been used in the **functional model of mental health** developed by Clemens Hosman (1997) and modified by Lahtinen and colleagues (1999). This model takes into consideration the two-way nature of mental health. It does not separate the predisposing factors into different categories, but points to the underlying causes. The model also acknowledges that mental health has a cultural aspect. This is often left unacknowledged in social models of health determinants (Eckersley, 2001).

The data analysis suggests that constructions of the determinants of mental and somatic health differ to some extent. When, for example, the determinants of CVD (***Table 3***, below) and mental health (***Table 1***) were compared, the difference in the complexity of the affecting factors became more obvious. The determinants of CVD are mostly lifestyle factors such as diet, smoking, exercise and substance abuse, whereas the determinants of mental health are distributed quite evenly between social and societal and economic environment and lifestyle. Biological factors and physical environment were also mentioned as determinants of mental health.

Social, societal and economic environment and mental health were proposed as determinants of CVD in three documents (Denmark, 1992; The Netherlands; 1987; England, 1999). However, closer examination shows that CVD and mental health share determinants, such as alcohol consumption, unhealthy lifestyle and work-related stress, which emerged in the documents several times (for example Denmark, 1992, 2002; Portugal, 2003; The Netherlands, 1992, 2004; Sweden, 2000; England, 1999; Finland, 1986). Applying these determinants to the **model of the determinants of health** in ***Figure 1*** indicates that the determinants of mental well-being penetrate all the layers, from societal and economic and environmental conditions to fixed factors. In contrast, the determinants of CVD centred on one inner layer of individual lifestyle factors (determinants such as smoking, diet and physical exercise).

In the *Independent Inquiry into Inequalities in Health* report (DoH, 1998) it was acknowledged that tackling inequalities would require addressing all these 'layers of influence'. The complexity of inequality is similar to that of mental health (Solin & Lehto, 2004). The data suggests that mental health promotion also requires attention to all the layers in the model. Dahlgren and Whitehead's (1991) model has been linked to mental health, but in terms of improving equality in health in general and policy initiatives to achieve it (McCulloch & Boxer, 1997).

Smoking and alcohol can be considered relatively practical targets for policy action, as there are a range of potential – although politically often difficult – preventative

TABLE 3 ***Determinants of Cardiovascular Diseases***

Documents analysed	Biological factors	Social environment	Societal and economic environment	Lifestyle	Physical environment	Mental illness
The Health Promotion Programme Denmark 1992		✖		✖		✖
The Danish Government Programme on Public Health and Health Promotion Denmark 2000						
Healthy Throughout Life Denmark 2003				✖		
Health a Commitment Portugal 1999						
Contributions to the National Health Plan Portugal 2003				✖		
Health as a Focal Point The Netherlands 1987			✖	✖		
A Strategy for Health The Netherlands 1992				✖		
Healthy and Sound The Netherlands 1996				✖		
Living Longer in Good Health The Netherlands 2004						
Health on Equal Terms Sweden 2000						
Saving Lives: Our Healthier Nation England 1999		✖	✖	✖		✖
Health for All by the Year 2000 Finland 1986				✖		
Health for All by the Year 2000. Renewed Collaboration Programme Finland 1993				✖		
Valtioneuvoston periaatepäätös Terveys 2015 – kansanterveysohjelmasta Finland 2001						

interventions. The policy documents at hand offer interventions such as taxation of alcohol and tobacco, regulations on advertising, legislation for smoke-free areas, education and information about the risks of tobacco smoking and excessive alcohol consumption. For example, the English White Paper *Smoking Kills* (1998) proposed to decrease the number of smokers by several actions focused on the individual. **Healthy schools** programmes aim to get children to adopt healthier diet and eating habits. While preventative actions are aimed at reducing risk, other interventions offer early screening and more effective treatment.

Discussion

It seems that the conceptual models of health determinants give a fruitful theoretical view of health promotion, and offer a frame for better understanding of where determinants of health are located. According to Graham (2004):

> *models have been developed to translate the concept of social determinants for a policy audience.*

These models also show the difference between the determinants of somatic and mental health; there is no adequate model that can take both aspects of overall health equally into consideration. When health promotion policy is designed, the application of diverse models of health may not be a rational choice. As, for various reasons, mental health is considered a problematic issue in policy-making (Solin & Lehto, 2004), use of mental health models alone in overall health promotion may easily be ignored. On the other hand, epidemiology as the primary discipline in the field of health promotion and health determinants, with smoking as the 'flagship example' of effective health promotion, can lead us to forget the complicated nature of various social determinants (Bunton & MacDonald, 2002) which are crucial in mental health.

The paradigmatic shift in health promotion policy needs not only to accept the complex nature of social factors and well-being, but also to take the idea of 'the creation of health' and the connection between the two, instead of disease, as a starting point (Ziglio *et al*, 2000). However, acceptance of a new paradigm requires overcoming the old one (Kuhn, 1996), and the old paradigm seems to rest on quite a strong foundation. Until there is a change in the dominant health paradigm, or modification of those obsolete models, it seems likely that mental health policy decisions will remain conservative and, perhaps, inefficient (Wolff, 2002). Commers (2002) has stated:

> *documenting what the public believes to determine its health offers the possibility of the discovery of determinants of health which are as yet unbeknownst to health professionals.*

According to Mangen (1985) and Goodwin (1997), the psychiatric profession has acted reluctantly towards alterations in the profession. Since mental illness is one of the major public health burdens and is determined by a variety of factors, it seems that revolutionary solutions are needed in order to diminish the public health risk. What if the reconstruction of the paradigm were shifted from the professionals to the public? As Commers (2002) continues:

> *practice, rather than health research or theory, has also shown the necessity of respect for 'lay' opinions on health goals and the means employed to achieve them.*

One of the recommendations in the new *Mental Health Action Plan for Europe* (WHO, 2005) is to recognise the experience and importance of service users and carers in planning and developing services. For this to be carried out completely would require extensive preparation (Thornicroft & Rose, 2005).

Conclusions

Comparison of the determinants of mental illness and CVD from the perspective of Dahlgren and Whitehead's (1991) model of the determinants of health shows that the causes of mental illness penetrate all the layers and are situated in various sectors, whereas the determinants of CVD lie mainly in individual factors. In health promotion policy-making, individual lifestyle factors such as smoking, diet and substance abuse are relatively simple targets to focus on, because applicable interventions are available. In the area of mental health, the determinants vary more, and they are also riskier targets for policy-making; there are no short-term interventions with unambiguous results to compare with epidemiological data. It may also be a common view that the determinants would not reach the individual layer as easily. The data shows that mental health promotion also requires the attention of all the layers of Dahlgren and Whitehead's model. The case of the determinants of mental health is especially complicated, as the underlying factors are varied and widely connected to the social environment.

According to the data analysis, the determinants of mental and somatic health differ to a considerable extent.

However, this difference is not substantial enough to be the sole reason for the awkwardness in mental health policy-making. Knowledge of the relevant determinants of mental health is set out clearly in the health policy documents analysed. Compared with somatic health determinants there are differences in the emphasis, as would be the case for any single disease or illness. The most significant observation is the role of mental health as a determinant of somatic health. The documents also acknowledge that psychological problems may cause unwanted effects such as isolation, which, in turn, are mentioned as determinants of mental illness. The development of this vicious circle, which applies to most determinants of mental health, is recognised in several documents, yet action seems to be insufficient. Nevertheless, the interactive and cyclic nature of various mental health determinants is becoming a clearer focus of research.

According to Evans and Stoddart (1990), a mechanical model tends to forget this cyclic and two-way aspect. Causal connections between issues like stress or self-esteem and well-being are difficult to accommodate in existing categories. Evans and Stoddart have proposed an analytic framework comprehensive and flexible enough to take on and understand 'a wider range of relationships among the determinants of health'. According to Ziglio and colleagues (2000), all aspects of human life, including political, economic, social, cultural, environmental, behavioural and biological factors, have both separate and combined impacts on health and well-being. Underrating this complex relationship between determinants and factors may impede successful health promotion policy (Evans & Stoddart, 1990), not only in the area of mental health, but also from physical and social perspectives as well. Social environment as a determinant is equally important for mental health, but the area includes factors that cannot be as easily affected by health promotion interventions as they challenge the individualistic paradigm in health promotion.

It has also been suggested that in the policy arena conceptualisation of the determinants of health has been carried out using poor tools. Framing of a problem for policy purposes is therefore incomplete (Evans & Stoddart, 1990). According to Andrés (2004), mental health policies should recognise the importance of social problems such as unemployment and social cohesion, as they are significant for mental health. These were both areas (among a few others) which clearly emerged from the documents as important determinants of mental health. Altogether, although the diversity and cyclic nature of the determinants of mental health is undeniably recognised in health policy documents, this knowledge does not convert as easily into recommendations for policy action.

Address for correspondence

Tampere School of Public Health, FIN-33014 University of Tampere, Finland. E-mail: pia.solin@uta.fi.

Acknowledgments

The author wishes to acknowledge Professor Juhani Lehto and Dr Pirjo Nikander for their opinions, support and advice during the process. A special acknowledgement to Dr Eeva Ollila, Dr Meri Koivusalo and Dr Marita Sihto for their expertise in the field of health policy. Thanks to the reviewers of the manuscript for their valuable comments and to Virginia Mattila for proofreading the manuscript. The support of the Ministry of Health and Social Welfare is also gratefully acknowledged.

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Targeting suicide

–qualitative analysis of suicide prevention strategy documents in England and Finland

Authors:

Pia Solin, Researcher, MSocSc, Tampere School of Public Health, University of Tampere. Tampere, Finland & Dr. **Pirjo Nikander**, University of Jyväskylä, Methodology Centre for Human Sciences. Jyväskylä, Finland.

Address for correspondence: Pia Crista Milana Solin, Researcher, MSocSc, Tampere School of Public Health, FIN-33014 University of Tampere, Finland. E-mail: pia.solin@uta.fi Tel. +358400746606

Acknowledgements: The authors wish to acknowledge Professor Juhani Lehto for his comments. Special thanks to the reviewers of the manuscript for their most valuable comments. The financial support of Tampere University, The National School in Social and Health Policy, Management and Economics and Medical Research Fund of Tampere University Hospital (Grant 9K125) is also acknowledged.

Keywords: suicide prevention, mental health policy, qualitative content analysis, interpretative repertoire analysis

Abstract: Suicide as a stigmatic issue presents a huge challenge for prevention policy and policy itself is often difficult to turn into action. This research describes the interpretative repertoires found in suicide prevention strategies of England and Finland, and explores their potential functions and audiences. It was found that the political repertoire was formed from four sub-repertoires; the public health epidemiology, the everyday, the preventive action and the reflective repertoires. The paper discusses the polyphonic and multi-layered nature of these policy documents and how different repertoires may be used for various functions. The polyphonic nature of policy documents is necessary to reach a wide readership and to capture suicide as a controversial phenomenon. However, the downside is that the argumentative style may also undermine some of the measures and actions recommended.

Implications for practice:

- To raise discussion between different actors on how political manners of speaking affect the acceptance and implementation of prevention programmes
- To inspire further research on the area of suicide prevention at the policy level

INTRODUCTION

Suicide is a major public health issue, comparable to deaths due to traffic accidents (Jenkins *et al*., 2002) and constitutes one of the largest public health risks when scrutinized through mental and somatic illnesses (Lahtinen *et al*., 1999). According to World Health Organisation (WHO), however, research or prevention of either suicide or attempted suicide is not always considered a priority (WHO, 1991). Despite a slight and much welcomed increase in suicide research, prevention policies still require a more solid knowledge base to be effective (Lönnqvist *et al.*, 1993). Several national suicide prevention strategies have been developed in the European region and the growing problem of mental health has led to actions towards establishing the Mental Health Action Plan for Europe which presents 12 challenges including prevention of suicide (WHO, 2005). This also encouraged the European Union to take actions towards a Green Paper for a strategy on mental health for the European Union (Commission of the European Communities, 2005).

Suicide as a phenomenon is not easily defined, understood or prevented (Singh & Jenkins, 2000; De Leo, 2002). In addition to the complexity of background factors, suicide carries a long-lasting mental and social burden on those left behind, as well as direct and indirect consequences on the health sector and society as a whole (De Leo, 2002; Anderson & Jenkins, 2005). The costs from suicide thus include both the loss of productive years from premature death and "substantial personal, psychological, social, political, cultural and economic impact on societies". (Anderson & Jenkins, 2005)

Given this, suicide prevention, in some cases, is still under-emphasized and under-researched when looking at national health programmes. This may originate from simultaneous

preparation of both special mental health or suicide prevention programmes. This results in a lack of attention on suicide in the broader design of general health programmes. According to Hawton (1998) the preparation of separate suicide prevention programmes should not mean that diminishing suicide rates are left out from general health promotion programmes. Hawton (1998) argues further that suicide remains the best and perhaps the sole indicator of mental health and leaving it out can mean that the whole issue of mental health is left out of health promotion priorities. The use of suicide statistics as an indirect indicator of mental health or lack of psychosocial wellbeing has strengthened the idea of suicide as a result of mental health problems. Even though depression has been recognised as a major risk factor for suicide (Goldstein & al, 1991), primarily it results of a combination of stress, maladaptive coping behaviours and lethality of the behaviour (Cantor & Baume, 1999).

Suicide prevention thus clearly is a problematic part of mental health policy. De Leo (2002) argues that suicide prevention suffers from inconsistency between political convenience and scientific adequacy, which too often is "resolved in the favour of the former". According to Wilkinson (1994), instead of suicide prevention, one should concentrate on more efficient care of mental health problems. This is supported by the argument discussed above that many suicides are typically connected to mental illness (e.g. Jenkins & Singh, 2000). As mental health problems and suicide risk are strongly linked, the current study's focus on the policy level deepens our understanding of not only suicide but of mental health problems and their vital role in general health policy area. This helps future research within the subject area to orientate itself and to identify its pivotal focus.

Policy documents are always the product of several co-authors and policy makers, and as texts they participate in the definition of the phenomenon in question. Documents are both results as well as tools of concrete policymaking: policy decisions are actualized in strategies and programmes which are thereafter used to carry out the decisions in reality. Policy texts are also a means of gaining power and moulding public opinion through choice of words (see Zaller, 1992). This persuasion becomes noticeable and can be revealed through detailed analysis of policy texts. The aim of this explorative paper is to examine how suicide is described as an issue and a target of preventive actions in two suicide prevention strategy documents. Through the careful analysis of interpretative repertoires in these documents, we also aim to identify the audiences the documents address and the functions that the repertoires attempt to achieve. Thus we proceed by discussing the use of power behind political talk and its influence on the audience. Finally the paper concludes by suggesting future research objectives in this area.

THE DATA

This study was conducted as part of a larger research project, ”Finnish national health promotion policy from an international comparative perspective”, which began in 2002. The project was funded by Academy of Finland and was led by professor Juhani Lehto from University of Tampere. It focused on the health policies of Finland, Sweden, Denmark, England, the Netherlands and Portugal and collected material from the years 1986-2004 (see Solin & Lehto, 2004). During the project, an extensive dataset consisting of health policy documents, programmes, working papers and scientific articles was collected from several European countries. The main dataset consisted of health promotion strategies from the countries and is

presented in more detail in Solin & Lehto (2004). While focusing on the argumentation around mental health, the often ambiguous theme of suicide repeatedly surfaced. Suicide seemed to be more than just one of the problem areas of mental health and illness. It was also given a further role as an end result of mental health problems and therefore argumentation easily culminated around the issue of suicide. Mental health seemed at its most visible, measurable and solvable through the notion of suicide and its prevention. Given this, for the purposes of this paper, national official suicide prevention documents from England (2002) and Finland (1992) were chosen as targets for more detailed analysis. The documents are approached here as examples of a policy genre with characteristics that remain relatively unchanged across time. Although the documentation chosen only include those from ministries of health, the role of the division of labour and other actors within the field is implied in the policies selected. The fundamental elements of political talk; such as persuasion, remain the same regardless of time, culture or place, thus it enables the use of chosen strategies.

England and Finland are both Western or North European states with relatively similar political cultures and health policies that have followed closely WHO's Health for All –thinking. These similarities, also reflected in policymaking, enable us to give prevention programmes an equal value as data (see also Solin & Lehto, 2004). Furthermore, as documents, they shared a similar general structure. They first discuss suicide on a general level followed by national objectives, guidelines and strategies aiming to reduce the number of suicide and suicide attempts through various action plans.

Analyzing the structure and argumentation of the documents, our focus in this paper was on similarities outlining the comparisons for future research. The policy documents are

approached as key platforms where one phenomenon linked to mental health, regardless of country of origin, becomes defined and determined as an object of policy measures.

The publication span of the documents is 1992-2002. Their authorship is similar consisting of ministries of health, academics and other policy actors and experts. The documents consisted of 30 (English document) and 42 pages (Finnish document) (both without appendices).

METHODS

The initial analysis of the data was carried out with qualitative content analysis. The parts discussing suicide were screened and organized. (Berelson, 1952). The guiding question in the process was "in what ways is suicide discussed in national suicide prevention strategy documents?" The data finally consisted of core sentences, statements and paragraphs that condensed key representations of suicide in the data. The basic unit of qualitative as well as quantitative analysis was a sentence. However, when a sentence could not be separated from its larger context, the sample may have consisted of longer than sentence-length entities (Berelson, 1952; Polit & Hungler, 1991). Change of chapter was interpreted as an end of one unit.

The content analysis phase functioned as a tool for organising the data, and the results are presented in a quantified form in Table 1. In the next analytic phase, interpretative repertoire analysis (Wetherell & Potter, 1988) was used as a tool to further discover the variability, and delicate use of language in the documents. The repertoire analysis also helped to reveal the potential functions and the use of persuasion and power in the policy texts. Interpretative

repertoire analysis is widely used in the analysis of both texts and talk. The concept originates from discourse analysis and underlines the functional nature of language as a means for explaining, justifying, excusing or blaming (Wetherell & Potter, 1988). According to Edley (2001) there is a pre-existing "library", which consists of linguistic material and this material may be formed flexibly and creatively into repertoires. This means that events, groups, policies or, like in this study; suicide as an issue, may be reconstructed using various elements such as certain phrases, metaphors or figures of speech. As a concrete method, interpretative repertoire analysis stresses the researcher's dedication to the data, as often only absolute familiarity with the data results in identifying distinct elements and their variability. (Edley, 2001)

In the course of the analysis, it became clear that health policy texts consist of several argumentative, interpretative and persuasive layers. The text genre in policy documents is out of necessity broadly political in nature. Detailed analysis using interpretative repertoire analysis revealed, however, that this genre consists of five distinct sub-repertoires. The political repertoire is considered here as an umbrella term, under which four additional repertoires were identified. In what follows we explore the multi-voiced nature of the political repertoire by describing each sub-repertoire in turn. The data extracts characteristic and identifiable in every document are included and the interaction between different repertoires is discussed. In the data there are also cases where more than one repertoire co-exists within one extract. Examples of such cases are presented in the results. Each repertoire is formed from unique features, even though some of the functions are shared between two or more repertoires. The various purposes of each repertoire as well as the possible audiences and the tone used in the repertoire are condensed in Table 2. In the text we will concentrate on the main features and the purposes of the repertoires.

RESULTS: How is the political repertoire formed?

The repertoire of public health epidemiology

In suicide prevention policy documents, decisions and suggested actions concerning suicide are ideally based on thorough research and scientific knowledge of various experts, especially from *the epidemiological field*. Suicide is the focus of research, a phenomenon which can be specified into quantitative examples, such as *figures* of death rates with different correlations *or statistical information.* Within this type of policy text, which we identified as the epidemiology repertoire, claims in the text are typically reinforced by the use of tables and charts, national statistics are typically compared with those in other countries and the term *suicidology* is in wide use. This repertoire is based on specialist language, and sections of defining key terms are often included. This clearly demarcates the language from lay terminology and concepts. Prevention programme text within this repertoire also presents different theoretical models for the implementation of action. The need for suicide prevention as well as justification for selected actions is typically rationalised through evidence, such as in following:

"Research evidence on suicide prevention is a crucial foundation of this strategy." (DoH, 2002)

Despite already existing knowledge on suicide, the repertoire typically constructs a need for further information, such as in these examples:

"A large amount of data is already collected by the Office for National Statistics and through programmes of research. However, additional information is required to support the strategy's objective." (DoH, 2002)

"More research data is needed constantly, even though unambiguous answer in expected accuracy will never be available due to the nature of the phenomenon." (STM, 1992)

(Note that all the extracts from Finland's prevention strategy document have been translated into English by the authors.)

The making of decisions within this repertoire, becomes justified by appealing to research data and evidence provided therein. In case the reader is not a researcher within the field, however, it is very difficult to verify any such results, their validity or reliability. Interestingly, the repertoire also builds on the notion that further research and data collection are needed. Complexity of suicide as a phenomenon always opens the door for potential failure. Any risk in this direction, is however explained by the continuous lack of adequate epidemiological research evidence. Simultaneously this repertoire directs the pressure away from those behind specific policy decisions. By presenting facts, figures and the results of research studies this widely used repertoire (see Table 1.) aims to convince those working in the field of suicide prevention, policymakers and the general public, of the importance of the repertoire and the policy more generally.

The everyday repertoire

The everyday repertoire is distinct in its use of language and the way it addresses the

audience is in stark contrast to that in the previous repertoire. Information on suicide is offered here in general terms appropriate to "ordinary" recipients. Within this repertoire, suicide is treated as an issue that can touch, be overcome and understood by everyone. The everyday repertoire operates at the level of survivors, carers and ordinary readers instead of experts. The repertoire uses quotations from persons who have attempted suicide or their relatives and seeks to expand existing knowledge by discussing questions of taboo and stigma:

"Large financial losses apparently crushed him totally" (STM, 1992)

"He/she felt himself/herself useless" (STM, 1992)

Quotes like the ones above are an effective way of making suicide as an issue more humane and closer to the everyday reader. They describe the emotions experienced by those affected, simultaneously stressing the wide emotional and psychological consequences of suicide:

"Every suicide builds up a load in several people's lives. Society and those nearby should not become unconcerned by the anxiety and despair that precedes the decision of suicide." (STM, 1992)

Trading in emotional terms like *anxiety, despair* or *loss* the everyday repertoire gives centre stage not to scientific fact but to people's experience. Foregrounding experience, sympathy and understanding it also, in part, uses these as the basis for political concern and decision making. The data extract below is an example of repertoire blending and of how the everyday and the

preventive action repertoire (presented in the next section) form the basis for the political:

"Each suicide represents both an individual tragedy and a loss to a society. Suicide can be devastating for families and other 'survivors' – economically, psychologically and spiritually. For these reasons the Government has made suicide prevention a health priority." (DoH, 2002)

The extract starts with everyday repertoire with an emotional tone only to quickly merge with an emphasis on preventive political action and political priorities. Simultaneous reference to several repertoires is not uncommon in text and talk data (Reynolds & Wetherell, 2003). Here, the everyday repertoire clearly lends credibility and supports decisions described in the political sphere.

The preventive action repertoire

In this repertoire suicide is considered as a public health problem in need of effective preventive action. Suicide is described as "a malfunction" which at its worst can lead to death. It also has consequences. While the everyday repertoire underlines the psychological and emotional consequences of suicide, the preventive action repertoire centre-stages more concrete and practical outcomes, such as in the extract presented earlier as an example of repertoires co-existing and in the following extract:

"Its emotional and practical consequences are felt by family and friends…" (DoH, 2002)

This extract is yet again an example of two repertoiresmerging. In the extract the emotional as

well as practical consequences are simply mentioned without further explanation and readers are expected to be aware of their nature. The repertoire discusses also ways of effective intervention and action and can typically be found in 'the suggested guidelines' –part of the documents. Proposed action and preventive work are not only directed at the health care sector. As suicide is acknowledged as a problem with multiple causes and risk factors, multi-sectoral cooperation is encouraged, for example:

"A coherent, co-ordinated suicide prevention strategy therefore needs the collaboration of a wide range of organisations and individuals." (DoH, 2002)

"The programme shows that suicides cannot be prevented by one act, or actions of one sector of society." (STM, 1992)

Stressing the collaboration of several sectors simultaneously strives to include everyone in a common effort, while dividing the responsibility of suicide prevention evenly among different actors. The language in the preventive action repertoire has a counselling or an informative tone which resembles that typical to the medical or public health field. Individuals with suicidal intentions are referred to as *patients*. Actions and interventions are referred to mostly as *treatment* and *care* focused on *risk groups*. Suicide risk factors within this repertoire are sometimes estimated in terms similar to that of high blood pressure in cardiovascular diseases. The main audience for the repertoire seems to be those who are actors in the field and implementers of the actions suggested.

The reflective repertoire

Suicide prevention documents sometimes refer to ethical issues by redefining suicide as something more than just a public health problem and by discussing whether a person has a right to end his or her own life. This, according to our analysis, marks a shift into the reflective repertoire. An example of this is:

"Suicide attempt and suicide intention always express serious dead end situation and despair, not always an irrevocable intension to die." (STM, 1992)

The data extract stresses that attempted suicide often results from an unbearable situation, is not automatically based on a wish to die but rather seen as a way out of long-lasting anxiety. Within the reflective repertoire also cultural variation in understanding life and death as well as religious and legal aspects of suicide are typically brought to the text's surface. Cultural ways of thinking are acknowledged as having an influence on local conceptualisations of suicide. Here is an example of this:

"The public discussion of suicide and the potential causes should be revised in Finland. Do we speak of suicide in ways that strengthen conceptions of it as an accepted or even expected Finnish solution to problems? Has suicide turned into a specific test of Finnish masculinity? Is suicide treated as a model solution without offering a model of coping or survival? Is the dominance of negative news criteria leading into public gloating of Finnish suicide?" (STM, 1992)

This extract raises questions about the status of suicide as an accepted – perhaps a national – solution to problems. The policy document does not answer these questions, but hints that a focus on negative media coverage may be involved in the matter. Discussing media as a factor which may provoke or support (attempted) suicide as a behaviour pattern, the repertoire again merges somewhat with the preventive action one.

Cultural elements can be brought into the discussion by a range means. Explaining the main methods of suicide can, for instance, be read as part of the reflective repertoire, particularly when presented from a national perspective. Below, in an excerpt for the English documents, treating certain cultural or expert knowledge as a given and listing what 'we' know to be the case here and for now simultaneously makes available that other cultural variations may exists elsewhere.

"We also know that the main methods of suicide are hanging and self-poisoning with psychotropic or analgesic drugs." (DoH, 2002)

The reflective repertoire may also raise the element of spirituality into the discussion (see quote from the Department of Health (2002) in the section on the everyday repertoire). Even though the subject of spiritually is not opened or discussed further, the mere mentioning of it indicates an understanding that suicide operates on several levels and dimensions. To summarise, the reflective repertoire underlines local and cultural differences concerning the definition and social outcomes of suicide. It also entails intense opinions as well as emotions. Given this, suicide is not an easy target for universally acceptable solutions, interpretations or policy

decisions. By its reflective, analytical and nevertheless humane approach the repertoire seems to show cultural understanding, encourage broader discussion and increase knowledge and attitude change.

Conceivable functions of repertoires; towards understanding

To understand the existence of the repertoires identified above, they need to be examined for their functions within the documents. Below we therefore engage in some further analysis that may start to explain both the discursively layered nature of policy documents and the existence of several interpretative repertoires and their functions (see Table 2.).

First, repertoires and the inter-connections between them may act as tools that make policy programmes work. Successful suicide prevention requires taking recipients and actors from various fields and sectors into account. Therefore the use of several, even contradictory, interpretative repertoires allows readers who implement and carry out the programme to make optimal use of it. To succeed even to some degree, policy texts must "speak the same language" as their readers, and the use of multiple repertoires works to ensure a wide readership. An effective policy document is thus not only thorough but also persuasive.

The second function of the repertoires is to provide additional information. Actions in suicide prevention may be seen as irrelevant, excessive or inefficient. As repertoires yield information on the problems and perspectives included in the phenomenon, they also stress that there are no easy solutions. The reflective and everyday repertoires aim to make an otherwise stigmatic and taboo issue familiar. These repertoires help discuss complicated issues in ways that

widen the perspective of potential readers and emphasize the sensitivity of the phenomenon.

The third function of the repertoires is to provide justification for the actions proposed. The public health epidemiology repertoire, for instance, uses "hard" data and expert opinion in order to ensure that all measures suggested are thoroughly considered, well-planned and executed for the good of all. Epidemiological data on prevalence, risk factors and effectiveness of intervention are needed for confident and well-grounded decision-making.

Whether the use of repertoires for the above-mentioned functions is the result of conscious or strategic work is not at issue here. Wetherell & Potter (1988) claim, that using various repertoires is not necessarily deliberate or intentional. However, according to Juhila (2007) "each repertoire provides access to specific speaking and acting positions with certain rules and rights". By using certain repertoires policy documents thus address readers by appealing to the humane, the professional or reflective aspects. Doing this, they also legitimate the position taking of those behind the policy text. The political repertoire gives the right to formulate policies, to suggest actions and to monitor their subsequent execution. Sub-repertoires, by their various functions, reinforce this right.

Accordingly each repertoire seems to function towards a specific goal within the broader political repertoire. This has advantages as well as disadvantages. Policy documents are typically written collectively by several experts and it is natural that these voices are reflected in the use of different repertoires. Therefore all four interpretative sub-repertoires do not exist evenly in the documents or between countries. Variations and differences are natural as each

document “speaks” from its own point of view and constructs its unique emphasis on the issue. As repertoires vary, so does the number of them between the documents. However, comparing countries was not our goal, and variability in general could well be expected due to cultural, societal as well as nation and time-specific factors.

The data show that the existence of several repertoires also results in conflicts between them. For example, even though the repertoires typically acknowledge suicide as a major health burden, it is constructed as different from other health promotion targets. The key question remaining unanswered is: What if suicide is a totally unique societal and cultural problem in comparison to health issues and it is incorrect to treat suicide as a preventable disease? What if, the only similarity is the possible outcome; death. This is left unanswered and may be the aim of further research. However, building on multiple repertoires the programme texts strive to reach a diverse readership and thus to ensure carrying out the strategy as planned. This explains the multi-voiced nature of such documents. It has been suggested that multi-causal explanations with various solutions may be created by those who have “the greatest chance of building support”. (Rochefort & Cobb, 1994). The planning of mental health strategies and the various stakeholders behind it require a range of arguments backing up the relevance of suggested actions. This is crucial as “no strategy will succeed unless a critical mass of stakeholders is satisfied or at least compliant.” (Jenkins *et al*., 1998)

Traditionally political actors wish to emphasize background factors as most suitable for the strategies of their choice. As suicide is not a new phenomenon, it cannot count on gaining attention by its novelty value. However, it is possible to emphasize incidence (Rochefort &

Cobb, 1994); the fact that suicide statistics are changing. Therefore the most logical way of making the issue more comprehensible is to treat it as a preventable health problem. From the perspective of the various repertoires, however, it seems that the reflective repertoire may work against this goal. It underlines culturally diffuse connotations, the often unconscious, emotion-ladenaspects from shame and fear to ideas of suicide being an act of heroism or following one's destiny. It thus supports specific, local decisions by understanding the cultural complexity of the issue, while also raising aspects of suicide that do not fit the "suicide as a disease" -thinking. The somewhat contradictory role of the reflective repertoire may also explain its weakvisibility in the documents while the preventive action repertoire is in most frequent use. (see Table 1.).

The interpretative repertoire analysis of policy documents underlines the existence of various, sometimes contradictory styles of depicting and constructing a given phenomenon in the same text and within a specific political genre. Resorting to several interpretative repertoires in a single policy document may be a factor that weakens the suicide prevention programme, as one repertoire questions the other and leaves the reader confused in the middle of conflicting perspectives. In order to be truly functional, however, policy documents have to be polyphonic. The repertoires and their multi-voiced inter-relationship interact with readers' own interpretations in order to convince them and reach intended policy goals.

DISCUSSION

What does the polyphonic and multi-voiced nature of policy documents discussed above mean for the writing and execution of intervention programmes? In order to succeed,

suicide prevention requires efficient actions and choosing between several successful prevention interventions (Wasserman et al., 2004). Does the existence of different repertoires lead to a situation where different interventions exist for each means of conceptualising the phenomenon? And is it even possible to include such a range of actions in a single e.g. national programme? Furthermore, can they be successfully executed in their variety? It is evident that uncertainty about the effectiveness of actions constitutes an obvious risk for policy designers and decision-makers who prefer quick and favourable results (Braverman, 1989). This may lead to the so-called "shotgun effect" where mental health policy, including suicide prevention, is filled with multiple alternative actions under the assumption that at least some of these interventions reaches the intended target. In case of failure, one can still claim that all possible measures were taken. Often some extent of ineffectiveness is tolerated and critique muffled if the programme otherwise fits with the prevailing values or aspirations of political actors (Weiss, 1993; Wolff, 2002).

Policy writing always entails the use of discursive and political power as political forces seek to manipulate public opinion by choice of words (see Zaller, 1992). Doing this, they have the power to determine what gets considered as fact (Fischer, 2003). In this case, policy documents open up a window of opportunity for policy actors to feed their "pet ideas" and arguments to the audience (Kingdon, 1984). As political coalitions and actors fight over their own definitions and understanding on the phenomenon, they simultaneously fight over the domination of the audience (Entman, 1993). The use of different interpretative repertoires foregrounds, selects and describes different aspects of the issue and as decision-making gets done in certain political, historical and cultural context, even minor changes easily place

previous guidelines and actions into new light. During political tugs of war suicide prevention as a political issue may change beyond recognition to the point that when implementation finally takes place, interventions have to be executed from a starting point totally different from the original.

As can be seen in Table 1, quantitative differences in the repertoires used are not substantially significant. However data representing suicide prevention policy documents from significantly different cultural origins could have produced different kinds of results for two reasons; first of all, repertoires themselves are collected from "culturally available resources" (Juhila, 2007). Using Edley´s (2001) metaphor of a public library where repertoires can be picked out as books from the shelves, each culture has its own library and therefore the selection of books. This means that repertoires and their local uses may differ. Secondly, also the issue; suicide, is culturally defined. So, to use the same metaphor, similar books do exist in different libraries, however they may be written in various languages. Even if they consist of various languages; they still speak about the same issue.

As very few suicide studies concentrate on scrutinising policy documents, this piece of research has entered into a field still largely unexplored. In the future, research in this field could focus on whether various themes included in policy documents constrict or assist the most critical phase of the whole process: policy implementation. Another possible aspect concerning the functions of different repertoires could be to concentrate on how particular arguments and emphases originating from national policy documents get citied, recycled and refuted in trans-textual contexts, political speeches and negotiations concerning e.g. European mental health

issues both nationally and internationally. As suicide prevention remains a challenging health target, research like the one attempted in this study continue to help detect which interpretative themes and discursive expert constructions of suicide receive political rhetorical power and prevalence in the future.

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Interpretative repertoires	**Public health epidemiology repertoire**	**Everyday repertoire**	**Preventive action repertoire**	**Reflective repertoire**	**Total**
Finland	13	9	17	4	**43**
England	12	2	11	1	**26**
Total	**25**	**11**	**28**	**5**	**69**

Table 1. Number of the repertoires mentioned in the data

Table 2. Specific features of the repertoires

	Purpose	Possible audience	Tone used in the frame
Public health epidemiology	-legitimises suggestions and decisions given (in the documents) by presenting evidence and research data	-actors in the field -other policymakers and specialists -ordinary people	-scientific, evidence-based -contains specialist terminology
Everyday	-discusses suicide in lay terms and from everyday perspective	-survivors, carers -ordinary recipients (laymen) in comparison to experts	-emotional, familiar, personal -less scientific, colloquial -easy approachability
Preventive action	-supports the primary frame by introducing a serious public health problem -focuses on action by health professionals and other implementers of the programme	-actors in the field -those who implement the suggested policy actions in the programme	-informative, counselling
Reflective	-discusses the ethical and moral issues of suicide -attempts to show the understanding of the issue in its diversity -points out the complexity of the phenomenon	-policymakers -evaluators of the programme	-analytical, reasoning, reflective -humane, spiritual

Scandinavian Journal of Public Health, 2011; 39: 255–261

ORIGINAL ARTICLE

Mental health in complex health promotion policy programmes: The contribution of programme evaluations

PIA SOLIN & JUHANI LEHTO

School of Health Sciences, FI-33014 University of Tampere, Finland

Abstract

Background: In order to develop policymaking, evaluation is required. The research project studied national health promotion policies concentrating on mental health promotion policy. In this paper the focus is on the position of evaluation. *Aim:* To explore the position of evaluation in the development of the national public health strategies of England and Finland and particularly with regard to mental health promotion policies. The evaluation phase of the policymaking process is also scrutinised through multiple streams of policy change. *Methods:* Meta-evaluative approach applying a conceptual framework of policy analysis. *Results:* Evaluations of national health strategies were executed in both countries. These evaluations entailed multiple tasks; not only to monitor the progress of the targets but to learn for the future in a wider perspective. Aims of mental health policy are not easily turned into quantitative targets and therefore outcome evaluation was not felt to be satisfactory as it lacks focus on process as well as null, perverse, and unintended consequences. ***Conclusions:*** **While the position of evaluation is almost always more complicated than is assumed in so-called rational policymaking theory, mental health appears to be even more challenging in this respect. Possibilities for alternative evaluation strategies should be studied further.**

Key Words: *Evaluation, mental health promotion, policy analysis, streams of policy change*

Background

According to a mainstream idea in policymaking, policies are developed and implemented in a cyclical recurrent process with at least five consecutive and interdependent phases: agenda setting, policy formulation, policy adoption, implementation, and evaluation [1]. This understanding of policy development has also greatly influenced national health promotion policy development, notably through the advocacy of the World Health Organization (WHO) of target-based comprehensive Health for All programmes and of evaluation being a core activity in developing these programmes [2].

Much of the health programme evaluation literature not only sees evaluation as the last phase of the policy cycle and as a tool for assessing the outcome of a given policy but also as a part of programme planning by contributing to defining an operational target through incidence and prevalence, risk groups, and numbers [e.g. 3]. This approach also advocates setting exact numerical targets and may claim that a programme or a policy without clear targets is detrimental to effectiveness. Thus evaluation measures success, but it also motivates the programme designers to specify the programme targets. This happens when programme designers and researchers understand how and why a certain programme works and what the effects of the implemented programme are. It has been realised that evaluation is most useful when it provides information for other programmes as well. [4] For example, in agenda setting, political decision-makers have to decide when the effort is worth the costs, as it is not reasonable to put a lot of effort into a lost cause [5].

Seeing evaluation as the last phase of a rational policy cycle fits fairly well with the assumption of "rational policymaking" [6]. Much of policymaking, however, is rather "incremental", meaning that policy development does not occur in a formal,

Correspondence: Pia Solin, MSocSc, School of Health Sciences, FI-33014 University of Tampere, Finland. E-mail: pia.solin@uta.fi

(Accepted 28 January 2011)

DOI: 10.1177/1403494811401473

linear setting, but with small adjustments and by small steps due to various characteristics of political decision-making. [6]. Policymaking seems moreover often to follow a kind of "garbage-can" model, in which problems and possible solutions drift, waiting for convenient combination for coupling [5].

Mental health is certainly a problematic area to promote, starting from the conceptual level, as the concept "mental health" has various meanings depending on who is defining the issue [e.g. 7]. Furthermore, lack of indicators for monitoring the state of mental health also hinders policymaking. It is often recommended that health programmes should be based on targets where progress can be monitored and without solid indicators this is difficult [8]. We have learned in the earlier phases of our project [e.g. 9] that mental health seems to be quite a problematic issue by definition and indicators, but also by care, measurement, and data, and thus it is difficult to be dealt in accordance to the public health programme framework developed with mainly chronic somatic diseases in mind. Mental illness does not have a unidirectional causality but, rather, many of its determinants have a circular relationship between each others. Furthermore, mental health promotion can be delivered in various settings and sectors as well as for variety of vulnerable groups (e.g. elderly) [7].

The aim of this study was to explore the position and contribution of evaluation in developing mental health promotion as a part of comprehensive and complex national health promotion programmes. A meta-evaluative approach [10] with a policy-analysis conceptualisation by Kingdon [5] is applied. Both outcome and process evaluation aspects with regard to mental health are explored. The paper ends with a discussion about the results from the perspective of the multiple streams of policy change.

Theoretical perspective

The contribution of evaluation to the policy process

There are several models for executing assessment and the most traditional way to approach health promotion programmes is to choose *outcome evaluation*. This approach suits best as programmes are often based on targets and the focus of outcome evaluation is to find out whether they have been achieved [10]. *Process evaluation*, on the other hand, concentrates on "processes by which a policy or program is formulated and implemented" [11]. In contrast to outcome evaluation, process evaluation attempts to reveal all the consequences of an intervention, intended or unintended, such as null, perverse, and side effects [10].

It has been stressed that one method of evaluation cannot be appropriate in every situation [e.g. 4]. A combined method or a tailored evaluation to suit the unique conditions of a certain programme is preferable [12]. Unfortunately, due to scarce resources of time and money as well as a desire to please the electorate, policymakers favour quick and unambiguous results from evaluation research [12]. However, good evaluation does not always have to be long-lasting or expensive; instead, choosing the most suitable method is crucial. By providing "the facts" – unbiased data on the consequences of programmes – evaluation assists decision-makers in making wise choices among future courses of action and thereby considerably improving decision-making [3,4,12].

A number of factors have been mentioned in the literature [7,13] that may challenge the position of evidence produced through evaluation in the mental health policy process. First of all, many policymakers do not know the terminology, terms, or processes of the mental health field and need to have them explained to them. Second, policymakers may also think that scientists may underestimate their task in administrating health policies. Third, the evidence may not reach the policymakers or the policymakers may think that mental health cannot produce proper evidence and therefore the activity is also useless [13]. Fourth, policymakers tend to see mental health as a rival to other health issues, instead of seeing it as a part of health [7]. Finally, decision-makers tend to act on changes and emergencies and it is argued that mental health rarely produces such occasions [13].

The position of evaluation in policy development

Evaluation in general also takes place in a political context and one has to be aware of the three following premises. First, the targets of the evaluation; the policies and strategies are the results of political decisions, thus everything happens in the political field. It may even be possible that political pressures may change the perspective of evaluation to suit political purposes. Second, "because evaluation is undertaken in order to feed into decision-making, its reports enter the political arena". In the political arena it has to compete for attention with other significant issues. However, some degree of ineffectiveness may be tolerated "if a program fits well with prevailing values, if it satisfies voters, or if it pays off political debts". Finally, it is often unrecognised that evaluation itself has a political dimension [14].

Kingdon [5] presents a different view of evaluation. The amount of knowledge needed is seldom either available or adopted. Also, there are numerous actors linking in to the process simultaneously

affecting its development and, furthermore, the policy process rarely proceeds in orderly stages. Stages do exist, but they do not follow each other chronologically.

Incremental decision-making seems to be little a more adequate for a number of policy processes [5,6]. The ongoing task or programme is only slightly altered in the desired direction. There are several benefits in this approach: minor adjustments do not require an excessive amount of new information, time, or other resources, and smaller steps may be more acceptable to the actors. However, this also places evaluation in a fairly narrow space: there is no room for major critique suggesting major changes in policy.

The garbage can model solves some of the restrictions of the two alternatives described above. It allows the consideration of policy problems, policy solutions, and policy coalitions at the same time and not only one after another. It also allows larger policy changes, if only a window of opportunity for such a change opens.

According to Kingdon [5], a window of opportunity for a policy change is created if opportunities develop simultaneously at three levels of policy-making, which he calls streams. The first condition or process where agendas are influenced is a problem stream. The prerequisite for change is that there is an understanding in the policy community about a problem that demands a policy change. The second is a policy stream, which means that the generation of policy proposals happens through extending the knowledge and perspectives of the specialists in the policy area. The prerequisite for change is that there is an understanding in the policy community that there is a realistic policy alternative. The third political stream affects agenda setting through processes like changes in the national mood, public opinion, or administration. The prerequisite for change is that relevant actors in politics want and are capable of accepting a policy change. When the prerequisites occur simultaneously, a window of opportunity for a policy change opens.

Policymakers may use indicators or other evaluation results to assess the magnitude of the problem as well as to become aware of changes in it. Sometimes changes in indicators may be exaggerated and thus have effects on the policy agenda [5]. Evaluation of the programme may also be one way to show that the policy process for that part is complete.

In the policy stream there is a variety of specialists, all of whom having their pet ideas floating around in policy communities [5]. Kingdon [5] compares the policy generation to a process of biological natural selection. Various possible ideas float around in a "policy primeval soup" where they are revised, altered, and combined with each other. However, in order to be selected, an idea has to meet several criteria. The policy expert community is particularly adept at using evaluation results as evidence of such criteria being met [14].

The political stream is formed of various factors such as swings in the national mood, movement of interest groups, election results, or changes in administration. Kingdon [5] suggests that "public policy analysis could treat these political events as somehow outside of policy-making process". Evaluation as technical activity may not as such affect the political stream, but when evaluation results are made public and when there are public reactions to these results and the results are given public interpretations, they may become a significant material for political discussion and action related to the policy in question [15].

Aims

The aim of this study was to explore the position and contribution of evaluation in developing mental health promotion as a part of comprehensive and complex national health promotion programmes. A meta-evaluative approach [10] with a policy-analysis conceptualisation by Kingdon [5] is applied.

Materials and methods

The documentary data included both official and some unofficial evaluations of England's Health of the Nation (HOTN; 1992) and Finland's Health for All by the Year 2000 (HFA2000; 1986) strategies and also scientific articles and editorials on the assessment of these programmes.

Official documents were collected from governmental websites. Unofficial evaluations and reports were located with the help of the interviewees using the snowball technique. Also keywords such as "evaluation", "assessment", "Finland", "England", "national health strategy", "national health promotion programme", and "target" were used in web-based data search (e.g. MEDLINE, EBSCOhost).

Also seven semi-structured, in-depth interviews with policymakers, health authorities, and academics in the field were conducted in 2003 in England. The main use of the interviews was to locate officially unavailable documents, but also they were used in the analysis to gain more insight in interpreting the policy documents. The interviews consisted of topics related to designing mental health promotion and policy and the role of mental health in the area of

health policy. Interviews were tape-recorded and transcribed for possible further use.

Expertise for insight and understanding of Finnish documents as well as locating them was available inside the research project group. The research project "Finnish national health promotion policy from an international comparative perspective" began in 2002. It was funded by Academy of Finland and it was led by Professor Juhani Lehto and carried out by a team of researchers from the University of Tampere and National Agency for Welfare and Health (STAKES). The project focused on health policies of Finland, Sweden, Denmark, England, the Netherlands, and Portugal.

As content analysis allows testing theoretical issues in order to enhance the understanding of the data, qualitative content analysis with a theory driven focus was applied [16]. After organising the data with content analysis, evaluations and material that could be considered as evaluative were chosen for in-depth policy analysis with meta-evaluative approach [1,10].

Results

Evaluation of the public health programmes in both countries had multiple officially stated tasks (see Table I). In England the purpose was not only to draw lessons for improving the next strategy, but to also assess the implementation of HOTN locally [17]. Finland's situation was slightly different as it acted as a pioneer country in the Health for All strategy. External evaluation of the strategy was requested from WHO. The role of the evaluation was to set an example for the international public health community "and within possibilities, to suggest alternative models of action" [18].

When the overall programme success was evaluated, the Finnish report revealed that the implementation of the programme had suffered from inefficient involvement of local actors [19]. There was criticism that municipalities, universities, and the public had been excluded from the preparation [20]. Prioritisation of the targets was also missing, likewise quantitative targets [19]. One criticism was directed at actions. It was also argued that HFA2000 targets were impossible to achieve with existing means [21]. In England the implementation was hindered by the poor acceptance of targets. The lack of common definitions of "severely mentally ill people" [22], but also other problems of definition and overall understanding of suicide and mental illness were brought to the fore. The suicide reduction target did not receive much support from the respondents as it was considered as "the normal functioning of normal people who are under stress" instead of as a problem. Mental illness and other emotional problems were also recommended to be separated from each other in order to have separate targets. However, it was realised that in this division there may be a risk of stigmatising those with more serious mental illness even more [23].

The outcomes of the HOTN mental health targets were considered as a question mark as evaluation of C1, "improving health and social functioning of those with mental illness", and C2, "preventing suicides of severely mentally ill", was not possible due to the lack of a monitoring system [24]. However, this situation stimulated the development work on monitoring systems of the area [e.g. 24]. In Finland the third evaluation of Health for All strategy reported that the number of disability pensions due to mental disorders had increased. At the same time Finland was suffering from an economic recession and cuts in mental healthcare resources may have made the situation worse. However, the overall success was seen in the implementation of both

Table I. Mental health targets and evaluation aims of Health of the Nation (HOTN) and Health for All by the Year 2000 (HFA2000) strategies.

Health promotion strategy	Mental health targets/action lines in the strategy	Evaluation aims
HOTN (1992)	C1: to significantly improve the health and social functioning of mentally ill people	Identify achievements, failures, limitations and successes
	C2: to reduce the overall suicide rate by at least 15 % by the year 2000	Assess implementation
	C3: to reduce the suicide rate of severely mentally ill people by at least 33 % by the year 2000	Improve next strategy
HFA2000 (1986)	Human relationships and mental health	Carry out a review of programme formulation and implementation
	Suicide prevention	Focus on three chosen sub-areas
	Mental health work and psychiatric health care	Check and revise Health for All strategy
		Set an evaluation example and to raise discussion in the health policy arena inside and between WHO member countries

suicide prevention and national schizophrenia projects [25]. Suicide rates showed a decrease in both countries. Between 1993 and 1994 English suicide rates dropped about 6 % [26]. In Finland the decrease between 1990 and 1995 was 8.2 % [27]. During that time in Finland a national suicide prevention strategy was started in 1992, which may have had time to affect suicide rates.

The analysis of the data revealed several obvious problems in evaluation execution (Table II). Even though some of the problems concerned all health targets, some of them were especially connected to mental health. Both lack of time and financial resources were mentioned as obstacles. The lack of appropriate data also hindered the assessment. However, one of the biggest problems seemed to be the target itself. It was not understood, it was ambiguously introduced from the start, or the target itself was considered unsuitable for policymaking.

How to interpret the results?

Deciding whether to choose "safe aims" that are easily attained or whether, for one reason or another, to "aim for the stars" with very little opportunity for likelihood of attaining the aim is complicated. The evaluation of policy programmes has expectations from several actors [12] such as the general public, policymakers, planners, and providers. It is impossible to please everybody. It has been argued that overuse of policy targets may start working against the idea "as time is spent on reporting rather than on implementing policy" [27]. Furthermore, seeing targets as mainly symbolic may also hinder the execution [17]. As we have seen, mental health does not convert easily as a target. Our analysis indicated that mental health and its targets suffered from disagreement on definitions, but there was also unambiguity of what the problem was and what are its determinants, which should be addressed an measured. Before these obstacles are overcome, mental health cannot be dealt with using the same logic as, for example, reducing smoking or traffic accidents.

Table II. Obstacles for successful execution of evaluation of mental health targets of Health of the Nation (HOTN) and Health for All by the Year 2000 (HFA2000) strategies.

Health promotion strategy	Lack of time	Lack of data	Target itself was problematic	Financial resources	Target could not be monitored
HOTN	−	+	+	+	+
HFA2000	+	+	−	+	−

+, obstacle present; −, no obstacle present.

If designing health promotion strategy is based on numerical targets, it leads to outcome evaluation with the measurement of indicators. However, only evaluating targets' outcomes gives us only a part of the truth as it disregards assessment of process as well as null, perverse, and unintended consequences [1]. It seems obvious that in Kingdon's [5] terms, mental health is a strong candidate to rise from the problem stream. People are concerned about mental health and there is a strong opinion that mental health problems are increasing [7]. Mental illness itself occasionally produces dramatic events (such as violent acts of the mentally ill) and public feedback may quickly raise the issue to the agenda. For example, English mental health policy has been said to have been media driven with a long tradition of user organisations [28] which may have kept the issue afloat in the policy stream [5]. However, mental illness in its various forms cannot surpass suicide as a quantitative target.

Policymakers mainly consider those alternatives that are marginally different from present policy. This allows only a limited number of new issues to get onto the policy agenda [6]. Prevention of suicide is a very common theme as a mental health target in various countries [2]. Usually key target areas in health are chosen for being major health hazards or causes of premature death and therefore offer suitable opportunities for effective interventions and, most importantly, they are areas where target setting and progress monitoring are possible. Thus reducing the suicide rate has been an acceptable choice as a mental health target. Suicide is a major killer, intervention alternatives to prevent it are available, and monitoring the suicide rate is relatively easy. Based on Lindblom's [6] argument, it is only marginally different and therefore suitable enough for a target. According to a health policy informant interviewed in June 2003, even though choosing suicide caused disagreement, the trend in mental health policy in England in recent decades had been mainly the prevention of suicides together with diminishing stigma. If we therefore relate to Kingdon [5], it seems that the battle against suicide had already been floating in the primeval soup for a long time. All this makes sense; however, does mental health need yet something else? It has been suggested that mental health targets with no likelihood of proper monitoring should be considered as warning signs and harmful for all mental health strategy [8].

From the perspective of the politics stream, the stigma attached to mental health problems [7] is another complicating issue in including mental

health in general public health policy programmes. Several of our interviewees mentioned stigma as one complicating factor for mental health promotion policy. It seems that narrowing mental health to reducing the suicide rate or overextending it to increasing wellbeing, self-esteem, and happiness may both be understood as attempts to evade the stigma attached to the mental health problems of the "real world".

Discussion

Evaluation is an essential part of the health promotion process and therefore it is included in the programmes as a joint process which should clarify and monitor the policy aims and guide future actions. As resources are scarce, policymakers benefit from knowing what will work, what needs modifying and what is worthless [4]. However, in order to reach the policymakers researchers have to simplify their assessments to be easily and quickly adopted [29].

Tailored evaluations, especially those concentrating more on the process than only an outcome, cost both money and manpower. The effects of the programme may be difficult to point out as behaviour is affected by multiple background factors of mental health problems. Not to evaluate may also be a conscious decision as stakeholders and policymakers may be afraid of unexpected and unwanted results [4]. Therefore investing in meta-evaluation could reveal what kind of areas societies should concentrate on [11].

This research on evaluation would situate itself as its own subphase of the policy cycle between evaluation and agenda setting. As a policy phase, an assessment can be considered to be linked to agenda setting in a non-linear cycle of decisions and actions [1]. Determining the definitions or designing a proper monitoring system should be the tasks executed at a very early phase in policy design. If it is felt that a target is unsuitable or cannot be monitored, as was seen in the data, thus it easily leads to unwillingness to react towards reaching the target. A specific task for future research could also be to study the use and impact of evaluation results in informing mental health programme designers and policy makers. Probably we should not assume too simple relationship between evaluation and future programme improvement especially when mental health targets are concerned. Perhaps we should not expect programme improvement to be "based" on evaluation but, rather, "advised" by evaluation. Thus the relationship could be rather one of deliberation rather than determination. This is also what we can learn from many critical analyses of the possibility of evidence-based policy [e.g. 30].

Funding

This work was supported by Emil Aaltonen Foundation, Doctoral Programs in Public Health, and Tampere University Hospital (grant number 9K125).

Acknowledgements

Dr Pirjo Nikander is gratefully acknowledged for her advice and comments at the beginning of the research. Special thanks to the reviewers of the manuscript for their most valuable comments and to Virginia Mattila for proofreading the manuscript.

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