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Sanità

Health Promotion Hospitals
& Health Services

Mental Health Promotion Glossary

The Ottawa Charter (WHO, 1986) marked a global turning point in health policies. From then on, at various times, every Health Care System has gradually changed from a health service management, mainly oriented towards disorders, to an 'intersectoral' health management system, paying attention to the conditions of the total well-being of people.

In Lombardy, the concept of health promotion has been introduced in hospital culture since 1998, as a result of the adhesion to the International Network of 'Health Promoting Hospitals' (HPH). In 2008, the Lombardy HPH network renewed the agreement with the International Network of Health Promoting Hospitals & Health Services for another four-years, involving other health facilities in health promotion activities, together with hospitals and social and medical facilities of the Third Sector.

In this context, the Lombardy Network identified the promotion of mental health among the priority areas of regional interest, with the aim of creating a network between health professionals working in the field of prevention in mental health starting from a common language: a shared glossary. This document sets the target of favouring a 'positive mental health' culture likely to overcome still existing prejudice and stigma, regarding mentally disturbed people. The hope is that it can constitute a reference point for professionals, administrators, civil employees and volunteers who work towards improving mental health and well-being of those who use the services and the community.

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Content

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Introduction

• Why the choice of a glossary

Generally, glossaries are used to collect and illustrate technical or specialized terms. The terms included in this glossary have been chosen because they specifically describe mental health promotion or because they assume a specific meaning when used in this context. The group is convinced that, first of all, 'health promotion' in general and 'mental health promotion' in particular, represent a 'vision', that is the projection of a future scenario. Therefore, the glossary terms, if considered as a whole, refer back to the values and aspirations which characterize this vision.

We can quote, as an example, one of the 'mental health' definitions of the World Health Organization (WHO): *"a state of well-being in which an individual realizes his/her own abilities, manages to handle the ordinary strains of life, succeeds in working productively and fruitfully and is able to contribute to the community in which he/she lives" (WHO 2007)*. Not only this and other definitions delineate a cultural horizon in the widest and noblest sense of the term, but they also refer back to past experiences and create life scenarios. More specifically, the WHO states that the notion of 'promotion' is distinct from that of 'prevention'.

"*Mental health promotion means promoting a positive mental health notion increasing the psychological well-being of the person, as well as competence and resilience, and planning means to support life conditions ..<while> the prevention of mental disorders aims at alleviating symptoms and reducing disorders*" (WHO 2002).

It is true that there are large areas in which the two notions overlap. Mental health promotion strategies can be used for prevention purposes, that is, to reduce the incidence of mental disorders, while prevention techniques may end up promoting mental health and well-being. Nevertheless the two notions remain distinct. The notion of mental health derives from a conception of health as a 'human right', but also as a resource for society, accurately delineated in the Ottawa Charter (WHO 1986), which opens new horizons when indicating intersectoral collaboration practices which – in the world of health and social services – up until now have not been totally developed. The vision inaugurated by the Ottawa Charter can be completely assumed by the same mental health services that, in our country, are

bearers of a culture particularly receptive towards WHO directions, as many experiences of 'opening up' to society can testify. However, in many cases, the inspiration of these policies becomes a limit. The strong denounce of the unacceptable stigma which still marks mental health services users usually does not help to bridge the gap between a policy which focuses on mental health service users and a policy focusing instead on mental health of all citizens. Mental health promotion culture can reduce this gap and set a new path.

• Mental health and well-being

Mental health promotion literature mostly comes from two research areas. The first represents research developed in the treatment of mental disorders. The result is a contiguity to the territories of suffering. This is why, "*it is common experience, even today, especially in institutional areas, to intend 'mental health' as an euphemism which actually refers to 'mental disorders'… This fact makes it difficult to think of mental health as being independent from values, myths and fears that generally surround the notion of mental health"* (MacDonald G., 2006).

We are not talking about a purely conceptual dimension, but we are considering the world belonging to the psychiatric health care professionals and the large number of patients and citizens who believe that mental health is none other than the absence of mental disorders. However, we feel that the contiguity and continuity with the suffering experienced, more than setting an actual limit, represents a resource to accommodate a renewed vision aimed at health promotion.

The second area of research is represented by the activity of those who, in the psychological sector, have elaborated the notion of well-being as a condition that involves various aspects of human beings. As an example, we have quoted the psychological notion of well-being elaborated by Carol Ryff (Ryff C.D. et al. 1999) which identifies six fundamental dimensions:

- to set life goals;
- to aim at personal growth and maturity;
- to develop positive relationships with people;
- to become expert in mastering your living environment;
- to accept yourself despite your limits and your weaknesses;
- to acquire personal autonomy.

The two areas have now merged, not only from a conceptual point of view, but also in many experiences that do not necessarily explicitly recall mental health

promotion. Whilst in the past well-being practices were paradoxically reserved to healthy people, today, due to the crumbling of the walls of mental hospitals that separated, even symbolically, from the outer world, the interest in 'well-being' has spread in the treatment of mental disorders. In our country in particular, the closing down of psychiatric hospitals resulted, among other things, together with the differentiation of forms of treatment for psychical suffering, in the dissemination of mental health care facilities. Such widespread unavoidably lead to a positive contamination with society, and to the interest in a healthy lifestyle, which in the past was not considered for individuals with psychiatric disorders. We here quote, as an example, how rehabilitation and re-socialization methods based on sports activities spread in many mental health services. We have asserted that – beyond pharmacological treatment or psychotherapeutic methods both aimed at specific symptoms – treatment practices of people's mental disorders tend to coincide with health promotion practices as a "process which intends enabling people all the more, to control themselves and improve their health conditions." (Ottawa Charter). And it is perhaps the difficulty we all find in taking care of the environment and in changing our lifestyles that contributes to mitigating the differences between service users and the other citizens who are always more aware of uneasiness. In this sense the World Health Organization slogan can be intended: "Mental Health is everybody's business" (WHO, 2004).

- **Besides psychiatry and beyond stigma: the notion of 'positive mental health'**

In psychiatry and in the world of mental disorder treatment, the struggle against stigma has constituted both an essential objective and a limit. As mentioned above, the mental health promoting notion may allow to go beyond this limit, to overcome the protest, practicing inclusion instead of fighting against exclusion. In this way, the salutogenic theories (Antonovsky A., 1996), that seemed apparently destined to remain on a generous but widely utopian plan, found new momentum in practices and in the promotion of healthy lifestyles as did the sports activities quoted earlier, that involve underprivileged mental health service customers.

The 'Positive Mental Health' notion can have the effect of unifying well-being language and research. Allowing to move beyond psychiatry, this notion refers to:

- a positive sense of well-being;
- individual resources that, somehow, can be learned as self-esteem, sense of self-efficacy, optimism, self-mastery and a sense of coherence with our world

- the ability to start, to develop and to keep mutually satisfactory personal relationships;
- the ability to face up to the trials of life, nowadays called resilience, which for some people represents a new edition of the old word 'fortitude'.

These abilities, ever more object of teaching in mental health services, make possible an active role for users in prevention of disorders and in health promotion, equal to the one accomplished by patients who suffered from cardiac disorders.

• Mental health promotion: a cultural challenge for psychiatric services

Many mental health professionals are diffident, or at least feel a sense of inadequacy towards the new paradigm character – separated from the 'pathogenic' vision – that the 'salutogenic' mental health conception openly represents.

Such inadequacy surely constitutes an issue of competence which needs new training. Besides the competence fault, an uneasiness for the assuage of the distance between professionals and users is by now unavoidable. The 'psychiatric patients' crowd roads, as we all do, and cross stations and airports: therefore places and 'non-places' (*non-lieux)* in Marc Augè's meaning (Augé M., 1992) swept away by the same apparent needs for movement. As we all do, hurrying towards a goal that is always less and less defined, they look for a meaning in life and they question themselves about their identity (Mastroeni A., 2009). And by now they are definitely *in time*, and no longer *out of time*. If we feel compassion for them, it is not for their poor health conditions, but because we feel they are people exactly the same as we are, even without disregarding problems that need specific treatment. Patients, on their behalf, find new care pathways in self-mutual-aid and in peer support.

All that is left for health workers to do is to learn to work not only for the 'patient's well-being and interest' but also for their own good and well-being, whilst the extension of 'modeling' that is, 'creating a model', to everyday lifestyles is required, goes far beyond the strictly psychotherapeutic area. On the other hand, the development of neuroscience, neuro-psycho pharmacology, molecular biology right up to genome study, does not attenuate the necessity to think about the roots of mental suffering and to identify new paradigms which support practices.

Another mental health problem, to consider among contemporary challenges, is undoubtedly the widespread use, especially among youngsters, of psychotropic substances which highlights the number of people who are ill, an illness that –

according to Galimberti – does not simply express psychological or even existential discomfort, but – above all – cultural discomfort. The author acknowledges the origin of this discomfort in the presence of a *disquieting guest* that had already been identified by Heidegger in nihilism and in the desertification of meaning that it brings with it; so much so that according to the philosopher:

"*… it is useless to put <this guest> at the door, because everywhere, and for a long time now, invisibly, this guest has been haunting the house. What is needed is to notice this guest and look him straight in the eyes"* (Galimberti U., 2007).

Therefore the philosophical problem can be intimidating, but it is inescapable by now for all common citizens and thus, educators, parents and teachers, public administrators, quoted in the Ottawa Charter, and hence for health and healthcare workers. Consequently, the necessity to face problems of our times links patients and those who are taking care of them. The cultural renewal of the vision of mental health promotion is not a limit, but guarantees an appropriate approach to directly face main issues such as happiness and 'feeling well', the subject of well-being, the relationship between mental health and physical health and indicates the direction for community development.

- ## Mental Health Promotion: the reorientation of Health Care Systems

There is no doubt that repositioning therapy in the health promotion framework implies an important change for the healthcare services, including the network of mental health services.

First of all, the 'health gain' notion defined in the Declaration of Jakarta (WHO, 2007) induces all health workers (all those who are engaged in health care) to reflect on the effective health advantage generally gained, from each and every health intervention and in particular from the advantage related to one intervention compared with another. At the same time – within the quality improvement policy – the entire staff training, besides the mere learning of techniques which is necessary, should be based on practicing breathing space and examining how institutional aims can actually be reached, including a full corporate social responsibility. Therefore it is necessary – also for mental health services – as indicated by the Ottawa Charter, to frame preventive, curative and rehabilitation practices into an overall policy promoting mental health of the community.

In this frame, at a social level, services must be opened to the users' as affirmed in Helsinki (WHO European Region, 2005) whilst at the user/service relationship, the

new setting implies passing from “I'm on top of you” – besides the demagogic “I'm like you” – to the more authentic “I'm with you” (Bertini M., 2008).

- **The promotion of mental health: recovery movement and the role of the user**

The total vision of mental health promotion in the service world is surely represented by the practices which in English-speaking countries constitute the ‘recovery approach’. In Donabedian's opinion, users should assume three roles in order to assure the service quality: contribute to satisfactory standard definitions, consciously participate in health co-production, use information to find the most appropriate treatments.

In fact, for the user movement, mental health means much more than just the absence of disorder. Increasing resilience and developing practices based on positive health notions or ‘positive health’ can contribute to the treatment of psychopathological disorders. But, above all, users seem to have understood that disorder symptoms and positive health can coexist and allow people to manage their own lives adequately and satisfactorily.

In our country, consumer associations are now playing a leading role, whilst till now this role was represented by family associations. There is no doubt that both movements together will be able to make their decisive contribution to this ongoing transformation.

At the same time, the above delineated approach seems to be the only one appropriate to face treatment for people with addiction problems. Actually, the Lombardy Region guidelines on the “prevention of different forms of addition in the pre-adolescent and adolescent population” are largely inspired by the vision of mental health promotion (Lombardy Region, 2007).

- **Critical aspects and effectiveness evaluation**

The cultural vision of health promotion does not exempt but imposes the necessity to develop evaluation research on the practice efficacy. The criticality elements have bluntly been identified, by one of the supporters of the need to overcome the current guidelines for health care. Without any assessment studies, Antonovski wrote in the article quoted which, published posthumously, seems to be a sort of scientific testament: “*an attractive concept, brilliant ideas ... and promises of salvation … can generate enthusiasm, but they cannot establish an understanding that could guide action < one might as well > remain in the field of disorder*

prevention. Anyway there are good theories, a world of empirical knowledge, sophisticated techniques and methods which prove the ability to understand and to handle many problems". And it is not enough to simply make generic references to healthy practices and lifestyles without a sturdy supporting theory. Antonovski states: *"When 'lifestyles' are carefully examined as in literature, we can actually find a list of risk factors, generally well documented: smoking, other abusive substances, overeating, drunken driving, unprotected sex, possibility of injury. We are clearly in the disorders prevention field".*

Obviously we are not ignoring the risk factors, nor the diagnosis. The same decrease in wealth and complexity of the human organism can and must be ignored when a hemorrhage is being dealt with or when resuscitation is being practiced. According to Antonosvski, all this does not justify the dichotomous division between individuals subject to temporary, permanent or fatal disorders (listed by ICD 10 or DSA IV) and healthy individuals.

"It is not only a moral matter: it is scientific. It is necessary to ask oneself how one can help a person progress towards better health. One must consider all the aspects of the person … there are enough ideas including the instrument – no longer considered magical – of social support. The problem" concludes Antonovski *"is that the ideas, as bright as they may be, until they are subject to assessment, are useless".*

Following this way of thinking, the European World Health Organization included four recommendations (WHO 1998) regarding research that must:

- be participated in, i.e. they must involve the stakeholders at every stage;
- be multidisciplinary in their ability to gather information traditionally relevant to different disciplines;
- build abilities to allow the growth of individuals, of the community and of the organizations;
- be appropriate, i.e. they must be designed bearing in mind the complex nature of health promotion.

Added to the above-mentioned considerations is the fact that – practically – mental health promotion has developed relatively independently from health promotion in general. Just recall, for example, the history of the American Community Health Centers in the sixties, widely influenced – under a theoretical profile – by social and community psychology, or – in our country – the history of Community psychiatry following the law 180 of 1978. The fact remains that the theoretical constructs and the values of community psychology are similar to the constructs and values regarding mental health promotion. Let's consider the concepts of auto-efficacy,

self-esteem, empowerment, resilience used in analyzing situations and problems connected to ecological, sociological and psychological models. In the actual setting of the intervention, furthermore, communication and learning theories are referred to, when not to political and organizational ones. Given, therefore, the complexity of the interventions, that are largely intersectoral, and the multitude of theoretical models, assessment studies must be completely clear because they must indicate cultural and theoretical references: randomized controlled studies, but also qualitative studies, including descriptive studies and narrative analyses provided that they allow a before/after comparison and sufficient clarity of the purposes. For this reason, a term in the glossary defines certain evaluation criteria concerning the practices of mental health promotion.

• Concluding remarks: the toolbox

The choice in publishing a glossary originates from the conviction that to be able to move on the grounds of mental health promotion requires the knowledge of specific vocabulary that – in turn – assumes the knowledge of the lexemes. To make things easier, other words belonging to health promotion in general were added to these. Therefore, these specific and generic lexemes were added together with a restricted number of terms that belong to vocabulary concerning mental health (such as, anxiety, depression, psychosis) that can be encountered when operating on field. The vision of mental health promotion, in fact, must be reflected in a type of policy that requires the definition of values, principles and targets and must be expressed so that the roles and responsibilities of different sectors, and in general of the stakeholders, can be identified. The policy implementation must then be translated in operative terms. By behaving in this way, a 'toolbox' could be useful.

The result of our work that we have submitted to the judgment of our readers, is also intended as a toolbox to help operate according to the WHO principles.

Health, mental health and mental health promotion in official international documents on mental health promotion

In our introduction we defined the glossary as a 'toolbox' to operate in the field of mental health promotion, excluding this last notion from the list of terms of which a definition as concise as possible is supplied. To make consulting easier, however, we feel it is useful to dedicate this appendix to a list of the definitions that can be found in the international documents of the World Health organization.

- Health is a state of complete physical, mental and social well-being, and not simply the absence of illness or infirmity. *Prevention of Mental Disorders* (WHO, 2004).
- Health is a state of well-being in which an individual realizes his /her own abilities, can cope with the normal stresses of life, and is able to work productively and fruitfully and is able to make a contribution his or her community. *Promoting Mental Health: Concepts, Emerging Evidence* (WHO, 2004).
- Mental health and well-being are fundamental for the quality of life, to enable people to give meaning to life and to be active and creative citizens. Mental health is an essential component of social cohesion, of productivity, of peace and stability in the environment of life and contributes to the social capital and to the economical development of society. *WHO European Ministerial Conference on Mental Health (Helsinki, 2005)*.
- Mental health is determined by biological, psychological, sociological, economical, political and cultural strength. *Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress Related Disorders in Europe* (Berkels et al. 2004).
- Mental health promotion intends acting on determining factors of mental health with the aim of increasing positive mental health, reducing inequality, building social capital, creating better health and reducing the differences in life expectations that exist between nations and among social classes. *Prevention of Mental Disorders* (WHO, 2004).

- Prevention interventions are focused on risk reduction and on the strengthening of protection factors linked to mental disorders. *Jakarta statement* (WHO, 1997).
- Mental health promotion is an integral part of public health … mental health status is associated with behaviour at all stages of life, tied to certain social and economic health determining factors, depending on the partnership between all the sectors and uses the entire general health promotion methodology. *Promoting Mental Health: Concepts, Emerging Evidence* (WHO, 2004).
- Mental health promotion requires a public health approach. It includes health promotion, prevention of disorders and disabilities, treatment and rehabilitation. *Promoting Mental Health: Concepts, Emerging Evidence* (WHO, 2004).
- Mental health promotion improves the quality of life and increases the entire population's well-being, including people with mental disorders and those who take care of them. *WHO European Ministerial Conference on Mental Health (Helsinki, 2005).*
- Mental health promotion aims at strengthening the well-being of individuals, social groups and communities. The aim is to create conditions for individuals, social groups, society and the environment that allow optimal development by reducing mental health problems. *Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress Related Disorders in Europe* (Berkels et al. 2004).
- Mental health promotion and the prevention of mental disorders act on the determining individual, family, community and social factors of mental health, strengthening the protective factors (for example resilience) and reducing the risk factors. *Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union* (Commission of the European Communities, 2005)

Modified by
"Mental Health Promotion. A lifespan approach"
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Open University Press .McGraw Hill Education, 2006.

List of terms

1	Advocacy
2	Anxiety
3	Clinical governance
4	Community: community care, community development
5	Coping skills
6	Corporate social responsibility
7	Depression
8	Determinants of mental health
9	Disability
10	Emotions
11	Empowerment
12	Enable/habilitate
13	Epidemiology
14	Equity
15	Evaluation of mental health promotion and mental disorders prevention
16	Happiness
17	Health aim
18	Health cities
19	Health favourable environments
20	Health gain
21	Health indicators
22	Hope
23	Hospital and health services for health promotion - HPH network
24	Lifestyles
25	Life skills

26	Meditation
27	Mental health promotion
28	Motivation
29	Mutual-Self-Help
30	Organizational environments for health
31	Partnership
32	Personal growth
33	Positive psychology
34	Prevention of mental disorders
35	Primary care
36	Protective factor
37	Psychosis
38	Public health
39	Quality of life
40	Recovery
41	Reorienting mental health services
42	Resilience
43	Risk factor
44	Schools for health promotion
45	Social capital
46	Social networks
47	Social policies
48	Social support
49	Spirituality
50	Stakeholder
51	Sustainable development
52	User and carer movements
53	Vulnerability
54	Well-being

1. Advocacy

Advocacy means promoting and actively sponsoring someone else's case. In the health field, it consists in the strategic use of information and other resources (economical, political etc.) to change political decisions and collective and individual behaviour with the aim of improving the health conditions of single individuals and the community. The first association of advocacy for psychiatric patients was founded in 1948 in the USA ('Fountain house') and was made up of users, family members and ex-users of the 'Rokland psychiatric center'. In Europe the Advocacy Associations for psychiatric patients started in the 70's in various countries, especially in Anglo-saxon countries, in parallel with the foundation of Advocacy Associations for disabilities, with the aim of promoting research, educating patients and the public, raising funds to improve the conditions of those who are suffering, promote legislative interventions connected to the national health policy.

2. Anxiety

Anxiety is a particular physical and mental condition that occurs when the individual is subject to a dangerous or uncertain, internal or external, situation. The external situation is a real situation perceived by the individual as hostile, that could actually put the individual's safety at risk. The internal situation is a dangerous, imaginary or real situation, a negative thought, a negative internal dialogue. It is a complex combination of negative emotions of fear, apprehension and worry, as well as physical sensations such as palpitations, chest pain and/or shortness of breath, nausea, internal trembling. It can exist as a primary brain disorder or it may be associated with other medical problems, including other psychiatric disorders. Anxiety seems to have cognitive, somatic, emotional and behavioural components. The cognitive component entails expectations of widespread and uncertain danger. From a somatic point of view, the body prepares the organism to deal with the threat (emergency reaction): blood pressure and heartbeat increase, sweating increases, blood flow to the most important muscle groups increases and the immune system functions as well as the digestives ones decrease. On the outside, somatic anxiety signs may include pale skin, sweating, trembling, and pupil dilation. From an emotional point of view, anxiety causes a

sense of dread or panic, nausea and chills. From the behavioural point of view, there may be both voluntary and involuntary behaviour aimed at escaping or avoiding the source of anxiety. This behaviour is frequent and often maladaptive, due to the fact that it is most extreme in anxiety disorders. However, anxiety is not always pathological or maladaptive: it is a common emotion such as fear, anger, sadness and happiness, and it is an important function in relation to survival.

3. Clinical governance

In the definition of the English National Health Service, clinical governance represents "A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish". It is also defined as "a system of steps and procedures adopted by the National Health Service to ensure that patients receive the highest possible quality of care. It includes: a patient centered approach, an accountability for quality, ensuring high standards and safety, improvement in patient services and care".
Clinical governance is not a new methodology for quality improvement but rather the organizational infrastructure construction that completely uses already known methodologies integrating them in service organizational and management mechanisms. The clinical governance's innovative element is not in its instruments, but rather in the knowledge that these instruments can be useful only if supported by a health policy and by organizations that actually make it possible to use. This implies that health policies must organically and structurally direct decision-makers towards service quality. The instruments used by the clinical governance are Evidence Based Mental Health, managing clinical risk management, clinical audit, adoption of guidelines and clinical performance monitoring.

4. Community: community care, community development

The term 'community care' indicates a modern social policy orientation with at least two meanings worth highlighting. In the first instance this designates care *in* the community, i.e. the tendency to move away from care provided by services and

professionals in large separate, segregating institutes (psychiatric hospitals, in the case of mental illness), where undifferentiated and dehumanising treatments were provided, towards the natural living environment of an individual, either at home or in day centers and/or in small residential facilities located in a person's local community.

In the second instance, 'community care' may be understood as care provided *by* the community, an expression which refers to the idea that help, or a significant part of it, can and must be provided by the community itself and, first and foremost, by relatives.

In a network perspective, the two forms should not be considered as alternatives to each other and apparent formal/informal, statutory/community, organised/spontaneous dichotomies must rather be thought of as elements that should be combined and integrated, with a view to the mutual reinforcement of different instances of care.

More recently there was a partial redefinition of the abovementioned concepts. The concept of community, for example, was the theme of a large critical debate that highlighted the fragmentation of the original concept of community as a microcosm, sustained by uniformity and reciprocity, in many communities characterised by plural, transitory and/or partial affiliations.

Its identification with the local dimension, on the other hand, highlighted risks that cannot be ignored, the first being the risk of segmentation and inequality on a national level (in terms of differences in development and welfare) between low social capital environments and areas with greater community resources.

As a result of this, the need to overcome the assumption of an automatic equation linking community and solidarity was progressively re-examined, the latter appearing more the result of a collective process of re-appropriation and responsibility (community development or community building) rather than a given condition.

Indeed, a community is considered as such – or rather, it is considered competent – if its members become aware that protection from risks (for example mental health risks) and acceptance of differences (for example disabilities) are needs that concern everyone (and not just certain individuals), and that it can find within itself the resources necessary to tackle problems that one or more of its members may have.

This process of creating community self-help, if not autonomously applied, can be solicited with ways which must be coherent with the expected results, i.e. through involvement (where people become active), participation (where people enforce

their powers and make decisions that, with their contribution, influence the process of change), connection (where people pool their respective knowledge and resources) and negotiation (where people learn to manage conflicts so that different interests turn into collective opportunities and not into a zero-sum game).

Also see Social capital and Social networks

5. Coping skills

The term 'coping' was introduced in psychology in 1966 by R. Lazarus. It is a concept strictly connected to the concept of stress: it indicates in fact, the set of cognitive (or mental) and behavioural strategies put into action by a person to face a stressful situation.
In other words, it refers to what the individual does to face a difficult, annoying, painful situation or a situation for which the individual is not however prepared, as well as the way in which the individual adapts to this type of situation.
The concept of coping can thus be synonymous of acting up to, active management, efficient response, ability to solve problems.
Every individual is able to develop his/her own coping skills, but the degree of reactivity is very elastic and variable due to the fact that it depends on how it is involved with external factors and on the type of stimulation the individual receives.
The ability to cope refers not only to the practical solution of problems, but also to the management of one's own emotions and the stress derived from contact with problems. In developmental disabilities, the coping ability of family members seems to have a significant role in determining mental health of the child, parents and siblings.

6. Corporate social responsibility

The notion of 'corporate social responsibility' in general denotes the integration of ethical concerns within the corporate strategic vision and it represents a manifestation of the company's willingness to effectively manage the issues of social and ethical impact both internally and in their activity areas. The concept applied to health care organizations express the idea that organizations consider the interests of society by taking responsibility for their impact on users,

employees, communities and environment in all aspects of their activity. This obligation is seen as something that goes beyond the legal requirements and implies that organizations voluntarily undertake initiatives to improve quality of life of workers, families, local community and society at large.

7. Depression

Depression is a very common disorder. In fact 15 people out of 100 suffer from depression. Statistics say that in a group of six people at least one suffers from depression in their life. It is a mood disorder characterized by a group of cognitive, behavioural, somatic and affective symptoms that together are able to decrease in a mild to more serious manner the individual's mood, compromising the 'functioning' of a person, as well as his/her ability to adapt to social life. Depression is not therefore, as it is often considered, a simple mood swing, but a set of symptoms more or less complex that alter in a consistent manner the way in which a person reasons, thinks and portrays his/herself, others and the outside world.

Generally, anyone who has clinical depression may suffer daily from the following symptoms: depressed mood, lack of pleasure and interest for almost everything, lack of energy, fatigue, tiredness, significant gain or loss of appetite and thus of body weight, sleep disorders (sleeps more or sleeps less than usual, or wakes up frequently during the night), slowing down or agitation, lack of concentration, feelings of being useless, negative or constantly guilty, death or suicidal thoughts.

During developmental age and adolescence, depression can present itself in different forms than in adults, often very similar to 'normal' behaviours, and has been underestimated for too long. Children can refuse to go to school, have constant somatic symptoms, be overly attached to their parents or worried that they could die, or may be provocative and aggressive, always angry, difficult to handle at home and at school. Symptoms must be assessed carefully and with time, but not underestimated, because they interfere significantly in the lives of children and their families, and the presence of a disorder that is not dealt with can have serious consequences on mental health in adulthood.

8. Determinants of mental health

The determinants of mental health are the full range of personal, socioeconomic and environmental factors which determine the mental health status of individuals or populations. The factors that affect mental health are multiple and interactive: from socio-economic factors (such as social class, minority membership or education levels) to lifestyle, the quantity and quality of interpersonal relationships, to physical and living environmental conditions, genetic heredity and accessibility and use of social and health services.

While health interventions can prolong survival and improve the prognosis of specific disorders, the most significant results for health of the entire population can be achieved by changing the economic and social factors that contribute to the origin of disorders and the need for medical care. Due to the fact that life expectancy is shorter and the majority of disorders are more frequent at lower levels of the social scale of any society, health policy must face the social and economic determinants of health. Basically therefore, the promotion of mental health deals with identifying and intervening on all those mental health determining factors, factors that are potentially modifiable (thus not only those that are related to the actions of individuals, like behaviour and lifestyles that are beneficial for mental health, but also factors such as salaries, social status, education, occupation and working conditions, adequate access to health services and physical environments) and that create life difficulties affecting mental health. Managing to change lifestyles and conditions that determine the state of mental health can be considered one of the intermediate health results.

9. Disability

According to the World Health Organization's Classification of Functioning, Disability and Health (ICF), disability is intended as the consequence or result of a complex relationship between the health condition of an individual and the personal and environmental factors that represent the circumstances in which the individual lives.

A radical change of perspective has therefore taken place, from negative (disability and handicap) to positive (functions), from the opposition between a medical and a social model to a bio-psycho-social model.

In the medical model, disability was in fact considered linearly as the direct result of the illness/impairment, and consequently, interventions were undertaken on the 'individual' level, to 'fix' the 'faulty' part.
In the social model, the opposite was believed and thus the problem wasn't the person but the surrounding environment, that needed to be changed to allow the maximum possible functioning of the individual.
In the ICF's new bio-psycho-social model, disability becomes the result of the interaction between the individual and the contextual factors. Each and every person is therefore characterized by various functioning patterns, determined by the dynamic interaction between personal factors and contextual factors, that can act as barriers or facilitators, in a circular and dynamic perspective that is no longer linear. This wholly includes the field of mental health.
It is no longer a classification of the consequences of illnesses, but of the health components, that do not only regard disabled people but everyone, precisely because it provides information that describe human functioning and its restrictions, in particular concerning social participation.

10. Emotions

The field of the psychological study of emotions is rich in positions and perspectives. In general terms, emotions can be understood as intense emotional reactions that occur rapidly and have short duration. They appear on different levels (physiological, expressive, motor-behavioural, cognitive-experiential) that, in order to carry out a thorough analysis, should all be taken into consideration because they are not necessarily knit by a close relationship. Emotions can be classified in many ways: anger, fear, surprise, disgust, shame, etc.
Recently, studies have started paying attention to the topic of emotion regulation. They are no longer considered only negatively due to their ability if interfering with useful/necessary behaviour, but in positive terms, for their ability, if properly governed, to facilitate decisions and take suitable action. Therefore the ability to recognize, express and handle emotions in childhood, in order to improve adjustment, is particularly important.

11. Empowerment

A widely-used concept in human sciences (used in psychology, educational science, political science, social work, etc.), empowerment can be defined as a process through which underprivileged individuals or groups recognise and exercise their ability to act.

The outcome of this process is both a subjective experience (a sense of self-efficacy, i.e. a feeling of being able and competent, experiencing a sense of power and control) and an objective redistribution of power (which on an individual level manifests itself in the acquisition of a person's actual power to govern his or her own life).

The concept of empowerment, however, not only refers to what is experienced by those concerned but also indicates the process and the methodology through which an external person, usually a social worker or health service professional, acts to restore balance and increase a user's power (personal, interpersonal and political). In such a perspective, the official holders of therapeutic power do not limit themselves to handing over part of their power to people who were traditionally confined to a passive position as service beneficiaries, but value their clients' skills and knowledge (as limited as these may be) on a similar and equivalent footing to that of their own professional expertise, turning a hierarchical and unbalanced help process into a relationship where problems and solutions are exchanged and shared.

12. Enable/habilitate

It is not only an abstract norm to dictate the reasons for equal rights. There are various capabilities and access possibilities. Advantages and differentiated possibilities must be guaranteed in order to really permit equal access to rights. Who has (or is) less, must have more to be able to have access to his rights.

Intended in this way, enabling people in the area of mental health is a process that must act on three levels of intervention that are validated if joined, and perverted if dissociated.

1. The modification of the legislation (regarding treatment, curing duties, curing institutes, on user rights, work, social interventions, etc.) represents an

essential level, that may vanify every other intervention or on the contrary, support, promote and implement it.

2. The real availability of resources (houses, work, money, places of actual training, possible social relations, etc) to be obtained, on one hand, and the recognized right to accede to them, on the other hand, constitute a second essential level.
3. The rehabilitation project contributes then mainly via training procedures and information, given occasions, collective practices, determining therefore the ability to gain access to the value.

Activities that only develop the role of the consumer, or activities meant to stimulate new or unexpressed needs in subjects may also be considered habilitating activities.

During development, the concept of habilitation is even more relevant, as one does not generally experience the loss of the functions that have already been acquired but their lack of development. The term 'enable' is therefore used to highlight the support given to the development of new functions, often different from the 'normal' ones, because built on the illness, but nevertheless useful in satisfying the needs of the subject. In recent time, greater emphasis has been placed on the importance of the active role of the child and of its motivation in a problem solving process. It is essential to extend the concept of habilitation to the family via the transmission of specific skills to adapt the environment to the needs of the child. In a very young child with great difficulties, the family needs to be enabled to manage him/her, i.e. to develop skills and resources that allow parental functions even in front of severe disability (how to hold the child, feed him, reorganize spaces, how to interact, face anger tantrums, etc). Enabling the context decreases the sense of impotence, transforms difficulties into resources and seems to be one of the more significant factors for the mental health of the child and its family.

Modified from: Franco Rotelli "Riabilitare la riabilitazione" 1993
In: www.triestesalutementale.it/letteratura/testi/14riabilita.htm

13. Epidemiology

Epidemiology deals with the distribution of disorders in populations, with the factors that influence this distribution and with applying the results of these studies

to the control of health problems. Epidemiological information, particularly information that define the risks faced by individuals, population and/or physical environment, is essential for public health and has formed the basis of disorder prevention.

Epidemiology has analytical purposes, relating to scientific generalizations about the natural history of disorder, and intervention purposes relating to the development and evaluation of practical interventions aimed at protecting the populations' health. Unlike the clinic, the main study units are groups of people rather than single individuals. The epidemiology tools are case-control studies, cross-sectional or prevalence studies and cohort ones. The epidemiology tools and methods can find their application in the field of mental health promotion, because on one hand epidemiology research can identify risk factors for mental health and on the other it can evaluate the effectiveness of health programs aimed at developing mental health and reducing risk factors.

14. Equity

The term refers, in general, to the access to services and resources in relation to needs. Equity is linked to the concept of equal opportunity and it is expressed in the battle against discrimination. In the field of mental health promotion, equity concerns the effort to create equal opportunities to develop mental health in a positive sense ('positive mental health').

According to Mangalore and Knapp, if it is true that the new paradigm of equity in health is based on the concepts of need and capacity, regarding mental health, needs and capabilities must be understood as factors that contribute to mental health in a positive way.

According to these authors:

1. The needs on which to base an equal distribution of resources in the field of mental health must be defined: equal use and access to services for equal needs (horizontal equity) and more resources where there are more needs (vertical equity).
2. Allocating resources so that the poor can benefit by applying the concept of minimum level (or a decent minimum) is needed.
3. Ensuring equal opportunities to services does not guarantee equal mental health opportunities because services are only a part of social resources necessary for good mental health.

4. The research on equity in mental health should build strong indicators beyond the ones used for the measurement of income and social classes.

Unequality and unfairness refer to differences not only unnecessary and avoidable but also unjust and unfair. A situation can thus be defined unequal if the conditions that cause it are considered unfair in the context of what happens in the rest of society. Recently, the National Health Service and the British Health Department launched a programme 'Equalities in Mental Health' to fight against inequalities and to eradicate discrimination in mental health. The projects underway concern inequalities related to gender, race, migrant status, old age, disability and religious and spiritual orientation.

15. Evaluation of mental health promotion and mental disorders prevention

The evaluation of the programmes for the prevention of mental disorders and mental health promotion includes two aspects:

1. Assessment of the extent to which the intervention subject to evaluation satisfies the criteria for inclusion in the area of mental disorder prevention or mental health promotion (for criteria refer to the relative chapters).
2. Assessment of the impact of the programme by detecting, once intervention is complete, the changes of the outcome indicators, that is the incidence of mental disorders which are the object of prevention intervention or the changes in a positive direction of the mental health indicator identified in the description of mental health promotion. It should be noted that the lack of definition of outcome indicators makes the programme evaluation impossible.

16. Happiness

Happiness, a concept that has often been incorporated into the broader concept of 'quality of life', could refer to a long-term mental state, clearly distinct from momentary positive emotions and moods. You could then define happiness as a feeling, separate from judgmental values about its state, in its own conditions, which refers instead to the cognitive components.

According to Argyle, one of the greatest experts on this emotion, happiness is represented by a general sense of well-being that can be broken down in terms of satisfaction in specific areas such as marriage, work, leisure time, social relationships, self-fulfillment and health. Studies on happiness have focused largely on the subjective factors with which it deals. These factors can be identified in the satisfaction of one's own life, both in general and in individual life areas (family, work, sports, friendship, retirement, health, social and cultural life, etc.), as opposed to objective factors (welfare, such as economic, housing and environmental) which mostly affect other disciplines. The majority of authors seem to agree, however, with these two sets of interrelated factors.

17. Health aim

The health aims are generic declarations of intent and aspirations that reflect the values of the community in general and of the health department, in particular, for a healthy society. Many countries adopted a program according to which health targets and goals are defined in the form of declarations of intent and indications on the orientations to pursue for health investment.
The World Health Organization supported the development and passed the use of health targets and goals on a local, regional and national level.

From: "Glossario della promozione della salute"
Regione Emilia Romagna – November 2000

18. Health cities

The World Health Organization's 'Health Cities' programme engages local governments in developing health through a process of political commitment, institutional change, capacity-building, partnership-based planning and innovative projects. The programme promotes policies and planning designed to tackle inequality in access to services and poverty; to meet the needs of vulnerable groups, through governance based on a partnership approach (participation) that addresses social, economic and environmental determinants of health. Furthermore, the programme is committed to include health issues in the development of economic policies, urban development and regeneration. In

December 2009, more than 1200 cities in more than 30 countries of the European WHO Region participated in the programme. The WHO European Health Cities Network is thus committed in producing health and sustainable development. The criteria are updated every 5 years. Every five years, priorities are defined. The most important goal in the 2009-2013 phase is the struggle for equal health opportunities in all social policies. Main themes in this phase are the development of healthy environments that provide support as well as a health-orientated urban design (Zagreb Declaration, October 2008). The Health Cities Programme has today been extended to all 6 of the WHO Regions. In Italy in 1995 the "Italian network of health cities – OMS" was established, as a municipality movement, that in 2001 became a non-profit association: (www.retecittasane.it). Every year the Italian Network of Health Cities organizes a national meeting, to which qualified speakers are invited to speak about an issue identified by the Technical Management Committee. The meeting is open to all members of the network and to those who are involved in health promotion/prevention issues.

19. Health favourable environments

Favourable environments protect people from threats on their health, allowing them to increase their capabilities and develop health self-confidence. These environments include the place in which people live, work, spend their free time, their local community, their homes, access to health resources and the opportunity to gain more authority.

From: "Glossario della promozione della salute"
Regione Emilia Romagna – November 2000

20. Health gain

Refer to Determinants of mental health

21. Health indicators

An indicator is a variable that is used to briefly describe a health phenomenon and that allows to make decisions to obtain or maintain changes in care quality. The

indicators are highly informative variables that allow a summary evaluation of complex phenomena, providing sufficient elements to guide decisions. In the perspective of Continuous Quality Improvement (MCQ) they are used to evaluate the significant dimension of health interventions, such as structure, process and outcome. They are usually represented by proportions, or rates or average (in all these cases it is necessary to specify numerator and denominator). The desirable characteristics of an indicator can be divided into intrinsic (reproducibility, validity, accuracy, sensitivity to change) and extrinsic, related to the detection procedure (that is, relevance, completeness and timeliness of detection).

In the field of mental health promotion a mental health indicator is related to a characteristic of an individual, a population or environment and it can be used to describe one or more aspects of the mental health of an individual or population. Mental health indicators can be used to define public health problems at a particular time, the changes over time in the mental health level of a population or a single person, the differences in the mental health area that occur among different populations and, finally, to assess to what extent the goal of a particular program can be reached.

The measurement of the state of disorder or psychic distress and the positive aspects of mental health such as quality of life, or positive behaviour of individuals associated with mental health can be used as indicators of mental health. Indicators that measure the socio-economic conditions and the physical environment as well as the content and implementation methods of health policies may also be included.

22. Hope

It is well known that the main difference between the idea that clinicians and scientists have about recovering from a mental disorder, compared to the conception developed by the consumer's movement, especially in English-speaking countries, is that clinicians and scientists refer to recovery as a result, while users tend to see it as a process. Within this process, hope is a factor of decisive importance, as much as desperation leads to an absolute risk of fatal outcome. This is quite clear when first-person statements are taken into account: “For those of us who have been diagnosed with a mental disorder and who have lived in at times desolate areas of mental health services, 'hope' is not only an euphemism that

sounds good. It is a matter of life or death" (Deegan, 1996). Hope, in fact, in the way of overcoming a mental disorder which is carried out by the consumer's movement, represents the light that illuminates the personal journey that allows the individual to refuse its identification with the disorder.
Having hope, today people with persistent mental disorders can live in the same way as patients with chronic disorders such as diabetes or heart disorder that may interfere with the person functioning but never define the person.

Also see Recovery

23. Hospitals and health services for health promotion - HPH network

The Health Promoting Hospitals – HPH programme began on a European level at the end of the 80's, with a series of health promotion initiatives developed by the European Department of the World Health Organization for primary health care and community life, after acceptance of the request expressed by urgent government action in the Alma Ata International Conference (12 Sept. 1978) of the international community and of all those who work for health and the development to protect and promote health in everyone.
The general aim of the initiative was and still is, to activate and support a process of European hospital re-orientation that allows to add a new approach concerning health to the traditional cure activities of each hospital. In particular the HPH engages members to improve hospital care quality, incorporating in their organizational structure as well as in their daily behaviour, principles, strategic health promotional actions.
Three phases in the European development programme of Health promoting hospitals can be identified.
In the first phase, that lasted up 'till 1992, the European department of the World Health Organization, the L. Boltzmann Institute in Vienna and a few large European hospitals experimented the possibility of applying to the hospital, treatment temple for illnesses, an advanced strategy, that is, health promotion. The result of this initial theoretical elaboration was the Declaration of Budapest (1991) that summarizes the principles and certain practices for hospitals that want to promote health.

The second phase of the programme is represented by the European Pilot Hospitals Project (EPHP) that goes from 1992 to 1997: 20 hospitals belonging to 11 European countries formally committed to the WHO European Committee and with the L. Boltzmann Institute of Vienna, the project technical secretary, to develop, in five years, at least 5 subprojects regarding health promotion to activate explicit mechanisms of evaluation and reporting inside and outside the various Hospitals (in Italy, the Hospital of Padua and the Hospital 'Buzzi' in Milan, cities that also adhered to the 'Health Cities' pilot project).

At the end of the Pilot phase of the programme, the Vienna Recommendations on hospitals for health promotion (1997) were also published.

The satisfactory results achieved by the hospitals that participated in the pilot programme, the request from a large number of hospitals to participate in the initiative as well as the interest shown by the States, lead the European department of the World Health Organization to develop the initiative in a more differentiated and complex manner and launch a third phase of the programme: the national and/or regional HPH networks .

The development of the National and regional HPH networks represented the natural evolution of the first two phases and has now become the main strategy of the HPH programme. This allowed to accomplish a widespread branching out of experience that allows a more immediate connection between European and Extra European hospitals.

The Italian HPH network, up 'till now, is made up of 12 regions (Piemonte, Valle D'Aosta, Veneto, Lombardia, Emilia Romagna, Liguria, Trentino, Toscana, Campania, Friuli Venezia Giulia, Sicilia and Calabria). In particular for the contents of the Lombardy network, visit the website www.sanita.regione.lombardia.it at the title 'Prevention'.

In 2007 the International health care and hospital network was constituted (maintaining however the same acronym HPH), that is an autonomous legal entity with its own constitutional act: a network of networks is made up of a pool of organizations that coordinates institutions, hospitals and health services as well as the World Health organization collaborating centers.

24. Lifestyles

Mental disorders, in their varied symptoms and characteristics, are often associated with stress, related to lifestyles that produce intra-psychic, relational and social discomfort. The pathogenesis of these disorders is therefore not only biological, but also or mainly depending on dysfunctional lifestyles, on behaviours related to an altered relationship with oneself and with society, often due to learning experiences that during their course of life originated from misconceptions and destructive behavioural patterns.

It seems that, paradoxically, the high level of well-being of our society brings with it sickness of the psyche caused by lifestyles that are always more hectic, generating an increase in anxiety, depression and other psychopathological disorders. Indeed, lifestyles based on social and cultural patterns imposed by media and advertising lead to act and to think according to illusory and deceptive expectations. They do not correspond to the real needs and desires of the person, and may therefore induce a state of frustration and dissatisfaction. The majority of mental disorders manifested in our society is the tip of the iceberg: a varied symptomatology of underlying problems, deeply rooted and released by human relationships. In this way problems in communication and interaction within the family emerge and usually arise in conjunction with significant phases of family life cycle (marriage, birth of a child, passage to adulthood) or during particular events (separation, bereavement, illness, retirement) that involve a reorganization of family roles. The task of society, of its institutions, especially of the health and social area, is to promote mental health within the local community to help building a culture which encourages healthy lifestyles and appropriate behaviour, through the commitment to improve environmental, relational and social contexts.

By analyzing the highly individual sphere of a person, in terms of self-considerations, awareness of his/her values, resources and potential, the abilities below can be considered as factors which can create lifestyles preventing individual distress:

- to manage own emotions, perceive them, elaborate them and functionally express them to oneself and to others;
- to dilate gratifications with adequate acceptance of daily frustrations;
- to give value to achievement of results;
- to tolerate diversity;
- to build self-esteem for an appropriate awareness of one's values and limits;

- to perceive health not only as absence of disorder but as a biological, intra-psychic, relational, social existence resource;
- to concretely enable easy access to preventive and medical-psychological treatment in education.

25. Life skills

'Life skills' are essential for an adaptive and positive behaviour, which put people in the condition to effectively face the needs and challenges of everyday life. Life skills are personal, interpersonal, cognitive and physical skills which allow people to control and manage their lives and to acquire the ability to live and modify their environment. Examples of personal life skills include the ability to make decisions and to solve problems, to think creatively, to be self-aware and to show empathy, to have communication skills, to manage emotions and to handle stress. These skills are the fundamental building blocks for the development of those personal skills for the health promotion that the Ottawa Charter considers one of the main areas of intervention.

26. Meditation

As it happens in every incommunicable reality, it is very difficult to find the most appropriate words to define the personal experience of meditation, because it is not an action to perform, but rather, represents a state of being. The Italian dictionary defines the term meditate as “considering something carefully and for long time, in order to understand it better and to examine it in every detail”; this definition does not stray from the more general considerations about meditation, where the 'something' on which we focus is none other than our own interiority.
Meditation is equivalent of being aware of whatever you are doing (or not doing) at that particular moment; it means paying attention and being/becoming aware of your own actions, thoughts, emotions here and now. Meditation represents a state of total self-presence in which we consciously achieve inner silence, or a condition in which it is possible to look at ourselves without passing judgments of any kind. There is no real purpose, because meditation is merely an end in itself.

However, through this condition of being, the flow of thoughts can be slowed down, identification can be overcome with the mind so much so that thoughts are endured and escape control, and finally, a method of self-understanding and intuitive knowledge can be acquired. The meditation techniques are not 'meditation', but they represent the tools to prepare the mind for such an experience and they are numerous: from Yoga to active meditation techniques, from Buddhist meditation focusing on the chakras to the session, typical of the Zen philosophy. In recent years there was the development and dissemination, even in clinical practices, of the 'mindfulness' approach (awareness/warning calls): this is based on paying close attention, in a highly specific manner, to the entire interior and exterior landscape of one's own experiences, including the most intense emotions.

27. Mental health promotion

The term mental health promotion denotes an intervention that aims to improve the psychological well-being of the general population or its subgroups, through the modification of individual and socio-environmental conditions associated with positive mental health.

The interventions to promote mental health should have the following characteristics:

- definition of psychological well-being indicators used to identify the objective of the intervention;
- identification of the association between psychological well-being indicators and individual or socio-environmental conditions supported by sufficient evidence;
- plausibility of the intervention in relation to individual or social-environmental identified conditions, supported by sufficient evidence or credible hypotheses;
- definition of the intervention methods to change individual or socio-environmental conditions;
- definition of the target population group;
- collection of the psychological well-being indicators before and after intervention through the use of valid instrument;
- longitudinal design involving a sufficient period to assess the impact of the intervention on mental health of the population;

- sufficient resources to maintain the intervention over the necessary period of time.

These stringent criteria do not necessarily need to be entirely satisfied to identificate mental health promotion programmes. However, it is important to check how near programmes are to the criteria and establish a minimum acceptability threshold.

28. Motivation

Motivation is the expression of the forces that lead an individual to perform a particular action: broadly speaking, it concerns the reasons for the behaviour, so its causes, motives and purposes.

The behaviour of every living being is directed towards the accomplishment of a certain number of purposes, and to satisfying certain needs; they can be of different nature and appear related to the body's biological needs (hunger, thirst, etc..), or related to strictly psychological needs such as maintaining the level of self-esteem, accomplishing one's own aspirations and expectations, preserving the social bond with others.

They are the product of learning processes and cultural influences that significantly affect also some closely linked personal variables as, for example, self-efficacy (or the evaluation of the probability to complete a certain task successfully) and the locus of control (beliefs about ability to control one's own destiny).

Both imply a correct evaluation of the relationships between the organism's resources, goals and the environmental conditions in which they must operate. People who attribute their successes to their personal abilities and their failures to their insufficient commitment, undertake more difficult tasks and persist despite failures. In contrast, those who associate their failures to lack of skills and their successes to situational factors tend to undertake less and give up more easily at the first difficulty.

29. Mutual self-help

The terms of self-help, mutual help and mutual self-help, which tend to be used interchangeably, indicate that specific social phenomenon (combining many

different theoretical references and values and many different adopted methods) where support, help and the care of people in distress are provided by people who have or have experienced the same problems.

Both an individual's own responsible actions (meaning the concept whereby a person chooses and sets his or her own path towards improving the difficult situation he or she is experiencing, recognising the existence of a problem and actively working to solve it) and reciprocity (i.e. the process whereby within the protected environment of a group, members of that group learn from each other, in a relationship of equals) are contained and combined in the experience of self and mutual help. In mutual self-help groups, in fact, one gets help – obtaining assistance and receiving emotional support as well as exchanging information about how to face common problems – but at the same time one provides help and it is precisely that help we offer others that allows us to feel useful, strengthening our self-image and self-esteem, encouraging the development of empowerment and allowing us to tackle our problems in a new way.

It is clear that mutual self-help practices, no matter what model they are based on, differ significantly from the forms of help provided by formal standardised services: while for the latter, those who have a problem tend to be considered users (or at best, as clients or consumers), in mutual self-help, a person with a problem is recognised as a person with resources and as a producer, so that while in the first case diseases and deficiencies may be emphasised, leading to passivity and the delegation of powers in favour of technical and specialised knowledge, in the second case the emphasis is placed on individuals' resources and skills (emotional, cognitive and behavioural), valuing the wisdom of experience, encouraging participation and the taking of responsibility. This does not mean that the two approaches cannot meet and complement each other: in the virtuous dynamics of mutual self-help, the well-being generated in an individual following his/her participation in a group becomes a collective benefit, not only made available to other members of the group but also to all the wider relationships within the community at large. Mutual self-help groups can, in this sense, play a role in raising awareness and advocacy skills for the problems/conditions dealt with, both in the community and in professional services, suggesting more effective ways of getting help.

Also see: Advocacy, Empowerment, User and carer movements

30. Organizational environments for health

An organized environment is the place where people use and create the environment and, thus, create or solve problems related to health. Organizational environments are typically identified by the fact that they have physical boundaries, organizational structures and that well defined roles are assigned to people. Action aimed at health promotion through different organizational environments can take many shapes, often through a kind of organizational development which includes a change in the physical environment, organizational structure, administration and management. Organizational environments can be used to promote health bringing people together, or manage to gain access to certain services and through the interaction of different organizational environments with a larger community. Examples of this type are schools, workplaces, hospitals, countries, cities.

From: "Glossario della promozione della salute"
Regione Emilia Romagna – November 2000

31. Partnership

The subject of "Partnership and mental health" was debated in the XII Congress of the World Psychiatric Association, the first one held in Asia (Yokohama, 2002). On that occasion it was clearly stated that the world of psychiatry that had reached a unitary language could not continue alone. It was necessary to join science and practice; East and West, developing countries and industrialized countries, given that – even in the latter case – the subject of equal opportunities still prevailed. Limiting the development of partnership meant – in fact – creating ghettos and isolating not only people suffering from mental illnesses but also their families, and in general, those how looked after them. A new 'social contract' between citizens and the government was invoked, due to the fact that the responsibilities of individuals as well as those of public administrators was changing, similar to what was happening in the relationship between patients and mental health professionals. It was not therefore a psychiatric problem but respect for human rights.

In the same congress it was stipulated that psychiatry as a profession could no longer exist without deep commitment to the development of mental health,

providing scientific knowledge to change the environment by developing partnerships with other sectors of society, instead of yielding to the temptation of politicizing their practice in a sort of omnipotent vision of their own role. In the services specifically dedicated to caring for people suffering from mental disorders the mother of all partnerships is the one between professionals and patients, whose needs must be at the heart of mental health policies, as required by the recovery approach that was created by the user rights movement.
A further conceptual change is determined by passing from the idea of primary prevention to the new vision of mental health promotion that requires collaboration among various sectors of public administration, starting from the partnership between mental health care services and social services and, in general, services for the individual or between health services and schools. Strategically, to build the capability of society to promote mental health, the idea of partnership occupies a central position next to organizational changes (top down methods), building from the bottom up (bottom up method) and working with citizens on the territory. There are, however, certain critical points in the development of partnership, given the permanent traditional separation between the different sectors of public administration. What is thus needed, is sustainable planning that goes on beyond the end of each single finance plan and that focuses on changing the relationship between agencies, also through a change in the procedures and occasions of common training. This is why it is necessary to monitor and assess the collaboration among the institutions, the network densities and the re-orientation of services and of the projects produced by each single organization.

Also see Recovery and Reorienting mental health services

32. Personal growth

In the field of positive psychology the construct of personal growth comes from the evidence that even adverse events (violence, illnesses, etc.) can produce positive changes in the victim, that is, they can produce 'beneficial effects' and contribute to personal development. These positive changes in the existential vicissitudes occur in the area of relationships, in the idea of oneself, in the philosophy of life and in the ability to face problems.

Through constructive resolution of crises arising from these types of events, individuals can in fact, achieve a better integration of their personality and development of coping skills.
In particular, still in the field of positive psychology, post-traumatic growth (but also stress-related growth) that follows – unexpectedly at times – particularly upsetting events in life, has been studied.
Thus personal growth does not mean returning to the psychological conditions existing before the trauma, but an assimilation of the destabilizing event inside a new psychological condition that includes the ability of facing exceptional future events of life more effectively.

Also see Positive psychology and Coping skills

33. Positive psychology

The area of research and practical applications that is called positive psychology has been in act for half a century but only a little more than a decade ago did it take on a precise configuration as a movement that goes back to the original psychology mission: developing personal qualities and potential and making each individual's everyday life more rewarding. In general terms, positive psychology develops research on the psychological conditions that can be configured as an excellent personal experience. More precisely, positive psychology is considered as an update of humanistic psychology – which provides an empirical basis – therefore, as a psychological perspective no longer centered on the care of mental disorders but on the pursuit of personal well-being and happiness. Positive psychology has developed from two perspectives. The 'hedonic' one, focused on personal welfare and that of 'eudaimonia' that emphasizes collective welfare, which takes place in the social field.
Mental health professionals can draw on this theoretical and practical approach (which deals with issues such as optimism, satisfaction, self-acceptance, self-efficacy) to help suffering individuals to identify, enhance and reinforce their strengths (abilities, skills), to use them to achieve their goals and increase their personal well-being and their quality of life.

Also see Well-being

34. Prevention of mental disorders

The prevention of mental disorders refers to an intervention that aims at reducing the incidence in the general population or in one of its subgroups of one or more mental disorders defined by recognized diagnostic criteria, through the reduction of one or more risk factors associated with the disorder itself. The prevention is called 'universal' when referred to an entire group of people regardless of the risk level in individuals who are part of it; it is called 'selective' if it is referred to individuals or subgroups of the population identified as carrying a higher risk of developing a certain disorder, in relation to a greater exposure to biological, psychological or social risk factors; it is called 'indicated' when dealing with individuals identified as presenting characteristic signs or symptoms not enough to satisfy the diagnostic criteria of a given disease, but sufficient to indicate a high risk of progression to overt the disease.

The interventions to prevent mental disorders should have the following characteristics:

- definition of the disorder object of the intervention;
- identification of the association between risk factor and disorder supported by sufficient evidence or identification of early symptoms or signs supported by sufficient evidence;
- plausibility of the intervention in relation to risk factors or early signs or symptoms identified, supported by sufficient evidence or credible hypotheses;
- definition of the intervention methods for reducing the risk factor;
- definition of the target population group;
- identification of a group of people large enough to evaluate the effect of the intervention on the incidence;
- acquisition of epidemiological data on the incidence of the disorder in question;
- longitudinal design involving a sufficient period to assess the impact of the intervention on the incidence;
- sufficient resources to maintain the intervention over the necessary period of time;
- incidence data collection before and after intervention has taken place.

Also see Evaluation of mental health promotion and mental disorders prevention, and Mental health promotion

35. Primary care

Primary care consists in providing essential health care, accessible at an expense that the nation and the community can afford with practical methods, scientifically helpful and socially acceptable. In developing countries it is often provided by nurses, whereas in high income countries it is provided by physicians.
The Declaration of Alma-Ata of the World Health Organization emphasizes that primary care should be accessible to everyone and everyone should be involved in this process. The approach to primary care includes the following key factors: equity, community involvement/participation, intersectorality, technological adequacy and affordable costs. As the group of activities, at least individual and community sanitary education should be included in primary care, which aims at making people aware of the extent and nature of problems related to health in general and mental health in particular as well as methods for preventing them and keeping them under control. Mental health actions provided in primary care represent the first level of response of the health system to the mental health needs of the population. They focus on the early diagnosis of mental diseases or, in the case of children, also on development delay and distortion, on the treatment of common emotional disorders, the management of patients with severe mental disorders in the stability phase, the support and the accompaniment of the family and the transfer to a specialist level in case there is need for specialist care. Within the primary care there is the opportunity to undertake actions to promote mental health through daily contact between professionals of primary care services and people in their community. The role of primary care in childhood, is of particular importance, for its widespread contact with all children through periodic health evaluation which can be very important tools for the early diagnosis even in the context of infant mental health.

36. Protective factor

A protective factor is defined as a quality of a person or context or of the person's interaction that predicts better outcomes, especially in high risk or seriously adverse situations. As in the case of risk factors, it can either be a behavioural aspect or an intrinsic characteristic of the individual or genetics, or environmental exposure or lifestyle. In early studies, protective factors were mainly conceived as

the opposite of risk factors: if an inadequate parent-child relationship was a risk factor, it was assumed that a good relationship constituted a protective factor. Only later they were directly studied in depth. Among the protective factors there are individual characteristics (sociable and adaptable temperament, good cognitive skills, effective strategies for emotional and behavioural regulation, positive vision of one's self and the world, social skills), family characteristics (stable and supportive family environment, good economic conditions, high educational levels, commitment to solidarity or religious activities), characteristics of the community (neighborhood solidarity, good cooperative and non-competitive schools, employment opportunities for parents and young people, good public health systems, access to emergency services, possibility of relationships with adults in leadership roles and peers with pro-social attitudes), social and cultural characteristics (protective policies for children, values and resources for education, prevention and protection from oppression and political violence, low tolerance of physical violence). The possibility to count on at least one adult person and on a social supportive network seems to be particularly important.

Acting to reduce factors that predispose mental disorders and increase healthy lifestyles through protective factors is indispensable and essential to promote mental health in all ages and regardless of economic and social status. Elements, conditions, actions which are summarized in the phrase mental health 'protective factors' cross several areas of social, family, educational, individual life.

It is political competence to alleviate situations for all people from pregnancy to old age, through elements that go from a healthy and balanced diet to educational resources and employment opportunities, so that they can reach real social and economic integration, benefitting from social and health services. Among protective factors for mental health, a wide-ranging integration that makes the person aware not only of the individual but also social function, is essential. In childhood, screening initiatives and transmission of skills to life contexts, if properly conducted, allow not only to diagnose and precociously and adequately treat disorders, but are also useful to transform, risk factors into protective factors, representing a multiplier of mental health for the population. Screening for early detection of cases of dyslexia, for example, is intended not only to implement appropriate specialist actions on the child with the disorder, but also to work on the entire class and on the teachers to introduce protective factors and to decrease risk factors for the whole group.

Also see Social networks

37. Psychosis

Psychosis refers to the manifestation of considerable delusions and/or hallucinations of any type, unarticulated speaking and/or to disorganized, bizarre or catatonic behaviour and to the detachment from emotions and from one's own events as well as those of others. Specifically, the common characteristic of psychotic disorders is the presence of a psychopathological removal from the environment surrounding the individual, and difficulty in planning and commencing activities and having feelings towards other individuals. Psychotic disorders are thus highlighted by strong alterations in psychological equilibrium resulting from the distance from external reality and from intense mind disorders. One of the main characteristics, in fact, of psychotic disorders is the presence of disorders of the line of thought (alteration in flow of ideas, until reaching incoherence, and the impairment of associative links), disorders regarding the thought content, sensorial-perceptive disorders , hearing, smell, touch, taste). People who are affected by psychotic disorders are therefore unable to face social life, sentimental life, work and family due to their strongly disturbed thoughts , the blurring of attention and concentration and the weakening of initiative and pleasure of speaking and relating to others and to carry out and plan activities in general. Usually psychotic disorders begin during adolescence or during early adulthood and very often are a result of psychological, physiological and genetic factors, but the precise causes for such disorders are not yet clear. Certain psychic factors such as intense and chronic stress, may trigger off or negatively influence a personal predisposition to developing a psychotic disorder. Psychotic symptoms probably have both biological as well as environmental causes, that is, they depend on a cerebral functioning disorder that makes an individual more sensitive towards stressful situations.

38. Public health

Public health can be defined as the complex of structures and processes by which the health of populations is understood, protected and promoted through the organized efforts of society (WHO - European Region, 1998). Public health therefore has the task of monitoring the health of populations, identifying their health needs, striving for the development of policies that promote health and evaluating health services. The first consequence of a public health approach is that

mental health services should be accessible to anyone who needs them, regardless of their ability to pay. A second consequence is that mental health of a population is related to the more general social and economic health of its community. Favouring a public health approach instead than an individual approach in response to the needs of psychiatric patients should not be considered simply a moral imperative. In fact, "a system providing social equity is by far the most effective for the health of an entire nation".

39. Quality of life

The World Health Organization defined 'quality of life' as how the individual perceives his/her own place in life in relation to the cultural context and to the system of environmental values in which the individual lives and with respect to his/her goals, aspirations, criteria and interests. It deals with a very complex construct that involves physical health, psychological state, independence level, social relationships, personal opinions and the relationship with the main environmental characteristics. It is clear that the quality of life, defined as such, is personal, made up of positive and negative aspects of life and is multidimensional. [The WHOQOL Group, 1995, p. 1405].

An instrument that is even now very much used in the effort to measure the quality of life is the World Health Organization Quality of Life questionnaire (WHOQOL), elaborated for various cultures and linguistic contexts, that provides a multidimensional profile in 6 areas: Physical area, psychological area, independence level, social relationships, environment and religion/spirituality/personal opinions. It is evident that health and quality of life define complementary conceptual areas with ample overlapping areas; the quality of life, as defined above, expresses however, the perception of the level of satisfaction of one's own needs, including the right to have a happy and fulfilling life, regardless of one's health or economic conditions. In the World Health Organization's prospect, the notion of 'quality of life' differentiates itself from the notion of 'subjective wellbeing' in the sense that the latter mainly regards the positive or negative affective condition, whereas the quality of life, even though influenced by the affective conditions, implies the subjective assessment of oneself and of the social, economic and physical world. But in fact, the perception of quality represents an internal experience: it is influenced by what happens in the outside world but is coloured by the individual's previous experiences, by his/her

mental conditions, by mentality and expectations. The importance of studying the quality of life in relation to mental health services has been re-launched by the process of deinstitutionalization, in order to evaluate in the patient's perspective the transition from assistance based on psychiatric asylum to psychiatric community care. In childhood and adolescence, the same journey that has taken place simultaneously with the closing down of special schools and institutions for disabled children and the activation of child and adolescent neuropsychiatry services in the community. The growing interest in the user's perspective has also led to a revival of studies on quality of life as a criteria for assessing quality of care both in general health and specifically in the field of mental health. Despite the complexity of the conceptual construct of 'quality of life', its measurement appears to be essential for the evaluation of policies for health promotion. It is believed that wellness and mental health promotion, as essential components of overall health, are factors that determine the quality of life (the Helsinki Conference, 2005).

40. Recovery

In recent years a real Copernican revolution has profoundly changed the philosophy of psychiatric care in many countries, especially in English-speaking ones. It is called the 'recovery' approach. This is not a new therapy or a concept born in academic areas or professional environments. The term, which means recovery, care, healing, was adopted by the associations of users of mental health services as a symbol of the possibility of 'succeeding in doing something'. Succeeding in regaining control of their lives, regardless and despite that – in some cases – psychiatric disorders may remain as well as the necessity of medication. In the users' vision the term 'recovery' has gradually been assuming a semantic value that moves it away from – even if it does not oppose to – the idea that clinicians have about healing and makes it, actually, untranslatable. The recovery in this new sense, represents "both an internal event and assumption of responsibility. The experience of a person who accepts and overcomes the challenge of disability... and wants to regain a new sense of self and a meaning in life beyond the limits of disability" as stated in an account in first person by a user. And it is here that a term like 'hope', foreign to clinical and scientific language, becomes an essential value that can determine recovery. Hope, ' with open eyes' to self-manage or minimize the limits that the disability conditions place or tend to place on life and on desire

to feel happy and fulfilled. Hope that opens the possibility to feel happy and fulfilled and to get the most out of life beyond mental health problems. This extraordinary approach in its simplicity has won the mental health policy in the United States, as well as in Britain, in Australia and in Canada and it is beginning to spread in Italy with the growing and the affirmation of the users' movement.

41. Reorienting mental health services

Since the Ottawa Charter and, more recently, the Helsinki Conference (2005), in fulfilling their care duties, mental health services should reorient themselves towards the promotion of health, i.e. they should place the necessary interventions within a larger effort to promote physical and mental health. Medical and psychotherapeutic treatment, in fact, are part of the aid needed as disorder – and the diagnosis that defines it – is part of a person's life. The effectiveness of treatment depends, besides the quality of the procedures based on scientific evidence, on family, friends, schools, employers, neighbours and on the real possibility of using a wide range of community services and resources just the as any other citizen. For this reason services promote social inclusion and education, the qualification of the living environment and the improvement of interpersonal relationships in the community to support and participate in living, in searching for job opportunities and in satisfactory ways to spend leisure time. Consequently, the primary mission to assist people suffering from serious mental and emotional disorders is not questioned by what has been expressed above, but it deeply changes the way in which care is provided. Not only does the promotion of mental health of this group of citizens becomes a part of community mental health promotion by general practitioners and public administrators, but these same 'vulnerable' citizens can become protagonists of co-production of mental health, also through their involvement in service planning and quality monitoring, e.g., ensuring equal access to health care for current and potential users. Through the development of users associations of mental health services, there could be an increase in commitment to open new channels of cooperation not only between health services and social services, but also among health care centres and other vital institutional areas such as, for example, schools. A critical element is the lack of resources and the expected competition between investments in prevention activities and investments for the care and rehabilitation of mental disorders. De

facto, however, if we consider, as outlined above, the promotion of mental health not as an additional health care cost, but as a mode of public action, actively supported by voluntary organizations, there is increasing evidence of the possibility not only to increase the 'efficiency and effectiveness of these services, but also to make available additional resources for the entire community. In any case, reorienting services towards the promotion of mental health is a non-negotiable aspect of a values based business.

Also see Mental health promotion

42. Resilience

In psychology and sociology literature the term resilience refers to the individual's ability to overcome the negative and traumatic events through an effective adaptation process that, not only can overcome difficulties, but also lead to the growth and the personal development in highly stressful life contexts. Classically, in the domain of physical science and technology, from which the term is taken, in order to measure its resilience, a material is placed on an anvil and struck by a mallet until it breaks. In this way it is possible to measure the resilience expressed by the amount of energy absorbed by the material per unit area. Compared to the traditional notion of prevention (pathogenic approach) which tends, above all, to identify the disorder risk factors, the salutogenic approach and, more recently, the contribution of positive psychology, have attributed a central value to the study of resilient subjects which seem capable of turning situations that for other people may be highly destructive or disruptive into their advantage. As part of mental health promotion, and more generally of a positive vision of health that permanently overcomes the old notion of mere absence of disorder, the notion of resilience has profoundly changed the policies and practices of intervention. Therefore, even in the Lombardy Region, the development of resilience in youngsters is now considered a central goal to contrast drug addiction in schools. Some experts, promoters of an ecological vision, highlighted a critical element in the notion of resilience as an individual and absolute quality of a person, regardless of life contexts. In terms of mental health promotion, in particular, it seems clear that resilience has to be evaluated in relation to the environment where people live and that individual resources may be appropriate only in relation to the difficulties that the context of life poses. There is no doubt that in severely degraded life contexts uncommon qualities of resilience are required, and that, vice-versa, in

relatively easy contexts our resilience is not so sorely tested. Nevertheless, the concept of resilience plays a central role in the notion of mental health.

43. Risk factor

A risk factor is any element, event or condition that may favor the development and the progression of a disorder, and is always linked to the person's health. A risk factor can be a behavioural aspect or an intrinsic characteristic of the individual or a genetic trait, or an environmental exposure or a lifestyle. Risk factors are often inter-related and not necessarily causal, because correlation does not necessarily imply causality.

Risk factors are generally divided into non-modifiable and modifiable. In the first category there are various factors that do not depend on human will and that cannot be changed. Among them, the most important factors are age and genetic inheritance. Among the modifiable risk factors there are all the abnormalities of the organism connected to the person's life choices, whose values may always vary with specific therapies. Some of these are smoking, taking drugs, and uncontrolled alcohol consumption.

44. Schools for health promotion

A 'health promoting school' is committed to promoting the health and welfare of students, teachers and the community in which the school is located. This means striving to create a healthy environment, spread knowledge and skills on health, health services, in addition to developing projects that involve both the school and the community, outdoor activities, health promotion programs included in the curriculum, development of knowledge on nutrition and healthy eating. It also means educating and providing opportunities for physical activities, recreation, social services and provide support to promote mental and emotional well-being of the students. The research has highlighted an undividable link between education and health. And at stake here is a dynamic that cannot be ignored if we want to protect, support and strengthen the education and health of young people. The European Network of Health Promoting Schools (ENHPS) indicated that the policies, principles and methodology of health promotion, when properly conducted, can contribute significantly to the educational experience of young

people who live and learn in this context. In other words, students who are educated are healthier and healthier students are more educated. In addition to put these experiences inside a network contributes to the welfare of teachers, administrators and those who manage and support schools and the community. The Network was launched simultaneously by three major European agencies: European Commission (EC), Council of Europe (CE) and the Regional Office for Europe World Health Organization (WHO / EURO).

A. The first conference was held in Thessaloniki in May 1997. On that occasion it was determined that every child and every young person should have the right and genuine opportunity to be educated in a school for the promotion of health, a school, therefore, based on the following principles:

1. Tending to the promotion of democracy, social, personal and health development.
2. Equity (Equal Opportunities) to incardinate in educational experiences allowing emotional and social development by giving each individual the opportunity to express their full potential without fear of discrimination.
3. Empowerment and action competence to increase the sense of self-efficacy and to be able to participate in critical decisions.
4. School as a learning environment critical for promoting and maintaining health.
5. Curriculum in which to place the acquisition of knowledge and skills that are essential in life.
6. Teacher education as an investment in education as well as in health.
7. Evaluation of the effectiveness for both the school and the community.
8. Collaboration firstly between the Ministry of Health and Ministry of Education.
9. Active citizenship that is reflected in a positive impact on both physical and social health to produce more health.
10. Sustainability as investing in health promotion in schools contributes to a sustainable development of communities that in turn will become a resource for schools.

B. The second conference was held in Egmond aan Zee in Holland in 2002. Here the role of the Partnership with the system of health services was discussed.

C. The third conference was held in Vilnius, Lithuania in June 2009 characterized by the active participation of young people, stressed the importance of participation to make 'their' school a better place to work and learn.

Meanwhile, the technical secretariat of the network EHNPS was assumed by the Danish Institute of Health Promotion and Disorder Prevention, WHO Collaborating Centre. Today (October 2011) 43 countries and regions adhere to the network that is now called 'Schools for Health in Europe' (SHE). The network has assumed the tradition of the previous network, has a positive conception of health and wellness and recognizes the United Nations Convention on the Rights of the Child and the Convention of European Council for exercising children's rights (http://www.schoolsforhealth.eu).

45. Social capital

In order to describe a complex construct such as social capital, which has not yet been completely explored, it may be useful to refer, among others, to Jane Jacobs's analyses on the crisis of American cities. This anthropologist observed that when the shops on one street close down, many people change their usual route, and as a consequence many streets become less populated and less safe, requiring extra security that was previously guaranteed simply by the sheer number of passersby. This example (which highlights the importance that informal relationships assume even in highly organised contexts in the structural and functional mechanisms of an economic and social system) helps us understand how social capital is a resource that is not to be found either in an individual's characteristics (if this were the case, one would refer to it as human capital) or in the physical characteristics of places, but rather in the quality of social interactions.
This therefore recalls the idea of an asset 'nested' in self-cumulative social relationships that can be built upon, an asset that individuals can draw from in various ways, but at the same time it suggests a consumable asset that, as resilient as it may be, if not maintained and nurtured through shared and intentional action, could diminish and/or disappear: social capital can thus only be considered as such if it is able to produce further sociability (i.e. improve existing relationships and facilitate the creation of new ones) and to promote cooperative action.
It must therefore be understood in a procedural and dynamic sense, i.e. as a property that social relationships can develop (or not) rather than as a quantitative tangible asset.
Despite the easy analogies with economic capital that it suggests in terms of accumulation, investment and profit, compared to the latter, social capital is characterised by the greater importance of the inter-individual/collective

dimension in its production and/or fruition, and for the central role that concepts of trust, sharing, participation and reciprocity have in most of the theories concerning it.

Also see Community: community care, community development and Social networks

46. Social networks

The term network/social network – which refers both to an interpretative category used to describe social relationships as well as a methodological approach used in social work – has over time acquired a growing importance, as it has proved to be particularly suited to the job of tackling complexity. Implicit characteristics of the concept of network are indeed their plurality and their horizontality. Plurality relates to the ability to simultaneously take into consideration different elements whether they be stakeholders (such as operators, users and the families etc) or resources (both formal and informal etc), or the different meanings attributed to particular phenomena by different players. Horizontality relates to their tendency to recognise equal legitimacy to the different nodes and, consequently, to promote relationships between them which are as un-hierarchical as possible.

In practical terms, except for differences arising from theoretical reference models, the network approach can be used:

- in working with people in distress (by adopting an empowering perspective and involving the person concerned, as well as his/her frame of reference, in coping strategies);
- in the organisation of services (by promoting integration between different formal agencies);
- in working with the community (by encouraging the empowerment of communities and supporting forms of grass-roots organisation).

In order to maximise the efficacy of network action, any intervention should electively seek and support an interplay between these three levels.

In recent decades, the field of social policies has witnessed a growing interest in informal networks (i.e. family, friends, neighbours, etc.). This interest appears to have emerged mainly due to two factors. Firstly, the reduction of financial resources has put a stop to the development of the formal care sector, referring the management of many social and health problems (e.g. chronicity) to primary networks. On the other hand, a critical view of one of the assumptions of Western-

type welfare (i.e. that well-being can only be generated by capital investment aimed at creating organisations that provide standardised techniques) has now become widely shared. Regardless of whether or not the necessary financial resources for the implementation of this model are available and therefore its *de facto* revision or resizing as a result, the idea that the creation of well-being can also be reached through relational capital i.e. through grass-roots interaction in social networks (take the role played by so-called 'natural facilitators' or the experience of foster care for clients of psychiatric services, etc.) and that the two strategies must find points of contact and interaction (subsidiarity) has increasingly gained ground.

However, this approach, which is also the founding element of community psychiatry, is exposed to some risks: on a daily operational level, uncritical emphasis on the value of informality can overshadow the fact that not all networks actually produce well-being (there are in fact supportive networks and dysfunctional networks, networks that connect and networks that tie down). Furthermore, on a wider level, the promotion of the informal can be used to conceal the retreat of the welfare state in relation to its role of protecting citizens. The assertion that users, families and communities have the power to act and that if they themselves are able to solve their problems, it is not right for someone else to do so, could make the reduction of a public commitment to welfare politically acceptable, reducing it to a mere role of governance, thus running the risk of improperly overloading informal networks.

Also see Empowerment

47. Social policies

When discussing social policies we are referring to that sector of public policies which aims to solve problems and reach social objectives that generally concern the well-being of citizens.

Through these policies, norms, regulations and standards concerning the production and distribution of certain resources and opportunities – considered particularly important in guaranteeing protection to citizens in relation to codified sets of risks and needs – are set.

Social policies include:

- pension policies that protect citizens from risks related to old age, loss of earning ability and economic security, disability and death where there are surviving members of the family;

- health policies that protect against the risk of disease and meet health needs;
- labour policies whose scope is the regulation of the labour market and the promotion of balancing demand/supply as well as protection from the risk of being left unemployed;
- social welfare policies which cover a wider range of risks and needs and which aim to promote social inclusion i.e. connecting individuals and families to the fabric of society.

It is precisely the importance these risks and needs have in the lives of individuals and communities that has made it necessary – in different forms and degrees according to different welfare models adopted – for the state to intervene directly, given that market, family and social networks cannot ensure equal access to the resources that are necessary to be able to tackle them.

Currently, social policies are facing two issues in all Western countries: the first is the need to reconcile the constraints caused by the slowdown of economic development (as well as demographic imbalances, mainly due to aging populations and, to a lesser extent, waves of immigration) with a commitment to continue enforcing the right to social protection, i.e. the duty to reconcile efficiency and economic competitiveness on the one hand with wealth redistribution and social assistance on the other. The second matter, which is particularly important for mental health promotion policies and the treatment of psychiatric disorders and disabilities, regards efficiency and refers to the need to promote integrated forms of action and management when tackling problems whose cumulative and multidimensional nature require us to go beyond policies limited to specific sectors or categories.

48. Social support

Social support is a complex and multidimensional construct, represented by all psychological (emotional), social (affiliate), educational, economic transactions occurring positively in relation to an individual in needy conditions – for example, a person suffering from mental disorders and/or disability or great limitations of his or her autonomy – due to the social network they belong to. These actions in favour of the person in need are oriented to ease the burden deriving from the specific condition that person is experiencing by providing the individual with support tools – which he/she does not have – to overcome the condition. Support

either can reach the needy person through an informal network of relationships (family, relatives, friendship, work) which is created around that person or can be provided by the formal services networks as well. It can be activated directly by the individual who is in difficulty, which means to arise spontaneously out of solidarity or it may come from the activation of different specifically competent institutional entities. Social support can be created only in favour of the person with limits or may be extended to those who, in the natural social network of the person in need, takes care of this individual. It also exercises the action – health protective – to moderate the harmful effects of stressful life events and helps to maintain/regain individual physical and mental health.

Moreover, the presence and intervention of those who constitute the natural network make a person feel appreciated and strengthen its sense of belonging to the network itself (and the motivation to keep it/nourish it/enrich it even with attitudes of reciprocity/exchange). Social support is divided – and takes on a greater or less importance/impact – depending on the characteristics of the subject (individual differences, the subjective perception of the support that is offered and received) and the network to which the subject belongs. Several tools for the assessment of social support have been developed; these tools evaluate both perceived social support (also related to the instilled/acquired sense of security) and objectively received social support in relation to identified needs; they may detect quality and quantity profile, and effectiveness. The effectiveness of social support may also be assessed in terms of increased well-being.

Also see Social networks

49. Spirituality

Spirituality can be defined as the level of involvement or the state of awareness or devotion towards a higher being or a philosophy of life. This awareness is not always correlated with conventional religious beliefs. Religiosity is defined as the level of religious involvement, characterized by a belief or a series of beliefs or dogmas concerning the spiritual dimension and involves a series of practices that arise from these dogmas. Spirituality is the field of human experience to which religion intends to connect us. 'Spiritual' has a more general meaning and it is not synonymous with 'religious', nevertheless, the respect of spirituality implies respect for people who believe in a religion, which – in other words – have internalized the

beliefs and practices of a religion. The Dreem Questionnaire (Ridgway and Press), which assesses the orientation of mental health services towards recovery explores the respect of spirituality by asking the patient:

1. if professionals are interested in his spiritual beliefs;
2. if professionals help him to connect with spiritual resources, provided that this represents an interest for the actual patient himself;
3. if professionals encourage spiritual practices coherent with his faith, such as prayer or meditation which can support his well-being.

The above approach, on one hand, reflects the value of respect for the spiritual and religious orientation as human rights; on the other hand the belief that spiritual practices are associated with the ability of life, including the ability to react to stressful events. In this regard it has been suggested that the beneficial effects of spiritual practices do not depend on being religious, but on the way of being religious, that is spiritual style. Gordon Allport has opposed an extrinsic religious orientation (motivated by the need for security or family and social influences) to an intrinsic orientation (motivated by faith and the search of the meaning of life). According to Allport people with an intrinsic religious orientation have a better ability to face stressful life events. Other researchers have explored spiritual style and the way of being religious by relating it to the ability of facing adversity.

Also see Recovery

50. Stakeholder

Literally stakeholder means 'bearer of interests'. It indicates all types of private or public, individual or collective subjects, which are somehow linked by a level of sharing and attachment to the organization, its mission and its activities. Since the level of 'commitment' varies from category to category and within the same category, between subject and subject, we speak about a 'stakeholder map' that represents the level of involvement via the primary, secondary and external levels of stakeholder. Not all stakeholders have in fact the same relevance in a project., In order to deal effectively and efficiently with its various interlocutors, a project manager should carry out their careful classification.

A typical matrix model for the stakeholder's classification is set on two variables / axes:

1. Interest: indicates the level of influence that the project has on the stakeholder's business area, in terms of aims, activities and results.
2. Power: indicates the level of influence that stakeholder can have on setting, on accomplishment, on the results of the project.

Depending on the values (low / high) taken on by the two variables, we identify four quadrants of a matrix, which correspond to four types of stakeholder:

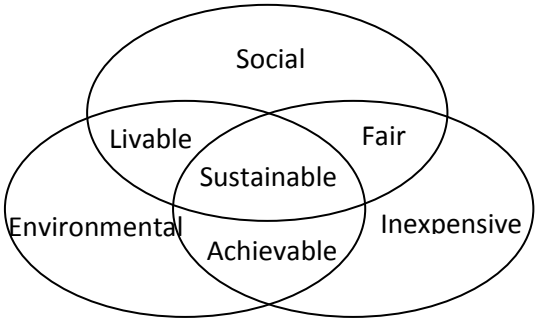
1. Marginal stakeholder (low interest / low power). They are the figures surrounding the project, which experience the project indirectly without being able to significantly influence it.
2. Institutional stakeholder (low interest / high power). They are all those who are indirectly involved in the project, however, exerting corporate control and/or supporting function.
3. Operational stakeholder (high interest / low power) These are the entities involved in a significant way in the project in terms of organizational effects, activities carried out, outputs delivered. However, they have little influence on project decisions.
4. Key stakeholder (high interest / high power) They are figures with a focal role in the life of the project, because personally affected by the results and with strong powers to intervene in decisions regarding the project.

Power	High	INSTITUTIONAL STAKEHOLDER E.g. Other Pm, external minor suppliers	KEY STAKEHOLDER E.g. team members, purchaser, suppliers, partners
	Low	MARGINAL STAKEHOLDER E.g. logistics, purchases, management control	OPERATIONAL STAKEHOLDER E.g. final users, other consultants
		Low	High
		Interest	

Matrix classification of stakeholders

51. Sustainable development

The first definition in order of time was the one contained in the 1987's 'Brundtland Report' (named by the President of the Commission, the Norwegian Gro Harlem Brundtland), and later taken over by the 'World Conference on Environment and Development', ONU (World Commission on Environment and Development, WCED): "Sustainable development is a development that satisfies present needs without compromising the ability of future generations to satisfy their own needs."



Scheme of sustainable development, at the confluence of three concerns.

Although this definition summarizes, very simply, some important aspects of the relationship between economic development, social equity, environmental protection, it cannot be operable. It is the so-called 'three balance rule': ecology, equity, economy. This definition starts from an anthropocentric view, in fact the center of the matter is not so much the ecosystem, and thus survival and welfare of all living species, but rather the human generations. This definition can be operable as follows: a socio-ecological process characterized by a behaviour search for ideals. It can also be defined as the possibility of the economic growth of a territory in accordance with its environmental and social characteristics which provides for a restructuring of productive processes and social relationships in order to make them more harmonious with the land and its resources.

52. User and carer movements

Independent collective user and carer initiatives (first and foremost, the relatives of users), such as mutual self-help groups, associations, etc., now constitute an important front of social action with characteristics distinctive enough to justify the need to consider them separately from the traditional 'third sector' (non-profit companies that generally speaking are not managed by the beneficiaries of such intervention), forming a 'fourth sector' which includes the projects set up by those who, operating collectively for themselves, are a form of empowerment that acts independently.

This subsidiary way of reappraising welfare has been well summarised by the slogan 'nothing for us without us' which efficiently expresses and justifies the need to go beyond the dependency on a formal care system in favour of a broadening of civil society's abilities and responsibilities.

An indirect advantage, but increasingly and purposefully adopted as an aim by user and carer movements, is made up of the fact that their work, besides bringing benefits to those individuals directly concerned, can have an important function in 'public learning', in that on the one hand it contributes to changing the social image of the problem tackled, reducing any stigma associated with it (in the case of mental disorders and disabilities, this is a particularly important aim), and on the other hand, it envisages the idea of a community that is actively responsible for, and promotes its own, well-being.

As far as Italy is concerned, it is important to point out that, while in the aftermath of the 1978 psychiatric care reform, relatives had already started to form associations, the creation of groups bringing users together took place more slowly, generally in contiguity with service professionals and relatives' associations, and only in recent years have achieved visibility and made their voices heard, developing important schemes for social inclusion.

Also see Empowerment

53. Vulnerability

The term vulnerability is associated with the term diathesis that in medicine indicates the predisposition to a syndrome or a disorder, or more precisely, it indicates a group of predisposing factors (genetic or biological factors in addition to

psychological factors such as the cognitive and interpersonal ones) that make the person disorder-prone. In the models of the pathogenesis of mental disorders the notion of vulnerability is always related to the notion of stress or stress factors that allow the disorder to manifest itself in predisposed individuals. Although the term stress, which denotes tension, solicitation, may refer to external individual factors, it has been empirically demonstrated that the internal factors(as the style of relationships that can create dysfunctional relationships or ability to perceive an event as stressful) are also determinants. The literature on vulnerability has played a major role in 'stress vulnerability' pathogenic models where the external and internal events that determine distress were object of evaluation as risk factors. Prevention strategies that derive from these models tend, in turn, to reduce risk factors in individuals and groups, based on the knowledge of disorders and improving the access for the subject at risk to the relevant departments.
Vulnerability can be considered the opposite of resilience as the risk factors are the opposite of protective factors. In other words, vulnerability and resilience are opposite values on a continuum. In terms of mental health promotion an efficient strategy based on the development of protective factors, that is resilience, would be virtually applicable regardless of those at risk and it would therefore be much more effective in terms of public health. On the other hand, the individuals considered at risk could benefit in turn from a general non-stigmatizing approach. Those who suggest salutogenic models generally believe that approaches aimed directly at the population are more suitable for promoting health than approaches aimed at groups at risk.

Also see Resilience and Protective factor

54. Well-being

According to the World Health Organization well-being defined in a psychological sense is that state in which the individual is able to use his or her cognitive or emotional capabilities to respond to the daily needs of everyday life, establish satisfactory and mature relationships with others, constructively adapting to external conditions and internal conflicts.
On the basis of an ‘eudaemonist’ approach, wellbeing corresponds to the full realization of human potential, to the search of intrinsic significance in human nature and to the complete functioning of various aspects of the person.

Not all factors that yield pleasure promote a person's wellbeing; subjective (personal) happiness cannot be equated with wellbeing. According to a 'hedonic' approach instead, wellbeing corresponds to happiness just as it is experienced and expressed by the single individual, it concerns experiences and personal judgment of pleasure vs. displeasure, positive vs. negative, that regard various aspects and areas of life on the person.

The study of wellbeing thus consists in investigating and analyzing that which makes human experiences and life in it global sense, pleasant or unpleasant.

By the term subjective wellbeing we mean an experience of 'wellbeing' just as it is perceived, evaluated and experimented by the individual according to criteria, parameter and standard references that are completely personal (subjective).

Two determining types of personal wellbeing can be identified. The first is a top down type in which the level of a person's wellbeing derives from global personal dimensions that are substantially independent from external factors and contexts; the second type is a bottom up type in which a person's level of wellbeing derives from the feelings of gratification and satisfaction related to specific areas of his/her life, strongly influenced by the objective circumstances and conditions of life.

Also see Positive psychology

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Annex 1

The Ottawa Charter for health promotion

From the 1st International Conference on health promotion 17-21 November 1986 Ottawa, Ontario, Canada.

http://www.who.int/healthpromotion/conferences/previous/ottawa/en

First International Conference on Health Promotion, Ottawa, 21 November 1986

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.
This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for Health

The fundamental conditions and resources for health are:

- peace,
- shelter,
- education,
- food,
- income,
- a stable eco-system,
- sustainable resources,
- social justice, and equity.

Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by

nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health Promotion Action Means:

Build Healthy Public Policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create Supportive Environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance, to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization – is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen Community Actions

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.
Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop Personal Skills

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.
Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient Health Services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments.
They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health

promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.
Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

Moving into the Future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.
Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to Health Promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;

- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for International Action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

CHARTER ADOPTED AT AN INTERNATIONAL CONFERENCE ON HEALTH PROMOTION* The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada.

* Co-sponsored by the Canadian Public Health Association, Health and Welfare Canada, and the World Health Organization.

Annex 2

WHO European Ministerial Conference on Mental Health

WHO European Ministerial Conference on Mental Health: Facing the challenges, building solutions - Helsinki, Finland, 12-15 January 2005

Mental Health Declaration for Europe. Facing the challenges, building solutions: http://www.euro.who.int/_data/assets/pdf_file/0008/88595/E85445.pdf

Preamble

1. We, the Ministers of Health of Member States in the European Region of the World Health Organization (WHO), in the presence of the European Commissioner for Health and Consumer Protection, together with the WHO Regional Director for Europe, meeting at the WHO Ministerial Conference on Mental Health, held in Helsinki from 12 to 15 January 2005, acknowledge that mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens. We believe that the primary aim of mental health activity is to enhance people's well-being and functioning by focusing on their strengths and resources, reinforcing resilience and enhancing protective external factors.

2. We recognize that the promotion of mental health and the prevention, treatment, care and rehabilitation of mental health problems are a priority for WHO and its Member States, the European Union (EU) and the Council of Europe, as expressed in resolutions by the World Health Assembly and the WHO Executive Board, the WHO Regional Committee for Europe and the Council of the European Union. These resolutions urge Member States, WHO, the EU and the Council of

Europe to take action to relieve the burden of mental health problems and to improve mental well-being.

3. We recall our commitment to resolution EUR/RC51/R5 on the Athens Declaration on Mental Health, Man-made Disasters, Stigma and Community Care and to resolution EUR/RC53/R4 adopted by the WHO Regional Committee for Europe in September 2003, expressing concern that the disease burden from mental disorders in Europe is not diminishing and that many people with mental health problems do not receive the treatment and care they need, despite the development of effective interventions. The Regional Committee requested the Regional Director to:

- give high priority to mental health issues when implementing activities concerning the update of the Health for All policy;
- arrange a ministerial conference on mental health in Europe in Helsinki in January 2005.

4. We note resolutions that support an action programme on mental health. Resolution EB109.R8, adopted by the WHO Executive Board in January 2002, supported by World Health Assembly resolution WHA55.10 in May 2002, calls on WHO Member States to:

- adopt the recommendations contained in *The world health report 2001;*
- establish mental health policies, programmes and legislation based on current knowledge and considerations regarding human rights, in consultation with all stakeholders in mental health;
- increase investment in mental health, both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations.

5. Resolutions of the Council of the European Union, recommendations of the Council of Europe and WHO resolutions dating back to 1975 recognize the important role of mental health promotion and the damaging association between mental health problems and social marginalization, unemployment, homelessness and alcohol and other substance use disorders. We accept the importance of the provisions of the Convention for the Protection of Human Rights and Fundamental

Freedoms, of the Convention on the Rights of the Child, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and of the European Social Charter, as well as the Council of Europe's commitment to the protection and promotion of mental health which has been developed through the Declaration of its Ministerial Conference on Mental Health in the Future (Stockholm, 1985) and through its other recommendations adopted in this field, in particular Recommendation R(90)22 on protection of the mental health of certain vulnerable groups in society and Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder.

Scope

6. We note that many aspects of mental health policy and services are experiencing a transformation across the European Region. Policy and services are striving to achieve social inclusion and equity, taking a comprehensive view of the balance between the needs and benefits of diverse mental health activities aimed at the population as a whole, groups at risk and people with mental health problems. Services are being provided in a wide range of community-based settings and no longer exclusively in isolated and large institutions. We believe that this is the right and necessary direction. We welcome the fact that policy and practice on mental health now cover:

i. the promotion of mental well-being;

ii. the tackling of stigma, discrimination and social exclusion;

iii. the prevention of mental health problems;

iv. care for people with mental health problems, providing comprehensive and effective services and interventions, offering service users and carers[1] involvement and choice;

v. the recovery and inclusion into society of those who have experienced serious mental health problems.

[1] The term 'carer' is used here to describe a family member, friend or other informal care-giver

Priorities

7. We need to build on the platform of reform and modernization in the WHO European Region, learn from our shared experiences and be aware of the unique characteristics of individual countries. We believe that the main priorities for the next decade are to:

i. foster awareness of the importance of mental well-being;

ii. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;

iii. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;

iv. address the need for a competent workforce, effective in all these areas;

v. recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

Actions

8. We endorse the statement that there is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment. Therefore we, ministers responsible for health, commit ourselves, subject to national constitutional structures and responsibilities, to recognizing the need for comprehensive evidence-based mental health policies and to considering ways and means of developing, implementing and reinforcing such policies in our countries. These policies, aimed at achieving mental well-being and social inclusion of people with mental health problems, require actions in the following areas:

i. promote the mental well-being of the population as a whole by measures that aim to create awareness and positive change for individuals and families, communities and civil society, educational and working environments, and governments and national agencies;

ii. consider the potential impact of all public policies on mental health, with particular attention to vulnerable groups, demonstrating the centrality of mental health in building a healthy, inclusive and productive society;

iii. tackle stigma and discrimination, ensure the protection of human rights and dignity and implement the necessary legislation in order to empower people at risk or suffering from mental health problems and disabilities to participate fully and equally in society;

iv. offer targeted support and interventions sensitive to the life stages of people at risk, particularly the parenting and education of children and young people and the care of older people;

v. develop and implement measures to reduce the preventable causes of mental health problems, comorbidity and suicide;

vi. build up the capacity and ability of general practitioners and primary care services, networking with specialized medical and non-medical care, to offer effective access, identification and treatments to people with mental health problems;

vii. offer people with severe mental health problems effective and comprehensive care and treatment in a range of settings and in a manner which respects their personal preferences and protects them from neglect and abuse;

viii. establish partnership, coordination and leadership across regions, countries, sectors and agencies that have an influence on the mental health and social inclusion of individuals and families, groups and communities;

ix. design recruitment and education and training programmes to create a sufficient and competent multidisciplinary workforce;

x. assess the mental health status and needs of the population, specific groups and individuals in a manner that allows comparison nationally and internationally;

xi. provide fair and adequate financial resources to deliver these aims;

xii. initiate research and support evaluation and dissemination of the above actions.

9. We recognize the importance and the urgency of facing the challenges and building solutions based on evidence. We therefore endorse the Mental Health Action Plan for Europe and support its implementation across the WHO European Region, each country adapting the points appropriate to its needs and resources. We are also committed to showing solidarity across the Region and to sharing knowledge, best practice and expertise.

Responsibilities

10. We, the Ministers of Health of the Member States in the WHO European Region, commit ourselves to supporting the implementation of the following measures, in accordance with each country's constitutional structures and policies and national and subnational needs, circumstances and resources:

i. enforce mental health policy and legislation that sets standards for mental health activities and upholds human rights;

ii. coordinate responsibility for the formulation, dissemination and implementation of policies and legislation relevant to mental health within government;

iii. assess the public mental health impact of government action;

iv. eliminate stigma and discrimination and enhance inclusion by increasing public awareness and empowering people at risk;

v. offer people with mental health problems choice and involvement in their own care, sensitive to their needs and culture;

vi. review and if necessary introduce equal opportunity or anti-discrimination legislation;

vii. promote mental health in education and employment, communities and other relevant settings by increasing collaboration between agencies responsible for health and other relevant sectors;

viii. prevent risk factors where they occur, for instance, by supporting the development of working environments conducive to mental health and creating incentives for the provision of support at work or the earliest return for those who have recovered from mental health problems;

ix. address suicide prevention and the causes of harmful stress, violence, depression, anxiety and alcohol and other substance use disorders;

x. recognize and enhance the central role of primary health care and general practitioners and strengthen their capacity to take on responsibility for mental health;

xi. develop community-based services to replace care in large institutions for those with severe mental health problems;

xii. enforce measure that end inhumane and degrading care;

xiii. enhance partnerships between agencies responsible for care and support such as health, benefits, housing, education and employment;

xiv. include mental health in the curricula of all health professionals and design continuous professional education and training programmes for the mental health workforce;

xv. encourage the development of specialized expertise within the mental health workforce, to address the specific needs of groups such as children, young people, older people and those with long-term and severe mental health problems;

xvi. provide sufficient resources for mental health, considering the burden of disease, and make investment in mental health an identifiable part of overall health expenditure, in order to achieve parity with investments in other areas of health;

xvii. develop surveillance of positive mental well-being and mental health problems, including risk factors and help-seeking behaviour, and monitor implementation;

xviii. commission research when and where knowledge or technology is insufficient and disseminate findings.

11. We will support nongovernmental organizations active in the mental health field and stimulate the creation of nongovernmental and service user organizations. We particularly welcome organizations active in:

i. organizing users who are engaged in developing their own activities, including the setting up and running of self-help groups and training in recovery competencies;

ii. empowering vulnerable and marginalized people and advocating their case;

iii. providing community-based services involving users;

iv. developing the caring and coping skills and competencies of families and carers, and their active involvement in care programmes;

v. setting up schemes to improve parenting, education and tolerance and to tackle alcohol and other substance use disorders, violence and crime;

vi. developing local services that target the needs of marginalized groups;

vii. running help lines and internet counselling for people in crisis situations, suffering from violence or at risk of suicide;

viii. creating employment opportunities for disabled people.

12. We call upon the European Commission and the Council of Europe to support the implementation of this WHO Mental Health Declaration for Europe on the basis of their respective competences.

13. We request the Regional Director of WHO Europe to take action in the following areas:

(a) Partnership

i. encourage cooperation in this area with intergovernmental organizations, including the European Commission and the Council of Europe.

(b) Health information

i. support Member States in the development of mental health surveillance;

ii. produce comparative data on the state and progress of mental health and mental health services in Member States.

(c) Research

i. establish a network of mental health collaborating centres that offer opportunities for international partnerships, good quality research and the exchange of researchers;

ii. produce and disseminate the best available evidence on good practice, taking into account the ethical aspects of mental health.

(d) Policy and service development

i. support governments by providing expertise to underpin mental health reform through effective mental health policies that include legislation, service design, promotion of mental health and prevention of mental health problems;

ii. offer assistance with setting up 'train the trainer' programmes;

iii. initiate exchange schemes for innovators;

iv. assist with the formulation of research policies and questions;

v. encourage change agents by setting up a network of national leaders of reform and key civil servants.

(e) Advocacy

i. inform and monitor policies and activities that will promote the human rights and inclusion of people with mental health problems and reduce stigma and discrimination against them;

ii. empower users, carers and nongovernmental organizations with information and coordinate activities across countries;

iii. support Member States in developing an information base to help empower the users of mental health services;

iv. facilitate international exchanges of experience by key regional and local nongovernmental organizations;

v. provide the media, nongovernmental organizations and other interested groups and individuals with objective and constructive information.

14. We request the WHO Regional Office for Europe to take the necessary steps to ensure that

mental health policy development and implementation are fully supported and that adequate priority and resources are given to activities and programmes to fulfil the requirements of this Declaration.

15. We commit ourselves to reporting back to WHO on the progress of implementation of this

Declaration in our countries at an intergovernmental meeting to be held before 2010.