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Review

Is there a case for mental health promotion in the primary care setting? A systematic review

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ABSTRACT

Objectives. To evaluate the effectiveness of mental health promotion (MHP) interventions by primary health care professionals in the adult population.

Methods. Systematic review of literature in English and Spanish for randomized controlled trials (RCTs) and observational studies evaluating the impact of interventions carried out by primary care professionals explicitly to promote and improve the overall mental health of adult patients. PubMed, PsycINFO, and Web of Science were independently searched by two investigators to identify all MHP articles from inception to October 2013 (no restrictions).

Results. We retrieved 4262 records and excluded 4230 by a review of title and abstract. Of 32 full-text articles assessed, 3 RCTs were selected (2 in USA, 1 in UK); two focused on the mental health of parents whose children have behavioral problems, the other on older people with disabilities. One study reported a MHP intervention that improved participants' mental health at 6-month follow-up. All studies had low-moderate quality (2 of 5 points) on the Jadad Scale.

Conclusion. There is a lack of implementation and/or evaluation of mental health promotion activities conducted by primary care professionals. More research is needed to clearly understand the benefits of promoting mental health in this setting.

Contents

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Introduction

Mental Health has been defined as '*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*' (WHO, 2010). Therefore, the promotion of good mental health is critical not only for the person, but also for society.

People with poor mental health have lower life expectancy. This difference is explained both by suicide rates and by the higher prevalence of chronic medical conditions (e.g., cardiovascular disorders, cancer) in this population (Lawrence et al., 2013). In addition, mental disorders are associated with high disability and related costs for society, a substantial proportion of which are due to absences and loss of productivity (Bloom et al., 2011), as well as to earlier retirement of withdrawal from the workforce (Mcdaid and Park, 2011). With the increasing recognition of the burden associated with mental illnesses (Whiteford et al., 2013), there has been a rise in research on mental health promotion (MHP).

In 1996, MHP was defined as '*the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity*' (Joubert et al., 1996). Five years later, the World Health Organization (WHO, 2001) described MHP as "*(…) an umbrella term that covers a variety of strategies all aimed at having a positive effect on mental health. The encouragement of individual resources and skills and improvement in the socioeconomic environment are among them*". Both definitions suggest that MHP requires initiatives both at macro level (e.g., policies leading with inequity and promoting social justice) and micro level (e.g., individual interventions). Although MHP and health promotion share the values presented in the Ottawa Charter (1986), there are two major differences. First, MHP *directly* aims to increase resilience and empower people, by increasing their ability to cope with significant adversity or stressful life events (CAMH, 2010). Second, MHP targets the cognitive, social, and emotional skills (e.g., problem solving, social skills, and social support), while health promotion is focused on lifestyle factors (e.g., promotion of physical activity and healthy eating and reduction of smoking and drinking behaviors). It is important to highlight that these approaches are complementary: healthy lifestyles increase mental wellbeing (Penedo and Dahn, 2005), and by improving emotional wellness we also improve physical health (Wiest et al., 2011).

MHP also differs from primary prevention of mental disorders. Primary prevention focuses on reducing or eliminating the risk factors for a specific pathology. In contrast, MHP targets a broad variety of problems and focuses on the positive factors (Stachtchenko and Jenicek, 1990). However, the two approaches overlap and are interrelated, making it difficult to separate them in day-to-day practice. It is known that multiple risk and protective factors are involved in the onset of mental disorders; therefore, most initiatives designed to prevent specific mental disorders also include strategies to improve the protective factors. The main difference, then, is in the final aim: MHP aims to enhance overall wellbeing, not to "fight" against a specific disease (Min et al., 2013; Saxena and Maulik, 2002; Stachtchenko and Jenicek, 1990; WHO, 2004). Finally, MHP differs from therapeutic interventions because it targets the general healthy population, while treatment focuses on people who are already ill. Although people with mental disorders may be able to benefit from MHP initiatives, this population is not the main target of these strategies (Min et al., 2013; Saxena and Maulik, 2002; Stachtchenko and Jenicek, 1990; WHO, 2004). In summary, MHP has a primary preventive component (i.e., the main target is the healthy people), but focuses on positive aspects of mental wellbeing. It is valued to separate prevention and promotion strategies in the field of mental health, because it facilitates giving adequate attention to both, and it is easier for decision-makers to evaluate the results of the programs (Saxena and Maulik, 2002).

The effectiveness of MHP interventions has been well documented in school settings (Barry et al., 2013; Evans et al., 2005; Franze, 2004; Michaelsen-Gartner and Witteriede, 2009; Mishara and Ystgaard, 2006; Roberts et al., 2003; Weare and Nind, 2011), at the workplace (Czabala et al., 2011; Lerner et al., 2013; Mattke and Van Busum, 2013; Patel et al., 2013; Sun et al., 2013; Torp et al., 2013; Tsutsumi et al., 2009), and in community centers serving older adults (Chapin et al., 2013; Forsman et al., 2011; Ichida et al., 2013). This is in line with the results of a recent systematic review (Mcdaid and Park, 2011) and a report presenting different economic models for mental health promotion and prevention (Knapp et al., 2011). Both documents concluded that there is a case for some interventions to promote mental health and wellbeing in some very specific contexts and settings. However, just one of the contexts analyzed in these documents included primary care centers, and it was for alcohol misuse.

In theory, primary health care centers are, well positioned within the community to perform the MHP activities. Primary care is in the "front lines" of health care delivery and serves as the primary point of contact for most individuals in most health systems. This venue is therefore among the most accessible in health care and likeliest to reach a larger swath of the population. Equipping these professionals with mental health skills promotes a more holistic and integrated approach and ensures not only improved detection and treatment, but also prevention of mental disorders and promotion of mental health and wellbeing (WHO, 2008). The role of primary health care professionals dealing with mental disorders have been highlighted in different reviews, concluding that primary health care providers can treat common mental disorders, specially depression (Gerrity et al., 2004; Gilbody et al., 2003; Gunn et al., 2006; Woltmann et al., 2012); however, as we