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## The influence of social, demographic and physical factors on positive mental health in children , adults and older people.

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 **Foresight**

**Mental Capital and Wellbeing:  
Making the most of ourselves in the 21st century**

**State-of-Science Review: SR-B3  
The Influence of Social, Demographic and Physical Factors on  
Positive Mental Health in Children, Adults and Older People**

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Mental Capital and Wellbeing. The views expressed do not represent the policy of  
any Government or organisation.*

## Summary

**This report reviews the literature on the conceptualisation of positive mental health and outlines current understanding on the determinants of mental health and their implications for research, policy and practice. The concept of positive mental health is introduced and its contribution to the future health, social and economic capital and wellbeing of society is discussed. The determinants of positive mental health across the lifespan from infancy to old age are reviewed, focusing particularly on the modifiable psychosocial, economic and environmental determinants. Enhancing factors for mental health operating at the structural, community and individual level are considered, including socioeconomic circumstances, distribution of wealth, living environments, education, employment, access to natural and community resources, social inclusion, social support, and individual skills and attributes. The review considers the need for further research on the nature and determinants of positive mental health. The evidence suggests that policies focusing on curing or preventing mental disorders will not necessarily deliver on improved mental health at a population level. The growing evidence of the effectiveness of mental health promotion interventions strengthens the case for action across all sectors in creating conditions that promote positive mental health, flourishing and wellbeing.**

## 1. Introduction

Mental health is fundamental to good health and quality of life and also influences social and economic outcomes across the lifespan. In the UK, Europe and globally, there has been an increasing recognition of the importance of mental health and wellbeing to overall health in recent years (WHO, 2001; 2002, 2004a; 2004b; Jané-Llopis and Anderson 2005; Mental Health Foundation, 2005; NIMHE, 2005). The WHO European Mental Health Declaration and Action Plan (WHO, 2005) and the EC Mental Health Green Paper and Strategy (European Commission, 2005) highlight two emerging themes: 1) the social and economic prosperity of Europe will depend on improving mental health and wellbeing; 2) promoting mental health will also deliver improved outcomes for people with mental health problems.

On any matrix, the social and economic costs of mental ill-health are extremely high, amounting to over £110 billion in the UK 2006/07: no other health condition matches mental ill-health in the combined extent of prevalence, persistence and breadth of impact (Friedli and Parsonage, 2007). In addition, however, there is growing evidence that beneficial outcomes are not necessarily or solely the result of the absence of mental illness, *but are due, wholly or in some degree, to aspects of positive mental health* (Herrman et al., 2005; Lyubomirsky et al., 2005; Friedli and Parsonage, 2007; Keyes, 2007). This evidence also informs the recovery agenda, with its focus on living a satisfying, hopeful and contributing life, even with the limitations caused by illness (Anthony, 1993; Pevalin and Rose, 2003). Public mental health is, therefore, concerned with the promotion of positive mental health, as well as prevention, both for the general population and for those with mental disorders.

The growing emphasis on the need for mental health promotion is both explicit and implicit in a very wide range of policy on health, education, culture, employment, crime, regeneration and social inclusion (WHO 2004a; 2005; European Commission, 2005; Department of Health 2004a; 2004b; US Department of Health and Human Services, 1999; NIMHE, 2005)<sup>1</sup>. This expanded focus on the benefits of positive mental health is

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<sup>1</sup> See for example: Scotland's National Programme for Improving Mental Health and Well-being [www.wellscotland.info](http://www.wellscotland.info); NIMHE/CSIP (2005) *Making it possible: improving mental health and well-being in England* [www.csip.org.uk/silo/files/making-it-possible-full-version.pdf](http://www.csip.org.uk/silo/files/making-it-possible-full-version.pdf); Welsh Assembly (2006) *Mental Health Promotion action plan for Wales: consultation document* <http://new.wales.gov.uk/consultations/closed/healandsoccarecloscons/958389/?lang=en>; Northern Ireland *The Bamford Review* (Bamford, 2004; DHSSPS, 2006) and *WHO Declaration and Action Plan on Mental Health* (WHO, 2005) [www.euro.who.int/mentalhealth/publications/20061124\\_1](http://www.euro.who.int/mentalhealth/publications/20061124_1)

matched by a growing evidence base on the value and effectiveness of interventions concerned with mental health promotion and a call for more studies on the determinants of mental health, as distinct from the determinants of mental illness (Herrman et al., 2005; Hosman et al., in press; Jané-Llopis and Barry, 2005). Wanless (2002; 2004), for example, argues that the assessment of population health should move beyond morbidity and mortality data to the inclusion of measures of positive physical and mental health.

Promoting positive mental health also overlaps with wider concerns about how a 'wellbeing focus' might influence the future direction of UK policy on the economy, health, education, employment, culture and sustainable development (Layard, 2005; Friedli, 2007; Marks and Shah, 2005; Donovan et al., 2002; Carlisle, 2007; Dolan et al., 2006). At the heart of this discourse is a concern that economic growth strategies in both mature and emerging European market economies do not result in greater wellbeing and also have damaging psychosocial side effects (Pickett et al., 2006; Eckersley, 2006; Marks et al., 2006).

This report reviews the literature on the conceptualisation of positive mental health and outlines current understanding on the determinants of mental health and their implications for research and practice.

## **2. Positive mental health**

Positive mental health is more than the absence of clinically defined mental disorder. The WHO definition of mental health as a 'state of wellbeing in which the individual realises his or her abilities, copes with the normal stresses of life, works productively and fruitfully, and makes a contribution to his or her community' (WHO, 2001, p.1), challenges the idea that mental health is simply the opposite of mental illness.

Individuals without a mental disorder may have varying degrees of positive mental health. Indeed, there is growing evidence to support a two continua model of mental health (Keyes, 2002; 2005; Whittington and Huppert, 1996; Ryff et al., 2006). Keyes (2005) provides empirical support for the hypothesis that mental health and mental illness are not opposite ends of a single continuum but rather constitute distinct, though correlated, axes. Thus, the absence of mental illness does not equal the presence of mental health. Analysing data from the MIDUS study in the USA, Keyes (2005) reports that some 50% of the general population are moderately mentally healthy, 17% are flourishing, 10% are languishing and a further 23% meet the criteria for diagnosable mental disorders such as depression. Keyes argues that, when compared with those who are flourishing, moderately mentally healthy and languishing adults have significant psychosocial impairment and poorer physical health, lower productivity, and limitations in daily living (Keyes 2004; 2005).

Huppert and Whittington (2003) also provide empirical support for the independence of positive and negative wellbeing, which they report as being differentially influenced by demographic, health and social factors. As Keyes (2007) points out, 'curing or eradicating mental illness will not guarantee a mentally healthy population' (p.1).

## **3. Conceptualising positive mental health**

The emerging literature on positive mental health and wellbeing considers the necessary or sufficient elements of positive functioning (Keyes, 2002; Huppert, 2005; Kovess-Masfety et al., 2005; Zubrick and Kovess-Masfety, 2005), and these generally include skills or attributes associated with emotion (feeling) and cognition (thinking) and their influence on social function (relating). Positive mental health is usually conceptualised as encompassing aspects of emotional (affect/feeling), psychological (positive functioning), social (relations with others and society), physical (physical health) and spiritual (sense of meaning and purpose in life) wellbeing.

The integration of mental health, clinical, lifespan development and health psychology theories points to converging aspects of positive psychological functioning. Ryff (1989), for example, operationalised six theory-guided dimensions of psychological wellbeing derived from the literature (i.e. self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth). The relatively few scales designed to measure positive mental health since then have also based their indicators on similar constructs, including resilience, self-esteem, self-efficacy, optimism, life satisfaction, hopefulness, perceptions and judgements about sense of coherence and meaning in life, and social integration (Antonovsky, 1993; Mauthner and Platt, 1998; Stewart-Brown, 2005; Ryff and Singer, 1996; Zubrick and Kovess-Masfety, 2005)<sup>2</sup>. These indicators, which include both general measures and validated scales of specific constructs (see Zubrick and Kovess-Masfety, 2005) have been found to be associated with better physical health, improved recovery rates, fewer limitations in daily living, greater productivity, educational attainment, employment and earnings, better quality of life, relationships, and health behaviours (NIMHE, 2005; Dolan et al., 2006; Lyubomirsky et al., 2005).

There is a large research literature on measures of subjective wellbeing, life satisfaction and quality of life (Andrews and Withey, 1976; Bradburn, 1969; Diener, 1994; WHOQOL Group, 1998), which is also relevant to our understanding of mental health. The application of quality of life measures to mental health has, however, been restricted mainly to measuring outcomes for people with chronic mental disorders (Katschnig et al., 2006; Barry and Zissi, 1997). This body of research is mainly data-driven and has generated remarkably little theory. In contrast, the indicators of positive mental health outlined above are drawn largely from theoretical models of psychological functioning and conceptual models such as salutogenesis (Antonovsky, 1987). In addition, the socio-ecological model of health, which underpins mental health promotion practice, emphasises the importance of concepts such as empowerment and competence enhancement (Barry, 2001; 2007). It also recognises that positive mental health is embedded in, and influenced by, a wider social, economic and cultural ecology (Zubrick and Kovess-Masfety, 2005).

The emergence of positive psychology has also brought a greater focus on the study of optimal human functioning (Seligman and Csikszentmihalyi, 2000; Seligman et al., 2005). However, to date, much of its scientific endeavour has focused on individual-level interventions to increase happiness and enhance positive emotions and characteristics. As Gable and Haidt (2005) point out, there has been a lack of progress in studying the positive institutions and social conditions necessary for flourishing and optimal functioning. Further research is needed to understand the factors and conditions that build psychological strengths, promote resilience, and enhance positive relations with others and society. The development of this knowledge will be key to realising the potential of this new focus on positive aspects of mental health and wellbeing.

Positive mental health is a broad concept. There are a range of constructs and theories relevant to its understanding and assessment. Many of those discussed have already been incorporated into the practice of mental health promotion, and have informed interventions designed to enhance the psychological strengths and competencies of individuals and communities (Jané-Llopis et al., 2005; Barry and McQueen, 2005). Mental health promotion interventions are driven off a socio-ecological model of health, as they seek to improve the everyday contexts (home, schools, communities, workplaces) where mental health is created, while also addressing the broader social, physical and economic environments that determine the mental health of populations and individuals (Mittelmark et al., 2005).

Good progress has been made over the last decade in establishing a sound theoretical and evidence base for mental health promotion. There is compelling evidence from high-quality studies that mental health promotion interventions can have a lasting positive effect on a range of health and social outcomes. Findings

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<sup>2</sup> See also Warwick-Edinburgh Mental Well-being Scale (WEMWBS); Tennant et al., (2007) and [www.wellscotland.info](http://www.wellscotland.info) and [www.healthscotland.com/understanding/population/mental-health-indicators.aspx](http://www.healthscotland.com/understanding/population/mental-health-indicators.aspx).

from systematic reviews indicate that there is sufficient knowledge to move evidence into practice (Jané-Llopis et al., 2005), and there are effective interventions that can be implemented successfully with diverse population groups in a range of settings (Friedli, 2003; Keleher and Armstrong, 2005; Herrman et al., 2005; Barry and Jenkins, 2007; Barry, 2007). Kovess-Masfety et al. (2005) argue that the challenge now is to gain a better understanding of the mechanisms that enable people to develop and maintain positive mental health, and to determine how these vary across populations and cultures. The development of validated indicators of positive mental health for different population groups is essential to supporting this endeavour and advancing our understanding of the field.

#### **4. Determinants of mental health**

Mental health is determined by biological, psychological, social, economic and environmental factors which interact in complex ways, so identifying direction of causality is rarely straightforward (Mrazek and Haggerty, 1994; Rogers and Pilgrim, 2005). The relative contribution of genetic inheritance and very early life experiences is influenced by a wide range of risk and protective factors that continue to determine the likelihood of mental ill-health across the life course. Demographics such as age, gender and ethnicity are important determinants in influencing exposure to risk factors (e.g. poverty, discrimination, violence, sexual abuse), prevalence, incidence, and the way in which poor mental health is expressed.

Recognition of the social determinants of mental wellbeing has led to a growing emphasis on models of mental health promotion that address them at different levels, for example:

- Strengthening individuals – through interventions designed to promote self-esteem, self-efficacy, life/coping skills and resilience, and lifestyles that enhance and protect mental health e.g. physical activity, diet, drinking moderately, maintaining social networks;
- Strengthening communities – by increasing social support, social inclusion and participation, improving community safety and neighbourhood environments, promoting childcare and self-help networks, developing health and social services which support mental health, and improving mental health within schools and workplaces e.g. through anti-bullying strategies and work/life balance policies;
- Reducing structural barriers to mental health – through initiatives to reduce poverty, discrimination and inequalities and to promote access to education, meaningful employment and housing, as well as services and support for those who are vulnerable.

(Health Education Authority, 1997; Department of Health, 2001; Lehtinen et al., 1997; Lahtinen et al., 1999)

Few epidemiological studies have focused on analysing the determinants of positive mental health among whole populations. The existing evidence regarding the factors that enhance mental health is derived mainly from intervention studies and extrapolations from community epidemiological studies of psychiatric morbidity. Keyes (2007) articulates this situation as the ‘roadmap to health is through illness’. The paucity of research on positive mental health and its determinants across populations limits our capacity to monitor the full impact of policies and practices that seek to promote mental health and wellbeing. The scope of epidemiological studies and national health surveys needs to be expanded to include indicators of positive mental health so that we can achieve a greater understanding of the determinants of mental health and how they unfold across the lifespan.

The Eurobarometer 2002 (Lehtinen et al., 2005), which surveyed 10,878 people over the age of 15 across 11 European countries, employed the Energy and Vitality Index from the SF-36 questionnaire as a measure of positive mental health. This study reported that positive mental health was higher for men than for

women, with scores decreasing with age, lower levels of family income, living on a pension, being widowed or separated, and residing in large cities. The lowest income quartile had the poorest mental health status in all countries/regions. A recent review of causative factors associated with subjective wellbeing, (including primary analysis of the British Household Panel Survey), identified income (absolute and relative), health, employment, relationships and neighbourhood social contact, but noted the difficulty of establishing clear evidence of causality (Dolan et al., 2006).

## **5. Structural determinants**

Poor mental health is both a cause and a consequence of social, economic and environmental inequalities; mental health problems both reflect deprivation and contribute to it (Social Exclusion Unit, 2004; Melzer et al., 2004). Mental health problems are more common in areas of deprivation. Poor mental health is consistently associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events (WHO, 2000; Patel, 2005; Petticrew et al., 2005; VicHealth, 2005).

Recent research also suggests that both the experience of racial harassment and perceptions of racial discrimination contribute independently to mental health outcomes (Chakraborty and McKenzie, 2002; Aspinall and Jacobson, 2004), and that higher national levels of income inequality are linked to a higher prevalence of mental illness (Pickett et al., 2006).

Taken together, these findings suggest that higher levels of education, improved standards of living, freedom from discrimination, fewer adverse life events and good physical health enhance positive mental health.

## **6. Community level determinants**

‘Community’ generally refers to communities of place but may also include identity, culture, ethnicity and faith. Communities with high levels of social capital such as, for example, trust, reciprocity, participation and cohesion have important benefits for mental health (Morgan and Swann, 2004; Whiteford, Cullen and Baingana, 2005), and social support and social inclusion play a significant role in maintaining positive mental health (Lehtinen et al., 2005; Wilkinson and Marmot, 2003; Social Exclusion Unit, 2004). A culture of co-operation and tolerance, a sense of belonging and strong social relationships are all protective of mental health (Moodie and Jenkins, 2005).

Environmental, physical and ecological effects are also significant (Chu et al., 2004; Brunner and Marmot, 1999). Mistrust and powerlessness amplify the effect of neighbourhood disorder: hopelessness and a difficulty in imagining solutions, which are also risk factors for suicidal behaviour, are influenced by neighbourhood culture and the physical environment.

Social relationships and social engagement, in the broadest sense, are significant factors in explaining differences in life outcomes, both for individuals and communities. Even so, social support and social participation do not mediate the effects of material deprivation (Mohan et al., 2004; Morgan and Swann, 2004). In a systematic review of the evidence on social capital and mental ill-health, De Silva et al., 2005 conclude that, while there is strong support for an association at the individual level, there is less evidence in relation to childhood and ecological studies.



## 7. Individual level

Among the enhancing factors for mental health operating at the individual level, the following have been identified: generic life skills and social competencies including effective communication; cognitive style; problem-solving; relationship and coping skills; together with resilience, self-esteem and sense of control or efficacy (Lister-Sharp et al., 1999; Tilford et al., 1997; Barry and Jenkins, 2007). These skills are relevant across the lifespan and may be particularly so during periods of transition.

In contrast, persistent anxiety, insecurity, low self-esteem, poor self-efficacy, social isolation and lack of control over work and home life can have powerful negative effects on mental health (Wilkinson and Marmot, 2003). These psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. These factors also interact in complex ways with social and economic factors. For example, the lower people are in the social hierarchy of industrialised countries, the more common are these problems (Wilkinson and Marmot, 2003). Depression, for example, is 1.5 to 2 times more prevalent among low-income groups of a population.

Further research is needed to determine the complex interaction or 'web of causation' among the biological, psychological, social and environmental determinants of mental health and how they affect the ability of individuals and communities to exercise a sense of control over their life. Improved knowledge of the relative impact of determinants operating at the structural, community and individual level, and the synergistic impacts and outcomes that are likely to arise from comprehensive interventions operating across levels, are critical to understanding the key drivers of mental health.

## 8. Enhancing factors for mental health across life stages

### 8.1. Children

The foundations for good mental health lie in the perinatal period and early childhood. Developmental theorists have highlighted the importance of early attachment, warm and affectionate parenting, a secure and safe home, and informal sources of community support. Attachment and the security of attachments in close relationships contribute to resilience in adulthood, notably in the face of adverse social environments e.g. fragmented or deprived neighbourhoods (Stansfeld et al., 2004; Fagg et al., 2006). Cognitive ability and emotional adjustment influence readiness for school or learning, as well as capacity, motivation and rationale for healthy behaviours (Schoon, 2006). There is a complex and dynamic relationship between parenting style, the home environment and socioeconomic factors. Economic adversity has a significant influence on the risk of poor adjustment and there are marked socioeconomic gradients in social and emotional adjustment across childhood, with no evidence that the gradients narrow as children get older (Graham and Power, 2004). Socioeconomic status patterns anxiety, aggression, confidence, emotional and cognitive development, concentration and hence readiness for school (Sacker et al., 2002; Bartley, 2006). Nevertheless, the influences of parenting on child development are profound and pervasive. The EPPE study showed that the strongest effect on children's resilience (defined as better than expected educational attainment) at ages five and 10 was their level of self regulation (independence and concentration) at the start of school (Sylva et al., 2007). This demonstrated the crucial contribution of a high-quality home learning environment (HLE)<sup>3</sup> on children's development, which was stronger than for other traditional measures of disadvantage such as parental socioeconomic status, education or income (Sylva et al., 2007).

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<sup>3</sup> HLE refers to the provision of structure, extensive educational stimulus and activities, a high level of parent/child interaction and the family's sense of efficacy in supporting their children's learning.



Relationships with peers and the wider community are also significant. Social support from at least one caring adult is protective in relation to a wide range of adversities including living in high-crime neighbourhoods, parental substance abuse, family conflict, child abuse and early parental loss (Wolkow and Ferguson, 2001). Poor emotional health in children (mood, behaviour or development problems) predicts poor mental health and social functioning in later life, with a significant causal impact on crime, substance misuse, low earnings and suicide (Fergusson et al., 2005; Bynner et al., 2000). Substantial social and economic benefits, in addition to improved mental health, accrue from high-quality, early childhood interventions (Schweinhart and Weikart, 1997; Schweinhart et al., 2005; Karoly et al., 1998; Scott et al., 2001). Interventions in the following areas have the most significant impact on improving the mental health of children and preventing (or ameliorating) early symptoms: home visiting programmes (Olds et al., 1997); pre-school education (Schweinhart and Weikart, 1997; Schweinhart et al., 2005); and group parenting classes (Scott et al., 2001; Barlow et al., 2001; Ferguson et al., 2005; Jané-Llopis et al., 2005; Moran et al., 2004). However some studies suggest that 'emotional and cognitive advantage are generally trumped by material advantage' (Friedli, in press). At age 16, children from economically disadvantaged backgrounds with above-average reading skills early in life do worse in their exams than economically privileged children who had lower reading skills at age five. High ability in early life is generally not able to protect against the effects of childhood economic disadvantage (Bartley, 2006; Schoon, 2006).

Positive educational experience and academic achievement can contribute significantly to the mental health of young people. School is a key setting for promoting emotional and social competence as well as academic learning (Weare, 2000; 2004; Zins et al., 2004). The early identification of problems and disaffection with, or exclusion from, school are risk factors for children from an early age (DFES, 2001). Educational opportunities throughout life are associated with improved mental health outcomes, while low literacy is a risk factor for depression (Feinstein et al., 2003; Chevalier and Feinstein, 2006). The promotion of emotional health and wellbeing is now one of the essential criteria for 'National Healthy School' status (DFES, 2005) and a core feature of the WHO's Health Promoting Schools initiative (WHO, 1998).

There is good evidence that mental health promotion programmes in schools (including cognitive skills training, peer-led and mentoring programmes, and early interventions to address emotional and behavioural problems) can produce long-term benefits for young people (Hallam et al., 2006; Weare and Gray, 2003). These include improved emotional and social functioning, positive health behaviours, and improved academic performance (Durlak and Wells, 1997; Harden et al., 2001; Lister-Sharp et al., 1999; Wells et al., 2001; 2003; Tennant et al., 2007).

## 8.2. *Adults*

The workplace is a key environment affecting the mental health and wellbeing of working adults (WHO, 2000). Effective approaches to mental health promotion in the workplace address key influencing factors such as social support, enhanced job control, increased staff involvement, workload assessment, effort/reward balance, role clarity, and policies to tackle bullying and harassment (Williams et al., 1998; Stansfeld et al., 1999; Ferrie, 2007).

A poor work environment, characterised by features such as high demand/low control, and effort-reward imbalance, is one of the main factors explaining the higher prevalence of depressive symptoms among participants in lower employment grades (Stansfeld et al., 1999). Organisational and cultural factors have a stronger mental health impact than individual lifestyles, but exercise, socialising outside work, supportive colleagues, a healthy diet and achieving a work/life balance can all promote mental health.

The mental health impact of unemployment is well documented: a higher risk of suicide, higher levels of anxiety, depression, uncertainty about the future, anger, shame and loss of self-esteem (Breslin and Mustard,

2003; Dooley et al., 1994; Johansson and Sundquist, 1997; Blakely et al., 2003). Interventions to facilitate reemployment, particularly in good-quality jobs, are one of the most effective ways of promoting the mental health of the unemployed (Vinokur et al., 2000; Vuori and Silvonen, 2005; Barry et al., 2006).

### **8.3. Older people**

Across the life cycle, the rich get richer in terms of mental health, while classes four and five get poorer (Rogers and Pilgrim, 2005). Key factors influencing mental health in older people (i.e. over 65 years), notably prevalence of depression, include poor physical health, bereavement, loss of social support, material adversity, residential care, and experience of elder abuse (Rogers and Pilgrim 2005; Godfrey and Denby, 2004; NHS Health Scotland, 2004; Age Concern, 2006). Fear of crime and lack of transport may be additional barriers to protective factors such as social activity (Social Exclusion Unit, 2006).

Promoting mental health among older people has been widely neglected so the evidence base for effective interventions is limited. Promising approaches focus on improving overall quality of life and engagement, including befriending, peer and group support, volunteering, intergenerational projects, approved trader schemes, work with providers to promote greater uptake of education, sports and leisure, and targeted outreach with those who are most isolated and vulnerable (Lieberman and Videka-Sherman, 1986; Wheeler et al., 1998; Social Exclusion Unit, 2006).

## **9. Implications of addressing the determinants of mental health**

Much of the current debate about the determinants of mental health and wellbeing is driven by different views on the relative importance of material factors (income, housing, employment) and psychosocial factors or attributes (relationships, life satisfaction, positive affect, cognitive style), as well as the influence of material inequalities on people's subjective wellbeing (Eckersley, 2006; Pickett et al., 2006; Wilkinson and Pickett, 2006).

Although it is frequently noted that health enables a person to function as an agent and contributes to inequalities in people's capability to function (Anand and Ravillion, 1993), we suggest that it is *mental health* that constitutes the key determinant of agency. A major question for policy-makers, then, is the balance between addressing proximate, individual-level determinants targeting inequities in mental health among the vulnerable, disadvantaged and marginalised, and those broader social determinants which help to explain population-level patterns of mental health and mental illness.

## **10. Conclusion**

Positive mental health is a key asset and resource for population wellbeing and the long-term social and economic prosperity of society. In addressing the current and future health challenges of increasing globalisation, urbanisation, epidemiological and demographic shifts, and changing family and work structures, mental health promotion and prevention have a key role to play in enhancing the capacity of individuals and communities to respond to, and positively shape, the future direction of their lives and those of their families and communities.

Promoting mental health and wellbeing will deliver improved outcomes not only for the general population but also for people with mental health problems. The existence of review-level evidence of the effectiveness of mental health promotion interventions further strengthens the case for action (WHO, 2004a; 2004b; Jané-Llopis et al., 2005; Keleher and Armstrong, 2005; Barry and Jenkins, 2007).

Responsibility for promoting mental health extends across all disciplines and government departments and encompasses a concern with social values, culture, economic and social policies. The evidence reviewed in this paper suggests that policies focused on curing or preventing mental illness will not necessarily deliver on improved mental health at a population level.

The increasing interest in positive mental health and wellbeing needs to be accompanied by an investment in research on the determinants of positive mental health across the lifecourse, as distinct from studies on the determinants of mental disorders. To fully capitalise on the potential of mental health promotion, our 'roadmap to mental health' needs to be driven by a clear understanding of the nature of positive mental health and the factors that determine its maintenance and promotion across population groups and settings.

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