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Nina Tamminen

Mental Health Promotion Competencies in the Health Sector

UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF SPORT AND
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ABSTRACT

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This study aimed to investigate competencies for mental health promotion and to determine what competencies are needed in health sector practice. The research was based on the views provided by professionals and experts by experience working and acting in the field of mental health promotion.

The research was carried out in stages. First, the concept of mental health promotion was analysed to provide a framework for the subsequent studies. Next, the views of mental health professionals regarding mental health promotion-related competencies were examined by means of focus groups (2 groups; 6+7 participants) and an open-ended questionnaire survey (20 participants); the data was analysed with content analysis. A Delphi survey followed in order to facilitate a consensus-building process on the identification of the mental health promotion competencies (32 participants). In addition, the qualitative data from the Delphi survey were analysed using thematic analysis. Finally, experts by experience (10 participants) assessed the produced competencies in a focus group meeting, which was analysed by thematising the data (unpublished results).

In the study, 16 main competencies and 56 subcompetencies for mental health promotion were identified. These were divided into theoretical knowledge, practical skills, and attitudes and values, with each category representing an aspect of mental health promotion competency. The results highlighted the great variety of competencies needed for mental health promotion. Knowledge of positive mental health emerged strongly, as did requirements for intersectoral collaboration skills. According to the results, domains such as a client-based approach and empowerment of individuals and communities were especially emphasised in the competencies.

The results provide a resource for competency development. The identified competencies provide a tool to enhance education and training in mental health promotion. They can be used to assess the level of proficiency of the workforce and as a follow-up. Furthermore, the competencies aid in identifying training needs of staff and can be used as a self-assessment tool to appraise current competencies and to identify areas for professional development.

Keywords: Delphi method, health sector, mental health promotion competencies, qualitative research

TIIVISTELMÄ (ABSTRACT IN FINNISH)

Tamminen, Nina
Mielenterveyden edistämisen osaaminen terveyssektorilla
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Tämän tutkimuksen tarkoituksena oli tutkia mielenterveyden edistämisen osaamista ja määritellä, millaista osaamista tarvitaan terveyssektorin käytännöissä. Tutkimus pohjautui mielenterveyden edistämisen alan asiantuntijoiden sekä kokemusasiantuntijoiden näkemyksiin.

Tutkimus toteutettiin vaiheittain. Aluksi toteutettiin mielenterveyden edistämisen käsiteanalyysi, joka tarjosi viitekehyksen myöhemmille tutkimuksille. Seuraavaksi selvitettiin sisällönanalyysillä mielenterveyden ammattilaisten näkemyksiä mielenterveyden edistämiseen liittyvästä osaamisesta fokusryhmien (2 ryhmää; 6+7 osallistujaa) ja avoimista kysymyksistä koostuvan kyselytutkimuksen avulla (20 osallistujaa). Tätä seurasi Delphi-tutkimus, jossa yhteisymmärrystä rakentamalla toteutettiin mielenterveyden edistämisen osaamisalueiden tunnistaminen (32 osallistujaa). Lisäksi tutkittiin Delphi-tutkimuksen laadullinen aineisto temaattisella analyysilla. Lopuksi kokemusasiantuntijat arvioivat tulokseksi saatuja osaamisalueita fokusryhmähaastattelussa (10 osallistujaa), joka analysoitiin teemoitellen (julkaisemattomat tulokset).

Tutkimuksen tuloksena identifioitiin 16 mielenterveyden edistämisen pääosaamisaluetta ja 56 alaosaamisaluetta. Osaamisalueet jaettiin tieto-osaamiseen, käytännön taitoihin, sekä asenteisiin ja arvoihin. Jokainen luokka kuvaa yhtä mielenterveyden edistämisen osaamisen ulottuvuutta. Tulokset korostivat tarvittavan mielenterveyden edistämisen osaamisen monimuotoisuutta. Positiivisen mielenterveyden tuntemus sekä yhteistoimintataidot tulivat vahvasti esiin vaadittavana osaamisena. Tulosten mukaan osaamisessa korostuivat etenkin asiakaslähtöisyyteen ja yksilöiden ja yhteisöjen voimaantumiseen liittyvät osa-alueet.

Tulokset tukevat mielenterveyden edistämisen osaamisen kehittämistä. Tunnistetut osaamisalueet tarjoavat välineen mielenterveyden edistämisen koulutuksen vahvistamiseen. Niiden avulla voidaan arvioida osaamista ja sen kehittymistä. Lisäksi niitä voidaan hyödyntää koulutustarpeiden tunnistamisessa sekä käyttää itsearviointina osaamisen ja ammatillisen kehittämistarpeen kartoittamisessa.

Avainsanat: Delphi-metodi, laadullinen tutkimus, mielenterveyden edistämisen osaaminen, terveyssektori

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LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the following papers:

1. Tamminen, N., Solin, P., Barry, M. M., Kannas, L., Stengård, E. & Kettunen, T. 2016. A systematic concept analysis of mental health promotion. International Journal of Mental Health Promotion 18 (4), 177–198.

2. Tamminen, N., Solin, P., Stengård, E., Kannas, L. & Kettunen, T. 2019. Mental health promotion competencies in the health sector in Finland: a qualitative study of the views of professionals. Scandinavian Journal of Public Health 47 (2), 115–120. Article first published online: July 12, 2017.

3. Tamminen, N., Solin, P., Kannas, L., Linturi, H., Stengård, E. & Kettunen, T. 2018. Mental health promotion competencies in the health sector based on a Delphi study. The Journal of Mental Health Training, Education and Practice 13 (6), 297–306.

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In the original publications, Nina Tamminen had the main responsibility for all phases as the first author. The author carried out the manuscript preparation for the publications and submissions of the articles. All authors performed review and editing of the publications.

FIGURES

TABLES

ABBREVIATIONS

ASSIA	Applied Social Sciences Index & Abstracts
CAQDAS	Computer-assisted qualitative data analysis software
EBSCO	Elton B. Stephens Company (online research platform)
EU	European Union
EUPHA	European Public Health Association
GBD	Global Burden of Disease
MHiAP	Mental Health in All Policies
MHP	Mental health promotion
NGO	Non-governmental organisation
SWEMWBS	Short Warwick-Edinburgh Mental Well-being Scale
UK	United Kingdom
WEMWBS	Warwick-Edinburgh Mental Well-being Scale
WHO	World Health Organization

CONTENTS

1 INTRODUCTION

There is increasing emphasis on a public mental health approach to improve the mental health and well-being of a population (Wahlbeck 2015; Lindert et al. 2017). Mental health is recognised as an integral part of public health, and it has a significant impact on human, social and economic capital (VicHealth 2009; World Health Organization [WHO] 2013b). Mental health problems are considerable public health challenges; mental health disorders constitute one third of the disease burden in Europe (WHO 2013b) and up to half of the Finnish population may suffer from mental health difficulties at some point in their lives (Suvisaari et al. 2009; Ministry of Social Affairs and Health 2020b). Public mental health actions aim to develop positive mental health and mentally healthy societies (Herrman & Jané-Llopis 2005; Forsman et al. 2015).

Mental health promotion with its focus on positive mental health and well-being (Barry et al. 2019) is recognised as a key approach in public mental health policies and actions aiming to strengthen mental health and increasing well-being (Wahlbeck 2015; Lindert et al. 2017). Positive mental health, or mental well-being – a concept often used interchangeably with positive mental health, is one of the key resources for health and well-being (WHO 2005b; Barry et al. 2019). The concept has evolved from the understanding that mental health encompasses more than just the absence of mental health disorders; it embraces positive concepts of mental health, well-being and resilience (WHO 2005b; Barry et al. 2019). This salutogenic (Antonovsky 1996) perspective is enshrined in the World Health Organization's (WHO) definition of mental health 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 2018, p. 1). Positive mental health refers to human resources such as positive self-esteem, optimism, coherence and a sense of mastery; satisfying personal relationships; and resilience, that is, the ability to cope with change and adversities (Lehtinen 2008; Vaillant 2012). Positive mental health has been shown to contribute to the individual's well-being and quality of life, ensure greater resilience when individuals and communities are faced with stressors, and enable all people to

manage their lives successfully (Jané-Llopis et al. 2005). Mental health promotion focuses on strengthening positive mental health and protective factors for good mental health and quality of life, creating supporting living conditions and environments, and enabling access to resources and life opportunities for individuals and communities that will promote their social and emotional well-being (WHO 2005b; Barry et al. 2019). The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders (VicHealth 2009) stressed that mental health promotion is everybody's concern and responsibility; that mental well-being is best achieved in equitable, just and non-violent societies; and that mental health is best promoted through respectful, participatory means where culture and cultural heritage and diversity are acknowledged and valued.

Effective public mental health policy and practice requires a trained workforce that is competent in mental health promotion and delivering on improved mental health at a population level. In Europe, the European Pact for Mental Health and Well-being (European Commission 2008) and the WHO European Mental Health Action Plan (WHO 2013b) both stress the importance of capacity building and training health professionals in the area of mental health and mental health promotion. Moreover, the European Public Health Association's (EUPHA) Public Mental Health section has recognised the need for training in the field of public mental health (Lindert et al. 2017).

In Finland, the National Plan for Mental Health and Substance Abuse Work (Ministry of Social Affairs and Health 2010) outlined core principles and priorities for the future of mental health and substance abuse work until 2015. Among the main themes put forward was the promotion of mental health and a proposal to develop education and training in mental health. The plan recognised that the vocational and higher education and training of social and health sector professionals did not reflect the public health significance of mental health. Teaching on mental health was seen to be increased for vocational and higher education qualifications and degrees in the health and social sectors. In addition to this, the plan emphasised that diverse and multi-professional continuing education and training in mental health work was needed. The initial incentive for this doctoral thesis arose from these recognitions in the Plan. The topicality of this research was further supported by the newly released Finnish National Mental Health Strategy and Programme for Suicide Prevention 2020–2030 (Ministry of Social Affairs and Health 2020b), highlighting that there is still a need for capacity building and training to equip professionals with the necessary mental health competencies, including the promotion of mental health. The strategy proposed focal areas for mental health work up until the year 2030, including the identification of professionals for whom mental health skill development would be particularly useful and increasing competence in these groups. This provides a solid argument for this research and its purpose.

Competent mental health promotion workforce is equipped with the necessary knowledge, skills and abilities to implement effective mental health

promotion practice. However, it has been noted that there is a lack of professionals skilled and competent in implementing effective mental health promotion (Barry 2007a; Ministry of Social Affairs and Health 2010). Barry (2007a) proposed that at least two different levels of the workforce for mental health promotion may be needed: 1. dedicated mental health promotion specialists who facilitate and support the development of policy and practice across a range of settings, and 2. the wider workforce drawn from different sectors, such as health, education, employment, community and non-governmental organisations. Capacity building and training to equip professionals with the necessary mental health promotion competencies is required (Wahlbeck 2015; Lang et al. 2016).

In order to develop mental health promotion skills and proficiencies and train professionals in mental health promotion, we need to know what the required competencies for mental health promotion are. However, there is a scarcity of knowledge on the matter as the existing research has been sporadic. Earlier research on mental health nurses, for example, has revealed the important role of mental health promotion in their practice (Woodhouse 2010; Doyle et al. 2018). Yet, the evidence suggests that mental health nursing education needs to be reoriented towards a more salutogenic and strengths-based model of mental health practice. Doyle et al. (2018) conducted an exploratory study detailing the knowledge, skills, and attitudes required by master's level mental health nurses, proposing that mental health nurses need to have knowledge of the factors that impact mental well-being and adopt a client-based attitude and approach in their practice.

One of the few studies specifically investigating mental health promotion workers was carried out in Australia, where the researchers identified programme evaluation skills as a key skill that can support programme development and strengthen the evidence base of mental health promotion programmes (Reupert et al. 2012). Greacen and partners (2012) conducted a study that sought to identify quality criteria for training social and health care professionals in mental health promotion. They recognised ten criteria for training, among them embracing the principles of mental health promotion, adopting an interdisciplinary and intersectoral approach, including people with mental health problems, and empowering community stakeholders. In England, on the other hand, a national framework for leadership and workforce development in public mental health was developed in consultation with a wide range of stakeholders (Stansfield 2015). The framework outlined six key ambitions for change that focus on advocacy, expertise, community empowerment, promotion, prevention and parity. In addition, 12 core principles for mental health across the workforce were suggested to identify the core knowledge, values and skills required to improve mental health. Among these were competencies such as advocacy and communication skills and an understanding of positive mental health. These earlier efforts add valuable knowledge to the domain of mental health promotion. Nevertheless, systematic research and information on the competencies required specifically for mental

health promotion practice is lacking, thus calling for further investigation (Greacen et al. 2012; Lang et al. 2016).

This doctoral research was designed to respond to this lack of systematic data on mental health promotion competencies. The main aim of the thesis was to investigate competencies for mental health promotion and to determine what mental health promotion competencies are needed in health sector practice. The research started with an examination of definitions of mental health promotion concepts in current scientific literature and policy papers to provide a framework for the study. The study then focused on practice-based evidence and understandings provided by professionals and experts by experience working and acting in the mental health promotion field. The identified competencies provide a resource for workforce development, as well as a tool to enhance education and training in mental health promotion.

2 THEORETICAL PERSPECTIVES ON MENTAL HEALTH PROMOTION

This chapter presents theoretical perspectives on mental health promotion. The purpose is to clarify key concepts and principles of mental health promotion and provide context for the study on mental health promotion competencies. First, the concept of mental health promotion is introduced. This is followed by discussions on the importance of mental health and the determinants of mental health. Finally, the concept of positive mental health and known frameworks for mental health promotion are described.

2.1 Concept of mental health promotion

Mental health promotion aims to enable and achieve positive mental health and well-being at the levels of the individual, community and population (Lahtinen et al. 2005; Barry et al. 2019). The focus of mental health promotion is on strengthening protective factors for good mental health and quality of life, fostering individual and communities' competencies, creating supportive living conditions and environments, and enabling access to resources and life opportunities for individuals and communities that will promote their social and emotional well-being (Barry 2001; WHO 2005b; Lehtinen 2008; Kobau et al. 2011; Barry et al. 2019). Mental health promotion aims to deliver programmes designed to reduce health inequalities in an empowering, collaborative and participatory manner. It seeks to address the broader determinants of mental health (Jané-Llopis et al. 2005). Mental health promotion strategies and actions require a cross-sectional approach and partnerships, as good mental health is constructed in everyday contexts and living environments, such as the home, schools, the workplace, and the community (VicHealth 2009).

2.2 The importance of mental health

The WHO Constitution of 1946 defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 2020). Mental health cannot, therefore, be separated from overall health; mental health is an integral part of health. There is no health without mental health, as the slogan says (WHO 1999; Prince et al. 2007). Mental health is fundamental to good health, well-being and quality of life, and it ensures greater resilience when individuals and communities are faced with stressors (Perth Charter for the Promotion of Mental Health and Wellbeing 2012). Mental health problems and mental ill health, on the other hand, are considerable public health challenges. On the global level, mental health problems are one of the main contributors to the overall disease burden (GBD 2015 Disease and Injury Incidence and Prevalence Collaborators 2016). WHO World Report (2001) reported that more than 450 million people experience mental health disorders worldwide. In Europe, mental health disorders constitute one third of the disease burden, a figure which is on the increase (WHO 2013b). A study by Wittchen et al. (2011) estimated that each year 38.2% of the EU population suffers from a mental health disorder. In Finland, around 40% of the population may suffer from mental health difficulties at some point in their lives (Suvisaari et al. 2009), and nearly half of disability pensions are caused by mental health disorders (Finnish Centre for Pensions 2020). Suvisaari et al. (2009) found a 35% prevalence of mental health disorders among young men and 46% among young women. The most common disorders reported in Finland were depressive disorders, anxiety disorders and substance use disorders (Pirkola et al. 2005; Suvisaari et al. 2009). According to a Finnish population survey, the FinHealth 2017 study, 20% of women and 15% of men were experiencing considerable psychological distress at the time of the survey (Suvisaari et al. 2018). With regards to depression, the rates were 8% and 6% respectively.

The importance of mental health and well-being is currently widely understood, and there has been a drive for plans and actions to promote and strengthen mental health. The essential role of mental health in achieving health for all people has been addressed in high-level European and global policies and strategies, and the well-being of the population has become a central focus for governments. The global WHO Mental Health Action Plan (WHO 2013a) sets out a comprehensive and multisectoral approach with an overall goal to promote mental well-being, prevent mental health disorders, provide care, enhance recovery, promote human rights and reduce mortality, morbidity and disability for persons with mental health disorders. Equally, the European Mental Health Action Plan (WHO 2013b) highlights the promotion of mental health and the prevention and treatment of mental health disorders as fundamental to safeguarding and enhancing the quality of life, well-being and the productivity of individuals, families, workers and communities, thus increasing the strength and resilience of society as a whole. Both policy

documents acknowledge the challenges faced in today's societies, such as unemployment, economic challenges, an ageing population and, importantly, the high burden associated with mental ill health (WHO 2013a; WHO 2013b). These key facts established by the WHO are presented in Table 1.

TABLE 1 Key facts from the WHO Fact Sheet on Mental Health: strengthening our response (WHO 2018) (https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response)

- Mental health is more than the absence of mental disorders.
- Mental health is an integral part of health; indeed, there is no health without mental health.
- Mental health is determined by a range of socioeconomic, biological and environmental factors.
- Cost-effective public health and intersectoral strategies and interventions exist to promote, protect and restore mental health.

In Finland, the newly published National Mental Health Strategy and Programme for Suicide Prevention 2020–2030 (Ministry of Social Affairs and Health 2020b) includes focal areas for mental health work up until the year 2030. The strategy recognises that in order to meet the diverse needs ranging from mental health promotion for the entire population to the urgent treatment of severe mental health disorders, a broad approach is needed to promote mental health on several different levels and using multidisciplinary approaches. Importantly, the strategy emphasises that mutually accepted values and principles are needed to facilitate action planning. In addition, guidelines for concrete decisions are provided. The strategy is guided by the understanding that mental health is a resource, a form of human capital, for individuals, families, communities and society as a whole. This capital should be looked after and invested in at all life stages, during studies and at work, in everyday circumstances, communities and recreational activities, and in connection with societal and environmental changes. It is understood that good mental health strengthens trust, reciprocity and a sense of belonging in society and that high levels of good mental health in the population will support success of the population as a whole. The strategy has five focus areas: 1. mental health as human capital, 2. mental health for children and young people, 3. mental health as a right, 4. appropriate, broad-based mental health services, and 5. mental health management (Ministry of Social Affairs and Health 2020b).

2.3 Determinants of mental health

Mental health is influenced by various biological, psychological, social, cultural, economic, political and environmental factors (Lahtinen et al. 1999; Shah &

Marks 2004; WHO 2004; WHO 2013a; WHO & Calouste Gulbenkian Foundation 2014; Carbone 2020). Although genetic and biological factors are important influences on mental health, social and environmental factors play a major role in affecting mental health on individual, family, community and societal levels. These influences can act as risk or protective factors for mental health and function at each stage of an individual's life course (Mrazek & Haggerty 1994; Lehtinen 2008; WHO & Calouste Gulbenkian Foundation 2014; Carbone 2020). The determinants of mental health can be clustered into three key areas (Figure 1): individual-level factors, community-level factors and societal-level factors. Individual-level factors include individual attributes such as self-esteem, emotional resilience, the ability to cope with stressful or adverse circumstances, and the ability to manage thoughts and feelings. Community-level factors comprise a sense of belonging, social support, a sense of citizenship and participation in society. Societal-level factors include determinants such as education, employment status, quality housing, and living environments (Fryers et al. 2003; WHO 2004; Jenkins & Minoletti 2013; WHO 2013a; WHO & Calouste Gulbenkian Foundation 2014). The social determinants of mental health – defined as those conditions in which people are born, grow, live, work and age – that impact mental health and well-being, as well as their significant influence on mental health and well-being, have been widely acknowledged (Lahtinen et al. 1999; WHO and Calouste Gulbenkian Foundation 2014; WHO Europe 2019). WHO Europe (2019) has calculated that 90% of health inequalities can be explained by financial insecurity, poor quality housing, social exclusion, a lack of decent work, and poor working conditions. The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders (VicHealth 2009, p. 1) also asserts that mental health and well-being are 'a fundamental right of every human being, without discrimination', and that they are most threatened by poor and unequal living conditions, conflict and violence, and best achieved in equitable, just and non-violent societies.

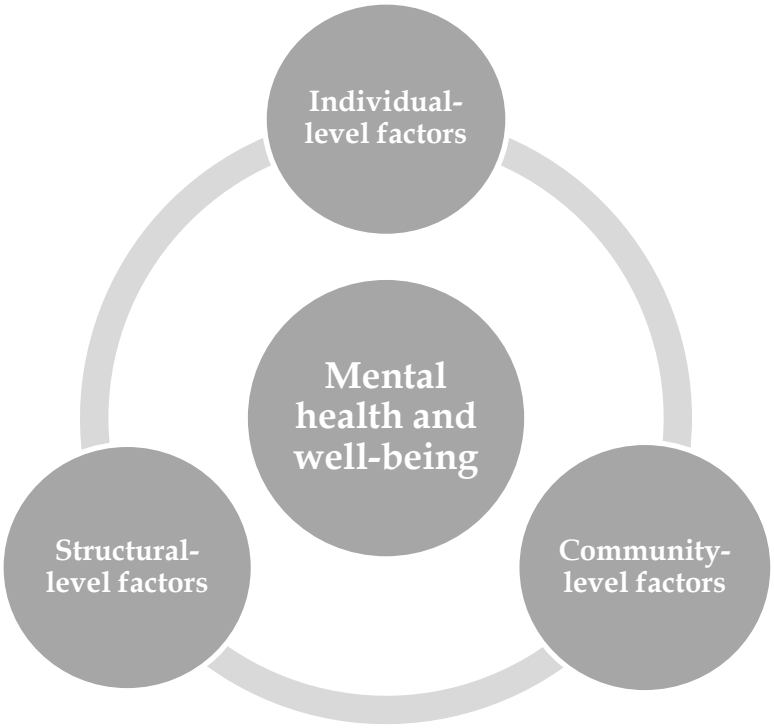

FIGURE 1 Different levels of influences on mental health.

Protective factors enhance and protect mental health and well-being and reduce the likelihood that a mental health disorder will develop. Protective factors increase people's psychological, social and emotional well-being and their capacity to successfully cope with and enjoy life and alleviate the effects of negative life events. Risk factors for mental health increase the likelihood that mental health problems and mental health disorders may develop. Risk factors may also increase the duration and severity when mental ill health occurs (Lehtinen 2008; WHO & Calouste Gulbenkian Foundation 2014; Barry et al. 2019). The presence of multiple risk factors, the lack of protective factors and the interplay of these culminate in a greater likelihood of poor mental health and well-being and the development of mental health problems (VicHealth 2009). To promote mental health, we should ensure that those factors that protect mental health and well-being are accessible to all and those that place people at risk of poor mental health or illness are reduced or eliminated. Table 2 presents applied examples of risk and protective factors for mental health at the different influencing levels from several sources (WHO 2004; WHO 2013a; WHO & Calouste Gulbenkian Foundation 2014; Barry et al. 2019).

TABLE 2 Examples of risk and protective factors for mental health (WHO 2004; WHO 2013a; WHO & Calouste Gulbenkian Foundation 2014; Barry et al. 2019)

	Protective factors	**Risk factors**
Individual level	Positive sense of self Good coping skills Stress-management skills Attachment to family Good physical health	Low self-esteem Poor coping skills Poor stress management Insecure attachment in childhood Chronic pain, illness
Community level	Positive experience of early attachment Support of friends and families Sense of social belonging and social inclusion	Adverse early life experiences – abuse and violence Lack of social support, separation and loss Social exclusion
Societal level	Economic security Social justice Employment Well-functioning health and social services Safe and secure living environment Possibility for participation and influence	Poverty Social injustice Unemployment Health and social services not functioning well or lack of access Neighbourhood violence and crime Discrimination, denial of human rights

As a result of these multiple levels of determinants, the responses to them need to be multi-layered as well as multisectoral. A 'Mental health in all policies' approach (MHiAP) emphasises the impacts of public policies on mental health determinants and aims to develop mental health promotion by integrating mental health in all policies (WHO 2013c; EU Joint Action on Mental Health and Wellbeing 2016). Mental health is created and supported in people's daily living environments and actions; thus, the responsibility for mental health and well-being extends across all sectors of society (WHO 1986; Lahtinen et al. 1999; Herrman & Jané-Llopis 2005; WHO 2013a; WHO 2013b). Sectors such as health, education, housing and welfare, employment, the environment, the workplace and so on all have a significant role in promoting the mental health of individuals, communities and populations (Jané-Llopis et al. 2005; Perth Charter for the Promotion of Mental Health and Wellbeing 2012; WHO 2013a; WHO & Calouste Gulbenkian Foundation 2014). A MHiAP approach proposes that mental health should be incorporated in the strategic planning of ministries responsible for education, social welfare, police, courts, prisons, probation services and child protection, among others. To give an example, a study by Wahlbeck et al. (2017a) demonstrated that interventions located outside of the health sector may mitigate the effects of poverty on mental health. Housing and active labour market interventions, among others, have been shown to have a beneficial influence on mental health. Education setting and the school environment have also been shown to provide successful opportunities for supporting children's and adolescents' mental health (Anttila et al. 2000; Weare & Nind 2011; Wahlbeck et al. 2017b; García-Carrión et al. 2019).

For a MHiAP approach to succeed, political commitment and intersectoral collaboration are needed (Jenkins & Minoletti 2013). Collaboration between different sectors can be problematic, as improved mental health is not often a primary policy objective of sectors outside the health and mental health sectors (McDaid et al. 2019). Partnerships working for mental health promotion entail challenges that need to be acknowledged and resolved. Shared and mutually beneficial goals and communication that supports a common language that is understandable to all partners have been found to be beneficial in engaging partners in health-promoting actions and joint work (Koelen et al. 2012; Corbin et al. 2018; Wiggins et al. 2021). Furthermore, sharing of resources and strengthening capacity across the individual, organisational and community dimensions is thought to be required for successful collaboration (WHO 2005b; WHO 2014; EU Joint Action on Mental Health and Wellbeing 2016). Corbin and partners (2018) recognised in their study, for example, that a balance between human and financial resources is needed for positive partnership processes, including a broad range of participation from diverse partners. Also, van Dale et al. (2020) emphasised the importance of sufficient resources and an effective mix of different partners with diverse backgrounds and skills to sustain successful intersectoral collaboration. The Joint Action on Mental Health and Well-being (2015) proposed recommendations for Mental Health in All Policies, including incorporating mental health in all policies, strengthening capacity, and ensuring effective structures, processes and resources for mental health in all policies, as well as building mental health literacy and understanding of mental health impacts.

Mental health literacy is considered as a determinant of mental health, having the potential to benefit both individual and public mental health (Jorm et al. 2006; Jorm 2012; WHO 2013d). Mental health literacy has been conceptualised as understanding how to obtain and maintain positive mental health, understanding mental health disorders and their treatments, decreasing stigmas related to mental health problems, and enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities) (Kutcher et al. 2016). Defined as such, mental health literacy relates to conceptions of what is needed to increase and strengthen positive mental health, help-seeking behaviour and mental health outcomes (Bjørnsen et al. 2019). Mental health literacy can be empowering, as it helps people better understand their own mental health and enables them to act upon the learned information. It can also increase people's resilience, and, on a broader scale, reduce the burden on health and social care services and health inequalities (Public Health England 2015).

2.4 Positive mental health

The term 'mental health' is often misunderstood and interpreted as referring to mental ill health, causing confusion regarding the relationship between mental health and mental health disorders. As a consequence, terms such as 'positive mental health' and 'mental well-being' have been adopted to better describe this relationship. The World Health Organization has defined positive mental health 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 2018, p. 1). Positive mental health is thus based on the assumption that mental health is more than just the absence of mental health disorders; it embraces positive concepts of mental health, well-being and resilience reflecting thereby a salutogenic perspective of mental health (Antonovsky 1996; Barry et al. 2001; Keyes 2002; Jané-Llopis et al. 2005; WHO 2005b). Through this salutogenic orientation, positive mental health refers to the individuals', communities' and societies' recourses and capital, which support all people to survive in the environment (Lahtinen et al. 2005; Lehtinen 2008).

Definitions of positive mental health are affected by the culture and the context that define them (Gopalkrishnan & Babacan 2015). The meanings of the definition may also depend on current socioeconomic and political influences (Kovess-Mastefy et al. 2005; Rogers & Pilgrim 2005). Positive mental health is usually conceptualised as encompassing aspects that are emotional (affect/feeling), psychological (positive functioning), social (relations with others and society), physical (physical health and fitness) and spiritual (sense of meaning and purpose in life) (Keyes 2002; Kovess-Mastefy et al. 2005; Barry 2013). Positive mental health is not a static characteristic; it constantly shifts and develops in relation to the environment over the life course. Thus, it can be understood as a resource that is connected to time and place, but also that can be strengthened (Lahtinen et al. 1999). Positive mental health has been recognised as one of the key resources for health and well-being and contributing to quality of life (WHO 2005b; Huppert 2009; Barry et al. 2019).

Positive mental health has been defined as integrating two theoretical perspectives: namely, hedonic and eudaimonic (Ryan & Deci 2001; Stewart-Brown et al. 2015). The hedonic perspective (feeling good) focuses on subjective experiences of happiness, life satisfaction and positive affect. The eudaimonic perspective (functioning well), on the other hand, understands well-being as a wider phenomenon than just the individual's subjective feeling. Eudaimonic well-being includes aspects of positive psychological functioning, good relationships with others, and self-realisation (Ryan & Deci 2001; Stewart-Brown 2015). Positive mental health contributes to the individual's well-being and quality of life, ensures greater resilience when individuals and communities are faced with stressors, and enables all to manage their lives successfully. Moreover, it contributes to society and the economy by increasing

social functioning and social capital (Jané-Llopis et al. 2005; Lehtinen 2008; Vaillant 2012). Positive mental health is understood to refer to human resources (such as positive self-esteem, optimism, a sense of mastery and coherence), satisfying personal relationships, and resilience, that is, the ability to cope with change and adversities such as unemployment, bereavement or physical ill health (Lehtinen 2008; Vaillant 2012).

Terms such as 'flourishing' and 'languishing' are used when discussing positive mental health. When people have optimal levels of both hedonic and eudaimonic well-being, they can be defined as having flourishing mental health, in other words, they both feel good and function well (Keyes 2002; Huppert 2009). Languishing, on the other hand, is used to describe a person with low positive mental health; that is, the person has a low level of psychological, emotional and social well-being, so he or she is not feeling good nor functioning effectively (Keyes 2002). This view recognises that mental health and mental ill health belong to two separate but correlated dimensions (Keyes 2002; Keyes 2005a). This merging of the pathogenic (ill health) and salutogenic (health) perspectives is outlined in the dual continua model proposed by Keyes (2002; 2014) (see Figure 2). In this model, one continuum represents the presence of positive mental health and the other indicates the presence or absence of mental health disorder. Following the dual continua model, a person with mental health disorder can also have positive mental health, which supports his functioning and emotional, psychological and social well-being. On the other hand, a person with a low level of positive mental health can feel unwell and function badly, even in the absence of a diagnosed mental health disorder. Health and ill health, therefore, can exist at the same time.

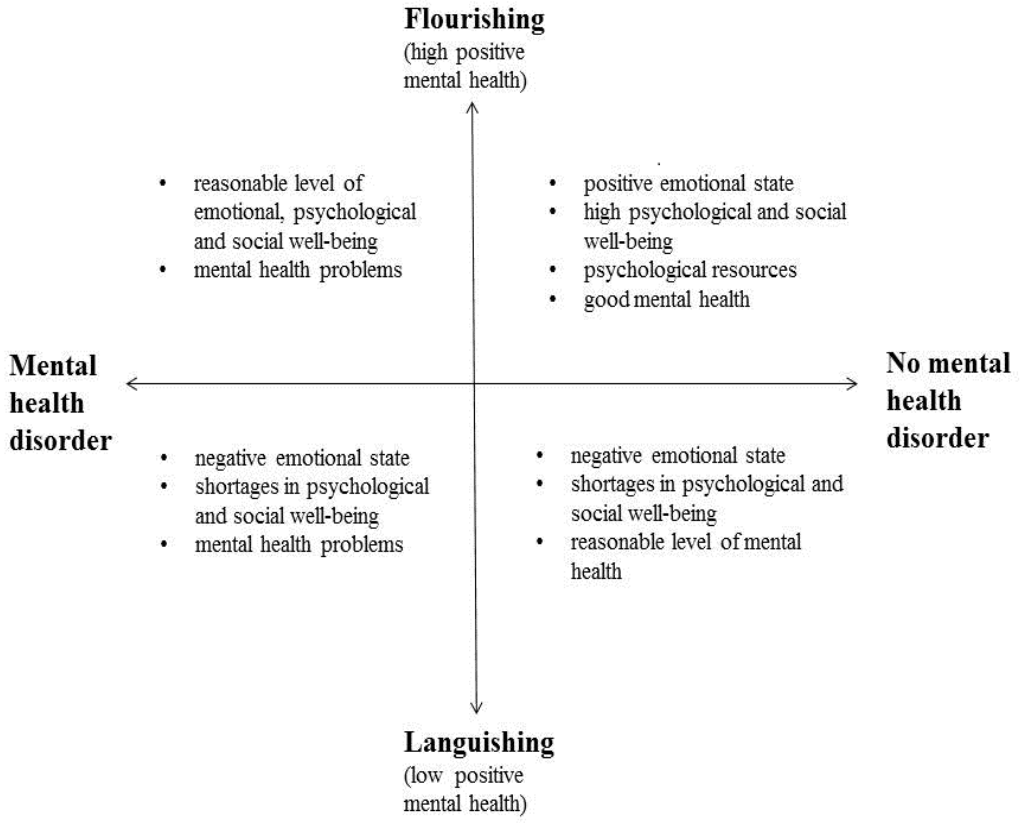

FIGURE 2 The dual continua model based on Keyes' work (2005a; 2007).

Research findings give evidence for the need to support and promote positive mental health and flourishing against the loss of good mental health and mitigation of the risk of future ill health. Population studies indicate that even though a majority of the adult population reports being free from mental health disorders, a much smaller percentage reports experiencing high positive mental health or flourishing. The National FinHealth 2017 Study carried out in Finland (Solin et al. 2018), for example, showed that almost 70% of the respondents had a moderate level of positive mental health, but only 14% had a high level of positive mental health. Respondents that were 60 years old or older seemed to have higher positive mental health than younger respondents. Similar results were reported in a mental health survey conducted in the Lapland region in Finland (Solin et al. 2019): 71% of the participants had moderate positive mental health and 17% high positive mental health. Research shows that moderately mentally healthy and languishing adults have significant psychosocial impairment and poorer physical health than those who are flourishing (Benyamini et al. 2000; Pettit et al. 2001; Keyes et al. 2005b; Keyes & Annas 2009). According to a study by Keyes & Simoes (2012), the absence of positive mental health increased the probability of all-cause mortality for men and women at all ages after adjusting for known causes of death. Furthermore, the 2011 Health Survey for England results (Taggart et al. 2016) showed that mental

well-being was generally lower among people with health conditions (e.g. cardiovascular disease, diabetes, hypertension, chronic pain).

There is also growing evidence on the relationships between positive mental health and lifestyle factors and health behaviour. Research has shown positive mental health to be associated with improved sleep, exercise and diet (Pressman & Cohen 2005; Mental Health Foundation 2006). Smoking and fruit and vegetable consumption have been found to be associated with both low and high positive mental health in both sexes; fruit and vegetable consumption, for example, was associated with increased odds of high mental well-being and reduced odds of low mental well-being (Blanchflower et al. 2013; Stranges et al. 2014). Furthermore, physical activity has been shown to have a relationship with positive mental health, showing some potential benefits in increasing the level of positive mental health (Richards et al. 2015; Zhang & Chen 2019). Tamminen and partners (2020) found that physical inactivity was strongly associated with low levels of positive mental health. The causality of these observed relationships could not, however, be established due to the cross-sectional nature of the studies. Interestingly, research suggests that associations with a low level of positive mental health follow a different pattern than associations with a high level of positive mental health (Stranges et al. 2014; Stewart-Brown et al. 2015; Ng Fat et al. 2016). To give an example, differences between predictors of the low end of the positive mental health scale with the high end of the positive mental health scale have been found with such health behaviours as diet, smoking and alcohol consumption (Stewart-Brown et al. 2015).

The importance of positive mental health is supported by research evidence demonstrating the cost-effectiveness of actions to promote positive mental health (Knapp et al. 2011; Clark et al. 2018). There is growing evidence of actions targeted especially at children and adolescents that have been shown to be good value for money (Zechmeister et al. 2008; Knapp et al. 2011; Reini 2016; McDaid et al. 2019). Furthermore, some workplace interventions have been shown to be cost-effective; improved positive mental health at the workplace, for example, can help employees stay at work (less sickness and absenteeism) and achieve their full productive potential (less presenteeism, or lost productivity while at work). In addition, interventions promoting positive mental health can generate significant savings in public health expenditures, such as reductions in health and social care costs (Knapp et al. 2011; Clark et al. 2018).

In order to focus mental health promotion and public mental health actions on improving positive mental health, appropriate measurements need to be available. Public mental health has been hampered by a lack of valid instruments suitable for measuring positive mental health in the general population or able to evaluate projects, programmes and policies which aim to improve positive mental health. As a result, the development of a suitable instrument was commissioned by NHS Health Scotland. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS), which measures positive

mental health at the population level, is based on the conceptualisation of positive mental health as feeling good and functioning well (Taggart et al. 2016). The WEMWBS consists of 14 positively worded items covering positive affect (feelings of optimism, cheerfulness, relaxation), satisfying interpersonal relationships, and positive functioning (energy, clear thinking, self-acceptance, personal development, competence and autonomy). Respondents rate their feelings over the previous two weeks from 1 (none of the time) to 5 (all of the time) on statements such as 'I've been feeling optimistic about the future', 'I've been feeling useful', 'I've been dealing with problems well', 'I've been thinking clearly', 'I've had energy to spare', 'I've been feeling close to other people', and 'I've been interested in new things', leading to a score between 14 and 70. The higher scores represent higher levels of positive mental health (Tennant et al. 2007). There is also a shorter, 7-item version of the scale (SWEMWBS). Research that has used the WEMWBS scale to measure positive mental health has found positive mental health to be associated, among other things, with better self-rated states of health, higher levels of physical activity, higher levels of perceived social provisions, better functional capacity, and positive health behaviours (Stranges et al. 2014; Appelqvist-Schmidlechner et al. 2017; Appelqvist-Schmidlechner et al. 2020; Tamminen et al. 2020).

2.5 Frameworks for mental health promotion

Mental health promotion is a multidisciplinary approach, which is why mental health promotion practice is informed by a number of theoretical frameworks (VicHealth 2009). Mental health promotion is often understood as a broader umbrella term and an overarching approach to the overall goal of promoting mental well-being. Related, but conceptually distinct is the prevention of mental health disorders. The prevention of mental health disorders and the promotion of mental health are separate notions but with overlapping boundaries (WHO 2004; WHO 2005b; Tamminen et al. 2016). Mental health promotion focuses on positive mental health, and its aim is to increase psychological well-being, competence and resilience, and to create supportive living conditions and environments. In contrast, mental health disorder prevention targets the reduction of the incidence (primary prevention) and prevalence (secondary prevention), or seriousness (tertiary prevention), of targeted mental health problems and disorders (WHO 2004; Tamminen et al. 2016). It may use mental health promotion strategies as one of the means to achieve these goals. The two areas thus have different starting points and they seek to effect different outcomes. However, there is some common ground between the two fields, especially with regard to primary prevention and mental health promotion interventions. Furthermore, mental health promotion, with its aim of enhancing positive mental health in the community, may also have the secondary outcome of decreasing the incidence of mental health disorders, as positive mental health can serve as a strong protective factor against mental ill health (WHO 2004).

One of the well-known and commonly used prevention frameworks was proposed by Mrazek and Haggerty (1994). This framework, called the mental health intervention spectrum for mental disorders, was depicted as a half circle, in which prevention activities were placed in the wider intervention spectrum of treatment and maintenance (also including rehabilitation). Three main categories of prevention activities were identified: universal, selective and indicated prevention (see Table 3).

TABLE 3 Definitions of universal, selective and indicated prevention (Mrazek & Haggerty 1994; Lahtinen et al. 1999; WHO 2004)

Universal prevention is defined as those interventions that are targeted at the general public or a whole population group that has not been identified on the basis of increased risk.
Selective prevention targets individuals or subgroups of the population whose risk of developing a mental disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors.
Indicated prevention targets high-risk people who are identified as having minimal but detectable signs or symptoms of a mental disorder or biological markers indicating a predisposition for a mental disorder but who do not meet diagnostic criteria for the disorder at that time.

The mental health intervention spectrum for mental disorders framework articulates the different types of prevention, but it does not include interventions that focus on promoting positive mental health. However, the universal prevention activities outlined in the framework and mental health promotion activities seem to overlap considerably. Barry (2001) included mental health promotion in the Mrazek and Haggerty (1994) prevention framework, completing the circle. Some examples of core concepts of mental health promotion, such as competence, are specified in this area. The competence approach embraces an emphasis on psychological strengths and resilience thus the goal being enhancing rather than focusing on reducing disorders (Barry 2001). The amended circle depicts mental health promotion as the largest part of the circle, given its universal relevance. The circle demonstrates the relationship between the different interventions and indicates the unifying central area between them as being strategies for promoting well-being and quality of life. The modified mental health intervention spectrum is presented below (Figure 3).

FIGURE 3 The modified mental health intervention spectrum (Barry 2001) (Adapted from Barry (2001) and reprinted by permission of the International Journal of Mental Health Promotion).

As stated earlier, mental health is an integral part of overall health and, therefore, it is of universal importance to all. A health promotion framework locates mental health within this holistic, salutogenic definition of health. The health promotion approach can be considered as a guide for the promotion of mental health, drawing attention to individual, social and societal factors that influence mental health. Health promotion is understood to be the process of enabling people to increase and improve their health (WHO 1986). Mental health promotion endorses a competence enhancement perspective and seeks to address the broader determinants of mental health, thus pertaining to the fundamental principles of health promotion (WHO 1986). Following the framework of the Ottawa Charter for Health Promotion (WHO 1986; Jané-Llopis et al. 2005; Eriksson & Lindström 2008; Barry et al. 2019), mental health promotion includes:

- building healthy public policy to support positive mental health,
- creating environments that support positive mental health,
- strengthening community action to achieve positive mental health,
- developing mental health literacy and personal skills, and
- reorienting health services towards mental health promotion.

Building healthy public policies puts mental health and mental health promotion on the agenda of all policymakers with the goal of helping different sectors to identify common, mental health-supporting aims and coordinated action across the sectors (Jané-Llopis et al. 2005; Barry et al. 2019). Political decisions have an effect, for example, on how safe people feel, their income, and their trust in institutions (EU Joint Action on Mental Health and Well-being 2015). Creating supportive environments emphasises the influence of wider social, physical, cultural and economic factors on mental health. The importance of mediating structures and everyday settings such as the home, schools, workplaces and community settings as key contexts for creating and promoting positive mental health is recognised. Strengthening community action emphasises the empowerment and participation of communities in identifying their needs, setting priorities, and planning and implementing actions to achieve positive mental health. In addition, relations to others, trust and support networks create social well-being. Developing mental health literacy and personal skills includes enabling personal and social development through providing information and education, and enhancing life skills, for mental health. Reorienting health services towards mental health promotion requires that health services embrace the importance of mental health for overall health and well-being, and that mental health services include promotion and prevention strategies as well as treatment and rehabilitation (Jané-Llopis et al. 2005; Barry et al. 2019).

The health promotion framework provides a distinctive conceptual model for mental health promotion that is underpinned by the socio-ecological perspective (Bronfenbrenner 1979). The socio-ecological approach acknowledges the importance of the wider socio-environmental influences and nested systems for the promotion of mental health (Barry et al. 2019). These interconnected, socially organised environments range from the micro, meso, exo and macro levels, with each level inside the next (Bronfenbrenner 1979). Thus, mental health can be promoted at individual, family, social group or community, and broader society levels (Lahtinen et al. 2005; Barry et al. 2019). The evidence suggests that a strategic and effective approach to mental health promotion comprises a balance of multiple actions and working at multiple levels: developing individual coping skills, promoting social support and community networks, and addressing structural barriers to mental health in areas such as education and employment (Jané-Llopis & Barry 2005; Jané-Llopis et al. 2005; Barry 2007b).

The health promotion approach underscores the need for integrated multilevel action and intersectional collaboration and partnerships between different sectors (including but not exclusive to health) of society. The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders (VicHealth 2009) also followed the health promotion principles and recommendations, and recognised the interconnecting influence of social, economic, cultural, environmental and personal determinants on

mental health and well-being. The charter stressed that mental health promotion is everybody's concern and responsibility; that mental well-being is best achieved in equitable, just and non-violent societies; and that mental health is best promoted through respectful, participatory means where culture and cultural heritage and diversity are acknowledged and valued (VicHealth 2009).

Based on the adoption of a health promotion framework, Barry and colleagues have identified several key principles of mental health promotion (Barry 2007b; Barry et al. 2019). Mental health promotion:

- involves the population as a whole in the context of their everyday life, rather than focusing on people at risk of specific mental health disorders,
- focuses on protective factors for enhancing well-being and quality of life,
- adopts a life course approach to improve mental health,
- addresses the social, physical and socioeconomic environments that determine the mental health of populations and individuals,
- adopts complementary approaches and integrated strategies, operating from the individual to socio-environmental levels,
- involves intersectoral action and partnership working across sectors and extending beyond the health sector,
- is based on public participation, engagement and empowerment (embraces an empowerment philosophy), and
- addresses inequalities.

The above principles can be seen to capture the core of mental health promotion and guide the actions to promote positive mental health.

This chapter presented key concepts and principles and frameworks of mental health promotion providing theoretical perspectives on the issue. The importance of mental health and the promotion of mental health were discussed. The discourse provides background for the next chapter in which research on mental health promotion competencies is scrutinised and an overview of the mental health promotion workforce in Finland is given.

3 COMPETENCIES FOR MENTAL HEALTH PROMOTION BASED ON EARLIER LITERATURE

In this chapter, the concept of competence is explained; what competence means and what it comprises. Furthermore, research on mental health promotion competencies is viewed followed by descriptions of mental health promotion workforce operating in the health sector in Finland.

3.1 Research on mental health promotion competencies

Competence can be conceptualised in different ways. The Oxford English Dictionary defines competence (equal to competency) as 'the ability to do something successfully or efficiently' (2020). According to Shilton et al. (2001), competencies are a combination of attributes – such as knowledge, abilities, skills and attitudes – that enable an individual to perform a set of tasks to an appropriate standard. Public Health England has outlined competence as 'the ability to apply knowledge, skills and values effectively in practice' (2015, p. 5). Glaesser (2019) reviewed the current usage of the concept of competence in academic research, highlighting its different meanings. She underlined the significance of context, namely, that competencies relate to situations and demands in specific domains. Hager and Gonczi (1996) also emphasised the importance of context. They presented an integrated conception of competence as 'conceptualised in terms of knowledge, abilities, skills and attitudes displayed in the context of a carefully chosen set of realistic professionals tasks which are of an appropriate level of generality' (1996, p. 15). This view considers competence as consisting of more than just a series of tasks; competence is a series of desirable attributes in the kinds of contexts in which they are employed in the practice of an occupation. In a health promotion context, Barry et al. (2012, p. 649) applied a description of competencies that defined competencies as 'a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion'. The EU

Lifelong Learning programme defined competence as 'the proven ability to use knowledge, skills and personal, social and/or methodological abilities, in work or study situations and in professional and personal development' (European Parliament and Council of the EU 2008, p. 4). The Key Competences for Lifelong Learning (European Commission 2019, p. 5) identified knowledge, skills and attitudes as key competences and outlined them as follows:

- *knowledge* is composed of the concepts, facts and figures, ideas and theories which are already established, and support the understanding of a certain area or subject,
- *skills* are the ability to carry out processes and use the existing knowledge to achieve results, and
- *attitudes* describe the disposition and mindset to act or react to ideas, persons or situations.

The above descriptions of competence emphasise the domains of knowledge, skills and attitudes. This categorisation of three domains of learning originates from Bloom's learning taxonomy: cognitive domain (knowledge), psychomotor domain (skills) and affective domain (attitudes) (Bloom et al. 1956; Krathwohl et al. 1964; Simpson 1972; Anderson et al. 2001).

Knowledge is also sometimes divided into two components: theoretical knowledge and practical knowledge. *Theoretical knowledge* includes the concepts, facts and theories of a subject or topic (such as mental health promotion), as identified in the Key Competences for Lifelong Learning described above (Bereiter & Scardamalia 1993; Katajavuori et al. 2006; Tynjälä 2008; European Commission 2019, p. 5). *Practical knowledge* or *skills*, as it is also referred to, is the competence to put theoretical knowledge into practice (Bereiter & Scardamalia 1993; Tynjälä 2008). Practical knowledge is gained through doing things, whereas theoretical knowledge is gained, for example, via books or lectures. In this thesis, the terms 'theoretical knowledge' and 'practical skills' are used to make the distinction between knowledge and skills clear.

The affective or attitudes domain in Bloom's taxonomy also included values as dealing with things emotionally and valuing something (Krathwohl et al. 1964). *Values* are described as the beliefs, traditions and social customs held dear and honoured by individuals and collective society. Both *attitudes* and *values* may change as individuals gain life experience (Public Health Agency of Canada 2008).

Earlier research on competencies related to mental health and health promotion has been carried out, albeit not extensively. Here, an overview of well-known competency initiatives is presented starting with health promotion setting and proceeding to public mental health and mental health promotion specifically. Barry et al. (2012) identified 11 domains of core competencies for health promotion in their study, articulating the necessary knowledge, skills, and abilities that are required for effective practice. The core domains were

based on the multidisciplinary concepts, theories, and research that make health promotion distinctive. Ethical values such as belief in equity and social justice, and collaborative and consultative ways of working, together with health promotion knowledge, were seen to underpin all health promotion actions detailed in the other nine domains. The other core competencies were: enabling change, advocating for health, mediation through partnership, communication, leadership, assessment, planning, implementation, and evaluation and research. Each domain dealt with a specific area of health promotion practice. In Canada, Pan-Canadian Health Promoter Competencies were developed in 2015 (Health Promotion Canada 2015). The development process was based on online surveys, review of literature and other consultation processes. Core values and principles – such as commitment to equity, civil society and social justice, and respect for cultural diversity and sensitivity – guided the development of the competencies. The Health Promoter Competencies framework was based on a social-ecological model of health that takes into account the cultural, economic and social determinants of health. Nine domains of competencies were identified: health promotion knowledge and skills, situational assessments, planning and evaluating health promotion action, policy development and advocacy, community mobilization and building community capacity, partnership and collaboration, communication, diversity and inclusiveness, and leadership and building organizational capacity. The Pan-Canadian Health Promoter competencies and the health promotion competencies identified by Barry and colleagues (2012) included similar competency domains such as ethical values of equity and social justice, and skills of planning and evaluating health promotion actions. In addition, partnership and collaboration were acknowledged as key competencies in general health promotion.

Competency development work in public mental health was done in England, where a national framework for leadership and workforce development was introduced in 2015 as a result of a wide consultation and research process (Stansfield 2015). The purpose of the framework was to help develop public health leadership and workforce capability in mental health. The framework was developed in local contexts, together with national partners and the local public health workforce, responding to local needs and national policy. The overall aim of the framework was to build the capacity and capability of leaders and a workforce that is confident, competent and committed to 'promoting good mental health across the population', 'preventing mental illness and suicide', and 'improving the quality and length of life of people living with mental illness' (Stansfield 2015, p. 181). The competencies focused on three key groups: leaders, public health specialists and frontline staff. The framework outlined six key ambitions for change, focusing on advocacy, expertise, community empowerment, promotion, prevention and parity. In addition, 12 core principles for mental health across the workforce were suggested, identifying the core knowledge, values and skills required to improve mental health. These core principles or competencies included knowledge-based domains, such as knowing how mental health is a positive

asset and resource to society and knowing what works to improve mental health and prevent mental health problems within one's own area of work. Value-based domains were, among others, principles such as appreciating that there is no health without mental health and that the mind and body work as one system, commitment to a life course approach, and investment in healthy early environments. Communicating effectively with children, young people and adults about mental health, considering social inequalities in the work and acting to reduce them, and empowering others were, among other things, suggested as skill-based principles.

With relation to mental health promotion competencies specifically, Greacen and partners (2012) carried out a study producing European guidelines for training social and health care professionals in mental health promotion. The project identified the following ten quality criteria for training:

1. embracing the principles of mental health promotion,
2. empowering all community stakeholders for effective involvement,
3. adopting an interdisciplinary and intersectoral approach,
4. including people with mental health problems,
5. advocating,
6. consulting the knowledge base,
7. adapting interventions to local contexts and needs in a holistic, ecological approach,
8. identifying and evaluating risks,
9. using the media, and
10. evaluating training implementation and outcomes.

The first of these criteria underlines the fact that training programmes in this area need to embrace the principles of mental health promotion as distinct from mental health disorder prevention or curative care. The criteria also emphasise what kinds of actors need to be involved in mental health promotion: all community stakeholders and a wider network of partners via an interdisciplinary and intersectoral approach. Lang et al. (2016), on the other hand, developed a scale in their research to identify the training needs of mental health promotion implementers across different settings.

Following the Ottawa Charter for Health Promotion framework (WHO 1986) and its five areas of action, Barry (2007a) suggested skills that are needed for mental health promotion: 1. actions to build healthy public policy to support mental health require high-level policy and advocacy skills, and the capacity to influence inter-governmental policies and structures; 2. actions to create mental health supportive environments call for skills of working at the level of settings and adopting a systems-based approach to practice; 3. strengthening community action to achieve positive mental health entails community development skills to strengthen public participation and empowerment; 4. developing mental health literacy and personal skills involves practice skills in implementing competence enhancement programmes; and 5. reorienting health

services towards mental health promotion requires attention to the organisation and structure of health services and the training and education of the broader health workforce.

These efforts and the developments described above add valuable knowledge and understanding to the domain of mental health promotion and related competencies. Nevertheless, there is a scarcity of research on competencies specifically related to mental health promotion (Greacen et al. 2012; Lang et al. 2016). Among the few studies is an Australian one that investigated the programme evaluation skills of mental health promotion workers (Reupert et al. 2012). One of the identified competency themes related to both knowledge and attitudes was the understanding and appreciation of the importance of planning and evaluation in mental health promotion programme development. It was recognised that programme evaluation skills support programme development and strengthen the evidence base of mental health promotion programmes. Collaboration was also identified as a relevant competency theme in the study. In a similar way, interdisciplinary and intersectoral working skills were identified as important competencies by Thomas et al. (2016) who investigated mental health promotion and mental health disorder prevention in general practice in the UK. They proposed several competency-based recommendations to general practice: communication skills, knowledge of the risk and protective factors of mental health, and a holistic approach both towards patients and in the practice in general. Doyle et al. (2018) examined mental health promotion and wellness aspects in the context of mental health nursing practice in five European countries. Competencies related to knowledge, skills and attitudes required by master-level mental health nurses to practice were identified. Knowledge of positive mental health and an understanding of the salutogenic approach to mental health were recognised as important competencies. Furthermore, the skill to plan appropriate and needs-based mental well-being interventions to patients and adopting a client-based open attitude and approach in one's practice were considered important. Jormfeldt and partners (2018) also investigated master's level mental health nursing competencies dividing them into knowledge, skills and attitudes. Knowledge of the duty of mental health nurses to promote mental health in mental health service users; skills of teamwork and collaboration; and engagement in person-centred nursing practice to promote overall health were identified, among others, as needed competencies by master's level mental health nurses. A Finnish study on school nurses (Anttila et al. 2020), on the other hand, found communication skills and interaction skills, such as establishing social relations with adolescents, to be necessary in mental health promotion practice in schools. These earlier studies provide worthwhile, albeit partial, evidence of the possible competencies for mental health promotion work in health sector practice.

3.2 Mental health promotion workforce in the health sector in Finland

In Finland, mental health promotion work is scattered and carried out at various levels. Here, a brief overview of some of the main workforce is provided. This is to get a clearer picture of the professionals involved with mental health promotion work and needing competencies in mental health promotion.

In Finland, health promotion is based on the Health Care Act (Health Care Act 1326/2010 2010) and is part of public health activity. The Act includes actions to strengthen mental health and states that local authorities shall assign coordinators for health and welfare promotion. These coordinators are responsible for the promotion of health and well-being in partnerships with other sectors and actors in the municipality, as well as with regional actors. Their role may include reporting to the municipality's management team on the well-being situation, ensuring partnerships and co-operation, dissemination of examples of good practice, organising training, communication and supporting the implementation of national health promotion and welfare programmes (Paahtama 2016).

The objective of the government of Finland regarding the health and social services reform is to reinforce primary-level services and to shift the emphasis towards preventive work (Finnish Government 2020; Finnish Institute for Health and Welfare 2020b). To promote the attainment of this objective, a development programme for the future health and social services centres has been launched. As part of the shift towards preventive work, various implementation models have been proposed, many of them including the promotion of mental health (Finnish Institute for Health and Welfare 2020c). This reform is implemented in the form of regional development projects carried out around Finland (Finnish Institute for Health and Welfare 2020b). Among the responsibilities of primary healthcare and health centres is the promotion of well-being and health, including mental health (Ministry of Social Affairs and Health 2020c). Currently, mental health work and mental health services concentrate on prevention of mental health disorders, early diagnosis, treatment and rehabilitation (Ministry of Social Affairs and Health 2020a). The expectation is that promotion and prevention work will gain a stronger role, thus creating a push for a more salutogenic and mental well-being-based approach. Workforce to carry out the preventive and promotive work may be needed to be employed.

In relation to a more specific workforce, mental health nurses across all communities and settings have a role in the promotion of mental well-being (Kivelä 2016; Doyle et al. 2018). Mental health promotion in the school context implemented by psychiatric nurses is a relatively new approach in Finland (Päätalo 2012). Psychiatric nurses (comprehensive school level) have both promotive and preventive mental health-related activities as part of their work

role in schools. Their practice involves, among other things, sharing information, low-threshold functions, collaboration, support for parenthood and personalised support for pupils. Also, public health nurses in schools and school psychologists have responsibilities for the promotion of the mental health and well-being of school children and adolescents (Hietanen-Peltola et al. 2018; Putkuri et al. 2021). With regards to public health nurses in general, the promotion of mental health is a statutory part of their work in Finland (Government Decree 338/2011 2011).

In Finland, non-governmental organisations (NGOs) have traditionally played a significant role in promoting the health and well-being of people, including positive mental health. NGOs develop implementation models and provide activities and services in people's everyday settings, offering opportunities for participation and leisure-time activities (Lyytikäinen et al. 2017). Positive mental health is supported via community participation and interaction, as well as targeted mental health promotion actions. There are currently around 13,000 registered NGOs in Finland that operate in social and health-related areas (Finnish Institute for Health and Welfare 2020a). Many of them work in the mental health and mental health promotion sphere (Mielenterveyspooli 2021). Their activities include providing information, training and activities on mental health and well-being, and mental health promotion, organising volunteer activities, and providing support in crisis situations, among others.

The above examples provide a glimpse of the kind of workforce operating in mental health promotion in the health sector in Finland. Further examples are illustrated in Figure 4.

There is also a wider workforce across different sectors (e.g. health, education, employment, environment, housing), which plays an important role in promoting the mental health and well-being of all people. These comprise such professions and roles as school welfare officers, workplace mental health promoters, youth workers, and environmental planners.

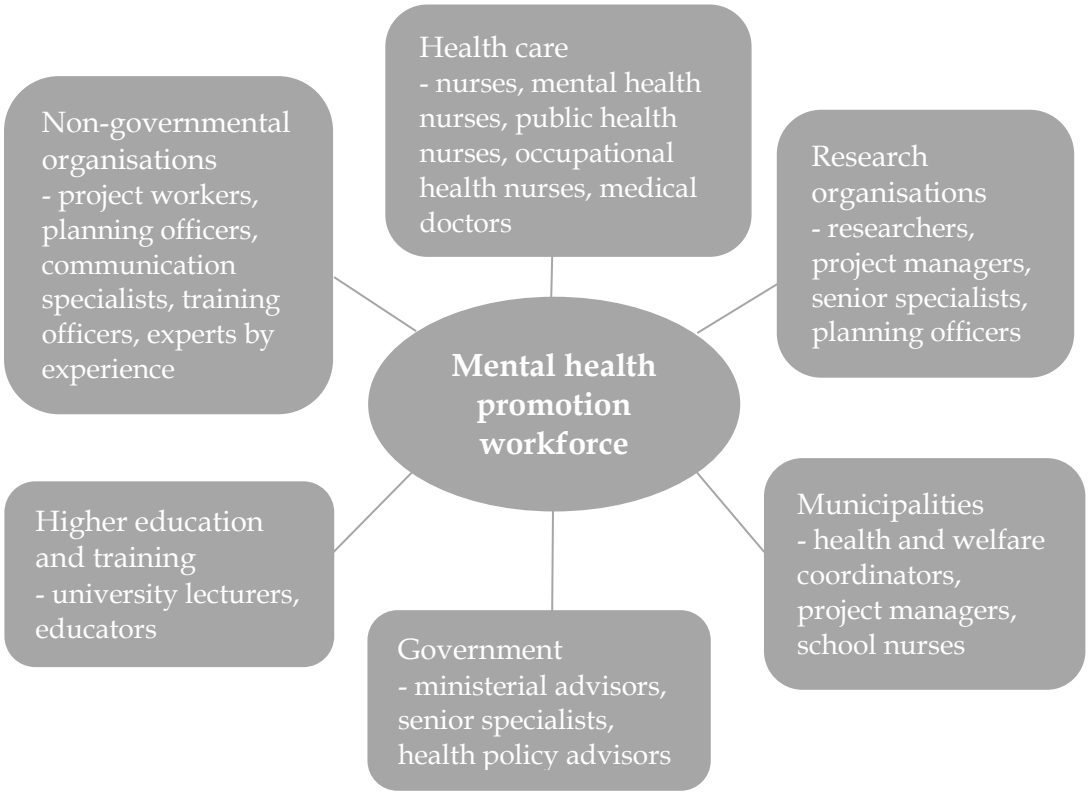

FIGURE 4 Examples of mental health promotion workforce in the health sector in Finland.

3.3 Rationale for the study

In the previous sections, concepts and principles of mental health promotion and mental health promotion competencies were discussed. Furthermore, research on the area was introduced. The purpose was to provide context and rationale for the current study.

The reviewed literature and investigations of the subject matter have demonstrated the importance of mental health for population well-being (e.g. VicHealth 2009; WHO 2013a) and the significant role of mental health promotion to achieve better population mental health (e.g. Jané-Llopis et al. 2005; Barry et al. 2019). Furthermore, it was acknowledged in the literature that a skilled workforce is needed to provide efficient mental health promotion practices in the health sector, and more importantly, that there is a shortage of professionals that are competent in providing and implementing mental health promotion (e.g. Barry 2007a; Lindert et al. 2017).

In order to train professionals effectively, it is necessary to determine the competencies that are required in mental health promotion work. The examination of the literature here revealed that systematic information on the

competencies needed for mental health promotion in the health sector is currently lacking, and require further investigations. As a consequence, this study was designed.

4 AIMS OF THE STUDY

The aim of this study was to investigate competencies for mental health promotion and to determine what mental health promotion competencies are needed in health sector practice. The main aim was divided into four specific research questions:

1. How were mental health promotion concepts defined in current scientific literature and policy papers? (Study I)

2. What were the views of professionals regarding mental health promotion and related competencies needed in health sector practice? (Study II)

3. What were the competencies for mental health promotion practice, and what kinds of practices were specific, in the health sector based on a Delphi study? (Study III a & b)

4. What were the experience-based views of experts by experience on the mental health promotion competencies (Study IV, unpublished results)

5 METHODS

5.1 Study design

This thesis is based on four successive studies with different designs to answer the research questions of the study; the first two studies were qualitative investigations, and the third and fourth studies used mainly qualitative approaches with some quantitative elements. In Study I, the nature and characteristics of the concept of mental health promotion were explored by means of conducting a literature review. The study also investigated how these characteristics appear in current policies and strategies. The results provided a frame of reference and guidance on what questions to include in Study II. Study II employed focus groups and an open-ended questionnaire survey to examine the views of mental health professionals regarding mental health promotion-related competencies. By employing data collection methods such as focus groups, it was possible to explore qualitative data and gain deep insights into and understanding of the issue. The questionnaire survey allowed wider participation from the professionals. The two different data collection methods were used to increase trustworthiness of the study (Mays & Pope 2006; Bengtsson 2016; Tolley et al. 2016). Furthermore, the data sets acquired through the two methods supported each other.

For Study IIIa, a Delphi survey was carried out to facilitate a consensus-building process on the identification of the mental health promotion competencies. The Delphi method was chosen, as it is an approach commonly used to gain consensus among a panel of experts on a complex issue or when there is a lack of knowledge (Linstone & Turoff 2002; Jorm 2015). It has also been widely applied in health and mental health research (de Meyrick 2003; Barry et al. 2012; Jorm 2015). The Round 1 questionnaire in the Delphi survey was based on the results of Study II. The Delphi questionnaire included also open questions. The descriptive data from the open responses in the Delphi survey revealed that intersectoral collaboration and partnership work and

related competencies are highly emphasised in mental health promotion practice. As a result, in Study IIIb, the open answers from the Delphi survey were used to investigate how intersectoral collaboration and partnership work are constructed and adopted in mental health promotion practice. Finally, a focus group meeting in Study IV with experts by experience was carried out to discuss their assessments on the identified competencies and to examine whether any adjustments needed to be made as a result.

The study design is presented in Figure 5. (The individual designs are described in detail in the original articles.) This doctoral study's ethical acceptability followed the guidance of the University of Jyväskylä Ethical Committee; the Committee confirmed that no ethical statement was required.

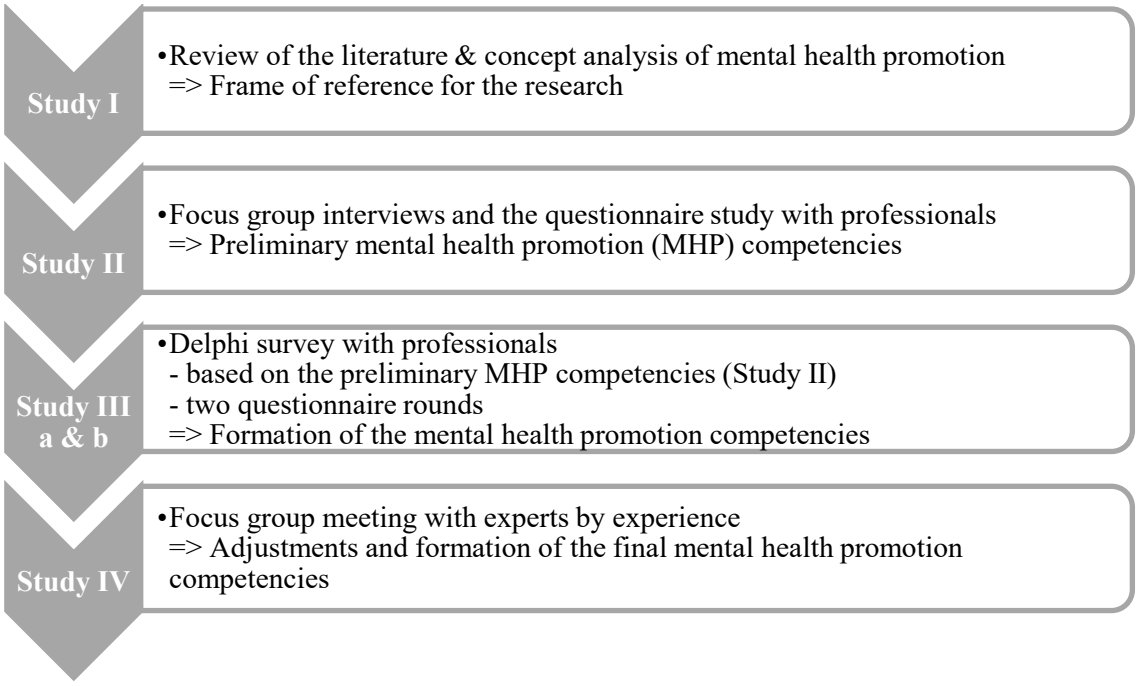

FIGURE 5 The study design.

5.2 Data collection and participants

The data in Study I was collected in November 2013 via a literature search in several electronic databases (EBSCO, Medline, Web of Science, ASSIA, Google Scholar). *Mental health promotion* and *promotion of mental health* were used as keywords for the literature search, as they appeared in the title or abstract. The search was subsequently narrowed down by combining each keyword separately with words *concept* and *definition* using the Boolean operator AND (except for Google Scholar). The search was limited to texts written in English with no time limit. All titles and abstracts retrieved were scanned for relevance and eligibility, that is, whether they were dealing with definitions or concepts of mental health promotion or promotion of mental health. Duplicates and articles

not relevant or not meeting the inclusion criteria were removed. Research articles were also searched manually from the International Journal of Mental Health Promotion. Furthermore, reference lists were examined via the snowball technique (Booth et al. 2016) for any relevant literature not identified through the electronic databases. As a result, 20 research articles were initially identified. Repeated searches in 2014 and 2016 to update the results produced three further articles. In addition, seven (7) high-level policy and strategy documents in mental health – six (6) international and one (1) from Finland (English-translated version) – were included in the data. As a consequence, the final data set comprised 30 texts. Figure 6 presents the search process in more detail in PRISMA flowchart (Page et al. 2021).

In Study II, the data were collected via two (2) focus groups and a questionnaire survey with professionals working in the health sector in Finland. Purposive sampling was applied to gain knowledge pertaining to the aims of the research (Tolley et al. 2016). The sample included participants that represented wide practical expertise in mental health and mental health promotion in the health sector. The focus groups comprised 13 professionals (females=11, males=2): five (5) senior experts working in mental health promotion development and research areas, and eight (8) mental health professionals conducting further academic studies in mental health. The interviews were carried out in spring 2014 and autumn 2015 (duration 90 and 100 minutes). A thematic-based interview guide was used (Appendix 1). The interviews were recorded and transcribed verbatim (46 pages in total).

The survey in Study II consisted of an open-ended questionnaire (Appendix 2) that followed the thematic structure of the focus group interviews. The questionnaire was distributed by hand to 70 health professionals working in mental health-related practice and attending the final seminar of the National Mental Health Programme (Ministry of Social Affairs and Health 2010) held in Helsinki December 2015. The professionals represented healthcare, higher education, non-governmental organisations, and health development and research areas. Ten (10) questionnaires were received. In order to attain a sufficient amount of data, purposive sampling was used to select information-rich cases (i.e. participants who were expected and/or known to have knowledge on the subject matter) (Tolley et al. 2016). As a result, further 14 high-level mental health professionals were approached via email or in person in January 2016, and asked to fill in the questionnaire; ten (10) of these answered the questionnaire. Altogether, questionnaires from 20 participants (female=13, male=7) were received and transcribed (41 pages in total).

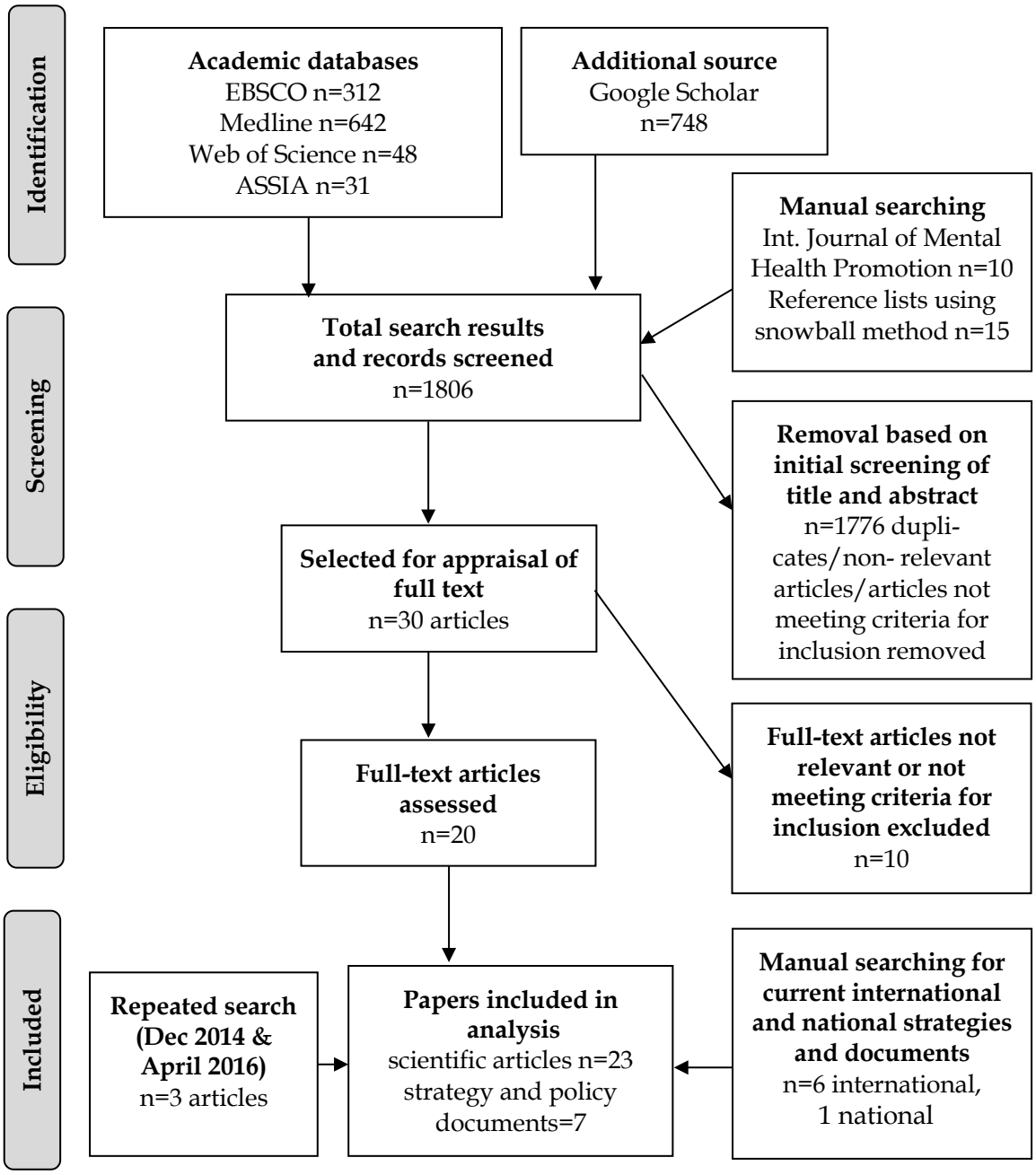

FIGURE 6 PRISMA flowchart of the literature search process (Page et al. 2021).

For Studies III a and b, the data was received from a Delphi survey conducted in spring 2017. Again, purposive sampling was applied; invitations to participate in the Delphi survey were sent to 43 health sector professionals that had been identified as having experience in mental health and/or mental health promotion. Initially, 38 experts registered with the online survey (eDelphi.org), which was used for the data collection. Eventually, 32 panel members (female=27, male=5) answered the questionnaire in Round 1 (response rate 74.4%) and 27 (female=22, male=5) in Round 2 (response rate 62.8%). The panel members represented a wide range of expertise areas in mental health

promotion: 15 experts worked in the public sector (mental health care of municipalities, health promotion in municipalities, research organisations, the Ministry of Health and Social Affairs), 12 experts in the third sector (NGOs with expertise in grassroots intervention, advocacy, experts by experience work, research and development work), and 5 experts in the private sector (the higher education system). The survey comprised two (2) Delphi rounds; both questionnaire rounds included five-point Likert scales as well as space for open responses from the panel members. The Round 1 questionnaire (Appendix 3) was based on the results of Study II and complemented with further literature review and discussions within the research group. The questionnaire in Round 2 (Appendix 4) was formed according to the results of Round 1. In Round 1, the panel members were asked to indicate on a Likert scale the importance of the competencies, give reasons and justify their answers. They were also asked whether any of the competencies should be removed or new ones added. In Round 2, the panel members assessed their level of agreement with each main competency statement, again using a five-point Likert scale. For Study IIIb, the open responses in the Delphi survey formed the study data. Figure 7 presents the Delphi process.

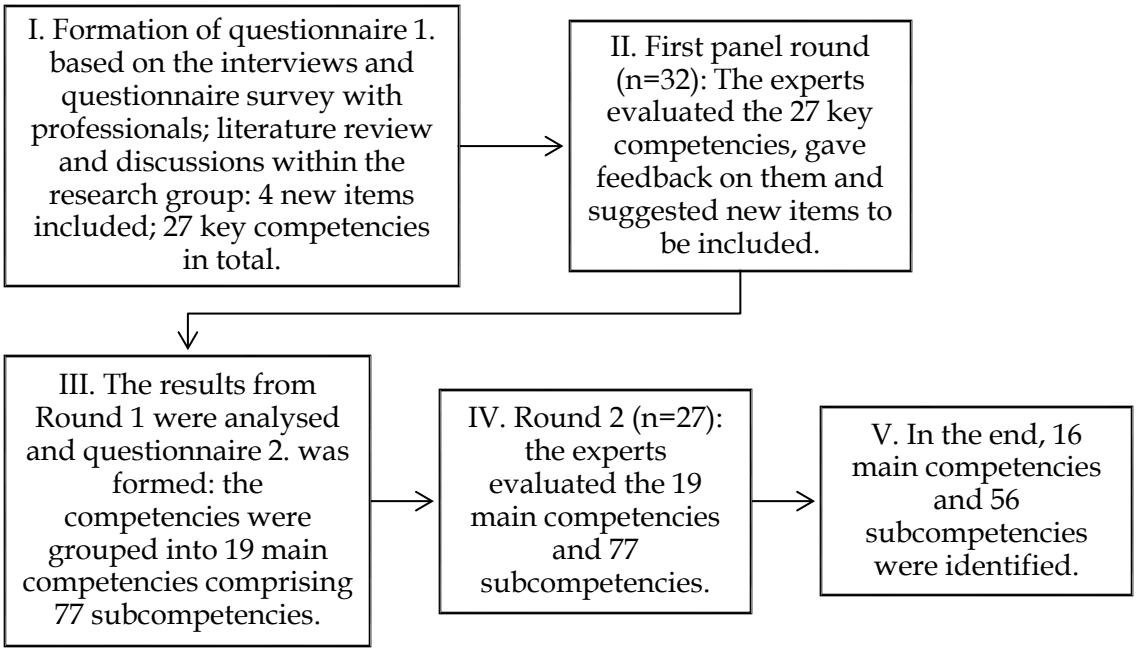

FIGURE 7 The Delphi process.

Further data (unpublished) was collected from a focus group meeting with experts by experience in Study IV. Organised in autumn 2018 was a meeting that ten (10) experts by experience attended (female=7, male=3). The term 'Expert by experience' is used to describe people with lived experience of mental health or other health problems and it usually refers to roles beyond the immediate experience of being a service user or carer when that expertise is deployed in other situations (for example, for contributing to teaching,

research, policy consultation or service improvement) (Curran et al. 2015; Horgan et al. 2020). The attendants' expertise of lived experience was mainly mental health problem related; two also had lived experience of physical ill health. All participants had attended formal training in experts by experience programme and worked in various development worker roles in the field. The participants were asked to fill in a questionnaire where they assessed the importance of each competency using a five-point Likert scale (1=not at all important, 5=very important) (Appendix 5). The discussion of the focus group session was also recorded (duration 109 minutes) and transcribed verbatim (32 pages).

5.3 Data analysis

In Study I, Rodgers's (1989; 2000) systematic evolutionary concept analysis method was used as theoretical framework for analysing the concept of mental health promotion. Rodgers' method was considered an appropriate approach, as it provided a methodological approach to explore the concept of mental health promotion through inductive inquiry and rigorous analysis. In addition, the method has been widely used in health sciences (e.g. Balwin 2008; Sykes et al. 2013; Pueyo-Garrigues et al. 2019).The analysis involved an in-depth exploration of the different definitions and understandings of mental health promotion in the literature. The method encompassed a systematic analysis and identification of key elements of the concept: attributes, related concepts, antecedents, consequences, surrogate terms and references related to mental health promotion (Rodgers 2000). Attributes refer to the key characteristics that define the concept. Related concepts are those that have a relation to the concept being analysed (however, not sharing the same set of attributes). Surrogate terms are terms that are used interchangeably to express the same concept. Antecedents are events or incidents that either occur or are in place prior to the occurrence of the concept. Consequences, on the other hand, are events or incidents that occur as a result of the occurrence of the concept. References of the concept refer to actual situations where the concept is being applied (Rodgers 1989; Rodgers 2000). The analysis began with inductive content analysis to examine the data and identify main themes (Krippendorf 2003; Tolley et al. 2016). This was followed by thematic grouping based on the key elements. Subsequently, the data were systematically classified into relevant categories presented by Rodgers (2000).

For Study II, the transcribed texts from the focus groups and the questionnaire survey were analysed using the qualitative data analysis software Atlas.ti. Inductive content analysis was carried out with the purpose of an iterative process and ideas and themes emerging from the data (Krippendorf 2003; Graneheim & Lundman 2004; Tolley et al. 2016). This method was chosen as a systematic way to gain a depth of understanding and capture the richness of the phenomena of interest. Meaning units and text fragments containing

information about the research question were identified and labelled with codes that were relevant and meaningful to the study aims. Finally, the codes were compared based on similarities and differences and sorted into subcategories and main categories (Graneheim & Lundman 2004; Malterud 2012). The domains of learning by Bloom (Bloom et al. 1956; Krathwohl et al. 1964; Simpson 1972; Anderson et al. 2001) (discussed in chapter 3.1) had some influence on the categorisation at this stage, thus making the analysis partly deductive (Fereday & Muir-Cochrane 2006; Elo & Kyngäs 2008).

The Delphi survey data in Study IIIa were mainly analysed qualitatively with some quantitative measures. Quantitative analysis was used to measure the level of consensus for each competency. Consensus was agreed as occurring when at least 70 per cent of respondents scored 3.5 or more on the five-point Likert scale for each competency. This consensus level was considered appropriate for the study (Keeney et al. 2006; Barry et al. 2012). Furthermore, the open responses in the questionnaires were coded and analysed using qualitative content analysis (Krippendorf 2003). The data analysis software Atlas.ti was used to aid the analysis. The consensus scores together with the main themes arising from the content analysis formed the basis in each Delphi round for what competencies to retain, remove or modify and what new competency areas to include.

As the open responses in the Delphi survey were rich and versatile, and highlighted especially intersectoral collaboration and partnership work and related competencies in mental health promotion practice, a further study and analysis was carried out on this descriptive data. In Study IIIb, the descriptive data from both rounds of the Delphi survey were analysed using the data analysis software Atlas.ti. The analysis included two stages: 1. data-driven inductive analysis applying the thematic analysis method (Braun & Clarke 2006; Clarke & Braun 2014) and 2. an analysis-driven process where the findings from the inductive stage were organised according to a theoretical framework. In stage 1, the transcripts were read several times to become familiarised with the data and to identify items of potential interest. Meaningful units of text were coded and codes discussing similar ideas or issues were grouped into themes. In stage 2, the findings were identified and collated according to the study's research question, together with the theoretical framework of collaboration advantage outlined by Vangen and Huxham (Huxham 2003; Vangen & Huxham 2010).

The data from the focus group interview in Study IV were first analysed with quantitative methods to measure the mean Likert score and the Likert-score distribution (%) of each competency identified in the Delphi survey. Second, the transcribed discussion was thematically itemised around each identified competency. This content specification (i.e. 'theory') guided the analysis, thus reflecting the explicit content of the data (Clarke & Braun 2014; Tolley et al. 2016). The combined analysis aimed to identify the participants' scores and justifications for each competency and the rating given. This data complemented the data received from the Delphi survey.

An overview of the research and the original studies is presented in Table 4.

TABLE 4 Overview of the research

Research question	**Data collection**	**Data analysis**	**Original paper**
Study I			
How are mental health promotion concepts defined in current scientific literature and policy papers?	Systematic literature review	Concept analysis using Rodgers' systematic evolutionary concept analysis method	Tamminen, N., Solin, P., Barry, M. M., Kannas, L., Stengård, E. & Kettunen, T. 2016. A Systematic Concept Analysis of Mental Health Promotion. International Journal of Mental Health Promotion 18 (4), 177–198.
Study II			
What are the views of professionals regarding mental health promotion and related competencies needed in health sector practice?	Focus group interviews and a questionnaire survey	Content analysis	Tamminen, N., Solin, P., Stengård, E., Kannas, L. & Kettunen, T. 2019. Mental health promotion competencies in the health sector in Finland: a qualitative study of the views of professionals. Scandinavian Journal of Public Health 47 (2), 115–120. Article first published online: 12 July 2017.
Study III a, b			
What are the competencies for mental health promotion practice, and what kinds of practices were specific, in the health sector based on a Delphi study?	Delphi survey	Delphi questionnaire: - level of consensus measured (mean Likert scores and score distributions %) - open responses: thematic analysis	Tamminen, N., Solin, P., Kannas, L., Linturi, H., Stengård, E. & Kettunen, T. 2018. Mental health promotion competencies in the health sector based on a Delphi study. The Journal of Mental Health Training, Education and Practice 13 (6), 297–306. Tamminen, N., Solin, P., Barry, M. M., Kannas, L. & Kettunen, T. 2021. Intersectoral partnerships and competencies for mental health promotion: a Delphi-based qualitative study in Finland. *Submitted.*
Study IV			
What are the experience-based views of experts by experience on the mental health promotion competencies (Study IV unpublished results)	Focus group interview	Mean Likert scores and score distributions %; thematically itemised around each competency	*unpublished*

6 RESULTS

This chapter describes the key findings of the original studies, along with some previously unpublished results. First, chapter 6.1 presents the results of Study I: the examination of definitions of mental health promotion concepts in current scientific literature and policy papers. This is followed by chapter 6.2, which provides the results of Studies II, IIIa and IV, all of them concerning exclusively the identification of the competencies for mental health promotion. Finally, the Study IIIb results of a specific characteristic of mental health promotion practice are described in chapter 6.3.

6.1 The concept of mental health promotion

Systematic concept analysis of mental health promotion in Study I produced a picture of the concept, giving the necessary framework and context for the onset of the study. The analysis illustrated the characteristics of mental health promotion, and how it appears and is understood in the literature and current policies and strategies. Key elements of the concept were identified: attributes, related concepts, antecedents, consequences, surrogate terms and references related to mental health promotion (Figure 8).

With regards to *attributes*, mental well-being and positive mental health (used interchangeably) were seen as key components of mental health promotion and, among the main goals of mental health promotion, understood to be the enhancement of mental well-being and positive mental health. Empowerment and the participation of stakeholders in both strategic approaches and actions of mental health promotion were also identified as key attributes of mental health promotion. Furthermore, intersectoral and multisectoral work and partnerships were seen to be integral to mental health promotion at all levels of actions. Other attributes identified were resilience, the socio-ecological model and a holistic approach.

Essential *antecedents* of mental health promotion were political will and a high appreciation of mental health and mental health promotion (i.e. political and societal recognition of the value of mental health and mental health promotion to improve the mental health and well-being of the population). Moreover, together with theoretical developments and the establishment of an evidence base for mental health promotion, research was identified as essential for the advancement and development of mental health promotion. *Consequences* of mental health promotion were the improvement of mental health and mental well-being and quality of life; the strengthening of positive mental health and protective factors for mental health; and prevention or the reduction of risk for mental ill health. In addition, mental health promotion was seen to lead to wider societal consequences, such as reduced structural barriers to good mental health, more supportive environments, safer communities, improved relationships within families and better educational performance, among others.

Mental health promotion was used with *reference* to the goal of promoting and improving mental health and mental well-being. In this context, the concept referred to policies and strategies as well as practice. Furthermore, mental health promotion was used with reference to different levels of action (mental health promotion at the individual level, in wider settings, and at the societal level). Settings included home, school, the workplace and community, or, alternatively, population groups such as children and adolescents, adults or older people. Societal-level mental health promotion included actions to improve housing and outdoor living environments and opportunities for leisure and cultural activities. Occasionally, the concept of mental health promotion was used in the context of public health and population health perspectives, as well as within the health promotion approach.

Prevention of mental health disorders was identified in the analysis as a *related concept* to mental health promotion. Mental health promotion and the prevention of mental health disorders were seen as distinct concepts with different sets of principles and conceptual frameworks. However, it was acknowledged that the two concepts overlap. No surrogate terms – that is, terms identical to the concept of mental health promotion – were identified.

As a result of the analysis, a concept map of mental health promotion was developed to illustrate the nature and the characteristics of the concept, and to portray the framework more clearly in order to support the identification of mental health promotion competencies (Figure 8).

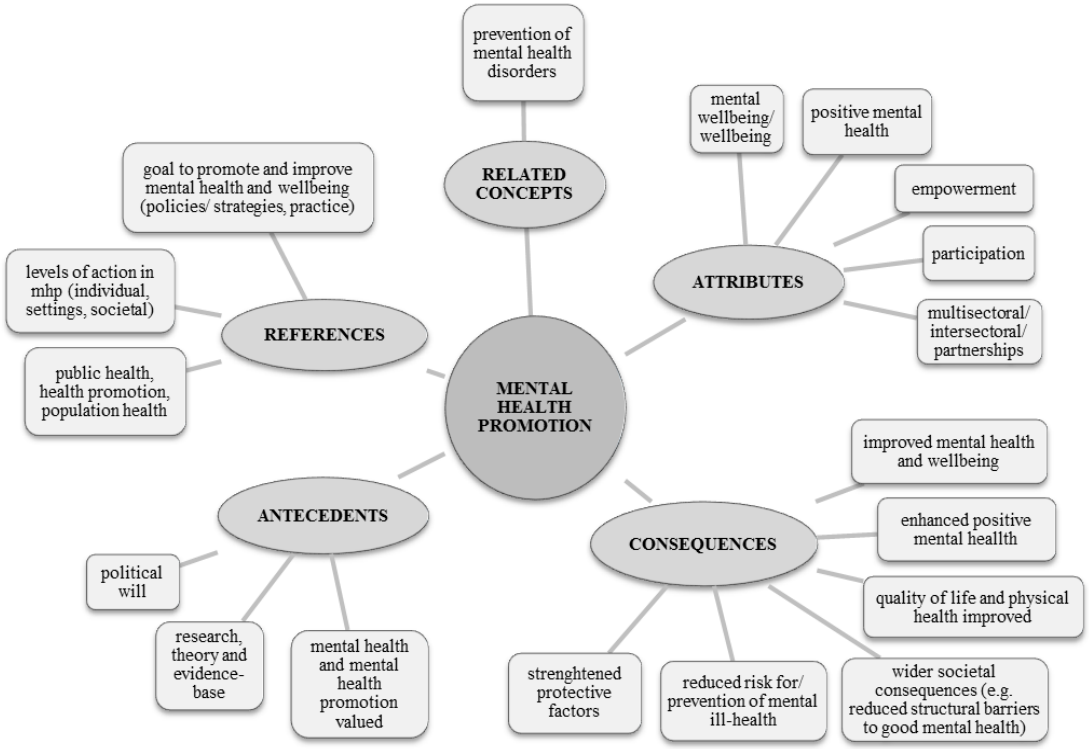

FIGURE 8 Concept map of mental health promotion based on literature review (Study I).

6.2 Mental health promotion competencies in the health sector

As illustrated in the methods section, the identification of the competencies for mental health promotion began by means of focus group interviews and a questionnaire survey in Study II. The analysis of the data from the focus group interviews and the questionnaire survey with mental health professionals generated 23 subcategories for mental health promotion competency. The competencies were clustered under four main categories: theoretical knowledge, practical skills, personal attitudes and personal values (Table 5). The participants thought that in order to be able to promote mental health, it is necessary to have knowledge of the principles and concepts of mental health promotion, including methods and tools for effective practices. Furthermore, an understanding of how society works and how to influence it was needed. In addition to theoretical knowledge, a variety of skill-based competencies were seen as necessary, especially with regards to mental health promotion practice. Skills such as planning and implementing mental health promotion actions and collaboration skills were described, among others. Under the main categories of personal attitudes and personal values, themes such as a holistic approach and

a positive attitude towards mental health promotion, respect for human rights and being customer-friendly were identified by the participants.

TABLE 5 Main categories and subcategories of mental health promotion competencies identified in the focus group interviews and the questionnaire survey (Study II)

Theoretical knowledge	**Practical skills**	**Personal attitudes**	**Personal values**
- Knowledge of principles and concepts of mental health promotion - Human development knowledge - Knowledge of positive psychology - Societal understanding - Knowledge of human rights	- Communication skills - Planning skills - Implementation skills - Needs assessment skills - Leadership - Evaluation and research skills - Advocacy skills - Marketing skills - Collaboration skills - Multisectoral working	- Positive attitude - Broad-minded - New ways of working - Holistic approach - Multidisciplinary approach	- Respect for human rights - Equality - Customer-friendly

The next stage of the competency development process, the Delphi survey, resulted in several steps that are presented in the methods section (Figure 7). Here, the key results of the Delphi survey (Study IIIa) are described in more detail. The questionnaire in Round 1 was based on the previously developed main categories and subcategories of mental health promotion competencies. In addition, further literature review and discussions within the research group lead to formulation of four additional competencies. Thus, the round 1 questionnaire included 27 key mental health promotion competencies. A strong consensus was reached by the participating experts; the panel viewed all competencies as important. All competencies exceeded the agreed consensus point mean of 3.5, with at least 70 per cent of the panel members scoring 3.5 or more. The mean ratings ranged from 3.89 to 5. There was, however, some debate on the proficiency level of a competency, depending on the professional's role in the workplace. Table 6 presents the results from Round 1.

TABLE 6 Results from Delphi panel Round 1, according to main categories and subcategories (Study IIIa)

Main category	Subcategory	Mean Likert-rating (1–5)*
Theoretical knowledge	Knowledge of principles and concepts of mental health promotion	4.7
	Human development knowledge	4.2
	Knowledge of positive psychology	4.6
	Societal understanding	4.5
	Knowledge of human rights	4.6
Practical skills	Communication skills	4.6
	Interpersonal skills	4.9
	Needs assessment skills	4.6
	Planning skills	4.1
	Implementation skills	4.4
	Able to identify components of positive mental health	4.8
	Able to identify risk factors of mental health	4.7
	Leadership	4.2
	Collaboration skills	4.9
	Managing skills	4.4
	Evaluation and research skills	4.3
	Advocacy skills	4.6
	Marketing skills	3.9
	Multisectoral working	4.7
Personal attitudes	Positive attitude	4.7
	Broad-minded	4.9
	New ways of working	4.1
	Holistic approach	5.0
	Multidisciplinary approach	4.7
Personal values	Respect for human rights	5.0
	Equality	4.9
	Customer-friendly	5.0

* Likert rating: 1=not at all important, 5=very important (n=32)

Based on the feedback and comments from the panel members, decisions were made on what competencies to retain, remove or modify, and what new competency areas to include. As a result, some changes were made for Round 2 and its questionnaire:

- the domains of attitudes and values were combined into one domain
- the number of the main competencies were reduced from 27 to 19
- some main competencies were combined into one to better embody the competency (e.g. *respect for human rights* and *equality* into *ethical values*)
- repetition and overlapping competencies were modified
- detailed subcompetencies were collected into the main competency categories (77 subcompetencies were formulated)
- some competencies were reworded (e.g. *customer friendly* to *customer-based*)

- some new areas of competencies were suggested, such *as enabling and utilising peer support/experts by experience* in mental health promotion activities

In Round 2, the mean scores of all main competencies again exceeded the predetermined consensus point of 3.5, with the mean ratings ranging from 4.04 to 5. The Delphi panellists regarded all competencies as highly important; however, the extent of proficiency was again seen to depend on the working role of the professional. Round 2 results are shown in Table 7.

TABLE 7 Results from Delphi panel Round 2, according to main competencies (Study IIIa)

Main competency	**Mean Likert-rating (1–5)***	**Number of sub-competencies**
Theoretical knowledge		
Knowledge of principles and concepts of mental health promotion	4.5	4
Human development knowledge	4.0	2
Societal understanding	4.7	5
Knowledge of human rights	4.3	3
Practical skills		
Communication skills	4.0	4
Interpersonal skills	4.9	4
Needs assessment skills	4.5	6
Planning skills	4.6	3
Implementation skills	4.3	2
Collaboration skills	5.0	4
Leadership skills	4.3	4
Evaluation and research skills	4.3	5
Advocacy skills	4.7	5
Attitudes and values		
Positive attitude	5.0	4
Broad-minded	4.8	4
New ways of working	4.2	7
Holistic approach	5.0	3
Customer-based	5.0	5
Ethical values	4.9	3

* Likert-rating: 1=not at all important, 5=very important (n=27)

Once more, some changes were made in Round 2: some rewording was done (e.g. *customer* to *client*); overlapping subcompetencies were combined; the word *personal* was omitted, as attitudes and values were seen to concern the whole working environment, not just the individual worker, and the main competencies were reduced to three by combining overlapping competency areas in the attitudes and values domain (e.g. *customer-based* was included in the *holistic approach* as a subcompetency). In the end, the number of main

competencies was reduced from 19 to 16, and 56 subcompetencies were identified. The competencies were divided into three category domains: *theoretical knowledge*, *practical skills*, and *attitudes and values*.

The subsequent stage of the process, the focus group meeting with the experts by experience in Study IV (unpublished), gave further results with regards to the identified mental health promotion competencies. The mean Likert ratings ranged from 3.5 to 5, as shown in Table 8. Each competency thus received a rating of importance at some level. Consequently, consensus was achieved following the guidelines of the earlier Delphi expert panel study, where the consensus point was reached when 70% of respondents scored 3.5 or more for each competency (Tamminen et al. 2018).

TABLE 8 Mean Likert ratings of the mental health promotion competencies from the focus group with experts by experience (Study IV)

Main competencies in the order of importance by experts by experience	**1 n**	**2 n**	**3 n**	**4 n**	**5 n**	**Mean Likert rating (1–5)***
15. Holistic approach	0	0	0	0	10	5
4. Knowledge of human rights	0	0	0	1	9	4.9
6. Interpersonal skills	0	0	0	1	9	4.9
16. Ethical values	0	0	0	1	9	4.9
10. Collaboration skills	0	0	0	2	8	4.8
14. Positive attitude	0	0	0	3	7	4.7
3. Societal understanding	0	0	1	3	6	4.5
9. Implementation skills	0	0	1	3	6	4.5
7. Needs assessment skills	0	0	1	4	5	4.4
8. Planning skills	0	0	2	2	6	4.4
1. Knowledge of principles and concepts of mental health promotion	0	1	0	4	5	4.3
5. Communication skills	0	0	1	5	4	4.3
12. Evaluation and research skills	0	0	2	5	3	4.1
13. Advocacy skills	0	1	0	7	2	4
2. Human development knowledge	0	0	4	3	3	3.9
11. Leadership skills	0	2	2	5	1	3.5

* Likert-rating: 1=not at all important, 5=very important (n=10)

None of the competencies were regarded as 'not at all important' (score 1). Fourteen out of sixteen competencies received a mean score of 4 or higher. *Holistic approach* was rated as 'very important' (score 5) by all focus group participants. In addition, *Knowledge of human rights*, *Interpersonal skills* and *Ethical values* were rated as 'very important' by 90% of the participants. Only two competencies scored below 4: *Human development knowledge* (mean score 3.9) and *Leadership skills* (mean score 3.5).

The verbal feedback from the experts by experience was positive and they welcomed the development of mental health promotion competencies. The participants appreciated that their views were valued and taken into consideration in the development process. They felt that it was important for all

individuals, not just professionals, to understand what mental health is and to view the concept broadly, as it touches every person at some point in life. This view is reflected in the score of 'very important' given to the competency *Holistic approach*. Criticism was expressed regarding highly medicalised and diagnosis-centred modern health care, which has difficulties in seeing the service user as a whole person:

> It is still a bit divided, so that you are either healthy or you are ill. But you can still have plenty of mental health and the ability to function.

In addition to having knowledge of key concepts in mental health promotion ('Knowledge of principles and concepts of mental health promotion' competency), it was felt to be important that professionals have some understanding of society and how it works. As one of the participant described:

> So that they understand how the concepts of health and ill-health overall are developed and shaped in discussions and actions of the society… That there is a lot of (discussion)… how they are understood, how they are socially conceptualised.

The six most highly scored competencies ('Holistic approach', 'Knowledge of human rights', 'Interpersonal skills', 'Ethical values', 'Collaboration skills' and 'Positive attitude') exemplify that the experts by experience value the professional's ability to interact positively, with appreciation and respect with service users. In addition, the ability to be present and able to listen and view the service user fully during a face-to-face interaction was viewed as important. As one of the experts by experience said:

> So that a right kind of connection can be created between the care provider and the service user…

Interpersonal and collaboration skills were seen as tools to create trust and a welcoming environment, so that the service user can have *courage to say how things are*. This view, on the other hand, was further supported by 'Leadership skills' receiving the lowest score given by the participants. The need for an equal, open and interpersonal relationship was valued by the experts by experience, not the professional's authoritative leadership and management over the service user:

> Just that it is not coming from up to down but it is done together.

This ethical value was seen as an important issue and it raised discussion among the experts by experience. The competency of 'Ethical values' includes a subcompetency and description of 'Acting tolerantly and respecting differences'. The word 'tolerantly' was seen problematic, as one of the participants expressed:

> This tolerance, I see it as a really frightening word because it entails a thought of looking down on someone from above.

Tolerance was therefore not viewed as a good ethical value. An alternative wording that better captured the idea of equal relationships was suggested:

> Equality might be a better word… 'Acting in an equal manner and respecting differences'…
>
> Yes, it might be a better word in that it describes bringing support to all, what they need, so that they would be on the same level…

Based on the results from the focus group interview with the experts by experience, 'Acting tolerantly' was changed to 'Acting in an equal manner' in the Ethical values competency. Otherwise, the results were in line with and supported the competencies developed earlier in the Delphi process. Knowledge of human rights received slightly higher scores by the experts by experience than by the professionals. Collaboration and interpersonal skills, a holistic approach, and ethical values were among the competencies that were viewed as highly important by both groups. Knowledge of human development, on the other hand, was among the least appreciated competencies in both groups. The final developed mental health promotion competencies are presented in Table 9.

TABLE 9 Final mental health promotion competencies (Studies IIIa & IV)

Main competencies	**Subcompetencies**
Theoretical knowledge	
1. Knowledge of principles and concepts of mental health promotion (MHP)	1.1 Knowledge of the concept of positive mental health, resilience, and the importance of strengths, resources and protective factors 1.2 Knowledge of supportive living conditions and environments 1.3 Knowledge of the concept of mental health 1.4 Knowledge of the risk factors of mental health 1.5 Knowledge of effective methods, practices and tools for MHP
2. Human development knowledge	2.1 Knowledge of MHP aims and activities according to the life course approach 2.1 Knowledge of the psychosocial and physiological human development
	continues

TABLE 9 continues

Main competencies	Subcompetencies
Theoretical knowledge	
3. Societal understanding	3.1 Understanding how society works and how to influence on it 3.2 Understanding the factors that support and challenge mental health in society 3.3 Understanding the significance of different sectors and their role in MHP 3.4 Understanding the influence of political decisions on well-being and on MHP
4. Knowledge of human rights	4.1 Knowledge of equality, justice and appreciation and respect for others 4.2 Knowledge of cultural differences and similarities and their significance to MHP work
Practical skills	
5. Communication skills	5.1 Mastering different communication methods, including verbal and written communication, as well as technological communication methods 5.2 Providing information on factors and activities related to MHP 5.3 Influencing positive and supportive attitude towards mental health, and reducing stigmas
6. Interpersonal skills	6.1 Mastering interaction skills when working with various stakeholders 6.2 Considering others with appreciation, respect and empathy taking into account the views and values of others and using them as a starting point for working 6.3 Mastering group and bilateral work as well as different guidance methods
7. Needs assessment skills	7.1 Assessing client/stakeholder needs while utilising different methods, tools and indicators 7.2 Engaging clients/stakeholder groups with needs assessment as well as setting and monitoring objectives and actions 7.3 Monitoring mental health with different indicators and indicating the effectiveness of MHP 7.4 Recognising and supporting components of positive mental health and client's/stakeholder group's strengths and resources and supporting those 7.5 Recognising risk factors of mental health
	continues

TABLE 9 continues

Main competencies	Subcompetencies
Practical skills	
8. Planning skills	8.1 Planning objective-oriented MHP actions and interventions 8.2 Utilising available resources with planning 8.3 Engaging clients/stakeholder groups and other players when planning and developing activities 8.4 Developing new innovations, methods and tools
9. Implementation skills	9.1 Implementing effective MHP methods and interventions 9.2 Providing objective-oriented and targeted MHP actions to and with clients/stakeholder groups as well as part of wider MHP 9.3 Implementing effective MHP methods and interventions
10. Collaboration skills	10.1 Working in partnership with others beyond organisations, sectors and disciplines while planning and developing MHP actions 10.2 Networking and creating partnerships and utilising different networks 10.3 Working in partnership with clients/stakeholder groups 10.4 Enabling and utilising peer support (experts by experience) in MHP activities
11. Leadership skills	11.1 Leading and supporting MHP actions in practice and in different levels from client work to population level actions 11.2 Guiding systematically objective-oriented and knowledge-based MHP and its actions 11.3 Utilising scientific knowledge in decision-making, in both the health sector and other sectors
12. Evaluation and research skills	12.1 Seeking scientific knowledge to support MHP work and utilising research-based effective interventions 12.2 Mastering different evaluation and research methods and indicators 12.3 Studying and evaluating MHP planning, implementation and impact
13. Advocacy skills	13.1 Influencing by networking and working with different sectors 13.2 Marketing MHP and MHP actions to other stakeholders and players 13.3 Influencing decision makers, decision-making and policies at different levels 13.4 Lobbying for resources needed for MHP actions
	continues

TABLE 9 continues	
Main competencies	**Subcompetencies**
Attitudes and values	
14. Positive attitude	14.1 Working with an open-minded attitude in MHP actions with different people, population groups and cultures 14.2 Inspiring, encouraging and motivating people 14.3 Recognising and utilising possibilities and resources and strengths 14.4 Renewing and improving ways of working with courage in order to promote and support mental health
15. Holistic approach	15.1 Seeing the client/stakeholder group holistically with strengths and limitations, supporting their own expertise and agency 15.2 Working in a multisectoral and multidisciplinary manner in MHP activities 15.3 Taking into account the biological, psychological, social, spiritual and societal factors that affect mental health 15.4 Promoting client-oriented operating culture
16. Ethical values	16.1 Respecting human rights and strengthening equality 16.2 Acting in an equal manner and respecting differences 16.3 Making human rights visible and realised in MHP actions

6.3 Intersectoral collaboration and partnerships: a specific characteristic of mental health promotion practice

The descriptive data from the open responses in the Delphi panel (Study IIIb) were rich and versatile, and highlighted that intersectoral collaboration and partnership work and related competencies are highly emphasised in mental health promotion practice. As a result, a separate study was carried out to investigate the matter of collaboration within the competencies in more detail, that is, how intersectoral collaboration and partnership work are constructed and adopted in mental health promotion practice. The practice-based theoretical framework of collaboration advantage outlined by Vangen and Huxham (Huxham 2003; Vangen & Huxham 2010) was used to organise the findings. Eight overlapping themes of collaboration advantage were identified in the descriptive data from the Delphi panel: management structure, leadership, communication and language, common aims, working processes, resources, trust, and commitment and determination (Figure 9).

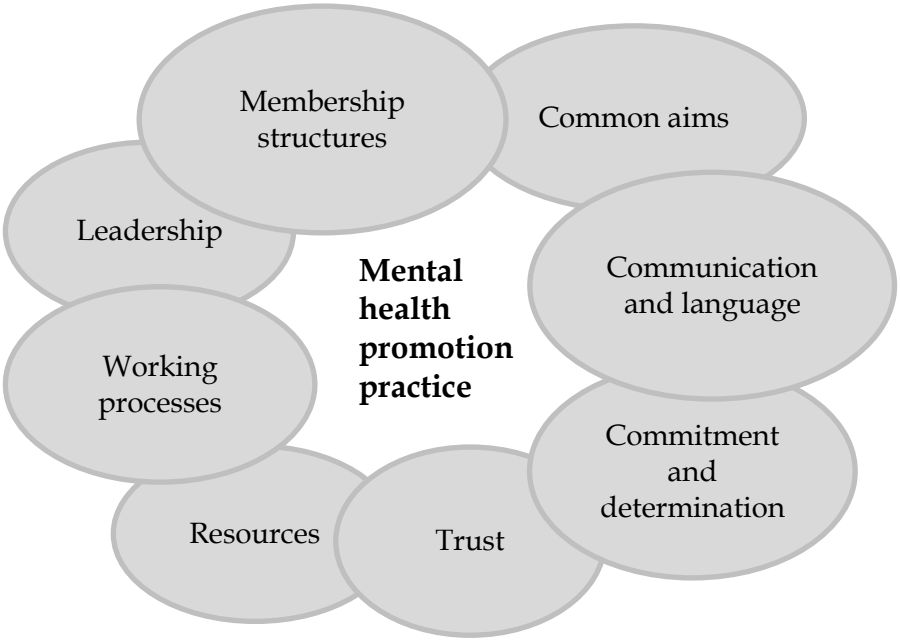

FIGURE 9 Themes of intersectoral collaboration and partnership work (Study IIIb).

The complexity of real-life practice and the potential challenges involved became evident from the findings, as several themes overlapped and were connected with each other. For example, working processes and resources were closely linked with each other, as it was emphasised that close collaboration required active working processes, such as joint planning, but also preferably joint resources, such as shared funding. Further, the communication and language theme was related to the theme of common aims. A shared understanding created by common concepts and a common language was seen to lead to the development of a shared vision and common aims. On the other hand, sharing goals was seen to support commitment and determination for partnership work. Overall, the identified themes were closely entwined; they all entailed a shared understanding and appreciation of the value of intersectoral collaboration and wide partnerships in mental health promotion and the necessity of competencies related to collaborative practice. The collaboration-related mental health promotion competencies were seen as being essential to manage successful mental health promotion practice and to achieve collaboration advantage, namely, the synergy of effective partnerships.

The identified themes capture the competencies required to influence and work with others to improve the mental health and well-being of individuals and communities. They illustrate what kinds of competencies are seen as being central for successful intersectoral partnership work in mental health promotion practice in the health sector.

7 DISCUSSION

7.1 Identified mental health promotion competencies

This research examined competencies for mental health promotion, aiming to determine what mental health promotion competencies are needed in health sector practice in Finland. The study adds to the understanding of the required competencies for mental health promotion practice. The results illustrate the views provided by the study participants. The obtained knowledge represents not only individual views of professionals and experts by experience but also provides wide and rich descriptions of the practice of mental health promotion in the health sector. The competencies identified are the result of a comprehensive development process, where a shared understanding and a strong consensus were reached among the participating professionals and the experts by experience.

The investigations produced 16 main competencies and a high number of subcompetencies, altogether 56 of them. The competencies highlight the great variety of different competencies and competency areas that the participants regarded as necessary for mental health promotion practice. Especially intersectoral collaboration and partnership work came up strongly in the results, reflecting an understanding that mental health is influenced by various biological, psychological, social, cultural, economic, political and environmental factors, calling for a multisectoral approach to the promotion of mental health. Furthermore, the results illustrated the notion of empowerment. Many of the competencies either explicitly or implicitly referred to the empowerment of individuals and/or communities. In addition, the concept analysis of mental health promotion initially carried out in this study confirmed that empowerment – referring to the level of choice, influence and control that a person or communities can exercise, or have power, over events in their life – is

an essential attribute and aspect of mental health promotion (Joubert & Raeburn 1998; Masterson & Owen 2006; VicHealth 2009; Kalra et al. 2012).

The study results answer to the lack of systematic information and knowledge of the required competencies (Greacen et al. 2012; Lang et al. 2016), thus providing novel knowledge that has not been produced previously. These competencies are practice-based and provide a salutogenic approach to mental health and related competencies, thus presenting evidence that currently is urgently needed in the mental well-being domain. Moreover, the study responds to the demand presented by relevant mental health policies and strategies, such as the WHO European Mental Health Action Plan and the Finnish National Mental Health Strategy and Programme for Suicide Prevention 2020–2030 (WHO 2013b; Ministry of Social Affairs and Health 2020b), both strongly promoting capacity building and training of health professionals in the area of mental health and mental health promotion. The implementation of the Finnish National Mental Health Strategy for 2020–2022 has begun, and one of the focal areas is the identification of the professionals, networks, people and communities for whom mental health capacity building and skill development would be particularly useful, and increasing competence in these groups (Ministry of Social Affairs and Health 2020b). This creates a timely moment for the exploitation and making good use of these competencies in the implementation of the strategy.

The competencies presented here are in line with the European guidelines for training social and health care professionals in mental health promotion (Greacen et al. 2012). The developed competencies include all but one (evaluating risks) aspect of those guidelines, thus strengthening the significance of the study results. Some have argued that much of the knowledge and many of the skills required for mental health promotion are inseparably linked to general health promotion (Mittelmark 2003; Barry 2007a). These study results give partial support for this notion, as many of the identified competencies are comparable with the health promotion competencies developed earlier (Barry et al. 2012). Furthermore, they show some similarities to the public mental health competencies developed in the UK (Stansfield 2015). Nevertheless, there are some significant differences and novel information specific to the promotion of mental health, which will be discussed in the following chapters, together with any other relevant aspects.

7.1.1 Theoretical knowledge

The study results showed that in order to promote mental health, it is necessary to have knowledge of the principles and concepts of mental health promotion, including the methods and tools for effective practices. The theoretical knowledge that was seen to underpin all mental health promotion actions and competencies was the knowledge of positive mental health. This is the most outstanding feature of mental health promotion and a major difference from the theoretical knowledge required for health promotion generally. This competency area is in line with the quality criteria 'Embracing the Principles of

Mental Health Promotion' developed for training social and health care professionals in mental health promotion (Greacen et al. 2012) and highlights the specific mental health and well-being-related knowledge needed in mental health promotion practice. The approach of mental health promotion is salutogenic, aiming to achieve positive mental health in individuals, communities and society in general. This result concurs with the public mental health leadership and workforce development framework in the UK (Stansfield 2015) which identified as one of the core principles for public mental health practice the knowledge of how mental health is a positive asset and a resource to society. The results of this thesis illustrate that positive mental health is a unique component of mental health promotion and its approaches.

The focus on positive mental health is also a key factor that makes mental health promotion conceptually distinct from the prevention of mental health disorders (WHO 2004; WHO 2005b). Mental health disorder prevention targets the reduction of the incidence, prevalence or seriousness of targeted mental health problems and disorders (WHO 2004). The identified mental health promotion competencies in the theoretical knowledge domain thus emphasise this discrepancy. The results showed that having knowledge of the principles and concepts of mental health promotion is essential, as it provides the basis for systematic and effective mental health promotion. In addition, they showed that it is important to differentiate the concept of mental health from mental health problems and mental health disorders. The study results are thus consistent with the quality criteria for training social and health care professionals in mental health promotion which underlined the fact that training programmes in this area need to embrace the principles of mental health promotion as distinct from mental health disorder prevention or curative care (Greacen et al. 2012). Nevertheless, it is worth keeping in mind that by promoting positive mental health, it may also be possible to decrease the incidence of mental health disorders, as positive mental health can serve as a strong protective factor against mental ill health (WHO 2004).

The identified mental health promotion competencies emphasise the knowledge of resilience, strengths, resources and protective factors for mental health, as well as knowledge of the determinants of mental health. The factors that influence mental health and well-being are, in many ways, explicit to mental health (Jorm et al. 2006; WHO 2013a; WHO 2013d; WHO & Calouste Gulbenkian Foundation 2014), requiring detailed and well-considered targets and designed interventions. Societal understanding, which was identified as one of the competencies in the theoretical knowledge domain, provides further awareness of the wider determinants of mental health, such as social and environmental factors affecting different levels. These competencies thus seem highly relevant, as they correspond with current high-level policies and strategies on mental health (WHO 2013b; Ministry of Social Affairs and Health 2020b).

7.1.2 Practical skills

The study revealed an extensive number of skill-based competencies, demonstrating the variety of skills needed in mental health promotion practice. Many of these skills closely accord with the practice-related skills of health promotion developed by Barry et al. (2012), such as communication and implementation skills. It could be argued that these skills are more generic in nature and, for example, generic implementation frameworks can be applied to both mental health promotion and health promotion generally (Durlak & DuPre 2008; Durlak 2016; Barry et al. 2019). This result suggests that the skill-related competencies of health promotion and mental health promotion are fairly similar, at least to a certain degree. Some earlier studies have also conveyed this view (Mittelmark 2003; Barry 2007a).

Intersectoral collaboration and partnership work were highly emphasised in the mental health promotion competencies, thus providing further evidence of the key role of intersectoral partnerships and collaboration work in mental health promotion practice. Interdisciplinary and intersectoral working skills were also identified as key competencies for general practice in the UK in order to promote mental health and prevent mental health disorders (Thomas et al. 2016). The importance of collaboration in mental health promotion programme development and evaluation was similarly underlined by a study by Reupert et al. (2012). Consequently, our results are in accordance with earlier research that highlights the importance of positive partnership processes, such as shared goals and the inclusion of a broad range of participation from diverse partners in health promotion actions (Koelen et al. 2012; Corbin et al. 2018; van Dale et al. 2020; Wiggins et al. 2021). Our study showed that practical skills, such as communication skills, are strongly related to collaboration work, as the use of a common language leads to shared understanding, which is required to develop a shared vision and common aims. The importance of partnerships and collaboration to promote mental health and well-being has also been widely recognised in health promotion and mental health strategies (WHO 1986; WHO 2013a; WHO 2013c) with the understanding that the necessary knowledge and skills for facilitating effective partnerships across sectors may need to be developed. The socio-environmental nature of the determinants of mental health (Lahtinen et al. 1999; WHO & Calouste Gulbenkian Foundation 2014) demand that a cross-sectoral approach is needed to effectively influence these determinants.

An intersectoral approach was also highlighted in the guidelines developed for training social and health care professionals in mental health promotion (Greacen et al. 2012) and the identified competencies for health promotion (Barry et al. 2012). There is, however, an important aspect included in the identified collaboration skills for mental health promotion that makes them distinctive: the enabling and involvement of experts by experience and peer support in mental health promotion activities. Including the expertise of lived experience in the competencies was considered essential and a much-needed practice to be employed alongside mental health promotion work by

professionals. Emphasis on client-based perspectives and involving experts by experience in planning, implementing and evaluation of services are also included in the proposals for action in the Finnish National Mental Health Strategy (Ministry of Social Affairs and Health 2020b). The involvement of experts by experience generally concerns the plans and actions to promote service user involvement and co-production of mental health services. This approach of co-production is fairly new in Finland, although it has been practised longer in other countries (Slay & Stephens 2013; Partanen et al. 2015; Story & To 2016). In the co-production activities, there is often a strong emphasis on prevention of mental health problems and addressing stigmas, with few mental well-being-related outcomes being addressed (Slay & Stephens 2013). However, the literature suggests that there are some conceptual links between mental well-being and outcomes of co-production, especially related to the eudaimonic aspect of positive mental health, that is, functioning well (Slay & Stephens 2013). In this respect, our results have common ground with co-production processes and the involvement of experts by experience.

Evaluation and research skills were also identified as practical competencies in the study. These skills give the ability to base mental health promotion actions on scientific knowledge and methods, and to evaluate the effectiveness of these actions. This study result gets support from a study by Reupert et al. (2012), in which programme evaluation skills were identified as an important competency of mental health promotion workers supporting programme development and strengthening the evidence base of mental health promotion programmes. The importance of utilising evidence-based approaches and methods was also recognised by the Finnish National Mental Health Strategy, as well as by health and social services reform (Finnish Government 2020; Ministry of Social Affairs and Health 2020b), thus predicting that the future workforce is required to be able to research and develop mental health-promoting activities as part of their work. Worth noting is that in order to translate from research into effective practice, good implementation skills are required (Barry 2007a).

7.1.3 Attitudes and values

Competencies within the attitudes and values domain referred to equality, a client-oriented operating culture, an individual's own expertise and agency, and empowering communities in the promotion of mental health and well-being. These results thus highlighted the aspect of empowerment, of both individuals and communities, in mental health promotion actions. A study by Doyle and partners (2018) also identified a client-oriented operating culture and attitudes, such as respect for the autonomy of the client, as central competencies of mental health nurses. Empowerment and participation are similarly highly valued domains in the health promotion competencies developed by Barry et al. (2012). Moreover, encouraging and empowering all community stakeholders for effective involvement in mental health promotion in general or in developing specific mental health promotion projects is underlined in the

quality criteria for training social and health care professionals in mental health promotion (Greacen et al. 2012). This representation of empowerment in the results thus reflects earlier research. The identified request for attitudes and values that promote and enable empowerment also reflect the core aim of mental health promotion – increasing the positive mental health of all (WHO 2005b; Barry et al. 2019).

Ethical values such as equality and respect for human rights (Sihvo & Koski 2020) are at the heart of mental health promotion practice and the identified mental health promotion competencies. Good mental health is a right of everyone, and mental health promotion actions should consider the wide-ranging factors that influence mental health, such as the different biological, psychological, socioeconomic and societal influences. The identified competencies for mental health promotion reflect this approach by including a broad, holistic and positive approach towards mental health and mental health promotion, as well as towards all individuals and communities. This holistic approach is similarly reflected in the multi-sectoral approach discussed earlier. In this respect, the study results are in line with the guidelines for training social and health care professionals in mental health promotion (Greacen et al. 2012).

7.2 Methodological considerations

In qualitative research, the rigour and *trustworthiness* of the study is assessed using the concepts of credibility, dependability, confirmability and transferability (Lincoln & Cuba 1985; Graneheim & Lundman 2004; Tolley et al. 2016). *Credibility* refers to the confidence in the truth of the study and its findings, as well as how well the data and the processes of analysis address the intended focus of the research (Graneheim & Lundman 2004). Credibility corresponds to internal validity in quantitative research (Lincoln & Cuba 1985; Korstjens & Moser 2018). In this study, credibility was established by choosing participants with various experiences, both professionals and experts by experience, who could shed light on the research questions from a variety of perspectives, consequently contributing to a richer variation of the phenomena under study. The expertise of the participants was preferential; gender was not, even though both sexes were represented. The professionals who took part in the study represented various areas within the health sector and had varying work roles in different levels, from the mental health policy level to mental health promotion practice. In addition, the participating experts by experience were trained and worked in different development worker roles in experts by experience programmes. This wide variety of participants allowed variation and broad views of the needed competencies in the health sector.

Furthermore, data triangulation and method triangulation were used to increase credibility (Korstjens & Moser 2018). Data were collected from multiple sources and by using different methods of data collection (literature review,

focus groups, questionnaire survey, Delphi panel). Each stage of the research (four successive studies) provided new information and guided the next stage further thus enhancing trustworthiness across the four studies. Investigation triangulation (Korstjens & Moser 2018; Stahl & King 2020) was attained by using other researchers, with analysis and interpretation of the findings at each stage of the research. Each study and its data collection method will be discussed in the following paragraphs.

The first study of this thesis, a systematic concept analysis of mental health promotion, aimed to open up the concept of mental health promotion, thus providing needed understanding and a framework for the development and implementation of the following studies. The nature and characteristics of the concept were explored by means of conducting a literature review and applying a systematic concept analysis method (Rodgers 1989; Rogers 2000) to analyse the results. The literature review was carried out meticulously and by using key electronic databases for the search (see Figure 6). Rodgers' model provided a methodical way of analysing the data through inductive inquiry and rigorous analysis, critically examining the different features of mental health promotion. Following this systematic method, the quality of the study results was ascertained and the credibility of the study increased.

The thesis employed focus group interviews and an open-ended questionnaire survey for data collection. By employing qualitative study methods such as focus groups, it was possible to explore and seek depths of understanding regarding the subject matter, in order to gain more profound insights into the issues. The informants were able to present their views and understandings from their practice-based experiences. The questionnaire included the same open questions and followed the same structure as the focus groups to ensure consistency and coherence between the two methods of data collection and within the obtained data. Both the focus group interview guide and the questionnaire were piloted (n=3 mental health promotion experts) prior to implementation. This allowed testing and reformulating the questions. As discussed in chapter 2.5, mental health promotion stems from a multidisciplinary approach and is informed by a number of theoretical frameworks which may impede the understanding of the matter. Furthermore, both in public health and in research, mental health has traditionally been understood from a disease-based premise to mainly concern mental ill health, not considering the positive, mental well-being aspects of the term. These two matters may have had some influence on the questionnaire survey and its participation rate. Even though the questionnaire was distributed to 70 professionals, only 10 returned the form. This could have reflected their lack of knowledge and understanding of the subject matter and lowered their participation. This lack of knowledge may also have been reflected in the questionnaires as some of the answers provided were concise, even though the questions were open-ended and plenty of space was provided for the answers in the forms. Nevertheless, with the use of two different data collection methods, it was possible to obtain data that were varied and rich.

Member checking is another way to achieve credibility in qualitative research. Member checking involves feeding back data, analytical categories, interpretation and conclusions to members of those groups from whom the data were originally obtained (Korstjens & Moser 2018). The Delphi technique was also one of the methods used in this thesis. The Delphi method provided a means where the participants, the Delphi panel members, were able to express their views in an iterative process and discuss anonymously. This allowed the expression of genuine views, reducing the possibility of peer pressure or influence of professional status. The panellists were able to see each other's comments and opinions on the subject matter, thus constantly back feeding the data. This consensus-building process to develop the competencies for mental health promotion can be seen as establishing credibility in the research. The Delphi method, however, contains certain limitations (Hasson et al. 2000; Keeney et al. 2001; Keeney et al. 2006; Donohoe et al. 2012) that were also applicable to this study. The limitations were minimised by adhering to the recommended design principles of the Delphi process as closely as possible. The panel members were carefully recruited and informed of the purpose of the study, their role and the processes involved in the survey. As purposive sampling was used, there was a potential for bias in the selection of the panel members. Nevertheless, this is an inherent and recognised aspect of the Delphi method, as recruitment is based on the principle that panel members, or experts, must have knowledge of the subject area and thus cannot be selected randomly. Efforts were made to try to mitigate bias, however, by selecting informants with as wide expertise and experiences within the mental health promotion field as possible. The questionnaire in Round 1 of the Delphi survey was based on the earlier focus group and a questionnaire study where initial mental health promotion competencies were identified. This initial study could be considered as a preliminary round of the Delphi survey. Further two rounds were carried out, which is consistent with earlier Delphi research (Keeney et al. 2006). High response rates were achieved in both rounds (84% and 71%, respectively) which, in turn, gives further support for the credibility of the study. The high response rate may be the result of following up with the non-responders and also due to the participants' interest in the subject matter. And while there is no universally agreed level of consensus in the Delphi, 70% agreement was decided upon as ensuring the rigour of the study and based on earlier research (Keeney et al. 2006; Barry et al. 2012).

Data-driven inductive analysis (e.g. Graneheim & Lundman 2004) was carried out in three sub-studies (Studies I, II and IIIa). In addition, thematising according to a model/framework (Study I: model by Rodgers 1989; Rodgers 2000; Study IV: framework by Vangen & Huxham 2010) or formal thematic analysis was used (Study IIIb) (e.g. Braun & Clarke 2006). To achieve credibility with these analysis methods, the meaning units in the analyses were kept as concise as possible to contain the meaning but not narrow it down too much. Also, illustrations of the analysis process – meaning units, condensations and/or categorisations – were presented in the articles in question, as well as

quotations from the transcribed text to ensure transparency. Persistent observation – that is, identifying the characteristics that were most relevant to the research questions – was the key focus of the analyses (Graneheim & Lundman 2004; Korstjens & Moser 2018). Partial deductive analysis (guided by Bloom's learning taxonomy 1956) took place towards the end of the analysis process in Study II when comparing the codes based on similarities and differences and sorting them into subcategories and main categories (e.g. Elo & Kyngäs 2008).

The content analyses in the study were carried out by using the computer-assisted qualitative data analysis software (CAQDAS) Atlas.ti. While CAQDAS is helpful in better understanding and representing data, researchers have been cautioned not to place too much emphasis on CAQDAS outputs early in the analysis, when emergent patterns and broad thinking about the output are needed (Friese 2011; Friese 2019; O'Kane et al. 2021). The researcher must first fully understand their methodological choices to ensure that emergent patterns, and not the CAQDAS capabilities, are driving the data exploration. There is, however, some suggestion that computer-assisted qualitative data analysis software can support qualitative research in efforts to present the analysis and findings in a transparent way, thus enhancing trustworthiness (O'Kane et al. 2021). CAQDAS techniques enable researchers to immerse in the data and explore the text, code and clarify the codebook, check coding, and explore patterns and emerging themes within both the textual and coded data. In this thesis and its sub-studies, CAQDAS techniques (such as code retrievals) were used to enable all data in a code to be quickly checked (confirmability) and appropriate changes made to ensure that the data represented the construct under investigation and vice versa (credibility).

Dependability signifies the stability of the findings, showing that they are consistent and could be repeated (Tolley et al. 2016; Korstjens & Moser 2018). This can be attained by an audit trail, describing the steps used from the start to reporting the findings and engaging in peer debriefings. In this doctoral thesis, each sub-study and the research processes involved were reported as accurately as possible in the corresponding published article. This is a strength of the research, as the results were peer-reviewed and accepted for publishing in international scientific journals. Moreover, each sub-study was discussed with other researchers, starting with setting the aims of the study to discussing and interpreting the findings.

The qualitative analogue to the concept of generalisability is *transferability*, namely, that the findings have applicability in other contexts and settings (Tolley et al. 2016; Stahl & King 2020). To facilitate transferability, the study context, participant characteristics, data collection and process of analysis were described in detail. Furthermore, rich presentations of the study findings were given together with appropriate quotations in each sub-study publication. The study findings offer extensive and abundant descriptions of the practice of mental health promotion in the health sector in Finland. Even though these

findings were identified within the Finnish health sector context, they may possibly be applied to other sectors and to other countries as well.

The fourth criterion of trustworthiness is *confirmability*, which is equal to objectivity in quantitative research (Lincoln & Cuba 1985; Korstjens & Moser 2018). Confirmability refers to the extent or degree to which the findings of the research can be confirmed by other researchers. The term implies that the researcher should maintain a degree of neutrality and not let their own views or values shape the findings (Korstjens & Moser 2018). The study findings and their interpretation need to be grounded in the data. This aspect of trustworthiness was especially critical due to my professional role as a mental health promotion expert at a national research and development organisation working and carrying out tasks in the field daily. In an attempt to ensure neutrality and objectivity, I made an effort not to allow my own perceptions affect the data. During the focus group interviews, for example, I tried to allow the participants express their views freely and not to influence their opinions. Also, as with dependability, transparently describing the research steps (again, an audit trail) was a way to ascertain neutrality and confirmability. In this doctoral thesis, each sub-study and the research processes involved were reported as accurately as possible in the corresponding published article. However, it cannot entirely be ruled out that some of my own professional views or values may have influenced the research or its findings, albeit unintentional.

This doctoral study's ethical acceptability followed the guidance of the University of Jyväskylä Ethical Committee; the Committee confirmed that no ethical statement was required. In addition, the study's data management followed the University of Jyväskylä guidance (also data management plan was designed). To ensure ethical acceptability, informed consent was received from the study participants. This was obtained by using formal consent forms with the focus group participants. In the questionnaire survey and the Delphi survey, consent was confirmed by the participants voluntarily taking part in the study. In addition, all participants were informed of the purpose of the research, how they were chosen to participate, the voluntary nature of participation, the data collection procedures, what was involved for the participant and who to contact if questions or concerns should arise. Individuals taking part in the study were participating in their professional roles and it was their professional views and experiences that were sought after. This, however, only partly applied to the experts by experience. The experts by experience have attended formal training and have had training in their roles as peer supporters and the tasks of experts by experience. An essential part of their role is, however, their expertise of lived experience. To keep with the ethical acceptability of the study, a signed informed consent form was obtained from each participating expert by experience. Furthermore, the descriptions of the experts by experience participants in this thesis are kept to a minimum to ensure anonymity and trust.

7.3 Future perspectives and implications

7.3.1 Contributions to mental health promotion capacity building and competency training

The identified competencies provide a valuable resource for workforce development, as they demonstrate what theoretical knowledge, practical skills, and attitudes and values are required from professionals working in mental health promotion and public mental health in the health sector, and what is needed for them to perform their job successfully and improve practice. They can be used to inform and influence the development of mental health promotion and the public mental health workforce, and to build the capacity and capability of a workforce that is competent in promoting good mental health across the population (e.g. Wahlbeck 2015; Lang et al. 2016). It would be sensible to formulate these competencies into recommendations to be applied in the health sector and their mental health promotion practice.

These competencies help managers understand mental health promotion work roles and aid in developing job descriptions related to mental health promotion, for example, in the health and well-being programmes of municipalities. The competencies are for mental health promoters and those who have a role to play in improving the public's mental health and well-being, and who address the wider determinants of mental health. For example, the implementation of the new health and social services reform (Finnish Government 2020; Ministry of Social Affairs and Health 2020b) may call for a new workforce. As the focus is shifting towards promotive and preventive work, these competencies are of use for training a future workforce and to build capacity in the future health and social services centres. The workforce would especially benefit from the skill-based competencies identified in this study. By attaining these competencies, professionals are able to assess needs, plan and implement evidence-based mental health promotion actions and interventions, and evaluate the work and its impact. More importantly, they are able to work in collaboration with various partners and other stakeholders, as is expected in the reform (Ministry of Social Affairs and Health 2020c).

It is worth noting that the level of proficiency required for each competency may depend on the professional's role in the health sector; working as a leader or in a development working role may require a different level of expertise than working in a more client-based role. This understanding was also noted in the Public mental health leadership and workforce development framework which proposed competencies for three key groups: leaders, public health specialists and frontline staff (Stansfield 2015). Each competency identified in this thesis may therefore need to be adjusted to the specific working environment and the role of the professional working in that setting. Refining the required competencies and expertise levels for the setting can be seen as a continuous capacity-building development process of each organisation and mental health promotion setting. It may be necessary to

review the competencies periodically to meet the changing demands and challenges in the health sector and in mental health promotion work.

Although these competencies were identified in relation to the health sector, they can be applied, tested and modified, as applicable, to different workforce and different sectors. They can be utilised in increasing the competence and capacity of the municipalities' wider workforce to promote and improve mental health. Effective mental health promotion includes a wide range of activities, from raising awareness to supporting and sustaining new skills and initiatives. These competencies may be adjusted according to the setting and the role of the professional working in that setting, whether it is the environment, education or leisure sector.

The competencies can be used to assess the level of proficiency of the workforce in mental health promotion and public mental health practice, and as a follow-up to see the possible changes in their knowledge and skills after training or years of service. The competencies can work as a tool to help to identify training needs of staff as well. In addition, they can be used by individual staff members as a guide and self-assessment tool to appraise their current knowledge, skills, and attitudes and values, and to identify areas for personal and professional development.

An initial familiarisation with curricula of higher education providers in the health sector in Finland (e.g. nursing education, medical training, health education and promotion training) showed that course contents vary considerably. For example, many of the mental health-related training seemed to concentrate on mental health problems, prevention and care, and not on the positive aspects of mental health and mental health promotion (look also Partanen et al. 2015; Kivelä 2016; Mäkelä et al. 2018). Naturally, this brief desk review does not fully reflect the practice of training but does offer some indications of the minor or absent role of mental health promotion in the education and training programmes. As the promotion of mental health is gaining more official endorsement, this would be a good time to put more effort into designing course contents in mental health promotion and increasing the number of programmes in mental health promotion in Finnish higher education units and other training institutions. The competencies provide a tool to develop and enhance education and training programmes, thus contributing to a more skilled workforce. Course developers, teachers and trainers can use these competencies to inform the production and delivery of education and training programmes. They provide guidance and a framework for course content through which learning can be achieved. To give an example, the competencies identified in this doctoral thesis and reported in an article (Tamminen et al. 2018) are being used as course learning material and recommended literature in the Evidence-based Mental Health Promotion course at Jyväskylä University of Applied Studies (Jyväskylä University of Applied Sciences 2020). This gives further evidence of the relevancy of the identified competencies and how they can be a much-needed resource for education and training institutions and organisations.

In Finland, the professionals whose work includes mental health promotion represent a diverse workforce with varying levels of training and qualifications. This needs to be taken into consideration when planning mental health promotion education and training and continuing professional development, in order to ensure adequate emphasis on each competency area. Appropriate and relevant education and training and workforce development are critical to successful implementation of mental health promotion actions and interventions.

7.3.2 Suggestions for future research

As earlier studies have shown, these competencies are timely and needed. An interesting future step would be to use observation methods to examine mental health promotion competencies in a real practice setting and compare the results with the findings of this study. Moreover, it would be beneficial to find out how the competencies identified here could be utilised in practice settings in the best possible way to enhance the implementation of mental health promotion. Evaluation research answering the questions of what, how and when would provide needed evidence of, for example, what competencies are most crucial in the implementation of mental health promotion. To support this, a tool to assess and measure the competencies would be a recommended research development. These study findings offer a foundation for development work of new or possible extensions of already existing measurement scales and indicators to assess the competence and proficiency level of professionals in mental health promotion.

Intervention research could be applied to investigate the effectiveness and impact of mental health promotion training regarding the outcomes of a project that aims to strengthen positive mental health. Outcomes could be measured, for example, in relation to growth in competency of those trained or an increase in the positive mental health of the project stakeholders. A further nuance would be achieved if training would be provided only to certain individuals or projects carrying out mental health promotion, and during and after implementation of these projects comparison of inputs, processes and outcomes in each project would be made.

Within education and training contexts, a future study topic would be to assess and measure the increase of the competency proficiency of students as a result of mental health promotion education or training. In addition, pedagogical studies could be carried out to investigate what kinds of teaching and learning strategies enable growth in mental health promotion competency. As mental health promotion competencies include knowledge, skills, and attitudes and values, it would be expected that different teaching and learning strategies need to be used to increase competency in each domain.

These competencies were originally identified in relation to the health sector setting. Even though they can be adapted and applied to other sectors, it would be worthwhile to investigate possible mental health promotion-related competencies in other sectors as well. This is especially valuable, as mental

health is influenced by so many diverse factors that operate on different levels and in different sections of society. Much mental health promotion work is carried out by NGOs, and often this valuable work goes unnoticed. This would warrant future research on the activities and programmes of non-governmental organisations and associations, in order to evaluate their work and mental health-promoting competencies.

Another interesting perspective would be to compare the mental health promotion competencies presented in this thesis with mental health promotion-related competencies identified in other sectors. Furthermore, as intersectoral collaboration and partnership work were identified as key competencies of mental health promotion, it would be valuable to conduct a study exploring how and to what degree intersectoral collaboration exists at different levels of society in Finland: at a policy level in the strategy developments and implementations of ministries and municipalities, and at a more local level in municipalities in the practices of professionals whose remit lies within mental health promotion. Identifying positive partnership processes would enhance mental health promotion collaboration and actions to promote positive mental health.

8 CONCLUSIONS

There is a timely requirement to improve the mental health and well-being of all. The importance of good mental health is widely acknowledged (Knapp et al. 2011; WHO 2013b), and it is of utmost importance to place effort towards all actions that aim to support and strengthen mental health and well-being. A skilled and competent workforce is needed to translate research and policies into successful mental health promotion practice. This study provides new and highly needed information on what competencies are required to plan, implement and evaluate mental health promotion in health sector practice, with the aim of contributing to a more skilled and effective workforce. The identified competencies highlight the great variety of different abilities and skills needed for mental health promotion, ranging from theoretical knowledge to practical skills, and further comprising attitudes and values.

The study offers a well-timed response to the scarcity of knowledge on mental health promotion competencies. Further, it provides evidence to support the goals of the Finnish National Mental Health Strategy and Programme for Suicide Prevention 2020–2030 (Ministry of Social Affairs and Health 2020b) by identifying the required competencies for successful mental health promotion practice.

These competencies can be used to inform education and training and capacity building for professional practice in mental health promotion. They provide aid in planning education and training programmes and qualifications in mental health promotion. Furthermore, they can help in developing job descriptions and roles in health sector workplaces that involve the promotion of mental health. The competencies allow identification and assessment of each competency, thus advancing professional development and abilities to promote mental health.

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APPENDICES

APPENDIX 1 Focus group interview guide

Fokusryhmähaastattelun runko
(Focus group interview guide)

1. **Haastattelun tarkoitus ja eteneminen lyhyesti** (haastattelija)
   (The purpose and progress of the interview briefly, interviewer)
2. **Esittelykierros** (Introductions)
   - osallistujien lyhyt esittely (toimii myös johdatuksena keskusteluun)
     (short introductions of the participants, leads also to the discussion)
3. **Teema I Mielenterveys** (Theme I Mental health)
   - pohjustusta aiheeseen, määrittelee myös mielenterveyden edistämistä
     (into the topic, also defining mental health promotion)
   - mitä on mielenterveys - millaista se on - mitä se tarkoittaa
     (what is mental health - what kind of it is - what does it mean)
   - miten se näkyy ihmisessä/toiminnoissa
     (how does is appear/show in individuals/functions)
4. **Teema II Mielenterveyden edistäminen** (Theme II Mental health promotion)
   - mitä on mielenterveyden edistäminen
     (what is mental health promotion)
   - mitä siinä edistetään
     (what is promoted)
   - miten edistetään mielenterveyttä - kertokaa esimerkkejä
     (how is mental health promoted – give examples)
   - mielenterveyden edistäminen terveydenhuollon/sektorin käytännöissä - kertokaa esimerkkejä
     (mental health promotion in the health care/sector practice – give examples)

- kuka tekee edistämistyötä – terveydenhuollossa/sektorilla
  (who does mental health promotion work – health care/sektor)

- oletko sinä tehnyt edistämistyötä – millaista/ millaisessa roolissa
  (have you done mental health promotion work – what kind of/ in what role)

- tarvitaanko mielenterveyden edistämistä, miksi
  (is mental health promotion needed, why)

5. **Teema III Mielenterveyden edistämisen osaaminen** (Theme III Competencies for mental health promotion)

   - millaista osaamista mielenterveyden edistämiseen tarvitaan
     (what kind of competencies are needed to promote mental health)

   - millaista mielenterveyden edistämisen osaaminen on
     (what are mental health promotion competencies)

   - millaisia taitoja / tietoja / kykyjä / asenteita se sisältää
     (what kind of skills/knowlegde/abilities/attitudes is involves)

   - millaista mielenterveyden edistämisen osaamista
     (tiedot/taidot/kyvyt/asenteet) tarvitaan terveydenhuollon/sektorin käytännöissä – kertokaa esimerkkejä
     (what kind of competencies [knowlegde/ skills/abilities/attitudes) are needed in health care/sector practice – give examples)

   - miten mielenterveydenedistämisen osaaminen / osaamattomuus näkyy terveydenhuollon/sektorin käytännöissä – kertokaa esimerkkejä
     (how does mental health promotion competence/incompetence appear in health care/sector practice)

   - kuka tarvitsee mielenterveyden edistämisen osaamista yleisesti/ terveydenhuollossa
     (who needs mental health promotion competencies generally/ in health care/sector)

   - mistä tätä osaamista saadaan - mistä sitä tulisi saada
     (where is this competecy received from – where should it be received from)

APPENDIX 2 QUESTIONNAIRE

TUTKIMUS: MIELENTERVEYDEN EDISTÄMISEN OSAAMINEN TERVEYSSEKTORILLA
(STUDY: MENTAL HEALTH PROMOTION COMPETENCIES IN THE HEALTH SECTOR)

TAUSTATIEDOT (Background information)

1. Sukupuoli (gender)
   1. nainen (female)
   2. mies (male)

2. Ikä (age)_____

3. Koulutus (Education)
   _____

4. Ammatti (Profession)
   _____

5. Kokemuksenne mielenterveyden edistämistyöstä (Your experience of mental health promotion work):

   a. Millaisessa yksikössä teette/ olette tehneet mielenterveyden edistämistyötä? (In what kind of unit do/did you do mental health promotion work?)
      _____
      _____
      _____

   b. Kuinka kauan olette tehneet mielenterveyden edistämistyötä? (How long have you been doing mental health promotion work?)
      _____
      _____
      _____

   c. Millainen työnkuvanne mielenterveyden edistämistyössä on/on ollut? (What kind of work description do you have/have had in mental health promotion?)
      _____
      _____
      _____

MIELENTERVEYS (Mental health)

6. Mitä teidän mielestänne on mielenterveys, mitä se tarkoittaa? – voitte antaa esimerkkejä (What is mental health in your opinion, what does it mean? – you can give examples.

   _____
   _____
   _____

7. Miten mielenterveys näkyy ihmisessä/toiminnassa/jne.? (How does mental health show in individulas/functions/etc.?)

   _____
   _____
   _____

MIELENTERVEYDEN EDISTÄMINEN (Mental health promotion)

8. Mitä teidän mielestänne on mielenterveyden edistäminen? Mitä siinä edistetään? (In your opinion, what is mental health promotion? What is promoted?)

   _____
   _____
   _____

9. Miten mielestänne edistetään mielenterveyttä? – voitte kertoa esimerkkejä (In your opinion, how is mental health promoted? – you can give examples)

   _____
   _____
   _____

10. Miten mielenterveyden edistäminen ilmenee terveyssektorin käytännöissä? – voitte kertoa esimerkkejä
    (How does mental health promotion appear in health sector practice? – you can give examples)

    _____
    _____
    _____

11. Kuka tekee mielenterveyden edistämistyötä? Entä terveyssektorilla?
    (Who does mental health promotion work? What about in the health sector?)

    _____
    _____
    _____

12. Oletteko itse tehnyt mielenterveyden edistämistyötä – millaista/ millaisessa roolissa? (Have you done mental health promotion work – what kind/in what role?)

_____
_____
_____

13. Tarvitaanko mielenterveyden edistämistä, ja jos, niin miksi?
(Is mental health promotion needed, if yes, why?)

_____
_____
_____

MIELENTERVEYDEN EDISTÄMISEN OSAAMINEN
(Mental health promotion competencies)

14. Millaista osaamista teidän mielestänne tarvitaan mielenterveyden edistämiseen/ edistämistyöhön? (In your opinion, what competencies are needed to promote mental health/ in mental health promotion work?)

_____
_____
_____

15. Millaisia taitoja/tietoja/kykyjä/asenteita mielenterveyden edistämisen osaaminen sisältää? (What kind of skills/knowledge/abilities/attitudes mental health promotion includes?)

_____
_____
_____

16. Millaista mielenterveyden edistämisen osaamista (tiedot/taidot/kyvyt/asenteet) tarvitaan terveyssektorin käytännöissä? – voitte kertoa esimerkkejä (What kind of mental health promotion competencies (knowledge/skills/abilities/attitudes) are needed in health sector practice? – you can give examples)

_____
_____
_____

17. Miten mielenterveyden edistämisen osaaminen/osaamattomuus näkyy terveyssektorin käytännöissä? – voitte kertoa esimerkkejä (How does competence/incompetence in mental health promotion appear in health sector practice? – you can give examples)

_____
_____
_____

18. Kuka/ ketkä teidän mielestänne tarvitsevat mielenterveyden edistämisen osaamista? (In your view, who needs mental health promotion competencies?)

_____
_____
_____

19. Mistä tätä osaamista saadaan / tulisi saada? (From where are these competencies obtained/should be obtained?)

_____
_____
_____

APPENDIX 3 DELPHI QUESTIONNAIRE ROUND 1 (CONCISE VERSION)

DELPHI-KYSELY, 1. KIERROS (Delphi questionnaire, 1. round)

Tutkimus mielenterveyden edistämisen osaamisesta terveyssektorilla (Study on mental health promotion competencies in the health sector)

Osa 1. Johdatus kyselyyn ja ohjeet sekä osallistujan taustatiedot
(Part 1. Introduction to the questionnaire, instructions and background of the participant)

Background information:
Gender
Age
Employment status
Education
Region
Work experience in MHP (in years)
Own competency of MHP

Mielenterveyden edistämisen asiantuntijuus
(Mental health promotion expertise)

Merkitse alla olevaan asiantuntijamatriisiin, mihin ryhmään/ryhmiin koet kuuluvasi. (Mark in the matrix below, into what group/s you belong)

	HALLINTO (governance and administration)	KOKEMUS-ASIANTUN-TIJUUS (expert by experience)	TUTKIMUS JA KEHITTÄMINEN (research and development work)	OPETUS (Education)	TYÖ-ELÄMÄ (Worklife)
VALTIOT JA KUNNAT (JULKIS-SEKTORI) (Government and municipalities, Public sector)					
JÄRJESTÖT (KOLMAS SEKTORI) (Non-Governmental organisations, third sector)					

YKSITYI-NEN SEK-TORI (Private sector)					
MUUT (other)					

Osa 2. Teoreettinen tieto-osaaminen (Part 2. Theoretical knowledge)

Mielenterveyden edistämisen periaatteet ja käsitteet
(Mental health promotion principles and concepts)

Miten tärkeänä pidät mielenterveyden edistämisen periaatteiden ja käsitteiden tiedollista osaamista mielenterveyden edistämistyössä terveyssektorilla?
(How important are mental health promotion principles and concepts in mental health promotion work in the health sector?)

TÄRKEYS (importance)

Ei lainkaan tärkeä/ Melko vähän tärkeä/ Ei vähän, eikä melko tärkeä/ Melko tärkeä/ Erittäin tärkeä
(Not at all important/ Slightly important/ Not slightly nor fairly important/ Fairly important/ Very important)

Ihmisen kehitys (Human development)

Miten tärkeänä pidät tietoa ihmisen kehityksestä mielenterveyden edistämistyössä terveyssektorilla?
(How important do you think is the knowledge of human development in MHP work in the health sector?)

Positiivinen psykologia (Positive psychology)

Miten tärkeänä pidät tietoa positiivisesta psykologiasta mielenterveyden edistämistyössä terveyssektorilla?
(How important do you think is…)

Yhteiskunnallinen ymmärrys (Societal understanding)

Ihmisoikeudet (Human rights)

Osa 3. Käytännön taidot (Part 3. Practical skills)

Viestintätaidot (Communication skills)

Ihmissuhdetaidot (Interpersonal skills)

Tarvearviointitaidot (Needs assessment skills)

Suunnittelutaidot (Planning skills)

Toimeenpanotaidot (Implementation skills)

Taito tunnistaa positiivisen mielenterveyden osatekijöitä (Ability to recognise positive aspect of mental health)

Taito tunnistaa mielenterveyden riskitekijöitä (Ability to recognise risk factors of mental health)

Ohjaustaidot (Guidance skills)

Yhteistyötaidot (Collaboration skills)

Johtajuustaidot (Leadership skills)

Arviointi- ja tutkimustaidot (Evaluation and research skills)

Vaikuttamistaidot (Advocacy skills)

Markkinointitaidot (Marketing skills)

Monisektoriaaliset työskentelytaidot (Multisectoral working skills)

Osa 4. Henkilökohtaiset asenteet (Part 4. Personal attitudes)

Positiivinen asenne (Positive attitude)

Avarakatseinen (Open-minded)

Uudet työskentelytavat (New ways of working)

Kokonaisvaltainen lähestymistapa (Holistic approach)

Monitieteellinen lähestymistapa (Multidisciplinary approach)

Osa 5. Henkilökohtaiset arvot (Part 5. Personal values)

Ihmisoikeuksien kunnioittaminen (Respecting human rights)

Tasa-arvo (Equality)

Asiakasystävällisyys (Client-friendly)

Osa 6. Muu osaaminen (Part 6. Other competencies)

- Mitä muuta osaamista tarvitaan? (What other competencies are needed?)
- Osaamisalueiden otsikot (Competency headings)

Mitä mieltä olet jaottelusta? Onko se sinusta hyvä jako vai huono? Mitä muita otsikoita voisi olla tai pitäisikö otsikot kirjoittaa toisessa muodossa?
(What do you think of the categorisation? Do you think they are good or not so good? What other headings there could be or should they be written in a different form?)

APPENDIX 4 DELPHI QUESTIONNAIRE ROUND 2 (CONCISE VERSION)

DELPHI-KYSELY, 2. KIERROS (Delphi questionnaire, 2. round)

Osa 1. Johdatus kyselyyn ja ohjeet (Part 1. Introduction to the questionnaire and instructions)
Tutkimus mielenterveyden edistämisen osaamisesta terveyssektorilla
(Study on mental health promotion competencies in the health sector)

Osa 2. Teoreettinen tieto-osaaminen (Part 2. Theoretical knowledge)

1. Mielenterveyden **edistämisen periaatteet ja käsitteet** (Principles and concepts of mental health promotion)

Mielenterveyden edistämisen periaatteiden ja käsitteiden tietämys on keskeistä mielenterveyden edistämistyössä terveyssektorilla.
(Knowledge of principles and concepts of MHP is essential in mental health promotion work in the health sector.)

Merkitse alla olevaan asteikkoon, mitä mieltä olet esitetystä väitteestä. Voit myös kommentoida vastaustasi. (Mark in the scale below what you think of the statement. You can also comment on your response.)

Täysin eri mieltä/ Jokseenkin eri mieltä/ Ei eri eikä samaa mieltä/ Jokseenkin samaa mieltä/ Täysin samaa mieltä (Strongly disagree/ Disagree/ Not disagree, nor agree/ Agree/ Strongly agree)

Aseta alla esitetyt osaamisalueet tärkeysjärjestykseen.
Alla olevaan kommentoi-laatikkoon voit perustella valintaasi. (Arrange the competencies below in the order of importance. In the box below, you can give reasons for your choice.)

1.1 tuntee mielenterveyden edistämisen periaatteet kuten positiivisen mielenterveyden käsite, resilienssi, vahvuuksien ja voimavarojen merkitys sekä tukea antavien elinolojen ja –ympäristön merkitys (knowledge of the principles of MHP such as the concept of positive mental health, resilience, and the importance of strengths and resources and supportive living conditions and environments)

1.2 tuntee mielenterveys-käsitteen (knowledge of the concept of mental health)

1.3 tuntee mielenterveyden riskitekijät (knowledge of the risk factors of mental health)

1.4 tuntee mielenterveyden edistämisen vaikuttavia menetelmiä, käytäntöjä ja työkaluja (knowledge of effective methods, practices and tools for mental health promotion)

2. Ihmisen kehitys (Human development)

Ihmisen psykososiaalisen ja fyysis-motorisen kehityksen tietämys on keskeistä mielenterveyden edistämistyössä terveyssektorilla. (Knowledge of human psychosocial and physiological development is essential in MHP work in the health sector)

2.1 tuntee mielenterveyden edistämisen päämääriä ja toimintoja elämänkaarinäkökulman mukaisesti (knowledge of MHP aims and activities according to the life course approach)

2.2 tuntee ihmisen psykososiaalisen ja fyysismotorisen kehityksen (knowledge of the psychosocial and physiological human development)

3. Yhteiskunnallinen ymmärrys (Societal understanding)

Tietämys yhteiskunnan merkityksestä mielenterveydelle ja mielenterveyden edistämistyölle on keskeistä mielenterveyden edistämistyössä terveyssektorilla. (Knowledge of the importance of society to mental health and mental health promotion work is essential.)

3.1 ymmärtää yhteiskunnan toimintaa ja siihen vaikuttamista (understanding how society works and how to influence on it)

3.2 ymmärtää yhteiskunnassa vallitsevia mielenterveyttä tukevia ja mielenterveyttä haastavia tekijöitä (understanding the factors that support and challenge mental health in society)

3.3 ymmärtää eri sektoreiden merkityksen mielenterveyteen ja niiden roolin mielenterveyden edistämisessä (understanding the significance of different sectors and their role in mental health promotion)

3.4 ymmärtää mielenterveyden edistämisen merkityksen väestötasolla (understanding the importance of mental health promotion at population level)

3.5 ymmärtää poliittisen päätöksenteon vaikutukset hyvinvointiin ja mielenterveyden edistämiseen (understanding the influence of political decisions on wellbeing and mental health promotion)

4. Ihmisoikeudet (Human rights)

Tietämys ihmisoikeuksista on keskeistä mielenterveyden edistämistyössä. (Understanding of human rights is essential in mental health promotion work.)

4.1 tuntee ihmisoikeudet kuten tasa-arvo, oikeudenmukaisuus ja toisen arvostaminen ja kunnioittaminen (knowledge of equality, justice, and appreciation and respect for others)

4.2 tuntee ihmisoikeuksien näkyväksi tekemistä ja toteutumista mielenterveyden edistämistyössä (knowledge of making human rights visible and realisalised in MHP work)

4.3 tuntee kulttuurien välisiä eroja ja yhtäläisyyksiä ja niiden merkitystä mielenterveyden edistämistyöhön (knowledge of cultural differences and similarities and their significance to MHP work)

Osa 3. Käytännön taidot (Part 3. Practical skills)

5. Viestintätaidot (Communication skills

Viestintä ja tiedottaminen tiedon välittämiseksi muille ja teknologisten viestintätapoja käyttäminen viestinnän apuna on keskeistä mielenterveyden edistämistyössä. (Communication and information dissemination to others and with the use of technological communication methods are essential in mental health promotion work?)

5.1 hallitsee eri viestintämenetelmiä, mukaan lukien suullinen ja kirjallinen taito sekä teknologiset viestintätavat (mastering different communication methods, including verbal and written communication as well as technological communication methods)
5.2 tiedottaa mielenterveyden edistämiseen liittyvistä tekijöistä ja toiminnoista (providing information on factors and activities related to mental health promotion
5.3 lisää viestinnän avulla tietoa mielenterveyden edistämiseen liittyvistä asioista (increasing knowledge of mental health promotion via communication)
5.4 vaikuttaa viestinnän avulla yleisiin mielenterveyttä edistäviin ja vahvistaviin asenteisiin, tavoitteena mm. stigman vähentäminen (influencing via communication positive and supportive attitude towards mental health, aiming at reducing stigma

6. Ihmissuhdetaidot (Interpersonal skills)
6.1 - 6.4
7. Tarvearviointitaidot (Needs assessment skills)
7. 1 - 7.6

8. Suunnittelutaidot (Planning skills)
8.1 - 8.3
9. Toimeenpanotaidot (Implementation skills)
9.1 - 9.2
10. Yhteistoimintataidot (Collaboration skills)
10.1 - 10.4
11. Johtajuustaidot (Leadership skills)
11.1 - 11.4
12. Arviointi- ja tutkimustaidot (Evaluation and research skills)
12.1 - 12.5
13. **Vaikuttamistaidot (Advocacy skills)**
13.1 - 13.5

Osa 4. Henkilökohtaiset asenteet ja arvot (Part 4. Personal attitudes and values)

14. Myönteinen asenne (Positive attitude)
14.1 - 14.4
15. Avarakatseisuus (Broadmindness)
15.1 - 15.4
16. Uudet työskentelytavat (New ways of working)
16.1 - 16.7
17. Kokonaisvaltainen lähestymistapa (Holistic approach)
17.1 - 17.3
18. Asiakaslähtöisyys (Client-centred)
18.1 - 18.5
19. Eettiset arvot (Ethical values)
19.1 - 19.3

APPENDIX 5 EXPERTS BY EXPERIENCE EVALUATION FORM (CONCISE VERSION)

Mielenterveyden edistämisen osaaminen terveyssektorilla Suomessa
(Mental health promotion competencies in the health sector in Finland)

Fokusryhmä (Focus group meeting)

Arviointilomake osallistujille (Participant's evaluation form)

Miten tärkeänä näet seuraavat osaamisalueet mielenterveyden edistämistyössä terveyssektorilla? (In your view, how important are the following MHP competencies in the health sector practice?)

ARVIOI ASTEIKOLLA 1-5. YMPYRÖI OMA NÄKEMYKSESI. (Assess on scale 1-5. Circle your choice)

1= ei lainkaan tärkeä, 5=erittäin tärkeä.
(1= not at all important, 5= very important)

1. Mielenterveyden edistämisen periaatteet ja käsitteet (Principles and concepts of mental health promotion)

1	2	3	4	5

2. Ihmisen kehitys (Human development)

3. Yhteiskunnallinen ymmärrys (Societal understanding)

4. Ihmisoikeudet (Human rights)

5. Viestintätaidot (Communication skills)

6. Ihmissuhdetaidot (Interpersonal skills)

7. Tarvearviointitaidot (Needs assessment skills)

8. Suunnittelutaidot (Planning skills)

9. Toimeenpanotaidot (Implementation skills)

10. Yhteistoimintataidot (Collaboration skills)

11. Johtajuustaidot (Leadership skills)

12. Arviointi- ja tutkimustaidot (Evaluation and research skills)

13. **Vaikuttamistaidot** (Advocacy skills)
14. **Myönteinen asenne** (Positive attitude)
15. **Kokonaisvaltainen asenne** (Holistic approach)
16. **Eettiset arvot** (Ethical values)

ORIGINAL PAPERS

I

A SYSTEMATIC CONCEPT ANALYSIS OF MENTAL HEALTH PROMOTION

by

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A systematic concept analysis of mental health promotion

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ABSTRACT

This study explored and clarified the nature and characteristics of the concept of mental health promotion. The study also investigated how these characteristics appear in current policies and strategies. A total of 30 scientific articles and policy documents were identified and analysed using Rodgers's systematic evolutionary concept analysis method. The analysis provided valuable information on the attributes, related concepts, antecedents, consequences and references of mental health promotion, indicating that the concept is a distinct concept comprising a unique set of attributes and characteristics. A concept mapping of mental health promotion was subsequently developed. The analysis and the concept mapping provide health professionals, policy-makers and researchers with a framework, upon which well-grounded mental health promotion practice and evaluation research can be based.

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Mental health promotion; mental health; concept analysis; Rodgers's evolutionary method; concept mapping; characteristics

Introduction

Attempts have been made to define the concept of mental health promotion by various academics and professionals over the last couple of decades. However, agreement on a common, universally acceptable definition has proven difficult (e.g. Barry, 2001; Herrman & Jané-Llopis, 2005). This is because there are differing views on the concept, which are the result of the different understandings, frameworks and cultural considerations belonging to those looking at the concept. In addition, discussions surrounding the concept have been guided by various conceptualisations of mental health. A common feature has been the rather puzzling use of the term 'mental health' to describe matters related to mental ill health, causing confusion regarding the relationship between mental health and mental illness. Such differing definitions make it difficult to comprehend what mental health promotion is and what it constitutes.

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Aim of the study

The aim of this study is to conduct a theoretical concept analysis to explore what is understood by the concept of mental health promotion in the literature. The analysis involves an in-depth exploration of the different definitions and understandings of mental health promotion and examines and clarifies the features and characteristics of the concept in order to provide greater clarity on the definition upon which well-grounded mental health promotion practice and evaluation research can be based. The study employs an evolutionary model of concept analysis provided by Rodgers (1989, 2000). Specifically, the analysis will identify the attributes, related concepts, antecedents, consequences, references and possible surrogate terms relating to mental health promotion. Furthermore, a concept mapping of mental health promotion will be developed. The analysis and the concept mapping will provide health professionals, policy-makers and researchers with a context and a framework, upon which they can plan and implement mental health promotion practice as well as initiate further scientific study. Moreover, how these characteristics of mental health promotion appear in well-acknowledged policies and strategies in mental health – such as the newly launched WHO Global mental health action plan (World Health Organization, 2013a) – will be discussed.

Background

The different views of mental health promotion appear to reflect how mental health is understood. However, definitions of mental health are diverse and affected by the culture and the context that define them. In general, definitions also vary as a function of time and place. Furthermore, the meanings of the definition of mental health may depend on socio-economic and political influences (Kovess-Mastefy, Murray, & Gureje, 2005; Rogers & Pilgrim, 2005). The importance of context is also acknowledged by the World Health Organization (2014a). However, it has also proposed a definition that can be universally accepted regardless of cultural values. The organization's view is that mental health possesses a core common-sense universal meaning that can be understood across cultures. Vaillant (2012) presents seven different models of mental health that offer an excellent perspective on the complex and multifaceted aspects of mental health and provide a straightforward way of trying to understand the theoretical and cultural starting points of each model. To give an example, Vaillant traces the model of 'mental health as subjective well-being' back through history to the philosophers' contemplations of happiness. Nowadays, the model of mental health as subjective well-being is employed, for example, in positive psychology and the work on flourishing (e.g. Huppert & So, 2013; Keyes & Simoes, 2012).

The various definitions of mental health promotion thus originate from the different understandings of mental health. The majority of the definitions, however, share the common view of mental health as being more than the absence of mental illness. Moreover, many of the definitions emphasise the concept of positive mental health, thus widening the understanding of mental health further. Furthermore, the emphasis on positive mental health also reflects the view that good mental health is a resource for everyday life and contributes to quality of life and well-being (Barry & Jenkins, 2007).

Some definitions of mental health promotion are presented in Table 1 in order to illustrate the approaches and understandings used and the difficulty in creating a shared

Table 1. Examples of mental health promotion definitions with different emphases.

Environmental determinants in focus
'Mental health promotion is concerned with enabling people to maximize their wellbeing through influencing the environmental determinants of mental health. These determinants are broadly based in all aspects of life and, as a consequence, the gains from mental health promotion activities generalise to improvements in physical health as well as productivity in the school, home and workplace'. (Commonwealth Department of Health & Aged Care 2000, 2000)
Promoting positive mental health
'Mental health promotions aims to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments'. (World Health Organization, 2004)
Competence enhancement perspective
'Mental health promotion targets the whole population and focuses on enabling and achieving positive mental health. This multidisciplinary area of practice aims to enhance well-being and quality of life for individuals, communities and society in general. Mental health promotion conceptualises mental health in positive rather than in negative terms and delivers effective programmes designed to reduce health inequalities in an empowering, collaborative and participatory manner. Mental health promotion endorses a competence enhancement perspective and seeks to address the broader determinants of mental health'. (Jané-Llopis et al., 2005)
Comprising both promotion and prevention strategies
'Mental health promotion includes both preventing illness and increasing wellbeing'. (Perth Charter for the Promotion of Mental Health & Wellbeing, 2012)

understanding on the concept. It is worth noting that the position or background affiliation of the definer of the concept affects the definition itself. Each definition emphasises different aspects of mental health promotion, for example, environmental determinants of mental health (Commonwealth Department of Health & Aged Care 2000, 2000) or competence enhancement approaches (Jané-Llopis, Barry, Hosman, & Patel, 2005).

Methods

Rodgers's evolutionary method

Rodgers's evolutionary method of concept analysis formed the framework for the theoretical analysis of the concept of mental health promotion (1989, 2000). As Rodgers' model has been widely used in health sciences, especially in nursing and health sciences (e.g. Balwin, 2008; Sykes, Wills, Rowlands, & Popple, 2013), it was considered to be an appropriate method to utilise when analysing the concept of mental health promotion. According to Rodgers (1989), analysis of the common use of a concept enables it to be defined and clarified, and as a result, used more effectively. Rogers's model is based on the idea that concepts are dynamic, continually changing and developing as a result of their significance, use and application (1989, 2000). Moreover, concepts contribute to the continuing development of knowledge through their explanatory or descriptive powers. Rodgers' approach provides a methodological approach to explore the multifaceted nature of the concept of mental health promotion through inductive inquiry and rigorous analysis. The method involves a systematic analysis of key elements of the concept such attributes, related concepts, antecedents, consequences, references of the concept and possible surrogate terms. The attributes of the concept refer to the key characteristics that define the concept. Rodgers (2000) states that 'identification of the attributes of the concept represents the primary accomplishment of concept analysis and constitutes a "real" definition of a concept' (p. 91). Related concepts are concepts that have a relation to the concept being analysed. However, they do not share the same set of attributes. Surrogate terms, on the other hand, are terms that are used interchangeably to express the same concept. (Rodgers, 2000). Antecedents are events or incidents that either occur or are in place prior to the occurrence of the concept. Consequences,

on the other hand, are events or incidents that occur as a result of the occurrence of the concept. (Rodgers, 1989, 2000). References of the concept refer to actual situations where the concept is being applied (Rodgers, 2000). Identification of the relevant characteristics of the concept add to the knowledge and understanding of mental health promotion and provide a clearer description of its relevant uses, while taking into consideration possible changes in the concept over time.

Rodgers's (2000) evolutionary model of concept analysis includes six activities:

(1) identifying the concept of interest
(2) identifying and selecting the setting and sample
(3) collecting and managing the data
(4) analysing the data
(5) identifying an exemplar, if appropriate
(6) interpreting the results and identifying implications for further development of the concept.

Data search

The data sources included electronic databases EBSCO, Medline, Web of Science and ASSIA as well as Google Scholar as an additional source. *Mental health promotion* and *promotion of mental health* as they appeared in the title or abstract were used as keywords for the literature search. The search was subsequently narrowed down by combining each keyword separately with words *concept* and *definition* using the Boolean operator AND (except for Google Scholar). The search was limited to texts written in English as translation of non-English papers was not available. No time limit was set. All titles and abstracts retrieved were scanned for relevance and eligibility, that is, whether they were dealing with definitions or concepts of mental health promotion or promotion of mental health. Duplicates and articles not relevant or not meeting the inclusion criteria were removed. More research articles were searched for manually from the International Journal of Mental Health Promotion. In addition, reference lists for articles were examined via a snowball technique (Lewis-Beck, Bryman, & Liao, 2004) for any relevant literature not identified through the electronic databases. Full-text papers were obtained for articles that were selected for inclusion. Papers were subsequently selected relating to definitions of mental health promotion and promotion of mental health. The initial search process carried out in November 2013 produced 1806 articles, of which 30 articles were selected for full-text review. Of these, 10 articles did not meet the inclusion criteria. As a result, the data consisted of 20 research articles. Furthermore, seven high-level policy and strategy documents in mental health – six international and one Finnish national (English translated version) – were included in the analysis to widen the perspective, resulting in a total number of 27 texts being included. Repeated searches were conducted in December 2014 and April 2016 to update the results and include articles published between November 2013 and April 2016. During the repeated searches, a further three articles were identified. As a consequence, the final data-set comprised 30 texts for analysis. Figure 1 presents the search process and the results in more detail.

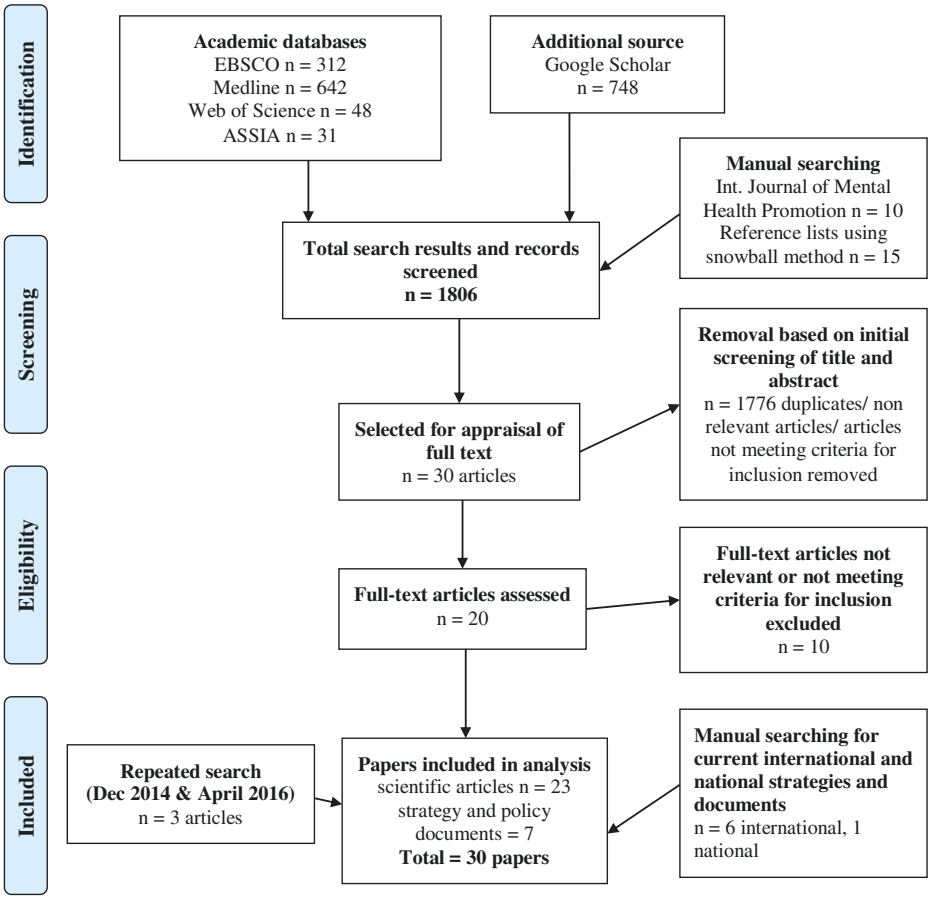

Figure 1. Search process and results.

Analysis of the data

The articles and documents were first read through in order to become familiar with the data. The texts were then re-read twice in order to systematically classify the data into relevant categories: attributes, related concepts, antecedents, consequences, surrogate terms and references related to mental health promotion (Rodgers, 2000). A meaning unit consisted of a half or full sentence, or a paragraph containing one idea or piece of information containing the contextual meaning. Thematic analysis was carried out and each category of data was examined to identify major themes in the literature. Colour codes were used to aid the thematic grouping and highlight the different features of the concept. The data were subsequently collected and characteristics relating to the specific categories (attributes, antecedents, etc.) were recorded on a data matrix. Table 2 shows the articles and documents reviewed in the analysis and the core characteristics identified in the analysis.

Table 2. Articles and documents reviewed and core characteristics identified in the analysis.

Article	Attributes	Related concepts	Antecedents	Consequences	References of the concept
Hodgson, 1996; Wales	partnerships well-being	prevention of mental health disorders	mental health and mental health promotion valued political will evidence-base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health	goal to promote/ improve mental health levels of action in mental health promotion public health
Joubert & Raeburn, 1998; Canada & New Zealand	empowerment well-being	prevention of mental health disorders	mental health and mental health promotion valued political will	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health	goal to promote/ improve mental health levels of action in mental health promotion public health
Orley & Birrell Weisen, 1998; Switzerland	mental well-being	prevention of mental health disorders	mental health and mental health promotion valued	improved mental health and well-being reduced risk for/ prevention of mental ill-health	goal to promote/ improve mental health levels of action in mental health promotion
Secker, 1998; UK	positive mental health empowerment participation	prevention of mental health disorders	mental health and mental health promotion valued research	improved mental health and well-being reduced risk for/ prevention of mental ill-health	goal to promote/ improve mental health levels of action in mental health promotion health promotion
Friedli, 1999; UK	participation multisectoral mental well-being, well-being	prevention of mental health disorders	mental health and mental health promotion valued political will	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health	goal to promote/ improve mental health levels of action in mental health promotion public health
MacDonald, 1999; UK	empowerment participation	prevention of mental health disorders	mental health and mental health promotion valued political will	improved mental health and well-being reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion public health, health promotion

Mauthner, Killoran-Ross, & Brown, 1999; UK	positive mental health well-being	prevention of mental health disorders	mental health and mental health promotion valued political will	improved mental health and well-being	goal to promote/ improve mental health levels of action in mental health promotion
Sainsbury, 2000; Australia	positive mental health participation multisectoral well-being	prevention of mental health disorders	mental health and mental health promotion valued political will	improved mental health and well-being reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion public health
Stansfield, 2000; UK	positive mental health empowerment participation partnerships mental well-being	prevention of mental health disorders	mental health and mental health promotion valued political will research, theory-base, evidence-base	improved mental health and well-being	goal to promote/ improve mental health health promotion
Barry, 2001; Ireland	positive mental health empowerment intersectoral well-being	prevention of mental health disorders	mental health and mental health promotion valued theoretical developments, research, evidence-base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion population health perspective, health promotion
Friedli, 2001; UK	participation multisectoral well-being	prevention of mental health disorders	mental health and mental health promotion valued political will evidence-base	improved mental health and well-being strengthened protective factors wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion public health
Herrman, 2001; Australia	participation intersectoral well-being	prevention of mental health disorders	mental health and mental health promotion valued political will research, evidence-base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health health promotion

(Continued)

Table 2. *(Continued)*

Article	Attributes	Related concepts	Antecedents	Consequences	References of the concept
Herrman & Jané-Llopis, 2005; Australia & the Netherlands	positive mental health	prevention of mental health disorders	mental health and mental health promotion valued	improved mental health and well-being	goal to promote/ improve mental health
			political will	reduced risk for/ prevention of mental ill-health	levels of action in mental health promotion
			evidence-base	wider societal aspect	health promotion, public health
	participation				
	partnerships				
Jané-Llopis & Barry, 2005; The Netherlands & Ireland	positive mental health	prevention of mental health disorders	mental health and mental health promotion valued	improved mental health and well-being	goal to promote/ improve mental health
	participation			strengthened protective factors	
	partnerships, intersectoral		political will	reduced risk for/ prevention of mental ill-health	levels of action in mental health promotion
			research, theoretical development, evidence-base	wider societal aspect	health promotion
Moodie & Jenkins, 2005; Australia	positive mental health	prevention of mental health disorders	mental health and mental health promotion valued	improved mental health and well-being	goal to promote/ improve mental health
	participation			strengthened protective factors	levels of action in mental health promotion
	partnerships		political will	reduced risk for/ prevention of mental ill-health	health promotion
			research, evidence base	wider societal aspect	
Barry, 2007; Ireland	positive mental health	prevention of mental health disorders	mental health promotion valued	improved mental health and well-being	goal to promote/ improve mental health
	empowerment		political will	strengthened protective factors	levels of action in mental health promotion
	participation		research base, theoretical base, evidence base	reduced risk for/ prevention of mental ill-health	population health perspective, health promotion
	intersectoral			wider societal aspect	
	mental well-being, well-being				

Jané-Llopis, 2007; WHO, Regional Office for Europe	positive mental health empowerment participation intersectoral mental well-being, well-being	prevention of mental health disorders	mental health and mental health promotion valued political will research, evidence base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion population health perspective, health promotion
Sturgeon S. 2007, South Africa	positive mental health empowerment participation multisectoral mental well-being, well-being	prevention of mental health disorders	mental health and mental health promotion valued evidence-base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion public health, health promotion
Barry, 2009; Ireland	positive mental health empowerment participation partnerships mental well-being, well-being	prevention of mental health disorders	mental health and mental health promotion valued political will research, theory, evidence-base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion population health approach, public health, health promotion
Christodoulou & Christodoulou, 2012; Greece & UK	positive mental health well-being	prevention of mental health disorders	mental health and mental health promotion valued evidence-base	improved mental health and well-being wider societal aspect	goal to promote/improve mental health levels of action in mental health promotion health promotion
Herrman & Jané-Llopis, 2012; Australia & Switzerland	positive mental health participation partnerships well-being	prevention of mental health disorders	mental health promotion valued political will research, evidence-base	improved mental health and well-being reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion health promotion, population health

(*Continued*)

Table 2. *(Continued)*

Article	Attributes	Related concepts	Antecedents	Consequences	References of the concept
Kalra et al., 2012; International	positive mental health empowerment intersectoral mental well-being, well-being	prevention of mental health disorders	mental health and mental health promotion valued research	improved mental health and well-being	goal to promote/ improve mental health levels of action in mental health promotion public health, health promotion
Min, Lee, & Lee, 2013; Republic of Korea	positive mental health well-being	prevention of mental health disorders	mental health and mental health promotion valued	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health	goal to promote/ improve mental health levels of action in mental health promotion
Strategy/policy document					
Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, 21 November. 1986, WHO. International	empowerment participation multisectoral mental well-being	prevention of mental health disorders	(mental) health and (mental) health promotion valued political will	improved mental health and well-being wider societal aspect	goal to promote/ improve mental health levels of action in (mental) health promotion health promotion
Promoting mental health: concept, emerging evidence, practice: report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. 2005, Herrman H, Saxena S & Moodie R (eds.) International	positive mental health empowerment participation partnerships well-being	prevention of mental health disorders	mental health and mental health promotion valued political will research, evidence-base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion public health, health promotion

European Pact for Mental Health and Well-being. EU high-level conference Together for Mental Health and Well-being. Brussels, 12–13 June, 2008. Europe	participation partnerships mental well-being, well-being	prevention of mental health disorders	mental health and mental health promotion valued political will research, evidence-base	improved mental health and well-being reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion
Plan for Mental Health and Substance Abuse Work. Proposals of the Mieli 2009 working group to develop mental health and substance abuse work until 2015. Reports of the Ministry of Social Affairs & Health, 2010: 5. Helsinki. Finland	participation multisectoral well-being	prevention of mental health disorders	mental health and mental health promotion valued politicawill	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion public health, health promotion
Perth Charter for the Promotion of Mental Health and Well-being. An outcome of the Seventh World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders. October 17–19, 2012, Perth, Western Australia. Coordinated by the Clifford Beers Foundation (UK) and Mentally Health WA (Curtin university, Western Australia). International	multisectoral, partnerships well-being	prevention of mental health disorders	mental health and mental health promotion valued political will	improved mental health and well-being strengthened protective factors wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion public health, health promotion

(*Continued*)

Table 2. *(Continued)*

Article	Attributes	Related concepts	Antecedents	Consequences	References of the concept
Mental Health Action Plan 2013–2020. 2013, WHO, Geneva. International	empowerment multisectoral mental well-being	prevention of mental health disorders	mental health and mental health promotion valued political will research, evidence-base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion
The European Mental Health Action Plan. Regional Committee for Europe. Sixty-third session. Çeşme Izmir, Turkey, 16–19 September, 2013. WHO Regional Office for Europe. Europe	empowerment multisectoral, partnerships mental well-being, well-being	prevention of mental health disorders	mental health and mental health promotion valued political will evidence-base	improved mental health and well-being strengthened protective factors reduced risk for/ prevention of mental ill-health wider societal aspect	goal to promote/ improve mental health levels of action in mental health promotion population health perspective, public health

Results

Attributes

The analysis revealed several attributes of mental health promotion of which the most common are presented here:

- mental well-being, well-being
- positive mental health
- empowerment
- participation
- multisectoral/ intersectoral/ partnerships

Mental well-being and *well-being in general* were found to be attributes of mental health promotion. In 25 papers out of the total 30 analysed (83%), mental well-being and well-being were considered essential components of mental health promotion. As such, increasing and enhancing mental well-being and general well-being were seen as characteristics of mental health promotion in several texts included in the analysis (e.g. Barry, 2009; Orley & Birrell Weisen, 1998). The more recent texts especially emphasised the importance of mental health promotion and positive mental health for population well-being (e.g. Kalra et al., 2012; Min, Lee, & Lee, 2013). Mental health promotion was therefore seen as a way to increase overall well-being by enhancing positive mental health and positive mental well-being. Mental well-being and well-being attributes were further strengthened by the WHO Mental Health Action Plans (2013a, 2013b) as well as by the Perth Charter (Perth Charter for the Promotion of Mental Health & Wellbeing, 2012); the focus of all being to increase and improve mental well-being and well-being in general. Thus, it appears that the contribution of mental health promotion to mental health and mental well-being also extends to general well-being.

Positive mental health was identified as a common attribute related to mental health promotion in the analysis. The majority of the scientific articles, 16 out of the 23 papers reviewed (70%), emphasised that the aim of mental health promotion is to enhance positive mental health (e.g. Jané-Llopis et al., 2005; Sturgeon, 2007). Positive mental health was seen to include individual resources such as self-esteem and optimism, a subjective sense of well-being and the capacity to cope with adversity (Kalra et al., 2012). The attribute of positive mental health, however, did not emerge as strongly in the current policy and strategy texts included in the analysis. Nevertheless, the emphasis on positive mental health is linked to the general health promotion approach which focuses on positive health rather than illness (Barry, 2009; World Health Organization, 1986).

Another attribute of mental health promotion was *empowerment* (Barry, 2007; Stansfield, 2000). Nearly 50% of all papers analysed considered it a key attribute of mental health promotion. Empowerment refers to the level of choice, influence and control that a person can exercise over events in their life. Empowerment was seen an essential aspect of mental health promotion both in the older and newer articles analysed in the study (Joubert & Raeburn, 1998; Kalra et al., 2012). This emphasis on empowerment is also one of the main aspects of the Ottawa Charter for Health Promotion (World Health Organization, 1986) and one of the key values of current policies such as the European Mental Health Action Plan (World Health Organization, 2013b) which addresses empowerment in several of its objectives and states that 'Governments have a central role in creating conditions to empower individuals and communities' (p. 5).

Participation is an attribute which was discussed in several articles analysed (15 out of the 23 scientific papers; 65%) (e.g. Jané-Llopis, 2007; Jané-Llopis & Barry, 2005). Friedli (2001) highlights in her writing that facilitating participation is a principle which should inform mental health promotion initiatives and that a strategic approach to mental health promotion should aim to include opportunities to participation. Some of the texts associated participation with the *empowerment* attribute. Secker (1998), for example, makes suggestions that participatory methods may be empowering. The link between participation and empowerment, however, seems to be more in line with the health promotion framework of the Ottawa Charter (Barry, 2007; World Health Organization, 1986) which emphasises empowerment and participation in its health promotion principle of Strengthening Community Actions.

All seven policy and strategy documents reviewed place emphasis on *multisectoral* work and/or *partnerships* across all sectors (e.g. Plan for Mental Health and Substance Abuse Work, Ministry of Social Affairs & Health, 2010; World Health Organization, 2005). These attributes are highlighted by the WHO's Mental Health Action Plans (2013a, 2013b) as being essential in the promotion of mental health: 'Responsibility for promoting mental health … extends across all sectors and all government departments' (2013a, p. 17). In a similar way, the Perth Charter in its Principle 3 states: 'Mental health promotion … requires a cross-sectoral approach' (2012, p. 3). A similar term to describe the mental health promotion work between different sectors used was *intersectoral* (Barry, 2007; Herrman, 2001). The majority of the reviewed papers (77%) considered partnership working to be integral. The scope and opportunities available in partnership work are well-described by Herrman and Jané-Llopis (2005) in their recommendations for action to strengthen the evidence base and to stimulate work on mental health promotion in a country. They propose (p. 45):

> … to develop partnerships with people, governments and organisations in the public, private and nongovernmental sectors, leading to an integrated health promotion approach that includes horizontal action through different sectors in society.

In addition to the most common attributes presented here, other attributes were also identified, such as resilience, the socio-ecological model and holistic approach.

Related concepts and surrogate terms

No surrogate terms, that is, terms identical to the concept of mental health promotion, were identified.

Prevention of mental disorders was, nonetheless, identified in the analysis as a related concept to mental health promotion. As such, a relation between the two concepts was revealed in the articles as well as the studied policy and strategy documents. Mental health promotion and prevention of mental disorders were seen as distinct concepts with different sets of principles and conceptual frameworks (Barry, 2001; Kalra et al., 2012). Several current international policies and strategies support this view and treat promotion and prevention as separate concepts (e.g. European Pact for Mental Health and Well-Being, 2008; Plan for Mental Health and Substance Abuse Work, 2010; World Health Organization, 2013a). However, it is acknowledged that the two concepts overlap (Barry, 2001; Herrman, 2001). Kalra et al. (2012, p. 81) refers to this issue by stating:

> Promotion of mental health overlaps with prevention in many aspects, yet both of them are also distinct in that the emphasis in mental health promotion is on positive mental health … rather than illness prevention.

The Perth Charter (2012, p. 2) supports the view of interrelated approaches by stating: 'Mental health promotion includes both preventing illness and increasing wellbeing'.

Antecedents and consequences

Antecedents

Essential antecedents for mental health promotion to occur are *political will* and a high appreciation of mental health and mental health promotion, that is the political and societal recognition of the *value of mental health* and the *value of mental health promotion* in order to improve the mental health and well-being of the population. This acknowledgement has slowly risen as mental health is increasingly seen as fundamental to overall health and well-being and quality of life (Kalra et al., 2012; Perth Charter for the Promotion of Mental Health & Wellbeing, 2012; World Health Organization, 2005). In addition to improving population health and well-being, mental health promotion is recognised as an efficient way to reduce the growing burden of mental health problems (Barry, 2007; European Pact for Mental Health and Well-Being, 2008). Furthermore, mental health promotion is seen to have a wider contribution in the society, that is, it is linked to other areas of society such as housing, transport and crime (Friedli, 1999; Herrman & Jané-Llopis, 2005). The high recognition of the value of mental health promotion itself is capsulated in the European Mental Health Action Plan:

> The promotion of mental health … are fundamental to safeguarding and enhancing the quality of life, well-being and productivity of individuals, families, workers and communities, thus increasing the strength and resilience of society as a whole. (World Health Organization, 2013b, p. 1)

Research, together with *theoretical developments* (Barry, 2001) and the establishment of an *evidence-base* for mental health promotion (Friedli, 2001), were all seen as essential necessities for the advancement and development of mental health promotion. Furthermore, research on the effectiveness of mental health promotion interventions, for example, was seen as crucial in terms of understanding what works and what does not (Kalra et al., 2012). The importance of evidence-based mental health promotion was particularly visible in the newer literature. In addition, an improved understanding of mental health promotion called for theoretical developments and the provision of a multidisciplinary theory base for mental health promotion (Herrman & Jané-Llopis, 2012; Stansfield, 2000).

Consequences

Three key themes were identified in the literature as consequences of mental health promotion. Firstly, a direct result of mental health promotion was the improvement of *mental health and well-being* (European Pact for Mental Health and Well-Being, 2008; World Health Organization, 2013b), a fact which was clearly stated in all the articles and policy documents analysed. This outcome of mental health promotion was collectively understood and accepted. Improved mental health is thus integral to the concept of mental health promotion. In addition to improved mental health, positive mental health (Barry, 2009; Moodie & Jenkins, 2005) as well as quality of life and physical health would be enhanced (Min et al., 2013; Perth Charter, 2012).

Secondly, mental health promotion was also seen to *strengthen the protective factors* and to *reduce the risk for or prevent mental ill-health*. As such, mental health promotion would result in strengthened protective factors for mental health, such as resilience and empowerment (Perth Charter, 2012; World Health Organization, 2013b) on the one hand, while reducing the risk for or preventing mental illness (Barry, 2001; Hodgson, 1996) on the other hand.

Thirdly, as a *wider societal aspect*, mental health promotion would lead to reduced structural barriers to good mental health, more supporting environments, better housing and reduced crime among others (Jané-Llopis, 2007; Moodie & Jenkins, 2005). Furthermore, additional consequences of mental health promotion were identified, such as better educational performance, greater productivity of workers, improved relationships within families and safer communities (World Health Organization, 2005).

References of the concept

In general, the concept of mental health promotion was used with reference to the *goal of promoting and improving mental health and well-being*. In this context, the concept referred to policies and strategies as well as practice. The analysed policy and strategy documents either stated the concept explicitly – by including mental health in the terms of health and health promotion – or implicitly, as in the Ottawa Charter (World Health Organization, 1986). Moreover, many of the policy documents analysed, referred to local mental health promotion policies (Perth Charter, 2012; World Health Organization, 2013a). Mental health promotion practice was referred to in the form of programmes, interventions and activities (European Pact for Mental Health and Well-Being, 2008; Kalra et al., 2012; World Health Organization, 2013b).

The concept was also used with reference to different *levels of action in mental health promotion,* that is, on an individual level, in a wider settings level and on a societal level (Barry, 2009; Herrman & Jané-Llopis, 2005; MacDonald, 1999). The settings level was most commonly referred to with reference to mental health promotion actions taking place in settings such as the home, schools, workplace and community, or alternatively, with different population groups including children and adolescents, adults and older people (Barry, 2007; Kalra et al., 2012; Min et al., 2013). Societal level mental health promotion included actions such as improving housing and outdoor living environments and improving opportunities for leisure and cultural activities (Moodie & Jenkins, 2005).

In addition to using the concept of mental health promotion within the realms of mental health promotion policy and practice, mental health promotion was occasionally applied in the context of *public health* and *population health perspectives (*Barry, 2007; Herrman & Jané-Llopis, 2005; Perth Charter, 2012) as well as within *health promotion approach* (Christodoulou & Christodoulou, 2012; Stansfield, 2000; World Health Organization, 2005). This again reflects the multifaceted nature of the concept and the various interpretations of its definition.

A concept mapping of mental health promotion, developed according to the analysis results, is presented in Figure 2.

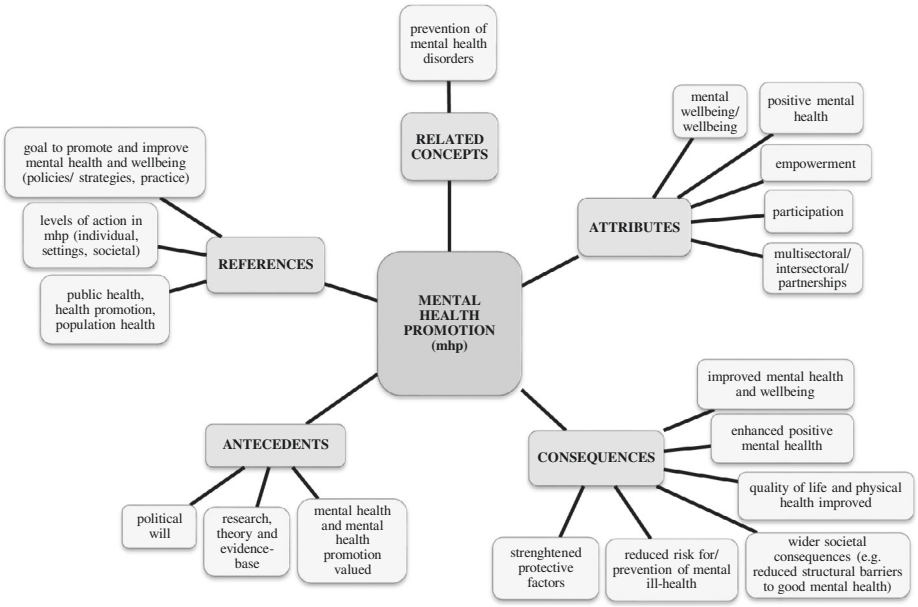

Figure 2. Developed concept mapping of mental health promotion based on the analysis.

Discussion

The aim of this study was to explore and clarify the nature and characteristics pertaining to the concept of mental health promotion. Slight variations of emphasis were evident in the analysis, thus confirming the difficulty of agreeing a common, universally acceptable definition of the concept. Nevertheless, since a relatively shared understanding of the features describing the concept of mental health promotion did appear to exist, it was possible to develop a concept mapping for mental health promotion (Figure 2). Concept mapping provides a framework that can be applied to different contexts, offering areas and aspects of mental health promotion which can be prioritised according to local values and needs. Furthermore, concept mapping can serve as a foundation from which to plan, implement and evaluate mental health promotion practice. It may also aid in planning how to involve other sectors in the promotion of mental health by offering a clear picture of potential areas for intersectoral collaboration.

Mental health promotion: a distinct and wide-ranging concept

A key finding of the study was that mental health promotion is a distinct concept comprising a unique set of attributes and characteristics. The prevention of mental health disorders (or illnesses) was found to have some relation to mental health promotion. However, the analysis supports the view that mental health promotion is a distinct concept. This uniqueness of mental health promotion is most clearly evident when looking at one of the key attributes of mental health promotion, that is, positive mental health. Mental health promotion was seen to concentrate on positive mental health, with the aim of building strengths, competencies and resources (Barry, 2001). However, according to World Health Organization (2004),

the aim of mental health disorder prevention is to reduce the incidence, prevalence and symptoms of mental disorders, thus concentrating efforts on the illness rather than positive mental health. In addition, positive mental health was seen as a strong protective factor against mental disorders; the literature analysed suggested that mental health promotion and mental health promotion activities may produce, as a secondary outcome, a decrease in the incidence of mental disorders (World Health Organization, 2004). Keyes (2005) and Huppert and Whittington (2003) provide a refreshing view on the matter of mental ill health, as in their view a person experiencing a mental disorder can at the same time experience positive mental health. This would suggest that mental health promotion with an emphasis on positive mental health would also strengthen the positive mental health of a person experiencing mental disorders.

Rodgers' evolutionary concept analysis model emphasises the changing and developing nature of concepts. An interesting matter related to this concerns one of the attributes of mental health promotion identified; mental well-being and well-being. The data search was conducted using the search terms 'mental health promotion' and 'promotion of mental health'. As a result of the search, the most recent article identified was from year 2013, which could be an indication of a lack of any current theoretical analyses of mental health promotion. This could also mean that there is less concern in the current literature with defining the concept and the field of mental health promotion, as it is perhaps now better understood due to the progress and work in the area over the last 20 years. Nonetheless, the newly developed research priorities for public mental health in Europe acknowledge the need for theoretical developments (Forsman et al., 2015). One of the priorities emphasises that the theory base for public mental health research should be strengthened, including definitions and validity of concepts. Nevertheless, several of the newer theoretical articles and all of the current policy and strategy texts that were analysed made strong associations between mental health promotion and mental well-being/well-being, thereby suggesting that mental health promotion could have a pivotal role in improving mental well-being as well as well-being in general. The low number of new articles could also imply that the focus of promotion has shifted from mental health to a wider view of mental well-being, and that mental well-being has gained a stronger position in the theoretical discourse of mental health promotion during the last few years. Redefining the search terms to include mental well-being could produce different results and possibly include newer theoretical articles. In addition, the emphasis of mental health promotion on strengthening positive mental health, rather than mental disorder prevention, may have resulted in the wider use of mental well-being to make the distinction between promotion and prevention even clearer. However, there appears to be no common understanding of the definition of the concept of mental well-being to date (Davies, 2014; Herrman & Jané-Llopis, 2012; Stewart-Brown, 2013). Some researchers, such as Keyes (2013), suggest though, that positive mental health equates to mental well-being or at least, to subjective well-being.

Interestingly, this emphasis on mental well-being and well-being in general is clearly manifested in the current mental health-related policy and strategy documents that were analysed in this study. Positive mental health is seldom mentioned; instead, mental health promotion actions are directed towards improving and strengthening mental well-being and well-being in general (Perth Charter, 2012; World Health Organization, 2013b). It appears that positive mental health and mental well-being and well-being are intertwined. Positive mental health is also emphasised in the newly published Health in All Policies approach (Jenkins & Minoletti, 2013). One of its key messages is that 'positive mental health should

be a priority in public policies given its importance for quality of life, social relationships, productivity and social capital' (p. 81).

A common understanding between the scientific literature and the policy documents included in this analysis concerns the antecedents and consequences of mental health promotion. Both sets of literature agree that political will is needed for mental health promotion to occur and that mental health promotion practice needs to be based on evidence and theory. The call for evidence-based mental health promotion is especially strong in the literature from the last decade. A clear conceptual analysis of mental health promotion is critical to defining what evidence of effectiveness should be like in terms of positive mental health outcomes, that is, mental health promotion interventions should be assessed on the basis of whether they promote positive mental health. Both literatures also see mental health promotion as having wider consequences than simply improved mental health and well-being and a reduced risk for mental ill health. They concur that mental health promotion can also result in improved physical health, well-being and quality of life. Moreover, mental health promotion is seen as having societal consequences such as reduced structural barriers to good mental health, more supportive environments, safer communities and reduced crime. This shared understanding provides a clearer basis on which to build mental health promotion in practice. The theoretical and policy/strategy data also seem be in accord that a health promotion framework offers an appropriate approach for promoting mental health. This is clearly evident in the identified attributes of mental health promotion such as empowerment and participation and the need for an integrated multilevel approach, which are essential features in the Ottawa Charter (World Health Organization, 1986). Moreover, a joint understanding exists to support the concept that mental health promotion needs to be located in a wider public health arena addressing the public health potential of mental health promotion (Davies, 2014; Friedli, 2001; Perth Charter, 2012). Some countries such as the UK consider mental health promotion as a specific component under the more encompassing umbrella term of public mental health (Davies, 2014).

An interesting issue concerns the relationship between mental health promotion and suicide prevention. The two areas may be viewed and treated as separate domains. However, it can be argued that mental health promotion policies and programmes can contribute to the prevention of suicides through enhancement of positive mental health and well-being, and strengthening protective factors for mental health such as resilience. Indeed, this view is adopted by WHO and countries such as Ireland (Department of Health, 2015; World Health Organization, 2014b).

Methodological considerations

This study used Rodgers' evolutionary concept analysis method to analyse the concept of mental health promotion. The use of another method of concept analysis may produce different results. However, Rodgers' model provided a systematic way of analysing the data and critically examining the different characteristics and features of mental health promotion. The study used several academic databases in the literature search, which resulted in a very large number of results. As a consequence of this, the original search words were combined with defining words in order to limit the number of results. The results might have been dissimilar without this restriction. Furthermore, the analysis of the data was carried out by only one person, the main researcher, which can be seen as a limitation to the study.

Nevertheless, the purpose of the analysis was to provide some clarity regarding the characteristics of mental health promotion and not to provide a definite definition of the concept. The findings do not represent a definitive list; rather they represent a set of characteristics of mental health promotion.

Conclusion

This evolutionary concept analysis of mental health promotion has provided an insightful and systematic analysis of the definition and use of the concept of mental health promotion. The theoretical articles and the policy and strategy documents included in the analysis offered a range of perspectives on the contexts in which mental health promotion is used and understood. Moreover, the analysis clarified and revealed unique aspects and characteristics of mental health promotion, including a strong emphasis on positive mental health and the consequences on a wider societal level. The results indicate that mental health promotion is a distinct concept with its own features and references of use. The developed concept mapping of mental health promotion offers a framework to health practitioners, policy-makers as well as researchers from which to plan, implement and evaluate mental health promotion practice. However, the conceptualisation of mental health promotion by practitioners and the practice of mental health promotion were not included in this analysis. In the future, it would prove worthwhile to investigate how mental health promotion is defined by the practitioners themselves and how their views relate to the results of this conceptual analysis.

Disclosure statement

No potential conflict of interest was reported by the authors.

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II

MENTAL HEALTH PROMOTION COMPETENCIES IN THE HEALTH SECTOR IN FINLAND: A QUALITATIVE STUDY OF THE VIEWS OF PROFESSIONALS

by

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ORIGINAL ARTICLE

Mental health promotion competencies in the health sector in Finland: a qualitative study of the views of professionals

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Abstract

Aims: In this study, we aimed to investigate what competencies are needed for mental health promotion in health sector practice in Finland. *Methods:* A qualitative study was carried out to seek the views of mental health professionals regarding mental health promotion-related competencies. The data were collected via two focus groups and a questionnaire survey of professionals working in the health sector in Finland. The focus groups consisted of a total of 13 professionals. Further, 20 questionnaires were received from the questionnaire survey. The data were analysed using the qualitative data analysis software ATLAS.ti Scientific Software Development GmbH, Berlin. A content analysis was carried out. *Results:* In total, 23 competencies were identified and clustered under the categories of theoretical knowledge, practical skills, and personal attitudes and values. In order to promote mental health, it is necessary to have a knowledge of the principles and concepts of mental health promotion, including methods and tools for effective practices. Furthermore, a variety of skills-based competencies such as communication and collaboration skills were described. Personal attitudes and values included a holistic approach and respect for human rights, among others. ***Conclusions:*** **The study provides new information on what competencies are needed to plan, implement and evaluate mental health promotion in health sector practice, with the aim of contributing to a more effective workforce. The competencies provide aid in planning training programmes and qualifications, as well as job descriptions and roles in health sector workplaces related to mental health promotion.**

Key Words: *Mental health, mental health promotion, competencies, health sector, professionals, qualitative study, Atlas.ti*

Introduction

Mental health promotion plays a pivotal role in public health. The importance of mental health for population well-being is acknowledged by various European governments and key European level strategies. These include the European Pact for Mental Health and Well-being and the World Health Organization (WHO) European Mental Health Action Plan [1,2]. To achieve better mental health, the Pact recommends European States to take action and 'promote training of professionals involved in the health, education, youth and other relevant sectors in mental health and well-being' (European Commission, p. 4) [1]. Consequently, mental health promotion is seen as a way to achieve better population mental health. Mental health promotion aims to enhance positive mental health and well-being. It is a distinct concept comprising a unique set of attributes and characteristics such as emphasizing

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empowerment and participation of individuals, and supporting multisectoral working [3]. The focus of mental health promotion is on the whole population and on strengthening protective factors for good mental health and quality of life [4].

A skilled workforce is needed to provide efficient mental health promotion practices in the health sector. However, it is recognized that there is a lack of professionals that are skilled and competent in providing and implementing effective mental health promotion [5,6]. In order to train professionals effectively, it is necessary to determine the competencies that are required in mental health promotion. Many studies on general health promotion and public health competencies have been conducted. The CompHP project developed core competencies for health promotion [7] and European Core Competences for Public Health Professionals were identified in ASPHER's European Public Health Core Competences Programme [8]. With relation to mental health promotion competencies, the European PROMISE project identified 10 quality criteria for training care professionals in mental health promotion [9]. These criteria are meant to be used as generic guidelines for training social and healthcare professionals in mental health promotion. The criteria embrace the principles of mental health promotion and concern issues such as promoting positive mental health, empowering community stakeholders and adopting an interdisciplinary and intersectoral approach. Systematic information on the specific competencies needed for mental health promotion in the health sector is currently lacking, and requires further investigations.

Competence and competencies are versatile concepts. The Oxford Dictionaries [10] define competence as 'the ability to do something successfully or efficiently'. According to Shilton et al., [11] competencies are a combination of attributes such as knowledge, abilities, skills and attitudes that enable an individual to perform a set of tasks to an appropriate standard. The CompHP project [7] applied a description of competencies that defined competencies as 'a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion' (Barry et al., p. 649). For this study, competencies and abilities are understood as equivalent [12].

In order to define the needed competencies for mental health promotion, a qualitative study was carried out to seek the views of mental health professionals regarding mental health promotion-related competencies. Through qualitative analysis, it was possible to explore and deepen the understanding of the required competencies in health sector practice in Finland.

Methods

Data collection

The data was collected via two focus groups and a questionnaire survey of professionals working in the health sector in Finland (professionals in healthcare, non-governmental organisations, health development and research, etc.). We applied purposive sampling covering participants representing wide practical expertise in mental health and mental health promotion in the health sector. The first author conducted the interviews and the questionnaire survey. The focus group interviews were carried out in spring 2014 and autumn 2015 (duration 90 and 100 minutes). They consisted of a total of 13 professionals: five senior experts working in mental health promotion development and research and eight health professionals conducting further academic studies in mental health. Written, informed consent was acquired from all focus group participants before the interviews. An interview guide addressing participants' experiences and views on mental health promotion and related competencies needed in the health sector practice was used. The interviews were recorded and verbatim transcribed. In addition to the focus groups, a qualitative, open-ended questionnaire survey was conducted to widen the available data and obtain as comprehensive results as possible. The questionnaire was designed according to the structure of the focus group interviews and included the same themes and questions. The questionnaire together with a return envelope was distributed by hand to 70 health professionals working in mental health-related practice and attending the final seminar of the National Mental Health Programme [2] held in December 2015. A total of 10 questionnaires were returned. In order to attain a sufficient amount of data, an additional 14 high-level mental health professionals in Finland were approached individually via email or in person in January 2016, asking them to fill in the questionnaire. Ten of these answered the questionnaire. Altogether, 20 questionnaires were received and transcribed for the analysis.

Data analysis

The transcribed text from the focus groups and the questionnaire survey was analysed using the qualitative data analysis software Atlas.ti (version 7). An inductive content analysis was carried out with the aim of ideas and themes arising freely from the data [13,14]. This method was chosen as a systematic way to capture the richness of the phenomenon of interest. The text was read repeatedly to achieve immersion and to obtain a sense of the whole picture.

Table I. An example of the analysis process.

Meaning unit/quotation	Subcategory
'You need to have strong enough theoretical knowledge base adopted. And also, it would be helpful to be able to present effective practices and methods how to… [promote mental health].'	Knowledge of principles and concepts of mental health promotion
'Strong communication and information know-how in order to communicate knowledge.'	Communication skills
'…you need to have courage to speak for mental health promotion in different occasions. And especially in situations… where people think disease-oriented, you need to present your view and highlight fairly strongly the matters.'	Advocacy skills
'At least what is needed is… a positive attitude.'	Positive attitude towards mental health promotion
'Viewing the psychological and somatic aspects as a whole and not to divide them into 'specialities'. With somatic diseases, trying to connect the illness as part of the person's everyday life and mental view.'	Holistic approach
'An experience of everyone's equality, equal rights to equal needs and to fulfilling them.'	Equality

Table II. Summary of the main categories and subcategories of mental health promotion competencies.

Subcategory	Main category
Knowledge of principles and concepts of mental health promotion	Theoretical knowledge
Human development knowledge	
Knowledge of positive psychology	
Societal understanding	
Knowledge of human rights	
Communication skills	Practical skills
Planning skills	
Implementation skills	
Needs-assessment skills	
Leadership	
Evaluation and research skills	
Advocacy skills	
Marketing skills	
Collaboration skills	
Multisectoral working	
Positive attitude	Personal attitudes
Broad-minded	
New ways of working	
Holistic approach	
Multidisciplinary approach	
Respect for human rights	Personal values
Equality	
Customer-friendly	

Meaning units and text fragments containing some information about the research question [15] were identified. The meaning units comprised sentences or words associated with their content. The meaning units were labelled with codes that were meaningful and relevant to the study aims. The codes were compared on the basis of similarities and differences and finally grouped into subcategories and main categories. The analysis yielded 23 subcategories for mental health promotion competence. These were clustered under four main categories of mental health promotion competencies: theoretical knowledge, practical skills and personal attitudes and values. The first author carried out the initial data analysis, after which two other researchers went over the categorization of the results, followed by discussions among the researchers regarding the analysis and the results. An example of the analysis process is illustrated in Table I.

Results

Theoretical knowledge

Participants stressed that it is important to have *knowledge of the principles and concepts of mental health promotion.* It was necessary to know what mental health promotion means and what good and positive mental health is. Further, in order to promote mental health, you need to know what mental health is and what factors influence it. Furthermore, knowledge of the protective factors and risk factors related to mental health was important. Participants mentioned that you need to know the methods, tools and effective practices of mental health promotion. On the whole, with this knowledge of mental health promotion it was possible to 'comprehend the cornerstones of mental health and understand how mental health can be promoted', as expressed by one of the participants.

A *knowledge of human development and positive psychology* were also identified as a key category. As one participant summarized: 'You need at least […] knowledge of positive psychology; of resources, survival, development, resilience, but also, to some extent, of mental illnesses and how to live with them.' The knowledge of human development was seen as important, especially with relation to promoting young people's mental health. Participants viewed *societal understanding* as needed; to understand how society works and how to affect it. In addition, *knowledge of human rights* was mentioned as a competence for mental health promotion.

Practical skills

An extensive number of practical skills were identified as important. Participants described *communication* skills as being necessary. Communication skills included those such as listening and interaction skills. Being able to encounter and interact effectively with individuals and groups of people was required. The ability to use communication technology when desirable was also recognized. Related to communication skills were the skills of *advocacy* and *marketing*. As one participant said: 'You need to be able to make matters visible to others and to influence.' Marketing and '*selling*' mental health promotion were seen as necessary by the participants. It was felt that mental health promotion needed to be put forward strongly, especially in disease-oriented settings and practices.

Regarding mental health promotion practice, *planning* and *implementation* skills were mentioned. In addition, *needs assessment* skills were stated as central in order to be able to plan mental health promotion actions that were suitable for the needs of each specific group and individual. Furthermore, *evaluation and research* skills were identified: 'You need to be able to look for information and introduce it in practice.' Evaluation and research skills gave the ability to base mental health promotion actions on scientific knowledge and methods, and to evaluate the effectiveness of these actions.

Participants said that *leadership* and management are also needed skills in the health sector. Leadership and guidance were needed in order to include mental health promotion as an all-encompassing scheme in health services. Guidance, negotiation and leading teamwork were also mentioned.

Collaboration skills were described as a needed skill because a great deal of mental health promotion work was seen to happen in collaboration with others and working in groups with different actors. Collaboration work supported mutual understanding with regards to mental health promotion work. Closely associated with collaboration was *multisectoral* working. As one of the participants described well:

> I have noticed in my own project that one can do very good mental health promotion work with the culture sector, and sports services are an excellent partner. So that it is not always the social and health sector. That we would break the boundaries and work more boldly together and appreciate everyone's expertise and different perspectives on matters.

Personal attitudes

A positive attitude towards mental health and mental health promotion, as well as towards individuals was also mentioned as a needed competence. A positive attitude included support and encouragement for individuals. Participants stated that being *broad-minded* and having the ability to appreciate difference was required. *New ways of working* were also described as an attitude by some of the participants. This included having courage to do things differently and learning to move away from the old models of working.

A holistic approach as an attitude was described as 'seeing the person as a whole' and viewing the psychological and somatic aspects as a whole and not separating them. *A multidisciplinary approach* reflected a broader attitude and a view that mental health and promotion of mental health is a matter of different sectors, not just the health sector. 'So that you see the possibilities […] for mental health promotion with other actors and actions', as one participant said.

Personal values

Values were grouped into three subcategories: *respect for human rights, equality* and *customer-friendly*. Participants stressed that equality and equal rights were fundamental in mental health promotion. It was recognized that respect for the individual and their rights was required. Participants described the value of being customer-friendly as an all-encompassing approach that placed the customer, an individual or a group, at the centre of mental health promotion. As one participant said: 'A customer-friendly working culture where the customer's own actions are supported and his aims are the starting point.' Another participant mentioned that giving room and opportunity for customers to express themselves was the starting point of mental health promotion. Table II presents the summary of the main categories and subcategories of mental health promotion competencies.

Discussion

The study adds to the understanding of the competencies that are required for mental health promotion practice in the health sector. The obtained knowledge represents not only individual views of professionals but also provides wide and rich descriptions of the practice of mental health promotion in the health sector. It is novel knowledge that has not been produced previously.

In order to promote mental health, it is necessary to have a knowledge of the principles and concepts of mental health promotion, including methods and tools for effective practices. Knowledge of positive mental health, protective factors for mental health and determinants of mental health were emphasized in our study. This competence echoes the quality criteria 'Embracing the Principles of Mental Health

Promotion' developed by the PROMISE project [9] and highlights the specific mental health-related knowledge needed in mental health promotion. In health promotion, on the other hand, the required knowledge and competence revolves around knowledge of the concepts and principles of health promotion [7].

The study revealed an extensive number of competencies that were labelled as skills, demonstrating the variety of skills-based competence needed in mental health promotion. The identified skills relate to mental health promotion practice. Skills such as planning, implementation, needs assessment and evaluation skills are needed to develop, implement, manage and evaluate mental health promotion actions. Moreover, participants emphasized communication skills as important. Communicating mental health promotion actions is needed and skills such as interaction were seen to be essential to engaging with individuals and groups. Interestingly, the described mental health promotion skills are closely in accordance with the practice-related skills of health promotion developed in the CompHP project [7]. Domains such as assessment, planning and implementation were identified as core competencies for health promotion practice. This suggests that the skills-related competencies of health promotion and mental health promotion are alike and equally applicable to their practices. Some earlier studies have also conveyed this view [5,16].

The study participants also identified competencies that referred to personal attitudes and values required in mental health promotion. A broad, holistic and positive approach towards mental health and mental health promotion, as well as towards individuals is needed. The participants found that mental health promotion practice should be based on respect for individuals' rights and equality, and be customer-friendly. The customer and their needs are at the heart of mental health promotion actions. This holistic approach similarly reflects the multidisciplinary approach to mental health promotion. This study result therefore emphasizes the concept of mental health promotion and its attribute of multisectoral partnership work [3]. Promotion of mental health is a matter for different sectors as also proposed by the recently published European Framework for Action on Mental Health and Wellbeing [17].

Our study investigated the views of mental health professionals regarding mental health promotion competencies needed in health sector practice. An extensive number of competencies were described by the participants. As a final point, it is worth noting that competencies depend on the needs and aims of an individual organization or setting as also indicated by Sydänmaanlakka [18]. This suggests that the variety of competencies identified in this study need to be tailored to the specific mental health promotion practice setting they are applied to. For this reason, refining the list of competencies can be seen as a necessary and continuous process of each organization/mental health promotion setting. As mental health promotion actions need to be based on needs, so do the competencies required for those actions.

Methodological reflections

The data collection and the initial data analysis were carried out by the first author of this article. The two different data collection methods (focus groups and questionnaire survey) were used to increase the validity of the study [19]. Furthermore, the data sets acquired through the two methods supported each other. These different qualitative study methods were employed as a way of improving the validity of the research [19,20]. In addition, by employing qualitative study methods such as focus groups, it was possible to gain deep insights into the issue. The questionnaires were distributed at a seminar held in December, and this timing, close to the holiday season might have had a negative effect on the return rate of the questionnaires. A more careful consideration of the timing of the study may have resulted in more returns. However, the data obtained were rich and varied, thus meeting the study aims. Another form of triangulation and study rigour was attained by two other researchers going through the categorization of the results, followed by detailed discussions among the researchers [19]. The study investigated the views of professionals only, which could be considered as a limiting factor. It would be highly valuable to explore the perspectives of the health sector customers as well, and by applying different study methods.

Conclusion and implications

The study provides new information on what theoretical knowledge, practical skills, and personal attitudes and values are needed to plan, implement and evaluate mental health promotion in health sector practice, with the aim of contributing to a more effective workforce. The competencies inform capacity building for professional practice in mental health promotion. They provide aid in planning training programmes and qualifications, as well as job descriptions and roles in health sector workplaces related to mental health promotion. Moreover, the identified competencies allow measurement of competencies, thus furthering the development of the competencies

in mental health promotion practice. In addition, this new evidence allows further development and evaluation of the issue. A Delphi study will be conducted in order to acquire more detailed information on the identified competencies and what they entail. It could prove worthwhile to compare these competencies identified by professionals working in the field with theoretical definitions and approaches of mental health promotion.

Declaration of conflicting interest

The authors declare that there is no conflict of interest.

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III

MENTAL HEALTH PROMOTION COMPETENCIES IN THE HEALTH SECTOR BASED ON A DELPHI STUDY

by

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Mental health promotion competencies in the health sector based on a Delphi study

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Introduction

There is increasing emphasis on a public mental health approach to improve the mental health and wellbeing of a population (Lindert et al., 2017; Wahlbeck, 2015). Mental health is an integral part of public health, and it has a significant impact on European human, social and economic capital. Public mental health actions aim to develop positive mental health and mentally healthy societies (Forsman et al., 2015; Herrman and Jané-Llopis, 2005). Mental health promotion with its focus on positive mental health and wellbeing (Barry and Jenkins, 2007; Tamminen et al., 2016) is recognised as a key approach in public mental health policies and actions aiming to strengthen mental health and increasing wellbeing (Lindert et al., 2017; Wahlbeck, 2015). Mental health promotion is grounded on the notion of mental health being "a state of well-being in which an individual realizes his or hers own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to her or his community" (World Health Organization, 2014). Thus, mental health is more than the absence of mental illness.

Effective public mental health policy and practice requires a trained workforce that is competent in mental health promotion and delivering on improved mental health at a population level. The European Pact for Mental Health and Well-being (European Commission, 2008) and the WHO European Mental Health Action Plan (World Health Organization, 2013) both stress the importance of capacity building and training health professionals in the area of mental health and mental health promotion. Moreover, the

EUPHA Public Mental Health section has recognised the need for training in the field of public mental health (Lindert et al., 2017).

Competent mental health promotion workforce are equipped with the necessary knowledge, skills and abilities to implement effective mental health promotion practice. However, it has been noted that there is a lack of professionals skilled and competent in implementing effective mental health promotion practice (Barry, 2007; Plan for Mental Health and Substance Abuse Work, 2010; Tamminen et al., 2017). Capacity building and training to equip professionals with the necessary mental health promotion competencies is required (Lang et al., 2016; Wahlbeck, 2015). In order to train professionals in mental health promotion, we need to know what these required competencies are. The PROMISE project produced European guidelines for training social and health care professionals in mental health promotion (Greacen et al., 2012). The project identified ten quality criteria for training: 1. embracing the principles of mental health promotion, 2. empowering all community stakeholders for effective involvement, 3. adopting an interdisciplinary and intersectoral approach, 4. including people with mental health problems, 5. advocating, 6. consulting the knowledge base, 7. adapting interventions to local contexts and needs in a holistic, ecological approach, 8. identifying and evaluating risks, 9. using the media, and 10. evaluating training, implementation and outcomes. Lang et al. (2016), on the other hand, have developed a scale to identify the training needs of mental health promotion implementers across different settings. These efforts add valuable knowledge to the domain of mental health promotion. Nevertheless, systematic research and information on the competencies needed for effective mental health promotion practice is currently lacking (Greacen et al., 2012; Lang et al., 2016; Tamminen et al., 2017).

In order to respond to this lack of systematic data on mental health promotion competencies, a study was developed to investigate what competencies are needed for mental health promotion in health sector practice. In the first phase of the study, the views of mental health professionals regarding mental health promotion-related competencies were examined by means of focus group interviews and a questionnaire survey. The investigation resulted in 23 identified competencies for mental health promotion (Tamminen et al., 2017). A Delphi study was subsequently carried out with the aim of refining the previously identified competencies through a consensus building process. The aim of this article is to describe this Delphi

consensus process and present the final results of the mental health promotion competencies study.

Methods

Delphi survey

The Delphi method was chosen as it is an approach commonly used to gain consensus among a panel of experts on a complex issue or when there is a lack of knowledge (Jorm, 2015; Linstone and Turoff, 2002). It has also been widely applied in health and mental health research (Barry et al., 2012; de Meyrick, 2003; Jorm, 2015). The group consensus is normally achieved through a series of panel rounds in which questionnaires are sent out to the panel members, the results analysed, and the finding reported back to the participants (Jorm, 2015). The method has the advantage of being an anonymous, iterative process where experts are able to present their views freely. The study's ethical acceptability followed the guidance of the University of Jyväskylä (Finland) Ethical Committee.

Data collection

Invitations to participate in the Delphi survey were originally sent to 43 health sector professionals that had been identified as having experience in mental health and/or mental health promotion. Furthermore, the sampling aimed to cover wide expertise and interest in public, private and third sectors: professionals working in policy level, research and development areas, higher education, mental health promotion practice and 'experts by experience' peer support work. Initially, 38 experts registered with the online survey, eDelphi.org, which was used for the data collection. Eventually, 32 panel members (female=27, male=5) answered the questionnaire in round 1 (response rate 84%) and 27 (female=22, male=5) in round 2 (response rate 71%). All targeted expertise and interest areas were covered by the panel members. The round 1 questionnaire was based on the earlier study with professionals (Tamminen et al. 2017) in which 23 mental health promotion competencies were identified. These competencies were grouped under four domains: theoretical knowledge, practical skills, personal attitudes and personal values. Further literature review and discussions within the research group lead to formulation of four additional competencies. Thus, the round 1 questionnaire included 27 key mental health

promotion competencies. In round 1, the panel members were asked to indicate the importance of the competencies using a 5-point Likert scale, and give reasons and justify their answers. They were also asked whether any of the competencies should be removed or new ones added. The questionnaire in round 2 was formed according to the results of the round 1. In round 2, the panel members assessed their level of agreement with each main competency statement again using a 5-point Likert scale. The online survey allowed iterative discussions among the panel members in both Delphi rounds. The questionnaire in both rounds was accessible to the participants for the duration of eight days. Half way of the survey, reminder emails were sent to the panel members that had not yet answered the questionnaire to increase the participation levels on both rounds. Figure 1 presents the Delphi process.

Figure 1. The Delphi process

Data analysis

The Delphi data were analysed mainly qualitatively with some quantitative measures. Quantitative analysis was used to measure the level of consensus for each competency. Consensus was agreed occurring when at least 70% of respondents scored 3.5 or more on the 5-point Likert scale for each competency. This consensus-level was considered appropriate for the study based on earlier studies (Barry et al., 2012; Keeney et al., 2006). In addition, the responses to the open questions in the questionnaires were coded and analysed using qualitative content analysis to identify common themes and issues arising (Krippendorf, 2003). The consensus scores together with the main themes arising from the qualitative analysis formed the basis in each Delphi round for the decisions made within the research group on what competencies to retain, remove or modify and what new competency areas to include.

Results

In round 1 of the Delphi survey, all competencies exceeded the agreed consensus point mean of 3.5 with at least 70% of the panel members scoring 3.5 or more. The mean ratings ranged from 3.89 to 5 as shown in Table I.

Table I Results from the Delphi round 1

The Delphi panel acknowledged the importance to "strengthen the competencies for mental health promotion in the health sector". There was some debate on the proficiency level of a competency depending on the professional's role in the health sector. All responses viewed the competencies important, although few thought the significance depended whether the professional worked in a grass root setting or in a more general development and research setting. Some new areas of competencies were suggested such as 'enabling and utilising peer support ("experts by experience") in mental health promotion activities' and including cultural understanding and respect in the personal attitudes competency domain. Further, repetition and overlapping competencies were modified.

In addition, the qualitative data of round 1 was utilised to form detailed and specific subcompetencies under each main competency in order to supplement the competencies and describe better the detailed competency needed.

As a result, the following changes were made after round 1:

- combining the domains of attitudes and values into one domain
- reducing the number of the main competencies from 27 to 19
- combining some main competencies into one to better embody the competency (e.g. "respect for human rights" and "equality" into "ethical values")
- working up detailed subcompetencies into the main competency categories according to the comments and feedback received from the panel participants (77 subcompetencies formulated)
- rewording some competencies based on the feedback from the panel members (e.g. "customer friendly" to "customer-based")

In round 2, the mean scores of all main competencies again exceeded the predetermined consensus point of 3.5, the mean ratings ranging from 4.04 to 5 as presented in Table II. In addition to scoring the main competencies, the panel members were asked to indicate the order of importance of each subcompetency. This task, however, proved to be trivial as participants consistently expressed the view that all subcompetencies were equally important and that it was not possible to put more value on one competency over another.

Table II Results from the Delphi round 2

The panellists regarded all competencies as highly important. However, the same concerns re-emerged as in round 1 including continued overlapping of competencies and some requests for rewording. It was again mentioned by some panel members that the extent of proficiency depends on the role of the health sector professional. As a result of this feedback, the main competencies within the personal attitudes and values domain were reduced down to three by combining overlapping competency areas. In addition, word 'personal' was left out as attitudes and values were seen to a great extent concern the whole working environment, not just the individual professional. Consequently, the number of main competencies was reduced from 19 to 16 and divided into three categories: 'theoretical knowledge',' practical skills' and 'attitudes and values'. Further, overlapping subcompetencies were combined. Altogether 56 subcategories were identified. The consensus-based mental health promotion competencies are presented in Table III.

Table III Mental health promotion competencies

Theoretical knowledge

Knowledge is the body of facts, principles, theories and practices that is related to a field of work or study. It can be described as theoretical and/or factual and it refers to the outcome of the assimilation of information through learning. (European Parliament and Council of the EU, 2008) The professionals stressed that having knowledge of the principles and concepts of mental health promotion was essential as "they provide the base for systematic and effective as well as ethical mental health promotion". They felt that it was important to differentiate the concept of mental health from mental health problems and mental health disorders as this misunderstanding was seen as a common problem in the health sector and within the health sector professionals. Knowledge and understanding of the concept of positive mental health was considered crucial.

In addition, societal understanding, i.e. understanding society's influences and relationship with mental health and mental health promotion work was viewed as an important main competency. As one professional vividly commented: "It surely is the water that surrounds the fish that defines pretty many matters in its life…". According to the experts, societal

understanding is vital especially when developing policies and services related to mental health promotion. Understanding the significance that different sectors have for mental health and their role in mental health promotion is needed.

Practical skills

In short, practical skills mean the ability to apply knowledge and use know-how to complete tasks and solve problems, and involve manual dexterity and the use of methods, materials, tools and instruments (European Parliament and Council of the EU, 2008). Nine main competencies related to practical skills were identified highlighting the variety of skills needed in mental health promotion practice in the health sector. Many of these were related to mental health promotion actions and interventions such as planning, implementing and evaluating skills. However, it was collaboration skills that scored full marks by all experts. The skill to truly "do and act" together instead of just collaborating artificially was underlined. Closely related to collaboration skills were advocacy skills emphasising the need to influence decision makers, decision-making and policies at different levels and different sectors.

Furthermore, another highly ranked practical skill was interpersonal skills. As one professional expressed: "It is often thought that people are born with interpersonal skills. They can be learnt and it would be imperative to teach them, and not just speak about their importance". Even though it was recognised that the structures of the society need to be taken into consideration, the view was that mental health is overwhelmingly promoted in interactions between people.

Attitudes and values

Attitudes are beliefs or feelings about a concept, person or object. Values, on the other hand, are beliefs, traditions and social customs held dear and honoured by individuals and collective society. As such, they are closely related. Both attitudes and values may change as individuals gain life experience. (Public Health Agency of Canada, 2008) Three main competencies in relation to attitudes and values were identified in the study: positive attitude, holistic approach and ethical values. These areas of competency are closely linked reflecting the experts' view that a customer-oriented operating culture was essential in mental health

promotion work. For example, positive attitude was to "identify, find and utilise actively opportunities and resources" believing that each person has positive resources in them, they just need to be found. In addition, working with an open-minded attitude with different people, population groups and cultures, as well as acting tolerantly and respecting differences highlighted the ethical values that the professionals expressed.

Discussion

The mental health promotion competencies identified in this Delphi consensus survey are the result of a shared understanding among health sector professionals. A strong consensus was reached within the participating experts, them viewing all competencies as important. The identified competencies highlight the great variety of different competencies and competency areas that are needed for effective mental health promotion practice in the health sector. The competencies provide a valuable resource for workforce development, as they illustrate what theoretical knowledge, practical skills and attitudes and values are required from professionals working in public mental health and/or mental health promotion. They also provide an instrument to enhance education and training programmes in mental health promotion thus contributing to a more skilled workforce and improved quality of practice. These, undoubtedly, lead to improved mental health and wellbeing of populations and individuals.

The study employed the competency approach to define the knowledge, skills and attitudes and values needed in mental health promotion. This concurs with the current mental health promotion dialogue in Europe and the established use of the concept of competency (Barry et al., 2012). Nevertheless, there has been some debate on the use of the competency term in other contexts (Lozano et al., 2012; Weigel et al., 2007).

The competencies presented here are consistent with the PROMISE project's European guidelines for training social and health care professionals in mental health promotion, as described in the discussion section (Greacen et al., 2012). The developed competencies include all but one (evaluating risks) aspect of those guidelines thus strengthening the significance of the study results.

The identified competencies clarify a vital aspect of mental health promotion, namely empowerment. The competencies either explicitly or implicitly refer to the empowerment of individuals. Competencies within the values and attitudes domain, for example, refer to equality and individuals' own expertise and agency with regards to the promotion of their mental health and wellbeing. Practical skills based competencies such as interpersonal skills and needs assessment skills refer to customer's strengths and resources and recognising them. Theoretical knowledge related competencies such as knowledge of mental health promotion principles address the issue as well.

Furthermore, the study and its findings are supported by the public mental health research priority recommendations provided by the ROAMER project (Forsman et al., 2015). These priorities included an emphasis on positive mental health and well-being as it was recognised that mental health promotion is under-researched. The findings of the study presented here add to the shared view of the importance of mental health promotion for strengthening mental health and well-being of populations.

Finally, it is worth to note that the level of proficiency required for each competency may depend on the professional's role in the health sector. This view was expressed by some of the participating experts. This suggests that working in a development role might require different level of proficiency of a competency than working in a more customer-based role. Each competency may therefore need to be adjusted to the specific working environment and the role of the professional working in that setting. Moreover, in Finland, for example, the professionals whose work includes mental health promotion actions represent a diverse workforce with varying levels of training and qualifications. This needs to be taken into consideration when planning mental health promotion training and continuing professional development to ensure adequate emphasis on each competency.

Strengths and limitations

The study used a consensus-building process to develop the competencies for mental health promotion. The use of an electronic Delphi survey proved to be fruitful and convenient way to seek opinions and views of experts. It provided a method where it was possible for the panel members to express their views in an iterative process, and discuss anonymously. While the response rates (84%, 71%) were fairly high, some decline occurred during round 2.

This may have been the result of participation fatigue which is considered common in Delphi surveys (Keeney et al., 2006; Linstone and Turoff, 2002). Personal reminder emails were sent to participants to enhance response rates. Furthermore, lack of time was given as an explanation when an expert refused the invitation to participate in the survey, a fact that could also explain the slight decline in response rate in round 2. Nevertheless, 27 experts participated in round 2 reaching consensus and thus producing stable results (Jorm, 2015).

The panel members in the study were professionals with experience of mental health and/or mental health promotion and working in the health sector representing a wide variety of expertise such as policy, research and practice areas. This strategy produced practice-based evidence which was considered appropriate in order to answer the research aims.

Conclusion

A strong consensus exists among experts on needed competencies for mental health promotion. The competencies identified highlight the great variety of different competencies ranging from theoretical knowledge to practical skills, and further comprising attitudes and values. Mental health promotion takes place in various settings and environments, with different individuals and populations, valuing a holistic view of mental health and the individual.

These competencies are later formulated as competency recommendations for mental health promotion in the health sector. A further development stage is to develop a tool to assess and measure mental health promotion competencies. Although these competencies were developed to the health sector, they can be applied and modified, as applicable, to other sectors as well. It also needs to be acknowledged that the competencies need to be reviewed periodically to meet the changing demands and challenges in the health sector and in mental health promotion work.

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Figure 1. The Delphi process

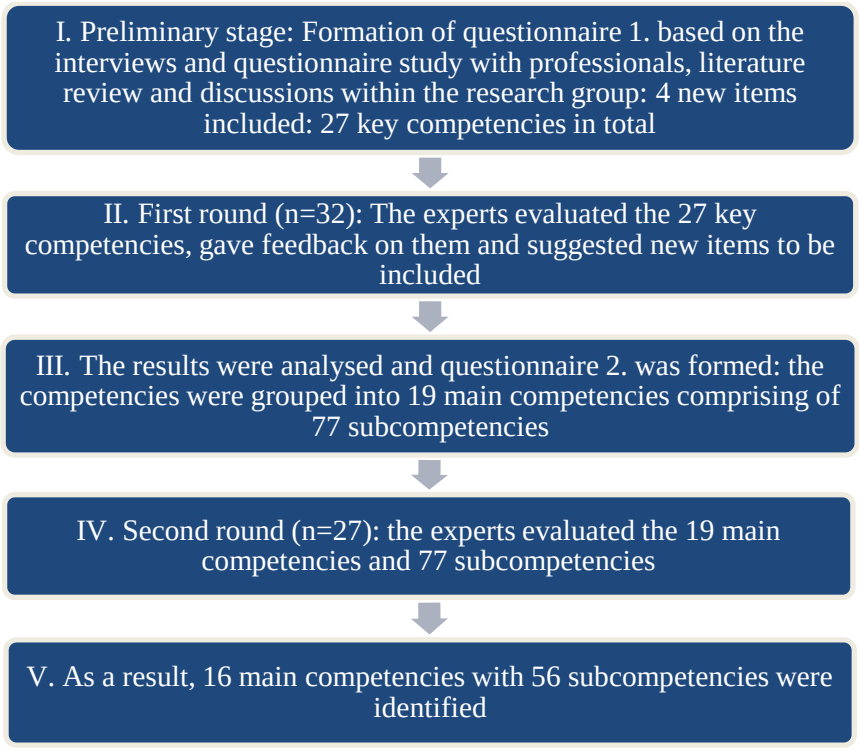

Table I Results from the Delphi round 1

Main category	**Subcategory**	**Mean (%)**
Theoretical knowledge	Knowledge of principles and concepts of mental health promotion	4,72 (100)
	Human development knowledge	4,16 (84,38)
	Knowledge of positive psychology	4,63 (100)
	Societal understanding	4,48 (100)
	Knowledge of human rights	4,56 (90,63)
Practical skills	Communication skills	4,55 (96,55)
	Interpersonal skills	4,93 (100)
	Needs assessment skills	4,55 (93,08)
	Planning skills	4,14 (85,71)
	Implementation skills	4,43 (85,71)
	Able to identify components of positive mental health	4,75 (100)
	Able to identify risk factors of mental health	4,68 (100)
	Leadership	4,18 (82,14)
	Collaboration skills	4,89 (100)
	Managing skills	4,36 (89,29)
	Evaluation and research skills	4,25 (89,29)
	Advocacy skills	4,61 (100)
	Marketing skills	3,89 (71,43)
	Multisectoral working	4,7 (96,67)
Personal attitudes	Positive attitude	4,69 (96,55)
	Broad-minded	4,86 (100)

	New ways of working	4,14 (82,75)
	Holistic approach	4,97 (100)
	Multidisciplinary approach	4,7 (96,66)
Personal values	Respect for human rights	5 (100)
	Equality	4,93 (100)
	Customer-friendly	5 (100)

Table II Results from the Delphi round 2

Main competency	**Mean (%)**	**Number of subcompetencies**
Theoretical knowledge		
Knowledge of principles and concepts of mental health promotion	4,52 (100)	4
Human development knowledge	4,04 (85,18)	2
Societal understanding	4,70 (100)	5
Knowledge of human rights	4,3 (96,29)	3
Practical skills		
Communication skills	4,04 (85,18)	4
Interpersonal skills	4,93 (100)	4
Needs assessment skills	4,52 (88,89)	6
Planning skills	4,58 (100)	3
Implementation skills	4,26 (96,3)	2
Collaboration skills	5 (100)	4
Leadership skills	4,3 (96,3)	4
Evaluation and research skills	4,26 (100)	5
Advocacy skills	4,74 (96,3)	5

Attitudes and values		
Positive attitude	4,96 (100)	4
Broad-minded	4,81 (100)	4
New ways of working	4,22 (96,3)	7
Holistic approach	5 (100)	3
Customer-friendly	5 (100)	5
Equality	4,93 (100)	3

Table III Mental health promotion competencies

Main competencies	Subcompetencies
Theoretical knowledge	
1. Knowledge of principles and concepts of mental health promotion (MHP)	1.1 Knowledge of the concept of positive mental health, resilience, and the importance of strengths, resources and protective factors 1.2 Knowledge of supportive living conditions and environments 1.3 Knowledge of the concept of mental health 1.4 Knowledge of the risk factors of mental health 1.5 Knowledge of effective methods, practices and tools for mental health promotion
2. Human development knowledge	2.1 Knowledge of MHP aims and activities according to the life course approach 2.2 Knowledge of the psychosocial and physiological human development
3. Societal understanding	3.1 Understanding how the society works and how to influence on it 3.2 Understanding the factors that support and challenge mental health in the society 3.3 Understanding the significance of different sectors and their role in MHP 3.4 Understanding the influence of political decisions on wellbeing and mental health promotion

4. Knowledge of human rights	4.1 Knowledge of equality, justice, and appreciation and respect for others 4.2 Knowledge of cultural differences and similarities and their significance to MHP work
Practical skills	
5. Communication skills	5.1 Mastering different communication methods, including verbal and written communication as well as technological communication methods 5.2 Providing information on factors and activities related to MHP 5.3 Influencing positive and supportive attitude towards mental health, and reducing stigma
6. Interpersonal skills	6.1 Mastering interaction skills when working with various stakeholders 6.2 Considering others with appreciation, respect and empathy taking into account the views and values of others and using them as a starting point for working 6.3 Mastering group and bilateral work as well as different guidance methods
7. Needs assessment skills	7. 1 Assessing customer's needs while utilising different methods, tools and indicators 7.2 Engaging customers/target groups with needs assessment as well as setting and monitoring objectives and actions 7.3 Monitoring mental health with different indicators and indicating

	the effectiveness of MHP 7.4 Recognising and supporting components of positive mental health and customer's strengths and resources and supporting those 7.5 Recognising risk factors of mental health
8. Planning skills	8.1 Planning objective-oriented MHP actions and interventions 8.2 Utilising available resources with planning 8.3 Engaging customers and other stakeholders when planning and developing activities 8.4 Developing new innovations, methods and tools
9. Implementation skills	9.1 Implementing effective MHP methods and interventions 9.2 Providing objective-oriented and targeted MHP actions to and with customers as well as part of wider MHP 9.3 Monitoring systematically the planned actions
10. Collaboration skills	10.1 Working in partnership with others beyond organisations, sectors and disciplines while planning and developing MHP actions 10.2 Networking and creating partnerships and utilising different networks 10.3 Working in partnership with customers/target groups 10.4 Enabling and utilising peer support ("experts by experience") in MHP activities
11. Leadership skills	11.1 Leading and supporting MHP actions in practice and in different

	levels from customer work to population level actions 11.2 Guiding systematically objective-oriented and knowledge based MHP and its actions 11.3 Utilising scientific knowledge in decision making both in the health sector and other sectors
12. Evaluation and research skills	12.1 Seeking scientific knowledge to support MHP work and utilising research based effective interventions 12.2 Mastering different evaluation and research methods and indicators 12.3 Studying and evaluating MHP planning, implementation and impact
13. Advocacy skills	13.1 Influencing by networking and working with different sectors 13.2 Marketing MHP and MHP actions to other stakeholders and players 13.3 Influencing decision makers, decision-making and policies at different levels 13.4 Lobbying for resources needed for MHP actions
Attitudes and values	
14. Positive attitude	14.1 Working with an open-minded attitude in MHP actions with different people, population groups and cultures 14.2 Inspiring, encouraging and motivating people

	14.3 Recognising and utilising possibilities and resources and strengths 14.4 Renewing and improving ways of working with courage in order to promote and support mental health
15. Holistic approach	15.1 Seeing the customer as a whole person with strengths and limitations supporting customer's own expertise and agency, and empowering them 15.2 Multisectoral and multidisciplinary working manner with MHP activities 15.3 Taking into account the biological, psychological, social, spiritual and societal factors that affect mental health 15.4 Promoting customer-oriented operating culture
16. Ethical values	16.1 Respecting human rights and strengthening equality 16.2 Acting tolerantly and respecting differences 16.3 Making human rights visible and realised in MHP actions

IV

INTERSECTORAL PARTNERSHIPS AND COMPETENCIES FOR MENTAL HEALTH PROMOTION: A DELPHI-BASED QUALITATIVE STUDY IN FINLAND

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