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Introduction

Mental Health is the emotional and spiritual resilience, which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief on our own and other's dignity and worth.

Mental health is central to the human, social and economic capital of society - however, the incidence of mental distress and disease is increasing rapidly throughout Europe.

Against this background, the ProMenPol-project set out to identify useful and practical approaches to the promotion and protection of mental health by developing a systematic multidimensional approach to identifying and classifying effective tools across the lifespan in three settings: Schools, the workplace and older people's residences.

This report summarises the activities of the ProMenPol-Project, which was funded by the European Commission under the 6th Framework Programme and carried out by a european consortium over the 2007-2009 period.

The first chapter covers general project objectives, methodologies employed, results achieved and the impact the project had on the stakeholder community. Furthermore, information about the consortium and contact details are provided.

The second chapter contains a characterisation of the main ProMenPol products.

1. Project execution

In the following sections the most important aspects regarding the project's implementation are described starting with an explanation of the project's background and context.

1.1 General project objectives and state of the art

The incidence and costs associated with mental distress and ill health are very substantial and expected to rise globally over the next 15 years. This trend must be viewed within a context where there is an equally rapid proliferation of soi-disant 'solutions' and responses ranging from self-help manuals, through personal development regimes to organisational, professional and commercial intervention options. ProMenPol is predicated on the assumption that amongst this wide diversity of theories, models and methods, there are useful and practical approaches and strategies that can form the basis for a systematic multidimensional approach to promoting personal mental health and managing the risk factors that predispose distress and pathology.

Working with specialist and mainstream researchers, stakeholders, networks, professionals, practitioners and representative organisations ProMenPol set itself a number of ambitious but very concrete goals. It aimed to develop the following:

- Conceptual framework: This activity involves the integration of different conceptual and practical approaches to the issue of mental health and illness which draw upon the traditions of health protection and promotion (using the settings approach based on the Ottawa Charter), the WHO International Classification of Functioning (ICF) as applied to mental health and

illness and the practice based approaches of public health. This framework should form the basis for an online database where mental health promotion tools could be classified and therefore be retrieved by practitioners and stakeholders in a timely manner.

- Online database and toolkit: A major focus of the project was the identification of tools for the protection and promotion of mental health customised to the life span stage of target users and predominant context within which they live their lives i.e. school, work and residences for older people. Those tools should be coded into the ProMenPol online database. In addition a toolkit manual should help users to find the most adequate tools according to their personal needs.

- Field trials: To evaluate and review the knowledge base, ProMenPol aimed at undertaking different types of field trials. These should vary in scope from testing the ProMenPol online database and documenting its utility (type I) to choosing one (or more) tool(s) from the online database, implementing it and reporting on it (type II). Alternatively to the latter, organisations could also report on already existing initiatives of their organisations (type III).

- Knowledge management system: ProMenPol has taken a multi-element approach to dissemination. This included the development of a website which was aimed at becoming a vortal (vertical portal) in the area of research, good practice and policy development. The vortal should act as a pan-European gateway to results, documentation and related issues emanating from the project. Within the framework of the vortal, activity were supposed to centre on establishing an online community among the project stakeholders where the dissemination of good practices, awareness-raising and dialogue should take place throughout the duration of the project and beyond. A project newsletter should be produced on a quarterly basis as part of this task.

- Sustainable collaboration: ProMenPol aimed at creating sustainable collaboration between key actors to carry forward the results and deliverables into the later stages of the project and beyond. Therefore three annual conference and policy workshops were scheduled.

By all of those actions ProMenPol was directly addressing key issues of the current European debate on mental health promotion as mentioned in documents such as the Green Paper: "Improving the mental health of the population", the "Mental Health Action Plan for Europe" or the "European Pact on Mental Health and Well-Being". All of those documents state that there is a need for:

- Partnership and collaboration
- Harmonisation of existing information (to allow comparison and sharing)
- New mental health knowledge and information

By harnessing the existing knowledge of different sectors and countries and amalgamating it in a user-friendly knowledge management system, ProMenPol hoped to improve the knowledge base of prevention measures, best practice and impact of measures, making it available for both practitioners and policy makers at European and national level.

1.2 Methodology

The ProMenPol products (database, toolkit-manual, field trials and network) were developed on the basis of certain methodologies and "a priori" positions.

The following subchapter summarises the relevant approaches and the methodologies chosen during project implementation.

1.2.1 Focus on positive mental health

Much of the policy, research and practical materials available to date deal with mental illness in various forms. However, the ProMenPol project focuses on mental health promotion and protection, i.e. the maintenance of good psychological functioning and the protection of mental health from harmful influences.

In order to achieve this, the project adopted a settings approach, i.e. it targets major environments where people are educated, work and live. The settings of interest in the project are as follows:

Schools

- In the ProMenPol project, schools refer to educational settings for children and adolescents. Educational systems in the European community differ substantially. In some countries, children begin schooling from five years of age (e.g. United Kingdom, Sweden), whereas in other countries, starting age may be as late as 7-years (e.g. Estonia). Additionally, the duration of the whole study period varies between countries, as does the distribution of years between elementary, primary and high school. In the context of the ProMenPol Project it has been established, that educational settings are to include children and adolescents in formal education (from 5/6 years of age) up to including university students.

Workplaces

- Formal definitions of the workplace, as used for example by statistical agencies, did not seem appropriate for the ProMenPol project. Instead, the workplace has been defined in a broader sense as the site where people work in some kind of contractual relationship with an employer. This relationship is embedded in a specific working environment, work organisation and corporate culture and offers particular possibilities for participation and personal development for employees. All of these aspects will be referred to when the word workplace is used in the context of the ProMenPol project.

Residences for older people

- Within the ProMenPol project, residences for older people include older people in 'permanent' homes, whether this is a nursing home or another residential facility. It also includes older people who live at home and who avail of some form of supportive service. By contrast, older persons in 'transitory' homes, for example hospitals and rehabilitation centres are excluded.

ProMenPol addresses the factors in these environmental settings, which can influence mental health, and wellbeing in either a positive or a negative way.

Mental health, as a prerequisite for general health, reflects the equilibrium between the individual and his/her environment. The determinants of mental health include:

- Individual factors and experiences (e.g. childhood events, trauma, etc.),
- Social interactions (e.g. family relationships, work relationships, etc.),
- Societal structures and resources (e.g. welfare and support systems),
- Cultural values (e.g. transitional cultures, multi-cultural conflicts).

Mental health can also be seen as a bio-psycho-social process, including compromising, protective, predisposing, precipitating, restoring and supporting factors, together with various consequences and outcomes.

This positive and multifaceted concept of mental health was the notion the ProMenPol team had in mind when designing and structuring the database. The development of the most relevant elements of this structure (conceptual framework, tool descriptors and step approach) is described in the following sections.

1.2.2 Development of the conceptual framework

At the core of the ProMenPol approach is the recognition that there is an increasing need for an efficient way of handling the complexities of mental health promotion and protection. These complications arise not only due to the abundance of instruments, tools, methodologies, techniques, theories and approaches that have been developed over the years, but also due to the challenges in correctly selecting out of this vast repertoire, the appropriate tool to address a particular issue at a specific time.

The ProMenPol database and the toolkit-manual aim to manage this complexity on behalf of the frontline staff member of an organisation, who is motivated or required to implement mental health promotion and protection activities. In the ProMenPol database, tools and techniques are coded so that they can be retrieved by users and implementers in a systematic and simplistic way.

The first task facing the ProMenPol team was to develop a framework, which could efficiently manage the variety and complexity of the field, while at the same time acting as a reference point in order to search for tools. Two sources of models and classification systems were considered, upon which the framework was based: The recently developed International Classification of Functioning, Health and Disability (ICF) and the models developed within the health promotion field. Both coding systems were included in the initial version of the database.

The International Classification of Functioning, Disability and Health, known more commonly as ICF, is a classification of health and health-related domains. The ICF contains a hierarchy of classifications and codes for each of the components- body functions and structures, activities and participation, and environmental factors. Each of these categories are broken down further into

related items. Every item in the ICF is given a specific code. There are approximately 1500 codes in the ICF classification system.

The methodology used to reduce the overall complexity of the framework was adapted from studies which have been implemented in relation to the ICF. These studies utilised a combination of Delphi survey techniques, document analysis and expert focus group methodologies to reduce the 1500 codes of the ICF to a manageable number, for a specific condition in a specific service context. In the context of ProMenPol this meant that each of the ICF codes was considered in terms of suitability to mental health promotion. These selective sets of ICF categories are commonly called 'core sets' i.e. the reduced number of ICF codes that have been selected to suit a particular topic and setting. From a ProMenPol perspective the target was to reduce the number of ICF categories to specifically target mental health in a health promotion context. In order to retain a focus, it was agreed that three core sets would be developed, one for each of the settings within the scope of the project, i.e. schools, workplaces and older people's residences. From a mental health promotion (MHP) perspective the methodology involved building an initial classification system and testing it through a similar procedure to that used for the ICF. As a result, two core sets were generated which were presented at the first ProMenPol conference and validated against the views of participants and their contacts.

During the course of the project the partners populated the database by applying the framework to over 400 mental health promotion tools covering the three settings; education, workplaces and older people's residences. The frequency with which the elements or codes of the framework were coded in relation to a particular setting was taken as an indication of the relevance of that element or code. For example if the item 'Energy and Drive' which has the code b130 was ticked as being relevant to a number of different mental health promotion tools, it would further indicate that the code 'energy and drive' was relevant to the area of mental health promotion. The prototype framework included a number of 'other' codes, one for each sub category school, workplaces and older people's residences, which were accompanied by a free text field. This allowed a coder to specify another element of the mental health promotion tool that was not incorporated into the ProMenPol framework.

Once the database was populated, practitioners as well as experts in the field of mental health promotion implemented numerous field trials. These field trials provided another mechanism for the ProMenPol framework to be reviewed. More information on details of the field trails can be seen in 1.3.

In early 2009, a final review and rationalisation of the framework was carried out based on a frequency analysis of the coding systems. This is where the coding of mental health promotion tools against the ProMenPol framework of codes was analysed. The frequency analysis looked at the frequency with which each code within the ProMenPol framework was coded against the mental health promotion tools. The final review and rationalisation also incorporated the feedback from the field trials.

As a result, the final coding system was produced based on the revised framework which underpins the searchable ProMenPol database.

1.2.3 Tool descriptors

To ensure the credibility and utility of each tool, three core criteria and one additional criterion were developed. Initial criteria were developed based on information from the literature and discussion with researchers internal to the project. The criteria were revised based on discussions between all project partners at a ProMenPol meeting in February 2008, and the final conceptualisation of the criteria was decided upon. The section below outlines these core criteria and includes a detailed explanation of each descriptor.

The core criteria are:

1. Application in the field

This criterion regards the extent to which a tool or approach is currently in use and how widely it is applied. There is no implication in this rating that tools which are mainly used in one jurisdiction are any more or less appropriate than tools that have International scope. The aim is to indicate to the user how easy it is to transfer the tool or approach in a particular context. Thus the criterion concerns how widely accepted an approach is, rather than how 'good' it is. At other times, tools that are widely applied and for which there is general professional acceptance across jurisdictions, are more likely to be easily transferred in terms of risk and usefulness. The aim of this project was to create an international toolkit, and therefore this was taken into account while selecting tools.

The descriptors used for this criterion were:

> **A. Applied internationally**: This was checked through the explanatory materials describing a tool and/or through a Google search. For tools that were not in English the search was carried out in the home language of the tool and the English equivalent, if it existed.
>
> **B. Primarily used in one country**: This was judged from knowledge of the tool or from the descriptive and technical materials associated with a tool. Once again a Google search was carried out to confirm that it is primarily applied in one jurisdiction only.
>
> **C. Limited application**: This was judged on the basis that the tool website or descriptive and technical materials do not refer to scope of application and the Google search yields relatively little information about where it is being applied.

2. Stage of Development

A related criterion was the tool's level of development. Once again it was important to emphasise that there was no implication that tools at an earlier stage of development were any less effective or useful than more established tools. In fact, the opposite may be the case - designers of more recent tools will have considered the problems encountered during previous attempts to produce tools. Nevertheless, it is important for the user of the toolkit to be aware that vigilance is required in applying the approach or instrument.

The following descriptors were applied to this criterion:

> **A. Well established**: This descriptor was used for tools and approaches which have been in place for more than three years. Generally speaking these types of tools will have been used

in international studies or will be considered as the standard or benchmark for other tools. The Ottawa Charter is clearly well established as are many of the central policies that have been promoted by NGOs in fields such as occupational health and workplace health promotion. If expert knowledge was not available the best way of checking the extent to which a tool has been established was to examine the bibliography (if any) provided with the tool to identify the earliest reference to the tool. A Google search was also used with a date criteria over 5 years previously and the researcher then reviewed the hits for evidence that it was being used at that time.

B. Recently produced (2-3 years): This was judged on the basis of the descriptive and technical materials associated with the tool or with the Google search using the tool title and date as described above.

C. First experiences available/pilot phase: This was judged from the tool website, descriptive and technical materials or associated reports. A Google Scholar search also provided researchers with the details of some recent articles.

3. Evaluation and Research

This criterion was more relevant to certain types of tools. It was most applicable to any normal/standardised assessment tool or to specific individual interventions which need to be tested using appropriate research designs. It was less relevant with regards to general frameworks or implementation guidelines for policy and procedures.

The following descriptors were applied to this criterion:

A. Research, evaluation studies or technical data are available: This descriptor was judged on the basis of the user's manual in the case of a standardised instrument where reliability and validity data was reported. For other types of tools the website provided a bibliography. A Google Scholar search was also useful. This descriptor was only used if there was a clear abundance of research or statistics available.

B. Referred to in a wide range of reports and papers: This descriptor was used when there were no specific reports, evaluations or technical data on a particular tool but it was referred to or used in the context of other studies or papers. The distinction between this descriptor and the one below is that references were frequent and relatively easy to find. The primary sources for judging this was Google Scholar or expert opinion.

C. Research evidence is inconsistent: This was judged from a Google Scholar search. The descriptor referred not so much to the content of the articles but to the fact that they are relatively scarce.

The additional criterion is:

4. Beneficiary involvement in design

In particular settings, user involvement has high importance when judging the appropriateness of a tool or intervention. Thus, person-centred approaches tend to be given priority in choosing to implement a particular intervention option. This is frequently the case with vulnerable groups such

as younger children, people with disabilities and older people. The same requirement for use centre design is not evident in the field of workplace mental health promotion and protection.

The descriptors used for this criterion were:

A. Active participation in the design clearly described: The main source for reviewing this criterion was the website or descriptive and/or technical materials associated with the tool or approach. Given that user involvement is an important criterion in many fields of activity it is likely that this will be emphasised by those promoting the approach. This descriptor was only used where it was absolutely explicit that part of the design process involved the genuine participation of potential beneficiaries.

B. Some reference to active participation in the design: This descriptor was used when it was not clear from documentation associated with the tool that users were involved in the design process, but where the principle of active participation was referred to either in a general way or where the principle of users participation was inherent in descriptions of the tool.

C. No reference to active participation in design: Once again this was judged primarily from tool documents, websites and descriptions. If no reference was made to active participation and when it was considered that user involvement would have been appropriate, this descriptor was used.

In some cases the person coding the tool may have been unable to identify an appropriate data source to come to any conclusion about the value of one or more core criteria. In this case the descriptor 'Information about the application on this issue was not found' (NF) was applied to that criterion. It is also important to note that not all criteria apply to all tools and thus, in some instances, the descriptor that was applied was 'This criteria is not applicable to this type of tool' (NA). For example, there were some tools such as survey questionnaires which require to be tested for validity and reliability while for other types of tools, such as a policy framework, this approach is irrelevant. Another example is where beneficiary involvement in the design of a tool is more relevant to some settings than to others.

1.2.4 4 Step process model

In addition to being judged on the descriptors explained above, the tools of the database were also categorised using a four step-process which is described below.

Development of the 4 Step Process Model

There are a relatively large number of tools and models which adopt a phased approach to the workplace health intervention process. Many of these have been designed for the purposes of designing and implementing health and safety interventions, which are in turn based on the hazard control cycle and risk analysis. Other influences on these models are project management tools and problem solving methodologies. Within the context of health promotion, such models are relatively rare, since the main traditions of health promotion have emanated from health education where the predominant paradigm is focused on the individual and on individual learning, rather than on project management or organisational change. However, within the workplace setting, because of the strong influence of health and safety paradigms, it has been necessary and useful

to design health promotion interventions using a stepwise approach that is consistent with how health and safety is practiced. Two such models have been drawn upon, each of which have had some International usage, particularly in Europe. While these implementation or process models have been designed for implementing a mix of workplace health promotion and occupational safety and health (OSH) interventions in the workplace, they have not been specifically designed for use in relation to mental health promotion, or for use in settings other than the workplace. Nevertheless, the principles of project management and of health promotion (e.g. project team formation, setting up the project) are embedded within these models and this feature makes them suitable for adaptation within the three settings of interest in the current project.

The first of these is the European Methodology for Workplace Health Promotion (Wynne et al, 1996). The methodology describes a 7-phase model to implement workplace health promotion: 1. Getting started; 2. Marketing; 3. Needs analysis; 4. Planning; 5. Implementation; 6. Evaluation; and 7. Consolidation. Each phase is described in terms of a set of activities, priorities, typical problems and their resolution and provides a set of tools to support these activities. The methodology can be used by anyone who wants to implement any form of workplace health promotion including mental health promotion.

The second model has been developed in Finland by the Finnish Institute of Occupational Health to support the implementation of the National Maintenance of Work Ability Programme. This programme combines interventions from the disciplines of health and safety, occupational hygiene, occupational health, health promotion and rehabilitation. It is also capable of supporting mental health promotion in the workplace. This model has been widely used in Finland and elsewhere. These models both address the issue of how to implement health promotion initiatives in a systematic way. For the purposes of ProMenPol, however, there was a need to ensure that the main activities outlined in each model were covered in the integrated model that was developed. In addition, activities and approaches which were specific to the workplace setting were altered or omitted in order to make the model sufficiently generic to be applicable in the other settings. A final consideration in developing the model was to make it simple enough for its main features to be understandable within the other settings of interest.

The two models were then edited and organised according to the 4 step procedure outlined in the FIOH model (4 steps were adopted as this leads to a simpler approach to the issue). The activities within this model were then checked for their applicability to the non-workplace settings. Following comments from the project partners, a final 4 Step Process Model was produced as follows:

Step 1: Preparation

This step is about getting ready to embark upon a mental health promotion initiative within an organisation. Thus the kind of tools and materials that are placed in this category are:

- Reports and generic information about mental health promotion
- Background information about mental health promotion
- Information about the target group
- Other more general policy documents

The tools aim to:

- Enhance the capacity to build up collaboration
- Improve communications with the target group
- Develop a project team

Step 2: Needs Analysis and Planning

Before selecting and introducing a mental health promotion initiative, good practice advises that one should carry out an analysis of the needs of the organisation and the intended beneficiaries to identify the priorities for intervention. Once the most important needs have been identified it is essential to develop a plan/strategy to respond to these requirements. The kinds of tools, which are classified under this step, include:

- Needs analysis/organisation survey type tools
- Instruments that allow the setting of targets and/or the establishment of baseline information of the activities
- Identification of at risk individuals
- Tools to evaluate what functions well in the setting and what could be improved
- Framework documents that allow a systematic approach to Mental health promotion

Step 3: Implementation/Intervention

The tools that are relevant to this step can be divided into two sub-groups. The first sub-group includes tools that:

- Provide guidance on how to carry out plans and manage a project. These tools will address such issues as – how is responsibility distributed, who should participate, how are the targets of the actions measured, ways and means of providing feedback, etc.
- "How to" manuals are also relevant to this step.
- Many of these documents are generic rather than specific to the target group, although there will be exceptions.

The second sub-group includes all instruments that concern interventions with people. Thus it includes:

- Individual assessment instruments
- Individual planning tools
- Training and development tools
- Counselling and support approaches

- Programmes of promotion and prevention, e.g. life-skills programmes

Any tools that aim to bring about changes in people's attitudes, awareness or behaviours in relation to mental health are included under this step.

Step 4: Follow up and evaluation

This step is concerned with measuring and evaluating the impact of initiatives which have been carried out and reviewing the implications for future action. Follow-up tools assist the person responsible for mental health promotion to adapt what is currently in place in search of more effective and efficient ways to achieve better results. Thus many of the tools involve:

- Review and monitoring
- Evaluation
- Continuous improvement
- Reporting
- Policy development

There is an overlap between the tools that are useful in the needs analysis and planning phase and those that can be used for feedback and follow-up procedures.

To evaluate and review the database and in order to promote the dissemination of best practice in relation to mental health protection and promotion in the settings of interest, a series of field trials were conducted. The procedures that were applied in this regard are explained in the following sections.

1.2.5 Field trials: Procedure

The main methods used to attract practitioners to take part as a pilot site in the course of the project included the ProMenPol conferences, personal contacts of the project partners and the involvement of partners in expert networks.

For definition and process purposes, a work flow was developed which described how interested practitioners were to be supported by the project. Practitioners could express their interest in three different types of field trials which varied in purpose.

Field trials of the first type (type I) covered and assessed the utility, functionality and the practicability of the online database and toolkit of mental health promotion instruments. Field trials of type II were defined as pilot sites which selected and implemented a MHP tool from the ProMenPol database. In contrast, type III field trials reported on prior and ongoing implementation practices and experiences.

The first stage of the procedure involved an interested practitioner expressing his/her interest in the project, followed by assigning contact partners from the project's consortium (based on country and setting). This also involved providing pilot sites with a manual on how to implement mental health promotion as well as details on further steps and a time frame for the field trial.

If the practitioner was interested in a type I field trial, he or she received a usability questionnaire and was asked to provide feedback on the usability, functionality and content of the online database and toolkit. The questionnaire was structured in four sections and provided the participant with the opportunity to make comments. The first section covered the respondents' profile (professional background and internet usage); section two investigated the usability of the database/toolkit; section three obtained ratings of the content and; in the fourth section users' described their satisfaction with regards to the quality of the database and toolkit. This feedback was requested at two points in time: Following finalisation of the *first* version of the online database/toolkit and following the *final* version of the database/toolkit.

Practitioners could also opt for a pilot project of Type II. Due to ethical reasons, potential participants were asked to summarise and explain the purpose of their Field trial and to complete an ethics questionnaire. An ethical committee – which consisted of a number of ProMenPol project partners – commented on the implementation purpose and asked for clarification of any relevant ethical issues if this were necessary. If no ethical risks were identified, the pilot site received permission to start with the preparation work of the field trial. Throughout all steps of the project, it was possible for pilot sites to obtain support from the work package leader or from the allocated experts. In addition, the ProMenPol website and newsletter supported users and implementers with additional and up-to-date information. Upon completion of the field trials, each pilot site was asked to fill out implementation documentation which was standardised and comparable across all pilot sites, countries and settings of origin. The documentation was structured in several parts which covered all important steps in the implementation process: Part A covered administrative information (the tool being implemented, the setting, start and end date of implementation, organisation type, number of employees). Part B was about structural and background issues and the planning phase of the implementation (including experiences with MHP so far, use of supporting information, main aims of the implementation and characteristics of the target groups). Part C dealt with the implementation of the tool and enquired about the assessment of the implementation process, i.e. what were the enhancing and inhibiting factors during implementation; what changes were needed and adaptations from the original implementation plan; and the emergence of ethical issues or problems during implementation. Section D concerned the outcomes and results related to the MHP tool implementation. The issues covered in this section were whether or not the objectives, expected benefits and the aims of the MHP tool were achieved, what kind of evaluation was adopted and the strengths, weaknesses and other experiences in relation to the implemented tools. The final section E covered lessons learned and recommendations from and for various points of view. It covered the most important lessons learned from practice for policy, the main opportunities and threats for the development of MHP in the future and enquired about emerging missing elements at policy level. In addition, practitioners were asked to rate concrete actions for the future improvement of MHP using a Likert scale format questionnaire (strongly agree to strongly disagree).

It was recognised in the early stages of the project that much could be learned from experienced practitioners and organisations which had already implemented mental health promotion in practice. Type III field trials offered a possibility for these kinds of organisations and practitioners to take part in and to share their experiences with the project. The administrative procedure was the same as that with type II field trials.

1.2.6 Creating sustainable collaboration: Events & Website

As mentioned above, ProMenPol aimed at creating sustainable collaboration between key actors to carry forward the results and deliverables into the later stages of the project and beyond.

Therefore three annual conference and policy workshops were scheduled and brought together stakeholders from different spheres of policy, practice and science. The themes of each conference and policy workshop differed.

The first conference focused on the conceptual framework and possible amendments based on user feedback, the second conference focused on presenting the first version of the database and on setting up pilot studies, and the third conference focused on the final version of the database and the results of the pilot studies. During these conferences, recent developments of mental health promotion at EU-level were presented and discussed.

The policy workshops served as platforms for national and european policy makers to discuss the emerging project findings and results. For the final conference and policy workshop the two events were combined in order to foster communications between practitioners and policy makers.

Furthermore the website was designed to act as a pan-European gateway to results, documentation and related issues emanating from the project. A newsletter was produced on a quarterly basis as part of this task. In addition, the website was built interactively, i.e. registered users also have the opportunity to share information about their tools, events and news in the field by uploading this information on the website.

Finally, project partners made use of their extensive networks to disseminate project findings. In this context links with the Support Project, the European Network of Workplace Health Promotion, the PEROSH network, the Move Europe Project, the DataPrev project, the KNOWandPOL project, ENETOSH Network and three Leonardo projects (Reintegrate, Ageingatwork, WHP-Training), have all been established.

1.3 Results

The main results of the ProMenPol project are the online database & toolkit manual, the experiences of the field trials and the creation of a global network on mental health promotion.

1.3.1 Online database & toolkit manual

The ProMenPol Database contains a structured selection of more than 400 mental health promotion (MHP) tools which can be applied in three settings:

- Schools
- Workplaces
- Older People´s Residences

Examples of MHP tools include social-competence programmes for schools, guidelines for employers on how to promote a mentally healthy working environment, or a friendship enrichment programme for older women.

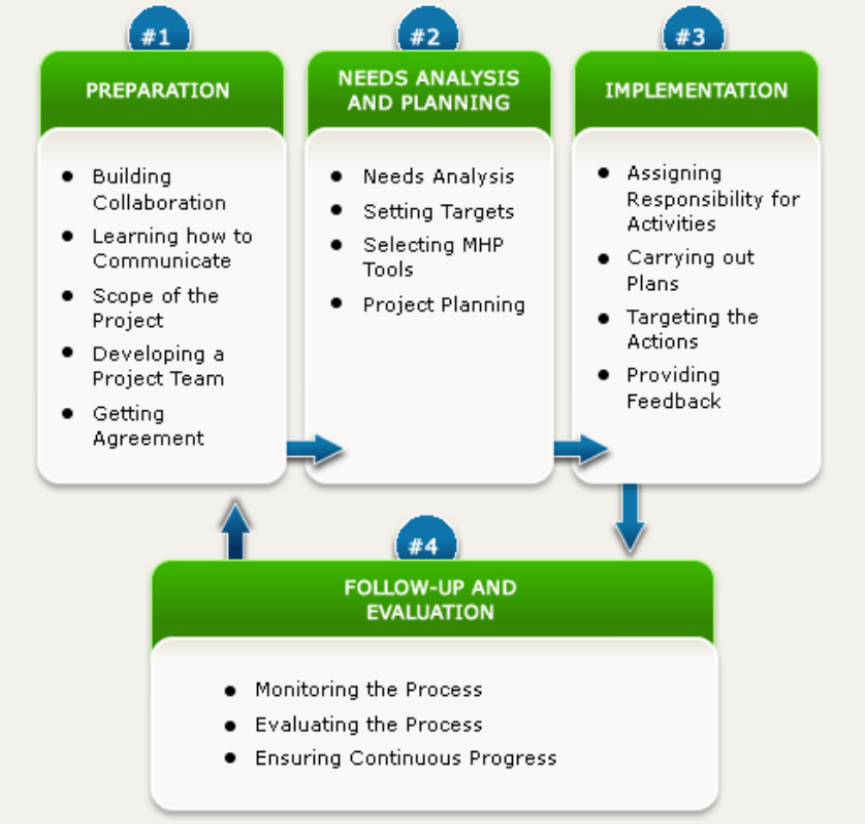
Tool descriptions come with a wide range of information that helps users to select the appropriate tool for their needs. For example, when users select a tool of interest, they obtain general information about the tool, publication information, alternative tool languages, the tool URL, its' stage of development, evaluation information and developer's contact details. This helps the user find the most appropriate tool for their needs.

Tools are also categorised using a modification of the ICF Classification, the ICD10 Classification and a categorisation based on health promotion models. These codes provide a description of the contents of each tool, and they can also be used as a keyword system to help identify the most appropriate tool of interest for the user.

The tools have also been classified using a four step project implementation cycle. This structure helps guide the user through every step in the process, from preparation for the introduction of a programme or project to implementation and progress monitoring.

Step-Approach:

Figure 1: Step approach



This step approach is supplemented by an implementation manual (ProMenPol toolkit-manual) which provides the user with more detailed directions as to how each of the steps should be implemented and consequently more specific information upon which to select the most

appropriate tool. Thus the tools displayed under each step were specifically relevant to that step and the manual described what types of actions, and consequently which types of tools, were most appropriate during the stage. The revised ProMenPol toolkit contains four parts each of which is structured on the basis of the four step process.

1. A generic manual for promoting mental health and wellbeing which provides the user with a overview of the key issues to be addressed and useful strategies that are common to all contexts.

2. Three supplementary manuals for promoting mental health and wellbeing which provide a description of the main issues to be faced during each of the four steps of implementation, details of the most relevant MHP tools from the ProMenPol database that may be used in implementing MHP for each phase of implementation and links to the relevant ProMenPol case studies that have been undertaken using some of the tools customised to:

    a. A Workplace Settings

    b. An Educational Setting

    c. Older People's Residential Settings

The database has been evaluated and amended accordingly based on user feedback. At present, it contains more than 400 tools that can be searched for in English, German, Finnish and Estonian.

1.3.2 Field trials

This subchapter covers the main results from the evaluation of the online database and toolkit (type I field trials) and the results from the pilot sites documentation and reports done by the field trials type II & III.

Type I results

With respect to the usability test, in the first wave 47 experts responded and in the second wave more than 20 users filled in the questionnaire.

More than 90% of the respondents use the internet daily. Before answering the questionnaire people reported having investigated the database between 5 and 300 minutes.

Each dimension of the usability-test was operationalised by more than one statement. Respondents were asked to rate the statements on a 5-point Likert scale ranging from 1 (strongly agree) to 5 (strongly disagree).

On average the rating on the subjective satisfaction and communication of the database and the toolkit was very good. Ratings on three different statements on this dimension varied between 1.7 and 1.9 on the 5-point scale. In general the toolkit was rated slightly better than the database.

In terms of user interface, ratings varied between 1.7 and 1.9 indicating a high level of satisfaction with the interface. User control, user-centered design and interaction were rated between 1.7 and 2.0. Site visibility and memorability of the site was also rated highly with an average score of 1.9

for the database and 2.0 for the toolkit. Flexibility of use and structural integrity of the database and the toolkit was also within these margins (1.7 to 2.0) and the content/presentation was rated on average as 2.0.

Besides the usability dimension described above, the general utility of the database and toolkit was also very satisfactory because of an average rating of 1.8 (database) and 2.3 (toolkit) on a 5-point Likert scale with answer categories from 1 (very good) to 5 (very poor). The overall rating of the content was between 1.7 and 2.0 referring to a high acceptance of the database and the toolkit. The overall satisfaction with the toolkit and the database was rated 1.8.

Compared to the first usability-test nearly all aspects were rated better in the second survey wave after the amendments had been made. In the first survey results varied between 1.9 and 2.6 whereas the results of the second survey varied between 1.7 and 2.0. This can be interpreted as an improvement of the usability, functionality and practicability. Users are highly satisfied with the product.

As an additional indicator the last question in the usability-test investigated how long the database and the toolkit should stay online in future. 59.1% of the respondents stated that the resource should stay online for more than 5 additional years. In contrast only 22.7% stated "2 – 5 years" and only 18.2% stated "up to 2 years".

Type II and Type III results

In total 16 field trials documented and reported their implementation of a mental health promotion tool. Out of the 16 trials, 8 were of type II and 8 of type III. Field trials of type II & III come from all three settings; 6 from schools, 6 from workplaces, and 4 from the older people setting. Mental health promotion tools were implemented in many different countries including Austria, Ireland, Finland and United Kingdom.

Type II field trials were implemented in the course of the ProMenPol project and were implemented between November 2007 and August 2009. Type III field trials already started before the ProMenPol project and some are still ongoing.

Most organisations came from the non-profit and the public sector. Three of the field trials came from the private sector. The size of the organisations varied from small and medium size enterprises (e.g. 1-49 employees) to large and very large enterprises (e.g. more than 100 employees).

In total, field trials reported either a good or very good experience of implementation.

One part of the explanation of this overall implementation rating covers enhancing and inhibiting factors: More than half of the participants (9 out of 16) rated the organisational structures as a helping factor for the implementation of the MHP tool with 6 out of 16 stating the same about the staff involved. In addition, 5 out of 16 stated that the political framework, ethos and culture of the organisation, and the organisational structure were extremely helpful to achieve the aims of the Field trial. In addition, the commitment of the stuff and the client base was of great avail.

Only 3 out of 16 field trials found the financial structures/health budget and existing quality standards helpful when implementing mental health promotion activities. This corresponds with

the 7 out of 16 field trials that stated that the financial structures and the health budget even were a barrier for the implementation process.

Furthermore, in collectively 10 cases organisational structures and/or the ethos or the culture of the organisation was mentioned as another inhibiting factor.

In relation to the MHP tool, in half of the cases slight adaptations and changes were necessary for Field trial implementation, because e.g. the material was not useful or was lacking (for example no questionnaires available). In these cases a new teaching method was applied (interactions and games instead of presentation slides) or a new technique developed (e.g. a questionnaire). Other pilot sites reported other changes and adaptations in relation to general organisational issues (e.g. delayed beginning of the implementation because of a conflict with another campaign, ongoing changes due to the restructuring of the organisation which led to an adapted implementation plan).

In only two field trials ethical issues arose in the course of the implementation of the Field trial. One Field trial reported an issue of informed consent, one an issue in relation to confidentiality, anonymity and data protection. The ethical committee checked that those issues were dealt with adequately.

In relation to the specific objectives and the expected benefits, the majority of the field trials reported that their aims were achieved completely.

On average, it was (strongly) agreed that "the tool promoted individual health and well-being" by the mean of 1.75 on a theoretical answer scale from 1.0 to 5.0 and that "there was a broad acceptance of the MHP process by the target group during implementation" (1.85). In addition, pilot sites generally agreed with the statement that "there was high satisfaction with MHP outcomes by the target group".

Not only positive effects on individual level were achieved. There were also some good effects on the organisational level which shows in the field trial's agreement with the statement that "the results will have a sustainable effect on the organisation" (2.08) and "that the implementation of the tool affected organisational structures positively" (2.09).

These good results on both individual and organisational level can be validated by the fact that most pilot sites "would be keen to implement additional MHP tools in future" (1.75). There was also agreement with the statement that "there was a beneficial relationship of costs to benefits" (2.08). Furthermore, pilot sites agreed to a great extent that "the results are easily transferable to other organisations in the same setting" (1.93) or to "other organisations in a different setting" (2.00).

On the basis of the field trials reports and documentation, we can conclude that the implementation was in most cases successful and most of the aims were achieved. There were plenty of positive process and outcome related effects on the one hand and many positive effects on the individual and organisational level on the other that were both associated with the MHP tool implementation. Furthermore, the results indicate that the tools are transferable and sustainable.

Respondents were asked to indicate the main lessons that they learned during the MHP implementation.

For the practice field, these lessons included increased awareness and knowledge of mental health promotion, the need to have well-designed and structured, user-friendly and easy to implement MHP initiatives, the need for the use of project management techniques, the need to tailor interventions to the specific needs of your target group (respect the diversity of the target group and involve them in the planning if possible), the need to ensure high participation, adapting the tool as necessary (e.g. avoid overlapping with existing initiatives), allow enough preparation and implementation time and realistic scheduling of the initiative, ensure training, resources and a supportive and encouraging environment are available, seek skilled staff to support and co-facilitate, and evaluate the MHP implementation on a continuous basis.

The lessons learned for the policy field range from the need to ensure resources (e.g. skilled staff, training) and financial support (e.g. funding, grants), the need to develop strong policy (e.g. parental work, staff support, counselling), the need for MH education and curriculum development (e.g. primary and secondary schools but also for trainers in the field), the need to conduct awareness programmes on MHP (e.g. media campaigns such as anti-stigma), the need to find local MHP champions for policy initiatives, the desirability of integrating MHP into physical activity programmes and in health and safety laws, the need to support the development of co-operative relationships and networks between experts and practitioners in the field, and to promote a more widespread discussion about MHP and well-being issues in a greater context.

The ProMenPol team believe that valuable insights into practice should also be considered during policy making. Relying solely on scientific evidence neglects the rich and varied information yielded from real-life practice and personal experience that could potentially improve policy development and the monitoring process.

1.3.3 Global network on mental health promotion

Last but not least, an important result of the project's activities has been the creation of a global network of different stakeholders involved with mental health promotion.

This was achieved in part through the annual conferences and policy workshops and in part through the successful website and newsletter. Furthermore all partners pursued extensive networking activities.

Attendees of the first two conferences mainly came from practice, science and NGOs; policy workshop attendees represented different DGs (Employment and Social Affairs, Directorate General for Health and Consumer Affairs, Education and Culture, Research), national Ministries, WHO, ILO as well as the European Parliament. To foster direct communications between practitioners and policy makers the last conference and policy workshop were combined in one event. Eighty participants from 26 countries seized the opportunity of networking for two days in Berlin in October 2009.

Conference evaluations generally showed high levels of satisfaction. When participants were asked about the strongest point of the conferences the following answers were listed most frequently:

- Networking opportunity
- Workshops

- Interdisciplinary approach to conference topics and multidisciplinary background of participants
- ProMenPol developments (database improvements and new toolkit)
- Conference discussions
- Information about (implementing) MHP in Europe

In addition, the website and the newsletter helped to promote and disseminate the project's findings very widely (see also chapter 1.4.1).

Given this success, the ProMenPol team plans to formalise this network in order to foster the sustainable promotion of mental health in Europe and beyond.

1.4 Impact

While it is difficult to measure the impact of the project in precise numbers, the following indicators may give some impression of the project's reach.

1.4.1 User statistics

The project's website and newsletter have been very well received by the stakeholder community as can be seen from the statistics:

Statistics gathered for the ProMenPol website between 01/1/2009 - 30/11/2009 indicate a 1,694.346 hits and 55,998 unique visitors (A unique visitor is a statistic describing a unit of traffic to a website, counting each visitor only once in the time frame of the report). Web traffic numbers are reflected in the graph and tables below.

Additionally, in excess of 4800 web pages can be visited on the ProMenPol website.

Figure 2: Monthly ProMenPol History

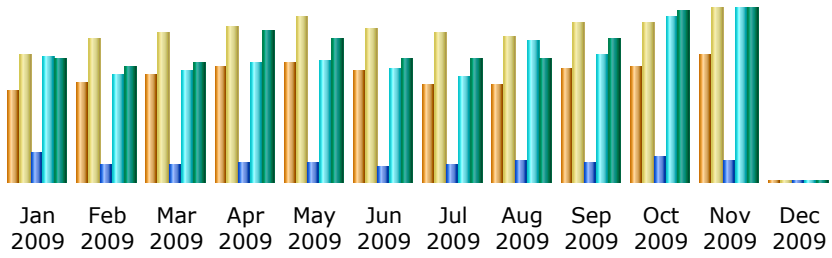


Figure 3: Monthly ProMenPol History

Month	Unique visitors	Number of visits	Pages	Hits
Jan 2009	4259	5939	34178	150044
Feb 2009	4667	6712	20693	129337
Mar 2009	5047	6977	19528	133663
Apr 2009	5370	7264	22279	141697
May 2009	5557	7712	21578	143723
Jun 2009	5198	7158	18913	136067
Jul 2009	4598	7030	19392	124937
Aug 2009	4538	6791	24662	168917
Sep 2009	5335	7448	22201	152934
Oct 2009	5430	7484	29217	197447
Nov 2009	5999	8462	24634	215580
Dec 2009				
Total	55998	78977	257275	1694346

The project's newsletter is now distributed to in excess of 800 recipients. Because of this broad acceptance, the consortium plans to carry on the production of the newsletter even beyond the end of the project.

1.4.2 Dissemination of best practice

As described in chapter 1.3.2, various organisations across Europe started to implement mental health promotion activities in their organisations with the assistance of ProMenPol.

Not only were most of the results positive, but institutions also reported sustainable effects on the organisation as well as the intention to continue implementing mental health promotion activities in the future.

At the third ProMenPol conference, the field trial representatives from each setting were given a forum to report on their experiences to a live audience including representatives from the scientific community, policy makers as well as other practitioners.

Since the experiences of the field trials are also displayed on the ProMenPol website, the dissemination of best practices will be carried on also beyond the project's end.

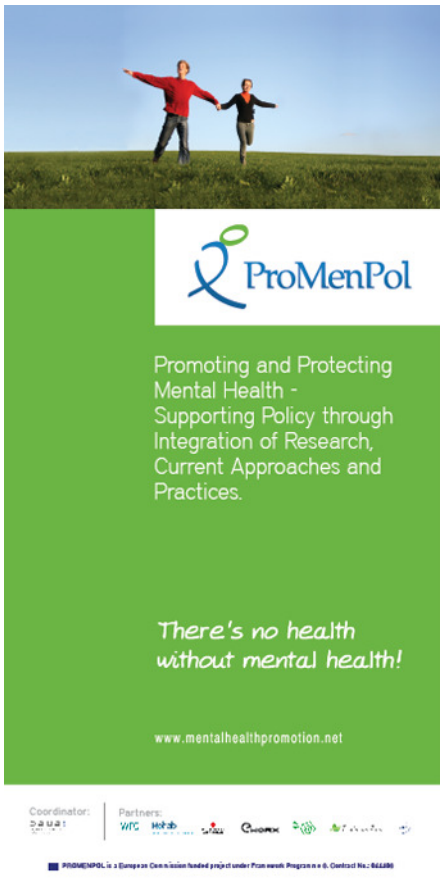
1.4.3 Policy support

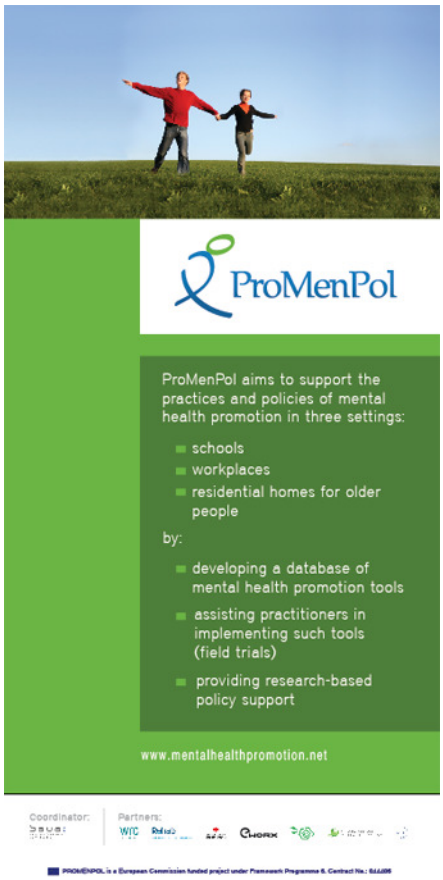
The ProMenPol consortium actively supported policy through various means.

Different project partners were involved in the writing of the consensus papers that were produced in the context of the EC high level conference in June 2008. In addition, ProMenPol presented a

poster at the first thematic conference about mental health in youth and education that took place in Stockholm on September 29-30 2009. Different partners will also be involved in the planning of the upcoming next thematic conferences.

Figure 4: Poster for thematic conference





Furthermore ProMenPol helped to disseminate information about the European Pact for Mental Health and Well-Being to practitioners on the ground. This was done through various presentations and workshops during the ProMenPol conferences. Interestingly many participants –although active in the field of mental health promotion- never had heard about the European Pact for Mental Health and Wellbeing before. After discussing its contents at the conferences, ProMenPol also reported the practitioner's feedback and suggestions back to the policy makers at the policy workshops in Brussels.

At the final ProMenPol conference policy makers had the chance to directly listen to the experiences of practitioners who had implemented mental health promotion tools in their organisation. Different workshops and an interactive panel discussion fostered communications between the different spheres of practice, policy and science.

1.4.4 Sustainability: Two follow-up projects

Finally, the consortium successfully applied for two follow-up projects, which will build on the results of ProMenPol.

The first one is a two-year project, funded under the Leonardo programme that will concentrate on the conceptualisation of an MHP E-Learning tool.

The second one is a three-year project, funded under the Public Health Programme that will focus on the preparation of handbooks for mental health promotion.

Both of these projects will further build on the ProMenPol products, in particular the website (www.mentalhealthpromotion.net) with its database, and they will continue to develop the global network for mental health promotion.

1.5 Contractors involved

The ProMenPol consortium included partners from a variety of different backgrounds and expertises. Each organisation is described briefly below. In subchapter 1.5.10 contact details of all partners are provided.

1.5.1 BAuA (Coordinator) - Germany

The Federal Institute for Occupational Safety and Health (BAuA) with head office in Dortmund is an public law institute without legal capacity within the portfolio of the German Federal Ministry of Labour and Social Affairs.

The Federal Institute for Occupational Safety and Health as a major governmental research institution advises the Federal Ministry of Labour and Social Affairs in all matters of safety and health and of the humane design of working conditions. As a federal institution with R&D functions the Federal Institute operates at the interface between science and politics and renders transfer services from the science system into policy, corporate practice and the broader society and vice versa. BAuA's tasks range from policy advice, the performance of sovereign duties and knowledge transfer into corporate practice through to the educational and instructional work done by the German Occupational Safety and Health Exhibition (DASA).

As a pool of competence and a knowledge service provider in matters of safety and health at work, BAuA offers advice and practical assistance to companies, government, the social partners and the general public. The main focus of all research is to help bring about a humane world of work with safe, healthy and competitive workplaces.

1.5.2 WRC - Ireland

The Work Research Centre is a research and consultancy company providing a multidisciplinary perspective and service in five main areas:

- Socio-economic aspects of telecommunications and telematics
- Health and wellbeing in the workplace

- ICT solutions for disabled and older people
- Human resource aspects of organisational change
- Health and social service innovation

1.5.3 Rehab Group - Ireland

Rehab is a leading non-governmental organisation, which works towards a world where every person has the opportunity to achieve his or her potential. It works in local communities to provide high-quality services and opportunities to people who need them.

Over 3,600 Rehab staff provide health and social care, training and education, and rehabilitation, employment and commercial services in Ireland, the UK, the Netherlands and Poland. These services enhance the quality of people's lives, by supporting people in fulfilling personal goals, in accessing new opportunities and in playing a more active role in their communities. Rehab enables people to make the most of their skills and talents, to take up employment or further education and to live more independent lives.

The people who currently use our services include young people and adults with physical, sensory and intellectual disabilities, people with mental health difficulties, people with autism and people with an acquired brain injury. A range of essential services is also provided to older people, carers and others who are marginalised.

Every year, more than 56,000 people and their families benefit from the supports provided by Rehab in over 200 locations. Rehab works to influence leaders and policymakers to deliver positive change in the lives of the people who access their services, and has consultative status as a non-Governmental organisation at the Economic and Social Council of the United Nations.

1.5.4 FRK - Austria

The Research Institute of the Red Cross broadly approaches and discriminatingly deals with relevant societal problems and – in cooperation with its partners – works on developing creative and innovative solutions. The central concern and also integral part of all their activities is to guarantee the transfer of project results back into the practical context of health and social services. Theory and practical experience go hand in hand in order to assure the quality of their research.

The Research Institute of the Red Cross works in four research fields:

- Rescue, emergency care and security
- Health care and nursing
- Labour market, employment and volunteer services
- Health promotion and prevention

1.5.5 EWORX - Greece

EWORX S.A. offers ICT consulting and software development services leveraging on the convergence of electronic media and the growing need for innovative solutions to organisational and corporate challenges in the globalised economy. Established in 2001 and headquartered in Athens, the company currently employs over 20 highly trained and skilled professionals who blend experience with multi-disciplinary expertise in consulting, technology, project management, marketing and branding, content and design.

EWORX main services include ICT consulting as well as design, development and deployment of bespoke networked software solutions with emphasis on innovation and usability. The company promotes open source and open standards -based solutions fostering portability and interoperability, vendor-independence and quick return of investment. Application areas include Client/Server Applications, Internet/Intranet/Extranet Portal development, Content Management of multi-lingual and content-rich, database-driven websites, e-Government, e-Learning and e-Business Solutions. In order to provide quality and state-of-the art solutions, EWORX maintains and develops a rich skill-set which includes: ICT strategy and requirements definition, business process modelling, object oriented analysis and design, system development, content strategy development and editorial policy definition, branding and electronic marketing.

1.5.6 ERSI - Estonia

The Estonian-Swedish Mental Health and Suicidology Institute (ERSI) is a non-governmental organisation established in 1993. Since 2000 ERSI is a research group of the Estonian Centre of Behavioural and Health Sciences and since 2004 registered at the Estonian Ministry of Education and Research as a research and development institution. ERSI is a leading centre and a focal point of the Estonian Ministry of Social Affairs in mental health and suicide research and prevention in Estonia. ERSI has broad collaborative contacts both nationally (Tallinn University, University of Tartu, National Institute for Health Development) and internationally (WHO, IASR, IASP, AFSP, NASP at Karolinska Institute, Leipzig University, Würzburg University, Frankfurt Goethe University, FIOCH, WRC) and is involved in several thematic EC funded prevention, intervention and research projects (7FP SEYLE, 7FP OSPI-Europe, 6FP ProMenPol, EAAD, MONSUE, T-MHP, MHPHands, SUPREME) and WHO collaborative projects (SUPRE-MISS, HBSC).

1.5.7 THL - Finland

The National Institute for Health and Welfare (THL) is a research institute under the Finnish Ministry of Social Affairs and Health.

- THL works to promote the well-being and health of the population, prevent diseases and social problems, and develop social and health services.
- THL is the statutory statistical authority in health and welfare and maintains a strong knowledge base within its own field of operations. THL is also responsible for the application of this knowledge.
- THL has a wide range of tools to carry out its responsibilities: research, follow-up and evaluation, development, expert influence, official tasks as well as international co-operation.

- THL seeks to serve the broader society in addition to the scientific community, actors in the field and decision-makers in central government and municipalities.

1.5.8 MHE - Belgium

MHE is a non-governmental organisation set up in 1985 and committed to the promotion of positive mental health and well-being, the prevention of mental disorders, the improvement of care, advocacy for and the protection of the human rights of (ex)users of mental health services and their families and carers. MHE's mission is to promote mental health and wellbeing of all citizens, from all minority groups and the whole of Europe.

Together with its member organisations MHE develops European exchange projects, formulates recommendations for policies and strategies on mental health and well-being and lobbies the European institutions in order to increase awareness of the issue of positive mental health and well-being – just as MHE members' campaign at the national and local level.

MHE offers an opportunity for every organisation that wants to contribute to building a Europe in which all citizens enjoy a high level of mental health, within the European Union as well as beyond it in the larger Europe. MHE supports the emancipation of different groups in the mental health field in order to establish equal partnerships and opportunities among the different parties and to ensure that the mental health needs of the population are met.

In order to fulfill this strategic role, MHE works closely with the World Health Organization Regional Office for Europe, has a participative status with the Council of Europe and a liaison function for mental health promotion with the European Commission.

MHE is a member of several European advocacy and lobbying groups: the European Public Health Alliance, the European Disability Forum, the Social Platform and the European Women's Lobby. MHE's Secretariat is based in Brussels (Belgium).

1.5.9 MAAS - The Netherlands

Dr. Frans Nijhuis, Prof. in Psychology of Work and Health at Maastricht University supported the ProMenPol project during the first two and a half years of the project.

1.5.10 Contact details

Contact details of all partners are provided below:

ProMenPol-Partners:

Organisation	**URL**	**Contact**
Bundesanstalt für Arbeitsschutz und Medizin (BAuA)	www.baua.de	Dr. Karl Kuhn (project leader): kuhn.karl@baua.bund.de Katrin Zardo (project manager): zardo.katrin@baua.bund.de
Work Research Centre Ltd. (WRC)	www.wrc-research.ie	Dr. Richard Wynne: r.wynne@wrc-research.ie

The Rehab Group (REHAB)	www.rehab.ie	Collette Ryan: collette.ryan@rehabcare.ie
Maastricht University (MAAS)	www.unimaas.nl	Dr. Frans Nijhuis: f.nijhuis@beoz.unimaas.nl
Research Institute of the Red Cross (FRK)	www.w.roteskreuz.at	Gert Lang: gert.lang@w.roteskreuz.at
EWORX S.A. (EWX)	www.eworx.gr	Tilia Boussios: tb@eworx.gr
National Institute for Health and Welfare (THL)	www.thl.fi	Dr. Eija Stengård: Eija.Stengard@thl.fi
Estonian – Swedish Mental Health and Suicidology Institute (ERSI)	www.suicidology.ee	Merike Sisask: merike.sisask@neti.ee
Mental Health Europe – Sante Mentale Europe (MHE–SME)	www.mhe-sme.org	Mary van Dievel: mvandievel@mhe-sme.org

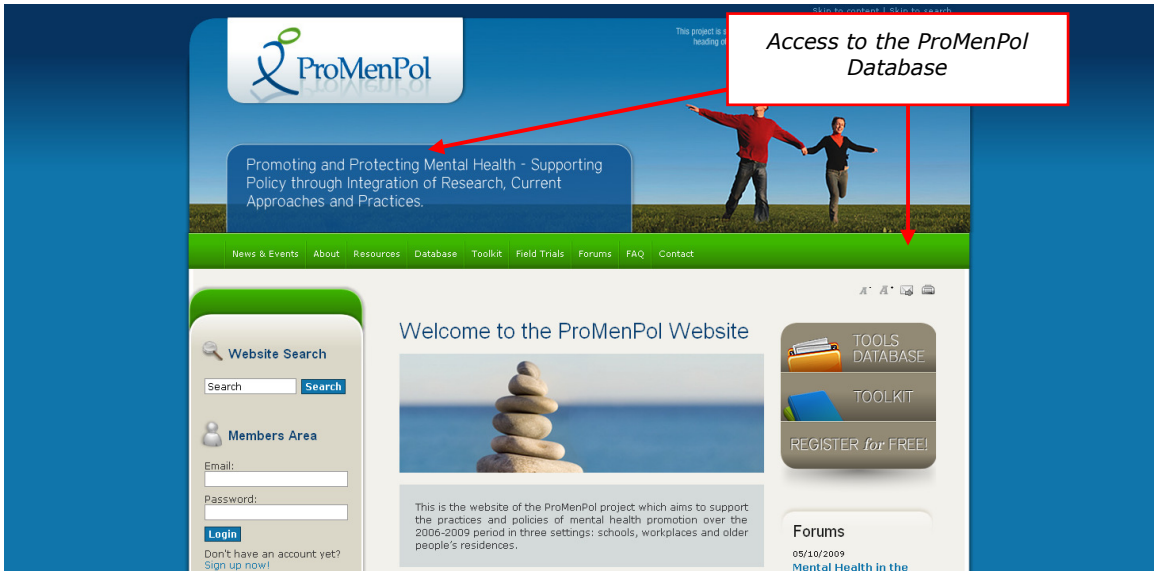
2. Dissemination and use

The main publishable results emanating from the ProMenPol project concern the online database and toolkit-manual. In addition, the ProMenPol website itself is a public result of the project. Below a technical description of both is provided.

2.1 The ProMenPol database and toolkit-manual

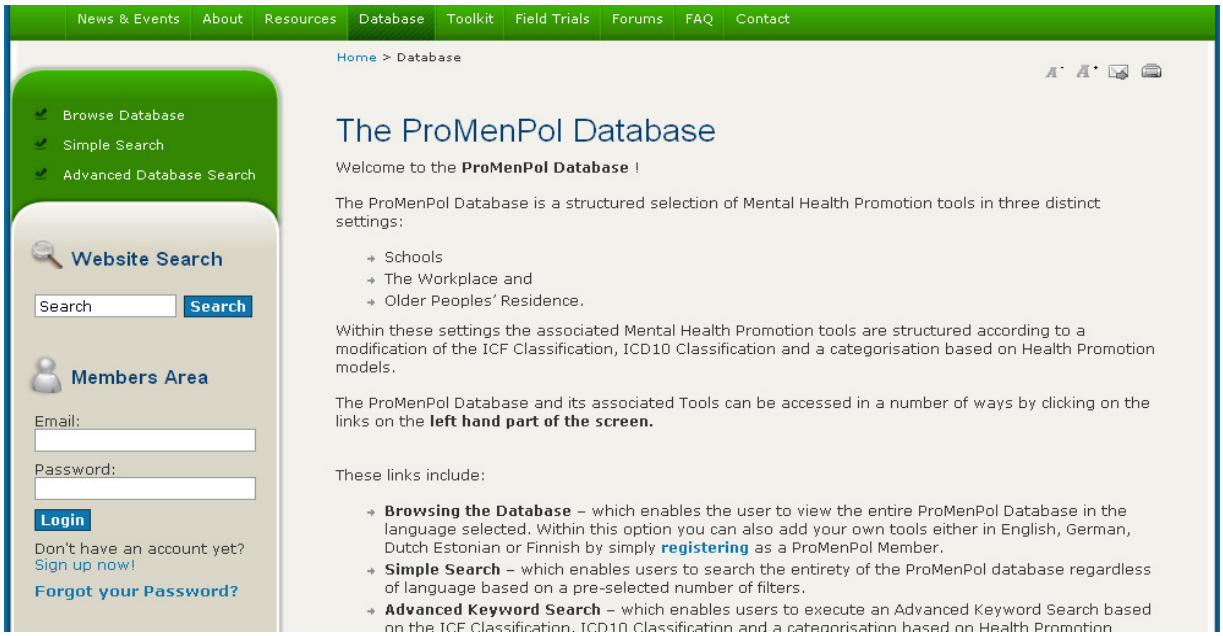
The ProMenPol database can be accessed from the ProMenPol website www.mentalhealthpromotion.net - toolkit menu option which is found in the menu bar that is located below the header at the top of the page.

Figure 5: Database Access Options



Once the database option has been selected the following introductory screen will appear which describes the purpose and functionality associated with the database.

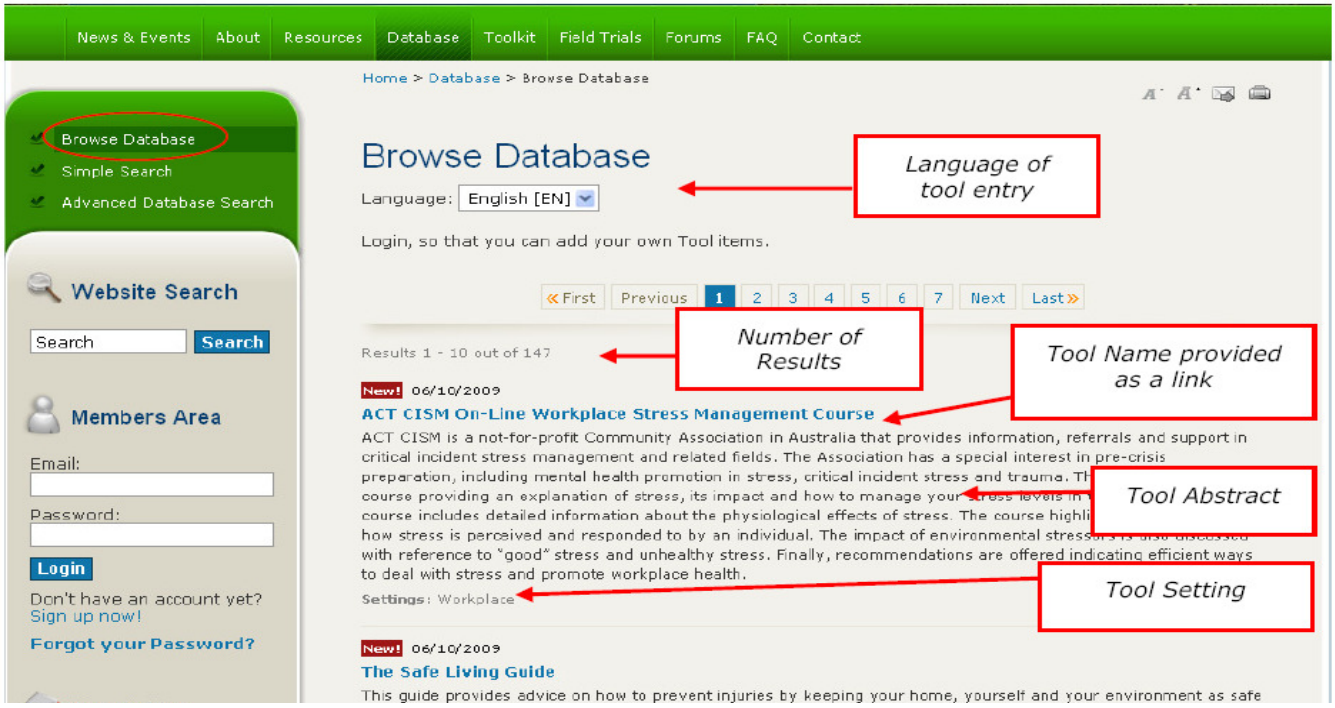
Figure 6: ProMenPol Database Page



Within this screen users have a number of options through which to access the ProMenPol database.

In order to browse the ProMenPol database ensure that you are in the Database option. Then click on the link on the left hand side menu browse database. This action will result in the following screen appearing:

Figure 7: ProMenPol Database – Tool Listing Page



The purpose of this display page is to present a sequential list of all the tools that are currently available within the ProMenPol database. In the current example 10 out of 147 tools are displayed that are available in English. This value is displayed at the top of the first tool – whereas the language entry is available from a drop down menu beneath the title browse database.

Within this initial screen a short abstract about the tools is provided as well as the setting details and the date that the tool went live within the ProMenPol website.

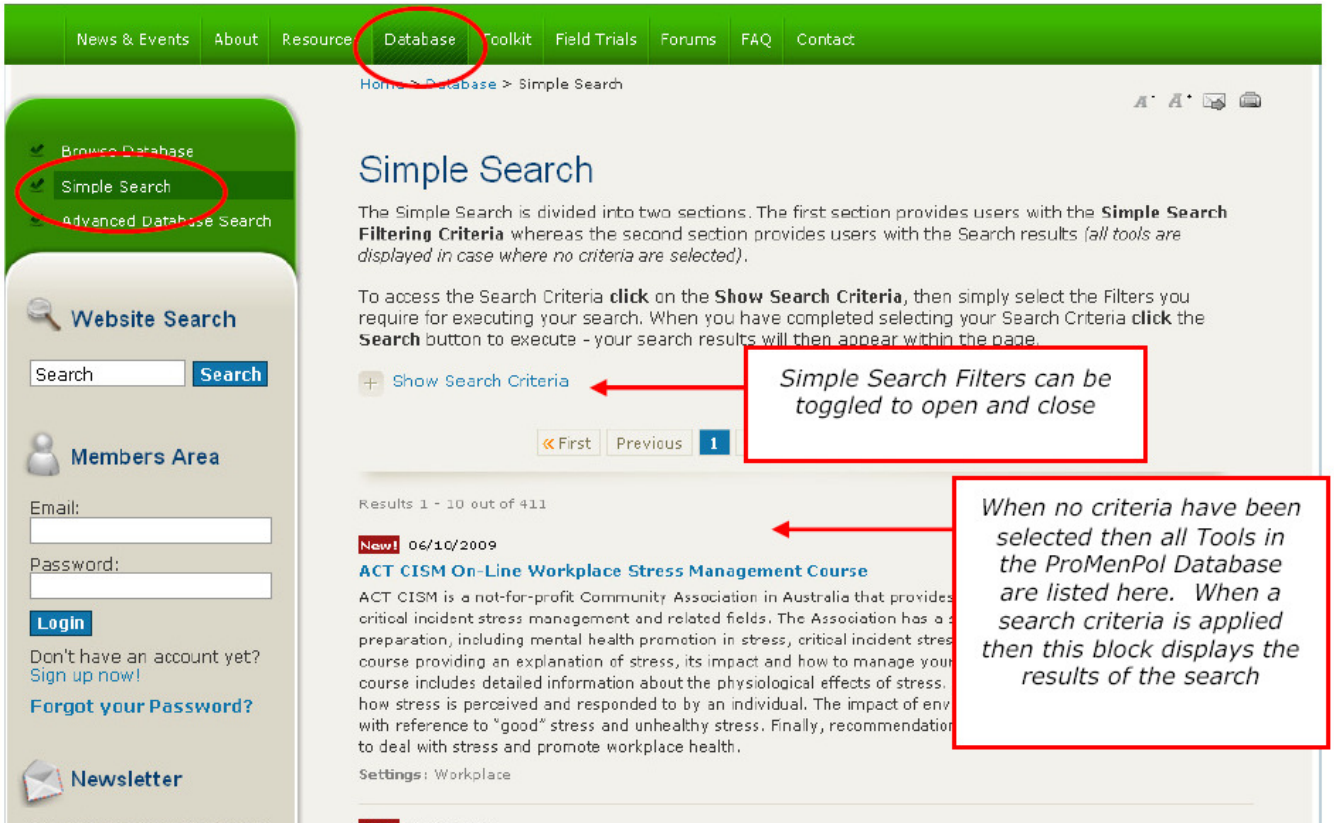
In order to view more details about a specific tool simply click the link associated with the tool Title. For instance, in order to find out details about the tool 'The Safe Living Guide' click the name of the tool. This action takes the user to the respective tool's home page which provides detailed information about the selected tool.

The simple search – A simple search has been incorporated into the ProMenPol database which serves as a filtering option for the database toolset. Users are provided with the option to filter their search results according to the following criteria:

- Setting
- MHP step
- Country of origin
- Tool language
- Language of entry
- Evaluation information
- Tool focus
- Tool types
- Application in the field
- Stage of development
- Evaluation and research
- Beneficiary involvement in design

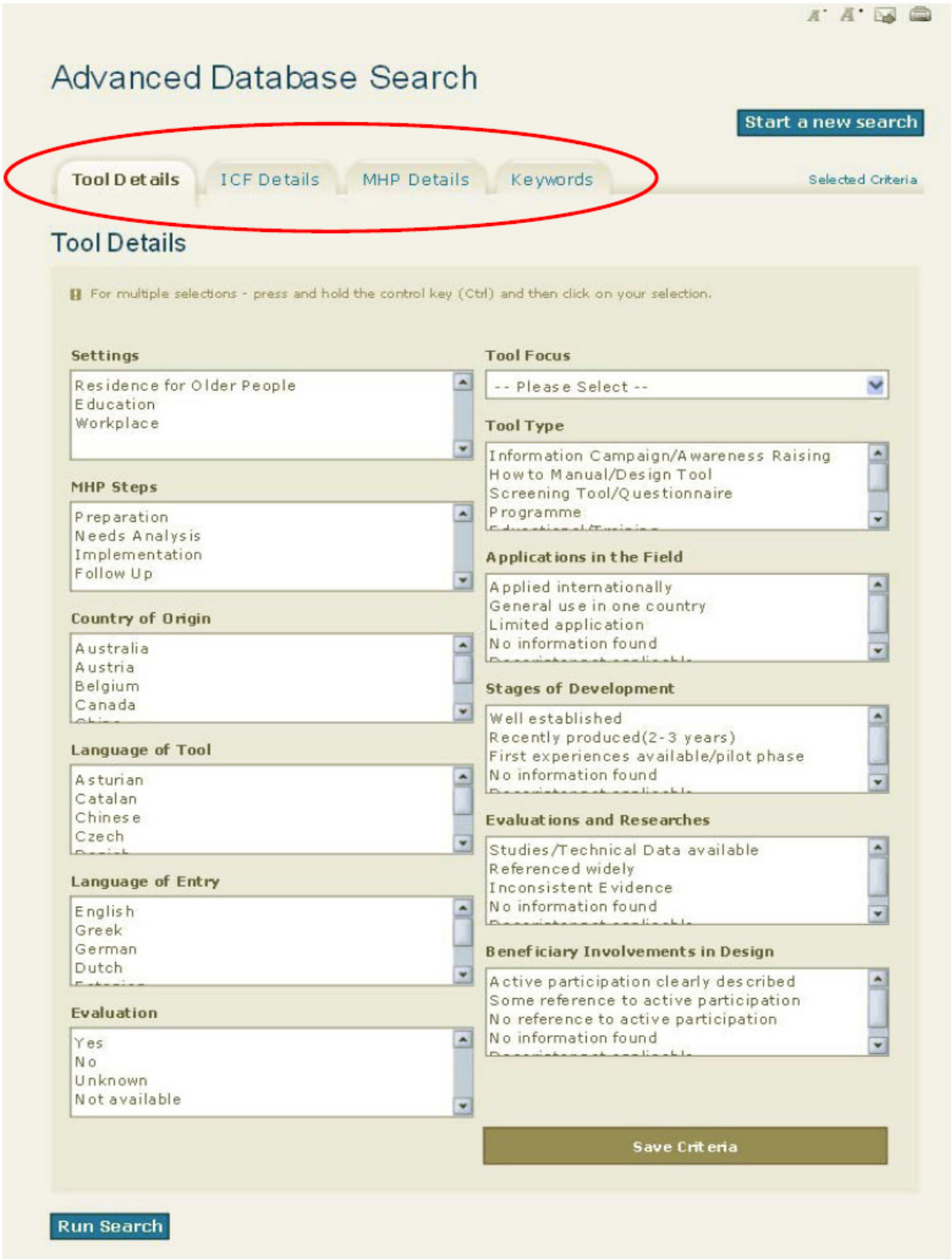
An example of the simple search screen is presented below.

Figure 8: Simple Search Screen



The advanced search - In addition to providing users with a simple search function – an advanced search has also been launched. From within the advanced database search users have the possibility to build an advanced search using any of the tab buttons provided at the top of the screen i.e. Tool Details, ICF Details, MHP Details or Keywords. These tabs can be used independently of each other or in combination.

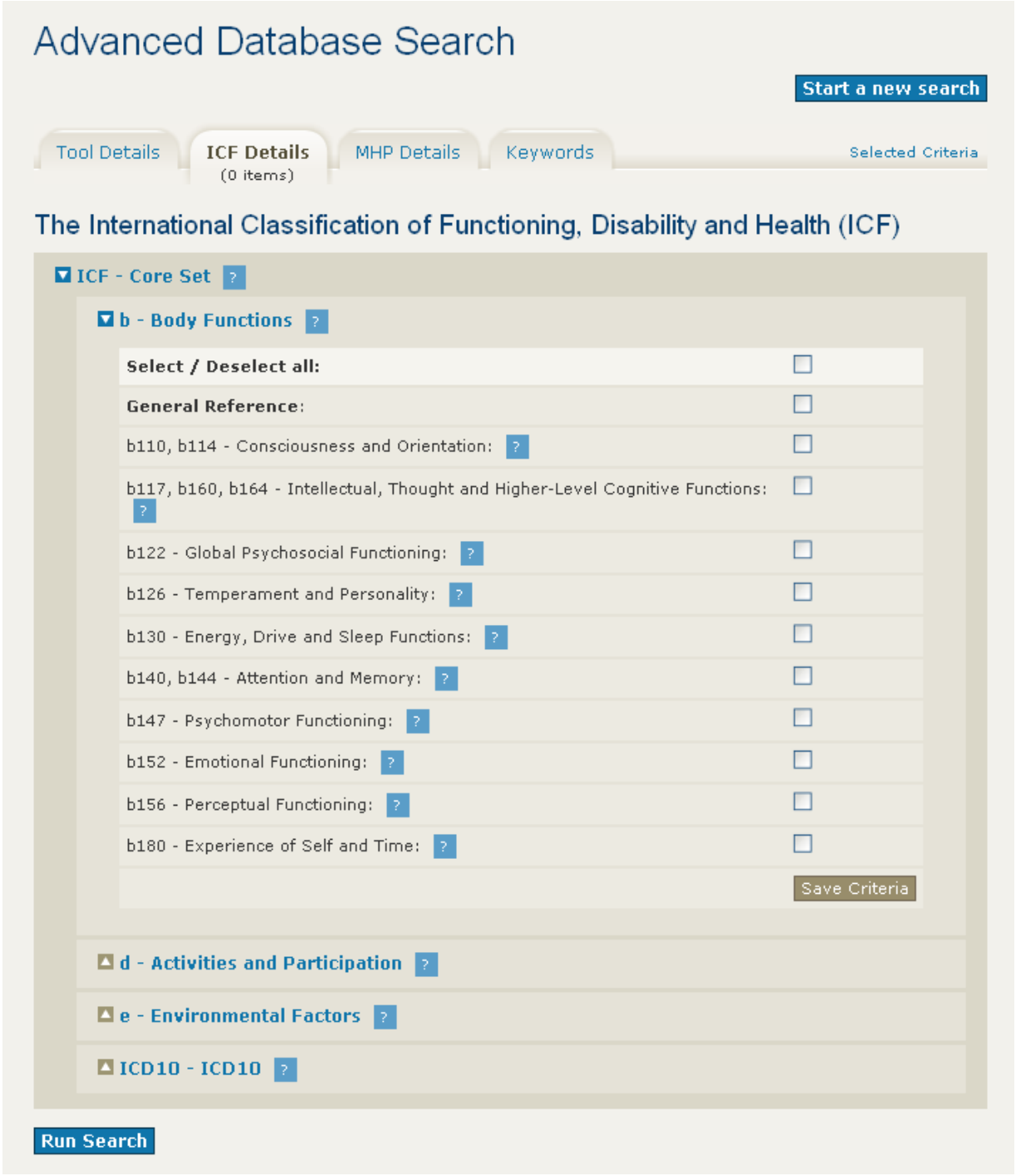
Figure 9: Advanced Search Screen



The **Tool Details** tab provides users with search elements which are identical to the search criteria in the simple search (see above).

From within the **ICF Details** tab users can select ICF Details which match the tools they are interested in retrieving. In order to access the categories associated with the ICF Core Set, user have to click on Core Set to expand the listing which is organised in a three-level hierarchical structure. Further expanding the sub-categories associated with the higher categories, will allow users to place a tick against the search items of interest.

Figure 10: ICF Core Set Body Functions – Categories Screen

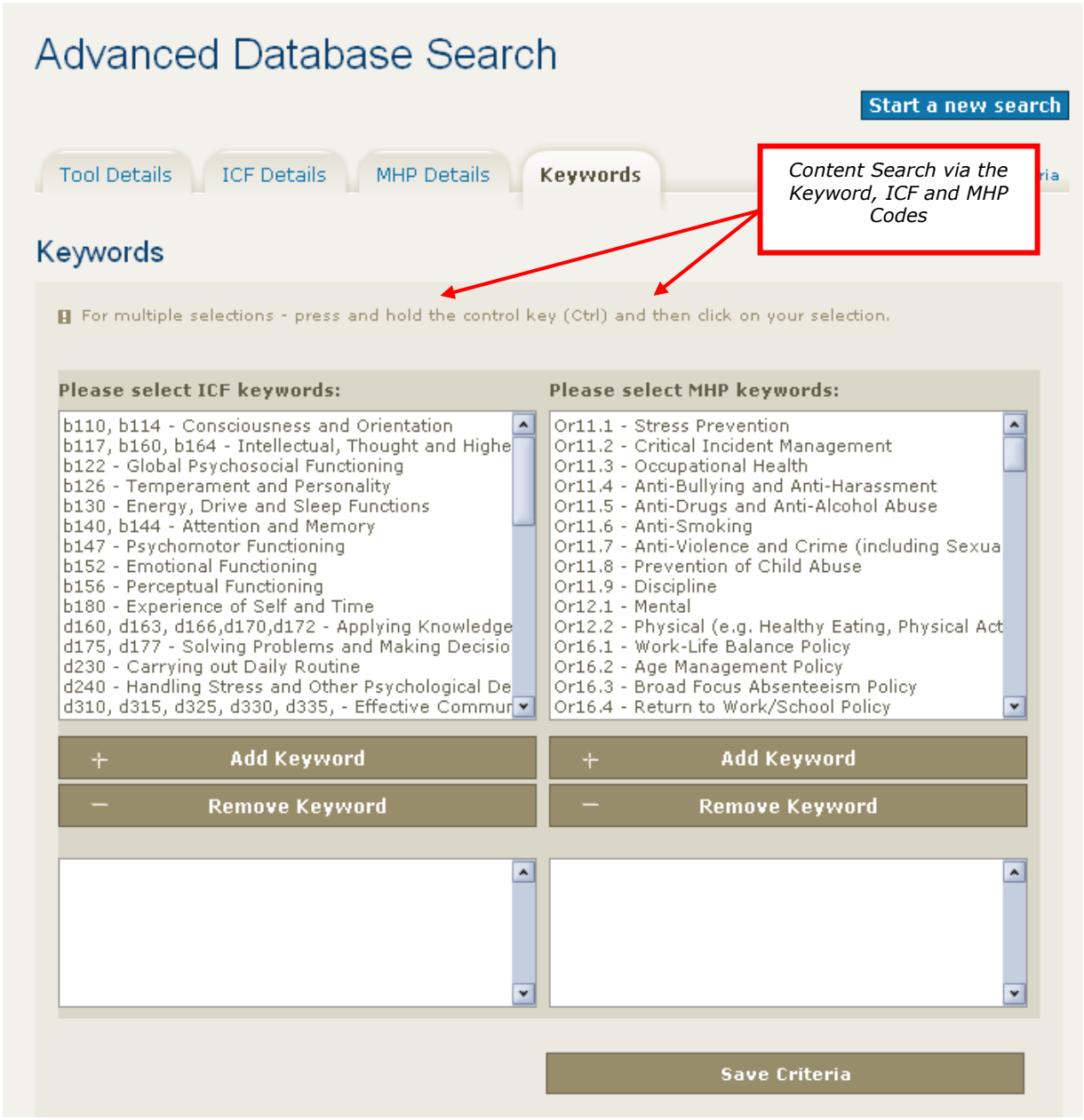


From here users can select their search terms of interest. Having selected each search term of interest, users must click the save criteria button at the end of the list of terms. Additionally, once saved the number of items selected are reflected in the number of items beneath the ICF Details tab. Once the criteria have been selected and saved by clicking save criteria users can move to the next tab or alternatively click run search.

The functionality associated with the MHP Details tab is identical to that described for the ICF Details tab above.

In contrast to the ICF details and MHP details tabs the 'keywords' tab enables users to quickly assemble a selection of ICF and MHP details which match the tool they are interested in retrieving. From within this screen users can select and deselect the keywords they wish to search on.

Figure 11: Keywords Tab Screen



Free Text Search - In addition to the database simple search and advanced search – the ProMenPol website offers users the possibility to carry out a simple text search. This search is available form all pages within the ProMenPol website and is located on the left side of the screen.

Figure 12: ProMenPol Free Text Search

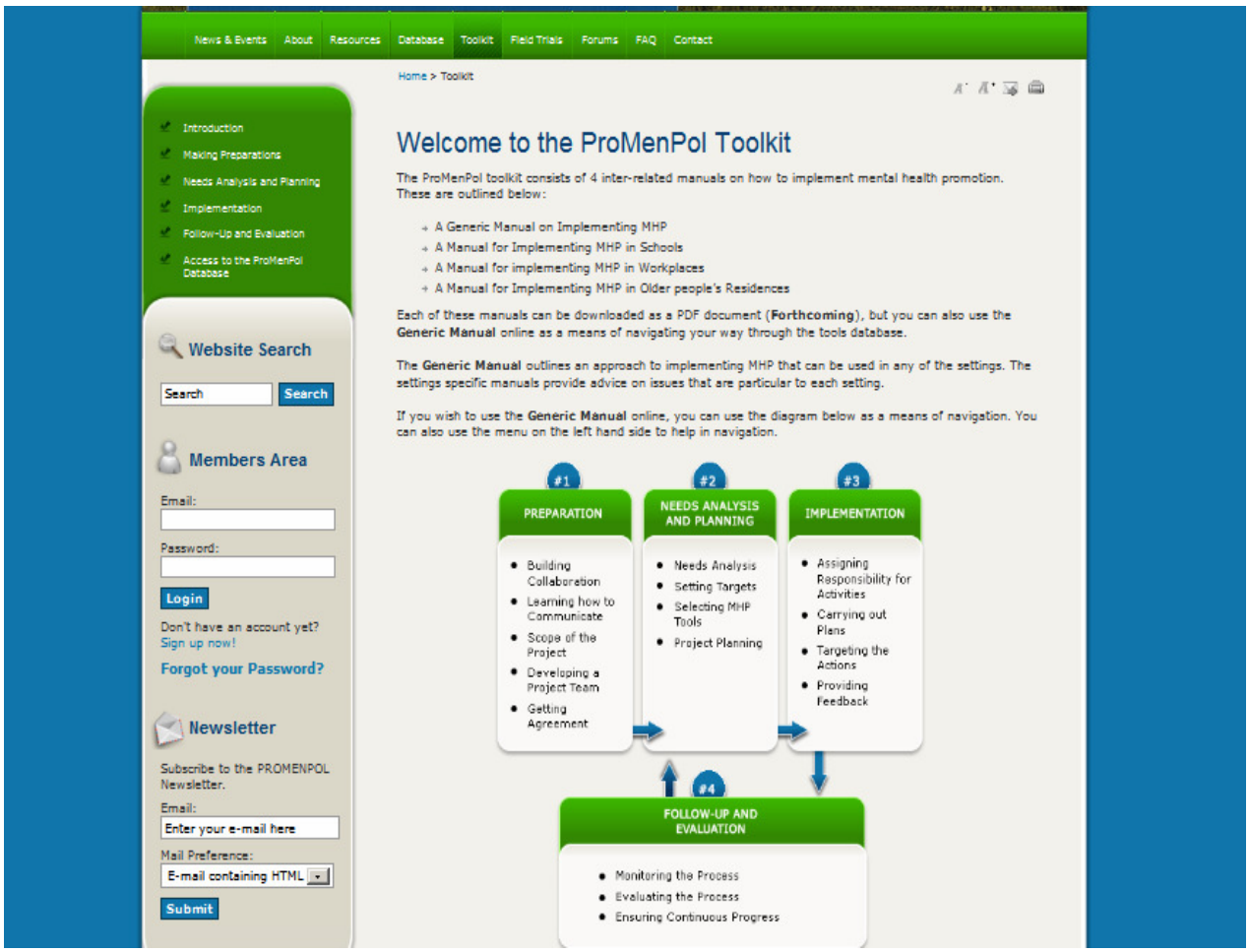
Additionally to the ProMenPol database the ProMenPol toolkit-manual has been created. The toolkit can be viewed as an extensive and structured entry into the database, which describes user in detail the steps involved in implementing mental health promotion. The toolkit itself is available in English only, but refers to tools in English, German, Finnish, Estonian and Dutch.

The ProMenPol toolkit can also be accessed from the ProMenPol website www.mentalhealthpromotion.net. In order to Access the **ProMenPol Toolkit** click on the link on the right hand side menu or on the tab in the menu bar that is located below the header at the top of the page.

Figure 13: Toolkit Access Options

This action will result in the following screen appearing:

Figure 14: ProMenPol Toolkit Page



The implementation process has been condensed into the four steps 1. preparations, 2. needs analysis/ planning, 3. implementation and 4. follow-up/ evaluation. Subsequent to a generic part for each step, the user may access setting-specific parts of the toolkit (education, workplace, older people's residences), which also contain at the end a set of tools which are applicable to the according MHP step and setting.

The toolkit itself is available in English only, but refers to tools in English, German, Finnish, Estonian and Dutch.

2.2 The ProMenPol website

The ProMenPol website was designed to act as a pan-European gateway to results, documentation and related issues emanating from the project. Additionally, the website holds several possibilities for registered members to disseminate their own results, tools, events and news.

For ProMenPol members accessible parts of the website include the following sections:

News & Events: Here latest developments in the field of mental health promotion can be published ranging from conference announcements, project launches, new publications to policy developments. Newly added events and news will be displayed in the right hand column on the ProMenPol website's main page.

Projects: Here projects related to mental health (and its promotion) can be entered and described. Mainly projects which are primarily undertaken on a European level have been entered. However the section is open to actions on national and local level, too.

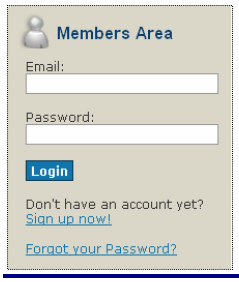
Networks and other Organisations: The section contains links to mental health associated networks and organisations.

Policy Documents: Policy related documents in the field of mental health (promotion), such as the European Pact for Mental Health and Well-Being are entered here. These policy documents may relate to activities and actions on both a European level as well as a national level.

Bibliography: References to (scientific) articles regarding mental health and public health are provided in this section. The section is open to English references as well as publications in other languages.

Database: In addition to retrieving tools form the ProMenPol Database, it is also possible for registered members to upload tools to the database themselves.

In addition, registered member receive the ProMenPol newsletter which is send out on a quarterly basis and is used as a vehicle to disseminate information about latest developments in the field mental health promotion.

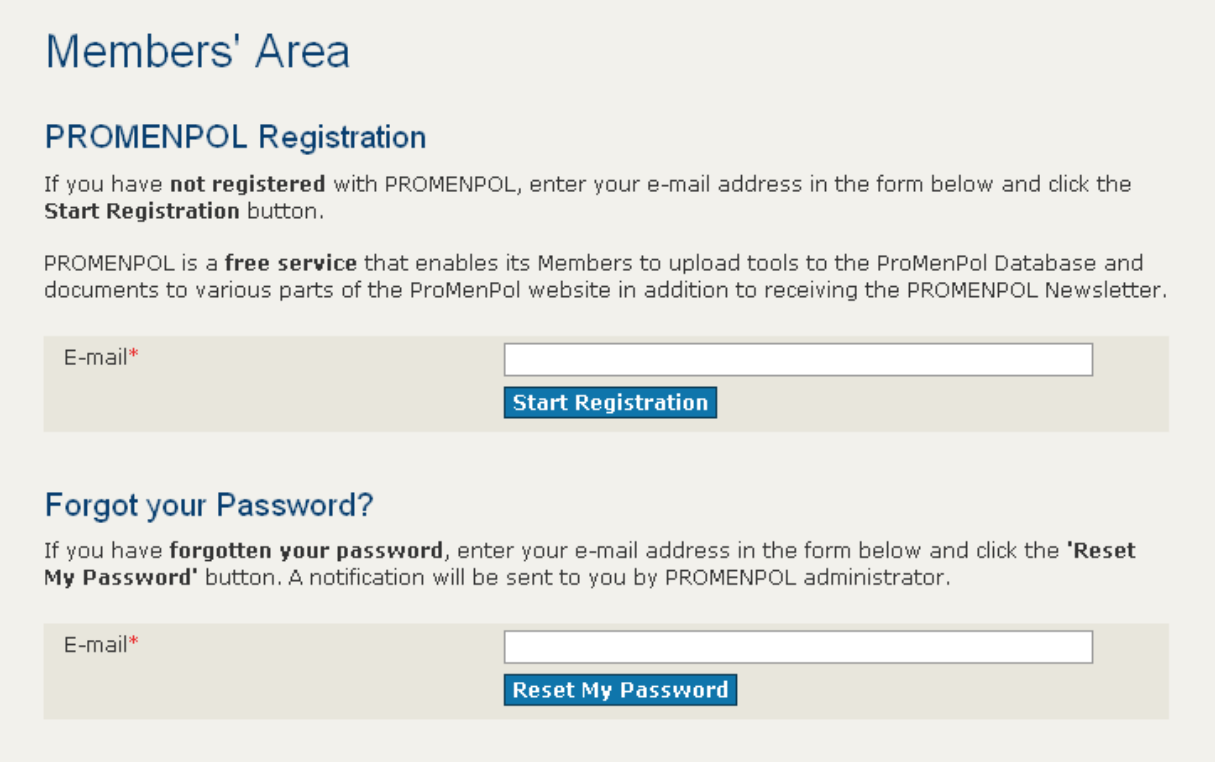


In order to become a ProMenPol member users must sign up using the 'Sign up Now!' link provided on the left side of the screen – just below the 'Login' button in the Members Area.

Once accessed, users are provided with the 'Members Area-ProMenPol

Registration' screen which requests the users email address for verification purposes and the commencement of the registration process.

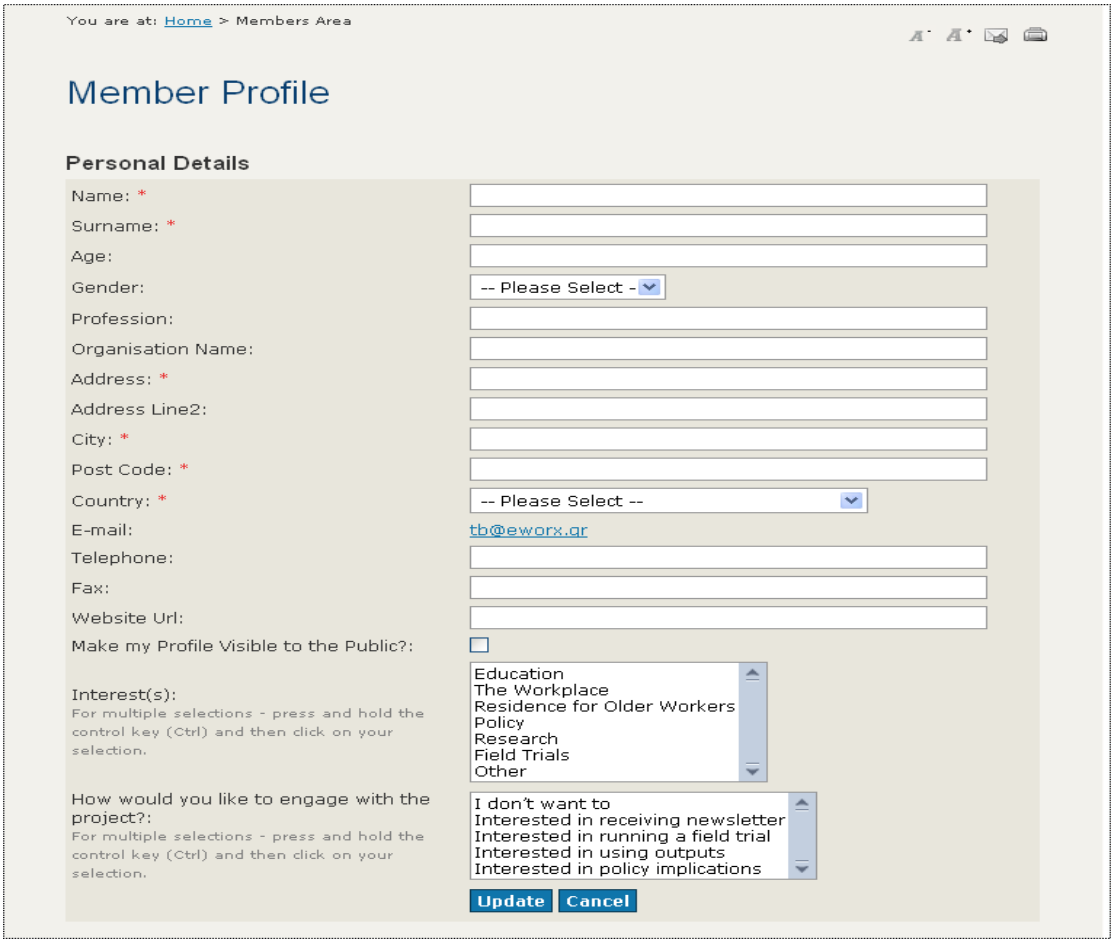
Figure 15: ProMenPol Members Area – ProMenPol Registration



Please Note, when the 'start registration' button is clicked an e-mail notification will be automatically sent to the user's e-mail along with their members password.

Once a valid email is entered and the start registration button is clicked users are provided with the following 'Members Profile' screen (next page).

Figure 16: ProMenPol Members Profile Screen



The Members Profile screen asks users to complete basic information about themselves and the respective organisation that they represent. Additionally, questions about how they would like to engage with the project are asked as is the privacy question "Make My Profile Visible to the Public?".

Once the registration process is completed, users may then login using the 'members area login' screen and begin to add their events, news, publications and tools to the ProMenPol database.