



*Making It Happen*

A guide to delivering  
mental health promotion

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## **Purpose of this document**

This document is designed to provide information about mental health promotion and the evidence to support it to enable MSF Standard One leads and others to develop an effective implementation plan for Standard One of the National Service Framework for Mental Health.

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# Acknowledgement

*Making It Happen* outlines a process that will enable a wide range of groups and agencies to meet their responsibilities in relation to Standard One of the National Service Framework for Mental Health. It will also equip them to begin some of the strategic development necessary to establish public mental health.

This document was produced by **mentality**, building on the wealth of work which has been undertaken in the field of mental health promotion over the past five years. We would therefore like to thank all those who contributed their time and ideas to help us make it happen.

We are grateful to all those who attended *Making It Happen* consultation workshops in February and March 2001, to all those who completed feedback forms with suggested improvements to the pilot copy and to all those who submitted projects as models of good practice.

We are also grateful to all the advisory group members who commented on previous drafts of the document and would particularly like to acknowledge contributions from Jane Lethbridge, Woody Caan, Pratihba Datta, Ken Fox, Evelyn Krasner, Kate Phipps, Kate O'Hara, David Morris, Jude Stansfield and Dave Tomson.

Finally, we would like to thank the Department of Health's Mental Health Promotion Project Team for their support during this project. *Making It Happen* is not the final word on mental health promotion. Evidence will continue to be gathered, programmes will continue to be implemented and we hope this document will continue to make mental health promotion happen.



Dr Lynne Friedli  
Chief Executive, mentality



# Foreword

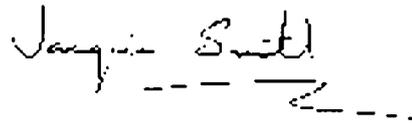
The inclusion of Standard One in the National Service Framework for Mental Health puts mental health promotion centre-stage. For the first time, health and social services have a clear remit to promote mental health for all and to reduce the discrimination experienced by people with mental health problems. We have set clear targets to ensure that local services implement Standard One but we are clear that the Department's role goes beyond exhortation. Delivery will present a challenge and we have a clear responsibility to support local services.

Mental health promotion has a wide range of health and social benefits - improved physical health, increased emotional resilience, greater social inclusion and participation and higher productivity. It can also contribute to health improvement for people living with mental health problems and to challenging discrimination and increasing understanding of mental health issues.

Mental health promotion also has a key role to play in service delivery. It should not be the sole responsibility of health promotion staff. People with mental health problems do have important needs for medical treatment and we must improve the delivery of mental health services. However, medical treatment is only one part of the support they need. All staff working in services have a responsibility to address the wider needs of the 'whole person': for example, for employment or other occupational activity, for suitable housing and for their appropriate entitlement to benefits. Family, friends, schools, employers, faith communities and neighbourhoods all have an important role to play, too, in enabling people with mental health problems to enjoy the same range of services and facilities within the community as everyone else.

Many of the factors which influence mental health lie outside health and social care, so mental health promotion is relevant to the implementation of a wide range of policy initiatives, including social inclusion, neighbourhood renewal and health at work. Effective mental health promotion depends on harnessing expertise, resources and partnerships across all sectors and disciplines.

I commend *Making it Happen* to you. It was developed in extensive consultation with a wide variety of stakeholders from the field. The guidance is intended to be helpful rather than prescriptive. I hope that it will provide practical support to help services develop their local strategies for mental health promotion.

A handwritten signature in black ink that reads "Jacqui Smith". The signature is written in a cursive style and is positioned above a dashed horizontal line.

Jacqui Smith  
Minister of State for Health

# Summary

This guidance provides a wide range of information to support people working to promote mental health, with a specific focus on delivering Standard One of the National Service Framework for Mental Health.

Work to promote mental health will be undertaken by agencies and individuals in many different sectors, with different backgrounds, roles and areas of expertise. These include users and carers, teachers, health visitors, public health specialists, community workers, primary health care staff, prison officers, advocates and many others. For this reason, people's information needs will vary widely. We hope that this guide will serve as a resource, which people can dip in and out of, making use of those sections which are most relevant to their work. The following summary is designed to help you to find the information which will be useful to you.

## *Chapter One - Introduction*

Chapter One introduces the guide and sets the scene for creating a positive climate for mental health promotion. It describes 'public mental health' and the key elements of challenging stigma and discrimination. It outlines the five mental health promotion targets which health authorities must meet by March 2002 and the national, regional and local support available.

## *Chapter Two - Defining mental health promotion*

Chapter Two describes what is meant by mental health and mental health promotion and summarises risk and protective factors for mental health problems. This chapter may be most useful for people who want a brief overview of mental health promotion.

## *Chapter Three - Making the case for mental health promotion*

Chapter Three is intended to help people make the case for investing in mental health promotion. It summarises the benefits of mental health promotion and presents different examples of how mental health promotion can contribute to improved health and well-being. These include preventing mental health problems, improving physical health, strengthening communities, improving information and reducing work related ill-health. This chapter also includes a brief summary of effective interventions in key settings, including home, schools and the workplace.

This chapter will be of special interest to practitioners who want to demonstrate the relevance of mental health promotion to a range of stakeholders e.g. primary health care teams, mental health service providers, local authorities and employers.

### *Chapter Four - The policy context*

Chapter Four describes local and national policy initiatives which are relevant to mental health promotion. It aims to make links with health, education, employment and regeneration initiatives which have the potential to contribute to mental health promotion. Identifying policies with supporting goals is an important part of building a local mental health promotion strategy. This chapter will be helpful for people working to develop strategic links across professional and sector boundaries.

### *Chapter Five - Framework for developing a mental health promotion strategy*

Chapter Five provides a framework for developing a mental health promotion strategy and outlines some of the key tasks involved. It gives examples of different approaches and questions to consider when planning, mapping and selecting interventions.

### *Chapter Six - Types of evidence available*

Chapter Six describes the types of evidence that are available and the strengths and weaknesses of different grades of evidence. It includes questions to ask about sources of data, for example surveys. This chapter will be most useful to people involved in planning evaluations or who want to critically assess the literature on effectiveness. It may also be of interest to anyone who wants to engage with current debates about evidence of effectiveness and how these debates relate to mental health promotion.

### *Chapter Seven - Examples of evidence-based interventions*

Chapter Seven provides a summary of interventions for which there is reasonably robust evidence of effectiveness. It is not a complete guide, but aims to give practitioners an indication of what works at different levels and in a range of different settings.

### *Chapters Eight and Nine - Applying the evidence*

These chapters look at ways of applying what we know about what works. They aim to support practitioners in developing the evidence base and in designing initiatives at a community and policy level. They may be of special interest to people with a background in community development or who are working on neighbourhood or community wide initiatives.

### *Chapter Ten - Evaluation*

Chapter Ten provides basic information on evaluation. It may be helpful for those planning local activities, for example around World Mental Health Day, and can be photocopied and distributed separately.

### *Appendix One - Mental health promotion models and frameworks*

There are many different models and frameworks for promoting mental health. Appendix One gives two examples, drawn from the West Midlands Regional Framework and the Scottish Development Centre's Public Mental Health Project.

### *Appendix Two - Mapping mental health promotion*

Appendix Two includes an example of a questionnaire which can be used as a basis for mapping local mental health promotion activity.

### *Appendix Three - Problem trees*

Appendix Three describes how to use a 'problem tree' to set aims and objectives for a local strategy and gives four examples.

### *Appendix Four - Examples of good practice*

Appendix Four gives examples of good practice, outlining what each project adds to what is already known about effectiveness and identifying areas for future research.

### *Appendix Five - Citizenship and community in mental health*

Appendix Five describes a citizenship programme which is designed to achieve real access to community opportunities for people with mental health problems.

### *Appendices Six and Seven - Feedback*

These appendices include a pro-forma for further examples of good practice and a feedback form to record your views on these guidelines.

## Delivering Standard One

The Department of Health has developed a revised performance management framework to monitor progress on implementation of all the NSF Standards and the NHS Plan as it relates to mental health. The tables overleaf summarise Standard One and relevant key performance targets. The NSF required services to develop a local mental health promotion strategy by April 2001. In recognition of the publication of *Making It Happen* in July 2001, a revised performance target of March 2002 has been set for services to develop and agree an evidence-based mental health promotion strategy based on local needs assessment.

### Standard One: Mental Health Promotion

#### Aim

To ensure health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems.

#### Health and social services should:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Meeting Standard One will require action across whole populations, as well as programmes for individuals at risk.

Performance will be assessed nationally by improvements in the psychological health of the population, measured by the National Psychiatric Morbidity Survey and by a reduction in suicide rates. At a local level health improvement programmes (HImPs) should include evidence of action to:

- combat discrimination against the social exclusion of people with mental health problems
- promote mental health in schools, workplaces and neighbourhoods; for individuals at risk; and for groups which are most vulnerable.

## Standard One: Performance Targets

By March 2002, develop and agree evidence-based mental health promotion strategy based on local needs assessment.

By March 2002, build into local mental health promotion strategy action to promote mental health in specific settings, based on local needs.

By March 2002, build into local mental health promotion strategy action to reduce discrimination.

By March 2002, the written care plan for those on enhanced Care Programme Approach (CPA) must show plans to secure suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits.

By March 2002, implement strategy to promote employment of people with mental health problems within health & social services.

## Developing a mental health promotion strategy: a checklist

The following checklist outlines the key stages in developing a strategy and indicates the relevant sections of the guide. For each stage of the strategy, it is helpful to consider:

**Levels** e.g. individuals, community, structural/policy.

**Settings** e.g. schools, workplaces, prisons, mental health services, home/early years, primary care, residential homes, acute services and A&E, media, neighbourhoods.

**At risk and vulnerable groups** e.g. people sleeping rough, people in prison, victims of abuse or domestic violence, refugees, people with drug and alcohol problems, looked after children, black and minority ethnic groups, low income and excluded groups.

## Key stages in developing a strategy

### **Agreeing a vision and setting aims and objectives**

Defining mental health promotion – Chapter Two  
Framework for developing a strategy – Chapter Five  
Mental health promotion models and Frameworks – Appendix One  
Using a problem tree – Appendix Three

### **Mapping existing initiatives**

Mapping existing initiatives – Chapter Five, Section 5.2  
Mapping questionnaire – Appendix Two

### **Identifying key settings and target groups**

Making the case for investing in mental health promotion – Chapter Three  
Risk and protective factors – Chapter Two, Section 2.4

### **Making the links with policy initiatives with supporting goals**

The policy context – Chapter Four  
Citizenship and community development – Appendix Five

### **Identifying key stakeholders – consultation and gaining commitment**

Making the case for investing in mental health promotion – Chapter Three  
Tackling discrimination – Chapter One, Section 1.2

### **Selecting interventions**

Types of evidence available – Chapter Six  
Examples of evidence based interventions – Chapter Seven  
Applying the evidence base – Chapters Eight and Nine

### **Finding the evidence to support the approach taken**

Examples of evidence based interventions – Chapter Seven  
Types of evidence available – Chapter Six

### **Establishing indicators of progress**

Applying the evidence base – Chapters Eight and Nine  
Examples of good practice – Appendix Four

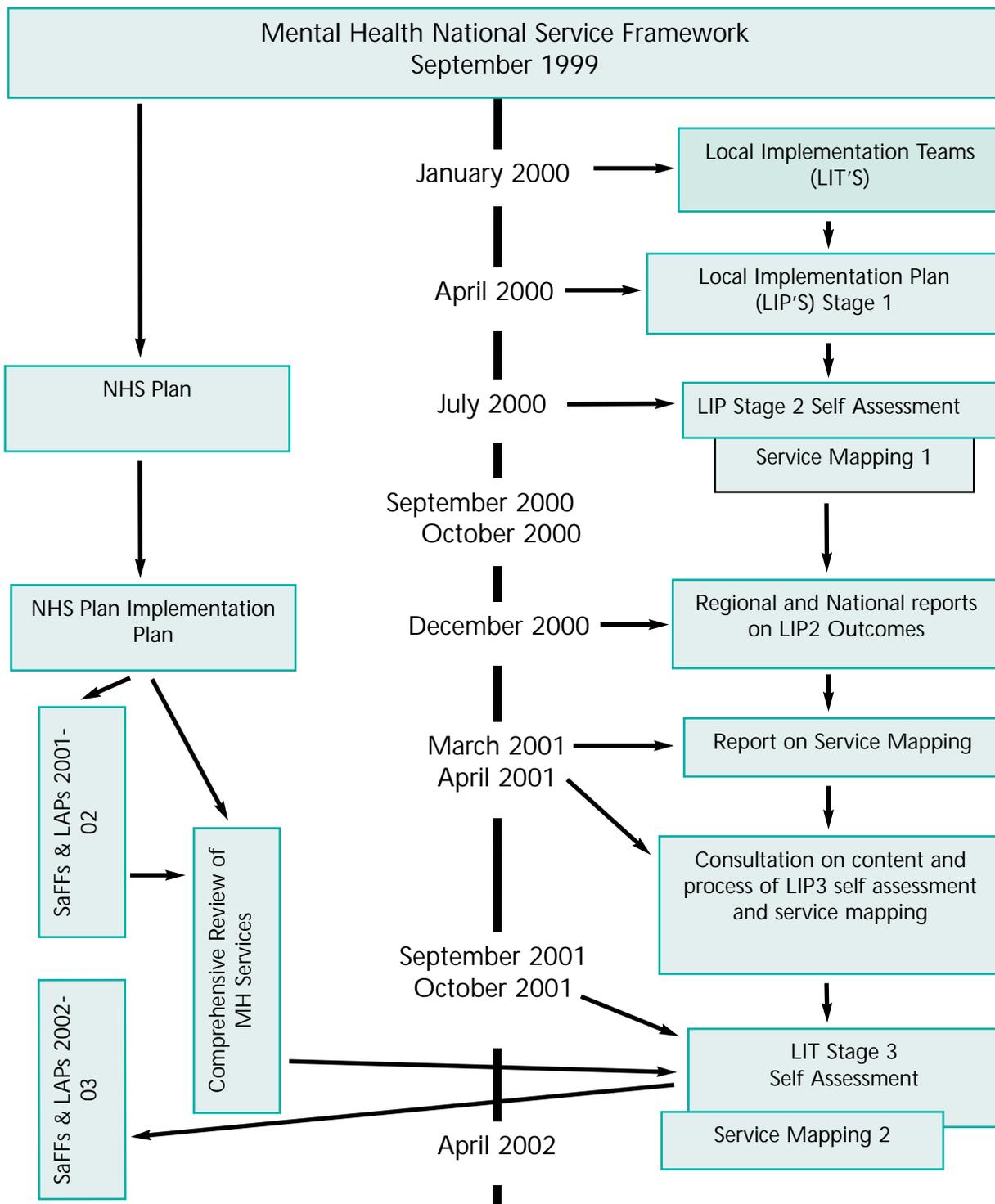
### **Building in evaluation**

Evaluation – Chapter Ten

### **Identifying staffing and resource implications**

Local services will need to identify the staffing and resource implications of implementing their strategy

### Mental health performance management processes





*“How society works at every level influences the way people feel about themselves. And how people feel influences how well society functions.”* (Public Mental Health Project, Scottish Development Centre for Mental Health Services, 1999)

This guide aims to provide support for people working to promote mental health and offers guidelines for the effective delivery of Standard One of the National Service Framework for Mental Health (NSF). The aim of Standard One is to ensure that health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems. Health and social services should:

- Promote mental health for all, working with individuals and communities
- Combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Many of the factors that influence mental health lie outside the remit of health and social care. Effective mental health promotion depends on expertise, resources and partnerships across all sectors and disciplines. Mental health promotion is also relevant to the implementation of a wide range of policy initiatives including social inclusion, neighbourhood renewal, community strategies and health at work. The new agenda for service delivery, including the modernisation of the NHS, outlined in the NHS Plan, and the improvement of mental health services, will also benefit from applying the principles of mental health promotion.

Although health authorities have the lead role in ensuring delivery of Standard One, these guidelines are relevant to local authorities and to colleagues working in all sectors, including the voluntary sector, private sector and in primary care, transport, housing, social services, education, the workplace and occupational health.

**This guide:**

- Defines mental health and mental health promotion
- Makes the case for investing in mental health promotion
- Shows how mental health promotion fits in with other policy initiatives
- Provides a framework for developing local strategies
- Describes the types of evidence and their strengths and weaknesses
- Gives examples of effective interventions
- Describes how to apply the evidence
- Gives information on evaluation

## 1.1 Public mental health

Standard One of the National Service Framework presents a significant opportunity for further developing mental health promotion work. It comes at a time when there are many policy initiatives in the UK that could benefit from mental health promotion input. For those working at local level with relatively scarce resources, it will be important to demonstrate the relevance of mental health promotion to a wider public health agenda, with a focus on what mental health promotion can contribute to health improvement and the reduction of health inequalities.

The requirement in the National Service Framework to ‘promote mental health for all’ provides a valuable opportunity to transform the terms of the debate about mental health and to consider what the Scottish Development Centre for Mental Health Services and others have called the ‘public mental health’. (Henderson and McCollam 2000; Friedli 1999) ‘Public mental health’ takes a broader view of mental health and provides a framework for looking at how to create a mentally healthy society. This involves looking beyond prevention, to the relationship between mental well-being and physical health, and the relationship between mental health and behavioural problems, violence, child abuse, drug and alcohol abuse, health in the workplace and risk taking behaviour such as smoking and unsafe sex. It also involves addressing the **mental health impact** of policies, planning and implementation.

Mental health promotion is arguably the most challenging area of the NSF and delivering Standard One will involve a major change in the way most agencies, above all the NHS, will have to work. It will require a shared understanding and vision of what mental health promotion actually is, and what it can deliver – not just for those involved in mental health, but much more broadly. This will entail:

- looking beyond prevention, to the social, economic and health benefits of investing in mental health promotion
- a greater understanding of the values and strategic priorities underpinning a broader public health agenda – notably institutionalising partnership, involving the community, regeneration, social inclusion and reducing inequalities – and their relationship to mental health promotion
- enhanced public health expertise in relation to risk and protective factors for mental health problems.

Many agencies working in areas that have a direct impact on mental health, for example social exclusion or regeneration, would not describe themselves as involved in mental health promotion. There is a need to address the problem of language and conceptual frameworks in relation to mental health promotion, so that a meaningful debate can take place across professional and sector boundaries. Involving communities and engaging with lay perceptions of mental health could help to achieve this: the high priority given by residents to friendliness, community spirit, security, feeling safe from crime and proximity to friends and family indicate that communities attach a central importance to feelings of mental well-being. (Villaneau et al 2000, Russell and Killoran 2000)

## 1.2 Tackling discrimination: fostering a climate for mental health promotion

The discrimination faced by many people with mental health problems can be one of the most debilitating aspects of their daily lives. Challenging prejudicial attitudes is therefore an important goal in its own right, but it can also help to foster a climate of public understanding which is more receptive to broader mental health promotion initiatives. Alongside work to change public attitudes, we also have a responsibility to ensure that discrimination against people with mental health problems is tackled through the effective application of the Disability Discrimination Act.

Improving public understanding will also play an important role in reducing the stigma attached to working in mental health services, which contributes to low morale and may discourage people from seeing a career in mental health.

### 1.2.1 *Public attitudes*

The emphasis in Standard One of the National Service Framework on stigma and discrimination has led to a renewed interest in public attitudes to mental health, media coverage of mental health issues and interventions which seek to promote greater acceptance and understanding of mental health problems. This area needs to be treated with some caution because there is a considerable discrepancy between public attitudes, as expressed in surveys, public attitudes revealed in more detailed, qualitative research, and public behaviour, as experienced by service users and those delivering services.

The most recent RSGB (Research Services Great Britain) omnibus survey commissioned by the Department of Health shows greater acceptance by the public of people with mental health problems.

The vast majority of people have a caring and sympathetic view and believe that virtually anyone can become mentally ill. Fewer than one in five people consider it frightening to think of people with mental health problems living in residential neighbourhoods, with nearly half disagreeing strongly with the statement 'I would not want to live next door to someone who had been mentally ill'. Although the public still express concern over how much responsibility can be given to people with mental health problems, they are becoming more tolerant. There is a growing belief that people with mental health problems should be integrated into the community, with support from community based services. (Department of Health 2000)

### 1.2.2 *The experience of people with mental health problems*

Unfortunately, this positive picture is not matched by the experiences of service users. Qualitative research from mental health charities and voluntary sector organisations shows that the quality of life of people with mental health problems is diminished by stigmatising attitudes, negative and distorted media coverage and discrimination. (Dunn 1999; Philo 1996) Discrimination is particularly powerful in the areas of employment, housing and access to services (notably in relation to 'nimby' campaigns). Unemployment rates amongst those with long term mental health problems are higher than in other groups of people with disabilities. Only 13% of people with long term mental health problems are in employment, compared to over a third of people with disabilities generally. (ONS 1998) These factors contribute centrally to the experience of social exclusion, which is consistently reported by those who use, or have used, mental health services.

One explanation for this discrepancy is that there is a difference between people's declared attitudes and how they in fact behave. Based on public responses to a range of vignettes, a major American study in 1996 found that the public wanted the greatest social distance from people with cocaine dependence (90%), followed in order by alcohol dependence (70%), schizophrenia (63%), depression (47%) and 'troubled person' (29%). (Link et al 1999) Link et al found a strong connection between ideas of danger and fear of violence and the desire for social distance.

### *1.2.3 Knowledge and behaviour*

Increased knowledge of mental illness does not necessarily result in a reduction in stigma. (Link et al 1999) For this reason, there is a need for further research to explore the most effective local and national initiatives for reducing stigma and discrimination. The Institute of Psychiatry, through its AD 2000 project, is piloting local approaches to tackling discrimination against people with mental health problems. Local measures to increase social contact and familiarisation with service users have had positive results. (Sayce et al 1999) Personal experience or contact with people with mental health problems is associated with more favourable attitudes (Angermeyer & Matschinger 1996) and with greater understanding of the term schizophrenia. (Hillert et al 1999)

### *1.2.4 Attitudes of mental health professionals*

A number of studies indicate that mental health professionals also hold negative attitudes to people with mental health problems. (Royal College of Psychiatrists 2001, Fleming and Szmukler 1992, Roskin et al 1988, Farrell and Lewis 1990, Chaplin 2000) Attitudes to self-harm, eating disorders and substance abuse may be particularly negative. Mental health professionals who experience mental health problems themselves may also face particular problems. (Caan et al 2001) A positive approach to employing people with mental health problems within the mental health workforce and including mental health promotion in the training of mental health professionals could make a significant contribution to changing this. Tackling the role that psychiatrists and other health professionals play in maintaining stigma is one of the themes of the Royal College of Psychiatrists' 'Changing Minds Campaign'. For more information, see their website. ([www.changingminds.co.uk](http://www.changingminds.co.uk)) Concerns have also been raised about the misleading and stigmatising nature of advertisements for antipsychotic medication in professional journals. (McKay 2000)

### 1.2.5 Attitudes towards the mental health workforce

Both mental health services and professional bodies will need to take forward work to address the stigma associated with people who work in mental health services – which has a significant effect on recruitment and retention. Mental health services face severe pressure in terms of staff shortages, high turnover and low morale across all the main staff groups. Although there is a need for further research on the links between public perceptions of mental health workers and recruitment difficulties, there is some evidence that negative attitudes to psychiatrists, psychologists and mental health nurses contribute to low morale and early retirement. (SCMH 2000)

Addressing misconceptions about the mental health workforce will require a co-ordinated strategy which includes work in schools, further and adult education, improved media coverage, partnerships with professional bodies across all sectors and a more proactive approach to opportunities for exchange, secondments and work experience within the mental health sector. Mental health services will need to address their reputation as an employer, working not only to address stigma but to improve their image. Many of the staff who participated in a recent review felt that mental health nursing was seen as a job with low pay and low status, but with high levels of stress and risk. A perceived culture of blame and a poor physical working environment were other factors which were seen to contribute to the poor image of the sector. (SCMH 2000)

### 1.2.6 National anti-discrimination campaign

The Department of Health has appointed a communications consultancy to develop a new campaign aimed at tackling the stigma and discrimination faced by people with mental health problems and at supporting their social inclusion. The campaign *mind out for mental health* will also support the implementation of Standard One of the National Service Framework for Mental Health.

The Forster Company will run one of the biggest public behaviour change initiatives of its kind, and will target information at and through the media, the corporate sector and young people. *mind out for mental health* proposes an integrated public education campaign focusing on the perpetrators of discrimination against mental health service users, rather than their perceived “victims”. It aims to:

- improve public understanding to reduce discrimination towards people with mental health problems;
- encourage the public to question their attitudes towards mental health;
- give mental health users a voice and opportunities to speak out about mental health;

- complement and support existing activities undertaken by the Department of Health and mental health organisations.

*mind out for mental health* is a sustained, year-round awareness and action programme, with partners in the voluntary sector, the media and business working together to change attitudes and behaviour surrounding mental health. Through such partnerships (both on a national and local level), and through high profile communications and events, *mind out for mental health* reaches out to key audiences – informing, challenging and giving practical help, and showing that the discrimination surrounding mental health is illegal, unfair and no longer acceptable.

Attitudes cannot be changed overnight, but by working with a range of partners from the start, *mind out for mental health* aims to build a network and momentum that can take the work forward for the future. And by focussing on three specific groups – employers, the media, and young people – *mind out for mental health* aims to activate genuine change. In tandem with its network of partners, *mind out for mental health* will be running initiatives and events for each of these key audiences, as well as major awareness and participation events for the general public.

The Department of Health has written to its network of local organisers and mental health promotion specialists providing up to date information on the *mind out for mental health* campaign. In addition the campaign website ([www.mindout.net](http://www.mindout.net)) has now been launched for regular updates, copies of press releases and electronic materials.

### 1.2.7 Mental health literacy

The term mental health literacy has been used to describe knowledge and belief systems about mental health and mental health problems, including attitudes to causes, different treatments and the role of different mental health professionals. Negative beliefs about antidepressant and antipsychotic medication are very widely held, while counselling and alternative therapies are viewed more positively. Although GPs are generally seen as more likely to be helpful than psychiatrists or psychologists, in 1996, the majority of the public in a UK survey said they would be embarrassed to consult a GP for depression, mainly because the GP would see them as unbalanced or neurotic. (Jorm 2000) Jorm et al (1997) found a clear gulf between public and professional beliefs about mental health problems. As with the literature on stigma, it is not easy to identify clear connections between health beliefs and behaviour. However, based on a recent review of the literature, Jorm has argued that an improvement in mental health literacy will be an important contributor to the success of prevention, early intervention, self-help and support for people with mental health problems in the community. (Jorm 2000)

### 1.3 Towards a strategic approach

Mental health promotion has made notable gains in the last five years. Standard One is a significant recognition of the importance of mental health promotion and for those working locally presents an important opportunity to take mental health promotion forward. The challenge now is to ensure that, in the face of competing priorities, mental health promotion is not side-tracked.

Local work to implement Standard One is already raising some fundamental questions about the relevance of mental health promotion to those delivering services, and the kind of partnerships which will be necessary to effectively deliver Standard One.

#### Figure 1:1 Standard One. Mental Health Promotion

##### **Aim**

To ensure health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems.

##### **Health and social services should:**

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Meeting Standard One will require action across whole populations, as well as programmes for individuals at risk.

Performance will be assessed nationally by improvements in the psychological health of the population, measured by the National Psychiatric Morbidity Survey and by a reduction in suicide rates. At a local level health improvement programmes (HIMPs) should include evidence of action to:

- combat discrimination against the social exclusion of people with mental health problems
- promote mental health in schools, workplaces and neighbourhoods; for individuals at risk; and for groups which are most vulnerable.

Although the mapping of mental health promotion activity in many areas has demonstrated a very wide range of initiatives, there is now a need to develop a more strategic approach. Mental health promotion is more than just the sum of a range of individual projects. The performance management framework for Standard One (Figure 1.2) demonstrates the increasing emphasis on laying the foundations for local mental health promotion strategies which can be monitored, evaluated and developed over the longer term.

Demonstrating what mental health promotion can contribute to a diverse range of agendas is one of the major tasks facing those trying to implement Standard One. From a resource perspective, increased investment in mental health promotion is essential for a long-term improvement in mental health. This will come when many sectors, not just the health sector, recognise the social, economic and health benefits of mental health promotion. The growing awareness of the links between mental and physical health further strengthen the need for mental health promotion to be recognised as part of a public health strategy. Interventions to, for example, reduce stress in the workplace, to tackle bullying in schools, to increase access to green, open spaces and to reduce fear of crime all contribute to health gain through improving mental well-being, in addition to any impact they may have on preventing mental disorders.

#### Figure 1:2 Performance Management Framework

By March 2002, develop and agree evidence-based mental health promotion strategy based on local needs assessment.

By March 2002, build into local mental health promotion strategy action to promote mental health in specific settings, based on local needs.

By March 2002, build into local mental health promotion strategy action to reduce discrimination.

By March 2002, the written care plan for those on enhanced Care Programme Approach (CPA) must show plans to secure suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits.

By March 2002, implement strategy to promote employment of people with mental health problems within health & social services.

## 1.4 Supporting a strategic approach

### 1.4.1 National support for Standard One

A Mental Health Promotion Project has been established within the Department of Health, led by Richard Berry, to take forward work around policy development and implementation of mental health promotion and suicide prevention. The aim of the project is to promote mental well-being in the general population and empower people with mental health problems to participate in society to their fullest possible extent. Contact details for the project team are given at the end of this section. In addition, a Project Group has been appointed, bringing together service users, voluntary organisations, researchers, clinicians, health promotion specialists and others, to provide the expertise required to support the development of mental health promotion.

The Mental Health Promotion Project has seven objectives, each of which is being taken forward through a series of initiatives, some of them providing support to local services or direct action in pursuit of project objectives, and others influencing and working with other stakeholders:

- support implementation of NSF Standard One
- take steps to reduce the death rate from suicide and undetermined injury by at least one fifth by 2010
- raise awareness of mental health issues with a view to reducing discrimination against people with mental health problems
- promote greater opportunities for people with mental health problems to access suitable employment, housing, education, welfare benefits, leisure and financial services
- promote mental health for specific groups of people
- promote mental health in specific settings
- encourage and support international co-operation in sharing good practice in mental health promotion.

Many people working locally have felt a sense of isolation in advocating for mental health promotion. The Mental Health Promotion Project Team in the Department of Health is determined to address this by stimulating the development of a mental health promotion community. To this end, with the help of the regional offices, the team has mapped the regional and local networks in place to support mental health promotion. The project team will

maintain a database of Standard One Leads – those people who have direct responsibility for implementing Standard One of the NSF – as well as a broader database of other mental health promotion stakeholders. This will facilitate direct communication with the field to trail central Departmental initiatives to support mental health promotion, share information about initiatives from other government departments and agencies which are relevant to mental health and disseminate further examples of good practice. The project team is exploring the possible establishment of a website, linked to the various websites for mental health promotion which are being developed at a regional level, and the development of a newsletter to support effective communication with the field.

The publication of *Making It Happen* is therefore the beginning of a process of dialogue with the field which we hope will keep mental health promotion firmly on the agenda, both nationally and locally. The project team will act as advocates for mental health promotion within the Department and with other government departments and national agencies with a view to ensuring long-term, sustainable investment in mental health promotion. Further guidance will follow on specific aspects of mental health promotion to ensure that *Making It Happen* evolves to remain a useful and practical guide for local use.

#### 1.4.2 Regional support for Standard One

The Regional Offices of the NHS Executive are putting in place a variety of mechanisms to support the development of mental health promotion in their areas. The Mental Health Promotion Project Team has convened a Mental Health Promotion Regional Liaison Group to bring together representatives from each of the Regional Offices, under the chairmanship of Richard Berry, Head of the Department of Health's Mental Health Promotion Project Team. The aim of that group is to promote shared development and learning between regions to ensure that all is being done to prevent wasteful duplication of effort and to promote good practice throughout the country.

#### 1.4.3 Local support for Standard One

In many parts of the country, designated NSF Standard One Leads have been appointed. The national Mental Health Promotion Project Team has mapped those local leads (see above) to facilitate effective communication with the field. In some areas, mental health promotion representatives have been included in the generic NSF Local Implementation Teams. However, this is by no means universal. Delivery of Standard One is as important as delivery of the other service-based standards. It is therefore important that mechanisms are in place in each locality to ensure that Standard One is adequately addressed alongside all the other standards and that mental health promotion expertise is included in Local Implementation Teams.

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# Defining mental health promotion

## 2.0 What is mental health promotion?

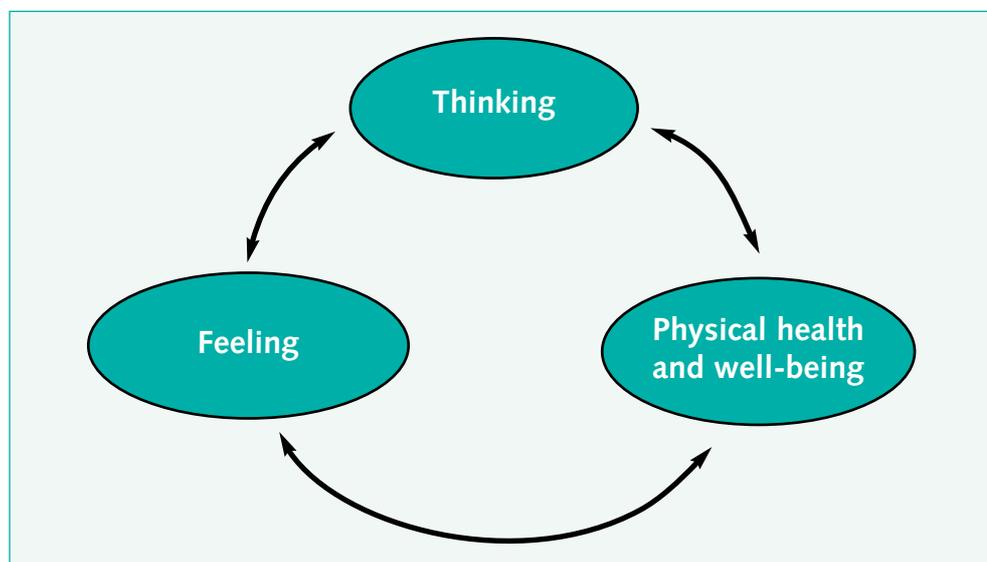
Mental health promotion involves any action to enhance the mental well-being of individuals, families, organisations or communities

There is a wide range of theoretical perspectives on mental health promotion and a number of different models that can be used to develop a strategic framework. The model in this chapter is drawn from *Mental Health Promotion: A Quality Framework (HEA 1997)*. Other models are included in Appendix One.

Mental health promotion is essentially concerned with:

- how individuals, families, organisations and communities think and feel
- the factors which influence how we think and feel, individually and collectively
- the impact that this has on overall health and well-being. (Friedli, 2000)

Figure 2:1 What is mental health promotion?



Mental health problems are often defined in relation to specific diagnoses, for example depression or schizophrenia. However, a mental health problem can refer to any problem that disrupts the way we think and feel, either temporarily, for example following a bereavement, or on a more severe and enduring basis.

## 2.1 Mental health and well-being

Mental health is more than an absence of mental illness. There are many different definitions of mental well-being and these are influenced by individual experiences and expectations, as well as by cultural and religious beliefs. Mental health influences how we think and feel, about ourselves and others and how we interpret events. It affects our capacity to learn, to communicate, and to form and sustain relationships. It also influences our ability to cope with change, transition and life events – having a baby, going to prison, experiencing bereavement. Mental health may be central to all health and well-being, because how we think and feel has a strong impact on physical health.

Mental well-being is influenced by many factors, including genetic inheritance, childhood experiences, life events, individual ability to cope and levels of social support, as well as factors like adequate housing, employment, financial security and access to appropriate health care. Gender has a significant impact on mental health and vulnerability to mental health problems. Racism, homophobia and other forms of discrimination also affect mental health and can be an underlying cause of mental health problems. Mental health is not simply a characteristic of individuals: schools, neighbourhoods, organisations or specific groups of people e.g. refugees may have low levels of mental health as a result of poverty, deprivation, exclusion, isolation or low status.

Everyone has mental health needs, whether or not they have a diagnosis of mental illness. These needs are met, or not met, at home, at work, on the streets, in prisons and hospitals, in schools and neighbourhoods – where people feel respected, included and safe, or on the margins, in fear and excluded. Because everyone has mental health needs, the need for mental health promotion is universal and of relevance to everyone. Mental health promotion does have a role in preventing mental health problems, notably anxiety, depression, drug and alcohol dependence and suicide. But mental health promotion also has a wider range of health and social benefits. These include improved physical health, increased emotional resilience, greater social inclusion and participation and higher productivity. Mental health promotion can also contribute significantly to the health and well-being of people with mental health problems and has a key role to play in challenging discrimination and increasing understanding of mental health issues.

## 2.2 Different perspectives

It is important to remember that there are different views and perspectives on mental illness and diagnostic labels like schizophrenia and manic depression. Some people do not believe it is helpful to use one label to describe a wide range of different experiences. Not everyone believes that seeking a cure for mental health problems, notably schizophrenia, is necessarily the right approach. Experiencing and coping with depression, hearing voices, visions or radical changes in thoughts and feelings can be frightening and distressing, but can also enrich people's lives. (Health Education Authority 1998;1999)

Professional prejudices also impact on diagnosis, treatment and assessment of need. Young African and Caribbean men, (especially second generation) are much more likely to receive a diagnosis of schizophrenia (Wessley, 1991), are more likely to be detained under the Mental Health Act and less likely to be offered psychological treatments.(Nazroo, 1998) Black and minority ethnic communities (including refugees) may experience social exclusion and discrimination that causes or compounds mental health problems. The NHS Plan recognises that mental health needs and concerns of black and minority ethnic communities are often unrecognised and poorly responded to. Addressing different religious and cultural perspectives in relation to mental health is crucial to the development of local mental health promotion strategies.

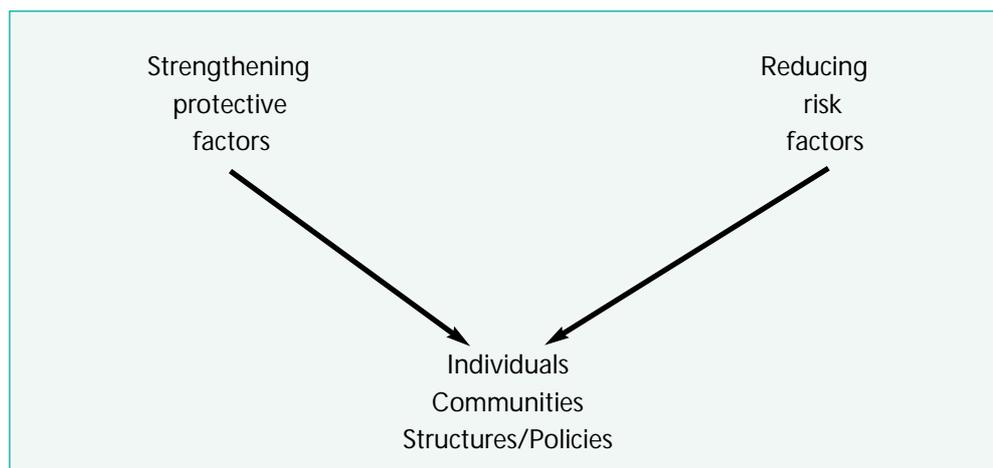
An active and growing user/survivor movement, including self-help groups and campaigning groups like 'Mad Pride', are playing an important role in setting a new agenda for mental health care. (Rose 2001) There is an ongoing debate about the extent to which health and other professionals are equipped to engage with alternative conceptual frameworks for understanding, treating and managing mental health problems - whether such alternatives derive from secular or spiritual beliefs regarding mental health. (Health Education Authority 1999, Faulkner and Layzell 2000) Key issues include civil liberties, user and carer involvement in services, challenging discrimination, alternative and complementary therapies and exploring the positive dimensions of living with a mental health problem. In working with groups with a wide range of different perspectives and backgrounds, it may be more helpful to focus on strategies for solving problems, rather than trying to achieve consensus on definitions and labels.

## 2.3 Mental health promotion at different levels

Mental health promotion works at three levels: and at each level, is relevant to the whole population, to individuals at risk, vulnerable groups and people with mental health problems.

- **Strengthening individuals** - or increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
- **Strengthening communities** - this involves increasing social inclusion and participation, improving neighbourhood environments, developing health and social services which support mental health, anti-bullying strategies at school, workplace health, community safety, childcare and self-help networks.
- **Reducing structural barriers to mental health** - through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

Figure 2:2 Risk and protective factors at three levels



## 2.4 Risk and protective factors

At each level, interventions may focus on strengthening factors known to protect mental health (e.g. social support, job control) or to reduce factors known to increase risk (e.g. unemployment, violence).

Risk factors for mental health problems include bereavement, a family history of psychiatric disorder, violence, childhood neglect, financial strain, family breakdown, long term caring and unemployment. These can be reduced by strengthening factors known to protect mental well-being. Gender has a significant impact on both risk and protective factors. Women are at greatly increased risk of depression and anxiety, eating disorders and self-harm. (Piccinelli and Wilkinson 2000) Rates of suicide are four times as high in men as in women and the difference is increasing. (Meltzer et al 1996)

A mental health promotion strategy needs to address ways of strengthening protective factors and working to reduce risk factors at an individual, community and structural or policy level. Many risk factors for mental health problems, such as long term economic problems and the growing gap between rich and poor, are difficult to address and are outside the remit of the health sector.

Figures 2:3 and 2:4, taken from Australia’s National Mental Health Strategy, summarise protective and risk factors at different levels and in different settings. The strength of evidence for protective and risk factors varies but is particularly robust in relation to the impact of early childhood experiences, notably the importance of socio-economic circumstances that support warm, affectionate parenting and strong family attachment. (Fonagy and Higgitt 2000; Heijmens Visser et al 2000; Rutter and Smith 1995)

**Figure 2:3 Protective factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)**

Individual factors	Family factors	School context	Life events and situations	Community and cultural factors
easy temperament	supportive caring parent	sense of belonging	involvement with significant other person (partner/mentor)	sense of connectedness
adequate nutrition	family harmony	positive school climate	availability of opportunities at critical turning points or major life transitions	attachment to and networks within the community
attachment to family	secure and stable family	prosocial peer group	economic security	participation in church or other community group
above-average intelligence	small family size	required responsibility and helpfulness	good physical health	strong cultural identity and ethnic pride
school achievement	more than two years between siblings	opportunities for some success and recognition of achievement		access to support services
problem-solving skills	responsibility within the family (for child or adult)	school norms against violence		community/ cultural norms against violence
internal locus of control	supportive relationship with other adult (for a child or adult)			
social competence	strong family norms and morality			
social skills				
good coping style				
optimism				
moral beliefs				
values				
positive self-related cognitions				

Reproduced from: Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – A Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra

**Figure 2:4 Risk factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)**

<b>Individual factors</b>	<b>Family/social factors</b>	<b>School context</b>	<b>Life events and situations</b>	<b>Community and cultural factors</b>
prenatal brain damage	having a teenage mother	bullying	physical, sexual and emotional abuse	socioeconomic disadvantage
prematurity	having a single parent	peer rejection	school transitions	social or cultural discrimination
birth injury	absence of father in childhood	poor attachment to school	divorce and family breakup	isolation
low birth weight, birth complications	large family size	inadequate behaviour management	death of family member	neighbourhood violence and crime
physical and intellectual disability	antisocial role models (in childhood)	deviant peer group	physical illness/impairment	population density and housing conditions
poor health in infancy	family violence and disharmony	school failure	unemployment, homelessness	lack of support service including transport, shopping, recreational facilities
insecure attachment in infant/child	marital discord in parents		incarceration	
low intelligence	poor supervision and monitoring of child		poverty/economic insecurity	
difficult temperament	low parental involvement in child's activities		job insecurity	
chronic illness	neglect in childhood		unsatisfactory workplace relationships	
poor social skills	long-term parental unemployment		workplace accident/injury	
low self-esteem	criminality in parent		caring for someone with an illness/disability	
alienation	parental substance misuse		living in nursing home or aged care hostel	
impulsivity	parental mental disorder		war or natural disasters	
	harsh or inconsistent discipline style			
	social isolation			
	experiencing rejection			
	lack of warmth and affection			

Reproduced from: Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – A Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra

# Making the case for mental health promotion

### 3.0 Introduction

The case for investment in mental health promotion extends far beyond its impact on mental illness. This chapter brings together research from a range of disciplines to demonstrate what mental health promotion can contribute to many different agendas and policy priorities.

**Figure 3:1 Benefits of mental health promotion**

**Mental health promotion can:**

- improve physical health and well-being
- prevent or reduce the risk of some mental health problems, notably behavioural disorders, depression and anxiety, substance misuse
- assist recovery from mental health problems
- improve mental health services and the quality of life for people experiencing mental health problems
- strengthen the capacity of communities to support social inclusion, tolerance and participation and reduce vulnerability to socio-economic stressors
- increase the 'mental health literacy' of individuals, organisations and communities
- improve health at work, increasing productivity and reducing sickness absence.

**A strategic approach to mental health promotion should aim to include a balance of:**

- developing coping skills e.g. parenting, communication
- promoting social support and networks e.g. tackling bullying, supporting bereaved families, addressing domestic violence, facilitating self-help groups, increasing access to information and opportunities to participate
- addressing structural barriers to mental health in areas like education, employment, housing and income distribution.

### 3.1 Case One - Prevention and promotion

The case for investing in mental health promotion is often debated in terms of whether it can contribute effectively to the prevention of mental illness. (Figure 3:2) There is a body of evidence to show that mental health promotion can contribute to the prevention of certain disorders, for example anxiety, depression and substance abuse. It can also contribute to health improvement for people whether or not they are at risk of mental illness, as well as for people living with mental health problems. (Mental Health Foundation, 2000)

Interventions to reduce stress in the workplace, to tackle bullying in schools, to increase access to green, open spaces and to reduce fear of crime all contribute to health gain through improving mental well-being, in addition to any impact they may have on preventing mental disorders. Mental health promotion also aims to create an environment in which people with mental health problems can live fulfilling lives.

The debates about prevention and promotion raise questions about how mental health and mental illness are conceptualised. Curing illness does not necessarily result in health. (Barker, 2000) The call for “Mad Pride” is part of a demand for acceptance by service users that includes recognising positive aspects of mental health problems. (Curtis, Dellar et al, 2000) This relationship between identity and diagnosis has been forged through the experience of discrimination and the conditions under which people with mental health problems have used mental health services. The user/survivor movement has concerns about wider civil liberties issues if the goal of interventions is to eliminate all disorders of the mind, in the same way that the disability rights movement challenges attempts to eliminate all conditions that cause disability.

Standard One offers an opportunity to transform the terms of the debate about mental health, as well as highlighting the importance of challenging discrimination. The requirement to promote mental health for all will mean openly talking about the mental health needs of the whole community. This will challenge the myth that people can be neatly divided into those who do, or do not, have mental health problems.

### Figure 3:2 Prevention and promotion

**Mental health promotion** involves any action to enhance the mental well-being of individuals, families, organisations or communities.

**Primary Prevention** refers to interventions designed to prevent a disorder or problem occurring.

Prevention may be:

- universal – targeted to the whole population e.g. pre-school day care
- selective – targeted to individuals or groups at increased risk e.g. home visits for low income mothers
- indicated – targeted to individuals with early symptoms e.g. cognitive therapy for children with behavioural problems.

**Secondary prevention** is concerned with reducing prevalence through early interventions and **tertiary prevention** with reducing disability as a result of a disorder.

**Early interventions** target individuals developing or experiencing a first episode of a mental health problem.

The distinction between prevention and promotion is not clear cut:

- some promotion programmes e.g. initiatives to promote employee participation, may reduce stress related illness, and result in a range of broader outcomes e.g. increased job satisfaction and higher productivity
- interventions designed to prevent specific problems e.g. post-natal depression, may also have a wide range of socio-economic benefits, extending well beyond the impact of the intervention on the mother
- World Mental Health Day initiatives to reduce negative media coverage of mental health issues have the same goals as tertiary prevention: to reduce the problems experienced by people with a diagnosis.

(Mrazek and Haggerty 1994; Commonwealth Department of Health and Aged Care 2000; Caplan 1961)

Figure 3.3 gives a small number of examples of effective interventions in different settings and signposts sources of further information. The focus is on interventions that have been effective in preventing mental health problems, although in many cases, interventions have also resulted in other health and social benefits. More detailed information on the evidence-base is provided in Chapters Six, Seven and Eight. UK examples of evidence-based good practice are listed in Appendix Four.

### Figure 3:3 Summary of interventions for different settings Home/ Early years

Successful programmes are those that work to strengthen the relationship between the child and the caregiver or parent and to address socio-economic factors associated with family conflict, maltreatment and poor attachment.

Home visit programmes for first time mothers, beginning in pregnancy and continuing for two years, greatly improve the physical and mental health of children and reduce physical maltreatment. They also have significant social and economic benefits for the caregiver. Important elements include parenting support, education, work opportunities and social support. Trained volunteers may be as effective as experts. (Olds et al 1997; Hodnett and Roberts Cochrane Review 2000; Fonagy and Higgitt 2000)

Home Start is a national scheme offering friendship, practical help and support to families with pre-school children. Home Start uses trained volunteers and has been effective in improving parental self-esteem, reducing depression, reducing demand for health visitor support, improving child/parent relationships and increasing use of community services. (For more information, see [www.home-start.org.uk](http://www.home-start.org.uk))

Other examples of UK home visit programmes include Newpin and Pippin. Details of these and other early years projects are included in *Sure Start: A Guide to Evidence-Based Practice*. (DfES Publications 1999) Further examples are included in *Up Start*, the newsletter for everyone in Sure Start. (DfES Publications)

Day care for pre-school children improves behavioural development, school achievement and mother/child relationship. Long term follow up demonstrates increased employment, lower teenage pregnancy, higher socio-economic status and decreased criminal behaviour. Most of the day care trials in the literature combined day care with parent training or support. Two examples of programmes are High/Scope Preschool (Schweinhart and Weikart 1992) and Perry Preschool. (Berrueta-Clement et al 1984) (Zoritch et al Cochrane Review 2000) A key feature of the High/Scope curriculum is active learning, in which children are supported to initiate their own play and activities.

The family group conference approach is a model, drawn from Maori practice in New Zealand, which has been adopted by around 60 local authorities, to address concerns in areas like crime, mental health, domestic violence and child welfare. This approach aims to draw on the resources, goodwill and ingenuity of the wider family and to generate alternatives to custody, fostering and adoption. (Department of Health/ Home Office/ Department for Education and Skills 1999)

## Schools

A health promoting schools approach including the following features is likely to be most effective: combining changes to the school culture, staff morale and environment, family/community involvement, peer education, problem solving and social skills rather than topic based approaches. (Lister- Sharp et al 1999)

Anti-bullying schemes which involve the whole school, parents and the community e.g. The Campaign Against Bully-Victim Problems are effective and have significant long term impacts on criminal behaviour, alcohol abuse, depression and suicidal behaviour. (Olweus 1993) This whole school approach has been replicated by Sheffield City Council, in a controlled trial over three years, with a significant reduction in bullying in the project schools.

The Everybody's Different Program in Australia which focussed on improving self-esteem was effective in reducing body dissatisfaction in young people and altering weight control behaviour in girls. (O'Dea and Abraham 1999)

Suicide prevention programmes in schools are not proven to be effective and there is some evidence that they may increase risk for vulnerable young people, particularly boys. (Lister-Sharp et al 1999)

The National Healthy School Standard (NHSS) is part of the Healthy Schools Programme, led by the Department for Education and Skills and the Department of Health. The National Standard offers support for local healthy school programmes, based in education and health partnerships, to make schools healthier places for staff and pupils to work and learn. The target is that all Local Education Authorities should be involved in an accredited education and health partnership by March 2002. Each school will identify health related targets, offering considerable scope for promoting mental health and emotional well-being.

There is also a range of active school travel projects which are relevant to mental as well as physical health. Recommendations for developing active travel for schools are provided by the School Travel Advisory Group, endorsed by DH, DTLR and DfES ([www.localtransport.detr.gov.uk/schooltravel](http://www.localtransport.detr.gov.uk/schooltravel)).

## Workplace

Organisation-wide approaches are most effective and should include support for staff, enhanced job control, increased staff involvement, workload assessment, role clarity and policies to tackle bullying and harassment. (Williams et al 1998; HEA/HAWNS 1998; Peersman et al 1998)

Enhancing social support within the workplace for people working in a stressful environment has been found to reduce mental health problems among employees. (Heaney 1992)

There is a lack of evidence that debriefing following trauma in workplace settings is effective and some evidence suggests that it is harmful. (Yamey 2000; Institute for Employment Studies 2000; Wessely et al 1999)

The Health and Safety Executive is currently considering the introduction of an Approved Code of Practice on stress, which would enable work-related stress to be tackled through the application of health and safety legislation. The Health and Safety Commission is planning a major programme of work to address occupational stress. For further information see [www.hse.gov.uk](http://www.hse.gov.uk)

## Prisons

The most recent ONS survey (1997) showed that a large proportion of prisoners had several mental health problems. Only one in ten or fewer showed no evidence of any of the five disorders considered in the survey (personality disorder, psychosis, neurosis, alcohol misuse and drug dependence). Rates of all mental health problems, especially drug and alcohol misuse are higher in prisons than in the general population. 90% of all prisoners have a diagnosable mental health problem – 2% of remand prisoners attempt suicide in any given week. Just over a quarter of female remand prisoners had tried to kill themselves in the year before interview. (ONS 1997) The vulnerability of people in prisons makes prisons a key setting for reducing inequalities and beginning to address the problems of people from some of the most deprived groups.

Promoting the mental health of both staff and prisoners in a prison setting is particularly challenging. Developing mental health promotion skills, awareness and capacity of prison staff will require a sustained programme, as part of the Prison Health Plan. Some examples of positive practice are included in the WHO Europe Guide to promoting health in prisons ([www.hipp-europe.org/resources/internal/good-practice/](http://www.hipp-europe.org/resources/internal/good-practice/)), which includes UK examples.

These include:

- Developing a comprehensive suicide prevention policy
- Action to prevent bullying, including involving inmates in the identification of bullying risk and making anti-bullying a part of induction
- Providing support to wives and girlfriends of prisoners
- Providing parenting skills courses for fathers
- Introducing opportunities for art, poetry, drama and creative pursuits
- Providing private access to helplines e.g. Samaritans
- Promoting opportunities for choice e.g. in relation to food
- Developing a comprehensive programme of support and treatment for drug and alcohol misuse.

### **The setting or whole prison approach**

Healthy prisons adopts a setting or whole prison approach, along the same lines as Healthy Schools. The 15 nation WHO Health in Prisons Project was established in 1996 and the Prison Health Policy Unit is the WHO Collaborating Centre. A Healthy Prisons Network has been established and there are currently 14 healthy prison pilot sites.

### **Prison Health Policy Unit**

The Prison Health Policy Unit and Task Force were established in April 2000 to replace the former Directorate of Health Care, (DHC) HM Prison Service. The Prison Health Policy Unit and Task Force are dually responsible to the Director General of the Prison Service and the Permanent Secretary at the Department of Health. The Policy Unit is responsible for policy development to improve the health of, and health services to, prisoners. The Health and Safety Policy Group of the Personnel Directorate of the Prison Service is responsible for staff health. Two Ministers have responsibility for prison health, Beverly Hughes (Prisons Minister, Home Office) and Lord Hunt DH.

The new Prison Health Policy Unit and Task Force are taking forward a substantial programme of change in the organisation of prison health care. All prisons are now required to assess prisoners' health needs and identify the services required to meet those needs. These will form part of the Prison Health Improvement Programme (Prison Health Plan), developed in partnership with the health authority. Each health authority now has a named prisons lead.

The principle underpinning these changes is that prisoners must have access to an equivalent range and quality of services as the general public receives from the NHS in the wider community. Health inequalities must be tackled, the prison environment monitored to avoid creating any new inequalities and there should be no discrimination on grounds of age, gender, ethnicity, religion, disability or sexuality.

## Primary Care

Brief interventions in primary care are effective in reducing excessive alcohol consumption by over 20%. (Ashenden et al 1997; Peters et al 1998)

There is also a strong case for detection of alcohol misuse, followed by brief interventions, in Accident and Emergency departments, using an approach developed at St Mary's Hospital NHS Trust in Paddington, London. (Hunter et al in press) A randomised controlled trial of reducing alcohol misuse in A&E is scheduled for 2001. [Robin.Touquet@st-marys.nhs.uk](mailto:Robin.Touquet@st-marys.nhs.uk) See also Appendix Four.

A number of trials suggest that patients respond positively to GP advice to take more exercise. (Killoran et al 1994)

Strengthening the links between primary care and education has been under researched, although there is good evidence of the physical and mental health benefits of involvement in learning. (Challis 1996) Research from the Basic Skills Agency shows that around 7 million adults with poor basic skills will class themselves as long term sick, rather than being classed as unemployed. Prescriptions for Learning, led by the National Organisation for Adult Learning, in partnership with the Nottingham Health Action Zone, uses a learning adviser in primary care settings to provide learning support for patients with poor basic skills. Interim results of the project will be published later in 2001 [www.niace.org.uk](http://www.niace.org.uk). See also Appendix Four.

Training midwives, health visitors and practice nurses to detect mental health problems can improve early identification of perinatal depression. In North Essex, primary care offers an integrated service which addresses the emotional needs of pregnant women, which aims to improve early detection of perinatal anxiety and depression. The project will continue throughout 2001 and is being replicated in South Essex. (See Appendix Four).

Thurrock Community Mothers programme is another example of a project, now replicated nationally, which uses the expertise of trained volunteers with experience of mothering, to support local parents. There is equal emphasis on developing the skills of the Community Mother volunteers themselves and many move on to other employment opportunities. Community mother programmes have demonstrated positive socio-economic and health improvements for children, parents and volunteers, and have also been successful with traveller communities. (Johnson and Molloy 1995; Fitzpatrick, Molloy and Johnson 1997; Johnson, Howell and Molloy 1993)

## 3.2 Case Two - Mental well-being and physical health

### 3.2.1 Mental health underpins physical health.

There is a growing body of research that demonstrates the impact of mental health on physical health. (Figure 3:5) Much of the research in this area is concerned with how the social environment acts on biology to cause disease. (Marmot & Wilkinson 1999) What has been called ‘stress biology’ looks at the relationship between chronic stress and the nervous system, the cardio-vascular and the immune systems, influencing cholesterol levels, blood pressure, blood clotting, immunity, and growth in childhood.

*“We are now beginning to recognise that people’s social and psychological circumstances can seriously damage their health in the long term. Chronic anxiety, insecurity, low self esteem, social isolation and lack of control over work appear to undermine mental and physical health.*

*The power of psycho-social factors to affect health makes biological sense. The human body has evolved to respond automatically to emergencies. This stress response activates a cascade of stress hormones which affect the cardio-vascular and immune systems. The rapid reaction of our hormones and nervous system prepares the individual to deal with a brief physical threat. But if the biological stress response is activated too often and for too long, there may be multiple health costs. These include depression, increased susceptibility to infection, diabetes, high blood pressure and accumulation of cholesterol in blood vessel walls, with the attendant risks of heart attack and stroke.”*

(Brunner and Marmot 1999, p.41)

These findings have had an important impact on debates about health because they address the way in which a wide difference in income distribution – the gap between rich and poor – results in chronic stress for whole communities. (Wilkinson 1996)

Stress biology also calls into question the likely effectiveness of public health (and indeed health promotion) interventions which focus on physical health and prompts renewed consideration of how poverty and deprivation impact on health. It may be that poverty, inequality and social exclusion affect physical health via their impact on mental health. (Figure 3:4)

Figure 3:4

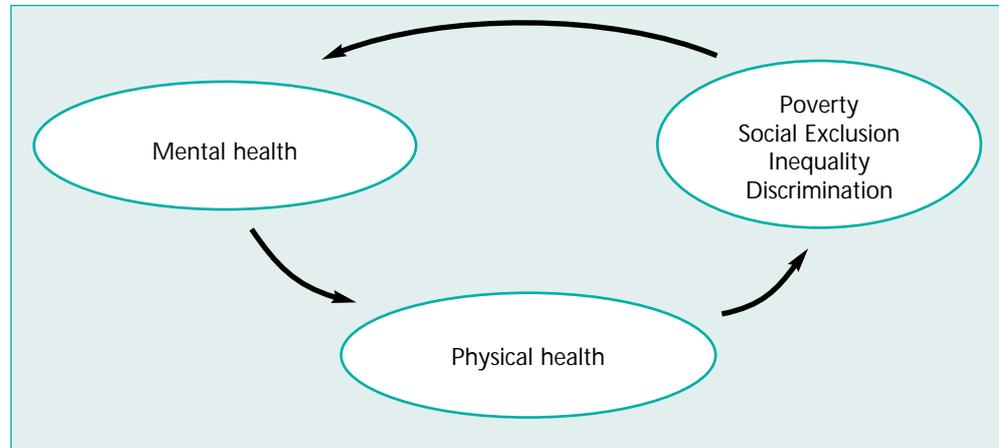


Figure 3:5 The impact of mental health on physical health

Depression increases the risk of heart disease fourfold, even when other risk factors like smoking are controlled for. (Hippisley-Cox et al 1998)

Lack of control at work is associated with increased risk of cardiovascular disease. (Bosma et al 1997; Marmot et al 1991; Niedhammer et al 1998)

Perceived low control beliefs (e.g. powerlessness and fatalism) accounted for more than half the raised mortality risk for people of low socio-economic status. (Bosma et al 1999)

Sustained stress or trauma increases susceptibility to viral infection and physical illness by damaging the immune system. (Stewart-Brown 1998; Cohen et al 1991 and 1997; Marucha et al 1998; Vedhara et al 1999)

Emotional well-being is a strong predictor of physical health. Men and women who scored highest in a survey on emotional health were twice as likely to be alive by the study's end. The link between subjective feelings of happiness and good health held even after controlling for chronic disease, smoking, drinking habits, weight, sex and education. (Goodwin et al 2000)

Depression is a risk factor for stroke. (Jonas and Mussolino 2000)

Depression has a significant impact on health outcomes for a wide range of chronic physical illnesses, including asthma, arthritis and diabetes. (Turner and Kelly 2000)

It is widely understood, in relation to physical health, that anyone can experience physical ill-health, and that while not all physical ill-health can be prevented, people can take steps to improve their physical health and to reduce their risk of physical health problems. This is reinforced by a wide range of policies in schools, in the workplace and in communities, to promote physical well-being and reduce the risk of physical health problems. Achieving the same policies in relation to mental health is one of the underlying rationales for mental health promotion. For this to be successful, there will have to be a greater understanding of the links between mental well-being and physical health by policy makers and practitioners.

### *3.2.2. Physical activity within mental health promotion*

Convincing evidence now exists in support of the mental health benefits of physical activity. Four avenues through which physical activity has the potential to positively influence mental health have been identified: (Fox, 2000a)

- As treatment or therapy for existing mental health problems
- To improve the quality of life for people with mental health problems
- To prevent the onset of mental health problems
- To improve the mental well-being of the general public.

#### **Physical activity as treatment**

Physical activity is emerging as an effective treatment for directly tackling existing mental health problems. The strongest evidence is for the anti-depressive effects of physical activity, where recent reviews suggest that a causal link exists between physical activity and decreased depression. (Craft and Landers, 1999; Mutrie, 2000). Meta-analyses support the case that physical activity has a comparable level of effect on depression as that obtained from psychotherapeutic interventions (Mutrie, 2000). Evidence has also accumulated in support of the anxiety-reducing effects of physical activity. It appears that both regular exercise and single exercise sessions can be effective in reducing anxiety. (Taylor, 2000) Taylor concluded that on the basis of existing research exercise has a low to moderate anxiety reducing effect, but noted that the strongest effects were found in the best-designed studies. At present, little research has been carried out into the effects of physical activity on other mental health problems, although recent evidence suggests that exercise may be effective in treating the symptoms of schizophrenia. (Faulkner and Biddle 1999)

### **Physical activity for quality of life and coping**

Improved quality of life enhances people's ability to cope with and manage a mental health problem. Physical activity has the potential to improve both physical and psychological quality of life in people with mental health problems. Individuals with mental health problems have the same physical health needs as the general population. Physical activity is a well-accepted method of promoting important aspects of physical health such as improved cardiovascular fitness and blood sugar management, and reductions in hypertension, cholesterol, and obesity. (Killoran, Fentem, and Casperson, 1994) In addition, physical health issues in people with mental health problems may be compounded by the adverse effects that prescribed medications have on cardiovascular health and body weight. It is particularly important that people receiving medications are provided with practical strategies to combat these negative physical side-effects and physical activity may be particularly useful.

Evidence now exists to suggest that the psychological quality of life and emotional well-being of people with mental health problems can be improved through regular physical activity. Several studies have documented positive psychological effects from physical activity, even when there is no improvement in symptoms. (Faulkner and Biddle, 1999) These benefits may take the form of emotional or mood improvements from single bouts of exercise (Biddle, 2000) or improvements in self-esteem gained from mastery of new skills, taking personal control of an aspect of life, or social contacts made through regular group activity. (Fox, 2000b) Improvements in quality of life are likely to be particularly important for people with severe and enduring mental health problems. (Faulkner and Sparkes, 1999)

### **Physical activity for prevention**

Reviews agree that in general physical activity participation is associated with positive mental health outcomes. (Biddle, Fox and Boutcher, 2000; Morgan, 1997) Lower instances of mental health problems are generally reported among people who exercise regularly. This finding does not in itself mean that physical activity caused positive mental health outcomes. Prospective epidemiological studies are required to convincingly show that regular exercise participation directly results in a reduced risk of mental health problems. Research studies of this kind are expensive and time-consuming to carry out; consequently few have been conducted. However, Mutrie (2000) reports four studies which examined the effect of regular physical activity on the incidence of depression some years later. In all four studies, those people who were least active reported the greatest subsequent incidence of depression. Mutrie concludes existing evidence strongly supports the view that physical activity has a protective effect against the development of depression. More research still needs to be conducted to determine the extent that physical activity may be an effective approach to the prevention of other types of mental health problems.

### **Physical activity for improved mental well-being**

A range of data, for example self-reported health status, stress levels, fear of crime and believing that unfamiliar others are untrustworthy, suggests that a substantial percentage of the population, particularly the elderly, appear to suffer from poor mental well-being. This is expressed as low self-esteem and worthlessness, frequently depressed mood, poor body image, lack of self-confidence, poor sleep quality and social isolation. There is now good evidence to support the “feel good” phenomena that is often reported anecdotally. Physically active people report higher levels of subjective well-being and taking part improves mood following the exercise. (Biddle, 2000) Although the evidence that exercise improves self-esteem is inconsistent, it is clear that exercise helps people feel better about themselves physically through improved body image, perceived fitness and health. (Fox, 2000b) In addition, there is increasing evidence that exercise helps improve the quality and length of sleep in those with and without sleep problems. Research has been conducted into the effect of exercise on cognitive abilities both in children and older adults, but remains inconclusive.

Surprisingly, there has been little research conducted around the benefits of physical activity participation for social well-being. The potential of sports clubs, exercise or recreational activity groups to produce social cohesion and a sense of belonging or affiliation is clear. Although not evaluated rigorously, these outcomes are reported frequently by organisers and participants of a diverse range of activities from children’s sport to exercise for the 60s plus classes.

Finally, there is some cause for concern that exercise may cause overdependence or even addiction. Although this condition has been identified, it exists in a very small percentage of participants. (Szabo, 2000) However, particular attention should be paid to those with obsessive-compulsive tendencies or those suffering from eating disorders, where exercise is used to sustain low body weight.

### **Implications**

The evidence base for exercise/physical activity and mental health has grown over the last 20 years. There is now strong support for considering exercise as part of treatment for depression and anxiety and perhaps helping patients cope with other problems such as schizophrenia. It may assist in treatment, but will also improve physical health and life quality. There is also good reason for promoting physical activity in the general public, both as a preventive measure and as a means of improving mental and social well-being. At this point, the rigorous evaluation of effectiveness of existing community physical activity promotion schemes for the promotion of mental health is a rarity.

Currently, there is no simple message for the amount and type of physical activity for optimal mental health. It will vary with the needs and characteristics of populations and many options are open to scheme organisers. However, becoming more active more often, using the larger muscle groups as in brisk walking, preferably in sociable surroundings, provides a suitable starting point.

### 3.3 Case Three - Social capital: individuals, organisations and communities under stress

Social and economic problems impact on physical, mental and emotional health. Equally, as we have seen, mental well-being influences physical health. Recent research on social capital and inequality suggests that how individuals and communities feel - levels of trust, tolerance and participation - may be a critical factor in determining health. (Wilkinson 1996 and 2000; Cooper et al 1999; Kawachi et al 1997; Kawachi and Kennedy 1999) Social capital has been defined as 'the features of social life such as networks, norms and social trust that facilitate co-ordination and co-operation for mutual benefit'. (Putnam 1995 p67) Income inequality is thought to damage social capital, eroding networks, co-operation and cohesion within neighbourhoods, which in turn contributes to poor health.

Figure 3:6 Key elements of social capital

**Key elements of social capital:**

- Social resources e.g. informal arrangements between neighbours or within a faith community
- Collective resources e.g. self-help groups, credit unions, community safety schemes
- Economic resources e.g. levels of unemployment, access to green, open spaces
- Cultural resources e.g. libraries, art centres, local schools

(Adapted from Cooper et al 1999)

The work of Wilkinson, Marmot, Baum and others has prompted reconsideration of the pathways through which material deprivation leads to poor health and a renewed interest in the psychosocial component of health. This involves looking at the impact of the social environment on health, and addressing the link between disease patterns and the way in which society is organised. Research on social capital has had a significant influence on the social inclusion and neighbourhood renewal agendas. (Social Exclusion Unit 2000) The National Strategy for Neighbourhood Renewal explicitly identifies the failure to tackle the erosion of social capital – entire communities lacking in social connections – as a key reason for the failure of previous regeneration initiatives.

The field of social capital has become a hotly contested area and has been criticised for according greater significance to psychosocial factors than to material deprivation. (see papers by Lynch 2000 and response from Wilkinson 2000) Nevertheless, research on social capital provides an opportunity to place mental health at the centre of the debate about health inequalities.

There is growing evidence that communities with low levels of trust, tolerance and opportunities for participation in decision making have poorer physical and mental health, even when poverty levels are controlled for. Some of the research in this area is summarised in Figure 3:7.

### Figure 3:7 The impact of social capital on health

In a cross-sectional ecologic study based on data from 39 states in the USA, Kawachi et al found lower levels of social trust and reciprocity were associated with higher rates of most major causes of death, including coronary heart disease, malignant neoplasms, cerebrovascular disease, unintentional injury and suicide. (Kawachi et al 1997)

A more recent study found that of trust in friends, family and community, only lack of trust in community predicted psychological distress. Thus an important factor that determines distress is the extent to which people believe that unfamiliar others are trustworthy. (Berry and Rickwood 2000)

Cohen et al found that large and diverse social networks increase resistance to the common cold and upper respiratory tract infections. (Cohen et al 1997)

In Roseto, a small town of descendants of Italian migrants in Pennsylvania, rates of heart attacks in the 1950's were 40% lower than in surrounding towns, although smoking, exercise and obesity rates were similar. Kawachi, Kennedy and Lochner found that the only significant feature distinguishing Roseto was the high level of social cohesiveness and income parity. As this was eroded during the late sixties and seventies, the rate of heart attacks rose. (Kawachi, Kennedy and Lochner 1997)

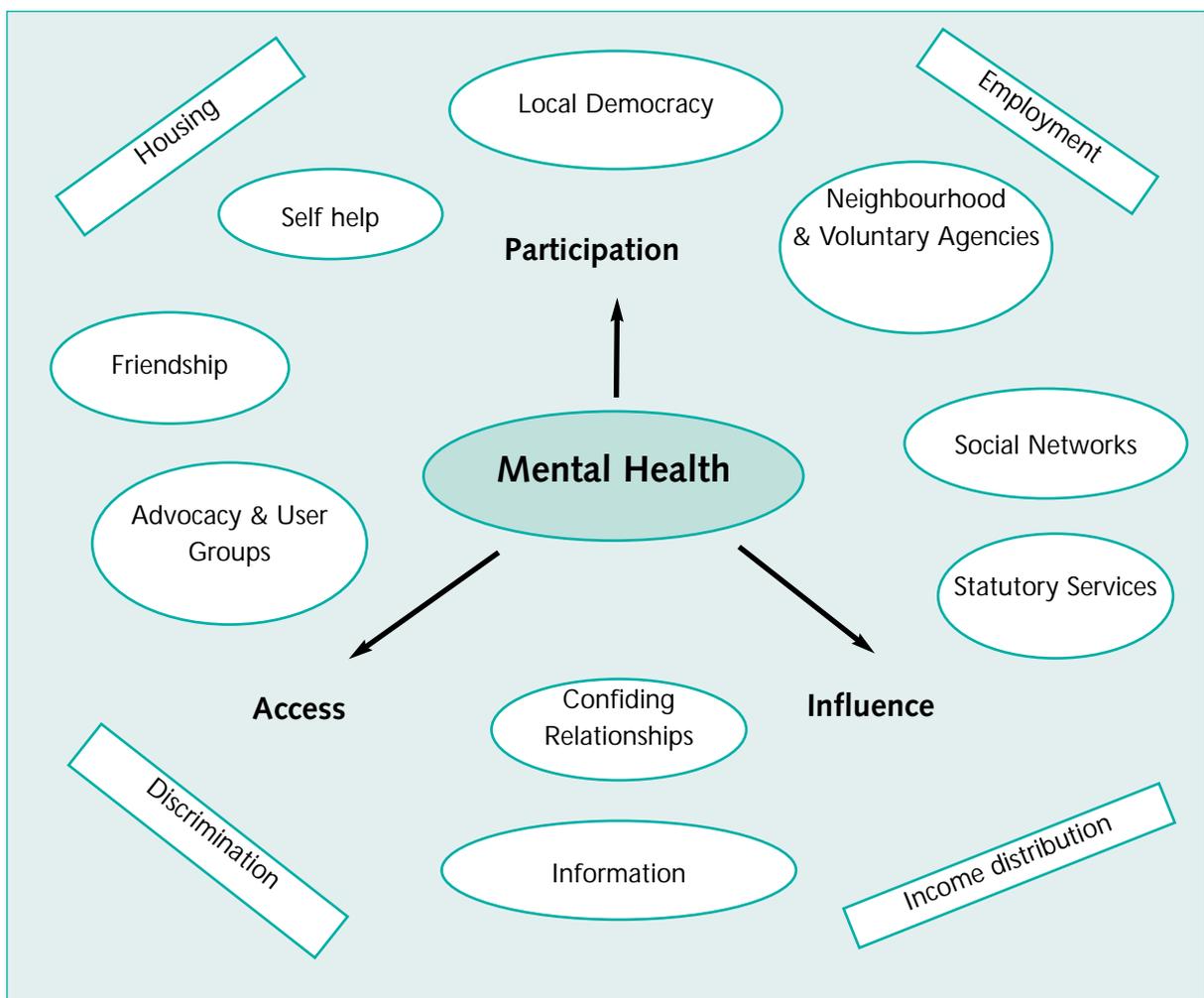
In a survey of nearly 6000 adults, (Rainford et al 2000) a range of social/ environmental factors were associated with increased likelihood of reporting poor health:

- lack of control over decisions affecting life
- lack of influence over neighbourhood decisions
- low neighbourhood social capital
- having no personal support (especially for men)
- having no involvement in community activities.

These factors also had a significant independent impact on stress levels.

The strength of community life, high levels of social support, participation in social networks and opportunities for the exchange of skills and information may reduce vulnerability to the mental and physical ill-effects of socio-economic stressors. (Cooper et al 1999) Stimulating community activity and getting residents involved in turning round their neighbourhoods are key elements of the National Strategy for Neighbourhood Renewal. At the same time, while regeneration initiatives have a positive impact and can improve the quality of life for people with mental health problems, concerns have been raised about communities coming together to exclude or move on people they see as less desirable. (King's Fund Briefing, May 2000)

Figure 3:8 Factors influencing the mental well-being of communities



For this reason, programmes concerned with rebuilding communities also need to address issues of diversity and equal citizenship. (Appendix Five)

The importance of opportunities to participate and to influence decisions which affect one's life has significant consequences for the design and delivery of services. Structures which facilitate community planning and local decision making in the provision of services may have an impact on the health of the community over and above the value of the services themselves. Mental health promotion has a crucial role to play in reducing and limiting the impact of psycho-social stressors, both through strengthening individuals, and through strengthening and supporting a diversity of social, communication and information networks, which link people within the community.

These issues form part of a broader social inclusion agenda, which should be included as an indicator of effectiveness when planning interventions.

### 3.4 Case Four - Local authorities and mental health promotion

Health authorities and local authorities are responsible for implementing Standard One effectively. Although health authorities are tasked to take the lead role locally, most of the determinants of the local population's mental health fall within the remit of the local authorities. Health strategies and strategies for regeneration and sustainable development will need to be mutually reinforcing and both will need to address the significance of mental health.

The Local Government Act 2000 gives local authorities a statutory responsibility and powers to address the needs of their population by improving the economic, social and environmental circumstances of their area. Plans which address this responsibility, eg. Community Strategies, should include mental well-being in the work on social well-being, as well as the mental health impact of economic and environmental factors.

Local authorities work in partnership with a range of agencies:

- They will produce Community Strategies which offer an umbrella to organisations working together to improve individual well being and regenerate communities.
- With health authorities they contribute to the preparation of the HImP (Health Improvement Programme).
- Local authorities have many mechanisms to engage their residents in planning and monitoring services and through these, can specifically involve individuals with a mental health problem.

- The duty of Best Value ensures that local authorities consult widely, review services and secure their continuous improvement. This process provides opportunities for mental health service users to influence the shape of services.
- Council members have opportunities in their scrutiny role to consider the mental health aspects of their role as community leaders, employers, landlords, educators and information resource.

Community Strategies will provide an overall framework for a range of existing and complementary initiatives, including Local Agenda 21, Lifelong Learning Development Plans, and Community Safety Strategies (required under the Crime and Disorder Act 1998). LA21 priorities, which include protecting the natural environment, locally accessible goods and services, healthier communities and community participation, deal with issues which are closely linked to mental health. (DTLR 2000)

Local authorities are also key partners on a number of regional bodies with goals that are relevant to mental health promotion. Government Offices represent central Government in the Regions on behalf of the Department for Education and Skills (DfES), Department for Trade and Industry (DTI) and the Department for Transport Local Government and the Regions (DTLR). Each Government Office has close links with the Regional Development Agency (RDA), the Regional Assembly and the Regional Chamber. Links to Government Offices can be accessed via [www.rcv.gov.uk](http://www.rcv.gov.uk)

The RDA is responsible for the development of a Regional Economic Strategy, with specific responsibility for inward investment, site development, Single Regeneration Budget (SRB) and rural regeneration. The Regional Assembly is a voluntary partnership of local authorities with a remit to promote democratically elected community leadership and the economic, social and environmental well-being of the region.

London Region's Mental Health in London: A Strategy for Action(2000) has identified key questions which Councillors might ask of their officers and users of their services. These are outlined below:

- What is your Council doing to promote the mental well-being of your whole community?
- How is your Council working in partnership with other organisations to promote the mental well being of the whole community?
- What is your Council's policy for employing people who have experienced or are experiencing mental health problems?
- How is your Council promoting a positive approach to people who experience mental health problems?

- How is your Council supporting its tenants who experience mental health problems?
- How do you know that your policies are working?

The London Borough of Havering is piloting the use of these questions. These will demonstrate how elected councillors can assure themselves that their services are having a positive impact on the mental health of their community. Merton Council will also pilot the same set of questions.

For information contact:

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Havering Council Town Hall, Main Road, Romford RM1 3BD  
Tel. No.: 01708 773001  
e-mail: [anthony.douglas@havering.gov.uk](mailto:anthony.douglas@havering.gov.uk)

Further details on community strategies are available from the Department for Transport Local Government and the Regions in *Preparing Community Strategies, Government Guidance to Local Authorities*

DTLR

PO Box 236, Wetherby, West Yorkshire LS23 7NB.

Tel. No.: 0870 1226 236/0870 1226 237

[www.detr.gov.uk](http://www.detr.gov.uk)

[www.info4local.gov.uk](http://www.info4local.gov.uk) is a useful website providing information for and about local authorities. It gives quick access to information from the DTLR, DfES, DH, Home Office and Department for Work and Pensions.

### **Social Services**

Social services are specifically tasked with the delivery of Standard One. However they also have a broader mental health promotion role:

- As part of the corporate local authority.
- As an employer.
- As a commissioner/provider of services across whole populations.
- As a partner in implementing the NSF and NHS Plan.

Social Services are represented in Local Implementation Teams for Mental Health and share the responsibility for implementation of the whole NSF (as partners, see over). They will also have relationships with a number of agencies in the statutory and independent sectors as well as contact with a broad spectrum of vulnerable people who may seek assistance with issues which are not obviously mental health related.

Social Services can:

- Direct people to support services and activities provided in the voluntary sector and elsewhere.
- Include mental health promotion within overall service provision as part of the package. For example, in carer support services, stress management techniques have been found to be helpful and could be part of a service specification.
- Ensure that staff induction, training and development programmes equip staff with an understanding of broad principles which support good mental health.
- Assess the mental health impact of service planning and development and ensure consultation exercises with communities and specific groups are considered as opportunities to raise the issues of mental health promotion.
- Include mental health promotion as an aspect of service development in mental health services for which they are responsible and as part of defined outcomes for individual service users and carers.

Social Services also have a duty to take account of the views of users and carers and will need to be key players in developing more effective models for involving users. These include the provision of information, advocacy, training and support for independent user groups and new approaches to consultation. (Leggett et al 2000)

Social Services contribute to regeneration and neighbourhood renewal through primary prevention services, notably through healthy ageing initiatives funded under the Prevention Grant (part of the modernisation programme for social care launched in 1998). A substantial number of authorities are beginning to fund services with a direct relevance for mental health promotion eg., community networks, information, advice and advocacy, capacity building and empowerment. (Wistow et al 2000, Wistow and Randall 2001)

As partners in Joint Investment Plans, the preparation of HImPs, Local Implementation Plans for Mental Health and as a member of PCG boards, they have the opportunity to take the overall ethos of mental health promotion into those activities.

New induction standards for social care staff, published in March 2000, have a special focus on understanding the needs of service users. The standards apply to the public, private and independent social care sectors to ensure that new staff understand the needs and expectations of service users and their responsibility for working as part of a competent workforce. The standard states that staff must understand the importance of promoting the values of individuality and identity, rights, choice, privacy, independence, dignity, respect and partnership at all times.

Social Services also work closely with a number of at risk and vulnerable groups, for example young people in care. Foyer Programmes, a partnership between the Foyer Federation and 19 local social services, provide a wide range of support for young people leaving care and have helped to heighten awareness of the issues facing these young people, and their impact on mental and physical health ([www.foyer.net](http://www.foyer.net)). Local authorities are responsible for 58,100 looked after children.

Social Services have considerable potential to move mental health promotion up the agenda and stronger partnerships between health and social services should assist this.

### 3.5 Case Five Primary care and mental health promotion

The importance of Primary Care Teams as partners in the commissioning and delivery of comprehensive mental health services is now firmly established. Most people with a mental health problem are managed in primary care. One in four of all GP consultations will have a significant mental health component. The prevalence of mental health problems, particularly in inner city areas, and the central contribution of primary care to dealing with these, is represented in the NSF's Primary Care standards 2 & 3. The proposals to strengthen mental health in primary care outlined in the NHS Plan focus on the following areas:

- patient information and empowerment, for example patient involvement in decisions about their care
- prevention and risk management, for example patients know who to contact in an emergency and better physical health care for people with mental health problems
- partnerships, for example with users and carers and with mainstream services like education and employment
- new professional resources, including 1000 new mental health workers and 500 gateway workers
- better performance, assessed through patient satisfaction, levels of psychiatric morbidity and access to NHS Direct.

These goals, particularly those on prevention, partnership and empowerment, fit equally well with the key role of primary care as a resource for mental health promotion, and the focus on a whole system approach which supports the needs of the whole person.

The NSF recognises the responsibility of primary care across a wide range of mental health needs and various models exist for balancing these demands in partnership with other local statutory agencies and the voluntary sector. The new mental health workers in primary care will work as part of the primary care team, participating in the provision of information, assessment, screening and onward referral where appropriate. These staff will also be trained in brief interventions, for example anxiety management. Gateway workers will have a special role in developing greater opportunities for user and carer involvement. Further details of the Primary Care Mental Health Project to strengthen mental health in primary care are available from the Department of Health.

However, the mental health promotion potential of primary care lies in its capacity both as a local partner in providing services and as commissioner of services from organisations which go well beyond the domain of statutory agencies.

The co-ordination and governance of individual practices as Primary Care Groups (PCGs) has presented a new opportunity for primary care in supporting joint health promotion activity, in line with the local commissioning priorities set out in the Health Improvement Plan. By April 2001, when around 25% of PCGs will have achieved Trust status (PCTs), approximately 50% of the population will have primary care provided from within PCTs. This offers further opportunities for primary care to engage with organisations in the community, voluntary and informal care sectors.

A number of primary care groups are already involved with supporting generic health initiatives e.g. school based projects on substance misuse, work to combat post-natal depression and domestic violence and work to support healthy living centres. These links are often the outcome of a strategy for health promotion, which a large PCG may develop for itself or which might be a local adaptation of the health authority's strategy. Some PCGs/PCTs now have health improvement sub-committees and are developing sub-district health strategies, which might include a specific focus on mental health promotion in relation to local needs. In any event, a strategy for mental health promotion needs to have as a core aim, the reduction of discrimination against people with mental health problems and increased access to mainstream employment, housing and leisure facilities. This should also include access to health promotion, screening and other prevention services which explicitly address the physical health needs of service users, which are often neglected. (Phelan et al 2001).

Strategies can seek to achieve this by:

- Establishing links to relevant local authority departments, e.g. social services, housing, education, leisure and employment.
- Establishing links to local strategic initiatives which have strong mental health promotion potential, e.g. Community Strategies, Local Agenda 21 Strategies, Community Safety Partnerships, Sure Start Programmes and Lifelong Learning Development Plans.
- Targeting primary prevention at excluded groups such as homeless people or specific minority ethnic groups, especially those who have difficulty in accessing primary care.
- Supporting employment schemes in which mental health service users are employed, for example in health and social care agencies.
- Improving access by arranging locally based specialist clinics for mental health problems.
- Developing local employment and housing projects for people with severe mental illness.
- Employing community development link workers, primary care workers or mental health facilitators to link with local community leaders, politicians, employers and schools.
- Addressing the needs of vulnerable groups, for example women who may be experiencing domestic violence.
- Addressing the physical needs of people with long term mental health problems.

Many PCGs/PCTs will find the employment of community development or primary care link workers to be of great benefit in successfully implementing a mental health promotion strategy. Tomson identifies three functions for link workers in primary care:

- Providing care
- Increasing the capacity of the Primary Health Care Team
- Improving communication, i.e. the flow of information between primary care and various agencies.

(Dave Tomson, Primary Mental Health Care Education and Development Unit, [d.p.c.tomson@ncl.ac.uk](mailto:d.p.c.tomson@ncl.ac.uk))

Of these, improving communication may offer the most scope for further development. The National Strategy for Neighbourhood Renewal (Social Exclusion Unit 2000) and a range of regeneration initiatives provide an opportunity for primary care to work within the context of a renewed focus on community development. Work in progress at the National Primary Care Research and Development Centre in Manchester ([www.npcrdc.man.ac.uk](http://www.npcrdc.man.ac.uk)) and PCGs/PCTs in the South East Region, has shown a high level of support amongst PCGs for such arrangements. (Gask, Rogers, Roland and Morris 2000)

### **Facilitation between primary care and the voluntary sector improves outcomes**

Findings from a recently reported randomised controlled trial provide evidence of the way in which voluntary sector input benefits people presenting with psycho-social problems in primary care. The study, conducted in Avon with 26 participating general practices, found that people who were referred from primary care to a liaison organisation (Amalthea Project) showed greater improvement in a number of areas, compared to patients receiving routine general practitioner care. Those referred to the project had better mental health scores (e.g. less anxiety), found it easier to carry out everyday activities and had more positive feelings about general health and 'quality of life' than those who were not referred. (Grant, Goodenough et al 2000)

There is a key role for primary care in working more closely with user led organisations in order to:

- develop care which places user experience, interpretation and meaning at the centre of support, for example the hearing voices network, which provides new ways of understanding and working with the voices experienced by some people
- develop links between mental health user organisations and mainstream community groups
- involve user organisations in promoting best practice, ensuring that users are involved, where appropriate, in training health professionals, assessing the quality of services and contributing to the design of evaluation.

There is, then, a role for primary care groups and Trusts in developing a strategy for improving contact with community/voluntary agencies and networks and linking individual patients with community initiatives. This in turn can help to support delivery of specialist services from Community Mental Health Teams, Assertive Outreach Teams, Crisis or Early Intervention Teams and Home Treatment. The WHO guide to mental health in primary care has recently been adapted for the UK and provides helpful guide lines for an integrated approach, including a resource directory of voluntary agencies. (WHO Collaborating Centre 2000)

At a practical level, practices could:

- ensure that information on local, voluntary and non statutory agencies and community groups is available
- make links with voluntary and user/survivor groups that provide alternative ways of enhancing mental health. Develop joint models of care by integrating care and support with established voluntary groups
- ensure that a range of written materials and other information is available for patients in appropriate languages
- consider using practice premises as a community space, where self-help groups could be established. This is the key aspect of healthy living centres and an important way in which primary and community care resources can be integrated to promote mental health
- talk to existing sites of good practice, including primary care beacons.

Increasingly, primary care will be working with others to prevent ill health, co-ordinating holistic packages of health and social care and expanding services delivered at the local community level. This will include networking and partnerships with local authorities, social services, healthy living centres and a wide range of advice workers, advocates, patient and user groups, art, leisure, music and educational initiatives. Neighbourhood assets, including tenants associations, schools, libraries, faith communities, leisure services and voluntary organisations provide a potentially valuable adjunct to, and support for, specialist health and social care providers. (Goldberg & Gournay 2000)

### For further information

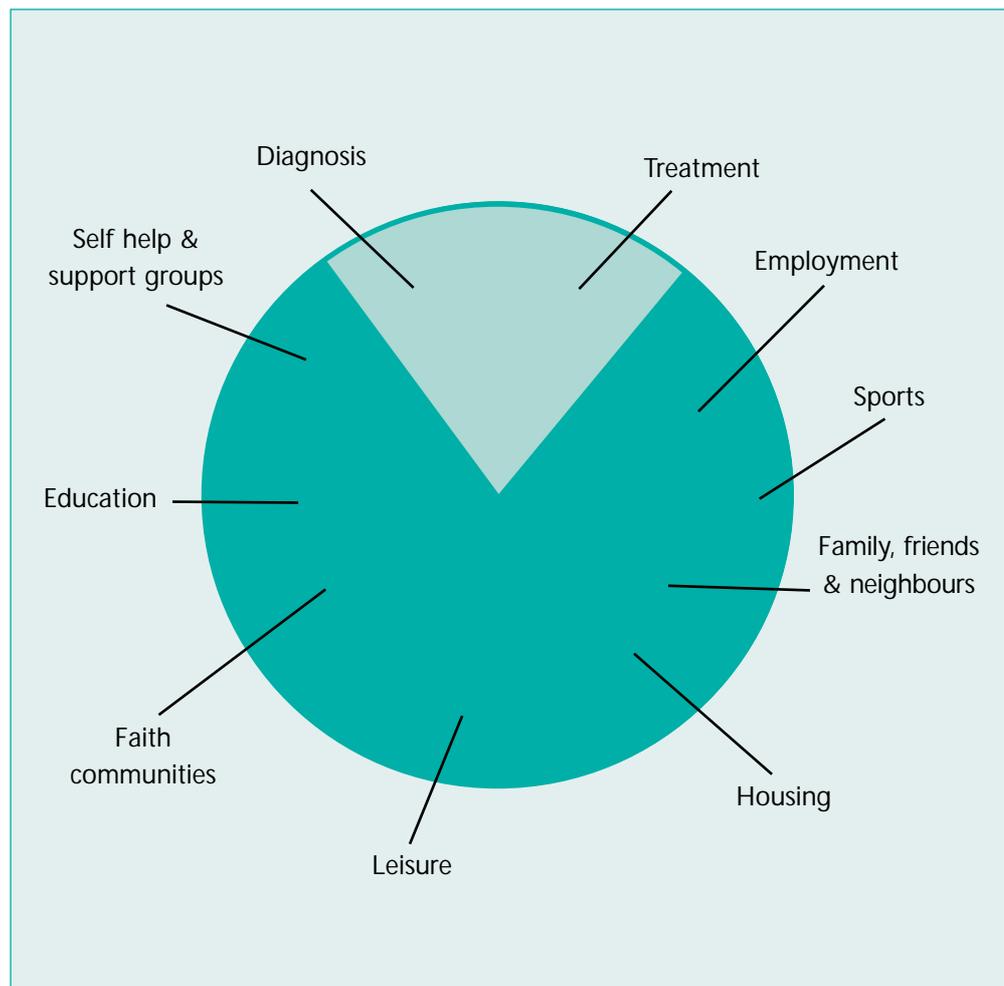
PriMHE (Primary Care Mental Health and Education) is a multi-funded, collaborative, charitable organisation. Using its unique “bubble-up” approach, it is dedicated to the education, training, information and mental health needs of primary health care professionals and seeks to support them as they work together to improve the mental health of the nation. ([www.primhe.org](http://www.primhe.org))

pcmhnet (Primary Care Mental Health Net) is an interactive and educational network for primary care mental health in the Northern and Yorkshire Region. pcmhnet, as well as linking to new service developments, current thinking, good practice, directional papers and training updates, provides a forum for primary care mental health to give opinions and help develop a consensual voice in the region. ([www.pcmh.net](http://www.pcmh.net)) Contact: [editor@pcmh.net](mailto:editor@pcmh.net)

### 3.6 Case Six - Mental health services and mental health promotion

Mental health promotion and the delivery of mental health services are often seen as separate tasks, in competition for scarce resources. This view may be based on the belief that mental health promotion is not relevant to people with long term mental health problems. However, just as a diagnosis is only one part of a person's life, so medical treatment is only one part of the support they need – to cope, to recover and to avoid relapse. The other support – by far the largest part – will come from family, friends, schools, employers, faith communities, neighbourhoods – and from opportunities to enjoy the same range of services and facilities within the community as everyone else.

Figure 3:10 Sources of support for people with mental health problems



There is growing evidence that engaging with these wider issues improves physical and mental health and promotes recovery:

*“This means that the mainstream networks and opportunities – for employment, housing, leisure, friendship – become the central concern of mental health service providers, rather than a secondary gain from efficiently implemented care programmes; and that effective work to enhance different communities’ hospitality and tolerance of difference, becomes a key responsibility of mental health agencies. The more that mental health services succeed in supporting people to take up non-segregated, mainstream opportunities, rather than participate in specialist services such as mental health day centres – the more accepted are people with mental health problems likely to become. Without such initiatives, fear and prejudice are likely to grow, even as safer services are achieved.”* (Sayce et al 1999)

The importance of engaging with issues like friendship, social networks and employment has been central to the success of early intervention programmes, which aim to engage young people experiencing a first episode of psychosis. (Birchwood et al 1997; McGorry and Jackson 1999)

These and other initiatives are part of broader concerns about social inclusion and provide an opportunity for mental health promotion and mental health services to identify shared goals and work towards a common agenda. They are also consistent with a ‘whole systems approach’ to mental health care, which aims to address the needs of the whole person.

This means:

- treating people as individuals, not illnesses
- recognising patients’ expertise
- shared decision making between service users and clinicians
- focus on prevention and self-help strategies
- recognising the importance of quality of life
- access to high quality information.

(Speech by Alan Millburn to Long Term Medical Conditions Alliance Conference, March 2001)

**Figure 3:11 Examples of interventions relevant to reducing social exclusion include:**

- Supported employment in a real working environment
- Increasing compliance with the Disability Discrimination Act and extending this to include people who have had psychiatric treatment for less than 12 months
- Including personal experience of mental health problems in person specifications
- Media training for service users
- Primary care referrals to voluntary, user and self-help groups
- Initiatives to increase access to mainstream services – education, leisure, transport

The importance of meaningful public participation in the delivery of services is a central feature of both the National Service Framework and the NHS Plan. User and carer involvement should now be a key feature of the way in which mental health services are planned and implemented. However participation in, and influence over, health care may have intrinsic health benefits.

Lack of control and lack of influence are independent risk factors for stress. (Rainford et al 2000) This suggests that indicators of participation, inclusion, access and influence need to be built into clinical indicators of effectiveness. In other words, the way in which a service is delivered may have an impact on health, over and above the clinical effectiveness of the treatment provided.

Local information strategies, which have a key role to play in facilitating greater public participation, should recognise that opportunities to influence, participate in and be consulted about services are a crucial element of the impact of services on the mental well being of those who use them and, of course, on those who deliver them.

### 3.7 Case Seven - Mental health promotion and local information strategies (LIS)

*Information for Health* (Department of Health, 1998) sets a framework for identifying and addressing health information needs and places a responsibility on health authorities to develop local information strategies. Information strategies for priority areas like cancer have also been developed and a Mental Health Information Strategy was launched by the Department of Health in the Spring.

Mental health promotion can provide accessible information that can play a significant role in reducing fear and misconceptions about mental illness and increasing understanding of the needs and experiences of those with mental health problems.

There is also considerable evidence that the health information needs of users are not adequately addressed and that receiving a diagnosis of, for example, schizophrenia or bi-polar disorder often means that physical health is disregarded. People with mental health problems are at higher risk for a range of physical health problems. (Harris and Barraclough, 1998)

An increase in mental health literacy across all sectors, among both the general public and health professionals, is an important goal in terms of reducing stigma, enabling people to seek help, improving services and increasing the capacity of communities to include and support people with mental health problems. It may also help to reduce the stigma attached to working in mental health and enhance the status of mental health as a positive career choice, particularly among young people.

Initiatives to increase access to on-line information, primary care partnerships with voluntary and user agencies and proactive patient/primary care programmes have considerable potential for exploring the mental health impact of improved information pathways. Ferguson (2000) provides an example of a partnership between general practitioners and online patient helpers in the USA. A number of primary care initiatives focussing on information are included on the NHS Beacon website [www.nhs.uk/beacons](http://www.nhs.uk/beacons). Manor House Surgery in Derbyshire, for example, has developed a website and email access for patients. (NHS Beacon Services 2000/1)

**Figure 3:12 Public mental health information needs**

The public need information which covers the following areas:

- how to look after your own mental health and that of others
- mental health promotion in schools and the workplace
- protective legislation in relation to mental health e.g. the Disability Discrimination Act and Health and Safety legislation
- health promotion information which links mental and physical health
- simple self-help techniques for managing mental distress
- when and where to seek help
- how to support a friend, colleague, family member experiencing mental health problems
- how services are delivered locally, who is responsible for what and fora for community involvement, consultation and participation
- guidance on evaluating the quality of information on mental health issues

**Figure 3:13 Examples of recommendations for action for local information strategies**

- Existing health promotion information should be assessed to ensure that it includes relevant information on mental health promotion.
- Existing health promotion information should be provided in a way that is accessible to users and carers, and makes clear its importance and relevance for people with mental health problems.
- Information packs and directories of sources of national and local support for people with mental health problems should be informed by mental health promotion evidence for the value of creative, sporting and leisure activities.
- Local information strategies should recognise that opportunities to influence, participate in and be consulted about services are a crucial element of the impact of services on the mental well being of those who use them and those who deliver them.

### 3.8 Case Eight – Mental health promotion in the workplace

#### The cost of work related ill-health

- Work related stress affects about one in five workers: approximately 5 million people.
- 6.7 million working days are lost each year due to stress related illness, at a cost of between £3.7 billion and £3.8 billion (1995/6 prices).
- 187 million working days are lost to sickness absence for all causes.
- The cost to employers of work related ill-health is about £1.6 billion (1995/6 prices).

(Health and Safety Executive 1999)

Mental health promotion in the workplace has a wide range of health and social benefits and also improves productivity.

There is now good quality evidence that both how employees feel about their work and how they are managed make a significant difference to organisational outcomes and profitability. (Pfeffer 1998; Sainsbury Centre for Mental Health 2000) Furthermore, poor individual performance nearly always reflects wider system failure.

In a review of the research in a Sainsbury Centre for Mental Health publication *Finding and Keeping* key findings were as follows:

- The more satisfied employees are with their jobs and the more committed they are to the organisation, the better the organisation is likely to perform, in terms of its subsequent productivity and profitability.
- Human factors are more significant than any other aspect of organisational culture in predicting organisations' differential success (in terms of productivity and profitability) over a 3-4 year period. Key factors include the extent to which employees:
  - feel valued, trusted and supported;
  - are enabled to be autonomous in undertaking their work roles;
  - are supervised and trained.

In addition, management style clearly affects health. Many of the factors that influence both the physical and mental health of staff are psycho-social and relate to working culture, levels of support and job security. A wide range of studies demonstrates the impact of organisational factors on individual health and suggests that working patterns may be a key source of stress. (Casper Healthcare Knowledge Systems 1998; Sheffield University 1996; North et al 1993; Stansfield et al 1999)

The Whitehall II Study found that low job control, high job demands, low social support at work and a combination of high effort and low rewards were all associated with poor mental and physical health. Key findings (Stansfield et al 1999) included:

- imbalance between effort and reward increased the risk of alcohol dependence in men by 70%-90%
- psychological demands, work overload, low social support and an imbalance between effort and reward were associated with an increased risk of psychiatric disorder in both men and women.

Studies published by the Health and Safety Executive estimate that 5 million UK workers suffer from high levels of stress. Based on responses of 8000 people in the Bristol area, they demonstrated:

- a link between design of jobs and levels of stress
- the impact of stress on physical and mental health, including back pain, drinking, smoking
- low levels of job control are associated with poor mental health in men and increased risk of alcohol dependence in women
- feeling unsupported increased the risk of psychiatric problems.

As was described in Chapter One, low morale, high levels of psychological disturbance and poor physical health are also of particular concern within the NHS and there is some evidence that these problems are more prevalent in the NHS than in comparable jobs in other sectors. Wall et al (1997) also found that high work demands increased the risk of psychiatric disorder among NHS staff.

All the evidence suggests that an effective policy to improve health at work cannot only focus on one or two work characteristics or on individuals, but must tackle work organisation and management practice. This raises important questions about the value of individual stress reduction programmes.

### Figure 3:14 Workplace health

- In a four year longitudinal study of more than 21,000 nurses, low job control, high job demand and low levels of social support at work were associated with poor physical and mental health over time. The declines in health were as large as those associated with smoking and sedentary lifestyles. (Cheng and Kawachi 2000)
- Studies in the US, UK, Sweden and the Czech Republic have demonstrated a strong association between psychosocial factors at work and overall health, notably in relation to risk for heart disease. (Bobak et al 1998; Johnson et al 1996; Bosma et al 1997)
- A study of 13,226 employees in France demonstrated that hypertension (a risk factor for heart disease) was related to low decision latitude in both women and men. (Niedhammer et al 1998)
- A number of studies have found that health service workers have greater levels of sickness absence and poorer mental health than those of employees generally. (Borrill et al 1996; Sainsbury Centre for Mental Health 2000)
- Studies on job security demonstrate that health declines when jobs first become insecure, whether or not the final outcome is unemployment. (Ferrie et al 1998)

The following issues can be addressed by a mental health promotion strategy in the workplace:

- the impact of stress-related disorders on sickness absence and the high levels of psychological distress among NHS staff
- the significance of psycho-social factors in the perceived quality of working life
- the relationship between how employees feel and organisational outcomes
- the influence of mental well-being on lifestyle factors e.g. smoking, drug and alcohol abuse, healthy eating and exercise.

Key elements of an effective mental health promotion strategy include:

- redressing effort/rewarding imbalance
- improving communications and staff involvement
- enhancing social support, especially from managers to subordinates
- increasing job control and decision making latitude
- assessing job demands.

(Williams et al 1998; Stansfield et al 1999)

Finally, a comprehensive workplace mental health policy should aim to:

- promote the mental well-being of all staff
- support staff returning to work following a mental health problem
- include a positive approach to the employment of people with mental health problems.

The Department of Health will shortly be publishing guidelines which aim to increase employment opportunities in the NHS for people with mental health problems and to assist health authorities to meet the target of increasing employment of people with mental health problems within health and social services.

The development of social firms has also been used to promote employment opportunities for people with mental health problems. Social firms are businesses created for the employment of people with disabilities or other disadvantages in the labour market (further information can be found at [www.socialfirms.co.uk](http://www.socialfirms.co.uk)).



# The policy context

### 4.0 Introduction

Many policy initiatives in both the health sector and local government are relevant to promoting mental health. Identifying policies with supporting goals will help to prevent duplication and to build partnerships across all sectors.

Social inclusion, social capital, neighbourhood renewal and community development describe processes that aim to strengthen social networks and structures to support local communities. Policy initiatives that address regeneration are concerned with reducing health inequalities, raising educational standards, improving health, tackling social exclusion and developing sustainable work and independence. Mental health promotion can make a real contribution to these areas of concern, and in turn the initiatives undertaken will help promote mental health.

The three main regeneration policies using an Action Zone approach (Health Action Zone, Education Action Zone and Employment Action Zone) aim to intervene at:

- an individual level (Employment)
- a community or organisational level (Education)
- a service or strategic level (Health).

The New Deal for Communities includes many of the aims of the specific Action Zones and will deliver improvements at a neighbourhood level. This is directly comparable with a mental health promotion strategy that aims to promote public mental health at all levels in society.

A policy analysis of the main health and regeneration policies currently being delivered at local level is set out in Figure 4:1.

Figure 4:1 Analysis of six regeneration initiatives

POLICY	AIMS	CONTENT	PROCESS
Education Action Zones	Through partnership with leading businesses, parents and community, zones will use new skills, experience and funding to raise educational standards.	Major innovations include: 24 hour class rooms, wrap school service, super teachers, new curriculum.	Schools involved will be prepared to work in partnership with each other, the LEA, local business, parents and community groups and TECs and existing local partnerships to develop a programme of action to address their difficulties.
Health Action Zones	Through working in partnership with NHS, local authorities, the voluntary sector and business to develop and implement a health strategy to deliver within their area measurable improvements in public health and in the outcomes and quality of treatment and care.	To address health inequalities: identifying and addressing health needs of the local area. Service modernisation: increasing effectiveness, efficiency and responsiveness of service.	HAZs are coordinated locally by a Partnership Board and performance managed by NHS Regional Offices through health authorities covered by the HAZ. HAZs will have to complete a self assessment of their progress.
Employment Action Zones	To help long term unemployed people into sustainable work and independence.	Participation is mandatory for eligible clients. Referrals will be made by the Employment Service at restart interviews. People will be offered a personal adviser service. Payments to contractors will be by results.	Participation of all sectors of the community to run the schemes was encouraged. Each successful contractor has to work with other public and voluntary organisations locally.

Figure 4:1: continued

POLICY	AIMS	CONTENT	PROCESS
New Deal for Communities	To tackle multiple deprivation in the very poorest areas, taking forward the Government's aim to tackle social exclusion through a national strategy for neighbourhood renewal.	To tackle problems in the most deprived neighbourhood: Tackling worklessness Improving health Tackling crime Raising educational achievement.	Schemes are led by local partnerships and the New Deal for Communities is administered through Government offices.
New Deal for Disabled People	To help disabled people and those with long term illness into work and training. The scheme pilots a range of initiatives as part of the Government's Welfare to Work.	The programme involves a Personal Adviser Service to help disabled people overcome barriers to work; Innovative Schemes to explore best practice; an Information Campaign to improve knowledge and change attitudes; and a programme of Research and Evaluation.	Schemes are led nationally jointly by the Department for Education and Skills and the Department for Work and Pensions.
Connexions	To increase the achievements of young people by enabling them to participate effectively in appropriate learning. The service aims to raise the aspirations of young people, helping them to realise their full potential.	The service is delivered through Personal Advisers linking in with specialist support services. The Connexions partnerships deliver comprehensive services to young people to ensure access, support and guidance.	It is envisaged that Connexions will be delivered through a network, drawn from existing public, private, community and voluntary organisations.

The process of delivery is different for each of the initiatives:

- some work with formal local partnerships (a partnership Board – Health Action Zone)
- some with informal local partnerships (Education Action Zone)
- the Employment Action Zone encouraged local contractors to bid and will expect them to work with local statutory and voluntary organisations
- Health Action Zones will be performance managed by the local Health Authority
- A Government Office manages New Deal For Communities
- New Deal for Disabled People will be delivered through personal advisor services and coordinated by local authorities
- Connexions will be delivered through special advisors and overseen by a structure yet to be formalised.

The implications of these different working processes and systems of accountability will emerge in trying to develop joint initiatives. They may make ways of working difficult initially.

## 4.1 Related NHS policy initiatives

The following national policy initiatives are all to be led by the NHS although their success depends on the involvement of a range of local agencies. These five policies will provide important complementary initiatives that are also working towards promoting mental health. Once again the language used is different to the initiatives addressing regeneration, even though many of the principles of empowerment through information and organisational development are similar.

### 4.1.1 The NHS Plan

Mental health has a high priority in the NHS Plan, which builds on the National Service Framework for Mental Health (NSF). The Plan provides extra resources to fast-forward the NSF. This will allow the creation of 500 extra secure beds, over 320 24 hour staff beds, 170 assertive outreach teams and access to services 24-hours a day, seven days a week, for those with complex mental health needs. In addition, the NHS plan recognises that mental health services are not always sensitive to the needs of women and sets out that by 2004, services will be redesigned to ensure there are women-only day centres in every health authority.

New investment, combined with major reforms, will modernise mental health. There will be a radical move away from hospital based services to community based care. Although mental health promotion is not explicitly addressed in the Plan, it is implicit in the principles of increased consultation and patient participation. In addition, successful delivery of community care will require greater levels of public understanding and acceptance of mental health problems.

#### *4.1.2 Our Healthier Nation*

Our Healthier Nation stresses the complementary roles of the individual, communities and the government in taking action to improve health. Mental health is one of the priority areas and action to change the determinants of health is a part of the strategy. Health Action Zones are seen as a framework for delivering the strategy at local level. There are obvious links between the two policies.

#### *4.1.3 Information for Health*

Information for Health deals with the information needs of the NHS. There is an important acknowledgement about the public's need for information about health, self-care and policy and future services as well as the information needs of patients. The recognition that the public need information for several purposes is an important one when considering how institutions and agencies can support the promotion of mental health. Information that enables people to participate in the planning of services and in informing their awareness of their own health plays an important role in the delivery of mental health promotion interventions.

#### *4.1.4 Working Together*

Working Together focuses on the NHS as a workplace. The workplace is one of the three organisational settings that are seen as essential for promoting mental health in a healthy neighbourhood. As the NHS is often the major employer in many districts, the implications of promoting health through the workplace are important for mental health promotion. Several of the strategies outlined relate directly to the promotion of mental health e.g. increased consultation and participation, ability to speak out without fear of victimisation and family friendly policies.

#### *4.1.5 National Service Framework for Older People*

The National Service Framework (NSF) for Older People is aimed at driving up the quality and reducing variations in services for older people. For the first time it sets national standards and defines service models for the health and social care older people receive; puts in place programmes to support implementation; and establishes milestones and performance indicators against which progress will be measured.

Many ongoing initiatives aimed at promoting independence and quality of life for older people have been funded as part of the prevention grant within the modernisation programme for social care, launched in 1998. Low intensity primary prevention services are not merely relevant to diverting demand from health and social care services for older people. They are also fundamental elements of the Government's responsibility to promote sustainability and well-being. (Winston & Randall, 2000)

## 4.2 International policy

International policy can provide legitimacy for approaches that are perhaps less well developed at national or regional level. The World Health Organization Healthy Cities initiative was taken up by those working at local level all over the world and has contributed to an understanding of how to work to improve health with many agencies at a city level.

A resolution passed by the Council of the European Union in November 1999, calls on the European Commission to recognise the importance of promoting mental health and to assess the mental health impact of policy. The resolution invites the member states to:

- develop mental health promotion policies
- collect and share relevant data
- develop and implement action to promote mental health and prevent mental illness
- stimulate research on mental health and its promotion.

It calls on the European Commission to:

- incorporate mental health into the public health programme
- monitor mental health as a component of the community health monitoring system
- analyse the impact of the community activities on mental health
- consider drawing up a recommendation on the promotion of mental health.

This resolution may become an important influence in validating the promotion of mental health, used both by member states and the Commission.

Also relevant to mental health promotion is the European Convention of Human Rights and the Human Rights Act (1998). NHS bodies now have to act in compliance with the convention and a breach can lead to a claim for damages as well as being an additional ground for challenging decisions by way of judicial review. Of specific relevance to health delivery will be: prohibition of inhumane or degrading treatment; prohibition of detention; right to respect for family and private life; right to marry and found a family; and the definition of mental disorder.

Finally, international initiatives like World Health Day (7<sup>th</sup> April) ([www.who.int/world-health-day](http://www.who.int/world-health-day)) and World Mental Health Day (10<sup>th</sup> October) ([www.wfmh.com](http://www.wfmh.com)) also provide an important impetus for local and national action.



# Framework for developing a mental health strategy

## 5.0 Introduction

### **Standard One: Performance Management Targets**

By March 2002, develop and agree evidence-based mental health promotion strategy based on local needs assessment.

By March 2002, build into local mental health promotion strategy action to promote mental health in specific settings, based on local needs.

By March 2002, build into local mental health promotion strategy action to reduce discrimination.

By March 2002, the written care plan for those on enhanced Care Programme Approach (CPA) must show plans to secure suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits.

By March 2002, implement strategy to promote employment of people with mental health problems within health & social services.

Developing a mental health promotion strategy is a complex task. It will need to engage stakeholders across many different settings and sectors, with competing and often opposing perspectives, in a shared vision. Local strategies need to reflect the importance of intervening at different levels e.g. strengthening individuals, strengthening communities and tackling structural or policy barriers to mental health. Action to promote mental health in different settings will need to reflect local conditions and priorities and the needs of vulnerable individuals and at risk groups.

This chapter provides a framework for developing a mental health promotion strategy, together with some examples of different approaches to agreeing a vision and setting aims and objectives.

**Table 5:1 Framework for a mental health promotion strategy**

Agreeing a vision and setting aims and objectives

*What does the strategy hope to achieve?*

Mapping existing initiatives

*Identifying gaps and duplication*

Identifying key settings and target groups

*Local needs assessment to agree key settings and target groups*

Making the links with policy initiatives with supporting goals

*For example, National Strategy for Neighbourhood Renewal, Health & Safety Executive's Securing Health Together, Information for Health/Mental Health Information Strategy, Sure Start, Community Safety, Lifelong Learning*

Identifying key Stakeholders

*Whose commitment will be essential to the delivery of the strategy?*

*How will key stakeholders be involved/consulted?*

*What steps will be taken to involve users, carers and local communities?*

Selecting Interventions

*What are the chosen interventions, who are they targeting, in which settings?*

Finding the evidence to support the approach taken

*What strength of evidence is available to support the interventions selected?*

Establishing indicators of progress

*What kind of indicators will demonstrate progress?*

Building in evaluation

*How will the interventions/different components be evaluated?*

*How will the overall strategy be evaluated?*

Identifying staffing and resource implications

*Does the present workforce (across all sectors) have the capacity to deliver the strategy?*

*Have any skills/training/capacity development needs been identified?*

*How will workforce/skills gaps be addressed?*

## 5.1 Framework for a strategy

Table 5.1 provides a framework for a strategy for mental health promotion that can be applied to different settings and target groups. It outlines the key stages and tasks in developing a strategy. An effective framework will outline the roles of agencies, the responsibility of individuals, the resources made available and the process of review.

### 5.1.1 Agreeing a vision and setting aims and objectives

There are many different approaches to agreeing a vision for a mental health promotion strategy. It is essential for an effective strategy to have the commitment of key organisations who will be tasked with delivery, therefore consultation and ownership of a vision, aims and objectives must be the first step.

In Leicester, Leicestershire and Rutland, the following questions formed the basis of a major consultation exercise about mental health promotion, involving members of the public, service users and carers and professionals across all sectors.

#### **Public information needs**

How well do we educate the public, the media, people with mental health problems and their carers about good mental health, recovery and living with mental health problems?

#### **Stigma/Discrimination**

If a colleague, a pupil, an employee, friend or neighbour experiences a mental health problem – do they keep or lose their friends, their job, their home and their place at school or college?

#### **Training**

Do primary care professionals have the training, information and support they need to promote mental health and treat mental health problems? Is mental health promotion training, involving users and carers, available for schools, workplaces and communities?

(Adapted from: Kate Phipps, Leicester, Leicestershire and Rutland National Service Framework Development Plan)

In Hull and East Riding, the Health Promotion Service held a 'working towards a shared vision' conference involving representatives across all sectors, whose views and experiences could contribute to developing a strategy. The conference also provided an opportunity for local mental health promotion projects to describe their work. This is being followed up by workshops for people working in different settings or with specific target groups, to ensure that the strategy reflects local needs and takes account of different views.

(Evelyn Krasner, Hull & East Riding Health Promotion Service)

In North West Lancashire a consultation exercise has been carried out to establish the local priorities for a mental health promotion strategy. A series of focus groups took place based on settings:

- families
- education
- workplace
- criminal justice
- health care
- social care and welfare
- community

The groups were made up of all levels of staff in the statutory, voluntary and private sector and included users of services. The general public were also consulted through existing groups such as the leisure services, mums groups, age concern, school group and local youth clubs.

Resulting priorities to:

- increase the recognition of mental health and well being
- develop socially inclusive organisations and communities
- improve communication across and within families and organisations
- empower individuals and increase involvement at all levels within services
- create positive working environments that improve the mental well being of staff
- provide accessible, appropriate and holistic services.

(Submitted by Jude Stansfield, Health Promotion Unit, North West Lancashire Health Authority)

The West Midlands Regional Framework for the development of mental health promotion operates through two inter-related strands.

### Strand One

Steps for the development of local strategies:

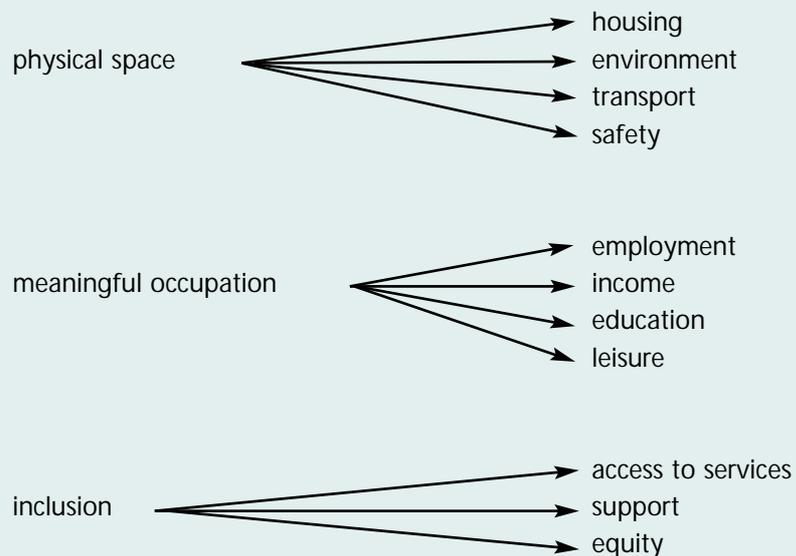
1. Create an infrastructure, and identify key personnel for delivery
2. Identify where mental health promotion is located in local policy
3. Share understanding of the meanings of 'mental health'
4. Plan based on identifying local needs
5. Review the evidence base for mental health promotion
6. Carry out local consultation all of which will help to set local priorities

(Strand Two can be found on page 87)

Further information on the West Midlands Framework is included in Appendix One

### Community priorities

This approach looks at community priorities, drawn from the literature on community development, to identify key areas which impact on mental health, to be included in Health Improvement Programmes (*see for example Villaneau et al 2000*)



### 5.1.2 Mapping existing initiatives

A framework for mapping mental health promotion should take account of different levels:

- Strengthening individuals
- Strengthening communities
- Strengthening organisations.

At each level, initiatives may be relevant to the whole population, individuals at risk, vulnerable groups and people with mental health problems. Initiatives may work at more than one level, target one or more groups and take place in a variety of settings.

In Redbridge and Waltham Forest, a mapping exercise was used as a starting point for developing a mental health promotion strategy (see Appendix Two). The aim was to build on existing good practice and identify gaps and duplication, before deciding on priorities for the strategy.

The first step is to achieve consensus about what should be included in the map, by bringing together key stakeholders from health and social care organisations, user and carer forums and relevant voluntary agencies and community groups. NSF leads and Local Implementation Teams may provide a good core group, and others can be added.

Getting people together from across professional and sector boundaries gives an opportunity to explore conceptual frameworks and definitions and to agree the scope and range of initiatives that impact on mental health - not just within health services but also those linked to work on social exclusion and regeneration, within education and elsewhere.

Addressing problems and solutions in this way helps to develop a shared understanding and vision. The process will also show the range of disciplines and agencies that need to be involved in finding solutions and delivering appropriate programmes. This helps to identify possible stakeholders for the strategy.

This group can be used to identify:

- mental health promotion initiatives to be included in the map
- key contacts in NHS, local authorities and voluntary agencies to be interviewed
- a list of local agencies and groups to take part in the mapping survey
- consultation and dissemination routes.

In the following example interventions were graded against the strength of evidence relating to their approach.

**Figure 5:2 Redbridge and Waltham Forest mapping exercise**

**Example 1: The User Involvement Project in Waltham Forest**

Targets:	People with mental health problems, employers and service providers
Aims:	To increase individual and collective empowerment through capacity building and training. To ensure the voice of users is heard. To promote the involvement of users in planning and training provision.
Work includes:	<ul style="list-style-type: none"><li>• a service users forum</li><li>• training users as co-trainers within health, social services and voluntary agencies</li><li>• training users to monitor services</li><li>• ensuring services have an explicit way of consulting with service users and formal ways for users to be involved</li><li>• users taking part in recruitment/interviews within social services</li></ul>
Settings:	Community, workplace
Levels:	Strengthening communities Strengthening organisations
Evidence:	Grade II, III, IV, V

**Example 2: GP Exercise referral scheme in Redbridge and Waltham Forest**

Targets:	Whole population
Aims:	To offer GP exercise referral schemes at local leisure centres To develop 'walking for health' initiatives
Settings:	Community
Levels:	Strengthening individuals Strengthening organisations
Evidence:	Grade I

(Submitted by Dr Pratibha Datta, Redbridge and Waltham Forest Health Authority)

Assessing initiatives against the evidence base is not designed to judge whether a specific intervention is effective. The aim is to give an indication of whether there is reasonably robust evidence to support a particular approach to promoting mental health. For example, there is good evidence to support the effectiveness of peer education, the benefits of volunteering for older people, anti-bullying strategies within schools, increasing social support, enhancing employment opportunities and exercise.

### 5.1.3 Identifying mental health promotion through Health Improvement Programmes

Health Improvement Programmes are developed by an alliance of key organisations to identify local needs and to translate national priorities into local action.

Work developed by Keith Wilson at the NHS Executive can be used and adapted to consider the range of activities in a local area which are contributing to the improvement of mental health and the reduction of health inequalities. Delivering mental health promotion through Health Improvement Programmes can ensure that health authorities, local authorities and partner agencies are signed up to the process before implementation.

How does the Health Improvement Programme demonstrate the following priorities and how will the NHS and partner organisations ensure that gaps in available support are addressed?

#### *Workplace*

Is there a strategy, action plan and local targets for reducing stress at work:

- within local NHS organisations
- within the local authority.

#### *Unemployment*

Are there links between NHS organisations and partners to promote social inclusion:

- through positive employment opportunities for people with a history of mental illness
- through an explicit policy within local NHS and local authority organisations to support rehabilitation through suitable employment
- through a programme of health promotion targeted at local employers and employment agencies

- through specific arrangements to support and promote the mental well being of people who have become unemployed or have experienced long term unemployment
  - operated by NHS and local authority organisations for their former employees
  - promoted to other employers and employment agencies.

#### *Communities*

Are there links between NHS organisations and partners to ensure a shared community health promotion strategy with a focus on:

- promotion of exercise, relaxation and stress management programmes to promote well-being
- education programmes to promote interpersonal awareness and maintain social contacts
- reducing dependence on drugs and alcohol.

#### *Individuals at risk*

Can individuals at risk of mental illness readily access clear and encouraging information about how and where to get advice and support from statutory agencies such as primary care teams or other sources of practical support such as self help groups?

Is professional emotional support readily available locally to:

Parents:

- mothers with depression, with rapid treatment available to prevent emotional harm to children
- pregnant women with children
- young single parents
- young isolated mothers.

Children:

- to tackle early child behavioural problems
- to help children with a learning disability, including dyslexia
- support for school children whose parents are divorcing.

Other adults:

- those vulnerable because of unemployment or divorce
- those who are recently bereaved
- those caring for people with dementia
- those caring for others with mental illness.

### *Vulnerable groups*

How are the needs of vulnerable groups understood and being addressed, in particular:

- vulnerable children
- victims of domestic violence
- people who sleep rough
- minority ethnic communities
  - in partnership with local communities and involving service users and carers
  - is there an action plan to develop services which are sensitive to the needs of patients from minority ethnic communities
- people with alcohol problems
  - do all primary care teams have protocols in place to apply brief interventions where excessive alcohol consumption is identified?
  - have members of the practice team received training in the early identification of alcohol related problems?
  - are formalised links established between community mental health services and drug and alcohol services to optimise interventions (and help reduce suicides)?

### *Combating discrimination and social exclusion*

Is there a comprehensive strategy to promote better public understanding about mental health issues, including:

- local media
- information to the general public
- schools and colleges
- local businesses
- police
- NHS employees
- local authority employees
- information for members of ethnic minority communities
- local authority elected members
- members of parliament.

### 5.1.4 Identifying key settings and target groups

A settings approach, like the one adopted by the West Midlands Region, can make the whole task of developing a strategy more manageable. The identification of target groups of vulnerable and at risk individuals and groups will reflect local needs and priorities. These may include:

- people sleeping rough
- people who misuse drugs and/or alcohol
- victims of child abuse or domestic violence
- people in prison
- black and minority ethnic groups
- refugees
- people with physical health problems
- parents and children in deprived neighbourhoods
- people who are long term unemployed
- carers.

#### West Midlands Regional Framework

##### Strand Two

The development of Guidance for Good Practice in mental health promotion will be undertaken by six setting task groups, which are:

- young people in schools and other settings
- neighbourhoods and communities
- the workplace
- Primary care groups and health services
- mental health services, users and carers
- media and information services.

The work of each has been assisted by a setting co-ordinator, funded by the NHS Executive Regional Office, for half a day per week and a Regional Co-ordinator for one day per week. Further work and support will continue within the West Midlands to take the framework forward from April 2001.

For further information on the West Midlands Strategy see Appendix One

### 5.1.5 Making the links with policy initiatives with supporting goals

A range of relevant policies has been described in Chapter Four. The following example lists settings where national and local policies can be joined:

#### Young People in Schools and other settings

- National Healthy Schools Plan
- LEA Education Development Plan
- LEA Behaviour Support Plan
- The Personal Social and Health Education and Citizen Framework
- Quality Protects Programme
- Teenage Pregnancy Strategy
- Connexions

#### Neighbourhoods and Communities

- Health Action Zones and Healthy Living Centre Strategies
- Local annual Public Health reports
- Service and Financial Frameworks (SAFFs)
- Long-term service level agreements
- Government 'New Deal for Communities'
- Local Authority Community plans
- Local Agenda 21 strategies
- The Crime and Disorder Bill and Local Community Safety plans
- Community Lifelong Learning strategies
- 'Sure Start' programmes
- National Strategy for Neighbourhood Renewal

## The Workplace

Local employer/Occupational Health/Human Resources strategies including anti-bullying, harassment, anti-discriminatory and equal opportunity policies.

New Deal for Disabled People

Health and Safety Guidance

Local policies on returning to work following mental health problems, and employment of people experiencing ongoing mental health problems

Stress management policy/strategies at the individual and organisational level

## Primary Care Groups and Health Services

The New National Health Service: Modern and Dependable

Local Health Improvement Programmes (HimPs)

Primary Care Investment Plans

Long Term Service Agreements

National Service Framework Standards Two and Three

## Mental Health Services, Users and Carers

Local policy/strategy on involvement of service users and carers in service development, treatment planning, and quality control

National Service Framework Standards Two to Seven

Local anti-discrimination legislation and policy

Employment policies of people who have experienced mental ill-health

Staff training programmes

## Media and Information Services

National Union of Journalist Guidelines on Reporting Mental Health

Press Complaints Commission

Advertising Standards Authority

(Reproduced from West Midlands Regional Framework)

### *5.1.6 Identifying key stakeholders – consultation and gaining commitment*

Consultation is crucial to the success of the strategy and different approaches to this have been described under 5.1.1 Agreeing a Vision. The examples included in Chapter Three - Making the Case for Mental Health Promotion - may be useful for gaining commitment from a range of stakeholders.

### *5.1.7 Selecting interventions and finding the evidence to support the approach taken*

A meta analysis of different programmes shows that mental health promotion is most effective when it:

- intervenes at a range of different times in the life cycle, e.g. infancy and adolescence
- is integrated within different settings, e.g. schools and primary care
- is planned at different levels, e.g. local/regional/national (Hosman et al, 1994)
- targets a combination of factors (e.g. coping skills and access to employment)
- involves the social networks of those targeted
- intervenes at different times/levels
- uses a combination of methods.

The following principles also appear to be underlying features of effective approaches for individuals, families, organisations and communities:

- reducing anxiety
- enhancing control
- facilitating participation
- promoting social inclusion.

Types of evidence and examples of evidence based interventions are described in Chapters Six and Seven. Figure 5:3 shows examples of priorities for action, drawn from a local strategy, which includes different grades of evidence of effectiveness.

### *5.1.8 Establishing indicators of progress and building in evaluation*

Further information on indicators and evaluation is included in Chapters Eight, Nine and Ten. The examples of good practice in Appendix Four may also be helpful in developing indicators.

**Figure 5:3 Examples of priorities for action in a local strategy (supported by evidence of effectiveness)**

Increasing public awareness and improving knowledge, attitudes and awareness e.g. World Mental Health Day, working with local media, user led programmes in schools and communities (V)

Influencing employers through programmes to increase employment of people with mental health problems and to develop understanding of the importance of mental health promotion in the workplace for all employees (I)

Supporting parents e.g. parenting skills, emotional support for young mothers, community mother programmes, pre-school education (I)

Mental health promotion in schools, through healthy schools initiatives, anti-bullying strategies, student councils, peer education (III) (IV)

Strengthening self-help and support networks and ensuring better links between primary health care and sources of information and support in the community (I-IV)

## 5.2 Conclusion

A key task will be to ensure that commitment to mental health promotion is embedded in policy across all sectors, underpinned by a recognition of the mental health needs of the whole population. Without this, there is a danger that work will focus on the provision of alternative services and sources of support for people with existing mental health problems, rather than ensuring that people who are vulnerable or at risk are able to enjoy the same services and amenities as everyone else.



# Types of evidence available

## 6.0 Introduction

There is an extensive evidence base on interventions which reduce the risk of developing certain mental health problems, depression or anxiety for example, and which demonstrate the effectiveness of enhancing coping/life skills and improving social support. Many examples are referenced in the National Service Framework and a detailed summary is also available in a review by the International Union for Health Promotion and Education. (IUHPE 1999)

This chapter looks at some of the current debates about evidence and effectiveness and reviews the types of evidence used in the National Service Framework. It is important that mental health promotion strategies are based on the best available evidence, while recognising that what constitutes evidence and how this is measured is part of a complex and ongoing debate. This can be summarised in terms of two essential questions:

- Who is defining effectiveness?
- What kind of evidence/measures are being used?

Reflective practice, the ability and willingness to think critically, is at the core of developing a robust and inclusive evidence base. This means recognising the potential of innovation and pioneering work, moving beyond medical or clinically driven definitions and engaging with the lived experiences of service users. Quantitative research often appears remote from the real issues faced by service users and local communities. At the same time, small scale studies relying on qualitative data may fail to address broader public health issues like inequality, low uptake of services by particular groups or long term health outcomes.

The literature on effectiveness is growing, but is still dominated by a focus on prevention and individual interventions. Using the existing evidence base effectively and contributing to its expansion will need to be done in a wider context of debates about the meaning, significance and impact of mental health. Definitions of effectiveness need to be informed by broader goals, for example social inclusion, and an understanding of the health impact of reducing anxiety and enhancing control.

This also means reviewing the way in which process indicators (how an intervention or programme is delivered) are seen, because of the proven impact of consultation, influence, participation, trust and subjective experience on mental health outcomes.

These issues are central to community development approaches, which aim to enable communities to make their own decisions about how to address health issues. Consulting and involving communities is a key part of government policy and this should assist in ensuring that consultation, capacity building and engaging excluded groups are included as indicators when evaluating effectiveness. Involving local communities in developing strategies, in planning and management arrangements, as well as providing training and resources for volunteers and local networks are key factors in the effectiveness of initiatives to improve health and well-being. (Nichols 1999; Gillies 1998; Audit Commission 1999)

## 6.1 National Service Framework Grades of Evidence

The NSF grades evidence as shown below. The use of expert opinion in the National Service Framework made a significant impact on the final framework in that the opinions of users and carers were recognised as a valid category of evidence. This influenced the type of approach taken in the overall Framework.

**Figure 6:1 Types of evidence in the National Service Framework**

I	systematic review, including one randomised control trial (RCT)
II	at least one RCT
III	at least one well-designed intervention
IV	at least one well designed observational study
V	expert opinion, including users/carers

All grades of evidence, including RCTs, have their own strengths and weaknesses. It is therefore helpful to identify the kind of evidence on which a planned intervention is based and to be clear about limitations.

### 6.1.1 Systematic reviews

Systematic reviews attempt to avoid some of the problems inherent in individual evaluations, by looking at results from a wide range of interventions addressing a common goal e.g. reducing excessive alcohol consumption. Systematic reviews use clear criteria for the inclusion of interventions and a scientific approach which aims to minimise bias. A good example is a recent review of employment schemes for people with severe and enduring mental health problems. (Crowther et al 2000) The review found that supported employment in a real workplace is more likely to result in paid employment than sheltered workshops or long term pre-vocational training. It could, of course be argued that sheltered schemes have many benefits, including providing social contact, increasing self-esteem and enhancing skills. However, for participants in employment schemes, it is important that there is clear evidence and transparency about likely outcomes. Similar concerns have been raised about the inclusion of life skills training as part of rehabilitation programmes, in the absence of evidence of their benefits for people with enduring mental health problems. (Nicol et al 2000 Cochrane Review)

Systematic reviews may have significant consequences for policy and practice. For example, the strength of evidence on brief interventions for reducing excessive alcohol consumption suggests that taking an alcohol history should be routine practice in primary care.

### 6.1.2 Randomised Controlled Trials (RCT)

RCTs are particularly useful for addressing the impact of a single intervention on clearly defined symptoms, e.g. depression. They allow a comparison to be made between different treatments e.g. anti-depressants, counselling or a leaflet. The use of a control group, (sometimes put on a waiting list) who do not receive any of these treatments will demonstrate whether over a period of time, people recover without an intervention, as well as which treatment is most effective in relation to the symptoms.

RCTs are much less successful at dealing with complex interventions, notably those that deal with predicaments, for example community development or school based interventions. The evaluation of this sort of intervention requires the use of qualitative and quantitative evidence. Health outcomes from complex interventions need to take account of a range of events, which might include service development, capacity building and community participation. One health researcher has described the failure to take account of these wider issues when looking at evidence and effectiveness as ‘using a ruler to measure a sphere’. (Hawe et al 1997)

Health impact assessment is a good example of a method using a multi-disciplinary process which combines qualitative and quantitative evidence in a decision making process. (Lock 2000; see also Caan 2000)

### 6.1.3 *Well designed interventions*

There are a number of criteria for well-designed interventions, many of which are intended to minimise the possibility of bias in interpreting the results. This includes factors which might influence the outcome of an intervention, e.g. selection bias or the relationship between the researcher and the researched. Well-designed interventions have clear aims and objectives, with key elements of the intervention clearly linked to specific goals. Quality criteria for interventions which meet the standards for inclusion in systematic reviews can be helpful in assessing the quality of an intervention design. The NHS Centre for Reviews and Dissemination has published guidance on this. ([www.york.ac.uk](http://www.york.ac.uk))

### 6.1.4 *Observational studies*

Observational studies, which may or may not include controls, are often used to evaluate interventions targeting pre-school children, for example observation to measure attachment and mother/baby communication. Participant observation and techniques like video diaries can provide a context for understanding complex areas like stigma or the experience of racism.

### 6.1.5 *Expert Opinion*

Expert opinion, drawn from service users and carers, is particularly important evidence in addressing quality of life issues and in informing service delivery and clinical priorities. For example, people with mental health problems consistently report that negative and sensationalised media coverage damages their health. For some people with mental health problems, the side effects of using services over which they have no influence, or the physical side effects of medication, like obesity, may outweigh clinical benefits e.g. a reduction in psychotic episodes. Including evidence from users and carers, and from the wider community, will have a significant impact on the way in which the effectiveness of mental health promotion is assessed. Equally, the application of principles and expertise drawn from mental health promotion can contribute centrally to the improvement of mental health services.

## 6.2 Strengths and weaknesses of the evidence base

For all these reasons, there are a number of questions which need to be addressed when considering the evidence base:

- Evidence – whose evidence?
- Evidence – which outcomes are being measured?
- Evidence – what are the strengths and weaknesses?
- Evidence – does it address quality of life issues?
- Evidence – does it address physical and mental health outcomes?

The literature on effectiveness is valuable in terms of identifying practical initiatives that can be included in Health Improvement Programmes. It can also guide the agreement of prevention priorities. For example, the strength of evidence on the value of cognitive behavioural therapy suggests that training in this area should take precedence over any further investment in generic counselling in primary care.

In designing the evaluation of activities, it is important to recognise that a range of evaluations can contribute to building the body of evidence to support mental health promotion, drawing on different disciplines and methodologies. Evidence should also be seen as a growing body of research that contributes to strengthening the case for mental health promotion. Measuring mental health promotion requires a range of methodologies and types of research that can capture the facets of mental health that are still being explored e.g. links between mental well-being and physical health.

## 6.3 Questions to ask about data sources

When trying to assess the value of data sources, there are a number of questions that will help to identify how reliable the sources are and how they can be used. It is helpful to consider similar studies and methods when considering data sources. To avoid the reinvention of the wheel it will be necessary to consider how useful the findings of other research has been. For example continued investment into surveys on public attitudes has been questioned, when the current data on attitudes does not marry with the experiences of mental health service users (see points 1.2.1 & 1.2.2). It may be time to consider a different approach to data collection and sourcing to measure knowledge, attitudes and behaviour.

Survey results can be useful for presenting the extent of a problem. However, many agencies use surveys to publicise the interests of their client group. The size of the sample, how it was constructed (particularly if self-selected), and the response rate are aspects of the survey that need to be considered when interpreting the results.

Translating the implications of surveys from national to local level also requires care. If there is local data available that can be used to verify some national trends, this obviously strengthens the argument. Broad social trends identified should also be analysed in terms of specific groups e.g. age, gender, ethnicity.

Although there is widespread acceptance that certain socio-economic conditions are linked to higher rates of ill-health, the causal relationships are complex. How these relationships are explored will give some indication of how much value can be placed on the results of research or at least what caveats need to be made in using the results.

“Futures” work is being used increasingly as a planning and strategy development tool. Future scenarios are based on a series of assumptions that are often extrapolations of existing trends. They are strongly influenced by the values of the agencies and individuals involved in generating the scenarios. It is important to try and establish what some of the basic assumptions are, so that these can be made more explicit when used for planning purposes.

The questions set out overleaf will help to explore some of the data sources available. They can also help in the design of evaluations.

### 6.3.1 Surveys

- What were the motives of the agency commissioning the survey?
- Was the agency working directly with the community / interest group that was the subject of the survey or was a research agency used?
- What was the purpose of the survey - publicity or to contribute to a body of research?
- Has this type of survey been completed previously?
- Has this survey been piloted?
- How was the survey conducted – postal, telephone, face to face?
- How was the sample constructed?
- What was the size of the sample?
- Were the subjects random or self-selected?
- What was the response rate?
- What types of questions were asked – open ended, closed or mixed?
- Were analyses made of specific population / interest groups e.g. age, gender.

### 6.3.2 *Costs*

What was the methodology used? For example:

- Economic costs – days lost through stress at work, social security payments to those with mental health problems?
- Social costs – break-up of families, schools dealing with distressed children.
- Fiscal costs – psychotropic drugs bill, costs of maintaining mental health services.

Can local data be obtained?

### 6.3.3 *Socio-Economic Factors*

- How have the causes of ill-health been explored?
- Does the study examine more than one cause of ill-health?
- Does it consider how several causes inter-relate?

### 6.3.4 *Futures*

- Which agency was involved in developing the future scenarios?
- How were the scenarios generated?
- What assumptions have been made?



# Examples of evidence based interventions

## 7.0 Introduction

This chapter includes examples of interventions for which there is a reasonably robust evidence base. Where there is a limited literature or findings of special interest, more detail has been provided, e.g. the section on improving the urban environment.

The current evidence base is not the last word on effectiveness. Mental health promotion has traditionally been under-resourced and many local initiatives have not been evaluated and/or results of evaluation have not been published in peer reviewed journals. As local strategies are developed, it will be important to achieve a balance between investment in approaches known to be effective and funding pioneering and innovative work which will in turn contribute to the evidence base. Appendix Four gives some examples of how new projects can build on what is currently known about effective practice, but also break new ground.

## 7.1 Effective interventions

A good starting point for identifying effective interventions is the recent collection of systematic reviews relevant to implementing the wider public health agenda, published by the Cochrane and Campbell Collaboration (Contributors to the Cochrane Collaboration 2000). This takes *Our Healthier Nation* as a starting point for identifying what individuals, communities and government can contribute to improving mental health (it also has sections on the other priority areas, cancer, coronary heart disease and accidents). Many projects exploring new ways of working have been developed within Health Action Zones and are currently being evaluated. HAZnet includes a database of local evaluation projects. There is a specific section for mental health, with details of local initiatives and a message board, to facilitate networking. ([www.haznet.org.uk](http://www.haznet.org.uk))

Other sources of evidence include:

- Cochrane Database of Systematic Reviews (CDSR),
- Database of Abstracts of Reviews of Effectiveness (DARE) available on [www.york.ac.uk/inst/crd](http://www.york.ac.uk/inst/crd)
- Health Technology Assessment Database
- A national register of research in progress is also available from the Department of Health ([www.doh.gov.uk/research/nrr.htm](http://www.doh.gov.uk/research/nrr.htm) )

The following summary is drawn from a range of sources and includes different strengths of evidence. It is not a complete guide to the literature on effectiveness, but aims to give practitioners an indication of what works at different levels and in a range of settings. Assigning levels and settings is not an exact science: for example a workplace intervention may also have an impact on the community and interventions targetting individuals may have important implications for policy.

***Setting: home***  
***Level of action: individual***  
**Improving mental health of mothers**

(Evidence Grade I/II) Early support during pregnancy for mothers in difficult social and economic circumstances has been shown to have a positive impact on birth weight as well as family relationships. Professional emotional support for pregnant women caring for their existing children can decrease the rate of post-natal depression and very young mothers can also be helped to cope better, reducing the risk of depression and family problems. Support from non-professionals e.g. an experienced mother living in the community can also reduce depression and improve parenting skills. Trained lay support during childbirth also improves mental well-being and reduces anxiety/depression. (Ray & Hodnett 1998; Durlak 1997; Johnson et al 1993; Hodnett 2000; Scott et al 1999)

***Setting: workplace***  
***Level of action: individual***  
**Reducing the social exclusion of people with long term mental health problems**

(Evidence Grade I) Supported employment within a normal working environment is more effective in improving employment prospects than sheltered workshops or pre-vocational training. (Crowther et al 2000) Pre-placement training reduces the likelihood of people with long term mental health problems gaining competitive employment. (Bond et al 1997)

**Setting: workplace**

**Level of action: structural**

**Reducing stress and improving mental health in the workplace**

(Evidence Grade I) Systemic, organisation-wide approaches are most effective and should include support for staff, effective two way communications, enhanced job control, increased staff involvement and improved working environment. (Williams et al 1998)

**Setting: school**

**Level of action: individual/community/structural**

**Promoting mental health in schools**

(Evidence Grade I/II/III) Interventions that focus on problem solving, social skills and negotiating skills appear to be more effective than topic based approaches, which tend to change knowledge and attitudes, rather than behaviour. Peer led programmes may have a greater impact on behaviour than more traditional approaches. (Durlak 1997; Tobler 1999)

There is some evidence to support the health promoting schools approach (Evidence Grade 1 Lister-Sharp et al 1999). Approaches that combine changes to the school culture, environment and family/community involvement are most effective, notably in influencing mental and social well-being. Health promoting schools initiatives should include a focus on the health and well-being of school staff.

**Setting: school**

**Level of action: community/structural**

**Reducing social disorder, criminal behaviour, anxiety, depression and suicidal behaviour in young adults**

(Evidence Grade III/IV) The Olweus study showed that being a bully or a victim of bullying is a predictor for later problems, including conduct disorders, crime, alcohol abuse (bullies) and depression, anxiety and suicidal behaviour (victims). There is therefore a strong case for including the basics of the Olweus anti bullying strategy as a key intervention for assisting the transition to adulthood. These include zero tolerance for bullying – every child has a right to be safe at school – a period of consultation and training which enables parents, teachers, school governors and the wider community to sign up to the principles of anti-bullying – clearly understood strategies for reporting and acting on bullying incidents. (Olweus 1993)

**Setting: primary care**  
**Level of action: individual**  
**Counselling in Primary Care settings**

(Evidence Grade II) Psychological therapy (cognitive behavioural therapy and non-directive counselling) is more effective in treating depression than usual general practitioner care in the short term, but after one year there is no difference in outcome. (Ward, King et al 2000) There is no evidence that psychological therapies are more cost effective in the long term.

**Setting: primary care**  
**Level of action: individual**  
**Reducing alcohol consumption**

(Evidence Grade I) Brief interventions in primary care (including taking an alcohol history and providing information and advice) are effective in reducing alcohol consumption in people drinking above the recommended levels. Routine or opportunistic screening for alcohol problems in A&E departments should be followed by a brief intervention. (Ashenden et al 1997; Peters et al 1998)

**Setting: primary care**  
**Level of action: individual**  
**Reducing the risk of depression in unemployed people**

(Evidence Grade I) Group cognitive behavioural therapy is effective in improving mental health and employment outcomes in unemployed adults. Interventions with a strong focus on job search self-efficacy, social and emotional coping skills and building social support are effective. (Price et al 1992) This approach also focusses on finding pleasant activities and improving social networks. A number of studies demonstrate the value of social support in mitigating the impact of stressful life events, including unemployment. (Bloom 1985; Whelan 1993)

**Setting: health services**

**Level of action: structural**

**Improving the mental health impact of health services**

(Evidence Grade V) Price (1998) suggests a strong case for a primary care led audit of current medical care practices to identify treatment policies and practices that may produce adverse mental health effects. This could be extended to include those aspects of service provision which create stress and could be linked to user consultation. Enhancing perceived personal control is a model that has evaluated positively. (Tadmor 1988; Tadmor et al 1998)

**Setting: mental health services/primary care**

**Level of action: individual**

**Improving the physical health of people using mental health services**

(Evidence Grade V) People with mental health problems have high rates of coronary heart disease and other physical health problems and an increased risk of premature death from both natural and unnatural causes. (Harris and Barraclough 1998) People with long term mental health problems are at greatly increased risk for HIV infection. Rejection, fear of rejection and consequent social withdrawal can intensify and lengthen periods of mental ill-health. (Sayce and Morris 1999; Link et al 1997)

Existing health promotion information should be provided in a way that is accessible to users and carers, and makes clear its importance and relevance for people with mental health problems. Information packs and directories of sources of national and local support for people with mental health problems should be informed by mental health promotion evidence for the value of creative, sporting and leisure activities.

**Setting: primary care/neighbourhood**

**Level of action: individual**

**Reducing marital breakdown and risk of depression**

(Evidence Grade III) In four and five year follow up, increasing communication and problem-solving skills reduced marital breakup in participants. The key emphasis was on modifying known risk factors for relationship problems, notably poor communications and problem-solving skills. (Markman et al 1988 and 1993)

Increasing coping skills can also reduce the risk of depression in people at risk as a result of divorce or marital breakdown. (Bloom et al 1985)

**Setting: neighbourhood**

**Level of action: individual/community**

**Arts and creativity**

(Evidence Grade IV/V) In a review of 60 community based arts projects, Matarasso found that participation in these projects brought a wide range of social benefits, including increased confidence, community empowerment, self-determination, improved local image and identity and greater social cohesion. (Matarasso 1997)

A review of good practice in community based arts projects suggested that arts projects can make a unique contribution to enhancing well-being and self-esteem. (Health Education Authority 2000)

**Setting: neighbourhood**

**Level of action: individual**

**Reducing stress**

(Evidence Grade II) Large-scale stress workshops were used as part of a Healthy Cities Programme in Birmingham. The workshops covered the physical, cognitive and behavioural aspects of anxiety and stress and offered a wide range of options for managing stress. In a three-month follow up, participants were less anxious, less distressed and more able to cope than those in control and placebo groups. The workshops, open to anyone, were successful in reaching and helping people whose problems are not picked up in primary care. (Brown and Cochrane 1999; Brown et al 2000)

**Setting: primary care/neighbourhoods**

**Level of action: individual**

**Exercise**

(Evidence Grade III) Evaluation of the Balance for Life scheme in Essex found that the 10 week programme of exercise significantly reduced depression and anxiety, increased overall quality of life and self-efficacy for exercise. 68% of clinically depressed patients had depression scores that became non-clinical within three months. (Darbishire and Glenister 1998)

(Evidence Grade I) Regular exercise improves cognitive functioning, reduces mental health problems and improves mental health of older people. (Etnier et al 1997)

(Evidence Grade I-V) The National Consensus Statements on physical activity and mental health (Grant ed. 2000) show that exercise prevents clinical depression and is as effective in treatment as other psychotherapeutic interventions. Exercise also reduces anxiety, enhances mood and improves self-esteem.

**Setting: primary care/neighbourhood**

**Level of action: individual**

**Support networks/self-help**

(Evidence Grade III/IV) Good personal support networks, for example friendship or a confiding relationship, protect mental health and enable people to recover from stressful life events like bereavement or financial problems.

Interventions include the promotion of self-help, advocacy, neighbourhood and voluntary activities, as well as structures that facilitate community planning and local decision making in the provision of services.

Self-help support e.g. basic psycho-social information, relaxation advice plus referral for self-help or to a self-help group is as effective as cognitive therapy and medication in treating generalised anxiety disorders. (Cuijpers 1997)

Active participation in user groups has a wide range of benefits.  
(Barnes and Shardlow 1997; Stark 1998; Whelan 1993; Rosengren et al 1993)

**Setting: neighbourhood**

**Level of action: structural**

**Improving the urban environment to reduce mental health problems**

Lewis and Booth found that while those living in rural areas had a much lower prevalence of mental disorder, people living in built up areas with access to gardens or green, open spaces had a lower prevalence than people in built up areas with no such access. (Lewis and Booth 1994; see also Halpern 1995)

(Evidence Grade III) Other evidence shows that improving the urban environment leads to reductions in overall psychiatric morbidity. Dalgard and Tambs, for example, challenge the view that the quality and proximity of social support is the key factor influencing mental health and argue that changes in the environment are more significant. Unfortunately, their research does not identify the specific significance of individual environmental changes, so it is not possible to assess whether parks and green, open spaces had a greater impact on mental well-being than other environmental improvements e.g. transport, reduction in graffiti. (Leighton 1965; Dalgard and Tambs 1997)

A national survey on public attitudes undertaken in 1995 demonstrated that nine in ten people value the countryside and that there is a very strong desire both for greater opportunities to access rural areas and for more green, open spaces in urban areas. (Countryside Commission, 1997) The most important benefit from visiting the countryside was the sense of relaxation and well-being. Fresh air and peace and quiet were also valued.

Generally, the health of people living in rural areas is better than that of people in urban areas. (Watt et al 1994) Urban residence is associated with a higher prevalence of neurotic disorders and those living in built up areas have a much higher prevalence of psychiatric morbidity, alcohol and drug dependence. (Paykel et al 2000) In the OPCS psychiatric morbidity survey, people from urban backgrounds were more likely to suffer from depression, anxiety and phobias.

Aspects of the physical environment which impact on mental well-being include:

- high population density: stress, anxiety, aggression, increased sense of physical and emotional vulnerability (Freeman 1984, Brain 1984)
- noise: stress, anxiety (Tarnopolsky and Clark 1984)
- information/stimulus overload: stress, anxiety (Freeman 1984)

Indicators of mental well-being, for example trust, tolerance, participation and feelings of safety, are directly influenced by environmental factors, notably population density. For example, the probability of helping a stranger is inversely related to the level of environmental stimulation, which includes density of pedestrians and motor traffic. (Freeman 1984) In 1980 Monahan & Vaux found that noise decreases the sense of connection between people and decreases the probability that people will help each other.

**Setting:neighbourhood**  
**Level of action: individual**

**Improving mental well-being in older people and reducing depression**

(Evidence Grade I) Providing opportunities for older people to do voluntary work increases mental well-being in those who volunteer and also reduces depression in older people who receive services from an older volunteer e.g. visits, peer counselling. (Wheeler et al 1998)

**Setting: school, neighbourhood, mental health services**  
**Level of action: individual/community/structural**

**Religious belief**

(Evidence Grade I) Systematic reviews have consistently found that religious involvement is associated with positive mental health outcomes (Ellison & Levin 1998).

(Evidence Grade V )A growing number of studies also emphasise the importance of spiritual beliefs and the value of support from faith communities for people with mental health problems (Rose 1996; Mental Health Foundation 2000). Other studies have found a resistance to spiritual issues within mental health services, where religious beliefs are sometimes interpreted as symptoms of illness. (Copssey 1997; Asian Health Development Project 2000; Clay 1999)

A number of faith communities across all denominations are centrally engaged in addressing the stigma surrounding mental health problems that has been commonplace in many different religions.(Friedli 2000). Recognition of how common mental health problems are, and the extent of the shared experience of mental distress within a congregation, can provide a strong foundation from which to explore the meaning and value of mental health promotion within the expression of religious faith. (HEA 1999; Friedli 2000) Some professionals working in the field of community development have also called for a greater emphasis on the significance of personal spirituality, which exists outside conventional faith communities. (Raeburn 2000; Pransky 1991)



# Applying the evidence - The health and social impact of interventions

Looking at the health and social impacts of interventions in different settings allows policymakers and practitioners to use existing evidence to project long term outcomes. An International Union for Health Promotion and Education study (IUHPE, 1999) brought together evidence of the effectiveness of mental health promotion and analysed it in terms of which protective factors it strengthened and what the long term health and social impact was of each intervention. Some key examples are set out below.

**Figure 8:1 The health and social impact of mental health promotion interventions**  
 Source: The evidence of health promotion effectiveness, IUHPE 1999

Home						
Setting	Programme	Target Group	Type of Research	Protective Factors	Impact - health	Impact / social and economic
Home	Child development programme (Barker, Anderson and Chalmers, 1992)	First time parents, parenting problems	Quasi-experimental design	Self-esteem, self control, parenting, social support	50% lower child abuse	41% lower rate in the child protection register
	Pre-natal infancy project (Olds, 1988, 1986)	First time mothers, early pregnancy	Experimental Design (RCT): Experimental comparison and control group	Social support, child rearing, health behaviours	Decrease in low birth weight, 75% smoking reduction in mothers and improved diet, decrease in child abuse and neglect 19%-4%	56% less use of the A&E department, fewer pregnancies, fewer pre-term deliveries (75%)

School						
Setting	Programme	Target Group	Type of Research	Protective Factors	Impact - health	Impact / social and economic
School	STAR: Students together and resourceful (Emshof, 1990)	Children (11-14) with substance abusing backgrounds	Experimental design RCT): Experimental control group	Relationship skills, school performance	Changes in perception of internal control, self-concept, decrease in depression and loneliness, lower levels of substance abuse	Changes in perception of internal control, self-concept, decrease in depression and loneliness, lower levels of substance abuse
	STEP: School transition environmental programme (Felner and Adan, 1988)	Entering ninth grade students, minority background	Experimental design: matched control sample	Peer support system, maintaining levels of functioning	Fewer increases in emotional and behavioural dysfunction	Fewer increases in emotional and behavioural dysfunction

Workplace						
Setting	Programme	Target Group	Type of Research	Protective Factors	Impact - health	Impact / social
Workplace	CSP: Caregiver, support programme (Hearney et al, 1995)	Care staff and home managers who provide residential care to the mentally ill	Experimental design (RCT): experimental control group	Individual skills, social support, problem solving, influencing decisions	Confidence in coping abilities. Less depressive symptoms and somatisation in high risk participants	Improved work team climate, increased resources of social support

Community						
Setting	Programme	Target Group	Type of Research	Protective Factors	Impact - health	Impact / social
Community	Jobs programme (Price et al, 1992)	Involuntary job loss, low assertiveness, economic hardship, unemployed, depressive symptoms	Experimental design (RCT): experimental/control group	Job searching skills, social support, positive attitudes	More job satisfaction & motivation, higher self-esteem & job seeking confidence, decreases in depression (39-25%)	Finding jobs more quickly and better jobs, stability and income
	Coping with stress course (Clarke et al, 1995)	Adolescents at high risk for depression, depressive symptoms	Experimental design (RCT): experimental/control group	Social and coping skills	Decrease in incidence rates for depression	Cost analysis in current investigation

The IUHPE study provides a useful analysis of mental health promotion interventions that helped to strengthen some protective factors and also led to measurable changes in health and social factors. The interventions with parents and young children show the links between a short-term increase in protective factors and the health and social impact of the intervention.



# Applying the evidence - Community wide approaches

## 9.0 Introduction

As outlined in Chapter Three, a strategic approach to mental health promotion should aim to include a balance of:

- developing coping/life skills e.g. parenting, communication, negotiation
- promoting social support and networks e.g. tackling bullying, supporting bereaved families, facilitating self-help groups, increasing access to information and opportunities to participate
- addressing structural barriers to mental health in areas like education, employment, housing and income policy.

However, developing a strategic approach to mental health promotion at a community level may require a more creative use of the evidence base. This involves applying what is known about effectiveness at different levels, to inform community interventions. For example, the evidence on protective factors for individuals is strong. These provide a framework for planning mental health promotion interventions at a broader level, in schools or workplaces, for example, as well as at structural and policy levels.

Figure 9:1 illustrates the kind of action at a community and policy level that will support and enhance the mental health of individuals.

Take the 'positive step' for mental health of talking things through. At the individual level, we know that having a confiding relationship protects both mental and physical health. This can be developed at the wider, community level, by looking at opportunities for people to be heard, for example through self-help groups, accessible services, consultation, clearly understood complaints procedures and so on. At the policy level, this could involve measures to regenerate local democracy.

Thinking about evidence in this way can help in the design of new initiatives, which can then be evaluated and contribute to the development of a stronger mental health promotion evidence base.

**Figure 9:1 Projecting evidence from individual to community and organisational levels.**

<b>Protective factors</b>	<b>Individual intervention</b>	<b>Community</b>	<b>Policy/Organisation</b>
<b>Self esteem</b>	Child development programme/support for parenting	Characteristics of a community able to support individual interventions to develop protective factors:	Characteristics of institutions/policies that support individual interventions to develop protective factors:
<b>Talking things over</b>	Self-help groups, volunteering	<ul style="list-style-type: none"> <li>• Access to resources and services</li> </ul>	<ul style="list-style-type: none"> <li>• Income parity</li> </ul>
<b>Physical activity</b>	Prescription for Leisure, exercise	<ul style="list-style-type: none"> <li>• Support for parents</li> <li>• Activities that bring members of community together</li> </ul>	<ul style="list-style-type: none"> <li>• Workplace policies that promote job control, training and work/life balance</li> <li>• Funding and capacity building for local groups/initiatives</li> </ul>
<b>Learning new skills</b>	Jobs programme, Coping with stress course for adolescents, Community arts Cognitive therapy Prescription for learning	<ul style="list-style-type: none"> <li>• Effective sharing of local information</li> <li>• Tolerance and trust</li> </ul>	<ul style="list-style-type: none"> <li>• Environmental improvement: housing, transport, leisure</li> <li>• Effective consultation processes</li> </ul>
<b>Support networks</b>	Child development/ parenting classes, adult education, internet access	<ul style="list-style-type: none"> <li>• Friendly physical environment</li> <li>• Robust local democracy and opportunities to participate</li> </ul>	<ul style="list-style-type: none"> <li>• Equal opportunities/anti-discrimination legislation</li> </ul>
<b>Creativity</b>	Arts on Prescription		
<b>Participation</b>	Pre-school programme		
<b>Relaxing</b>	Stress workshops		
<b>Able to seek help</b>	Group for children with substance abusing parents. Helplines		

(Adapted from Jane Lethbridge)

## 9.1 Healthy Neighbourhoods

The Healthy Cities initiative has much to contribute when translating the implications of individual interventions into action at a community and policy level. The vision of a healthy city was an attempt to link the different aspects of city life that would contribute to promoting and maintaining health. Many of the dimensions contribute to the promotion of mental health, for example, supportive communities, participation of the population in decisions and good communications. This has been expanded in Australia to define a “healthy neighbourhood”, which highlights organisational settings that promote health as well as communities that value people and their beliefs. The characteristics of a healthy neighbourhood are:

- A healthy population
- A population with the knowledge, skills and resources to make choices that promote health
- Organisational settings within the community that promote the health of the community that they serve (e.g. workplaces, schools)
- A high quality natural environment – people have access to a safe water supply, clean air, open space and low levels of contamination
- A health promoting man-made environment – houses and neighbourhoods appropriate to people’s needs, where they can live safely and access community services
- A social, economic and political environment that promotes health – people live in communities that value them and their beliefs and have access to employment opportunities and to processes that allow them to participate in the decisions that will affect their lives.

(Source: Harris and Wills, 1997)



### 10.0 Introduction

There is increasing recognition of the importance of evaluation and the need to build evaluation into the design of individual interventions and any overall strategy for delivering mental health promotion. Most evaluations will benefit from early input and assistance from researchers, health professionals, public health departments or community/voluntary agencies with specific experience of evaluating projects. They can start by identifying local sources of data which can be used to help measure effectiveness.

Sources of local data include:

- The annual reports of the Director of Public Health
- Data from public health observatories
- Health Improvement Programmes (HIMPs) and other local plans
- Local authority data sets
- Socio-economic data from census
- Regional data
- Local data
- Neighbourhood statistics.

Designing an evaluation for complex interventions, which include many different components is particularly challenging. Examples include

- a family centre offering activities for children, advice on benefits, a credit union and a fruit and vegetable scheme
- a community safety project which includes improvements to street lighting, neighbourhood watch and crime prevention awareness
- an environmental project including building a community garden, activities to reduce graffiti and a horticultural training scheme for young people with learning disabilities.

## 10.1 Monitoring

Once the project plan is completed with clear aims and objectives, it is important to outline how progress towards goals will be monitored and how this monitoring will fit into the final evaluation of the programme. Local targets can be set and time-limited to ensure that all agencies involved in delivering are working towards the same goals and monitoring the same outcomes. There is an urgent need for greater collaboration and partnership on evaluation across professional and sector boundaries and new strategies for involving those who use services in the design of evaluation frameworks.

## 10.2 Indicators

Indicators are measures to ensure that aims and objectives are being met. Indicators may be:

- **input**        measures of resources and action.  
Examples include - identifying goals, funds and research to support the programme.
- **process**     measures of implementation defined in the project plan.  
Examples include - multi-disciplinary planning, effective consultation and the number of sessions/events held.
- **output**       measures of the immediate impact of the programme.  
Examples include - number of individuals attending events, receiving resources.
- **outcome**    measures the extent to which the original objectives have been achieved  
Examples include - increases in self esteem, social networks and social support, reduction in rates of anxiety, depression or substance misuse.

### Checklist for setting local indicators

- Define target/problem/standard or criteria
- Establish aim and objectives
- Define roles & responsibilities for meeting targets and objectives
- Define delivery of the intervention
- Set a time frame for the intervention and for the broader programme
- Assess availability & quality of data - review evidence to date and its collection

- Devise a monitoring system to collect data and decide on the form to be used
- Set baseline or reference to standardise indicators and targets
- Test indicator or pilot data collection

(Adapted from the Health Development Agency 2000)

The following notes provide some basic information which may be helpful for planning local activities e.g. around World Mental Health Day. They can be freely photocopied.

### **Evaluation**

At the start of a project or piece of work, you will need to think about:

- What is needed from the activity by those intended to use it
- How will the activity meet those needs
- How you will tell if it does meet those needs
- Evaluation needs to be built into project plans from the outset, and your method needs to be chosen to suit the work being evaluated.

### **Four steps to evaluation**

Having a clear evaluation plan will help you to:

- Create a realistic timetable
- Determine what information you need and from whom
- Identify methods for collecting information
- Spot problem areas and make changes as you go
- Assess success, both expected and unexpected
- Use all the results in a constructive way

Evaluation can be split into four steps:

1. **Setting aims and objectives**  
Identifying the aims of what you are doing and the objectives you are working towards
2. **Identifying evaluation indicators**  
Identifying the indicators you will use to show progress towards your aims and objectives
3. **Choosing an evaluation method**  
Outlining how you will collect the indicator information, who will do it, how often, and how it will be analysed

4. Dissemination and action  
Describing what you will do with what you find out

### **Setting aims and objectives**

An *aim* is a broad strategic purpose of a project or activity. For example, ‘To involve local Bangladeshi youth in planning resources for young people with the aim of empowering and increasing self esteem and improving health amongst a currently marginalised group.’

An *objective* is a more specific goal, whose achievement will contribute to the overall aim. For example, ‘To establish a youth drama club in the community centre’.

It is important to ensure that members of the community for whom a project or activity is targeted have an opportunity to help shape aims and objectives. This should include those who may previously have not had a voice such as young people, mental health service users, people in poverty, the homeless, as well as local residents.

### **Identifying evaluation indicators**

There are usually a number of different aspects of an event that you can pinpoint that will give a good indication of what was achieved and these are sometimes referred to as indicators. Exactly what information you want from your evaluation will depend on the nature of your event or activity and what you are hoping to achieve. Many of the indicators will be relatively straightforward and easy to collect and record:

- How many people attended an event
- Who attended (age, sex, where they live, ethnic origin)
- How they knew of the event
- What publicity was achieved
- Was any funding secured
- Number of calls to a helpline (and changes over time)
- How many materials were distributed and to whom

Rather more imagination may be needed to devise appropriate indicators to evaluate what effect your event had. The starting point for this is to have a clear view of what the event intended to achieve. In general, it is easier to plan an evaluation when very specific objectives have been established at the outset.

Examples of specific objectives and indicators for a World Mental Health Day (WMHD) evaluation are:

- To organise an event that those in the target audience will enjoy  
*Did the people who attended enjoy the event?*
- To communicate that everyone can take positive steps to improve their mental well being  
*Are people able to name one or more positive steps they could take to look after their mental well being?*
- To publicise positive images of people experiencing a mental health problem through the local press  
*Has press coverage been positive?*
- To raise awareness of sources of help for people experiencing mental distress  
*Are people who attended the event aware of new sources of help?*

You might also want to keep a record of other practical details, which are all potential evidence that your event was well conceived and carefully planned, for example:

- Who was consulted at the planning stage
- What other groups were involved in organising the event
- What materials were developed
- What the event 'cost' in terms of time, money and other resources. (For example, for publicity, hire of venue, refreshments, materials, etc.)

### **Choosing an evaluation method**

There are many approaches and techniques that can be used in evaluation. As a general principle, it helps to give a quick background to why you are evaluating and what your objectives are, to encourage people to take part. Keep questions simple and to the point. Give some thought to how you are going to analyse the results.

The examples below do not represent a definitive list but they may provide a useful starting point:

#### **Observation**

This can provide a lot of information. Plan how you will record your observations, for example on paper, by commentating into a small tape-recorder, or by video. Be clear at the outset what in particular you will be observing, for example:

- Number of people attending
- Broad demographic details such as age and gender
- Which stalls are most popular
- Busy times and quiet times

### Questionnaire

This can be used to collect a relatively large amount of information in a short time. Start with a list of topics you want to know about and then decide the best way to ask about each.

- ‘Closed questions’ have pre-determined responses to choose from, are easier to analyse and provide quantitative data, for example:

Was the atmosphere (tick one)

Welcoming

Off-putting

- ‘Open questions’ have no pre-determined responses, collect qualitative data and are more difficult to analyse, for example:

How did you find the atmosphere?

- Self-completion questionnaires.  
This approach relies on individuals filling in a questionnaire themselves. They can be handed out at an event or posted, including a postage-paid return envelope to encourage return. Response rates are often low, and it may be worth offering an incentive to people to return a questionnaire (entry in a prize draw or raffle, for example).
- Pre- and post- event questionnaire  
With some groups it may be appropriate to collect data both before and after the planned event. This could, for example, provide an excellent way of identifying changes in knowledge or attitudes that could be attributed to your event.
- Telephone interviews  
You could telephone your sample and ask them questions over the phone.
- Exit interviews  
Prepare a short questionnaire or list of questions and stop people as they leave an event or service.

- **Qualitative interviews and focus groups**  
Interviews are usually one-to-one between the researcher and the participant.  
Focus groups involve a group of people, facilitated by someone who can guide the discussion to cover key topics. Both can provide useful information and understanding of how people benefited from an event and what they felt were the strengths and weaknesses. Think in advance about how many interviews you want to complete and how you will select the participants.

### **Dissemination and action**

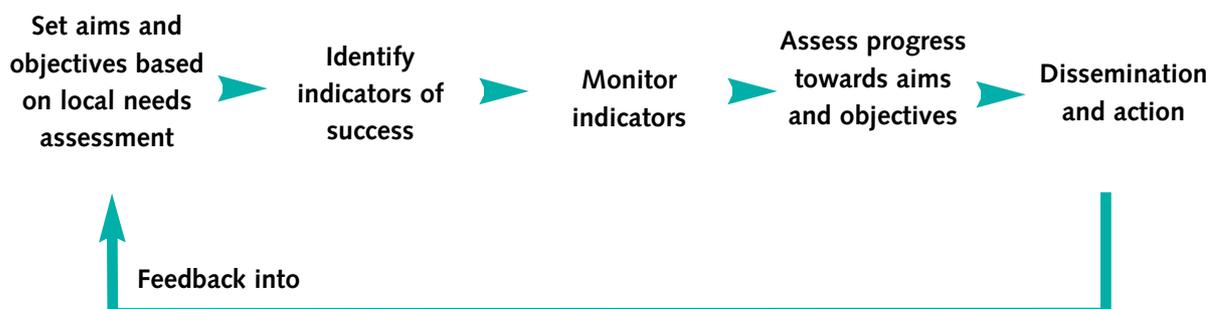
Evaluation is only useful if you do something with the results. There may be opportunities to publicise your findings. You could provide feedback to those who were involved with your event, for example through a newsletter. Other groups are often keen to know about events that have worked. Being able to point to a successful event may help to attract funding in the future.

If results are disappointing, then, hopefully, the evaluation will help to explain why. Useful pointers may emerge from the evaluation so that even if the event itself was disappointing, some benefits (in terms of lessons learned) will be gained. It is just as important to know what does not work, in order to refine work and plan future directions.

If work is on-going, you need to think about what the findings mean for the project, considering such questions as:

- What worked best?
- What does not seem to be working?
- Which partnerships work well and whom else could we work with?
- What changes or additions should we make?
- How might we tackle these and within what timescale?
- How can we improve our evaluation methods?

This will bring you back full circle to the start:



### **Collecting information on responses to posters and leaflets**

Written questionnaires are often used to get feedback on events, but getting people's responses to posters and leaflets can be achieved more effectively through one to one interviews or groups. Interviews and groups do not need to be facilitated by professional researchers. They can take many different forms and can take place in all settings. The following list provides a guide to some of the questions that can be asked to prompt discussion or invite a response. The aim is to collect information which records different reactions or lack of reaction to resources which might be used as part of a local initiative.

#### **What to record**

It is helpful to have the following information about respondents:

- Age
- Gender
- Ethnic identity

People should not be asked for names, addresses or any other information which might compromise confidentiality. Such details are completely unnecessary for this kind of evaluation. Where groups of people agree to talk about their response, the group may be happy to be described e.g. user group, office workers, young carers etc. This information will help to establish whether the resources work better for some groups than others, some age groups than others etc.

#### **Responses to poster images**

- Would you read this poster?
- Who is this poster for/who do you think it is aimed at?
- Is it interesting/eye catching?
- What do you think the poster is saying/does it have a message?
- What is your reaction to the message?
- How do you feel about what the poster is saying?

#### **Responses to case studies**

- What do you think about Jane/Joe/Meera's story?
- What is your response to his/her experiences?
- Do you think he/she is a real person?
- Do you care what happens to him/her?

### Responses to leaflets

- Would you pick this leaflet up?
- Who is the leaflet for?
- What is the leaflet about?
- Is it easy to understand?
- Is it useful?
- Would you keep it?
- Could it be improved/be made more useful?
- Would you like more information about mental health?
- If so, what?

### Further useful reading

An evaluation resource for healthy living centres, Jane Meyrick and Paige Sinkler, HEA 1999.

Much of the information included in this section on planning and evaluation is based on material in the above document. We would also like to acknowledge material produced by Mary Hainge for World Mental Health Day 1998.



# Mental health promotion models and frameworks

## West Midlands Regional Framework

This framework uses a settings approach and a model of mental health developed by McDonald and O'Hara 1998.

### **The Rationale for a Settings Approach.**

The inter-relationship between social, environmental and political influences, and their effect on individual and community health, is increasingly being recognised. As a result mental health promotion requires a co-ordinated approach, bridging these boundaries, directed at specific settings where problems arise, aimed at improving the health of whole communities.

The scope of Standard One is huge. It steps outside the age limits of the other NSF standards and includes children and the elderly in all environments. To be effective it requires the co-operation of many agencies and individuals. A settings approach allows for this effort to be more focused.

The Sainsbury Centre for Mental Health (1999) recognises that carrying out this task provides a major challenge. They point out that no organisation (particularly the NHS) is able to meet it alone. It has to become the responsibility of a wide range of agencies: statutory, private and voluntary. Mental health promotion has to become part of their agendas at a very senior level. Achieving this will necessitate addressing the cultural, political and practical barriers that impede cross agency working.

A settings approach can help tackle these issues by:

- Breaking the task down into more manageable chunks.
- Identifying particular health focus areas and interested groups to plan and implement action.
- Focussing skills and expertise.
- Creating links between different agencies concerned in the field.
- Creating a specific database of relevant research, experience, opportunities and barriers.

It is implicit that there will be overlaps between the different settings and a strategic overview has to be maintained to ensure co-ordinated planning and action. It is clear however that the settings approach can take account of whole populations, individuals at risk, vulnerable groups and people with mental health problems.

The knowledge base in each setting is variable and this approach provides a practical framework to focus further investigation and practice.

The map of '**Ten elements of mental health promotion and demotion**' (**Figure A1:1**) has been developed from well accepted empirical research (Albee and Ryan Finn, 1993), as well as a careful analysis of what ordinary people understand by the phrase 'mental health'. It was developed by the Society of Health Education and Promotion Specialists (SHEPS) (for more detail see MacDonald and O'Hara, 1998).

This model identifies five elements that promote mental health and another five that undermine it. Improvements are made by strengthening those factors lying above the dotted line in the illustration, and reducing the influence of those below. The best results are obtained by attending to both sets simultaneously.

Another important feature is the emphasis on three levels of action beyond the personal level:

Micro - the individual

Meso – groupings such as the family, workplace, peer groups, community groups and small neighbourhoods.

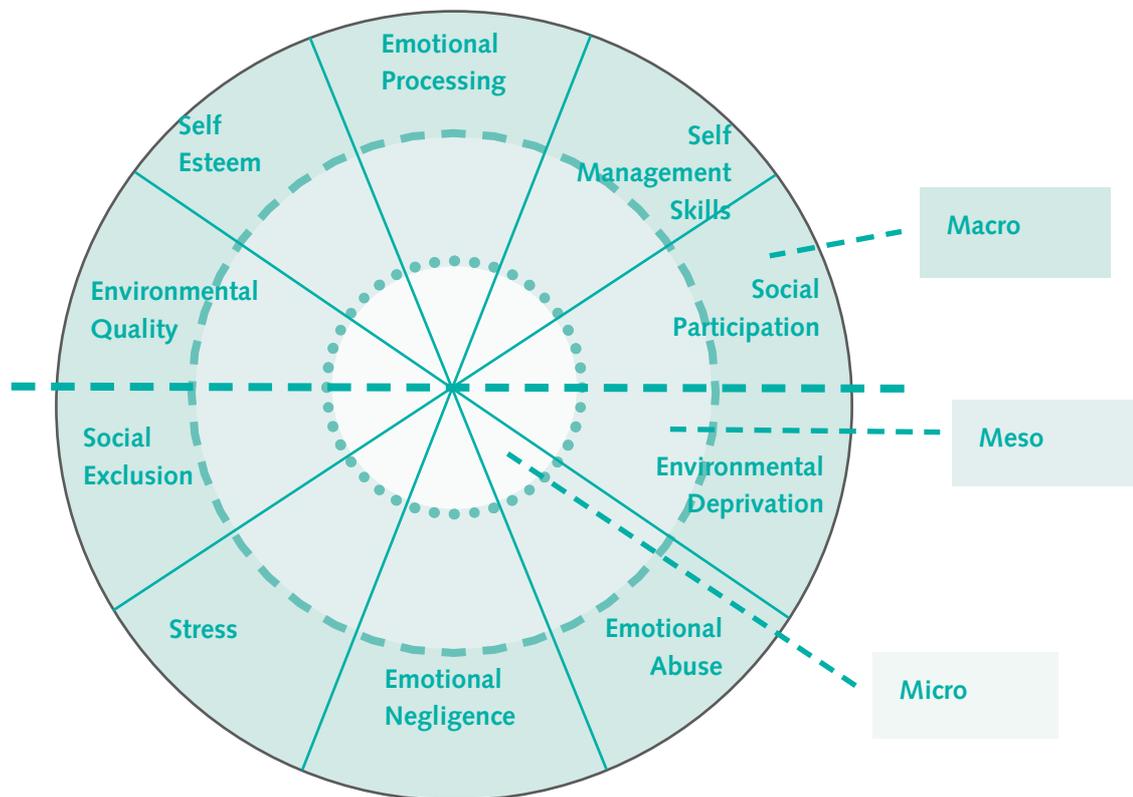
Macro – wider, larger systems that govern and shape many aspects of our lives such as government (local and national), large and influential companies and organisations like formal religions.

At the **micro**-level mental health promotion aims to increase each person's ability to manage their own health, build their self-esteem, gain trusting and supportive friendships, and advance their ability to influence decision making in the communities in which they work and live. However this cannot be carried out in isolation and action has also to occur in the wider system. This begins to improve the environment in which people live. Changes at the **meso**-level begin to re-inforce the way that people can co-operate to improve their lives. Tackling bullying in the work place improves everyone's sense of worth, improves output, and begins to demonstrate that working together is effective. All this effort has to be sustained and supported by government, and international, policy at the **macro**-level. Mental health promotion needs to demonstrate its

value so that measures are taken to support it. These may include company policies on bullying, anti-discrimination legislation from government, rethinking housing strategies, and involvement in urban regeneration.

The recognition of spheres of influence beyond the individual, and of factors undermining mental health, fits in with an increasing range of evidence and argument that is shifting health promotion away from working solely with the individual to a greater emphasis on the social and structural.

Figure A1:1 A map of the ten elements of mental health promotion and demotion



## The Public Mental Health Model

This model was developed by the Scottish Development Centre for Mental Health Services, as part of a Public Mental Health Project. Further information is available on [www.sdcformhs.org.uk](http://www.sdcformhs.org.uk)

	YOUNGER age	OLDER age	
<b>LEARNING</b>	<ul style="list-style-type: none"> <li>• Emotional intelligence</li> <li>• Parenting skills</li> <li>• Self-confidence</li> <li>• Ability to make positive life choices</li> <li>• Finding and nurturing the inner voice</li> </ul>	<ul style="list-style-type: none"> <li>• Ability to make, maintain and break relationships</li> <li>• Finding expression for the inner voice</li> </ul>	<ul style="list-style-type: none"> <li>• Wisdom</li> <li>• Lifelong learning</li> <li>• Letting go</li> </ul>
<b>WORK</b>	<ul style="list-style-type: none"> <li>• Interpersonal skills</li> <li>• Communication skills</li> <li>• Networking skills</li> <li>• Business skills</li> </ul>	<ul style="list-style-type: none"> <li>• Meaningful work opportunities</li> <li>• Freedom from discrimination, poor working conditions and low pay</li> </ul>	<ul style="list-style-type: none"> <li>• Active third age</li> <li>• Rethinking “retirement”</li> </ul>
<b>PHYSICAL ENVIRONMENT</b>	<ul style="list-style-type: none"> <li>• High quality housing</li> <li>• Safe streets</li> <li>• Safe play</li> </ul>	<ul style="list-style-type: none"> <li>• Opportunities for peace and quiet</li> <li>• Connection with nature</li> <li>• Sensitive architecture and design</li> </ul>	<ul style="list-style-type: none"> <li>• Accessible services</li> <li>• Transport</li> </ul>
<b>PSYCHO-SOCIAL ENVIRONMENT</b>	<ul style="list-style-type: none"> <li>• Positive early relationships</li> <li>• Respect for self and others</li> <li>• Safe and nurturing community</li> </ul>	<ul style="list-style-type: none"> <li>• Family cohesion</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive social networks</li> <li>• Tackling stigma</li> </ul>
<b>CITIZENSHIP</b>	<ul style="list-style-type: none"> <li>• Active engagement</li> <li>• Participation</li> </ul>	<ul style="list-style-type: none"> <li>• Societal validation</li> <li>• Supportive political structure</li> </ul>	<ul style="list-style-type: none"> <li>• Active involvement</li> <li>• Volunteering</li> </ul>
<b>CARE AND TREATMENT</b>	<ul style="list-style-type: none"> <li>• Health visiting, school health services</li> <li>• Family, group and individual therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Self-help groups</li> <li>• Retreats</li> <li>• Community based therapeutic programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Ageing Well programme</li> <li>• Equity of access</li> </ul>

Source: Public Mental Health Project, Scottish Development Centre for Mental Health Services. A project in partnership with the Scottish Council Foundation, Mental Health Foundation (Scotland) and the Research Unit for Health and Behavioural Change, University of Edinburgh [www.sdcformhs.org.uk](http://www.sdcformhs.org.uk), 1999

# Mapping mental health promotion –

### letter and questionnaire used by Redbridge and Waltham Forest

#### Letter

Dear Colleague

Mental health promotion has been identified as a priority in the government's National Service Framework for Mental Health, and each authority is required to map the initiatives and projects which aim to enhance the mental well-being of populations in their area.

The mapping process is a major task because of the diverse range of projects and initiatives that are provided by a variety of organisations locally, and we are therefore asking for your help. We are interested in any initiatives or projects that have an impact on mental well-being whether this is their primary objective or a secondary effect of the main activity.

The following definitions of 'mental health' and 'mental health promotion' may be helpful in deciding which initiatives/ projects to include:

'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 in our own and others' dignity and worth.'

'Mental health promotion includes any activity which actively fosters good mental health, through increasing mental health promoting factors such as meaningful employment and decreasing those factors which damage or reduce good mental health, such as abuse or violence. Activities which promote mental health may also prevent mental illness.' (Health Education Authority, 1997).

Attached is a questionnaire that we would be grateful if you could complete. We have tried to keep it as brief and simple as possible to minimise the time it takes. If you are in any doubt about what to include, tell us anyway! We want to capture as much information about as broad a range of work as possible.

Please photocopy and complete a separate questionnaire for each activity and feel free to copy this letter and form and pass on to colleagues and contacts as necessary.

Please return the completed questionnaire(s) by ..... to .....  
If you require any further information please do not hesitate to contact me. I look forward to hearing about your work.

## Questionnaire

### MENTAL HEALTH PROMOTION PROJECTS AND INITIATIVES

1. Please state the name of your initiative/project if appropriate:

2. Who is the key person to contact:

Name:

Organisation:

Address:

Tel number:

Fax number:

Email:

3. Who is the lead agency for your project, if different from above:

4. Are there any other organisations/agencies/groups involved in the project?  
Please list ...

5. Please state the main purpose of your project:

6. What do you consider are the aspects of the work that promote mental health?

7. Does the work target (please tick):

- an organisation
- local community
- family
- individual
  
- other (please state) ...

8. Which of the following age groups does the work **primarily** target?

- whole population
- infancy
- childhood
- adolescence
- early adulthood
- midlife
- old age

9. Who is your target group?

Please tick:

- pregnant women
  - new mothers
  - unemployed people
  - employees
  - people affected by divorce
  - people experiencing bereavement
  - people living in poverty
  - carers
  - homeless people
  - people with physical disabilities/illness
  - people with learning disabilities
  - people with mental health problems
  - people with alcohol problems
  - people with drug problems
  - specific ethnic groups (please state) ..
- 
- people who have experienced abuse of any kind
  - people who have experienced domestic violence
  - gay men, lesbians, bisexual people
  - the whole population - to reduce stigma and raise awareness around mental health problems
  - other (please state) ..

10. Does the work focus on a particular setting? If yes, please tick the main setting:

- school/s
- workplace/s
- neighbourhood/s
- primary health care
- media
- other (please state) ..

Please give details of the settings ...

11. Please briefly describe the project (use additional sheet if necessary)

12. What indicators do you use to measure success?

13. Is the project provided/funded as part of any of the following government initiatives? (please tick)

- Sure Start
- New Deal
- HAZ
- Single Regeneration budget
- Other (please state) ..

14. Please state the main source/s of funding for the project:

15. Is the project:

- On going
- Time limited

If time limited, when does the current funding end?

16. Please list any other project that you think should be included in this mapping exercise, with contact details if possible.

**Many thanks for your time in completing this form.**

**Please return by**

(This questionnaire was adapted from one developed by Nottinghamshire Health Authority)



# Using a problem tree

Defining a problem, identifying the causes and effects, and then using this “problem tree” to define a series of programme objectives can be a way of bringing different groups and agencies together to agree potential solutions to a problem. It will also help to explore issues of language that often present a barrier to getting mental health promotion strategies widely accepted.

A “problem tree” enables a problem to be analysed through looking at the causes and the effects of the problem. These then form the basis of an “objective tree” that sets out a programme that will address the initial problem. Having defined the problems and used these to inform programme objectives, a series of questions can be asked to act as prompts for strategy development. These are:

1. What are the objectives?
2. What are the key elements?
3. What evidence is available to support action?
4. Which policy initiatives support the action?
5. Who should be key stakeholders?
6. What are the chosen interventions – individual, community and organisation?
7. What indicators will show progress?

### **How to use the “problem tree” to redefine the problem and adjust the strategy?**

1. What has been achieved in year 1?
2. Have any new issues emerged during the first year of the implementation of the strategy?
3. How has the mental health strategy changed the perception of the problem?
4. What would a “problem tree” now look like?

(Problem trees developed by Jane Lethbridge)

### Figure A3:1 Four problems and solutions

#### EXAMPLE 1

#### Problem: Carers feel isolated and unsupported

##### The **CAUSES** of this problem:

- Carers being unable to meet other people or undertake activities of their own choosing and so feel socially isolated
- Carers have often given up paid work and so no longer have a workplace to provide some form of social interaction or income
- Through continued isolation, carers are unaware of any services that may be available locally
- Health services often focus on the person being cared for rather than the health of the carer
- Lack of information on the illness of the person they are caring for

##### The **EFFECTS** of carers feeling isolated and unsupported are:

- Carers become ill themselves and eventually become unable to care
- The relationship with the person being cared for breaks down
- The health of the person being cared for deteriorates and puts increased pressure on health services

##### A **SOLUTION** to this problem is:

- To increase local support for carers

##### This **OBJECTIVE** would be achieved through:

- Setting up a local carer support group
- Providing short term breaks from caring so that carers can participate in activities of their own choosing
- Providing information on services available to carers and on the illness of the person cared for
- Involving Primary Care in developing support plans for carers so that their own health needs can be considered on a regular basis

##### The **RESULTS** of these actions:

- Health of carers is maintained or improves
- Relationship between carer and person being cared for is maintained or improved, resulting in improved mental well-being of both
- Needs of carers more widely addressed and understood
- Improved local support networks for individual carers

## EXAMPLE 2

### Problem: Increased rates of depression among unemployed men

**The CAUSES** of this problem:

- Lack of employment
- Changing role in families with women becoming main wage earner
- Social isolation of unemployed men as no workplace to meet people
- Men unwilling to use local health services

**The EFFECTS** of this problem:

- Pressure on families
- Increased behavioural problems in children
- Higher rates of physical ill health among the community
- Lack of community activities

**A SOLUTION** to this problem is:

- To develop a series of activities that would contribute to the improved well-being of unemployed men

**This OBJECTIVE** would be achieved through:

- Setting up new training/ employment/ economic activities targeted at unemployed men
- Provision of family support through schools and local community centres
- Self-help group for unemployed men that addresses health as one of a range of issues
- Local health services become more accessible for men

**The RESULTS** of this programme might be:

- Families feeling more supported
- Children showing fewer behavioural problems in school
- Local health services becoming more aware of local health needs

### EXAMPLE 3

#### Problem: An increase in the number of excluded children

**The CAUSES** of this problem:

- Schools unable to deal with children with behavioural problems
- Families under pressure due to unemployment and poverty
- Parents lack support for care of children
- Lack of local facilities for children and young people

**The EFFECTS** of this problem

- Increase in number of children and young people on streets
- Increase in street crime and violence
- Young people lack skills and job prospects
- Erosion of community networks and structures

**A SOLUTION** to this problem is:

- To provide support for schools in dealing with children with behavioural problems

**This OBJECTIVE** would be achieved through:

- Schools supported in developing mental health promotion policies e.g. anti-bullying
- Resources for schools to provide breakfasts for children
- Support for parents through family centres
- Local health centre provides services for children with behavioural problems

**The RESULTS** of these actions:

- Schools are better able to deal with disruptive behaviour
- Fewer children on streets
- Young people have greater sense of own value
- Stronger links between school and community

#### EXAMPLE 4

##### Problem: Increasing levels of social isolation

**The CAUSES** of this problem:

- High rates of unemployment
- Increased pressure on families due to unemployment and poverty
- Low incomes mean no resources for social activities
- High rates of school exclusion, street violence, drug dealing

**The EFFECTS** of this problem:

- Increase in mental and physical ill health
- Increased rates of family break up
- Older people feel isolated in own homes
- Decline in community activities

**A SOLUTION** to this problem is:

- To develop activities that reduce social isolation

**This OBJECTIVE** would be achieved through:

- Increase in community based activities e.g. older people's group
- Training/ skills development for new employment
- Credit union set up to increase resources available to families
- Schools supported to deal with behavioural problems

**The RESULTS** of this programme might be:

- Improvements in mental and physical health
- Families feel more supported so decrease in domestic violence
- Older people feel able to meet at community centre
- Community support networks develop as a result of group activities



## Appendix Four

# Examples of good practice

### APNA HAQ - WORKING WITH THE ASIAN COMMUNITY SUPPORTING FAMILIES IN CRISIS

<b>What we know</b>	Domestic violence is a risk factor for mental health problems for both women and children. Lack of access to and/or inappropriate health services for black and minority ethnic groups is recognised as a key problem in the NSF and the Acheson Report. For some communities, language remains a significant barrier. English is not the main language of communication for the majority of Asians, although there is variation by age and gender. Day care mental health services are less likely to be accessed by black and minority ethnic groups and psychological therapies are less likely to be offered. These problems have led to calls to rethink the approach of providing a common service and to develop targeted and specific services, in a shift from concepts of the average citizen to a recognition of diversity.
<b>What this project will add</b>	Specific evidence on the effectiveness of developing targeted, culturally relevant programmes. This project also has the potential to provide additional data on building social networks and support and addressing different cultural perspectives on factors influencing mental health.
<b>Future research</b>	There is a need for further research, backed by long term funding, on the effectiveness of programmes which address the needs of black and minority ethnic communities. A further area would be the extent to which culturally specific services impact on mainstream provision and access.
<b>Setting</b>	Community centre Outreach – primary care, home-visits
<b>Level of action</b>	Individual Community
<b>Target group</b>	Whole population Vulnerable groups People at risk
<b>Aims</b>	The programme aims to enable Asian women and children to live their lives free of violence and intimidation. The programme provides community awareness raising and training events, training for professionals, outreach visits, individual support for women and group work for young people.

<b>Programme</b>	<p>The programme was established as Asian women in the Rotherham area find mainstream services inaccessible, largely due to language barriers. Mainstream agencies were seen to offer little information or support which was culturally sensitive or appropriate. Many women who wished to access these services required support in doing so.</p>
<b>Action</b>	<p>Apna Haq (Your Right) in Urdu provides individual support for women and children facing domestic violence. Women either self-refer or are referred by local agencies including the police, social services and health services.</p> <p>Project workers meet with clients in a safe setting, convenient to them, at the Youth Centre – project base, at their local GP surgery. The programme works with other organisations ensuring that issues facing local Asian women are raised with local service providers and agencies. The programme also works with the whole community providing education and information about the impact of domestic violence on women and families.</p>
<b>Proven outcomes</b>	<p>Fewer children on child protection registers and in local authority care. Increased take up of mainstream services such as housing, benefits and health.</p> <p>Reduction in admissions to casualty departments and local GPs.</p> <p>Increased self esteem and improved parenting techniques.</p> <p>Development of social support networks in the local community.</p> <p>Local agencies and service providers more aware of issues relating to Asian women and domestic violence.</p>
<b>Research evidence</b>	<p>Alexander Z (1999) <i>Study of Black, Asian and Ethnic Minority Issues</i> Department of Health</p> <p>Bardsley M, Hamm J, Lowdell C, Morgan D and Storkey M (2000) <i>Developing health assessment for black and minority ethnic groups</i> Health of Londoners Project: NHS Executive London</p> <p>Chondray S (1992) <i>Pakistan women's experience of domestic violence in Great Britain</i> Home Office</p> <p>Research &amp; Statistics Directorate – Research Findings no 43</p> <p>Mamma A (1989) <i>The Hidden Struggle: Statutory Responses to Violence Against Black Women in the Home</i> London Race &amp; Housing Research Unit, London</p> <p>Morley &amp; Mullender (1994) <i>Preventing Domestic Violence</i>. Police Research Group Crime Prevention Unit, HMSO, London</p>
<b>Contact</b>	<p>Zlakha Ahmed Co-ordinator Apna Haq Thornhill Youth &amp; Community Centre Tonter Street Rotherham South Yorkshire S60 1LB Tel: 01709 552121 Fax: 01709 550771</p>

## ASSESSING THE NEEDS OF REFUGEE CHILDREN

<b>What we know</b>	Schools can play an important role in reducing inequalities by addressing the needs of vulnerable or at risk children. There is also good evidence that school attachment/connectedness is a protective factor for mental health in children. Evaluation of Healthy Schools suggests that interventions are more likely to be effective when they address the whole school culture, including the attitudes of staff, children and the wider community.
<b>What this project will add</b>	There is limited data on approaches targeted at refugee communities, particularly when delivered to a whole community, such as a school, as well as targeted at those at risk.
<b>Future research</b>	There is a need for further research on programmes which target vulnerable children within schools and their effectiveness with refugee children. Long-term evaluation would be particularly welcomed, as would publication of results in peer reviewed journals.
<b>Setting</b>	School
<b>Level of Action</b>	Individual Community
<b>Target Group</b>	Vulnerable groups – refugee children People at risk People with mental health problems
<b>Aims</b>	The programme aims to increase staff awareness of the needs of refugee children and the impact of their background and status on their social, emotional and educational development. The programme also aims to increase staff awareness of the meaning underlying their behaviour and their family, cultural and experiential framework. It provides staff with support in managing the impact on themselves and their classes. It also provides counselling support within the school for the young people, when appropriate.
<b>Programme</b>	The programme is delivered by the Tavistock Clinic as part of an outreach child adolescent and mental health service. The programme was developed in consultation with the school, the Board of Management and individual departments dealing with children with special needs. The team also keeps in contact with a broader network of people dealing with the health of refugee groups.

<b>Action</b>	The programme delivers training and work discussion groups to staff within local schools. The staff identify children in need of additional support, provided through counselling, both one-to-one and individual. This service is provided at school by a visiting therapist. The programme is delivered mainly to children originally from the Horn of Africa and the former Yugoslavia and a significant number of these children are unaccompanied in this country.
<b>Proven outcomes</b>	Increased staff awareness and positive staff and head teacher feedback Positive classroom observations Reduction in staff anxiety and stress Improvements in classroom behaviour – increased capacity to relate to other children Increased levels of concentration among children Improvements in class attendance rates Increased attachment levels among children
<b>Research evidence</b>	Burnett A, Peel M (2001) Health Needs of asylum seekers and refugees <i>British Medical Journal</i> <b>322</b> 544-547 Lister-Sharp D, Chapman S, Stewart-Brown S, Sowden A (1999) <i>Health promoting schools and health promotion in schools: two systematic reviews</i> London: Health Technology Assessment No 22 Isca Wittenberg (1983) <i>The Emotional Experience of Teaching and Learning</i> RKP, London
<b>Contact</b>	Maureen Fox Tavistock Clinic 120 Belsize Lane London NW3 5BA 020 7435 7111 020 7447 3733

## BUILDING SOCIAL CAPITAL IN WEST HOWE

<b>What we know</b>	There is good evidence that communities rich in social capital have better mental and physical health, although there are many questions still to be answered about the relationship between psycho-social factors and material deprivation.
<b>What this project will add</b>	A local example of the extent to which initiatives to build social capital impact on health indicators e.g. uptake of exercise, further education and increased participation in arts activities.
<b>Future research</b>	There is a need for further research on definitions and indicators of social capital and multi-site initiatives, to explore the most effective interventions for building social capital.
<b>Setting</b>	Community Workplaces Schools
<b>Level of Action</b>	Individual Community Organisational
<b>Target Group</b>	Whole population Vulnerable groups – isolated individuals People at risk - people with learning disabilities and carers People with mental health problems – including people with substance misuse problems
<b>Aims</b>	The programme aims to build social capital in a deprived urban area which has adverse indicators for mental health. West Howe is an isolated part of Bournemouth, which is designated as a public health action area. The programme aims to make mental health promotion and the development of social capital the business of each local community.
<b>Programme</b>	The programme will establish an organisation of residents supported by statutory authorities and local voluntary agencies. They will promote social inclusion and progress an action programme based on local needs assessment.

<b>Action</b>	A local needs assessment profile has been constructed with residents and service providers. This has resulted in the implementation of an action programme to improve health of residents in West Howe. The programme employs a full time community worker to encourage and support local initiatives. A local health promotion co-ordinator involves local schools and workplaces and links with other initiatives such as Streetwise accident prevention centre and a Sure Start Scheme.
<b>Proven outcomes</b>	Establishment of a residents group Increased uptake of community art schemes Increased local consultation eg older people and transport Increased interest in local services eg exercise sessions, debates on teenage pregnancy etc Further education providers and services more connected with local people
<b>Research evidence</b>	Dalgard OS (1999) Social Integration and Mental Health Promotion <i>International Journal of Mental Health Promotion</i> 1(1): 32-36 Oxman TE et al (1992) Social support and depressive symptoms in the elderly <i>American Journal of Epidemiology</i> 135: 356-368 See also Chapter 3.3 Social Capital: individuals, organisations and communities under stress
<b>Contact</b>	Dr Paul Harker Healthworks, Jessopp House Mill Lane, Wimborne Dorset, BH21 1HG 01202 848567 01202 848641 <a href="mailto:paul.harker@dorsethc-tr.swest.nhs.uk">paul.harker@dorsethc-tr.swest.nhs.uk</a>

## COMMUNITY MOTHERS PROGRAMME, THURROCK

<b>What we know</b>	A number of systematic reviews and randomised controls demonstrate the effectiveness of home visit programmes for mothers, particularly those who are vulnerable or of low socio-economic status.
<b>What this project will add</b>	The community mothers model demonstrates that trained lay volunteers are effective in delivering home based programmes. In addition, this model also focuses on education and employment outcomes for the volunteers, as well as health and social outcomes for the parents and children who are supported.
<b>Future research</b>	There is a need for further replication of this model with hard to reach and excluded communities, particularly different Black and Minority Ethnic communities.
<b>Setting</b>	Early years - home Primary care
<b>Level of Action</b>	Individual – work with parents Community – community support participation and self help Organisational – facilitates consumer views & insights
<b>Target Group</b>	Parents with young children Whole population – non-stigmatising approach Vulnerable groups – although available for all outreach is more intensive in less advantaged areas
<b>Aims</b>	To offer comprehensive informal parenting support in order to prevent the need for crisis intervention at a stage when problems may have become entrenched and difficult to resolve To improve the health and development of young children through work with their parents To alleviate isolation and depression and to promote health and parenting skills and participation within the local community To enable parents to achieve their own goals using a non-directive approach To build up the skills and self-confidence of parents To build on existing strengths to provide new training opportunities and access to employment
<b>Programme</b>	The programme develops individuals, as workers and as parents and supports families and local communities. It addresses inequalities by improving the health and development of young children in disadvantaged areas through encouraging positive parenting. The emphasis is equal between parent support and the development of the community mothers.

<b>Action</b>	Experienced mothers are recruited and trained by experienced Community Development nurses to fulfil the role of community mothers. All parents who have recently had a baby or moved to the area with young children are offered regular visits for a defined period. Community mothers are supported by the trainers through accompanied visits, group sessions and formal and informal training events.
<b>Proven outcomes</b>	Reduced isolation/depression in mothers Raised maternal self esteem/confidence and positive feelings Improvements to child behaviour difficulties Improved cognitive stimulation of children Improved appropriate access to services eg health, parenting, training Volunteer skills development and increased access to employment opportunities  There are also outcomes not relating directly to mental health including improved maternal and child nutrition, increased immunisation uptake, improved speech development and improved safety awareness.
<b>Research</b>	Suppiah C (1994) Working in partnership with community mothers <i>Health Visitor Journal</i> vol <b>67 (2)</b> , 51-53 Johnson Z, Howell F & Molloy B (1993) Community Mothers Programme: randomised controlled trial of non-professional intervention in parenting <i>British Medical Journal</i> <b>306</b> , 1449-52 Johnson Z & Molloy B (1995) The Community Mothers Programme: empowerment of parents by parents <i>Journal of Children and Society</i> <b>9 (2)</b> 73-85 Fitzpatrick P, Molloy B & Johnson Z (1997) Community Mother Programme: extension to the traveller community in Ireland <i>Journal of Epidemiology and Community Health</i> <b>51</b> , 299-303
<b>Contact</b>	Celia Suppiah Community Development Specialist Nurst Tilbury Health Centre, London Road Tilbury, Essex, RM18 8EB 01375 843241 01375-856863

## CONFRONTING THE ISSUES - CHANGING MINDS A PILOT PROJECT RAISING MENTAL HEALTH AWARENESS IN SCHOOLS

<b>What we know</b>	There is some evidence that user-led programmes which are inter-active and allow young people to openly express their fears and anxieties can be effective in shifting attitudes. Much less is known about how to change behaviour.
<b>What this project will add</b>	A local example of user-led education, based on consultation within schools and with young people provides valuable information on attitude and possible behaviour changes.
<b>Future research</b>	Further research is needed on user-led programmes within schools and workplaces and the effectiveness of projects which promote social contact.
<b>Setting</b>	Schools
<b>Level of Action</b>	Organisational
<b>Target Group</b>	Vulnerable groups People at risk People with mental health problems
<b>Aims</b>	The programme aims to enable pupils and teachers of local secondary schools to increase their awareness and understanding of mental health issues and how they impact on people's lives. The programme also enables pupils and teachers to recognise the potential causes of mental ill health, signs of distress and sources of help available, locally and nationally.
<b>Programme</b>	The pilot project began after concern was raised in Dartford and Gravesham Mind about the unmet need for information in schools relating to stigma and mental health issues. Consultation began in local schools, which identified support for the project among teaching staff and pupils.
<b>Action</b>	This pilot project evaluated the effectiveness of mental health promotion literature and action in secondary schools in the local area. At the end of the pilot recommendations were made for future investment. A total of 15 sessions were held in six schools, including 7 workshops on stress and stress management, 2 on bullying, stigma and discrimination, 4 on mental health awareness and 2 assembly sessions for all pupils on general awareness and sources of help.

<b>Proven outcomes</b>	Increased knowledge about mental health issues among pupils (78%) Increased willingness to raise or discuss problems (66%) Reduction of stigmatising beliefs about mental health and those who experience mental health problems (100%) Continued work in all schools involved in the pilot to promote mental health
<b>Research evidence</b>	Byrne P (2001) Psychiatric Stigma <i>British Journal of Psychiatry</i> <b>178</b> :281-284 Haghighat R A (2001) Unitary Theory of Stigmatisation – pursuit of self-interest and routes to destigmatisation <i>British Journal of Psychiatry</i> <b>178</b> : 207-215 Mental Health Foundation (1999) <i>The Big Picture</i> MHF, London Mind (1998) <i>The Bird and the Word</i> Mind, London
<b>Contact</b>	Jon Manzoni Dartford & Gravesham Mind 16 Westhill Dartford Kent DA1 2EP 01322 291380 01322 285294 <a href="http://www.dgmind.freeserve.co.uk">www.dgmind.freeserve.co.uk</a> <a href="mailto:email@dgmind.freeserve.co.uk">email@dgmind.freeserve.co.uk</a>

## DETECTION OF ALCOHOL MISUSE IN A&E WITH SUBSEQUENT BRIEF INTERVENTION

<b>What we know</b>	Brief interventions in a primary care setting are effective in reducing alcohol consumption.
<b>What this project will add</b>	Information on the effectiveness of brief interventions in A&E on reducing alcohol misuse and recommendations for improving the interface between A&E and alcohol services.
<b>Future research</b>	Alcohol and Education Research Council have funded an RCT and economic evaluation of brief interventions in A&E (due to start March 2001).
<b>Setting</b>	Community – an urban A&E department
<b>Level of Action</b>	Organisational
<b>Target Group</b>	Vulnerable groups
<b>Aims</b>	<p>To explore the opportunities for A&amp;E departments to detect and refer patients who misuse alcohol</p> <p>To evaluate the effectiveness of brief motivational interventions in the treatment of alcohol misuse</p> <p>To assess the attitude of A&amp;E staff towards alcohol related attendances</p> <p>To monitor the use of the PAT (Paddington Alcohol Test) and to improve its relevance and uptake, making it a more effective tool</p>
<b>Programme</b>	The research aimed to demonstrate a strong case for the use of a standard alcohol misuse detection tool, followed up by targeted brief motivational interventions.
<b>Action</b>	The Paddington Alcohol Test was reviewed as a tool and the 'top ten' triggers to encourage staff to ask about alcohol use were refined. The programme then encouraged A&E staff to utilise this more effective detection tool in a non-judgemental manner and to encourage the patient to recognise they have a problem with alcohol and to refer (or encourage self-referral).
<b>Proven outcomes</b>	<p>Development of a relevant alcohol detection tool for use by health staff in A&amp;E departments</p> <p>Increased awareness among health staff of their role in detecting and treating alcohol misuse</p> <p>Encouragement of the appropriate use of an alcohol health worker</p>

**Research  
evidence**

Huntley JS, Blain C, Hood S, Touquet R (*currently in press*)  
Improving detection of alcohol misuse in patients presenting to an  
accident and emergency department *Emergency Medicine  
Journal*

Wright S, Moran L, Meyrick M, O'Connor R & Touquet R (1998)  
Intervention by an alcohol health worker in an accident and  
emergency department *Alcohol & Alcoholism* **33**: 651-6

Smith SGT, Touquet R, Wright S, Das Gupta N (1996) Detection  
of alcohol misusing patients in accident and emergency  
departments: the Paddington Alcohol Test *Journal of Accident &  
Emergency Medicine* **13**: 308-312

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## EARLY INTERVENTION IN POSTNATAL DEPRESSION PROJECT

<b>What we know</b>	There is strong evidence of the link between untreated post natal depression and poorer health outcomes for children. Effective interventions include early detection and treatment, social support and home visiting programmes.
<b>What this project will add</b>	There is very limited data on the treatment of perinatal mood disorders. By focussing on mental health from early pregnancy, this project could provide valuable information on the effectiveness of perinatal interventions.
<b>Future research</b>	Cost effectiveness of perinatal screening, for whole population and vulnerable groups, effectiveness of a range of mental health promotion interventions during pregnancy, including self-help and support groups.
<b>Setting</b>	Primary care – community midwifery
<b>Level of Action</b>	Individual
<b>Target Group</b>	Women in pregnancy and post-partum and their children People at risk People with mental health problems
<b>Aims</b>	To raise awareness of perinatal mood disorders, their impact on mothers and others, and the value of identifying and treating women appropriately. To reduce the development of behaviour disorders in pre-school children and reduce the incidence of mental health problems in later childhood, adolescence and adulthood by improving early detection and management of maternal perinatal anxiety and depression, for the benefit of the mother-baby relationship.
<b>Programme</b>	The programme consists of a range of primary care professionals, midwives, health visitors and practice nurses, with support from secondary services, offering an integrated service to perinatal women which addresses their emotional needs and the mental well being of both parents and children. Home-Start now has 285 local schemes in the UK, each scheme has 25-30 volunteers who work with 50-60 families and 120-150 children.

<b>Action</b>	<p>Midwives attended a seminar at which they identified screening tools that they could utilise effectively to screen mothers antenatally: the Edinburgh Postnatal Depression Scale and Coopers Pregnancy Index.</p> <p>Health visitors attended a 3 day training course in the detection and management of depression, including the Edinburgh Postnatal Depression Scale, awareness of clinical diagnostic criteria, counselling skills and simple cognitive behavioural techniques. Once trained the health visitors will routinely screen at 4-6 weeks postpartum and 6 months later and either treat or refer.</p> <p>Practice nurses in one Primary Care Group will also be offered awareness training seminars.</p>
<b>Proven outcomes</b>	<p>Raised awareness among midwives and health visitors of the impact of maternal emotional difficulties</p> <p>Motivation of midwives and health visitors to enquire about mental health issues routinely and screen the pregnant and postnatal population</p> <p>Increased confidence among non-mental health professionals to address mental health issues at an early stage</p>
<b>Research evidence</b>	<p>Sinclair D, Murray L (1998) Effect of postnatal depression on the children's adjustment to school. <i>British Journal of Psychiatry</i> <b>172</b>:58-63</p> <p>Field T (1997) The treatment of depressed mothers and their infants. In: Murray L, Cooper PJ (Eds) <i>Postpartum Depression and Child Development</i>. New York: Guilford Press, 221-236</p> <p>Cooper PJ, Murray L (1997) The impact of psychological treatments of postpartum depression on maternal mood and infant development. In Murray L, Cooper PJ (Eds) <i>Postpartum Depression and Child Development</i>. New York: Guilford Press, 1997 201-220</p> <p>Hearn G, liif A, Jones I et al (1998) Postnatal depression in the community <i>British Journal of General Practice</i> <b>48</b>:1064-6</p> <p>Holden J, Sagovsky R, Cox J (1989) Counselling in general practice setting: controlled study of health visitor intervention in treatment of postnatal depression <i>British Medical Journal</i> <b>298</b>:223-226</p>
<b>Contact</b>	<p>Maisie Allen, Sheelah Seeley, Mary Armour, Dr S Britten North East Essex Mental Health Trust Minerva Centre for CPD Harkenwell, St Peter's Hospital Maldon, Essex, CM9 6EG 01621-722912 01621-722914 <a href="mailto:maldon.CFCS@cwcom.net">maldon.CFCS@cwcom.net</a></p>

## EFFECTIVE PARTNERSHIPS FOR VOCATIONAL REHABILITATION

<b>What we know</b>	Enhancing social support within the workplace for people in stressful occupations and environments can reduce mental health problems. Supported employment in a real workplace is the most effective method of improving employment prospects for people who have used mental health services.
<b>What this project will add</b>	Information on the effectiveness of programmes focussing on prevention and retention, as well as re-employment of people with mental health problems.
<b>Future research</b>	Further research is needed on the benefits for employers of adopting policies which support the mental health of all staff, whether or not they have experienced mental health problems. It would be valuable to test the hypothesis that a workplace adapted to enable people with mental health problems to contribute will demonstrate greater productivity and profitability, as a consequence of increased diversity and improved mental health among all staff.
<b>Setting</b>	Workplaces
<b>Level of Action</b>	Individual – support and advocacy Organisational – co-ordinating the activity of all agencies
<b>Target Group</b>	Vulnerable groups – occupations with high stress levels People at risk – early intervention to prevent deterioration People with mental health problems
<b>Aims</b>	The project aims to increase awareness of mental health issues and enable clients with mental health difficulties to successfully return to work. This is achieved through: <ul style="list-style-type: none"><li>- early intervention and awareness - publicity materials</li><li>- GP surgeries, day hospitals etc;</li><li>- shifting the burden of responsibility – through co-ordinating role</li><li>- establishing back to work strategies</li><li>- providing on-going support</li><li>- promoting awareness of the Disability Discrimination Act and Health and Safety Legislation</li><li>- promoting health in the workplace</li></ul>
<b>Programme</b>	The Work Development Team have produced a strategy and agreed methodology for promoting mental health in the workplace. The service was initially established to facilitate clients successful rehabilitation to their workplace and where this was not possible to advise them about alternative careers. The initial target of supporting has been extended as the project team felt it was impossible to deal with retention without dealing with prevention.

<b>Action</b>	<p>The Team provides early intervention and support for clients. They identify clients' comfort zones, areas of stress and vulnerabilities and make them aware of these also.</p> <p>Support is provided to individuals on a one-to-one basis and in groups. The programme is delivered through cohesive partnerships built with occupational health, human resources departments, trade unions, local managers and work colleagues, primary care professionals, solicitors and specialist mental health teams.</p>
<b>Proven outcomes</b>	<p>Increased number of people returning to real work after experience of mental health problems – before the programme – 78% of people lost their jobs – after implementation 75% retained their positions</p> <p>Increased number of effective mental health promotion policies within the workplace</p> <p>Increased co-ordination among local agencies dealing with employment</p> <p>Improved re-employment rates and increased rates of accessing appropriate education</p>
<b>Research evidence</b>	<p>Butterworth R (1996) <i>Ways into Work Survey</i></p> <p>Butterworth R, Dean J (1998-2000) <i>Ways into Work Annual Reports – the outcomes</i></p> <p>Carter T (2000) <i>Factors determining the prevalence of mental ill health in the UK working population</i> BOHRF</p> <p>Department of Health (1995) <i>Health of the Nation - ABC of Mental Health in the Workplace</i> Department of Health, London</p> <p>Department of Health (1999) <i>National Service Framework for Mental Health</i>, HMSO, London</p> <p>Jenkins R, Macdonald A, Murray J and Strathdee G (1982) Minor psychiatric morbidity and the treat of redundancy in a professional group <i>Psychological Medicine</i> <b>12</b>: 799-807</p> <p>Jenkins R (1988) Mental health and primary care – implications for policy <i>International Journal of Psychiatry</i> <b>10</b>: 158-160</p> <p>Lloyd K &amp; Jenkins R (1995) The economics of depression in primary care <i>British Journal of Psychiatry</i> <b>166</b>: 60-62</p> <p>NHS Centre for Reviews and Dissemination (1997) Mental health promotion in high risk groups <i>Effective Healthcare Bulletin</i> <b>3</b>, York</p> <p>Rowlands P (1995) Redundancy and Mental Health <i>Occupational Health Review</i> <b>55</b>: 12-14</p> <p>Vinamaki H, Kosela K, Niskanen L, Arnkill R &amp; Tikanen J (1993) Unemployment and mental well being: a factory closure study in Finland <i>Acta Psych Sand</i> <b>88</b>: 429-433</p>
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## EXERCISE FOR MENTAL HEALTH USING COMMUNITY GYMS

<b>What we know</b>	There is good evidence to show the effectiveness of exercise for reducing symptoms of depression among people with a diagnosis. Exercise can also be an effective complementary treatment for negative symptoms of schizophrenia and a coping strategy for symptoms like hallucinations.
<b>What this project will add</b>	This programme will add to the evidence base on the effectiveness of exercise among people with severe and enduring mental health problems. It also has potential to identify ways to enhance service user access to mainstream leisure services.
<b>Future research</b>	Research on the impact of using community facilities to enhance the social networks and the social inclusion of people with mental health problems.
<b>Setting</b>	Day therapy unit (NHS) Local gyms (privately run)
<b>Level of Action</b>	Individual Community
<b>Target Group</b>	People with mental health problems
<b>Aims</b>	The programme aims to promote mental health and physical fitness of people with mental health problems who access day centre facilities. It also aimed to increase the confidence of local mental health service users to use non-NHS facilities within the community, also increasing contact and awareness of mental health within the community. The programme is also providing a basis for a study into the effects of exercise on people with diagnosed mental health problems, considering an improvement in self esteem, confidence and lifting mood.
<b>Programme</b>	The programme is delivered through a mutli-professional team including physiotherapists, occupational therapists and the day therapy team. The programme will enable clients to access community settings within a supportive environment. Similar programmes have since been developed in Avon and Western Wiltshire Mental Healthcare NHS Trust.

<b>Action</b>	Two groups of ten clients with a range of diagnosed mental health problems are supported to attend a privately run gym once a week. Two members of staff from the day therapy team attend with them. The ten week programme is monitored and evaluated with pre and post testing. Following the ten week trial stage clients are encouraged to continue to use the gym in a support group and it is hoped eventually independently.
<b>Proven outcomes</b>	Increased numbers of people with mental health problems using local community facilities Positive feedback from clients and staff at day centre and gym Positive changes in self esteem, mood and fitness levels (final analysis awaited)
<b>Research evidence</b>	Trudi Grant (ed) (2000) <i>Physical Activity and Mental Health – national consensus statement</i> . Health Education Authority, London Faulkner G & Biddle S (1999) Exercise an adjunct treatment for schizophrenia: A review of the literature <i>Journal of Mental Health</i> <b>8</b> (5) 441-457 Fox KR (2000b) Self esteem, self perceptions and exercise <i>International Journal of Sports Psychology</i> <b>2</b> (1): 4-12 Mutrie N (2000) The relationship between physical activity and clinically defined depression in <i>Physical activity and psychological well-being</i> Biddle SJH, Fox KR & Boutcher H Routledge, London
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## HACKNEY ANTI-BULLYING PROJECT

<b>What we know</b>	There is good evidence to show the effectiveness of implementing anti-bullying programmes as part of a whole school approach.
<b>What this project will add</b>	A local example delivered in primary and secondary schools which could help to identify any adaptations of anti-bullying programmes needed for different age groups.
<b>Future research</b>	Much of the data on the effectiveness of bullying programmes comes from a major study by Olweus in Norway. Further UK data is needed, particularly to assess replication of the long term effects on crime, drug and alcohol abuse and suicidal behaviour.
<b>Setting</b>	Schools
<b>Level of Action</b>	Organisational
<b>Target Group</b>	Whole population
<b>Aims</b>	The project aims to reduce the prevalence of bullying within Hackney. This will be achieved by developing a whole school approach to anti-bullying.
<b>Programme</b>	The project was established in 1998, currently completing its third year. It began in primary schools and is now being rolled out into secondary schools (already in four). It is funded by the Local Education Authority and staffed one day a week by a Community Psychologist.
<b>Action</b>	The project arose from a three year well-being in schools programme which identified the need for school-based anti-bullying policies and interventions. The schools receive support from the Community Psychologist who helps them develop policies and pilot and implement effective interventions.
<b>Proven outcomes</b>	Increase in the number of school-based policies Reduction in tolerance to bullying Increase in reported cases within schools

**Research  
evidence**

Olweus Dan (1993) *Bullying at school: what we know and what we can do* London: Blackwell

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## HOME-START

<b>What we know</b>	A number of systematic reviews and randomised controls demonstrate the effectiveness of home visiting programmes for mothers, particularly those who are vulnerable or of low socio-economic status.
<b>What this project will add</b>	Like the community mothers model, Home-Start demonstrates the effectiveness of trained lay volunteers.
<b>Future research</b>	There is a need for further identification of which elements of home visiting schemes are most effective and more resources for long term evaluation. There is a need to examine whether earlier involvement with families, pre-natal and immediately post-natal, would be more effective.
<b>Setting</b>	Early years - home Community settings (where appropriate)
<b>Level of Action</b>	Individual Community
<b>Target Group</b>	Parents & Families with young children Vulnerable groups e.g. single parents or parents living in deprivation People at risk e.g. parents with disabilities, parents of children with disabilities, parents of multiple births People with mental health problems e.g. parents with mental health problems.
<b>Aims</b>	To support parents in order to strengthen families and local social networks To help parents develop their own skills, to enable them to make better use of local services and to encourage confidence and independence To provide friendship, practical help and support to families under stress with at least one child under the age of 5 years.
<b>Programme</b>	Home-Start is a family support service offering friendship, practical help and support to families with children under 5 years. The service is provided by trained parent volunteers who work with individual parents in their own homes. The scheme aims to intervene before problems turn into crises and in a way that respects the dignity and autonomy of parents. There are 285 Home-Start schemes throughout the UK.

<b>Action</b>	<p>Home-Start trains volunteer parents, who are then matched on a one-to-one basis with families. Volunteers then visit the families in their own homes for as long as support is required.</p> <p>Volunteers are managed by a paid organiser who recruits, trains and supports between 25-30 volunteers. The volunteers then support 50-60 families offering practical help and friendship. The organiser takes referrals, usually from Health or Social Services professionals.</p>
<b>Proven outcomes</b>	<p>Improvement in parental self esteem Improvement in physical and mental health (depression) Reduction in the demand for health visitor support Development of social support networks Improved management of children's behaviour Improved use of community services.</p>
<b>Research evidence</b>	<p>Frost, N., Johnson, L., Stein, M. &amp; Wallis, L. (1996) <i>Negotiated Friendship – Home-Start and the delivery of family support</i>. School of Continuing Education, Leeds</p> <p>Kirkaldy, A. &amp; Crisp, A (1999) <i>Home-Start in Scotland – an Evaluation</i></p> <p>McAuley, C (1999) <i>The Family Support Outcomes Study</i> Queens University, Belfast</p> <p>Rajan, L., Turner, H. &amp; Oakley, A (1996) <i>A study of Home-Start</i> Social Science Research Unit - Institute of Education University of London</p> <p>Shinman, S (1994) <i>Family Album: snapshots of Home-Start in words and pictures</i></p> <p>Shinman, S (1996) <i>Family Health and Home-Start</i>. Brunel University</p> <p>Shinman, S (1996) <i>Needs and Outcomes in Families Supported by Home-Start</i>. Brunel University</p> <p>Utting, D., Bright, J. &amp; Henricson, C. (1999) <i>Crime and the Family: Improving child rearing and preventing delinquency</i></p> <p>van der Gyken, W (1990) <i>Home-Start – A four year evaluation</i> (2<sup>nd</sup> edition)</p>
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## LARGE SCALE STRESS WORKSHOPS FOR THE GENERAL PUBLIC

<b>What we know</b>	Around a quarter to a third of GP consultations are for mental health problems. Between 30%-50% of depression goes undetected in primary care; detection rates are poorest for mild to moderate depression. There is good evidence for the effectiveness of cognitive behavioural therapy in treating symptoms of depression and anxiety.
<b>What this project will add</b>	Large scale stress workshops are effective in reaching people whose problems may not be picked up in primary care. They may be as effective as individual psychological therapy and are more cost effective.
<b>Future research</b>	Replication of this model with hard to reach and vulnerable groups; cost effectiveness analysis.
<b>Setting</b>	Community setting – a leisure centre
<b>Level of Action</b>	Individual Community
<b>Target Group</b>	Whole Population
<b>Aims</b>	To offer members of the general public an opportunity to self-refer for help with managing their stress, whether or not they have consulted their GPs about these problems In the long term, this may reduce the prevalence of anxiety in the community.
<b>Programme</b>	Day long stress workshops are held for up to 30 people. The workshops aims to support individuals who recognise they may be experiencing an unhealthy level of stress.
<b>Action</b>	Publicity materials are distributed through community services eg leisure centres, GP practices and libraries to attract people to the events. Members of the general public can self refer for help with their stress problems. Individuals attend an introductory talk, a full day event, in which they are taught physical, cognitive and behavioural methods for coping with stress.
<b>Proven outcomes</b>	Increased interest in stress Increased interest in stress workshops from other Trusts and other regions including Chairs, clinical psychologists, health promotion officers and development managers Participants less anxious, less distressed and more able to cope than those in control and placebo groups

**Research  
evidence**

Brown, J.S.L., Cochrane, R. & Hancox, T. (2000) Large scale stress management workshops for the general public: a controlled evaluation. *Behavioural and Cognitive Psychotherapy*, **28**: 139-151

Brown, J.S.L. & Cochrane, R. (1999) A comparison of people who are referred to a psychology service and those who self-refer to large-scale stress workshops open to the general public. *Journal of Mental Health*, **8**(3), 297-306.

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## MENTAL HEALTH AWARENESS - AN ATTITUDE FOR THE NEW MILLENNIUM

<b>What we know</b>	<p>There are discrepancies between data on public attitudes to mental health and the experiences of people with mental health problems.</p> <p>There is some evidence that national campaigns supported by local initiatives are effective in this area and that work to promote social contact has a positive impact.</p>
<b>What this project will add</b>	<p>Information on the uptake of local programmes, the potential role of nurses in changing public attitudes and effectiveness of different elements of the campaign.</p>
<b>Future research</b>	<p>More research is needed on the most effective approach to changing discriminatory behaviour and increasing social inclusion of people with mental health problems.</p>
<b>Setting</b>	<p>Schools Community – local businesses</p>
<b>Level of Action</b>	<p>Individual</p>
<b>Target Group</b>	<p>Whole population</p>
<b>Aims</b>	<p>The programme aimed to raise awareness about mental health and individuals' attitude to it. The programme uses a self-completion questionnaire to encourage individuals to consider their feelings and attitudes. The results have enabled the project to develop a campaign for the whole community and a training package.</p>
<b>Programme</b>	<p>The programme was established to consider innovative approaches to tackling stigma associated with mental health issues. A strategy group was established including representatives from the Glasgow Advocacy Network, the Glasgow Health Board (Health Promotion) and the Greater Glasgow Primary Care NHS Trust. Details of the programme have been shared with colleagues in Gloucestershire NHS Trust, Inverness and Ireland.</p>
<b>Action</b>	<p>The programme has been delivered through advertising, targeting the whole population and a training resource package to deliver to varying communities from schools to businesses. The intervention incorporated group work and the clarification of values to improve self awareness and to begin the change of lifestyle attitudes of the individual. The programme used principles of self awareness from counselling techniques.</p>

<b>Proven outcomes</b>	Positive interest generated in the programme Positive feedback on the training resource package Repeat invitations to deliver training Increased debate about mental health issues among nurses and the local community Positive written evaluation of pilot documents Highly commended award at the Nursing Times National Nursing Award
<b>Research evidence</b>	Egan (1994) <i>The Skilled Helper</i> (5th edition) Ewles & Simnett (1992) <i>Promoting Health: A practical guide</i> Kaminski P, Harty C (1999) From Stigma to Strategy <i>Nursing Standard</i> <b>13</b> (38) 36-40 Kaminski P, Harty C (2000) Ignorance is not Bliss <i>Nursing Standard</i> <b>96</b> (2) 28-29
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## MENTAL HEALTH PROMOTION FOR UNEMPLOYED PEOPLE

See page 167 Large Scale Stress Workshops for the General Public

<b>Setting</b>	Community – unemployment organisation
<b>Level of Action</b>	Individual Organisational
<b>Target Group</b>	Vulnerable groups – unemployed people
<b>Aims</b>	To run large-scale Stress workshops specially adapted for unemployed people To develop a special workshop programme for unemployed people which also allows for possible literacy problems To assess the effectiveness of these workshops using a randomised control design To analyse the social class backgrounds of those who attend to see if this approach has attracted those from social classes 4 and 5 who tend to under-use health services generally.
<b>Programme</b>	The programme aims to set up, run and evaluate day-long stress workshops for unemployed people living in Southwark and Lewisham. The participants in the workshops will be recruited through PECAN, a local voluntary organisation specialising in organising training for unemployed people.
<b>Action</b>	Unemployed people will be able to self-refer to day-long workshops to help them manage their stress and anxiety. The general workshops will be used as a base for designing and developing the 'population-specific' programme, paying particular attention to the probable literacy problems of this group. Special attention will be given to presenting information visually (e.g. using video material) as well as encouraging small group discussions.
<b>Proven outcomes</b>	Too early for proven outcomes but expected outcomes include: Positive attendance and response to workshop Increased take up by those with literacy problems Increased take up by those from lower social classes Improved re-employment rate among attendees

**Research  
evidence**

Brown, J.S.L., Cochrane, R. & Hancox, T. (2000) Large scale stress management workshops for the general public: a controlled evaluation. *Behavioural and Cognitive Psychotherapy*, **28**: 139-151

Brown, J.S.L. & Cochrane, R. (1999) A comparison of people who are referred to a psychology service and those who self-refer to large-scale stress workshops open to the general public. *Journal of Mental Health*, **8**(3), 297-306.

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## OLD PARCELS OFFICE ARTS PROJECT HULL AND EAST YORKSHIRE MIND

<b>What we know</b>	Community based arts projects can increase confidence, community empowerment, self determination, local image and cohesion. Prescription for Leisure schemes have shown some moderate impact on self-esteem and social functioning. One study showed that psychiatric patients who participated in arts projects had fewer re-admissions than those who did not.
<b>What this project will add</b>	Further information on the mental health impact of arts and creativity within the local community.
<b>Future research</b>	There is a need for further research on the effectiveness of different types of arts programmes eg drama, creative writing, sculpture. This should include consideration of access to and participation in arts and creative pursuits as 'quality of life' indicators within regeneration programmes, and as measures of both social capital and social inclusion.
<b>Setting</b>	Community – workshop site & outreach to schools, workplaces, hospitals
<b>Level of Action</b>	Community
<b>Target Group</b>	Whole population Vulnerable groups People with mental health problems
<b>Aims</b>	The programme aims to promote positive mental health throughout the community in Bridlington through the development of creativity. This inclusive programme aims to reduce stigma, encourage inclusion and enable people to access information about mental health and self-help.
<b>Programme</b>	The programme is delivered by the Bridlington Arts Development Worker, the resident artist for mental health and East Riding and Yorkshire Council Community Education Tutors and WEA Tutors. Hull and East Yorkshire Mind is committed to promoting good mental health and supporting those coping with mental health problems. The arts programme enables people to develop creativity and self expression and to gain confidence in a supportive, non-stigmatising setting. It is open to all sections of the community and provides a low-cost or free activity for the community, building social networks and social capital.

<b>Action</b>	The Old Parcels Office offers a wide range of arts activities and events including visual arts, music, drama and sculpture. Courses are mainly free and cater for families, adults, young people including people who have used mental health services. Outreach programmes also run to engage with vulnerable groups and individuals at risk.
<b>Proven outcomes</b>	Increased number of people using the service Positive feedback through visitors book comments Large number of requests for repeat or extension to courses Increased number of individuals and agencies involved in the provision of work
<b>Research evidence</b>	Matarasso, F. (1997) <i>Use or ornament? The social impact of participation in the arts</i> Comedia Stroud Colgan S, Bridges K and Faragher B (1991) A tentative START to community care <i>Psychiatric Bulletin</i> <b>15</b> :596-8 Huxley P (1997) <i>Arts on prescription: an evaluation</i> Stockport
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## PEER MENTORING PROJECT SUPPORTING CHILDREN

<b>What we know</b>	There is some, albeit limited, evidence to show that peer led programmes may have a greater impact on behaviour than more traditional programmes. Also involving the whole school, staff, pupils and parents is supported by the evidence base.
<b>What this project will add</b>	Further information on transition periods for young people and the impact of a mentoring scheme, on the mentor, the recipient and the school as a whole.
<b>Future research</b>	Further replication of this model at different stress periods for young people eg exam time or relationship breakdown, among parents, would be helpful. There may also be a need to consider further which elements of peer mentoring are effective and how peer mentoring compares with adult/young person mentoring approaches.
<b>Setting</b>	Schools
<b>Level of Action</b>	Individual Community
<b>Target Group</b>	Whole population – within the school Vulnerable groups – young people finding it difficult to adapt to a new school environment.
<b>Aims</b>	The programme aims to support Year Seven pupils with the transition from primary to secondary school. Peer mentoring is delivered by Year Eight students to those in Year Seven to increase. The period of transition is recognised as a time of stress for young people and the programme aims to make them feel supported and secure in their new environment.
<b>Programme</b>	The programme was piloted in two schools successfully with both teachers and pupils evaluating it positively and both schools are continuing with implementation. Six more schools within the Health Action Zone area have been recruited to establish similar peer-mentoring schemes. The programme is funded by Health Promotion Services. The initial implementation was managed by a trainer from Relate who worked with the Head Teacher within the secondary school and the local Health Promotion Specialist in mental health for children and young people.

<b>Action</b>	<p>The Relate trainer trained Year Eight students as mentors, they were trained when they were in Year Seven and aware of the issues that other children were facing. They met the new pupils, who were still in Year Six so relationships could be established before they had joined the school. The mentors were present on the Year Seven's first day and the mentors were supported by teachers and received follow-up training before Christmas, to allow them to discuss with the independent trainer issues raised within the school.</p>
<b>Proven outcomes</b>	<p>Mentors valued the scheme and kept diaries of their experiences – many continued in the role Increased self-esteem and confidence of mentors Training received evaluated well – by both pupils and teachers Schools view the project as successful Year Seven pupils felt supported and could easily identify mentors and felt comfortable approaching them Year Seven pupils trained to be mentors for the following year</p>
<b>Research evidence</b>	<p>Mental Health Foundation (1999) <i>Bright Futures Report</i> MHF, London Black DR, Tobler NS, Sciacca JP (1998) Peer helping/ involvement: an efficacious way to meet the challenge of reducing alcohol, tobacco and other drug use among youth: a meta-analysis <i>Journal of School Health</i> <b>68</b>(3):87-93 Harden A, Weston R, Oakley A (1999) <i>A review of the effectiveness and appropriateness of peer-delivered health promotion interventions for young people</i> EPI-Centre, Social Science Research Unit, Institute of Education, London Roth J, Brooks-Gunn J, Murray L, Foster W (1998) Promoting healthy adolescents: Synthesis of youth development program evaluations <i>Journal of Research on Adolescence</i> <b>8</b>:423-459</p>
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## PRE-RETIREMENT HEALTH INITIATIVE

<b>What we know</b>	Physical activity, volunteering and programmes which enhance social contact, social networks and social support have a positive impact on the mental health of older people.
<b>What this project will add</b>	Structured evaluation of the scheme and the resource produced will provide local data on the needs of older people, as defined by older people themselves and how they can best be met.
<b>Future research</b>	There are considerable gaps in the evidence base on promoting the mental health of older people, including older people in black and minority ethnic groups and those in rural communities.
<b>Setting</b>	Community Primary Care Workplaces
<b>Level of Action</b>	Individual Community Organisational
<b>Target Group</b>	Whole population People at risk – pre-retirement age
<b>Aims</b>	The programme aims to promote the mental health of people approaching retirement in the local area. It will target the whole population and will focus on enabling people to continue to develop their potential throughout their retirement years.
<b>Programme</b>	The programme will explore the needs of people approaching retirement utilising twelve themes, all of which relate to the mental health of the community at large: general health, mental well-being, activities, hobbies, leisure, time and structure, socialising, volunteering, isolation, relationships, dealing with loss and financial management.
<b>Action</b>	As part of the Health Action Zone research programme in Hull and East Riding the views of older people were gathered to consider the determinants of their health and possible effective interventions. The programme offers a facility for people at a major life transition period, pre-retirement, to promote health and well-being. Through the promotion of positive images of older people myths and stereotypes are dispelled, up to date information on health is circulated and the contribution of older people is welcomed.

<b>Proven outcomes</b>	Agreed priorities for health improvement among older people identified recommendations for future worker Increased local uptake of the pre-retirement resource Increased number of settings where the resource is distributed and utilised
<b>Research evidence</b>	McDougall J (1999) The Mental Health and Mental Health Promotion of Older People – Hull & East Riding Mental Health Promotion Strategy Group McDougall J (2000) Health in Retirement – a survey report outlining themes to support people approaching retirement
<b>Contact</b>	Janet McDougall Health Promotion Service Hull and East Riding Community Health NHS Trust Victoria House Park Street Hull HU2 8TD 01482 617826 01482 617815 janet.mcdougall@herch-tr.nhs.uk

## PRESCRIPTIONS FOR LEARNING

<b>What we know</b>	Learning new skills is a protective factor for mental health and also has a range of social and economic benefits
<b>What this project will add</b>	Structured evaluation of the impact of promoting learning and access to education in a primary care setting; further data on impact of learning on individual health of vulnerable groups
<b>Setting</b>	Primary care
<b>Level of Action</b>	Individual Community Organisational
<b>Target Group</b>	Whole population – open access through GP Vulnerable groups – courses may be specified e.g. mother and baby People at risk People with mental health problems
<b>Aims</b>	To explore the impact of learning on individual health among adults in South Nottingham: <ul style="list-style-type: none"><li>• basing a learning advisor in GP surgeries who will provide information and advice about learning opportunities</li><li>• encouraging and supporting adults to access learning locally by establishing a prescription for learning service</li><li>• helping GPs and health workers to understand and make better use of education services for patients</li></ul>
<b>Programme</b>	NIACE has established this programme to explore the impact of learning to the health of adults in South Nottingham. NIACE has a strong commitment to equality of opportunity, widening participation to adult learning and recognising the links between opportunities to learn and develop and the health of individuals and communities.

<b>Action</b>	<p>There are two key strands to the programme:</p> <ul style="list-style-type: none"><li>• the use of a learning advisor within primary care</li><li>• a detailed study of how GPs and primary health care workers can better utilise education services for adults – using the model of ‘prescription for learning’.</li></ul> <p>The learning advisor takes referrals from primary care, they then work with the individuals to identify appropriate learning opportunities and to support them to access and utilise those services. Follow up work will identify the impact learning has had on their health and the support they received.</p>
<b>Proven outcomes</b>	<p>Improved relationships between learning advisors and health care workers Increased number of people accessing learning opportunities Expected positive impact on health</p>
<b>Research evidence</b>	<p>Judith Challis (1996) Adult Education on Prescription in ‘Adult Learning’ Sue Allies (1997) Learning for Life In ‘Adult Learning’ DFEE (1999) Improving Literacy and Numeracy – a fresh start. The report of the working group chaired by Sir Claus Moser</p>
<b>Contact</b>	<p>Kathryn James Development Officer, Learning &amp; Health NIACE - The National Organisation for Adult Learning 21 De Montfort Street Leicester LE1 7GE 0116 204 4200/1 0116 255 6049b (minicom) 0116 285 4514 <a href="mailto:enquiries@niace.org.uk">enquiries@niace.org.uk</a> <a href="http://www.niace.org.uk">www.niace.org.uk</a></p>

# Citizenship and community in mental health

## Programme Plan

### Introduction

Preventing exclusion from ordinary community life for people with serious, long term, perhaps disabling mental illness should be at the top of the mental health service agenda.

Ensuring real access to mainstream community opportunity requires an active approach to inclusion not just at the level of the individual, but with the local community. Improving the local public response is the corollary of helping individuals to better local access. This though is not only a task for mental health promotion and high profile media campaigns, important as these are. While our customary focus has been on managing the “message” through better communication, progress on inclusion; on bringing together communities of service users with broader local communities is at least as much to do with actual services and the ways in which they are planned and delivered as with the presentation of positive information. Strategies for reducing social distance, for extending the rights and responsibilities of citizens within communities, irrespective of disadvantage or disability, will succeed only if these strategies are represented practically in services which, themselves, link to ordinary community interests and, moreover, are locally perceived as doing so.

This focus on the interface of specialist services and community organisation is the starting point for a new inter-agency programme, sponsored jointly by the Sainsbury Centre for Mental Health (SCMH) and the Department of Health and based at SCMH.

### Aim

Taking current policy on community regeneration and citizenship as a significant opportunity for the inclusion agenda in mental health, the programme proposes greater integration of mental health services with mainstream community organisations. It aims to provide a basis in both theory and practice for achieving this, and for:

- extending social access and opportunity for individuals
- encouraging through increased practical local interest, participation and

- familiarisation, as positive and accepting a public response to services as possible.

In order ultimately to better enable individuals with mental health problems to function as citizens rather than as patients.

In so doing, the programme aims to make a significant contribution to the foundations for the long term implementation of the NSF, providing the means by which specialist service developments can be better embedded in a community context.

### **Outcome**

The outcome of the work programme will be a body of work which, when carried forward in conjunction with the work of NSF project teams, will contribute a clear direction for established mental health practice in line with NSF standards over the next 10 years. This will take the form firstly of some practical “tools” for advancing social inclusion in practice, and secondly an established process for partnership based learning and service development.

### **Policy Context**

The Government's strategy on mental health and the NSF itself is supported by a number of formal measures to reduce public risk through an emphasis in new services on assertive practical support and treatment, more effective crisis management and early intervention. This in turn is to be underpinned by a revised statutory framework providing for compulsory community treatment and new forms of detention for people with particular personality disorders.

If the community mental health services which are currently in the process of development are to become securely embedded in the local communities in which their users live, the foundations for the long term implementation of modernised services will undoubtedly need to reflect the need for improvement in the level of local public confidence. Equally however, it will be important to achieve greater local consensus for services and a reduction in the level of local resistance and individual negative discrimination to which currently, the absence of such consensus often gives rise.

This will need to be advanced in a variety of ways, including positive public education initiatives, media strategies and health promotion programmes. While a great deal of work of this kind is planned, is in process or has already been undertaken under the auspices of health promotion, prevention and primary care, these work streams are often dissociated from those concerning the design and organisation of specialist mental health services and from models of user engagement which themselves are focused on processes of recovery or social re-valorisation through community engagement.

In proposing some foundations for the long term development of community mental health services, this programme will support existing work streams in these key areas. However, it will also offer a specific focus on mental health service design and delivery, addressing in a systematic way the means by which services might become appropriately embedded in the communities of which their users are part, thereby promoting improved access, opportunity and social integration for individuals and, reciprocally, improved consensus through new forms of local community engagement at an organisational level.

It will seek to identify those community- level “discourses” (programmes, projects, associations) which appear most relevant to supporting the citizenship objectives of community participation and inclusion, then, taking account of the new multi-sectoral planning opportunities to which Government policy on community regeneration and neighbourhood renewal gives rise, seek to formulate ways in which these discourses can be effectively deployed in developing community capacity for support of specialist mental health services and the citizens which use these services.

To do this it will be necessary to consider new ways of linking the design and organisation of specialist mental health services on the one hand with these generic community themes and projects on the other.

### **Process**

The task of defining this linkage is multi-dimensional, requiring a process which can draw upon and accommodate practices and perspectives from a number of policy domains including those relating to:

- black, minority ethnic and equalities agendas
- principles of recovery and social role valorisation
- employment and the organisation of social enterprise
- community action, empowerment and capacity building
- primary care development
- existing best practice models of rehabilitation and social support in MH
- patient partnership and user involvement,
- the National Health Action Zone (HAZ) programme

and:

identify the cross-cutting themes through which they are, or could be linked when thinking through their relationship to systems of formal mental health service design. It also needs to be a process which is capable of generating new knowledge at both strategic and local service/community levels; one which engages the planners and strategic commissioners of mental health services, the Local Implementation Teams (LITs) and the managers and service practitioners

in local mental health teams. The process will need to be able to use tangible micro-level practice examples to inform this new framework for organisational thinking at a strategic level in order to identify potential for the transfer or replication of these practices, thereby avoiding the risk of their remaining isolated.

Correspondingly, as it progresses, the process will need to inform the work of a number of organisations, principally the key NSF implementation machinery in the Department by way of the Mental Health Task Force, National Mental Health Co-ordinating Group, underpinning programme groups such as those on workforce and performance indicators, and the NSF project teams themselves- primarily that for standard 1 (mental health promotion) and 2 (primary care) but importantly, also those for standards 3 and 4, from which new specialist team-based services for people with severe mental illness are being developed. The process will need to link with national organisations for best mental health practice dissemination, notably the new National Institute for Mental Health, other government Departments, the Social Exclusion Unit and, insofar as the ultimate intention of the programme is to shape more equitable and participative access to services through community oriented pathways, the new NHS Modernisation Agency.

### **Organisational Strategy**

It is intended that in general terms and within constraints of time and resource, the work should adopt the organisational principles of project and programme management, with the Head of Programme reporting to a programme Board comprising the joint commissioners i.e. the Director of SCMH and the Head of Mental Health branch at the Department of Health.

The strategic approach will be to organise this, the initial programme as a series of six parallel but inter related projects, leading both to practical outputs within the programme timeframe of 18 months, and the development of learning “collaboratives” to further define the subsequent programmes of change arising from this practical work and to form a platform for the continuing process of learning and knowledge development beyond the initial period of the programme. The work of each project will be overseen and synthesised within the overall programme approach by a Co-ordinating team on which project managers will be brought together. The programme will seek the guidance, support and involvement of key national organisations and individuals through a larger Programme Reference group.

The reference group will seek representation from the key individuals and organisations responsible for this work, together with representatives of organisations not associated specifically with MH but whose collaboration will be important as a signifier of the aim, objectives and structure of the programme.

The programme will seek to draw on a range of relevant experience from work streams in this area, for example:

- MIND's Creating Accepting Communities pilot sites and other initiatives on changing public response such as the joint National Schizophrenia Fellowship and Institute of Psychiatry's initiative, AD 2000
- initiatives from the work of **mentality** ([www.mentality.org.uk](http://www.mentality.org.uk))
- key work deriving from learning disability development on inclusion through community "bridge building" which the National Development Team (NDT) is undertaking
- work on developing indicators for Social inclusion within Primary Care Groups (PCGs) in progress between the South East Region (SER) of the Department of Health and National Primary Care Research and Development Centre (NPCRDC) at the University of Manchester
- work on social role valorisation and recovery, in progress at Canterbury Christchurch University College and the University of Central England and elsewhere
- Sainsbury Centre work on community development projects and their relevance to mental health which culminated in the S.C.M.H. report "On Your Doorstep"
- work on links to mainstream employment being undertaken by National Schizophrenia Fellowship, Centre for Mental Health Services Development and elsewhere

### **Key project themes and outputs**

Subject to further detailed discussion with the newly formed Programme Board, it is intended that projects will be established in six thematic areas to achieve the following outputs:

1. To co-ordinate and disseminate activity and outcomes from MIND's three "Creating Accepting Communities" pilot sites.
2. To develop criteria for defining socially inclusive practice in mental health using work from sources such as the National Inclusion network and joint work between N.D.T. and Office of Public Management.
3. To establish, initially through regional health and social care offices (and drawing on existing Learning Centres and other organisations) a number of regional "collaboratives" bringing together key change agents from health/social care, community and user organisations to:
  - map those existing community organisations and agencies, using existing knowledge and national community/ voluntary sector data sources (social/ neighbourhood/employment projects; community associations/projects/centres) across the region, which, in their practice could or already do demonstrate a level of partnership with specialist mental health service which is promoting of social inclusion (as defined by the project 2 indicators)
  - review the key characteristics of these partnerships specifically in terms of their implications for NSF service elements
  - agree service model(s) for further partnership promotion, and strategy for ensuring their implementation

As the work of the regional collaboratives progress, it is intended that they should develop as change agencies capable both of supporting transformative learning on community support systems and of incorporating new forms of knowledge for modernised service systems into the machinery of local and regional planning (principally Local Strategic Partnerships and Local Authority Community Strategies).

4. Complete the work on implementing social inclusion through PCGs which is in process in SER in conjunction with the NPCRDC, including work to assess feasibility of establishing PCG- based community development link workers, and disseminate outputs to regional collaboratives

5. Develop a Workbook on social inclusion to bring together theoretical contributions with practical tools for its achievement in practice, providing a knowledge resource which can be locally utilised but nationally revised and updated over time.
6. Develop a framework of standards for citizenship  
i.e. one which will define the key dimensions of citizenship which, in their principles and operation, services will be required to respect, and which a service focus on “ordinary life” opportunities and partnerships, will be expected increasingly to advance.

With an early emphasis on practical learning tools, the programme will seek to inspire support for a longer term vision for inclusion-oriented mental health service models, based on optimising sometimes unlikely organisational partnerships between specialist services themselves and those organisations with the active ability to build or deploy community capacity and knowledge for the benefit of fellow citizens with mental health problems. Equally however, the entitlement to, and expectation of improved social integration will need to be signalled within the range of service planning mechanisms and performance outcome objectives which have been conferred on service planners and commissioners as a result of the National Plan and NSF-stage 3 and Local implementation plans - Health Improvement Programmes (HIMP's), Joint Investment Plans (JIPs) and Health Promotion Strategies for 2002/3 and beyond; the requirements for the Care Programme Approach in respect of employment, housing and occupational activity.

The Citizenship and Community programme will seek to create the means by which a new vision for growing community level partnership or social capital can be developed, and indicate the relevant planning and performance approaches by which its implementation in practice will need to be ensured.

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# Examples of evidence-based practice pro-forma

## Mental Health Promotion: Making It Happen

### Models of Good Practice Pro-forma

We are still keen to collect information on models of good practice. We would welcome further submissions in the format set out below.

#### DETAILS

**Name of the Project**

**Host Organisation**

Name:

Contact person:

Address:

Type of organisation:

Tel:

Fax:

Website:

Email:

#### PROJECT

**Background**

**Rationale – why was the project set up?**

**Project Description**

**Level of Action**

Please tick If more than one level, please state why....

- Individual
- Community
- Organisational

**Target Group**

Please tick Please specify....

- Whole population
- Vulnerable groups
- People at risk
- People with mental health problems

**Setting (eg., workplace, schools, primary care)**

**Consultation – who is involved?**

**Partnership – who delivers?**

**Funding**

**PROJECT DELIVERY**

**Aims and objectives of the project**

**Start Date & Length of Project**

## **EVIDENCE BASE**

**Evidence Base for the Work – is there any published evidence to support the intervention?**

**How has the project been evaluated?**

**Indicators – what indicators do you use to measure the success of the project?**

**Outcomes - what results/impact has the project had?**

**Has the programme been replicated and implemented elsewhere? If so, please give details**

**Are there publications or has evidence of the programme been published? If so, please give details**

**Please return your completed questionnaire to Elizabeth Gale at mentality, 134-138 Borough High Street, London, SE1 1LB or email [enquiries@mentality.org.uk](mailto:enquiries@mentality.org.uk). Please feel free to call on 020 7716 6760 if you have any questions.**



## Appendix Seven

# Feedback form

We continue to welcome your comments on this publication and would welcome your feedback.

Please complete and return the attached form. You do not have to include your name and address if you would prefer not to.

<b>Name</b>
<b>Organisation</b>
<b>Address</b>
<b>Telephone/Fax</b>
<b>e-mail</b>
<b>Did you find this publication useful?</b>

**Which sections were most useful?**

**Is there anything else you feel should have been included?**

**Are there any other comments you would like to make?**

**Thank you for completing this questionnaire.**

**Please return to:**

**mentality**

**134-138 Borough High Street**

**London**

**SE1 1LB**

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## Summary

A key benefit of the programme's joint sponsorship by the Department and the Sainsbury Centre for Mental Health will be the opportunity to adopt a twin track approach in which both knowledge developed and links to existing performance management mechanisms are key dimensions.



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