

Better Mental Health For All

A public health approach to mental health improvement



FACULTY OF
PUBLIC HEALTH



Mental Health
Foundation

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Foreword

It gives me particular pleasure to write a few words of introduction to this important report, commissioned from the Mental Health Foundation by the Faculty of Public Health (FPH) and supported financially by Public Health England. Professor Sarah Stewart-Brown has chaired FPH's Mental Health Committee over a number of years, during which she has been a prime mover in putting public mental health, and in particular the role of good parenting and mental wellbeing, on the map.

The Mental Health Foundation continues to provide solid evidence-based leadership in an area which, until recently, was neglected and poorly understood. On behalf of FPH and all those who stand to benefit from this work, I extend my warm appreciation.

Over forty years ago I trained as a psychiatrist in Newcastle upon Tyne in a department under the formidable leadership of towering intellectual giant and president of the Royal College of Psychiatrists, Sir Martin Roth. It was a remarkable time in the early 1970s when psychiatry was briefly fashionable among the baby boom and sixties generation, and I was privileged to train with some of the brightest graduates of the day. Yet, drawn as I was to the big picture of population health, of policy and social change, I inevitably found my way to the London School of Hygiene and Tropical Medicine and a career in public health.

In those days, it was even more of a privilege that the Masters in Public Health lasted for two years; one year in the classroom and one year for a dissertation, the topic for which was very much in your own court. For me the obvious choice was something that set mental health within a public health and prevention framework. Try as I could, and whoever I took counsel from, including the college president, the nearest I could find was early diagnosis and treatment in the community.

Fortunately, I came across the writings of Gerald Caplan, who had trained in Manchester and the Tavistock Clinic before beginning a journey into public health which began with child guidance in Jerusalem and led to the Harvard School of Public Health. There, in the 1950s, he developed his ideas for a comprehensive approach to mental health, rooted in public health and described in his groundbreaking book 'An Approach to Community Mental Health'. The upshot of this was that I spent the next few years immersed in the world of research, policy and practice that engaged with the rich dividends to be paid in public health by work on Planned Parenthood.

In the same way that sex wasn't actually discovered in 1963 by the Beatles and the Baby Boomers, mental health was not discovered by Caplan in 1954. In fact four phases of mental health evolution can be identified in modern times, beginning with the private madhouses of the eighteenth century poor law, then responding to the turmoil of the French Revolution and the 'madness of King George III' with the advent of whole communities, complete with farms, workshops and gymnasia in the county asylums of the nineteenth century.

These early modern asylums were overwhelmed by the number of people with severe and enduring mental illness whose relatives had hidden away for fear of the gruel and chains of the madhouses. Asylums themselves became less and less therapeutic and more custodial institutions. It was against this background that the therapeutic optimism of the post Second World War, twenty first century phase began, following the discovery of antidepressants and major tranquillisers which revolutionised the management of the major psychoses. However, this was oversold and the resources for proper community care were never forthcoming. We have witnessed a mental health service in increasing disarray, unable to deliver for children and adolescents, let alone the 30% of adults with mental health problems and the increasing numbers suffering with dementia in an ageing society. Public health, wellbeing and prevention have barely had a look in.

Which brings me to this report's important and timely contribution to that fourth, twenty first century phase of mental health. This phase builds on the insights of Caplan and his colleagues from the 1950s onwards and begins to create a practical framework for public health practitioners and others to organise their work¹. Implicit is a twin track approach; we cannot neglect severe and enduring mental illness for which, at the moment, our answers often seem narrow with an emphasis on medication.

However, the second track that beckons recognises the importance of an asset based approach to mental health; to building resilience and aiming for wellbeing in which the goal of mental and physical health is indivisible. This track also makes clear the importance of a focus on the determinants of health and wellbeing, to a life course approach and to tackling inequalities. In this, my final presidential year, I am pleased to return to my roots in mental health and recommend this important contribution to our members and fellows, and all those engaged in the important mission of protecting and improving the population's mental health.



Professor John R Ashton C.B.E.

President of the Faculty of Public Health of the Royal Colleges of Physicians of London, Edinburgh and Glasgow.

Executive summary

This report focuses on what can be done individually and collectively to enhance the mental health of individuals, families and communities by using a public health approach. It is intended as a resource for public health practitioners to support the development of knowledge and skills in public mental health. It presents the latter from the perspective of those working within public health, giving valuable interdisciplinary perspectives that focus on achieving health gains across the population.

Public mental health is fundamental to public health in general because mental health is a determinant and consequence of physical health as well as a resource for living. A public mental health approach is concerned with promoting mental wellbeing, preventing future mental health problems and with recovery from mental health problems. The Faculty of Public Health has published this resource to encourage a proportionate universal approach with a focus on the promotion of mental wellbeing and on high level support for those at risk of poor mental health and mental health problems. In this way the resource complements recovery and prevention approaches.

- **Section one** maps out why mental health is an important and often overlooked aspect of overall health.

Supportive policy is emerging across the UK, but the full potential for public mental health is yet to be addressed. Provision on the ground of interventions and services that support public mental health has been badly affected by austerity measures. The economic and social costs of mental health problems are very high. Calculations to date have failed to take into account the additional value to society of improving mental wellbeing or the adverse effects on physical health.

Equality, diversity and the social determinants of health are as relevant in public mental health as they are in public health in general. To successfully address mental health, current models of practice need expanding to include:

- ▶ Psychological, sociological and interpersonal approaches,
 - ▶ Interventions that acknowledge the central role of the social context in which people live including infant development and family relationships,
 - ▶ Intersectional and cumulative impacts of discrimination, poverty and exclusion.
- **Section two** outlines the risk and protective factors through the life course and across communities.

Over three quarters of all mental health problems have emerged by the age of twenty, making childhood determinants primary in future mental wellbeing. Of these determinants, family relationships are pre-eminent because they mould the infant social and emotional brain and thus determine vulnerability throughout life. Later in life, risk and protective factors are important because they influence rates of recovery, remission and relapse from physical health conditions as well as mental health problems.

- **Section three** addresses approaches and interventions to improve mental health at different stages of the life course and in different settings.

Given the complex interaction of mental health determinants, public mental health needs to expand its research and methodology beyond traditional quantitative approaches, such as randomised controlled trials, to co-produce studies with communities and adopt mixed methods approaches as well as newer approaches such as realist evaluation. The Roadmap for Mental Health in Europe Study contributes to a broader understanding of public mental health research and evaluation.

The Roadmap for Mental Health in Europe study² contributes to a broader understanding of public mental health research and evaluation.

Interventions at different life stages and in different places interact with each other. To address family determinants, adult parents need support, knowledge, insight, strong supportive communities as well as a fairer and more equal society with a better distribution of opportunities.

- **Section four** offers a practical guide to enable practitioners to support their own mental wellbeing.

Public health professionals should invest in activities to explore and enhance their own mental wellbeing and the mental wellbeing of those they work with. This will enhance their practice through the insights and experience it generates.

A call to action

It is vital that public health practitioners become advocates for public mental health providing strong leadership and prioritising mental health within current public health practices. Here is a list of key actions that all professionals working in public health and beyond can take to promote mental wellbeing and prevent mental health problems.

- Whether you work in a specialised public health role or generalist/general work force, consider what you can do within your sphere of influence to advance the public's mental health as a leader, partner and advocate.
- Move, wherever possible, from deficit to strengths-based approaches and ensure you promote good mental wellbeing, address the factors that create mental wellbeing and tackle mental health problems.
- Adopt a proportionate universalism approach, including universal interventions to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at risk groups.
- As part of the universal approach, ensure that you are working towards your own mental wellbeing and that of your colleagues.
- Move towards ensuring mental health receives the same billing and priority as physical health in your work.
- Adopt a life course approach. The foundations of mental health are laid down in infancy in the context of family relationships. Place-based intervention in settings such as schools, workplaces and communities complements the life course approach and makes the most of existing opportunities.
- Reduce stigma and discrimination by increasing mental health and wellbeing literacy across the whole population. Include interventions to improve understanding of the impact stigma and discrimination have on the lives of people with mental health problems.
- Contribute to the expansion of the public mental health evidence base and focus on the interventions and activities that make the biggest impact.
- Ensure that you build evaluation into everyday practice and monitor the effects of practice on mental health.

Throughout the report, case studies showcase examples of innovative public mental health programmes and projects being run across the UK. These were selected from the thirty entries submitted to the *Faculty of Public Health 2016 Public Mental Health Awards* and celebrate the public health professionals who are pioneering role models for public mental health.

The roles of a front line public mental health practitioner

I am currently employed by a county council as a public health consultant. My role involves finding ways to improve the mental wellbeing of our local population. My approach encompasses four broadly overlapping areas of public health practice: leadership, partnership, advocacy and measuring change.

(1) As Leader: With control over the allocation and implementation of some of the public health grant, and responsibility for assessing the need and evidence base, direct contracting and procuring services, I have commissioned:

- Mental health awareness training
- A Healthy Workplace service offering health and wellbeing support for small businesses, support for offenders in the community³ via a Probation Health Trainer Service
- Reading Aloud – Community reading groups which help combat social isolation and aim to build confidence and mental resilience in those experiencing mental health problems.⁴

We are also responsible for direct commissioning of children and young people/school based mental health services, through which I have appointed two healthy school advisers to support schools to improve pupils' mental/emotional health and wellbeing and organised the follow Mental Health Promotion training in schools:

- Positive Psychology Coaching Skills (Youth Mental Health 1st Aid training)
- Suicide & Self Harm awareness training
- Teenage Mediation⁵
- 'Thinkwise' – CBT programme delivered to year 6 pupils

(2) As Partner: Understanding the health impact of other departments' and partner's policies, I work with others to develop joint initiatives. This can include joint strategies, commissioning and sharing of resources including budgets. This work has involved:

- Working with housing partners to influence the development of housing provision and neighbourhoods that are conducive to mental wellbeing. Forming alliances with CCGs/ other NHS partners and with the voluntary sector to support work to improve mental health but also to increase awareness of the mediating role of mental wellbeing in achieving wider health outcomes.
- Leading the local Suicide audit and prevention group

(3) As Advocate: When not in a position to have any direct control over an issue or policy, a key role of mine is to champion and advocate for change, tackling mental health inequalities, stigma and discrimination. This has included raising awareness of mental health and wellbeing with departments unaware of the effects of their decisions, completing health impact assessments, attending relevant boards and committees and engaging with the media, political bodies and individuals.

(4) As Evaluator: Where possible I adopt an evidence based approach in all of the programmes/ activities that I lead on and commission. I therefore aim to keep abreast of key developments and look to national bodies for guidance on best practice. However, public mental health is an emergent field and as a result there are gaps in the evidence base. Where there is a strong argument to intervene in an area where promising practice exists I see it as my role to ensure that these interventions are piloted and well evaluated before being implemented at scale. I also consider that I have a responsibility to share what is known to work and for whom in real life situations to influence not just local prioritisation but to help build the wider public mental health evidence base, including publishing findings and disseminating these more widely. This is an area of development for myself and colleagues in the coming years.

Section One

Public mental health: why bother?

Public mental health and public health practice

Mental health is now recognised as being profoundly important to growth, development, learning and resilience. Mental wellbeing protects the body from the impact of life's stresses and traumatic events, and enables the adoption of healthy lifestyles and the management of long term illness. Mental wellbeing is a valuable resource for individuals, families and communities. It is associated with better physical health, positive interpersonal relationships and socially healthier societies. It helps people to achieve their potential, realise ambitions, cope with adversity, work productively and contribute to their community and society^{6, 7, 8}.

The social, physical and economic environments in which people are born, grow, live, work and age have important implications for mental health⁹.

Promoting mental wellbeing and preventing mental health problems should be key elements of every public health strategy because mental health influences all other health outcomes. Neglecting it undermines public health interventions to reduce health inequalities and prevent premature death from preventable conditions¹⁰.

Concepts and definitions

Many constantly changing terminologies are variously used to describe realities and actively create meaning in the field of mental health^{11, 12}. They describe positive health, health problems, illness, disorders and those affected directly. Different communities of interest have preferences for different terms, but there is no consensus. Indeed, the language debate is in itself an illustration of the fact that mental health is both a social and an individual issue. Multiple actors are engaged in attempts to grapple with experiences and concepts which are fundamental to the human condition. This 'multiple discourse' can create problems with the dissemination and understanding of precise knowledge and poses a barrier to those wanting to engage with the subject. To avoid confusion, here is a summary of what we mean by the terms used in this report.

Public mental health

Public mental health is a term that has been coined to underline the need to emphasise the neglected element of mental health in public health practice. It spans promotion, prevention, effective treatment, care and recovery. It is built on the same principles as all areas of public health.

Mental health

The term *mental health* is used to describe a spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health. Some authorities argue that psychiatric disorder and mental wellbeing are two distinct continua; the dual continuum model. In this model a psychiatric diagnosis does not exclude mental wellbeing and lack of diagnosis does not exclude lack of mental wellbeing. The Faculty of Public Health model is based on the epidemiology of mental health in populations. The latter demonstrates a continuous distribution whatever measures have been used. The difference between the two approaches can be explained if it is understood that a psychiatric diagnosis is not itself a measure of psychological functioning or of emotional state. The dual continuum¹³ is useful conceptually for conditions that may be an enduring part of someone's life such as bipolar disorder. The single continuum model works well in public health where mental health problems are not static but the impact of the environment can be.

The widely recognised WHO definition of mental health, '... a state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community,¹⁴ is to be welcomed in that it emphasises positive health, rather than illness. This definition covers the 'functional' and 'productive' components of mental wellbeing, but critics argue that it does not capture the affective or feeling elements of mental health and the use of the word 'health' to represent the positive can create confusion in the context of health services which focus on disease. It is for this reason that we use mental health to capture the spectrum from positive to negative states of mental health.

Wellbeing

We use the term *wellbeing* as synonymous with the 1946 WHO definition of health – a state of mental, physical and social wellbeing. This is a holistic state to which all aspects of the human being contribute. The term wellbeing is often used as synonymous with mental wellbeing partly, perhaps, to counterbalance prevailing trends to focus on physical wellbeing. Mental and social wellbeing are inextricably linked in both cause and effect ways. Indeed the definition of mental wellbeing includes the capacity for healthy relationships.

Mental wellbeing

The term *mental wellbeing* is used in this report to cover the positive end of mental health covering both the hedonic (feeling good) and eudemonic components (functioning well). Feeling good is subjective and embraces happiness, life satisfaction¹⁵ and other positive affective states. Functioning well embraces the components of psychological wellbeing (self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and environmental mastery)¹⁶. Different aspects of mental wellbeing may be more or less manifest in different individuals. We regard mental wellbeing as closely related to positive mental health, first defined by Marie Jahoda in 1958¹⁷. Emotional wellbeing is sometimes used interchangeably with mental wellbeing especially with regard to children and young people.

Resilience

The term *resilience* is used to mean 'being able to cope with the normal stress of life' and 'bounce back from problems'. This is an important component of many definitions of mental wellbeing, with great relevance for the prevention of mental health problems.

Mental health problems

We use the term *mental health problems* synonymously with *poor mental health* or to cover the range of negative mental health states including, mental disorder – those mental health problems meeting the criteria for psychiatric diagnosis, and mental health problems which fall short of diagnostic criteria threshold. Mental health problems can be further categorised into the common mental problems such as anxiety and depression which may be transient (relapsing, remitting and recovered); and severe mental health problems such as schizophrenia and bipolar disorder; and the various behavioural disorders. We avoid the term mental illness as a catch all label because of its connotations with the bio-medical model.

Person with lived experience/experts by experience

There has been a move within the field of mental health, largely led by people with lived experience, to avoid the term 'patient' and use instead alternatives including 'survivor', 'service user' and person with lived experience/experts by experience. This language draws on the social model of disability, which moves away from defining people by a clinical diagnosis or service use to focus on people's individual and collective everyday realities. Seventy five per cent of people with a mental health problem of a severity to warrant diagnosis, do not receive secondary mental health services, and thus may never regard themselves as a 'patient' or 'service user'¹⁸.

History

Public mental health has a very transdisciplinary history. Calls to promote mental health and mental wellbeing and prevent mental health problems date back to the 1950s. Since then approaches have emerged from psychology^{19,20}, health promotion²¹, public health^{22, 23, 24}, sociology^{25, 26} and psychiatry²⁷.

Over the last two decades many books have appeared to support teaching, training and practice in this aspect of public health practice^{28, 29, 30} and new electronic resources appear regularly to support the dissemination of public mental health knowledge and skills tailored to the needs of professionals, practitioners and the general public^{31, 32, 33}.

Until the 1990s, a bio-medical model dominated thinking about both physical health and mental health. This model almost exclusively focuses on illness, has a preference for genetic and biological causes, underestimates the effect of developmental, social (relational, systematic and structural) and environmental determinants of health, and believes in the primacy of pharmaceutical and technological solutions. This model has delivered immense advances for health in general. It has been developed into the bio-social model by the public health community to include social and environmental determinants of health. For public mental health practice, the bio-social model needed developing further to include psychological and interpersonal factors. It is now being called the bio-psycho-social model.

New ways of thinking

To encompass all that we know about intervening in public mental health, the Dalgren and Whitehead model (1991)³⁴, where susceptibility to mental health problems may be determined by individual risk factors, which are influenced by settings and in turn by the broader socioeconomic, cultural and political context, needs to be expanded. This expansion needs to encompass the crucial role that family relationships play in formative years, moulding the infant's brain in a way which affects health throughout the lifecourse³⁵. It needs to recognise the complex interactions between all components of the model, in particular those between the social and physical environment and the human genome, which dictate the expression of inherited genes^{36, 37}. This model also does not adequately incorporate research on specific aspects of mental wellbeing such as health beliefs, health locus of control³⁸ and self-efficacy³⁹. All these are crucial to how people process and act upon health information, and this has implications for how resilience, susceptibility and responses to mental health problems are developed. Although the model emphasises social determinants it does not adequately address the role that equality plays in public health.

Evans and Stoddart included ecology in the model recognising the natural and physical, as well as the social environment in which people live⁴⁰. Ecological models enable understanding that individual or even family functioning alone will have limitations, as much of our health is influenced by the communities and structural context in which we live. The model demonstrates how decisions that impact on inequalities at a national policy level can support or undermine efforts to improve mental health.

It is now understood that public mental health must act in an empowering way to combat inequalities and the powerlessness which can accompany them⁴¹. Community Development is an approach to creating interventions for people with, or at risk of, mental health problems in a way which is essentially empowering, and ensures interventions take into account people's experiences and expectations, including Asset Based Community Development and Co-production. This approach is gathering recognition across the field of health improvement more generally^{42, 43}.

Case Study 1: Patient Empowerment Project

The Patient Empowerment Project (PEP) was developed in 2014 using a co-production approach in partnership with Patient and Clinical Leaders from NHS Leeds West Clinical Commissioning Group (CCG), local voluntary groups, CCG member practices and Leeds City Council. PEP enabled patients and communities to actively self-manage their health issues, improving patient experience and outcomes. PEP received 703 referrals in the first year.

The PEP service was a standalone specific project linked to the Health and Wellbeing Strategy for the city and the CCG strategy to create a formal referral process for general practitioners. They refer patients with social, emotional or practical needs to a variety of holistic, local community services via one of the community based PEP workers, thus expanding the range of options available in a GP consultation. Patients can also self-refer.

PEP is implemented in all practice areas in NHS Leeds West CCG, tailored to the needs of local practice communities aiming to provide better health outcomes and reduce health inequalities. Data is captured at baseline and outcomes are measured at three months or on exit of programme.

Feedback from patients, the public, local GP practices and the third sector highlighted the need to support patients to access local services that could help them with their health and wellbeing. Peer Support groups began to be developed, with PEP being integral to the CCG's self-care strategy and multi-speciality locality approach.

A mixed methods approach over four key domains was used to evaluate the impact of the first year of the PEP service. These are: clinical outcomes, economic outcomes, staff acceptability and feasibility and patient experience.

Mental health as a determinant of physical health

Historically, there has been a disconnect within healthcare of the mind and body, but it is now understood that this is an arbitrary separation; mental health and physical health are fully integrated and codependent. The mind and body are intrinsically linked on a physiological level.

Mental health is linked to physiological processes in the body mammalian (fight and flight) and the more phylogenically ancient (freeze) stress responses⁴⁴. The autonomic nervous system is integrally linked to emotional states and regulates cardiovascular, respiratory, digestive, repair and defence functions of the body at a subconscious level and so has a profound effect on resilience and susceptibility to disease. This is an important underlying mechanism to explain why cohort studies looking at different aspects of mental health demonstrate a survival advantage in those with mental wellbeing⁴⁵. The risk factors for physical and mental health problems commonly overlap, and the effect of social and environmental determinants on physical health can have a profound influence on resilience. This explains why the physical health of people with severe and enduring mental illness is often poor⁴⁶.

The Kings Fund estimates that more than four million people in England with a long term physical health problem also have a mental health problem⁴⁷. It is estimated that up to 70% of patients with 'medically unexplained symptoms' are also living with depression and/or anxiety related conditions⁴⁸. Care for the mental health of these populations improves management of their physical condition. Almost half of all tobacco is now consumed by people with a mental health problem, so further efforts to reduce smoking prevalence require effective action within this group. Mental health problems fundamentally affect the delivery and efficacy of care for physical health problems. Further to this, people with a mental health condition are more likely to experience higher costs for treatment of their physical health condition because of the complexity of dual conditions, the severity of the physical condition, and the lack of integrated treatment⁴⁹.

Case study 2: The COPD manual

To address the issue of chronic obstructive pulmonary disease (COPD), an issue frequently associated with frequent hospital admissions and amplified by inadequate self-management and psychological difficulties, Central and North West London NHS Foundation Trust trialled a COPD manual focused on both mental and physical health.

A number of patients were admitted to Hillingdon Hospital with COPD where anxiety and panic were seen to be a large factor in their admission, over and above their COPD exacerbation. However, the hospital had no formal service provision for the condition.

The COPD manual was designed to improve psychological adjustment and coping with COPD and breathlessness over a five-week period which included a home visit and follow up calls. The aim for the programme was to both prevent mental health problems as well as the promotion of mental wellbeing. Over the 12 month trial period:

- The total A&E visits in the COPD manual group fell by 42% compared with an increase of 16% in the control group.
- The total number of bed days reduced by 61% in the COPD manual group with an increase of 18% in the control group.
- The total savings from the COPD manual group amounted to £30,197.12, or £269.62 per participant, compared to a £50 cost of delivering the programme.
- At six months, 3% of the COPD manual group remained clinically anxious compared to 23% in the control group.
- At six months, 7% of the COPD group remained clinically depressed compared to 15% in the control group.

The COPD manual was concluded to be a straightforward cost-effective intervention that was worth offering COPD patients within primary or secondary care.

Mental wellbeing and resilience are protective factors for physical health as they reduce the prevalence of risky behaviours such as heavy drinking, illegal drug use, smoking and unhealthy food choices which are often used as coping and management mechanisms in the absence of other support

The silo approach to public health, in which physical health is considered independently of mental health, no longer makes sense. Mental health needs to be considered in all public health policies and programmes as an integral part of the formula for wellbeing.

Epidemiology of mental health and wellbeing

Epidemiology has delivered vital information about mental health and its determinants and effects. Whilst the emphasis in this research has been on mental health problems, there is now strong evidence relating to the protective effect of mental wellbeing. In healthy population cohort studies, from which people with mental disorders are excluded, both positive affect and positive dispositions reduce the hazard ratio for death by 20%⁵⁰. Positive relationships, a key component of mental wellbeing, are similarly protective against loneliness and death⁵¹. Positive affect (emotions or feelings) also reduces morbidity⁵².

The precise mechanisms are yet to be elucidated but it is very likely that the physiological processes described above; the adoption of healthy lifestyles, the proactive management of long term disease and relative influence of wider determinants all play a part. These demand, as a starting point, positive attitudes to self, environmental mastery and the positive relationships with others which underpin resilience and are essential components of mental wellbeing.

It is also clear that mental health problems are as much of a public health issue as physical health problems⁵³. According to WHO estimates, mental health problems account for more disability adjusted life years lost (23%) than cardiovascular disease (16%) or cancer (16%)⁵⁴. Estimates

of the prevalence of mental health problems vary depending on the country and the measurement process used. One recent study estimated that 38% of people in the European Union experience mental health problems each year⁵⁵, another suggested that half of the Western population will experience an episode of depression in their lifetimes⁵⁶, and the statistics from England, which will be revised in 2016, show that 23% of adults have at least one diagnosed mental health problem at any one point in time⁵⁷. Mental health problems are a key factor in determining premature mortality, with Nordic research estimating that a person who has been admitted to hospital for mental health reasons will die 15-20 years prematurely⁵⁸. There is strong evidence that investment in the protection and promotion of mental wellbeing, including early intervention and prevention, improves quality of life, life expectancy, educational achievement, productivity and economic outcomes, and reduces violence, antisocial behaviour and crime. This will be discussed further in the 'creating healthy people and healthy places' sections below. Strong evidence of the poor outcomes related to having a mental health problem means that prevention and early intervention need to be a priority. Equally, there is evidence that investing in the protection and promotion of mental wellbeing should be emphasised within public mental health.

The knowledge of risk and protective factors for mental health and wellbeing derives mostly from epidemiological studies using regression analyses. As in other parts of public health, these have proved valuable but they do have some limitations in public mental health for a number of reasons. Regression analysis is best suited to singling out a primary determinant for individual diseases. In mental health, co-morbidity is the norm and risk factors are not specific to specific disorders. Most risk factors in mental health are correlated with each other and many are associated in a cause and effect way. They may act as mediators or moderators rather than primary determinants. Although there are statistical methods to address these issues, most studies in mental health do not use them.

The most potent risk factors, for example abusive parenting, drug and alcohol misuse or bullying in workplaces or schools, are more difficult to measure than social factors such as income, education or marital status. The latter, which may often be proxies for the primary determinant, are used in the analyses. Regression analyses are therefore not well suited to investigating cause and effect in the complex system that is public mental health. And whilst the information they offer is a vitally important part of the overall picture, they rarely provide public health professionals with a clear plan for intervention. They can provide a map but identifying the best route to improving mental health constitutes the skill of public health practice at local level.

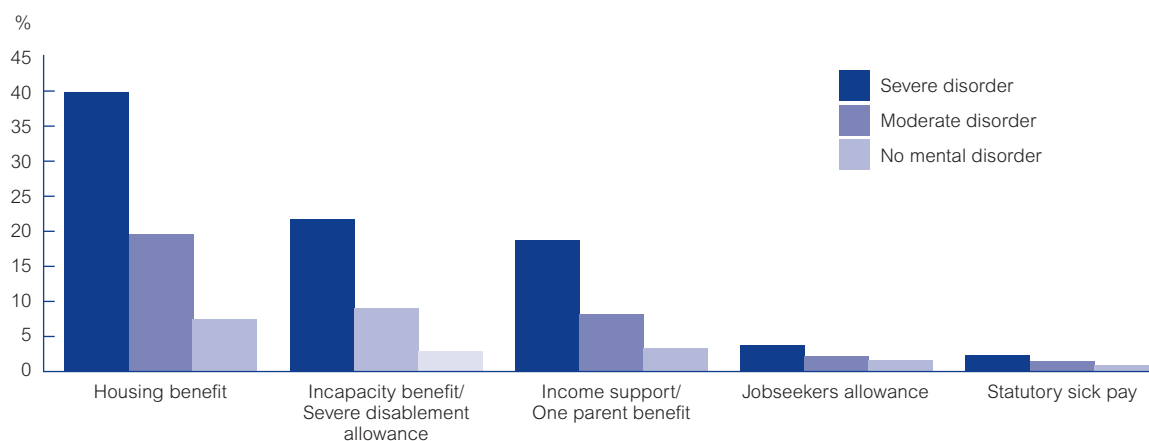
Mental wellbeing sits outside the medical model and thus is not a 'diagnosis.' At the present time there is no clear basis for creating cut points to define different categories within in. Researchers therefore either present mean levels in different populations or present proportions of the population falling above or below cut points representing plus or minus one standard deviation. Another approach is to present the data in population quintile groups. The latter approaches are valuable to illustrate concepts and social variations but cannot be used to assess prevalence for obvious reasons. As research into mental wellbeing increases it may prove possible and sensible to define cut points for optimum and near-optimum mental wellbeing.

The business case for public mental health

The economic and social cost of poor mental health

Poor mental health brings with it costs to individuals and their families as well as to society as a whole through costs to public services: health, social care, housing, education criminal justice, social security and the wider economy. People with mental health problems are more likely to experience physical health problems, smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty, and be over-represented in the criminal justice system. Productivity losses, benefit payments and cost to the NHS associated with mental health problems cost the English economy £70bn a year⁵⁹.

Figure 1: Proportion who receive a particular benefit, by type of benefit and by mental health status



Source: OECD calculations based on data from the Adult Psychiatric Morbidity Survey 2007

Mental health is the cause of 40% of new disability benefit claims each year in the UK⁶⁰. 70% of people with severe mental health problems are economically inactive and on disability benefit, compared with 30% of the general population. Although this is partly due to not being well enough to work, it is also due to not being able to remain in current work settings and not being able to find a workplace that will reasonably accommodate their needs. There is also a clear relationship between poor mental health and social class, with untreated mental health problems causing a downward shift in social class⁶¹. The welfare reform policy agenda has had marked and detrimental impacts both on disabled claimants, including those with mental health problems, and on the mental health and wellbeing of claimants⁶².

The opportunity gains of mental wellbeing

The economic benefits of mental wellbeing are broad, deep reaching and societal, but as yet few studies have addressed this. They include children who learn easily and are able to fulfil their full potential as members of society; people who are better able to manage life events and traumas; people who live in a way which supports their own and others' health, who can manage their health issues and provide compassionate support for relatives and friends when they are vulnerable; employees who are creative, adaptable, resilient and productive; and people who age well.^{63, 64} Conversely, poor mental health is associated with negative social outcomes that carry costs for individuals as well as society such as lower educational attainment, higher rates of health risk behaviours (such as unplanned pregnancy, smoking, alcohol and drug misuse), poorer social skills, and anti-social behaviours.⁶⁵

A range of public mental health interventions have been shown to give excellent returns on investment within one to two years⁶⁶: It is worth noting that the benefits of such studies are calculated in terms of the mental health problems they prevent, and do not include the added value from increasing mental wellbeing⁶⁷. The Early Intervention Foundation, a charity that champions and supports intervention in the preschool period, estimates that in England and Wales £17bn per year is spent on late intervention ‘addressing the damaging problems that affect children and young people, such as mental health problems, unemployment and youth crime’ (p4). This includes £440m per year on child mental health hospital admissions, £40m on child self-harm hospital admissions, £440m on children in specialist substance misuse services, and a range of other costs to public agencies including local authorities, the NHS, schools, welfare, police and the criminal justice system. They recommend that early intervention should be “a key priority of [the] incoming government”(p5⁶⁸). The Children and Young People’s Mental Health and Wellbeing Taskforce report Future in Mind acknowledge the importance of early intervention in not only avoiding crisis in young people but as a factor in avoiding a future trajectory into expensive and longer term service use across adulthood⁶⁹.

Poor mental health is associated with being unemployed which carries with it a whole range of negative outcomes for individuals alongside the costs to the economy. In the workplace levels of absenteeism create a burden on employers by impacting on productivity and quality of output. However, being in work with security and support gives individuals a sense of control that has a positive impact on mental health and wellbeing⁷⁰.

Table 1: Total returns on investment: economic pay-offs per £1 expenditure)⁷¹

Economic pay-offs per £1 investment	NHS	Other public sectors	Non public sector	Total
Early identification and intervention as soon as mental disorder arises				
Early intervention for depression in diabetes	1.08	1.78	5.03	7.80
Health visitor interventions to reduce postnatal depression	0.40	–	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.80
Early intervention for medically unexplained symptoms	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	–	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45
Promotion of mental health and prevention of mental disorder				
Prevention of conduct disorder through social and emotional learning programmes	9.42	17.02	57.29	83.73
School-based interventions to reduce bullying	0	0	14.35	14.35
Workplace health promotion programmes	–	–	9.69	9.69
Addressing social determinants and consequence of mental disorder				
Debt advice services	0.34	0.58	2.36	3.55
Befriending for older adults	0.44	–	–	0.44

Policy context

There has been a growing prioritisation of mental health treatment and care within policy over the last few decades, with unprecedented attention given in the run up to the last election. This was followed by the publication of the Mental Health Taskforce Five Year Forward View (FYFV) in early 2016⁷². The recognition of the importance of preventing mental health problems and promoting mental wellbeing has been slower, but policy across the UK is slowly coming into line with public mental health practitioners and researchers on this and policy makers are realising that much more can be done, often outside of the traditional health system. This was partially demonstrated in FYFV recommendations for a Prevention Concordat, Prevention Plans and a Research Strategy. There is a growing understanding that mental health is influenced by wide ranging public policies and therefore a cross-departmental approach is required to ensure policy is reflective of the challenges faced in this area of policy.

In Scotland, the Christie Report warned of ‘failure demand’ associated with not acting early to prevent poor health outcomes, including mental health. This report outlined the importance of working across public policy to reduce health inequalities⁷³. In Fair Society, Healthy Lives, Marmot recommends approaches that put wellbeing at the heart of policy instead of focusing on economic growth, warning of the human and economic cost of failing to act on health inequality⁷⁴. Mental Health in All Policies (MHiAP) is a relatively new conceptual approach within mental health that draws on the earlier ‘Health in All Policies’ approach⁷⁵. MHiAP aims to promote population mental health and wellbeing by initiating and facilitating action within different non-health public policy areas. The EU Joint Action for Mental Health and Wellbeing report ‘MHiAP emphasises the impacts of public policies on mental health determinants, strives to reduce mental health inequalities, aims to highlight the opportunities offered by mental health to different policy areas, and reinforces the accountability of policy makers for mental health impact⁷⁶.’

In the UK, the devolution of certain policy areas associated with public mental health, and the growing responsibility of local government in relation to public health, are both opportunities for public mental health to be addressed on a local level. There has been a range of policy developments in recent years targeted at specific stages of the life course, with perinatal mental health and the mental health of older people being two areas of significant focus across the UK. Themes have included early intervention, equality, choice and control.

Parity of esteem

‘Parity of esteem’ is the label being used by those calling for mental health to be given equal priority to physical health. The term is used primarily in England, and isn’t well understood outside the UK. The Royal College of Psychiatrists proposed that parity of esteem should be defined as “valuing mental health equally with physical health”. The usefulness of the term is contested, although there is consensus that mental health services is underfunded in comparison with physical health services.

Although the discourse around parity of esteem currently focuses on addressing the critically important issue of poor health and life expectancy of people with serious mental problems, the debate needs to broaden into challenging all aspects of disparity enshrined in how society and policy makers view mental and physical health from prevention through to treatment. Linking mental health so closely to physical health raises challenges, and it is important that calls for mental health parity are not too reductive or narrow, as mental health is not just the responsibility of the health and social care system.⁷⁷

Equality, equity and diversity

Understanding and addressing inequality is part of creating a mentally healthier society. It is also essential for working out how to allocate public mental health interventions in an evidenced based, meaningful way to ensure proportionate investment. The relationship between inequalities related to socio-economic status and protected characteristics¹ and poor mental health is two-way: experiencing

¹ Protected characteristics under equality legislation: age, disability, gender, marriage and civil partnership, sex, sexual orientation, race, religion and pregnancy.

disadvantage and adversity increases the risk of mental health problems and experiencing mental health problems increases the risk of experiencing disadvantage. Mental health problems can create a spiral of adversity where related factors such as employment, income and relationships are impacted, and these things in turn are known to compound and entrench mental health problems.

Evidence is now emerging that there is a strong contextual effect for material factors, with higher levels of wellbeing in more equal societies. One theory for this, and the strong gradient in health, is that relative deprivation is a catalyst for a range of negative emotional and cognitive responses to inequity⁷⁸. There is some emerging research showing that classic risk factors which predict mental health problems, such as educational underachievement, low income and ethnicity, do not seem to predict mental wellbeing, with some Black and Ethnic Minority groups being shown to have higher levels of mental wellbeing than expected⁷⁹. One explanation for this is that as mental wellbeing improves, feelings of self-worth become less influenced by social position and more by life experiences.

However, some Black and Ethnic Minority groups are also more likely to experience a mental health problem, irrespective of socio-economic status⁸⁰, and are less likely to have their mental health problems detected by their GP⁸¹. This poses interesting questions in relation to resilience within some communities, but also the increased risk of being diagnosed with a mental health problem and poor outcomes thereafter. A range of diverse hypotheses exist in relation to differences in cultural manifestations of distress, meaning attached to mental health and wellbeing and structural factors that impact on help-seeking behaviour and access to support. Overall, there is a need for more research to fully understand differences in mental wellbeing despite adversity/risk alongside higher levels of representation of people from Black and Minority Ethnic communities within specialist and most restrictive mental health services⁸².

The cumulative impact of being born into poverty, intersecting with other inequalities is evident throughout their life course. The health of children born to poor mothers is more likely to be compromised due to their mother's poor nutrition, exposure to stress, and poor working conditions⁸³. The experience of poverty during sensitive early development periods affect development and lead to children having poorer cognitive performances^{84, 85}. In adolescence it increases risks of depression, substance abuse, and early sexual and criminal activity⁸⁶.

Mental health related stigma and discrimination

Stigma, discrimination and social exclusion related to mental health are significant barriers to quality of life and mental wellbeing for people with lived experience, and their carers, and as such addressing these has become a priority nationally and internationally⁸⁷. Nine out of ten people who experience mental health problems have experienced stigma and discrimination through work, education, by health professionals or from family, and it is often felt that the reactions and behaviours of others can be more damaging than the diagnosis itself⁸⁸. People who experience mental health problems face more stigma and discrimination than those with physical health conditions, with the exception of those with HIV/AIDS⁸⁹.

Many people will not seek support due to the stigma they expect to face and the self-stigma of feeling a burden, and believing they have undesirable attributes⁹⁰. Although disability discrimination laws prohibit discrimination against people with lived experience, research has shown time and again that there have been clear examples of people being disadvantaged in terms of accessing health care, welfare benefits, housing, education and employment. The stigma attached to mental health multiplies the difficulties for older people with mental health problems⁹¹.

Mental health related stigma and discrimination can be compounded by discrimination related to the other inequality issues, such as race, gender, sexual orientation and disability⁹². More than half (55 per cent) of younger LGBT people experience homophobic bullying in Britain's schools. The majority of pupils who experience homophobic bullying have symptoms consistent with depression⁹³.

Universal approaches to promoting mental wellbeing complement existing approaches to tackling stigma because, in improving the capacity for healthy relationships, for compassion and for trust in others, they reduce the fear difference and the need to do better than others, which fuels stigma and discrimination. Tackling stigma is important both in terms of reducing the negative experiences of individuals affected but also in helping facilitate more equitable focus by policy makers and commissioners on mental health.

Section Two

Creating mentally healthy people: risk and protective factors

The life course approach provides a framework for understanding the development of mental health across the population, both in terms of mental wellbeing and mental health problems. It offers a framework for understanding the origins of the inequalities affecting mental health and identifying pressure and transition points significant to mental health. A life course approach aims to protect children against mental health problems from the earliest point possible, investing 'upstream' to reduce later distress and cost. This approach recognises points in the life course such as time of transition and change when there are both opportunities to promote mental wellbeing and opportunities to intervene in at risk populations. It emphasises the importance of putting in place systems to identify and respond to problems quickly and effectively. Supporting those who have faced multiple adversities can reduce the accumulation of risk enabling such individuals to fulfil their potential. Early intervention in childhood and adolescence is crucial to public mental health but is a longer term investment. Intervening in adulthood and later life is also effective at reducing mental health problems, supporting recovery and preventing losses for those who are currently at risk.

The most powerful childhood predictor of adult life-satisfaction is the child's emotional health⁹⁴. At the other end of the spectrum, the majority of mental health problems emerge in childhood, with 75% present by the age of twenty four. Therefore, the most modifiable and important risk factors for mental health problems and the most important determinants of mental wellbeing lie in the family, the environment, the community and the society into which a child is born and raised.

Families and early years

The family relational environment is of fundamental importance in pregnancy, infancy and childhood to future mental health⁹⁵. This is only now starting to be fully appreciated as the neuroscience of brain development is becoming known, and being seen to support understanding gained through observational studies of human beings and their mental health⁹⁶. The process that takes place in brain development during pregnancy, when most cerebral neurons develop, and during the first two years of life, is an extraordinarily plastic process where simple neurological circuits and skills develop which provide the scaffolding for more advanced circuits and skills over time. This development in infancy depends as much on human relationship as it does on nutrition.

Positive and secure attachment results in positive emotional and social development, with children being better able to cope with stress, having a higher perception of self-worth and being able to adjust better to adversity and change⁹⁷. It is therefore predictive of mental wellbeing in adulthood. Insecure attachment relationships in early childhood predict depression, anxiety, self-harm and suicidal tendencies and Post-Traumatic Stress Disorder, among other mental health problems^{98, 99, 100, 101}.

The sensitive, attuned and caring parenting that enables attachment security also enables infants to feel safe and to develop the capacity to trust others¹⁰². Parenting that is out of tune with infant needs, neglectful or abusive is stressful and disrupts the neurochemistry and architecture of the developing brain, nervous system and stress hormone systems. Failure to develop self-regulation and trust in others leads to lifelong problems in learning, behaviour, resilience, coping, and both physical and mental health¹⁰³.

It is estimated that between 10% and 20% of women develop a mental health problem during pregnancy or within the first year after having a baby, and although the exact number for men is unknown, it is also estimated to be a significant concern. Perinatal mental health problems interfere with the relational environment for the infant and therefore compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences¹⁰⁴. Paternal depression has been shown to have a negative impact on children¹⁰⁵.

From the age of eighteen months another aspect of parenting becomes profoundly important to children's mental health: parental boundary setting and positive discipline. Children need consistent boundary setting backed up with positive approaches to discipline in order to develop respect for the needs of others and to become social beings. On the other hand, harsh and inconsistent discipline is a key cause of conduct disorder: the most common mental health problem in childhood. And abusive discipline is one of the most recognised manifestations of child abuse.

Parental mental health problems can have a significant impact on children's growth and development throughout childhood. Research shows that the mental health problems of a parent are an important predictor of their children's mental health and wellbeing⁽¹⁰⁶⁾ at other stages of childhood. It is difficult to establish the rates of parental mental health problems due to under-identification of parental mental health and incomplete recording of mental health service users as carers¹⁰⁷. However, UK research has identified parental mental health problems as a significant factor in around 25% of new referrals to social service departments¹⁰⁸; more than one third of adults with mental health problems are parents and it is estimated that two million children live in households where at least one parent has a mental health problem¹⁰⁹. Parental mental illness disrupts warm and sensitive parenting and is associated with abuse and neglect. It can cause social isolation for the child¹¹⁰. Children may assume a caring role (reverse parenting), in order to maintain a relationship with their parents which can affect their educational performance¹¹¹. There may be no adult in the house providing the care and support that children need to make a transition into adulthood.

Drug and alcohol misuse and domestic violence are not infrequent accompaniments to parental mental illness and are both profound stressors for children with an impact on long term mental health¹¹². Separation, divorce and parental bereavement can create considerable upheaval for children and young people as this often involves a change for the worse in financial circumstances and may involve moving homes and schools. Estrangement from a parent or siblings as well as involvement in inter-parental conflict commonly accompany separation and are also damaging¹¹³.

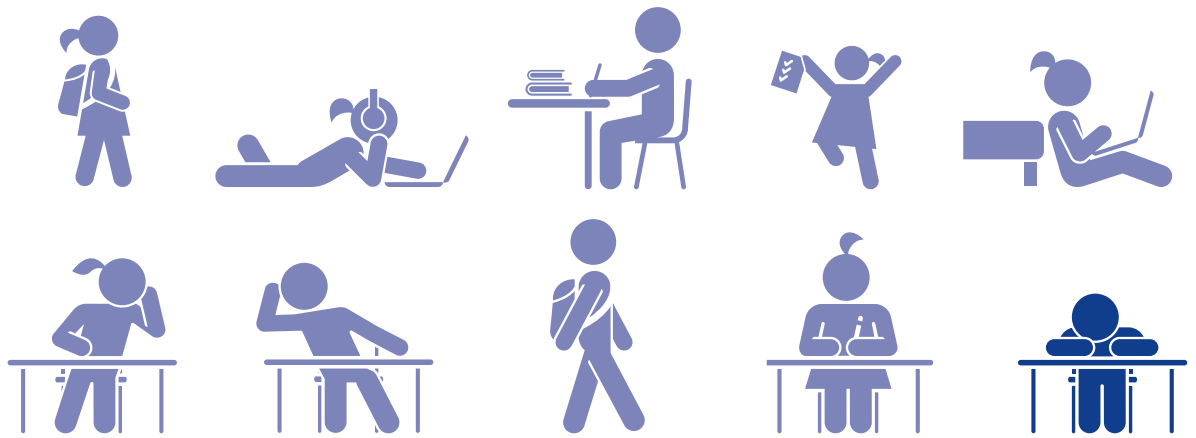
Children and young people

Families and parenting go on being important throughout childhood, but from the age of four or five other factors start to become important.

By the time they reach school age, one in ten children aged between five and sixteen years has a mental health problem that warrants support and treatment¹¹⁴. The primary predictor of such problems is the quality of the parent child relationship and parenting more broadly, as discussed above. Most children spend a high proportion of their waking lives in schools and this is an age where schools also matter for mental health and wellbeing. The school ethos, mental wellbeing of teachers, relationships with peers and prevalence of bullying all matter.

There are a proportion of children outside of the school system, or with disrupted experiences of education, whose experiences may lead to poor mental health and so warrant attention. Young people not in education, employment or training (NEETs) are more likely to report higher anxiety than other young people¹¹⁵.

Figure 2: By the time they reach school age one in ten children aged between 5 and 16 years has a mental health problem that warrants support and treatment.



Source: HM Government (2011). No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages

Adverse childhood experiences

The effect of these adverse childhood experiences has started to be researched collectively. The term is used to describe the occurrence of abusive or neglectful parenting, drug and alcohol misuse, parental mental illness, divorce or bereavement. These both individually and collectively are now being shown to be important predictors of adult health, both mental and physical (Bell et al, 2015¹¹⁶). Where risks are identified and problems addressed early, a virtuous cycle of accessing the right support and recovery can be established. Unaddressed, these can have a cumulative effect over years, creating a cycle of risk and distress. An issue for risk factor research in adulthood is that few studies adequately take into account childhood risk factors, so end up making estimates of risk that are imprecise.

Vulnerable and looked after children

Children may be considered vulnerable due to adverse life experiences (discussed above), disruption of their educational and social development, family and or/community environment or living with disability. Children who end up in local authority care have, by definition, experienced at least one adverse childhood experience and mental health problems are thus not surprisingly common in this group. Approximately 50% of five to seventeen year olds in care have at least one mental health problem, rising to 60% for those in residential care^{117, 118}. Children with learning disabilities experience mental health problems at 3.5 times the level of the general population: 37% of them had a mental health problem in the most recent prevalence survey (conducted in 2004¹¹⁹). Conduct Disorder, drug and alcohol misuse, and learning difficulties lead children into the criminal justice system and levels of mental health problems amongst children in prison or secure places vary between 50% and 95%, depending on the studies. Such children are vulnerable to membership of gangs and the latter are shown to be at increased risk of a range of mental health conditions including Conduct Disorder, Antisocial Personality Disorder, Anxiety, Psychosis and drug and alcohol dependence, and may experience particular barriers to engaging with services¹²⁰.

Adolescence

The transition into adolescence and adulthood is a time of upheaval and uncertainty, marked by considerable emotional, social and physical changes, and is often a time for developing a sense of self and identity. It is also the point when young people transition between learning centres or from school to workplace and may find significant changes in their peer group. Some experience very specific transitions in their families such as: living in unsafe home environments, moving from home or becoming homeless; additional caring responsibilities (such as becoming a young parent); bereavement; or separation of parents. Transitions are now recognised as central to children and young people's wellbeing and experience of childhood¹²¹. Despite this recognition, what works to reduce the stresses associated with teenage life and early adulthood and to improve resilience at this life stage requires more research to be fully understood. The role and opportunities that schools, colleges and universities can play in improving mental health and wellbeing have not yet been fully exploited.

Poor mental health at this stage is associated with several negative social outcomes such as lower educational attainment, higher rates of health risk behaviours (such as unplanned pregnancy, smoking, and alcohol and drug misuse), poorer social skills and anti-social behaviours¹²². Young people at this age are at heightened risk of experiencing specific mental health problems such as, eating disorders, body dysmorphia and self-harm¹²³. Being lonely in adolescence is associated with higher levels of smoking, body dysmorphia and of experiencing mental health problems such as depression during adulthood¹²⁴.

Adulthood

Adulthood is a time of greater independence and control over life, and is a particularly important point in the life course because of the influence adults have on others through their various roles as partner, co-worker, parent and carer. Many people become parents and the quality of relationships in the home with partners, if present, and children has a very strong influence on parents' mental health. Family relationships matter to adults as well as children. Being in a stable relationship is more strongly associated with both physical and mental health benefits, including lower morbidity, lower levels of smoking and drinking, and greater life satisfaction than being single. Unhappy relationships are more strongly predictive of mental health problems than not being in a relationship¹²⁵. Not all adults form families and loneliness can be an issue¹²⁶.

Many adults may also be required to take on the role of caring for a spouse or family member who is ill or has a disability. This can have a negative impact on their mental wellbeing, due to feeling increasingly isolated and unsupported¹²⁷.

Experiencing two or more adverse life events^{||} in adulthood is associated with mental health problems and for some this can have a cumulative effect following on from adverse life experiences in childhood (discussed above).

Work, or lack of it, matters greatly as well as the quality of the working environment. A 2006 meta-analysis exploring the associations between psychosocial work stressors and common mental health problems found that; 1) high demands at work, 2) reduced autonomy in decision making, 3) high efforts and 4) low rewards often resulted in stress, and were associated with common mental health problems¹²⁸. People in Great Britain who are unemployed are between four and ten times more likely to develop anxiety and depression¹²⁹. Workplace mental health is discussed in more detail below.

Access to community resources, such as friendship networks, facilities for children, opportunities for exercise, the quality of the environment and social inequity, stigma and discrimination all impact on adult mental health. A systematic review conducted in 2009 found that neighbourhood environment was an important factor in the health and functioning of adults. In particular, neighbourhood socio-economic status was a very strong predictor of a variety of health outcomes, suggesting that the impact of deprivation can continue all the way through to older ages¹³⁰.

^{||} Adverse life events can include serious illness, job loss, bereavement or other unpleasant events.

Later life

The UK's population over the age of fifty^{III} makes up over a third of the population, with the latest statistics putting this figure at 23.2 million¹³¹. Mental health and wellbeing of older people is often neglected across the spectrum of mental health improvement interventions and services¹³². But this can be when the cumulative impacts of poor mental health and adversity throughout life are most evident. To ensure mental wellbeing for all, preventing mental health problems in later life is vital.

Retirement can be associated with a period of high wellbeing, a time when people pursue leisure activities and volunteering, which can have as many benefits as paid employment. For some, however, a lack of choice impairs wellbeing, such as enforced retirement, or feeling compelled to continue to work for economic necessity beyond their intended retirement age¹³³. It can also result in older people feeling unengaged in meaningful activity, which is important for wellbeing.

Relationships and connecting with others is a key area for a mentally healthy later life. 3.5 million people aged sixty five or more live alone¹³⁴ and 17% of older people have less than weekly contact with family, friends and neighbours¹³⁵. In 2008, Age Concern found that 1.2 million people over fifty were severely socially excluded and had little to no engagement in their communities or society in general. Loneliness can have a negative effect on our health, with studies reporting an association with higher blood pressures, compromised immune system function and increased stress hormones. The cumulative effect means that being lonely can be as bad for your health as being a smoker^{136, 137}. Loneliness can lead to a higher risk of developing dementia and experiencing depression^{138, 139}.

There has been growing concern about the often overlooked prevalence of depression in older people, which affects one in five older people living in the community and two in five living in care homes. Depression has been linked to dementia, which can compound isolation, disempowerment and cognitive decline.

The Alzheimer's Society estimates that dementia affects 850,000 people in the UK. Historically, dementia has been seen as a disease associated with irreversible decline and deficits, but with the right support there is a growing understanding that people can live well with dementia, illustrated well in Scotland's National Dementia Strategy¹⁴⁰. A cultural shift in the way dementia is perceived and understood is taking place, with dementia now being viewed as having a rights-based dimension¹⁴¹.

There are approximately 3.3 million people in UK over the age of fifty in a caring role for a disabled, seriously ill or older relative or friend; many of whom face their own health problems in addition to coping with the needs of the person they are caring for¹⁴². Many older carers struggle to get the support and advice they need, which in turn increases the risk to their own health and wellbeing, both physical and mental.

^{III} We are broadly defining later life as starting at fifty years old. While it's true that many people do not self-define as 'older' at this share of their lives, we have taken this approach because physical decline or deterioration tends to begin for many in their fifties, and many people in their fifties begin to seriously plan for their retirement, take early retirement or find it difficult to secure employment. For those in society who face inequalities such as poverty, they are more likely to experience the effects of ageing earlier in their life course. In reality people reaching state pension age do not consider themselves as 'old' and many see growing older as a further state in life, a continuation of their present' rather than a new and distinct phase in life. For more see: Mental Health Foundation (2012) Getting on with Life – baby boomers, mental health and ageing well

Creating mentally healthy places: risk and protective factors

Although most existing evidence has focused on individual level interventions, there is a growing understanding that connected communities, supported through interventions designed to promote social inclusion and strengthen social networks, have the potential to make an important contribution to mental wellbeing within the community¹⁴³.

An individual's social setting heavily influences their capacity to develop and flourish. Although a large proportion of mental health problems arise before adulthood, being part of a community and having the ability to earn enough money to live sufficiently are important social factors for wellbeing, especially for those who are vulnerable to mental health problems. Improved social capital and social cohesion can result both in and from improved mental wellbeing. Our relationship with place can define experiences in many ways across the lifecourse¹⁴⁴.

Community

A community can be a place or a socially constructed shared identity. It is an all-encompassing term that is used to describe the relationships, values, identities and interests that connect people, or a shared investment in a place, movement or culture¹⁴⁵. Family homes, neighbourhoods, schools and workplaces all constitute communities. Mental wellbeing is a universal asset that we all share, enabling us to reach our potential not just as individuals but as members of our communities. Conversely, poor mental health can lead to a cycle of disadvantage that can impact negatively on the community by causing higher levels of physical morbidity and mortality, lower levels of educational and work performance, offending behaviour and poor community cohesion¹⁴⁶. Marmot acknowledged the important role of communities in supporting 'physical and mental health' stating that the 'physical and social characteristics of communities and the degree to which they enable and promote healthy behaviours all make a contribution to social inequalities in health'.

Communities have many assets that can support mental wellbeing, including capacity and skills, knowledge, connections, passions and interests¹⁴⁷. Actions intended to achieve good mental wellbeing for all need to be imbedded at multiple levels across communities: within family homes; streets and neighbourhoods; settings such as workplaces and schools; and systems like local NHS provision and community policing. Protecting and promoting mental wellbeing needs to become a shared and central aspiration in ensuring communities reach their potential¹⁴⁸.

Home

Having somewhere safe, warm, secure and suitable to live is fundamental to mental wellbeing¹⁴⁹. Housing can provide both a secure and positive base that supports people on a very basic needs level. A mentally healthy home enables children to grow up resilient and can prevent some mental health crises, promote recovery and reduce the burden on health services¹⁵⁰.

Quality of housing impacts on people's wellbeing with poor standards adversely affecting both physical and mental health¹⁵¹. Having control over the internal environment is important for mental wellbeing and people living in cold, damp housing are more likely to experience poor mental health. This results not only from the physical impacts but also from the stress and stigma attached to living in poor housing¹⁵². A secure home has positive effects, but this can be affected by increasing rent rates, security of tenure, policies such as the bedroom tax, increased

conditionality for housing benefit and the introduction of universal credit¹⁵³. Poor housing not only affects adults but children. Those children who live in poor housing have increased chances of experiencing stress, anxiety and depression.

Homeless, or being at risk of homelessness, is strongly associated with mental health problems. Whilst causality is bi-directional, the threat and actuality of loss of home puts great strain on the mental health of even the most robust individuals. Homeless Link reported in 2010¹⁵⁴ that seven out of ten of their clients had mental health needs and a third of those lacked the support they needed to address them. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to fifteen times higher¹⁵⁵.

Educational settings

An average classroom in the UK of thirty pupils is likely to include three with a mental health problem, seven who are being bullied and six who are self-harming¹⁵⁶. It is widely recognised that schools have a role to play in facilitating pupils' success by supporting them to be resilient and mentally healthy¹⁵⁷. They are an ideal setting for allowing young people to learn more about how to support their mental wellbeing¹⁵⁸.

School ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health. One study suggested that bullying by peers had more adverse effects on early or young adult overall mental health than maltreatment^{IV} in childhood¹⁵⁹. But such comparisons are hard to make accurately because maltreatment by parents increases the chances of children becoming both bullies and victims, and bullying is easier to detect by child or parent self-report or observation than problem parenting. While there is growing interest in mental health improvement within schools such as the 'Whole School Approach,' there has been less interest to date in the transition period from school and the role of further education, both of which can present important pressure points in the lives of young people¹⁶⁰.

Work settings

Employment is one of the most strongly evidenced determinants of mental health¹⁶¹. The Work Foundation makes the distinction between 'good work,' characterised by fair treatment, autonomy, security and reward, and 'bad work,' in which individuals do not feel supported, valued or stimulated¹⁶². Better mental health among employees has been associated with higher staff retention, improved productivity and performance, higher levels of collaboration, and reduced sickness and absenteeism¹⁶³.

The Marmot review identified people with mental health problems as being among the most likely to be in low-quality, low-status and insecure work. They are also more likely to be unemployed, with the employment rate for people living with mental health problems estimated between 10-35% (depending on the condition), compared to 59% for people living with a general health problem and 77% for those without either¹⁶⁴.

With appropriate support, terms and conditions, the workplace can be key to promoting mental wellbeing by enabling people to contribute to society, be financially independent and able to afford decent housing, food, clothing, leisure and luxuries. The DoH No Health without Mental Health report recognised that 'the workplace provides an important opportunity for people to build resilience, develop social networks and develop their own social capital.'¹⁶⁵

^{IV} Child maltreatment includes physical or emotional ill-treatment, sexual abuse, neglect, or negligent treatment resulting in actual or potential harm to the child's survival, development or dignity

The built environment and neighbourhood effects

The WHO defines 'environment' as the congregation of all the physical, chemical and biological factors external to a person, and all related behaviours, but excluding those natural environments that cannot reasonably be modified¹⁶⁶. This and the wider sociocultural and geopolitical environment can have an effect on individuals and communities' mental health.

The Marmot Review of Health Inequalities and the Sustainable Development Commission reports have evidenced how people with mental health problems experience area inequalities. The populations of deprived areas are characterised by concentrations of disabled people, including people with mental health problems¹⁶⁷; and studies have found that prevalence of mental illness maps closely with deprivation. Living in densely built-up areas have been shown to have an influence on the risk of developing schizophrenia¹⁶⁸.

Presence of escape facilities in communities has been identified as important for community wellbeing. These include community centres, cafes, green spaces and safe play facilities for children¹⁶⁹. Open space is linked to improving companionship, a sense of identity and belonging¹⁷⁰, and happiness¹⁷¹. However these spaces are not equally distributed and where they exist within more deprived areas they are not always safe or accessible¹⁷².

The natural environment

Living in an area with significant access or exposure to green spaces has a lasting positive effect on mental wellbeing for all ages and socio-economic groups^{173, 174}. Ensuring people are living in a safe and secure setting, free from conflict and limiting the effects of disasters, such as flooding, bombings and economic disasters can have a direct impact on mental wellbeing. If it isn't possible to ensure this, a key step to limiting the effects is to build resilient communities. Resilience is the capacity of people and society to confront and cope with life's challenges; to maintain their wellbeing in the face of adversity.

Distress following a disaster is a normal and expected reaction and is usually temporary. However, individuals with existing mental health problems or vulnerability factors are more likely to experience a subsequent decline in their mental health¹⁷⁵. A minority of individuals are at risk of developing more severe or prolonged symptoms. Fear of the experience being repeated, financial hardship and loss are some of the factors which impact considerably on mental wellbeing. A model developed by NATO¹⁷⁶ illustrates that the period of adjustment for communities following disaster can take up to three years.

Case study 3: Addressing emotional wellbeing as part of flood recovery in Somerset

In response to high levels of emotional distress resulting from the extensive 2013 floods in Somerset, a multi-agency Mental Wellbeing Action Group was convened to address those presenting with very complex needs and high levels of vulnerability. The aim of the Emotional Wellbeing and Flooding Programme was to provide a tiered response to emotional wellbeing that involved supporting and promoting community activity and delivering psychological first aid training for community support staff.

Between April 2014 and March 2015 Emotional Support Workers held or attended 83 events attended by an estimated 1,000 people. One to one extended support was provided by the flood support workers. GP practices were provided with advice about how to recognise and support the emotional impacts of flooding.

A limited number of cases emerged that did meet the threshold for specialist medical or social care intervention. In these cases, Adult Social Care helped to design and commission appropriate packages of support to meet these needs, with additional support from Somerset County Council.

The legacy of this work was that a deeper understanding of what resilience in this context was gained as well as demonstrating good practice regarding how to talk about emotional wellbeing in an open and meaningful way.

Socio-economic environment

The relationship between poverty and mental wellbeing is a complex one. Poverty refers to a lack of money or material possessions, but also to being in a state of having insufficient means, which can include social or education resources. Those living in poverty have a higher prevalence of mental health problems. This is due to both the higher causation among those living in deprivation and also by the drift of those with mental health problems into poverty¹⁷⁷.

The UK has experienced a prolonged economic downturn with rising unemployment and uncertain recovery since 2008. Welfare benefits in the UK are simultaneously undergoing significant reform with the danger of additional negative consequences for the mental health of the population¹⁷⁸. Associations observed from previous economic downturns suggest that the current UK recession may result in an increase in mental health problems including; depression, possible lower levels of wellbeing^{179, 180, 181}, more suicides and suicidal behaviours¹⁸², increased domestic violence and child neglect with associated impact on child mental health and wellbeing^{183, 184}, and an increase in drug and alcohol dependency¹⁸⁵. The Institute for Fiscal Studies suggest that child and working-age poverty will increase across the UK over the next decade partly as a result of the current recession¹⁸⁶.

However, the crisis may offer possibilities to strengthen social capital and to shift our value base from money to non-monetary components of life, provided that social protection is sufficient. A study in Iceland found that almost as many people increased as decreased their happiness between 2007 and 2009 (covering the period of the banking crisis), suggesting that some protective factors, like closer social relationships, can reduce the negative effect of such crises, or that economic factors do not influence people's mental wellbeing as much as has been inferred from studies of mental health problems¹⁸⁷. Longitudinal research is required to understand the long-term effects of the economic crisis on the mental wellbeing across the UK.

Section Three

Taking action for public mental health

Principles behind public mental health action

Public mental health is not fundamentally different or distinct to public health. It is simply an element that has been overlooked historically and needs to now be emphasised, researched and put into practice. But the silo approach to public health in which problems with the mind and body are treated separately no longer makes sense. Crucially, the determinants of poor mental health and mental wellbeing are the same as the determinants of physical health and illness. Therefore the principles underlying public mental health are not dissimilar from those underpinning any public health approach. Six principles that are especially important can be summarised as follows^{188, 189}:

- (1) Interventions which focus on the positive have added value over those which focus on finding or preventing the negative. Promoting mental wellbeing moves the focus away from illness and is central to an individual's resilience, social purpose, autonomy and ability to make life choices.
- (2) The social, economic, cultural and environmental determinants of mental health need to be considered and addressed. Different interventions can potentiate (increase power/effect) each other.
- (3) A proportionate universalism approach which addresses whole population mental wellbeing promotion and provides additional support for high risk groups is the optimum approach.
- (4) Engagement, both community and individual is central to public mental health. The former is concerned with building on assets and involving communities in framing the issues and the solutions, the latter with developing individual strengths and resilience.
- (5) Since personal risk and protective factors are determined in early childhood, primarily in the context of family relationships, a life course approach is essential.
- (6) A truly multidisciplinary and inter-sectoral approach must be adopted as no one discipline has all the knowledge or power to effect the required level of change.

The correlation between the social gradient and mental health is well evidenced, and it can sometimes be difficult to see what can be done to correct this without high level political intervention. However, there is a rapidly increasing evidence base about the effectiveness of interventions to support mental wellbeing of individuals, communities and society. While social issues such as poverty and social welfare responses such as benefits may be difficult for local practitioners to influence, other issues that determine mental health can be more easily targeted such as supporting healthy family relationships and tackling bullying and abuse. Supporting and promoting the mental wellbeing of future generations, however, requires the promoting of personal resilience and wellbeing in those charged with the care of children including parents, teachers and a range of other adults¹⁹⁰.

Measuring mental health: using data to make the case for change

Measurement is essential for public mental health in order to understand population health status and trends over time, as well as to measure the effectiveness of interventions to improve mental wellbeing. The measurement of mental health problems, mental wellbeing and mentally healthy communities presents a number of challenges not encountered in other areas of public health practice. This is discussed below.

Current data and evidence base

With the growth in public mental health practice over the past decade, there has been an increase in evidence and information regarding the measurement of both mental wellbeing itself and also its indicators and determinants.

However, there is a critical need to link data from different public services, agencies, researchers and providers to strengthen data on children and young people, improve local and national equalities data, and increase the evidence base for public mental health. This was highlighted by the Mental Health Taskforce in their 2016 report when they called for the development of “the NMHIN as a trusted national repository of robust and publicly available mental health data and intelligence over the next five years” (p52)¹⁹¹. The lack of appropriate data capturing in the UK is a barrier to prevention of poor mental health, promotion of mental wellbeing and the identification of co-morbidities.

There is a clear need for additional data to be captured that address public mental health. If the NHS England planned local Mental Health Prevention Plans, which will take a public mental health approach addressing the wider social determinants of mental health, are to be successful, they will need to be underpinned by robust evidence of the mental health needs of the population, which will require high quality evidence and data.

The Mental Health Foundation’s Landscape Report found that evidence is concentrated around family formation, early years, children and young people. There are still gaps in data on infant mental health, with a paucity of evidence in working age and later life. It commented that there is a lack of evidence from the perspectives of people with lived experience of mental health problems and specific equality groups, and studies about human rights and health¹⁹². One issue for public mental health is the prevailing belief that randomised control trials are the ‘gold standard’ for evidence, meaning many high quality interventions are less persuasive because they are not RCTs, despite the fact that RCTs are not always the most practical or ethical option, especially in the context of mental health^{193, 194}.

To continue to build the evidence base around what works best to improve mental wellbeing, it is important to build evaluation into all public mental health interventions. This can be achieved by applying a test of change approach through piloting, evaluating and learning what works in what context and before applying at scale. It is also vital that research covers a range of different approaches, including mixed methods and realist approaches. These methods are better able to incorporate a range of perspectives including of people with lived experience of mental health problems and from equality groups.

The box overleaf highlights some of the main sources of mental health statistics. A further summary of all the current available statistics on mental health can be found in the Mental Health Foundation’s Fundamental Facts Report 2015, which is updated annually. But, as with all areas of public health, there are major issues with gathering the right information to form a complete picture of mental health and mental wellbeing¹⁹⁵. Up until now, measurements within mental health have focused

on measuring mental health problems. It is now important to consider what the key indicators are for mental wellbeing to gain a full picture. Many of these may need to be proxy measures such as levels of productivity in a workforce alongside absenteeism for mental health reasons, or reports of bullying in schools alongside referral levels to more specialist mental health services.

Data sources

- 1. There are a number of mental health data sets in the HSCIC**
<http://www.hscic.gov.uk/searchcatalogue?topics=0%2fMental+health&sort=Relevance&size=10&page=1#top>
- 2. The Public Health England Mental Health Fingertips indicator set is easy to navigate and use**
<http://fingertips.phe.org.uk/profile-group/mental-health>
- 3. The National Mental Health, Dementia and Neurology Intelligence Network has information for commissioners and planners**
<http://www.yhpho.org.uk/default.aspx?RID=191242>
- 4. The Improving Access to Psychological Therapies web site is available here**
<http://www.iapt.nhs.uk/iapt/>
- 5. Information relating to Children and Young People is available from the Children and Young People's Health Benchmarking Tool.**
<http://fingertips.phe.org.uk/profile/cyp>
- 6. Adult Social Care Indicator in the HSCIC holds useful information about mental health and employment and social isolation**
<http://www.hscic.gov.uk/article/3695/Adult-Social-Care-Outcomes-Framework-ASCOF>
- 7. The ONS has undertaken an analysis of social capital in the UK**
<http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/2015-01-29>
- 8. The Mental Health Foundation Fundamental Facts report 2015 summaries all the statistics on public mental health and prevention available for the UK**
www.mentalhealth.org.uk
- 9. The ONS developed a national wellbeing wheel of Measures**
<http://webarchive.nationalarchives.gov.uk/20160105160709/http://neighbourhood.statistics.gov.uk/htmldocs/dvc146/wrapper.html>

Mental health problems

The Adult Psychiatric Morbidity Survey, a robust, stratified and multi-stage population survey which is conducted every seven years, is the most extensive source of information on the prevalence of mental health problems in adults within England. This report is the origin of the '1 in 4' statistic often quoted^{v, 196}. The current data is from 2007 but new data from the latest APMS is expected to be released in September 2016. The Mental Health Foundation will publish its initial analysis of the survey in its Fundamental Facts 2016 report¹⁹⁷.

The statistics available for the prevalence of mental health problems in children are now outdated, with the current statistic from an ONS survey conducted in 2004¹⁹⁸. New data is not expected until 2018. Anecdotally, prevalence is likely to be higher now than it was in 2004. Public health practitioners in England, Scotland, Wales and Northern Ireland could make a valuable contribution to the development of core mental health data sets in order to facilitate comparison across the

^vIt is worth noting that this statistic is for all mental health conditions, and that for public health or service planning, a more nuanced understanding of the pattern of different types of conditions, and of exposure to risk factors is required.

UK. Current opportunities include the implementation of the European Roadmap to Mental Health Research in Europe study (ROAMER), the English Mental Health Taskforce recommendations for the development of a five year Data Development Plan, and the development of Mental Health Joint Strategic Needs Assessments by local Health and Wellbeing Boards in order to inform Mental Health Prevention Plans^{199, 200}.

Mental wellbeing

Mental wellbeing, as defined in this report, is not a clinical concept with a defined cut point, but rather the positive end of a spectrum for which there are now some good measures.

The ONS have produced statistics relating to personal wellbeing as part of the 'Wheel of Wellbeing.' This covers a wide range of determinants of wellbeing. The personal wellbeing section relates to mental wellbeing and comprises four questions: anxiety, happiness, satisfaction and purpose in life. The statistics relating to personal wellbeing, available at local level, cover anxiety, happiness, life satisfaction and how worthwhile people rate the things they do. ONS also produced a review of available sources and measures for children and young people's wellbeing in 2013²⁰¹. The OECD and organisations in some other countries have gone down a different route with their wellbeing measures, combining measures of wellbeing itself with equity and the social determinants of mental health²⁰².

The most popular scales of mental wellbeing in the UK are the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) and the short version (SWEMWBS)²⁰³. Both cover feeling and functioning and sum to a single score. WEMWBS is now included in the Health Survey for England and in national surveys in Scotland. WEMWBS has been validated among people in remission from serious mental illness like schizophrenia²⁰⁴. However, none of these mental wellbeing measures have so far been shown to be valid in populations with active psychiatric disorder. Measures of mental wellbeing for these populations are important and are under development. Another useful scale is the Flourishing Scale, a brief eight item summary measure including a greater focus on social functioning²⁰⁵. The WHO-5 Wellbeing Index, which covers both mental and physical wellbeing, has also been widely used²⁰⁶.

Community mental health

Increasingly, there is an interest in understanding the mental wellbeing of communities rather than focusing only on individuals. The Wellbeing and Resilience Measure (WARM) is described as a tool and framework (rather than a validated measure) which focuses on community assets and vulnerabilities. WARM uses existing data to identify who is vulnerable, who is not and why^{207, 208}. Other indicators of mentally healthy communities include social capacity measurements (see data box above) and some indicators within the public sector outcomes framework, such as social connectedness which is a social capital indicator, and the social assets matrix developed in Northern Ireland²⁰⁹.

Public mental health interventions

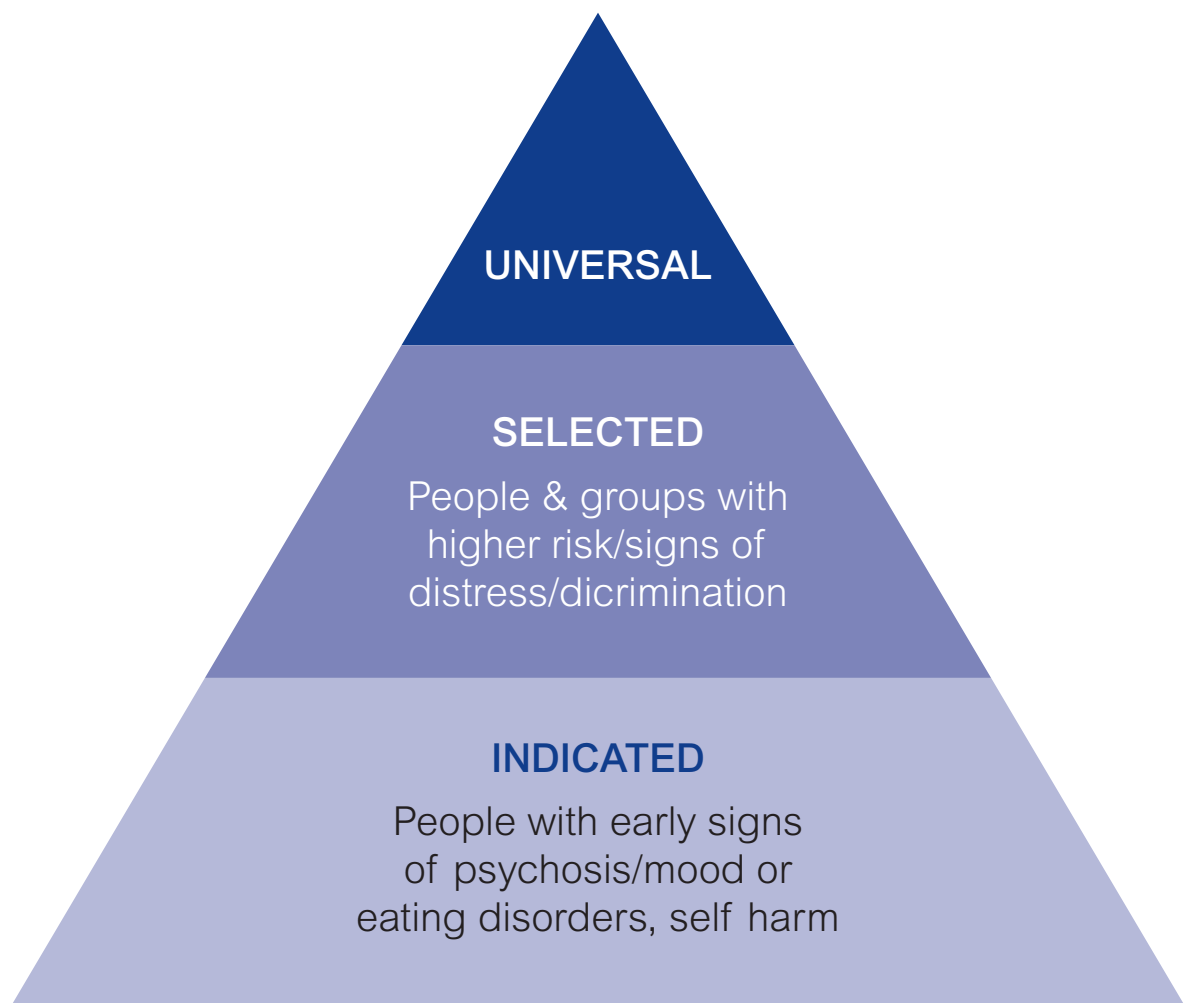
Universal, selective or indicated prevention

Both the promotion of mental wellbeing and the prevention of poor mental health can be undertaken on a universal, selective or indicated basis²¹⁰:

Universal – for everyone; targeting the whole population, groups or settings where there is an opportunity to improve mental health such as schools or workplaces.

Selective – for people in groups, demographics or communities with higher prevalence of mental health problems; targeting individuals or subgroups of the population based on vulnerability and exposure to adversity such as those living with challenges that are known to be corrosive to mental health.

Indicated – for people with early detectable signs of mental health stress or distress; targeting people at the highest risk of mental health problems.



Case study 4: Five Ways to Wellbeing (5WtW) in Warwickshire

Public Health Warwickshire's Mental Health and Wellbeing Team led the development of the Public Mental Health and Wellbeing Strategy and lead the delivery of the associated action plan which aimed to provide and commission good information, evidence, support and resources to improve the mental health and wellbeing of people living in Warwickshire and worked in partnerships across the country.

It assumed a three tier approach to promote mental wellbeing and prevent problems associated with mental health:

Level 1: Universal interventions to build resilience and promote wellbeing at all ages. This included launching the FWtW in Warwickshire campaign, which uses a public health perspective on population mental health by championing good mental health and wellbeing for all. The campaign raises awareness of wellbeing and supports the community to talk about wellbeing and build the ways to wellbeing into their lives. Bright and engaging resources were developed which encouraged people to make a pledge for their wellbeing and signposted to mental health and wellbeing services.

Level 2: Targeted prevention of poor mental health and early intervention for those at risk of mental health problems. This included suicide prevention training for GPs

Level 3: Early intervention and physical health improvement for people living with mental health problem and with lived experience. This included commissioning a Physical Activity on Referral service

During the first 18 months of the strategy implementation a total of 2,363 appointments were delivered through the wellbeing hubs to support individuals to improve their wellbeing. The strategy was evaluated through a variety of processes and outcomes. The 5WtW campaign has supported frontline staff to start conversations about wellbeing.

More information is available at: www.publichealth.warwickshire.gov.uk/5ways

Creating mentally healthy people: investment opportunities

Harnessing technology and social media

Technological advances in the last century cannot be ignored, both in relation to their effect on mental health and also their potential use in its prevention. Increased access to information offers an opportunity for empowerment, although the reliance of the information is questionable at times. The rapid evolution of online technology has created vast new opportunities for building connections and relationships: 76% of adults in the UK access the Internet every day²¹¹.

Studies on use of these online communities have found positive outcomes due to their impact in developing and widening social networks and social supports²¹². These sites can help encourage a feeling of connectedness with social support from online friends linked to increased mental wellbeing²¹³. These social networks, and the wider Internet, are valuable tools that could be harnessed to deliver interventions and public awareness campaigns. Big White Wall is an online community of people who are having difficulty coping or are feeling anxious who help each other while being guided by trained professionals²¹⁴. Aye Mind is an online toolkit that aims to improve the mental wellbeing of young people by making better use of the Internet, social media and mobile technologies²¹⁵.

There are a number of freely available apps to support individual interventions such as mindfulness, CBT and positive psychology approaches. There are also many resources that support professional and public intervention, which are discussed more in section four.

Interventions to support families, parenting and the early years.

Perinatal support

Universal programmes

- Universal infant programmes, which include programmes offered in the context of antenatal care and programmes offered at birth to help all parents develop sensitivity to their infants, have been shown to be effective in improving parental mental health as well as that of the infant. They show parents what infants are capable of, help them to identify temperamental differences, provide them with knowledge of child development, and help them manage infant behaviours like sleep and crying.
- Promotional interviewing, an approach which focuses on the positive and aims to empower and support parents as well as to identify needs, is recommended in the English Child Health Promotion Programme during pregnancy and the postnatal period²¹⁶.
- Every local area should ensure that perinatal commissioning and delivery complies with NICE guidance and that they follow recommendations on what needs to be in place to create effective perinatal care pathways^{217, 218}.
- Suicide prevention plans developed in local areas should address the perinatal period, following the Joint Commissioning Panel for Mental Health's three steps:
 - ▶ Identify those at increased risk of developing perinatal conditions;
 - ▶ Develop a personalised care plan for each woman at increased risk;
 - ▶ Ensure that women with a history of serious illness are prepared for pregnancy and receive preventative management when pregnant²¹⁹.

Targeted programmes

Targeted programmes address high risk groups which can include those at risk of perinatal mental health problems, teenage parents, and parents who abuse drugs and alcohol. Parents who experienced adverse childhood experiences such as abuse or being in care are also at higher risk. Programmes to support these groups can only work if the parents engage with them. Usually, this group of parents have experienced childhoods which have made it difficult for them to trust others. Effectiveness is therefore dependent on highly skilled facilitation with practitioners who are able to engage with and develop trusting relationships with these parents. This has implications for implementation of programmes because such skills are developed over many years. Programmes are more likely to fail because the practitioners are not adequately skilled than because of problems with the programme itself.

Programmes to address both antenatal and postnatal depression cover prevention in high risk groups and intervention in mothers with established depression. They include cognitive behavioural and person-based counselling, both of which are equally effective if the practitioner can establish a trusting relationship with the mother. Effective universal approaches to prevention have not yet been developed and programmes for fathers are still relatively new. Screening for postnatal depression is inefficient for various reasons so a case finding approach is recommended.

- The Maternal Mental Health Pathway²²⁰ sets out guidance for healthcare professionals supporting mothers during pregnancy and after birth to prevent the development or exacerbation of mental health problems during this period and to manage existing conditions.

- The Family Nurse Partnership Programme addresses parenting and parental wellbeing from pregnancy to the end of the first year of life in teenage parents. Many of the principles of this programme have been incorporated into the Solihull Approach, a UK developed programme used by health visitors. Such programmes are usually offered on a one-to-one basis through home visiting. They may need to be intensive, providing weekly visits for up to two years, starting before birth. They may be combined with centre-based care²²¹.
- There are several national training initiatives available including the Health Visitor Champions training²²² and the Perinatal Mental Health Training for midwives²²³.

Parenting

Many different programmes have been developed for, with and by parents and it can be confusing to know which to adopt locally. It is important in making this choice to establish which programmes are currently provided and how parents and practitioners rate them. The evidence base for these programmes is very large and demonstrates an impact on a wide range of outcomes including conduct disorder²²⁴ and parental mental health²²⁵. Most parenting programmes are strengths-based; identifying and building on what parents are getting right rather than on problems. All address behaviour management and most also address relationships quality. Some programmes can be offered at different levels by facilitators with different levels of training. Several NICE reviews have been produced; one relating to parenting programmes to prevent and treat conduct disorder, one in relation to supporting social and emotional development in the vulnerable under-fives and one with regard to disordered attachment interventions²²⁶. A low-cost training course for professionals on infant mental health is offered at Warwick Medical School²²⁷. A database of parenting programmes available in the UK and the evidence to support them has been developed by the National Academy for Parenting²²⁸.

Universal programmes

- Families and Schools Together (FAST), which is offered to reception class parents, has been shown to be effective in a series of RCT in the US and is being successfully provided in the UK by Save the Children²²⁹
- The Family Links Nurturing Programme is a programme developed in the third sector which is valued by practitioners and has been shown to enable parents to change in qualitative studies but has failed to show change in an RCT²³⁰
- Baby Steps is a programme designed to help parents cope with the pressures of a new baby which has been developed by the NSPCC²³¹.
- Triple P is a suite of programmes from universal media based through to intensive one-to-one support for families where children have clinical level problems. A large trial of Triple P offered at all levels is among the few studies to have demonstrated the impact of a universal and targeted approach combined²³². However, some studies of Triple P in the UK have failed to show effectiveness²³³. This can also be applied as a targeted programme.

Targeted programmes

- Mellow Parenting is a suite of programmes covering different age groups from Mellow Baby to Mellow Teen²³⁴.
- Strengthening Families Strengthening Communities is a programme for communities with a high level of minority ethnic families²³⁵
- Incredible Years (IY) was developed in the US and has been extensively trialled in targeted settings, including in the UK²³⁶.

Programmes to support children in families where parents have a mental health problems

Parental mental health has been most studied in the context of the perinatal period. The impact of parental mental health problems on children's mental health in later childhood has been much neglected. Programmes to support parents, children and parenting in families where a parent has a mental health problem which have been thoroughly evaluated and disseminated internationally are:

- The William Beardslee programme, a family-based approach for prevention in children at risk²³⁷
- Lets Talk About Children, a manual for a two session discussion with parents who are living with a mental health problem²³⁸
- Parenting under Pressure, a promising programme for supporting parenting in families where parents abuse drugs or alcohol²³⁹

Children and young people interventions

Universal

- The English Healthy Child Programme²⁴⁰ (2009) covers five to nineteen year olds and sets out the recommended framework of universal and progressive services for children and young people in order to promote optimal health and wellbeing.
- NICE advises supporting schools to adopt a comprehensive 'whole school' approach to promoting the mental wellbeing of children and young people (read more on this in creating health place section below)^{241, 242}.
- Evidence based bullying prevention programmes²⁴³ should be present in settings in which children and young people learn, live and spend their leisure time. Anti-bullying programmes are a top prevention investment²⁴⁴.

Targeted

It is important to ensure that children with risk factors such as living in care, having parents with mental health problems or using drugs or alcohol are identified for additional support. Vulnerable children are exposed to factors that place them at higher risk of developing a mental health problem. These factors include poverty, discrimination and long term health conditions. Some programmes are available which support children in the context of their families (see below).

- The NICE quality standards for looked after children featured the central recommendation that looked after children should have sufficient involvement in decisions to do with their care. It was also emphasised that it was vital these children had access to nurturing relationships that foster attachment²⁴⁵.
- Interventions to reduce drop-out and exclusion rates, and to focus on raising the educational standards of the most vulnerable children and young people²⁴⁶ should be rolled out.
- Develop targeted wellness services towards clusters of children identified as being at high risk of multiple poor behaviours, rather than providing single issue services only²⁴⁷.
- The Early Intervention in Psychosis (EIP) model, which was developed in Melbourne²⁴⁸ and has been adopted in England and Wales, is an effective intervention that should be implemented at a local area level.
- A prevention intervention aimed at children at risk of eating disorders is Cognitive Dissonance Activities. This initiative engages young people in conversation on body image²⁴⁹.
- The Increasing Access to Psychological Therapies (IAPT) programme has recently been extended to children, including those aged five and under. An IAPT programme aimed primarily at the practitioners who support parenting is also being planned.

Adult approaches

Universal

- Provide mental health literacy training to frontline housing and advice workers to help individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes.
- Use social media and other avenues to disseminate universal public mental health messages such as those promoted in 5 Ways 2 Wellbeing
- Mindfulness has a rapidly expanding evidence base and is increasingly popular in both people with mental health problems and risk factors and in general populations²⁵⁰.
- Promote body work that both exercises and stills the mind like Yoga and Tai Chi, which are increasingly popular and have a small evidence base to support their effectiveness.
- Promote walking and exercise on prescription schemes, books on prescription schemes, social prescribing and wellbeing pledge programmes in primary care.
- Promote the use of volunteering, such as timebanks²⁵¹, as a way of linking local people who share their time and skills, and enabling them to live well, improve their health and wellbeing, and link them to their community. Timebanking can help lower the number of GP visits by removing the kind of visits that do not require medical attention²⁵².

Targeted

The Sustainable Development Commission commented that self-care is a more sustainable approach to health service delivery and observed that as well as empowering people to be in charge of their own health care, it reduces health inequalities²⁵³. The Scottish Government in particular has focused on involvement of people with experience of mental health problems and mental health services and the importance of self-help, self-referral, self-directed, self-management and peer to peer support in service design and delivery²⁵⁴.

- Increasing people's capacity to use psychological treatment methods can prevent the development of mental health problems, particularly if used during periods of transition and pressure, such as redundancy, after birth or after a bereavement. Simple interventions and promoting available services such as cognitive behavioural therapy, have been successful in this way, particularly with those at increased risk of mental health problems, such as those with long term conditions and those who are isolated^{255, 256}.
- Provide bereavement counselling²⁵⁷ and relationship support²⁵⁸.
- Support unemployed working age adults into high quality work and ensure those who are unable to work have access to a reasonable standard of resources and are supported to lead fulfilling lives, moving towards employment as appropriate.
- Increase mental health literacy^{vi}, especially for people with limited financial and social resources, including older people, people with long term health conditions, refugees, people from Black and Minority Ethnic communities and people living with disabilities. Low mental health literacy limits opportunities for vulnerable groups to be actively involved in decisions about their health²⁵⁹ and increases delays in help-seeking and access to appropriate treatment.

^{vi} Jorm *et al* (1997) defined mental health literacy as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". Mental health literacy consists of: (a) the ability to recognise specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information. Reference for Jorm *et al* is: **Jorm, A. F., Korten, A. E., Jacomb, P. A., et al** (1997) 'Mental health literacy': a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, **166**, 182 -186.

Case Study 5: Dorset Mental Health First Aid Training

In response to concerns raised by local authorities' staff that they were ill-equipped to assist the increased numbers of people with mental health and other vulnerabilities they were coming into contact with, Public Health Dorset, in partnership with Mental Health First Aid England and Health Education Wessex, rolled out a pilot project to deliver Mental Health First Aid training to provide council staff with the confidence and means to act.

In the same way physical first aid is taught, Mental Health First Aid is an education course which teaches people how to identify, understand and help a person who may be developing a mental health issue. MHFA lite is an introductory three-hour mental health awareness course, which results in participants being able to:

- Define mental health and common mental health issues
- Identify stigma and discrimination surrounding mental health issues
- Relate to people's experiences and support people in distress
- Look after their own mental health

This course was rolled out to nearly 300 staff from the three Local Authorities covered by Public Health Dorset. An evaluation of the pilot, using pre and post training questionnaires, showed increased understanding and confidence around mental health issues, and the benefits continued to be seen six months after the training was delivered, suggesting that long-term workforce benefits are possible.

More information is available at:

<http://www.publichealthdorset.org.uk/2015/09/10/hundreds-supported-to-provide-mental-health-first-aid-in-dorset>
<http://mhfaengland.org/first-aid-courses/first-aid-lite/>

Targeted (continued)

- People living with serious mental health problems will benefit from regular general physical health assessments and from signposting to information and support that addresses diet, alcohol consumption, exercise, drug misuse and sleep²⁶⁰.
- Other important interventions include public health intervention that might otherwise be overlooked such as access to smoking cessation, free dental and optical examinations, and flu vaccinations²⁶¹.
- Services, facilities and resources should be inspected to ensure they are accessible. This can be done by assessing in collaboration with the local community and making any necessary adjustments.
- Ensure service navigators are available to people with complex needs and advocate for them to have peer experience and be skilled in negotiating the access barriers experienced by minority groups²⁶².
- Develop trauma informed care, particularly for those who have witnessed or experienced violence, abuse and/or severe neglect either in childhood or adulthood²⁶³.

Case Study 6: Smokefree LCFT

Lancashire Care NHS Foundation Trust (LCFT) implemented a nicotine management policy across its community and inpatient mental health services in January 2015, prompted by NICE guidance PH48 which advocates smoking cessation, temporary abstinence from smoking and smokefree policies in all secondary care settings.

The policy supports the Trust's ambition to achieve parity of esteem for people with a mental health condition by tackling smoking, as a key contributor to the difference in life expectancy.

All staff were encouraged to complete level 1 smoking cessation training, with some staff are trained as level 2 Stop Smoking Champions who provide advice, support and nicotine replacement therapy (NRT) to service users.

The policy looked to challenge both clinical practices as well as on going stigma noted in the local community. During the first six months of implementation, LCFT carried out staff surveys to understand staff perceptions and capture best practice. This was part of an on-going evaluation which led to service users developing an animation that provided information about the policy to service users and carers.

This policy proved extremely unpopular and highlighted the fact there needed to be a cultural shift about the role of smoking in mental health services. However, it was highly beneficial to the health and wellbeing of people with a mental health condition.

Later life interventions

The positive outcomes expected from public mental health interventions targeting later life include reduced isolation, improved mental wellbeing in later life, reduced prevalence of mental health problems and increased quality of life for people in later life living with mental health problems.

Universal

- The Campaign to End Loneliness provides adult social care, clinical commissioning groups and public health teams with guidance on developing strategies to address loneliness amongst older people in their local populations. Their Loneliness Framework set out interventions across the healthcare system and the wider community²⁶⁴.
- Community approaches to reduce isolation in older people that have been found to be effective include:
 - ▶ Befriending and mentoring²⁶⁵,
 - ▶ Social group schemes which incorporate self-help support and peer involvement are effective ways to reduce social isolation, such as the 'Standing Together' peer support service delivered by the Mental Health Foundation²⁶⁶

Targeted

- Implement the NHS Five Year Forward View vision for identifying and supporting carers with a focus on carers aged eighty five and over. Health and social care agencies should work together on this²⁶⁷.
- Dementia Friendly Communities is an Alzheimer's Society programme which enables the creation of dementia-friendly communities across the UK and ensures everyone understands that they have a shared responsibility for ensuring people with dementia feel understood, valued and able to contribute to their community. They have developed a range of resources and guidance on creating dementia friendly communities^{268, 269}. An extension of this is the Dementia Friends initiative which aims to change people's perceptions of dementia and to change the way the nation thinks, talks and acts about the condition²⁷⁰.

- Peer support groups for people with early stage dementia living in extra care, retirement housing and their families have had promising outcomes in the areas of wellbeing, social support and practical coping strategies, with improvements in communication abilities, managing memory and managing lives all linked to peer support²⁷¹.
- Reminiscence therapy for older people has a range of therapeutic and preventative effects, including reduction in symptoms of depression and improved feelings of self-esteem²⁷².
- NICE have produced public health guidance on mental wellbeing and older people. They recommend a range of activities including support sessions to assist with daily routines and self-care, community based physical activity programmes, walking schemes and training for practitioners. These have all been informed by occupational therapists²⁷³.

Investing in creating mentally healthy places

To ensure targeted and universal interventions reach the people most in need, it is important to ensure all frontline staff act as ambassadors. Much can be learnt from the NHS 'making every contact count' programme, which aims to ensure every contact with an individual is an opportunity to help them look after their wellbeing²⁷⁴.

Without comprehensive, easily accessible information being made available, frontline staff, those in the voluntary sector and people in the community may struggle to understand how to support mental wellbeing. Training and resources should be developed and delivered to cover wellbeing activities and services, promoted through local community groups and networks, and made accessible to all.

Case Study 7: Mental health & wellbeing strategy and action plan

NHS Ayrshire & Arran developed a 12-year population mental health and wellbeing strategy based on the Scottish national outcomes framework and indicator sets for mental health and wellbeing, to reach approximately 380,000 people across a health board area. It will be implemented by four, three-year action plans, the first of which will take place between April 2015 and March 2018. Findings from the Scottish Health Survey shows that the general population in Ayrshire and Arran had a WEMWBS score similar to the Scottish average, but noticeable differences remained regarding inequalities. Routine data collection indicated that mental health problems were increasing, especially in relation to anxiety and depression and this strategy looked to address upstream factors and help people to develop resilience.

The strategy takes a universal approach to infant mental health where resources had been developed for the whole population but there have also been parenting programmes for vulnerable families. As well as the production of a suite of materials and training for these staff groups, three times a year, seminars take place about infant, children and young people's mental health.

While this strategy is still in place, there has been a significant increase in commitment to public mental health approaches as part of a whole system approach to mental health. The time frame for the full evaluation was in 2016, the year after the year of mental health ends.

The evaluation will identify what has changed in services, what has changed from baseline for service users and what has changed for stakeholders, including employers, schools, voluntary organisations and the police.

Tackling stigma, discrimination and social exclusion and working on inequalities

Evidence of what works to reduce mental health stigma and discrimination suggests that successful projects combine a number of approaches including education, social contact and protest. The strongest evidence is that interventions with a high level of appropriate and relevant social contact are able to improve understanding and reduce social distance²⁷⁵. A highly targeted approach, alongside consistency of messaging and strategies for changing discriminatory behaviour, is most likely to be effective in producing measurable change. It has been suggested that projects which aim to promote recovery may then be effective in reducing stigma among the participants and that mutual support programmes would reduce self-stigma and increase quality of life for those who took part. Taking an inequality focused public mental health approach acknowledges that those with the most complex lives are most likely to achieve the poorest outcomes, both in degree of risk and resilience to adversity but also in relation to access to protective factors including services at the earliest point. Taking a universal approach increases the capacity of those without problems to be tolerant, supportive and compassionate to those with problems.

In Scotland, See Me was the first UK anti-stigma programme and applies a social movement theory in England and Wales, the main anti-stigma campaign is Time to Change. In Northern Ireland Change Your Mind was launched in March 2016²⁷⁶. These offer a wealth of information and support with challenging discrimination and stigma. The Time to Change Pledge in England²⁷⁷ and See Me in Work²⁷⁸ programme in Scotland invited employers to make a public commitment to addressing stigma and implementing a work plan to achieve this. A hallmark of such programmes is that baseline data is collected and monitored either quantitatively or via qualitative evidence in a portfolio approach.

Community

A public health approach to creating mentally healthy places requires targeting outwards from the home and institutional settings where people live, to education and working settings, to the community, then the physical environment, and finally to the overarching socio-economic conditions (Goldie et al, 2016)²⁷⁹. It also requires committed and proactive engagement with community members. NICE published updated guidelines on the community engagement to improve health and wellbeing and reduce health inequalities in 2016²⁸⁰. Working to empower communities in decision making in relation to planning and regeneration has been shown to increase resilience within communities²⁸¹. Community development approaches, like public health interventions more generally, are an opportunity to support empowerment. It is crucial that in addressing mental health equity for those that carry the highest risk of poor mental wellbeing, efforts to support this group to engage fully is a priority, as recognised by the World Health Organization²⁸².

Asset based community development (ABCD) is an emerging approach to developing flourishing communities and enhancing population wellbeing. Instead of focusing solely on problems and deficits in communities, the ABCD approach seeks to identify and build upon existing strengths that enable communities to flourish. People are viewed as active citizens and co-producers with something to offer, rather than passive clients and service users. The emphasis is on 'doing with' rather than 'doing to': empowering and enabling people to take control of their lives and supporting them to do more for themselves. This is similar in principle to the recovery model of support for mental health problems, which aims to lessen the long-term impact of mental ill-health and strengthen the individual's participation within their community. As funding across the NHS and public sector is declining, the ABCD approach is becoming increasingly valuable in preserving or further developing communities and services. The ABCD approach can be applied to any of the specific approaches outlined below²⁸³.

Case study 8: Torbay Lions Collective Mens Mental Health initiative

Torbay is in the top 20% of deprived areas in the country, with high numbers of male homeless, young people self-harming, alcohol abuse and rates of male suicide that continue to increase. 75% of those men who took their lives had not accessed mental health services and few had attended their GP.

Some of the local business men decided something needed to be done, and the Torbay Lions Collective was started by the local Barber, the local pub owner, the owner of the boxing club and others. The Torbay Lions Collective (TLC) focused on educating men on the links between physical and emotional health working through a variety of local services:

- They developed a Lion's Den with a cafe, gym equipment, and access to peer support groups and other facilities.
- The Lions Link was a phone line run by men on evenings and weekend. Lion Lairs were pop up awareness raising events.
- The Lions Roar website was developed to provide information on health, local events and finances.
- The Lions Logo was awarded to local businesses that were willing to engage in training for mental health.

The evaluative process was developed as a combination of Reflective Processes, Appreciative Inquiry, and Improvement Methodology. However one of the key lessons taken from the project was that it was possible to achieve positive emotional and physical outcomes without ever mentioning the word health.

Home

Alongside the family interventions mentioned above, here are some targeted approaches for those at risk or recovering from a mental health problem:

- Psychologically Informed Environment (PIE) is a promising approach, which centres services' physical and social environments on service users' emotional and psychological needs²⁸⁴. PIEs have been piloted in housing, homelessness, social care and criminal justice settings in England.
- Provide mental health literacy training to frontline housing and advice workers to make contact count in helping individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes.
- Develop partnership working with a broad range of stakeholders to co-produce an integrated housing, health and social care pathway.
- Work in partnership with government departments, public bodies and other agencies to provide specialist housing support for vulnerable people with mental health problems²⁸⁵.
- Advocate for the use of NHS land to make more supported housing available for vulnerable people with mental health problems, as recommended by the Taskforce²⁸⁶.

Educational settings

Schools are an ideal setting to support the promotion of mental wellbeing in young people. Programmes have been shown to offer long-term benefits including improved academic performance. The evidence base for school based interventions is perhaps the most extensive of all approaches.

- Implement preschool programmes for children who are at risk in order to promote school readiness, and communication, social and emotional skills²⁸⁷.
- The 'whole school' approach to prevention and promotion has been shown to be effective at building resilience in young people. This comprises of systematic changes (for example changes to ethos, anti-bullying policies and programmes to support teacher wellbeing), universal interventions for all pupils (for example curriculum based social education), and outreach programmes for parents and the wider community. Whole school approaches are best combined with targeted support (providing timely school-based input for those with risk factors such as behavioural problems)²⁸⁸.
- Whole college and university based approaches within future education, informed by the work of the English Healthy Universities Network and the World Health Organization's Health Promoting Universities Programme²⁸⁹, should be implemented.
- Ensure there is leadership for and commitment to supporting mental health within educational settings by providing training and support for teachers and head teachers in relation to mental health literacy, including protecting and improving their own mental health²⁹⁰.
- Highly effective parenting support programmes like FAST, mentioned above, can also be run through schools.

Eight principles to promoting a whole school and college approach to emotional health and wellbeing²⁹¹



Case study 9: Think Good Feel Good/TaMHS ‘Broadening the Reach’

The promotion of children’s emotional health and wellbeing and developing resilience across schools was the core aim of ‘Think Good Feel Good’. The project was Shropshire wide schools based programme that started as a pilot programme in 2009. The programme used a universal population based approach to for children and young people at Tier 1, and targeted support for those at Tier 2 and adopted a whole school/service approach

The fundamental purpose of TaMHS was to embrace an ‘everyone’s business’ approach across Shropshire in the prevention of poor mental health. Good mental health and wellbeing had been recognised as an important local issue in different forums.

The programme adopted a whole school approach with some of its objectives being to:

- Develop a common language that expresses thoughts and feelings
- Promote and develop strategies to support mental health, build confidence, self-esteem and resilience
- Improve communication and consultation with specialised services
- Support schools to develop their role as commissioners to achieve mental wellbeing outcomes
- Provide training for school staff and partners to deliver targeted support intervention programmes supporting varying emotional needs

The project also provided multiagency training to pastoral and specialist staff who work within schools to provide targeted interventions/programmes.

The work was supported on a multi professional basis by input from educational psychologists, primary mental health workers and school nurses. Evaluations found that the programme reached 84% of Shropshire schools and there were positive findings in relation to knowledge, confidence and improvements in pupil attitudes, anxiety and feelings.

It is important to remember that there are groups of children outside of the school system^{vii} who are exposed to factors that place them at higher risk of developing mental health problems but do not benefit from the protective factor of being in an educational setting. So although schools and colleges can play a significant role in helping to promote mental wellbeing, this must be done as part of a wider multi-agency approach²⁹².

^{vii}Such as children in immigration detention centres, homeless children, those in the criminal justice system and some members of Gypsy Traveller community.

Workplace

Mental wellbeing is a relatively new area of focus for workplace wellbeing programmes, with most workplace programmes up to now focusing on physical health. Although not specifically developed with mental health in mind, some of these can also have a beneficial effect on the mental wellbeing of workers. Effective workplace interventions should address the physical, environmental and psychosocial factors influencing mental health including workload, job control, role clarity and bullying, using a whole workplace approach. This integrated approach combines universal, selective and indicated preventative strategies, and pulls together core business missions, human resources (HR) strategy and corporate social responsibility programmes²⁹³.

Universal

The Workplace Wellbeing Charter is a voluntary, self-assessment scheme that is open to all England-based public, private and voluntary sector organisations. Though not exhaustive, the Charter covers a broad range of dimensions relating to workplace health and wellbeing through ten defined standards that cover leadership, healthy eating, wellbeing, work-life balance and others. An evaluation of the impact of the Charter found that two thirds of employees felt it had made at least some difference to the health of their organisation²⁹⁴.

- Work in partnership with local businesses leaders and employers to embed a whole workplace approach to protect and improve mental health at the individual, collective and organisational level, supporting them to:
 - ▶ Adopt the PHE Healthy Workplace Charter²⁹⁵
 - ▶ Embed mental health in all organisational policies and procedures
 - ▶ Deliver line management training to create mentally healthy environments, as detailed in NICE guidance²⁹⁶
- Share and use the British Heart Foundation advice on how employers can promote healthy eating using interventions to inform and educate, provide a supportive environment and actively promote healthy choices²⁹⁷.

Targeted

- Support workplaces to provide stress management support for employees experiencing distress²⁹⁸.
- Increase access to talking therapies for those who are experiencing common mental health problems^{299, 300}.
- Support local employers to engage with evidence based supported employment programmes such as Individual Placement and Support (IPS) and Access to Work in order to enable people to join the workforce³⁰¹.
- Use the recommendations made by CIPD around managing actual or potential problems due to alcohol or substance misuse to support employers³⁰².

The built environment and neighbourhoods

Neighbourhood community development initiatives have been successfully adopted in a number of disadvantaged communities. Sustained partnership working between community members and local series is a key feature, and this type of approach can lead to long term transformative outcomes in health and mental wellbeing, while also breaking through longstanding barriers. The steps required are: locating energy for change, creating vision, listening to communities, forming partnerships, sustaining momentum, taking action and continuing the trajectory of improvement³⁰³.

Increasing and strengthening the networks of relationships people can promote mental wellbeing³⁰⁴. This can be done through targeted interventions to build social relationships amongst isolated groups, by changing the way systems and services are currently run to facilitate social connections being developed, or by promoting peer support programmes between those who have experienced similar challenging life circumstances, such as bereavement or physical health problems³⁰⁵.

- Public Health England published a briefing on community centred approaches which can inform their inclusion in local public service planning and delivery³⁰⁶.
- The English Mental Health Task Force Report proposed the development of mentally healthy communities including through the use of social movement approaches³⁰⁷. The Mental Health Foundation have created a 'Whole Community' approach that aims to embed mental health improvement action within all settings, systems and policies where there are opportunities to make every contact count. In applying a wider approach to measuring change, this can address the social determinants and inequalities alongside measures of mental health problems and wellbeing³⁰⁸.
- Create and protect green spaces within neighbourhoods in order to generate better physical and mental health outcomes for individuals and communities³⁰⁹.

Case study 10: Well Connected – Social Prescribing for Mental Health & Wellbeing in Lanarkshire

NHS Lanarkshire aimed to reduce health inequalities and encourage greater mental wellbeing through social prescribing (SP). Its programme 'Well Connected' recognises that mental health services need to be bought together to deliver socially inclusive and sustainable treatment plans and to effectively address mental health stigma. The programme is centred around a culture of self-management.

Well Connected was developed in support of The National Mental Health Improvement Outcomes Framework which highlights 44 key indicators for mental health and wellbeing and reinforces the need to create the condition for supporting mental health at three levels: individual, community and structural.

A reduction in inequalities was achieved through the creation of a single information telephone point delivered through the third sector in North and South Lanarkshire providing information and practical support to people who require support to access. Local self-referral Occupational Therapy Community Clinics were also available which provided a hub for people to explore their needs and receive support to engage in community based programmes.

Well Connected focussed on implementing community interventions for which a strong evidence base already existed and sits as a key action as part of 'Towards a Mentally Flourishing Lanarkshire', which is Lanarkshire's overarching Mental Health Improvement Strategy. The results of the Scottish Health Survey have been encouraging regarding self-reported mental health problems and wellbeing.

Section Four

What can public mental health practitioners and other professionals do to support their own mental wellbeing

The adage that those working in public health are 'part of the problem as well as part of the solution' is particularly pertinent in public mental health. Universal approaches involve everyone in the population, which includes the public health workforce. Personal mental wellbeing is not an area of practice in which we can regard ourselves as having particular expertise. Indeed, the mental health of those working in health care disciplines tends to be below average and thus around one in five of us will be experiencing mental health problems at any one time.

No-one person or discipline yet has a handle on mental wellbeing in its entirety, but we know the direction of travel and many different disciplines have discovered helpful approaches. Engaging with the public mental health agenda means being prepared to engage at a personal as well as professional level, so that at each step of the way we can experience for ourselves the pros and cons, barriers and facilitators for what we are advocating. Working in this way, we get to understand mental health from many different perspectives and gain insight into the ways and circumstances in which different approaches are valuable. We become exemplars of mental health improvement and role models for when we face challenges. This will allow us to lead from a place of personal knowledge, not as experts but as co-producers of a society where mental health is more robust than the one we currently inhabit. It is for these reasons that personal mental wellbeing is now a key learning outcome for public health training through the Faculty of Public Health.

The benefits of better personal mental health accrue not just to us but to our colleagues and the public we serve. The journey towards mental wellbeing improves resilience and the capacity to withstand the stresses of working in public health, including the vicarious impact of working with people in distress and dealing with uncertainty, insecurity and reorganisations. It increases our capacity to see what needs to be done, and to work out what can be done now and what needs to wait. Our capacity to be compassionate, respectful and authentic increases as personal wellbeing increases and reduces the chances of any of us falling into the bully, victim or rescuer mindset which can happen when we are not in the most mentally healthy workplace.

Some of the things people have found to work for them are beginning to form a more robust evidence base. Some have a very long history of having been helpful, others are more recent arrivals on the scene. Some techniques have been incorporated in '5 Ways to Wellbeing,' a campaign for wellbeing developed by The New Economics Foundation on the basis of reliable predictors of mental wellbeing: Connect, Be active, Take notice, Keep learning and Give³¹⁰. These and some other practical, positive steps that can be used to protect and support mental wellbeing are explored below. To ensure lasting change, making a pledge or developing SMART^{VIII} goals can be helpful.

^{VIII}Specific, Measurable, Achievable, Relevant, Timely

Routes to mental wellbeing

Pay attention to your state of mental health and wellbeing. Work out what enhances it. You will already have many things that you know you enjoy. Start to explore others and see if those that used to give you pleasure are what really work for you now. Make a pledge or goal with yourself to do more of what gives you pleasure and enjoyment. For more see Mental Health Foundation (2016) How to Look After Your Mental Health Guide³¹¹. Get a clearer understanding of what stresses you. Investigate how much stress your system can take and resolve not to exceed that exposure.

Pay close attention to your relationships both at work and at home. Spend more time with people who feed you and less with those who drain you. Address relationship issues with colleagues and friends using the precepts of emotional literacy. Seek help with those that are particularly problematic when you cannot disengage from them. Make time for real connection with family, friends, colleagues and neighbours, at home, work, school or in the local community. For more see Mental Health Foundation (2016) Guide to Investing in Your Relationships³¹².

Be active and exercise. Exercising makes people feel good and is useful for relieving stress and anxiety. Any form of exercise and physical movement is a positive step towards supporting mental wellbeing, whether it's walking, running, cycling, going to the gym, cleaning the house, gardening or dancing. Mindful exercise practices such as Yoga and Tai Chi are particularly valuable because they quiet the mind as well as exercising the body.

Any form of exercise can, of course, be done mindfully and those who exercise in this way protect themselves from the problems of overdoing it. Pilates, the Alexander Technique and Feldenkrais are all Western approaches which address both body and mind to some extent. For more see: Mental Health Foundation (2016) How to Look after your mental health using exercise guide³¹³.

Take notice. Becoming aware of the world around you and how both yourself and others are feeling is an important skill for mental wellbeing. This means getting out of our heads and taking notice of how our bodies are feeling and functioning³¹⁴. Reflecting on experiences helps people appreciate what matters most to them. Mindfulness enables this skill and is becoming increasingly popular. Mindfulness derives from meditation practices which have been recognised as profoundly helpful for wellbeing for several millennia.

The formal evidence base for mindfulness relates primarily to the approaches Mindfulness Based Stress Reduction (MBSR) and Mindfulness Based Cognitive Therapy (MBCT) which have been employed for a broad range of health problems³¹⁵. The latter has shown that mindfulness can improve resilience, reduce stress and anxiety and reduce relapse rates and antidepressant use for those living with depression. The evidence cited relates to mindfulness interventions for adults but has great potential over the life course³¹⁶. Many free apps can be downloaded to support mindfulness practice, including buddhify³¹⁷, headspace³¹⁸ and beminful³¹⁹. For more information see: Mental Health Foundation (2016) How to Look After Your Mental Health Using Mindfulness Guide³²⁰.

Keep learning. Learning new things can help to support mental wellbeing and make people more confident. Most people working in public health are very good at learning new things for their work. Learning to do something unrelated to work may be more helpful here.

Volunteer. Volunteering has a small formal evidence base showing benefits to the physical and mental health of volunteers as it provides a sense of purpose and participation³²¹. Benefits include reduced mortality, increased physical wellbeing, increased self-rated health, higher life satisfaction³²² and reduction of depression in later life³²³. These benefits have been found to exist due to the higher levels of social support, social exchanges and sense of community that volunteering provides^{324, 325}.

Ensure you get enough sleep. Sleep quality and quantity are both a symptom and a cause of mental health. In so far as sleep is causal it is possible to improve mental health through sleep hygiene practices: ensuring some down time before sleep, making the bedroom a calm place separate from work and other stressful activities, eating early and plenty of time before retiring, and avoiding alcohol in the evening³²⁶. For more see: Mental Health Foundation (2016) How to Sleep Better Guide³²⁷.

Embrace positive psychology. The positive psychology movement has spawned a number of approaches to improving mental wellbeing. Positive psychology focuses the minds of those who use it on strengths, assets and solutions. Reframing events in positive terms may be part of this process, but the approach is more subtle than simply 'thinking positive'. Many of these approaches, like mindfulness, have their origins in spiritual traditions and all include a positive focus. They include:

- Recalling three things about the day that have gone well before sleep
- Naming five things for which you are grateful every day
- Identifying your strengths and ensuring that these are used
- Focusing as much on solutions and assets as on problems
- Recognising and praising behaviour in others that is helpful; ignoring behaviour that is unhelpful or damaging if at all possible

The East has provided a useful concept to encourage this mindset: what you pay attention to is what you get more of. It has also developed the skill of meditation which enables practitioners to train their minds. As interpreted in the Western practice of mindfulness this is described as 'paying attention on purpose in the present moment.'

Develop Interests. Creative arts such as painting, drawing, weaving and designing are well recognised by those who practice these things to support their mental wellbeing. It is the participation which matters, not the product. Art therapy has proved very useful in enabling people who have had damaging life experiences to remember, talk about and integrate those experiences in a way which enables coherence in their lives.

Singing has long been recognised as a foundation for wellbeing by those who enjoy it and is starting to acquire a formal evidence base for wellbeing. Community choirs which do not require any knowledge or skill in music are springing up all over the country and welcome those who do not think they can sing. Playing an instrument, belonging to a band or orchestra, writing songs or music are all much more accessible routes to wellbeing than many would have us believe.

Signposts to more support

At the other end of the spectrum, recognising and seeking help for problems that begin to feel unmanageable is important. There are many self-help groups who can assist at this time. Trusted friends or colleagues can help and there is a range of professional help both in and outside the health service. Your GP will be able to assist you to get the right support. Additional support can be found here:

- Samaritans offer emotional support twenty four hours a day via the freephone number 116 123.
- NHS Choices have developed a guide to accessing mental health services.
- Rethink mental illness provide an accredited advice and information line to everyone affected by mental health problems on 0300 5000 927.
- Mental Health Foundation have published practical advice guides to looking after mental health.

Annexes

Annex 1: List of all award entries

FPH received 31 entries for the public mental health award, which are listed below. The 10 shortlisted entries are included in this report. All other entries are available via the Better Mental Health for All section of FPH's website.

Project name	Submitter
Co-production evaluation of County Durham Real Time Suspected Suicide Surveillance Early Alert Pilot	Teesside University and Durham County Council
The Bridge Pilot	City of London Corporation
STOP Suicide	Mind in Cambridgeshire
Somerset Suicide Bereavement Support Project	Somerset County Council
The COPD manual	Central and North West London NHS Foundation Trust
NO MORE Zero Suicide Strategy	Champs Public Health Collaborative
Mental health training in the Workforce, Improving Awareness and Confidence	Public Health Dorset
Addressing emotional wellbeing as part of flood recovery in Somerset	Somerset County Council
Aj'jwa'ad Centre for Societal Care (ACSC)	King Saud University's Department of Psychology
Smokefree LCFT	Lancashire Care NHS Foundation Trust
Well Connected: Social Prescribing for Mental Health & Wellbeing in Lanarkshire	NHS Lanarkshire
Torbay Lions Collective	Public Health Torbay
Child and Youth Mental Health Improvement Early Intervention Strategy	NHS Greater Glasgow and Clyde
A collaborative approach to reducing social isolation and stigma	Orchard House Older Peoples Day Care with Newby and Scalby in Bloom
A Sense of Belonging Joint Mental Health and Wellbeing	NHS Lothian
Mental health & wellbeing strategy and action plan	NHS Ayrshire & Arran
Hearing Voices – A guide to understanding, helping and empowering individuals Mobile App	Mersey Deanery
Happy and Thriving Communities – Public Mental Health Strategy	Wandsworth Borough Council
Think Good Feel Good/TaMHS 'Broadening the Reach'	Public Health, Shropshire Council
London Mental Health: The invisible costs of mental ill health	Greater London Authority
Feel Good Greenwich	Greenwich Mind
Hertfordshire Year of Public Health	Hertfordshire County Council

Year of Mental Health	Hertfordshire Local Pharmaceutical Committee
Mental health and wellbeing: a series of special briefings for Shropshire county elected members	Help2Change
Dr Sara Ryan, University of Oxford /Justice for LB	UCL
London Mental Health: The invisible costs of mental ill health	Greater London Authority
WBCCG Mental Health Strategy	Wigan Borough CCG
Warwickshire Public Mental Health and Wellbeing Strategy and associated action plan (2014-16)	Warwickshire County Council
Designing and Advocacy of National Mental Health policy	National Institute of Health Research, Tehran University of Medical Sciences
Dumfries & Galloway's Public Mental Health Approach: Council and NHS Dumfries & Galloway)	DG Health & Wellbeing (Dumfries & Galloway
The 35-year Caerphilly Cohort Study	Cardiff University

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The Faculty of Public Health

The UK Faculty of Public Health (FPH) is committed to improving and protecting people's mental and physical health and wellbeing. Our vision is for better health for all, where people are able to achieve their fullest potential for a healthy, fulfilling life through a fair and equitable society. We work to promote understanding of public health issues and to drive improvements in public health policy and practice.

As the leading professional body for public health specialists in the UK, our members are trained to the highest possible standards of public health competence and practice, as set by FPH. With 3,800 members, in the UK and internationally, we work to develop knowledge and understanding, and to promote excellence in the field of public health. For more than 40 years, we have been at the forefront of developing and expanding the public health workforce and profession.

UK Faculty of Public Health
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Registered Charity No. 263894



www.fph.org.uk



[@FPH](https://twitter.com/FPH)

The Mental Health Foundation

Good mental health for all

Our mission is to help people understand, protect and sustain their mental health.

Prevention is at the heart of what we do, because the best way to deal with a crisis is to prevent it from happening in the first place. We inform and influence the development of evidence-based mental health policy at national and local government level. In tandem, we help people to access information about the steps they can take to reduce their mental health risks and increase their resilience. We want to empower people to take action when problems are at an early stage. This work is informed by our long history of working directly with people living with or at risk of developing mental health problems.

The Mental Health Foundation is a UK charity that relies on public donations and grant funding to deliver and campaign for good mental health for all.

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www.mentalhealth.org.uk



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