mind
for better mental health

Our communities, our mental health

Commissioning for better public mental health

Contents

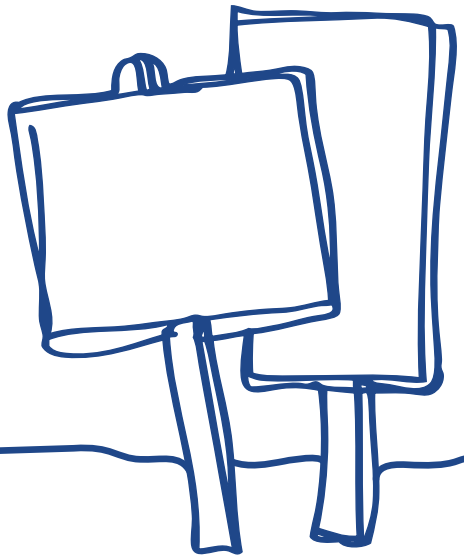
Why good public mental health matters

We know that having a mental health problem can have huge personal costs. It can impact on our relationships, our jobs, our physical health and much more. This is why preventing a mental health problem from occurring in the first place, as well as detecting problems early and helping people recover can be life changing. And we know that there are things that can help this to happen.

Over the last few years, we've been working to raise the profile of ways to promote wellbeing, build resilience and prevent mental health problems. We've also been championing the need for investment in this area because we believe this not only benefits individuals and their families but can also save health and social care services money.

When reporting on spend for different public health priorities, local authorities file public mental health under 'Miscellaneous'. This lack of parity with physical health is echoed in the fact that in 2014/15 only 1 per cent of public health budgets was spent on mental health. This needs to change.

This guide provides a background to public mental health: what it is, why it should be invested in and how to target interventions most effectively. It's aimed at those of you with a responsibility for public health in England. Interventions across the course of someone's life are summarised and a range of practical case studies are provided to help you commission successful public mental health programmes in your area.



What is public mental health?

Many of us are familiar with public health – the idea that actions can be taken to promote good health and prevent illness. Programmes to encourage people to exercise, quit smoking and reduce the amount of alcohol they drink are well established.

Public mental health however, while being discussed much more in recent years, including in government strategies, is still not widely recognised. Nevertheless more and more evidence is being gathered that demonstrates practical ways in which we can reduce the prevalence of mental health problems.

Just like physical health, we all have mental health. Our mental health can change over time, with periods where we may struggle and other times when we feel well. Public mental health interventions can play a role in improving the mental health of people across these different stages.

Primary prevention: promoting good mental health and preventing mental health problems

These interventions aim to prevent mental health problems from happening in the first place. This includes initiatives aimed at the whole population or groups of people particularly at risk of mental health problems to promote ways to look after your mental health and prevent mental health problems. These work in a similar way as being encouraged to quit smoking and take more exercise to improve our physical health and prevent health problems.

Secondary prevention: early detection of mental health problems

These interventions aim to reduce the development of mental health problems. This includes initiatives which aim to raise awareness of mental health including the signs and symptoms of mental health problems to encourage early detection. Such programmes aim to identify problems early and ensure people seek timely help, in the same way screening programmes such as mammograms aim to catch cancer early.

Tertiary prevention: supporting recovery

These interventions aim to reduce the impact of established mental health problems and prevent further complications. This includes initiatives aimed at people with mental health problems to assist them in avoiding relapse and supporting their recovery and wellbeing. This works in much the same way as self-management programmes and support groups can assist someone with diabetes.

Type of prevention	Stage	Target	Aim
Promotion and prevention (Primary)	No mental health problems	Whole population and 'at-risk' groups	Prevent mental health problems happening
Early detection (Secondary)	Early stage of mental health problems	'At risk' groups and those displaying early signs and symptoms	Detect signs of mental health problems early and seek timely help
Recovery (Tertiary)	Later stage of mental health problems	Those with mental health problems	Reduce complications of mental health problems and support recovery and wellbeing

(Adapted from Beaglehole, R., Bonita, R., and Kjellstrom, T., (1993). Basic Epidemiology. Geneva: World Health Organisation)

Why invest in public mental health?

Mental health problems are the largest single source of disability in the UK.[1] This represents a huge human cost as well as wider costs to society and the economy.

Having a mental health problem can impact on all aspects of our lives, from our relationships, work, and physical health. Without the right support it can prevent us from living the life we want to lead. The personal costs are immeasurable.

Beyond the distress having a mental health problem can cause a child and their loved ones, further costs can continue into adolescence and adulthood, including teenage pregnancy, poor educational achievement, poor employment outcomes, physical health problems, substance misuse, criminal activity and shorter life expectancy.[2]

Mental health problems have also been well documented to cost the economy greatly. A conservative estimate for 2009/10 found that mental health problems cost health and social care services £21 billion and a further £30 billion was lost in economic output (including through sickness absence and unemployment).[3]

It is well known that the NHS and social care services are experiencing unprecedented budget pressures, and mental health services in particular have historically been underfunded. It is therefore essential that we invest in reducing the impact mental health problems have in our local communities and local services. With clear evidence of the cost savings of prevention and early intervention for mental health problems,[4] we cannot afford not to invest in public mental health. Integration of budgets between health and social care services provides further impetus to invest in public mental health because this takes away the barrier that spending on prevention provides cost savings to other budgets and services.

What increases risk of mental health problems?

As with physical health problems, mental health problems are not equally experienced by all sections of our society, with some people being at higher risk of developing a mental health problem than others. The factors that contribute to someone's increased risk of mental health problems are complex and interrelated.

Risk factors for poor mental health

Trauma and stressful life events

Traumatic experiences and stressful life events can increase our risk of developing mental health problems.[5] The types of events which can increase the risk of mental health problems are wide ranging, but examples include serious accidents, military combat, violent assault, terrorist attacks, natural or man-made disasters or being diagnosed with a life-threatening illness.[5] They also include repeated trauma such as child abuse and neglect,[7] bullying,[8] domestic violence[9] and torture.[10]

Those who are likely to have experienced traumatic events have increased risk of mental health problems, including looked after children who have a five-fold increased risk of any childhood mental health problem.[11] Traumatic and stressful life events can be accumulative – the more adverse childhood experiences the increased likelihood of suicide attempts in adulthood.[12]

Poverty, unemployment and housing insecurity

Poverty and economic hardship can increase the risk of mental health problems and mental health problems can increase the risk of poverty and economic hardship. You are much more likely to experience mental health problems if your household earns the lowest levels of income compared to those earning the highest.[13] Equally those with mental health problems are more likely to be in debt.[14] Our study, Still in the red, highlighted the vicious cycle that can occur – of those in problem debt, over four-fifths thought that their mental health problems had made their debt worse, and almost nine out of 10 felt that their financial difficulties had made their mental health problems worse.[15]

Likewise, over a third of people with mild to moderate mental health problems, and almost two thirds of people with more severe mental health problems, are unemployed.[16] Poor housing conditions and homelessness are also related to mental health problems with common mental health problems being over twice as high, and psychosis 4-15 times as high amongst the homeless population compared to the general population.[17] Similarly, children living in poor housing have increased chances of experiencing stress, anxiety and depression.[18]

Social isolation and loneliness

Both social isolation and loneliness has been found to increase our likelihood of mental health problems. One study has found that working age adults living alone are more likely to develop mental health problems,[19] and for older people who experience loneliness and low social interaction there is an increased likelihood of depression[20] and suicide.[21]

Discrimination and inequality

Discrimination can play a part in why certain groups in our society are more likely to experience poor mental health compared to others. Direct experiences of prejudice and harassment impact negatively on our mental wellbeing, while indirect factors such as deprivation and exclusion also contribute to poor mental health. Studies have highlighted the role stigma and discrimination can play in the poor mental health of marginalised groups including Black, Asian and minority ethnic (BAME) people; lesbian, gay, bisexual and trans (LGBT+) people; and disabled people amongst others.[22]

By understanding the risk factors for poor mental health we can develop our understanding of protective factors for good mental health at the individual, community and societal level. Protective factors are often the converse of risk factors and include individual resilience; control and security (financial, housing etc.); meaningful activity including quality employment; participation and social networks; and respect of diversity.

When accessing the risk factors and protective factors for mental health, it's important to understand how these can differ across the course of someone's life. The evidence supports strong investment in public mental health programmes that are targeted at children and young people (including perinatal mental health)[23]. Interventions will however also need to be targeted at other points within someone's life course, including working age adults where employment (and unemployment) play a key role, through to older adults where loneliness and social isolation are particularly pivotal. Look at pages 14-27 for best practice public mental health programmes across the course of someone's life.

Mental health and the Equality Act

Under the Equality Act, public bodies have a duty to consider the needs of people who are marginalised or experience inequality when making decisions about their policies and the services they provide.

Reducing health inequalities is also a central concern for public health teams. Individuals or groups of people with 'protected characteristics' as identified under the Equality Act are often at high risk of developing mental health problems, and so it can be important to keep these different groups in mind when developing public mental health interventions.

Age

20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents.[24]

Disability

Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems.[25]

Gender reassignment

Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.[26]

Marriage and civil partnership

Separation, divorce and being widowed is associated with increased risk of mental health problems.[27]

Pregnancy and maternity

Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children.[28]

Race

Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups.[29] Young women from ethnic minorities are much more likely to take their own life than White British women.[30]

Religion or belief

Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing.[31]

Sex (gender)

There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women.[32]

Sexual orientation

Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety.[33]

What you can do to improve public mental health in your area

When designing and commissioning public mental health programmes, there are a number of things that should be done to make sure these programmes are effective:

Work in partnership

Public health teams play a crucial role in identifying levels of need in their local area and commissioning public mental health interventions accordingly. However, they should not be undertaking this work alone. All directorates within local authorities, as well as partner organisations (including Clinical Commissioning Groups (CCGs) and providers of services) all play a role in promoting good mental health, preventing mental health problems and early detection. This is particularly important because we know that many different things can impact on our mental health. This can include the conditions of our housing, having access to green spaces or whether we are in quality employment.

In practice this partnership can take many forms. Public health teams may assist other council directorates in assessing the mental wellbeing impact of their policies and programmes, for instance the impact of funding reductions to parks and green spaces. Some areas are pooling budgets between the local authority and CCG to commission public mental health interventions that contribute to the aims of both health and social care services.

Understand your community and who is at high-risk

It is very important that data about the needs of your local community underpin the commissioning of public mental health interventions. For this reason, it is vital to ensure that local mental health needs are properly assessed in Joint Strategic Needs Assessments (JSNAs). JSNAs should include data on:

- Levels of risk factors for mental health problems and poor wellbeing (including in higher risk groups)
- Levels of protective factors for mental wellbeing
- Numbers of people at higher risk of poor wellbeing and/or mental health problems
- Levels and variability of mental wellbeing across the local population
- Levels of, and numbers of, people with mental health problems (including those from higher risk groups).[34]

As with other public health interventions, it is important that public mental health interventions include both universal elements and work targeted at those most at risk of developing poor mental health. Some of the risk factors for mental health problems as well as some of the groups and communities that are known to be at higher risk of poor mental health has been highlighted previously.

It is important to identify those at high risk within your local community, for instance perinatal women or unemployed people. You may also identify that you have a high population of BAME people, LGBT+ people or older people and so may decide to design programmes that particularly target these groups. Understanding your local population and their needs will assist you in commissioning and developing the most effective programmes to improve the mental health and wellbeing in your community.

Case study 1: East of England Zero-Suicide Initiative

The East of England Zero Suicide Initiative aims to prevent suicides through a 'bottom up' approach which includes training and organisational and individual pledges to talk more openly about suicide and help those in distress.

East of England Strategic Clinical Network along with two other areas decided to pilot a 'zero suicide' approach based on the work of Dr Ed Coffey at the Henry Ford Health System in Detroit. The zero suicide approach is based on the premise that all suicides are preventable. Local Clinical Commissioning Groups (CCGs) were invited to be part of the programme and four – Cambridge and Peterborough, Bedfordshire, Hertfordshire and Mid Essex – were chosen.

As the majority of people who take their own life are not at the time of their death receiving support from specialist mental health providers, it was decided that the four areas would concentrate on reaching those who are not in contact with services. Each area delivered different interventions, but these included:

- Redesigning access to evidence based sources of help and support
- Suicide prevention training with a wide range of professionals, including GPs, police (including transport police), pub landlords, university staff, housing association staff, and voluntary sector workers / volunteers
- A 'top tips' template for GP IT systems
- Working with transport police to identify 'hot spots' and work with partners on safety planning
- Support for those bereaved by suicide who are themselves at increased risk of taking their own life
- Working with the local press to encourage them to signpost people to support following potentially distressing articles
- Stop suicide campaigns whereby organisations and individuals pledge to be alert to the warning signs of suicide, ask directly about suicide, and help those who are feeling suicidal to stay safe.

An evaluation by the Centre for Mental Health has found that with the clear vision and challenging objectives, local groups delivered creative and effective approaches to suicide reduction at relatively low cost.

I was with a neighbour, in the pub. He was drunk and disclosed to me that he wanted to end it all. We talked at length and were able to agree he would keep 'safe for now' and build on the strengths we identified together

Monitor and evaluate impacts

'Traditional' public health areas such as vaccinations, sexual health, smoking and cancer screening have had a long time to establish the evidence as to what interventions are effective. While good evidence exists for a range of public mental health interventions, there is a need to further expand and reinforce this evidence.

When considering what monitoring and evaluation data interventions should be collecting, you'll need to establish some clear aims – what do you want to see improved at an individual level? And what do you want to see improved at an organisational or societal level? It is important that such aims and the corresponding measures are decided in collaboration with relevant stakeholders, including your target audience. By working with your target audience, you will be more likely to develop more nuanced measures and take a holistic approach to improving mental health and wellbeing.

Example public mental health measurements

Individual level:

- **Qualitative measures** – for example, focus groups and depth interviews which will capture some of the impact of programmes on individuals that quantitative measures are unable to. This is important for all programmes but will be especially so for programmes aimed at people with mental health problems which should be focused on an individual's assessment of what recovery looks like.
- **Quantitative measures** – for example, mental wellbeing measures such as the Warwick-Edinburgh Mental Wellbeing Scale or mental health measures such as the Beck Depression Inventory-II.
- **Behaviour measures** – for example, if you are commissioning an anti-bullying programme in schools this would be about individual's experience of bullying.

Organisation / societal level:

- **Use of services** – for example, an exercise programme for people with mental health problems could measure uptake of physical activity services by this group. Or larger programmes may want to measure whether they've had an impact on the use of mental health services.
- **Organisational / societal impacts** – for example, a workplace wellbeing programme might assess levels of burn-out or sickness absence at an organisational level or a long-term programme might want to measure levels of wellbeing or mental health problems at a community level.
- **Wider impacts** – for example, measures of educational achievement, employment or community cohesion which recognise the wider and interrelated influences on mental health.

Measures such as these can be built into both programmes that are explicitly and primarily public mental health programmes (those aimed at promotion and prevention in relation to mental health) but also wider programmes that are likely to have an impact on people's mental health and wellbeing, for instance programmes addressing domestic violence or arts and culture programmes.


After I gave birth
I experienced
bad flash backs,
making it hard to
hold my baby.

Commission interventions across the course of someone's life

Public mental health interventions need to be provided for people at different ages, and should reflect and meet the needs at different stages of someone's life. Recommendations for different stages of the life course are outlined below:

Perinatal

Perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8 billion for each one-year cohort of births in the UK.[35] We need to promote good mental health and provide support for mums and their families during the perinatal period (pregnancy and a year after birth).Make sure services and support for new and expectant mums and their families are knowledgeable about mental health during the perinatal period and are able to provide appropriate support. This could include mental health training for front-line staff such as health visitors and support groups within Children's Centres for mums with mental health problems. The transfer of 0-5 children's public health commissioning to local authorities provides an opportunity for work on perinatal mental health to be joined up with public mental health programmes aimed at older children and the wider work of local authorities.

Case study 2: Family Nurse Partnership

The Family Nurse Partnership (FNP) is a maternal and early years public health programme which has found to have positive impacts on mothers and on the longer-term emotional wellbeing of children.

Using a psycho-educational approach it provides ongoing, intensive support to first-time young mothers and their babies (and fathers / other family members, if mothers want them to take part). Structured home visits are delivered by highly trained family nurses beginning early in pregnancy, continuing until the child's second birthday.

The programme focuses on improving three goals in partnership with other services:

- To improve pregnancy outcomes
- To improve children's health and development by developing parenting knowledge and skills
- To improve parents' economic self-sufficiency, by helping them to achieve their aspirations.

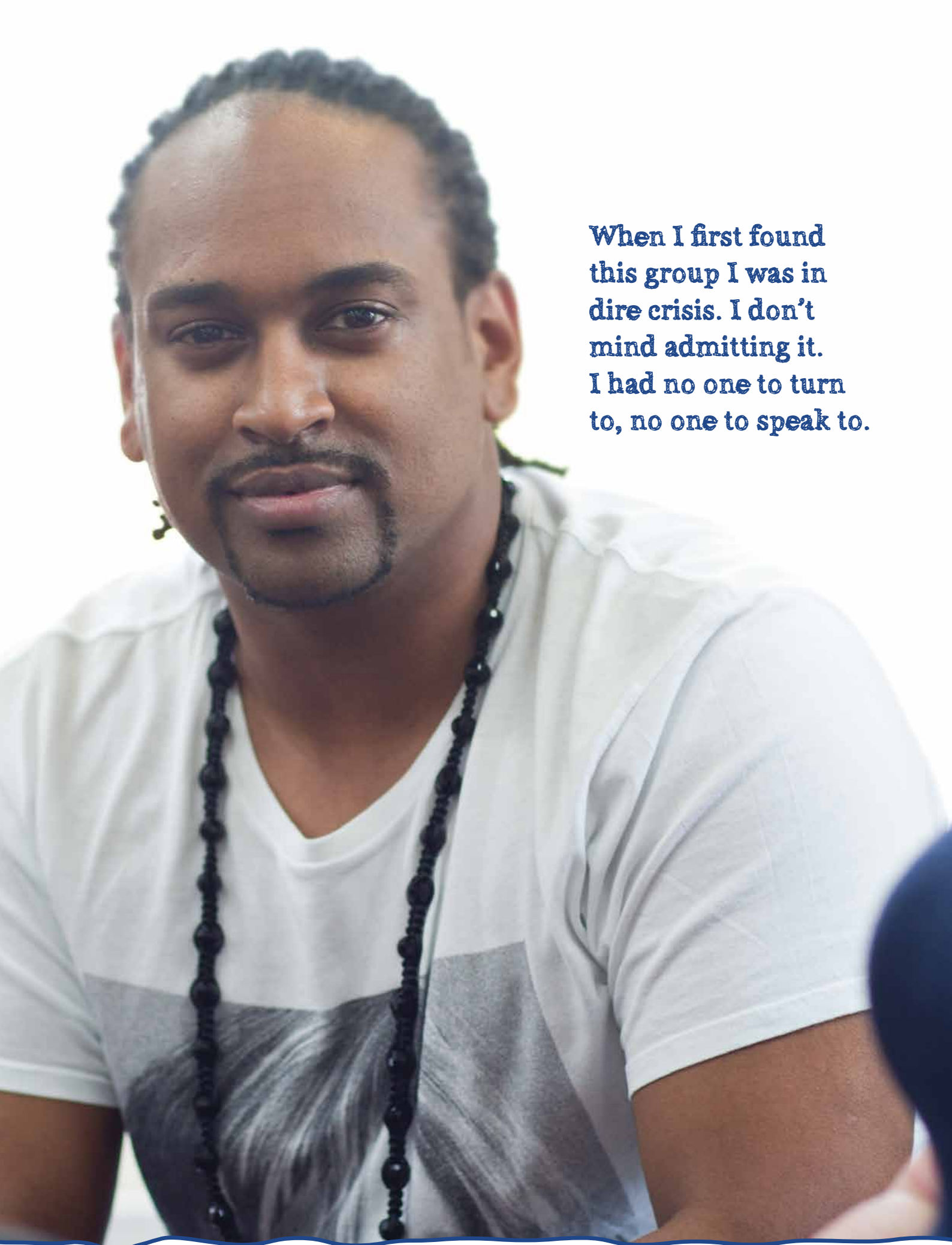
Family nurses also work with young parents to enable them to:

- Build positive relationships with their baby and understand their baby's needs
- Make the lifestyle choices that will give their child the best possible start in life
- Build their self-efficacy
- Build positive relationships with others, modelled by building a positive relationship with the family nurse.

The majority of the programme has been commissioned by NHS England. From October 2015 the programme will be commissioned by local authorities.

Studies in the US have found that a wide range of positive results for both mothers and children. This includes improvements in children's emotional and behavioural development, including a:

- 67 per cent reduction in behavioural and emotional problems at age six
- 28 per cent reduction in 12 year olds mental health problems
- 67 per cent reduction in 12 year olds use of cigarettes, alcohol and cannabis.[36]



When I first found this group I was in dire crisis. I don't mind admitting it. I had no one to turn to, no one to speak to.

Parenting

Mental health problems in childhood, particularly for the five per cent who meet the criteria to be diagnosed with conduct disorder and the further 15 per cent with moderate conduct problems, can have long-term negative impacts into adulthood including increased rates of depression and anxiety, personality disorder, self-harm and suicide.[37] We need to provide evidence-based universal and targeted parenting programmes to support parental and child mental health.

Parenting programmes should be commissioned which are supported by evidence to impact positively on parental and child mental health. To work best these should be targeted at those at greatest need and be linked with universal services such as health visiting, schools or general practice. Evidence-based programmes include the Incredible Years Programme and the Positive Parenting Programme (Triple P).[38]

Case study 3: Salford Dadz

Salford Dadz is a community initiative that has improved the wellbeing of both fathers and children through fathers developing their own ways to open up to one another and spend time with their children.

Within the community of Little Hulton it was identified that many fathers faced multiple disadvantages. Many had experienced family breakdown and had little contact with their children and this was having a negative impact on their mental health and wellbeing. Subsequently, Salford Dadz, was set up by a group of local fathers who explored ways of improving father's wellbeing, and whether this could also improve the wellbeing of their children.

Funded by Salford Clinical Commissioning Group, the project has followed the four steps of positive deviance theory:

- Define the problem for dads
- Determine common practices (what dads generally do about the problem)
- Discover dads who have found successful ways of dealing with the problem (for example, the positive deviants)
- Design a way of sharing successful solutions.

The project was launched with a 'men behaving dadly' competition where primary school children were asked why their father (or someone in a father's role) was the best in Little Hulton. The competition was judged at an event by the 'Council of Dadz', a group of local fathers who went on to lead the Salford Dadz' work and who set up regular social events where fathers could discuss their common problems. They identified that there were not enough venues or activities that were tailored to men and their children to enable them to have more contact. What was currently available was thought to be feminised and they often felt judged. So they set up a Saturday club and a series of activities so fathers and children could spend time together.

An evaluation from Leeds Beckett and Salford Universities concluded that men involved in Salford Dadz were provided an alternative to previous settings and relationships that often fostered negative coping mechanisms to stressful situations. They also had:

- A greater sense of positive identity and self-esteem
- Improved relationships with their partners and ex partners
- Improved opportunities for positive and interesting engagement with their children leading to greater confidence in their parenting ability and skills.

School

More than three quarters of adults who have accessed mental health services had a diagnosed mental health problem before the age of 18.[39] We need to promote good mental health in schools and tackle bullying.

The promotion of mental health in schools (including preventing violence and aggression) has been shown to be among the most effective school-based health promotion interventions.[40] Interventions within schools and colleges should be both universal, improving young people's emotional literacy as well as behaviour management, or targeted by providing support early to young people beginning to show signs of poor mental health. Bullying is a common risk factor for poor mental health and so school-based interventions which tackle bullying should also play a part in whole-school approaches to promoting good mental health.

Case study 4: Penn Resilience Programme

The Penn Resilience programme is a school-based series of workshops that aim to improve young people's emotional resilience and mental wellbeing, by teaching pupils ways to handle common day-to-day problems.

The programme was developed by the University of Pennsylvania and was tested by a series of longitudinal, controlled studies between 1990 and 2007. The programme was adapted and trialled in the UK in 22 secondary schools in South Tyneside, Manchester and Hertfordshire during 2007-8.

The programme was delivered to Year 7 pupils and was made up of 18 one-hour structured workshops which teach cognitive-behavioural and social problem-solving skills. The workshops were facilitated by school staff with extensive training, and were timetabled to be weekly or fortnightly.

An evaluation funded by the Department for Children, Schools and Families (now the Department for Education), found that compared to a control group, pupils receiving the Penn Resilience programme:

- Had significant small short-term (up to one year) improvement in depression symptom scores as measured by the Children's Depression Inventory, as well as school attendance and academic attainment in English
- Had some improvement in anxiety scores as measured by the Revised Children's Manifest Anxiety Scale, however this was inconsistent and concentrated in certain groups (pupils who are more deprived, pupils with lower academic attainment and those who started the year with worse psychological health).

Weekly workshops were shown to have a larger impact than those timetabled fortnightly.[41]

How to thrive, a not-for-profit trading entity hosted within Hertfordshire County Council now trains school staff across the UK to embed the Penn Resilience Programme lessons into the core curriculum. The programme has also been embedded into the 'Healthy Minds' programme. This is a national four year research project that aims to evidence how students can be supported to develop emotional resilience and self efficacy alongside their academic development.


I feel calmer at work. I'm able to maintain calmness in situations that, before this course, would have sent me in to a spin.

Working age

The total cost to employers of mental health problems among their staff is estimated at nearly £26 billion each year, which equates to £1,035 for every employee in the UK workforce.[42] We need to promote workplace wellbeing within all types of organisations in our community and provide appropriate support into employment.

Commissioners of public mental health interventions (local authorities and their NHS partners), are often one of the largest employers in their local area, so should play a key role in implementing workplace wellbeing programmes and good working practices. Each organisation, and in fact different teams in an organisation, will have different environments which impact on staff members' mental wellbeing, and so programmes should be tailored accordingly. Public health teams should also use their engagement with local businesses to promote workplace wellbeing initiatives.

There is also a key role to be played in providing the most appropriate support for people with mental health problems to stay in or gain employment, particularly because good quality employment is known to aid recovery and be a protective factor for good mental health.

Case study 5: Happier@work

Happier@work is a workplace wellbeing initiative that has resulted in improved mental health and wellbeing of NHS staff.

Happier@work was developed by the health improvement team at South London and Maudsley NHS Foundation Trust and Uscreates (a strategic consultancy company). The pilot followed the double diamond design process which follows four distinct phases – Discover, Define, Develop and Deliver, to design interventions to improve the mental health and wellbeing of staff employed by King's Health Partner organisations.

Following job-shadowing of staff within seven diverse teams and workshops with the teams to conduct Mental Wellbeing Impact Assessment's, happier@work interventions were designed to take a whole-organisation approach.

Individual

- Stress awareness sessions
- Mindfulness courses
- Leading light seminars.

Team

- Supporting and monitoring the implementation of the team action plans
- Early Intervention Mental Health Awareness for line managers
- Creating spaces for wellbeing through access to an expert on space and wellbeing plus a budget for minor alterations.

Organisation

- Working with HR and organisation development to support work with line managers and improve peer support as well as reward and recognition
- Working with occupation health to embed emotional support for staff
- Working with education and training to embed wellbeing into staff training plans.

Following the pilot, an evaluation conducted by the London South Bank University found that:

- Wellbeing increased by seven per cent
- Minor psychiatric disorder decreased by 19 per cent
- At-work productivity loss was reduced by seven per cent
- Staff burnout was reduced by five per cent
- Staff who would recommend their Trust as a place to work increased by 15 per cent.

Kent County Council's public health team have since commissioned a happier@work programme for their staff, which commenced in January 2014.

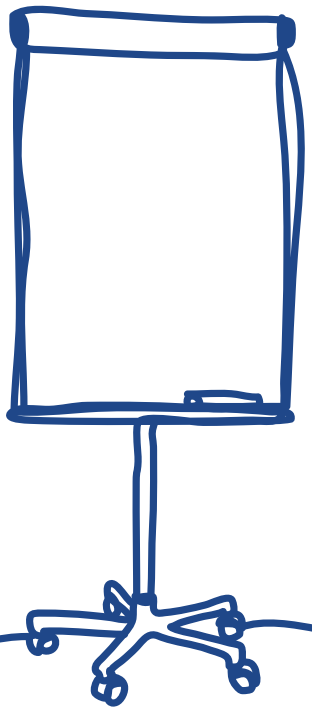

Hillside helped me to learn new skills and meet new people. I couldn't get a job but the... team found me a new job and I couldn't be happier.

Case study 6: Mental Health Working

The Mental Health Working (MHW) service works with people with mental health problems to assist them in staying in or gaining employment as a way to support their recovery.

Research has identified that appropriate employment improves mental health and protects against relapse, while conversely, unemployment is associated with poverty and financial insecurity, social isolation, increased physical and mental health problems, and consequently increased use of health services. The MHW service supports people with a long term mental health problem to make the journey back into work through training, education, employment or volunteering. It also supports those who are already in work, to help them remain in employment. The programme is jointly commissioned by the London Boroughs of Camden and Islington.

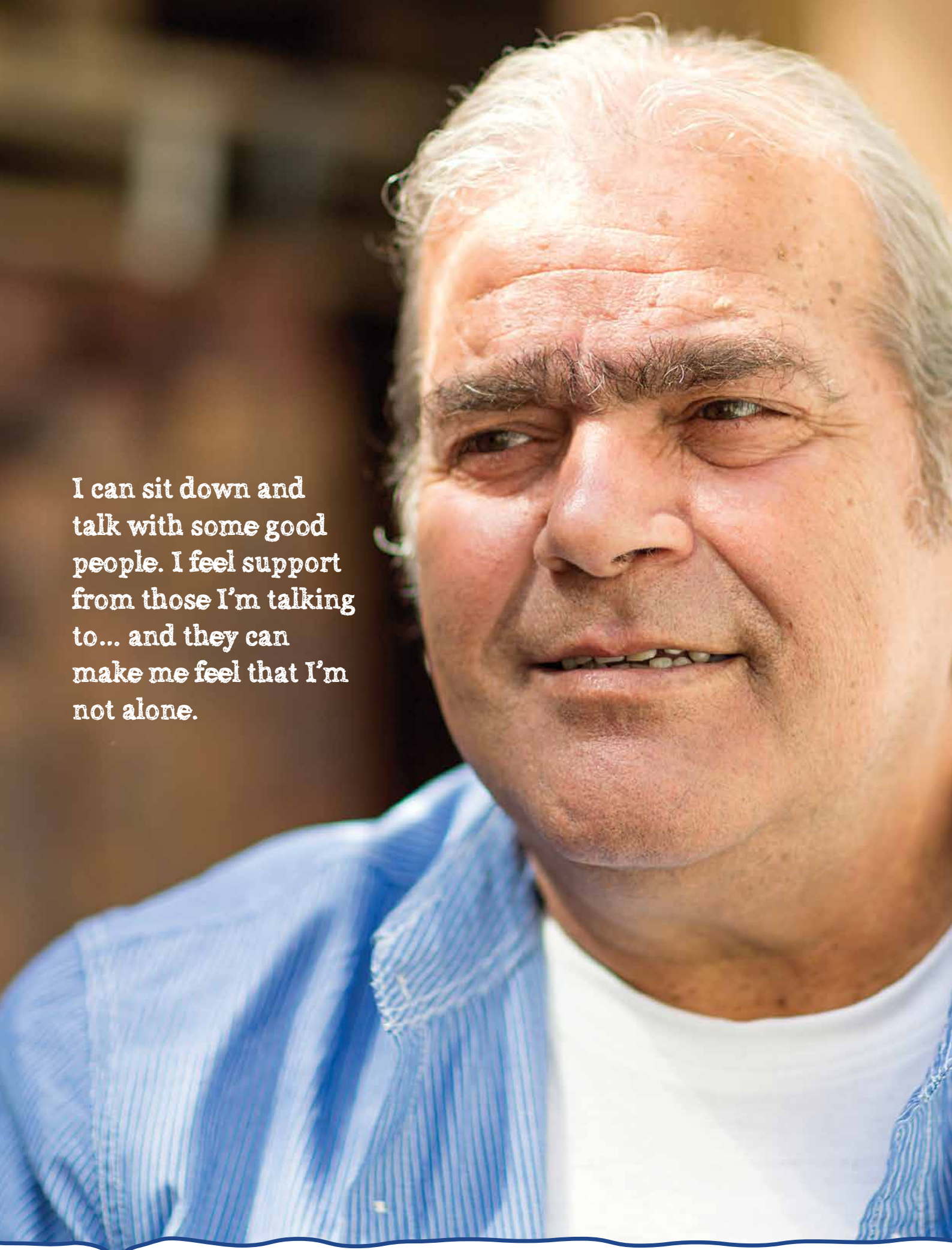
Experienced advisors provide specialist employment support for people with mental health problems. They work with each individual to develop a personalised support plan identifying barriers to work, career goals and steps needed to find, remain in or return to work. The advisors then provide ongoing advice and guidance.



Further support includes:

- Training and education
- Identify coping strategies that will help individuals to succeed in the workplace
- Helping employers to fully understand mental health and how they can support their employees
- Working alongside healthcare professionals (for instance psychological therapists) to enable people to return to work or retain their job following or during a period of poor health
- Online support
- Drop-in registrations
- Access to the service at various venues across the two boroughs
- Access to the Hillside Clubhouse 'Workday Programme' which provides practical work experience and recovery support
- Access to wider practical and emotional support (for instance dispute resolution, debt help, benefits problems, advocacy, social activities, outreach and home visits).

In 2014-15, the programme in Islington exceeded targets regarding the number of people engaged and met the target of 20 per cent of people registered on the programme being assisted into employment. Out of 712 people registered on the programme, 138 people with mental health problems were assisted to move into full-time, part-time or self-employment.


I can sit down and talk with some good people. I feel support from those I'm talking to... and they can make me feel that I'm not alone.

Older people, loneliness and social isolation

Feelings of loneliness has been found to be a risk factor for suicide amongst older people, while active participation in organisations has been found to be a protective factor.[43] We need to provide programmes that combat loneliness and programmes that address isolation for those most at risk. Programmes should be commissioned which address loneliness (the feeling that we lack social connections which can often be felt by those who may be heavy users of services) as well as programmes to tackle social isolation (for those with no or very limited contact with services). These programmes should target those most at need. Both loneliness and social isolation can be particularly important for many older people, but also others including people with mental health problems to support their recovery. Interventions are wide ranging and should be tailored to different needs, but can include befriending, mentoring, Community Navigators and social group schemes.

Case study 7: Tottenham Thinking Space

Tottenham Thinking Space is a community therapy approach to improving mental health and community wellbeing which was developed following the London riots in 2011.

The programme is funded by Haringey Council and delivered by the Tavistock and Portman NHS Foundation Trust. Its aims to provide a therapeutic space where Tottenham residents can share and reflect on their difficulties and challenges and think together about what options they may wish to consider to address these problems.

Tottenham Thinking Space is made up of regular meetings which are facilitated by clinical staff experienced in working with diverse and disadvantaged communities. Attendance is voluntary and participants share stories, experiences and at times select a theme to discuss. Facilitators seek to create a safe, inclusive and non-judgmental environment to enable local people to talk about their experiences and think about how best to address individual or community issues.

Based on attendee's feedback, Tottenham Thinking Space has evolved from one to four regular Thinking Spaces to meet the needs of residents who have different issues, including:

- Mother's tea and coffee mornings
- Women's health and wellbeing
- Men's group.

Attendees of the different Thinking Spaces have identified particular problems and ways to address these. For instance, following discussions in the Mother's group about the challenges of acquiring work-relevant skills, the group was supported to obtain funding to run a series of courses such as food hygiene.

The project has been independently evaluated by the University of East London which found:

- The project has helped to build a sense of community amongst participants that crosses generations and ethnic groups
- The therapeutic space enables participants to redefine and reposition mental health outside a medical model and to understand how solutions can be found amongst residents in their local community
- Attendees have reduced anxieties and improved personal and social functioning
- Attendees have developed the ability to form more meaningful social relationships and have reduced feelings of isolation and despondency associated with depression.

To take big sweeps with a pen or paintbrush, that is therapeutic in itself because it's opening out your body and opening up your senses.

Case study 8: Arts on Prescription

Arts on Prescription improves the mental health and wellbeing of people with mild to moderate mental health problems and supports their recovery with therapeutically supported creative activities.

Arts and Minds, a charity in the East of England, has been running Arts on Prescription programmes in Cambridgeshire since an initial pilot in 2009. The programme aims to provide a safe and therapeutic environment for participants with mild to moderate mental health problems where they can explore their creativity.

Participants are referred by their GP, mental health worker or they can self-refer. Those who self-refer are assessed by the Arts on Prescription mental health counsellor to determine their suitability for the programme.

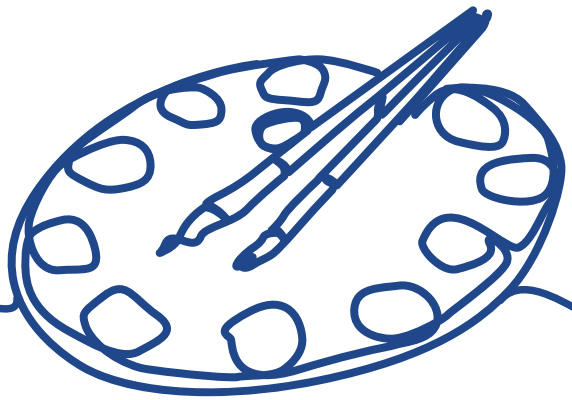
The programme lasts 12 weeks and is delivered by a professional artist and supported by a mental health counsellor. Weekly workshops last two hours and include a range of creative activities, including drawing, collage, stitching, clay and wire work. The presence of the mental health counsellor during the workshops provides participants the opportunity to discuss any issues away from the main group if they became distressed or anxious during a session.

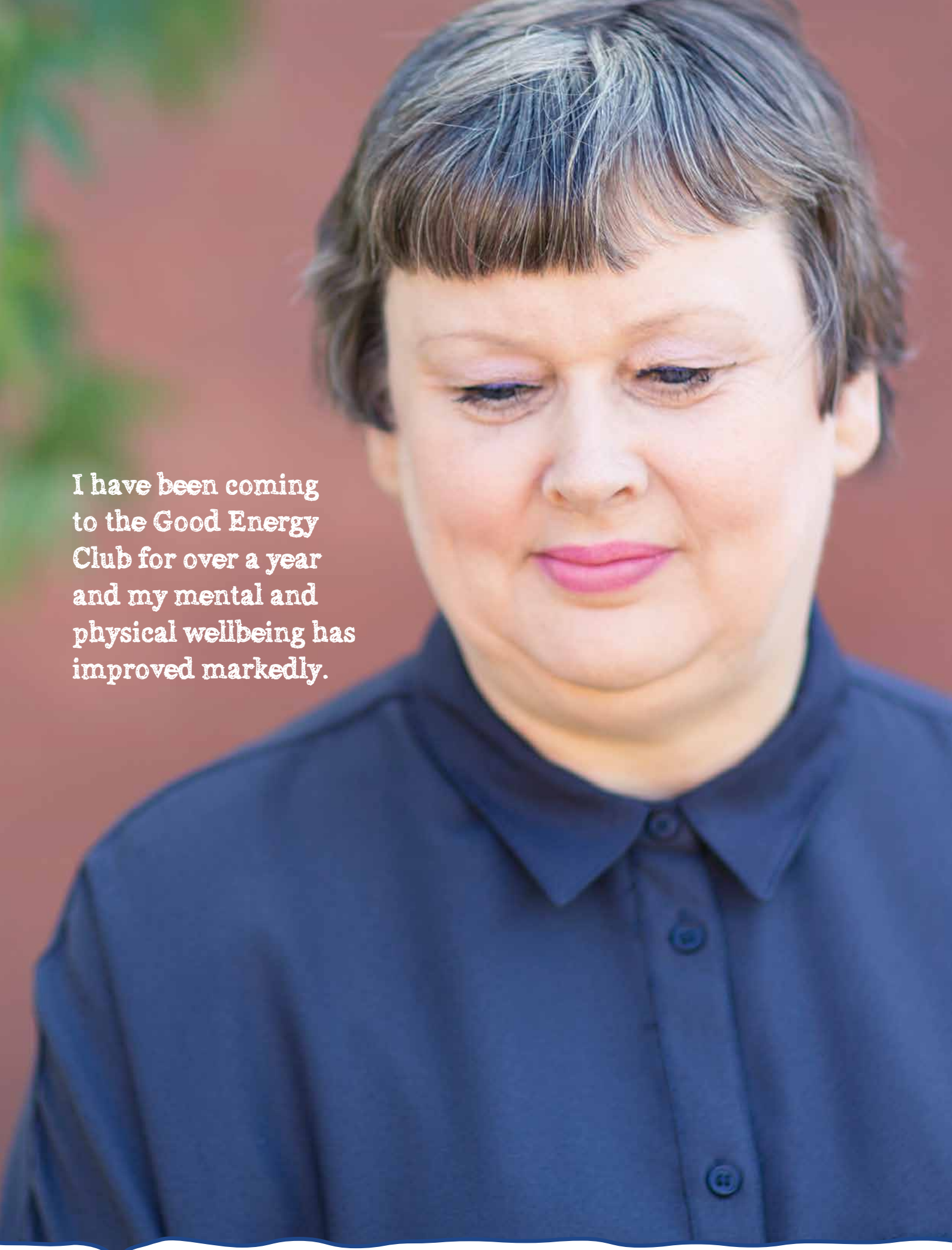
The first six weeks provides introductory activities, while the following six weeks gives the option of an extended period to develop one preferred artwork or art medium. Towards the end of each 12-week programme a number of additional social events are run in order to signpost participants to other creative opportunities available in the county.

If participants do not attend a workshop, the mental health counsellor makes regular contact through telephone and email to build a trusting relationship and encourage re-attendance.

A survey of participants before and after taking part in the 2014/15 programme found:

- 69 per cent reported an increase in social inclusion
- 76 per cent reported an increase in wellbeing
- 73 per cent reported a decrease in depression
- 71 per cent reported a decrease in anxiety




I have been coming to the Good Energy Club for over a year and my mental and physical wellbeing has improved markedly.

Address both physical and mental health

People with mental health problems are more likely to experience poor physical health, and people with serious mental health problems die 10–20 years younger than the general population.[44] A number of factors contribute to this, but this is largely due to issues which lead to poor physical health such as smoking.[45] A third of people with a mental health problem smoke compared to less than one in five people in the population as a whole.[46] Smoking rates within low and medium secure mental health units is even higher at 64 per cent.[47] Additionally, people with a serious mental illness are at much greater risk of obesity because some of the medications they use can lead to weight gain.[48] We need to improve the physical health of people with mental health problems.

Core public health programmes should include work targeted at people with mental health problems. This could include stop smoking programmes specifically designed for people with mental health problems or clear targets for engaging people with mental health problems in schemes to tackle obesity.

Case study 9: Good Energy Club

The Good Energy Club works with people with mental health problems or low wellbeing to encourage and support them to take part in physical activity.

Following a consultation with people with mental health problems about physical activity, the Good Energy Club was commissioned by Kingston-Upon-Thames Council. The project is run by Hestia and aims to improve the physical activity levels of people with mental health problems and low levels of wellbeing. Volunteers and staff support members to participate in activities already taking place in the borough or provide tailored activities.

A weekly social enables members to discuss any fears or anxieties they may have, gain support from staff, volunteers and other members and feedback on the activities available and any new activities they would like to take part in. Volunteers and staff keep in regular contact with members by phone and text to remind them of activities and encourage and support them to attend.

At the end of the first year of Good Energy Club activities, members were given feedback forms which found:

- 84 per cent agreed or strongly agreed that they had made friends/reduced social isolation since joining the Good Energy Club
- 79 per cent agreed or strongly agreed that they felt their confidence and self-esteem had improved since joining the Good Energy Club
- 84 per cent agreed or strongly agreed that they felt better about themselves since joining the Good Energy Club
- The overall average change in wellbeing score (measured by the short Warwick-Edinburgh Wellbeing Scale) was 2.7

The Good Energy Club has now been funded for a further year.


I feel much more in control. I still have down days, but not as many, and I can alter my mood more easily.

Case study 10: Achieving Self Care

The Achieving Self Care (ASC) project reduces use of health and social care services by working with people with Long-Term Conditions (LTCs) to address their health and wellbeing holistically.

The project is part of Blackburn with Darwen's Enhanced Integrated Care Service pilot which aims to improve the lives of people with LTCs through an integrated health and social care system. The ASC project is funded by the Department of Health and delivered by Lancashire Mind in partnership with Care Network.

A risk stratification tool is used by GP practices to identify those at moderate risk of inappropriate use of statutory health and social care services so they can be offered support through the ASC project. Self-care Facilitators conduct a holistic assessment of an individual's needs and barriers to improving health and wellbeing, and together set goals to work towards. Ongoing support is provided to motivate people to engage in healthy behaviour by utilising community resources and self-care skills. For those who prefer group sessions rather than one-to-one support, 'Rough Guide to being Happy' workshops are offered which last for six weeks.

The most common diagnosis of people receiving the ASC service is depression, followed by Chronic Obstructive Pulmonary Disease (COPD), asthma and diabetes.

The first year of the ASC service was associated with:

- A 41 per cent reduction in the GP consultation rate
- A 28 per cent reduction in antidepressant prescribing
- A 90 per cent self-reported improvement for those with severe anxiety or depression immediately after using the service (85 per cent were still less anxious or depressed one month after using the service).

This has been approximated to equal a cost saving of £140 for each person seen by the service through savings in GP consultation times and prescriptions.

People with physical long-term conditions (LTCs) such as heart disease and diabetes are two to three times more likely to experience mental health problems than the general population.[49] Mental health promotion, prevention and early detection should be targeted at people with physical LTCs. This could include mental health training for staff working with people with LTCs and programmes to promote good mental health and improve the resilience of people with LTCs.

In summary

We've all heard the phrase prevention is better than cure. This strikes most of us as common sense. This is why for some time we've invested in trying to get people to quit smoking, exercise a bit more, or recognise the early symptoms of ill health. We need to be doing the same for our mental health too. There are some examples of good practice where organisations are promoting ways we can look after our mental health, and others are raising awareness of ways to prevent mental health problems and to spot the early signs of when we are becoming unwell. But we need to do much, much more.

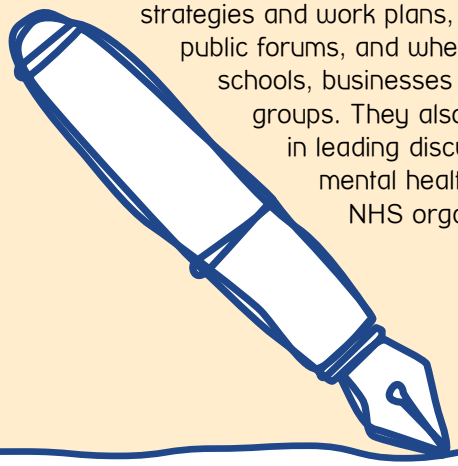
You can find out more about our work on public mental health at **mind.org.uk**, including:

- Building Resilient Communities, our report with the Mental Health Foundation which focuses on resilience; setting out the types of services, resources and infrastructure that need to be in place locally to support resilient communities
- Ecominds, our ecotherapy project which improved mental and physical wellbeing by supporting people to be active outdoors doing gardening, food growing or environmental conservation work and other activities in nature
- Get Set to Go, our programme to support people with mental health problems to get physically active
- Blue light, our programme to provide mental health support for emergency services staff and volunteers across England including resilience courses
- Workplace wellbeing, our mental health training, consultancy and coaching to promote mental wellbeing in workplaces and at home, helping to reduce absenteeism and encouraging a positive, healthy and productive workplace culture.

Sign up to the Mental Health Challenge

Mind alongside six other mental health organisations has set up the Mental Health Challenge. We are asking upper tier local authorities in England to sign up to the Challenge and promote mental health across all of their business, including appointing an elected member as 'mental health champion' across the council.

Once a councillor becomes a champion, their role includes raising awareness of mental health problems in the development of council policies, strategies and work plans, as well as in public forums, and when speaking with schools, businesses and community groups. They also play a role in leading discussions about mental health with local NHS organisations.



Champions are supported by the mental health organisations to develop their knowledge about mental health problems by linking them with local people with personal experience to understand their needs and concerns, and to help them tackle myths and misperceptions about mental health in their community.

"Recognising mental health as a preventable ailment is probably the most powerful remedy available to us."

Teresa Heritage, Mental Health Champion, Hertfordshire County Council

To find out more and sign up see **www.mentalhealthchallenge.org.uk**

References

1 Department of Health, (2011) No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages. Supporting document – The economic case for improving efficiency and quality in mental health.

2 Khan, L., Parsonage, M., and Stubbs, J. (2015) Investing in Children's Mental Health: A review of the evidence on the costs and benefits of increased service provision. London: Centre for Mental Health

3 Centre for Mental Health, (2010) Economic and social costs of mental health problems 2009/10.

4 Knapp, M., McDaid D., and Parsonage, M., (2011) Mental Health Promotion and Mental illness prevention: The economic case. PSSRU. London School of Economics and Political Science.

5 Thoits, P.A., (2010) Stress and health: major findings and policy implications. Journal of Health and Social Behavior. 51 Suppl: S41-53.

6 Royal College of Psychiatrists (2013) Post-Traumatic Stress Disorder leaflet. Available at rcpsych.ac.uk

7 Kessler, R.C., McLaughlin, K.A., Green, J.G., (2011) Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. The British Journal of Psychiatry, 197(5):378-385.

8 Takizawa, R., Maughan, B., and Arseneault, L. (2015) Adult health outcomes of childhood bullying victimization: Evidence from a 5-decade longitudinal British birth cohort. American Journal of Psychiatry, 171: 777-784.

9 Ouellet-Morin, I., Fisher, H.L., York-Smith, M., et al. (2015) Intimate partner violence and new-onset depression: A longitudinal study of women's childhood and adult histories of abuse. Depression and Anxiety, 32: 316–324.

10 Steel, Z., Chey, T., Silove, D., et al. (2009) Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. JAMA, 302: 537-49

11 Department of Health (2011) No health without mental health: A cross-Government mental health outcomes strategy for people of all ages. Analysis of the Impact on Equality (AIE) Annex B - Evidence Base. Available at gov.uk

12 Ibid.

13 Marmot, M. (2010) Fair Society, Healthy Lives: A Strategic Review of Inequalities in England. London: University College London.

14 Jenkins, R., Bhugra, D., Bebbington, P., et al. (2008) Debt income and mental disorder in the general population. Psychological Medicine, Vol.38 (No.10). pp. 1485-1493.

15 Mind. (2011) Still in the red: Update on debt and mental health.

16 OECD (2014), Mental Health and Work: United Kingdom. Available at oecd.org

17 Rees, S. (2009) Mental ill health in the adult single homeless population: A review of the literature. London: Crisis.

18 Harker, L., (2006) Chance of a Lifetime: The impact of bad housing on children's lives. London: Shelter.

19 Pulkki-Råback, L., Kivimäki, M., Ahola, K., et al (2012) Living alone and antidepressant medication use: A Prospective Study in a Working-Age Population. BMC Public Health, 12(1): 236

20 Cacioppo, J.T., Hughes M.E., Waite L.J., et al (2006) Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. Psychology and Aging, 21 (1) 140-51.

21 O'Connell, H., Chin, A., Cunnigham, C., and Lawlor, B. (2004) Recent developments: Suicide in older people. British Medical Journal, 29: 895–9.

22 Hatzenbuehler, M. L., Phelan, J. C., and Link, B. G. (2013) Stigma as a Fundamental Cause of Population Health Inequalities. American Journal of Public Health, 103 (5), 813–821.

23 Department of Health (2015) Promoting, Protecting and Improving our children and young people's mental health and wellbeing.

24 Department of Health (2011) No health without mental health: A cross-Government mental health outcomes strategy for people of all ages. Analysis of the Impact on Equality (AIE) Annex B - Evidence Base. Available at gov.uk

[25] Ibid.

[26] Ibid.

[27] Ibid.

[28] Bauer, A., Parsonage, M., Knapp, M., et al. (2014) The costs of perinatal mental health problems. London: Centre for Mental Health.

[29] LankellyChase Foundation, Mind, et al. (2014) Ethnic inequalities in mental health: Promoting Lasting Positive Change. Available at lankellychase.org.uk

[30] Department of Health (2011). No health without mental health: A cross-Government mental health outcomes strategy for people of all ages, Analysis of the Impact on Equality (AIE) Annex B - Evidence Base

[31] Ibid.

[32] Ibid.

[33] Ibid.

[34] Joint Commissioning Panel for Mental Health (2013) Guidance for commissioning public mental health services. Available at jcpmh.info

[35] Bauer, A., Parsonage, M., Knapp, M., et al. (2014) The costs of perinatal mental health problems. London: Centre for Mental Health.

[36] Evidence Base for Family Nurse Partnership (FNP): Summary Leaflet

[37] Parsonage, M., Khan, L., and Saunders, A., (2014) Building a better future: The lifetime costs of childhood behavioural problems and the benefits of early intervention. London: Centre for Mental Health.

[38] Brown, E., Khan, L. & Parsonage, M. (2012) A chance to change: delivering effective parenting programmes to transform lives. London: Centre for Mental Health.

[39] Department of Health (2014) Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the evidence. Available at gov.uk

[40] Stewart-Brown, S (2006) What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach? Copenhagen: WHO Regional Office for Europe: Available at euro.who.int

[41] Challen, A., Noden, P., West, A., and Machin, S. (2011) UK Resilience Programme Evaluation: Final Report. London: London School of Economics and Political Science.

[42] Parsonage, M (2007) Mental health at work: developing the business case. Sainsbury's Centre for Mental Health: London.

[43] Rubenowitz, E., Waern, M., Wilelmson, K., et al. (2001) Life events and psychosocial factors in elderly suicides—case-control study. Psychol Med. 31: 1193-202.

[44] Chesney, E., Goodwin, G. M. and Fazel, S. (2014) Risks of all-cause and suicide mortality in mental disorders: a meta-review. World Psychiatry, 13: 153–160. doi: 10.1002/wps.20128

[45] Chang, C-K. Hayes, R. D., Perera, G., Broadbent, M. T. M., Fernandes, A. C., et al. (2011) Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. PLoS One 6(5): [e19590]. 10.1371/journal.pone.0019590. Available at kcl.ac.uk

[46] McManus, S., Meltzer, H. Campion, J. (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. London: National Centre for Social Research.

[47] Public Health England (2015) Smoking cessation in secure mental health settings: guidance for commissioners. PHE publications gateway number: 2014632

[48] McElroy, S. L. (2009). Obesity in patients with severe mental illness: overview and management, Journal of Clinical Psychiatry, 70, Suppl 3:12-21

[49] The King's Fund and Centre for Mental Health (2012) Long-term conditions and mental health: The cost of co-morbidities. Available at kingsfund.org.uk

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We provide advice and support to anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding.

Mind's registered charity number is 219830.

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