

radical mentalities

BRIEFING PAPER 1

Making It Effective

A guide to evidence based
mental health promotion



mentality

Dr Lynne Friedli

mentality was established as a registered charity in April 2000. We are the first national charity dedicated solely to promoting mental health. We work with the public and private sector, user and survivor groups and voluntary agencies to promote the mental health of individuals, families, organisations and communities.

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This briefing is the first in a series called **radical mentalities**, designed to support and strengthen mental health promotion practice. **Making It Effective** provides a summary of effective mental health promotion interventions and looks at some of the debates about evidence from a mental health promotion perspective. It brings together findings from studies using different methodologies and working with many different measures of success. It includes interventions designed to reduce risk factors for mental health problems, for example bullying in schools, as well as interventions which aim to strengthen protective factors for mental health and well being, for example warm, affectionate parenting and strong social support networks.

This briefing is not a systematic review. Indeed, an over reliance on the findings of systematic reviews may have hampered the progress of mental health promotion, which needs an evaluative framework capable of capturing process and contexts, as well as outcomes (Pawson and Tilley 1997). How people feel about an intervention may be just as significant as clinical indicators of impact and the former will also influence the latter. Although mental health promotion and mental health services are often seen as separate domains, there is a need for greater awareness of the mental health impact of how services, in the broadest sense, are developed and delivered. A strong policy emphasis on user involvement will inevitably call into question 'evidence of effectiveness' derived solely from a clinical perspective. Growing evidence of the health and social impact of lack of control and lack of influence, as well as the role of psychological and cultural factors in achieving positive health outcomes, highlight the importance of new ways of thinking about 'what works' and how this is measured. The purpose of this briefing therefore, is to demonstrate the range of evidence of effectiveness for mental health promotion and to encourage practitioners both to engage with debates about the evidence base and, through their own practice, to contribute to its future development.

Making It Effective builds on and complements *Making it Happen: a guide to delivering mental health promotion*, which describes how to develop local mental health promotion strategies (Department of Health 2001). Over the coming year, the focus will move from the development of local strategies (which are required as part of the Performance Management Framework for Standard One of the National Service Framework for Mental Health – see Box 1 p.4) to implementation (Department of Health 1999). This provides a significant opportunity to strengthen the evaluation of mental health promotion activity and to contribute substantially to the emerging evidence base.

There is no intervention that will successfully improve mental well being or prevent mental health problems for every individual in all contexts. Equally, most interventions have been helpful to someone. **Making It Effective** attempts to draw out some of the principles of successful programmes, in specific settings, for example in schools or the workplace, and for different target groups, for example young mothers or people with mental health problems. It also identifies key indicators of mental health and well being, for example 'participation' or 'social networks' and summarises a range of interventions which have had good results in these areas. All research methodologies have their strengths and weaknesses and different intervention designs answer different questions. Therefore for

many of the interventions described, the type of study undertaken is indicated, for example randomised controlled trial, literature review or social action research, and a glossary of key research terms is provided in Appendix One. Also included, in Appendix Two, is an example of indicators developed by a local mental health programme.

A number of mental health promotion interventions, notably those concerned with primary, secondary or tertiary prevention, have been carried out by mental health professionals in clinical settings. Many more, however, have been developed by people working across a range of sectors, in housing, education, regeneration, arts, leisure and the environment, as well as in the voluntary and mental health voluntary sector. Many factors influence the mental health of individuals and communities and complex interventions have been developed to address this. In looking at the challenges involved in evaluating complex interventions, we have tried to draw out some lessons for practitioners working in many different contexts.

This briefing will be of interest to everyone concerned to move mental health promotion up the agenda and particularly to colleagues in all sectors working to implement Standard One of the National Service Framework. We hope that it will contribute both to making mental health promotion more effective and to generating further debate about what works, what doesn't work and why. We welcome your feedback and contributions via our '*evidence base forum*' on www.mentality.org.uk

Dr Lynne Friedli
mentality

Summary

Chapter One

Introduction

Chapter One provides an introduction to the briefing and a summary of the areas covered.

Chapter Two

Exploring mental health promotion

Chapter Two describes what is meant by mental health and mental health promotion and summarises risk and protective factors for mental health. It explores the challenges around identifying indicators for mental health, limitations of diagnostic tools and looks at ways to measure positive mental health.

Chapter Three

Evidence in context: debates about effectiveness

Chapter Three looks at some of the current debates about evaluation and evidence of effectiveness and their relevance for mental health promotion. It identifies two significant policy shifts which are influencing attitudes to defining and interpreting the evidence base: renewed interest in the broader determinants of health and user involvement.

Chapter Four

The evidence base and examples of effective interventions

Chapter Four sets out a range of evidence for the effectiveness of a variety of mental health promotion interventions for different age groups, target groups and key settings. It includes the case for action, evidence-based priorities and a summary of what works.

Appendix One

Glossary of research terms

This provides a brief description of different types of research methodologies.

Appendix Two

Developing indicators: an example from the Mellow Campaign in East London

An example of indicators designed to capture a wide range of outcomes, reflecting the objectives of a broad range of local stakeholders.

Box 1: Performance Management Framework for Standard One

The key target for Standard One is the development of local, evidence based mental health promotion strategies (by March 2002). Criteria for assessing the quality of local strategies are included in the Local Implementation Plan (LIP) Stage IV Self-assessment for Mental Health Promotion as follows:

Needs assessment

Has an assessment of local needs been carried out?

Does the strategy identify key settings and target groups? Please list them.

Does the strategy promote mental health at different levels including strengthening protective factors and reducing risk factors for individuals and for organisations/communities, and addressing policy/structural barriers to mental health?

Evidence

Does the strategy demonstrate a clear rationale for selected interventions which are based on the evidence or which, through their implementation, can add to the evidence base?

Challenging discrimination and promoting social inclusion

Describe the specific action being taken forward to work towards the elimination of discrimination against people with mental health problems and to promote their social inclusion.

Partnerships in place

Describe the links in the strategy to other initiatives which have supporting goals, including mainstream community development initiatives, such as, for example, neighbourhood renewal, education action zones, community safety partnerships, lifelong learning plans, rural proofing, National Service Framework for Older People, National Service Framework for Coronary Heart Disease, etc.

Is there a clear framework in place for delivery of the mental health promotion strategy across professional, organisational and sector boundaries?

Evaluation

Have locally agreed targets with criteria and an agreed process for monitoring progress and measuring success been established?

Local Implementation Team (LIT) representation

It is important to ensure that LITs have robust arrangements in place for overseeing implementation of NSF Standard One. Do you have a mental health promotion representative/NSF Standard One Lead on your LIT? If not, what alternative arrangements do you have for ensuring that mental health promotion is an integral part of your implementation agenda?

Chapter One

Introduction

This briefing aims to provide a rationale for action to promote mental health and a guide to the emerging evidence base for mental health promotion. It includes interventions to promote mental health and well being, to prevent or reduce the risk of mental health problems and to improve quality of life for people with mental health problems. This reflects the scope of Standard One of the National Service Framework for Mental Health, which requires local strategies to promote mental health for the whole population and for at risk individuals and vulnerable groups, as well as to take action to reduce the discrimination and exclusion experienced by people with mental health problems (Department of Health 1999).

There is considerable variation in the kind of programmes that are included within local mental health promotion strategies, and many interventions which might be classified as 'mental health promotion' do not describe themselves in these terms. Interventions may have multiple outcomes, for example, programmes to improve the confidence, self-esteem and support networks of low income pregnant women have also improved birth weight and reduced child abuse (Olds et al 1997; Hodnett and Roberts 2000). Conversely, interventions originally designed to improve physical health, for example, exercise on prescription to modify risk for cardiovascular disease, may have a more significant impact on mental health (Grant 2000). In many cases, broader health and social outcomes will not be apparent within the short time scale of a programme evaluation and this should be taken into account when making judgements about effectiveness.

A credible and accessible evidence base for what works in mental health promotion will underpin future investment in what is a relatively new field. Encouraging greater understanding of and critical engagement with debates about effectiveness will also be essential to building capacity for mental health promotion. This will mean moving beyond traditional disputes about the relative merits of quantitative versus qualitative research, to considering a much wider range of issues that influence mental health promotion practice (Tilford et al 1997; World Health Organisation 2002). Current work on realistic evaluation, which provides a new framework for understanding how interventions work or work differently, in the context of age, gender, race and socio-economic position, is of special interest and is covered in more detail in Chapter Three (Pawson and Tilley 1997).

Making It Effective will assist people working to promote mental health across all sectors and settings. It will be of interest to local implementation teams, local authorities, local strategic partnerships, primary care trusts, mental health trusts, health and social care, voluntary and community groups and the user/survivor movement. Colleagues working in specific settings, for example schools or the workplace, will also find many examples of relevant interventions, as well as summaries of the principles that appear to influence successful outcomes.

This briefing:

- ▶ defines mental health and mental health promotion
- ▶ identifies a range of indicators for measuring mental health
- ▶ outlines some of the debates about evidence and effectiveness
- ▶ provides evidence of effectiveness and gives examples of effective interventions for a range of age groups, target groups and key settings
- ▶ provides a glossary of research methods

Chapter Two

Exploring mental health promotion

This chapter looks at risk and protective factors for mental health and explores the links between how mental health is defined and the development of indicators to assess both individual and community mental well being.

Mental health promotion

Mental health promotion is both any action to enhance the mental well being of individuals, families, organisations and communities, and a set of principles which recognise *that how people feel is not an abstract and elusive concept, but a significant influence on health* (Friedli 2000).

There is now an abundance of data demonstrating the importance of mental health and well being to overall health and productivity (Stewart-Brown 1998; Department of Health 2001; World Health Organisation 2002; International Union for Health Promotion and Education 1999; Stansfeld 2002). Mental well being, like physical health, is a resource we need to promote and protect.

Mental health promotion is essentially concerned with:

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

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

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

(Department of Health 2001)

Risk and protective factors

Risk and protective factors for mental health may be used as a basis for developing indicators and measuring mental health impact. There is a wide range of interventions that aim to increase protective factors for mental health, for example social support or job control, and/or to modify risk or to intervene at points of enhanced risk, for example following bereavement, retirement or redundancy.

The strength of evidence on risk and protective factors for mental health varies, but social and economic factors which support warm, affectionate parenting and strong child/carer attachment are particularly significant (Fonagy and Higgitt 2000). Gender has a significant impact on risk and protective factors for mental health and the way in which the experience of mental distress is expressed (Department of Health 2002). Women are much more vulnerable to a range of key risk factors for mental ill health, including poverty, unemployment, domestic violence, sexual violence and rape and child sexual abuse (Gold 1998; Finkelhor 1994; Mulder et al 1998; Richardson et al 2002; Department of Health 2002). Although the overall prevalence of mental health problems is similar for men and women, there are clear gender differences for specific disorders. Rates of completed suicide are four times as high in men as in women, and the difference is increasing (Meltzer et al 1996; ONS 2001), whereas women are at greatly increased risk of depression and anxiety and eating disorders (Piccinelli and Wilkinson 2000). Women are also at greater risk of parasuicide, defined as suicide attempts and deliberate self-harm with no intent to die (Welch 2001).

As with other health indicators, there is a strong correlation between deprivation and poor mental health, using the rate of hospital admissions for mental illness as a measure of prevalence (Scottish Executive 2001). The Mental Illness Needs Index (MINI) and the Community Psychiatric Needs Index (CPNI) use a number of population features which have a strong correlation with admissions for mental health problems. These include the proportion of adults who are single, widowed or divorced, without a car, registered as permanently sick, unemployed, living in non-self contained households, resident in hostels or rough sleeping, lone parents, older people living alone and individuals without a carer. Other major risk factors for poor mental health include unemployment, homelessness, poor housing, bullying, racism, imprisonment, drug and alcohol problems, physical illness, sexual abuse and domestic violence (ONS 2000; Department of Health 1999).

The majority of mental health problems, notably those classified as neurotic disorders (including depression and anxiety), do not result in hospital admissions. They do, however, have a significant impact on the overall health and well being of individuals, families, communities and organisations. Anxiety and depression are among the commonest reasons for consulting general practice. For people from more deprived areas, incidence rates are around twice as high as rates in the least deprived areas (Kessler et al 1999; Shaw and Middleton 2001; Scottish Executive 2001).

Life events that increase risk include bereavement, physical illness, relationship breakdown, job insecurity, long term caring and moving into residential care. Modifying key risk factors

presents a serious challenge and will require long term strategic action. Nevertheless, at a local level, strengthening protective factors, for example in schools, in workplaces and in local communities, can make an important contribution to reducing risk, notably for those who are vulnerable.

Psychological protective factors for mental well being include feeling respected, valued and supported, together with a sense of hopefulness about the future (Pollock and Williams 1998; Williams and Pollock 2001). These psychological characteristics are influenced by wider socio-economic factors, for example parenting, schools, employment, housing and financial security. They also influence how individuals respond to stressful or traumatic life events. Broadly, interventions which aim to strengthen protective factors for mental well being can be classified as follows:

- ▶ **strengthening psycho-social, life and coping skills of individuals** e.g. interventions to promote self-expression, self-efficacy, self-esteem, opportunities to learn new skills, stress or anger management and relaxation
- ▶ **increasing social support as a buffer against adverse life events** e.g. initiatives that help build social contacts through self-help groups, networks and opportunities for new friendships
- ▶ **increasing access to resources and services which protect mental well being** e.g. initiatives to promote benefit uptake, supported employment, access to mainstream services.

(mentality 2002)

Indicators for mental health and well being

There are many different definitions of mental health and well being. These are influenced by individual experiences and expectations, as well as by medical, cultural and religious beliefs (Department of Health 2001; Bhui and Rudell 2002; Bhui and Bhugra 2002). How mental health is defined is of crucial importance to debates about evidence, because it will determine the measures of effectiveness used to assess the success of interventions, for example improvements in self-esteem or a reduction in symptoms of depression.

Identifying indicators of mental health presents a considerable challenge, partly because traditionally there has been a focus on measures to detect mental ill-health. Both the contents and scoring of common self-completion mental health measurement tools, for example the Beck Depression Inventory, tend to focus on negative symptoms such as sadness, anxiety, irritability or pessimism. Others, such as the General Health Questionnaire ask about both positive and negative symptoms, but are usually scored so that those with cut off scores above a certain point are regarded as mentally ill (Stewart-Brown 2002). In primary care, for example, scoring is used to identify 'caseness', in other words those patients with a sufficient number and combination of symptoms to constitute a case of anxiety or depression (Goldberg and Williams 1988; Bashir et al 1996). Overall therefore,

diagnostic tools, including those used in surveys of psychiatric morbidity, measure mental illness prevalence, rather than positive mental health.

Diagnostic tools – uses and limitations

In the case of, for example, anxiety and depression, many studies use a range of screening tools and scales to assess symptoms before and after an intervention. Snaith (2002) points out how different instruments may measure very different aspects of depression. For example, the Beck Depression Inventory is mainly geared to cognitive symptoms (hopelessness, low self-esteem, guilt) while the Hospital Anxiety and Depression Scale is directed to mood symptoms (feel sad, don't enjoy things). This is important because mood disorders are a characteristic of major depression (and a pre-requisite for diagnosis). Snaith argues that it is important to make a distinction between cognitive and mood symptoms because they require different treatments i.e. mood symptoms are more likely to benefit from pharmacological treatments, while cognitive symptoms may improve via psychotherapeutic approaches.

Over and above these problems, there are ongoing debates about the validity and usefulness of diagnostic criteria, notably in relation to schizophrenia (Double 2002; www.criticalpsychiatry.co.uk). Key critiques include the view that diagnoses are simply labels that classify and describe certain types of behaviour. They do not shed any light on the nature or causes of symptoms and frequently inhibit or deny patients an opportunity to participate in making sense of their experiences (Kinderman and Cooke 2000).

“Of course there is a biological component to mental illness, as there is in all behaviour, whether ‘normal’ or ‘abnormal’. The point is that the kinds of processes that underlie mental illness at the biological level may be no different from those that produce ‘normal’ thoughts, feelings and behaviour among people without a diagnosed mental health problem”

(Double 2002a p26)

As Perkins observes, these problems are not a unique feature of the bio-medical model. All mental health professions employ models of deficit, dysfunction, treatment and cure (Perkins 2002).

In addition there are concerns, in relation to anxiety and depression, about what has been called the medicalisation of socio-economic problems (Shaw and Middleton 2001). What Leibovici and Lievre describe is a confusion of boundaries in which *“the bad things of life: old age, death, pain and handicap are thrust on doctors to keep families and society from facing them.”* (Leibovici and Lievre 2002 p867; Moynihan 2002). While there are reliable diagnostic tools for severe depression, symptoms below that level are much harder to classify. They could represent the early or late stages of severe depression, reactions to life events or responses to adverse socio-economic circumstances (Freudenstein et al 2001).

“We do our patients a disservice if we restrict their distress to a clinical condition. Personal, relational, social, economic, political, and spiritual factors have significant impact on people’s circumstances, feelings, and future development. Medical assessment often effectively minimises or dismisses these issues, to the detriment of ourselves and our patients. The medicalisation of modern society has already deskilled many other professions and led patients into an unhealthy dependence on medical care. We should be careful not to reinforce this further.”

(Winston 2000 p1412)

All these debates are significant for the evaluation of mental health promotion interventions because they will influence:

- ▶ how the problem is defined
- ▶ identification of appropriate responses to the problem
- ▶ how success is measured.

For example, a biomedical model draws a boundary between mental health and mental illness and measures an intervention, for example arts on prescription, anti-depressants or cognitive behavioural therapy, in terms of its impact on symptoms. By contrast, a recovery model measures success in terms of regaining a meaningful life rather than by freedom from symptoms (Department of Health 2001b; Duggan et al 2002). In this case, quality of life indicators such as opportunities for friendship or feeling in control might be used to assess effectiveness.

Local mental health promotion strategies have the promotion of mental health and well being as a key objective. Assessing progress will require measures that can capture improvements in the mental health of individuals (including those who have a mental illness diagnosis) and the mental well being of communities, rather than measures of mental illness prevalence. By focussing on positive mental health and developing indicators based on individuals' and communities' own knowledge of what helps, mental health promotion has the potential to move beyond the limitations of a deficit model of mental health.

Measuring positive mental health

There are a number of well-validated instruments such as the General Health Questionnaire, the Psychological Wellbeing Scale, the Sense of Coherence Scale, the Affect Balance Scale and the Affectometer which include questions designed to identify aspects of positive mental health in individuals. Key elements include:

Table 1 Indicators of positive mental health for individuals

- ▶ agency
- ▶ capacity to learn, grown and develop
- ▶ feeling loved, trusted, understood, valued
- ▶ interest in life
- ▶ autonomy
- ▶ self-acceptance and self-esteem
- ▶ optimism and hopefulness
- ▶ resilience

(Stewart-Brown 2002)

Identifying indicators of mental health at the community level presents a further challenge. Individual responses to survey questions about, for example, fear of crime or social networks are aggregated to form community measures. In mental health terms, this means that the precise significance or 'mental health impact' of socio-economic and environmental factors are not captured, but rather are expressed in broad terms such as the correlation between substandard housing or unemployment and poor mental health status. These limitations also apply to the growing body of research exploring the relationship between social capital and health (Blaxter and Poland 2002), which has had a considerable influence on attempts to establish quality of life measures.

Quality of Life Indicators

The Audit Commission is currently piloting a series of quality of life indicators, many of which are relevant to mental health because they concern known risk or protective factors for mental well being (Audit Commission 2002). Although some of the data is gathered through surveys, other indicators address environmental factors, for example, access to green, open spaces, and community resources like cultural or leisure facilities. In localities where these indicators are being tested, the information gathered can be used to contribute to baseline data on mental health and well being at a community, ward or neighbourhood level, thereby helping to demonstrate the mental health impact and outcomes of local strategies.

Examples which may be particularly relevant, in addition to socio-economic data, include:

Table 2 Quality of Life Indicators

- ▶ the percentage of respondents satisfied with their neighbourhood as a place to live
- ▶ quality and amount of natural environment
- ▶ cultural, recreational and leisure services available
- ▶ opportunities to participate in local planning and decision making
- ▶ percentage of respondents who consider their neighbourhood is getting worse
- ▶ percentage of respondents concerned about noise
- ▶ area of parks and green open spaces per 1,000 head of population

(Audit Commission 2002)

A complete list of the indicators, together with details of local pilots in England, is available from www.audit-commission.gov.uk or email quality-of-life@audit-commission.gov.uk. A good example of how quality of life indicators are being used at a local level is available on Devon County Council's website www.devon.gov.uk/sustain/homepage.html

Further work in this area is being taken forward by the New Economics Foundation, working with 90 local authorities and local strategic partnerships to assess the influence of 'quality of life' indicators on local decision making (New Economics Foundation 2002). The project will produce a toolkit for practitioners on 'how to make measurement more meaningful and influential in local governance' (www.neweconomics.org).

Social Capital Indicators

The General Health Questionnaire and data on social support can also give a more detailed picture of overall mental well being and the presence or absence of key protective factors. For example, the proportion of adults reporting a severe lack of social support and high GHQ scores increases significantly as income decreases (Erens et al 2001). The Office for National Statistics website provides useful information on social support indicators, including links to validated questions which can be adapted for use at a local level. Other indicators drawn from research exploring the relationship between social capital and health, include formal and informal social networks, group membership, generalised trust, reciprocity and civic engagement (www.statistics.gov.uk/socialcapital).

Table 3 **Social Capital Indicators**

Indicators for which data is becoming more common (notably in localities where neighbourhood renewal and community strategies are well developed) include:

- ▶ feeling safe
- ▶ trusting unfamiliar others
- ▶ participation
- ▶ influencing local decisions
- ▶ believing the local neighbourhood is improving
- ▶ access to social support
- ▶ social inclusion indicators
- ▶ employment and meaningful activity indicators
- ▶ support for parents

The following table brings together indicators for individuals and communities, with quality of life indicators of particular relevance to mental health:

Table 4 **Mental well being indicators at different levels**

Individuals	Communities	Quality of life indicators
Feeling safe	Access to resources	Equity
Feeling in control	and services	Control
Trusting unfamiliar others	Support for parents	Involvement
Confiding relationships	Opportunities for lifelong	Safety
Access to social networks	learning	Lifelong learning
Financial security	Cultural life	Cultural assets
	Friendly physical environment	
	Robust local democracy	

Finding local data that is relevant to efforts to improve social outcomes is particularly challenging. A new Office for National Statistics service provides on-line data for England and Wales at postcode, town or city, ward or local authority levels and from 2003, it will be possible to use small area results from the 2001 Census (www.neighbourhood.statistics.gov.uk).

Moving forward

The implementation of local mental health promotion strategies should provide more opportunities to ensure that mental health indicators form part of the public health picture for strategic health authorities, local authorities and primary care trusts. Mental health indicators should also inform the priorities of Local Strategic Partnerships in their work to reduce health inequalities. Health Impact Assessments, used to evaluate the health impact of local plans and developments such as building a bypass or a new airport runway, should also include mental health indicators. Assessing the mental health impact of noise, increases in local traffic and new employment opportunities, for example, can help to build a more accurate picture of health impact than morbidity or mortality data (International Health Impact Assessment Consortium www.ihia.org.uk; Health Development Agency 2002).

Chapter Three

Evidence in context: debates about effectiveness

This chapter looks at some of the current debates about evaluation and evidence of effectiveness and their relevance for mental health promotion. It also identifies two significant policy shifts which are influencing attitudes to defining and interpreting the evidence base.

What's wrong with the gold standard?

It is well known that within the traditional hierarchy of research methods, systematic reviews and randomised controlled trials (RCTs) are equated with a 'gold standard' in research design, which is meant to guarantee unbiased, trustworthy assessments of interventions (World Health Organisation 2002; Tilford et al 1997).

The limitations of RCTs (also known as the experimental method) have been widely described and have generated a substantial critical literature (Holloway 2002; Wolff 2001; Slade and Priebe 2001; Higgitt and Fonagy 2002; World Health Organisation 2002). Research evidence produced by RCTs can be helpful for measuring mortality or morbidity rates, or the effect of discrete interventions. They are crucial, for example, in evaluating the effectiveness of medication. Equally, however, randomised trials are vulnerable to selection bias, unmeasured contextual variations and uncontrolled effects of the environment on the intervention (Wolff 2001). The trials are conducted in tightly controlled and largely artificial conditions. In addition, many types of interventions are not suitable for RCTs, notably complex interventions with complex outcomes and those where it is neither possible nor ethical to blind subjects and investigators to the intervention (Hotopf et al 1999). Finally, questions about how programmes are delivered i.e. the organisation and process are rarely addressed (Gilbody and Whitty 2002). Nevertheless, systematic reviews of a range of individual trials in one topic area, for example alcohol abuse, continue to exert a strong influence on received wisdom about what is and is not effective, in spite of the fact that such reviews are often unable to identify a clear pattern which explains the effectiveness of a particular approach (Pawson and Tilley 1997; Tilford et al 1997).

Outcomes research

An alternative to RCTs is 'outcomes research' which involves the secondary analysis of data that is routinely collected by clinical services, in order to judge the effectiveness of interventions and policy initiatives (Gilbody and House 2002). Outcomes research evaluates competing interventions that are already used in routine care settings, for example different types of treatment for the same symptoms. Unlike RCTs, outcomes research does not compare outcomes for those who receive an intervention with those who do not. Outcomes research has attracted considerable interest among mental health professionals, but in addition to sharing some of the weaknesses of RCTs, it is also driven by the outcomes data that is available, rather than by what people might want to study. Another example of giving the measurable importance, rather than making the important measurable (Slade and Priebe 2001).

Within the field of mental health promotion, the limited number of intervention programmes which meet the criteria for inclusion within systematic reviews has contributed centrally to the view that mental health promotion is both difficult to evaluate and/or is of limited effectiveness. In response to this, some mental health promotion specialists, drawing on a long tradition within health education and community development, have argued for alternative approaches to assessing the effectiveness of mental health promotion (Jenkins et al 2001; Barry 2002; Friedli 2001). Although attempts have been made to argue a special case for mental health promotion, the challenges facing those evaluating parenting skills training, anti-bullying schemes, social prescribing or community safety programmes are very similar to those experienced by clinicians and other colleagues assessing effectiveness in secondary care.

Realistic evaluation?

Mental health promotion has frequently reacted to the difficulties of fitting within existing evaluative frameworks by rehearsing the old quantitative vs qualitative debate. However, while quantitative research does not demonstrate how social programmes work, qualitative research has no method for abstracting principles beyond the specifics of time and place. For this reason, Pawson has argued that systematic reviews which focus on 'families of interventions', e.g. all those studies which address excessive alcohol consumption, are largely meaningless and should be replaced by reviews which looks at 'families of mechanisms'. In other words, identifying how a programme works in particular respects, for particular subjects in specific situations – the contextual variations (Pawson and Tilley 1997; Pawson 2002).

"The net effect of any particular programme is made up of the balance of successes and failures for individual subjects and locations. Any programme outcome depends not merely 'upon the programme' but also on its subjects and its circumstances."

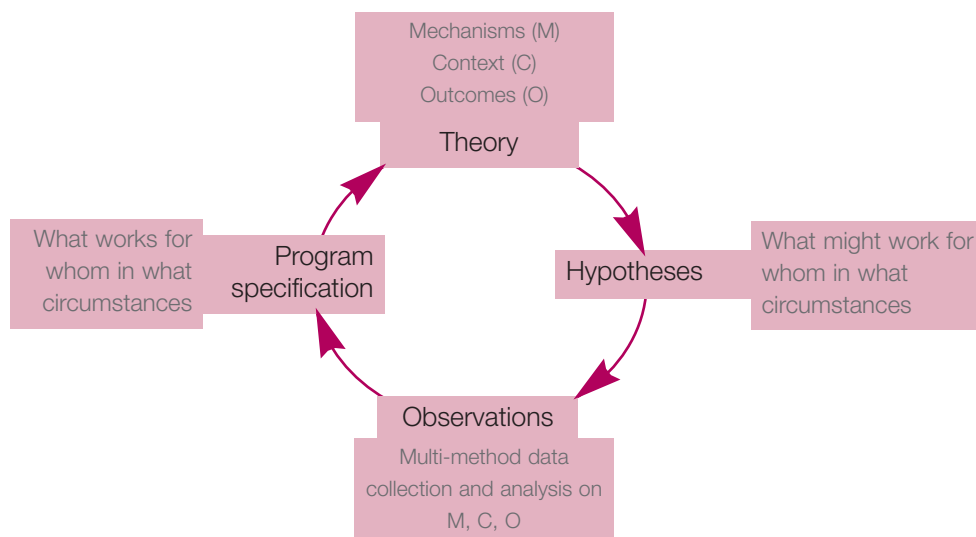
(Pawson 2002)

In this analysis, in order to assess the most effective approach or 'best buy', for example, in reducing weight altering behaviour in young women, it makes little sense to focus on outcomes in comparing

- a) peer education
- b) brief interventions from a school nurse
- c) advertising in teenage magazines.

Realist evaluation begins with a theory, for example, *'weight altering behaviour (which is a key risk factor for eating disorders) is a consequence of body dissatisfaction combined with a need to exercise control'*.

Diagram 1: The realist evaluation cycle (Pawson and Tilley 1997 p.85)



The focus of the evaluation is therefore on testing a series of hypotheses about different mechanisms for reducing body dissatisfaction and/or increasing opportunities for young women to feel in control. Key sources of expertise in generating different hypotheses will be young women themselves, young men, teachers and parents, as well as health and mental health professionals. Bearing in mind the original question: *'what works, for whom, in which circumstances?'*, we may conclude that school nurses influence behaviour in young children, or that peer education works well with low achievers. Programmes which work successfully in some schools, for example the Australian 'everybody's different' intervention, may not work in schools with a different culture, ethos or status within the community (O'Dea and Abraham 1999).

Pawson and Tilley's (1997) concept of realistic evaluation provides a valuable framework for thinking in new and creative ways about mental health promotion. Instead of asking whether parenting skills training, home visits, arts on prescription or anti-stigma campaigns 'work', we need to identify what an intervention actually does to change thoughts, feelings or behaviours, and which circumstances or contexts are, or are not, conducive to that process. Rather than asking, *'was it really the intervention which caused the mental health impact – in self esteem, in gaining employment, in problem solving skills?'*, mental health promotion needs to focus on how interventions achieve these changes in different contexts for different target groups. We know, for example, that the following appear to be important principles of effective interventions for mental health:

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

[Department of Health 2001]

What is less clear, is how these principles are achieved.

The policy environment

The growing interest in developing new research tools, capable of assessing complex interventions and addressing the broader context in which interventions are delivered, reflects a number of changes in attitudes to evaluation and what is meant by effectiveness. Two key policy shifts are of particular relevance. Firstly, the renewed interest in the socio-economic determinants of health and secondly, growing support for consumer/user involvement in the development of public policy.

Broader determinants of health

The current government's concern to address the broader determinants of health has given a new impetus to debates about how to measure and evaluate the effectiveness of socio-economic interventions. The Acheson Report (Acheson 1998) and the government's public health strategy *Our Healthier Nation* (Department of Health 1999a) revisited the issue of inequalities in health raised by the Black Report in 1980 (Department of Health 1980). Both recognised that solutions to major public health problems such as mental health are complex. In particular, they acknowledge the need for interventions that cut across sectors to take account of the broader social, cultural, economic, political and physical environments that shape people's experiences of health and well being.

The determination to address the accumulation of disadvantage that results in poor health is evident in a very wide range of policy initiatives including Healthy Living Centres, Health Action Zones and Neighbourhood Renewal. Many of the key themes which have been included as part of these initiatives, for example rebuilding social capital, arts, creativity, sport and the environment, signal a return to much broader, more holistic definitions of both health and inequalities. This is particularly clear in the importance of culture and sport as part of regional, urban and neighbourhood renewal agendas and in their perceived contribution to the Government's social inclusion agenda (Social Exclusion Unit 2000; Department for Transport, Local Government and the Regions 2002; Department for Culture, Media and Sport 2002).

"It is tempting to regard arts and sports as subsidiary and incidental to the task of 'turning round' neighbourhoods with multiple disadvantages. But arts and sport can tackle not only symptoms of social exclusion but also its causes."

(Department for Culture, Media and Sport 2002)

The renewed interest in the impact of psycho-social factors on health has provided an important impetus for mental health promotion. The work of Wilkinson, Marmot and others raised questions about the pathways through which material deprivation impacts on health, suggesting that inequality of income reduces life expectancy via the chronic stress of relative deprivation and the corrosion of social capital (Wilkinson 1996; Kawachi et al 1997; Brunner and Marmot 1999).

Social capital, broadly defined as the informal and formal networks, customs and relationships within a community, has generated considerable interest in evaluative

frameworks capable of capturing the relationship between community characteristics like trust and civic engagement and health (Health Development Agency 2002a). Key elements of social capital include:

- ▶ social resources e.g. informal arrangements between neighbours or within faith communities
- ▶ collective resources e.g. self help groups, credit unions, community safety schemes
- ▶ economic resources e.g. levels of unemployment, access to green, open spaces
- ▶ cultural resources e.g. libraries, art centres, local schools.

(adapted from Cooper et al 1999)

The literature on social capital has had an important influence on policy development in the area of regeneration and neighbourhood renewal, with an explicit recognition that how communities feel and the nature of community networks, norms and relationships, have an impact on health and economic outcomes. Indeed, it is the emphasis, within social capital theory, on psycho-social factors that has resulted in fierce criticism of its failure to recognise material factors as primary determinants of health (Baum 2000; Lynch et al 2000). Nevertheless, evidence that civic engagement and levels of participation may be more important for health than other elements of social capital have strengthened interest in community empowerment as a key factor in reducing inequalities in health (Campbell et al 1999).

Power to the People: public participation and user involvement

The second key influence on how success is measured is the growing emphasis on public participation, perhaps epitomised by the recent appointment of a 'public involvement' czar. The need to involve communities in efforts to tackle social and economic deprivation is now firmly embedded within the political agenda and forms part of the performance management framework for both local government and the NHS (Department of Transport, Local Government and the Regions 2002; Department of Health 2000; Department of Health 1999). Local people are viewed as partners in policy initiatives like the National Strategy for Neighbourhood Renewal (Social Exclusion Unit 2000), which aims to arrest the decline of deprived neighbourhoods and to narrow the gap between deprived areas and the rest of the country.

The requirement to consult with, engage and involve communities is now also a central responsibility for local authorities, notably through the development of community strategies. Strongly linked to Best Value, these aim to improve quality of life and promote economic, social and environmental well being, in order to contribute to sustainable development (www.neighbourhood.gov.uk/partnerships.asp). Community Strategies will usually be co-ordinated by a steering group or Local Strategic Partnership involving partners from health, primary care, education, transport and the voluntary sector. Building on Best Value, the local government White Paper Strong local leadership – quality public

services (Department for Transport, Local Government and the Regions 2002; www.local-regions.odpm.gov.uk) places quality of life and greater community engagement at the heart of the reform of local government. Key themes – of consultation and renewed local democracy, community cohesion, civic renewal and sustainable development, including building social capital – all point to a much stronger role for local communities in influencing local priorities and assessing performance. Although Local Strategic Partnerships are intended to be multi-agency, umbrella partnerships across all sectors, local authorities are expected to take the lead and have a particular responsibility to ensure consultation, engagement and inclusion (www.idea.gov.uk/knowledge).

The current emphasis on accessing the views and perspectives of the public – as citizens and also as users of particular services – dates back to the reform of the NHS in the early 1990s, although the Labour government has extended this trend to include social care and other public services. The involvement of communities and greater patient participation are key themes in the modernisation agenda, outlined in the NHS Plan and are also important elements of the move towards ‘person centered services’ and a whole systems approach (Department of Health 2000). Person-centred planning, for example, is a requirement of the NHS Plan.

User involvement in planning and developing services is a central principle of the National Service Framework for Mental Health (NSF) and is also evident in initiatives like the Expert Patient Programme (Department of Health 2001a), which explicitly acknowledges the expertise of people with experience of chronic illness. The move towards a more holistic approach is reflected in the requirement that everybody on enhanced Care Programme Approach (CPA) must have a plan that addresses their occupational, housing and benefits needs, thus creating a performance management framework for looking at people’s broader needs.

The emphasis on user perspectives and user involvement has potentially significant implications for how interventions, from medication to mass media anti-stigma campaigns, are evaluated and current debates about what constitutes evidence. One outcome is that research methods are changing to incorporate ways of determining the impact of social action programmes. Another, perhaps unanticipated outcome, is that the very process of involving and including individuals and communities, of seeking people’s views and valuing their knowledge and skills, promotes mental well being (Department of Health 2001).

At one level, the NSF’s recognition of ‘expert opinion’ (including users and carers) as a valid category of evidence has led to more widespread consultation and formal mechanisms for involving users in service planning, development, monitoring and evaluation (Harrison 2002; Gillam and Brooks 2001). At another level, however, user involvement has fundamentally challenged the paradigm of evidence based medicine (Laugharne 1999).

An example of this shift is the growing interest in the recovery model (Frese et al 2001; Repper and Perkins 2002). Central to this model is the view that mental health services should not focus exclusively on traditional outcomes such as compliance, treatment and preventing relapse, but should be broadened to include the goals of users, for example

employment, independence, satisfying relationships and quality of life (Drake et al 2001). The recovery model is described as '*a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness*' (Anthony 1993). Four elements of a recovery oriented approach outlined by Silvestri and Jue are:

- ▶ individual strength
- ▶ individual responsibility
- ▶ self-determination
- ▶ a life with purpose and meaning.

(Bates 2002)

Valued outcomes for treatment interventions include a sense of pride in achievement, productivity, meaning, self-expression and potential for growth, with the locus of control shifting from those providing treatment to the person who is recovering. Other themes include hope, healing, empowerment, connection, an emphasis on human rights and recovery oriented services (Jacobson and Greenley 2001).

At the heart of this is the need to rethink and expand definitions of treatment, to identify what an individual needs to regain or hold onto a life that has meaning for them, as well as enabling people to more easily integrate into society. Recovery is not limited to any particular model or theory about the causes of mental health problems, although as Double has argued, the concept of recovery is inherently critical of the biomedical model (Double 2002a) and will require a very different model of 'evidence based mental health' to the one that currently dominates the clinical literature (Evidence Based Mental Health 2001). Perkins describes this in terms of enabling people to:

- ▶ maintain existing activities and relationships
- ▶ reduce the barriers that prevent people from accessing new things they want to do
- ▶ gain access to the material resources and opportunities that are their right.

(Perkins 2002)

User perspectives

The final important element of the move to more holistic definitions of health and community engagement, is the growth of user led research. An emerging body of research seeks to identify treatments and therapies which those who use mental health services value, drawing on people's own expertise in living and coping with mental distress. The findings of two major surveys, Knowing our Own Minds (Faulkner 1997) and Strategies for Living (Mental Health Foundation 2000) have contributed centrally to a more holistic approach towards mental health, taking account of people's mental, physical, spiritual and emotional needs.

Four types of strategies were identified in these studies:

- ▶ ongoing survival
- ▶ crisis or life saving
- ▶ symptom management
- ▶ healing.

“The overwhelmingly predominant theme running through people’s ‘most helpful supports’ was the role and value of relationships with other people, in all their different forms”

(Faulkner 2002, p.193)

Conclusion

Attitudes to evaluation and what is meant by effectiveness are changing in ways that will influence health and other professionals across all disciplines. Mental health promotion is not alone in having to think differently about measuring what works. The limitations of randomised controlled trials are just as pertinent to clinicians, as to colleagues working to promote mental health in schools and prisons. If health outcomes are expanded to include goals which are valued by mental health service users, it will be clear that many types of interventions are not suitable for RCTs. It will no longer be sufficient to stand on the sidelines protesting that mental health promotion is too complex, too long term and too multi-faceted to swim in the pond with all the other interventions (Friedli 2002). At the same time, we will need different measures to capture a wider range of domains and research methods that can incorporate the perspectives of a much wider range of stakeholders. It will be impossible to answer crucial questions about health, well being and quality of life without adopting a holistic approach and without drawing centrally on the expertise of those at whom the intervention is aimed.

Chapter Four

The Evidence Base

The sections in this chapter set out a range of evidence for the effectiveness of a variety of mental health promotion interventions. They include findings from systematic reviews, experimental and quasi-experimental trials, literature reviews, programmes using mixed research methods, for example those which combine survey data with qualitative interviews, social action research and consensus statements.

Many of the studies included do not answer questions which may be crucial to the successful replication of a programme in another context, with a different target group. Nevertheless, the limitations in existing studies can be used to strengthen the design of future research. Above all, they provide a body of knowledge on which we can build and a robust case for the value of investing in mental health promotion.

We very much welcome feedback, input, questions and criticism via the 'evidence base forum' on www.mentality.org.uk

Early Years: Children and Families

The case for action

Childhood mental health problems are strongly predictive of poor mental health in later life. A review by Birmaher et al, for example, shows a continuity between childhood and adult depression, making recognition and treatment of childhood depression very important (Birmaher et al 1996). Poor mental health in children (for example anxiety, depression and behavioural problems) is a significant risk factor for poor school outcomes, poor physical health, poor social skills and suicidal behaviour (Mental Health Foundation 1999; Department for Education and Skills 2001).

A number of studies have identified parenting as a prime public health issue (Barlow et al 2001) and interventions to strengthen the relationship between infants and carers have a strong impact on both mental and physical health. Hoghughi found that parenting is the single largest variable implicated in health outcomes for children, notably accident rates, teenage pregnancy, substance misuse, truancy, school exclusion and under-achievement, child abuse, employability, juvenile crime and mental illness (Hoghughi 1998).

There is particularly robust evidence in relation to the impact of early childhood experiences, notably the importance of socio-economic circumstances that support warm affectionate parenting and strong family attachment (Fonagy and Higgitt 2000; Heijmens Visser et al 2000; Rutter and Smith 1995). Positive parenting can act as a buffer against adversity, such as poverty or peer pressure, and as a mediator of damage, for example in child abuse. Social support from at least one warm, caring adult is protective in relation to a wide range of adversities (Wolkow and Ferguson 2001). These include poverty (Luther and Zigler 1991), living in high crime neighbourhoods (Felsman and Vaillant 1987), parental substance abuse and family conflict (Werner 1993), child abuse (Spaccarelli and Kim 1995) and early parental loss (Brown et al 1986).

Interventions which promote resilience in children under five help those children to do well in spite of adversity (Titterton et al 2002; Mental Health Foundation 1999). Factors which strengthen resilience include family harmony, co-operative relationships between parents, opportunities to succeed and internal locus of control.

Evidence based priorities

Interventions in the following areas have the most significant impact on improving the mental health of children and preventing or ameliorating early symptoms of mental health difficulties:

- ▶ strengthening child/carer relationship
- ▶ improving toddler language skills and impulse control
- ▶ home visits and social support for new parents
- ▶ improving parenting skills
- ▶ opportunities for child-centered active learning.

A summary of what works

Successful programmes are those that work to strengthen the relationship between the child and the caregiver and to address socio-economic factors associated with family conflict, maltreatment and poor attachment. Parenting programmes should be planned and delivered to take account of parenting styles in different cultures.

Pre-school Development

Good results have been achieved by programmes that address pre-school development indicators e.g. the development of language skills and impulse control, and work to support parents in recognising, understanding and enhancing developmental milestones e.g. the Carolina Abecedarian Project (Horacek et al 1987 – **review**). This combined home visits, full time day care to enhance language and cognitive development and a parent support group. The positive effects of this programme are still evident in follow up at 21 years of age (Ramey et al 2000 – **longitudinal study**; Ramey and Ramey 2002 – **longitudinal study**).

Parents can promote language development, literacy and reading achievement by reading to pre-school children (Bus et al 1995 and 1997). A growing body of literature suggests that parent-child interactions with storybooks have both cognitive and emotional benefits for young children and are an important social context for the development of literacy (Baker et al 1997; Bus et al 1995; DeLoache and DeMendoza 1987; Neuman 1996, Sonnenschein et al 1996). A books for babies programme in Ireland with parents with very low literacy found that inviting parents to develop their own stories around the pictures in the books had the same positive effects (personal communication, Northern Area Board Health Promotion 2002).

Breast feeding and tactile stimulation, for example baby massage, are associated with improved psycho-social development in children (World Health Organisation 1998; Quinn et al 2001 – **cohort study**).

Home Visits (See also Primary Care: Community Mothers)

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

The most comprehensively evaluated randomised control programme, the Pre-natal/Early Infancy Programme (Olds 1997 – **randomised trial**) demonstrated the following benefits:

- ▶ reduced child abuse
- ▶ improved educational and employment opportunities
- ▶ strengthened social networks
- ▶ improved educational attainment
- ▶ improved diet.

Day Care

High quality day care for pre-school children improves behavioural development, school achievement and the mother/child relationship. Long-term follow up demonstrates increased employment, lower teenage pregnancy, higher socio-economic status and decreased criminal behaviour. Most of the day care trials in the literature combined day care with parent training or support (Zoritch et al 1998 – **systematic review**; Zoritch et al 2000 – **Cochrane Review**).

Two examples of programmes are *High Scope Pre-school* (Schweinhart and Weikart 1992 – **longitudinal study**) and *Perry Pre-school* (Berrueta-Clement et al 1984 – **longitudinal study**). A key feature of the *High Scope* curriculum is active learning, in which children are supported to initiate their own play and activities. Psycho-social gains were still evident at follow up at 19 years of age.

Promoting Parenting Skills

Group-based parenting training programmes improve the mental health of both parents and children (Barlow 1999; Barlow et al 2001 – **systematic reviews**) and may be more acceptable to parents than clinic-based programmes for individual parents.

A Primary Care Health Improvement Programme for mental health has established a partnership involving health, education and social services. They have set up a Healthy Schools Programme involving two primary schools and one upper school. The Primary

Care Trust is covering the cost of six 90 minute parenting classes for parents of children between 5 – 15 years of age. A creche is also provided. The classes are facilitated by school nurses and health visitors and promote positive parenting messages in a relaxed atmosphere. The aim of the classes is to increase parents' self-esteem and confidence about parenting (Social action research) (Email: alison.embley@educ.suffolkcc.gov.uk).

Addressing Anti-social Behaviour

Persistent anti-social behaviour in children strongly increases the risk of social rejection, youth offending and long term unemployment. The long term public cost of anti-social behaviour during childhood is up to ten times higher than for controls and involves many agencies (Scott, Knapp et al 2001). Parenting groups can effectively reduce serious anti-social behaviour in children in real life conditions. Effective programmes combine behavioural interventions (praise, incentives, setting limits and discipline) with sympathetic support which acknowledges parents' feelings and beliefs (**controlled trial**) (Scott, Spender et al 2001).

Detecting Depression in Children

Depression is usually caused by a combination of genetic vulnerability, negative early developmental experiences, and exposure to stresses. Physical illness may be another factor. A review by Birmaher et al (1996) shows continuity between childhood and adult depression, making recognition and treatment of childhood depression very important.

One systematic review of six randomised controlled trials, including two for pre-adolescent children, found cognitive behavioural therapy more effective than other therapies in reducing depressive symptoms in children (Harrington et al 1998 – **systematic review**).

Young People – School Setting

The case for action

School has a significant influence on the behaviour and development of all children (Rutter and Smith 1995; Wells et al 2001). The importance of school as a setting for promoting the mental health of children has recently been recognised by the Department for Education and Skills in their guidelines Promoting Children's Mental Health within Early Years and School Settings (Department for Education and Skills 2001 www.dfes.gov.uk/mentalhealth/). School is also crucial source of friends and social networks.

Poor achievement and poor school performance are risk factors for substance abuse, unwanted teenage pregnancy, conduct problems and involvement in crime (Rutter and Smith 1995; Department for Education and Skills 2001; Wells et al 2001). Educational achievement increases self-esteem and confidence, employment opportunities, life opportunities and social support. Schools can also strengthen the ability of young people to cope successfully with transition and change. School interventions can make an important contribution to reducing the impact of wider inequalities, but schools can also reinforce

inequality (Acheson 1998). Children from ethnic minorities are more likely to experience bullying than white children and black children, particularly boys, are much more likely to be excluded from school (National Society for the Prevention of Cruelty to Children 1999).

Key protective factors for positive mental health and health promoting behaviours for young people include both a sense of parent/family connectedness and school connectedness/identification.

Evidence based priorities

Methods associated with increased effectiveness include cognitive behavioural approaches, interactive interventions and, to a much lesser extent, peer-led education. There is a strong case for reviewing materials and resources used in school-based health promotion to assess the extent to which they are based on these approaches.

The most effective interventions in schools involve one or more of the following:

- ▶ social competence approach
- ▶ health promoting schools approach
- ▶ continuous implementation for more than a year
- ▶ promotion of positive mental health rather than prevention of mental illness
- ▶ social support.

Schools also need to develop their own health education practices that match the culture of the communities and groups that they serve, rather than trying to deliver some kind of national curriculum (Morrow 2002).

There is robust evidence for the value of a social competence approach, focusing on the promotion of generic skills designed to increase resilience, promote self-esteem and enable children and young people to avoid risk and attain and/or maintain health promoting behaviour. Throughout life, suicidal behaviour is more common in people with difficulties in solving problems (Pollock and Williams 1998), and this suggests that programmes which focus on resourcefulness and generic coping skills are especially valuable. The key components of the social competence model are:

- ▶ self-management
- ▶ problem solving
- ▶ communication
- ▶ resisting negative social influences.

A systematic review of universal approaches to mental health promotion found the most

robust positive evidence was from programmes that adopted a whole school approach and involved changes to the school ethos, were implemented continuously for more than a year, and aimed to promote positive mental health as opposed to brief, class-based mental illness prevention programmes (Wells et al 2001; Weare 2000 – both **systematic reviews**).

The strength of evidence about social support also suggests the value of initiatives for vulnerable children that promote access to a positive relationship with an adult, for example mentoring schemes. Of the various protective factors for mental health, social support may be the most amenable to intervention (Wolkow and Ferguson 2001).

A major review of health promotion in schools (Lister-Sharp et al 1999 – **two systematic reviews**) has significant implications for future investment in school programmes and should also inform health promotion initiatives with young people in other settings. On balance, findings support a health promoting schools approach, notably in relation to certain areas of health related behaviour such as diet and fitness, and aspects of mental health and social well being such as self-esteem and bullying. The health promoting schools approach improves the social and physical environment of the school in terms of staff development, school lunch provision, exercise programmes and social atmosphere.

Components of the health promoting schools approach include:

- ▶ improving the school ethos and environment
- ▶ curriculum approaches
- ▶ involving families and the local community.

Most studies included in the Lister- Sharp (1999) review used classroom-based curriculum approaches only. However, interventions that included changes to the school ethos and environment and promoted the involvement of families and the local community were more likely to be effective. These findings are borne out in a wide range of studies which suggest that traditional, topic based approaches to health education are of limited value.

A summary of what works

Successful programmes are those that involve parents and the wider community, strengthen school attachment and address the ethos and culture of the school as a whole. They should include a generic focus on skills that increase mental and social well being and mechanisms for identifying and supporting at risk and vulnerable children. The ‘whole school’ approach, which combines these different elements, appears to be crucial in reducing bullying and in reducing suicidal behaviour.

Health Promoting Schools

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

programmes are more effective than traditional, didactic approaches (Thomas et al 1999 – **systematic review**). An interactive, social competencies model reduces cannabis, alcohol, tobacco and other illicit drug use and is statistically superior to non-interactive programmes (Tobler and Stratton 1997 – **meta analysis**; Tobler et al 1999 – **quantitative synthesis**). For example, the DARE (Drug Abuse Resistance Education) programme was much less effective than programmes using social and general competencies.

Participation

A recent study of twelve schools demonstrated a strong association between student participation and enhanced self-esteem, motivation to learn, positive school attendance and overall GCSE attainment (Hannam 2001). A strong school culture of participation, collaboration, shared planning and decision making and shared responsibility for implementation resulted in a 'benign cycle'. Participative activities require students to take initiatives and decisions. This generates motivation, ownership and a sense of being independent, trusted and responsible. This supports the learning of communication and collaboration skills, leading to enhanced self-esteem and a greater sense of self efficacy. In the twelve 'student participative' schools, school attendance and GCSE attainment were higher than comparable schools and permanent school exclusions were lower (Hannam 2001 – **programme evaluation**).

Anti-bullying Schemes

Anti-bullying schemes which involve the whole school, parents and the community, for example the *Campaign Against Bully-Victim Problems*, are effective and have significant long term impacts on criminal behaviour, alcohol abuse, depression and suicidal behaviour (Olweus 1993 – **controlled trial; longitudinal studies**).

Body Image Programmes

The *Every Body's Different Programme* (EDAP) in Australia focused on improving self-esteem and was effective in reducing body dissatisfaction in young people and altering weight control behaviour in girls (O'Dea and Abraham 1999 – **randomised controlled trial**). This is very significant because a history of severe or moderate dieting is the single most important predictor for anorexia. The EDAP Puppet Programme also showed success in changing attitudes to large body sizes among primary school children (Irving 2000).

Suicide Prevention

Systematic reviews of suicide prevention programmes in schools have not proven them to be effective and there is some evidence that they may increase risk for vulnerable young people, particularly boys (Ploeg et al 1996 – **systematic overview**; Lister-Sharp et al 1999 – **two systematic reviews**). However, a comprehensive programme which included teacher training, parent education, stress management and life-skills, together with the introduction of a crisis team in each school, achieved a very significant reduction in suicide and attempted suicide over five years (Zenere and Lazarus 1997 – **longitudinal study**).

Prevention of Depression

Indicated prevention of depression in high school adolescents through cognitive behavioural

therapy has significant positive results (Clarke et al 1995 – **randomised controlled trial**). A universal school-based programme to prevent depression (RAP), focussing on a cognitive approach to life skills and problem solving resulted in significantly lower levels of depression and hopelessness (Dadds et al 1997 – **controlled trial**; Shochet et al 2001).

Coping with Transitions

Helping children to negotiate stressful transitions, combined with modifying the school environment, reduces psychological and behavioural problems and increases competencies (Durlak and Wells 1997 – **meta analysis**). Life skills and social skills training helps children to cope positively with the stresses of transition from junior to middle school. In the comparison group, boys had higher rates of alcohol consumption and violent behaviour and girls had higher rates of cigarette consumption and vandalism (Bruene-Butler et al 1997 – **controlled trial**).

Cognitive Behavioural Interventions

Behavioural or cognitive behavioural interventions significantly reduce problems in children with early signs of maladjustment (Durlak and Wells 1997 – **meta analysis**).

Young People – Outside School Settings

The case for action

There are a number of opportunities to promote the mental health of young people outside school and to work with networks of young people in the community. This is particularly important as children grow older and often spend more time with their friends than with their family (Morrow 2002). Peer group pressure is particularly significant in early adolescence (Heaven 1994).

Health risk behaviour is also an important aspect of expressing or acquiring gender identity (Working with Men 2001). For example, young men are three times more likely to be alcohol dependent than young women and twice as likely to be drug dependent (Coleman and Schofield 2000). There is a strong case for paying more attention to gender issues in developing interventions for young people.

For older children, programmes to promote mental and social well being are likely to improve the overall effectiveness of health promotion both within schools and in other settings. Work to address self-esteem, communication and negotiation skills, media influences, social, cultural and gendered norms will have a significant impact on the effectiveness of health promotion with young people. For example, findings from research with 15-16 year olds in the East Midlands indicate that for many young people, smoking has certain benefits in terms of coping with uncertain identities and being 'in control' of themselves and their lives (Denscombe 2001). This suggests the potential significance of addressing mental well being as part of an overall strategy to tackle risk-taking behaviours.

Evidence based priorities

The key priority in working with young people is to consult young people themselves, draw on and make use of their own expertise and to involve them in all aspects of interventions. The growing gap between the health of young women and young men, and the apparent impact of gender roles on the experience and expression of mental distress, has led to calls for a much greater emphasis on different approaches for young men and young women (Health Development Agency 2001; Men's Health Forum 1999; Meryn and Jadad 2001). Self-esteem, peer pressure, identity and coping styles are all important influences on young people's mental health and all have significant gender elements.

For young people with a range of risk factors, including young people in care and leaving care and young people in prisons, addressing mental health needs may be fundamental to improving overall health and well being (Big Step 2002). McCann found 67% of a sample of in-care adolescents had a diagnosable mental health problem (McCann et al 1996). Up to half of rough sleepers have some kind of mental health problem, with the majority becoming ill before they became homeless (Social Exclusion Unit 1998).

Finally, there is encouraging evidence that health promotion for adolescents can also be effective when delivered via practice nurses in a primary care setting. Although changes in behaviour are slight, such interventions are welcomed by young people and are cheap to deliver (Walker et al 2002).

A summary of what works

Effective programmes appear to be those which focus on strengthening life skills, building social support and which successfully consult and involve young people. There is some evidence that holistic approaches e.g. 'one stop shops' appeal more to young people and are less stigmatising.

Youth Offending

Cognitive behavioural programmes, real-life skills and generic problem solving skills are effective in reducing or preventing youth violence. Individual analytic therapy, psychotherapy and intensive casework are either less effective or not effective (Tolan and Guerra 1994). Cognitive behavioural therapy has also had positive results in reducing reoffending in offenders with a history of violence, sexual aggression and other anti-social behaviours (McGuire 1995 – **programme evaluation**).

Restorative justice is a community based model based on the practice in New Zealand where it was pioneered – offences are understood as breakdown in social bonds. Early outcome data from the US and New Zealand offer hopeful alternatives for offending youngsters, families and communities (Goren 2001 – **review**).

Building social responsibility by showing young people the consequences of vandalism may be helpful in reducing this behaviour (Barker and Bridgeman 1994 – **review of case studies**).

There is some evidence that football and other sports can play a role in reducing offending behaviour, notably for hard to reach young people in the 16 plus age range, who are not at school or in employment (Nacro 2002 – **project evaluation**).

Contact: National Football Development Officer, Nacro. Tel: 0115 985 7744

Parenting programmes aimed at parents of persistent offenders in England and Wales have had a positive impact. Parents involved in the scheme have said that the classes helped them to communicate better with their children. The number of recorded offences committed by the children of parents participating in the schemes had fallen by 50% during a two year period. Thirty four schemes were evaluated (Woodward 2002 – **programme evaluation**).

Risk Taking Behaviour

Brief interventions in primary care are effective in reducing alcohol consumption in heavy drinkers (Wilk et al 1997 – **meta analysis**). Early findings from an evaluation seem to show that this model can be effectively replicated in A&E settings, which is likely to reach young men who do not attend primary care (Huntley et al 2001- **programme evaluation**). Also of interest is an analysis of minimum age drinking laws in the USA, which demonstrated that lowering the legal drinking age was associated with increased suicide in young people (Birckmayer and Hemenway 1999).

AIDS risk reduction interventions are effective in changing risky sexual behaviour and attitudes, and increasing knowledge (Kim et al 1997 – **systematic review**; Juarez and Diez 1999 – **systematic review**).

Suicide prevention (see also young people in school)

Deliberate self harm is common in adolescents, especially young women. Risk factors include recent self harm by friends or family members, drug misuse, depression, anxiety, impulsivity and low self-esteem (Hawton et al 2002). Self harm was more common in pupils who had been bullied and was strongly associated with physical and sexual abuse in both sexes. Pupils of either sex who had been worried about their sexual orientation also had relatively higher rates of self harm. Self harming may be a response to a transient period of distress but may also be an important indicator of mental health problems and risk of suicide. The risk of suicide for people with a history of parasuicide persists for many years, suggesting the importance both of working to reduce self harm and suicide behaviour, as well as providing a higher standard of care following self harm (Jenkins et al 2002). Based on their recent findings, drawn from a cross sectional survey, Hawton et al argue for programmes addressing self-esteem, depression and anxiety, as well as routine screening of adolescents to identify those at risk. Helplines, self-referral agencies and school counselling services are other potential interventions (Hawton et al 2002; Meltzer et al 2001; Brent et al 1993). There is also an important role for tackling bullying and creating a safer and more supportive environment for young lesbians and gay men (Bagley 2000).

Social Skills Training

Social skills training e.g. coaching and cognitive problem solving is particularly effective with isolated children (Erwin 1994 – **meta analysis**) and is also effective in reducing aggression. (Goldstein and Pentz 1984) Skills-based approaches, role play, support and practical information based on needs assessment with young people are more effective than a top down, didactic approach (Oakley et al 1994 – **systematic review**).

Advocacy

The *331 Young People's Centre* in London is a jointly funded, multi-disciplinary service providing advice, information, support and counselling to young people from 12 – 21 years. Young people were involved in the Centre's development and young volunteers working in the Centre continue to input ideas. The main aim is to provide a high quality service that will inform, empower and respect young people so they are able to access the appropriate specialist local statutory and voluntary services.

Contact: 331 Young Peoples Centre, 331 Ballard Lane, London N12 8LJ Tel: 020 8492 7332) (User feedback /outcome data)

Primary Care

The case for action

The majority of mental health problems are managed within primary care and a high percentage of problems presented in primary care are psycho-social. Around 30% of all consultations and 50% of consecutive attendance concern some form of psychiatric problem, predominantly depression or anxiety (Kessler et al 1999; Goldberg 1992). In Scotland, during one year there are more than 300 consultations for mental health problems for every 1000 people in general practice (Scottish Executive 2001). Depression is also much more common in people with physical health problems (Peveler et al 2002). Primary care therefore has a crucial role in promoting the mental and physical well being of people with severe and enduring mental health problems, as well as those experiencing mild to moderate levels of distress (Jenkins and Ustun 1997; Gask et al 2000).

The public health responsibilities of primary care trusts mean that primary care also has a role to play in promoting mental health at a population level, notably in their role as key partners in Local Strategic Partnerships.

New models of primary care include integrated centres offering housing, social services, welfare support and education. There are new opportunities to develop services at the interface between primary care and local populations, to reach out to socially excluded groups such as refugees, homeless people and those with substance misuse problems, and to address inequalities in access to services such as talking treatments. Exercise, arts and education referrals, 'walking for health' schemes, increasing benefit uptake, protocols for shared care with user/survivor networks and referrals to self-help and voluntary groups are key aspects of the primary care role to strengthen mental health within communities

(Gask et al 2000). Primary care also has a role in addressing the physical health needs of people with severe and enduring mental health problems, as these are often missed or neglected (Sainsbury Centre for Mental Health/NHS Alliance 2002). Conversely, because depression is so common in physically ill patients, primary care has a special role in detecting and managing depressive illness where it co exists with physical illness (Peveler et al 2002).

Evidence based priorities

Mental health promotion is not currently part of quality incentive schemes for general practitioners and mental health promotion targets are not included within clinical governance and quality control for primary care. However, there is robust evidence for the effectiveness of the following:

- ▶ improving primary care links with, and access to, agencies able to influence the broader determinants of health e.g. benefits advice (Abbott and Hobby 1999)
- ▶ encouraging vulnerable groups to access community support, voluntary and self-help agencies (Grant, Goodenough et al 2000)
- ▶ Primary Care Trusts promoting and signed up to supported employment schemes for mental health service users (Crowther et al 2000)
- ▶ addressing the physical needs of people with long term mental health problems e.g. through annual health checks (Cohen and Hove 2001)
- ▶ brief interventions to reduce alcohol consumption (Ashenden et al 1997; Huntley et al 2001)
- ▶ social prescribing e.g. exercise, leisure, learning, creativity (Darbishire and Glenister 1998; Matarasso 1997; Health Education Authority 1999; Friedli et al 2002)
- ▶ education and life skills training (Renick et al 1992).

A summary of what works

A wide range of interventions have proven effective in reducing symptoms of mild to moderate anxiety and depression and in improving quality of life for people with severe and enduring mental health problems. Some of the most promising emerging findings come from programmes involving partnerships between primary care and other agencies, notably self help and voluntary agencies, leisure, arts and creativity and housing, benefits and welfare services.

Reducing Alcohol Consumption

Brief interventions in primary care are effective in reducing excessive alcohol consumption by over 20% (Ashenden et al 1997 – **systematic review**; Peters et al 1998 – **programme evaluation**; Babor and Grant 1992 – **randomised control trial**). There is also a strong case for taking an alcohol history, followed by brief interventions, in Accident and Emergency departments, using an approach developed at St Mary's Hospital NHS Trust in Paddington, London (Huntley et al 2001 – **programme evaluation**). Over half the men

who present to hospital after deliberate self harm regularly drink excessive amounts of alcohol and 23% are alcohol dependent (Merrill et al 1992; Waller et al 2002).

Promoting Exercise

A number of trials suggest that patients respond positively to GP advice to take more exercise (Killoran et al 1994 – **review**). National consensus statements on physical activity and mental health (Grant 2000 – **expert consensus**) show that exercise prevents clinical depression and is as effective a treatment as psychotherapeutic interventions. Exercise also reduces anxiety, enhances mood and improves self-esteem (Fox 2000; Mutrie 2000a). Regular exercise improves cognitive functioning, reduces mental health problems and improves the mental health of older people (Etnier et al 1997 – **meta analysis**).

Evaluation of *Balance for Life* found that a GP who prescribed a 10 week programme of exercise significantly reduced depression and anxiety and increased quality of life and self-efficacy for exercise. 68% of clinically depressed patients achieved non-clinical depression scores within three months (Darbishire and Glenister 1998 – **programme evaluation**).

The Island Health Walk Scheme in the Isle of Wight was established by the West Wight Primary Care Group in 1999. Short volunteer-led walks are offered for those who lack confidence or physical ability to walk alone. While targeted at people with mental health problems and learning disabilities, these walks are particularly beneficial for older people and have been very successful in enabling older people to make new friends and forge community links. User feedback has demonstrated enhanced self-confidence, self-esteem, improved physical fitness and increased independence (participant feedback).

Contact: Health Promotion, Isle of Wight Healthcare NHS Trust, St Mary's Hospital, Newport, Isle of Wight. Email: rosie.rae@iow.nhs.uk

Green Gyms are emerging as a national movement which offers people a way of meeting others, getting physically fit and improving the natural environment. Referral may be through primary care or by word of mouth. Local evaluations have demonstrated a range of physical and mental health benefits, including reductions in symptoms on the Hospital Anxiety and Depression Scale and improvements in quality of life (BTCV 1999; 2001). 'Being out in the countryside' emerged as a significant motivating factor, supporting other findings. A national survey on public attitudes undertaken in 1995 demonstrated that nine in ten people value the countryside and that there is a very strong desire for greater opportunities to access rural areas (Countryside Commission, 1997). The most important perceived benefit from visiting the countryside was the sense of relaxation and well being. Fresh air and peace and quiet were also valued.

Self Help and Support Networks and Volunteering

People with a small primary support group of 3 people or less are at enhanced risk of mental health problems (Brugha et al 1993). Social support reduces death rates, susceptibility to infection and depression, notably in older people (Cohen 1997; Oxman et al 1992).

Primary care can strengthen access to self-help and support networks by ensuring better links between primary health care and sources of information and support in the community. Effective interventions include the promotion of self-help, advocacy, neighbourhood and voluntary activities, as well as structures that facilitate community involvement in planning and local decision-making about the provision of services (Stark 1997; Whelan 1993; Rosengren et al 1993).

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

Social Prescribing

Social prescribing is a mechanism for linking patients in primary care with non-medical sources of support within the community. It provides a framework for developing alternative responses to mental distress and is part of a wider recognition of the influence of social and cultural factors on mental health outcomes across the whole spectrum of disorders. There are a number of different models for social prescribing. It is sometimes used to describe referrals to therapeutic services within the community e.g. activities which have been set up specifically for people with severe and enduring mental health problems, although it more often refers to activities which are open to anyone.

Examples of social prescribing include Exercise on Prescription, Prescription for Learning and Arts on Prescription. Social prescribing has been quite widely used for people with mild to moderate mental health problems, with a range of positive outcomes including enhanced self-esteem, reduced low mood, opportunities for social contact, increased self-efficacy, transferable skills and greater confidence (Huxley 1997; Oliver et al 1996; Matarasso 1997; Fox 2000 and 2000a; Mutrie 2000; Darbishire and Glenister 1998). It may also be appropriate for frequent attenders. The reasons for frequent attendance, (defined as those who consult more than 12 times in a year), are complex but there is good evidence that unresolved mental health problems are a significant factor (Heywood et al 1998; Dowrick et al 2000). Frequent attenders should therefore be considered as one of the target groups for social prescribing.

There is also a growing interest in social prescribing as a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with severe and enduring mental health problems (Colgan et al 1991; Bates 2002; Gask et al 2000).

Facilitating Access to Voluntary Sector Resources

Facilitating access to the voluntary sector through primary care improves psycho-social outcomes. Findings from a randomised controlled trial in Avon with 26 general practices found that people who were referred from primary care to a liaison organisation (who helped them to access sources of support within the voluntary sector) had better mental health scores (e.g. less anxiety), found it easier to carry out everyday activities and had more positive feelings about general health and 'quality of life' than those who were not referred (Grant et al 2000 – **randomised controlled trial**).

The *Well Family Service* is a comparable scheme in Hackney that combines referrals to appropriate services with practical and emotional support to help families build on their own resources and find ways around their problems. This approach has been well received by people of different ages and ethnicity and reaches families who might otherwise be excluded by poverty, limited education or lack of confidence (Goodhart et al 1999 – **programme evaluation**).

A *Community Liaison Worker* scheme in Hastings and St Leonards has demonstrated a range of positive outcomes. The liaison post operates between two medical centres and four general practices. Together with service users, the worker identifies different practical problems that can impact on mental health and provides a link with the many services that can help. Evaluation has shown an increased understanding and awareness of users' needs amongst practice staff leading to the provision of a more holistic service. Consequently service users are more satisfied and referrals to community resources from the statutory sector are more appropriate (qualitative evaluation).

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Prescription for Learning

Strengthening the links between primary care and education has been under researched, although there is good evidence of the physical and mental health benefits of involvement in learning (Challis 1996 – **review**; Aldridge and Lavender 2000; Niace 2001). The Basic Skills Agency has done research which shows that 7 million adults with poor basic skills will class themselves as long term sick rather than being classed as unemployed. Prescription for Learning uses learning advisers in primary care to provide learning support for patients with poor basic skills, as well as helping people access education and learning opportunities. (Niace 2001) (www.niace.org.uk).

Time Banks

The *Rushey Green Time Bank* began in 1999 when the New Economic Foundation piloted the scheme with a Lewisham GP practice. They had identified that many of the problems the practice were prescribing for were social rather than medical in origin. Community time banks work by measuring and rewarding the time people spend helping each other in local communities. You give one hour of time to help someone and earn an hour's time credit which you can redeem when you need help. A "time broker" matches up people's needs, keeps track of participation and helps recruit and support members. Initial evaluation showed that participants felt an increase in self-confidence and self-esteem (participant interviews).

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Managing Peri and Post natal Depression

The prevalence of postnatal depression has been estimated at between 10 – 15% (SIGN 2002). In addition to a past history of mental health problems, risk factors for post natal depression include low social support, poor marital relationship, recent adverse life events

and 'baby blues'. Training midwives, health visitors and practice nurses to detect mental health problems can improve early identification of perinatal depression but evidence to support routine antenatal screening to predict the development of postnatal depression is weak (SIGN 2002- **systematic review**). The most commonly used postnatal screening tool is the Edinburgh Postnatal Depression Scale, which has good evidence of effectiveness. In some localities, primary care offers an integrated service to address the emotional needs of pregnant women, aiming to improve early detection of perinatal anxiety and depression (Hodnett 2000 – **Cochrane Review**; Cooper and Murray 1998 – **clinical review**). Unfortunately, there is limited evidence of effective preventive interventions for low risk women, although home visits, psychological therapies and support during pregnancy are effective for women at high risk (SIGN 2002).

Promoting the Mental Health of Mothers and Children

Community Mothers programmes use the expertise of trained volunteers with experience of mothering, to support local parents. There is equal emphasis on developing the skills of the Community Mothers volunteers themselves and many move on to other employment opportunities. Community Mothers programmes have demonstrated positive socio-economic and health improvements for children, parents and volunteers, and have also been successful with traveller communities (Johnson and Molloy 1995 – **randomised controlled trial**; Fitzpatrick et al 1997; Johnson et al 1993). Other approaches include parenting groups for parents of children at local day nurseries.

Counselling in Primary Care

Psychological therapy (cognitive behavioural therapy and non-directive counselling) decreases psychological distress more than usual GP care in the short term, but after one year there is no difference in outcome (Ward et al 2000 – **randomised controlled trial**; Rowland et al 2001 – **systematic review**). There is no evidence that psychological therapies are more cost effective in the long term (Bower et al 2000).

On balance, cognitive behavioural therapy appears to be more effective than other psychological therapies for some specific problems, and in some cases, notably insomnia, more effective than medication. For example, over 50 RCTs and two meta analyses support the use of cognitive behavioural therapy for the treatment of persistent insomnia in primary care (Morin et al 1994 and 1999; Murtagh and Greenwood 1995).

Group Cognitive Behavioural Therapy to Reduce the Risk of Depression in Unemployed People

Group cognitive behavioural therapy is effective in improving mental health and employment outcomes in unemployed adults. Interventions with a strong focus on job search self-efficacy, social and emotional coping skills, building social support, finding pleasant activities and improving social networks are effective (Price et al 1992).

Improving the Physical Health of People Using Mental Health Services (see people with mental health problems)

Arts on Prescription (see communities and neighbourhoods)

Older People

The case for action

One in five people is aged over 60, life expectancy is increasing and the number of people over 80 will significantly increase over the next 20 years. Older people are not a homogenous group and older age is not inevitably linked with poor health, poverty and dependency. A great deal can be done to support mental well being and quality of life for older people, notably by working to change attitudes and raise expectations about health in old age.

Depression affects 3-5% of over 65s at any point in time, with milder forms of mood disorder being present in another 10-15%. Forty percent of people who have suffered a stroke become depressed and rates of depression are particularly high in long-term care settings (Scottish Executive 2000; Audit Commission 2000). Suicide is also more common among older people. About 25% of suicides occur in older people, although they form only 15% of the population. Ninety percent of such cases have serious depression, and most have visited their doctor in the three months prior to death.

People over 65 are also more likely to have a range of additional risk factors for mental health problems, including living alone, having poor health and/or difficulties with everyday activities, having no access to a car, needing (but not receiving) care and support. Older people on low incomes are more likely to experience anxiety and depression (Howarth et al 1999) and more older women than men are on state benefit.

Protective factors which are prevalent or more prevalent among older people include using leisure facilities, rating the neighbourhood highly, volunteering and voting in elections (Scottish Executive 2002 and 2002a).

Good mental health and well being are as important for older people as for any other age group and may also confer additional benefits, because of the links between positive mental health and good physical health, notably in relation to reduced risk of cardiovascular disease (Hippisley-Cox et al 1998; Bosma et al 1997). Emotional well being also protects against stroke, with sustained low mood and depression increasing the risk of stroke (Jonas and Mussolino 2000; Ostir et al 2001). Men and women who scored highest in a survey on emotional health were twice as likely to be alive by the study's end. The link between subjective feelings of happiness and good health held even after controlling for chronic disease, smoking, drinking habits, weight, sex and education (Goodwin et al 2000).

Evidence based priorities (see also primary care and communities)

Age discrimination is a significant problem within many of the health, social care and other services used by older people (Roberts et al 2002). Strategies for promoting the mental health and well being of older people will therefore also need to address age discrimination, notably in relation to low expectations for the mental health of older people among health and other professionals, and in many cases, among older people themselves. Improved detection and diagnosis of depression (for example using the Geriatric Depression Scale, a

simple 15-question checklist) could reduce much suffering and also prevent a proportion of suicides (Pearson and Brown 2000).

Good personal support networks, for example friendship or a confiding relationship, and opportunities for social and physical activities protect mental health and enable people at any age to recover from stressful life events like bereavement or financial problems (Cooper et al 1999). This can be particularly effective for older people whose social networks may have been reduced, through bereavement or relocation. Access to information and practical help can play an important role in reducing feelings of exclusion and isolation, which, as for other age groups, are crucial to mental health.

A summary of what works

Many programmes which are effective in promoting mental health with the general population should also be available to older people, notably exercise, social support and opportunities for arts and creativity. Emerging evidence suggests that a wide range of pre-retirement programmes, which prepare and support people in planning and managing ageing, are of value.

Reducing Alcohol Related Harm (see also primary care)

The elderly are the fastest growing segment of the population and this will increase the numbers of patients presenting with alcohol-related problems and their attendant health problems, including depression, anxiety and suicidal behaviour (Fink et al 1996). Brief interventions should be offered to older people.

Pre-retirement and Older People

A systematic review of 22 studies evaluating the effectiveness of health promotion interventions to alleviate social isolation and loneliness among older people found that group activities like discussion and self-help groups, bereavement support and counselling, were all found to be effective (Cattan 2002 – **systematic review**).

Walking and regular social activities are positively associated with successful ageing. Involvement in social activities provides significant protection against mortality, as well as good quality of life (Health Development Agency 2002b – **literature review**).

Early indications from a national pre-retirement programme (Health Development Agency 2000b www.hda-online.org.uk/html/improving/preretirement.html) suggest the importance of the following: targeting midlife age group i.e. 50-65 years; addressing inequalities by reaching long term unemployed, workers in small businesses and rural communities; engaging with local communities to build new approaches to ageing well; involving older people (programme evaluation – work in progress).

Volunteering

Providing opportunities for older people to do voluntary work increases mental well being in those who volunteer and also reduces depression in older people who receive services such as visits or peer counselling from an older volunteer (Wheeler et al 1998 – **meta analysis**).

Home Visits

Social support has been shown to be effective in countering depression. A systematic review by public health nurses with all groups in Canada showed that home visits reduced the levels of care required by elderly people (Ciliska et al 1996 – **systematic review**).

Home visiting programmes that offer health promotion and preventative care to older people living at home, including frail elderly people, were associated with a significant reduction in mortality and admission to institutional care (Elkan et al 2001 – **systematic review and meta- analysis**). This suggests that the role of health visitors in supporting elderly people should be strengthened.

Telephone Support

A telephone based support service provided through the social work service in the USA concluded that this sort of outreach strategy was moderately effective in targeting older adults with depressive symptoms, social isolation and unmet needs (Morrow-Howell et al 1998 – **randomised control trial**).

Community Support

The *Widow to Widow* programme provided one to one support to recently bereaved women and assisted them to access support and resources within the community, reducing symptoms of depression and increasing the development of new social relationships (Vachon et al 1980 – **controlled trial**).

Preventing Suicide

Late life suicide is seen primarily as a consequence of untreated mental disorder, particularly depression (Pearson 2000). Where suicide is strongly related to untreated depression, specialist services can play a positive role in identifying and preventing elderly suicide. An evaluation of one such initiative in the USA, the Centre for Elderly Suicide Prevention, concluded that community agencies with specialised programmes for older adults showed promise. After receiving agency services, hopelessness improved among clients but not in a comparison group. There were no significant changes in depressive symptoms or life satisfaction (Fisk and Arbore 2000 – **controlled trial**).

Twice weekly telephone support and needs assessment combined with a 24 hour emergency alarm service resulted in significantly fewer suicide deaths in a long term trial among elderly people in Northern Italy. The results were particularly positive for older women (de Leo et al 2002 – **controlled trial**).

People with Mental Health Problems

The case for action

People with mental health problems are among the most deprived and vulnerable groups, with poorer physical health than the general population and a significantly raised standardised mortality ratio (SMR), with greatly increased risk of mortality from cardiovascular disease and respiratory infection and a greater prevalence of diabetes and hepatitis C (Friedli and Dardis 2002; Phelan et al 2001; Harris and Barraclough 1998). The socio-economic consequences of having a diagnosis such as bad housing, lack of meaningful activity and limited financial resources significantly increase vulnerability to physical health problems. It is now widely recognised that social exclusion damages both mental and physical health and contributes significantly to health inequalities (Acheson 1998; Department of Health 2002a). On almost any indicator, for example employment, standard of living, housing and social support, people with mental health problems are among the most excluded groups (Sayce 1998; 2000; Bates 2002).

Evidence based priorities

People with mental health problems consistently identify stigma, discrimination and exclusion as major barriers to health, welfare and quality of life (Dunn 1999; Department of Health 2001b; Mental Health Foundation 2000). Exclusion from mainstream opportunities, notably employment, and lack of control, influence and participation in how mental health services are designed and delivered are a particular cause for concern (Bates 2002). A recent study of factors influencing empowerment among mental health service users in Canada found that choice, control, community integration and the acquisition of valued resources such as housing and employment had the most significant impact on feelings of recovery and mental well being (Nelson et al 2001).

Effective measures for reducing social exclusion include:

- ▶ opportunities for social contact and familiarisation (Sayce and Morris 1999; Angermeyer and Matschinger 1996) and for friendship and support (Mental Health Foundation 2000)
- ▶ supported employment in a real workplace (Crowther et al 2000; Perkins et al 2000) and reducing welfare benefits barriers to taking up employment
- ▶ the Recovery Model: broadening outcome measures to include the goals of users e.g. employment, independence, relationships and quality of life (Drake et al 2001; Bates 2002; Anthony 1993)
- ▶ proactive involvement of people with mental health problems in every aspect of the planning, delivery and review of services ('nothing about us without us') (Perkins 2002; Crawford 2001).

An emerging body of research seeks to identify treatments and therapies which those who use mental health services value, drawing on people's own expertise in living and coping with mental distress. The findings of two major surveys, *Knowing our Own Minds* (Faulkner 1997 and 2002) and *Strategies for Living* (Mental Health Foundation 2000) have contributed

centrally to the evidence base for a more holistic approach towards mental health, taking account of people's mental, physical, spiritual and emotional needs. The research seeks to identify treatments and therapies which those who use mental health services value, and demonstrates the importance of drawing on people's own expertise in living and coping with mental distress.

A summary of what works

People with mental health problems will benefit from the same range of mental health promotion opportunities as everyone else. Many of the following evidence-based interventions focus on addressing discrimination and reducing inequalities. Other interventions, for example strengthening opportunities for creativity and social support, have a protective effect on mental health and should be made available to people with existing mental health problems as well as benefitting the general population.

Physical Health care

People with mental health problems are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory diseases (Mortenson and Juel 1993). Smoking-related fatal disease is much commoner than in the general population, notably among people with schizophrenia (Addington et al 1998; McNeill 2002). Smoking is also associated with depression and contributes significantly to an increased risk of mortality in this group (Glassman et al 1993). Depression also increases the risk of stroke and emotional well being protects against stroke (Ostir et al 2001).

People with schizophrenia and bi-polar affective disorder have higher rates of physical illness, much of which goes undetected (Brown et al 1999 and 2000). Poor nutrition, poor housing, lack of meaningful activity and poor financial resources may all contribute to considerably raised risk of ill health and premature mortality from natural causes, including coronary heart disease, diabetes, infections and respiratory disease (Phelan et al 2001; Brown et al 2000; Harris and Barraclough 1998; Barr 2001). Obesity, smoking, lack of exercise and poor diet also contribute to very high rates of physical morbidity. A person with schizophrenia can expect to live for ten years less than someone without a mental health problem and around half of this excess mortality is caused by physical health problems (Brown et al 2000). Depression substantially increases mortality risk, especially by unnatural causes and cardiovascular disease (Wulsin et al 1999 – **systematic review**).

Some research suggests that people with mental health problems are much less likely to be offered health promotion interventions, despite much more frequent attendance in primary care (Burns and Cohen 1998). There is scope for considerable improvement in the detection and treatment of physical illness in this group. The provision of annual health checks and the same health promotion and prevention support as received by the general population could make a significant contribution to the reduction of health inequalities (Cohen and Hove 2001 – **expert opinion**; Friedli and Dardis 2002 – **qualitative research**).

Supported Employment

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

Community Business

First Step Trust is a national charity with eleven work projects in London, Sheffield, Scotland and Broadmoor High Security Hospital. The projects are run as community businesses providing a wide range of services to the general public, including gardening, removals, database design, printing and a high street restaurant. Workforce members take on as much responsibility as they are able and are involved at all levels of organising and delivering the work. Three hundred and fifty people work across all the projects and 35% of the salaried workforce are people with mental health problems or learning disabilities. Thus far over a hundred clients have moved on to salaried employment elsewhere (Outcomes data).

Contact: First Step Trust, 32-34 Hare Street, Woolwich, London SE18 6LZ

Volunteering

Stamford Volunteer Bureau works in partnership with the Community Mental Health Team to promote the benefits of volunteering for people with mental health problems. Community support workers offer advice, support and volunteering opportunities that as far as possible match people's motivation, skills and availability. Evaluation in January 2000 showed a significant increase in the numbers of people with severe mental illness taking up volunteering. Some people have taken on more than one job, and some of the tasks are complex with high levels of responsibility (qualitative research).

Contact: Stamford Volunteer Bureau, 2 St Mary's Hill, Stamford, Lincolnshire PE9 2DR
Email: organiser@stamfordvb.fsnet.co.uk

The *Work-Link Project* was established in 1986 to enable vulnerable groups and people with mental health problems or learning difficulties to take up meaningful volunteering opportunities. Although the jobs on offer are 'sheltered' they have a real purpose and include a range of administrative, IT and local vocational work. Since starting, the numbers of both full-time paid staff and volunteers has increased. Clients have moved on to employment, full-time education and training and open volunteering (Outcomes data).

Contact: Work-Link, Amity House, 6 Holliers Walk, Hinckley, Leicestershire LE10 1QW
Email: vols@w-l-p.freemove.co.uk

Promoting Access to Employment and Services

The *Mental Health Promotion Awareness Unit* at South London and Maudsley NHS Trust works specifically to address the problems that people have in accessing services and employment in the community as a result of their mental health problems. The Unit offers mental health awareness training to key local agencies, involving service users in its

delivery. The aim is to reduce the stigma linked to mental health problems. Proven outcomes include a more than doubling of students with serious mental health problems attending Lambeth College (Outcomes data/action research).

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Spirituality

Systematic reviews have consistently found that religious involvement is associated with positive mental health outcomes (Ellison & Levin 1998 – **critical review**). A growing number of studies also emphasise the importance of spiritual beliefs and the value of support from faith communities for people with mental health problems (Mental Health Foundation 2000 – **qualitative research**). A study of a Hindu healing temple in South India identified a significant improvement in the symptoms of people with psychotic illnesses, who received no psychopharmacological interventions during their stay. The authors suggest that part of the effect may have resulted from access to refuge in a supportive, non-threatening and reassuring environment (Raguram et al 2002). Other studies have found a resistance to spiritual issues within mental health services, where religious beliefs are sometimes interpreted as symptoms of illness (Friedli 2000a; Asian Health Development Project 1999; Clay 1999 – **unpublished dissertation**). Guidance on the role of faith communities in promoting mental health from Jewish and Christian perspectives was published by the former Health Education Authority in 1999 (Health Education Authority 1999a; Copsey 2001). A recent review suggests a need to tackle education, resources, environment (e.g. space and privacy) and personal obstacles (e.g. belief systems) in order to give greater precedence to spiritual care (Culliford 2002).

Exercise

There is robust evidence to support the mental health benefits of physical activity in four areas: as a treatment or therapy for existing mental health problems, to improve the quality of life for people with mental health problems, to prevent the onset of mental health problems and to improve the mental well being of the general public (Fox 2000 and 2000a – **literature review**). Exercise is an effective adjunct for some of the negative symptoms of schizophrenia, as well as for depression and anxiety. Exercise can also be a helpful coping strategy for symptoms like hallucinations (Faulkner and Biddle 1999 – **literature review**).

Creativity

A growing number of studies confirm that creative activity has positive mental health benefits. These may relate to the development of self-expression and self-esteem, to opportunities for social contact and participation (Huxley 1997 – **programme evaluation**), and/or to providing a sense of purpose, a sense of meaning and improved quality of life (Oliver et al 1996). These findings are significant because low self-esteem is a risk factor for depression, suicidal behaviour, eating disorders and being bullied (Emler 2002).

Evaluation of the *Stockport Arts on Prescription* scheme showed moderate impact on self-esteem and social functioning. However the increase in involvement in social activities,

particularly participative activities, was statistically significant, with some evidence that the use of general practitioners, social workers and other services was reduced (Huxley 1997 – **programme evaluation**; Health Education Authority 1998).

One study showed that psychiatric patients who participated in arts projects had fewer readmissions than those who did not (Colgan et al 1991 – **quantitative pre- and post-test**).

Other studies have shown the positive impact of writing, reading and music. Writing as a therapy has a significant impact on standard measures of disease severity over a four-month period (Smyth 1999 – **randomised trial**; Spiegel 1999). Other evidence suggests that for diseases that are mediated in part by the immune system, behavioural interventions that reduce emotional stress are valuable (Cohen 1997).

Bibliotherapy, where people join a guided reading scheme, has been used in West Yorkshire with people who are feeling low as a result of loneliness, bereavement or withdrawal from alcohol or drug addiction. Kirklees Council together with primary care staff organised the 'Reading and You Scheme' (Rays). Library staff had a strong belief, based on comments from the public, that reading could help people express their feelings about something or show them a different way to tackle a problem. Community psychiatric nurses and community workers refer people to the scheme and accompany people on their first visit. Group leaders come from backgrounds in teaching, community work or library work. The main aim of the scheme is to give readers a taste of normality through reading, away from the 'medical side of things.' The scheme has been adapted over time to broaden it from links only with GPs and now with other health professionals. Its success has led to a new scheme in Calderdale and the possibility of another over the border in Scotland (Action research) (Cunningham 2002; see also Cuijpers 1997 – **meta-analysis**).

Social Support (see also primary care)

Good personal support networks, for example friendship or a confiding relationship, protect mental health and enable people to recover from stressful life events like bereavement or financial problems. Effective interventions include the promotion of self-help, advocacy, neighbourhood and voluntary activities, and initiatives that facilitate user involvement in planning and decision making about service provision. Active participation in user groups has a wide range of benefits (Barnes & Shardlow 1997 – **qualitative case studies**; Stark 1998; Whelan 1993; Rosengren et al 1993 – **prospective study**).

Black & Minority Ethnic Groups

The case for action

Although there is a growing literature on improving the delivery of mental health services for black and minority ethnic communities (Bhui and Sashidharan 2003), there is much less information on the mental health promotion needs of different ethnic minority groups, who make up around 6% of the population, with people of Irish origin (the largest ethnic group)

making up around 11% (Modood et al 1997; Hickman and Walter 1997). In response to this, the National Institute for Mental Health for England has recently commissioned a toolkit to support mental health promotion with black and minority ethnic groups (www.nimhe.org.uk; www.mentality.org.uk). The toolkit will complement *Inside Outside*, a major report on black and minority ethnic mental health, which is currently being developed by the Department of Health (Department of Health, forthcoming).

Promoting mental health for different black and minority ethnic groups raises a number of complex issues. There are important differences in mental health across ethnic groups, notably apparently high rates of psychotic illnesses among African and Caribbean people and apparently low rates of mental illness among South Asian people (Sproston and Nazroo 2002). Over the past decade, a picture has emerged of inappropriate detention under the Mental Health Act, excessive use of medication, over diagnosis and failure to offer psychological therapies for some communities, together with the neglect of symptoms of mental distress for others (Bhui et al 2003).

Some studies have suggested cultural differences in the way in which psychological distress is presented, perceived and interpreted, and that different cultures may develop different responses for coping with psychological stressors (Bhugra and Cochrane 2001). However a recent major qualitative study found that idioms of distress bore great similarity across ethnic groups, although some specific symptoms were different. *"The fact that the broad narratives are remarkably similar across ethnic groups would suggest that, once contact has been established with appropriate medical services, there should be no reason for differentials in the diagnosis of mental health problems"* (O'Connor and Nazroo 2002 p.38). In addition, low rates of mental disorder among South Asians only apply to those who migrated to the UK in late childhood or adulthood. Second generation South Asian people do not have lower rates (O'Connor and Nazroo 2002). The importance of language and cultural factors will therefore vary considerably within the same ethnic group.

Ethnic differences are at least partly accounted for by socio-economic factors. The poor socio-economic position of many black and minority ethnic groups in this country is a major cause of poor health and also increases exposure to risk factors for poor mental health (Nazroo 1997; Lloyd 1998). People from black and minority ethnic groups are more likely to live in areas of high social deprivation and poor social cohesion and to report poor self-assessed general health and a severe lack of social support (Erens et al 2001). Although there are significant differences in the experiences of different minorities in education, housing, and the criminal justice system, some black and minority ethnic children are more likely to be looked after by local authorities, excluded from school, less likely to be in higher education and more likely to be unemployed on leaving university. Black and minority ethnic groups (including foreign nationals) make up 19% of the male prison population and 25% of female prisoners (Nazroo 1997; Nazroo 1998; Department of Health forthcoming; Alexander 1999). In qualitative research, the most commonly mentioned causes of mental distress were family difficulties, experience of racism, employment, financial problems and poor physical health (O'Connor and Nazroo 2002). The experience of racism, including racist bullying at school and at work, is central in both qualitative and quantitative analysis of

black and minority ethnic mental health (O'Connor and Nazroo 2002; Karlsen and Nazroo 2002; Chakraborty and McKenzie 2002).

The range of inequalities experienced by black and minority ethnic groups has contributed centrally to poorer mental health outcomes and poorer experience of mental health services at all levels (Department of Health forthcoming). As local mental health promotion strategies are rolled out over the coming year, the key question will be *'thinking about our local population, who's been left out?'* Recognising diverse religious, linguistic and cultural needs, consulting with and taking account of the views and priorities of minority groups and building partnerships with marginalised communities all depend on asking, and answering, this question. Mental health promotion in schools and nurseries, in prisons, in housing, in the workplace, in primary care and in the plethora of programmes to support parents, looked after children, young men, single mothers or people who are homeless, can contribute centrally to ensuring that services (in the very broadest sense) are responding to the needs of all cultural groups, both black and white. Mental health is a cross cutting theme that impacts on the achievement of a number of targets for reducing health inequalities. The failure to address the importance of psycho-social factors may have contributed to the limited success of a range of past public health initiatives, for example those concerned with neighbourhood renewal, regeneration and health at work. Psycho-social factors may have particular significance for black and minority ethnic groups because of the impact of racism and discrimination on individual and collective self-esteem and people's access to and experience of services.

Evidence based priorities (see also communities)

Tackling racism is likely to be the most effective route to improving the mental health of black and minority ethnic groups. Cumulative exposure to racism and racial discrimination is a key risk factor for mental health problems, notably for depression and is particularly damaging for people who are already vulnerable, for example mental health service users (Jackson et al 1996). Social exclusion and poor experience with statutory services, including mental health services, also influence both the prevalence and outcome of mental health problems among black and minority ethnic groups.

While differences in socio-economic position make a major contribution to the relationship between ethnicity and health, recent research suggests that racial harassment and perceptions of racial discrimination have a considerable health impact. Nazroo and Karlsen (2001) found that over and above socio-economic effects, both experience of racial harassment and perceptions of racial discrimination contribute independently to health (Chakraborty and McKenzie 2002; McKenzie and Chakraborty 2003). In their qualitative study of ethnic differences in the experience of psychiatric illness, O'Connor and Nazroo found that:

"There was a recurrent mention of how 'tiring' it was to cope with racism. Dealing with racism was said to require an enormous amount of energy, both in handling the situation itself and in coping with its 'internal' or personal consequences, in sustaining and encouraging themselves to move on and get over it"

(O'Connor and Nazroo 2002, p.23)

It is important to recognise that whole communities (including faith communities, ethnic communities and communities of identity) can feel marginalised, fearful, insecure, excluded, unable to influence decisions and/or unable to participate fully. These feelings impact on mental and physical health and may have a disproportionate effect on black and minority ethnic groups (**see also Communities and Neighbourhoods**).

Finally, there is a need to have programmes and support in place that will reduce the number of people, notably from African and Caribbean communities, who reach crisis point before accessing help and/or access mental health services via the criminal justice system. The findings of the consultation exercise with black and minority ethnic communities in the North East of England conducted by the Mental Health Act Commission as part of their long-term strategic Equal Opportunities Programme suggested strong support for a much broader and more holistic focus:

“Early intervention and mental health promotion were widely identified as being immediate priorities to address the situation. Alternative models of understanding and the provision of alternative therapies were also promoted by voluntary organisations as being conducive to improved mental health”

(Mental Health Act Commission 2001)

Other themes that emerged from the consultation that are relevant to the development of local mental health promotion strategies include:

- the stigma attached to mental illness in communities
- the need to recognise the religious, linguistic and cultural needs of black and minority ethnic communities
- the need to consult with and act upon the views, perceptions and priorities of black and minority ethnic communities
- the non-therapeutic environment of local services
- the need for greater partnerships with the black voluntary sector.

Following the Race Relations (Amendment) Act (2000), all public authorities have an explicit duty to actively promote race equality, including a Race Equality Scheme that sets out how they plan to address cultural diversity and ethnic equality within services. These duties provide a clear framework for ensuring that mental health promotion strategies engage with and respond to the needs of black and minority ethnic communities (Commission for Racial Equality 2002).

A summary of what works

The evidence base on effectiveness is very limited for black and minority ethnic groups and there is an urgent need for long term investment in mental health promotion research in this area. An example of work to develop indicators and an evaluative framework which reflects the perspectives of staff, users, and the wider community is included in Appendix Two.

Everyone has mental health needs and mental health promotion is delivered in a wide range of settings. It is crucial, as local mental health promotion strategies are developed and delivered, that the mental health promotion needs of black and minority ethnic groups are addressed and that steps are taken to ensure equitable access. With any initiatives, for example to support parents and young families, in schools, in the workplace, in prisons, with looked after children, with carers, with older people and as part of neighbourhood renewal, the needs of black and minority ethnic groups must be addressed and appropriate partnerships developed. In addition, as in the example of the Community Mothers programme described below, there is a need to replicate initiatives to ensure that they are effective with different ethnic groups – as has been done in this case with travelling communities.

Schizophrenia and Minority Ethnic Communities

A study in Camberwell, South London, based on contact with psychiatric services over a ten year period, found that the incidence of schizophrenia in non-white ethnic minorities increased significantly as the proportion of such minorities in the local population fell (Boydell et al 2001; Sharpley et al 2001). These findings add weight to the view that social factors provide an important explanation for the increased rate of schizophrenia among British born ethnic minorities. These could include reduced protection against stress and life events due to isolation and fewer social networks. As the authors suggest, people from ethnic minorities may be more likely to be singled out or to be more vulnerable when they are in a small or dispersed minority.

Mental Health Services

Although mental health services have received more attention than mental health promotion, ongoing concerns about appropriate, accessible and culturally sensitive services are relevant to mental health promotion because of the impact of poor services on the mental health of those who use them, their carers and the wider community (O'Connor and Nazroo 2002; Bhui et al 2003).

Both services and supporting mental health promotion initiatives need to be planned and implemented in partnership with local communities and involve service users and carers. Mental health promotion can contribute centrally to re-thinking and redeveloping acceptable and culturally sensitive services and to increasing awareness of the mental health impact of *how services are developed and delivered*.

Mental health workers need knowledge and skills to work effectively with diverse communities. Mental health service users from minority ethnic communities commonly report that mental health assessments take place from a perspective that does not respect or engage with cultural difference. Few traditional treatments are available on the NHS, even those that are widely accepted such as acupuncture, herbal remedies or relaxation techniques. GPs may be unaware of those culturally appropriate services that do exist and so fail to refer people.

A lack of recognition of language and culture can make many 'mainstream' services, including advocacy or counselling services, inappropriate. When language is a barrier, access to an interpreter is necessary. A longer-term strategy is to recruit staff from local communities to build cultural competence at all levels within the organisation.

Holistic Services

Needs assessment with black and minority ethnic communities has frequently demonstrated a strong demand for services which offer a holistic approach, promote greater community involvement in decision making and recognise the impact of racism on people's experiences of everyday life (Alexander 1999).

For African and Caribbean young men priorities include building partnerships involving arts, creativity, spirituality and alternative therapies, and integrating these with education, training and employment opportunities, to form the basis of a holistic approach (**mentality 2002, unpublished – review; participant feedback**).

Alcohol and Substance Misuse

Indian born men have more than twice the prevalence rates of alcohol related disorders than white men and alcohol related admissions accounted for 25% of all psychiatric admissions in this group in 1981 (Cochrane and Bal 1989 – **point prevalence**). There is good evidence for the effectiveness of brief interventions in reducing alcohol consumption, both in primary care and in A&E and a need to ensure that these interventions are accessible to Indian born men and tested for effectiveness with this population.

Irish people are also over represented in psychiatric admissions for alcohol disorders. Particular populations of Irish people may have alcohol problems linked to mental health problems, as well as wider isolation, poverty, employment histories, homelessness and marginalisation (Department of Health forthcoming; Harrison et al 1993; Harrison et al 1997).

Substance misuse is a significant risk factor for mental health problems. Strategies to tackle this should take account of the fact that choice and pattern of substance use is heavily influenced by religious, cultural and historical factors (Wanigaratne et al 2001).

Self-harm and Suicide

Deliberate self-harm is more common among Asian born women, although a recent major study of self-harming behaviour among school age young people did not find higher rates for Asian girls (Hawton et al 2002). Rates of attempted and completed suicide are much higher, notably in younger Asian born women. Among Asian women, attempted suicide is less likely to be related to untreated mental health problems (Glover 1989; Bhugra et al 1999 and 1999a; Soni-Raleigh and Balarajan 1992). There is an urgent need for evidence of effective approaches to the prevention and reduction of self harm among young Asian women.

Suicide rates among Irish born people of both sexes are also higher than for the majority population (Leavey 1999; Neeleman et al 1997). Again, there is little data on prevention programmes.

Promoting the Mental Health of Mothers and Children

Thurrock Community Mothers programme is an example of a project, now replicated nationally, which uses the expertise of trained volunteers with experience of mothering, to support local parents. There is equal emphasis on developing the skills of the Community Mother volunteers themselves and many move on to other employment opportunities. Community Mother programmes have demonstrated positive socio-economic and health improvements for children, parents and volunteers, and have also been successful with traveller communities (Johnson and Molloy 1995; Fitzpatrick et al 1997; Johnson et al 1993 – **randomised controlled trials**). Other approaches include parenting groups for parents of children at local day nurseries.

Primary Care

Strengthening the delivery of mental health promotion in primary care is particularly important because of the poor recognition of psychological distress in all ethnic minorities in primary care. Black and minority ethnic patients are also under-represented within counselling and psychotherapeutic interventions.

Supported Employment

The *Awaaz Asian Advocacy and Employment Project* started in 1997 with funding from the National Lottery. It has a special focus on disadvantaged and vulnerable people, or those with mental health problems, from the South Asian community. Its services include employment advice and support, one-to-one employment counselling, a job club, access to computers and training and a bank of job placements. A full evaluation is currently in process, but during 1999-2000 twenty six supported employment clients moved on to training or work. Outcomes also include the difference that clients say Awaaz has made to the quality of their lives (Outcome data).

Contact: Awaaz Group, Room 25, Woodville Resource Centre, Shirley Road, Manchester M8 7NE

Support Networks/ Self help – see primary care

Refugees and Asylum Seekers

Reducing isolation and dependence, locating suitable accommodation and promoting opportunities for work and education should underpin mental health promotion strategies for refugees and asylum seekers. Building partnerships to address hostility and racism is also crucial. In a study of Iraqi asylum seekers, depression was more closely linked with poor social support than with a history of torture (Gorst-Unsworth and Goldenberg 1998 – **mixed methods**). Burnett and Peel (2001 and 2001a – **overview**), in a review of the issues, identify support for people within their own communities and opportunities for developing links and friendships with the host community as crucial to promoting health and well being. Schools are often the first port of call for refugees and asylum seekers, making it particularly important for parents and carers from these groups to be included e.g. via support groups for parents.

Spirituality – see **People with Mental Health Problems**

Creativity – see **Communities and Neighbourhoods**

A qualitative study of the views and experiences of young African and Caribbean men in East London found very strong support for the mental health benefits of opportunities for arts and creativity (Friedli et al 2002).

Workplace

The case for action

Many factors in the workplace influence the mental health of individual employees, of particular sections or departments and of the whole organisation. A positive working environment and appropriate support at work has a significant impact on stress related sickness absence and long term outcomes for employees experiencing mental distress (Sainsbury Centre for Mental Health 2000; Stansfeld et al 2000). Overall, working has a positive effect on people's mental health. In addition to financial benefits, work is an important source of support, providing social and information networks, a sense of purpose and personal identity. Addressing mental health in the workplace has a wide range of benefits and can help to strengthen the positive, protective factors of employment and to reduce risk factors.

Mental health promotion is relevant to many aspects of employment including health and safety, equal opportunities, bullying and harassment, work/life balance, terms and conditions of employment, performance management and pay. In addition, changes in employment legislation such as the Disability Discrimination Act mean that employers need to assess their practice in relation to people with mental health problems (Department of Health 2002b).

Many of the factors that influence both the physical and mental health of staff are psycho-social and relate to style of management and working culture. For example, lack of job control is associated with alcohol dependence, poor mental health, poor health function and increased sickness absence (Stansfeld et al 2000; Cheng et al 2000; Niedhammer 1998). In both men and women, high job demands and low social support at work have been found to be predictive of depression (Pattani et al 2001). Although individuals can take steps to promote their own mental well being, mental health issues need to be addressed systemically, at an organisational rather than an individual level (Cooper and Cartwright 1996; Health and Safety Executive 2001; Stansfeld et al 2000).

Evidence based priorities

All the evidence suggests that an effective policy to improve health at work must tackle work organisation and management practice (Williams et al 1998). Organisational changes associated with a positive impact on the mental health and overall health of employees include:

- ▶ redressing effort/reward imbalance
- ▶ improving two way communications and staff involvement
- ▶ enhancing social support, especially from managers to subordinates
- ▶ increasing job control and decision making latitude
- ▶ assessing job demands
- ▶ developing a culture in which staff are valued
- ▶ enhancing team working.

(Williams et al 1998 – **systematic review**; Stansfeld et al 2000 – **longitudinal study**; Stansfeld 2002)

An effective mental health policy should include:

Promotion

Promoting the mental health and well being of all staff:

- ▶ recognising that all staff have mental health needs
- ▶ raising awareness of what people can do to look after their own and others' mental well being
- ▶ identifying and addressing the factors that affect mental health in the workplace.

Support

Offering assistance, advice and support to people who are experiencing mental health problems in the workplace, as well as support for staff returning to work following a mental health problem:

- ▶ building a working culture in which mental health issues are not taboo
- ▶ support options which are confidential and non-stigmatising.

Employment

Adopting a positive approach to employing staff who have a history of mental health problems (Perkins et al 2001):

- ▶ reviewing employment practice to ensure that people with mental health problems are not excluded, explicitly or implicitly.

(**mentality** et al 2002)

A summary of what works

Organisation-wide approaches are most effective and should include support for staff, enhanced job control, increased staff involvement, workload assessment, effort/reward balance, role clarity and policies to tackle bullying and harassment (Williams et al 1998; Stansfeld et al 2000). Adopting a positive approach to the employment of people with mental health problems also has many benefits (Department of Health 2002b).

Social Support

Enhancing social support within the workplace for people working in a stressful environment helps reduce mental health problems among employees (Heaney et al 1995 – trial).

Clarity and consistency of information and emotional support have a significant impact on employee health and well being (Stansfeld et al 2000 – **longitudinal study**). Social support at work is a protective factor against the negative impact of excessive job demands, notably from managers to their staff (Health Education Authority 1999b – **quantitative and qualitative study**; Holloway et al 2000, Health and Safety Executive 2001).

De-briefing following Workplace Trauma

There is a lack of evidence that debriefing following trauma in workplace settings is effective and some evidence which suggests that it is harmful (Rick et al 1998 – **literature review**; Yamey 2000). It may be more effective to enhance social support more broadly.

Reducing Stress

Counselling can achieve a reduction in work related stress. It helps people who are stressed to cope better but does not prevent or identify the structural sources of workplace stress (British Association of Counselling and Psychotherapy 2001). Consulting and listening to staff can make them feel more secure and valued, notably at times of organisational change which are associated with an increase in mental health problems and prevalence of smoking (Ferrie et al 1998 – **secondary data analysis from longitudinal cohort**).

A study over 25 years showed that job strain (high job demands combined with low job control) and effort reward imbalance are associated with a doubling of risk of cardiovascular disease (Kivimaki et al 2002).

Depression in Unemployed People (see also primary care)

Group cognitive behavioural therapy is effective in improving mental health and employment outcomes in unemployed adults. Interventions with a strong focus on job search self-efficacy, social and emotional coping skills, building social support, finding pleasant activities and improving social networks are effective (Price et al 1992 – **controlled trial**).

Bullying and Harassment

An effective response requires explicit policies and procedures for dealing with bullying, support from line management, an understood grievance procedure and a workplace

culture that challenges bullying behaviour. Bullying is linked to low job satisfaction, work related stress, depression and anxiety (Quine 1999 – **survey data**). Kivimaki et al (2000) found a link between bullying and increases in sickness absence.

Effort/Reward Imbalance

Effort/reward imbalance is associated with an increased risk of alcohol dependence (especially in men), psychiatric disorders, sickness absence and poor overall health (Stansfeld et al 2000 – **longitudinal study**). It may not be possible to reduce the effort required, but increasing rewards may include psychological, training, promotion and other options. As one aspect of effort/reward imbalance is the low social status attached to certain jobs, media campaigns to improve public attitudes may contribute to reducing effort/reward imbalance. Involving staff in addressing issues around effort/reward imbalance can help to identify what kinds of benefits or recognition they would value, if additional financial reward is not an option (**mentality** et al 2002).

Exercise (see primary care)

Active employees take 27% fewer days off for sick leave and on-site fitness programmes are associated with lower staff turnover (Physical Activity Task Force 2002 – **programme evaluation**). There are also mental health benefits. The National Consensus Statements on physical activity and mental health show that exercise prevents clinical depression and is as effective a treatment as psychotherapeutic interventions (Grant 2000 – **consensus statement**; Mutrie 2000 – **meta-analytical review**). Exercise also reduces anxiety, enhances mood and improves self-esteem (Fox 2000 – **literature review**; Fox 2000a – **literature review**; Biddle 2000 – **literature review**).

Communities and Neighbourhoods

The case for action

Mental health is not simply a characteristic of individuals. Whole schools, organisations, neighbourhoods and communities (including faith communities, ethnic communities and communities of identity, for example lesbians and gay men) can feel marginalised, fearful, insecure, excluded, unable to influence decisions and unable to participate fully. These feelings impact on mental and physical health e.g. job insecurity increases morbidity (Ferrie et al 1998; Marmot et al 2001), perceptions of racial discrimination are a significant factor in the poor health of black and minority ethnic communities, over and above socio-economic factors (Nazroo and Karlsen 2001) and lack of trust in unfamiliar others is a risk factor for psychological problems (Berry and Rickwood 2000).

Research on social capital and inequality suggests that indicators of community cohesion and efficacy – levels of trust, reciprocity and participation – may be an important influence on health status. Structural elements of social capital include roles, rules, behaviours, networks and institutions, while cognitive elements describe the values, attitudes and beliefs that produce cooperation for mutual benefit (McKenzie et al 2002). A range of studies suggest that participation in local community networks in particular has a positive

impact on health, and that the erosion of social capital may be one of the pathways through which income inequality impacts on health (Campbell et al 1999; Health Development Agency 2002a). McKenzie et al have suggested that there may be a synergy between social capital, social drift and environmental effects that has an impact on mental health. As they suggest, '*the puzzle is to unravel the interaction and mediating process*' (McKenzie et al 2002).

Other factors which influence how people feel e.g. low job control, job insecurity, poor social networks, living in a poor neighbourhood and perceptions of relative deprivation also increase the risk of coronary heart disease and influence recovery rates for myocardial infarction. MacLeod et al (2001) found that while individual income is predictive of recovery from myocardial infarction, living in a poor neighbourhood results in a significant additional health deficit and an individual's assessment of their standard of living in comparison to others is significantly associated with physical recovery.

The importance which should be attached to psycho-social factors, in relation to material factors, in understanding the health impact of deprivation, is hotly contested (Lynch et al 2000; Baum 2000). However, social capital is a relatively new field. Strong emerging evidence suggests that initiatives which aim to tackle inequalities and regenerate deprived communities do need to take collective psychological well being into account. In particular, there is a robust case for addressing social fragmentation and obstacles that stand in the way of community participation by excluded groups (Campbell and McLean 2002). For example, both suicide and mental illness are associated with deprivation (Office for National Statistics 1997) but suicide is more strongly associated with social fragmentation, characterised by neighbourhoods with high levels of private renting, single person households, unmarried persons and mobility (Davey Smith et al 2001).

It is now widely recognised that social exclusion damages mental and physical health and contributes significantly to health inequalities. Research in the field of 'stress biology' demonstrates how experiences associated with exclusion – the chronic stress of racism, injustice, fear of crime, lack of control and perceived powerlessness – impact on the immune system and the cardiovascular system, affecting blood pressure, cholesterol levels, susceptibility to infection and growth in childhood (Brunner and Marmot 1999). How people feel is written on the body and expressed through a wide range of physical health problems. Of course, on almost any indicator, people with mental health problems are among the most excluded groups (Dunn 1999). Social exclusion is therefore a major public health issue, both for excluded populations in general and for those who are excluded as a consequence of their diagnosis. It is becoming increasingly clear that the erosion of mental, emotional and spiritual well being is one of the key pathways through which social exclusion damages health (Friedli and Gale 2002).

Given that lack of control and lack of influence are independent risk factors for stress (Rainford et al 2000), how people feel about services (in the broadest sense) may be as significant as clinical indicators of effectiveness. There is both an ethical and a public health case for enabling people to influence the decisions which affect their lives.

Characteristics of communities which promote mental health and well being include:

- ▶ equitable access to resources and services
- ▶ support for parents and carers
- ▶ activities that bring members of the community together
- ▶ effective sharing of local information
- ▶ tolerance and trust
- ▶ friendly physical environment
- ▶ dealing effectively with crime and anti-social behaviour
- ▶ robust local democracy and opportunities to participate.

(Adapted from Department of Health 2001a)

Evidence based priorities

The UK is carrying out a range of research into effective approaches to building social capital, strengthening community networks and increasing participation. The demonstration of positive health outcomes is at an early stage. Promising findings are emerging from a range of initiatives within the *Nottingham Social Action Research Project* and from a range of programmes concerned with reducing the exclusion associated with a mental illness diagnosis (Nottingham SARP 2002; Bates 2002; Perkins et al 2000).

A range of interventions which improve the mental health of individuals, can also contribute to building one or more of the characteristics of communities that promote mental health and well being, for example arts and creativity, exercise, play schemes and volunteering. In some cases, the psycho-social value of activities may only become clear when they fall into decline. For example, the reduction in the number of children who experience family meals is now known to be detrimental to the social and emotional development of young people.

Available evidence supports the following interventions:

- ▶ supporting and empowering service users to access mainstream services (Bates 2002)
- ▶ changing organisational culture through user led input (Perkins et al 2000)
- ▶ building strategies that combine development of alternative services, challenges to mainstream service provision and address wider structural barriers to mental health (Friedli and Gale 2002)
- ▶ addressing fear of crime e.g. through neighbourhood wardens (Nottingham SARP)
- ▶ increased investment in arts, creativity and exercise e.g. 'walk your way to health' (see below and also 'primary care')
- ▶ open access 'stress workshops' (Brown and Cochrane 1999; Brown et al 2000)
- ▶ increasing access to green open spaces in urban environments (Dalgard and Tambs 1997).

A summary of what works

Some studies have shown that urban regeneration, including re-building neighbourhood social capital, promoting social networking and addressing crime, access to open spaces and the quality of the built environment can have a beneficial impact on mental health (Chu and Thorne 2002). However it is probably too soon to assess the impact of the wide range of initiatives which have been developed, notably over the past five years, or to draw firm conclusions about effectiveness. In addition, while data on material factors associated with health is widely available at a local ward level, psycho-social measures of community life are much more difficult to quantify, making the evaluation of mental health promotion particularly challenging and complex. In the following section, an extended summary of the evidence on arts and creativity is used as a case study to demonstrate some of the ways in which the effectiveness of community based mental health promotion interventions might be assessed.

See also **Primary Care: Green Gyms and Primary Care: Community Mothers.**

Arts and Creativity

There is growing evidence to show the mental health benefits of arts and creativity, which could be applied to a range of other community-based interventions. This includes:

- ▶ the impact of participation in the arts on self-esteem, self-worth and identity
- ▶ the role of creativity in reducing symptoms such as anxiety, depression and feelings of hopelessness
- ▶ arts and creativity as a resource for promoting social inclusion and strengthening communities.

Arts on Prescription is a model based on a partnership between primary care and community arts programmes, aiming to use arts and creativity to complement other forms of treatment and to:

- ▶ enhance compassion and intuition in doctors and other health professionals
- ▶ contribute to reducing social exclusion
- ▶ reduce dependence on anti-depressants
- ▶ empower patients
- ▶ strengthen the confidence and self-reliance of individuals and communities.

(Windsor Conference, www.nuffieldtrust.org.uk)

The positive outcomes resulting from individuals taking part in creative activity are summarised in **People with Mental Health Problems.**

Further research shows that benefits of arts and creativity extend beyond their impact on individuals currently experiencing mental distress and may be an effective mechanism for

community development and improving quality of life. Arts projects that involve the whole community, including service users, artists, mental health professionals and those who have had no contact with mental health services, have the potential to act as powerful solvents of the stigma surrounding a mental illness diagnosis, by increasing social contact and familiarisation between those who do, and those who do not, currently have mental health problems (Sayce and Morris 1999; Angermeyer and Matschinger 1996).

The value of art and creative expression as a resource for the whole community was a strong theme to emerge in the work of Matarasso (1997) and recent qualitative research with excluded communities in Tower Hamlets (**mentality** 2002; Friedli et al 2002). The strength of cultural life within a community may also be a significant quality of life indicator, notably in relation to social capital (Cooper et al 1999).

The results of reviews of arts and creativity by both the Health Education Authority (1999c) and Matarasso (1997) demonstrated improvements in well being as indicated by:

- ▶ enhanced motivation
- ▶ greater connectedness to others
- ▶ more positive outlook
- ▶ reduced sense of fear, isolation or anxiety.

These benefits were brought about by the opportunities that engagement in art afforded for self-expression, an enhanced sense of value and attainment, and pride in achievement (Health Education Authority 1999c; Matarasso 1997). In a review of 60 community based arts projects, Matarasso found that participation in these projects brought a wide range of social benefits, including increased confidence, community empowerment, self-determination, improved local image and identity and greater social cohesion (Matarasso 1997 – **literature review** and **project evaluation**).

In the *Hartcliffe Boys* programme, arts projects demonstrated educational benefits by developing transferable skills and arts skills, as well as fostering emotional literacy whereby people use art to express needs, frustrations or feelings that would otherwise remain unarticulated (Health Education Authority 1999c). Arts and creativity also help both children and adults to develop and learn (Department for Education and Employment 1999).

In a study of ten arts projects in Wales, Dwelly found that a focus on cultural well being, people's ability for self expression and engagement of their creative instincts has made a major impact in revitalising run down neighbourhoods (Dwelly 2001 – **review**).

Other benefits of arts and creativity include developing self-confidence and helping people into work, the exploration and affirmation of identity – of place, disability, faith, ethnicity – and as a mechanism which enables people to articulate their views and needs. Landry and Matarasso identify the special characteristics of the arts as:

- ▶ engaging people's creativity
- ▶ addressing meanings and enabling dialogue
- ▶ encouraging questioning and imagining
- ▶ offering opportunities for self expression – an essential characteristic of the active citizen.

(Landry and Matarasso 1996)

Access to Green Open Spaces

Access to green, open spaces has important benefits for mental and physical health (Lewis and Booth 1994 – **survey**; Dalgaard and Tambs 1997 – **longitudinal study**). Availability of such space is particularly important in urban areas where the built environment may influence the incidence of depression. A cross-sectional survey of almost 2000 adults living in North London found that those living in properties of newer construction, with limited access to the outside, had statistically significant increases in depression (Weich et al 2002). A greater recognition of the impact of the environment on health – notably mental health and quality of life – should prompt interventions to reduce inequality in access to green spaces and the development of accessible local green areas, for example community gardens.

Reducing Fear of Crime

Within the *Nottingham Social Action Research Programme*, a project in the Clifton Neighbourhood Ward shifted the focus from a crime/ antisocial behaviour enforcement role to community development and building social capital as a way of reducing the fear of crime. Training, support and the development of neighbourhood wardens have led to an increase in feelings of trust and safety, confidence amongst residents, and the building of networks and a framework for reciprocity. These are early findings, but they do indicate that a focus on enforcement responsibilities, in the absence of programmes to build social capital, may undermine broader community development goals (Nottingham SARP 2002 – **social action research**).

Play in the Parks

Play in the Parks is another initiative within the Nottingham SARP which uses play programmes for children in a deprived area to build social capital. Key features include the employment of local people as play workers, building networks between parents and different groups of young people (as opposed to running one off sessions), involving young people in planning activities, building reciprocity into the project and celebrating cultural diversity (Nottingham SARP 2002 – **social action research**).

Stress Workshops for the General Public

Large scale self-referral stress workshops are effective in reaching people whose problems are not picked up in primary care. A randomised controlled trial showed that participants were less anxious, less distressed and more able to cope than those in control and placebo groups. Based on cognitive behavioural therapy, the workshops may be as effective as individual psychological therapy and are considerably more cost effective (Brown and Cochrane 1999 – **randomised controlled trial**; Brown et al 2000 – **controlled evaluation**).

Conclusion

Building the evidence base and moving forward

Over the next few years, as local mental health promotion strategies are implemented, there should be new opportunities to evaluate mental health promotion initiatives and to contribute to the emerging evidence base. There is clearly still a need to evaluate specific interventions, and particularly to test programmes with different target groups and in different contexts. However, it will also be important to build on current work to develop mental health indicators, which can assist in assessing mental health promotion impact in the context of neighbourhood renewal, community strategies and the wide range of initiatives concerned with tackling inequalities. In addition, programmes to build capacity for mental health promotion locally, for example training and development, need to be evaluated in terms of their impact on mental health promotion activity and their success in moving mental health promotion up the agenda locally and regionally.

The Regional Development Centres of the National Institute for Mental Health for England (NIMHE) will have an important role to play in supporting capacity building for the delivery of local strategies and in strengthening the move towards evidence based mental health promotion (www.nimhe.org.uk). Other agencies with a key role to play include the Health Development Agency (www.hda-online.org.uk), which manages a major programme on evidence based working for better health and the Public Health Observatories (www.pho.org.uk). Finally, there are many things that individuals working to promote mental health from all sectors and backgrounds can do to contribute to the development of the evidence base. These include:

- using the good practice framework in Making It Happen (www.nelh.nhs.uk/mentality) to record mental health promotion projects and relate them to the evidence base
- publishing work in progress: journals with an interest in mental health promotion include Journal of Mental Health Promotion, Mental Health Review and Mental Health Today, all published by Pavilion (www.pavpub.com) and the International Journal of Mental Health Promotion (www.charity.demon.co.uk)
- using message boards to keep in touch with colleagues www.mentality.org.uk; www.virtuall.org.uk and www.nimhe.org.uk
- organising seminars to discuss evaluation at an early stage – invite in external expertise and try to involve colleagues from a range of different sectors
- colleagues in London might like to get involved with LoMHR&D, which works to influence the research agenda in mental health www.virtualinstitute.co.uk

The growing success of mental health promotion over the past decade and its increasingly visible contribution to public health has depended largely on the dedication of individual champions. The task now is to use a favourable policy environment to secure a lasting commitment to mental health promotion at all levels. The development and dissemination of evidence based mental health promotion practice will be a key element in achieving this.

Appendix One

Glossary of research terms

Action Research: the basic principle of action research models is that the researcher is a participant within the project being studied and all the stakeholders are aware of the process. It is the opposite of 'blinding' subjects and involves group learning over time. It has been most powerful in addressing 'how to questions' rather than questions like 'better or worse, 'more or less'.

Related category: social action research

Bias: any factor that distorts the nature of an event or observation. In research, a bias is any systematic factor other than the intervention that affects the difference in the outcomes of a treatment group and a control group. Randomization is used to decrease this form of bias. Bias also refers to a viewpoint that would affect someone's interpretation of a problem. Double blinding is a technique used to decrease this type of bias e.g. where neither the patient nor the doctor know whether a pill is a placebo.

Related category: randomized controlled trial

Case Study: in depth analysis and systematic description of one or several groups of people in similar settings to promote a detailed understanding of their circumstances.

Related category: qualitative case study

Cochrane Review: systematic review undertaken by the Cochrane Collaboration, an international partnership in which people from many different countries systematically find, appraise and review available evidence from RCTs (randomised controlled trials). The Collaboration aims to develop and maintain systematic, up-to-date reviews of RCTs of all forms of health/social care and to make this information readily available to clinicians and other decision-makers at all levels of health care systems.

Cohort Study: involves two similar groups (cohorts), one which is exposed and one which is not, to a risk factor or intervention. These cohorts are followed up over time and the incidence of the outcome in one group is compared with the incidence in the other. In a matched cohort study, the cohort groups have characteristics (e.g. age, gender, social class, disease severity) that are as similar as possible. A cohort study is an observational study, and it can be prospective or retrospective.

Related categories: longitudinal cohort, longitudinal study, prospective study

Controlled Evaluation: evaluation of a controlled trial

Controlled Trial: an assessment of an intervention which has not included randomising participants.

Related category: randomised controlled trial

Critical Appraisal: assessing and interpreting evidence, by systematically considering its validity, results, and relevance.

Critical Review: a review of a theme or topic area which has been informed by a critical appraisal or assessment of the literature and research on that topic.

Cross-sectional Study: this is essentially taking a snapshot of a group of people at one point in time and may determine the point prevalence of diseases, behaviours, etc, in that population. Cross sectional surveys, for example, can show whether depression or smoking are increasing for given age groups or ethnic communities.

Related category: longitudinal

Effectiveness: the extent to which an intervention does people more good than harm. An effective treatment or intervention is effective in real life circumstances, not just an ideal situation.

Efficacy: the extent to which an intervention improves the outcome for people under ideal circumstances. Testing efficacy means finding out whether something is capable of causing an effect at all.

Expert Consensus: usually takes the form of a consensus conference, a forum where experts in a particular field meet over a period of several days to debate the topic under review and then publish their proceedings.

Expert Review: acknowledged experts in a particular field provide an overview of a discrete topic or intervention and give their authoritative view.

Literature Review: a review of the literature on a particular topic or theme. Reviews may include unpublished or 'grey literature', qualitative reviews by single authors, as well as various systematic and quantitative procedures such as meta-analysis.

Longitudinal Study: longitudinal or 'panel' studies ask the same questions of the same group or sample of people over time. They can therefore analyse causal factors and the process of change e.g. the British Household Panel Survey, which has interviewed the same 5000 households annually since 1991.

Meta-analysis: a quantitative overview which summarises the results of several studies into a single estimate and gives more weight to the results from studies with larger samples.

Mixed Methods: combination of quantitative methods such as surveys or randomised controlled trials with qualitative methods such as one-to-one interviews or focus groups.

Observational Study: a study in which the investigators do not randomize participants to treatment and control groups, but only observe those who are (and sometimes those who are not) exposed to the intervention, and interpret the outcomes. Observational studies are often used to interpret research with pre-school children.

Outcomes Data: describe the impact of an intervention on health outcomes and may include economic evaluation.

Overview: a systematic review and summary of the literature.

Point Prevalence: one snap shot moment of time, as opposed to incidence, which refers to the rate of new occurrences over a specified period of time e.g. lifetime incidence. Epidemiologists use the metaphor of a bathtub, with incidence describing the rate of flow of water into the tub and prevalence the volume of water currently collected in the tub.

Programme Evaluation: review of a specific programme or intervention which might include both quantitative and qualitative measures.

Prospective Study: a study in which the investigators design the study in advance. People are then recruited and studied according to the study's criteria. A randomised controlled trial, for example, is always prospective, while a case-control study is commonly retrospective ('after the event'). In a prospective study, investigators do not know what the outcomes will be when they undertake the study (Contrast with retrospective study).

Qualitative Research: a systematic, subjective approach used to describe life's experiences and give them meaning... conducted to describe and promote understanding of those experiences.

Quantitative Pre and Post Test: a numeric measure before and after an intervention which aims to show an effect, for example, a training intervention's effect on participants' self-assessed knowledge.

Quantitative Synthesis: summary of the results of one or several quantitative research methods.

Randomised Controlled Trial: a trial of a treatment or intervention in which participants are randomly (i.e. by chance) assigned to two groups, one of which receives the intervention being tested (the experimental group) and one which receives no treatment, "usual" or "standard" treatment or a placebo (the control or comparison group). Both groups are followed up to see what effect, if any, the intervention has produced. Quasi-experimental or randomised trials are when allocation is not by chance, for example, using date of birth.

Randomised Trial: a trial of a treatment or intervention which does not include a control or comparison element.

Retrospective Study: a study in which investigators select groups of patients that have already been treated and analyze data 'after the event'. They are considered less reliable than prospective studies (Contrast with prospective study).

Review: any summary of the literature.

Related category: Overview

Secondary Data Analysis: secondary data has not been produced by the research project or intervention, but is collected and analysed to provide background information and context for a research project, for example, human resource policies as a source of information on recruitment and retention policies.

Survey Data: methodology which may be purely quantitative providing frequency data, or may include some open-ended questions providing some qualitative data.

Systematic Review: a review in which evidence on a topic has been systematically identified, appraised and summarised according to predetermined criteria.

Related category: systematic overview

Trial: a trial of a treatment or intervention which does not include either a control / comparison element or any randomisation of participants.

User Feedback: qualitative methodology which utilises participant experience of a service or intervention as a valid measure of impact.

Related category: participant feedback

Definitions adapted from:

CASP (Critical Appraisal Skills Programme) www.phru.org.uk/casp

McKie et al (2002) *The Evaluation Journey: An Evaluation Resource Pack for Community Groups* Edinburgh: ASH Scotland.

The Cochrane Collaboration www.cochrane.org/cochrane/cngloss.htm

Centre for Evidence Based Medicine www.cebm.net

We are also indebted to Dr Woody Caan.

Appendix Two

Developing indicators: an example from the Mellow Campaign in East London

The Mellow Campaign was launched in October 2000 and is a mental health network that aims to stimulate and develop creative and sustainable solutions to reduce the over representation of young African and Caribbean men in psychiatric services. The project is a partnership between the East London and City Mental Health Trust and an independent steering group of African and Caribbean service users, carers, mental health practitioners, youth and community development agencies, a pharmacist, a GP and faith organisations.

The Mellow Campaign is a pioneering project which is addressing a complex range of factors which influence the mental health of young African and Caribbean men and their experience of mental health services. Since its inception the Mellow Campaign has developed a range of approaches and services that aim to:

- ▶ raise awareness of the extent and root causes of mental ill health amongst young African and Caribbean men
- ▶ find ways of reaching and engaging the target group so that they can obtain help earlier
- ▶ develop alternative therapeutic models/approaches that will enhance mental well being.

“The big challenge is to create an environment where service users believe it is possible to change, to achieve their ambitions and aspirations, and to have a healthier lifestyle. And that it is possible, even with a mental health label, to break through the barriers and live a wholesome life.”

(Mellowzone: A Journey to Health, Mellow Review 2000 – 2002)

Mellow's evaluation framework is designed to capture a wide range of outcomes, reflecting the range of services it offers, as well as broader objectives concerned with influencing mainstream services. The following indicators were developed in partnerships with Mellow staff, local stakeholders and service users.

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Objective 1: Empowering Service Users

To facilitate the development of self-help and user led initiatives

Indicator: Service users gain the resources and support to identify their own needs and concerns

Indicator: Existing user-led initiatives receive support from Mellow

Indicator: Mellow programmes result in the establishment of user-led groups/ initiatives

Indicator: User involvement is central to Mellow's work

Indicator: Mellow creates opportunities for users to meet and network

Indicator: Users are less dependent on in-patient and community services

To identify employment and training opportunities for the target group

Indicator: Training and employment opportunities have been provided and users have taken steps into employment, work placement, vocational training and education

Indicator: Mellow activities provide opportunities to develop new skills

Indicator: Mellow users go on to work with Mellow in paid or voluntary roles

To increase opportunities for young African and Caribbean men who use services to achieve their potential and hold on to, or regain, a life that has meaning for them

Indicator: Mellow demonstrates that the contribution of users is fully valued

Indicator: Mellow provides opportunities and support for users to articulate their own views and perspectives

Indicator: Mellow creates opportunities for service users to have their voices heard

Indicator: Mellow facilitates development opportunities for users outside the mental health system

Indicator: Mellow promotes peer support

Indicator: Involvement in Mellow activities and events increases the self esteem and confidence of service users

Indicator: Mellow provides opportunities for users to try new activities, to succeed and to set and achieve goals

Indicator: Mellow involves the wider African and Caribbean community and creates opportunities for employment and achievement

To promote and develop a range of support services for young African and Caribbean men across the Health, Social Care, Youth and Education Sectors

Indicator: Mellow consults users and responds to their needs

Indicator: The number of African and Caribbean men on section who use the advocacy service in hospital

Indicator: Mellow provides information on mental health and mental health services, as well as other sources of support

Indicator: Mellow enables users to access services

Objective 2: Improving Mental Health Services

To facilitate the empowerment of the target group to participate in the design, planning and delivery of mental health services

Indicator: Mellow facilitates the involvement of users

Indicator: Mellow consults users and uses the findings to influence future provision of services

Indicator: Mellow helps people access primary care at a stage when their needs are less severe

Indicator: Users are on Mellow project planning groups and make a consistent contribution

Indicator: Needs assessment carried out by Mellow is starting to have an impact on services

To increase awareness of the concerns of the target group amongst mental health practitioners and other professionals

Indicator: Service providers are aware of Mellow and consult with them, and demonstrate a greater awareness of the needs of young black men

Indicator: Number of voluntary and statutory organisations working with Mellow

To provide training and information for professionals to improve service delivery to target group

Indicator: Information and training has been provided to professionals

Objective 3: Influencing the Policy Agenda

To influence service delivery and policy development at a local and national level

Indicator: Mellow is a member of different groups and committees

Indicator: Service level agreements and other contracts reflect the needs of young black men

Indicator: Local policy reflects issues raised by Mellow

Indicator: Mellow meets with policy makers to raise issues around mental health and African and Caribbean men

Indicator: Mellow is asked to contribute to decision making and to advise on service delivery

Indicator: Mellow has influenced the voluntary sector

Indicator: National organisations/ policy makers consult with Mellow

Indicator: Service reviews and research commissioned to enhance understanding and promote best practice

Objective 4: Involving the Wider Community

To increase awareness of mental health issues and their importance among the wider African and Caribbean community

Indicator: The range of different venues and localities used for Mellow events

Indicator: Activity continues in the community after Mellow events

Indicator: Events take place in evenings and weekends as well as during the day, and include music, entertainment and something for everyone, and are not billed as mental health

Indicator: Range of people attending and engaged at events

Indicator: Large numbers attend Mellow events

Indicator: Partnerships and the range of different stakeholders that Mellow works with

Indicator: Events influence and involve young people who have never considered mental health issues

Indicator: Mellow events receive coverage in local and national media

Indicator: Effective use of singers, artistes, film makers and other professionals in the media around mental health issues

Indicator: Range of events without a mental health focus where publicity is distributed

Indicator: Local schools know about and involve Mellow

Indicator: Links with other African and Caribbean organisations across the board

Indicator: Local employers and training providers know about Mellow and have a positive attitude to them

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Making It Effective is the first in a series from **mentality** called **radical mentalities**.

Making It Effective aims to strengthen understanding of what works in mental health promotion, support mental health promotion practice, provide a summary of effective mental health promotion interventions and also looks critically at current debates about evidence of effectiveness and provides a guide to developing mental health indicators. It brings together findings from studies using different methodologies and working with many different measures of success and gives examples of a very wide range of effective interventions for different settings and target groups.

Making It Effective will be essential for anyone who has ever had to deal with those 'that's all very well but does it work' moments when trying to secure resources for mental health promotion.