

CHOOSING MENTAL HEALTH

A policy agenda for mental health and public health

Foreword

This short report provides an overview of *Choosing Health*, the Government's recent public health White Paper, from a public mental health perspective. It aims to identify both the gaps and opportunities in the White Paper and to provide a framework for addressing these. Whilst the White Paper provides a major opportunity, we have a long way to go to establish a proper understanding of the role of mental health in public health. In the words of WHO Europe '*there is no health without mental health*'.

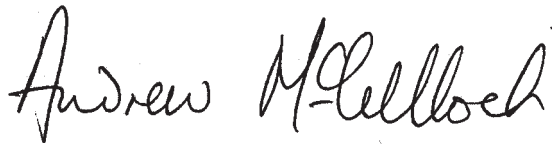
Public mental health is an emerging field and has been identified as one of Mental Health Foundation's priority areas. It has been described as the art, science and politics of creating a mentally healthy society. A fuller account of the Mental Health Foundation's views on what public mental health means forms Appendix 1 to this report. It includes the protection and enhancement of mental health and well-being and the prevention of mental health problems, as well as improving opportunities for recovery and quality of life for people with existing mental health problems. Like public health, it is therefore concerned with the beliefs, attitudes and behaviours of individuals as well as broader socio-economic and environmental determinants including family life, community cohesion, education, crime, housing, employment, income and access to resources. It must be underpinned by a pro-active approach to the human rights of people with mental health problems so that they can be enabled to live healthy lives as equal citizens and well as action to improve the mental health of the whole population.

While the Mental Health Foundation welcomes the White Paper, we also have to recognise some flaws in its treatment of mental health. The document provides little explanation of the fundamental role of mental health or its importance in relation to inequalities in health or risk behaviour. It fails to develop a life span perspective and there is a damaging lack of attention to older people. Age discrimination is a factor both in attitudes towards and service provision for the mental health needs of older people. The Foundation is trying to counter this through its joint inquiry with Age Concern on the mental health of older people chaired by June Crown. And finally there is an over-reliance on the individual choice agenda, which is not supported by the evidence base that indicates that multi-faceted approaches will be most effective.

One of the challenges for public mental health is to move from general observations about the importance of mental health and well-being to specific recommendations for action, supported by the research literature on evidence of effectiveness. It is notable that *Choosing Health* includes very few specific actions on mental health, in comparison with proposed action on smoking, obesity and diet, for example. This report, therefore, provides a series of recommendations and also identifies a range of opportunities to influence the future direction and status of public mental health. Recommendations and suggestions for further exploration are outlined in **bold** throughout the text.

Choosing Health is one of a number of policy documents that have significant implications for future developments in mental health. For this reason, the report also looks at *Choosing Health* in the context of a wider range of current health policy, both within the UK and Europe, and the opportunities these present to strengthen the position of public mental health across a range of disciplines and sectors. A more detailed scoping study on public mental health will be published by the Mental Health Foundation later in 2005.

We hope that you find this report useful. Finally, I would like to acknowledge Dr Lynne Friedli as first author of this report and pay tribute to her contribution to the public mental health agenda. I would also like to acknowledge the contributions of Foundation policy and research staff to the report.

A handwritten signature in black ink that reads "Andrew McCulloch". The signature is written in a cursive, flowing style.

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1.0 Introduction

Choosing Health is the first public health white paper since *Saving Lives: Our Healthier Nation*, published in 1999. It follows an extensive and wide ranging consultation exercise, including specific consultation on physical activity and diet, as well as an independent survey on public attitudes to health carried out on behalf of the King's Fund. *Choosing Health* sets out the agenda for public health over the next three to five years and will have a significant influence on investment and delivery priorities, notably for Primary Care Trusts, but also for a wider range of stakeholders in local government, the voluntary sector, and in some parts of the private sector, for example the food, drinks and leisure industries.

Choosing Health is strongly influenced by the *Wanless Reports*, commissioned by the Treasury, and is part of a growing acknowledgement of both the economic and public health case for a greater focus on promotion and prevention. (Wanless 2002; 2004) Wanless emphasises that health promotion policy must address 'individual behaviour and lifestyle risk factors, as well as wider determinants of health, such as poverty and education'. The report states that population health cannot be assessed solely in terms of morbidity and mortality data, but also requires measures of positive physical and mental health. 'A health service, not a sickness service' has become an increasingly significant catch phrase for the direction of NHS policy. The extent to which this is translated into action, targets and performance measures will become more apparent with the publication of the *Choosing Health Delivery Plan*, scheduled for the end of March 2005.

Wanless has calculated that the cost benefit of better mental health care would be a net saving across government as a whole of some £3.1 billion a year. (Wanless 2002) *This does not take into account the savings from promoting mental health and preventing problems in the first place.* The Sainsbury Centre for Mental Health has calculated that the total cost of mental ill health to the English economy is £77bn (SCMH 2003). So the total potential for savings is obviously much greater than Wanless's estimate, but as yet we lack the health economic data to predict the total savings that a public mental health strategy could yield (see for example, Mental Health Foundation, 2005).

Like its predecessors, *Our Healthier Nation* (Department of Health 1999) and *The Health of the Nation* (Department of Health 1992), *Choosing Health* also identifies mental health as a priority issue and exemplifies an important trend in health policy within the UK and Europe over the past decade: ***an increasing shift from a predominant focus on mental illness to a recognition of the importance of mental health and well-being to overall health.***

2.0 Overview of Responses to *Choosing Health*

Overall, responses to *Choosing Health* have been fairly positive, although some of this positive response could be considered tactical and pragmatic. There has also been considerable critical comment about the absence of a commitment to a complete ban on smoking in public places, concern over the relatively weak consideration of mental health issues and concern about the an over emphasis on lifestyle, rather than the wider determinants of health. The latter may well turn out to be its most important flaw in the long run.

An example of a pragmatic response is that given by Professor Rod Griffiths, President of the Faculty of Public Health, who argues that professionals should acknowledge the white paper as ‘a good start’ and build on it:

‘What we do not need is whinging by public health people that their “bit” didn’t get enough of a mention,’ he said. ‘We now have to say “thanks for the money” and get on with it. And if we do that, we stand a good chance of getting more.’ (McKenzie 2004)

Within mental health and the mental health voluntary sector, *Choosing Health* has also been widely welcomed. The Mental Health Foundation provides qualified support given that *Choosing Health* does not adequately address the fundamental importance of mental well being to overall health, despite evidence of some deterioration in the mental health of the public. The Foundation argued for a strategy which:

- > intervenes to prevent mental illness and encourages mental health and wellbeing through the provision of information and advice. The proven mental health benefits of a healthy diet, regular exercise and moderate alcohol consumption should be actively promoted
- > actively discourages people from putting their mental health at risk. Lack of exercise, over-consumption of alcohol and work-related stress must be tackled, and steps need to be taken to warn people of the mental health dangers associated with recreational drugs
- > protects children and young people’s mental health through universal parenting support and ensures that services and support for people with mental health problems should be improved to maximize their quality of life and well-being.

Rethink strongly criticised the white paper for failing to address the high prevalence of smoking and obesity among people with mental health problems:

“The government says it is committed to addressing smoking and obesity levels. Around 70 per cent of people treated on a mental health ward smoke, and weight gain is a common effect of psychiatric medicines. Yet there is no commitment in this white paper to ending this scandal.”
(Rethink press release www.rethink.org)

A number of organisations (including the Mental Health Foundation, mentality and the Sainsbury Centre for Mental Health) stressed the importance of mental health promotion/public mental health to achieving public health goals:

“It is vital for our nation’s health that efforts to promote good mental health become a real priority for public health professionals, and that more resources are put into mental health promotion. To date, mental health promotion has been starved of resources and existed on a shoestring.” (SCMH press release www.scmh.org.uk)

“Today’s White Paper is a step in the right direction for mental health but is not the comprehensive strategy for mental wellbeing we hoped to see.” (SCMH press release)

Both the Royal College of Psychiatrists (RCPsych) and SCMH challenged *Choosing Health’s* focus on individual lifestyle choices, arguing that lifestyle has little or no impact on risk of mental illness.

“Nobody chooses to have a mental health problem. Mental illness cannot be prevented by promoting healthy lifestyles. Promoting mental wellbeing is about tackling the things that put people at risk of mental ill health and taking action to offer fair chances in life to those with mental health problems.” (SCMH press release)

“While it can be argued that an individual’s risk of heart disease is, in part, a culmination of lifestyle and dietary choices, it is difficult to make the same argument for depression, schizophrenia, agoraphobia and most other mental health problems. The emphasis of the white paper is that individuals are responsible for their own health. The balance between individual and societal responsibility for people with mental health problems may be significantly different to that for preventable physical problems.” (RCPsych press release www.rcpsych.ac.uk)

To address this problem, the College recommends the development of a complementary but separate strategy for mental health.

The extent to which lifestyle or behavioural factors influence risk for mental health problems is in fact a matter of considerable debate, notably in relation to depression, anxiety, schizophrenia and anorexia, and this is addressed in more detail in section 5.0. Whilst the Mental Health Foundation is concerned about over-emphasising the choice agenda, there is abundant evidence that lifestyle choice can affect mental health outcomes and also that mental health affects lifestyle choices. As such the Foundation would challenge the extreme position taken by the Sainsbury Centre and the Royal College. The evidence base does not support the view that any major forms of mental illness are caused solely by genetic and environmental factors that are outside the individual, family or community’s control. The evidence from mental health service users and the positive outcomes associated with both the ‘recovery model’ and strategies to promote social inclusion suggest not only that people can and do exercise choice and autonomy in addressing their mental health, but also that addressing

environmental factors is critical in improving people's mental health. (Department of Health 2001; Social Exclusion Unit 2004; Mental Health Foundation 2000; Faulkner 2002)

Overall, there are also concerns about the lack to attention to older people in *Choosing Health*, both in relation to issues around lifestyle and health behaviours and to the specific impact of broader determinants like transport, housing and poverty. The influence of negative attitudes and low expectations, including among service providers, is well documented and has a significant impact on the mental health and well-being of older people, as well as responses to mental health problems among this population. (Seymour and Gale 2004)

There is also no attention paid to the needs of young people with learning disabilities who are particularly at risk of developing mental health problems. They have the same range of problems as other people but a more likely to develop anxiety or depression or to be diagnosed with schizophrenia. They need support to promote their emotional well-being and to access appropriate services if they are needed. (The Foundation for People with Learning Disabilities 2002)

3.0 **Choosing Health and the National Service Framework for Mental Health**

3.1 **Standard One: Promoting Mental Health and Tackling Stigma and Discrimination**

The specific commitment in *Choosing Health* to the delivery of standard one of the National Service Framework for Mental Health in England (Department of Health 1999) is welcome:

“we will ensure that standard one of the NSF for Mental Health, which deals with mental health promotion, is fully implemented.”

Standard one requires the NHS, in partnership with other public agencies e.g. local authorities, as well as with the voluntary and community sector, to promote the mental health of their local population, including at risk and vulnerable groups and to tackle the stigma, discrimination and exclusion experienced by people with mental health problems.

To achieve this, Primary Care Trusts (PCTs) are required to develop a local mental health promotion strategy. For a green rating in the self assessment framework, local strategies should satisfy the following criteria, with demonstrable progress on these issues:

- > assessment of local needs to identify key settings and target groups
- > a clear rationale for selected interventions which are based on the evidence or which, through their implementation, can add to the evidence base
- > action to reduce discrimination against people with mental health problems
- > evidence of links to mainstream community development initiatives to promote social inclusion, such as neighbourhood renewal, education action zones etc.

To date, 91% of Local Implementation Teams (LITs), established to drive local progress on the NSF, report that they have implemented a mental health promotion strategy, with 41% reporting good local systems for measuring its impact.

Nationally, however, it is widely considered that tackling discrimination and social exclusion have received a stronger focus than promoting mental health for all, notably with the publication of *Mental Health and Social Exclusion* by the Office of the Deputy Prime Minister and more recently, *From here to equality*, the National Institute for Mental Health's (NIMHE) strategy for tackling stigma and discrimination on mental health grounds. (Social Exclusion Unit 2004; NIMHE 2004) Reasons for this include the pressing need to address barriers to inclusion for people with mental health problems, lack of awareness of the relevance of mental health promotion to improved health and quality of life outcomes for people with mental health problems (Department of Health 2001) and the fact that most stakeholders involved in the delivery of the NSF work within or use mental health services. Louis Appleby, National Director for Mental Health, is on record as saying that social exclusion has been prioritised 'to compensate for lack of progress on standard one'. (Mental Health Today, February 2005) Nevertheless, this has been a cause of concern among some local and regional standard one leads and it is anticipated that the forthcoming National Framework for Mental Health Promotion, commissioned by NIMHE, will address this gap.

In his report *The National Service Framework for Mental Health: Five Years On*, Appleby says:

“We need to broaden our focus from specialist mental health services to the mental health needs of the community as a whole.” (Department of Health 2004)

Welcoming this commitment, the King’s Fund said:

“Given that the national director is talking about broadening the focus from specialist services to the mental health needs of the community, wouldn’t it be even better if we had £30 million more for mental health promotion and supporting people with mental health needs find decent homes and jobs?” (Mental Health Today, February 2005)

The report also calls for an increase in financial investment by local services in mental health promotion. Spending of £2.75 million was reported in 2003/04, unchanged from the previous year, but around half the sum reported in 2001/02. Although these figures may underestimate true spending, because they do not include national initiatives and because of ambiguities in how mental health promotion spending is defined, expenditure on mental health promotion in England appears to be lower than in Scotland, as well as in countries like New Zealand and Australia. (Gale et al 2004) This is a very small investment relative to the huge amounts of money spent in mental health services on interventions with no evidence base such as acute inpatient care, unfocused counselling and unfocused day care. (NICE 2004, Sainsbury Centre for Mental Health, 1998, Mental Health Foundation, 2004a)

Finally, the report states that prevalence of common mental health problems among adults has remained unchanged between 1993 and 2000, at 16%. This figure does not take account of robust evidence for a sharp rise in mental health problems among children and young people (Collishaw et al 2004) or levels of depression among older people. (Godfrey and Denby 2004) It also obscures the extent of inequalities in risk for mental health problems across the spectrum of disorders. (Melzer et al 2004; Rogers and Pilgrim 2003) Overall, the NSF report does not provide an account of what has been achieved to date in terms of promoting mental health for all and does not outline clear priorities for future action. It is also characterised by some conceptual confusion about the definition, scope and purpose of mental health promotion.

The *Choosing Health* commitment to full implementation of standard one therefore provides three significant opportunities:

- > to achieve a more **coherent approach** to the delivery of mental health promotion at local level in England
- > to **involve a much wider range of sectors and agencies** in taking responsibility for planning, delivering and evaluating mental health promotion strategies than can be achieved as long as mental health promotion is seen solely as a ‘mental health NSF’ issue, with over-reliance on NHS input
- > to highlight the extent of **inequalities in prevalence** of mental health problems and to demonstrate the relationship between inequalities in mental health status and inequalities in overall health.

Recommendations:

Choosing Health and Standard One of the National Service Framework

- ◆ Given that inequalities in mental health closely match inequalities in physical health, there should be investment in further analysis and research into these links; in particular, the psychosocial pathways through which material deprivation impacts on physical health (such as cardiovascular health and the immune systems), the mental health impact of poverty and deprivation on children, and the psychological consequences of social and economic inequalities on community cohesion/social capital. The best way of developing public mental health research would be for the Department of Health to coordinate a national public mental health research strategy.
- ◆ Existing evidence on effective interventions to promote population mental health should be more effectively disseminated. This could be undertaken by NICE after incorporation of the Health Development Agency.
- ◆ The effective implementation of local mental health promotion strategies should be supported by adequate and dedicated resources and staffing, including training. National standards for staff training and education in mental health promotion would go some way to ensuring quality and effectiveness.
- ◆ Appropriate evaluation methodologies and related performance management criteria should be agreed and disseminated to enable assessment of the effective delivery of local mental health promotion strategies.
- ◆ The proposed ‘*tool to assess local health and well-being*’ should include measures for the assessment of positive mental health, e.g. the Affectometer.¹ Scotland is currently developing a set of national public mental health indicators: a formal link should therefore be created between NIMHE/Department of Health and Scottish Executive/Health Scotland on this initiative.
- ◆ The new requirement for health impact assessments to be a component of all future legislation has considerable potential. At a local level, mental health should be included in all health impact assessments. To achieve this, a set of guidelines on assessing mental health impact should be developed perhaps by way of a mental health impact audit tool. An existing model which might be piloted and adapted has been produced by Lambeth PCT. (Lambeth PCT 2004)

The Foundation’s scoping study on public mental health (to be published during 2005) will support progress on the above.

1 The UK validation of Affectometer 2, which will assess its suitability for use in the UK, is currently being carried out by a team at Warwick Medical School and is due to report in early 2005. This validation is being carried out using data collected by the HEBS 2001 Health Education Population Survey (HEPS).

3.2 Other NSF Standards – Support, Treatment and Care for People with Mental Health Problems (16-65)

The other standards of the NSF primarily concern support, treatment and care provided to people with mental health problems aged 16-65. The five-year review of the implementation of the NSF (2005) demonstrates much greater progress on achieving these standards, but with some significant challenges ahead, such as:

- > challenging stigma, reducing discrimination and increasing the social inclusion of people with mental health problems
- > enabling people who use mental health services to have more choice and control over their treatment and care, in a manner which aids empowerment and recovery and protects their human rights. This lack of choice and control is even greater for children, older people, people from ethnic minorities and people with a learning disability
- > continuing to improve the quality and effectiveness of treatment and care.

Some positive progress is being made in all of these areas, with increased commitment by government to tackle social exclusion and stigma. However, it is likely that progress on tackling stigma and social inclusion of people with mental health problems is more likely to be effective if interventions form part of a population based strategy to promote mental well-being. (Gale et al 2004)

The Foundation believes that much more progress needs to be made in two key aspects of treatment and care for people with mental health problems, as this can have major benefits in terms of their quality of life and recovery:

- > promotion of the physical health of people with mental health problems
- > increased therapeutic options for people with mental health problems, including, self-management, peer support and training and non-pharmaceutical interventions
- > recognition of the benefits of a social model of mental health, with a greater emphasis on social inclusion and the wider determinants of quality of life for people with mental health problems.

Increased Therapeutic Options

The five-year review of the NSF says: “*It has proved difficult to put together a convincing case for the effectiveness of self-management on which local developments might be based.*” To some extent this is the result of a Catch 22, as the Department of Health has not prioritised research on either self management or the wider field of non-medical interventions for the prevention and treatment of mental health problems. There is, however, a growing evidence base on the effectiveness of a number of non-medical interventions to help people with mental health problems, for example exercise on prescription, prescription for learning, volunteering, time banks and arts on prescription. (Friedli and Watson 2004; Scottish Development Centre for Mental Health 2005). Further research on these approaches to both treatment and prevention is in line with NICE guidelines on the management of depression and anxiety:

“a focus on symptoms alone is not sufficient because a wide range of biological, psychological and social factors have a significant impact on response to treatment and are not captured by the current diagnostic systems” (NICE 2003, 2004)

In particular, the NICE guidelines recommend that further trials should be undertaken of the efficacy of a range of social support interventions for socially isolated and vulnerable groups of people with depression.

The Foundation's Strategies for Living User-led research programme (1996-2004) (Mental Health Foundation 2000, Mental Health Foundation 2003) demonstrated how much a range of therapeutic options were valued by people with mental health problems and the Foundation is currently supporting a range of initiatives which will further explore the benefits of such therapies, including its Arts Therapies, Creativity and Mental Health Initiative, work on the value of self help, a review of the benefits of complementary and alternative therapies and plans to undertake a wider scoping study on the evidence for a wide range of non-pharmaceutical interventions.

Improved Physical Health for People with Mental Health Problems

The poor physical health of people with mental health problems is well documented (mentality 2004, Jenkins,R., McCulloch,A., Friedli,L. and Parker,C. 2002). The causes are diverse and interactive. They include:

- > High prevalence of risk behaviours including substance misuse, smoking, and behaviour which increases risks of accidents and infections.
- > High levels of other risk factors for ill health including poverty, unemployment, poor housing, poor diet and low income.
- > Poorer access to physical health care and health promotion, together with evidence that people with mental health problems are less likely to be offered health promotion advice and support.
- > Low expectations on the part of health and other professionals.
- > Lower levels of motivation.
- > Low self esteem and morale.
- > Discrimination.

Improving the physical health of people with mental health problems requires a significant investment in a multi-factorial approach. **In addition to improving housing, employment opportunities (through the implementation of supported employment), ensuring action on the recommendations of the Social Exclusion Unit report, and greater recognition of the role of social networks and meaningful relationships in strengthening health, the following are required:**

- ◆ **Targeted health promotion activity, some of it led by service users themselves.**
- ◆ **Anti-discrimination activity to enable access, for example, to meaningful daytime activity, sports and exercise facilities, employment and adequate levels of income and housing.**
- ◆ **Motivational and other forms of counselling which support behaviour change.**
- ◆ **Ensuring the availability of health care by improving access to primary care. In some cases mental health services may need to employ physical health care specialists and a few already do.**
- ◆ **In addition to recognising poor physical health, clear targets for primary and secondary care are needed, including for screening, smoking cessation and immunisation.**

The Foundation specifically recommends the following:

- ◆ **Improved education and training of staff involved in mental health care services to enable them to further improve the quality of life, social inclusion, human rights and recovery of people with mental health problems. (*The Foundation is already supporting such progress among non-professionally affiliated staff through its Certificate in Community Mental Health Care.*)**
- ◆ **A major investment in the promotion of the physical health of people with mental health problems as set out above.**
- ◆ **A robust assessment of the benefits, including cost-benefits compared to usual care, of non-pharmaceutical therapies for people with mental health problems, including social prescribing and other non-pharmacological interventions in primary care (except CBT which already has an ample evidence base).**

4.0 European Declaration and Action Plan on Mental Health

The WHO European ministerial conference on mental health, in Helsinki, brought together all 52 countries in the European region of the WHO. Organised in partnership with the European Union and the Council of Europe, the conference's declaration and action plan will drive the policy agenda on mental health for the coming years. (WHO 2005)

The action plan sets out the details of commitments and responsibilities of both the WHO and national governments. It has 12 priority areas, with a strong public mental health focus, including:

- > promotion of mental wellbeing
- > incorporation of mental health as a vital part of public health policy
- > reduction of stigma and discrimination
- > prevention of mental ill health and suicide
- > access to good primary health care.

It stresses the need for “mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems.” Of special note is the emphasis on increasing awareness of the importance of mental well-being, the inclusion of promotion and prevention (alongside the need to improve treatment and services) and the recognition of the need for a competent workforce in all these areas.

Recommendations: Mental Health Action Plan and Declaration for Europe

- ◆ **Identify any specific additional actions that are required to support the UK's commitment and responsibilities to the Declaration and Action Plan, as well as clearly identifying how key policy initiatives in *Choosing Health, the NSF* etc., contribute.**

5.0 **Mental Health Foundation analysis of Choosing Health**

The rest of this paper provides comments on selected recommendations presented within *Choosing Health*. (The section headings refer to chapter titles within the white paper, for ease of reference.)

5.1 **Time for Action on Health and Health Inequalities and Health in a Consumer Society**

“the key to national health improvement is more people making healthier choices more of the time”

The White Paper aims to make the healthy choices the easy choices, while recognising a need to develop an environment where people who are disadvantaged have the same opportunities to choose health. It recognises the constraints on choice for people who do not feel in control of their environment or their personal circumstances:

‘people are more likely to take more control over their own health if they have more control over their lives’

The main thrust of *Choosing Health* – that health is inextricably linked to the way in which people live their lives – raises important issues for public mental health. Informed choice is crucial, but a wide range of psychological, social, economic and environmental factors influence and limit people’s choices. People’s mental well-being (that is their ability to function well both cognitively and emotionally) influences their capacity, capability and motivation to choose healthy behaviours. Likewise, people’s opportunities to achieve good health are fundamentally affected by their social and economic circumstances. For example, it is well established that people’s diet is influenced not just by choice but also by income and availability of healthy foods and levels of physical activity by people’s free time, access to amenities and safety concerns. There is also a marked socio economic gradient in the extent to which people believe that health is within the control of the individual, with higher proportions of those in socio economic groups D and E feeling that health is beyond their control and that tackling poverty is the best way of preventing illness. (King’s Fund 2004) It is also worth noting that even where people feel free to choose, choice is not necessarily benign; Schwartz for example, has linked the daily blizzard of choices with increased stress. (Schwartz 2004) Finally, we should also note the strong link between poverty and mental health problems in young people with learning disabilities. 57% of young people with learning disabilities who experience mental health problems live in poverty as opposed to 30% of young people in the general population. (Emerson 2003)

The determinants of both positive mental well-being and mental health problems are complex and include a mix of biological, psychological, social and environmental factors. However, the relative contribution of key risk factors such as material deprivation, genetic inheritance, family relationships

and adverse life events is difficult to determine. It has also proved difficult to identify the precise causal pathways through which different factors, for example, poverty, family conflict, experience of bullying, misuse of substances or violence impact on mental health outcomes. Identifying which protective or resilience factors, at which level (individual, family, community, structural) are of greatest importance in minimising the impact of risk factors is equally challenging.²

Nevertheless, there is growing and increasingly robust evidence for an association between a range of lifestyle behaviours and mental health status and outcomes. These include physical activity, diet, alcohol consumption and the use of cannabis and other psychotropic substances. Certain emotional and cognitive skills and attributes are also associated with positive mental well-being, including feeling satisfied, optimistic, hopeful, confident, understood, relaxed, enthusiastic, interested in other people and in control. (Kamman and Flett 1983; Mauthner and Platt 1998; Stewart Brown 2002)

There is also evidence of an increased risk of experiencing common mental health problems such as depression and anxiety amongst people who experience cumulative life stressors, notably material deprivation, family conflict, unemployment and physical disorders. (Melzer et al 2004) Other adverse life events which increase risk include workplace stress, bereavement and bullying. People in lower social classes are at increased risk of exposure to such cumulative stressors and also have higher prevalence of common mental health problems – representing the familiar pathways of inequalities in health. (Pilgrim and Rogers 2003; Melzer et al 2004)

Greater public awareness and understanding of mental health as a resource to be protected and promoted can also contribute significantly to reducing structural barriers. For example, prior to the widespread introduction of smoke free workplaces, many people had no choice but to work where they were exposed to second hand smoke. As awareness of the dangers of passive smoking increased, demand from unions and employees contributed to the adoption of workplace smoking policies. The same could occur for mental health if people are helped to understand the factors, which protect or threaten their mental well-being.

Recommendations: recognising the importance of mental health

The implementation plan for *Choosing Health* must include explicit and clear recognition of the central role of mental well being to achievement of overall health and this recognition should inform the detail of action set out in the plan.

The central role that mental health plays in supporting overall health will not be clear to the public or key partners and stakeholders unless *Choosing Health's* 'marketing health strategy' explicitly reflects this evidence. There is a wealth of baseline data on public attitudes to mental illness; what is now required is baseline data on how much people know about how to look after their own mental health and that of others. This, together with key evidence-based 'positive steps' for mental well-being (e.g. exercise, diet, talking, keeping in touch with friends, stress management, sensible drinking, help seeking etc.) should inform the design of proposed *Choosing Health* campaigns, notably on the themes of obesity, sexual health and alcohol as well as interventions targeting children and young people and the workplace. This should help to narrow the gap between public knowledge on physical health and public knowledge on mental health. The government should aim to create the same public demand for protection of mental health and well-being as there is for physical health.

2 The most up to date source of evidence on risk and protective factors and effective interventions to promote mental health is the National Electronic Library for Health (Mental Health Promotion) <http://www.nelh.nhs.uk/nsf/mentalhealth/whatworks/intro/risk.htm>

The recognition that while “*in many areas consumer demand and better information, supported by strategies to market health, will be sufficient to secure the changes needed to improve health, this will not be sufficient in areas like diabetes and heart disease*” – should be extended to include mental health. In other words, *Choosing Health’s* delivery plan must ensure an effective and balanced range of interventions across the wide range of social, economic and environmental factors which enable or inhibit health behaviours conducive to positive mental well-being in individuals (such as measures to reduce poverty, increase the availability and affordability of healthy food and support work-life balance) as well as ensure direct health education and support to individuals to help them achieve positive and sustained changes to their health behaviours. Without this mix of interventions, only modest change will be achieved and it is likely that health inequalities will increase. Key opportunities for highlighting mental health include the Food and Health Action Plan and the Physical Activity Plan, as well as the proposed Strategy (to be developed by an independent body) to promote health by influencing people’s attitudes – which will have an early focus on sexual health, obesity, smoking and alcohol, but should arguably start with mental health.

5.2 Children and Young People: Starting on the Right Path

Choosing Health complements and reinforces a range of policy on children and young people, notably, from a mental health perspective, the *National Service Framework (NSF) for Children, Young People and Maternity Services* (Department of Health 2004).

The above NSF’s standards are as follows:

- | | |
|-------------|--|
| Standard 1 | Promoting health and well-being, identifying needs and intervening early |
| Standard 2 | Supporting parents or carers |
| Standard 3 | Child, young person and family-centered services |
| Standard 4 | Growing up into adulthood |
| Standard 5 | Safeguarding and promoting the welfare of children and young people |
| Standard 6 | Children and young people who are ill |
| Standard 7 | Children in hospital |
| Standard 8 | Disabled children and young people and those with complex health needs |
| Standard 9 | The mental health and psychological well-being of children |
| Standard 10 | Medicines management for children |
| Standard 11 | Maternity services |

Standard 9 of the Children’s NSF is specifically concerned with the mental health and the psychological wellbeing of children and young people. It has a reasonably strong focus on promoting the mental health of all children, as well as improving service provision. Standards 1 and 2 address health promotion and support for parenting respectively.

Key strengths of the NSF which are also prominent in *Choosing Health* include:

- > The integration of mental and physical health promotion, notably in the Child Health Promotion Programme, a structured programme of interventions which will be provided for all children from birth to adulthood.
- > Recognition of the wider consequences of emotional and behavioural problems in children and their association with educational failure, poor socialisation, lack of participation, relationship difficulties, offending and antisocial behaviour.
- > A strong emphasis on support for parents, together with acknowledgement that “everyone in a community has a role to play in ensuring that the environment in which children are growing up promotes their mental health”.

Health visitors will lead and oversee delivery of the Child Health Promotion programme and a stronger, more developed role is envisaged for school nurses.

Standard 9 also states that all staff working directly with children and young people should have *sufficient knowledge, training and support to promote psychological well-being and to identify early indicators of difficulty*. This is an ambitious aim and one that is unlikely to be achieved without significant changes in the training of health, education and other professionals, not to mention major changes in public attitudes to children. The Level 3 Certificate in Child Mental Health, which is being developed by the Foundation, may be a useful tool in this respect.

Recommendations: Choosing Health and Children's NSF

◆ **Assess opportunities for fostering greater public awareness of and sensitivity to the emotional needs of children e.g. the recent media campaign by Health Scotland which promoted four positive messages to parents:**

- > *Building self esteem: 'the encouragement you give them now will last a lifetime'*
- > *Communication skills: 'listen to them now and they'll talk to you later'*
- > *Understanding and empathy: 'put yourself in their shoes'*
- > *Coping with adolescents: 'they may show it less but they need you more'*

Greater **action on communication with children** is of particular importance in view of emerging evidence of a decline in children's linguistic skills and a reduction in oral communication between parents and small children, which has important implications for emotional development. (Hart and Risley 1995; Basic Skills Agency Wales www.basic-skills-wales.org)

Arguably, the chapter on children and young people demonstrates the strongest evidence within *Choosing Health* of a recognition of the centrality of emotional well-being and a commitment to supporting all children and young people to attain both good physical *and* mental health.

"Emotional well-being underpins good physical health and reduces the likelihood that children and young people will take inappropriate risks"

There is also a clear recognition that:

- > children and young people who have good mental health learn more effectively
- > choosing health will be hardest for those who have poor self esteem and emotional health
- > children need more opportunities for creativity and play.

This emphasis is not followed through in relation to specific health issues however, for example, the importance of school sport in improving emotional well-being, the impact of obesity on mental health (and vice versa) and the relationship between self-esteem, confidence, expectations and social skills and sexual behaviour. For example, it is noted that teenage pregnancy may reduce self-esteem, but not that low self-esteem may play a role in the prevalence of unplanned teenage pregnancies.

Recommendations: children and young people

- ◆ **Bullying has a high profile in the national key stage 3 behaviour and attendance programme. What is also needed is more support for schools in developing and implementing effective anti bullying strategies, based on approaches known to be effective i.e. which involve the whole school, parents and the community e.g. the Campaign against Bully-Victim Problems. The positive long-term impact on criminal behaviour, alcohol abuse, depression and suicidal behaviour should be highlighted. (Olweus 1993, 1995)**
- ◆ **DfES is developing a common core of skills and knowledge to support training for all professionals working with children, young people and families and carers. This should specifically include the skills required to promote psychological well-being and identify early signs of difficulties. It may also be worth establishing what, if any, mechanisms are in place for monitoring progress on promoting children's mental health (Department for Education and Skills 2001)**
- ◆ **Parenting support, including group-based support, is cost effective and should be made available to parents for children of all ages. (Scott et al 2001)**
- ◆ **Poor quality relationships within the home during childhood predict poor mental and physical health. These effects are independent of socio-economic disadvantage; social deprivation alone does not account for the effects of poor quality relationships on health in later life. (Stewart Brown and Shaw 2004). These findings suggest a strong case for universal provision to support parenting, offered via primary care, alongside fiscal policy to reduce childhood poverty. Group based parenting programmes improve maternal mental health and reduce children's behavioural problems. (Barlow and Coren 2002; Barlow and Stewart Brown 2000; Barlow and Parsons 2002; Barlow et al 2002)**
- ◆ **Home visits for first time mothers, beginning in pregnancy and continuing for two years, should also be established, particularly for vulnerable groups including parents of children with a learning disability, as this greatly improves the physical and mental health of children, reduces physical maltreatment and has significant social and economic benefits for the caregiver.**

Home visiting is associated with improvements in:

- > parenting skills
- > the quality of the home environment
- > several child behavioural problems including sleeping problems
- > detection and management of postnatal depression
- > enhanced quality of social support to mothers.

(Elkan et al 2000; Hodnett and Roberts 2000; Olds et al 1997 and in respect of children with learning disabilities, The Foundation for People with Learning Disabilities 2003)

- > **The role of the National Healthy Schools Programme in promoting mental well-being needs to be made explicit, alongside the evidence for the effectiveness of universal, long term, whole school approaches to mental health promotion.**

A health promoting schools approach can impact positively on aspects of mental and social well-being such as self-esteem and bullying. (Lister-Sharp et al 1999) School health promotion initiatives that make changes to the school's environment and attempt to involve parents and the

wider community, provide a more effective framework within which to promote mental health than those that use a curriculum based approach only. (Lister-Sharp et al 1999) Systematic review level evidence demonstrates that *universal* school mental health promotion programmes can be effective. Long-term interventions that aim to promote positive mental health and involve changes to the school climate *are likely to be more successful than brief class-based mental illness prevention programmes*. (Wells et al 2001). The most robustly positive evidence was obtained for schools that adopted a whole-school approach, were implemented continuously for more than one year, and were mental health promoting rather than mental illness preventing. Programmes that aimed to improve children's behaviour and were limited to the classroom were less likely to be effective.

Interventions which enable children to develop appropriate levels of **independence and opportunities to succeed, for example through creative play and access to the natural world** should be actively encouraged, as these promote mental health, notably through strengthening imagination, problem solving and internal locus of control.

- > **Reading to pre-school children has considerable cognitive and emotional benefits, as well as promoting literacy (Bus et al 1997; Neuman 1996). Books for babies (launched by the charity Bookstart www.bookstart.co.uk and recently guaranteed long term funding) and similar pre-school initiatives to support parental reading to very young children should be strongly supported by health and social care.**

5.3 Choosing Health: Local communities Leading for Health

The community aspects of *Choosing Health* do not differ essentially from the aims of Health Action Zones (HAZs), launched in 1997 (which in turn were informed by earlier partnership approaches to public health at local level, such as Health For All and Healthy City Initiatives which were themselves influenced by the World Health Organisation's European Health for All Strategy and Healthy Cities Programme). The four broad categories of HAZ investment were:

- > addressing social and economic determinants
- > promoting healthy lifestyles
- > empowering individuals and communities
- > improving health and social care services.

A recent report by the King's Fund (Coote et al 2004) highlights tensions and challenges in the evaluation of government funded social programmes like HAZs, which have been well rehearsed. These are particularly challenging in relation to evaluating mental health outcomes and seem unlikely to be resolved in the foreseeable future. The Health Development Agency is leading a programme on the development of alternative approaches to synthesising evidence, drawing on different types and levels of evidence from those traditionally used in systematic reviews (which are not appropriate for assessing the majority of mental health promotion interventions). NHS Health Scotland is undertaking a similar exercise, aiming to develop alternative protocols for commissioning reviews of mental health improvement evidence. (Hogg 2004) **There is a case for a robust statement of support for these efforts.**

There have been a number of calls to strengthen local government's leadership role for public health, in view of its central influence on many of the key determinants of health locally (transport, housing, education, regeneration, leisure, environment). (LGA 2003) In relation to public mental health however, there is a need to identify specific actions.

Local government's mainstream services such as education and social services, play a major role in supporting public health, including mental health. In addition, local authorities also have other powers and responsibilities, which could enable them to play a more active role in public mental health, including:

- > the general duty for local authorities to promote population well being
- > flexibility for local authorities to develop local targets and work in partnership to respond to local need through the development of 21 Local Area Agreement pilot projects
- > more support for local authorities to improve parks and public spaces and 'whole town' approaches to walking, cycling and public transport
- > the national 'Healthy Schools Programme' focusing on food in schools, school travel and physical education and sport in schools
- > expanding the number of school nurses working with each Primary Care Trust (PCT) and its local schools.

(see also **section 5.8**)

Recommendations: local communities

- ◆ **The delivery plan and related guidance for *Choosing Health* should be informed by experience and the evaluation of previous partnership public health initiatives in the UK and internationally such as Health For All/Healthy Cities and Health Action Zones.**
- ◆ **Choosing Health confirms plans to extend the Healthy Communities Collaborative (HCC) which to date has covered accident prevention among older people, focusing on reducing falls. It is not yet clear how the HCC will be extended but a pilot initiative to promote mental well-being and reduce the prevalence of depression among older people should be considered.**
- ◆ **The revised guidance on neighbourhood renewal should include the growing evidence of the relationship between regeneration, social capital and the collective mental well-being of communities, including evidence on the role of arts and creativity in improving mental health at a community level. (Reeves 2002; Matarasso 1997)**
- ◆ **Both Local Strategic Partnerships – and the new Local Area Agreements about local delivery of national targets (which are to be piloted), should be supported with mental health and well-being targets and indicators of success. The national *Choosing Health* commitment is “we will have delivered if we improve the mental health and well-being of the general population”. To monitor this requires an agreed set of measures.**
- ◆ **The Wanless reports acknowledged that certain mental health problems are linked to deprivation and to poor physical environments and highlight the effect of poor quality housing, high rates of unemployment, poor transport, contact with the criminal justice system, and poor social support networks. *Choosing Health* also states that ‘mental health problems are more common in areas of deprivation’, but does not identify any action to address this. Mental illness is therefore the only one of the priority areas which does not include a specific range of initiatives designed to reduce prevalence, notably in the context of inequalities. The challenge is recommending feasible action. **One option is to develop a public mental health action plan which would specifically seek to reduce inequalities in mental health, perhaps focusing on depression in older people, unemployment, the early identification and treatment of conduct disorders and support for families of offenders.****

5.4 Health as A Way of Life and A Health Promoting NHS

Personal Health Trainers

- > There is considerable evidence that appropriate personalised support for individuals to help them with day to day living (e.g. personal support workers for people with learning disabilities and people with severe and enduring mental health problems, such as the Support Time and Recovery workers (STRs)), can be very valuable and effective (Brandon and Morris, 2002). There is also some evidence that other types of personalised support help individuals make appropriate and positive changes to health behaviour (e.g. diet, physical activity and breastfeeding) especially where the support is from people with whom there is a sense of common identity (e.g. lay, community health volunteers). The Foundation therefore welcomes proposals for personalised health trainers in principle. However, as indicated above, research indicates that the impact of such measures will be larger in population terms if they are supported by societal measures which enable people to achieve, for example, an appropriate work/life balance so they have sufficient time for physical activity and parenting and caring roles. In addition, if the government's commitment to reducing health inequalities is to be achieved, then personal support for excluded people must be complemented by effective societal measures to reduce social and economic inequalities, such as low income and poor housing.

- > The appropriate and effective training of the proposed personal trainers will be critical to success. The Foundation has concern about the timescales proposed in the White Paper – e.g. first trainers to be deployed by 2005 and wider roll out by 2006. Unless the government has already commissioned the training programme this will be difficult to achieve, especially if accreditation is sought

Recommendations: Personal Health Trainers

- ◆ **The personal health trainers training must give an adequate grounding in skills for mental health promotion, including the relationship between mental health and behaviour change, drawing on the extensive body of experience and research in health psychology and health education/promotion.**
- ◆ **People with severe and enduring mental health problems and people with learning disabilities should be a priority group for receiving support from personal health trainers, but this would require additional training.**

Alcohol

There is explicit recognition of the relationship between alcohol and mental health in the National Alcohol Harm Reduction Strategy (Strategy Unit 2003) and this needs to be emphasised. The focus in *Choosing Health* on tackling binge drinking is not evidence based. (Sewel 2002; Global Alcohol Policy Alliance 2003) Per capita alcohol consumption affects the prevalence of drinking problems and for this reason, alcohol policy needs to take into account both a population's general *level* of drinking and its *patterns* of drinking. There is no doubt that patterns of alcohol consumption are important for alcohol-related harm, but so are societal levels of alcohol consumption. The risk of becoming a hazardous drinker depends, to some extent, upon whether the ambient drinking culture encourages excessive intake. (Edwards et al 1994) The imminent introduction of 24 hour drinking is likely to undermine any public health and public mental health efforts in this area. A point of interest is that around 2/3rds of the general public oppose 24 hour drinking, with greater opposition among lower socio-economic groups. The Government's commitment to tackling alcohol related harm, both mental and physical, is currently very much in doubt and needs to be re-established.

Recommendations

The research evidence available indicates that a policy mix which focuses on harm reduction and makes use of taxation, control of access, drink-driving countermeasures, and treatment and support services, is most likely to be successful in reducing the level of alcohol problems

Physical activity

There is a very welcome emphasis throughout *Choosing Health* on the importance of physical activity. However, it often fails to take account of the growing evidence of the importance of physical activity to mental health, and to recovery from mental illness. (Biddle et al 2000; Carless and Faulkner 2002; Carless and Douglas 2004)

While the benefits to physical health of regular exercise are fairly widely understood, the benefits to mental health (regular activity has been associated with reduced anxiety, decreased depression, enhanced mood, and improved cognitive functioning and self-worth – Fox 1999) have been less widely reported and are less well-understood and accepted.

Official guidance has now begun to reflect the weight of evidence in favour of exercise as a response to mild-to-moderate depression. In April 2004, a report by the Chief Medical Officer on the impact of physical activity and its relationship to health stated that: ‘Physical activity is effective in the treatment of clinical depression and can be as successful as psychotherapy or medication, particularly in the longer term. (Department of Health 2004)

According to NICE, a number of different treatment approaches including exercise may be equally effective when it comes to the treatment of mild-to-moderate depression. (NICE 2004) This being the case, there are strong reasons for promoting exercise as a first-line treatment. Exercise referral is cost-effective and could be developed rapidly; it has positive “side effects”; it can be used to treat patients who have a mix of physical as well as mental health problems; it is a sustainable recovery choice, promotes social inclusion; and is a popular treatment. Although it is commonly believed that people with depression will be resistant to exercise, research carried out by the Mental Health Foundation suggests that, if patients are given the right support, compliance rates are often much higher than for treatments such as medication. (see also Carless and Douglas 2004) However, the same research (Mental Health Foundation 2005) has identified a lack of knowledge and acceptance of the benefits to be gained from using exercise referral in treating depression among GPs.

In March the Mental Health Foundation plans to embark on a campaign to promote exercise referral as a first-line treatment for mild-to-moderate depression. Wider messages will also be disseminated about the importance of exercise as a way of looking after and improving mental health in the general population. This will be part of an ongoing programme of work aimed at increasing general understanding of the value of non-medical interventions in mental health.

Recommendations: Physical Activity

GPs, patients and exercise referral scheme staff should be made aware of the efficacy of exercise referral as a treatment for mild to moderate depression. This is the main objective of the Mental Health Foundation’s campaigning activities for 2005.

The case for regular exercise as a way of maintaining and improving mental health should be made explicit in Government and voluntary sector public health campaigns targeted at increasing uptake of exercise among the general population

There is a need for further pilot projects and action research on the most effective ways of increasing exercise uptake and reducing the barriers to physical activity among the most vulnerable and disadvantaged groups including low income, people with mental health problems and older people.

A Health Promoting NHS

The Foundation appreciates the reasons for the government's renewed commitment to re-orientate and equip the NHS to support health improvement in *Choosing Health* and, more specifically, the commitment to enhance health improvement advice in primary care and routine clinical practice and for all staff to be able to give adequate advice to support mental and physical well being. The commitment to strengthen NHS health improvement and prevention services is particularly problematic in the case of mental health, as current NHS provision in this area is poorly developed. Also, given that most NHS staff receive little or no training on either public health, health promotion or mental health, this commitment represents a major training requirement, which would take many, many years and considerable resources to achieve. Given the latter challenges, combined with the NHS's limited influence over the wider factors which influence health and the considerable challenges the NHS faces just to ensure effective and equitable treatment and care, the Foundation believes the government should seriously re-consider NHS and local government responsibilities for wider public health, including public mental health.

Recommendations

- ◆ **Review the balance and nature of responsibilities for public health, including mental health, between local government and the NHS so that each organisation is enabled to support improvements in public health, which better reflect its core duties, powers and influences.**
- ◆ **The guidelines for the management of common mental disorders in primary care (developed by PCTs in accordance with the requirements of standards two and three of the NSF for Mental Health) need to be revised** to include a stronger promotion and prevention dimension, including the provision of non-pharmaceutical options (see above) in partnership with the voluntary and community sector and local government.

5.5 Work

Choosing Health has a strong, evidence based focus on workplace health with specific attention to tackling work related stress and a welcome acknowledgement of the importance of addressing structural, systemic factors. The workplace is an important setting for adults, in particular, because (after the first year of life) midlife is the period when social inequalities in health manifest themselves most strongly. Recent research supported by the Mental Health Foundation and undertaken by people with mental health problems confirms the importance of workplace and work place-related factors in either improving or diminishing people's mental health (Mental Health Foundation 2000 and 2003). In particular these include how people feel stigmatised at work if they have mental health problems and a lack of flexibility by many employers and in the welfare benefits system when people wish gradually to return to work after having time off because of being unwell.

'a focus on individual stress can be counterproductive, leading to a failure to tackle the underlying causes of problems in the workplace'

'the real task is to improve the quality of jobs by reducing monotony, increasing job control and applying appropriate HR practices and policies organisations need to ensure that they adopt approaches that support the overall health and well-being of their employees'.

New guidelines are to be published by 2005 on managing mild to moderate mental ill health in the workplace.

The Health and Safety Executive Management standards for tackling work related stress are impressive and should be strongly promoted. (Health and Safety Executive 2004) They cover:

- > job demand
- > job control
- > support from managers and colleagues
- > relationships at work
- > role in the organisation
- > change and how it is managed.

Recommendations: workplace

- ◆ **Organisations are to be invited to make pledges to improve health. There are a number of options: to draft some mental health pledges, perhaps in line with HSE standards on tackling stress, or to work with one or more key employers to come up with some examples and launch these in partnership.**
- ◆ **Action is required to raise mental health awareness and understanding of the Disability Discrimination Act as it relates to mental health among employers.**
- ◆ **Greater flexibility is required in the welfare benefits system to support people to return to work after being off for reasons of mental health problems. The Mental Health Foundation and The Sainsbury Centre for Mental Health have jointly presented proposals to the Department for Work and Pensions on how this might be achieved.**

A number of developments suggest a ground swell of support for fundamental changes in working life in the interests of reducing stress and promoting well-being. These include the campaign for work/life balance, launched by the Prime Minister, the 'heartbeat economy' which addresses the impact of working practice on the well-being of employees and customers, the 'well-being manifesto', recently launched by the New Economics Foundation, and calls from a number of prominent economists for alternatives to GDP as the measure of economic success. These developments should be informed by accurate and detailed information on mental well-being, which they tend to lack.

5.6 Making It Happen

Research

Action to strengthen public health research is a key *Choosing Health* commitment. Developments include:

- > a new public health research initiative will be established within the existing UK Clinical Research Collaboration (UKCRC)

- > the creation of a Public Health Research Consortium, bringing together key players from a range of disciplines
- > a National Prevention Research Initiative to provide funding aimed at primary prevention.

Public Health Observatories will have an expanded role, including taking the lead on developing a standard set of local health information. North East PHO (NEPHO) has lead responsibility for mental health, as well as environment and health, prison health and children and young people.

The Faculty of Public Health has recently recognised that mental health has had a low profile within public health, in spite of the fact that positive mental health is vital to achieving health and well-being. FPH has established a joint working group with NIMHE in order to strengthen future FPH action on public mental health and to demonstrate the importance of promoting positive mental health to achieving other public health goals.

Recommendations

- ◆ **It is important that public mental health concerns are properly considered by new public health research initiatives – spanning research on promotion, prevention and treatment and care, including recovery and quality of life for people with severe and enduring mental health problems. It is notable, for example, that mental illness is not included in the list of issues to be considered by the National Prevention Research Initiative (the fields included are obesity, cancer, coronary heart disease and diabetes).**
- ◆ **The work of the Health Development Agency (HDA) will now be subsumed within the National Institute for Clinical Excellence, (NICE) with the appointment of an executive director for health improvement to take the lead on public health. The Foundation has concerns about the priority that will be given to non-clinical research within this merged organisation, especially mental health promotion research, as the HDA does not have a recent track record in this area. It is therefore important to ensure that public mental health is included on the NICE agenda as its public health programmes are developed. NHS Health Scotland (previously HEBS and the Scottish equivalent of the HDA) has a robust programme for mental health improvement research and capacity building, which might serve as a useful model.**

Organisational Capacity and workforce capability

The main focus of *Choosing Health* is on training and capacity building for public health within the NHS. As indicated above, such a commitment represents a major training challenge for the NHS, but should also include the many local authority employees who have considerable ‘health promoting opportunities’ through their contact with the general public. As indicated above, the Foundation believes the respective public health roles of the NHS and local government should be reviewed, with a view to strengthening the role of local authorities.

Effective leadership supported by effective networking and collaboration by all stakeholders at local and national level also enhances the capacity and capability to plan, deliver and evaluate public health interventions. Organisational stability, adequate time frames and resources are, however, necessary if such approaches are to be effective. Unfortunately these important conditions for public health leadership, collaboration and partnerships have not been readily available over the last decade due to short time frames and time-limited resources for many government-led health initiatives and frequent reorganisation of the NHS.

Recommendations

There is considerable scope to ensure that mental health promotion awareness and skills are included in:

- ◆ Training, core competencies and job descriptions of the new NHS personal health trainers (see above).
- ◆ Occupational Standards and NHS Knowledge and Skills Frameworks (currently being assessed by Skills for Health to ensure that they ‘properly reflect health improvement and the science of behaviour change’).
- ◆ New induction programmes for all NHS staff.
- ◆ Core and work related competencies for public health professionals (currently being drafted by the Faculty of Public Health).
- ◆ A range of local authority and voluntary sector staff groups who have high levels of contact with the public and considerable opportunities positively to influence their health, such as teachers, social workers, youth workers and community workers.
- ◆ Strategic Health Authorities, which are being asked to strengthen and develop public health networks to deliver *Choosing Health*, should ensure that they are competent to address public mental health. For example, fewer than 30% of London PCTs have either a consultant or senior specialist dealing with public mental health.
- ◆ Every PCT is to run at least one local *skilled for health* programme (*skilled for health* is a partnership between DH, DFES and ContinYou, which combines adult basic skills with better understanding of health). Again, these should be informed by a mental health perspective in design, content and delivery.
- ◆ The national Public Health Forum for non-governmental organisations in England, *Phorum*, supports engagement between government and voluntary agencies on public health. Mental health representation appears absent or minimal and this should be rectified.
www.phorum.gov.uk

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Appendix 1: A description of public mental health

Public mental health

- (i) is concerned with improving the mental health of a defined population. This may be:
 - > international (e.g. Europe)
 - > national (e.g. UK or Scotland)
 - > a local population (e.g. city or town)
 - > a target group, such as single parents or people with mental health problems.

- (ii) is concerned with both cognitive and emotional dimensions of mental health, which are closely related.

- (iii) takes an ecological perspective – understanding the human being as a biological organism in complex interaction with its external environment (both natural and human-made). This interaction embraces complex and inter-acting biological, psychological, social and environmental factors. Public mental health also maintains that the brain, mind and body (i.e. physical and mental) are closely linked and mutually dependent. It also sees the individual as a social being, dependent on meaningful social interaction for its development and survival.

- (iv) is informed by a life course perspective, with a focus on normal human development and growth and key life transitions and events. It is also sensitive to gender, ethnicity, (dis)ability, social class, sexuality and religious beliefs.

- (v) is value based, embracing progressive values of:
 - > collective and individual responsibility for (mental) health
 - > social justice and equity
 - > empowerment

in so doing, public mental health respects human rights and the diversity of human needs and experience between different groups and cultures.

In seeking to improve the mental health of a defined population, public mental health supports a range of interventions, which are underpinned by adequate evidence of effectiveness or, where appropriate, it applies the precautionary principle. This can include interventions which:

- > promote mental well-being (cognitive and emotional)
- > prevent the onset of mental ill-health or problems
- > provide early support at the onset of mental health problems to help reduce severity and/or duration and to aid healing and/or quality of life by those affected
- > protects the rights and needs of people with mental health problems/illness to ensure they receive necessary social and economic support and effective therapeutic treatments, which maximise benefits and minimise harm.

Such interventions may take place at:

- > structural (macro) level (e.g. fiscal policy, NHS policy)
- > community (meso) level (e.g. community support projects; improved local amenities)
- > family/group/individual (micro) level (e.g. home support, counselling)

It is can often be more effective to implement different interventions at various levels which can have a synergistic effect. Interventions are also informed by qualitative and quantitative evidence of:

- > need and desired outcomes
- > measures that will achieve desired outcomes.

Notes

Notes



About the Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy, and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves.

We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and to promote mental well-being.

We also work to influence policy, including Government at the highest levels. And we use our knowledge to raise awareness and to help tackle the stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services.

If you would like to find out more about our work, please contact us.

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