HM Government

New Horizons
Working together for better mental health

Confident Communities, Brighter Futures

A framework for developing well-being

DH INFORMATION READER BOX	
Policy	Estates
HR/Workforce	Commissioning
Management	IM&T
Planning/	Finance
Clinical	Social Care/Partnership Working

Document purpose	Best Practice Guidance
Gateway reference	13485
Title	Confident Communities, Brighter Futures. A framework for developing well-being
Author	Department of Health: Mental Health Division
Publication date	25 Mar 2010
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Public health leads and specialists, National Mental Health Development Unit
Circulation list	Organisations of services users, Other Government Departments, Head teachers, Employers, Royal Colleges
Description	"Confident Communities, Brighter Futures: A framework for developing well being" sets out the argument and evidence base for prioritising well-being, and provides a systematic approach to improving mental well-being with selected evidence-based approaches and interventions that have been shown to be effective across the life course, and across key public health domains.
Cross ref	New Horizons: A Shared Vision for Mental Health
Superseded docs	N/A
Action required	**For information**
Timing	Immediate
Contact details	New Horizons Programme Administrator Mental Health Division Wellington House Waterloo Road, London SE1 8UG www.dh.gov.uk/newhorizons
For recipient's use	

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FOREWORD

I am delighted to introduce *Confident Communities, Brighter Futures*. It marks a big step forward in the Government's New Horizons vision for mental health, and opens the 'second front' in our campaign – improving the mental health and well-being of the population as a whole, and not just of individuals experiencing illness.

Whether we look at families, communities or nations, our well-being and mental resilience is critical to a host of social and economic benefits – our physical health, our relationships, our education, our work and our productivity. Pernicious social and health inequalities are both a result and a cause of poor mental health – which means the most deprived communities also have the poorest health and well-being. Understanding how to break this vicious circle is essential to developing a more equal society.

Unlocking the benefits of better well-being and mental health for all requires a sustained, systematic and concerted effort. This report outlines a genuinely innovative new approach to public mental health. It draws on a growing evidence base of what works, and offers a clear framework for local action.

Confident Communities, Brighter Futures will be an invaluable resource for informing public policy nationally and locally, and one that will continue to grow and develop. It is designed to apply equally across the whole lifespan, from a positive childhood to healthy and fulfilled older years. It has the potential to build the strength, safety and resilience of communities that are more inclusive and foster more supportive social networks. I and my colleagues across government are looking forward to putting this into practice alongside partners from across the statutory and independent sectors. If we get it right, the benefits will be felt by us all.

Phil Hope MP
Minister of State for Care Services

INTRODUCTION

This report is part of a continuing programme of action to improve the mental health and well-being of the whole population.

It will be followed by further advice and guidance on how to implement improvements in public mental health and well-being over the course of the year. It builds on and develops New Horizons, the new national vision for mental health in England for 2010 and beyond. New Horizons sets out a cross-government and cross-sector programme of action to advance the linked aims of:

- **improving the mental health and well-being of the population, and**
- **improving the quality and accessibility of services for people with poor mental health.**

This report outlines how to take forward the first aim of New Horizons: to improve the mental health and well-being of the population.

Improvements in well-being can be achieved through universal measures that apply to the whole population and through targeted approaches for high-risk groups and those with ill health, to reduce inequalities and aid recovery.

This report is intended for an audience that is able actively to contribute to the promotion of wider population well-

being. Its audience is the public health workforce – directors, consultants, specialists and practitioners in public health, whether working in local authorities, in primary care trusts (PCTs) or at national government level. It is also intended for directors of social services, local authority chief executives and those with responsibility for Local Area Agreements and Joint Strategic Needs Assessments.

The report's main purpose is to summarise the growing evidence base to inform and support Joint Strategic Needs Assessments and other plans and strategies, including commissioning, at national, regional and local levels.

The benefits that improving mental health and well-being bring to individuals, communities and society are increasingly recognised. We already know a great deal about what works, and interest and knowledge in this area are growing, nationally and internationally. The Mental Health Declaration for Europe highlighted that promotion of mental health and the prevention, treatment, care and rehabilitation of mental health problems are a priority and that mental well-being is fundamental to the quality of life and productivity of individuals, families, communities and nations (WHO, 2005). In 2008 the World Health organization (WHO) published the findings of its Commission on the Social Determinants of Health, which highlighted the importance of social circumstances in influencing health and well-being – and the need to take steps to tackle these – and the structural factors at wider policy and economic levels that lead to health inequities. This was followed by a strategic review of health inequalities in England (Marmot et al, 2010). In France, the 2009 Sarkozy Commission on the Measurement of Economic Development and Social Progress proposed a switch in focus from measuring economic productivity to people's well-being as an indicator of national wealth (Stieglitz et al 2009). Australia, Canada and the UK are among the many countries to re-orientate healthcare towards well-being and prevention.

Mental health is intrinsic to well-being. This was highlighted in the 2009 WHO report on mental health, resilience and inequalities (Friedli, 2009). The Foresight Mental Capital and Wellbeing project (2008) brought together an impressive

amount of evidence to support the economic and social arguments for policy development and government action in this area. The current economic climate, concerns about the environment and sustainable development, and our increasing life expectancy have generated further interest in well-being, with a focus on resilience and the value for money of different interventions and approaches.

There is a clear association between well-being, good mental health and improved outcomes for people of all ages and social classes, across a number of domains. These include longevity, physical health, social connectedness, educational achievement, criminality, maintaining a home, employment status and productivity.

It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Mental health problems are common, and the personal, social and financial costs are immense. Our most deprived communities have the poorest health and well-being.

Unlocking the benefits of well-being and mental health for the whole population requires a sustained, systematic cross-government approach at national and local levels, in partnership with the third sector, communities and individuals. Success depends on:

- prioritisation of well-being and mental health nationally and locally
- a clear strategy and approach supported by a broad consensus
- evidence-based service models and interventions; and
- information, performance management and high-quality outcome measures

delivered through:

- strong local and national leadership
- effective and resourced multi-agency commissioning, and
- a skilled workforce.

This document sets out:

- the argument and evidence base for prioritising well-being and mental health
- a public mental health framework to guide a systematic approach to improving mental health and well-being; and
- selected evidence-based approaches and interventions that have been shown to be effective across the life course and across key public health domains.

Further reports will be produced in due course that will expand and explore in greater detail the evidence base and interventions presented here for each of the key public mental health framework domains.

One of the notable features of this work is that some groups feature repeatedly throughout the report as being at high risk and are listed as key targets for several of the interventions. Those responsible for planning and commissioning services will need to decide which set of interventions are most applicable to each specific group in the light of local circumstances, needs and priorities.

The vision

To create confident communities and brighter futures through well-being for all.

The messages

- **The NHS spends 11% of its annual budget on mental health services. Recent estimates put the annual wider economic costs of mental health problems at around £77 billion.[1]**
- **There are substantial cost savings to be made by promoting mental health and well-being.**
- **Half of all mental illness (excluding dementias) starts by the age of 14.**
- **Ensure a positive start in life: potentially a quarter to a half of mental health problems are preventable through interventions in the early years.**
- **Poor mental health is both a contributor to and a consequence of wider health inequalities. It is associated with increased health-risk behaviours and increased morbidity and mortality from physical ill health.**
- **Promoting good mental health has multiple potential benefits. It can improve health outcomes, life expectancy and educational and economic outcomes and reduce violence and crime.**

Mental health and well-being can positively affect almost every area of a person's life: education, employment, family and relationships. It can help people achieve their potential, realise their ambitions, cope with adversity, work productively and contribute to their community and society.

Promoting mental health and well-being has multiple benefits. It improves health outcomes, life expectancy, productivity and educational and economic outcomes and reduces violence and crime.

[1] Annual wider economic costs of mental health problems in England were estimated as £77 billion (Sainsbury Centre for Mental Health). These were updated in 2007 to £110 billion for the UK (Friedl and Parsonage, 2007).

There are many determinants of well-being – individual factors such as psychological skills and attributes and also the circumstances of people's lives.

Poor mental health is both a contributor to and a consequence of wider health inequalities. It is associated with increased health-risk behaviours and increased morbidity and mortality from physical health causes.

A public mental health approach recognises the wider determinants and lifelong impact of poor mental health by addressing the causes and the consequences through a well-being framework combined with a life course perspective.

Improvements in well-being can be achieved through a wide range of evidence-based interventions, from universal measures that apply to the whole of the population through to targeted approaches aimed at high-risk groups and people with diagnosed mental illnesses.

Mental health problems are common and expensive:

- **One in six of the adult population experiences mental ill health at any one time.**
- **About 50% of lifetime cases of diagnosable mental illnesses begin by age 14.**
- **Dementias currently affect 5% of people aged over 65 and 20% of those aged over 80.**
- **The NHS spends 11% of its annual budget on mental health services. Recent estimates put the annual wider economic costs of mental health problems at around £77 billion.**
- **Mental illness accounts for over 20% of the total burden of disease in the UK, more than cardiovascular disease or cancer.**

Mental health and mental well-being

In New Horizons the Government adopted the following definition of mental well-being:

A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.

Mental health is not simply the absence of mental illness. People with mental health conditions can have a positive state of well-being, and vice versa.

The evidence shows that good mental health and well-being are associated with improved outcomes for individuals in education, employment and social relationships and in better health and increased resilience. In New Horizons the Government committed itself to improving the mental health and well-being of the whole population, including those recovering from mental illness. There is a developing evidence base on the risk factors for both mental illness and mental well-being. Importantly, the evidence is also growing on what can be done, cost effectively, to create the right conditions for good mental health and well-being, and on early interventions when things start to go wrong. This report summarises that evidence base.

The framework for action

There are a number of dimensions to understanding the risk factors associated with poor mental health and poor well-being and the policies and actions that can be taken to tackle them. These are:

- taking a life course approach
- building strength, safety and resilience
- developing sustainable, connected communities
- integrating physical and mental health
- promoting purpose and participation.

This report looks at each of these dimensions in turn. It summarises the evidence on risk factors and the evidence on potential cost-effective interventions. These dimensions are linked. Some risk factors cut across several dimensions, so some groups, such as abused children, appear in several dimensions. Planners need to take this into account in prioritising actions, and in developing plans which make most sense in their communities.

The dimensions in more detail are as follows.

A life course approach

Ensure a positive start in life. Half of all mental health problems, excluding dementia, start by the age of 14. Childhood and early adulthood are key periods in the development of personal resilience and educational and social skills that will provide the foundations for good mental health across the whole life course.

A positive start in life

- Estimates suggest that between a quarter and a half of adult lifetime mental illness may be preventable through prevention of and early intervention in mental problems and disorders in childhood.
- At any one time 10% of children and young people have a mental health problem, most commonly emotional and conduct disorders.
- There is more development in mental, social and physical functioning during the first years of life than at any time across the lifespan.

- Universal and targeted interventions during the first few years of life can influence the entire life course and can reduce inequalities.
- Key interventions to promote good mental health and well-being are:
  - promoting parental mental and physical health
  - supporting good parenting skills
  - developing social and emotional skills
  - preventing violence and abuse
  - intervening early with mental disorders
  - enhancing play.
- Considerable lifetime savings can be achieved through early interventions.

Healthy later years

- Well-being in older age is associated with both cognitive ability and reduced mortality.
- An increasing proportion of the population are living longer. By 2020, one in five people will be 65 or older; by 2026, the increased costs of dementia alone will be an extra £9 billion per year.
- Interventions that particularly help to maintain mental health in later years include reducing poverty, keeping active, keeping warm, lifelong learning, social connections and community engagement, such as volunteering.
- Early intervention benefits those affected by mental illnesses such as depression and dementia and their carers. Early diagnosis and treatment of physical conditions is also important.

Build strength, safety and resilience

Prevent suicide by addressing individual resilience. Build community resilience through interventions aimed at preventing violence; reducing poverty, debt, unemployment, poor housing and homelessness; and mitigating the impacts of climate change.

- Poor mental health and well-being can be both a determinant and an outcome of poverty, disadvantage and social inequalities.
- Building resilience at the levels of the individual, family, community and environment can help promote well-being during times of adversity.
- Developing personal resilience can help to prevent suicide, in combination with effective community suicide prevention measures.
- Interventions to increase individual, family and community resilience include those which reduce inequalities, prevent violence, reduce homelessness, improve housing conditions and debt management and promote employment.
- Environmental resilience includes adapting to the effects of climate change and adverse weather events such as flooding.

Develop sustainable, connected communities

Reduce social exclusion by addressing stigma and discrimination. Enhance sustainable communities by promoting social and ecological engagement to develop connected, inclusive communities.

- The communities and environment in which we live affect mental health and well-being.

- Sustainable development promotes a healthy environment to support the well-being of a population.
- Sustainable interventions that promote mental health and well-being include insulating homes, healthy eating, active transport and access to green spaces.
- Social isolation increases the risk of developing mental health problems. Promoting social capital[2] connects communities and supports sustainability and well-being. Interventions that enhance social capital and build social networks include volunteering and social prescribing.
- Increasing access to green spaces can enhance well-being, increase social interaction and increase physical activity.
- Discrimination and stigma create social exclusion and contribute to mental and physical ill health as well as socio-economic inequalities.
- Evidence-based interventions to promote well-being and prevent mental ill health need to combine universal measures with targeted approaches aimed at socially excluded populations.

Integrate physical and mental health

Ensure good overall health by integrating approaches to promoting physical and mental health to reduce health-risk behaviours and health inequalities and improve health outcomes.

- Physical and mental health are intimately linked – physical ill health affects mental health and vice versa.
- People with mental illness are less likely to have their physical health problems diagnosed and treated; people with physical health problems often have undiagnosed mental health problems.
- Excess mortality and morbidity are both mediated by higher levels of health-risk behaviour such as smoking and excessive alcohol consumption.
- Depression is two to three times more common in people with chronic physical health problems.
- Depression is associated with a 50% increase in mortality, comparable with the effects of smoking, and is associated with increased rates of coronary heart disease, cancer and strokes.
- Key interventions include targeted health improvement programmes and physical health checks for people with mental health problems.
- Early intervention and treatment of mental health problems, including referral for psychological therapies, can improve health outcomes for people with physical illnesses. Early physical health promotion in those with mental illness increases well-being and also prevents development of physical health problems.

Promote purpose and participation

Enhance well-being through a balance of physical and mental activity, a positive outlook, creativity and purposeful community activity.

- Promote activities that balance physical and mental activity – including physical activity, lifelong learning, relaxation and sleep.

[2] Social capital can be described as the collective value of a person's social networks, which are a key aspect of mental well-being and of stronger, healthier, connected communities.

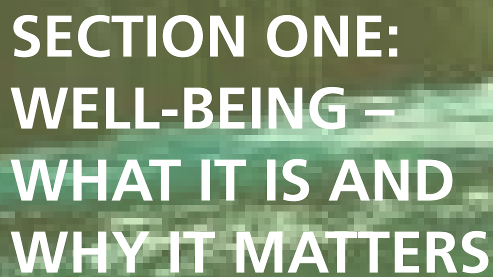
- Positive psychological interventions include psychological therapies, which promote positive thoughts and emotions, appreciation, goals and a sense of purpose.
- Mindfulness interventions promote awareness, quality of life, positive mood and reduce psychological distress; for some people, spirituality plays an important role.
- Participation in the arts and creativity can enhance engagement in both individuals and communities, increase positive emotions and a sense of purpose.
- 'Good Work' can provide meaningful activity and enhance well-being. Examples of healthy workplace practices include flexible working and initiatives to reduce workplace stress.
- Education and lifelong learning promote well-being and resilience and reduce the risk of mental illness.
- Leisure promotes well-being through associated meaningful engagement, self-expression, creativity and the opportunity to experience control and choice over such activities.
- Purposeful community activity, such as volunteering can help to develop values within communities and organisations.

What next

This is the first of a series of briefings on the evidence for how to promote positive mental health and well-being. Over the course of 2010 we will publish further detailed guidance for public health professionals, as well as short briefings for specific audiences such as Local Strategic Partnerships and Primary Care Trusts.

Summary of key messages for promoting well-being

- **Use a life course approach to ensure a positive start in life and healthy adult and older years. With such an approach, people develop and share skills to *continue learning* and have *positive social relationships* throughout life.**
- **Build strength, safety and resilience: *address inequalities* and ensure *safety and security* at individual, relationship, community and environmental levels.**
- **Develop sustainable, connected communities: create socially inclusive communities that promote *social networks* and *environmental engagement.***
- **Integrate physical and mental health: develop *a holistic view of well-being* that encompasses both physical and mental health, reduce health-risk behaviour and *promote physical activity.***
- **Promote purpose and participation to enhance positive well-being through a balance of physical and mental activity, relaxation, generating a positive outlook, *creativity* and *purposeful community activity*.**



SECTION ONE: WELL-BEING – WHAT IT IS AND WHY IT MATTERS

There are many definitions of well-being. For the purposes of this report, the following definition has been adopted:

A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.

1.1 Why develop well-being?

Mental health and well-being have been found to be associated with:

- **improved** educational attainment and outcomes, greater productivity and remaining in employment, improved cognitive ability and quality of life, and improved social connectedness
- **reduced** mortality, criminal behaviour, risk-taking behaviour (e.g. smoking), and sickness absence; and
- **increased** resilience – i.e. a greater ability to deal with life's problems and a reduced risk of developing mental illness or committing suicide.

The determinants of well-being and mental health are much more than simply the absence of risk factors for mental illness. Studies use different definitions and different populations, but the following factors have been shown to be associated with well-being and mental health:

- genetics, maternal care, upbringing and early experience
- personality factors
- age, gender and marital status
- strong social support

- socio-economic factors, including access to resources and reduced inequality
- work and other purposeful activity
- self-esteem, autonomy, having values such as altruism
- emotional and social literacy
- physical health.

1.1.1 The impact of poor mental health and mental illness

Mental illness is common and places an immense burden on individuals, families, friends and society. There are inequalities in the experience of care and treatment and inequalities that arise from having mental ill health.

One in four people will experience a mental health problem at some point in their life, and one in six of the adult population experiences mental ill health at any one time. For half of these people, the problem will last for longer than one year; for some it may last for many years.

One in 10 children has a mental health problem, which often continues into adulthood. Around 50% of lifetime mental illness (excluding dementia) starts by the age of 14 and continues to have a detrimental effect on an individual and their family for many years.

A quarter of adults have a hazardous pattern of drinking, 6% are dependent on alcohol, 3% are dependent on illegal drugs and 21% are tobacco smokers.

Mental illness is associated with a high prevalence of health-risk behaviour, such as smoking, alcohol and drug misuse, risky sexual behaviour and obesity.

Dementia currently affects 5% of people aged over 65 and 20% of those aged over 80. With the projected increase in longevity, the number of people living with and caring for those with dementia will continue to increase.

Although suicide rates have fallen to the lowest on record, this is not true for all groups, such as older men. A refreshed national suicide prevention strategy will address the needs of older men and other high-risk groups.

People with mental illness tend to have fewer qualifications, find it harder to get work, have lower incomes, are more likely to be homeless and more likely to live in areas of high social deprivation. Such socio-economic factors can disproportionately affect the mental health of people from black and minority ethnic communities in particular, as well as the effects of discrimination. This is

reflected in the higher rates of mental illness among some minority ethnic groups in the UK.

In the UK, mental disorder is responsible for 22.8% of the total disease burden, compared with 15.9% for cancer and 16.2% for cardiovascular disease, as measured by disability adjusted life years (DALYs) (WHO, 2008).

The NHS spends 11% of its annual budget on mental health services. Recent estimates put the wider economic costs at around £110 billion, of which £32 billion was estimated as due to lost productivity (Friedl and Parsonage 2007). Rates of mental illness may increase in the current economic climate.

Mental illness represents the single largest cause of disability. In England in 2007 service costs, which include NHS, social and informal care, were £22.5 billion. These costs are projected to increase by 45% to £32.6 billion by 2026 (at 2007 prices). This is mainly due to an increase of £9 billion in treatment and care for people with dementia (McCrone et al, 2008).

1.1.2 Mental health, mental illness and well-being

Well-being and mental health are not simply the absence of mental illness. Mental illness and mental health can be seen as separate but related so that it is possible for someone with a mental disorder to experience well-being and good mental health. Equally, it is possible for someone without clinical mental illness to have poor mental health. The absence of either mental health or mental illness does not imply the presence of the other. The presence of acute mental illness is likely to prevent a person from experiencing well-being or mental health although this would be possible during recovery.

According to the WHO (2005):

'Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies.'

The Foresight Mental Capital and Wellbeing Project (2008) defines well-being as:

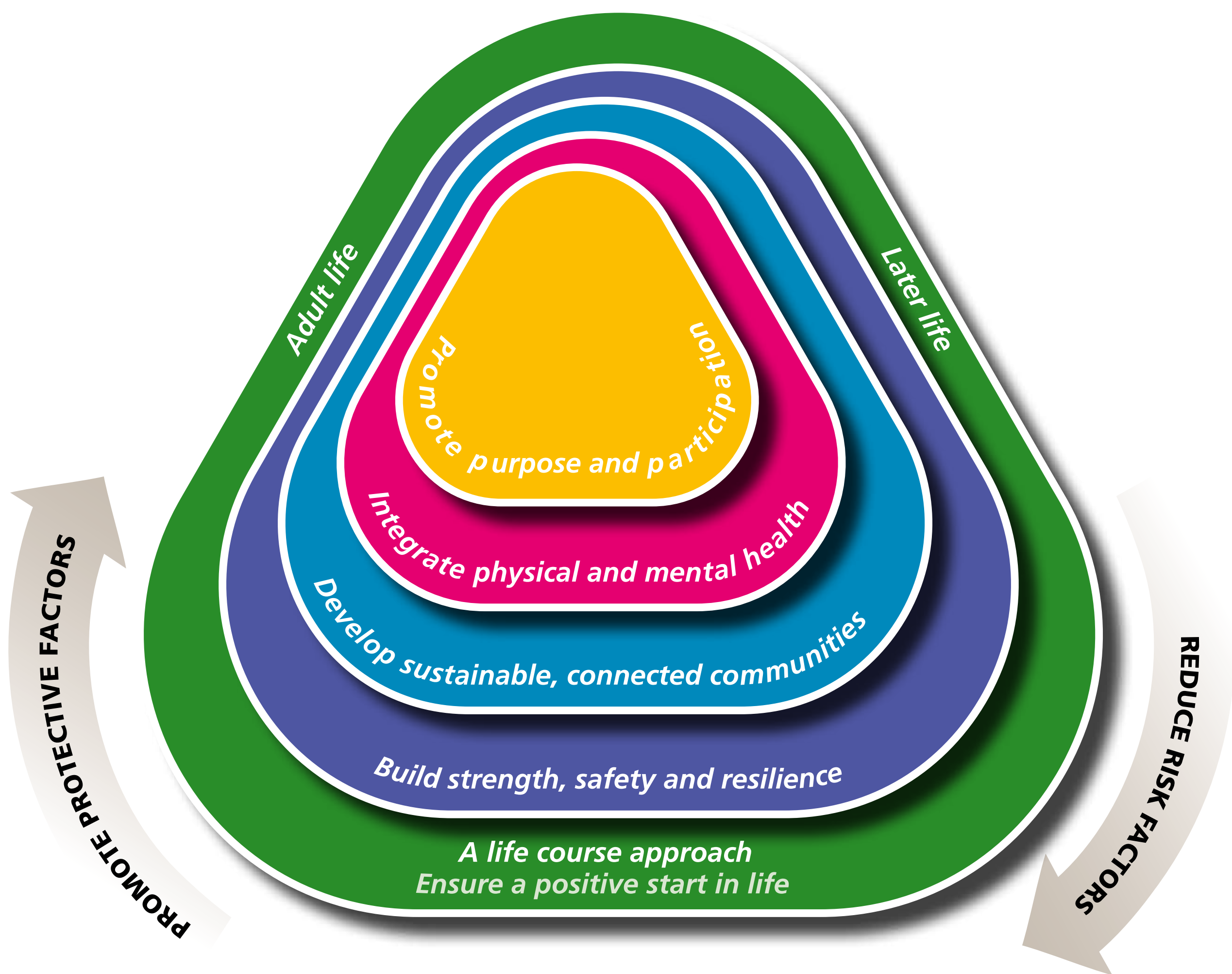
'[a] dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.'

A recent survey of 18,500 people in the North West of England found 20.4% of the population had relatively high levels of mental well-being (Deacon et al 2009). This is consistent with surveys from Scotland (Braunholtz et al 2007) and the US (Keyes 2002). In the North West survey rates of well-being across different localities varied widely.

1.2 A public mental health framework for well-being

The public mental health framework (see figure 1) below illustrates a structured approach to understanding how we can influence the mental health and well-being of individuals and communities. It takes a public health approach with a life course perspective. It seeks to make sense of the complex interplay between the many social, economic and environmental factors that influence individual and community mental

Figure 1: A framework for public mental health



health and well-being by organising interventions into five key domains:

- a life course approach: ensure a positive start in life and healthy older years
- build strength, safety and resilience
- develop sustainable, connected communities
- integrate physical and mental health
- promote purpose and participation.

This report is structured around the domains of the framework. It starts by setting out the policy context and the case for promoting mental health and well-being and then follows the framework headings.

1.3 The policy context and public service agreements

1.3.1 New Horizons

This report is part of New Horizons which is the Government's national vision for mental health in England (HMG, 2009). New Horizons adopts a dual approach: continued improvement of mental health services in England, coupled with actions across all government departments to promote the mental health and well-being of the whole population. Building on the National Service Framework for Mental Health and other key initiatives, New Horizons outlines how public services and agencies will take mental health forward through the next 10 years. It is the product of collaboration

between government departments and with a coalition of stakeholders from local government, the health and social care professions and the third sector.

This report supports New Horizon's aim to improve the mental health and well-being of the population.

1.3.2 Public Service Agreements

Improving population mental health and well-being supports a wide range of cross-government Public Service Agreements, as listed below.

Public Service Agreements (PSAs) associated with mental health and well-being*

PSA 2	Improve the skills of the population, on the way to ensuring a world-class skills base by 2020
PSA 8	Maximise employment opportunity for all
PSA 9	Halve the number of children in poverty by 2010-11, on the way to eradicating child poverty by 2020
PSA 10	Raise the educational achievement of all children and young people
PSA 11	Narrow the gap in educational achievement between children from low income and disadvantaged backgrounds and their peers
PSA 12	Improve the health and well-being of children and young people
PSA 13	Improve children and young people's safety
PSA 14	Increase the number of children and young people on the path to success
PSA 15	Address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief
PSA 16	Increase the proportion of socially excluded adults in settled accommodation and employment, education or training
PSA 17	Tackle poverty and promote greater independence and well-being in later life
PSA 18	Promote better health and well-being for all
PSA 20	Increase long-term housing supply and affordability
PSA 21	Build more cohesive, empowered and active communities
PSA 23	Make communities safer
PSA 25	Reduce the harm caused by alcohol and drugs
PSA 27	Lead the global effort to avoid dangerous climate change
PSA 28	Secure a healthy natural environment for today and the future

*See www.hm-treasury.gov.uk/pbr_csr07_psaindex.htm

1.3.3 The wider policy context

This report draws on an extensive policy background, including:

- **The Marmot review (2010)**
- **Keeping Children and Young People in Mind: The Government's full response to the independent review of CAMHS (2010)**
- **The Equalities Bill 2009**
- **The Health Act 2009**
- ***World class places: the Government's strategy for improving quality of place* (2009)**
- **The European Pact for Mental Health and Well-being (European Commission, 2008)**
- **The Climate Change Act 2008**

- ***Working Together To Protect The Public: The Home Office Strategy 2008–11*** **(2008)**
- ***Health, work and well-being – Caring for our future: A strategy for the health and well-being of working age people*** **(2008)**
- **Local Government and Public Involvement in Health Act 2007**
- ***Our Shared Future*** **(Commission on Integration & Cohesion, 2007)**
- ***Putting People First*** **(2007)**
- **The Children's Plan (2007)**
- ***Homes for the future: more affordable, more sustainable*** **(2007)**
- ***Our health, our care, our say: a new direction for community services*** **(2006)**
- ***Securing the future: delivering UK sustainable development strategy, HM Government*** **(2005)**
- ***Choosing health: Making healthy choices easier*** **(2004)**
- **Children's Act 2004**
- ***Every child matters: next steps*** **(2004)**

1.4 The science informing the report

This report draws on a review of the published literature and on a number of wider sources, including:

- National Institute of Health and Clinical Excellence (NICE) guidance
- WHO reports, including on the global burden of disease
- The Foresight review
- The Marmot review
- Publications of DH and other government departments
- Office for National Statistics (ONS) surveys
- North East Public Health Observatory (regarding data, maps and graphs)
- case studies of promising practice.

In addition, specific reviews were done in the following areas to support this work:

- a review of interventions to prevent mental illness and promote mental health
- a systematic review of school-based violence prevention interventions
- a review of the effect of housing interventions on mental health
- a review of positive psychology interventions and 'mindfulness' interventions
- a review of the co-morbidity of physical and mental health
- a summary of the health benefits of green spaces – building upon previous reviews
- a summary of the neuroscience and physiological processes affecting mental health
- a summary of the economics of mental illness, mental health and interventions to prevent mental illness, intervene early and promote mental health.

Research in this area is growing, but there are gaps in the evidence base. Critically, more research has been undertaken into the prevention of mental illness than into interventions to improve well-being.

A number of other factors have to be considered in interpreting the evidence

base. Different definitions and measures of well-being are used in different studies, with most studies using measures of mental illness rather than well-being. More evaluations and studies have been undertaken on interventions with children and young people and in the area of employment than on, for example, older people and on the environment. Some interventions are non-specific and may have effects over a number of domains. Findings in one group may not be applicable to another. Population-level interventions may impact differently on different groups and may inadvertently widen inequality. Not all studies are designed to measure both expected and unintended consequences.

It was not possible to undertake a systematic, comprehensive review of all the evidence in this area. However, specific reviews in a number of areas were undertaken, and all the evidence was graded to distinguish between systematic reviews, randomised controlled trials (RCTs) and small single studies, as follows:

- A = systematic review
- B = evidence from one or two RCTs
- C = evidence from non-RCT epidemiological studies
- D = research with high-level evidence for determinants or risk factors but without mental health outcomes
- E = qualitative research or promising interventions needing further epidemiological research.

The quality and types of evidence varied across the different parts of the framework. Greater emphasis has been given to those interventions for which robust evidence is available. Where RCTs were not available (as with many community-based approaches), a wider range of literature and evidence types was examined, using the following criteria:

- effectiveness of the interventions
- population impact – the percentage of the population that benefits from the intervention, combined with effect size
- potential for wider gains or co-benefits, including in health, education, employment, benefits to society, crime, and improved physical health
- cost effectiveness
- feasibility of implementation – for example, of mainstreaming within existing services or systems
- potential harm from the interventions
- potential barriers or obstacles in delivery of interventions
- the impact and benefits across the life course
- sustainability of interventions – in terms of both resources used and the environmental impact

Additionally, criteria for prioritising public health risks were considered, including:

- the size of potential risk – e.g. the number of people affected (mortality and morbidity), cost of harm
- the likelihood of the risk – range and certainty.

The interventions described here are not intended as a definitive list. They are simply a representative selection of those for which the available evidence is strongest and/or most promising. Care must also be taken to differentiate risk and causation: a risk factor is not necessarily causal and may be simply an association.

SECTION TWO: A LIFE COURSE PERSPECTIVE

2.1 Ensuring a positive start

National Indicators (NIs) relevant to ensuring a positive start

NI 43	Young people within the Youth Justice System receiving a conviction in court who are sentenced to custody (Ministry of Justice Departmental Service Objective (MoJ DSO))
NI 50	Emotional health of children (PSA 12)
NI 51	Effectiveness of child and adolescent mental health services (CAMHs), (Department for Children, Schools and Families (DCSF (DSO))
NI 53	Prevalence of breastfeeding at 6–8 weeks from birth (PSA 12)
NI 54	Services for disabled children (PSA 12)
NI 58	Emotional and behavioural health of children in care (DCSF DSO)
NI 62	Stability of placements of looked after children: number of moves (DCSF DSO)
NI 63	Stability of placements of looked after children: length of placement (DCSF DSO)
NI 64	Child protection plans lasting two years or more (DCSF DSO)
NI 65	Children becoming the subject of a Child Protection Plan for a second or subsequent time (DCSF DSO)
NI 69	Children who have experienced bullying (DCSF DSO)
NI 70	Hospital admissions caused by unintentional and deliberate injuries to children and young people (DCSF DSO)
NI 71	Children who have run away from home/care overnight (DCSF DSO)
NI 72	Achievement of at least 78 points across the Early Years Foundation Stage with at least six in each of the scales in Personal, Social and Emotional Development and Communication, Language and Literacy (PSA 10)
NI 87	Secondary school persistent absence rate (DCSF DSO)
NI 103	Special Educational Needs – statements issued within 26 weeks (DCSF DSO)
NI 109	Number of Sure Start Children's Centres (DCSF DSO)
NI 110	Young people's participation in positive activities (PSA 14)

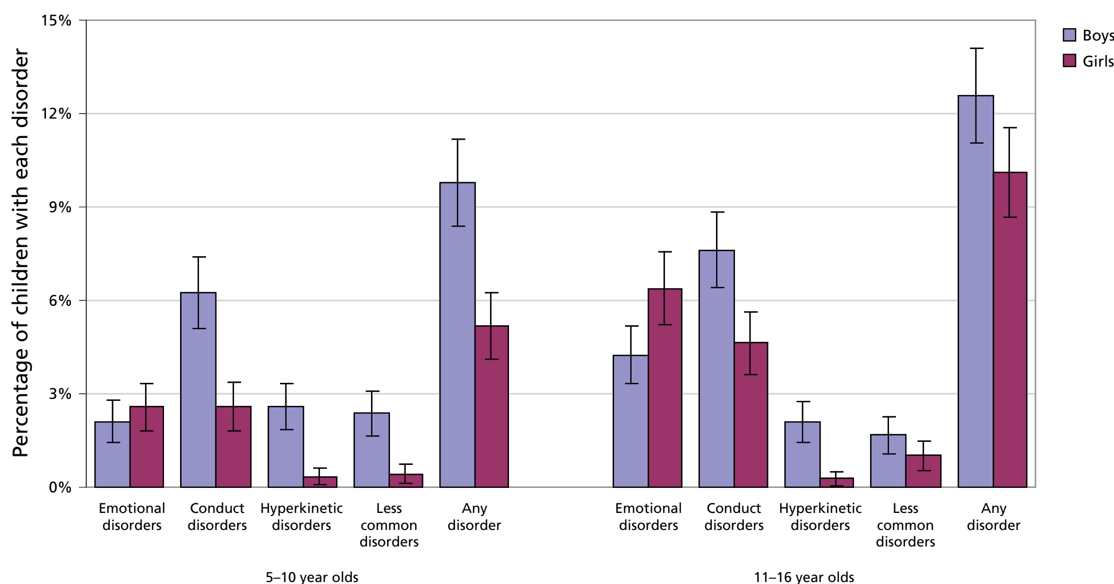
NI 111	First time entrants to the Youth Justice System aged 10–17 (PSA 14)
NI 114	Rate of permanent exclusions from school (DCSF DSO)
NI 116	Proportion of children in poverty (PSA 9)
NI 117	16–18 year olds who are not in education, employment or training (NEET) (PSA 14)
NI 118	Take-up of formal childcare by low-income working families (DWP DSO)
NI 126	Early access for women to maternity services (PSA 19)
NI 199	Children and young people's satisfaction with parks and play areas (DCSF DSO)

One in 10 children and young people at any one time has a mental health disorder (Green et al 2004). These include:

- **Conduct disorders** – 6% of 5–16 year olds have a conduct disorder. Conduct disorders are more common in boys than in girls.
- **Emotional disorders** – 4% of 5–16 year olds have an emotional disorder. They are more common in girls and include anxieties, depression and phobias.
- **Hyperkinetic disorders** – 2% of 5–16 year olds have a hyperkinetic disorder. They are more common in boys and include attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD).
- **less common disorders** – 1% of all 5–16 year olds suffer from less common disorders such as autism, eating disorders, tics and selective mutism.

As figure 2 demonstrates, the prevalence of emotional and conduct disorders increases with age. Eight per cent of children aged 5–10 have an emotional or conduct disorder, rising to 12% of children aged 11–16 years.

Figure 2: Prevalence of types of mental health disorder in children and young adults by age and sex, England, 2004



Source: ONS (Green et al, 2004)

Mental health and well-being in childhood influences mental health across the life course – up to half of lifetime mental health problems start by the age of 14 (Kessler, et al, 2005, Kim-Cohen, 2003) and estimates suggest that between a quarter to a half of adult mental illness may be preventable with appropriate interventions in childhood and adolescence (Kim-Cohen et al, 2003).

Poor mental health and well-being in childhood and adolescence is associated with many poor childhood outcomes such as lower educational attainment, increased likelihood of smoking, alcohol and drug use, poorer social skills and poorer phsyical health (see table 1 opposite).

Poor mental health and well-being in childhood and adolescence is also associated with a broad range of poor adult health outcomes. These include poorer adult mental health and an increased risk of suicide as well as higher levels of antisocial behaviour, involvement in crime, smoking, alcohol and drug misuse and poorer socio-economic status and lower levels of employment. (Fergusson et al, 2005).

Table 1: Relative risk (RR) of health and social skill outcomes, school outcomes and risk-taking behaviours in children and young people with and without mental disorders (Green et al, 2004)

		Emotional disorder	Conduct disorder	Hyperkinetic disorder	Whole survey
	Age	RR*	RR*	RR*	Prevalence
Health and social skill outcomes					
Health is fair or bad (parent report)	5–16	**4.6**	**3.4**	**2.6**	7%
Found it harder than average to make friends	5–16	**3.9**	**2.7**	**3.2**	10%
No friends	5–16	**6.0**	**8.0**	**5.0**	2%
School outcomes					
Two or more years behind in intellectual development	5–16	**1.4**	**4.0**	**4.4**	10%
More than 15 days' absence in the previous term	5–16	**4.3**	**3.5**	**2.2**	5%
Ever been excluded from school	5–16	**3.0**	**16.5**	**9.7**	4%
Self-reported risk-taking behaviours					
Regular smoker	11–16	**3.8**	**6.0**	**2.5**	6%
Regular drinker	11–16	**1.4**	**2.1**	**1.4**	9%
Drinks twice a week or more	11–16	**1.7**	**4.0**	**2.3**	3%
Taken drugs, mainly cannabis	11–16	**2.5**	**3.5**	**2.9**	9%
Taken drugs excluding cannabis	11–16	**4.0**	**2.5**	**5.0**	2%
Self-reported self-harm	11–16	**4.7**	**3.5**	**2.6**	7%

**RR = relative risk among those with the disorder, compared with those without it*

2.1.1 Risk factors and high-risk groups

A wide range of factors influence the risk of mental illness in childhood, including (Green et al, 2004):

- age (the older the child, the greater the risk)
- sex (boys are at greater risk than girls); and
- ethnicity (white children are at highest risk, Indian children at lowest).

Table 2 summarises these increased risks and their prevalence. Risk factors do not indicate causation – some risk factors are likely to be markers for other circumstances that increase the likelihood of mental disorders and illness.

Where possible, adjusted figures are given that take account of other factors. For example, having a mother with poor mental health means a child is five times more likely to develop an emotional or conduct disorder, even after account is taken of the influence of factors such as exposure to family discord and stressful life events.

Table 2A: Summary of risk factors and for poor mental health in children and young people

Risk factor	Impact on mental health and well-being	Prevalence in population
Poor parental mental health	4–5 fold increased rate in onset of emotional/conduct disorder in childhood (Meltzer et al, 2003)	10% of mothers experience post-natal depression (NICE, 2007)
Unemployed parent	2–3 fold increased risk in onset of emotional/conduct disorder in childhood (Meltzer et al, 2003)	1.9 million children live in a workless household (ONS, 2009)
Poor parenting skills	4–5 fold increased risk of conduct disorder in childhood (Meltzer et al, 2003)	
Parents with no qualifications	4 fold increased risk of mental health problems in children. (Green et al, 2004)	
Low birth weight	Associated with increased risk of common mental disorder (Colman et al, 2007)	
Deprivation – children in families with lower income levels	3 fold increased risk of mental health problems (15% vs 5%) (Green et al, 2004)	In 2007/08, 4 million (30%) children living in relative poverty (less than 60% of median income) after housing costs (DWP, 2009)
Four or more adverse childhood experiences (ACEs)	12.2 fold increased risk of attempted suicide as an adult 10.3 injecting drug use 7.4 alcoholism 4.6 depression in past year 2.2 smoking (CDC, 2005)	15% of females and 9% of males experience four or more ACEs (CDC, 2005)
Child abuse (physical, emotional and/or sexual abuse and/or neglect)	15.5 fold increased risk of minor depression as a child 8.9 suicidal ideation 8.1 anxiety 7.8 times increased rate of recurrent depression as adult 9.9 PTSD 5.5 substance misuse (Collishaw et al, 2007)	16% of children (1 in 6) experience serious maltreatment by parents (Cawson, 2002)

Risk factor	Impact on mental health and well-being	Prevalence in population
Adolescent dating violence (i.e. physical or sexual abuse by a dating partner)	8.6 fold increased risk of suicidality (Silverman et al, 2001)	8.9% of women and 1.2% of men aged 16–19 sexually assaulted in previous 12 months (Povey et al, 2009)
High level use of cannabis in adolescence	6.7–6.9 fold increased risk of developing schizophrenia (Zammit et al, 2002)	9% of children aged 11–15 report cannabis use in last year, 7% of 15 year olds report frequent drug use (NatCen, 2009)

Table 2B: Summary of risk factors for poor mental health in children and young people from high risk groups

Risk factor	Impact on mental health and well-being	Prevalence in population
Children with learning disability	6.5 fold increased risk of mental health problem (Emerson and Hatton, 2007)	2.6% of pupils have learning disabilities (Emerson and Hatton, 2008)
Children with physical illness (e.g. diabetes, asthma, cerebral palsy)	1.7/2.9 fold increased risk of emotional/conduct disorders over a three-year time period (Clements et al, 2008)	5% to 6% of children report /are reported by parents as being in 'fair or poor' health) (Health Survey for England, 2009). This equates to about 600,000 children
Homelessness in young people	8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation (Mental Health Foundation, 2002)	Three per 1,000 households accepted as homeless by Local authorities (CLG, 2009) Estimated 36,000 to 52,000 young people (aged 16–24) homeless in England (Pleace and Fitzpatrick, 2004)
Young lesbian, gay, bisexual and transgender (LGBT)	16% of young lesbians and bisexual women aged under 20 have attempted suicide (Hunt, 2008).	Estimate 6% of population are LGB (DTI, 2005)

Young offenders	18 fold increased risk of suicide for men in custody aged 15–17 (Fazel et al, 2005) 40 fold increased risk of suicide in women in custody age ≤ 25 (Fazel et al, 2009) 4 fold increased risk of anxiety/ depression (Lader et al, 2000) 3 fold increased risk of mental disorders (Lader et al, 2000)	Over 6,000 children aged under 18 entering custody during a year – the vast majority are boys (HM Government, 2009) 10% of 10–25 year olds report committing a serious offence in previous year (Roe and Ashe, 2008)
'Looked after' children	5 fold increased risk of childhood mental disorder (Meltzer et al, 2003b) 6–7 times conduct disorder (Meltzer et al, 2003b) 4–5 times suicide attempt as an adult (Vinnerljung, 2006)	60,900 children (i.e. 0.5% of children aged under 18) are 'looked after' in England (DCSF, 2007)
Children of prisoners	3 fold increased risk of antisocial-delinquent outcomes (SCIE, 2008)	160,000 children and young people per year have a parent in prison (Niven and Stewart, 2005)

*Adverse Childhood Experiences include physical, emotional or sexual abuse, neglect, mother treated violently, household substance misuse or mental illness and parental separation or divorce.

Emotional and conduct disorders also increase the risk of subsequent mental disorder. For instance, those with conduct disorder have a six fold increased risk of other mental health problems (Emerson and Hatton 2007). 40–70% of children with conduct disorder will go on to develop antisocial personality disorder (Steiner & Dunne, 1997; Gelhorn et al, 2007). Anti-Social Personality Disorder (ASPD) has similar prevalence rates to schizophrenia although rates of 63% occur in remand prisoners and 49% of male sentenced prisoners (Singleton et al, 1998). However, prevention of ASPD can occur through interventions for conduct disorder (NICE, 2009).

2.1.2 Influences at different stages of the life course

Experiences during pregnancy and in the first few years of life lay the foundations for all future learning, behaviour and health (Center on the Developing Child, 2007). Maternal health during pregnancy and the child–parent relationship during the first few years of life have a very significant influence on brain architecture, lifelong habits and patterns for dealing with life and adversity, and future mental health and well-being (CISECD, 2000).

Alcohol, tobacco and drug use during pregnancy increase the likelihood of a wide range of poor outcomes that include long-term neurological and cognitive-emotional development problems (WHO 2004). Maternal stress during pregnancy can increase the risk of behavioural problems in the child (O'Connor, 2005).

Between the ages of one and 10, the child undergoes very rapid intellectual, emotional and social development. As this development is experience dependant, positive activities and learning are very important (CISECD, 2000).

The preschool years (age three to five) are a period of exploration and growing independence. During this period social-emotional skills, such as self-awareness, self-regulation and empathy, also develop as the child learns how to express their emotions and interact with others. Play and the development of social relationships become increasingly important.

These skills continue to develop throughout primary school years. A positive relationship between the child and at least one parent, of either sex, is important in the development of resilience and well-being (O'Dougherty et al, 2006).

Factors that affect neurodevelopment during adolescence can influence the young person's emotional, social and cognitive functioning into adulthood. Powerful motivators of behaviour include social approval, acceptance and inclusion. Social reward is particularly important during adolescence (Sebastian et al, 2008).

During adolescence, alcohol and substance abuse may disrupt the neural reorganisation of the brain occurring during this period thereby affecting attention, learning and memory (Paulus and Tapert, 2008)

Resilience including resistance of peer pressure is associated with competence, confidence, connectedness, character and caring (Paus, 2008). Development of resilience is also associated with parental affection and involvement in the school as well as the presence of positive community role models.

2.1.3 Interventions that promote good mental health and well-being in children and young people

Effective interventions exist which both promote well-being and prevent mental illness. Good evidence also exists for interventions before a mental health problem has become more serious as well as early treatment if it has already developed.

Interventions during childhood and adolescence have both short-term and life-course impacts, including improved educational and psychosocial outcomes, reduced antisocial behaviour, reduced crime and violence, improved family health, reduced mental illness during adulthood as well as improved earnings.

There is an economic cost to *not* providing, as well as in providing, services to meet the needs of young people. Prevention of even a small percentage of mental and substance abuse problems will result in substantial cost savings and improved quality of life for children, families and communities.

Robust cost-benefit evidence exists for prevention and early intervention which can have lifetime benefits for the child, as they become an adult and a parent themselves. Prevention and early intervention can thereby break down cycles of inequality running through generations of families (Marmot et al, 2009). The economic returns of early childhood interventions exceed cost by an average ratio of six to one (NICE, 2009). A number of studies have demonstrated significant cost benefits from early years

interventions, and particularly for long-term outcomes (Karoly et al, 2005).

Table 3 summarises the evidence to support interventions with children and young people to promote mental health and well-being and prevent mental illness and disorders.[3]

Table 3: Summary of evidence review for ensuring a positive start in life

Intervention/programme area	Intervention/programme with evidence grade A/B/C/D/E	Outcomes achievable (key benefits and examples of size of benefit – small (S), medium (M), large (L))
Promote good parental mental and physical health – identify risk factors and promote good parent-child interactions. Intervene both antenatally, postnatally and in later years with universal and targeted approaches	Home visiting programmes (A) (Elkan et al, 2000)	Reduced maternal depression (L) Largest effect in high-risk families
	Health visitor training (B) (Morrell et al, 2009)	Reduced postnatal depression
	Parenting programmes (A) (Barlow et al, 2003)	Reduced parental depression (S)
	Cognitive Behavioural parenting programmes (A) (Barlow et al, 2003)	Improved parental psychological health
	Telephone peer support (B) (Dennis et al, 2009)	Reduced postnatal depression (M)
	Reduced smoking (A) (Einarson and Riordan, 2009) Breast feeding (A) (Horta et al, 2007)	Improved birth weight (L), Improved physical health (S), Reduced mortality (L) Higher intelligence scores, reduced hypertension, obesity and diabetes
Promote good parenting skills – universal as well as targeted programmes to improve the relationship between parent and child, improve child behaviour, prevent and treat conduct problems	Parenting programmes (B) (Barlow et al, 2003)	Improved parental efficacy (M) Improved parenting practice (M)
	Home visiting programmes (A) (Bakermans-Kraneburg et al, 2003)	Improved maternal sensitivity (S)
	Sure Start (C) (Melhuish et al, 2008)	Less negative parenting (L)

[3] Promoting the emotional health of children and young people: Guidance for Children's Trust Partnerships including how to deliver N.I.50 sets out a detailed service specification (using evidence-based approaches) to support Children's Trusts in developing a comprehensive strategic approach to promote emotional well-being. http://www.dcfs.gov.uk/everychildmatters/resources_and_practice/IG00639

Intervention/programme area	Intervention/programme with evidence grade A/B/C/D/E	Outcomes achievable (key benefits and examples of size of benefit – small (S), medium (M), large (L))
Promote child social and emotional skills – to support the development of good relationships with peers, friends and family; and to promote child's self-awareness, ability to manage feelings, motivation, empathy and social skills	Preschool/early child education programmes (A) (Anderson et al, 2003; Sylva et al, 2007)	Improvement in social and cognitive skills, school readiness, improved academic achievement and positive effect on family outcomes including for siblings. Prevention of developmental delay
	Home visiting programmes (A) (Tennant et al, 2007)	Improved child functioning, reduced behavioural problems
	Combined programmes for preschool children from disadvantaged areas (A) (Nelson et al, 2003)	Improved parent family wellness (S) Improved year 8 cognitive and social and emotional outcomes (S)
	Parenting programmes (A) (Barlow et al, 2003 Barlow et al, 2002; Tennant et al, 2007) (De Graaf et al, 2008) (Dretzke et al, 2009) (Kendrick et al, 2007) (Hutchings et al, 2007) (Woolfenden et al, 2001)	Improved parental mental health (S) Improved child emotional and behavioural adjustment in first three years (S/M) Improved behaviour in high-risk children Improved behaviour in children with conduct problems (M/L) Improved safety at home (M) Reduced antisocial behaviour (M) Reduced re-offending (M)
	School-based mental health promotion (A) (Stewart-Brown, 2006; Adi et al, 2007)	Improved well-being (M/L) Improved self-esteem (M) Reduced conduct problems and emotional distress (S). More effective approaches were long term, whole school, focusing on promotion and including teacher training and parental participation
	US social emotional learning (A) (Payton et al, 2008) (the UK programme SEAL is based on this)	Reduced conduct problems and emotional distress (S) Improved social and emotional skills (M), attitude about self, social behaviour
	Family intervention projects (C)	Reduced antisocial behaviour (L) Reduced domestic violence (L) Reduced poor parenting (L)

Intervention/programme area	Intervention/programme with evidence grade A/B/C/D/E	Outcomes achievable (key benefits and examples of size of benefit – small (S), medium (M), large (L))
Develop violence and abuse prevention skills – improve life skills to deal with conflict and promote respectful relationships; and to prevent bullying, youth violence and dating violence	School-based violence prevention programmes (A) (Mytton et al, 2006)	Targeted – reduced violence (M)
	School-based sexual abuse prevention (A) (Zwi et al, 2009)	Increased prevention skills (L) Behaviour change (L)
	School-based bullying prevention (A) (Ttofi et al, 2008)	Reduced bullying (S/M)
	Parent training programmes (A) (Woolfenden et al, 2001, Hutchings et al, 2007)	Reduced re-offending and antisocial behaviour
	Multi-systemic therapy (A) (Curtis et al, 2004)	Reduced unintentional injury (L) Reduced recidivism for serious antisocial behaviour in children (L)
Prevention of child emotional and conduct disorder Targeting high-risk groups with extra support	Reduced maternal smoking (C)	Reduced infant behavioural problems and ADHD (S)
	Home visiting programmes (A) (Waddell et al, 2007)	Reduced behavioural problems
	Parenting programmes (A) (De Graaf et al, 2008)	Improved child emotional adjustment and behaviour (M) in high-risk children
	Preschool programmes (A) (Tennant et al, 2007)	Prevention of emotional and conduct disorder (S)
	School programmes (A) (Tennant et al, 2007) (Horowitz and Garber, 2006; Merry et al, 2006)	Prevention of conduct disorder and anxiety (S) Prevention of depression (S)

Intervention/programme area	Intervention/programme with evidence grade A/B/C/D/E	Outcomes achievable (key benefits and examples of size of benefit – small (S), medium (M), large (L))
Intervention at first/ early signs of mental illness	School-based prevention and intervention programmes for children with emotional disturbance not yet a level of disorder (A) (Reddy et al, 2008)	Improved mental health (L), Improved behaviour at school and home (L), Improved social skills (L), Improved academic skills (L)
Intervene early with mental disorders	Early intervention for conduct disorder with individual parenting programmes (A) (Dretzke et al, 2009) Early intervention for emotional disorders (NICE, 2005) Early intervention for ADHD (NICE, 2009)	Improved child behaviour (M) Improved family relationships Reduced conduct disorder Improved educational outcome Reduced antisocial behaviour and crime (M) Reduced length of illness Reduced aggression and antisocial behaviour (Scott et al, 2008) Parent training intervention in first instance
	Treatment of those with earliest stage of psychotic illness or At Risk Mental State (ARMS) (B)	Early treatment of ARMS reduces transition to psychosis from 35% to 15% (NNT 4) (McGorry et al, 2002; McGlashan et al, 2006)
	Early intervention for psychosis (A) (Harvey et al, 2007)	Fewer psychotic symptoms, more likely to be in remission, better course of illness after eight years (Mihalopoulos et al, 2009), 50% suicide reduction (Harris et al, 2008), reduced homicide
	Early intervention for borderline personality disorder (B)	Improved functioning for adolescents, reduced pyschopathy and parasuicidal behaviour (Chanen et al, 2008)
Increase outdoor play	Enhance play and outdoor activity (C)	Improved attention and social skills, reduced obesity, increased physical activity
	US outdoor physical activity and group programme (A) (Wilson et al, 2000)	Reduced imprisonment/re-offending, reduced arrest and days in prison, reduced re-offending

2.2 Promoting mentally healthy living in later life

National Indicators relevant to promoting a mentally healthy later life

NI 2	Percentage of people who feel that they belong to their neighbourhood (PSA 21)
NI 3	Civic participation in the local area (PSA 15)
NI 4	Percentage of people who feel they can influence decisions in their locality (PSA 21)
NI 125	Achieving independence for older people through rehabilitation/intermediate care (PSA 18)
NI 138	Satisfaction of people over 65 with both home and neighbourhood (PSA 17)
NI 139	People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently (PSA 17)
NI 141	Number of vulnerable people achieving independent living (Communities and Local Government (CLG) DSO)
NI 142	Number of vulnerable people who are supported to maintain independent living (PSA 17)
NI 187	Tackling fuel poverty – people receiving income-based benefits living in homes with a low energy efficiency rating (Department for Environment, Food and Rural Affairs (Defra) DSO)

In 2008, there were 18.3 million people aged 60 and older in the UK (ONS, 2009). By 2033, the number of people in the UK aged 75 and over is projected to increase from 4.8 million to 8.7 million while for those aged 85 and over, the projected increase is from 1.3 million in 2008 to 3.3 million (ONS, 2009)

Life expectancy has also been steadily increasing in England over the last 25 years. For men, it has risen from 71.1 years in 1981 to 77.8 years in 2008. For women, it rose from 77.0 years in 1981 to 81.9 years in 2008 (ONS, 2010). However, increases in overall life expectancy have not been matched by increases in healthy life expectancy (ONS, 2008). The expected time lived in poor health for males rose from 6.5 years in 1981 to 8.7 years by 2001; for women it rose from10.1 years to 11.6 years.

Concepts of mental health in older people do not differ substantially from those held by younger people; most differences in behaviour are caused by physical and mental illness or social disadvantage, rather than the ageing process. However, age-related decline in mental well-being should not be viewed as an inevitable part of ageing and both the expectations of older people themselves and of society in general should be higher (Mental Health and Older People Forum, 2008; NICE, 2008).

Common misconceptions include the assumption that depression is natural and cognitive decline is a normal feature of ageing. Improved physical health, supportive social conditions and opportunities for personal growth improve mental health regardless of age. Wider benefits of mental health promotion in older age also impact on wider society and can reduce costs of care (UK Inquiry into Mental Health and Well-Being in Later Life, 2006).

Positive mental health is associated with reduced mortality (Chida and Steptoe, 2008). Poor mental well-being is more strongly associated with increased mortality risk than mental ill health (Huppert and Whittington, 2003).

Mental well-being is associated with improved cognitive capability (Lewellyn et al, 2008).

2.2.1 Influences on mental health and well-being in later life

The following factors have been found to be particularly important influences of the mental health and well-being of older people (NICE, 2008):

- discrimination
- participation in meaningful activities
- relationships
- physical health
- poverty (UK Inquiry into Mental Health and Well-being in Later Life, 2006).

Factors which were most frequently mentioned by older people as important to their mental well-being include social activities, social networks, keeping busy and 'getting out and about', good physical health and family contact (Third Sector First, 2005; Audit Commission, 2004).

2.2.2 Depression

An estimated 40% of older people who consult their general practitioner (GP) have some form of mental health problem, rising to 50% of older people in general hospitals and 60% of care-home residents (DH, 2005). Approximately 25% of older people in the community have symptoms of depression that require intervention, with 11% having minor depression and 2% having major depression (Godfrey et al, 2005; Craig and Mindell, 2007). Risk increases with age so that 40% of those over 85 are affected.

Approximately 20–25% of people with dementia also have major depression, while 20–30% have minor or sub-threshold depression (Amore et al, 2007). Treatment of depression in older people results in improved quality of life. Although depression in older adults occurs at similar rates to younger adults, only 15% of older people with depression are diagnosed and receive treatment in primary care (Godfrey et al, 2005).

2.2.3 Dementia

Dementia affects 5% of people aged over 65 and 20% of those aged over 80 (Knapp et al, 2007) although only a third of cases of dementia are currently ever diagnosed (NAO, 2007), meaning opportunities to minimise harm and promote good life quality are not taken. In 2004, Alzheimer's disease and other dementias accounted for 3.9% of total DALYs in the UK (WHO, 2008). Prevalence of dementia in England is predicted to rise from 680,000 in 2007 to 1.7 million people by 2051 (Knapp and Prince, 2007) with very considerable associated rise in the cost of care.

Factors associated with increased risk of developing dementia include high blood pressure, high body mass index, smoking and possibly diabetes, (Peters, 2009). This highlights the overlap with risk factors for cardiovascular disease. No clear evidence exists with regard to cholesterol while alcohol intake may be linked to the development of dementia in 10–24% of cases in the UK (Marshall et al, 2009). Binge drinking and increased consumption may result in earlier development of serious memory problems.

Interventions

Promoting good health and healthy behaviours throughout life has the potential to ensure that benefits are continued into later years. Substantial gains can occur through the adoption of a long-term strategy that prevents problems developing. For example,

interventions that help to look after the heart (not smoking, moderate alcohol, physical exercise, low blood pressure, healthy diet) also help to protect against cognitive decline and dementia in old age.

Many of the interventions in other chapters are applicable to people of all ages; the interventions in table 4 (below) apply specifically to those in their later years.

Table 4: Summary of evidence for interventions to promote mentally healthy later years

Intervention area and approaches	Intervention/programme	Evidence quality A/B/C/D/E	Outcomes
Promotion of well-being	**Psychosocial interventions**	A (Pinquart and Sorenson, 2001)	Control enhancing interventions, cognitive behaviour therapy (CBT), relaxation and group interventions were more effective
	High social support for older people before and during adversity	C	Increased resilience by 40–60%
	Prevention of social isolation	A (Cattan et al, 2005)	Improved self-reported measures
	Multi-agency response to prevent elder abuse	C	Improved well-being
	Walking and physical activity programmes	A (NICE, 2008)	Improved well-being, reduced mental health problems including depression
	Learning	C	Improved well-being, increased meaning
	Volunteering	A	Improved well-being
Prevention and early intervention for depression	**Early treatment of depression**	A	Reduced depression and improved quality of life
	Prevention of depression in high-risk groups	C	Reduced depression

Intervention area and approaches	Intervention/programme	Evidence quality A/B/C/D/E	Outcomes
Prevention of dementia	**Exercise**	C	Reduced risk of dementia in those without cognitive impairment
	Antihypertensive treatment	A (Fournier et al, 2009; Li et al, 2010)	Reduced risk of dementia with certain antihypertensive medication

SECTION THREE: BUILD STRENGTH, SAFETY AND RESILIENCE

National Indicators relevant to building strength, safety and resilience

NI 15	Serious violent crime rate (PSA 23)
NI 19	Rate of proven re-offending by young offenders (PSA 23)
NI 26	Specialist support to victims of a serious sexual offence (PSA 23)
NI 32	Repeat incidents of domestic violence (PSA 23)
NI 50	Emotional health of children (PSA 12)
NI 116	Proportion of children in poverty (PSA 9)
NI 117	16–18 year olds who are not in education, training or employment (NEET) (PSA 14)
NI 118	Take up of formal childcare by low-income working families (Department for Work and Pensions (DWP) (Department of Strategic Objectives)
NI 146	Adults with learning disabilities in employment (PSA 16)
NI 148	Care leavers in employment, education or training (PSA 16)
NI 149	Adults in contact with secondary mental health services in settled accommodation (PSA 16)
NI 150	Adults in contact with secondary mental health services in employment (PSA 16)
NI 152	Working age people on out-of-work benefits (PSA 8)
NI 156	Number of households living in temporary accommodation (PSA 20)
NI 158	Percentage of decent council homes (Communities and Local Government (CLG DSO)
NI 173	Flows on to disability benefits from employment (DWP DSO)
NI 187	Tackling fuel poverty – percentage of people receiving income-based benefits living in homes with a low energy efficiency rating (Defra DSO)
NI 195	Improved street and environmental cleanliness (levels of graffiti, litter, detritus and fly posting) (Defra DSO)

Resilience is an important aspect of well-being and mental health. Resilience may help mitigate the negative impacts of inequalities as well as promote personal and community capacity to face other challenges (Friedli, 2009).

3.1 Inequalities and mental health

A social gradient in health exists in that better social and economic position results in better health (Marmot et al, 2010). Social and economic inequalities

are fundamental drivers of health and well-being. In England each year, between 1.3 million and 2.5 million years of life are lost as a result of health inequality, which results in an annual cost of £56–68 billion (Marmot et al, 2010).

Relative deprivation is associated with increased risk of mental illness (Melzer et al, 2004), with 15% of children at the lowest income levels experiencing mental health problems compared with 5% of children at the highest income levels (Green et al, 2004). Higher income inequality is linked to higher rates of mental illness, decreased rates of trust and social capital, and increased hostility, violence and racism (Wilkinson and Pickett, 2007) as well as lower well-being scores (Alesina et al, 2004).

Poor mental health is associated with unemployment, lower income and other adversity. It is also associated with increased risk-taking behaviour, so that increased smoking is responsible for a large proportion of the excess mortality of people with mental health problems (Brown et al, 2000). One explanation for the strong social gradient in health is that relative deprivation is a catalyst for a range of negative emotional and cognitive responses to inequity (Marmot and Wilkinson, 2006). Such stress may underlie the causes of some unhealthy behaviours (Marmot, 2004).

Mental illness further exacerbates inequality, those with serious mental illness dying on average 25 years earlier than those without (Parks et al, 2005). Stigma and discrimination compounds this inequality.

Mental health, individual resilience and social exclusion are influenced by a range and interaction of different factors across the life course such as social position, education, housing, employment and exposure to violence. Addressing these wider determinants will improve health and reduce inequalities (DH, 2009; Marmot et al, 2010). The *Strategic Review on Health Inequality* identified six key areas:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.

- Strengthen the role and impact of ill-health prevention.

Action on these key areas may also improve levels of personal and community resilience and promote social capital.

3.2 Risks and resilience

Table 5 below summarises and quantifies the risk factors that can affect resilience and a sense of safety and security at individual and community level. They include adverse life events such as experiences of violence and abuse, debt, unemployment, poverty and poor housing, and climate-related events.

Note that risk means only that there is an association between the presence of the factor and an increased likelihood of poor mental health, not that the factor causes poor mental health.

Table 5: Risk factors associated with strength, safety and resilience

Safety, security and resilience	Risk factor associated with increasing risk of poor health outcomes	By how many times is this factor associated with an increase in risk?	How common is this risk factor in the population?
Life events:	Adults who experience two or more stressful life events are at risk of developing a common mental health problem (Melzer et al, 2004) Violence in the home is associated with increased rates of: • probable psychosis • current neurotic disorder • alcohol dependence • drug dependence (Bebbington et al, 2004)	3.2 9.0 5.2 3.1 3.7	
Household income Debt	People in lowest 20% of household income have increased rate of mental disorder compared with those in top 20% (McManus et al, 2009) Higher levels of debt associated with: • common mental disorder • psychosis • alcohol dependence • drug dependence (Jenkins et al, 2008)	2.7 3 4.1 3.1 3	Althouth both low income and debt are associated with mental illness, the effect of income may be mediated by debt (Jenkins et al, 2008)

Safety, security and resilience	Risk factor associated with increasing risk of poor health outcomes	By how many times is this factor associated with an increase in risk?	How common is this risk factor in the population?
Adult employment status	Compared to adults working full time, adults who are economically inactive are at increased risk of: • common mental disorder • disabling mental disorder (Melzer et al, 2004)	 1.9 5.6	In 2008/09 36% of households were economically inactive (26% retired) (CLG, 2009)
	Unemployment is associated with increased risk of: • common mental disorder • disabling disorder (Melzer et al, 2004)	 2.7 4.3	2.26 million working age adults are in receipt of disability benefits (DWP, 2010)
	Adults in work with low decision latitude have increased risk of: • depression • anxiety (Griffin et al, 2002)	 1.5 1.3–1.4	43% of people receiving incapacity benefit have mental health problems (DWP, 2009)
Housing	Compared to living in a detached house, living in a flat/bedsit is associated with increased risk of: • common mental disorder • disabling disorder (Melzer et al, 2004)	 1.8 3.3	In 2007, 34.6% of households lived in non-decent housing (CLG, 2009)
	Homelessness is associated with increased rates of: • probable psychosis • current neurotic disorder • alcohol dependence • drug dependence (Bebbington et al, 2004)	 11.3 3.9 5.5 5.6	3 per 1000 households are homeless (DCLG, 2009)
Fuel poverty	People living in fuel poverty are more likely to suffer: • anxiety or depression • high or moderate stress (Green & Gilbertson, 2008)	 4 2.5	36,700 excess winter deaths in England and Wales in 2008/09. At least 2.9 million households living in fuel poverty in 2007

Safety, security and resilience	Risk factor associated with increasing risk of poor health outcomes	By how many times is this factor associated with an increase in risk?	How common is this risk factor in the population?
Extreme weather events (Reacher et al, 2004) Cohort study	Adults who experience flooding in their homes are at risk of psychological distress (Reacher et al, 2004)	4	5.2 million properties at risk of flooding (Environment Agency, 2009)

The interventions outlined in this section seek to build:

- **personal resilience** – interventions relevant to reducing the risk of suicide and self-harm are discussed here, other aspects of personal resilience are covered in section 6, 'Promote purpose and participation'. Childhood social and emotional skills are covered in section 2.1, 'Ensuring a positive start'.
- **family and relationship resilience** – building strong relationships and addressing the fear of violence and abuse within the home and the community
- **financial resilience** – through debt management and reducing unemployment
- **resilience in the home** – through securing safe accommodation and ensuring affordable warmth
- **environmental resilience** – through measures to mitigate the impacts of flooding, heat waves and climate change.
- Table 6 below summarises the quality rated evidence for interventions aimed at addressing these risks. It is important to remember that lack of evidence or lower strength may simply reflect lack of research. It does not mean that interventions do not work or that topics do not have public health impact or importance. Also, the effectiveness of interventions can be affected by the quality of their implementation.

Table 6: Summary of quality and outcomes for interventions aimed at building strength, safety and resilience

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Suicide prevention	Targeting high-risk groups including those with serious mental illness, young men, prisoners	C	
	Restricting access to suicide hot spots	C	50% reduction in suicides
	Restricting sale of paracetamol	C	295 fewer suicides, 349 fewer accidental poisonings
	Collapsible fittings in psychiatric inpatient units	C	No suicides in units as a result of hanging from non-collapsible bed or shower curtain rails since 2004
	Education programmes for general public and health professionals	D	Improved staff skills Improved SSRI prescribing and reduced suicides
	Improved media reporting	D	
Violence prevention	See section 2.1, 'Ensuring a positive start'		
Reduced alcohol-related harm	Control of availability	C (WHO, 2009)	Reduction in violence
	Increase price	C (WHO, 2009; Matthews et al, 2006)	Reduction in violence
	See table 10 for other interventions which reduce alcohol use and thereby reduce related violence		

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Improve urban environment	Improved street lighting	C	20% reduction in overall crime
	Safe, green spaces	C	Reduced family aggression/violence indicators
	Neighbourhood improvement, estate regeneration	D	Reduction in crime Improved perceptions of social interaction
Work-based mental health promotion and stress reduction interventions	Workplace well-being programmes	C	Coordinated approaches can promote mental well-being of employees (NICE, 2009).
	Stress management interventions at work	A (Richardson et al, 2008)	Reduced work-related stress Reduction in sickness absence
	Early treatment of common mental health problems	B (Wang et al, 2007; Hill et al, 2007)	Workplace screening and early intervention reduce levels of depression and sickness absence
	Supported work for those recovering from mental illness	A (Bond et al, 2008)	61% v 23% employment rate for those on Individual Placement Support scheme 11% reduced rehospitalisation
Interventions targeting unemployed	Promote well-being of those who become unemployed and facilitate return to work	B (WHO 2004)	Increased employment, reduced depression and distress
	Benefits checks for those not in employment to ensure take-up of entitled benefits	E	Improved well-being due to reduced financial distress
	Smoking cessation	C	25% reduction in financial distress

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Debt and financial capability interventions	Debt advice Improve financial capability	D C	Improved mental health Improved well-being 5.6% and satisfaction 2.4% Reduced depression/ anxiety 14.7%
Housing support and prevention of homelessness – particularly in higher-risk groups	Housing improvement interventions	C	Improved physical and mental health outcomes as well as reduced crime (see 'Violence prevention' above)
	Medical priority rehousing	C	Reduced common mental disorder
	Housing support for high-risk groups: • high-risk families • those with mental health problems	C D C	Reduced readmission rates; reduction in homelessness and hospitalisation; improved well-being
	Prevent homelessness through provision of housing particularly to high-risk groups	C	Improved well-being
Reduce fuel poverty	Warm Front grants to provide home insulation and central heating, and to support take-up of benefit entitlements	C	Reduced psychological distress Reduced risk of depression and anxiety by 50% Associated benefit check increased average weekly household income by £1,616 per year
Reduce impacts of flooding and heatwaves	Target heatwave and flooding guidance to those at higher risk of flooding	E	

SECTION FOUR: DEVELOP SUSTAINABLE, CONNECTED COMMUNITIES

National Indicators relevant to developing sustainable connected communities

NI 1	Percentage of people who believe people from different backgrounds get on well together in their local area (PSA 21)
NI 2	Percentage of people who feel that they belong to their neighbourhood (PSA 21)
NI 3	Civic participation in the local area (PSA 15)
NI 4	Percentage of people who feel they can influence decisions in their locality (PSA 21)
NI 5	Overall/general satisfaction with local area (Communities and Local Government (CLG) (DSO))
NI 22	Perceptions of parents taking responsibility for the behaviour of their children in the area (Home Office (HO Department of Strategic Objectives) (DSO))
NI 23	Perceptions that people in the area treat one another with respect and dignity (HO DSO)
NI 47	People killed or seriously injured in road traffic accidents (Department for Transport (DfT) DSO)
NI 48	Children killed or seriously injured in road traffic accidents (DfT DSO)
NI 175	Access to services and facilities by public transport, walking and cycling (DfT DSO)
NI 176	Working age people with access to employment by public transport (and other specified modes) (DfT DSO)
NI 198	Children travelling to school – mode of travel usually used (DfT DSO)

The previous section focused mainly on preventing risks that threaten our sense of safety and security. This section outlines approaches that can enhance well-being through developing strong, sustainable social and environmental connections.

The cross-government *Securing the Future: delivering UK sustainable development strategy* (HM Government, 2005) identifies four priority areas for immediate action, shared across the UK:

- sustainable consumption and production
- climate change and energy
- natural resource protection and environmental enhancement
- sustainable communities.

The strategy recognises that changing behaviour is a cross-cutting theme closely linked to all of these priorities and that well-being is at the heart of sustainable development (see www.defra.gov.uk/sustainable/government/).

4.1 Social capital and well-being

Social capital can be described as the collective value of a person's social networks, which are a key aspect of mental well-being and of stronger, healthier, connected communities.

Social capital can occur at different levels:

- within groups such as families and friends
- across groups such as different communities
- across wider society.

Communities with higher levels of social capital have lower rates of crime, better health, higher educational attainment and better economic growth (WHO 2004). Social networks and social support may prevent mental health problems and promote a sense of belonging and well-being (Brugha et al, 2005, Melzer et al, 2004). This is particularly important in maintaining resilience at times of adversity (Bartley 2006). Active participation in social and community life is also associated with well-being and life satisfaction (Huppert, 2008). A wide variety of factors influence social cohesion (CIC, 2007).

Approaches known to be effective in building social capital are those that help people increase their social contacts, engage in community activities, and contribute to their local community (Health Development Agency, 2004).

These approaches occur at each of the different levels highlighted above and can be targeted at higher risk groups. However, effective community engagement is dependant on the existence of both community and organisational capacity (Popay, 2006) (see table 9 for different interventions).

Social capital can also be enhanced by improving community participation in local governance (Skidmore et al, 2006). Community engagement can increase involvement in the planning, design, delivery and governance of health promotion activities and initiatives to address the wider social determinants of health (NICE 2008).

4.2 Safe, green spaces

Increasing availability of urban green space, views of and access to safe, green spaces and greater engagement with the environment has been found to have multiple benefits for mental and physical

health and well-being. Environmental factors can also influence components of resilience and are key social determinants of individual and community well-being (Marmot et al, 2010).

There is a growing evidence base for a range of public mental health benefits associated with safe, green spaces. Observational and qualitative studies in urban areas have found associations between access to green spaces and:

- increases in strength of community indicators (Kuo et al, 1998)
- increase in social activity (Sullivan et al, 2004)
- social interaction and cohesion in different age groups, by providing inclusive places to meet (Bird, 2007)
- increased perception of community strength and pride through participation in local nature activities (Austin, 2002; Inerfield and Blom, 2002).

4.3 Social inclusion, stigma and discrimination

A key aspect of creating sustainable communities is to challenge the stigma and discrimination that excludes particular groups and divides communities.

Research shows that many people have negative views about people with mental illness (TNS, 2009).

Other forms of discrimination can also have a negative impact on mental health. For example, victims of racial attack are almost three times more likely to have depression and almost five times more likely to have psychosis than people reporting no harassment (Karlsen and Nazroo, 2002). Similarly, studies have found that people who believe that British employers would discriminate against someone on the grounds of race, religion, culture or ethnicity are at two and three-fold greater risk of common mental disorders and psychosis (Karlsen et al, 2005).

Anti-stigma and discrimination interventions in the UK

Time to Change is a four-year, charity sector-led anti-discrimination and well-being campaign for England. It has funding of £18 million. As well as an advertising campaign, its work includes a mass-participation exercise, 28 community-based physical activity projects, and a legal unit to pursue test cases of discrimination. Objectives over four years include a 5% reduction in discrimination reported by people with mental health problems and a 5% improvement in public attitudes. www.time-to-change.org.uk

Shift is a Department of Health-funded programme to tackle the stigma and discrimination associated with mental health issues in England. It was launched in 2004 by the National Mental Health Development Unit and has been extended to run until 2011. Shift's work complements that of Time to Change by focusing on employers and the media. www.shift.org.uk

The United Nations Convention on the Rights of Persons with Disabilities was ratified by the UK on 8 June 2009 and its Optional Protocol on 7 August 2009. Among its principles, the convention aims to promote non-discrimination, full participation and inclusion in society, respect for difference and diversity and equality. www.un.org/disabilities/

Table 7 opposite lists the socially excluded and discriminated groups that are at higher risk of mental health problems.

Table 7: Groups to target who are at higher risk of mental health problems

Children and young people	Adults
• Children with parents who have mental health or substance misuse problems • Those who suffer personal abuse or witness parental domestic violence • Looked after children • Child carers • Children and young people excluded from school • Teenaged parents • Young offenders • Lesbian, gay, bisexual, transgender (LGBT) young people • Black and minority ethnic groups, especially young Asian women • Families living in socio-economic disadvantage	• People with mental health illnesses or a history of self-harm • Black and minority ethnic groups, especially young men of Afro-Caribbean origin • Homeless people • Adults with a history of violence or abuse • Offenders and ex-offenders • Lesbian, gay, bisexual, transgender adults • Travellers, asylum seekers and refugees • A history of being looked after/adopted • People with learning disabilities • Isolated older people

Table 8 highlights the significant increased risk of mental illness which some of these groups experience.

Interventions for high-risk groups are the same as for the general population, but can be made more effective through targeted approaches as well as appropriate adaptation.

Table 9 summarises the level of evidence for interventions that seek to develop sustainable, connected communities. Sustainable development tends to involve community-based interventions, which are more difficult to evaluate through randomised controlled trials. However, high-quality evidence from a wide variety of sources is available. As previously explained, where evidence is weaker, other selection criteria have been used.

Table 8: Summary of increased risk of mental illness in some high-risk groups

Group	Impact on mental health and well-being	Prevalence in population
Black and minority ethnic	2-3 fold increased suicide risk (Bhui et al, 2008) 7 fold increased risk in black Caribbean group (Fearon et al, 2006) 2 fold higher risk in South Asian women (McManus et al, 2009) 2- to 3 fold increased suicide risk (Bhui, 2008)	7.9% population are BME (2001 census): 4% are Asian or Asian British, 2% are Black or Black British and 1.5% are Mixed
LGBT	2 fold increased risk of suicide attempt (King et al, 2008) 4 fold increased lifetime prevalence of suicide attempt in gay and bisexual men (King et al, 2008)	An estimated 6% of population are LGB (DTI, 2005)
Learning disability	3 fold increased risk of schizophrenia 2 fold increased risk of depression (Smiley, 2005) 58 times increased risk of dying before the age of 50 than the general population (Hollins, 1998) 17% of people of working age with learning disabilities had a paid job, compared with 67% of men and 53% of women without (Office for National Statistics, 2003/04)	210,000 people with severe and profound learning disabilities and 1.2 million people with mild/moderate learning disabilities in England (DH 2001)
Prisoners	20 fold higher risk of psychosis (Stewart, 2008) 10 fold higher risk of antisocial personality disorder (Fazel and Danesh, 2002) Risk of suicide 36 times higher in female and eight times higher in male ex-offenders than in general population (Pratt, 2006). Prevalence of learning disability of 6.7%, and of learning difficulty of 25.4% (Motram, 2007)	84,706 prisoners in England and Wales in 2009 (Berman, 2009)

Table 9: Summary of intervention type and outcomes for developing sustainable connected communities

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Strengthen social networks, especially in high-risk groups	Prevent social isolation and loneliness	A (Cattan et al, 2005)	Group programmes significantly reduce social isolation
	Peer support	A (Cattan et al, 2005; Shaw et al, 2006)	Self-help groups effective in reducing social isolation/ loneliness Increased quality of life
	Social prescribing by GPs	D	Break down isolation and provide meaningful occupation locally; increased levels of social support
	Timebanks	E	Increased quality of life through social interaction and having practical needs net
	Community arts	C	Increased levels of social support
	Enhance individual and community empowerment	A (Wallerstein, 2006)	Increased confidence, sense of community, social cohesion, social support and resilience

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Improve neighbour-hoods	Neighbourhood enhancements	D	Improved mental health and perceptions of neighbourhood
	Active Travel Town Schemes	D	Increased active (non-car) travel
	Encouraging mobility, particularly for vulnerable groups	E	Reduced fear
	Reducing traffic speed and volume	D	Increased play, community relations and quality of life
	Increasing functionality of neighbourhood and facilities	D	Reduced nuisance behaviour and increased tolerance
	Inter-generational discussion	E	
Enhance safe urban and green community spaces	Safe, green environments	C	Improved mental and physical health Increased physical activity and social interaction. Reduced violence and perceptions of crime/ violence
	Allotments/community gardens	D	Builds social capital, food production
	Green gyms	D	Improved mental and physical health
	Walkable neighbourhoods	C	Associated with doubled number of walking trips per week

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Reduce discrimination both for those with mental illness and general community/ other high-risk groups	Media campaigns to increase mental health literacy Combined contact and education targeted at specific groups	C C	Change attitudes and improve knowledge
Black and minority ethnic groups	Cultural adaptation of interventions	C (Griner and Smith, 2006)	Cultural/ethnic/racial matching of service providers and clients more effective
LGBT	LGBT adaptation of interventions	D	Same-sex orientation matching has greater benefits and is preferred by clients
Carers	Psycho-education interventions for carers	A (Sorensen et al, 2002)	Significant improvements in caregiver burden, depression, well-being and satisfaction

SECTION FIVE: INTEGRATE PHYSICAL AND MENTAL HEALTH

National Indicators relating to integrating physical and mental health

NI 39	Rate of hospital admissions per 100,000 for alcohol-related harm (PSA 25)
NI 40	Number of drug users recorded as being in effective treatment (PSA 25)
NI 119	Self-reported measure of people's overall health and well-being (DH DSO)
NI 120	All-age, all-cause mortality rate (PSA 18)
NI 124	People with a long-term condition supported to be independent and in control of their condition (DH DSO)
NI 130	Social care clients receiving self-directed support per 100,000 population (DH DSO)
NI 137	Healthy life expectancy at age 65 (PSA 17)
NI 138	Satisfaction of people over 65 with both home and neighbourhood (PSA 17)

The association between physical and mental health is two-way: mental disorders are associated with poor physical health and physical disorders are associated with poor mental health (see table 10 below). Broadly, the evidence indicates that poor mental health is a larger contributor to poor physical health and health risk behaviours than the other way round. However, good mental health and well-being are associated with reduced mortality rates, both in healthy people and in those with illness (Chida and Steptoe, 2008). Furthermore, the absence of well-being was more predictive of seven-year mortality than the presence of negative psychological symptoms (Huppert and Whittington, 2003).

5.1 Relationship between physical and mental health

Impact of depression on inequalities in physical health

- **Increased mortality at age 65** – a meta-analysis of 15 population-based studies found that a diagnosis of depression in those over 65 increased subsequent mortality by 70% (Saz and Dewey, 2001).

- **Overall increased mortality** – analysis of a large population survey found that after controlling for confounders, depression was associated with a 50% increased mortality which is comparable with the effect of smoking (Mykletun et al, 2009).

- **Increased mortality from different causes** – depression was associated with increased mortality from cardiovascular disease (odds ratio (OR) 1.67, 95% confidence indicator 1.38–2.01), cancer (OR 1.50, 1.19–1.89), respiratory disease (OR 2.06, 1.26–3.38), metabolic disease (OR 3.03, 1.46–6.28), nervous system diseases (OR 4.66, 2.44–8.92), accidental death (OR 2.09, 1.07–4.08), and mental disorders (OR 6.75, 2.09–21.78) after controlling for confounders (Mykletun et al, 2007).

- **Depression and risk of coronary heart disease** – systematic reviews of 11 prospective cohort studies in healthy populations show that depression predicts later development of coronary heart disease after adjustment for traditional risk factors (OR 1.90, 95% CI 1.48–2.42) (Hemingway and Marmot, 1999; Nicholson et al, 2006).

- **Depression and stroke** – increased psychological distress was associated with an 11% increased risk of stroke after adjusting for a range of possible confounders in analysis of a cohort study of 20,267 participants followed up over eight and a half years (Surtees et al, 2008).

- **Depression and other conditions** – prospective population-based cohort studies show that depression predicts later colorectal cancer (Kroenke et al, 2005), back pain (Larson et al, 2004), irritable bowel syndrome (Ruigómez et al, 2007) and multiple sclerosis (Grant et al, 1989).

- **Depression and compliance** – meta-analysis of factors related to non-compliance found that depressed patients were three times as likely to be non-compliant with treatment recommendations as non-depressed patients (Di Matteo et al, 2000).

Impact of serious mental illness on physical health

- People with schizophrenia and bipolar disorder die an average of 25 years earlier than the general population, largely due to physical health problems (Parks et al, 2006).

- Standardised mortality rates for those with serious mental illness are 150 for all cause, 250 for respiratory disease, 250 for cardiovascular disease and 500 for infectious disease (McEvoy et al, 2005).

- Compared with the general population, people with schizophrenia have an

increased prevalence of obesity (1.5–2 times), diabetes (2 times), dyslipidaemia (5 times), and smoking (2–3 times) (Newcomer, 2007).

Physical illness increases risk of poor mental health

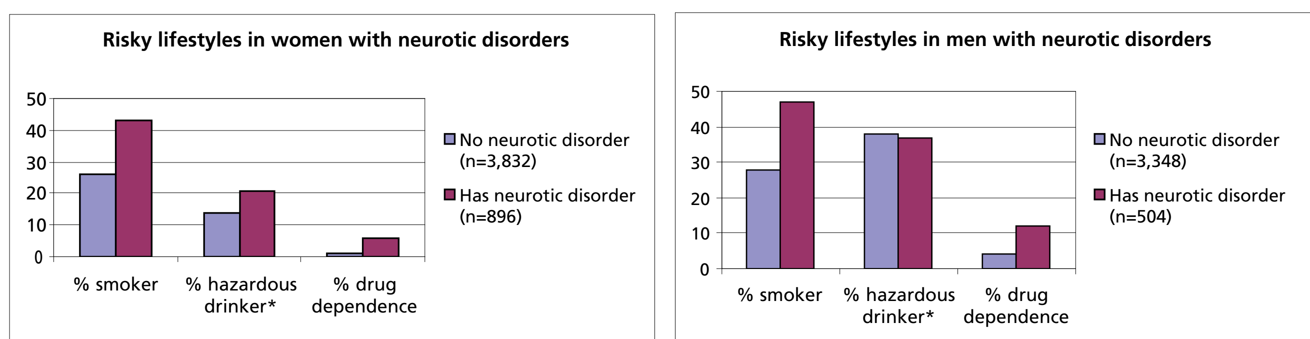
Many physical health conditions also increase the chances of poor mental health, for example:

- Physical illness increases the risk of developing depressive disorder (OR 2.5, 95% CI 1.3–4.6) in a large population-based cohort (Patten, 2001). The risk was similar for a wide range of physical illnesses, including hypertension, asthma, arthritis and rheumatism, back pain, diabetes, heart disease and chronic bronchitis.
- Physical illness combined with two or more recent adverse life events increases risk of mental illness by sixtimes compared to risk associated life events with no phsyical illness (Meltzer, 2004).
- Within one year of diagnosis of cancer or first hospitalisation with a heart attack, there is a 20% rate of new onset of depression or anxiety (Burgess et al, 2005; Dickens et al, 2004).
- Long-term conditions – depression is two to three times more common in people with a chronic physical health problem than in people who are in good physical health (NICE, 2009). Rates for depression were doubled in diabetes, hypertension, coronary artery disease and heart failure, and tripled in end-stage renal failure, chronic obstructive pulmonary disease and cerebrovascular disease (Egede, 2007). Prevalence of depression among those with two or more chronic physical conditions was 23%, compared with 3.2% in healthy controls (Moussavi et al, 2007).

5.2 Poor mental health and health-risk behaviours

High-risk groups are frequently exposed to multiple health risks, and have multiple health-risk behaviours to which poor mental health contributes as an underlying factor (OPMS, 2000) (see figure 6).

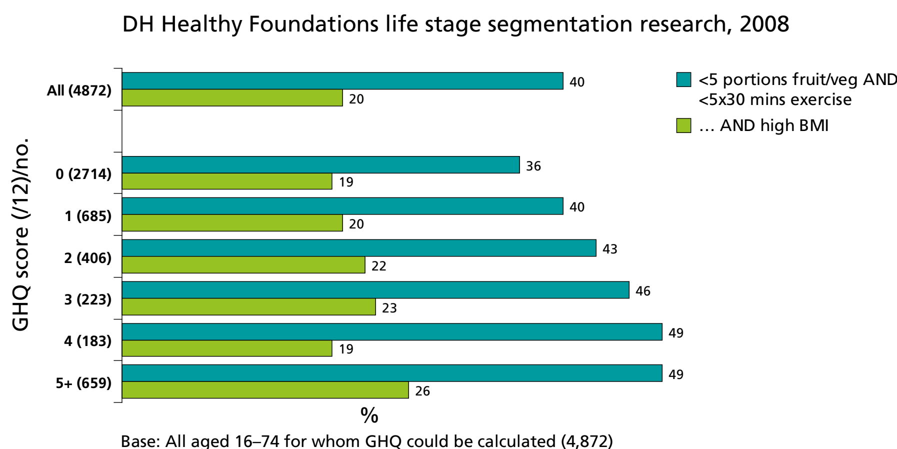
Figure 6: Risk behaviours in men and women with neurotic disorders (anxiety and depression) (Coultard et al, 2002)



* Hazardous Drinker – above safe levels however person has avoided significant alcohol related problems

DH's *Healthy Foundations* life-stage segmentation research (2008) found that the only health-risk behaviour that does not show a specific correlation with poor mental health is dangerous levels of alcohol consumption in men (see figure 7 below).

Figure 7: Poly-behaviours by General Health Questionnaire category – fruit/veg consumption, exercise, BMI



5.3 Health improvement, mental health and well-being

Changing people's health-related behaviour can have a major impact on some of the main causes of mortality and morbidity (NICE, 2008). The Wanless Report forecast a future in which public engagement with health is high and maximum use is made of preventive and primary care services, helping people to stay healthy (Wanless, 2004).

Behaviour change is influenced by a wide range of factors, including motivation and opportunity to adopt a healthy lifestyle, both of which are strongly influenced by mental health.

Reshaping people's daily environments is the most powerful way to encourage them to make healthier choices. This is where local government can play a very important role. For example, implementing smoke-free legislation, introducing car-free days, reducing the prevalence of fast food outlets on high streets and making it easier for people to walk or bicycle by changing street design can all make a major contribution to promoting healthier lifestyles in the local population.

A mixture of techniques is the best way to ensure effective and lasting behaviour change. Generally, information and education are relatively ineffective on their own. However, what is the 'right mix' will vary according to the group concerned, so segmentation and targeting are important. Intensive, individually targeted programmes tend to be more effective and the methods are likely to vary, depending on the behaviours being targeted. Methods for changing behaviour need to be aligned with cultures, cognitive styles and social contexts.

It is important that health improvement programmes target people with mental health problems, as they have higher rates of health-risk behaviour.

Consideration also needs to be taken of any mental health issues that affect a person's health-risk behaviour and their ability to adopt a healthier lifestyle.

Much of this work supports Choosing Health and other national programmes for health improvement (see box below).

National programmes aimed at improving health behaviours

Choosing Health: Making healthy choices easier **(DH, 2004)**
This White Paper sets out the key principles for supporting the public to make healthier and more informed choices in regards to their health. Its overarching priorities are to:

- reduce the numbers of people who smoke
- reduce obesity and improve diet and nutrition
- increase exercise
- encourage and support sensible drinking
- improve sexual health
- improve mental health.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550

Depression in Adults with a Chronic Physical Health Problem (NICE, 2009)
http://guidance.nice.org.uk/CG91

Choosing Health: Supporting the physical health needs of people with severe mental illness – Commissioning framework (DH, 2006),
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138212

Behaviour change at population, community and individual levels (NICE, 2007)
www.nice.org.uk/Guidance/PH6

Healthy Schools
The National Healthy Schools Programme is a joint initiative between DCSF and DH which promotes a whole-school/whole-child approach to health. The programme has existed since 1999 and it is recognised as a key delivery mechanism in *The Children's Plan* (DCSF, 2007)
http://home.healthyschools.gov.uk/

National Healthy Further Education programme
The National Healthy Further Education (FE) programme aims to improve the health of those who study or work in the FE sector. It is about working with FE providers to make the health and well-being of staff and students an integral part of all aspects of life in FE.
http://www.excellencegateway.org.uk/page.aspx?o=hfep

Health-promoting hospitals
The WHO health-promoting hospitals project and network supports the development of hospitals and other healthcare institutions in Europe and other regions of the world into healthy and health-promoting settings and organisations.
www.euro.who.int/healthpromohosp

NHS Health Trainers initiative
Health trainers work with people who are at a greater risk of poor health, for example offenders or people with mental health problems. They work on a one-to-one basis to assess clients' health and lifestyle risks, facilitate behaviour change and provide motivation and practical support. An integrated approach is taken to address the needs of the individual's physical and health problems. Success in changing physical aspects of health (such as increased physical activity and healthy eating) results in benefits for people with mental health problems. Some health trainer services also train local people to work as health trainers with social excluded communities and groups.
www.dh.gov.uk/en/Publichealth/Healthinequalities/HealthTrainersusefullinks/index.htm

There are two sets of behaviour-change interventions related to physical and mental health: those which aim to reduce mental illness through behaviour change (e.g. physical activity to reduce depression); and those which aim to reduce risk of physical illness in people with a mental illness (e.g. encouraging physical activity in people with schizophrenia in order to reduce their increased risk of cardiovascular disease).

Risk behaviours, including smoking, alcohol and drug misuse, high-risk sexual behaviour, lack of exercise, unhealthy eating and obesity, do not affect discrete population groups. Frequently, high-risk groups are exposed to multiple health risks and have multiple health-risk behaviours to which poor mental health contributes as an underlying factor. Low income and deprivation are also important factors and are particularly associated with the 20–25% of people in the UK who are obese or continue to smoke (Gordon et al, 2000). This population also experiences the highest prevalence of anxiety and depression (Melzer et al, 2004).

Table 10 below lists a range of evidence-based interventions that have been demonstrated as effective in improving health behaviours in high-risk groups.

Table 10: Summary of interventions for integrated physical and mental health

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Smoking	Prevention of uptake of smoking in children and young people	A (NICE 2008, 2010)	Prevention of physical and mental illness
	Smoking cessation (adults), including in those with mental illness	A (DH, 2009)	Improved well-being, reduced symptoms of depression and anxiety, reduced levels of psychiatric medication
Alcohol	Prevention and reduction of alcohol use in children and young people	A (NICE, 2007)	Reduced associated physical and mental ill health
	Brief interventions	A (Kaner et al, 2007)	
	Motivational interventions	A (Lundahl and Burke, 2009; Vasilaki et al, 2006)	
	Behavioural couples therapy	A (Powers et al, 2008)	
	Specialist alcohol services	A (Raistrick et al, 2006)	
Substance misuse	Prevention and reduction of substance misuse among young people	A (McGrath et al, 2006; Jones et al, 2006)	Reduced associated physical and mental ill health
	Contingency management	A (Lussier et al 2006; Predergast et al, 2007)	
Sexual health	Sexual health education	A (Johnson et al, 2009)	Reduced risk of STIs with education
	Education programmes for those with mental illness	A (Higgins et al, 2006)	Reduced sexual risk behaviour

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Obesity	Weight loss – with balanced diet and sufficient exercise	A (Franz et al, 2007; NICE 2006)	Reduced risk of physical ill health
	Weight-loss programmes for those recovering from mental illness	B (Faulkner et al, 2003; Evans et al, 2006)	Weight loss
Nutrition	Breast feeding	A (Horta et al, 2007)	Higher intelligence; reduced hypertension, obesity and diabetes
	Good nutrition	C	Improved mental and physical health
Physical activity	Recommended levels of activity	A (Sibley and Etnier, 2003)	Improved cognitive performance in school age children
		A (NICE, 2008;)	Improved mental health outcomes in older people
		A (NICE, 2009)	Improved sub-threshold, mild and moderate depression. Improved well-being
Improve physical health of those with mental illness	Physical health checks	E	Improved identification of physical health issues
	Healthy living interventions for those with schizophrenia	B (Bradshaw et al, 2005)	Improved smoking cessation, weight loss and physical activity
Integrate physical and mental health assess-ments into healthcare pathways	Integrate identification and treatment of mental illness within care pathways for those with coronary heart disease, cancer, chronic conditions, etc.	Majority based on A-grade evidence on standard practice	Improved levels of self-reported psychological well-being and overall functioning Positive outcomes for smoking cessation, weight management and exercise Reduced demand on primary care

SECTION SIX: PROMOTE PURPOSE AND PARTICIPATION

National Indicators relevant to promoting purpose and participation

NI 6 Participation in regular volunteering (Cabinet Office DSO)
NI 7 Environment for a thriving third sector (CO DSO)
NI 8 Adult participation in sport and active recreation (Department for Culture, Media and Sport (DCMS) DSO)
NI 9 Use of public libraries (DCMS DSO)
NI 10 Visits to museums and galleries (DCMS DSO)
NI 11 Engagement in the arts (DCMS DSO)
NI 161 Learners achieving a Level 1 qualification in literacy (PSA 2)
NI 162 Learners achieving an Entry Level 3 qualification in numeracy (PSA 2)
NI 163 Working age population qualified to at least Level 2 or higher (PSA 2)
NI 164 Working age population qualified to at least Level 3 or higher (PSA 2)
NI 165 Working age population qualified to at least Level 4 or higher (PSA 2)

Definitions of well-being often include concepts such as a sense of purpose; being creative; having strong relationships with others and being active citizens. Resilience – the ability to deal with adversity – is also an intrinsic aspect of well-being. Several studies have shown that well-being is strongly associated with, for example, a sense of meaning or purpose (Lyubomirsky et al, 2005; Peterson et al, 2005) and finding meaning and long-term benefits in daily events (Fredrickson, 2004).

Good evidence also exists for links between having a sense of purpose and lower levels of depression (Harlow et al, 1986) and suicidal ideation (Edwards and Holden, 2001).

Purpose can be derived from many sources, including family and friends and community participation. Interventions that enhance meaning and purpose to promote well-being can occur in all these different realms.

6.1 Leisure, sleep, physical activity, education and lifelong learning

Leisure enhances well-being in a number of ways, including increasing feelings of competency and relaxation, distracting from difficulties, and enhancing social inclusiveness and support (Caldwell, 2005). Leisure also results in improved well-being through associated meaningful engagement, self-

expression, creativity and the opportunity to experience control and choice over such activities. The benefits of leisure extend across the life course, however, more sedentary activity is associated with reduced well-being in adolescents (Ussher et al, 2007), while in children, passive leisure activities such as watching television are also associated with reduced well-being (Holder et al, 2009; Johnson et al, 2007).

Several studies highlight the importance of sleep for well-being (Hamilton et al, 2007; Steptoe et al, 2008). Sleep loss and sleep disorder are associated with a reduction in vitality, social functioning, physical and mental health and quality of life (Katz and McHorney, 2002; Roth et al, 2006). Mental illnesses such as depression and anxiety are also associated with sleep problems.

Education and lifelong learning promote well-being and resilience and reduce the risk of mental illness. In children, learning plays an important role in social and cognitive development, while continuation of learning through life enhances self-esteem and encourages social interaction and a more active life (Kirkwood et al, 2008). Learning increases earning potential and employability, which in turn protects well-being and reduces the risk of poor mental health and low levels of life satisfaction (Searle, 2008). Effects of learning on both improved well-being and recovery from mental health problems are mediated by improved self-esteem, self-efficacy, sense of purpose and hope, competencies and social integration (Hammond, 2004).

6.2 Psychological and spiritual health

The ideas on which Cognitive behaviour therapy (CBT) is based are consistent with many elements of well-being promotion as well as recovery (Slade, 2009). Some CBT approaches focus on building strengths and resilience (Kuyken et al, 2009). Psychological therapies have also been shown to be effective in reducing mental illness and promoting mental health and well-being for:

- parents (Barlow et al, 2003)
- children of parents with depression (Weissman et al, 2006; Clarke et al, 2001; Garber et al, 2009)
- young people with borderline personality disorder (Chanen et al, 2008c), and

- older people (Pinquart and Sorenson, 2001).

Positive psychology interventions actively promote positive emotions, behaviours and cognitions, and can be useful for people with low levels of positive emotion, engagement and meaning (Seligman, Rashid and Parks, 2006).

Spiritual experience is associated with improved subjective well-being and life satisfaction (Emmons, 2003), as well as self-esteem, personal growth, mastery and control (Koenig et al, 2001). Spirituality is also associated with recovery and reduced symptoms of illness (Koenig et al, 2001). The spiritual dimension may become particularly important in times of emotional stress, physical and mental illness, loss, bereavement and death.

6.3 Creativity and community participation

Actively being involved in creativity and the arts helps people to connect with a wider sense of meaning and fulfilment, which can increase well-being. A greater ability to think creatively and efficiently as well as integrating information is linked to positive emotions (Friedrickson, 2001).

Strong relationships with friends and community, and participation in activities that aim to make the world a better place, help to promote well-being, positive social involvement and ecologically sustainable behaviour (Kasser, 2008).

Volunteering provides many people with a sense of meaning and purpose within the context of community activity (Dolan et al, 2006; Thoits and Hewitt, 2001). For adults (in particular retirees), giving and sharing are important for defining a sense of purpose in the community and a sense of self-worth (Brown et al, 2003). For children and young people, volunteering can offer the opportunity to address some of the contextual and environmental factors that can undermine their emotional and mental well-being. For older people, volunteering improves quality of life, particularly when involving face-to-face contact with others (Wheeler et al, 1998; Rabiner et al, 2003).

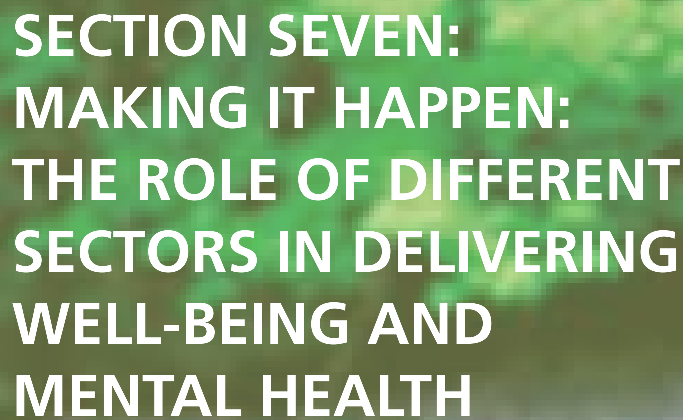
Work has an important role in promoting mental well-being (Grove, 2007), although beneficial health effects depend on the nature and quality of work (Waddell and Burton 2007). It is an important determinant of self-esteem and identity, and can provide a sense of fulfilment and opportunities for social interaction. Unemployment increases the risk of illness and a range of social problems such as debt and social isolation.

Table 11 summarises the evidence base for interventions that address these areas.

Table 11: Summary of intervention type and outcomes for meaning and purpose

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Enhance positive emotion	Positive psychology Interventions	A (Sin and Lyubomirsky, 2009)	Increased positive thoughts and emotions, quality of life, optimism, goals, engagement and meaning
	Psychological therapies	A (NICE, 2009)	Reduced depression, anxiety and stress; improved social interactions; enhanced resilience
	Mindfulness interventions	A (Grossman et al, 2004; Chiesa and Serretti, 2009)	Increased awareness; positive mood; improved quality of life, self-esteem, empathy, optimism and meaning Reduced psychological distress and depressive symptoms
		B (Kuyken et al, 2008)	Prevention of relapse in recurrent depression (NICE, 2009)
Participation in the arts and creativity	Arts and general population	C	Associated with enhanced well-being, better general health, improved community health
	Art and recovery from mental illness	C	• improved self-expression and self-esteem • opportunities for social contact/participation • providing sense of purpose, meaning, improved quality of life
Purposeful community activity	Volunteering	C	Defines sense of purpose in community Improves self worth and well-being Reduced anxiety Improved 5 year survival Benefits to participants of all age

Intervention area and approaches	Intervention/programme	Evidence grade A/B/C/D/E	Outcomes
Work-based mental health promotion and stress reduction interventions	Workplace well-being programmes	B (NICE 2009)	Coordinated approaches can promote mental well-being of employees
	Stress management interventions at work	A (Richardson et al, 2008)	Reduced work related stress Reduction in sickness absence
	Supported work for those recovering from mental illness	A (Bond et al, 2008)	61% v 23% employment rate for those on Individual Placement Support scheme 11% reduced rehospitalisation
Education across the life-course, including in school, adult learning and older people	Education	C (Chevalier and Feinstein 2006)	Reduced risk of depression Improved mental health
		C (Schuller et al, 2004)	Improved social competencies and social networks
		C (Sabates and Feinstein, 2006)	Associated improved health behaviour
Leisure	Active leisure	C (Caldwell, 2005)	Improved well-being



SECTION SEVEN: MAKING IT HAPPEN: THE ROLE OF DIFFERENT SECTORS IN DELIVERING WELL-BEING AND MENTAL HEALTH

The launch of the New Horizons programme and this framework signal the Government's commitment to well-being and mental health. There are a number of cross-government mechanisms to support improving mental health and well-being at local level. These include Local Area Agreements and World Class Commissioning, which support local authorities and health commissioners working in their local strategic partnerships. Local areas have powers to prioritise actions to address the economic, social or environmental well-being of their area, and the relevant National Indicators to support this have been highlighted in this report.

The public mental health framework outlined here draws together some of the currently available evidence for effective interventions across the different domains. This evidence will be built upon and expanded through a number of existing means and mechanisms.

For the NHS, **Quality, Innovation, Productivity and Prevention (QIPP)** is a mechanism for delivering on Lord Darzi's *High Quality Care For All* NHS review (2008), which aims to put quality at the heart of the NHS. New evidence will be evaluated and published on

www.dh.gov.uk/newhorizons as it becomes available. Links will be maintained with NICE and the National Quality Board to support the development of further guidance and relevant standards. Examples of good practice will be published on the New Horizons website.

7.1 Joint Strategic Needs Assessments

These provide a mechanism to establish the current and future health and well-being needs of a population, enabling commissioning for improved outcomes and reductions in health inequalities. Local authorities and primary care trusts are required to complete the Joint Strategic Needs Assessment and use it to inform commissioning. Information can be collated for each local authority area from community health profiles (see below), and further local and regional information will be available from the *Atlas for Mental Well-being* (see below). Additional supportive tools that can be used to develop local profiles of mental health and well-being include asset mapping and Mental Health Impact Assessments: see www.dh.gov.uk/en/Managingyourorganisation/JointStrategicNeedsAssessment/index.htm

Community health profiles provide a snapshot of the health status within each local authority area in England, using key indicators that enable comparison locally, regionally and over time: see www.apho.org.uk/default.aspx?RID=49802

The ***Atlas for Mental Well-being*** will provide local and regional level information on risk and protective factors for mental health and well-being in England, and is to be published in the spring of 2010: see www.nepho.org.uk

Mental Well-being Impact Assessments allow policies, strategies, programmes, projects and services to be assessed to see how effective they are in improving mental health and well-being: see www.liv.ac.uk/ihia/IMPACT%20Reports/mwia-toolit1.pdf

7.2 Commissioning for well-being

Good commissioning is based upon understanding and prioritising population needs (e.g. via the Joint Strategic Needs Assessments), and identifying evidence-based and cost-effective approaches

and interventions to improve health and well-being. The evidence in this report can be used to inform Joint Strategic Needs Assessments and commissioning priorities. Further resources to support commissioning will be made available on the New Horizons website later in 2010. See www.newhorizons.dh.gov.uk/index.aspx. These will include an **online cost calculator** and a **commissioning toolkit**.

Further evidence of effective practice to inform commissioning decisions will be made available in more detailed briefings targeted at specific sectors, for example the role of local authorities and the children's sector. Additionally, information can be found at www.nice.org.uk and www.cochrane.org/reviews/

NHS Evidence is an online portal that allows everyone working in health and social care to access a wide range evidence. See www.evidence.nhs.uk.

7.3 Information and measuring outcomes

Regular measurement enables local strategic partnerships to monitor outcomes, trends and progress as interventions are undertaken. Currently, the main mechanisms for this are via the National Indicator Set (relevant National Indicators are summarised at the beginning of each section of the framework). Additionally, the NHS measures indicators with Vital Signs.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

www.communities.gov.uk/publications/localgovernment/finalnationalindicators

More work needs to be done nationally on developing specific outcome measures on the different aspects of well-being and mental health. To support this work, the Warwick–Edinburgh Mental Well-Being Scale has been included for the first time in the Health Survey for England (2010).

An example of good practice is the recent North West Mental Wellbeing Survey of 18,500 people (Deacon et al, 2009). See www.nwpho.org.uk

7.4 Workforce development

A review of the workforce requirements to take this agenda forward is to be undertaken during 2010/11. The terms of reference for this work will include the identification of core skills and competencies, and how a public mental health workforce can be integrated within mainstream public health and workforce development mechanisms across different sectors without increasing costs.

7.5 Planned further work

1. *Five ways to improve mental health and well-being* – DH is working with other government departments to refine the 'five ways to improve mental health and well-being' message, originally developed for the Foresight report (2008), in order to plan a public campaign.

2. The case for a strengthened Public Mental Health Observatory will be considered.

3. Short briefings, including examples of best practice and targeted at different specific audiences – e.g. Local Strategic Partnerships and primary care trusts – will be published regularly from spring 2010 in order to update and inform local decision-makers.

4. A violence and abuse prevention framework will be published in spring 2010. This will draw together a number of government departments to address violence and abuse, and support the delivery of the action plans on sexual violence and abuse and domestic violence, and the cross-government strategy to end violence against women and children.
5. DH will work with other government departments to identify future priorities for action and ensure that policies are assessed to consider their impact on mental health.
6. An online cost calculator and a commissioning toolkit will be published to support local authorities and primary care trusts to jointly commission interventions and approaches designed to promote population well-being.
7. DH will work with research funders to identify priorities for future research.
8. DH will work in partnership with other sectors and government departments to incorporate mental health and well-being into future relevant health and cross-governmental policy.
9. DH will support work to help local organisations build capacity to determine local community needs and assets that create well-being.

APPENDIX: RATES OF MENTAL ILLNESS IN THE POPULATION IN ENGLAND

Mental health is the foundation for the well-being and effective functioning of individuals and communities. There is no health without mental health.

This section outlines why the active promotion of whole-population mental health and well-being is as important as helping those of us who experience mental health problems, to ensure good quality of life for all.

Mental ill health is common – one in four people will experience a mental health problem at some point in their lives.

- **One in six in the adult population experience mental ill health at any one time.**
- **10% of children have a mental health problem, and many continue to have mental health problems into adulthood.**
- **10% of new mothers suffer from postnatal depression.**
- **20% of women and 13% of men are affected by depression or anxiety at any one time.**
- **Half of all women and a quarter of men will be affected by depression at some time in their life and 15% experience a disabling depression.**
- **4% of the population have a personality disorder.**
- **Between 0.5% and 1% of the population have a serious mental health problem, including bipolar affective disorders and schizophrenia.**
- **24% of the adult population have a hazardous pattern of drinking, 6% are dependent on alcohol, 3% are dependent on illegal drugs and 21% are dependent on tobacco.**
- **Dementias currently affect 5% of people aged over 65 and 20% of those aged over 80.**

The best evidence about the number of people in the population with mental illnesses comes from the National Psychiatric Morbidity Survey programme (Meltzer et al, 1995; Singleton, Bumpstead et al, 2001a; Singleton, Lee et al, 2001b; McManus, 2009). Set up in 1993, the survey of adults takes place every seven years (1993, 2000, 2007) and interviews a sample of approximately 8,500 people randomly selected by postal address. There is a similar but separate survey of children.

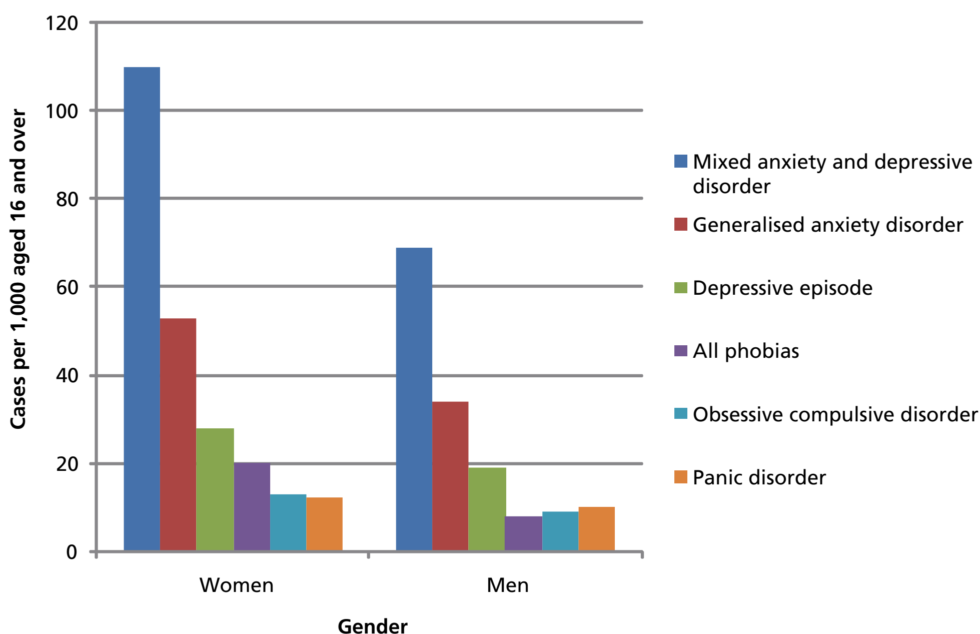
Individuals are asked about many symptoms, mostly as they have affected them in the week prior to the interview. A specific neurotic disorder, such as a depressive episode or a phobia, is identified when a person reports a sufficient number of the symptoms that characterise it in sufficient severity.

Figure A shows the numbers per 1,000 of the population aged 16–64 identified as having common mental disorders in the 2007 survey. People may have sufficient symptoms to qualify as having more than one disorder. The most recent figures show that 20% of women and 13% of men have a common mental disorder (mainly anxiety and depressive disorders) – an increase from previous levels (McManus, 2009).

The commonest group, 'mixed anxiety and depressive disorder', occurs in 9%. This group is not diagnostically or clinically defined. In this instance it is used as a 'catch-all' for people who do not reach the threshold for any of the more specific categories but have sufficient total symptoms to be considered unwell.

In the 2007 survey all of these conditions occurred significantly more commonly in women than men except panic disorder and obsessive-compulsive disorder where excess prevalence in women was not significant.

Figure A: Numbers of people aged 16 and above suffering from common mental disorders per 1,000 population, England, 2007



Some disorders are more common in some age groups. Figure B illustrates the variation in levels of generalised anxiety disorder and depression by age group in the 2007 survey.

The first National Psychiatric Morbidity Survey covered only adults aged 16–64, and therefore we only have data to show trends across the whole survey period for this age group. Figure C shows the changes over the survey period for each type of disorder.

Figure B: Numbers of men and women per 1,000 population suffering from generalised anxiety disorder or depressive episode by age group

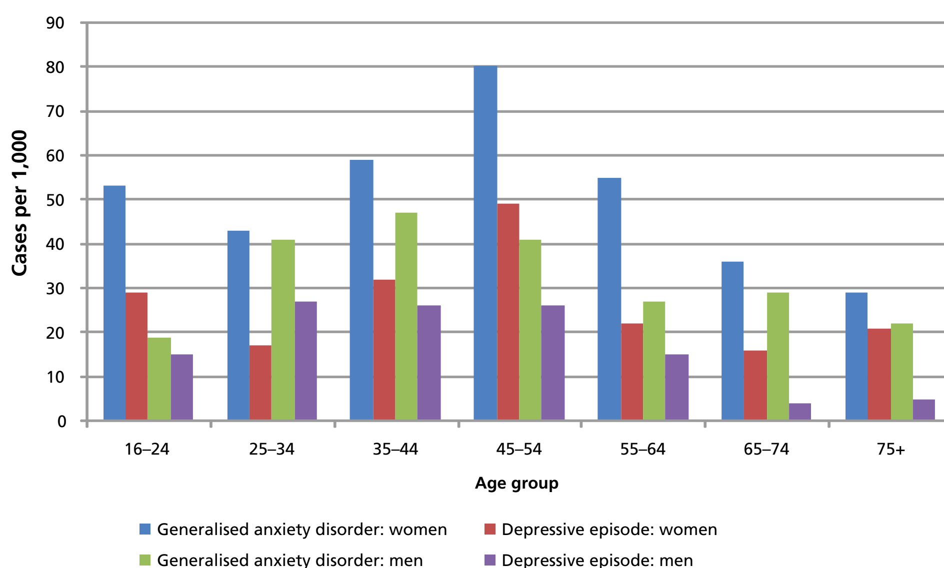
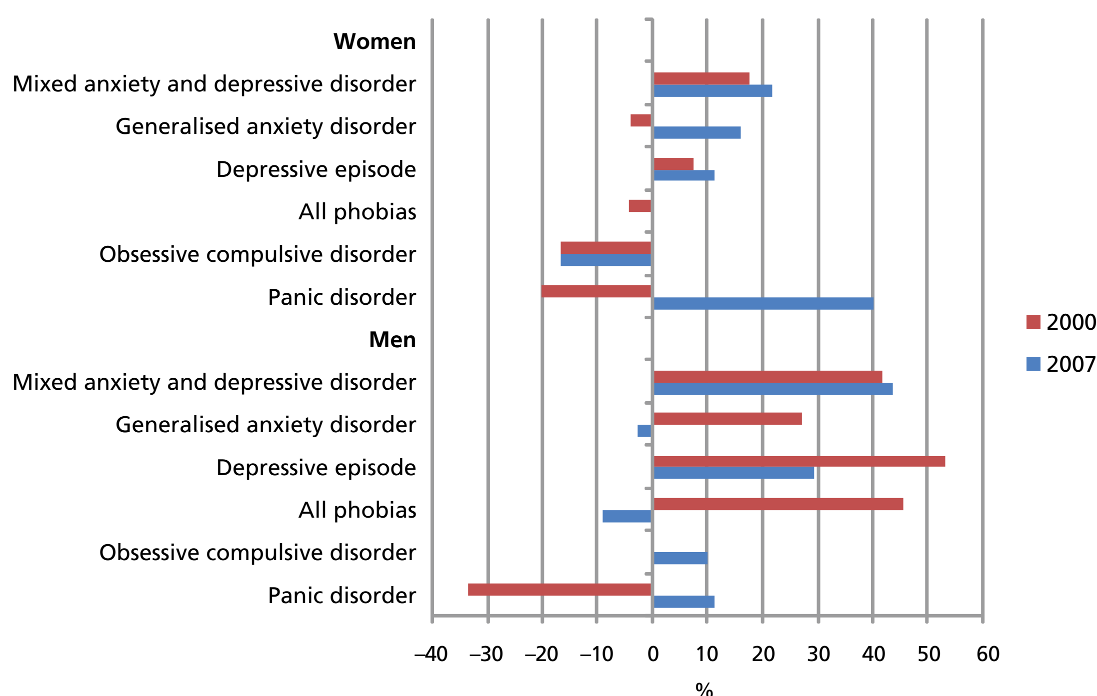


Figure C: Percentage change in the numbers per 1,000 population aged 16–64 with each and any common disorder, 1993 to 2000 and 2007



Less common types of mental disorder

The more severe mental disorders are less common. Population studies of the scale of the National Psychiatric Morbidity Survey are too small to produce satisfactory detail about the patterns. In the more recent survey (2007), five per 1,000 women and three per 1,000 men reported symptoms probably indicating one of these illnesses in the previous year. This is likely to be an underestimate, however, as the population survey does not include homeless people or people in prison or in hostels.

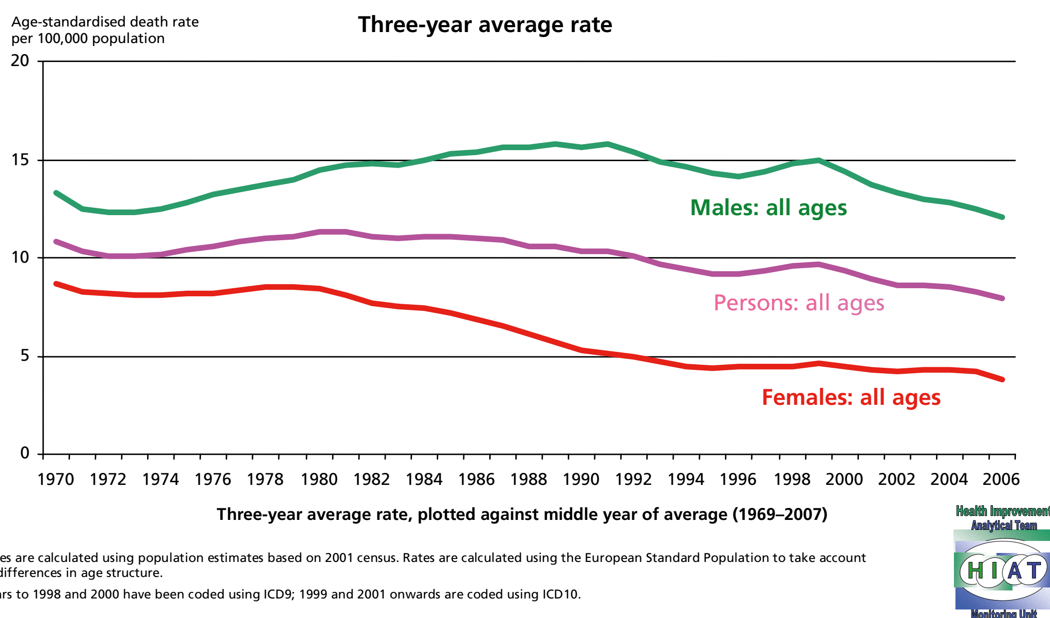
The 2000 National Psychiatric Morbidity Survey found that personality disorder appears in 54 per 1,000 men and 34 per 1,000 women. The 2007 survey found similar rates; prevalence of alcohol dependence was 5.9% (8.7% in men and 3.3% in women), with most dependence categorised as mild (McManus et al, 2009). It is most concentrated in the youngest age groups, where it is twice as common. Prevalence of drug dependence is 3.4% and predominantly occurs in those aged between 16 and 24 years (McManus et al, 2009).

Suicide

The national suicide prevention strategy for England was published in 2002 with the aim to substantially reduce the mortality rate from suicide and injury (and poisoning) of undetermined intent by at least 20% by 2010. Suicide rates in England have fallen to the lowest on record and are some of the lowest in Europe. Rates have fallen among young men under the age of 35 as well as among mental health inpatients and offenders. The three-year average suicide rate for 2006–08 was 7.8 deaths per 100,000 population – a fall of 15.2% from the baseline. Following a period in which the rate of decline slowed, if the trend of the last 10 years is maintained, the target will be met.

Figure D: Trends in suicide rate for males and females of all ages

Death rates from intentional self-harm and injury of undetermined intent, England



UK disability adjusted life years by mental illness

Disability adjusted life years (DALYs) are calculated from the number of potential life years lost due to illness combined with the number of years of productivity lost due to disability. The breakdown of DALYs for all mental disorders in UK (WHO, 2008) is as follows:

All mental disorders	22.8%
Unipolar depression	7.2%
Bipolar disorder	1.2%
Schizophrenia	1.1%
Alcohol use disorders	4.6%
Alzheimer's and other dementias	3.9%
Drug use disorders	2.0%
Self-inflicted injuries	1.3%

By comparison, the DALY measure for cancer is 15.9% and it is 16.2% for cardiovascular disease (WHO, 2008).

Trends in poor mental health

The first National Psychiatric Morbidity Survey covered only adults aged 16–64, and therefore we can only see trends across the whole survey period for this age group. Between 1993 and 2007, the number of men suffering from any common mental disorder rose from 119 to 136 per 1,000 although, given the numbers involved, this apparent increase is not statistically significant. The number of women rose from 191 to 215 – a statistically significant increase.

Figure C shows the changes seen in the survey over this period for each type of disorder. The apparent fall in obsessive compulsive disorder could be due to improvements in the interview wording following the 1993 survey. Given the numbers involved, apart from the overall figures, the only changes large enough to be statistically significant were the increases in the 'catch-all group' of mixed anxiety and depressive disorder, up from

97 to 118 women per 1,000 and from 53 to 76 men. As stated above, this is not a diagnostically or clinically defined group. The term is used to describe a 'catch-all' group of people who do not reach the threshold for any of the more specific categories, but who have sufficient total symptoms to be considered unwell.

By 2026, the number of people in England who experience a mental health problem is projected to increase by 14.2% from 8.65 million in 2007 to 9.88 million, which represents a rise of more than 1.2 million people and reflects the 15.1% expected increase in population over this period (McCrone et al, 2008). However, these predictions do not take account of societal changes, such as economic recession, that are likely to impact on trends over time.

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