Mental Health Foundation

Mental health and prevention:

Taking local action for better mental health

POLICY REPORT | 2016

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Executive summary: menu of top actions

Whole population approaches

Improving the mental health literacy of the population

- Take 'whole system' approaches to improving the mental health literacy of the public service workforce. The key elements are:
  - Adopting all recommendations that contribute to improving mental health within 'Making Every Contact Count'.[1]
  - Embedding mental health improvement practice within all publicly funded provisions (in recognition of the mediating role of mental health in determining health and social outcomes for community members) including: health visitor support to new parents; teaching within schools; support in housing; and social welfare contact.
- Ensure that health and social care staff, as routine, consider the impact of mental health inequalities and act to reduce them. This includes the identification of communities and individuals at greatest risk of mental health problems and an understanding of the potential impact of points of transition and adverse life experiences on mental health. Mental health improvement should be integrated into daily work and messages and interventions tailored to meet specific needs and areas of highest risk including people living in low income families, people who are LGBT or from BAME communities. The key elements are:
  - Implementation of the health and social care staff workforce development and leadership programmes as outlined in the Public Mental Health Leadership and Workforce Development Framework.[2]
  - Adoption of co-production approaches with communities to increase empowerment and to maximise programme impact.

- Develop local programmes that promote improved mental health literacy and capacity for self-management within communities. The key elements are:
  - Enabling access to peer support and self-management resources within settings such as schools, residential services and care homes, prisons and further education
  - Adapting interventions for groups and communities who are at higher risk of developing mental health problems such as people with long-term health conditions, refugees and people living with disabilities,[3] or those who have already experienced mental distress and are in the process of recovering their mental health.

Developing mentally healthy communities and places

- Apply a socio-ecological approach to mental health improvement that aims to work across the multilevel of individuals, families, communities, and structures (including settings such as schools, prisons and workplaces). Key elements are:
  - Adopting a universally proportionate approach that aims to address increasing levels of risk within communities and progressively applying resources where the greatest risks lie.[4]
  - Promoting an Asset Based Community Development (ABCD) approach to mental health improvement that enables individuals and communities to be active participants in planning, prioritising and implementing mental health improvement actions.
- Make use of available community resources and support social inclusion by developing social prescribing through local health and social care professionals - for example, primary care staff.
- Ensure that mental health improvement is viewed and measured as a central outcome in community investment and regeneration actions.

- Create and protect green spaces within neighbourhoods in order to generate better physical and mental health outcomes for individuals and communities.[5]

Reducing stigma and discrimination

- Develop evidence-based stigma and discrimination reduction activities that focus on sustained behaviour change. Key elements are:
  - Combining awareness raising and education with opportunities to reduce social distance[6] through engagement with people with a lived experience (social contact).
  - Targeting activities where the greatest stigma and discrimination are experienced and where outcomes need to be improved (improved outcomes in health, employment and education).
  - Ensuring consistency of messages and strategies to support long term discriminatory behaviour change.[7]
  - Ensuring that messages are recovery focused to challenge stereotypes and stigma.[8, 9]
  - Promoting mutual support opportunities to reduce self-stigma and increase quality of life for those experiencing mental health problems.[10]

Integrated approaches to health and social care

- Integrating mental and physical health care should be a central strategy for improving quality and efficiency in health provision, and should require the adoption of holistic approaches within primary care and accessible integrated pathways to acute services.

- Integrating health and social care services should be a central strategy for improving outcomes for people at risk or who have developed mental health problems, and should be achieved through establishing joint approaches to planning and the development of health, mental health and social care interventions between local authorities, primary care and the voluntary and community sector.[11] Key elements are:
  - Undertaking workforce development that allows staff to feel confident about supporting the mental health of people with long-term conditions and effectively and efficiently identifying physical health risks for those with mental health problems.
  - Adopting wellness models that bring together health and mental health alongside social functioning and spirituality, including practitioner-guided support, self-management and peer support options.[12, 13]
  - Providing support to help people with mental health problems and complex needs navigate health services in recognition of the health inequalities that they encounter, such as navigator or health link worker programmes.
  - Providing access to evidence based psychological interventions for people with addictions.

Life course

Pregnancy, children and young people

Improving family formation, perinatal and infant mental health

- As a minimum, every local area should ensure that the perinatal commissioning and delivery of comprehensive perinatal and infant mental health pathways complies with the National Institute for Health and Care Excellence (NICE) guidance and is focused on securing sustainable arrangements to meet the needs of women and their families before and during pregnancy and the year following childbirth;[14, 15] Key elements are:

- Developing Integrated Care Pathway approaches across local areas that take into account the physical needs of pregnancy and child development alongside the potential challenges to mental health and the significant opportunities in the perinatal period to improve mental health outcomes for families.[16]
- Investing in health visiting and home and family-based interventions to support maternal mental health improvement.[17, 18, 19]
- Producing prevention plans that address suicide within the perinatal period following the Joint Commissioning Panel for Mental Health's three steps.
    1. Identify those at increased risk of developing perinatal conditions.
    2. Develop a personalised care plan for each woman at increased risk.
    3. Ensure that women with a history of serious illness are prepared for pregnancy and receive preventative management when pregnant.[20]
- Ensuring that perinatal and infant mental health pathways include opportunities for those that need it to access appropriate support prior to conception and that every woman (where clinically appropriate) has access to mother and baby units.[21]

- Where appropriate, implementing national improvement initiatives locally, including: developing local Health Visitor Champions;[22] implementing the Family Nurse Partnership Programme for young first-time mothers;[23] ensuring that midwives have access to Perinatal Mental Health Training;[24] and implementing guidelines for GPs and primary care from NICE and the Royal College of General Practitioners (RCGP).[25, 26]
- Implementing the guidance for sustainable commissioning from NHS England.[27, 28]

Parenting and protecting mental health in early years

- Ensuring families at greater risk can access evidence-based support. Key elements are:
    - Provision of family-based interventions that are showing promising results including: Triple P;[29] the Solihull Approach;[30] Mellow Parenting;[31] Strengthening Families Strengthening Communities;[32] and Incredible Years.[33, i]
    - Parenting interventions should not only consider the care giving relationship between the parent and the child but also the relationship between parents;[34] taking a family systems approach.
    - Access to Video Interaction Guidance (VIG), as this is currently considered to be the best evidenced therapy for developing mother-child interactions.[35]

Parenting and improving the mental health of school-aged children

- Developing a whole school approach to embed mental health within all aspects of school life. NICE advises that primary and secondary schools should adopt a comprehensive whole school approach to promote the social and emotional wellbeing of children and young people.[36, 37] Key elements are:
    - Promoting leadership and commitment to the whole school approach by ensuring that head teachers and teachers can access mental health literacy support and training, including support to protect and improve their own mental health.[38]

[i] A database of effective approaches can be found at: http://www.kcl.ac.uk/ioppn/depts./cap/research/NAPR/index.aspx

- Creating a mentally healthy school environment through: providing teacher-led education; providing school nursing services; improving positive engagement with parents and families; providing opportunities for parenting education; creating meaningful opportunities for students to have a voice and share in decision-making; embedding mental health across the school curriculum; engaging students in school and community life; and coordinating work with other relevant children and young people support agencies.
- Implementing evidence-based bullying prevention programmes in school and other settings in which children and young people learn, live and spend their leisure time.[39]
- Providing parent training at the secondary school level in the implementation of interventions to promote pro-social behaviours and the reduction of bullying and disruptive behaviours.[40]
- Creating self-management opportunities and access to resources for students and teachers to protect and improve mental health.
- Taking a progressive approach to 'whole school' work to reduce stigma and promote help-seeking behaviours for children and young people in need of higher levels of support, such as Cognitive Behavioural Therapy and Acceptance Commitment Therapy.[41]
- Creating clear and supportive pathways through stepped care.

- Promote and implement the Healthy Child Programme through a multi-agency approach that incorporates, but is not limited to, schools and further education.[42]

- Collaborate with NHS England to support the local implementation of the Early Intervention in Psychosis (EIP) model, which was developed in Melbourne[43] and has been adopted in England and Wales.
- Implement NICE guidance on preventing psychosis, such as access to pre-emptive CBT for people considered to be at increased risk.[44]
- Adopt a range of prevention strategies for eating disorders. Key elements are:
  - Universal media literacy, using the media to critically look at body ideals.
  - Prevention interventions aimed at children at risk using body image focused cognitive-behavioural activities in schools.
  - Cognitive dissonance activities that engage young people in conversation on body image.[45]
- Promote and implement preschool programmes to: support school readiness, communication and the development of social and emotional skills.[46]
- Target support to children who are out / or at risk of being out of school and who have greater exposure to factors that negatively impact mental health (poverty and discrimination) including: children who are homeless; in the criminal justice system; part of a travelling community; or are in immigration detention centres.
- Prioritise the creation of local pathways to support the mental health of looked-after children and young people that are aligned with NICE standards for looked-after children.[47]
- Implement whole settings-based programmes within local colleges and universities informed by the work of the English Healthy Universities Network, Student Minds and the World Health Organization's Health Promoting Universities Programme.[48]

Working age

Developing mentally healthy homes

- Integrate mental health within local housing and regeneration policy and planning. Key elements are:
  - Creating Psychologically Informed Environments within housing, public services and community spaces, including within services for older people.[49]
  - Developing a public and private housing provision that provides a safe and stable environment and neighbourhoods where relationships can be facilitated and community cohesion built.
  - Developing housing, supported housing and residential services that enable older people to live independent and socially connected lives for as long as possible.
- Provide mental health literacy training to front-line housing and advice workers in order to help individuals and families secure and sustain appropriate accommodation, manage debt and maximise their incomes.
- Develop an integrated housing, health and social care pathway with relevant local partners that enables individuals at risk of developing mental health problems and their families to receive timely support that enables them to retain their tenancies.
- Work in partnership with the Department of Communities and Local Government, public bodies and other agencies to learn what works in practice in terms of supportting people at risk of or with mental health problems to secure and sustain adequate housing. Explore the use of any available local NHS estate to create more supported housing for vulnerable people, as recommended by the Taskforce.

Developing mentally healthy workplaces

- Work in partnership with local business leaders and employers to apply a whole workplace approach to protect and improve mental health at the individual, collective and organisational levels. Orientating the workplace as a key setting in the lives of its employees and their families, and an agent of influence in the community in which it operates. Key elements are:
  - Promoting local adoption of the Public Health England (PHE) Healthy Workplace Charter.[50]
  - Promoting line management training to create mentally healthy environments, as detailed in NICE guidance.[51]
- Support local employers to engage with evidence-based supported employment programmes such as Individual Placement and Support (IPS) and Access to Work.
- Explicitly address stigma and discrimination, guided by approaches developed in national programmes such as Time to Change, England and Wales[52] and See Me, Scotland.[53]

Ageing well

Reducing social and emotional isolation

- Invest in local projects that aim to improve mental health in later life through supporting emotional and social connections with family, the community and the people who are providing care and support services. Key elements are:
  - Identifying isolated older people who are less visible within communities and may be at risk of developing depression or dementia by ensuring that home help, GP's, podiatry, and hearing clinics are trained and supported to identify risk, distress and emerging mental health problems.

– Developing peer support programmes for older people, as these are already showing the potential to enhance empathy among older people or across generations and provide a cost-effective tool for addressing the difficult and widespread challenge of social isolation.[54]

Preventing depression in older people and improving outcomes for people with dementia

- Provide access to evidence-based interventions to prevent depression developing in older people. Key elements are:
  - Providing Mental Health First Aid training to enable services in contact with older people (such as home helps, AHPs, and Primary Care) to respond to distress.[55, 56]
  - Providing brief intervention approaches for people with physical health problems who are experiencing depressive symptoms, as these are feasible, therapeutically effective and also likely to prove cost-effective.[57]
  - Creating local service pathways for older people who often encounter significant barriers in accessing help to ensure that they have timely access to stepped care approaches, including CBT and psychotherapy (where data indicates higher recovery rates than those under 65).[58]
  - Developing initiatives that aim to improve mood and social connectedness including for those with dementia (such as Participatory Arts and Peer Support Programmes).[59]
  - Promoting the development of dementia-friendly communities.

Mental health and physical health in older age

- Adopting integrated approaches to health and mental health for older people who can experience higher rates of co-morbid mental and physical health problems. Key elements are:
  - Providing reminiscence therapy for older people[60] in health care settings.
  - Developing physical activity programmes for older people[61] and ensuring that these are accessible - for example, through social prescribing, including partnerships with local leisure facilities, community centres, and allotment associations.
  - Promoting access to liaison mental health teams for people being supported in specialist old-age acute physical health services as part of their package of care.
  - Ensuring older people are able to access addiction services.

Key Topics

Suicide prevention

- Work jointly to deliver the local elements of the National Suicide Prevention Strategy. Key elements are:
  - Development of joint local suicide prevention plans aimed at a 10% reduction in incidents of suicide. These plans should set out targeted actions in line with the guidance produced by PHE and draw on local evidence around suicide, including a strong focus on primary care, alcohol and drug misuse.
  - Implementation of interventions that target high-risk locations and support high-risk groups (young people who self-harm, people experiencing addictions) within the local population, drawing on localised real-time data.
  - Application of the suicide prevention profile tool

to ensure an effective audit of suicides is taking place locally and contributing to national data across the country.[62]

Criminal justice

- Local authorities and NHS bodies should work with local criminal justice settings (prisons, YOIs) to improve the mental health of prisoners, including prisoners with learning disabilities and autism (to comply with duties and the principle of equivalence under the Care Act 2014)[63] in recognition of the high prevalence of mental health problems and the risks to mental health posed by being in custody. Key elements are:
  - Commissioning and implementing local evidence-based liaison and diversion schemes for offenders with multiple needs (where there is now growing evidence of effectiveness)[64] and ensuring that people who would benefit from these are identified at the earliest point (people with mental health problems, learning disabilities or autism).
  - Supporting the development of Psychologically Informed Environments within local criminal justice settings, including mental health literacy training for criminal justice staff.
  - Supporting prisons and YOIs to provide access to evidence-based self-management and peer support opportunities and resources within criminal justice settings.[65]
  - Exploring the use of specific interventions, such as mindfulness in prisons. Studies have found important improvements in self-esteem, hostility and mood disturbances.[66]
  - Creating pathways into and out of prison that enable smooth transitions through education, housing, employment, health and social care support, including: providing criminal justice awareness and trauma-informed training for community-based staff and mental health literacy training for prison staff; and joint care planning between the custodial setting and community support services that address transition points.[67,68]

1. Introduction

'Taking local action for better mental health' is intended to support local areas to take positive and much needed action to improve public mental health and prevent mental health problems. This resource has been written to highlight and build upon the good work already taking place in local areas, to provide ready access to the evidence and propose effective and practical solutions.

The resource draws on a review of the prevention evidence commissioned from the Mental Health Foundation by Public Health England (PHE) to support its contribution to the work of the Independent Mental Health Taskforce. This review was necessarily rapid and draws heavily on NICE guidance (see Annex 2) and the Mental Health Foundation's Prevention Review Landscape Paper.[69]

In commissioning services, it is important to understand the case for change and what is known to be effective from the evidence base but also what has been shown to work when implemented in similar settings and has scope to be transferred. Therefore, in each section, we outline the case for change, summarise the evidence and make recommendations for improvement based on examples of promising practice across the sectors that influence mental health outcomes.

Strategic, system-wide activity is necessary to take advantage of the opportunities to improve mental health at all stages of life, particularly at pressure points when individuals, families and communities experience adversity and during times of transition from one life stage to another. If we are to rise to the challenge of reducing the prevalence of mental health problems, we will need to revise the way we view mental health and where it is owned. We will need to move from a dominant deficit model to one where health is viewed as a universal asset to be strengthened and protected. In this new way of thinking about mental health, managing mental ill health is still an important factor but not the central tenant, requiring commissioning that is expanded beyond specialist services to community and settings-based solutions.

In practice, we need to balance this transition, ensuring high-quality services for those that need them, while also intervening early to reduce the need for specialist provision and to give individuals, families and communities, the tools to protect and manage their own mental health. This will only be achieved through working alongside communities to understand the influences on their mental health, and where it is possible,k to build on existing strengths, assets and resilience. This work can be advanced through a 'Whole Community Approach', which provides a framework that takes account of all the factors that influence mental health at an individual, family, community and structural level and allows for mental health to be considered across a wide range of local policies, services, systems

and data that impact the mental health and wellbeing of communities.[70]

This is a wide agenda that can make prioritising preventative actions challenging. An important initial step is to map existing prevention-focused services onto the local data to understand the gaps and priorities for the locality. A sample mapping tool is provided in Annex 3.

To support prioritisation, this resource aims to be pragmatic and has identified:

- Key settings where there are opportunities to embed whole system approaches (schools, workplaces, criminal justice settings, residential settings)
- Issues of priority (suicide prevention).
- Opportunities that present at points of transition or times of high level public service contact. For example:
  - Perinatal and early years, when services have statutory duties to protect the health of mothers and babies.
  - People with disabilities, including people with learning disabilities, where there are duties under the Care Act 2014[71] or Equality Act 2010.[72]
  - Later life, where long-term conditions, or care and support needs can place people into ongoing contact with health and social care services.

Typically much of mental health promotion and prevention activity has been implemented through adopting universal interventions for the whole population. Although this can be the least stigmatising option, taking a 'one size fits all' solution can leave those with the most challenging lives behind. A progressively tailored or a 'universally proportionate' approach[73] allows for mental health to be protected overall, while ensuring that people at higher risk of mental health problems are proportionately prioritized.

Applying a progressive or whole system approach creates a framework for working at three key levels:

- Primary prevention to protect mental health by improving the social, emotional and physical environment for the whole population.
- Secondary prevention to identify and target support for selected groups at highest risk and at key transition/pressure points in people's life.
- Tertiary prevention where people are experiencing distress or a pre-existing mental health problem to prevent escalation and negative socio-economic or health outcomes.

Working systemically also has the benefit of creating an environment where mental health is an everyday consideration for all and, therefore, helps achieve the goal of producing an environment where it is possible to address mental health inequalities in a non-stigmatising way.

What is not involved in this resource is any cost/benefit analysis of the interventions; however, guidance on this can be found in the LSE 'Mental Health Promotion and Prevention: The Economic Case' report[74] and the LGA 'Money well spent?' briefing.[75] Overall in producing this resource, the intent was not to be comprehensive but instead to focus on where adopting an embedded and progressive framework can present quick but important wins.[76]

Levels of prevention[77]

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

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

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

The Independent Mental Health Taskforce report The 5 Year Forward View (5YFV) for Mental Health provides an important context for this publication, and its recommendations for the system are referred to throughout. A key aspect is the development of a national Prevention Concordat Programme to support all Health and Wellbeing Boards (along with CCGs) to put in place Joint Strategic Needs Assessment and Mental ill health Prevention Plans by no later than 2017. The 5YFV for Mental Health will be supported by a Ten Year Mental Health Research Strategy and a key consideration within this is the need to learn what works to reduce the prevalence of mental health problems.[78]

At the point of publication Sustainability and Prevention Plans (STPs) and CAMHS Transformation Plans are emerging as significant opportunities for local areas to take action to improve and protect the public's health. Together, these endorse the case for a much needed shift towards reducing demand on services and improving outcomes for people through taking preventative and community and settings-focused approaches.

During the Independent Mental Health Taskforce public consultation,[79] prevention emerged as a priority with important areas of focus identified as:

- Support for new mothers and babies.
- Mental health promotion within schools and workplaces.
- Being able to self-manage mental health.
- Ensuring good overall physical and mental health and wellbeing.
- Getting help early to stop mental health problems from escalating.

Innovation and the opportunities emerging through devolution in the UK will be central to achieving mental health improvement in many community based settings and systems, particularly for those areas that have chosen to prioritise mental health. This resource aims to further support these efforts alongside making the case for mental health related prevention across all localities that are yet to be convinced that this is the key public health concern of our time.

This level of system-wide change will only be fully realised if developed collaboratively, with partners across local and national systems working together. In 2015, PHE convened a new 'National Prevention Alliance for Mental Health' including organisations such as the Local Government Association and charities from a range of sectors that can influence mental health inequalities, including long-term conditions, housing and homelessness - to help build momentum and promote new ways of working on this ambitious but vital agenda.

1.1 The case for change

- Mental health problems are the largest global cause of years lived with disability.[80]
- One in four adults and one in ten children are likely to have a mental health problem in any year.[81]
- People with severe mental health problems die 15-20 years prematurely.[82]
- 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age.[83]
- 30% of people with a long-term physical health problem also had a mental health problem, and 46% of people with a mental health problem also had a long-term physical health problem.[84]

The effective support of people experiencing mental health problems is set to become one of the greatest public health challenges of this decade. Without action on the increasing demand for public services, it will not be possible to absorb the rising costs of providing care and support for those experiencing mental ill health in the long term. This creates an economic imperative for working to prevent mental ill health arising and worsening.[85] We need to act decisively as we have in the past when faced with significant risks to public health.

The historical approaches to curing illness and responding in crises has left a legacy of services designed to fix deficits. While access to good quality service provision for those times when people are experiencing ill health must continue to improve and rapidly, it is essential that we also draw our attention to preventative approaches so that illness is a rarer event, not only in acknowledgement of the direct savings in service provision but also in the indirect costs to society resulting from poor mental health and mental health problems.

- 70 million days are lost from work each year because of poor mental health.[86]
- Mental health costs the UK economy £70-100 billion each year, or 4.5% GDP.[87]
- A longitudinal study published in 2011 that analysed the data of 17,634 children from England, Scotland and Wales, found associations between childhood psychological problems and the ability of affected children to work and earn as adults.[88]

More key mental health statistics are available from Fundamental Facts About Mental Health 2015.[89]

The adoption of integrated approaches to health, mental health and social care will help ensure that scarce resources are deployed most efficiently and effectively. This will assist in delivering smoother pathways that provide 'whole person'/holistic support and reduce the risk of people falling through gaps. Opportunities to protect and improve mental health within places and spaces where people spend significant time need to be better exploited. We need to take every opportunity to make a change – 'Making Every Contact Count'.[90] Place based approaches[91] offer a useful whole system framework to ensure that people are able to access help earlier and receive the least restrictive interventions. This will reduce the number of people ending up with more complex and long-term needs - and the associated distress to individuals and families, while also reducing the current social and economic costs to society.

Overall, poor mental health impacts negatively on health status. Those with health conditions and disabilities are not only concentrated in higher numbers within areas of deprivation, but are also disproportionately affected by mental health problems.[92] Furthermore, groups that experience discrimination including Black, Asian and Minorities Ethnic (BAME) communities are at higher risk of developing mental health problems and of receiving poorer and more restrictive care, later.

Having a mental health problem can be both a consequence and a cause of socio-economic inequalities. Mental health problems are not evenly distributed across society and social ills such as being born into poverty or experiencing discrimination places us at greater risk.[93] The lack of life opportunities and the stress of living a difficult life are challenging enough

to our mental health. This can be compounded by the social stigma attached to having less than others in society and being reliant on social welfare. In turn, having a mental health problem can lead to reduced life opportunities that can create 'social drift'.

Despite the complexity of addressing these issues the inverse care law[94] prevails: the staff that work in areas of highest deprivation have insufficient time available to make a real difference to the lives of people within their practice. Although we have NICE approved, evidence-based interventions that deliver a broad range of impacts, only a small proportion of people with mental health problems currently receive any treatment.

There are challenges ahead but the changing attitudes to health across society aer in our favour. There is a shift in public attitudes and towards policy drivers that have a stronger focus on protecting health and building assets.[95] People understand more about their minds and bodies than ever before and are rightly demanding a say in their services. Individuals, families and communities are increasingly inclined to find ways to support and manage their own health often outside of traditional services.

Currently, as few as 25% of people with mental health problems use specialist mental health services,[96] highlighting the need to review what is on offer to people and to reach them in ways that are accessible, meaningful and that operate in the least stigmatising way. That means that we need to focus on mental health in the places where people live. Their houses and communities will need to be viewed as environments that can support recovery.

This calls for collaboratively developing new ways of working that bridges service boundaries.[ii] These initiatives need to be woven into the fabric of training and development for future and current staff across a range of publicly funded health and social care services. Those who are already in positions that play a role in shaping mental health, whether housing officers, social care staff or employers, should be provided with the skills and agency to embed mental health improvement in their everyday working practice – 'Making Every Contact Count'.[97]

[ii] By commissioning services we often mean CCG's and local government but also that there are a very wide range of commissioners responsible for areas that influence the factors that determine mental health

2. Whole Population Approaches

2.1 Mental health literacy of the population

2.1.1 Making the case

Mental health literacy involves developing everyone's understanding of mental health in the following areas:

- What mental health encompasses.
- What supports and protects it.
- What can negatively affect it (for example, adverse life experiences such as relationship breakdown, redundancy, neglect, abuse and violence) and growing people's confidence and skills to identify and respond to mental distress (our own and other people's).

Being mental health literate includes having the ability to understand the impact of specific mental health problems; knowing how to access mental health information; knowledge of risk factors, self-management approaches, and of the professional help available; and attitudes that promote recognition and appropriate help-seeking behaviour.

The principles of prevention, early intervention and stigma reduction need to be applied across local systems so that services can identify at the earliest point that support is needed. This will require advances in the content and structure of pre- and post-qualification training programmes for professionals within public support sectors, including social work, health and social care and housing staff.

2.1.2 Evidence

Increasing mental health literacy may achieve mental health improvement effects,[98] particularly in communities that experience higher levels of stigma and for groups at heightened risk of developing mental health problems.

Peer support and self-management models encompass skills and strategies that individuals and groups can use to effectively manage and gain control over their lives. The Health Foundation provides an overview of different approaches to self-management, including those taken within mental health.[99] In the 5 Year Forward View, the NHS is significantly investing in evidence-based approaches that are aimed at supporting people in becoming active participants in managing their own health, such as self- management educational courses, as well as encouraging independent peer-to-peer communities to emerge. This is echoed in the 5 Year Forward View for Mental Health (Independent Taskforce report). Self-management is already widely applied to physical health problems but the technique has more recently been shown to be effective as a strategy for people living with bi-polar disorder and schizophrenia. Research by Lemmi et al[100] found that self-management for people with severe mental illness improved well-being and health-promoting lifestyles. After an increase in the short term, costs appeared to decrease in the long term. The evaluation of a self-management[101] and peer support intervention developed

and delivered by mental health service users to 262 people with psychiatric diagnoses living in the community, found that participants reported significant improvements in wellbeing and health-promoting lifestyles 6 and 12 months after self-management training. Effective self-management has the potential to improve detection rates, access and early intervention. Improving the mental health literacy of carers has also been found to be effective in reducing depression.[102] This model is being tested in further areas in relation to selected higher risk groups and in settings such as schools and workplaces but more needs to be understood in relation to any potential to prevent the onset of mental health problems.

2.1.3 Recommended action

Improving the mental health literacy of the population

- To take 'whole system' approaches to improving the mental health literacy of the public service workforce. The key elements are :
  - Adopting all recommendations that contribute to improving mental health within 'Making Every Contact Count'.[103]
  - Embedding mental health improvement practices within all publicly funded provisions, (in recognition of the mediating role of mental health in determining health and social outcomes for community members) including: health visitor support to new parents; teaching within schools; and support in housing and social welfare contact.
- Ensure that health and social care staff, as routine, consider the impact of mental health inequalities and act to reduce them. This includes the identification of communities and individuals at greatest risk of mental health problems and an understanding of the potential impact of points of transition and adverse life experiences on mental health. Mental health improvement should be integrated into daily work and messages and interventions tailored to meet specific needs and areas of highest risk including people living in low-income families, and people who are LGBT or from BAME communities. The key elements are:
  - Implementation of the health and social care staff workforce development and leadership programmes as outlined in the Public Mental Health Leadership and Workforce Development Framework.[104]
  - Adoption of co-production approaches with communities to increase empowerment and to maximise programme impact.
- Develop local programmes that promote improved mental health literacy and the capacity for self-management within communities. The key elements are:
  - Enabling access to peer support and self-management resources within settings such as schools, residential services and care homes, prisons and further education.

  - Adapting interventions for groups and communities who are at higher risk of developing mental health problems such as people with long term health conditions, refugees and people living with disabilities,[105] or who have already experienced mental distress and are in the process of recovering their mental health.

2.2 Developing mentally healthy communities and places

2.2.1 Making the case

A place-based approach for either community level prevention or prevention within settings where people learn, work and live (including criminal justice as discussed in Section 4.2) is an efficient and effective way of reaching significant numbers of people within particular areas and being able to work with them over a period of time through multiple and varied interventions. This requires effective partnership approaches with coordinated efforts across a whole range of stakeholders.

For communities and places in which populations who have experienced multiple and cumulative adverse life experiences and trauma live, learn and work, trauma informed interventions are valuable. Trauma affects the mind and body and requires a multitude of approaches to healing. Trauma can be expressed in a range of mental health problems and behaviours towards the self and others such as self-harm, addiction, disruption, criminal activity and hoarding. Trauma-informed care is an organisational structure and treatment framework that involves understanding, recognising, and responding to the effects of all types of trauma in order to help survivors rebuild a sense of control and empowerment in their lives. Trauma-informed care involves training for service providers across a range of public, voluntary, community and private sector services to reduce the use of negative and coercive practices. These principles facilitate healing after trauma for a broad array of individuals including survivors of domestic violence, young people and adults within criminal justice settings, and homeless people.

2.2.2 Evidence

Within the community, social determinants of mental health include the economic status of the community, levels of neighbourliness, degree of personal safety, levels of loneliness, the quality of housing and open spaces.[106] Our immediate living environment has a significant impact on mental health outcomes with homelessness and poor quality housing both risk factors (as high as 3 and 4 fold risk respectively).[107] Other factors within the home such as fuel poverty are also associated with higher levels of mental health problems.[108] People with mental health problems are more likely to be socially isolated[109] with more than 50% having poor social contact compared to 6% of the general population,[110] and they are four times more likely than the general population to be living alone.[111]

The importance of working alongside communities who are most at risk of poor health outcomes has been

recognised by the World Health Organization (2010) which stated that '*a crucial direction for policy to promote health equity concerns the participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health. Broad social participation in shaping policies to advance health equity is justified on ethical and human rights grounds, but also pragmatically*'.[112,113]

Specific models such as neighbourhood committees, peer leadership and community champions have potential to be applied within a 'whole community' approach to improving mental health. NICE published updated guidance on community engagement to improve health and wellbeing and reduce health inequalities in 2016.[114] Working to empower communities in decision making in relation to planning and regeneration has been shown to increase resilience within communities.[115] Asset Based Community Development is a long established, effective approach to meaningful and effective work with communities.[116]

In the US, Baltimore City has committed to training every front-line city worker to becoming fully trauma-informed. This is a critical step in ensuring that residents are treated with dignity and in lessening the impact of trauma across the lifetime and between generations.[iii]

2.2.3 Recommended actions

- Apply a socio-ecological approach to mental health improvement that aims to work across the multilevel of individuals, families, communities, and structures (including settings such as schools, prisons, and workplaces). Key elements are:
  - Adopting a universally proportionate approach that aims to address increasing levels of risk within communities and progressively applying resources where the greatest risks lie.[117]
  - Promoting an Asset Based Community Development approach (ABCD) to mental health improvement that enables individuals and communities to be active participants in planning, prioritising and implementing mental health improvement actions.
- Make use of available community resources and support social inclusion by developing social prescribing through local health and social care professionals for example primary care staff.

Social prescribing

Social prescribing improves mental health by addressing people's social and physical wellbeing. It promotes the concept that community based settings can form support structures. Social prescribing can be used as an early intervention tool for people who may be struggling or displaying symptoms of distress, but it can also lead to wider mental health improvement gains through increasing community cohesion and connectedness.[118] The Centre for Welfare Reform has developed a guide to commissioning social prescribing for mental health, which includes options for measuring progress.[119] The Health Foundation's report on social prescribing within City and Hackney in London illustrates this approach.[120]

- Ensure that mental health improvement is viewed and measured as a central outcome in community investment and regeneration actions.
- Create and protect green spaces within neighbourhoods in order to generate better physical and mental health outcomes for individuals and communities.[121]

The GoWell Project

The GoWell Project,[122] which is a research programme investigating the impact of investment in housing, regeneration and neighbourhood renewal on the health and wellbeing of individuals, families and communities. This programme operates in 15 deprived areas in Glasgow and has shown some evidence that this investment has yielded positive impact on levels of community cohesion and wellbeing.

2.3 Reducing stigma and discrimination

2.3.1 Making the case

Mental health stigma can prevent people with mental health problems from seeking and accessing help; and can contribute to a range of negative outcomes including late help seeking behaviour and social isolation.[123, 124] Stigma and discrimination have a severe impact on the lives of people with mental health problems, their families and carers. Together they are driving factors in maintaining the status quo of: poor access to healthcare, reduced life expectancy, exclusion from education and employment, victimisation, poverty and homelessness. Mental ill health is associated with higher rates of morbidity and mortality and is a risk factor for poorer health, social and economic outcomes.[125] People diagnosed with schizophrenia experience early death from a range of physical health conditions particularly cancer and cardiovascular disease.[126] This is compounded by the lack of access to good quality care for physical health conditions among people experiencing mental ill health due in part to diagnostic overshadowing (when health care professionals attribute symptoms to an individual's mental health and do not investigate physical causality).[127, 128] This impact on care also extends to the experience of mental health care.[129]

2.3.2 Evidence

Mental health stigma can have an impact at two levels. First, due to the lack of parity between mental health and physical health services, people with mental health problems

[iii] More info: http://health.baltimorecity.gov/trauma-informed-care

are less likely to have access to health improvement interventions.[130] Whole communities have been found to feel unable to approach services for mental health support. In particular BAME communities have reported having lost trust in mental health services due to poor experiences and discrimination over a lifetime. Stigmatising and discriminatory treatment can be particularly distressing when a person is experiencing a health crisis. Members of some BAME communities are at higher risk of being admitted to services in a crisis, detained and subject to compulsory treatment. This has been recognised by the Independent Police Commission, the NHS, Home Office and others as being partly related to discrimination.[131]

Secondly people can internalize stigma and experience feelings of shame, leading to low confidence and self-esteem, withdrawal and social isolation; such self-stigma can lead to individuals and groups becoming less likely to seek help when they are experiencing mental distress.[132]

Stigma and discrimination constitutes a barrier for people who experience mental health problems entering, remaining in and returning to, work. Self-stigma and fear of discrimination may also prevent people from applying for jobs or disclosing their mental health conditions to employers and colleagues and seeking/accessing appropriate adjustments. While there is some evidence that employer attitudes to mental health are improving,[133] a recent study describes a prevailing culture of silence around mental health at work for fear of associations with weakness and failure,[134] and evidence suggests that employers are less likely to hire an applicant who discloses mental health problems.[135] There is a strong economic and moral case for reducing mental health stigma and discrimination in the workplace in terms of reducing loss from absenteeism, presenteeism and staff turnover.[136] Moreover if a person falls out of work with a mental health problem their chances of returning to work are low. This sets up a spiral of disadvantage.

Evidence suggests that stigmatising attitudes begin to form at a very young age, influenced by parents, peers and media depictions of mental ill health[137] and this seems to endure over time.[138] Many mental health conditions begin to emerge before the age of 14. Therefore childhood and adolescence is a critical period in terms of recognising the signs of developing mental health conditions and supporting appropriate help seeking. Bowers et al found that young people perceived stigma to be the greatest barrier to accessing school-based mental health services and that young males were the least likely to access services.[139] Those who do use services and particularly those on medication often feel shame and the need for secrecy and withdraw from peer relationships.[140]

2.3.3 Recommended actions

- Develop evidence based stigma and discrimination reduction activities that focus on sustained behaviour change. Key elements are:
  - Combining awareness raising and education with opportunities to reduce social distance[141] through engagement with people with a lived experience (social contact).
  - Targeting activities where the greatest stigma and discrimination are experienced and where outcomes need to be improved (improved outcomes in health, employment and education).
  - Ensuring consistency of messages and strategies to support long term discriminatory behaviour change.
  - Ensuring that messages are recovery focused to challenge stereotypes and stigma.[142, 143]
  - Promoting mutual support opportunities to reduce self-stigma and increase quality of life for those experiencing mental health problems.[144]

2.4 Integrated approaches to health and social care

2.4.1 Making the case

Those with mental health problems experience significant physical health inequalities due to the early onset of mental health problems and the elevated health risk behaviours among this group, for example, 42% of the tobacco consumption in England is by those with a mental health problem.[145] Those with mental health problems are at a greater risk of and experience high rates of heart disease, diabetes, respiratory disease, cancer and infections.[146] This results in lower life expectancy, with people living with mental health problems dying 5-10 years younger than the general population.

As mentioned in the 5 Year Forward View, there is an imperative to move beyond more traditional boundaries. Health, mental health and social care services should be integrated around individuals with physical illnesses, as well as to improve the physical health of people with mental health problems.

2.4.2 Evidence

Closer working arrangements between long-term health condition management and mental health has been called for by a number of key agencies including the Royal College of GPs and The King's Fund.[147] Approximately £13 billion is currently spent on dealing with the physical health consequences of poorly managed mental health.[148] People with long-term conditions are 2-3 times more likely than the general population to encounter mental health problems, most commonly depression and anxiety. It is estimated that NHS England spends £8-13 billion annually as a result of mental health problems among people with long-term conditions.[149] The correlation between living with long term conditions and experiencing mental health problems increases with greater co-morbidity (e.g. the number of conditions someone has) and when deprivation is also present.[150]

People who have an addiction are at risk of developing both physical health and mental health problems. NICE therefore recommends that people who misuse alcohol be offered evidence-based psychological interventions.[151]

Integration also refers to adopting the World Health Organization's framework of working across promotion to recovery – so integrating mental health into wider public health approaches (see Introduction).

2.4.3 Recommended actions

- Integrating mental and physical health care should be a central strategy for improving quality and efficiency in health provision, requiring the adoption of holistic approaches to health to be adopted within primary care and integrated pathways accessible through to acute services.
- Integrating health and social care services should be a central strategy for improving outcomes for people at risk or who have developed mental health problems and should be achieved through establishing joint approaches to planning and development of health, mental health and social care interventions between local authorities, primary care and the voluntary and community sector.[152] Key elements are:
  - Undertaking workforce development that allows staff to feel confident about supporting the mental health of people with long term conditions and effectively and efficiently identifying physical health risks for those with mental health problems.
  - Adopting wellness models that bring together health and mental health alongside social functioning and spirituality including practitioner supported, self-management and peer support support options.[153, 154]
  - Providing support to help people with mental health problems and complex needs navigate health services in recognition of the health inequalities that they encounter, such as navigator or health link worker programmes.
  - Providing access to evidence based psychological interventions for people with addictions.

3. Life course

Interventions that are aimed at reducing prevalence and risk of developing a mental health problem are relatively new. Although we have always taken steps to understand the causation of mental health problems, much of the investment to date has been on care and treatment.

By taking a life course approach it is possible to intervene early to address developmental factors and neglected determinants that can increase risk (primary prevention) while working to identify those at heightened exposure to adversity to prevent mental health problems from resulting and reducing the impact of these when they do (secondary and tertiary prevention). We have divided the life course into a number of key phases in an individual's life and describe the 'pressure points' and the periods of transitions between these. These map onto service provision to support whole place interventions for example in schools and workplaces.

This approach allows the identification of life stages and transitions, where risk is the highest or where opportunities to intervene successfully are the greatest. Currently, the delay in identifying children at risk and in providing effective early intervention means that many young people enter adulthood with untreated conditions; and for others symptoms only develop once they have reached adulthood. Prioritising children and their families is therefore a worthwhile priority investment, although it will remain important to work to prevent mental health problems across the life course including in later life.

Socio-economic disadvantages place people at greater risk of developing mental health problems. Children and young people living in these circumstances are two to three times more likely to develop mental health problems. This sets the scene for a spiral of disadvantage that all too often accumulates across life. When mental health problems are established these can lead to a series of detrimental effects on people's life chances. Even when not born into disadvantage, people who experience mental health problems are more likely to be workless, to live on benefits and to experience debt all of which can stack up to produce a poorer quality of life that can worsen across the life course.[155] The stress attached to being reliant on social welfare can also compound existing mental health problems.[156] Where risks are identified and problems prevented, a virtuous cycle of accessing the right support and recovery can be established for example supporting young people to stay in education and adults to access and remain in employment.[157, 158]

3.1 Pregnancy, children and young people

3.1.1 Improving family formation, perinatal and infant mental health

3.1.1.1 Making the case for change

During pregnancy and the postnatal first year, women are at a greater risk of developing a range of mental health problems, including anxiety, depression, post-traumatic stress disorder and postnatal psychotic disorders. These are referred to as 'perinatal mental health problems'. Perinatal mental health has been declared as a priority for the National Clinical Leads for Children, Maternity and Mental Health in NHS England, for Public Health England and for Health Education England.

Prevention has an important part to play within the perinatal and infant mental health pathways. Investment in specialist provision as well as public mental health interventions (including peer support and self-management) reduces the distress experienced by women and their wider family, and supports the vital attachment and development that takes place during the first year of life.

The Maternal Mental Health Alliance (MMHA)

The MMHA is a coalition without formal association of about 90 national organisations, hosted by the Mental Health Foundation. It is focused on improving access to mental health support during the pivotal perinatal period and is a valuable source of national and local information. The Alliance's 'Everyone's Business' campaign draws on the NICE guidance and standard to progress ACT:

Accountability for perinatal mental health care is clearly set at a national level and complied with locally.

Community specialist perinatal mental health services meeting national quality standards are available for women in every area of the UK.

Training in perinatal mental health is delivered to all professionals involved in the care of women during pregnancy and in the first year after birth .

The First 1001 Days Manifesto - a cross party initiative that calls for all babies to receive sensitive and supportive care in the first days of their lives.[159]

3.1.1.2 Evidence

Over one in ten mothers will be affected by a diagnosable mental health problem during pregnancy or after the birth of their baby. This means that each year in the UK more than 70,000 families will experience the impact of these mental health problems.[160] Perinatal mental health problems lead to many women dying by suicide each year,[161] and the chances that a woman with a previous diagnosis of bipolar disorder will experience a major episode of ill health in pregnancy are between 1 in 2 and 1 in 4. The cost of failing to protect and support perinatal mental health has been estimated at £23billion each year. [162]

Investing £400 per normal birth to bring services up to the NICE recommended level and standard of perinatal mental health care would save conservatively £10,000 over the lifetime of the mother and child.[163] The Joint Commissioning Panel for Mental Health recommends that all women requiring admission in late pregnancy or after childbirth should be admitted with their infant to a mother and baby unit, not an adult admission ward. They note that these units must be linked to perinatal services provided by Mental Health Trusts and be commissioned by the NHS Commissioning Boards.[164] However, currently less than 15% of localities provide full specialist perinatal mental health services and more than 40% provide no service at all.[165] Consequently, many admissions to hospital for mental health care mean being placed at an unacceptable distance from home and separated from children, partners and networks of support.[166] As well as being distressing for the mother and her family, this disrupts vital attachment and development during the first year of life.

The linkages within and between primary and secondary care to identify, which women are at risk, and the specialist perinatal psychiatric advice to support their care, remain variable. And as a result many women and families remain unsupported.[167, 168]

Vulnerable populations that have been identified include mothers living in deprived areas or on a low-income, women in some BAME communities, women with a pre-existing psychiatric diagnosis and new mothers with an increased risk of depression. However, because mental health problems can affect anyone universally proportionate services provide the least stigmatising approach, where support can be stepped up and tailored according to need. Although home visits and family based support interventions appear to be effective in promoting maternal mental health, improving parenting skills and confidence and improving outcomes for children including those most vulnerable, effectiveness of these interventions depend upon practitioner's confidence in their ability to talk to mothers sensitively about how they feel they are coping.[169] This includes providing support to mothers, fathers and others involved in care.

3.1.1.3 Recommended actions

3.1.1 Improving family formation, perinatal and infant mental health

- As a minimum, every local area should ensure that the perinatal commissioning and delivery of comprehensive perinatal and infant mental health pathways complies with NICE guidance and is focused on securing sustainable arrangements to meet the needs of women and their families before and during pregnancy and the year following childbirth;[170, 171] Key elements are:

- Developing Integrated Care Pathway approaches across local areas that take into account the physical needs of pregnancy and child development alongside the potential challenges to mental health and the significant opportunities that present in the perinatal period to improve mental health outcomes for families.[172]
- Investing in health visiting and home and family based interventions, to support maternal mental health improvement.[173, 174, 175]
- Producing prevention plans that address suicide within the perinatal period following the Joint Commissioning Panel for Mental Health's three steps.
    1. Identify those at increased risk of developing perinatal conditions;
    2. Develop a personalised care plan for each woman at increased risk;
    3. Ensure that women with a history of serious illness are prepared for pregnancy and receive preventative management when pregnant.[176]
- Ensuring that perinatal and infant mental health pathways include opportunities for those that need it to access appropriate support prior to conception and that every woman where clinically appropriate has access to mother and baby units.[177]
- Where appropriate implementing national improvement initiatives locally, including: developing local Health Visitor Champions;[178] implementing the Family Nurse Partnership Programme for young first time mothers;[179] ensuring that midwives have access to Perinatal Mental Health Training;[180] and implementation of guidelines for GPs and primary care from NICE and the RCGP.[181, 182]
- Implementing the guidance for sustainable commissioning from NHS England.[183, 184]

3.1.2 Parenting and protecting mental health in early years

3.1.2.1 Making the case

Evidence based parenting programmes are one of the most effective ways to improve the mental health and wellbeing of children and their parents. There is a growing recognition of the value of integrating approaches to parenting, mental health and couple relationships. Only focusing on the mother-child relationship or the relationships between partners misses opportunities to benefit children's wellbeing.[185] From a child's perspective family relationship problems were found to be the biggest presenting problem in a recent survey of over 4,500 children attending CAMHS services.[186]

There is increasing evidence of the importance of infants receiving early sensitive care as a foundation for optimal development. Infants' brains develop rapidly in response to early interactions and evidence from disciplines such as neuroscience, psychology, biology and psychoanalysis indicates that early caregiving relationships have long-term influences on the way individuals regulate their emotions and behaviour, and make relationships.[187, 188, 189, 190]

Developing a mental health problem in early childhood can have long lasting social and economic consequences. Once a child has developed a problem they are: less likely to do well in school and in the labour market; more likely to be in contact with the criminal justice system; and have a shorter life expectancy.[191] The average potential savings from early intervention has been estimated at £150,000 per case.[192]

The four Children Commissioners in the UK, in their 2015 submission to the UN Committee on the Rights of the Child, raised concerns at the consequences of austerity measures, which have seen the loss of early parenting support services.[193]

3.1.2.2 Evidence

A wealth of evidence is building in support of the implementation of evidence-based parenting programmes. These show great potential in improving and maintaining both infant and parent mental health.[194, 195] The sensitivity of care has been shown to directly affect the developing neural pathways, with significant consequences in terms of the infant's developing sense of self, capacity for regulation and engagement with the environment.[196, 197, 198] "Serve and return" is a concept used by The Center on the Developing Child at Harvard University to describe the reciprocal interaction between a baby and parent.[199]

A meta-analysis of interventions to enhance maternal / caregiver sensitivity and interventions to improve attachment suggests that interventions which focus exclusively on enhancing maternal / caregiver sensitivity are more effective both in enhancing maternal/ caregiver sensitivity and security of infant attachment (largely assessed by the Ainsworth Strange Situation). Interventions effective in enhancing parental sensitivity were universally effective, including among high risk populations. Scott's earlier 2006 review of parenting programmes also found that they are particularly positive for children who are at greatest risk of developing a mental health problem, including those living in poverty, having a parent with a serious mental health problem or who have an addiction.[200]

Evidence suggests that information concerning parenting can effectively be provided through a variety of strategies, including group based training, videos and one-to-one interventions.[201]

Studies have also examined the application of a family systems approach to improving mental health outcomes for parents and babies. This approach has shown promising results, moving beyond maternal mental health to consider other parents, family members and siblings.[202] In part this approach looks at dynamics across the whole family unit and can help to avoid the risk of over focusing on the role of mothers thus avoiding adding another layer of stigma to mothers with existing mental health problems, while recognising the important role of fathers, siblings and extended family in care giving. It has been recognised that looked after children also need to

have strong positive relationships with those that care for them[203] and there have been calls for the state parenting concept to be extended to those young people in the criminal justice system – many of whom have been in care previously.[204]

3.1.2.3 Recommended actions

- Ensuring families at greater risk can access evidence-based support. Key elements are:
  - Provision of family based interventions that are showing promising results including: Triple P;[205] the Solihull Approach;[206] Mellow Parenting;[207] Strengthening Families Strengthening Communities;[208] and Incredible Years.[209, iv]
  - Parenting interventions should not only consider the care giving relationship between the parent and the child but also the relationship between parents.[210] Taking a family systems approach.
  - Access to Video Interaction Guidance, or VIG, as this is currently considered to be the best evidenced therapy for developing mother child interactions.[211]

3.1.4 Improving the mental health of school-aged children

3.1.4.1 Making the case

Developing a mental health problem early in life can hamper a child's ability to fulfil their potential. A child's mental health and wellbeing is a central mediating factor that influences their cognitive development and ability to learn;[212] physical and social health outcomes; and can determine mental health status across adult life.[213] Excluding dementia, over half of adult mental health problems start by the age of 14 and a staggering 75% by 18.[214] As noted by the Children and Young People's Mental Health and Wellbeing Taskforce report 'Future in Mind': "early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood".[215]

Poor mental health can have a negative effect on the wider health and development of adolescents. Moreover, poor mental health is associated with several negative social outcomes such as lower educational attainment, higher rates of health risk behaviours (unplanned pregnancy, smoking, alcohol and drug misuse), poorer social skills and anti-social behaviours.[216]

The UK's four Children Commissioners recommended in their 2015 submission to the United Nations Committee on the Rights of the Child that the state should invest in universal preventative and early intervention children's services, to prevent an increase in mental health problems among children.[217] They advised that particular attention should be given to those at greatest risk including: disabled children; children deprived of parental care; children affected by conflict, trauma, abuse, domestic violence and neglect; those living in poverty; and those in conflict with the law alongside calling for further investment in child and adolescent mental health services to meet the needs of children requiring such support.

[iv] A database of effective approaches can be found at:http://www.kcl.ac.uk/ioppn/depts./cap/research/NAPR/index.aspx

3.1.4.2 Evidence

Mental health programmes delivered in schools have the potential to help protect the mental health of young people through building resilience[218] as well as creating a more tolerant and supportive environment that can enhance young people's abilities to learn.[219] There is high quality evidence of the effectiveness of multi-component programmes covering the classroom curricula and school environment,[220, 221] together with programmes for parents[222] including parenting programmes for children identified as having conduct disorders.[223, 224] Considering the role of the parents has been shown to be important as the relationship between parents has an impact on how well children do at school.[225] There is a growing body of evidence that bullying prevention programmes,[226, 227] which aim to change the ethos of the school and develop zero tolerance policies and practices, are one of the most effective ways to support children and young people's mental health.[228] Alongside supportive evidence on violence and sexual abuse prevention programmes.[229] The Department for Education (DfE) recognises that: "in order to help their pupils succeed; schools have a role to play in supporting them to be resilient and mentally healthy".[230] There is evidence to support this assertion and Ofsted has highlighted that children and young people themselves say that they want to learn more about how to keep themselves emotionally healthy.[231] Moreover schools have a duty to promote the wellbeing of students[232] and doing so results in improved academic attainment.[233] NICE have produced advice on developing an action plan to improve the social and emotional wellbeing of children and young people.[234]

There is also an economic imperative to intervene early to prevent negative outcomes for young people. Lifelong savings of supporting children and young people have been estimated as high at £150,000 for children who would otherwise go on to develop a conduct disorder.[235]

Many mental health problems emerge in late childhood and early adolescence and young people at this age are at heightened risk of experiencing specific mental health problems such as ADHD, eating disorders, body dysmorphia and self-harm.[236] Depression among young people is a growing concern.[237] However, many of these problems can be prevented as noted by the World Health Organization.[238]

As an example, schizophrenia accounts for almost 25% of all psychiatric admissions in young people aged between 10 and 18 with a rise in incidence from age 15 onwards. There is a worse prognosis for psychosis and schizophrenia when the onset is in childhood or adolescence. Around a third of young people who experience psychotic symptoms will find these severe enough to have a major negative impact on their lives, including their personal, social and educational functioning.

There are over 68,000 looked after children and young people in England and according to the Department for Education (2013) 62% of these children

were in care due to reasons of abuse or neglect with the majority aged between 10 and 15. Three quarters of these children are living in foster care, with 9% cared for in residential accommodation that included children's homes, hostels and secure accommodation.[239] There is a range of documents concerned with best practice for promoting the health and wellbeing of looked after children and regulations that protect their rights, including the Health and Social Care Act (2012)[240] that required NICE to develop quality standards for looked after children[241] and the Ofsted framework for inspection.[242] One central feature within the quality standards is ensuring that looked after children have sufficient involvement in decision making in relation to their care and service developments and that they have access for nurturing relationships that foster attachment.

3.1.4.3 Recommended actions

- Developing a whole school approach to embed mental health within all aspects of school life. The National Institute for Health and Care Excellence (NICE) advises that primary and secondary schools should adopt a comprehensive 'whole school' approach to promoting the social and emotional wellbeing of children and young people.[243, 244] Key elements are:
  - Promoting leadership and commitment to the 'whole school approach' by ensuring that head teachers and teachers can access mental health literacy support and training including support to protect and improve their own mental health.[245]
  - Creating a mentally healthy school environment through: providing teacher led education; school nursing services; improving positive engagement with parents and families; providing opportunities for parenting education; creating meaningful opportunities for students to have a voice and share in decision making; embedding mental health across the school curriculum; engaging students in school and community life; and coordinating work with other relevant children and young people support agencies.
  - Implementing evidence based bullying prevention programmes[246] in school and other settings in which children and young people learn, live and spend their leisure time.
  - Providing parent training at secondary school level in the implementation of interventions to promote pro-social behaviours and the reduction of bullying and disruptive behaviours.[247]
  - Creating self-management opportunities and access to resources for students and teachers to protect and improve mental health.
  - Taking a progressive approach to 'whole school' work to reduce stigma and promote help-seeking behaviours for children and young people in need of higher levels of support, such as Cognitive Behavioural Therapy and Acceptance Commitment Therapy.[248]
  - Creating clear and supportive pathways through stepped care.
- Promote and implement the Healthy Child Programme through a multi-agency approach that incorporates but is not limited to schools and further education.[249]

The Healthy Child Programme

The Healthy Child Programme for five to 19-year-olds sets out the recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. It is important to take account of the need to influence wider social, economic and ecological factors that work to determine mental health including: access to outdoor space and opportunities to play; nutrition and exercise; poor housing and impact of poverty; disability (including learning disability) and long-term conditions etc.

- Collaborate with NHS England to support the local implementation of the Early Intervention in Psychosis (EIP) model, which was developed in Melbourne[250] and has been adopted in England and Wales.
- Implement NICE guidance on preventing psychosis such as access to pre-emptive CBT to a person considered to be at increased risk[251]

NICE guidelines recommends that early intervention approaches are provided for the first 3 years after the onset of psychosis and that these operate in environments that are 'normalising' to reduce stigma, maximise life chances and prevent a life-long trajectory into specialist clinical services.[252]

- Promote and implement preschool programmes to promote school readiness, communication and the development of social and emotional skills.[253]
- Target support to children who are out / or at risk of being out of school and who have a greater exposure to factors that negatively impact on mental health (poverty and discrimination) such as children who are homeless, in the criminal justice system, part of a travelling community or are in immigration detention centres
- Prioritise the creation of local pathways to support the mental health of looked after children and young people that are aligned with NICE standards for looked after children[254]
- Implement whole settings based programmes within local college and universities informed by the work of the English Healthy Universities Network, Student Minds and the World Health Organization's Health Promoting Universities Programme.[255]

Mindfulness

Mindfulness for different members of the school community (pupils and teachers) is an emerging development and is the focus of a number of current studies.[256] An evaluation of the Mindfulness in Schools Project, for example, showed that well conducted mindfulness interventions can improve the mental, emotional, social and physical health and wellbeing of young people who take part. It was shown to reduce stress, anxiety, reactivity and bad behavior, improve sleep and self esteem and bring about greater calmness and relaxation.[257]

However, more needs to be understood about using mindfulness, such as the dose response rate and optimum age range.

Figure 1: The Whole School Approach[258]

3.1.5 Transitions and Pressure Points

3.1.5.1 Childhood transitions

Children experience several key transition points involving moving between different learning centres and changes within their social groups. Some experience very specific transitions in their families such as: living in unsafe home environments (characterised by domestic violence, neglect, physical and / or sexual abuse); caring responsibilities; bereavement; separation of parents; parental unemployment; moving house or homelessness; developing a disability or health condition; migration-related trauma and discrimination. Transitions are now recognised as central to children and young people's wellbeing and experience of childhood.[259]

Equally colleges and universities are places where mental health can be improved or placed at risk and represent for the majority of young people significant periods of change.

Models exist that have been helpful to support young people in transition, including those that work to create a platform for young people to be able to share their experiences and influence change. The particular challenges experienced by young people with disabilities transitioning out of school have been recognised.[260] Evidence based guidance developed in the United States addressed 5 key essential components that support effective transitions: student focused planning; career preparatory experiences; leadership development; family involvement; and connecting activities through interagency collaboration.[261]

3.1.5.2 Transition from Children and Adolescent Mental Health Services (CAMHS) to adult services

School readiness initiatives address: children's readiness for schools, schools' readiness for children, and families' and communities' readiness for school, with particular attention on transitions and gaining competencies. While school readiness considers all children, there is a particular focus on vulnerable and disadvantaged children. It has been linked to positive social and behavioural competencies in adulthood, and improved academic outcomes in primary and secondary schools (both in terms of equity and performance).[262] Ofsted has published 'Are You Ready? Good Practice in School Readiness'.[263]

Young people between the ages of 16 and 18 are at heightened risk of developing a mental health problem.[264] They are going through a period of physiological change and are making important transitions in their education. If they have developed a mental health problem by this age they will also be moving from CAMHS to adult mental health services. The Children Commissioners across the UK noted in 2015 that: "cuts to universal, preventative services and to youth service provision, will result in a greater need for more significant CAMHS interventions".[265] In particular, they noted that there is a lack of CAMHS provision for children who commit or are at risk of committing serious crime, and those with a history of prior abuse and neglect.[266] According to the Commissioners children who have been sexually abused should be offered early intervention through CAMHS to decrease their trajectory into adult services.[267] 'Future

in Mind' the report of the Children and Young People's Taskforce outlines an agenda to improve the CAMHS and the transition from CAMHS to adult services. Local Transformation Plans will be an important route to achieving this.

However, there are indications that services are struggling due to increased referrals and low staffing levels, which can result in some children being placed at increased mental health risk when earlier intervention could have prevented this.[268] There are gaps in service pathways and young people can have difficult transitions or find themselves without adequate support. 'Future in Mind' has made a series of recommendations including dismantling artificial barriers between services and delivering a clear joined up approach that links services so that pathways are easier to navigate for all children and young people.[269] The 5 Year Forward View for Mental Health has recommended the full implementation of Future in Mind.

3.2 Working age

Reaching adulthood brings with it greater levels of independence and often control over life. Finding a partner and forming a family can be protective of mental health but managing relationships and the stresses associated with parenting and relationship breakdown alongside job pressures can also place mental health at risk. Experiencing two or more adverse life events in adulthood is associated with mental health problems and for some this can have a cumulative effect following on from adverse life experiences in childhood. Many adults also find themselves caring for older relatives alongside their parenting role. However not all adults form families and for some loneliness is an issue. For a more detailed review of evidence on the impact of relationships and mental health see the Mental Health Foundations' 'Relationships in the 21st century' report.[270]

For most adults there are two key settings where mental health can be improved: the home and the workplace.

3.2.1 Developing mentally healthy homes

3.2.1.1 Making the case

Housing should provide not only shelter but also a secure and positive environment that supports people as their lives progress.[271] Suitable accommodation that is safe and warm is one of the foundations for personal wellbeing; it enables people to access basic services, build good relationships, and maintain independence.[272] Stable, secure, safe and appropriate housing of good material quality is fundamental to the prevention of mental health problems. Mentally healthy homes facilitate recovery, prevent some mental health crises and can help reduce the demand for health and social care services.[273] Local authorities can play a central role in developing mentally healthy homes within their communities.

People who have experienced poor housing or homelessness are at higher risk of developing mental health problems.[274] Children living in poor housing have increased chances of experiencing stress, anxiety and depression. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high.[275]

National mental health policy has paid increasing attention to the relationship between housing and mental health; focusing on enabling people to live safely, more independently and in homes that support recovery. Policy recognises the need for partnership and co-production with a broad range of stakeholders: people who experience mental health problems, their families and carers, housing providers, and services (including social care, health, housing and homelessness, criminal justice and advice).[276]

3.2.1.2 Evidence

Housing can impact mental health because it is *unhealthy* (due to noise, temperature, damp, air quality, light, ventilation, sanitation), *unsuitable* (due to disability and age, household composition, overcrowding), *unsafe* (design, hazards to mobility, intruders) and / or *insecure* (temporary accommodation, appropriate provision for Gypsies and Travellers, insecure social networks).[277] Poor housing conditions have been associated with psychological distress; for example having a cold home contributes to social isolation and may be associated with stigma: a quarter of people with a cold home report that they are reluctant to invite people there.[278]

People with mental health problems are much less likely to be homeowners and far more likely to live in unstable environments;[279] and people living in unstable circumstances are at higher risk of developing mental health problems. An integrated housing, health, social care and advice pathway can contribute to providing co-ordinated early intervention across services that supports stability and recovery. It could prevent individuals and families from experiencing deterioration in their situation including crisis. Such early intervention delivers significant savings for local authorities and other public services.[280]

There is growing evidence of the high levels of mental health problems affecting people experiencing homelessness. Amongst this group there are high levels of histories of multiple adverse childhood experiences of neglect, abuse and trauma,[281] leading to 'complex trauma'.[282] In addition to experiences of complex trauma, people who are homeless may be affected by substance misuse and deep social exclusion;[283] and may have increased contact with the criminal justice system.[284] Women in particular may have experienced complex trauma. It is therefore importance to develop approaches and services, which are trauma informed but also gender sensitive.[285] The 'Psychologically Informed Environment' (PIE) is a promising approach, which centres services' physical and social environments on service users' emotional and psychological needs. PIEs have been piloted in housing, homelessness, social care and criminal justice settings in England.[286]

3.2.1.3 Recommended actions

- Integrate mental health within local housing and regeneration policy and planning. Key elements are:
  - Creating Psychologically Informed Environments within housing, public services and community spaces, including within services for older people.[287]
  - Developing public and private housing provision that provides a safe and stable environment and neighbourhoods where relationships can be facilitated and community cohesion built.
  - Developing housing, supported housing and residential services, that enable older people to live independent and socially connected lives for as long as possible.
- Provide mental health literacy training to frontline housing and advice workers in order to help individuals and families to secure and sustain appropriately accommodation, manage debt and maximise their incomes.
- Develop an integrated housing, health and social care pathway with relevant local partners that enables individuals at risk of developing mental health problems and their families to receive timely support that enables them to retain their tenancies.
- Work in partnership with the Department of Communities and Local Government, public bodies and other agencies to learn what works in practice to support people at risk of or with mental health problems to secure and sustain adequate housing; and explore the use of any available local NHS estate to create more supported housing for vulnerable people, as recommended by the Taskforce.

3.2.2 Developing mentally healthy workplaces

3.2.2.1. Making the case

Being in work is generally good for physical and mental health.[288] As the national policy 'No Health without Mental Health' recognizes: "the workplace provides an important opportunity for people to build resilience, develop social networks and develop their own social capital."[289] Adults who are economically inactive are at increased risk of common mental health problems such as depression.[290] However, those in employment where they experience low levels of autonomy or control are also at risk.[291] Therefore although work can be protective of mental health the work environment needs to be conducive to good mental health.

Whole work place approaches are showing promise in providing ways to reach and engage significant numbers of people through creating social, emotional and physical environments that support mental health for the whole workforce, including employers themselves, as well as preventing the development or escalation of mental health problems and supporting recovery. They can support employees to remain in work, reduce absenteeism, presenteeism and the loss of staff on health grounds. Such approaches support both workers with mental health problems and also workers with long-term physical health conditions or disabilities who are at heightened risk of developing mental health problems.

Local authorities and the NHS are uniquely placed to enhance the mental health and wellbeing of their staff. They can provide leadership to other public services as well as model mentally healthy work environments to voluntary, community and private sectors employers in their area. As purchasers of goods and services, local authorities and the NHS can lever their substantial purchasing power to improve mental health by including mental health and wellbeing at work requirements within their procurement arrangements.

For people unable to work either temporarily or longer term, local authorities can support their engagement in volunteering. Contributing to one's community through altruistic activities including volunteering has been shown to produce a range of benefits such as: enhanced feelings of happiness and reduced stress; bringing a sense of belonging and reduced isolation; creating a new perspective on one's own situation; feelings of being valued and of making a positive contribution to society; and has even been shown to impact positively on longevity.[292]

3.2.2.2 Evidence

It is good work, rather than simply a job, that is associated with good mental health. 'Good' work and employment is a substantial health asset. Psychosocial attributes (insecurity, demands, control, and support) and material aspects such as income are ways in which people weigh 'good' or 'bad' work. Key characteristics of work and employment, which is protective and beneficial for health, are: high levels of supervisor and peer support, and job control; and low levels of insecurity and the absence of in-work poverty.[293]

Adverse physical and psychosocial conditions at work, poor pay or insufficient hours and insecurity can all be detrimental to mental health. In 2014, an estimated 1.2 million people in the UK had a health condition believed to be caused or exacerbated by their work placement- with depression, stress and anxiety being among the most common work-related illnesses.[294] In times of austerity the mental health of the population is put under strain, with numerous studies showing that unemployment, significant reduction in income and high levels of debt, can lead to 'lower levels of well-being and resilience, greater mental health needs and alcohol misuse, higher suicide rates, greater social isolation and worsened physical health.'[295]

The Royal College of Psychiatry found that people who are unemployed consult their GPs more often than the general population[296] and are between four and ten times more likely to develop anxiety and depression.[297] Experiencing mental ill health leads to many employees leaving employment. It is the most common reason for claiming health-related unemployment benefits; some 42% of the 6.2 million people. Many others have a secondary mental health condition that contributes to their inability to work or return to the workplace.[298]

People who are already experiencing mental health problems are less likely to be in employment than the rest of the population. Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments. Just 9% of people with a severe mental disorder are working fulltime and a further 19% part-time.[299] A number of barriers to employment have been identified, with stigma being significant.

3.2.2.3 Recommended actions

- Work in partnership with local businesses leaders and employers to apply a whole workplace approach to protect and improve mental health at the individual, collective and organisational level. Orientating the workplace as a key setting in the lives of its employees and their families, and an agent of influence in the community in which it operates. Key elements are:
  - Promoting local Adoption of the Workplace Wellbeing Charter.[300]
  - Promoting line management training to create mentally healthy environments, as detailed in NICE guidance.[301]
- Support local employers to engage with evidence based supported employment programmes such as Individual Placement and Support (IPS) and Access to Work.
- Explicitly address stigma and discrimination guided by approaches developed in national programmes such as Time to Change, England and Wales[302] and See Me, Scotland.[303]

Workplace Wellbeing Charter

The Workplace Wellbeing Charter provides employers with an easy and clear guide on how to make workplaces a supportive and productive environment in which employees can flourish.

The Workplace Wellbeing Charter comes in three levels, each containing different standards that need to be achieved. Some, or all, will be relevant to you depending on the size and direction of your organisation. The three levels are Commitment; Achievement and Excellence. Each of the three levels will consider, in different ways, issues such as leadership, sickness and absence management, awareness of alcohol and drug abuse, smoking, mental health and stress, healthy eating and physical activity.

The PHE supported charter and associated tools can be downloaded at: www.wellbeingcharter.org.uk

3.2.3 Transitions and pressure points

Working age people experience a wide range of transitions and pressure points during this period of their lives.

Some of these changes can impact on their housing situation for example when a new job or looking for work leads people to move to a new part of the country; or when relationship breakdown means that someone loses the stability of an established home including living with their children. These are trends within contemporary society that impact relationships and thus mental health. If appropriately supported people can negotiate these transitions without experiencing negative impacts on their mental health or having crises.[304]

Unemployment, debt, domestic violence, health issues including mental health problems or substance misuse may lead to insecure housing or homelessness. High numbers of women within homelessness services have experienced complex trauma (including domestic violence, separation from children, bereavement and relationship breakdown).[305] People may be forced to leave their country and come to the UK as a refugee or asylum seeker. At these pressure points individuals and families may be dealing with both the causes and consequences of the loss of home, with significant detrimental impact on their mental health.[306] Public services can support people to develop resilience so that they can deal with such changes when they occur. Services can intervene early with advice and support so that pressures do not escalate into crises. Local authorities can develop Psychologically Informed Environments within services, collaborate to integrate the diverse range of supports that benefit people when their home life is disrupted, and create initiatives that keep people socially connected through existing and new relationships.

Mental and physical health problems may impact their ability to work leading them to drift into more insecure and lower paid employment or reliance on welfare benefits. Since the economic recession there has been an increase in job insecurity and the growth of poorer terms and conditions such as zero hour contracts, which create pressure on people's ability to manage their finances and sustain housing and social arrangements.

It is important that public policy and services support people to remain in work and to move back into work if they have had a period of mental ill health. This includes in-work mental health support and reasonable accommodation as well as local authorities' pro-activity supporting programmes such as Individual Placement Support (IPS) and Access to Work for people with mental health problems. The 5 Year Forward View for Mental Health recommended that by 2010/21 NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and doubling the reach of IPS. Further, it recommended that NHS England should seek to match this investment in IPS by exploring a Social Impact Bond or other social finance options. Other recommendations included calling for the the Department for Work and Pensions to ensure that when it tenders the Health and Work programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes - as well as improved health outcomes – at a greater rate than under the current Work Programme contracts.

This period of life is also characterized by experiences of relationship and family formation[307] and a wide range of life experiences that can have both enhancing and adverse impacts on mental health and wellbeing.

3.3 Ageing well

There are a range of different views on when later life begins. Some people may self-define as older in their 50's and for others this may be much later. Traditionally health and social care services for older people have begun at 65. In reality many people will begin to experience the first signs of older age such as physical decline or deterioration sooner and some will begin to seriously plan for their retirement or take early retirement through choice or finding it difficult to secure employment as early as 50. The term 'the squeezed middle' is used to describe this age group, who may be experiencing additional caring responsibilities for parents, whilst still raising their children.

Some people in society who face inequalities such as poverty and mental and physical ill-health are also more likely to experience the effects of ageing earlier in their life course, so a definition starting at, for example 65, does not recognise this. However many people reaching state pension age now do not consider themselves as 'old' and many see growing older as a further stage in life, a 'continuation of their present' rather than a new and distinct phase in life. Although this blurring makes it more difficult to draw distinctions between 'adults' and 'older adults', in many respects this is to be welcomed, and has been reinforced by the abolition of the default retirement age in 2011 and the Equality Act 2010 coming into effect, which bans discrimination on the basis of age in the provision of goods and services.[308]

3.3.1 Making the case

Supporting people to age well involves local action to: reduce social and emotional isolation, improve the lives of people living with dementia, prevent depression, and support mental health and physical health in later life.

Loneliness and isolation are linked to poor physical and mental health in older age including cognitive decline and the onset of dementia.[309] Life events associated with social isolation amongst older people include: retirement and losing connection with colleagues; falling ill and becoming less mobile; a spouse dying or going into care.[310] Age Concern (2008) found that 1.2 million people over 50 were severely socially excluded, with little to no engagement in their communities or society in general; making them vulnerable to developing a mental health problem. An evidence review undertaken by Age UK recommended that '*the NHS needs to work with primary care providers as well as agencies that are in contact with lonely individuals to identify people at risk, understand their circumstances and develop strategies to support them*'.[311]

The most common form of dementia is Alzheimer's disease which affects around two thirds of people with dementia. Age is the greatest risk factor for dementia but it is also linked with diabetes, hypertension, smoking and learning disabilities (e.g. Down's syndrome). The Alzheimer's Society estimates that there are 850,000 people living with dementia across the UK of which 40,000 are young people.[312] The cost to the UK economy of services for people living with dementia is far higher than all other conditions put together. They currently make up 66% of all mental health service costs and Kings Fund estimates that by 2026 they will make up 73% of all mental health service costs.[313] Alzheimer's Society notes that the current funding for dementia research does not reflect the disease burden on society.[314] Currently the causes of dementia remain under researched, however to prevent dementia those causes and contributing factors must be understood. The Department of Health recognises there is less understanding about dementia than any other major disease. For this reason, it has pledged to increase annual funding of dementia research to around £66 million by 2015.

There has been growing concern about the prevalence of depression in older people; depression affects one in five older people living in the community and two in five living in a care home.[315] Depression has been linked to dementia and it is estimated that up to 40% of people with dementia may have a co-morbid depression.[316] Depression can compound isolation and speed up cognitive decline. Depression in later life can often go undiagnosed despite the exposure to risk factors and losses including bereavement, retirement, and loneliness and deteriorating physical health.[317]

The most vulnerable older people are those who live with physical health problems associated with ageing. At particular heightened risk are older people experiencing depression and anxiety in degenerating conditions, such as stroke, Parkinson's disease and the dementias.[318] Many older people live with one or more long-term conditions and make up the majority of patients in acute hospitals. A lengthy stay in hospital for a physical health problem can leave people feeling lonely with little opportunity for social contact.

3.3.2 Recommended actions

3.3.2.1 Reducing social and emotional isolation

- Invest in local projects that aim to improve mental health in later life through supporting emotional and social connections with family, the community and the people who are providing care and support services. Key elements are:
  - Identify isolated older people who are less visible within communities and may be at risk of developing depression or dementia through ensuring that home help, GP's, podiatry, and hearing clinics are trained and supported to identify risk, distress and emerging mental health problems.
  - Developing peer support programmes for older people as these are already showing the potential to enhance empathy amongst older people or across generations and provide a cost-effective tool for addressing the difficult and widespread challenge of social isolation.[319]

3.3.2.2 Preventing depression in older people and improving outcomes for people with dementia

- Provide access to evidence based interventions to prevent depression developing in older people. Key elements are:
  - Providing Mental Health First Aid training to enable services in contact with older people such as home helps, AHPs, Primary Care to respond to distress.[320, 321]
  - Providing brief intervention approaches for people with physical health problems who are experiencing depressive symptoms as these are feasible, therapeutically effective and also likely to prove cost effective.[322]
  - Creating local service pathways for older people who often encounter significant barriers in accessing help, to ensure that they have timely access to stepped care approaches including CBT and Psychotherapy where data indicates higher recovery rates than those under 65's.[323]
  - Developing initiatives that aim to improve mood and social connectedness including for those with Dementia such as Participatory Arts and Peer Support Programmes.[324]
  - Promoting the development of dementia friendly communities.[325]

3.3.2.4 Mental health and physical health in older age

- Adopting integrated approaches to health and mental health for older people who can experience higher rates of co-morbid mental and physical health problems. Key element are:
  - Providing reminiscence therapy for older people[326] in health care settings.
  - Developing physical activity programmes for older people and ensuring that these are accessible for example through social prescribing including partnerships with local leisure facilities, community centres and allotment societies.
  - Promoting access to liaison mental health teams for people being supported in specialist old-age acute physical health services– as part of their package of care.
  - Ensuring older people are able to access addiction services.

3.3.3 Transitions and pressure points

A wealth of evidence shows that ageing is a positive experience and a satisfactory stage of life. Older people have been found to be more resilient and likely to see loss as to be expected at this stage of life. Older people also report high levels of life satisfaction, and the majority of older people are much better at emotional regulation strategies and appears to have better emotional wellbeing stability.[327]

Getting older no longer automatically means a transition into a care setting. NICE has recently published its first guidance on how to plan and deliver person-centred care for older people living in their own homes.[328] Despite this according to Age UK 60% of older people in the UK believe that age discrimination exists and impacts on their lives typified by negative portrayals and common stereotypes.[329] The Report of Older People's Psychological Therapies Working Group in Scotland notes that "a key preventative strategy would be to pursue the more positive and evidence based presentation of old age".[330]

4. Key topics

4.1 Suicide prevention

4.1.1 Making the case

Although a steady decrease in the suicide rate was seen between 1981 and 2007 in England, since then there has been a steady increase with 10.7 deaths through suicide per 100,000 people aged 15 and over recorded in 2013 (the latest available figures). The male suicide rate was more than three times higher than the female rate, with 19.0 male deaths per 100,000 compared to 5.1 female deaths.[331] Rates of self-harm, recognised as an indicator of suicide risk, are also on the rise, especially among young people.[332] Perinatal suicide remains the second biggest killer of women in the first year after child birth.[333]

Suicide prevention requires the full implementation of the national strategy, and the development of local action plans cross-sectorial strategies.

4.1.2 Evidence

Targeted prevention is needed for men, specific BAME groups, and those recently discharged from inpatient care.[334] Suicide is the single biggest killer of men aged 20-45 in England, with 78% of all suicides in 2013 being men.[335] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that 18 in-patients a year died by suicide while under observation.[336]

Evidence shows that suicide prevention education for GPs can have an impact as a population-level intervention to prevent suicide.[337] With greater identification of those at risk, individuals can receive treatment, such as cognitive behavioural therapy (CBT) which has been shown to reduce the risk of future suicidal events by up to 50%.[338] Reducing access to means, such as installing a safety barrier as suicide 'hot spots' may be another effective method to preventing suicide, although it is unclear if these averted suicides are not simply diverted to other means.[339]

Zero Suicide

There is a growing movement towards the local development and implementation of zero suicide strategies inspired by the pioneering approach within the Henry Ford Hospital System, Detroit, Michigan. The Henry Ford Hospital System managed to implement a philosophy and practice of 'perfect depression care' which led within four years to a 75% drop in suicides, and eventually to years without a single suicide.[340]

Mersey Care along with colleagues in the South West and East of London have developed a Zero Suicide Strategy centred around actions to develop: patient and partner engagement; safe and effective care and treatment; competent workforce; and research and evaluation.[341]

4.1.3 Recommended actions

- Work jointly to deliver the local elements of the National Suicide Prevention Strategy. Key elements are:
  - Development of joint local suicide prevention plans aimed at a 10% reduction in incidents of suicide. These plans should set out targeted actions in line with the guidance produced by PHE and draw on local evidence around suicide, including a strong focus on primary care, alcohol and drug misuse.
  - Implementation of interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within the local population, drawing on localised real time data.
  - Application of the suicide prevention profile tool to ensure an effective audit of suicides is taking place locally and contributing to national data across the country.[342]

4.2 Criminal justice

4.2.1 Making the case

The prison service does not currently record the number of prisoners entering with a pre-existing mental health condition or the number that develop problems while incarcerated. The most recent national data relates to 1997, where 92% of male prisoners were reported to have one of the following five conditions: psychosis, neurosis, personality disorder, alcohol misuse and drug dependence and 70% had at least two of these.[343] The prevalence of common mental health problems also appears to be higher than in the general population. 10% of men and 30% of women have had a previous psychiatric admission before entering prison with 26% of women and 16% of men saying they had received treatment for a mental health problem in the year before custody. A study published by the Ministry of Justice in 2009 found that 49 % of women prisoners and 23% of men prisoners were living with anxiety and depression, compared to 19% of women and 12 of men in the general population.[344] Personality disorders are particularly prevalent among prisoners (62% of men and 57% women).

4.2.2 Evidence

There is a wealth of slightly dated evidence which suggests that a large portion of young people who are in contact with the criminal justice system are living with a mental health problem; in 1997 a report by the National Office of Statistics found that 95% of imprisoned young offenders had a mental health disorder while a 2002 study finding that 85% of children in custody had signs of personality disorder and 10% had signs of a psychotic illness.[345]

In 2009, the Bradley Review – a review of people with mental health problems or learning disabilities in the criminal justice system- noted "there is a growing consensus that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide".[346] 2014 saw the highest number of self-inflicted deaths in English and Welsh prisons ever recorded, with 141 inmates taking their own lives, including 14 young adults

aged between 18 and 24. There has also been a 9% increase in the incidents of self-harm between 2012 and 2014.[347] A particular problem in Young Offender Institutions is bullying. The published response of the Howard League for Penal Reform to the Harris Review into Self-Inflicted Deaths in National Offender Management Service (NOMS) Custody of 18-24-year-olds highlighted the widespread extent of this problem in the young adult estate.[348] Lord Bradley in his first and follow up reviews, and the Harris Review recommended the reorientation of criminal justice services and interventions towards prevention and early intervention.

The constraints of the prison environment have been deemed as anti-therapeutic and counter-productive to the effective provision of care.[349] The Psychologically Informed Planned Environments Approach has been piloted in criminal justice settings in England with some promising results. These are summarized in the Mental Health Foundation's recent review of Psychologically Informed Environments.[350]

Vipassana meditation retreats have been introduced in several U.S. prison systems including California, Washington and Alabama. Although only small qualitative studies have evaluated the impact of the programs, the results indicate that they have had a positive impact on inmates' mental wellbeing.[351]

Liaison and Diversion schemes have mixed but promising evidence in relating to diverting people with multiple needs and mental health problems through other support and rehabilitation routes such as Mental Health Courts.[352]

4.2.3 Recommended actions

- Local authorities and NHS bodies should work with local criminal justice settings (prisons, YOIs) to improve the mental health of prisoners, including prisoners with learning disabilities and autism (to comply with duties and the principle of equivalence under the Care Act 2014)[353] in recognition of the high prevalence of mental health problems and risk to mental health posed by being in custody. Key elements are:
  - Commissioning and implementing local evidence based liaison and diversion schemes for offenders with multiple needs where there is now growing evidence of effectiveness[354] and ensuring that people who would benefit from these are identified at the earliest point (people with mental health problems, learning disability or autism).
  - Supporting the development of Psychologically Informed Environments within local criminal justice settings, including mental health literacy training for criminal justice staff. Evidence informed approaches such as PIEs equip offenders with the tools they need to build resilience and create networks of support to keep well.
  - Supporting prisons and YOI to provide access to evidence based self-management and peer support opportunities and resources within criminal justice settings.[355]
  - Exploring the use of specific interventions such as mindfulness in prisons. Studies have found important improvements in self-esteem, hostility and mood disturbances.[356]
  - Creating pathways into and out of prison that enable smooth transition through education, housing, employment, health and social care support, including: providing criminal justice awareness and trauma informed training for staff involved in providing this support within the community and mental health literacy training for prison staff; and joint care planning between the custodial setting and community support services that address key transition points.[357, 358]

Annex 1 Methodology

Public Health England commissioned the Mental Health Foundation to undertake a rapid policy review of evidence to inform PHE's contribution to the NHSE Mental Health Taskforce.

The Mental Health Foundation reviewed public mental health literature on universal, selected and indicated interventions at individual, family and place (including communities; services such as health, education and criminal justice; and workplaces) levels. Peer reviewed and grey literature around public mental health, published in the English language between 2005 and 2015, and pertaining to the UK and other countries that are transferrable to the UK due to similar contextual circumstances and factors (Europe, New Zealand, Australia, Canada and USA) were sourced through academic databases and the Google search engine. Although rapid a stepped approach was taken to identify the strongest levels of evidence (systematic reviews; longitudinal cohort studies/multiple RCTs; non-control epidemiological studies; high quality qualitative evidence), however some more promising practice has also been identified on occasion where there is growing interest some test of change evaluations but not yet substantive studies. This is in recognition of the fast moving pace of developments within public mental health and the time lag to produce highest quality evidence. Where this is the case the indicative terms 'promising evidence or practice' is applied. Evidence was cross checked with NICE guidelines (see Appendix 1).

Using this original work, this publication has been developed between June–December 2015, informed by the work of the Taskforce and the development of PHE's mental health work programme including the establishment of the Prevention Alliance. The strong interest in prevention demonstrated through the Taskforce's engagement with people with lived experience of mental health problems, family members and carers, clinicians and the public highlighted the value of making the synthesis of evidence available through 'Mental Health and Prevention: taking local action'.[359]

The original review has been strengthened through iterative sourcing of literature and case studies by:

- reviewing bibliographies;
- seeking stakeholder recommendations;
- national and international events including the 2015 International Mental Health Leadership Programme;
- engagement with the Prevention Alliance; and
- Engagement with wider PHE and MHF staff, networks and consultants.

'Mental Health and Prevention: taking local action' is a resource to progress public mental health across a local and national government, public services and bodies and civil society.

Annex 2: NICE guidelines and recommendations related to prevention

NICE (2005) Depression in children and young people (CG28 updated March 2015 regarding psychological therapies and antidepressants)

NICE (2008) Social and emotional wellbeing in primary education, London: National Institute for Health and Care Excellence [PH12]

NICE (2008) Mental wellbeing in over 65s: occupational health and physical activity interventions [PH16]

NICE (2008) Social and emotional wellbeing: early years [PH40].

NICE (2009) Social and emotional wellbeing in secondary education, London: National Institute for Health and Care Excellence [PH20]

NICE (2010) Alcohol Use Disorders: Preventing the Development of Hazardous and Harmful Drinking (PH24)

NICE (2012) Promoting the social and emotional wellbeing of vulnerable preschool children (0-5 yrs): Systematic review level evidence.

NICE (2013) Social and emotional wellbeing for children and young people. Developing an action plan. Advice [LGB12]

NICE (2013) Looked after children and young people [QS31]

NICE (2013) Psychosis and schizophrenia in children and young people: recognition and management [CG155]

NICE (2014) guideline CG192 Antenatal and postnatal mental health clinical management and service guidance. (CG192)

NICE (2015) Workplace health: management practices [NG13]

NICE (2015) Home care: delivering personal care and practical support to older people living in their own homes [NG21]

NICE (2015) Alcohol: preventing harmful use in the community (QS83)

NICE (2015) Older people with social care needs and multiple long-term conditions (NG22)

NICE (2015) Older people: independence and mental wellbeing (NG32)

NICE (2016) Antenatal and postnatal mental health (QS115)

NICE (2016) Domestic violence and abuse (QS116)

NICE (2016) Community engagement: improving health and wellbeing and reducing health inequalities (NG44)

Annex 3: Whole community prevention framework

	Individual	Family	Community - Structural	Systems
Early Years and Family Formation	Perinatal pathways of support for mothers General mental health support Assessment or risk and early intervention Specialist support	Support for Attachment	Peer Support Groups for young mums (or young fathers)	**Maternal health** **Health visiting** **Primary Care**
Children and Adolescents	Self Management Approaches (including digital) Psychological interventions	Parenting Programmes Family Therapy	Whole School Approaches Bullying Programmes Behaviour Interventions	**Education** **Further Education** **Primary Care**
Adults	Workplace support - line management interventions Psychological Interventions - CBT, Solution focused	Parenting support Carers support	Stigma & discrimination programmes Mentally Healthy Workplace approaches Trauma informed services	**Workplace** **Housing** **NHS - General**
Later Life	Self management for long term conditions Pre-retirement prep	Family based Dementia support Socially connected care homes	Volunteering opps Peer mentoring/ Befriending Psychologically informed Physical health settings	**Primary Care** **Home Help** **NHS - General** **Care Home Sector**

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