

Mental Health and Well-Being in the South East



Authors

Jo Nurse and Jonathan Campion

Statistical Analysis

Liz Rolfe, Steve Morgan, Briony Tatem, Jo Watson

Reviewers

Alison Hill, Di Swanston, Philip Brooks, Poppy Jaman, Chris Morgan, Mike Gill, David Sheehan, Robert Kyffin, Jenny Bywaters, Shannon Robalino

Acknowledgements

The authors would like to thank all those who have shaped and contributed to this report, including the development and piloting of the Dynamic Model for Well-Being:

The South East Public Health Observatory

The South East Development Centre

The South East Regional Public Health Group

Particular thanks is given to all those who contributed case studies, including the South East Arts and Health Partnership, KeyRing, MindOut and The Star Project; and thank-you to all those whose contributions could not be included in the report.

Many thanks is given to Clare Hart and Toni Cheal for administrative support.

The Cox Design Partnership

Front cover

Watercolour by Jo Nurse

Publication Date

October 2006

Further Information

Jo.Nurse@dh.gsi.gov.uk

Foreword

Mental Health and Well-Being are both areas that have been previously marginalised and neglected. This relates to the historical stigma and lack of understanding attached to mental illness. This report presents a new approach to understanding mental health and promoting well-being, whereby poor mental health are viewed as factors which frequently underpin risk behaviours, poor physical health and lack of social well-being. Essentially, mental health, physical health and social well-being should not be seen as separate aspects, as each aspect inter-relates and influences the other.

At any one time, one in six people have a mental health problem. Those living with most socio-economic deprivation or physical health problems are more likely to have mental health problems; these interact with each other and contribute to poor educational outcomes, high crime levels, unemployment and poor quality of life. Significantly, poor mental health and stress related illnesses affect economic productivity, costing the economy nationally £77 billion a year. The South East is seen as the economic engine for England, however, it has the highest rates of sickness absence in the country, of which mental illness and stress related illnesses are the largest factors. **Priority issues** that have arisen from this report include:

- **The need for greater emphasis on promoting well-being in children**, especially those at higher risk of mental health problems. One in ten children and young people have a mental health problem – they are at greater risk if they live in poverty, have a history of abuse or adverse experience. Early intervention saves money – each individual with a conduct disorder costs society £70,000, mainly due to crime incurred. Ensure services relate to need, promote life and social skills, including emotional intelligence.
- **Exploit opportunities for earlier prevention-tackle alcohol related violence** – adverse childhood experiences including violence and abuse, underlie many risk behaviours, including school exclusion and offending behaviour. Address alcohol related violence by greater partnership working, and promote protective factors including the development of respectful relationships.
- **Balance tackling risk factors with an emphasis on promoting protective factors** – especially for those at risk of mental health problems – including addressing alcohol, drug and tobacco use, and promote social and life skills, healthy eating, and keeping physically active.
- **Reduce sickness absence by promoting well-being in the workplace** – this will benefit productivity, performance, enhance employer profile, work morale, efficiency and sustainability.
- **Challenge stigma and discrimination** – promote respectful relationships and social inclusion- actively support independent living, employment, and meaningful activity. Promote diversity and creativity at work and in the community, this will benefit everyone, not just those at risk of mental health problems.

The report recommends an integrated approach to well-being, by addressing risk factors and promoting protective factors for mental, physical and social well-being in a comprehensive way. This can be developed within the context of a setting, for example schools, prisons, hospitals or workplaces; and needs to be supported by mental health promoting environments and policies. At regional and local level, therefore, individual organisations should promote well-being according to their setting, and work together in partnership to prioritise well-being via Community Plans and Local Area Agreements. Additionally, placing well-being centrally, will assist in achieving a wide range of Public Service Agreements, and benefit the quality of life and the economy in the South East region.



Dr Yvonne Doyle
South East Regional Directors of Public Health



Dr Simon Tanner



Jackie Ardley
Director of the South East
Development Centre

Abbreviations

A & E	Accident and Emergency
ANC	Ante-Natal Care
ASBO	Anti-Social Behaviour Order
BCS	British Crime Survey
CAMHS	Child and Adolescent Mental Health Services
CDRP	Crime and Disorder Reduction Partnership
CI	Confidence Interval
CSIP	Care Services Improvement Partnership
DV	Domestic Violence
GUM	Genito–Urinary Medicine
HDA	Health Development Agency
HO	Home Office
LAA	Local Area Agreement
LSP	Local Strategic Partnership
MH	Mental Health
NICE	National Institute for Clinical Excellence
NIMHE	National Institute of Mental Health
NSF	National Service Framework
ODPM	Office of the Deputy Prime Minister (now Department of Communities and Local Government – DCLG)
PCT	Primary Care Trust
PHC	Primary Health Care
SARC	Sexual Assault Referral Centre
SEDC	South East Development Centre
SEPHO	South East Public Health Observatory
VCS	Voluntary and Community Sector
VVAPP	Victims of Violence and Abuse Prevention Programme
WHO	World Health Organisation

Key Points

Why Mental Health is Important

Mental well-being has been a frequently ignored aspect of health and well-being, however; it often underpins and interacts with wider physical and social aspects of health and well-being.

- **Mental Health Problems are Common and have a significant impact upon health:** one in six of the adult population experiences mental ill health at any one time- causing an estimated 23% burden of overall disease, which is predicted to increase.
- **Interaction between mental, physical and social health and well-being** – there is growing evidence of the links between how mental, physical and social health and well-being interact with each other.
- **Social Exclusion and Inequality** occur as a result and cause of mental illness. Promotion of physical and social well-being increases social participation, mental health and self-esteem.
- **High impact on health services** people with mental health problems have higher use of all health services for mental and physical health problems.
- **High cost** to the individual, relationships, families, society and the economy, with the South East region having the highest level of sickness absence rates in England, significantly impacting upon productivity.

A Dynamic Model for Well-Being

This report is based upon a model specifically created within the South East in order to develop a comprehensive approach to promoting well-being. The model places well-being at the centre of improving physical and social well-being, and recognises the need to address risk factors, balanced with promoting protective factors. These aspects need to be contextualised within a particular setting, supported by mental health promoting policy and environments.

Addressing Risk Factors: Social and individual risk factors all impact negatively upon mental health and need to be addressed.

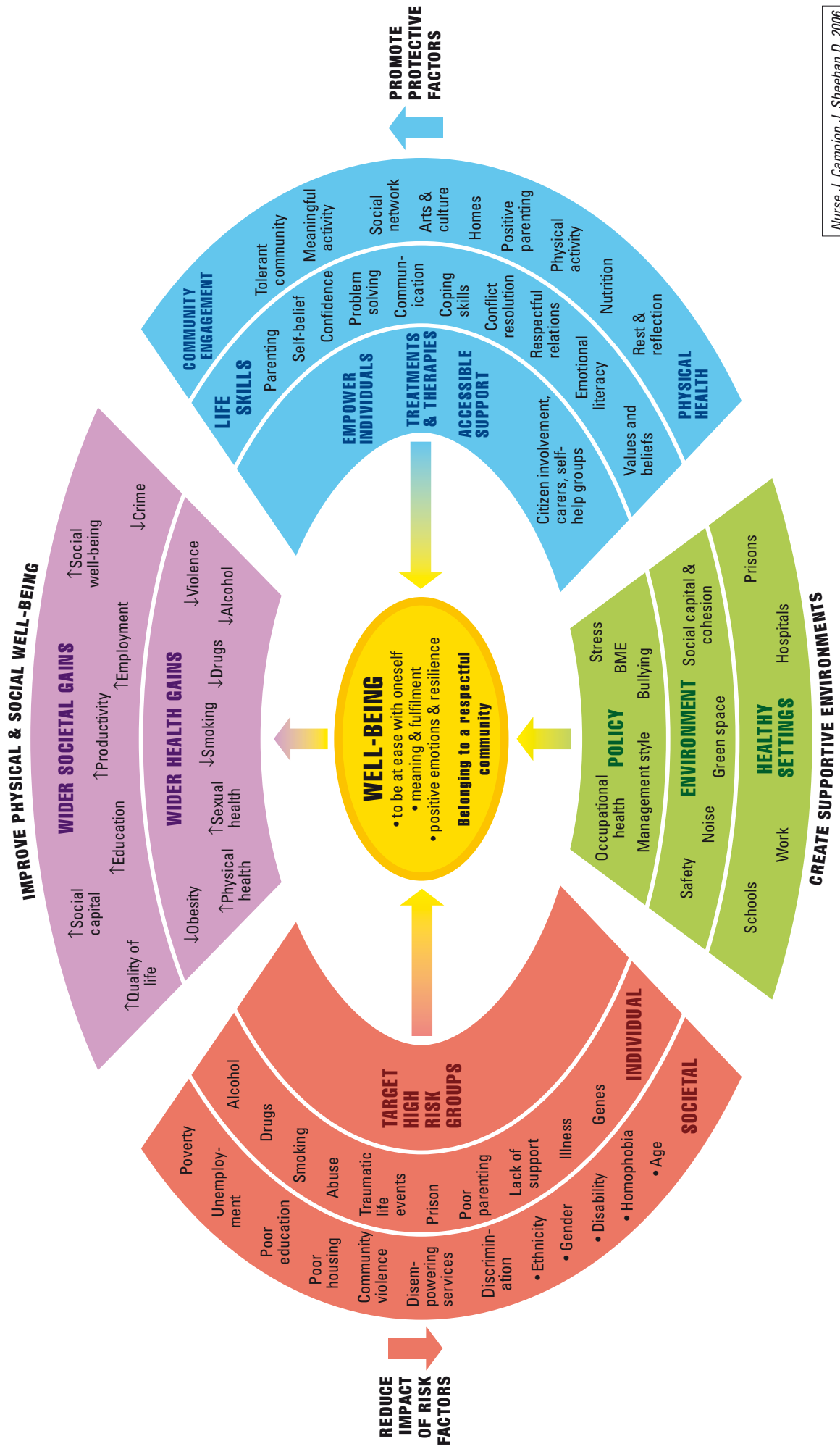
- **Social factors** include: housing, unemployment, poor education and income, community violence, stigma and discrimination.
- **Individual factors** include poor parenting, abuse, substance misuse, traumatic life events, prison, and lack of support.

Promoting Protective Factors: need to be developed in balance with addressing risk factors in order to increase an individuals' resilience to dealing with the ordinary stresses of life. Those already with existing mental health problems often need additional input to promote resilience. Protective factors that promote well-being, include:

- **A supportive and respectful community**, having a home, being engaged with meaningful activity, for example being in employment or volunteering.
- **Physical health**, including good food, keeping active and sufficient rest.
- **Life skills**, including parenting skills, emotional intelligence, skills that protect from abuse, and good inter-personal relationship and social skills are important aspects that underpin and promote positive mental well-being.
- **Accessible support** with empowering treatments and therapies are key for those experiencing mental health problems, and promote recovery.

Creating Supportive Environments: an integrated approach to well-being, which balances addressing risk factors with promoting protective factors is presented at the end of the report. This needs a public mental health approach to promoting well-being within particular settings and the wider environment, supported by regional and local level policy, including LAAs, and strategies affecting the wider determinants of health.

A Dynamic Model for Well-Being



Nurse J, Campion J, Sheehan D, 2006

Contents

Glossary

1. Introduction

- 1.1 Why is mental well-being important?
- 1.2 The policy context

2. Mental health and well-being

- 2.1 What is mental health and well being?
- 2.2 A dynamic model for well being
- 2.3 Relationship with wider physical health
- 2.4 Gains for wider social well being

3. Prevalence of mental health problems in the south east

- 3.1 Suicide – comparisons with england, europe and world
- 3.2 Self-harm
- 3.3 General mental health – indicators and admissions
- 3.4 Depression and anxiety
- 3.5 Psychotic disorders
- 3.6 Personality disorders
- 3.7 Dementia and organic disorders

4. Addressing risk factors for mental health

- 4.1 Demographic patterns
- 4.2 Socio-economic factors
- 4.3 Black and minority ethnic issues
- 4.4 Gender differences
- 4.5 Alcohol and substance misuse
- 4.6 Violence and abuse
- 4.7 Vulnerable young people
- 4.8 Lesbian, gay, bisexual and transgendered people
- 4.9 Prisons and offenders
- 4.10 Learning disability
- 4.11 Stigma and social exclusion

5. Promoting protective factors for mental health

- 5.1 Promoting protective factors in childhood and young adulthood
- 5.2 Promoting well-being in older people
- 5.3 Housing and homes
- 5.4 Employment and meaningful activity
- 5.5 Keeping physically active
- 5.6 Good nutrition
- 5.7 Promoting safer communities
- 5.8 Resilience, respectful relationships and social networks
- 5.9 Creativity, meaning and fulfillment
- 5.10 Empowering, appropriate and quality services

6. Bringing it together and ways forward

- 6.1 Promoting an integrated approach to well-being
- 6.2 Creating mental health promoting settings, environments and policies

References

Glossary

Common diagnoses of mental health problems

Anxiety – “Anxiety states” are described as chronic fear, tension and panic attacks that are so severe that they become a person’s main experience and interfere with their ordinary lives.

Depression – Depression can be a completely natural reaction to stress or unhappy life events such as unemployment, bereavement or relationship breakdown and many make a complete recovery. Clinical depression, has more severe physical and mental health symptoms however, and can have a disabling effect on individuals. Severe depression can be life threatening and most people who commit suicide are seriously depressed. Depression is often experienced together with anxiety.

Bi-polar disorder – Often referred to as “manic depression”, bi-polar disorder is characterised by intense and extreme mood changes. A person can swing from profound depression and lethargy to periods of elation, “hyperactivity” and an unrealistic sense of their own importance/ abilities.

Dementia – Dementia is a condition that manifests itself in mental confusion, impaired memory, reduced mental and physical functioning and altered behaviour. A person with dementia will become increasingly forgetful, anxious and confused as the disease advances.

Eating disorders – Anorexia nervosa is the term for starving one’s self to the extent of severe, sometimes life threatening thinness. Compulsive eating, followed by self-induced vomiting is known as bulimia nervosa. Both are potentially dangerous to health and both behaviour patterns may be a way of coping with psychological or emotional problems.

Personality disorders – Personality disorders are a group of disorders involving long-standing attitudes, behaviours and ways of viewing the world that are outside socially accepted limits. Personality disorders can be seen as extreme examples of negative tendencies that everyone shares. People with personality disorders often cause distress and disruption to themselves and to those around them to the extent that daily life is difficult.

Psychosis – Is a state when someone is unable to distinguish clearly between what is real and what is imaginary, what is external or internal to their own thought processes. Psychosis is a symptom, which often indicates that someone is experiencing severe mental distress and can be experienced in schizophrenia, bi-polar disorder and severe depression. A person may experience just a single episode of psychosis or may experience repeated episodes.

Schizophrenia – Is a form of psychosis, in which a person’s sense of their self, their thoughts and perceptions are out of the range of normal experience. People experiencing schizophrenia may hear imaginary voices, believe they are being controlled by someone or something else, or believe that they are being persecuted.

Self harm – Self harm is a broad term that encompasses the many different ways of inflicting pain on oneself as a means of expressing deep distress. Self harm may help individuals cope with such feelings, as a way of “getting the emotional pain out”, of being distracted from it, of communicating feelings to somebody else or of finding comfort.

For more information about different diagnoses of mental health problems go to:
www.mind.org.uk/information/factsheets.

Mental Health Problems in Children and Young People (0–18 years) (BMA, 2006)

Conduct Disorders: 6% of 5–16 year olds have a conduct disorder; they are more common in boys and includes challenging behaviour for more than 6 months or challenging behaviour that is extreme or at an inappropriate age. Symptoms include: frequent or severe temper tantrums; severe and persistent disobedience; defiant provocative behaviour; excessive levels of fighting or bullying; cruelty to animals and offending behaviour.

Emotional Disorders: 4% of 5–16 year olds have an emotional disorder. They are more common in girls and include anxieties, depression and phobias. Symptoms include sadness, irritability and loss of interest in activities. Associated features include tiredness, sleep disturbance, loss of appetite, difficulty concentrating, feelings of guilt, worthlessness and suicide.

Hyperkinetic Disorders: 2% of 5–16 year olds have a hyperkinetic disorder. They are more common in boys, and include Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD). Characteristics include impaired attention and over activity, which affect the ability to concentrate and disruptive behaviour.

Less Common Disorders: 1% of 5–16 year olds have a less common disorder, including autism, eating disorders, tics and selective mutism;

- Autistic Spectrum Disorders: more common in boys and range from mild forms, e.g. Asperger's Syndrome, to more extreme forms of learning disability, with difficulties in interacting and communicating with others;
- Eating Disorders: (more common in young women) with up to 1 per cent of women in the UK between the ages of 15 and 30 suffer from anorexia nervosa, and between 1 and 2 per cent suffer from bulimia nervosa. The average age of onset of anorexia is 15 and of bulimia, 18.

Definitions of abuse referred to from the British Crime Survey, (Home Office, 2006)

Partner abuse (non-sexual): non-sexual emotional or financial abuse, threats or physical force by a current or former partner. Partner abuse is often referred to as domestic violence or abuse. Partner is defined as a current or former spouse, boyfriend or girlfriend.

Family abuse (non-sexual): emotional or financial abuse, threats or physical force by a family member other than a partner.

Sexual Assault: Less serious includes indecent exposure, sexual threats or unwanted touching. Serious includes rape, or assault by penetration including attempts, by any person including a partner or family member.

Stalking: two or more incidents causing distress, fear or alarm, of obscene/ threatening unwanted letters or phone calls, waiting or loitering around home or workplace, following or watching, or interfering with or damaging personal property by any person including a partner or family member.

Intimate Violence: refers to all of the above collectively.

1. Introduction

Mental health and well-being are both aspects of public health that historically, have been relatively neglected. However, poor mental health is a key factor that underpins many physical health problems and acts as an underlying driver for much health risk behaviour, including smoking, substance misuse and obesity. Additionally, poor mental health has a significant impact on wider society, affecting parenting skills, family and social cohesion, educational achievement, anti-social and offending behaviour, sickness absence and economic productivity.

This report, aims to raise the profile and importance of not just addressing poor mental health, but also of aspiring to the development of a greater sense of individual and societal well-being within the South East Region. In order to achieve this, a new model of well-being has been developed within the South East: 'The Dynamic Model of Well-Being' and this report is structured around the concepts within this model.

The first section of this report gives an overview of why mental health is important. Section two describes what well-being is and the 'Dynamic Model of Well-Being' and is followed by the impact of poor mental health upon physical health and wider social well-being. Section three, then gives more detail of the size and patterns of the problem of poor mental health. Section four and five then follow the format of the Dynamic Model of Well-Being, by highlighting the need to balance addressing risk factors (section 4), with promoting protective factors (section 5). Lastly, section 6 describes how to take this forward (the lower section of the well-being model), using an integrated approach to well-being and by creating policy and environments which support and promote well-being.

1.1 Why Is Mental Well-Being Important?

Mental well-being has been a frequently ignored aspect of health and well-being, however; it often underpins and interacts with wider physical and social aspects of health and well-being.

Mental health problems are common and have a significant impact:

- In the South East, at any one time, 16% of women and 12% of men are affected by depression or anxiety; approximately 4% were assessed as having a personality disorder and less than 0.5% have a probable psychotic disorder such as schizophrenia or bipolar affective disorders, (Singleton, 2000).
- Half of all women and a quarter of men will be affected by depression at some time in their life and 15% experience a disabling depression (Mental Health NSF, 1999).
- Mental health problems are estimated to be the commonest cause of premature death and years of life lost with a disability – 23% of the burden of disease in high income countries, and 40% of years lived with disability, (WHO, 1996 and 1999).
- Suicide is in the top five causes of lost years of life. As the South East is the largest region, it has the highest total number of suicides in the country, (Brooks, 2006).

Interaction between mental, physical and social health and well-being:

- Poor mental health significantly increases the risk of poor physical health and premature death (DH, Making it Possible, 2005). Mental illness increases the risk of heart disease, diabetes, respiratory disease and infections, (Phelan, 2001);
- Risks of heart disease estimated to be twice as high for people with depression or mental illness and 1.5 times for those who are generally unhappy (Keyes, 2004);
- A diagnosis of schizophrenia reduces average life expectancy by 10 years largely due to physical health problems and death, mainly from infectious diseases, endocrine, respiratory, digestive and genito-urinary disorders which are significantly more common in adults with severe mental health problems (Harris, 1998);
- People with mental health problems exhibit more behaviours that are detrimental to overall health, with poor diets, less exercise, heavy smoking, drug and alcohol misuse; (Phelan, 2001);
- Seventy percent of all new cases of depression in older adults are associated with poor physical health (Evans, 2003).

Social exclusion and inequality:

- Stigma and shame are barriers to engagement and employment of people with mental illness, negative media images contribute to this discrimination (ODPM, 2004);
- Only 24% of people with long-term mental illness are employed – the lowest of any disabled group. Being in employment helps protect peoples mental well-being. (ODPM, 2004);
- Isolation is common and 84% of people with mental health problems felt isolated compared to 29% of the general public; whilst 40% of people with serious mental health problems had no social contacts outside mental health services (Ford, 1994);
- Those with mental health problems are less likely to be offered regular reviews of medication, alcohol and drug use, smoking, heart disease and risk of diabetes than the general population (Mentality, 2003).

Impact on health services:

- Nearly one third of those going to GPs have mental health problems and mental health problems occupy one third of GP time (ODPM, 2004);
- Of all people with mental illness, only 3% have seen a psychiatrist and 2% a psychologist in the previous year, (Singleton, 2000);
- Most people with personality disorder or psychotic disorder are already known to community mental health services, either voluntary or statutory. Eighty-five per cent of people with a psychotic disorder receive treatment for their disorder; and over a third had used community care services within the previous three months. (Singleton, 2000).

Personal, social and economic cost:

- At an individual level, mental illness is one of the biggest causes of personal unhappiness in our society;
- The wider cost of mental health problems are estimated to cost the country £77 billion a year, mainly due to people with stress related and mental health problems being unable to work. This compares with Treasury spending on the NHS as a whole of £76 billion in 2005–6. (ODPM, 2004);
- Approximately 850,000 people claim incapacity benefit for a mental health problem, this costs the economy 2% of GDP. (Layard, 2005);
- Work stress is responsible for 30% of staff sickness in the NHS, costing the service over £300m each year;
- Ill-health or stress in the workplace can lead to a reduction in efficiency and productivity, leading to sickness, absence and job loss. (DH, 2005);
- Sickness absence costs UK employers around £12.2 billion each year, of which the South East region has the highest rates of sickness absence in the country, see table 1.

Table 1 Sickness absence rates by region of residence and workplace, Winter 2005

	Region of residence	Region of workplace
	%	%
UK	2.7	2.7
North East	1.9	1.9
North West	2.2	2.1
Yorkshire and Humberside	2.8	2.9
East Midlands	2.8	2.8
West Midlands	3.0	3.0
East of England	3.2	3.3
London	3.2	3.1
South East	3.3	3.3
South West	2.6	2.5
Wales	2.4	2.5
Scotland	2.3	2.3
Northern Ireland	1.6	1.6

Source: ONS, Labour Force Survey

Note: percentages relate to the proportion of employees who were absent from work for at least one day in the reference week

1.2 The Policy Context

This report addresses a wide national policy context, including Every Child Matters, (DfES, 2004) and subsequent documents; and Home Office strategies, including on reducing re-offending (HO, 2006), the Respect Action Plan, (2006) and a number of developing Home Office strategies to address violent crime, including domestic and sexual violence.

Within the health sector, the *Mental Health National Service Framework* provides the foundation for subsequent policy. The Mental Health National Service Framework (DH, 1999), set out seven standards, of which standard 1 is on mental health promotion, standards 2 and 3 focus on primary care and access to services, standards 4 and 5 on effective services for people with severe mental illness, and standard 6 on carers and standard 7 on suicide. This report has mainly focused on standard 1 on mental health promotion, which is also most closely related to standard 7 on suicide prevention; these areas have been relatively neglected area areas whilst work has focused on service improvement.

Standard One: Health and social services should:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Saving Lives, Our Healthier Nation 1999, set the target of reducing the death rate from suicide by at least 20% by 2010, which is one of the Public Service Agreements contributing to reducing health inequalities. *The National Suicide Prevention Strategy* (DH, 2002), supports the achievement of this target, by improvements to mental health services with the 12 Points to a Safer Service, and outlines community and service actions to reduce suicides.

Choosing Health: making healthy choices easier; (DH 2004), emphasises the importance of improving mental health because mental well-being is crucial to good physical health and making healthy choices, and that stress is the commonest reported cause of sickness absence and mental ill-health can lead to suicide. This policy is supported by the Mental Health and Social Exclusion report (ODPM 2004), which outlines the importance of breaking the cycle between mental illness and social exclusion, by tackling stigma and discrimination and ensuring increased social inclusion: by improving housing, social participation and employment of people with mental health problems.

More recently to support the implementation of the above policy, *Making It Possible: Improving Mental Health and Well-Being in England*, (NIMHE and CSIP 2005), was launched. This is a framework for

Improving Mental Health and Well-being based upon mainstreaming public mental health in the following areas: Marketing mental health and well-being; equality and inclusion; violence and abuse; early years; schools; employment; workplace; communities; and later life.

Lastly, *Our Health, Our Care, Our Say – A new direction for community services*, (DH 2006), includes commitments to:

- Help people with health problems and disabilities to remain in or return to work
- Improve access to Computerised Cognitive Behaviour Therapy
- Emphasises promoting independent living and social well-being, care at home, increasing activity, individual choice and prevention.

At regional level, policies, strategies, reports and partnerships, are developed to further support the implementation of national policy on the ground. This report aims to provide regional level information based upon a model of well-being, in order to influence regional level work (including Local Area Agreements) that affect many of the wider determinants, and provide an integrated approach to promoting mental well being at local level.

Throughout this report, where at all possible, information from national and regional high quality surveys or research has been cited; case studies have been used where there is less good quality evidence in certain areas. The approach and areas covered by the dynamic model for well-being are all consistent with national policy and regional level work.

2. Mental Health and Well-Being

2.1 What is Mental Health and Well-Being?

Mental Health

The World Health Organisation defines mental health as:
'Mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.'

Well-Being

Well-being is difficult to define and therefore measure. Some argue that well-being is best understood in terms of overall happiness or satisfaction with life. However, other models (Marks, 2005) include two personal dimensions and a social context:

- **Satisfaction:** measured by an indicator called "life satisfaction" which captures satisfaction, pleasure and enjoyment;
- **Personal development:** includes being engaged in life, curiosity, autonomy, fulfilling potential and feeling that life has a meaning (Ryan, 2001);
- **Social well-being:** sense of belonging to communities, positive attitude to others, feeling of contributing to society.

While life satisfaction is strongly (and inversely) related to mental health and depression, personal development seems to be more strongly linked to overall health, longevity, resilience and ability to cope with adverse circumstances and thrive. For example, older people who score highly on the personal development dimension are less likely to develop serious illness (Singer B, 2001). The personal development dimension is also about being actively engaged which has positive implications regarding social cohesion. Research suggests the following three main influences on well-being (Lykken, 1999; Sheldon, 2003):

- **Genetics:** accounts for 50% of variation in people's happiness although there are also interactions between genetics, upbringing and environment;
- **Life circumstances:** including income, material possessions, marital status and neighbourhood environment. People quickly adapt to changes in circumstance so researchers estimate it explains only 10% of the variation in well-being. However, society spends a disproportionate amount of time on this aspect;
- **Intentional activities:** Pursuits we actively engage in account for 40% of variation in happiness. They include things like working towards our goals, socialising, exercising, engaging in meaningful activities and work, and appreciating life, for example art and culture. Adaptation rarely occurs for these activities and this is the area where well-being can be most influenced.

After increases in income over the poverty line, and basic needs are met, people adapt, so there is no alteration in life satisfaction. (Easterlin, 2003). Many things associated with economic growth can reduce well-being such as stress from working long hours. Research shows that those who are more materialistic are less happy than those who value other things (Kasser, 2002). Although there has been a near doubling of economic output in the last 30 years there has been no substantial change in rates of depression and mental illness.

2.2 A Dynamic Model for Well-Being

In the South East, the concept of well-being has been further explored, with the development and piloting of a model for well-being with local, regional, and national review, including multi-disciplinary professional and citizen perspectives. This has resulted in the Dynamic Model for Well-Being for which the term well-being is understood to mean:

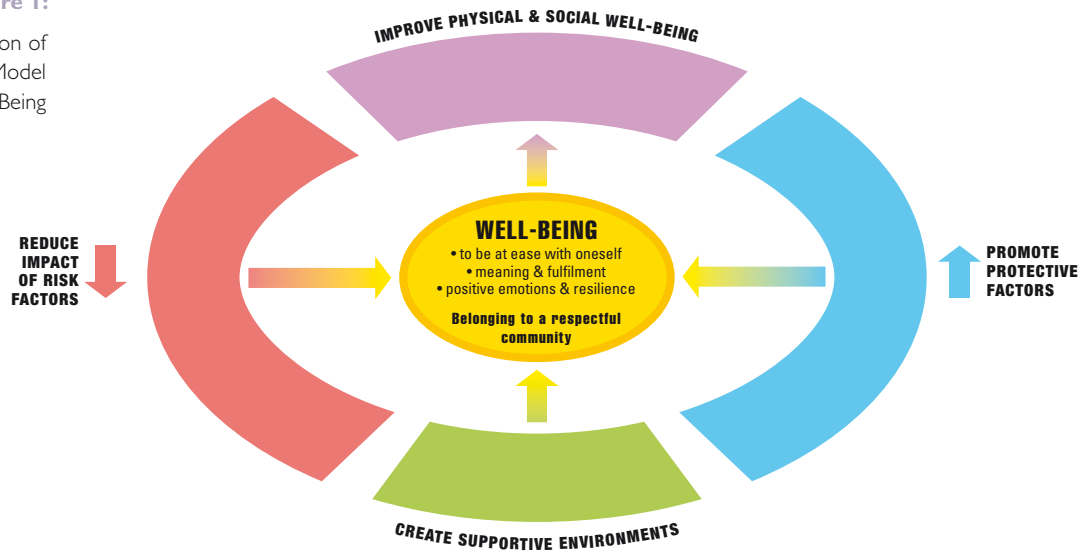
- Being at ease with oneself;
- Having a sense of purpose, meaning and fulfilment;

- Experiencing positive emotions and having the resilience to deal with life's difficulties;
- Belonging to a respectful community.

This model incorporates aspects of risk and protective factors, solutions and outcomes in four directions of concentric circles, and tend to move from an individual focus on the inner rings to a societal level on the outer rings. The basic version, in figure 1 illustrates the need to balance the impact of risk factors (red) with promoting protective factors (blue), with the addition of supportive environments (green) in order to develop well-being (yellow), and achieve wider health and societal gains (purple). Figure 2, the intermediate version, provides sub-headings of the different levels that need to be addressed, for example, from individual to societal levels, and figure 3 the comprehensive version of the Dynamic Model for Well-Being, gives the detail under each of the sub-headings.

Figure 1:

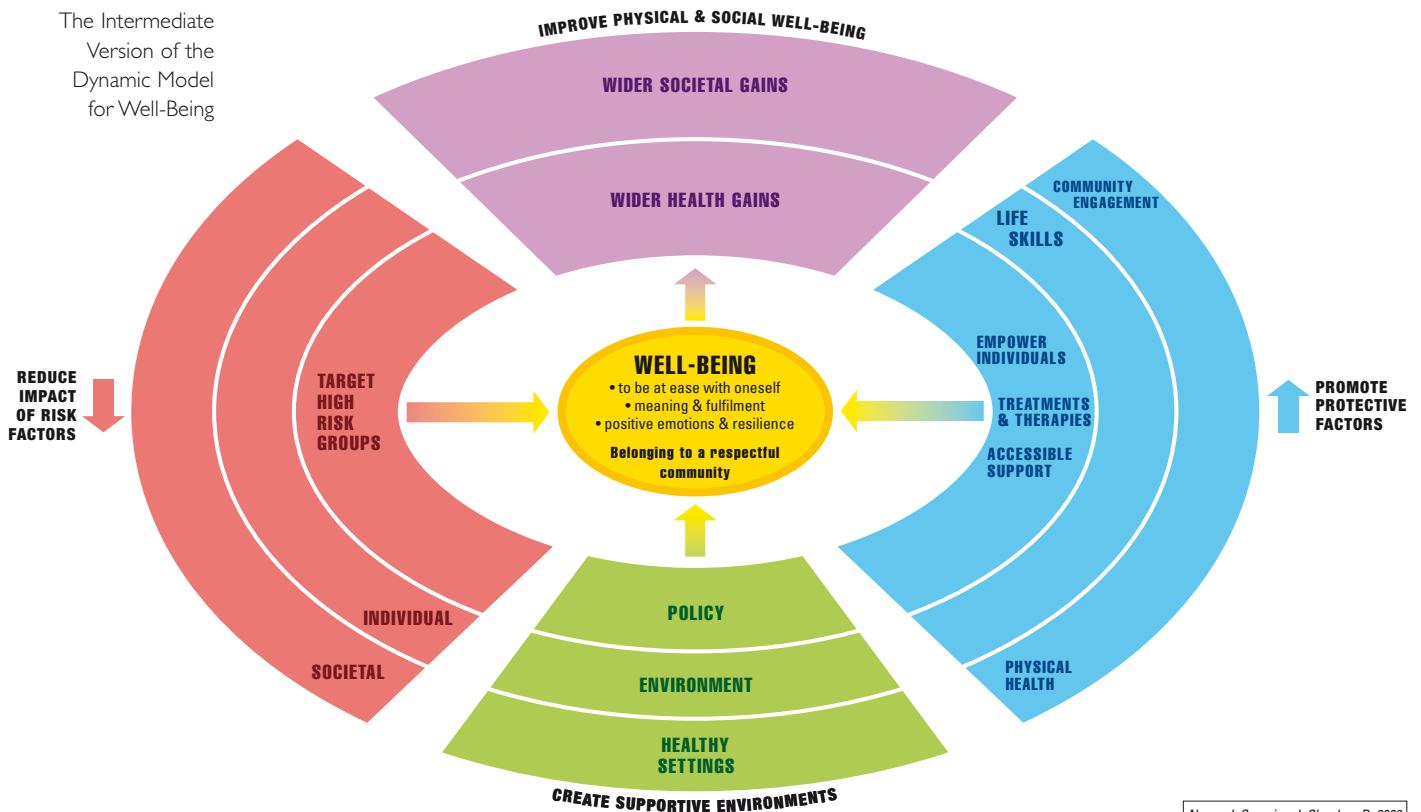
The Basic Version of the Dynamic Model for Well-Being



Nurse J, Campion J, Sheehan D, 2006

Figure 2:

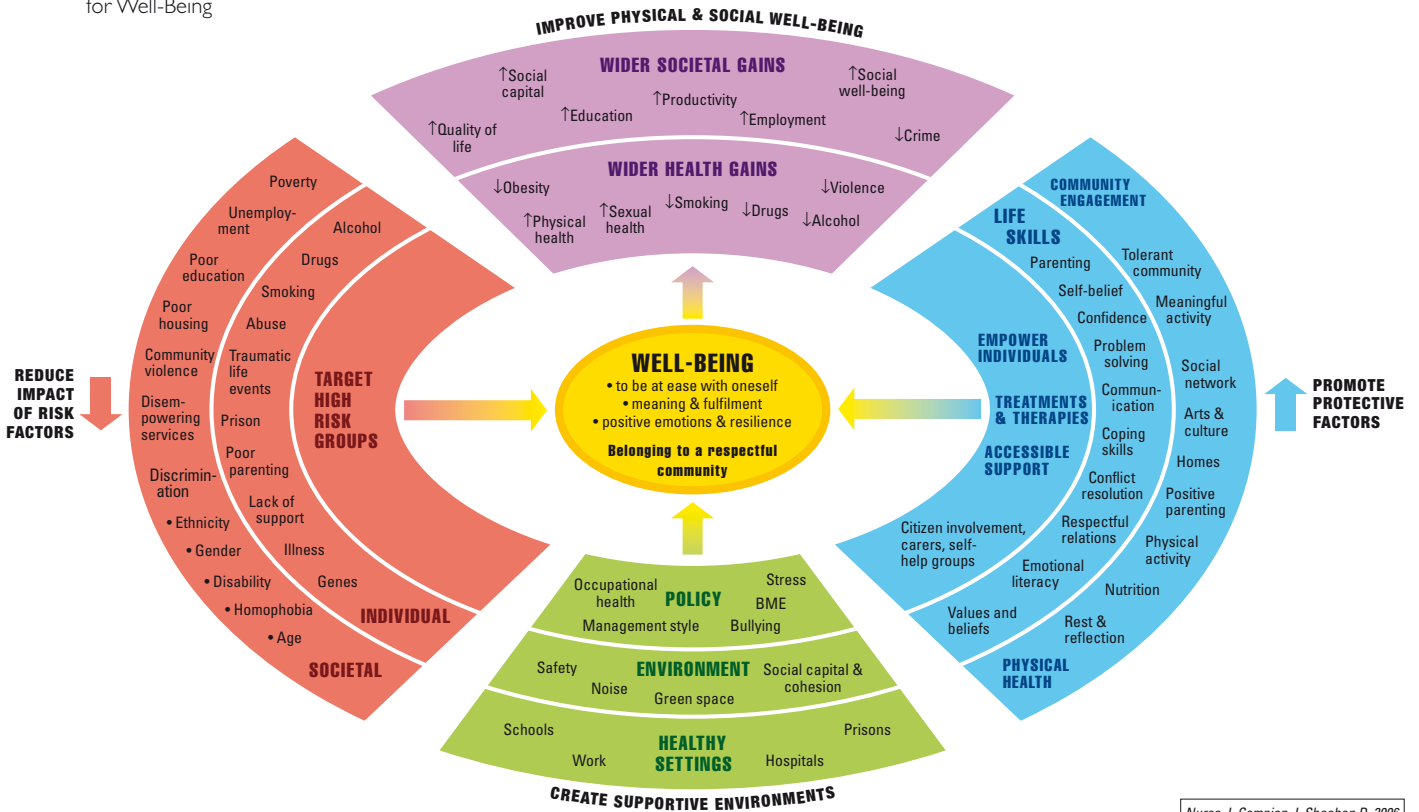
The Intermediate Version of the Dynamic Model for Well-Being



Nurse J, Campion J, Sheehan D, 2006

Figure 3:

The Comprehensive Version of the Dynamic Model for Well-Being



Nurse J, Campion J, Sheehan D, 2006

2.3 Relationship with Wider Physical Health

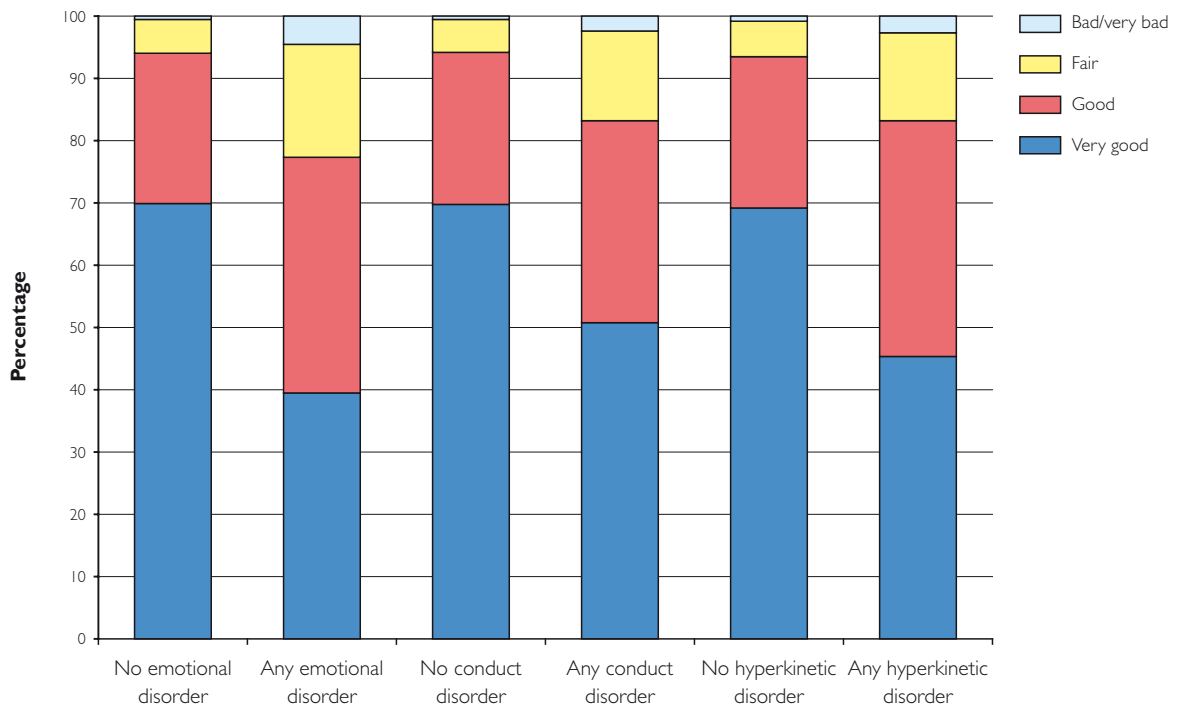
Poor mental health is associated with a variety of health damaging behaviours, including smoking, drug and alcohol misuse, unwanted pregnancy and poor diet. More importantly, a history of anxiety and depression has been found to be a stronger long-term predictor for mortality due to heart disease than smoking in men, and is associated with an increase in cancers, (Weitof, 2005). Negative emotions such as feelings of despair, anger, frustration, hopelessness and low self-worth are associated with high cholesterol levels, raised blood pressure and lowered immune responses. For heart disease, the increase in risk from negative emotions are similar to smoking, high blood pressure, obesity and raised cholesterol. (Making it Possible, 2005).

Conversely, positive emotions have been found to be protective for health. Positive emotions such as contentment, gratitude, happiness, hope, interest or love in early adulthood have been found to be associated with a decreased risk of early death and increased longevity by 2.5 times, compared to those displaying negative emotions, (Danner, 2001).

Figures 4 and 5 illustrate how mental disorders are associated with poor physical health in both childhood and adulthood. This relationship is likely to be complex in that some part of this association is due to having poor physical health initially which then contributes in itself to mental health problems. However, longitudinal studies as cited above, indicate that negative emotions and poor mental health in a previously healthy person, can underpin the later development of physical illness.

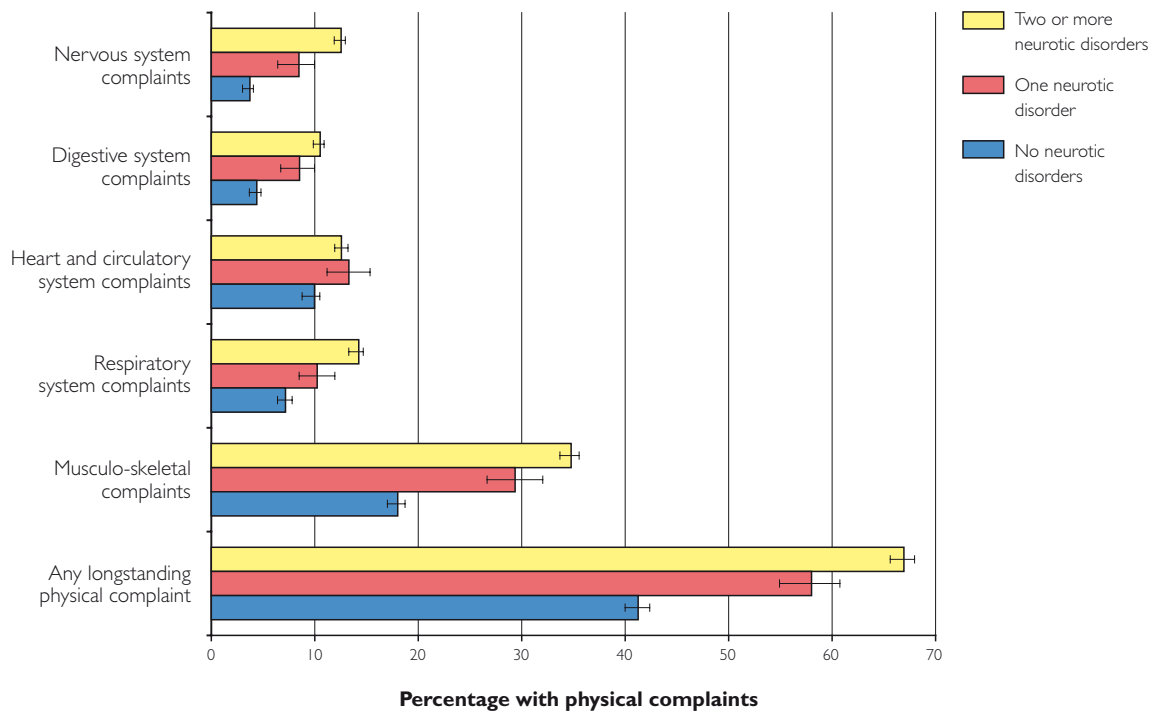
This illustrates that the mind and body are not separate units but are constantly interacting with each other. For example, the brain secretes hormones and neurotransmitters that influence our ability to deal with stress and our immune response; and conversely, what we eat, physical exercise and substance abuse also affects the brain and our body's well-being.

Figure 4:
Children's general health by emotional, conduct or hyperkinetic disorder, England, 2004



Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

Figure 5:
Association between mental health and different forms of physical illness, England, 2000



Source: Office for National Statistics, *Psychiatric Morbidity Among Adults Living in Private Households*, (Singleton, 2000)

2.4 Gains for Wider Social Well-Being

The social cost of poor mental health starts with children and the family. Maternal depression may negatively affect parenting skills, which in turn may affect child mental health and behaviour, which may lead to lower educational attainment. In adolescence this can continue on into poor educational attainment and anti-social and offending behaviour. (Making it Possible, 2005).

In adulthood, poor mental health continues to influence anti-social and offending behaviour, affecting societal levels of fear and cohesion. Additionally, poor mental health is estimated to cost the economy £77 billion each year, and sickness absence (of which the main cause is stress related), costs employers in the UK £12.2 billion each year. The South East has the highest rates of sickness absence in the country, affecting economic productivity. (ODPM, 2004).

Conversely, promoting mental health and well-being, can have significant benefits to wider societal well-being and in achieving local and national targets (for example, Public Service Agreements and Local Area Agreements), including:

- Child behaviour and educational achievement
- Reduced anti-social offending behaviour, violence and abuse
- Improved employment and retention levels with increased productivity
- Social inclusion, acceptance of diversity, less fear, and increased trust
- Enhanced social participation, cohesion and the development of respectful relationships and communities
- Improved social well-being and quality of life (Making it Possible, 2005).

It is estimated that better mental health care would save the government £3.1 billion a year (Wanless 2002;2004). This does not take into account the savings from promoting mental health and prevention.

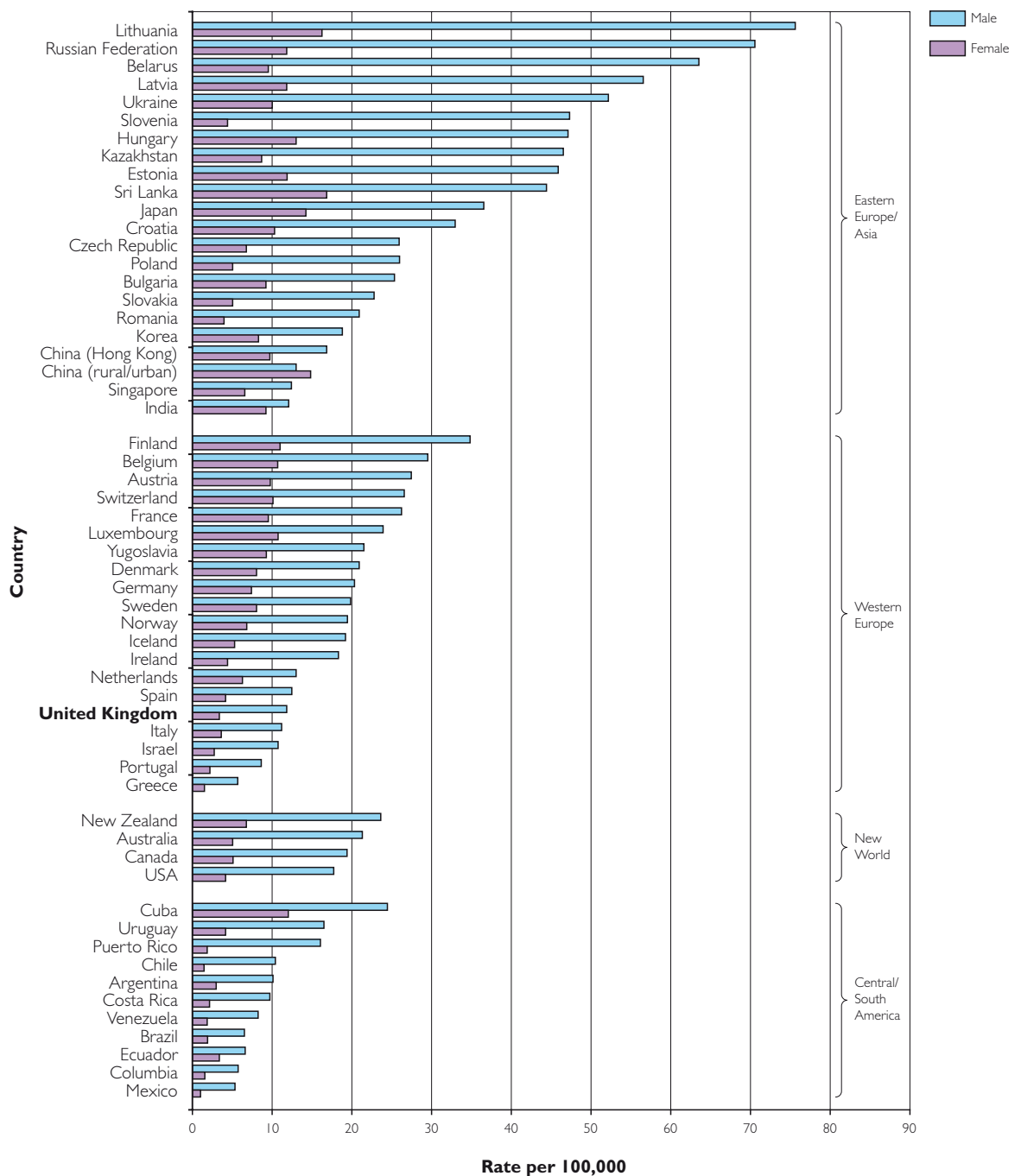
3. Prevalence of Mental Health Problems in the South East

The following chapter outlines the prevalence of suicide and different mental health problems, in England and where possible, within the South East, and makes comparisons between regions, Europe and the rest of the world. This information represents population need, and can be used to compare current service provision and use, with actual need. Often service provision follows historic patterns that reflect demand rather than need. Using information on population need helps to ensure inequalities are addressed and services are more appropriately provided. See the glossary for descriptions of the main forms of mental health problems.

3.1 Suicide: Comparisons with England, Europe and World

International Comparisons

Figure 6:
World mortality rates per 100,000 from suicide: Most recent year available as at June 2003



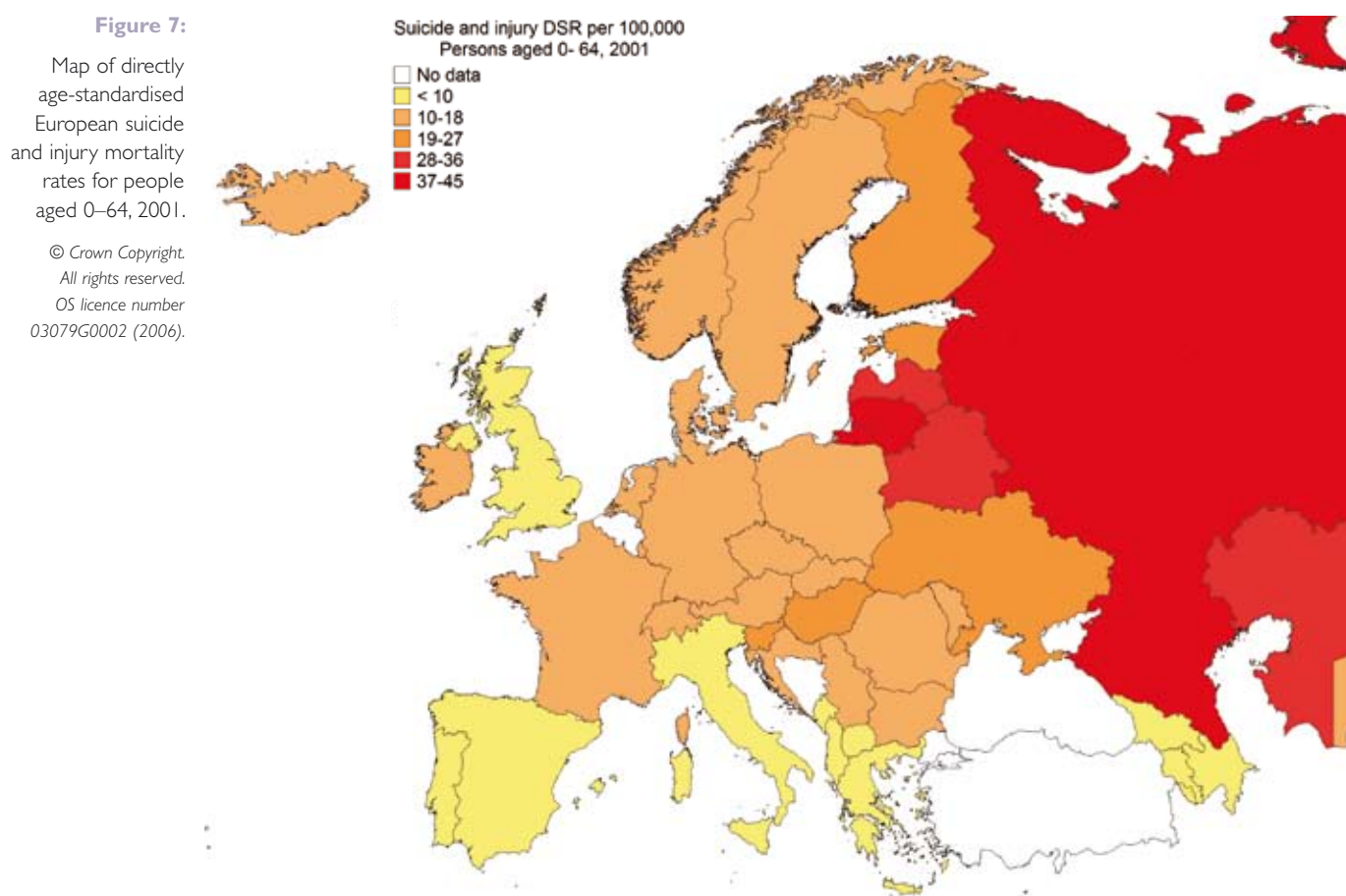
Source: © World Health Organisation 2004.

Figure 6 describes suicide rates for men and women in different countries classified into four global regions. Although there may be differences in the accuracy of recording methodologies, they demonstrate consistent patterns, including the preponderance of males committing suicide. Variations in suicide rates are related to social tensions, cultural norms, levels of alcohol consumption and protective factors including social networks and mental health services.

The lowest rates for suicide tend to be found in Central/South America, except for Cuba. Western European rates are next lowest and the United Kingdom has one of the lower rates of suicide within Europe. The New World has intermediate levels of suicide, and Eastern Europe and Asia have the highest rates of suicide in the world.

Within Europe, (see Figure 7) the highest rates for suicide are in Eastern Europe. These high rates have been associated with the degree of social stress experienced during the recent period of socio-economic transition, cultural norms and high levels of alcohol consumption.

The European World Health Organisation has developed an action plan: Mental Health: facing the challenges, building solutions, (WHO Euro, 2005), and the European Commission has produced a Green Paper on Improving the Mental Health of the Population (European Commission, 2005). They highlight the importance of poor mental health on the economy, variations in suicide across Europe and plans to share and extend good practice in reducing suicide and improving mental health across Europe.



Source: WHO/Europe Health for all database, June 2006.

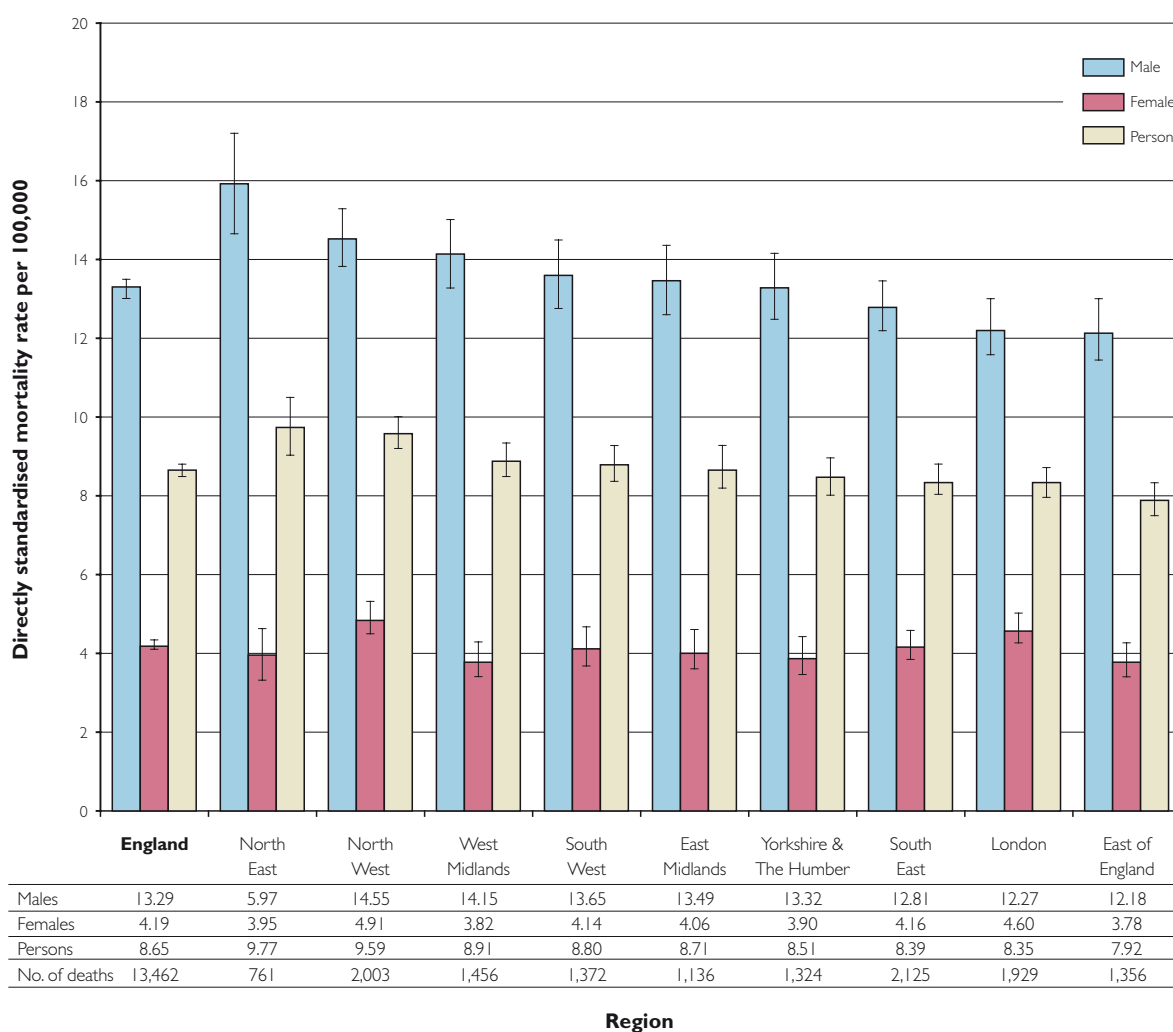
Regional Variations in Suicide Mortality Rates - the South East Compared to English Regions

The South East region shows the third lowest suicide rate in comparison with other regions in England, and both sexes show rates below the national average. (see figure 8). However, because the South East is the largest region with over 8 million people, it has the highest absolute number of suicides with 2,125 suicides between 2001–3. This represents about a sixth of all suicides in the country.

Figure 8:

Suicide and injury mortality rates for males, females and persons of all ages in England and the regions, 2001–2003

© Crown copyright



Source: *Compendium of Clinical and Health Indicators, April 2005, Health and Social Care Information Centre.*

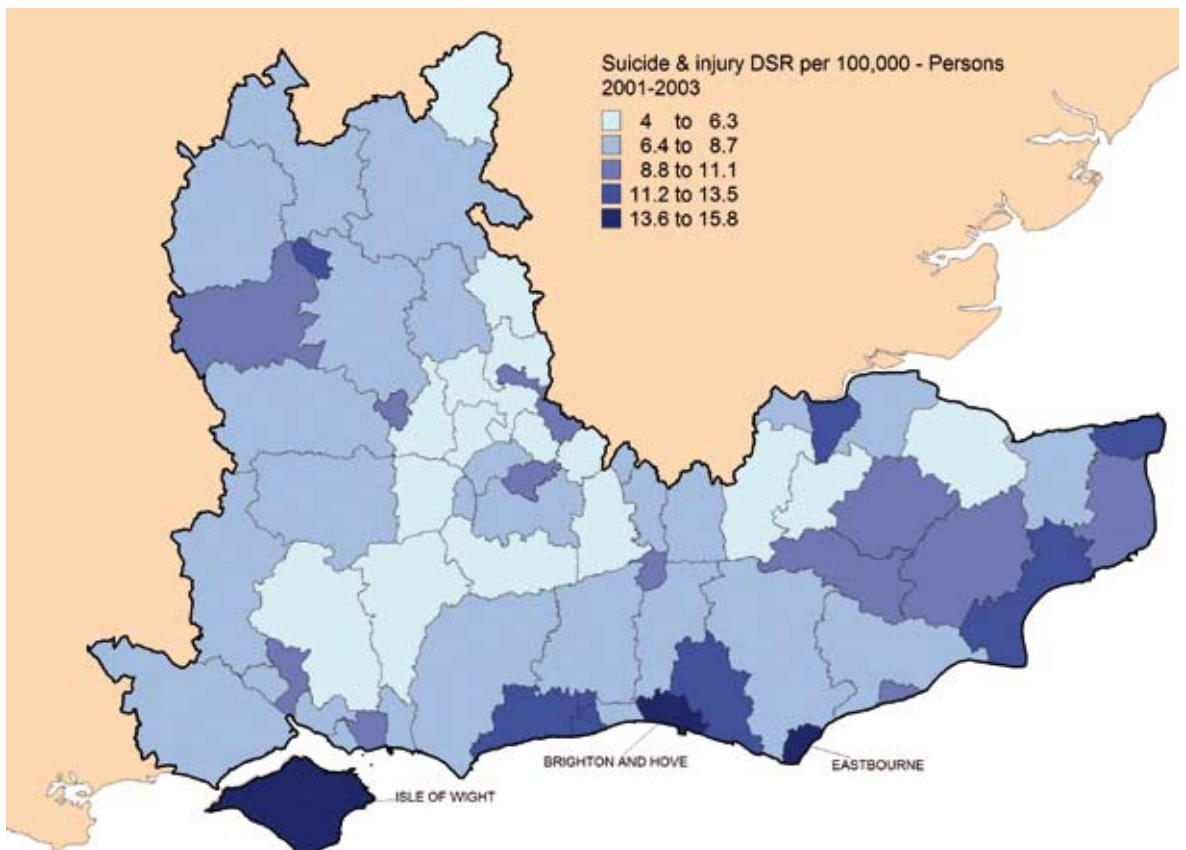
Suicide in the South East by Local Authority Regions

Within the South East region, the Isle of Wight, Brighton and Hove, and Eastbourne have the highest rates of suicide (see figure 9). Within Kent and Medway, Gravesham and Thanet have the highest rates, and Oxford City has the highest rate within Thames Valley (old SHA area). The recent SEPHO report – ‘A profile of Suicide Mortality in the South East’ – provides further regional information (Brooks, 2006).

Figure 9:

Map of directly age-standardised suicide mortality rates by Local Authority in the South East, people of all ages 2001–03

© Crown Copyright.
All rights reserved.
OS licence number 03079G0002 (2006).



Source: *Compendium of Clinical and Health Indicators*, April 2005, Health & Social Care Information Centre. © Crown Copyright.

Note: The England and South East rates for people of all ages are 8.65 and 8.39 per 100,000 respectively.

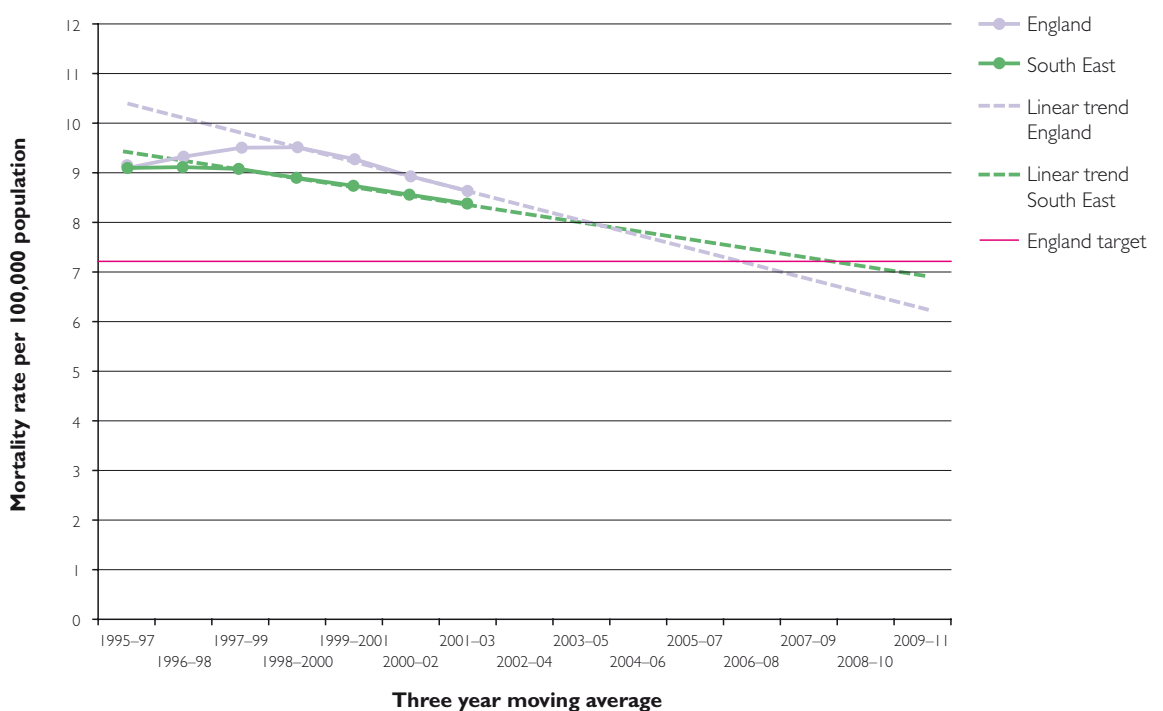
Trends in Suicide Rates in the South East

Figure 10 shows that the suicide rate in the South East has been reducing and extrapolation of the linear trend should just meet the government target for 20% reduction by 2010 from the baseline rate in 1998–87. However, the rate of decrease is slower than the England average.

Figure 10:

Mortality rates from suicide and injury of undetermined intent in England and the South East from the PSA baseline 1995–97 to the 2010 target (persons of all ages) and linear trend line based on the most recent 5 years

© Crown Copyright.



Source: *Compendium of Clinical and Health Indicators*, April 2005, Health and Social Care Information Centre.

Suicide Among Offenders and Ex-Offenders

Prison suicides have increased in the last 25 years, and prisoners have higher rates of suicide whilst in prison compared to the general population. Compared to men of the same age, prisoners of all ages have a 5 times higher risk of suicide. This risk is particularly high for young offenders, with an 18 fold increased rate of suicide in 15–17 year olds, (Fazel, 2005). In the South East region there was a total of 11 prison suicides in 2004; and 8 in 2005. The SE has more prisoners and prisons compared to any other region (see figure 11), with 34 prisons in total (of which 28 are public prisons, the remaining being private prisons, detention and removal centres). This comprises between 12–13,000 prisoners within the South East, see figure 11 for the distribution of prisons within the South East (as of July 2006).

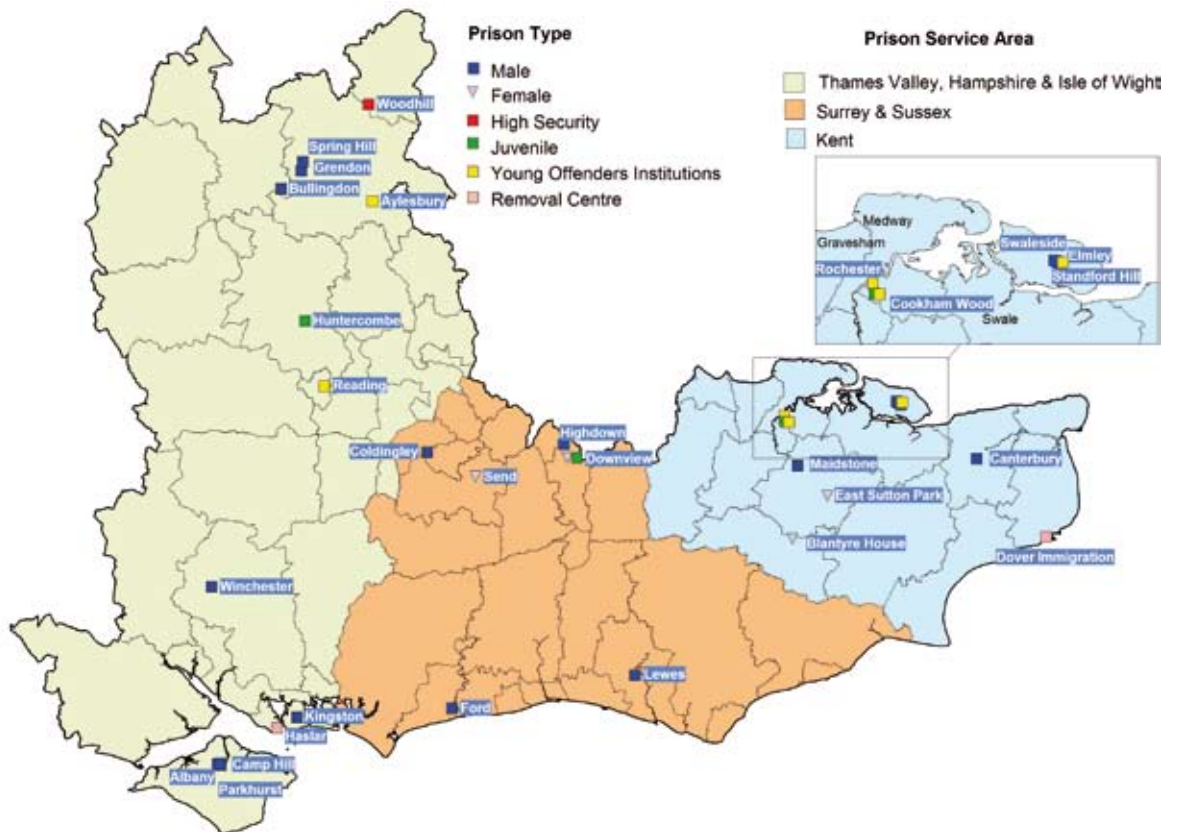
A recent study has highlighted the high rate of suicide in recently released prisoners: compared to expected figures in the general population, female ex-offenders are 35.8 times more likely to commit suicide and male ex-offenders are 8.3 times more likely to kill themselves. The risk is especially high in the first month after release and for older ex-offenders, (Pratt D, 2006).

Some of these deaths are related to loss of tolerance upon returning to drug misuse, however, the majority are related to high psychiatric morbidity combined with a high stress situation. Many prisoners are released with no mental health or drug service through-care, no housing or income support, plus rejection and discrimination from families and wider society.

Figure 11:

Map showing location of HM Prison Service Establishments in the South East, 2005

© Crown Copyright.
All rights reserved.
OS licence number
03079G0002 (2006).



Source: HM Prison Service Annual Report and Accounts: 2004–05.

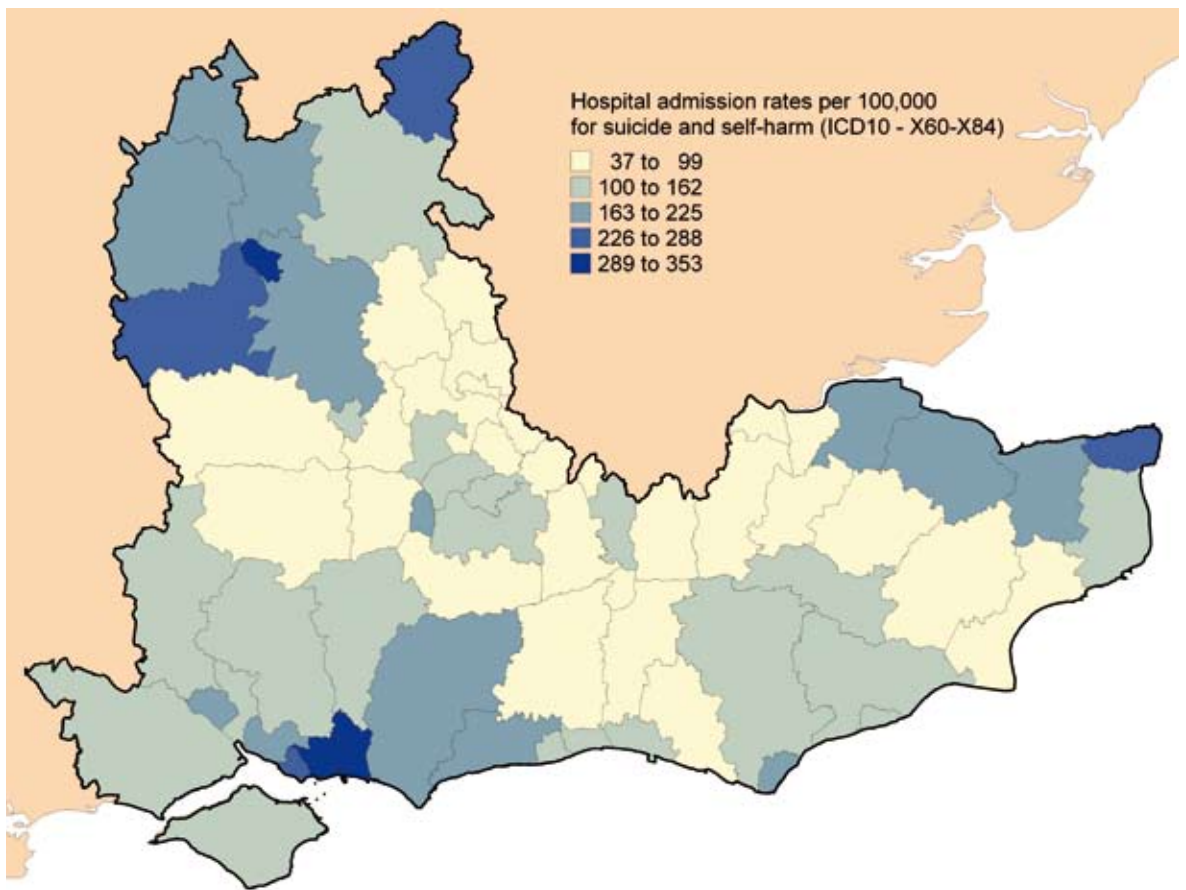
3.2 Self-Harm

Self-harm can be seen as a symptom and expression of internal distress, which many perceive as a coping mechanism that is frequently hidden. However, a history of self-harm increases the risk of subsequent suicide. Figure 12 illustrates hospital admissions due to self-harm; highest rates in the South East include Oxford, Portsmouth, Milton Keynes and Thanet.

Figure 12:

Map of directly age-standardised hospital admission rates for suicide and self-harm by Local Authority in the South East, 2004/05

© Crown Copyright.
All rights reserved.
OS licence number
03079G0002 (2006).

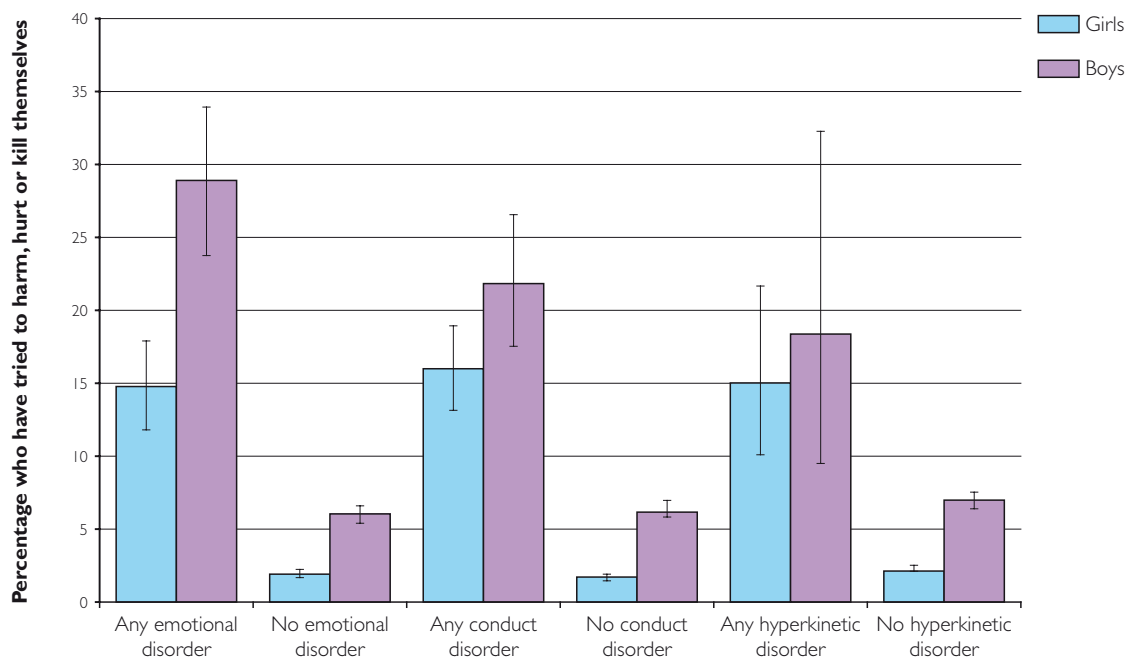


Source: The National Hospital Episode Statistics (HES2) online database, Department of Health, 2006.

Self-harm occurs more frequently in young people compared to adults, and is associated with a history of abuse. Figure 13 shows that self-harming behaviour occurs in over 1 in 4 young people with an emotional disorder, e.g. anxiety, depression or phobia, and 1 in 5 young people with a conduct disorder. A recent National Inquiry 'Truth Hurts' (Brophy, 2006), highlights the importance of understanding the underlying reasons for self-harm and how many young people were met with ridicule or hostility by professionals instead of being offered appropriate support.

Figure 13:

Children who have tried to harm, hurt or kill themselves by emotional conduct or hyperkinetic disorder, England 2004



Source: Office for National Statistics, Mental Health of Children and Young People in Great Britain, (Green 2004)

3.3 General Mental Health – Indicators and Admissions in The South East

The Index for Multiple Deprivation, (IMD) 2004, Mental Health Indicator is comprised of the following components and can be seen as an expression of mental health need across the South East region:

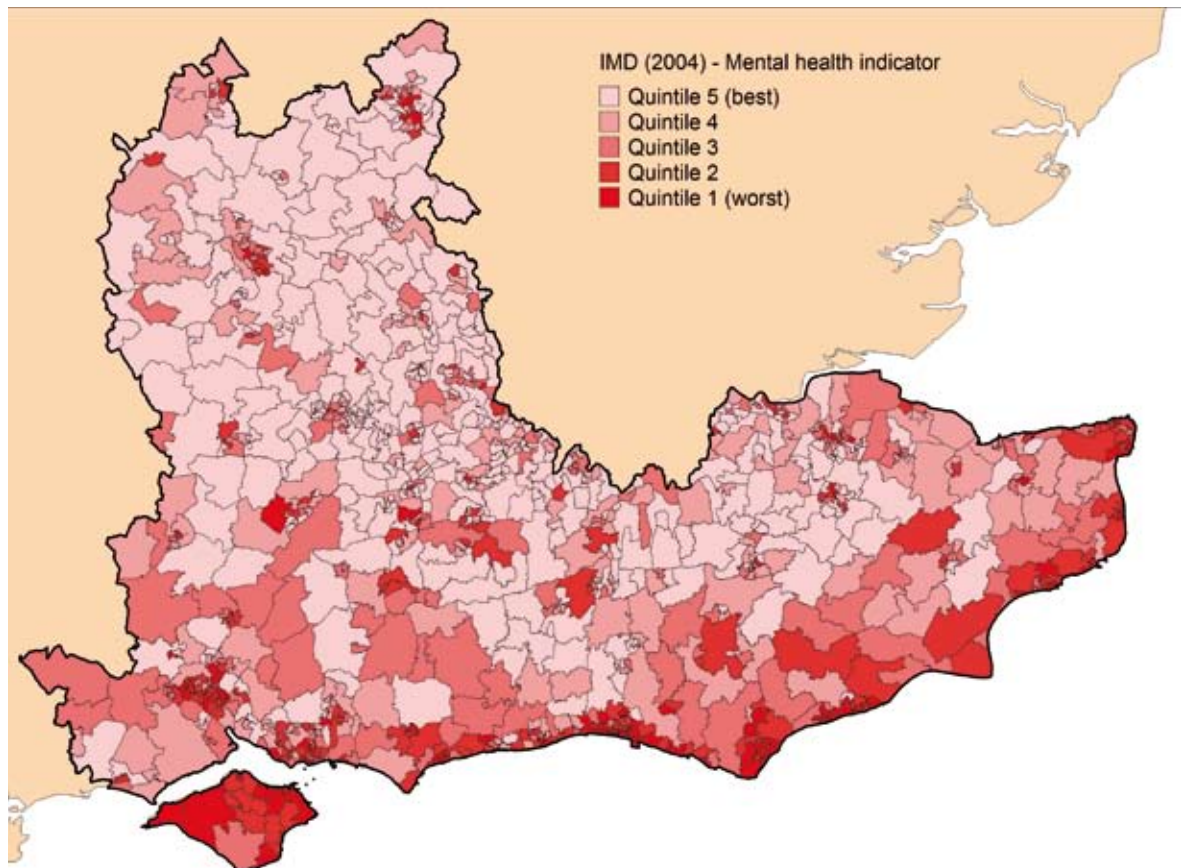
- Suicide (proportion of the population committing suicide in a year);
- Benefits for mental health conditions (proportion of the working age population claiming benefits for depression or anxiety);
- Prescribing for anxiety/depression (proportion of the population receiving drug therapies for depression and/or anxiety);
- Psychiatric admissions (admissions to hospital for depression or anxiety).

Figure 14 Shows higher Mental Health IMD scores along the South Coast and in urban areas – much of which correlates to areas of socio-economic deprivation.

Figure 14:

Map showing distribution of the ranked mental health indicator scores from the IMD 2004 by middle super output areas in the South East.

© Crown Copyright.
All rights reserved.
OS licence number 03079G0002 (2006).



Source: Indices of Deprivation 2004, Mental Health Indicator. Office of the Deputy Prime Minister (ODPM).

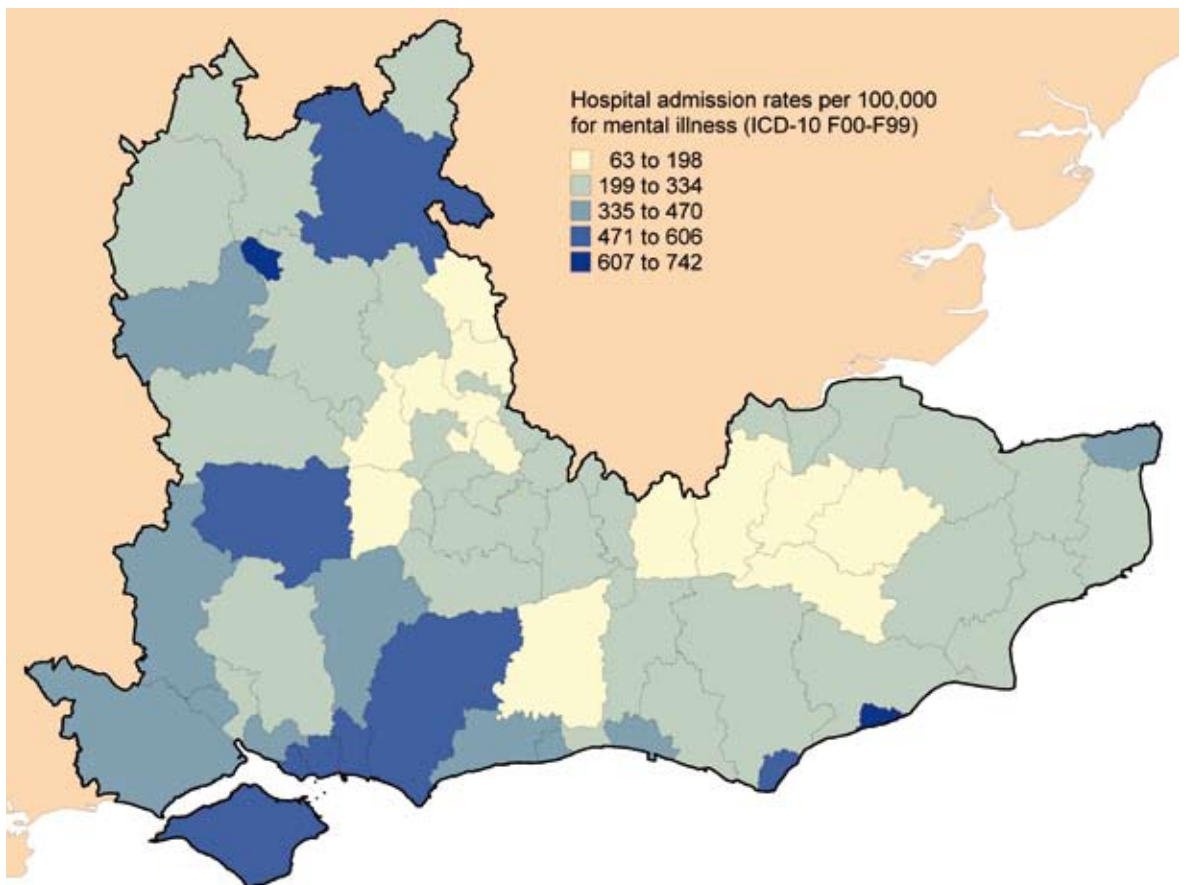
Figure 15 illustrates hospital admission rates for mental health illnesses across the South East. Although this correlates with the IMD for mental health (as would be expected as hospital admissions are one of the indicators), there are exceptions. For example, Southampton has lower admission rates than might be expected compared to need (from the IMD indicators). This may be due to a combination of restricted bed numbers and/ or due to greater levels of care based within the community.

Figure 16 is based on the ONS population survey of mental health, and is another way of illustrating mental health need across a population. In the South East, at any one time, 16% of women and 12% of men are affected by depression or anxiety. Approximately 4% are assessed as having a personality disorder and less than 0.5% have a probable psychotic disorder such as schizophrenia or bipolar affective disorder. The figures for neurotic disorders (depression and anxiety) appear a little lower than the England average, however this difference is not statistically significant. The prevalence of personality disorders in the South East cannot be estimated from this survey due to small sample sizes and is therefore not shown in this figure.

Figure 15:

Map of directly age-standardised hospital admission rates for mental illness by Local Authority in the South East, 2004/05

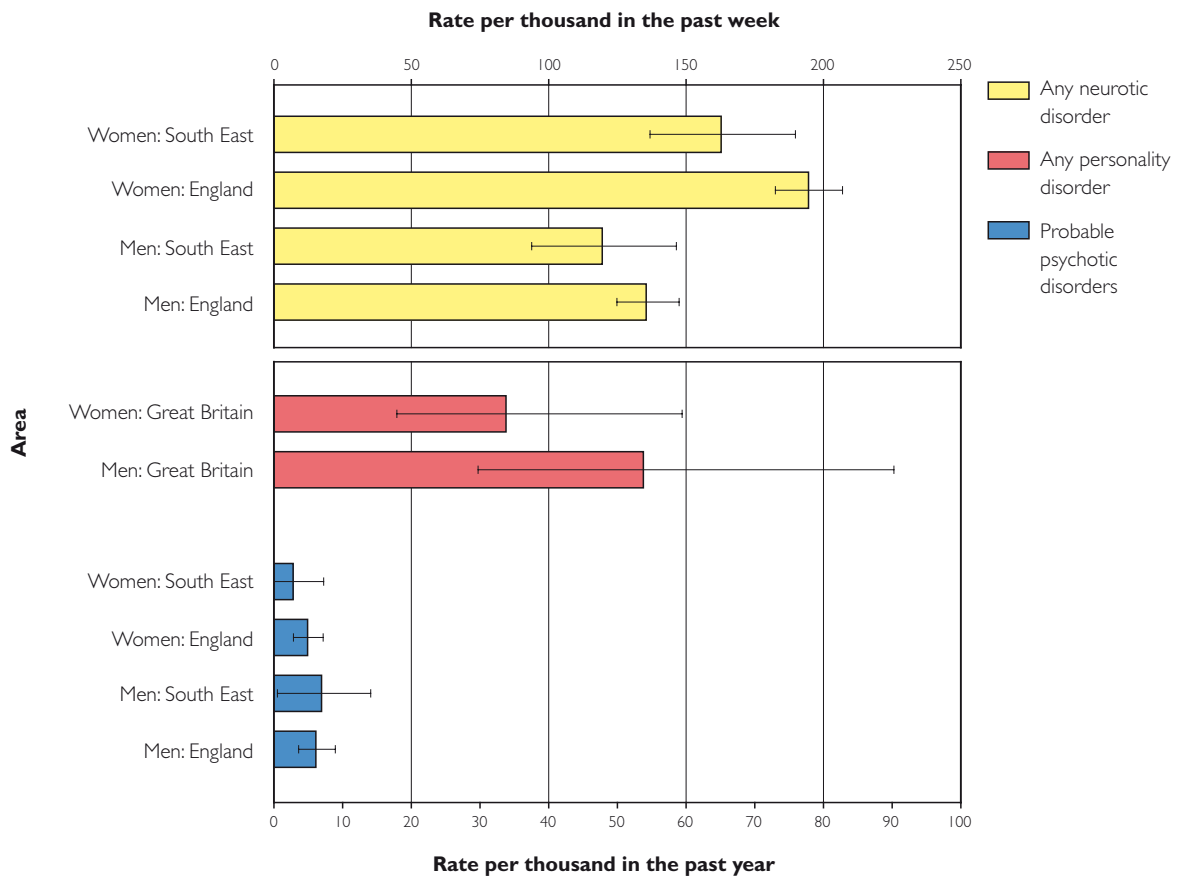
© Crown Copyright.
All rights reserved.
OS licence number
03079G0002 (2006).



Source: The national Hospital Episode Statistics (HES2) online database, Department of Health, 2006.

Figure 16:

Prevalence of neurotic, personality and probable psychotic disorders among people aged 16 and over in the South East, England and Great Britain 2000

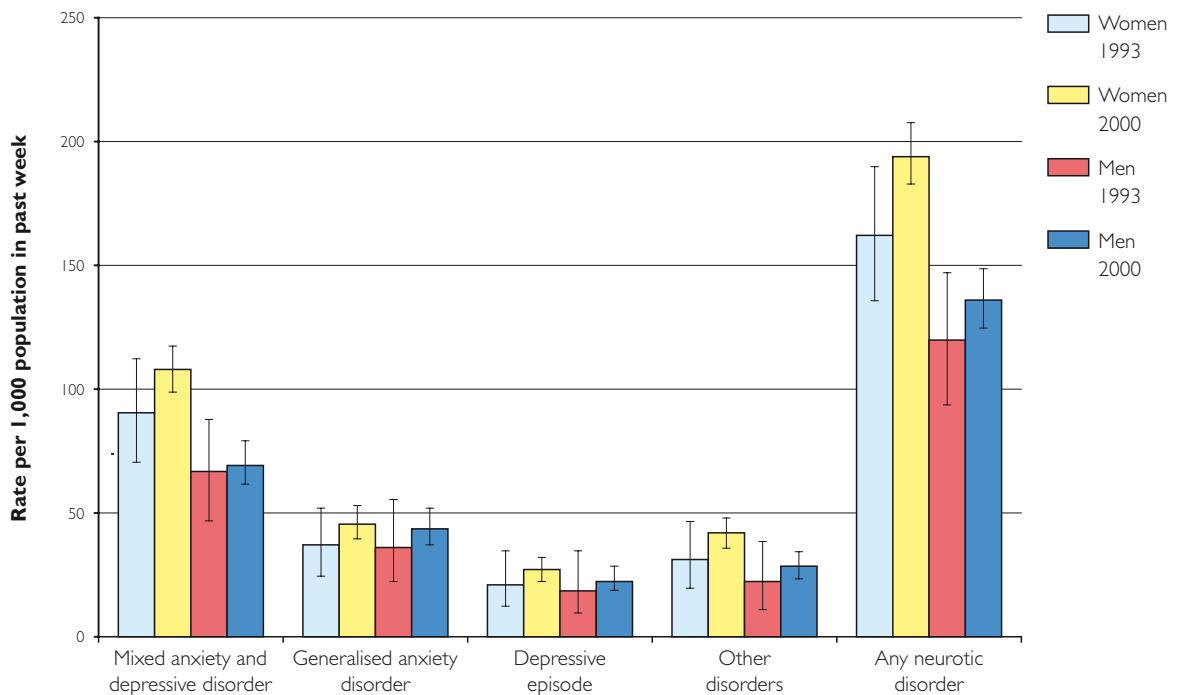


Source: Office for National Statistics, Psychiatric Morbidity Among Adults Living in Private Households, (Singleton, 2000)
Note: Prevalence of neurotic disorders is measured as a rate per thousand in the past week whereas any personality disorders and probable psychotic disorders are measured as rate per thousand in the past year

3.4 Depression and Anxiety

Figure 17 estimates that approximately 16% of women and 12% of men in the South East experience a neurotic disorder e.g. depression, anxiety or phobia, at any one time. These figures are not statistically different from England averages, nor from any of the other English regions.

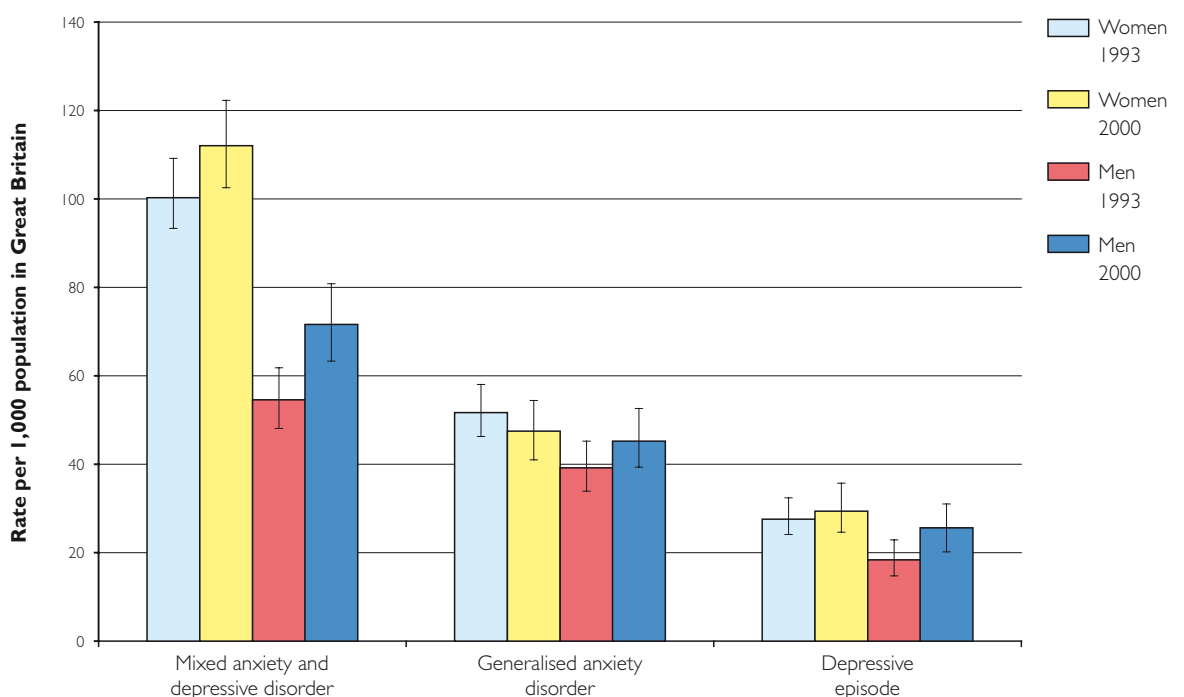
Figure 17:
Prevalence of neurotic disorders, adults in South East, 1993 and 2000



Source: Office for National Statistics, *Psychiatric Morbidity Among Adults Living in Private Households*, (Singleton, 2000).

Although there appears a slight increase in neurotic disorders over time, there is no statistically significant change in overall rates for any neurotic disorder for adults between 1993–2000 within the South East. However, within Great Britain there is a small statistical increase in all neurotic disorders in men, from 12.6% in 1993 to 14.4% in 2000, (See Figure 18).

Figure 18:
Comparison of the prevalence of neurotic disorders between years 1993 and 2000, Great Britain



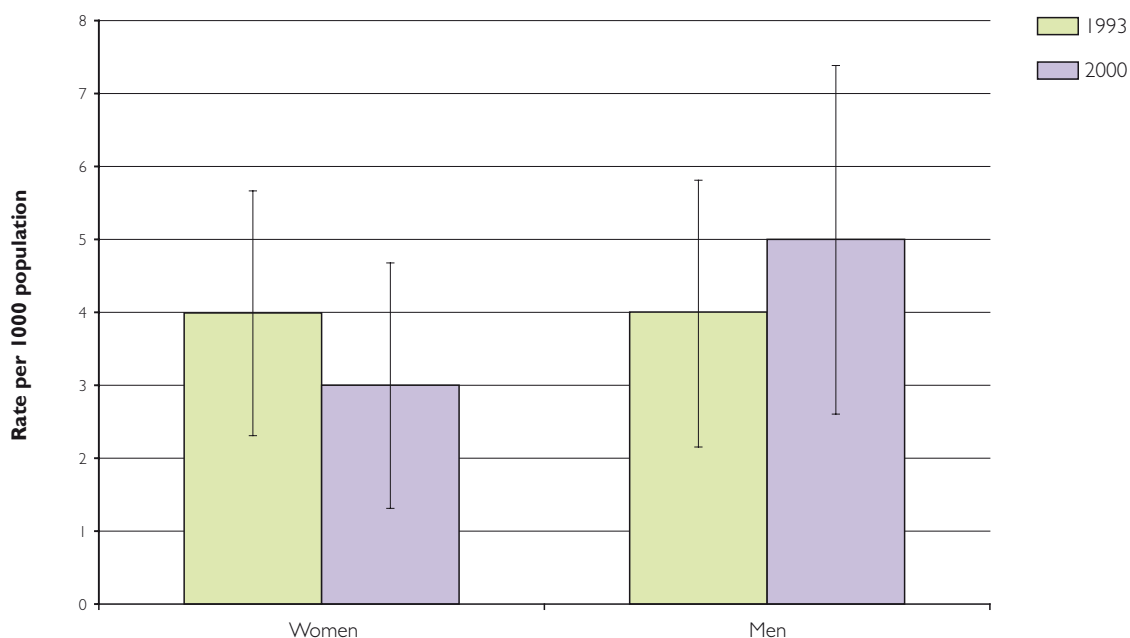
Source: Office for National Statistics, *Psychiatric Morbidity Among Adults Living in Private Households*, (Singleton, 2000).

3.4 Psychotic Disorders

Psychotic disorders include the more serious mental illnesses, for example bipolar disorder and schizophrenia. In England, the overall prevalence of people living with a psychotic disorder at any one time in 2000 was 0.5% for women and 0.6% for men. Numbers are too low to distinguish any statistical different rates in the South East compared to other regions or the England average. Likewise, no difference in trend was found between 1993–2000, (see figure 19).

Figure 19:

Comparison of the prevalence of psychotic disorder experienced in the past year between years 1993 and 2000, adults aged 16–64, Great Britain



Source: Office for National Statistics, *Psychiatric Morbidity Among Adults Living in Private Households*, (Singleton, 2000).

3.6 Personality Disorders

Prevalence for all personality disorders in England is estimated to be 5.4% for men and 3.4% for women. There is a suggested trend of an increase in personality disorders in women with age, but similar rates in all ages for men. However, numbers are too small to distinguish statistical differences, and likewise there is no statistical difference between the South East and other regions.

3.7 Dementia and Organic Disorders

A recent report by the Kings Fund, (Poole, 2006), estimates that 652,600 people in England have dementia. This represents just over 100,000 people in the South East region and the absolute numbers are predicted to increase due to improvements in life expectancy. Dementia symptoms increase over time and include cognitive impairment, behaviour problems and psychosis. Most dementia is due to Alzheimer's disease (55%), and 20% due to vascular causes.

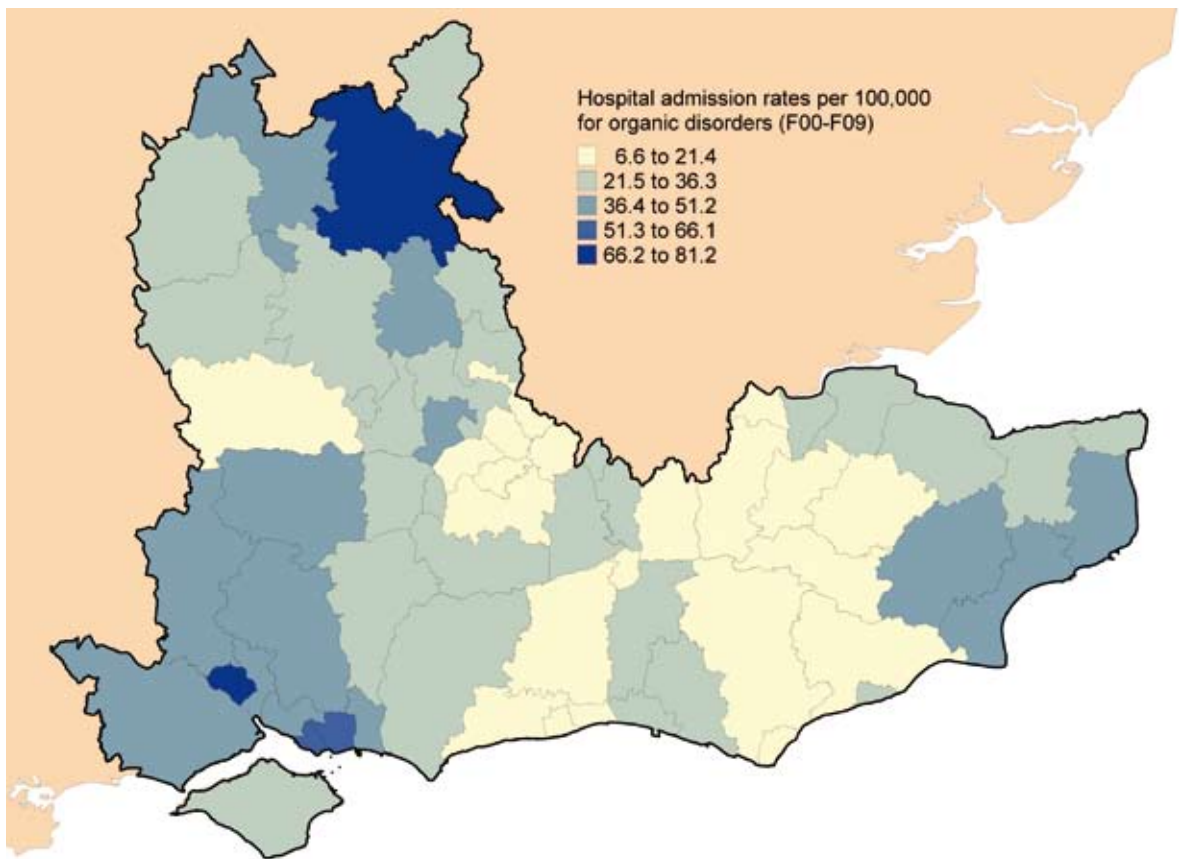
The risk of dementia increases substantially with age, with approximately one in a hundred 60–69 year olds, one in twenty 70–79 year olds, one in ten 80–84 year olds and one in five 85–90 year olds developing dementia. Other risk factors include poor linguistic abilities and mental activity, lack of physical activity, being overweight or obese, high blood pressure or cholesterol levels and smoking.

Figure 20 shows the rate for hospital admissions for organic disorders. These include cerebral disease, brain injury, cerebral dysfunction (dementia, Alzheimers, delirium, personality and behavioural disorders due to brain disease, damage, dysfunction,) within the South East. Higher rates of hospital admissions are found in Aylesbury Vale, Southampton and the Portsmouth area. This may reflect variations in community care as other South Coast areas with high proportions of older people have relatively lower rates of hospital admissions.

Figure 20:

Map of directly age-standardised hospital admission rates for organic mental illness by Local Authority in the South East, 2004/05.

© Crown Copyright.
All rights reserved.
OS licence number
03079G0002 (2006).



Source of data: The national Hospital Episode Statistics (HES2) online database, Department of Health, 2006.

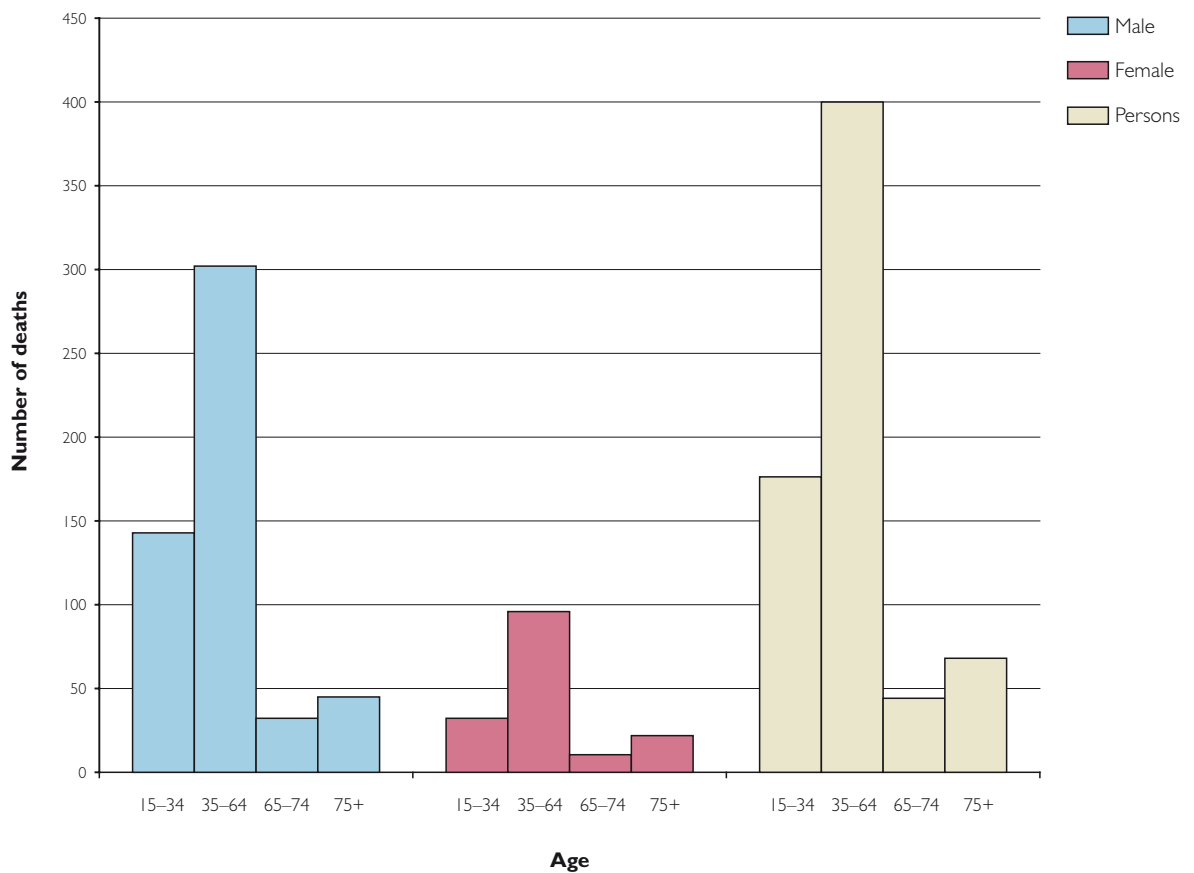
4. Addressing Risk Factors for Mental Health

This chapter explains the need to reduce the impact of risk factors from the dynamic model of well-being (the red section), and includes factors related to individuals socio-economic circumstances and discrimination that contribute to poor mental health.

4.1 Demographic Patterns

Figure 21 shows that in terms of absolute numbers, most suicides occur in young and middle-aged men (15–64 year olds) within the South East, this trend is also reflected to a lesser degree in women. These figures illustrate that although numbers of suicide deaths are small compared to overall causes of mortality (approximately 1%), the impact on society is higher due to the younger age that it usually occurs.

Figure 21:
Number of deaths from suicide and injury of undetermined intent by age in people aged over 15. South East Region, 2003

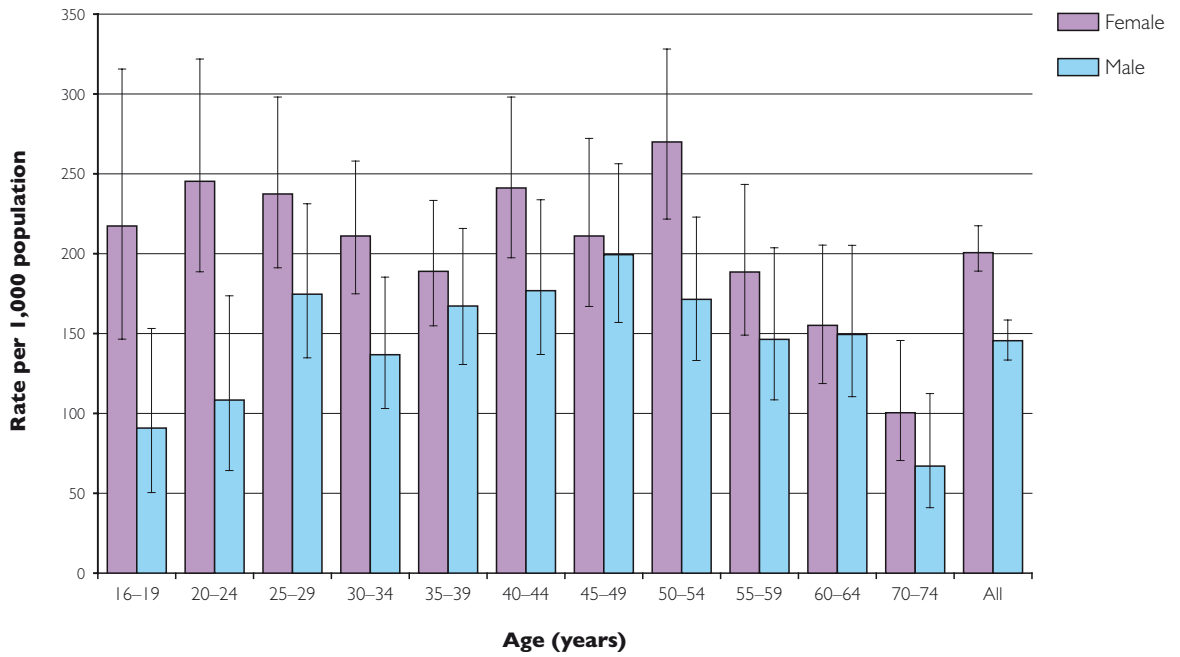


Source: *Compendium of Clinical and Health Indicators, April 2005, Health & Social Care Information Centre. © Crown Copyright.*

Figure 22 shows the prevalence of depressive and anxiety disorders by age for males and females in England. For females, there is little difference in the rate of depression in young adulthood and middle age, ranging from approximately 19–27% experiencing depression at any one time. Men have lower rates in young adulthood, increasing to highest levels in middle age. Lowest rates of depression are experienced in both males and females in older age groups.

Figure 22:

Prevalence of any neurotic disorder by age and sex, England, 2000



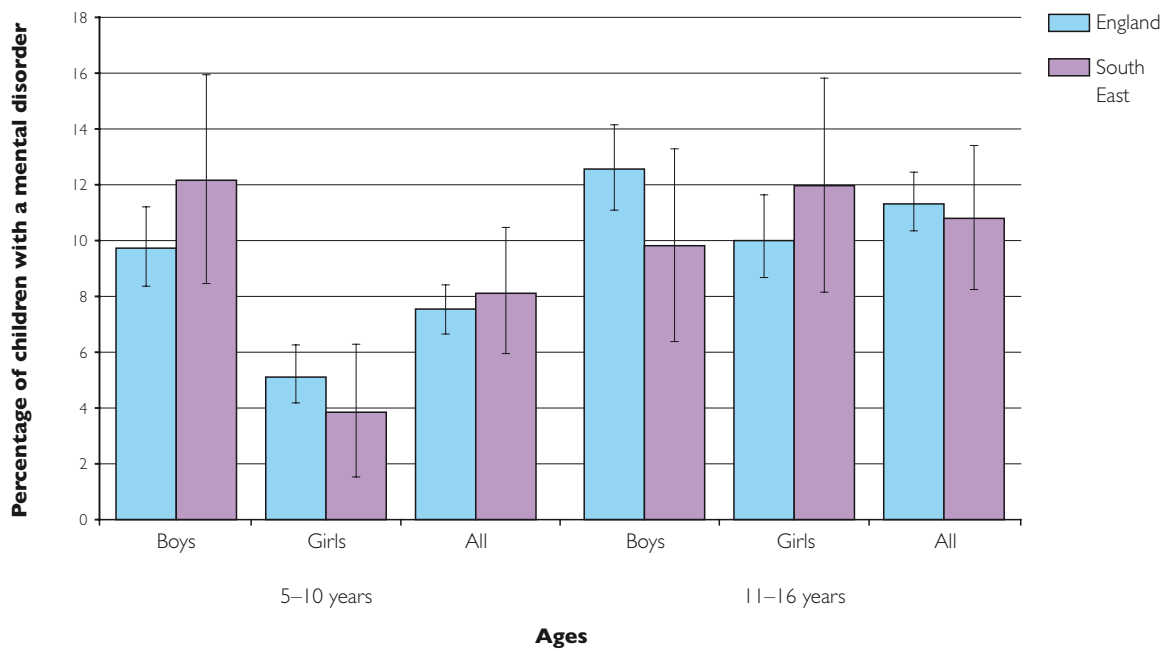
Source: Office for National Statistics Social Survey Division, *Psychiatric Morbidity Among Adults Living in Private Households, 2000* [computer file]. Colchester, Essex: UK Data Archive [distributor], 7 May 2003. SN: 4653.

Children and Young People

Over 1 in 10 five to sixteen year olds have a mental disorder (mainly emotional or conduct disorders) in the South East. These rates are not statistically significant from England or other regions. Rates increase with age and are higher for boys compared to girls, especially in the five to ten year age group. See figure 23 for rates of mental disorders by age and sex. See the glossary for different forms of mental disorders in children and young people.

Figure 23:

Prevalence of children and young people with a mental health disorder; England and the South East, 2004

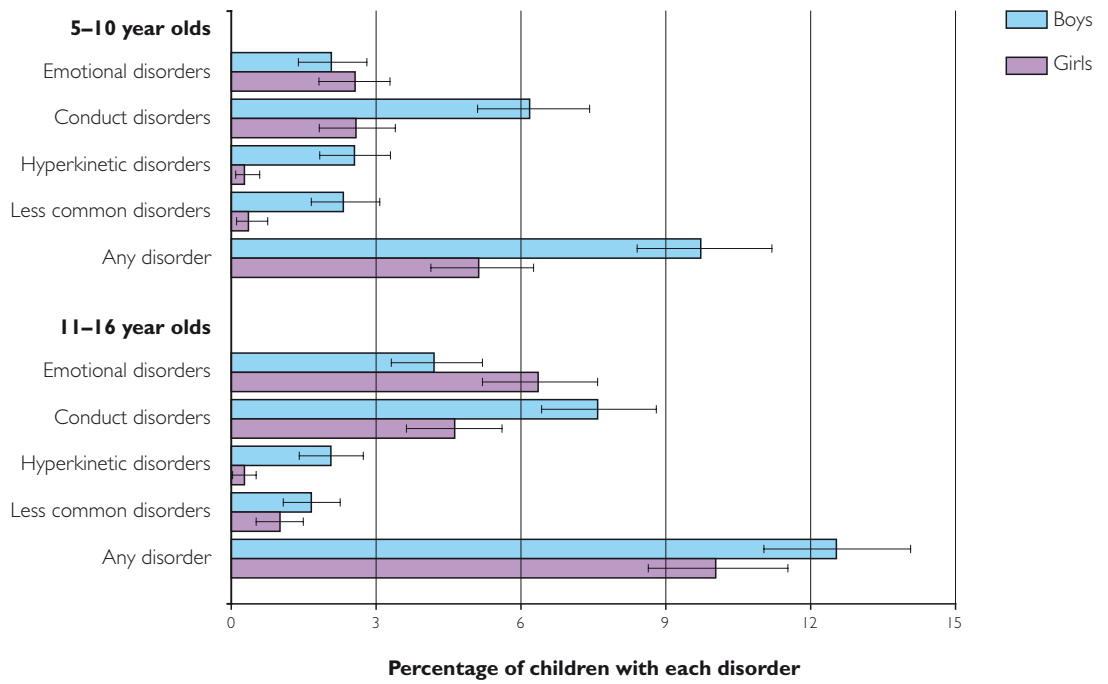


Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

The most common type of mental health problems in children and young people are conduct and emotional disorders, both increase with age. There are higher rates of conduct disorders in boys and emotional disorders in girls, (see figure 24).

Figure 24:

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



Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

Risk factors (after adjusting for socio-economic factors), for developing an emotional disorder; include: increasing age, physical illness and number of stressful life events; whilst independent risk factors for developing a conduct disorder include: being male, having a special educational need, stepchildren in the family, and poor maternal mental health. Independent risk factors for persistence of emotional disorders included only poor maternal mental health; and for conduct disorder; independent risk factors for persistence included: special educational needs, maternal mental health and whether the child was frequently shouted at. (Meltzer, 2003).

Adult outcomes of young people with depression and conduct disorder: a study found that young people with depression and conduct disorder were more likely to have been mental health inpatients, used healthcare services and involved with criminal justice services, when compared to adults in the general population; (Knapp, 2002).

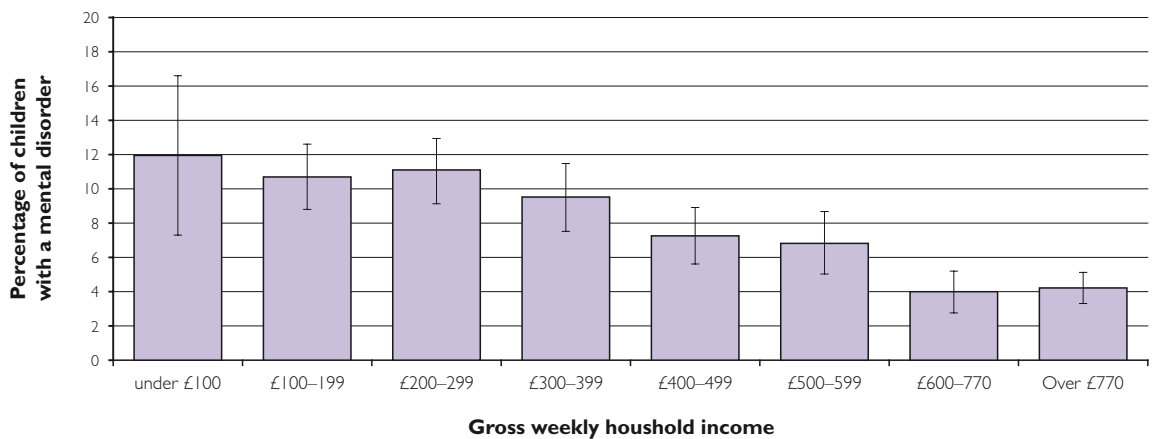
4.2 Socio-Economic Factors

Children and Young People:

Figure 25 illustrates how child poverty (as measured by parental income) increases the risk of mental health problems in children: with approximately 15% of children experiencing mental health problems at the lowest income levels compared to 5% of children at the higher income levels.

Figure 25:

Percentage of children with a mental health disorder by parental income. England 2004.

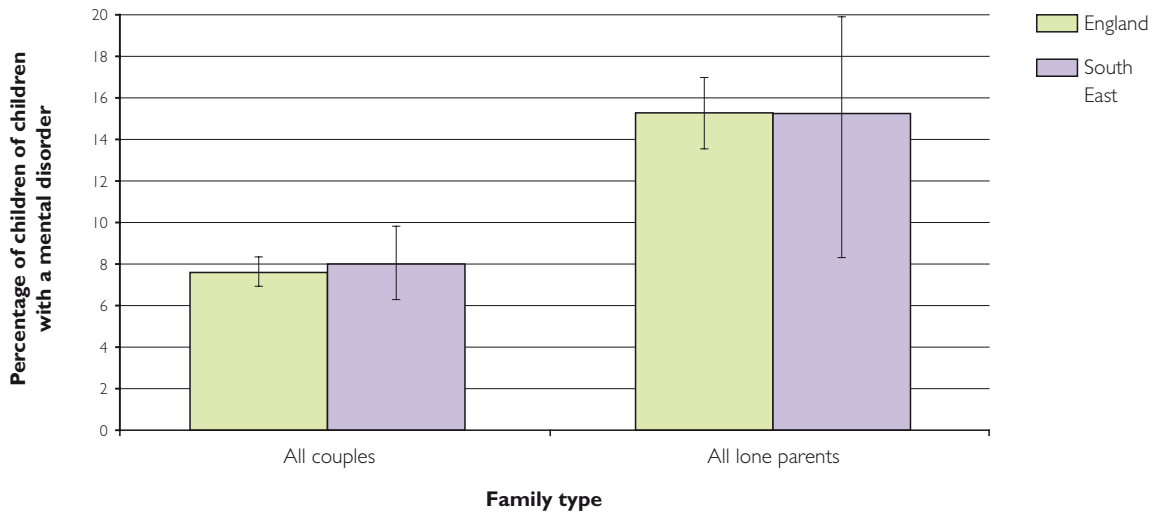


Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

Over 15% of children living with a single parent have a mental health problem, compared to 8% living with two parents. There is no statistical significance between rates in the South East compared to England, (see figure 26).

Figure 26:

Percentage of children with a mental health disorder by family type. England and the South East, 2004.

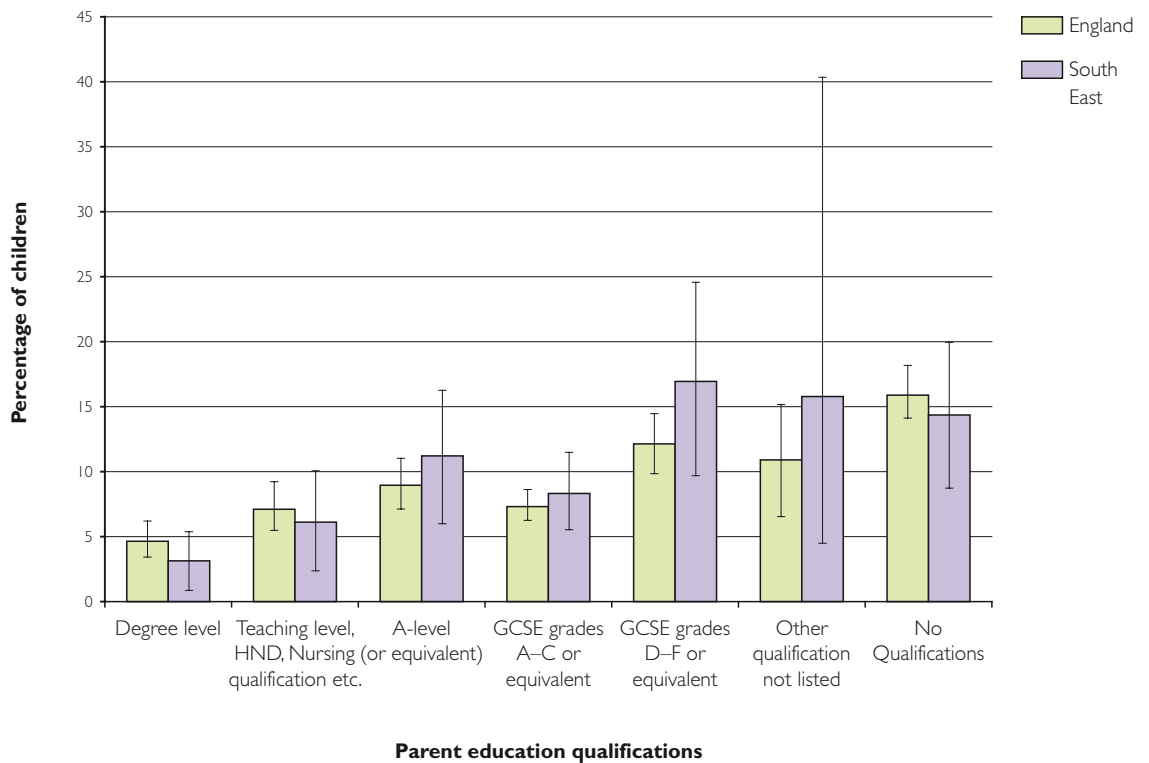


Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

Children with parents with a lower educational achievement are more likely to have a mental health problem, with less than 5% of children having a mental health problem if their parents have a degree, compared to approximately 15% for children with parents with no qualification, (see figure 27). Some of this effect will be accounted for by differences in income. There is no statistical difference in rates in the South East compared to England averages.

Figure 27:

Percentage of children with a mental health disorder by educational status of parent. England and the South East, 2004.

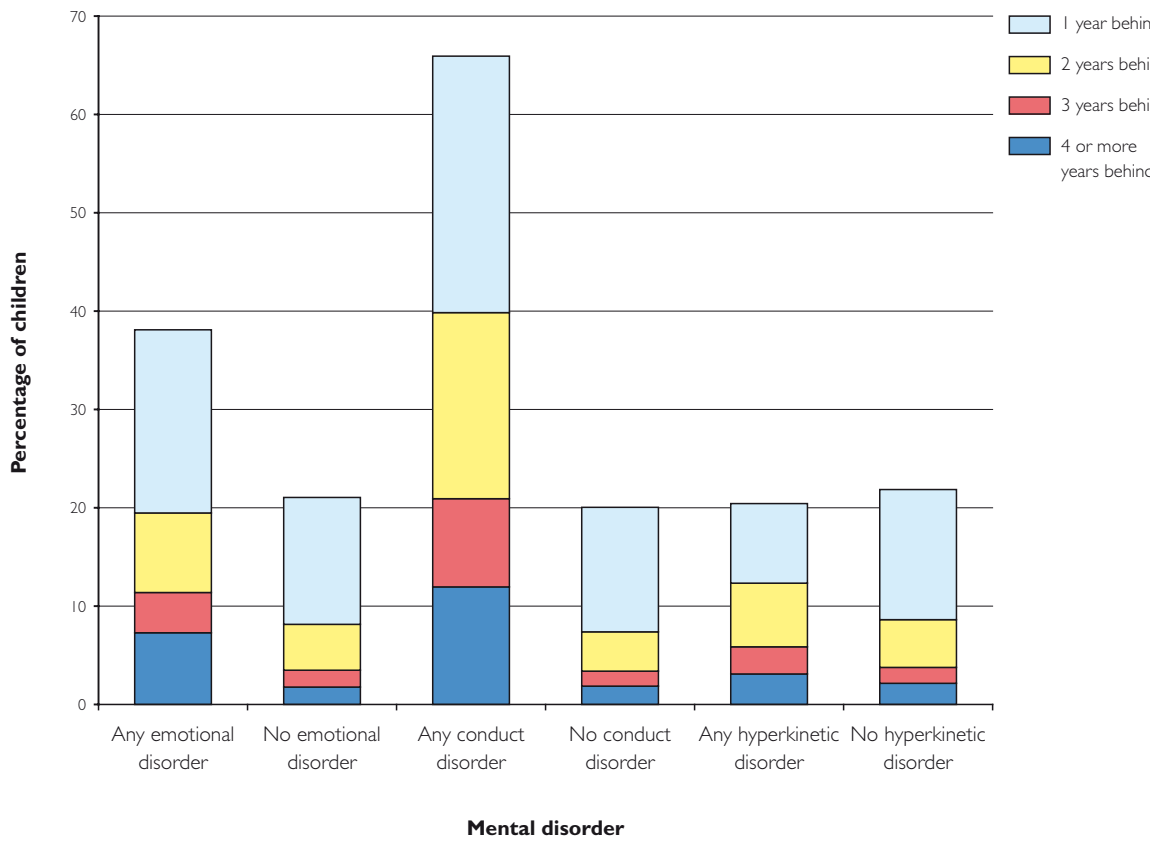


Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

Having a mental disorder as a child has a considerable impact upon educational achievement, especially for conduct and emotional disorders, (see figure 28). Some of this difference will be accounted for by the co-occurrence of learning disabilities with mental disorders.

Figure 28:

Percentage of children behind in school ability by type of mental health disorder: England, 2004

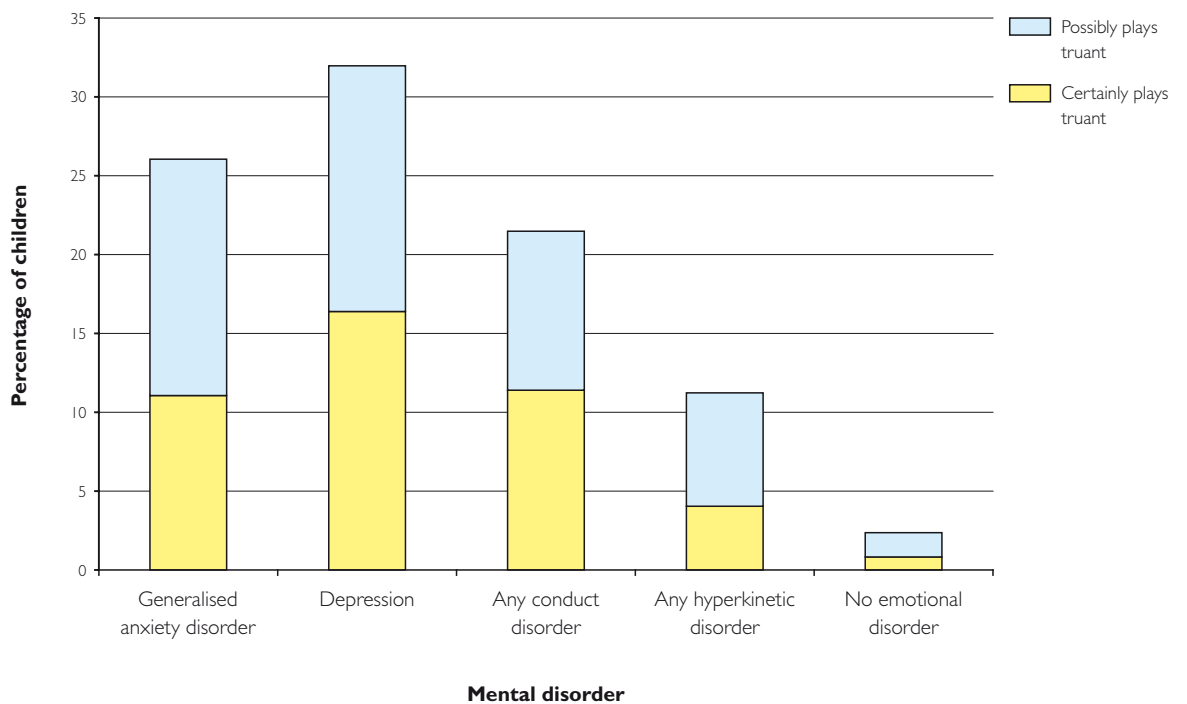


Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

There is also a high correlation between having a mental disorder and missing school: Approximately 25–30% of depressed and anxious children and 20% of children with conduct disorders truanting from school, (see figure 29). Additionally, having a mental disorder in childhood makes it more likely to miss school due to sickness or school exclusion.

Figure 29:

Percentage of children playing truant by mental disorder; England 2004.



Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

Socio-Economic Status of Adults with Mental Health Problems:

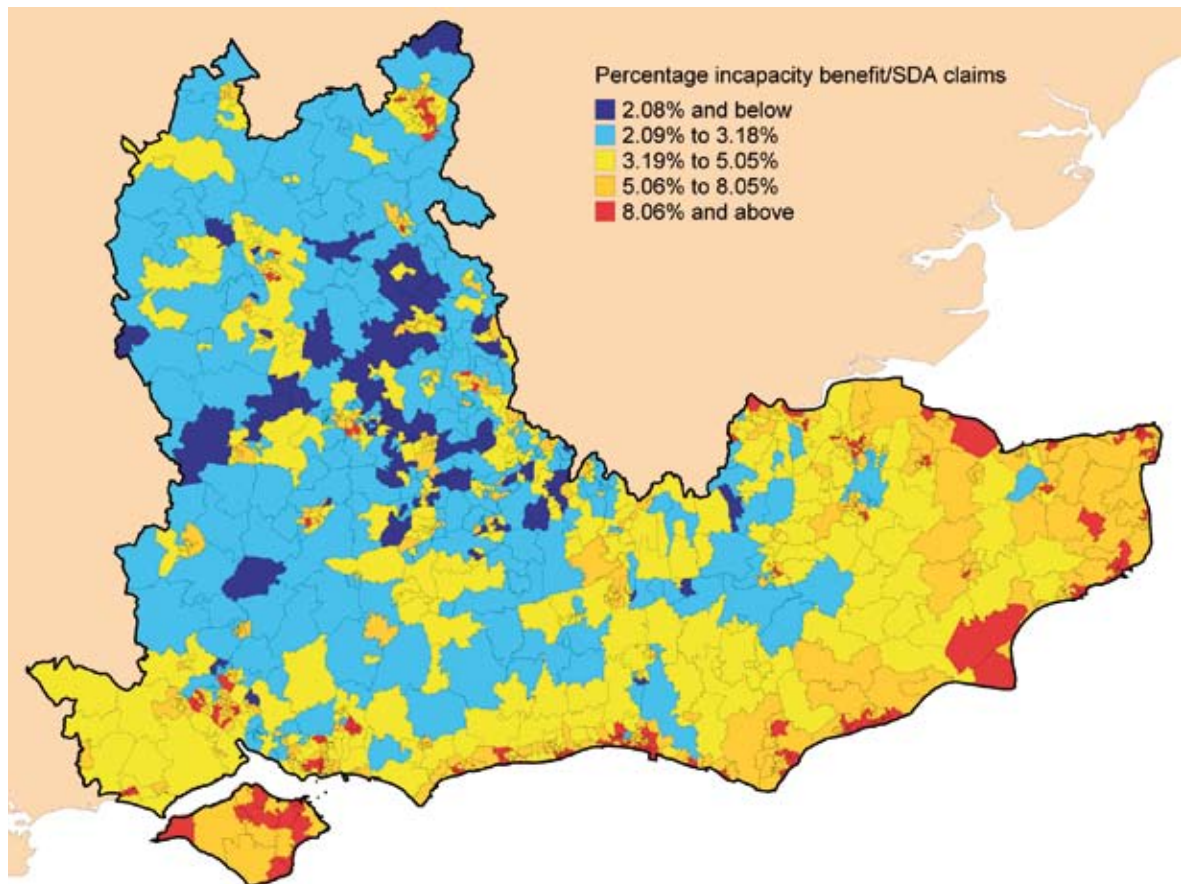
Employment:

Figure 30 depicts the Isle of Wight, Hastings and Swale/Medway, along with the main urban areas that have the highest rates of incapacity benefit claimants in the South East.

Figure 30:

Map showing rates of Incapacity Benefit and Severe Disablement Allowance claims by Middle Super Output area in the South East, 2005.

© Crown Copyright.
All rights reserved.
OS licence number 03079G0002 (2006).



Source: Neighbourhood Online Statistics (Office of National Statistics).

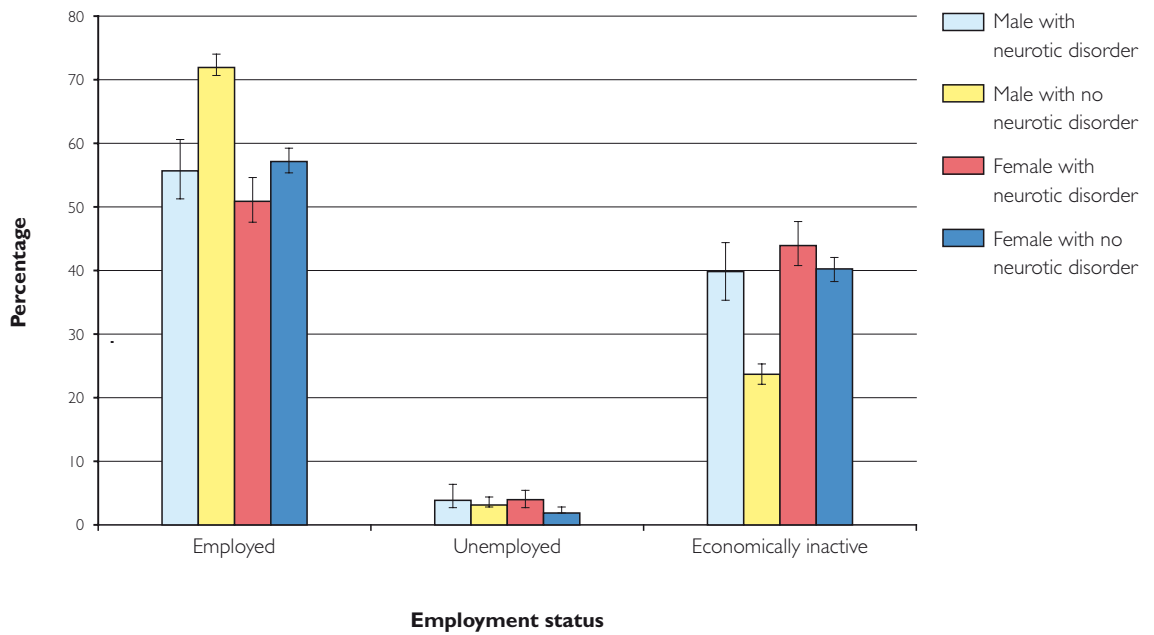
Mental Health and Employment:

- Low control in one's job significantly increases the risk of heart disease, even after accounting for other risk factors;
- The number of days taken off sick due to mental ill health has increased 20% since the 1970s. Stress related absences account for half of all sickness and cost about £4 billion/year. (Layard, 2005);
- Only 24% of people with long-term mental illness are employed – the lowest of any disabled group. Being in employment helps protect peoples' mental well-being. This is a missed opportunity for increasing overall social well-being and costs the economy £23 billion/year. (ODPM, 2004);
- Stress also contributes to physical health problems, including musculo-skeletal problems, alcohol and drug misuse, smoking and heart-disease.

Figure 31 illustrates that being depressed or having anxiety is especially associated with being economically inactive amongst men, whilst employed men are less likely to have a neurotic disorder. A similar pattern is seen in women, but to a lesser degree. However, for adults there is no statistical difference in the rate of having anxiety or depression with educational status or social class.

Figure 31:

Comparison of employment status between adults with and without a neurotic disorder; England 2000



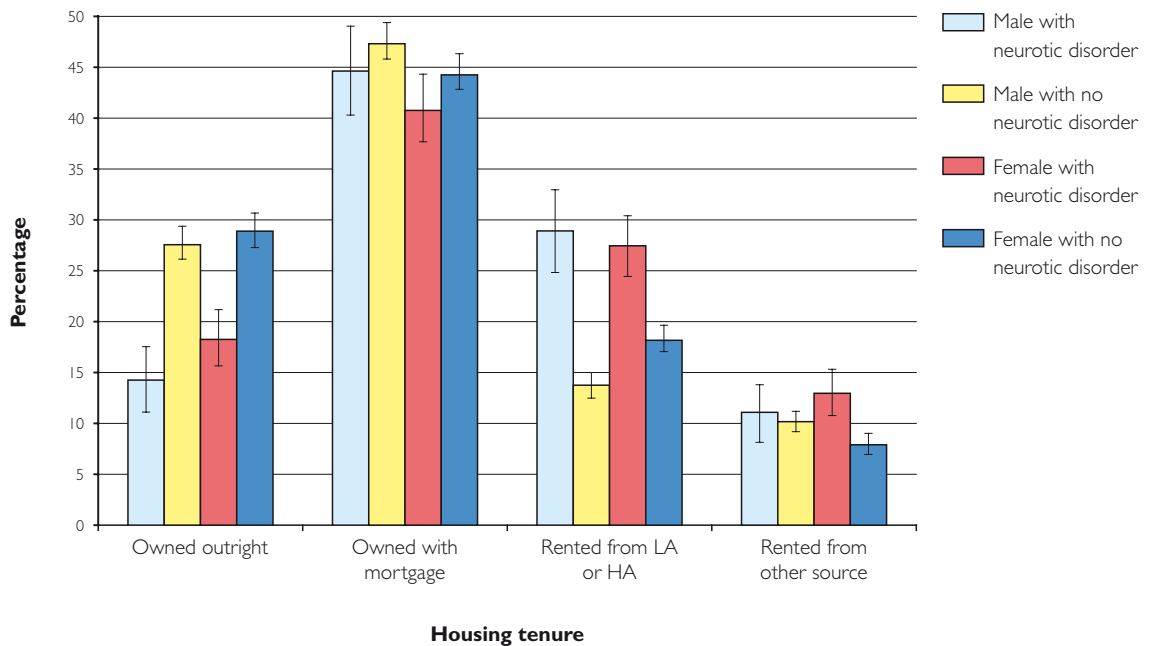
Source: Office for National Statistics, Psychiatric Morbidity Among Adults Living in Private Households, (Singleton 2000)

Housing:

Figure 32 shows that both men and women who have depression or anxiety are more likely to be in Local Authority or Housing Association rented accommodation compared to adults with no neurotic disorder. Conversely, those with no neurotic disorder are more likely to own their property outright.

Figure 32:

Comparison of housing tenure between adults with and without a neurotic disorder; England 2000



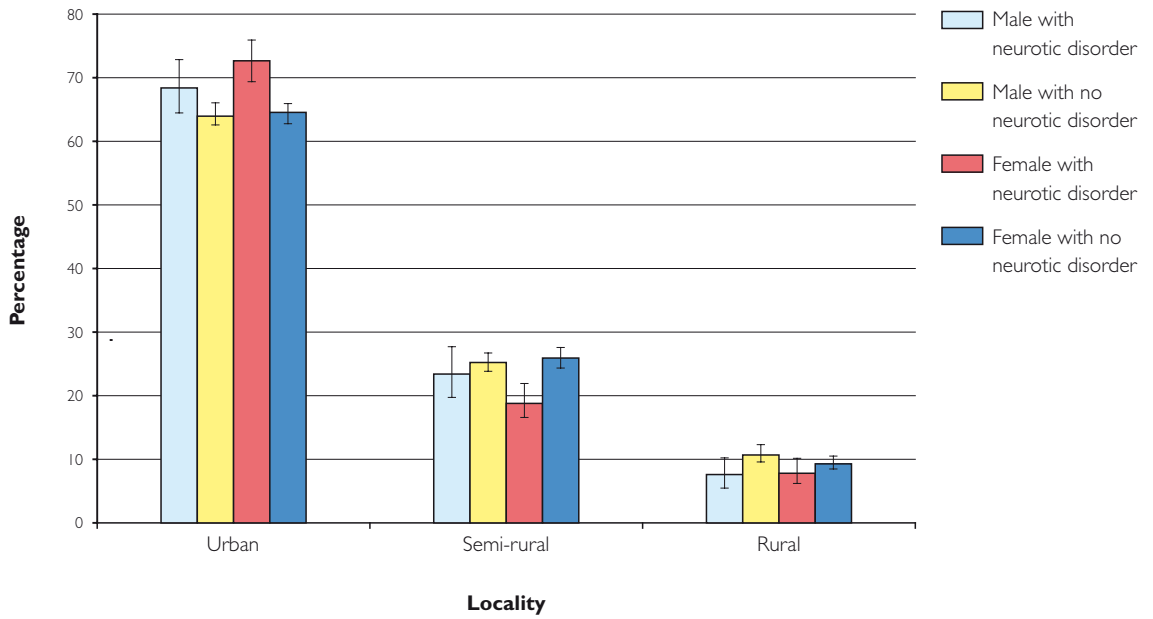
Source: Office for National Statistics, Psychiatric Morbidity Among Adults Living in Private Households, (Singleton 2000)

Urban Versus Rural Location:

Figure 33 shows that living in an urban location is associated with having depression or anxiety, especially for women. The difference is not statistically significant for men. Living in a semi-rural area is associated with lower rates of depression or anxiety (neurotic disorders) for women. The trend for rural areas also supports the association of living in an urban area with a greater risk for having depression or anxiety, although this is not statistically significant. Some of this difference may be accounted for by differences in income.

Figure 33:

Comparison of locality of residence between adults with and without a neurotic disorder, England 2000



Source: Office for National Statistics, *Psychiatric Morbidity Among Adults Living in Private Households*, (Singleton 2000)

4.3 Black and Minority Ethnic Issues (BME)

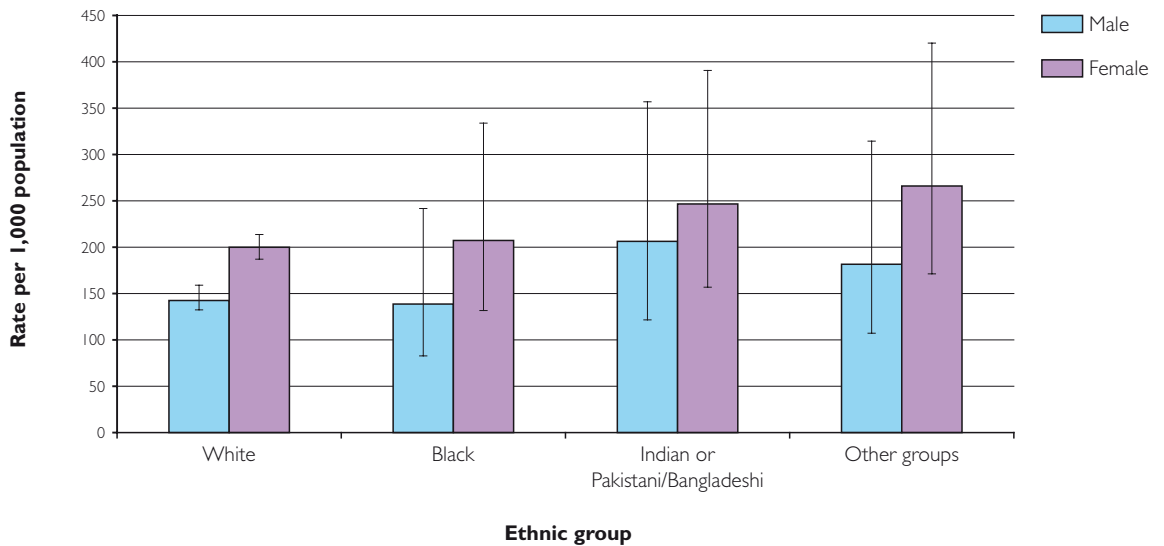
Six per cent of the South East population are from Black and minority ethnic (BME) groups, the majority of whom are Asian or Black. Slough, Reading and Southampton have higher than South East average proportions of BME groups. Mental Health Services are frequently not appropriate or accessible to the needs of BME groups. A new study has highlighted the need for more research into why, compared with the proportion of Black patients in the general population, a much higher proportion of Black patients were admitted to high-security psychiatric hospitals. The study also found that un-met needs were more common among Black than White patients in high security psychiatric hospitals. (Healthcare Commission, 2005).

Higher rates of psychotic disorders have been reported amongst men of Afro-Caribbean origin compared to other BME groups, this may be related to genetic susceptibility or to greater levels of substance misuse. Additionally, higher than expected suicide rates have been reported in young Asian women compared to women from other BME groups. This in part may be related to tensions in fulfilling cultural expectations combined with a lack of appropriate support services.

Figure 34 suggests higher rates of depression and anxiety in Indian, Pakistani and Bangladeshi males and females compared to other BME groups, however this is not statistically significant.

Figure 34:

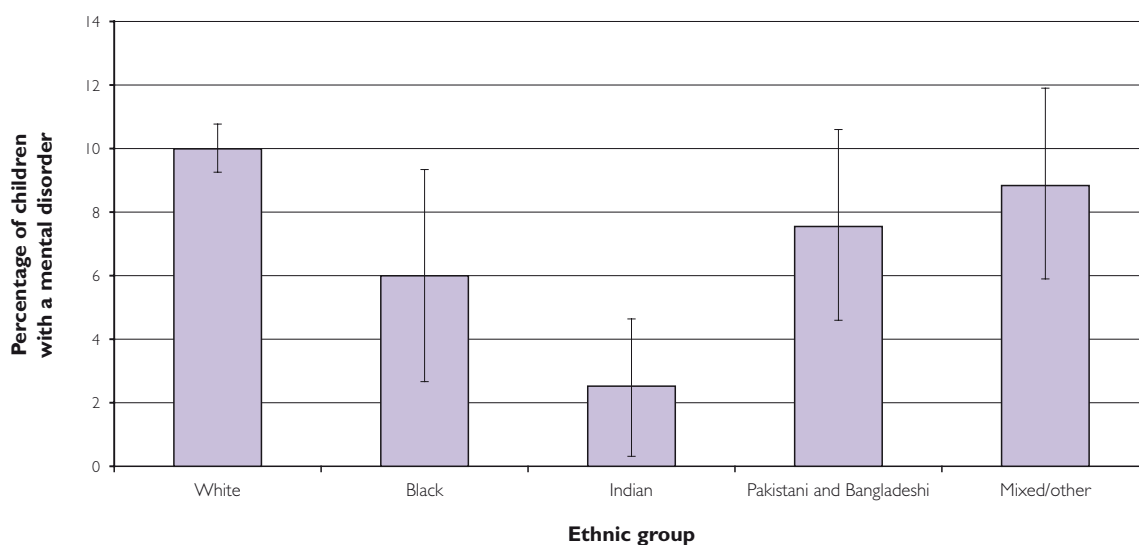
Rate of neurotic disorders by age, sex and ethnic group, England 2000



Source: Office for National Statistics, *Psychiatric Morbidity Among Adults Living in Private Households*, (Singleton 2000)

In children, mental disorders appear to be higher in the white population compared to other BME groups (this is only statistically significant between Indian and White BME groups). This pattern may be influenced by variations in social and cultural norms regarding parenting styles and acceptable childhood behaviour; see figure 35.

Figure 35:
Percentage of children with a mental health disorder by ethnic group



Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

4.4 Gender Differences

Mental health problems are expressed differently in girls and boys, and men and women. Variations in the expression of behaviour are influenced by an interaction of genetics, hormones, socio-economic conditions and cultural norms of gender. Only a small difference is accounted for by genetic predispositions. For example, in psychotic illnesses, which have a stronger genetic component than most mental health problems, there are only slightly more men than women who develop psychotic symptoms (0.5% women compared to 0.6% men).

Hormonal influences, cultural and behavioural norms of gender affect the expression of emotional distress and mental illness. Men and boys are more likely to express their distress externally and women more likely to internalise their distress. Below are the main gender differences seen in mental health problems:

- Rates of conduct disorders are higher in boys compared to girls;
- Rates of emotional disorders are higher in girls than boys;
- Rates of depression and anxiety are higher in women compared to men;
- Rates of personality disorders are higher in men than women;
- Suicide rates are higher in men compared to women.

Cultural norms also influence risk factors for mental health problems. For example, girls are more likely to be sexually abused and be re-victimised in the form of sexual assault and partner violence at a later age. Boys are more likely to experience physical abuse as a child and to perpetrate physical and sexual abuse with acquaintances, partners and children. Additionally, young men, compared to young women, are more likely to express distress in risk taking behaviours, including alcohol and drug misuse, (DH, 2002). Some of these issues are explored in the following sections.

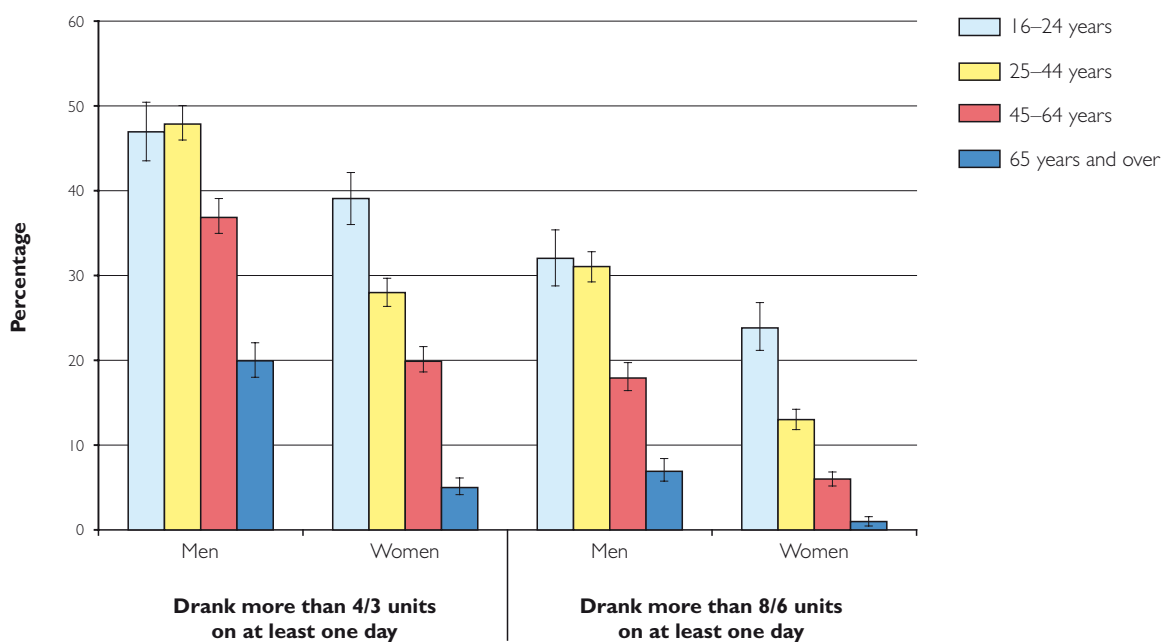
4.5 Addressing Substance Misuse

Alcohol

Figure 36 shows that high levels of young men (46%), and to a lesser extent, young women (39%), drink more than the recommended limits. Men are more likely than women to be dependent on alcohol (12% vs. 3%) or hazardous drinkers (38% vs. 15%). Rates in the South East are not substantially different from the England average.

Figure 36:

Percentage of adults drinking over the recommended drinking limits in the previous week by sex, Great Britain, 2004.



Source: General Household Survey, 2004.

Growing up with one or more adverse childhood experiences (emotional, physical or sexual abuse, a substance abuser in the household, mental illness, incarceration, parental domestic violence, separation or divorce), is associated with a 20–70% increased likelihood of initiating alcohol use during mid adolescence. The higher the number of adverse events, the stronger this association was found to be. This trend was found across four birth cohorts, suggesting exposure to early trauma transcends secular approaches to reduce alcohol misuse in young people, (Dube, 2006).

In adulthood, a longitudinal study of mental health found that, especially for women, the risk of developing hazardous drinking increased following two or more stressful life events, (Singleton, 2003). People with a common mental disorder were twice as likely to have a dependency on alcohol than those without a mental health problem, and people with a severe and enduring mental illness are at least three times more likely to be alcohol dependant compared to the general population, (Cornah, 2006).

Alcohol gives an initial sense of euphoria and is used to numb feelings of anxiety or depression. However, alcohol depletes levels of serotonin, which contributes to depressive symptoms. A third of suicides in young people are linked to alcohol intoxication and 65% of suicides in the adult population are associated with excessive drinking. Additionally, alcohol depresses the central nervous system, and disinhibits underlying feelings, which is why people are more likely to become angry, aggressive or sexually aroused when intoxicated, (Cornah, 2006). This explains why alcohol is associated with the perpetration of violent and abusive behaviour, (Haggard-Grann, 2006), which as seen later, as a victim, contributes to poor mental health.

Table 2 summarises the evidence of effective approaches to reduce alcohol related harm including the impact of alcohol on mental health and on violent behaviour, (Alcohol Harm Reduction Strategy, 2004, and NICE evidence summary).

Alcohol screening is used to detect those individuals who are drinking above sensible levels, and can be done in primary care or during a mental health assessment.

Brief intervention refers to advice and information that can be provided opportunely within a 5–10 minute interval but can also extend to a few sessions of motivational interviewing or counselling. These interventions tend to be targeted at those drinking in a hazardous or potentially harmful fashion rather than dependent drinkers. By their very nature they are ideally suited to settings like primary care, A&E and a range of criminal justice venues making the most of opportunities with individuals who are in difficulty as a result of their alcohol consumption.

Table 2 Summary of what works to reduce alcohol consumption

<p>Individual/Community:</p> <ul style="list-style-type: none"> • Availability and price/strength of alcohol; • Alcohol exclusion zones; • Blood alcohol concentration laws (80mg alcohol/100ml blood) can reduce alcohol related crash fatalities; • Sobriety checkpoints are effective; • Ignition interlock devices; • Server training programmes.
<p>Brief Interventions for a range of drink problems:</p> <ul style="list-style-type: none"> • Brief interventions for heavy drinkers moderates drinking; • Multi contact brief interventions can reduce net weekly drinking; • Extended brief interventions in primary healthcare settings decreases alcohol intake in women; • Extended brief interventions in primary healthcare are effective for men and women for hazardous consumption; • Cognitive behaviour interventions by nurse practitioners or brief advice reduces consumption; • Brief interventions in opportunistic (non-treatment settings) samples and delivered by healthcare professionals; • Self help manuals are effective at reducing at-risk and harmful drinking especially with those seeking help and identified via screening; • Increase engagement by GPs in screening and giving advice for hazardous and harmful consumption.
<p>Treatment for heavy/hazardous drinking:</p> <ul style="list-style-type: none"> • Community structured counselling and therapy; • Community detoxification via primary care; • Specialised residential services; • Self help groups.

Drugs

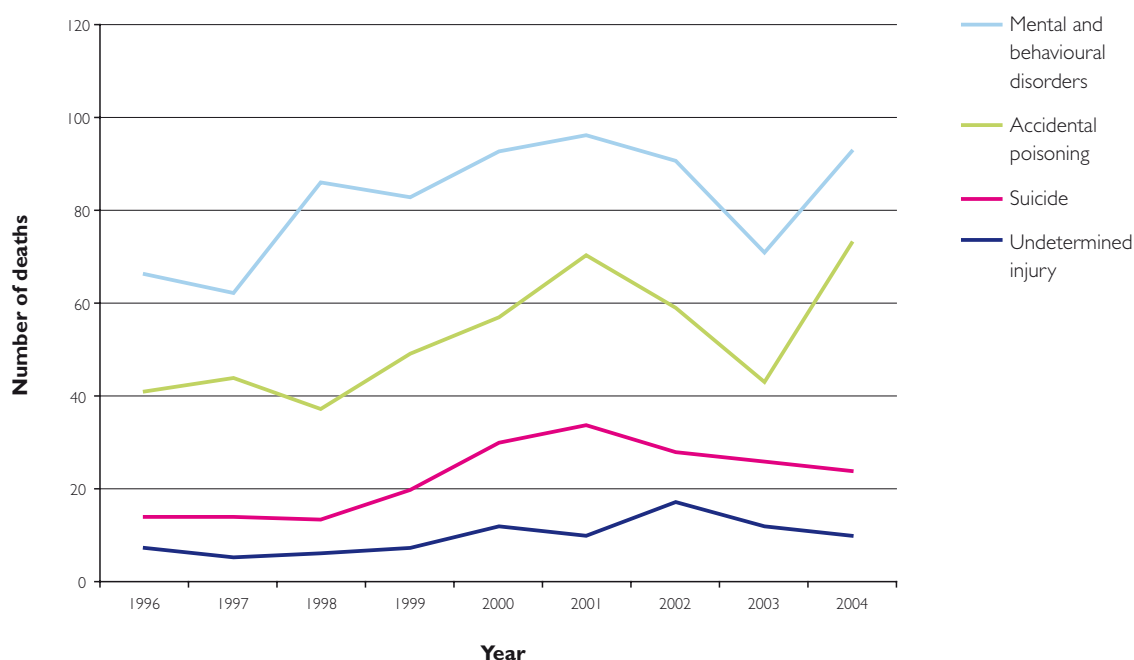
In the general population, the lifetime prevalence for cannabis use is 24%; for amphetamines 7%; for ecstasy, cocaine or LSD 4%; for glue 1% and less than 1% for crack or heroin. The overall prevalence for any drug is 4%, for which cannabis use is reported most commonly at 3%. Drug misuse is higher in men compared to women, (32% vs. 21% ever taken drugs). For more general information about substance misuse, see the recent SEPHO report on Drugs in the South East at www.sepho.org.uk

One in twenty 16-64 year olds from the general population had taken any drug in the last year. This compares with one in eight people reporting a mental health problem in the ONS psychiatric morbidity survey on tobacco, alcohol and drug use and mental health, (Coulthard, 2000). In comparison, 31% of adults receiving mental health services reported problem drug use in the past year (Weaver, 2002).

Drug misuse is higher in prisoners, with over 60% of prisoners reporting drug use in the last year, (Singleton, 1997). Drug related deaths are frequently related to mental health problems as can be seen in figure 37 A particular high-risk time for drug overdose is following release from prison.

Figure 37:

Number of drug-related deaths by cause in the South East from 1996–2004.



Source: Office for National Statistics

A longitudinal population study found that the onset of higher levels of symptoms of common mental disorders (depression and anxiety), or of stressful life events between interviews, were associated with increased rates of onset of drug use at follow-up, (Singleton, 2003). Anxiousness or depression in childhood are associated with later increased use of ecstasy (Hazard ratio 2.22, CI: 1.20-4.11), (Huizink, 2006).

There is growing evidence from cohort studies that earlier use of cannabis increases the risk of developing schizophrenia, (sole use of cannabis 50 or more times increased the risk of developing schizophrenia by 6.7 (CI: 2.1-21.7), (Zammit, 2002). Cannabis affects dopamine processing in the brain, which biochemically is related to psychosis and can worsen psychotic symptoms. However, the majority of people who use cannabis do not develop schizophrenia, (Fergusson, 2006).

Substance misuse (alcohol and/or drugs), is strongly associated with increased rates of relapse, readmission to hospital, violence and suicidal behaviour. Significantly poorer clinical outcomes are evidenced among psychiatric clients who are substance misusers. Substance misuse is usual rather than exceptional among people with severe mental health problems. Individuals with these dual problems require high quality, patient-focused and integrated care that should be delivered within mainstream Mental Health Services, (DH 2002). An integrated approach is summarised below:

- Assigning a senior management lead in both the mental health Trust and substance misuse service;
- Development of joint treatment protocols between mental health Trust and substance misuse;
- Ensure recording and monitoring of mental health problems and substance misuse problems at assessment and where appropriate referral to specialist services;
- Training of staff in mental health trusts on substance misuse;
- Training of staff in substance misuse centres on mental health problems;
- Provision of information on the combined effects of substance misuse on mental health and vice versa for users of services;
- The effective representation of mental health services on Drug and Alcohol Action Teams and of Drug and Alcohol Services on Local Implementation Teams, is a necessary step to provide comprehensive services for individuals with dual diagnosis.

Dual Diagnosis Good Practice Guide, DH 2002, addresses the neglected issue of treating people with substance misuse and mental health problems in a holistic way: ensuring greater joined up working between mental health and substance misuse services, with training and awareness, screening and assessment, service models and care pathways. www.doh.gov.uk/mentalhealth

Tobacco and Mental Health

In the ONS population survey, people with anxiety or depression are more likely to smoke (and smoke more heavily) than the general population, (44% compared to 27%), whilst 64% of those with probable psychosis were smokers compared to those without psychosis (Coulthard, 2000).

Depression in earlier adolescence, predicted onset of smoking in later adolescence and teenagers who smoke are more likely to develop symptoms of depression later (Brown, 1996). Smoking tobacco increases the risk of anxiety disorders during late adolescence and early adulthood, (Johnson, 2000); and anxiety predicts the uptake of smoking (Patton, 1998; Sonntag, 2000). Anxiety and depression occur less in ex-smokers than current smokers and perceived stress levels reduce on stopping smoking but increase again following relapse, (Cohen and Lichtenstein, 1990). The effects of nicotine appear to benefit negative symptoms of schizophrenia, but make positive symptoms worse. Smoking reduces average life expectancy by 8–10 years, and overall is likely to represent a greater loss of life and life years than the 10–15% lifetime risk of death from suicide in those with psychotic illnesses.

There is no clear evidence that smoking cessation exacerbates psychotic illness, (Smith, 1999) or that it causes depression or anxiety. Additionally, there is no evidence for increased aggression or deterioration of mental health after introduction of smoke-free policies in mental health settings. Psychological problems decreased significantly in smokers who stopped for 6 months (Mino, 2000) and anxiety reduces in the first week of abstinence, (West, 1997).

High levels of smoking amongst people with mental health problems are not inevitable. Smoking cessation treatments are cost-effective, and smoke free policies in mental health settings have been applied successfully without detriment to staff or patients. In order to reduce smoking related health inequalities, smoking cessation support needs to be targeted at those with mental health problems and mental health staff. Additionally, smoke free policies within mental health trusts including community settings, need to be introduced in a consistent, pragmatic and co-ordinated way, (Campion, 2006).

4.6 Violence and Abuse

The following section describes the extent of violence and abuse within the South East, whilst sections 5.1, 5.7 and 5.9 outline effective approaches to promote safety and prevent violence and abuse.

Violence and abuse (including child abuse, partner abuse, youth violence, bullying and sexual assault) are common though often hidden occurrences, especially in the younger age groups. See the glossary for definitions used by the British Crime Survey for intimate violent crimes and table 3 for percentages of different forms of all types of violence and abuse in the general population. Experiencing violence and abuse has a number of negative consequences on mental health described below:

- Adverse childhood experiences of one of either: emotional, physical or sexual abuse, household substance abuse, mental illness, incarceration, parental domestic violence, separation or divorce; increased the lifetime risk of attempted suicide by 2-5 fold, compared to no adverse childhood experiences. The more adverse experiences the greater the risk, (Dube, 2001).
- A history of child abuse (emotional, physical or sexual), increases the risk of lifetime prevalence of depression 1.8–2.7 times for women and 1.6–2.6 times for men, compared to no history of child abuse, (Chapman, 2004).
- Children who have been abused or witnessed family violence, are more likely to show aggressive and anti-social behaviour; have low self-esteem and do less well at school, (Dixon, 2006).
- Abuse in childhood alters brain functions in the limbic system, producing symptoms of reduced impulse control, hyperactivity, withdrawal and dissociative disorders, and Post Traumatic Stress Disorder- PTSD (Glaser, 2000). All of which can be expressed as emotional, conduct or hyperkinetic disorders in childhood, with PTSD, depression and personality disorders in adulthood.
- Men or women who have been abused or been victims of intimate violence (psychological, sexual or physical abuse) have higher rates of mental health problems, including depression, anxiety, Post Traumatic Stress Disorder, Personality Disorders, and substance abuse (Coker, 2002; Krug, 2002).
- High background levels of community violence is associated with higher levels of depressive symptoms, (Nicolaidis, 2004); and bullying and youth violence are associated with poor mental health (Krug, 2002).

- Depressed women in primary care, are nearly six times more likely to have a history of physical, emotional or sexual partner abuse, compared to non-depressed women, (Hegarty, 2004). Over 90% of suicidal inpatients reported Intimate Partner Violence perpetration and victimisation in their relationships in the past year (Heru-Alison et al 2006).

Table 3 Prevalence of Violence and Abuse- Percentage in England/ UK from population surveys experiencing violence or abuse at least once in their lifetime.

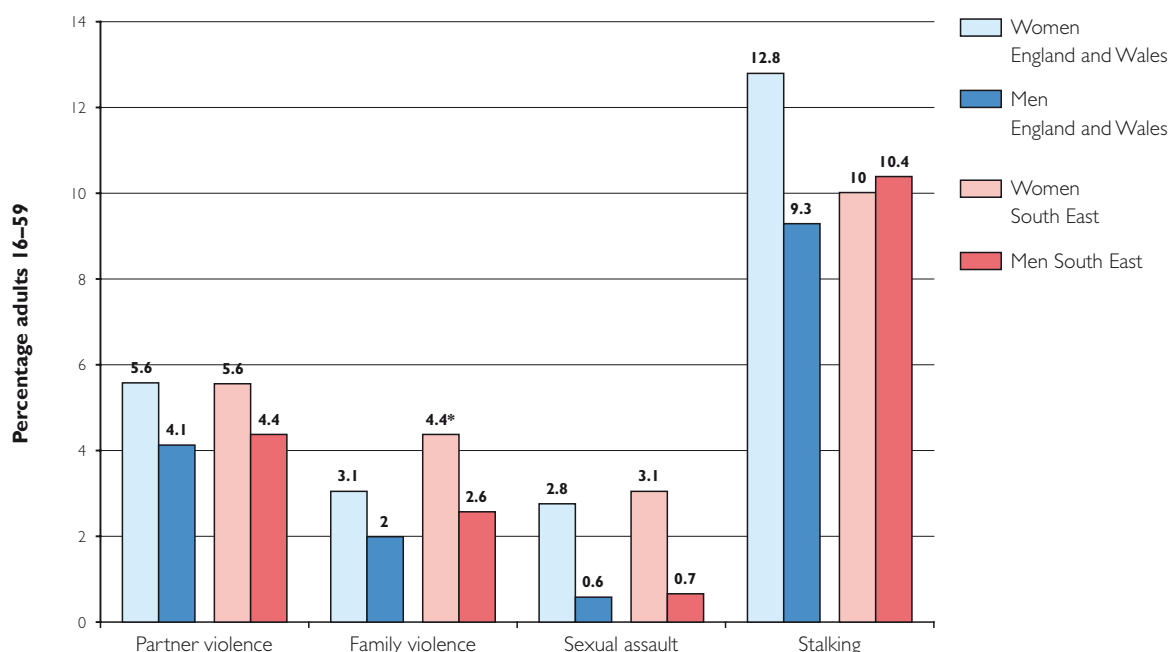
Type of Violence	Female	Male	Source and location of study
Child Sexual Abuse (all forms and contact abuse)	21% all forms 16% contact abuse	11% all forms 7% contact abuse	Cawson, 2000 NSPCC UK study
Child Physical Abuse (violent treatment from anyone)	23%	27%	Cawson, 2000 NSPCC UK study
Child Emotional Abuse (humiliation by parents)	20%	16%	Cawson, 2000 NSPCC UK study
Bullying (10–14 year olds at school)	46%	43%	Smith, 2000 England
Youth Violence (16–24 year old victims of violent crime in last year)	7.6%	15.5%	Dodd, 2004 England & Wales
Sexual Assault and Rape (16–59 year olds ever experienced)	Sex Assault: 23% Rape: 5%	Sex Assault: 3% Rape: 0.4%	Finney, British Crime Survey, 2004/5
Partner Abuse (non-sexual) (16–59 year olds ever experienced)	25%	16%	Finney, British Crime Survey, 2004/5

Figure 38 Illustrates how women experience higher rates of intimate violence, (partner; family and sexual violence) compared to men. In the South East rates of different forms of intimate violent crimes are similar to England and Wales averages. The exception to this is higher rates of family abuse/violence in the South East compared to other regions and the England and Wales average. Over 1 in 10 men and women experienced being stalked in the last year in the South East.

Figure 38:

Percentage of adults aged 16–59 who were victims of intimate violence in the last year by type. South East Region compared to the England and Wales average, 2004/05.

* indicates a statistically significant difference from the average.



Source: British Crime Survey 2004/05 (Home Office, 2006)

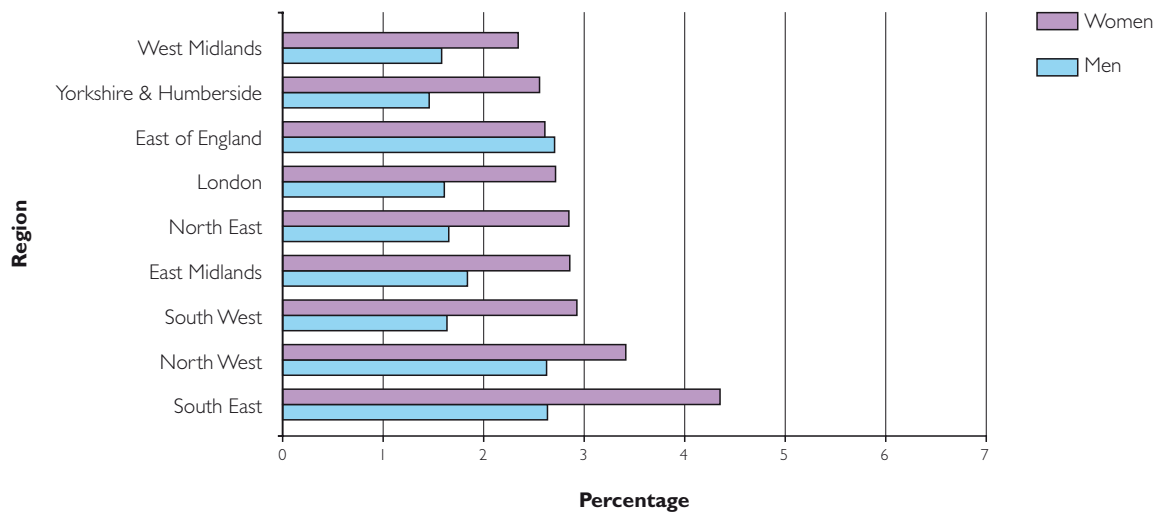
Recent Home Office data shows that from a peak in 1995, there is an overall downward trend in violent crimes (domestic, mugging, stranger and acquaintance violence) from the annual population British Crime Survey (BCS). However, there has been a small increase in violent crimes recorded to the police. This pattern may relate to the beginning of a reduction in societal tolerance to violence. The increase in police reported violent crimes was higher in the South East compared to the rest of England (5% vs. 2%) between 2004/5–2005/6. Hampshire had a higher rate than the English average (24 vs. 23/1000 population) for recorded violent crime in 2005/6, whilst Kent has had the largest percentage increase in recorded violent crime of 16% between 04/05 to 05/06. There has been a substantial increase in perception of anti-social behaviour and fear of crime across England with similar rates mirrored in the South East.

There are higher rates of violent crime in urban areas compared to rural areas and in areas of deprivation compared to least deprived areas. Being young, single or separated was also a risk factor for violent crime. Young men, aged 16–24 were at greatest risk of being a victim of violent crime, with one in eight experiencing some sort of violent crime in the previous year before the BCS interview. Nearly half (48%), of all BCS violent offenders in 2004/5 were under the influence of alcohol, this compares to 40% in 1995. However, at present there is no clear trend in violent crimes following the introduction of the extension of alcohol licensing hours in November 2005, (Home Office, 2006).

Figure 39 shows that over 4% of women in the South East experienced some form of family abuse in the last year, and that this rate is higher than other regions in the country. The England and Wales average prevalence of family abuse since the age of 16 is 12% for women and 9% for men, (Home Office, 2006). Having a limiting illness or disability is more strongly associated with family abuse than other forms of intimate violence. Figure 40 shows that young age, especially for women is a strong risk factor for family abuse.

Figure 39:

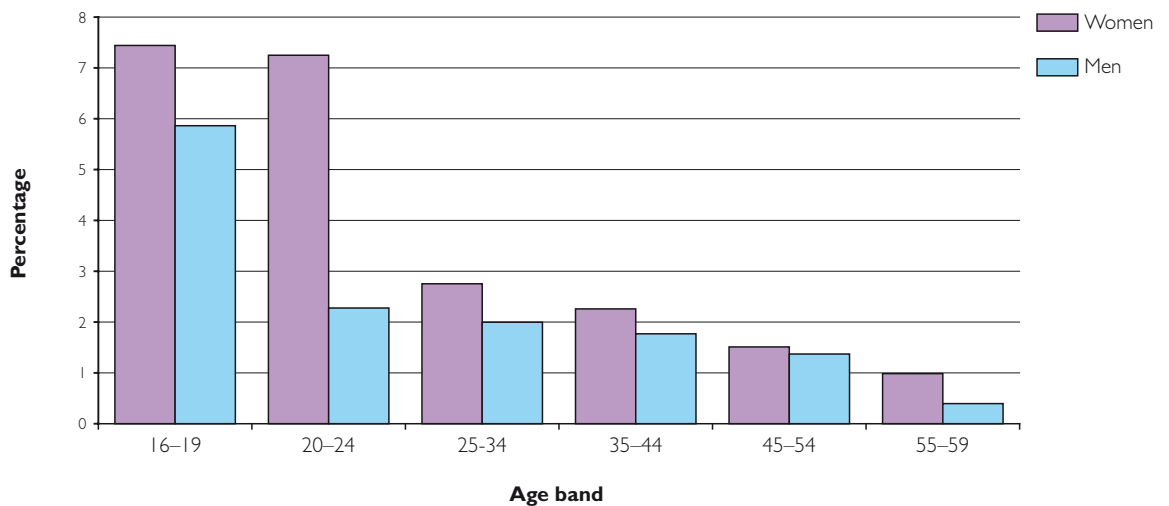
Percentage of adults aged 16–59 who are victims of family abuse (non-sexual) by Region in the last year, 2004/05.



Source: British Crime Survey 2004/05 (Home Office, 2006)

Figure 40:

Women and men experiencing non-sexual family abuse by age in the last year, 2004/05.



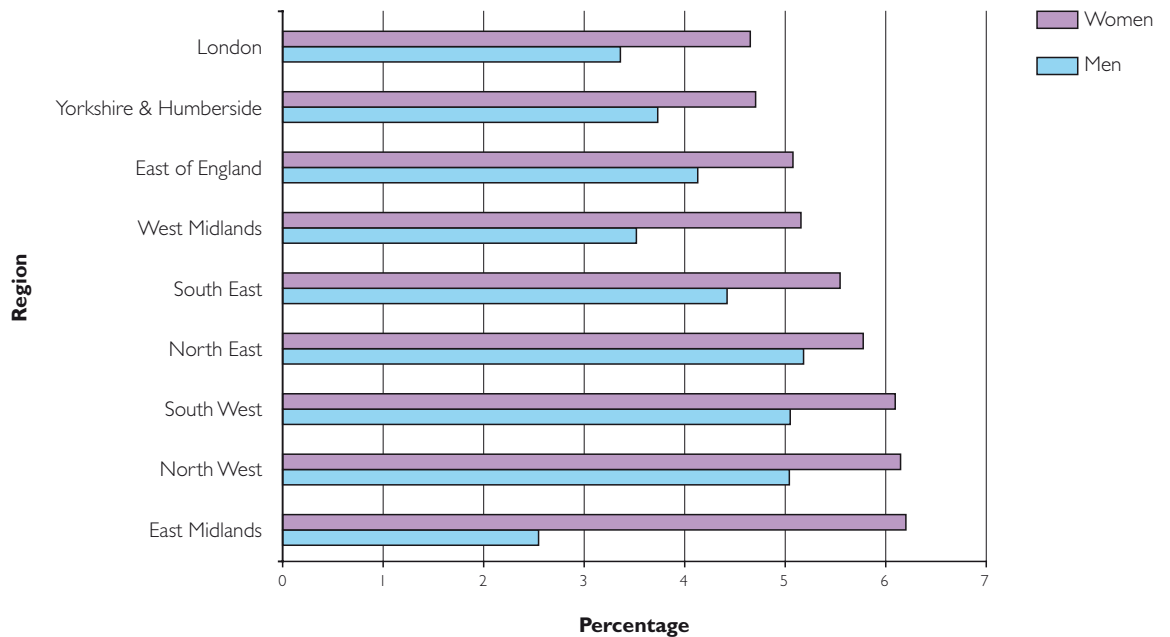
Source: British Crime Survey 2004/05 (Home Office, 2006)

The prevalence of non-sexual partner abuse, (frequently referred to as domestic violence or abuse), in England and Wales, since the age of 16 is 28% in women and 18% in men. Figure 41 shows that in the last year, over 5% of women and 4% of men will have experienced partner violence in the South East, which is similar to other regional rates. Women are more likely to be repeatedly victimised, more severely injured and have more negative consequences upon their mental health than men experiencing partner violence.

Pregnancy is a high-risk time for the onset or worsening of partner abuse. More frequent visits to the pub was found to be associated with increased levels of partner abuse, stalking and sexual assault and probably reflects the association of alcohol consumption and violence, (Home Office, 2006).

Figure 41:

Percentage of adults aged 16-59 who are victims of partner abuse (non-sexual) by Region in the last year, 2004/05.

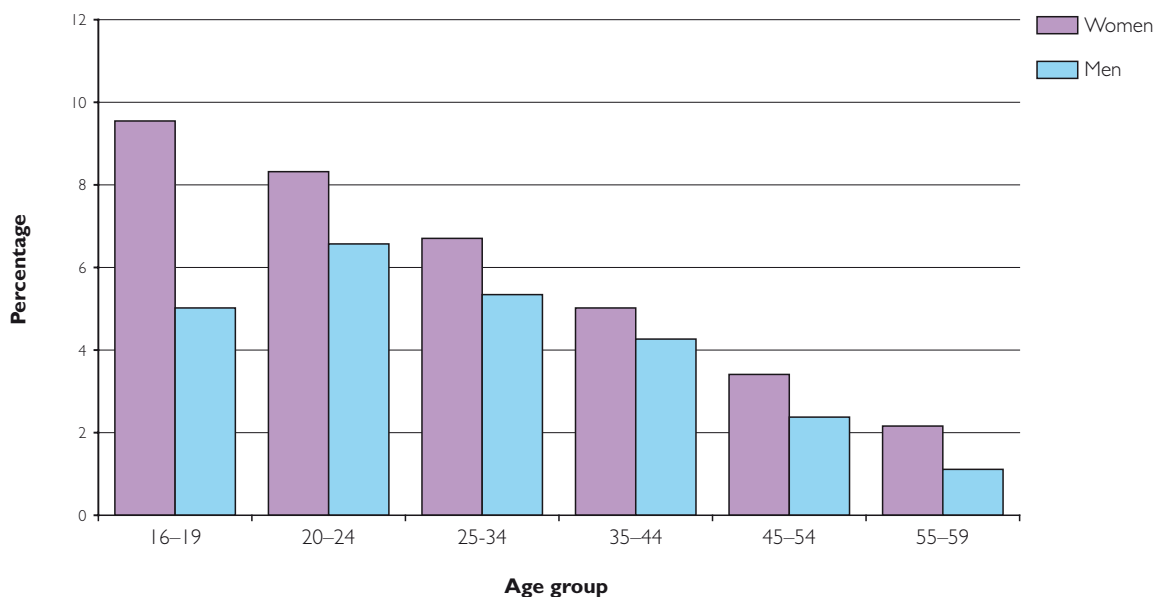


Source: British Crime Survey 2004/05 (Home Office, 2006)

Figure 42 illustrates that younger women in particular are at higher risk of experiencing partner or domestic violence, with nearly one in ten 16-19 year old women experiencing partner violence in the previous year. This risk goes down with age for both men and women; this pattern may reflect increasing maturation with age in dealing with conflict and power tensions in relationships, decreases in binge drinking patterns, and also separation from previously violent relationships.

Figure 42:

Women and men experiencing non-sexual partner violence (domestic violence or abuse) by age in the last year, 2004/05.



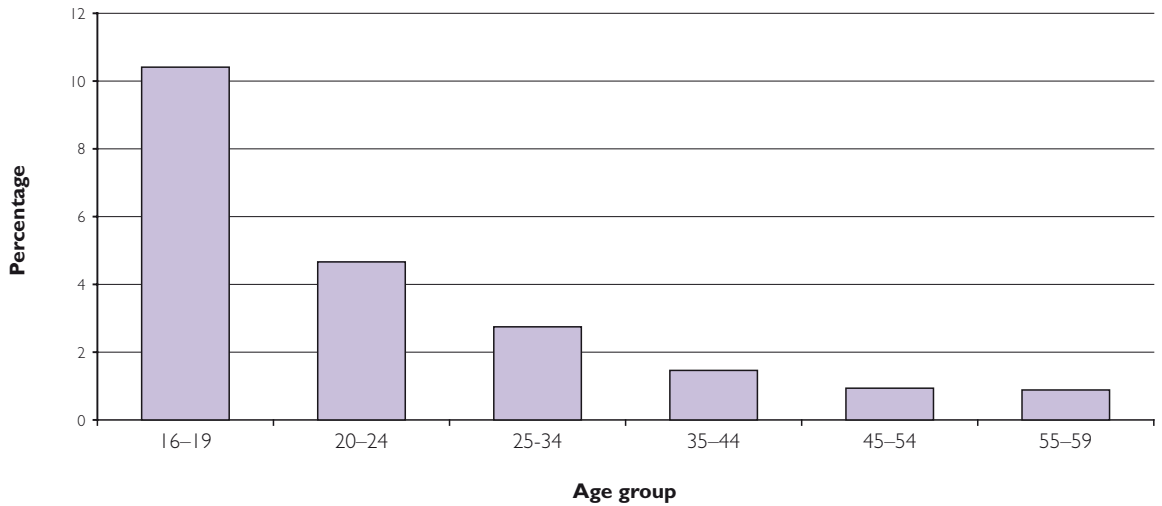
Source: British Crime Survey 2004/05 (Home Office, 2006)

Figure 43 from the British Crime Survey, illustrates how younger women are at considerably higher risk of sexual assault than older women, with over one in ten 16–19 year old women being sexually assaulted in the previous year compared to approximately one in a hundred women aged over 40.

Nearly one in four (23%) women will have experienced a sexual assault since the age of 16, compared to 3% of men. Whilst approximately one in twenty women will experience a serious sexual assault, including rape and attempted rape, since the age of 16, compared to less than 1% of men, (Home Office, 2006). In the South East there were a total of 9,144 sexual offences reported to the police during 2005/6, with the highest number in Hampshire at 2,701.

Figure 43:

Women experiencing sexual assault by age in the last year, 2004/05.



Source: British Crime Survey 2004/05 (Home Office, 2006)

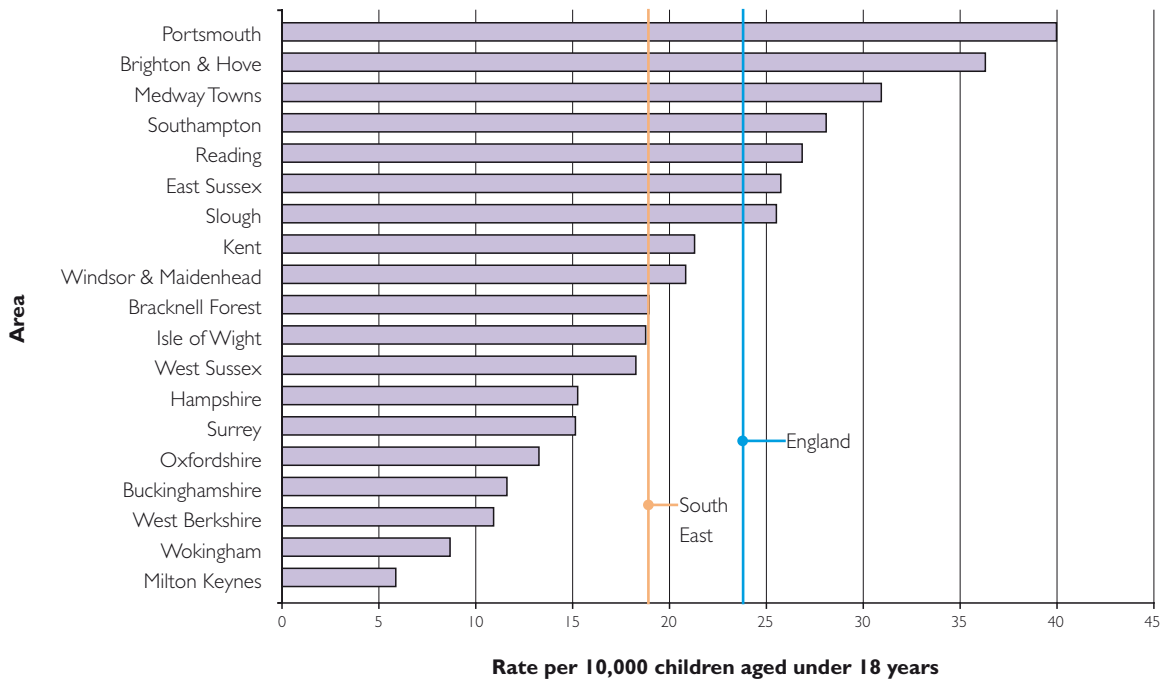
4.7 Vulnerable Young People

Child Protection and Looked After Children

Children on the Child Protection Register and Looked After Children and those on local Child Protection registers are a particularly vulnerable population. They have higher rates of adverse childhood experiences, including physical, sexual and emotional abuse or neglect, compared to children in the general population. Figure 44 shows variations in rates of children on child protection registers, with higher rates in Portsmouth, Brighton and Hove, Medway and Southampton compared to England and the South East.

Figure 44:

Rates of children aged under 18 on the child protection register in the South East at 31 March 2004.



Source: Department for Education and Skills (DfES)

Looked After Children are 6-8 times more likely to have a conduct disorder than children in the general population, (36.5% vs. 4.6% of 5–10 year olds, and 40.5% vs. 6.2% of 11–15 year olds). They are also 2–3 times more likely to have an emotional disorder, and 5–7 times more likely to have a hyperkinetic disorder, compared to children in the general population. Girls were more likely to have an emotional disorder with increasing age.

Having any of the mental disorders (emotional, conduct or hyperkinetic), increased the likelihood of truancy or being in trouble with the police, compared to no mental disorder. All of the mental disorders, and especially hyperkinetic and conduct disorders, are associated with poor performance at school. This reflects that some of the mental disorders are associated with learning difficulties, however, being distressed also affects learning.

Looked After Children with emotional and conduct disorders are several times more likely to smoke, drink alcohol, take drugs or have early sexual intercourse, than Looked After Children with no disorder or children in the general population, (Meltzer, 2002). A follow-up study of Looked After Children found they were 4–5 times more likely to attempt suicide and 4–6 times more likely to be admitted to hospital with a mental illness as a young person, compared to their peers. Children in long-term care had the worst outcomes, (Vinnerljung, 2006).

4.8 Lesbian, Gay, Bisexual and Transgender People (LGBT)

A study in 2003 compared the mental health of over 1,000 gays and lesbians with over a 1,000 heterosexual men and women in England and Wales. They found that lesbians and gay men were more likely than heterosexuals, to experience:

- Violence, harassment or bullying at school or as an adult;
- Psychological distress and self-harm.

However, mental health services were seen as difficult to access and insensitive regarding issues to do with sexuality. (King, 2003).

Other research has found high rates of depression, substance misuse, self-harm and suicide amongst lesbian, gay, bisexual and transgender people, when compared to the general population. This risk seems particularly high with young LGBT people, with a 2–3 times greater risk of suicide compared to young people in the general population. This risk has been found to be associated with homophobic bullying at school. As many as 20–42% of gay men have attempted suicide. These high levels of suicide in young gay men especially, can be seen to account for a proportion of excess suicides in young men across the country, (Scott, 2004). The first case study (1) is a description from a project in the South East on how being LGBT impacts upon mental health, followed by a description of what MindOut does to promote mental health (case study 2).

Case Study 1: from MindOut, Brighton

How discrimination affects the mental well-being of LGBT People:

Lesbian, gay, bisexual and transgender people will and do encounter homophobia and transphobia in their daily lives, in their family and friendship networks and within health and social care services. Many will encounter bullying, victimisation and assault. This can have a pernicious effect on their mental health and on their vulnerability to the whole range of mental health problems.

Homophobic and transphobic beliefs were, until very recently, enshrined in law and in psychiatric practice. As a result, many LGBT people are very reluctant to use primary or secondary mental health services, believing that their sexuality or gender identity will be pathologised and patronised. Internalised homophobia and transphobia is widespread and can lead to and exacerbate mental health problems.

LGBT people are vulnerable to low self-esteem, depression, suicidal distress, self harm, anxiety disorders, alcohol and substance misuse. Risk of self-harm, suicide and substance misuse is higher than in heterosexual populations.

Case Study 2: Mindout – Lesbian, Gay, Bisexual and Transgender Mental Health Services

MindOut in Brighton, provides a service run by and for LGBT people providing:

- Advice and information;
- Advocacy;
- Support, self-help and social groups;
- Training for mental health service providers.

They lobby for homophobia and heterosexism awareness within mental health services and to reduce the stigma experienced by people within the LGBT community.

For more information email info@gbtmind.com or visit www.lgbtmind.com

4.9 Prisons and Offenders

Prisoners and ex-offenders are a group at particularly risk of mental health problems, and by not addressing their mental health problems contributes to re-offending. As children, many of them have a history of being abused, learning difficulty, being looked after as children or running away from home (which is associated with a history of child abuse). As young people, their distress from earlier life events is frequently expressed as conduct and behaviour disorders, leading to school exclusion, anti-social and offending behaviour that often leads to custodial care. These individuals then graduate to become the prisoners with personality disorders, depression and anxiety, and substance misuse.

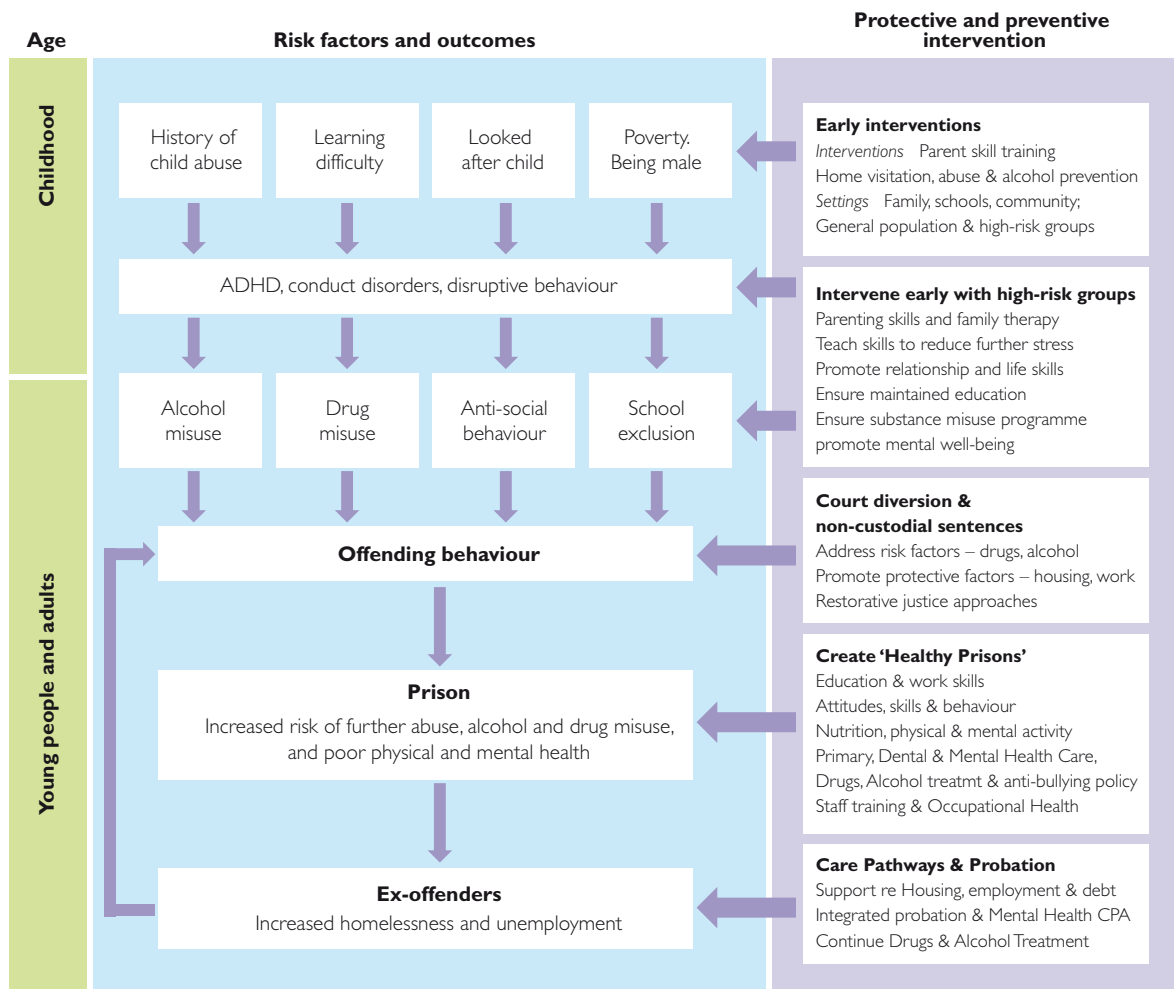
There is also a higher proportion, compared to the general population, of men and women in prison who have a serious mental health problem, including psychosis. Additionally, the majority of prisoners have some degree of learning difficulty, with over one in 10 remand prisoners having an IQ under 65. For male and female prisoners, 27% have been in care as a child, compared to 2% in the general population. Table 4 summarises the proportions of mental health problems in prisoners compared to the general population.

Female prisoners make up only 6% of all prisoners, however, over the last 10 years there has been a 192% increase in women prisoners. Ninety per cent have a mental health or substance misuse problem. A higher proportion of female prisoners have a psychotic illness or have a serious drug dependency compared to male prisoners. There are also high levels of self-harm and suicide in female prisoners, which in part relates to high levels of abuse. Fifty per cent of female prisoners having suffered abuse – 33% physical, 33% sexual and 33% both. Many are imprisoned on minor charges, however only 5% of prisoners' children remained with other family at home during their mother's imprisonment, (Butler, 2006). Figure 45 illustrates the opportunities to intervene early to prevent youth offending and to reduce re-offending; further information on reducing re-offending can be found in the South East Regional Reducing Re-offending Strategy, (NOMS, 2006).

Table 4 Percentages of male and female prisoners with mental health problems compared to the general population, (Singleton, 1997; Singleton, 2001; and Coulthard, 2002)

Mental Health Problem	Male			Female		
	Remand	Sentenced	General Population	Remand	Sentenced	General Population
Depression or Anxiety	26%	19%	12%	36%	31%	16%
Psychosis	10%	7%	0.5%	14%		0.4%
Personality Disorder	78%	64%	5.4%	50%		3.4%
Self-Harm	5%	7%	-	9%	10%	-
Suicide attempt – ever	27%	20%	-	44%	37%	-
Sexual abuse (NB variation in definitions)	10%		11%	33%		21%
Hazardous drinking	58%	63%	38%	36%	39%	15%
Heroin in the last year	29%	21%	<1%	41%	26%	<1%
Crack-cocaine in the last year	24%	18%	<1%	32%	20%	<1%

Figure 45:
Preventing Youth Offending and Reducing Re-Offending (Nurse J, 2005)



4.10 Learning Disability

The estimated number of people with mild learning disabilities in England is 1.2 million, with 210,000 people (65,000 children, 120,000 adults of working age, 25,000 older people) in England estimated to have severe learning disabilities. The estimated figure for the South East region is 34,000 people.

Between 25–40% of people with learning disabilities also have mental health problems. Twenty three per cent of adults with learning disabilities have experienced physical abuse, and a high proportion have experienced sexual abuse, 47% of adults with learning disabilities have experienced verbal abuse and bullying. People with learning disabilities have a high level of unrecognised illness and reduced access to health services and health promotion activities, (Valuing People, the story so far, DH, 2005).

Social exclusion is a further contributory factor to poor mental health for people with learning disabilities. One in twenty (5%) people with learning difficulties have no friends and do not see anyone from their family. Only 17% of people with learning difficulties of working age have a paid job, compared with 67% of men and 53% of women without learning difficulties. Case Study 3 highlights the impact of social exclusion upon mental health. (ONS, 2003/4)

Case Study 3: KeyRing Living Support Networks

How having a learning disability affects mental health

Mary cannot remember much about growing up or her family. Files from her previous life, prior to KeyRing, do have her life history detailed and Mary does not have access to it. Little is known about her past relationships. The only history Mary can recall relates to living in hospitals and hostel/institutional accommodation.

Having spent so many years in institutional settings Mary had little involvement in her local community, she was, and still is, very anxious about going anywhere new. Her GP is very supportive but likes Mary to go to the surgery with support staff. At Care Planning meetings the professionals involved tend to discuss and make decisions without really involving Mary.

4.11 Stigma and Social Exclusion

Our society still misunderstands mental health problems and this leads to discrimination against people with mental health problems as being a source of additional stress and a major reason for social exclusion. This prejudice makes it difficult for people with mental health problems to work, participate in communities and enjoy family life. Negative media coverage continues influence public perceptions and to make discrimination acceptable. The stigma associated with mental health problems, including social exclusion, contributes to continued poor mental health and can act as “barrier” to developing many of the protective factors for well-being described in the next section (OPDM, 2004). The Louis Appleby quote in table 5 highlights how unacceptable this discrimination is.

Table 5 National Director for Mental Health, Louis Appleby's speech, 20 March 2006.

“The stigma of mental illness, like racism, has no place in a civilised society. People should not be discriminated against because of the colour of their skin. Equally, people should not be discriminated against because they have a mental health problem. It has long been recognised that racism is unacceptable, but unthinking discrimination against people with mental health problems still seems to be socially acceptable. More than six out of ten employers, for example, freely admit they would not recruit someone with a mental health problem. Even more worrying is that some research indicates that you are more likely to be attacked in the street if you have got a severe mental health problem. Black people who have experienced mental illness can suffer the double whammy of racism and mental health stigma, neither of which are acceptable. This is simply wrong. It is high time that society caught up and realised that it is not okay to be prejudiced against people with mental health problems ... Suicide is a needless and avoidable tragedy. If we could break down the shame and prejudice surrounding mental illness, we could encourage people to seek help, and save lives.”
www.nimhe.org.uk

5. Promoting Protective Factors for Mental Health

The following section highlights the need to balance risk factors with protective factors in order to promote mental well-being, and corresponds to the blue section of the Dynamic Model for Well-Being. There is a variable evidence base for many of these emerging areas, and case studies have been used throughout much of this section, especially where there is weaker evidence.

5.1 Promoting Protective Factors in Childhood and Young Adulthood

Promoting mental well-being in childhood is key to addressing poverty and social inequalities. By improving long-term educational and social achievement you can reduce behavioural and emotional problems, (Stewart Brown, 2004). The following section outlines the most important contributions to promoting mental well-being in childhood.

Good Parenting: In earlier childhood the most protective aspect of promoting mental well-being and for reducing the risk of abuse for children is good parenting skills. Additionally, long term follow-up of Home Visitor programmes to develop parent skills found reductions in adolescent anti-social and offending behaviour as well as improved educational and employment outcomes, (Olds, 1997). Table 6 highlights key effective elements of good parenting skills.

Table 6 Effective aspects of parenting skills

Parent education programmes for young children	Parent Skills for Later Childhood & Adolescence
<ul style="list-style-type: none">● Warmth, positive regard, empathy;● Clear boundaries and positive discipline;● Parental sensitivity and attunement.	<ul style="list-style-type: none">● Love and connection;● Monitor and Observe;● Guide and Limit;● Model and Consult;● Provide and Advocate.

Emotional Literacy: Social and Emotional Aspects of Learning, (SEAL) is a primary school programme interwoven and integrated into the main curriculum. It is voluntary for schools to adopt the SEAL curriculum, with approximately 30% of primary schools nationally signed up to it. SEALs programmes bring about an immediate reduction in self-reported depression, reduction in drug and cigarette use and improved educational outcomes. Details can be found on the DfES website at: <http://tinyurl.com/ho24l>

A similar programme is being developed for secondary schools. The key components of emotional literacy programmes are summarised in figure 46.

Figure 46:

Aspects of
Emotional Literacy.

<p>Five effective Components</p> <ol style="list-style-type: none"> 1. Teach person to calm down 2. Increase awareness of emotional states of others 3. Learn to describe own emotional state to others 4. Learn planning & thinking ahead skills 5. Empathy – consider how others feel & how own behaviour affects them 	<p>Four Key Guidelines</p> <ol style="list-style-type: none"> 1. Emotions are important signals 2. Feelings are separate from behaviour 3. You can't think until you're calm 4. Treat others the way you want to be treated
	<p>Traffic Lights for when upset:</p> <ul style="list-style-type: none"> ● Red: Pause: Deep breath. Identify problem & feeling ● Orange: Find a positive solution What can I do? Does it harm others? ● Green: Act and reflect on solution identified: Try best idea. Did it work?

Violence and Abuse Prevention: The SEAL programme provides many of the skills needs to deal with conflict: learning how to peacefully problem-solve, calm down strategies, understand emotions, be assertive and anti-bullying messages. However, there are additional aspects that are needed to prevent the risk of child abuse and sexually abusive adolescent relationships (Krug, 2002). These include the development of:

- Mutual rights and respect in relationships (peers, family and dating);
- Challenge gender norms that support partner, family and sexual abuse;
- Abuse awareness and protective skill development;
- Communication and conflict resolution skills;
- Where and how to seek help.

Youth suicide prevention: The HDA Evidence briefing summary, (2005), recommends the development of school multi-year, multi-component strategies to address high-risk behaviour:

- Restrict access to paracetamol and responsible media reporting;
- Education on coping skills benefits depression and suicidal ideation;
- Target protective programmes for high-risk groups;
- Problem solving skills and emergency contact cards for preventing self harm.

Integrate into substance misuse and sexual health programmes: It is important to address the underlying risk factors for substance misuse. The evidence base to support school based mental health promotion and violence prevention programmes is much stronger than those that support substance misuse programmes (alcohol, drugs, tobacco), which are largely ineffective. In that some substance misuse is driven by emotional distress, mental health promotion and violence prevention programmes, which also address substance misuse, are likely to be more effective than substance misuse educational programmes alone, (Stewart-Brown, 2006).

There are good opportunities to integrate mental health promotion and abuse prevention approaches into Sure Start programmes, wider Healthy Schools work, including the SRE, PHSE and citizenship curriculum. Additionally, this needs to be done in the context of a whole school approach for behaviour improvement, including bullying and abuse prevention, with staff training on educational and communication styles, prevention policies, including improved nutrition and physical exercise. Further information on the wider aspects of health can be found in the report 'Health and Well-Being of Children and Young People in South East England' (2005).

5.2 Promoting Well-Being in Older People

Promoting Health is one of the standards in the Older People's National Service Framework, of which mental health promotion is an aspect of this; however, it is an area that tends to be relatively neglected. Key evidence based recommendations from a recent report for promoting mental health and well-being in later life, by Age Concern and the Mental Health Foundation (Lee, 2006), includes the following:

Address Discrimination: promote age equality, value and respect for older people. Develop inter-generational activities to strengthen understanding and respect between older and younger people;

Participation in meaningful activity: staying active physically and mentally benefits both physical and mental health. Reduce barriers and promote opportunities for older people to actively participate in mainstream life;

Relationships: promote opportunities to develop and maintain social networks and relationships, including the creation of safer communities to reduce fear and isolation. Tackle abusive and violent relationships (address alcohol misuse and provide support for carers) and provide support following bereavement: Also, recognise the benefits of pets. Ensure good access to and participation in community facilities and development initiatives;

Physical Health: physical health benefits mental health and remaining physically active reduces the development of dementia. Ensure access to age and disability appropriate physical activity opportunities. Promote a healthy diet and moderate alcohol intake;

Address Poverty: give older people the choice to continue to work, and facilitate benefits checks and advice to maximise income. Additionally, tackle fuel poverty since warmer homes have been found to improve mental well-being, (Wilkinson, 2006).

5.3 Having a Good Home

Having a good home is central to people's well-being, providing security, warmth and a place within a community. There are three aspects to having a good home, firstly the built or surrounding environment: including how safe it is, social networks, access to services and green spaces; secondly is the quality of the house, for example state of repair and how warm it is, (illustrated below). Thirdly, is individual need, of which being homeless or in temporary or insecure housing are particularly detrimental to mental health. Conversely, being in a good home helps to protect mental health.

A recent evaluation of Warmfront, found that following a combination of interventions to address fuel poverty, including a benefits check, central heating and insulation measures, there were improvements in mental health. Residents with bedroom temperatures of 21 °C were 50% less likely to have symptoms of depression or anxiety compared to those with temperatures of 15 °C. Additionally, residents reported an overall improvement in well-being, and were able to move around and use the whole house as opposed to being huddled in front of a heater in one room, (Wilkinson, 2006). Improvements to winter warmth can also benefit social networks, in that residents do not feel embarrassed to invite people back to a cold house.

Other house improvements have been shown to benefit mental health. For example, re-decorating housing association houses has shown a reduction in depression, (Thomson, 2001; NICE Review, 2005). People with mental health problems are more likely to be in vulnerable housing situations leading to homelessness, with 30–50% of homeless people having mental health problems (OPDM, 2004): Being homeless in itself can then have further detrimental effects upon mental health. Therefore, local homelessness and housing strategies should include people with mental health problems as a priority group and health Trusts and housing offices should provide additional support to reduce the risk of homelessness and ensure rapid re-housing if homelessness occurs. (Homelessness Strategy, ODPM, 2005).

Having a home is key to an individual's stability, independence and well-being, (Supporting People, 'Our Health, Our Care, Our Say' DH, 2006), and can help to promote social networks and reduce social exclusion, with positive benefits to mental well-being, (Mental Health and Social Exclusion Report, 2004). Case study 4, illustrates how independent living, within a supported housing scheme, can actively help to promote mental health.

Case Study 4: How Supported Living in KeyRing has Improved Mental Well-being

Although Mary has maintained many of the routines she picked up while in institutional care she has also managed to live independently in her own flat for over 12 years, despite having periods of mental ill health. She is clearly able to articulate what she does not want to do and with encouragement from workers she trusts, will sometimes express what new things she may like to try.

Mary is now known within her local community by neighbours, shopkeepers and the local café and they watch out for her. In the past, when she has been unwell during the night, the neighbour has rung the Community Living Volunteer to let her know.

Mary is still extremely cautious over who she chooses to socialise with but being part of a network of people has encouraged her to look at more opportunities to try new things, she has invited other KeyRing members back to her flat, and allowed them to support her with things like clearing her garden.

On the whole her mental health has remained relatively stable, although she has had a couple of episodes of ill health over the past 10 years. However, because the support that KeyRing has offered has been consistent, it has been easier to pick up on early warning signs and address them much earlier.

KeyRing Living Support Networks Contact: www.keyring.org

KeyRing exists to enable people with learning disabilities exercise choice in and take responsibility for their own homes. Each project is established within the community with ten ordinary properties scattered around a small neighbourhood. You can walk easily from one property to another. Nine flats or houses are for people with learning disabilities and the tenth flat is for KeyRing's community Living Worker who works part-time on a flexible basis.

5.4 Employment and Meaningful Activity

Only 24% of adults with long-term mental health problem are in work. However, work for most people helps to promote and protect mental health. Not everyone with a mental health problem will be able to work, however, being engaged in education, community work or volunteering provides meaning and engagement in wider society and is protective for mental health. This has recently been reflected in national policy to help support people back into work and promote healthier workplaces:

- Social Exclusion and Mental Health report, Social Exclusion Unit, ODPM, July 2004. <http://www.socialexclusion.gov.uk/downloaddoc.asp?id=134>
- Choosing Health: Making healthy choices easier, Public Health White Paper, 2004. <http://www.dh.gov.uk>
- Health, Work and Well-being "Health, work and well-being - Caring for our future: A strategy for the health and well-being of working age people" DH, DWP and HSE, 2005. www.health-and-work.gov.uk
- Our Health, Our Care, Our Say- A new direction for community services, 2006. <http://www.dh.gov.uk>
- A New Deal for Welfare - Empowering people to work, 2006 (Green paper). <http://www.dwp.gov.uk/aboutus/welfarereform>.

This requires two approaches: First, providing support for people with mental health problems to enter the workplace, e.g. through Pathways to Work (see resource table) and Cognitive Behaviour Therapy programmes connected to Job Centre Plus and primary health care. Secondly, ensure that the workplace is a healthy and supportive place to work.

Resources: Promoting Mental Well-Being in the Workplace:

Tackling Stress: The Management Standards Approach

The Health and Safety Executive leaflet that contains notes on good practice which are not compulsory but which you may find helpful in considering what you need to do: www.hse.gov.uk

Mindout Line Manager's Guide:

A line manager's guide to reasonable adjustments for people with mental health problems: www.mhmedia.com

'Leading by Example'

A guide to making the NHS an exemplar employer of people with mental health problems. Sainsbury centre for mental health website: www.scmh.org.uk

'The Mindful Employer' is a collaboration of employers who have signed up to promoting mental well being and work place fitness for Mental Health Service Users.

Sainsbury Centre: www.scmh.org.uk and www.mindfulemployer.net

Employers Forum on Disability: A practical guide to adjustments for people with mental health problems.

A series of briefing papers published by the Employers Forum on Disability providing practical guidance on specific subjects relating to the employment of disabled people, including 'Realising Potential - the Business Case' for employers to employ people with disabilities: www.employers-forum.co.uk

Health Trainers – providing support and advice to self-manage long-term health conditions to enable individuals to get back into work: Alternatively, health trainers could be used to promote healthy workplaces.

Pathways to Work – to start in the South East in 2008

In 2002, the Government announced plans to provide "a new framework of help for those who through illness or disability have applied for incapacity benefit" to assist them back into work. The proposals are set out in "Pathways to work: helping people into Employment" www.dwp.gov.uk. Since then, several areas have piloted the scheme. Examples can be found on www.scmh.org.uk

5.5 Keeping Physically Active

Inactive people are more likely to develop clinically defined depression, (Camacho, 1991).

Individuals who partake in regular physical activity not only say it is of benefit to their physical health but they feel mentally fitter; and is associated with improved subjective well-being, mood and emotions. These effects are seen in all ages regardless of socio-economic or health status, (Biddle, 2000). Physical activity improves self esteem and self-worth, (Fox, 2000). The effect is stronger for those with initially low self-esteem including those with mental health problems. Active individuals also report fewer symptoms of anxiety or emotional distress and report improved sleep patterns.

Epidemiological studies have shown that physically active individuals are less likely to suffer from depression, (Paffenbarger, 1994). There is substantial evidence illustrating the benefits of physical activity to mood, cognitive functioning and improved self-perception, self-esteem and self-efficacy, (Jones, 2005). Physical activity has been found to be as effective in the treatment of mental ill health as anti-depressant drugs and psychotherapy, (Mutrie, 2000; Babyak, 2000). Those who maintain physical activity for six months report less use of medication and are more likely to recover than those solely on medication.

The Chief Medical Officer's recommendation of moderate physical activity, such as walking, cycling, or badminton, for 30 minutes five times a week is sufficient to promote good mental well-being, (Mummer, 2004). Additionally, there are social health benefits from engaging in organised and group activities, for example green gyms and health walks. Case study 5 shows a good practice illustration of promoting physical well-being for people with mental health problems. Further information on how to promote physical activity can be found in the SEPHO Choosing Health report on Physical Activity, 2006.

Case Study 5: Promoting Physical Well-being for People with Mental Health Problems

Cambridge Mental Health Trust has developed a Physical and Mental Health Promotion Partnership with the help of the council, health practitioners and the VCS:

- Exercise referral (12 week programme) by any health professional;
 - Activities including swimming groups, badminton, yoga, 5 a side football, gym with buddy to accompany if needed as well as gym facilitators;
 - Healthy walks supported by the Council and Countryside Agency accessed by inpatient and community patients;
 - Well-being days were set up with dancing, singing, poetry, yoga, football, line dancing;
 - Physical Health forums and staff training;
 - Multi-Disciplinary Team health promotion road-shows and talks;
 - Pilot GP health screening;
 - Physical health resource folders for wards;
 - Smoking cessation training for staff;
 - Physical health audits and development of weight gain protocol.
- Opportunities exist to further develop the mental and social well-being aspects of such an approach.

5.6 Good Nutrition

The impact of nutrition upon physical health is now well established, however, the effects of nutrition upon mental health and well-being is a relatively emerging area, and although there is growing evidence on the positive benefits of nutrition on mental health, the quality of evidence is not as robust as with other more established interventions.

Obesity is associated with poor mental health indicators, especially for women. Being overweight or obese at age 18, was found to increase the later risk of suicide by 2.31 (CI: 1.20-4.42), 12 years later, (Van Dam, 2006). People with mental health problems eat less fresh fruit and vegetables, and are less likely to have breakfast, compared to those with no mental health problems, (which may relate to income or the mental illness itself).

Research on the bio-chemical functioning of the brain shows that the nutritional quality of our food can affect how well our minds work. As the brain consists of 60% fat, the fats that are eaten affect the functioning of the brain. Saturated, trans and hydrogenated fats (vegetable fats damaged by heat), introduce higher levels of damaging free-radicals into the brain's cell membranes and block the presence of healthy essential fatty acids. Sugars, caffeine, nicotine and alcohol all negatively affect the balance of neuro-transmitters, causing down regulation of acetylcholine, serotonin, dopamine, and adrenaline, and therefore can have a direct effect on mood and mental health. Many vitamins also affect the brains functioning, and relative deficiencies can affect concentration, behaviour and mood; (Cornah, 2006).

Foods which are protective for mental and physical well being include the following recommendations (SEPHO, 2005):

- At least 5 a day fruit and vegetables a day;
- Reduce sugar intake, including fizzy drinks;
- Reduce unhealthy fats (hydrogenated, trans or saturated fats), and increase unsaturated fats, including sunflower and olive oil;
- Increase intake of Omega 3 essential fatty acids – in linseed oil, nuts and seeds and oily fish;
- Increase proportion of carbohydrates with low glycaemic index, eg wholemeal bread, pasta and cereals;
- Reduce salt intake – don't add salt to food, and eat no more than 6 gm/day;
- Increase water intake – have 6–8 glasses a day.

Eating breakfast helps with mental concentration, maintains energy levels and weight maintenance. Cook and Eat and Luncheon Clubs, can also provide opportunities to widen and maintain social networks which support mental and social well-being. Further information on reducing obesity and nutritional guidelines can be found in the SEPHO Choosing Health report on Obesity, 2005.

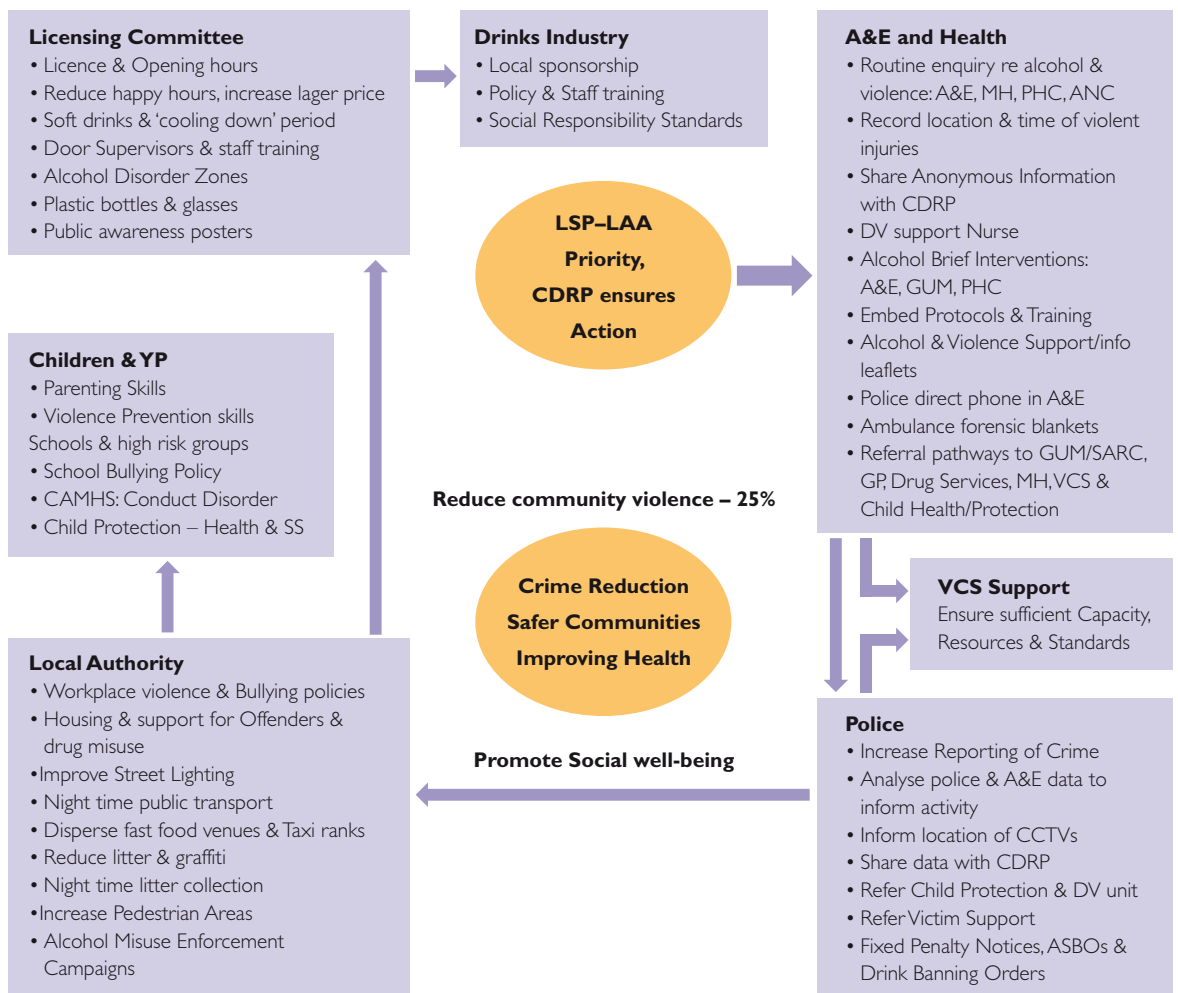
The Food and Mood Project:

Is a web-based, user led, self-help service to help individuals explore the relationship between food, emotional and mental health, it can be accessed at: www.foodandmood.org

5.7 Promoting Safer Communities

The immediate community affects individual safety and well-being. Figure 47 illustrates a model developed in Cardiff, which is being implemented by several Crime and Disorder Reduction Partnerships (CDRP) across the South East. This model is based upon sharing depersonalised hospital data on alcohol related violent incidents with the police, local authority, and CDRP partners to reduce violent, assaults. Follow up research in Cardiff has found a 25% reduction in A & E violent injuries, (Warburton, 2006; Shepherd, 2005).

Figure 47:
Reducing Alcohol Related Violence and Promoting Safer Communities (Shepherd J, Sheehan D and Nurse J, 2005)



5.8 Resilience, Respectful Relationships and Social Networks

Life, by its very nature, presents everyday stresses and traumatic events. A history of stressful life events predicts poor mental health for both children and adults. Having a mental health problem itself then often makes it more difficult to deal with other life stresses and traumas. Hence, the importance of developing resilience both within the general population and for people at higher risk of mental health problems, in order to be able to better deal with traumatic and stressful life events, and to prevent them having a further negative impact upon mental health. The main aspects of resilience, involve:

- Developing life skills to deal with difficult life events, including housing, benefits, transitions, work, bereavement etc.
- Protective skills to raise awareness and avoid potentially abusive situations and relationships
- The development of positive protection – of which social capital in the form of social networks and relationships are key
- Access to support, advice and advocacy.

Pro-social and life skills can be taught within the context of schools as a general population approach (for example SEALs as discussed earlier). Adult education and volunteering reduce isolation and social exclusion, and community engagement improves the well-being of those involved and also improves the well-being of others (Helliwell and Putnam 2004).

Additionally, high-risk groups of young people and adults often need additional input to develop these protective skills. An example of a Southampton project working in schools and with vulnerable young people to raise awareness on self-protection of abusive situations, the development of respectful relationships and where to seek help is illustrated in case study 6. Further work of this sort needs to be developed for adults at risk of mental health problems including those with mental illnesses.

Case Study 6: The Star Project – Southampton Together Against Rape

The S*tar Project is the Southampton Rape Crisis (SRC) education and outreach initiative which aims to reduce the incidence of rape and sexual abuse and raise awareness of support services via creative and innovative workshops with young people in Southampton.

All S*tar work is framed by four key aims:

- To raise awareness of the issues surrounding rape and sexual abuse;
- To assist young people in developing skills around negotiating respect and consent within relationships;
- To provide information to young people about SRC counselling service for young women and young men as well as other relevant information, advice and support agencies;
- To develop targeted work with young people identified as being particularly vulnerable.

Feedback from young people:

“Don’t feel under pressure in a relationship, remember, you have a voice! Stand up and speak up!” (Female, 15).

“I liked the openness of Star. It was great and I learnt the consequences of choices that can ruin the relationship. I learnt the values and disadvantages of sex”, (Male, 15).

If you would like any more information about the work of the Star Project, please ring, email or visit the website:

T: 023 8063 6315 E: michelle@starproject.org.uk W: www.starproject.org.uk

Many people in contact with mental health services already have a history of abuse. Having been abused in the past, increases the risk of being abused again, especially for women, whilst men are more likely to develop offending behaviour and become perpetrators of abuse. This abuse needs to be recognised and responded to appropriately with counselling, Cognitive Behavioural Therapy (CBT) and the development of protective skills include the ability to develop respectful relationships.

Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse, (Itzin, 2006), outlines the DH, CSIP, NIMHE and HO - Victims of Violence and Abuse Prevention Programme (VVAPP). This programme includes mapping, research and consultation on: child, adolescent and adult victims and perpetrators of child sexual abuse, sexual assault, sexual exploitation and domestic abuse' in order to inform future practice including health service responses. The programme is piloting Sexual Assault Referral Centres and routine enquiry of a history of abuse during the assessment stage of those in contact with mental health services, including within the South East. Further work is being done to prevent earlier abuse and to work with young and adult offenders, and on developing partnership approaches to prevent violence and abuse.

5.9 Creativity, Meaning and Fulfilment

Actively being involved in creativity and the arts helps people to connect with a wider sense of meaning and fulfilment, and can increase positive emotions and a sense of well-being. The impact of arts and creativity upon health is a relatively emerging area, and although there is growing evidence on the positive benefits of the arts to mental health, the quality of evidence is not as robust as with other more established interventions.

The arts helps the patient to find new ways of self expression and acts as a vehicle for establishing communication with others (Killick, 1999a; Killick, 1999b; Allan 2000). For example, the use of creative writing enables individuals to organise and regain control over their inner world, increasing their wellbeing. (Jensen 1997). Developing the narrative of patients' own mental illness help families and caregivers as well, (McGihon, 1996). Similarly, therapeutic storytelling and poetry can give benefits as the individual can safely identify oneself with fictional characters, (Mazza, 1993).

An evaluation of the role of therapeutic theatre for people with deficits in communication, showed a positive effect in alleviating cognition and social skills disabilities, (Snow, 2003).

Visual arts can contribute to a sense of well being through colours and forms as in the case of Willem de Kooning, an artist who continued creating works of arts in spite of his Alzheimer's disease and associated dementia, (Espinel 1996).

Music has benefits too. For example singing has shown to increase the quality of life of people with progressive dementia, as well as being able to provide comfort, awareness and inclusion to people from different cultural and social backgrounds, (Clair, 1990; 1996 In 2000). Studies by Thomas (1997) showed a positive effect of music on routine daily tasks and sleeping patterns of Alzheimer patients.

Arts that involve both users of mental health services and members of the public, for example drama, can challenge stigma around mental illness. Arts also help Mental Health professionals. For example, using reflective narratives help nurses think about the user as whole person. (Graham 1999). The use of arts has been recognised by mental health professionals as a positive intervention to facilitate counselling (Gladding, 2003). Case study 7 illustrates the range of arts projects in the South East.

Table 7 Arts and Health in the South East

There are numerous projects in the South East that are led by artists with mental health problems in the community through organisations such as Creative Response, ITHACA, Green Room Poets, Ark T Centre. There are also arts activities provided within the Mental Health Trusts such as Surrey Mental Health Trust and NHS Trusts such as Milton Keynes NHS Trust. Primary Care Trusts such as East Surrey PCT and Eastbourne PCT have developed arts projects to challenge stigma of Mental Health. Equally, many arts activities such as festivals, carnivals, arts in the public realm, visual arts, dance, music, and crafts activities promote the sense of self worth and community identity and contribute to the sense of mental well being. Research has shown that creativity appears to trigger the body's relaxation response, promoting health and healing, and reducing stress.

For further information on arts and health projects and activities in the south east, please visit the new South East England health and arts website www.seeha.com.

5.10 Empowering, Appropriate and Quality Services

A Citizen's Perspective

The term citizen is used in this report following feedback from 'service users' at a workshop piloting the well-being model. Citizen is an inclusive and dignified word, which conveys that we are all at potential risk of, or can be recovering from mental health problems, we may be carers at different stages in our life, and that we all have an interest in well-being. Access to services that are empowering, appropriate and of high quality, is a key factor for promoting protective factors for people with mental health problems, and is highlighted in the inner circle of the blue section of the dynamic model for well-being. A citizen's, (including users and carers) and Voluntary and Community Sector perspective should be included throughout the development, planning and implementation of approaches to promote well-being. Figure 48 is a summary of what people with mental health problems identified as the most helpful supports, (Faulkner, 2000).

A recent survey of mental health service users, found the majority felt they were listened to and treated with respect and dignity by mental health staff, and nearly 80% rated the care they received as excellent, very good or good overall. Most people were involved in decision making regarding their care programme and medication, although 20–25% were not involved in the process. However, more support was required regarding finding work and sorting out accommodation, with 50% wanting or needed more help in these areas; whilst only 25% wanted more help with getting benefits. Additionally, 40% wanted or needed more information about local support groups. (Health Care Commission, 2005).

Figure 48:

User perspectives of 'most helpful' strategies and supports.

<p>Relationships with others:</p> <ul style="list-style-type: none"> ● Family; ● Friends; ● Other service users/people with similar problems; ● Mental health professionals; ● Counsellors/therapists; ● People encountered in day centres, drop-ins, voluntary sector projects. 	<p>Medication</p>
	<p>Physical exercise</p>
	<p>Religious and spiritual beliefs</p>
	<p>Money</p>
<p>Personal strategies:</p> <ul style="list-style-type: none"> ● Peace of mind; ● Thinking positively, taking control. 	<p>Other activities:</p> <ul style="list-style-type: none"> ● Hobbies and interests; ● Information; ● Home; ● Creative expression.

Appropriate services – Provision versus need

Mental Health Promotion and Suicide Prevention: Despite the high prevalence of common mental health problems and the long-term impact it has on families, society and the economy, a recent stock-take of mental health promotion and suicide prevention activity around the South East found that this aspect of mental health is largely neglected. It was seen as a low priority even within mental health providers, and less than 20% of Local Implementation Teams have an identified budget or access to other sources of funding for either mental health promotion or suicide prevention.

There were only 15 whole time equivalent posts to address these issues for 8 million people, which reflected patchy capacity and active work across the region. Only 20% of Local Implementation Teams actively worked with high-risk groups for mental health problems and suicide, including abused, excluded or looked after children, unemployed people, homeless people, offenders or ex-offenders, (Brooks, 2005).

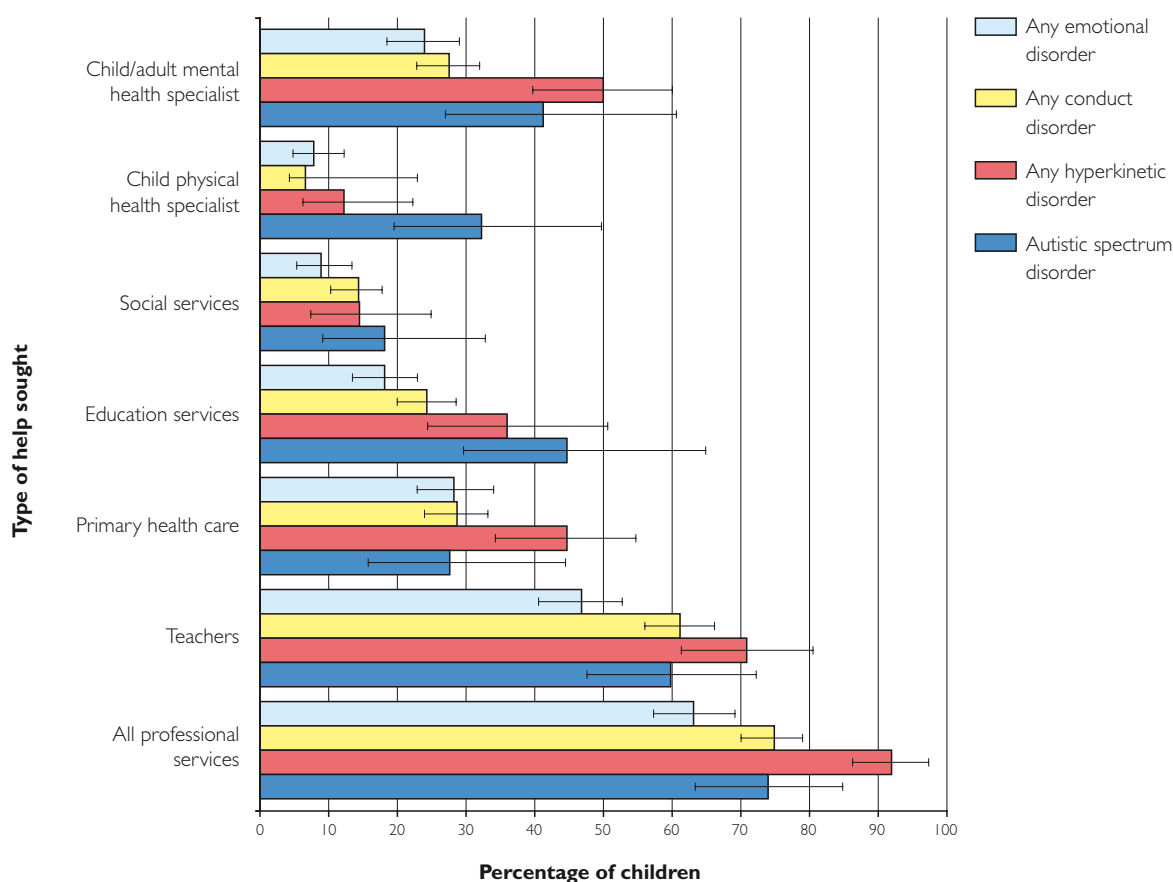
Children and Young People: A recent mapping exercise of Child and Adolescent Mental Health Services (CAMHS) in England found that although budgets have increased CAMHS services are still

under resourced. The South East has relatively less workforce capacity compared to many other regions. In terms of the balance of services provided, in England in general and even more so within the South East, there are gaps in adequate provision for high-risk groups for poor mental health and suicide.

In the South East, provision for Looked After Children make up only 3–8% of the caseload, which is 2–3 times lower than other regions. Young Offenders, who have an 18 fold increased risk of suicide, make up only 5% of the caseload, and in Kent and Medway and Hampshire and Isle of Wight in particular they have poor access to specialist CAMHS services. Across the South East, only 25–50% of CAMHS services have specialist services for Learning Disabilities, compared to 75–100% in many other regions, (Wistow, 2004). A BMA report highlights these issues, and also identifies the need to improve provision and transition to adult services for 17–18 year olds, and to ensure appropriate services for BME groups and refugees and asylum seekers; (BMA, 2006).

Figure 49 illustrates how only 23–28% of children with emotional and conduct disorders are seen by CAMHS services, and receive less support from other services, despite being the most common forms of mental health problems in children.

Figure 49:
Help Sought by
Children and Young
People, England, 2004



Source: Office for National Statistics, *Mental Health of Children and Young People in Great Britain*, (Green, 2004)

Early intervention saves money: By age 28, those with conduct disorders in childhood, were ten times the cost to society compared to those with no conduct disorder. Each individual with a conduct disorder had a total cost of £70,000, mainly due to crime incurred, followed by extra educational provision, foster and residential care, state benefits and health costs, (Scott, 2001).

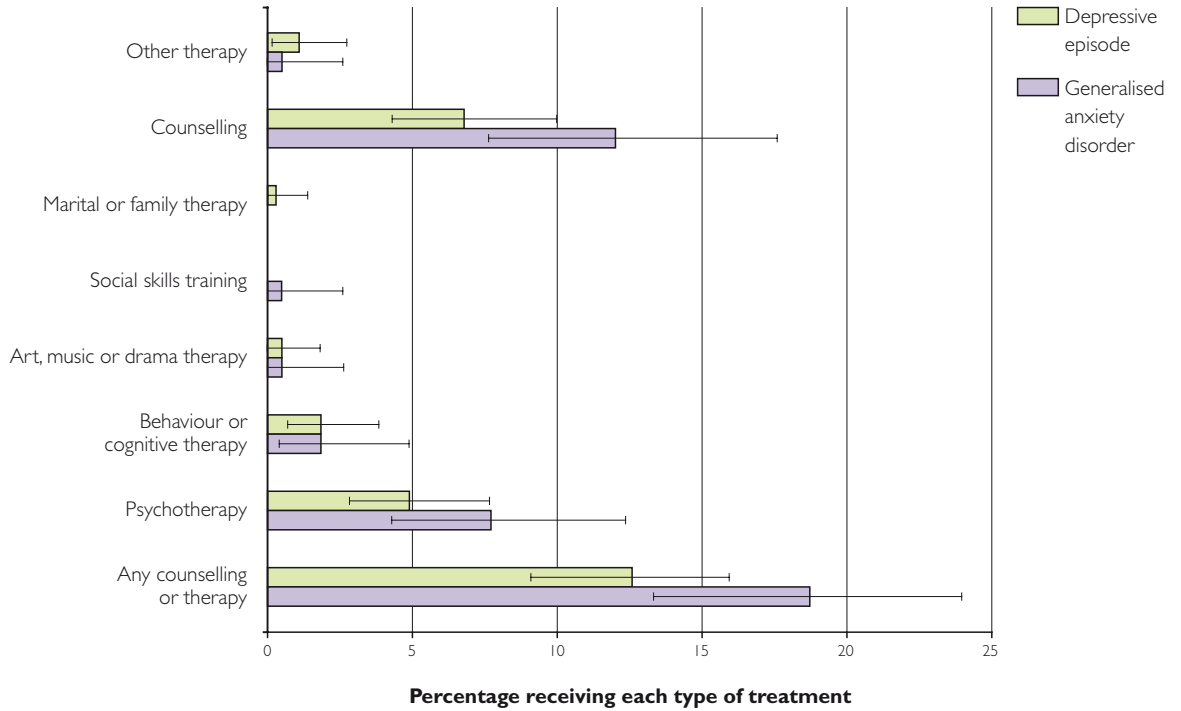
Parent skills and education, and day care for young children have been found to have long-term benefits in reducing neglect and abuse, and criminal and anti-social behaviour in young adults. It also improves protective factors, including maternal mental health, educational and employment outcomes, (Olds 1997, Zoritch 2006, Barlow 2006). Additionally, later intervention is also effective with family and parenting interventions in child and adolescent young offenders with conduct disorder, decreasing time spent in offender units and reducing re-offending rates (RR 0.66, CI: 0.44-0.98); (Woolfenden, 2006). Parent education/ training programmes cost between £629–£3,839, depending upon type and intensity. This compares with the long-term costs of conduct disorder of £70,000, and highlights the benefits of earlier intervention, (Dretze, 2005).

Access to Psychological Therapies: Recent policy (Choosing Health 2004, Our Health, Our Care, Our Say, 2006), and evidence (see NICE guidance), has highlighted the need to increase access to psychological therapies, in order to reduce the re-occurrence of common mental health problems and to reduce long-term unemployment. Within the South East, pilots are being established in the Isle of Wight and Hastings, two areas with high rates of incapacity benefits.

However, figure 50 illustrates how only 12-18% of people with anxiety or depression are receiving any form of counselling or psychological therapy. For more serious mental illnesses, the Mental Health User Survey (2005), found that 40% had received counselling or psychotherapy in the previous year, the majority of which had found it helpful.

Figure 50:

Counselling and therapy treatment by type of disorder, adults, England 2000



Source: Office for National Statistics, Psychiatric Morbidity Among Adults Living in Private Households, (Singleton 2000)

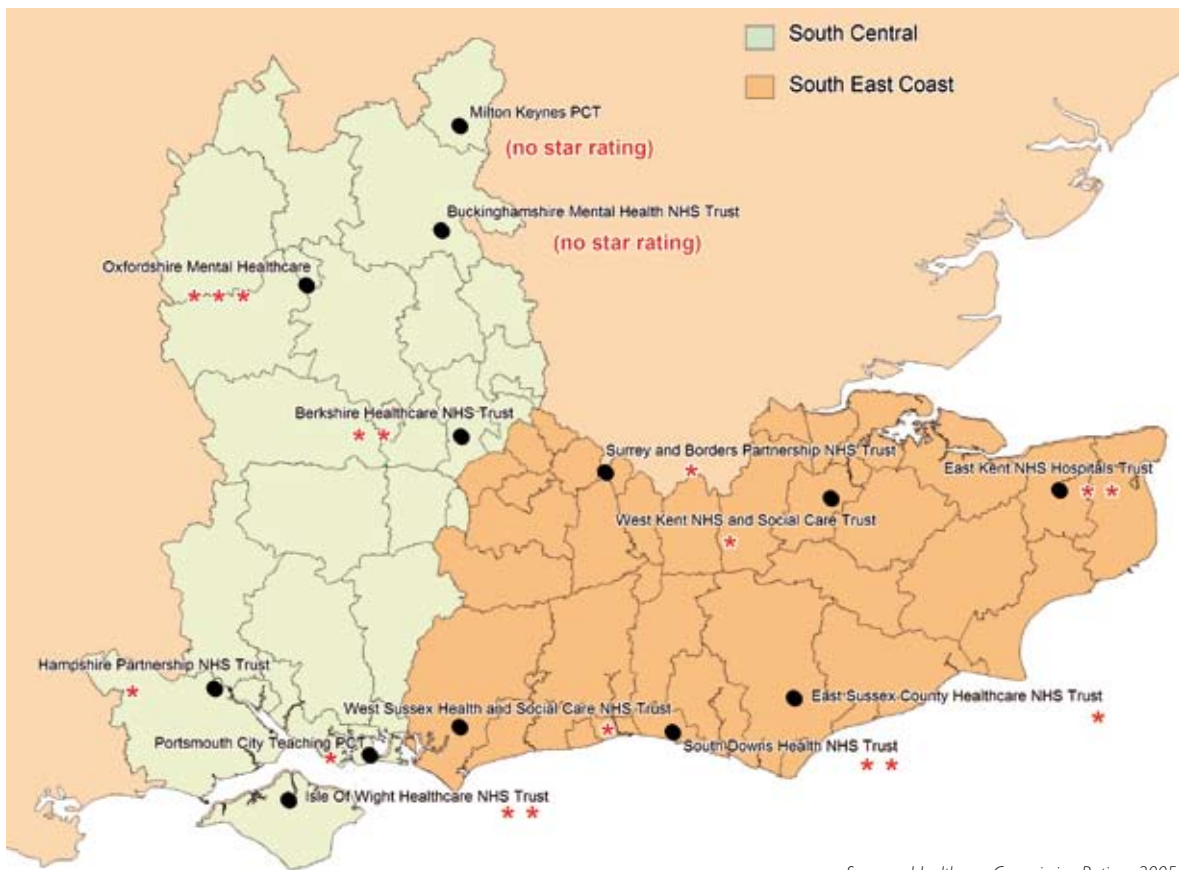
Quality and Standards

Mental Health Trusts are assessed for the quality of their services each year by the Healthcare Commission. Seven areas are assessed including: Safety; Governance; Accessible and Responsive Care; Public Health; Clinical and Cost Effectiveness; Patient Focus and Care Environment and Amenities. Each Trust is given a star rating, from 0 at the lowest to 3 stars as the highest. Figure 51 shows the star ratings in 2004/5 for each mental health trust within the South East.

Figure 51:

Map showing Health Care Commission Star ratings 2004/05 for Mental health trusts in the South East – with new Strategic Health Authority boundaries

© Crown Copyright.
All rights reserved.
OS licence number
03079G0002 (2006).

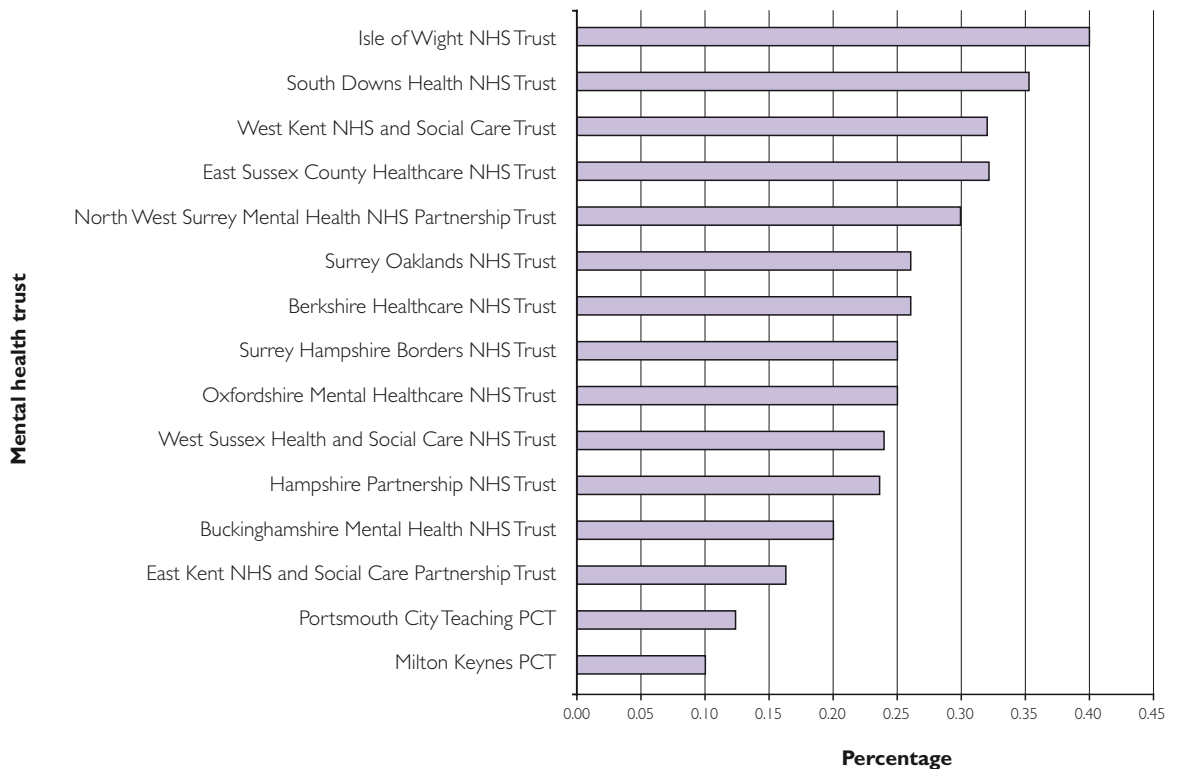


Source: Healthcare Commission Ratings 2005.
Please note that the organisation codes and names are those trusts in existence at 31/03/05

Figure 52 shows the three year rolling averages of suicides for inpatients and recently discharged patients from mental health Trusts around the South East, which reflects one of the high risk areas to address in suicide prevention.

Figure 52:

Three year average suicide rate for mental health inpatients and recently discharged patients by mental health Trusts in the South East, 2001–04



Source: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001/02, 2002/03, 2003/04) and Hospital Episodes Statistics (Financial Year 2003/04), published by Healthcare Commission as part of the 2005 Ratings for Mental Health Trusts.
Note: The indicator is the three year average of suicides of mental health inpatients and recently discharged (3 month period) patients divided by the number of admissions in financial year 2003/04 and is expressed as a percentage.

Evidence Base – Summary Of Nice Guidance:

Below is a summary of Evidence Based Guidance from the National Institute of Clinical Evidence – NICE, and the Health Development Agency (now a part of NICE). Implementation of these is one of the standards assessed by the Healthcare Commission.

Parent-training/education programmes in the management of children with conduct disorders:

The NHS now has two years to make the funding available for all patients who are treated in line with this guidance. www.dh.gov.uk/PublicationsAndStatistics/Legislation/DirectionsFromSecretaryState/DirectionsFromSecretaryStateArticle/fs/en?CONTENT_ID=4075685&chk=R4/Zyn

Guidelines on bipolar disorder in children and adults, NICE, July 2006

Clinical guidelines on the early identification, treatment and management of bipolar disorder in children and adults. <http://www.nice.org.uk/page.aspx?o=CG038>

Anxiety: management of anxiety in adults in primary, secondary and community care. Clinical guidance (CG22), NICE, 2004 <http://www.nice.org.uk/page.aspx?o=235216>

Guidelines on the management of anxiety, recommends provision of information, shared care and self help; initial primary care management with regular review, with referral to specialist services if treatment is unsuccessful.

Depression: management of depression in primary and secondary care. Clinical guidance (CG23), NICE, 2004 <http://www.nice.org.uk/page.aspx?o=235213>

- Screening in primary care and secondary care for high risk groups
- “Watchful waiting” for mild depression and reassessment within 2 weeks
- Antidepressants not recommended for initial treatment of mild depression. Guided self help cognitive behaviour therapy (CBT) programme recommended
- Psychological treatment should be considered for mild and moderate depression (6-8 sessions over 10–12 weeks)
- Recommended antidepressant is a selective serotonin reuptake inhibitor (SSRI) with information about potential withdrawal symptoms
- A combination of antidepressants and CBT is recommended for severe depression.

Depression in children and young people. Clinical guidance (CG28), NICE, 2005

<http://www.nice.org.uk/page.aspx?o=273073>

- Assessment should consider and record potential co morbidities, social, educational and family context and interpersonal relationships
- Psychological therapies should be by trained therapists/trained child and adolescent mental healthcare professionals
- Parental mental health needs to be considered, assessed and treated
- CAMHS to support training needs for primary healthcare staff and schools to improve identification of those at risk of depression
- Antidepressants should not be used initially to treat mild depression
- Moderate to severe depression treated initially with psychological therapy for at least 3 months. Antidepressants only offered in combination with a psychological therapy.

Schizophrenia. Clinical guidance (CG1), NICE, 2002 <http://www.nice.org.uk/page.aspx?o=42424>

- Holistic care across all stages with recovery approach
- Early Initiation of treatment
- Treatment of acute episodes to include clinical, emotional and social needs
- Promote recovery, e.g. with CBT and address social needs including meaningful activity to reduce symptoms and prevent relapse
- Rapid tranquillisation should not routinely be used. Identify and reduce risk factors for rapid tranquillisation.

Post-traumatic Stress Disorder. Clinical guidance (CG26), NICE, 2005

<http://www.nice.org.uk/page.aspx?o=248114> for children and adults

- Single session interventions on the traumatic incident should not be routine practice
- Mild symptoms <4 weeks, watchful waiting with 1 month follow up
- Severe symptoms, trauma focused CBT offered in first month after traumatic event
- Drug treatment not first option, unless psychological treatment refused (adults)
- Screening to be considered 1 month after major disaster for high risk individuals.

Self Harm. Clinical guidance (CG16), NICE, 2004

<http://www.nice.org.uk/page.aspx?o=213665>

- People who have self harmed should be treated with care, dignity and respect
- Training for staff, to promote understanding and appropriate care
- Activated charcoal available in A&E and ambulance staff to treat poisoning
- A preliminary psychological assessment should be offered at triage
- Patients waiting for treatment should be in a safe, supportive environment
- Treatment for physical harm should be offered and pain relief for painful treatments
- Information should be provided on treatment options to enable an informed choice
- All should be offered an assessment of the factors specific to the self harm, and a risk assessment
- Referral decisions for further treatment should be based on a comprehensive psychiatric, psychological, social and risk assessment.

Violence: short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments (NICE, 2005) <http://www.nice.org.uk/page.aspx?o=244477>

- Comprehensive risk assessment and management and policy re staff training and techniques, recognising anger, risk factors and preventing violent/disturbed behaviour
- Service users should receive information on their assigned staff member, why they have been admitted, their rights/consent and what might happen if they become violent
- Service users identified as at risk of violent/disturbed behaviour should have the opportunity to have their needs and wishes recorded as an advance directive
- Rapid tranquillisation, physical intervention or seclusion should only be considered after other strategies have failed, and staff involved should receive life support training.

Eating Disorders. Clinical guidance (CG9), NICE, 2004 <http://www.nice.org.uk/page.aspx?o=101239>

- Manage most with anorexia as outpatients with specialist psychological support
- Inpatient treatment for anorexia to provide re-feeding and psychological interventions
- Family interventions to be offered to children and adolescents with anorexia nervosa
- Initially management of bulimia a self help programme or antidepressant drug
- CBT to be offered for Bulimia Nervosa or Binge Eating Disorders.

Obsessive-compulsive Disorder: Core interventions in the treatment of obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD), NICE, 2005 <http://www.nice.org.uk>

- Each Mental Health Trust should have access to a specialist OCD/BDD multidisciplinary team offering age appropriate care
- Initially psychological treatments should be offered, if symptoms are more severe or not responding to treatment, an SSRI and more intensive CBT should be offered.

Evidence Reviews from the Health Development Agency:

Youth suicide prevention. Evidence briefing summary, HDA, February 2005

<http://www.publichealth.nice.org.uk/page.aspx?o=503371>

Emotional health and wellbeing through the National School Standard, HDA, May 2004

<http://www.publichealth.nice.org.uk/page.aspx?o=502723>

Worklessness and health – what do we know about the causal relationship?

Evidence review, HDA, 2005

<http://www.publichealth.nice.org.uk/page.aspx?o=503434>

Work, non work, job satisfaction and psychological health. Evidence review, HDA, March 2005

<http://www.publichealth.nice.org.uk/page.aspx?o=503404>

Evidence about work and health, HDA, 2004

<http://www.publichealth.nice.org.uk/page.aspx?o=502797>

Prevention and reduction of alcohol misuse. Evidence briefing summary, March 2005, HDA

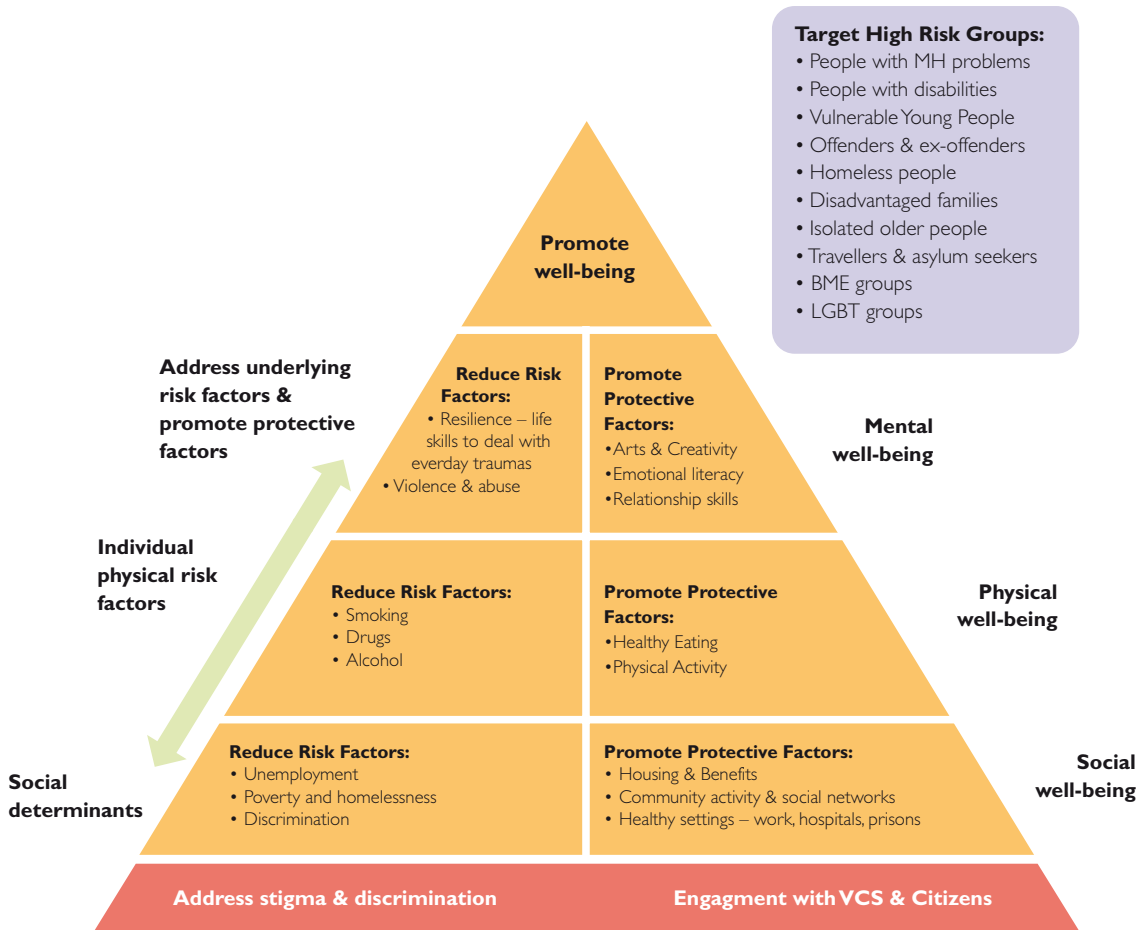
<http://www.publichealth.nice.org.uk/page.aspx?o503424>

6. Bringing It Together and Ways Forward

6.1 Promoting an integrated approach to well being

Historically, there has been sporadic best practice to promote only certain elements of well-being for people at high risk of mental health problems. The integrated model below, is a simplified version of the concepts of the dynamic model of well-being to assist with implementing this work on the ground. It highlights the need to develop a balanced approach to reduce the impact of risk factors whilst actively promoting protective factors at an individual mental, physical and social level in order to achieve well-being. The following tables are based upon the model and outline high-risk groups to target, and suggested ways forward under the headings Mental, Physical and Social Well-Being for Adults, Children and Young People. This is followed by a concluding section on creating mental health promoting environments and policy.

An Integrated Well-Being Model: For Social, Physical & Mental Well Being (Nurse J and Campion J, 2006)



Groups to target who are associated with higher risks of mental health problems:

Children and Young People	Adults
<ul style="list-style-type: none"> ● Children with parents who have mental health or substance misuse problems; ● Personal abuse or witnessing parents with domestic violence; ● Looked After children; ● School excludees; ● Teen Parents; ● Young Offenders; ● Lesbian, Gay, Bisexual, Transgender: young people; ● Young Men; ● Black and Minority Ethnic groups, especially Young Asian Women; ● Families living in socio-economic disadvantage. 	<ul style="list-style-type: none"> ● People with mental health illnesses or a history of self-harm; ● Young and middle aged men; ● BME groups, especially young men of Afro-Caribbean origin; ● Homeless people; ● Adults with a history of violence or abuse; ● Alcohol or substance misuse; ● Offenders and Ex-offenders; ● Lesbian, Gay, Bisexual, Transgender adults; ● Travellers, Asylum seekers and refugees; ● A history of being looked after/adopted; ● People with Learning Disabilities; ● Isolated older people.

An Integrated Approach to Well-Being for Adults – Guidance for Service Leads and Commissioners

Ways forward – Mental Well-Being	
General	<ul style="list-style-type: none"> ● Identify a Lead for each Mental Health Trust/PCT/Local Authority, to develop and implement programmes for people at high risk of mental health problems on cognitive skills, social and communication skills, positive emotions, resilience and life skills, respectful and non-abusive relationships.
Emotional literacy Positive emotions Resilience	<ul style="list-style-type: none"> ● Emotional literacy programmes should be developed for adults with mental health problems. These could be designed to facilitate respectful relationships, communication, emotional literacy, positive emotions, development of skills to cope with stress and difficult situations including protection from violence and abuse; ● Access to arts and creativity which promote positive emotions and a sense of well-being.
Life Skills and Relationship support	<ul style="list-style-type: none"> ● 'Life mentors/coaches' to support and develop life and social skills, promote self-esteem, enhance motivation and develop social networks; ● Provision of relationship, personal counselling, support with where and how to seek assistance, especially targeting stressful life events such as parenting, moving house/ homelessness, release from prison.
Abuse prevention	<ul style="list-style-type: none"> ● Extension of the Victims of Violence and Abuse Programme for Mental Health Trusts to adopt routine enquiry into history of abuse during assessment process, with referral pathways and protocols for support; ● Ensure single sex wards and staff training on the effects of previous abuse and reduce risk of further abuse as an inpatient; ● Integrate aspects of developing respectful, and healthy relationship skills with awareness of protective skills regarding further abuse into programmes for interpersonal skills, e.g. emotional literacy/life skills.

Ways forward – Physical Well-Being

General	<ul style="list-style-type: none"> ● Each mental health Trust/PCT/Local Authority, to assign a senior manager with a lead role in developing well-being for people at high risk of mental health problems; ● Ensure the following aspects of physical well being, (smoking, weight, exercise, drug and alcohol intake) become a routine part of the assessment and care planning process for people at risk of mental health problems.
Smoking	<ul style="list-style-type: none"> ● Development of policy and implementation of smoke free mental health Trusts – needs to be a graded, pragmatic approach with support for smoking cessation for staff and patients alike.
Substance Misuse: Drugs and alcohol	<p>Integrated approach to substance misuse and mental health by:</p> <ul style="list-style-type: none"> ● Assign a senior management lead in both mental health and substance misuse services; ● Develop joint protocols between mental health and substance misuse providers; ● Ensure recording and monitoring of mental health problems and substance misuse problems at assessment and where appropriate referral to specialist services; ● Training of staff in mental health Trusts on substance misuse; ● Training of staff in substance misuse centres on mental health problems; ● Provision of information on the combined effects of substance misuse on mental health and vice versa for users of services; ● Ensure representation of mental health services on DAATs (Drug and Alcohol Teams) and of Drug and Alcohol Services on LITS (Local Implementation Teams for National Service Frameworks) to provide comprehensive commissioning and planning of services for individuals with dual diagnosis.
Healthy eating	<ul style="list-style-type: none"> ● Ensure healthy food options are mainstreamed within mental health Trusts; ● Withdraw vending machines with unhealthy food options and replace with healthy options within mental health Trusts; ● Provision of healthy eating cooking sessions – for inpatients and within community settings.
Physical activity	<ul style="list-style-type: none"> ● Incorporate physical activity into mainstream programmes and group sessions, e.g. walking, swimming, cycling, games such as rounders, green exercise, including allotments and community ecology projects; ● Provide support buddies for individuals to access mainstream physical activities within the community; ● Develop an active transport plan to increase walking and cycling to work or appointments for both staff and service users.

Ways forward – Social Well-Being	
General	<ul style="list-style-type: none"> ● Identify Lead for each Mental Health Trust/PCT/Local Authority, to ensure the assessment process, care-pathways and protocols address those at high risk of mental health problems and include: housing, employment, community participation and social networks; ● Local Authorities and Mental Health Trusts to identify advocates/ support workers/ buddies to give practical assistance with housing, debt, finding employment, advocacy to negotiate service, provide support and advice in the following areas:
Housing	<p>Promote independence and address housing needs of people at risk of mental health problems, especially ex-offenders, people with learning disabilities, substance misuse problems or where increased stress will be of detriment to mental health. Mental Health Trusts to increase engagement with local Housing and Homelessness Strategies to improve housing using:</p> <ul style="list-style-type: none"> ● Local Supporting People plans; ● Direct Payments; ● Mental Health LITS (Local Implementation Teams for the National Service Framework); ● Drug Action and Alcohol Teams; ● Probation. <p>Mental Health Trusts should provide a housing support officer and maintain close links with the housing department. Protocols should be established to address homelessness.</p>
Community participation and Social Networks	<ul style="list-style-type: none"> ● Support and facilitate active engagement in community and volunteering programmes; ● Improve access and engagement with cultural, artistic and creative activities; ● Promote time banks and reward card schemes to attract people into community engagement.
Meaningful activity and Employment	<ul style="list-style-type: none"> ● Ensure appropriate support to assist individuals into employment or meaningful activity, e.g. volunteering, community action or education; ● Promote wellbeing in the workplace by adopting HSE standards on reducing stress at work; ● Mental Health Trusts to refer to the 'Leading by Example' guidance and sign up to the 'Mindful Employers' Initiative and promote local networks of Mindful Employers with surrounding businesses.
Media and Stigma	<ul style="list-style-type: none"> ● Advertising and awareness campaigns with high profile consumers and advocates to reduce the stigma of mental illness; ● Use of DVDs and access to websites to promote awareness and self help for mental health.

Ways forward for Children and Young People – School-based Settings, and Target High-risk Groups

Mental Well-Being	<ul style="list-style-type: none"> ● Parenting education and skills e.g. via Sure Start programmes, for young children and adolescents, for general population and high risk groups – address maternal mental health; ● Violence and abuse prevention skills for self-protection, ability to deal with conflict, and promotion of respectful relationships; ● Emotional Literacy adoption of Social and Emotional Aspects of Learning in primary schools. Pre-school and secondary schools still being developed; ● Access to arts and creativity which promote positive emotions and a sense of well-being; ● Healthy whole school approach to ensure mental health promotion and violence and abuse prevention programmes underpin Healthy Schools curriculum for Sexual and Relationship Education, PHSE and citizenship, including substance misuse and sexual health; ● Appropriate CAMHS services to ensure Child and Adolescent Mental Health Services are appropriate to local need, and support schools and health professionals in identifying, managing and referring emotional and conduct disorders; ● Access to youth-friendly services ensure children and young people have the skills and information of how and where to seek support and information for issues surrounding abuse and mental health.
Physical Well-Being	<ul style="list-style-type: none"> ● Healthy Eating promoted in schools and families, increase provision of healthy foods and reduce unhealthy foods in schools. Provide healthy school meals, tuck shops and vending machines; ● Physical Activity – children and young people should have at least 60 minutes of moderate physical activity each day, (e.g. walking, cycling, badminton). Ensure school travel plans support active transport (walking or cycling) to and from schools; ● Substance Misuse – ensure programmes for tobacco, drugs and alcohol are underpinned by mental health promotion and abuse prevention work.
Social Well-Being	<ul style="list-style-type: none"> ● Promote social, relationship and life skills – mentors and buddies for high risk children; ● Promote volunteering, participation in community programmes, including inter-generational projects that increase creativity, physical activity, self-esteem, and social skills.

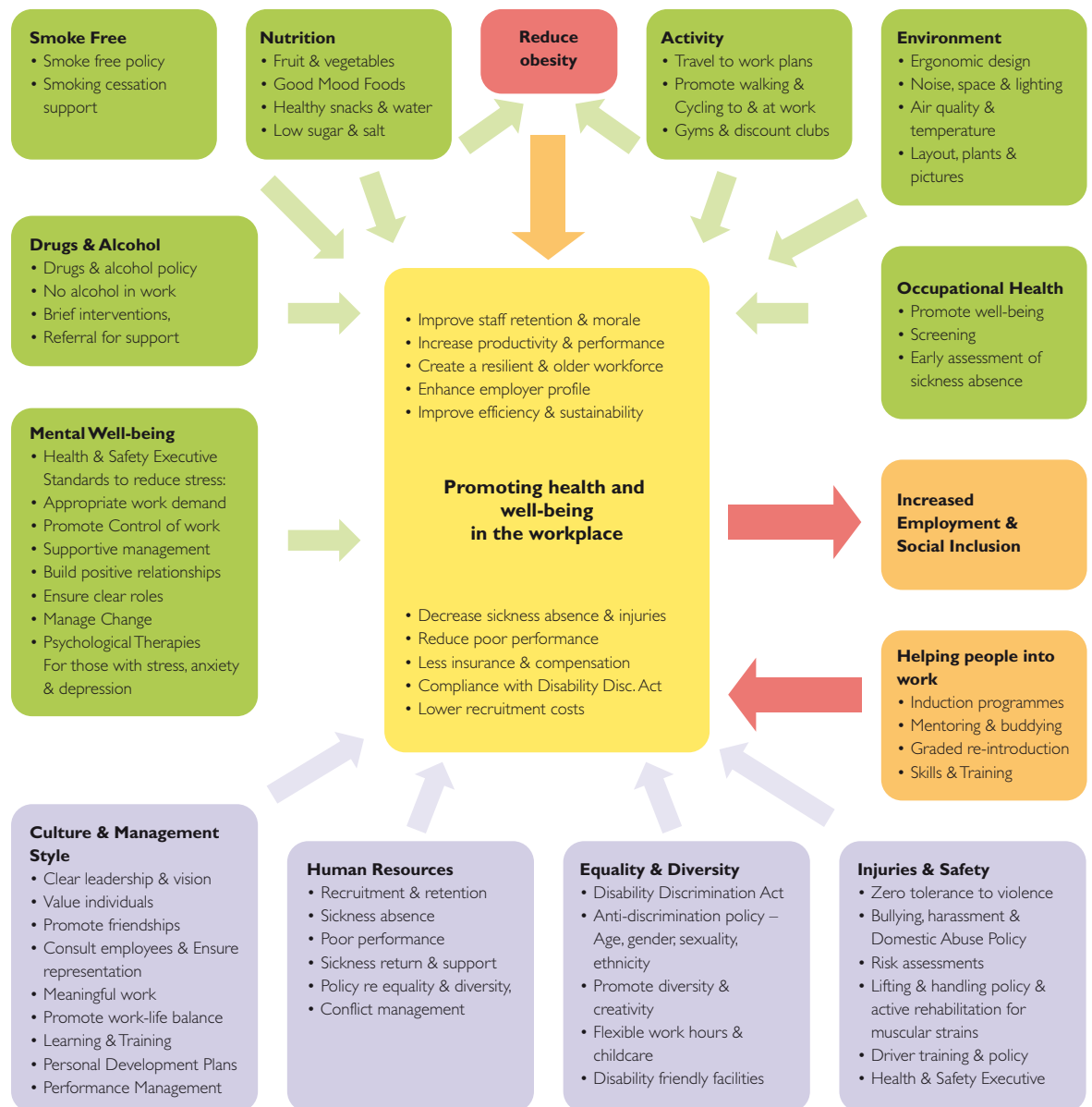
6. 2 Creating Mental Health Promoting Settings, Environments and Policies

In order to achieve the wider social and health gains that can be obtained by promoting well-being, environments which are supportive to the development of mental well-being need to be created. There are three aspects which can help support well-being: applying a settings based approach; addressing factors in the wider environment and ensuring mental health promoting policies:

Settings:

Schools, hospitals, prisons, workplaces are all examples where a settings based approach can be successfully developed. Taking a settings approach has the advantage of being able to apply an integrated approach to improving mental, physical and social well-being within a defined population or area. Figure 53 provides an example of promoting well-being within the workplace;

Figure 60:
A settings-based approach to promoting well-being in the workplace (Nurse J, 2006)



Environments

The environment that we live in affects our access to green space and safety on roads. Within the built environment, housing conditions and access to community resources all influence social capital and cohesion. These are all factors that can promote or reduce mental well-being, and are important aspects for Local Authority planners and Environmental and Public Health professionals to work together to maximise health gain; See the South East Regional Public Health Group Information Series on Health and

Homes for further suggestions on promoting health promoting environments, at www.gose.gov.uk/gose/publichealth or www.sepho.org.uk.

Policy

Human resources policy: by ensuring human resources, occupational health and workplace management style policies: reduce stress, discrimination and bullying; and promote diversity and support people with mental health problems in employment, will reduce sickness absence and increase moral and productivity within the wider workplace.

Regional and local level policy which affect the wider environment and also influence the shape of service provision within a settings context e.g. schools, hospitals, prisons. These need to take into account all relevant aspects of mental, physical and social well-being which are able to positively promote health and well-being. Examples include the following regional and local strategies:

- The Regional Economic Strategy
- The South East Plan
- Regional and Local Housing Strategies/Plans
- Regional and Local Transport Strategies/Plans
- Regional and Local Children and Young Peoples Strategies/Plans
- The Regional Reducing Re-offending Strategy.

Local Area Agreements are a particular opportunity to prioritise aspects of well-being within Local Strategic Partnerships, which will also impact upon wider societal benefits. There are relevant indicators across all four blocks (Children and Young People; Safer and Stronger Communities; Healthier Communities and Older People; and Economic Development), which can positively promote mental well-being. See Table 7 for further resources.

Table 7 Further resources – South East Public Health Group Information Series

Information Series: Further evidence, supportive information and recommended ways forward, including suggested LAAs indicators, can be found in the Information Series produced by the South East Public Health Group at www.gose.gov.uk/gose/publichealth or on the South East Public Health Observatory website at www.sepho.org.uk

Below is a list of current topic areas covered by the Information Series:

- Alcohol
- Employment
- Health and Homes
- Mental Health and Well-Being
- Addressing Obesity – Eat well and keep active
- Prevention of Violence and Abuse
- Teenage Pregnancy
- Tobacco.

Additionally, the following topics will be developed during autumn 2006 including:

- The Health Service's Role in Reducing Re-offending
- Learning Difficulties
- Older People
- Public Health in the South East – An Overview
- Promoting Mental Health and Well-Being in Children and Young People
- The Role of Public Health in Climate Change and Sustainability
- Winter Warmth.
- Europe and Public Health.

References

- Alcohol Harm Reduction Strategy for England, Department of Health, 2004; <http://www.strategy.gov.uk/output/page3669.asp>
- Alesina A, Di Tella R, MacCulloch R (2001) Inequality and Unhappiness: are Europeans and Americans different? (National Bureau of Economic Research, Cambridge, MA) NBER Working Paper 8198
- Allan K; Killick J (2000) Undiminished possibility: the arts in dementia care' *Journal of Dementia Care*, 8, 3 p16-17
- Argyle M (2001) *The Psychology of Happiness* (Routledge, London) p103 www.antidote.org.uk
- Babiyak M, Blumenthal JA, Herman S, Khatri P, Doraiswamy M, Moore K, Craighead WE, Baldecwicz TT, and Krishnan KR (2000) Exercise Treatment for Major Depression: Maintenance of Therapeutic Benefit at 10 Months. *Psychosomatic Medicine* 62: 633-638
- Barlow J, Coren E, Stewart-Brown S 'Parent training programmes for improving maternal psychosocial health' *The Cochrane Database of Systematic Reviews*, 2006, Issue 1. www.cochrane.org/reviews/en/ab002020.html.
- Biddle, S. J. H. (2000). Emotion, mood and physical activity. In S. J. H. Biddle, K. Cycling and Health Briefing Paper Final Draft 28 Feb 2003 45. R. Fox & S. H.
- Brophy M (2006) 'Truth Hurts: Report of the National Inquiry into Self-Harm among Young People' Mental Health Foundation, www.selfharmuk.org
- BMA, 2006 'Child and adolescent mental health, A guide for healthcare professionals' www.bma.org.uk
- Boutcher (Eds.), *Physical activity and psychological well-being* (pp. 63-87). London, Routledge.
- Brooks P 'Mental health promotion and suicide prevention activity stock-take within the South East 2005' South East Development Centre, www.sedc.nhs.uk
- Brooks P, Watson J (2006) 'A profile of suicide mortality in the South East' SEPHO/ CSIP/ SEDC; www.sepho.org.uk
- Brown RA, Lewinsohn PM, Seeley JR, Wagner EF. Cigarette smoking, major depression and other psychiatric disorders among adolescents. *J Am Acad Child Adolesc Psychiatry* 1996;35(12):1602-10
- Butler P, Kousoulou D (2006) 'Women at Risk- the mental health of women in contact with the judicial system' Care Services Improvement Partnership and Health and Social Care in Criminal Justice; www.londondevelopmentcentre.org
- Camacho, T. C., Roberts, R. E., Lazarus, N. B., Kaplan, G. A., & Cohen, R. D. (1991). Physical activity and depression: Evidence from the Alameda county study. *American Journal of Epidemiology*, 134, 220-231.
- Campion J, McNeill A, Chęcinski K 'Exempting mental health units from smoke free laws- would worsen health inequalities for people with mental health problems' *BMJ*, 2006; 333: 407-8.
- Care and Repair: A national charity aimed at improving housing conditions of older and disabled people; www.careandrepair-england.org.uk
- Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, Anda RF 'Adverse childhood experiences and the risk of depressive disorders in adulthood' *Journal of Affective Disorders*, 2004; 82; 217 – 225.
- Cohen S, Lichtenstein E. Perceived stress, quitting smoking and smoking relapse. *Health Psychol* 1990;9(4):466-78
- Cornah D (2005) 'Understanding the relationship between alcohol and mental health' Cheers- Mental Health Foundation, www.mentalhealth.org.uk
- Coker AL, Davis KE, Arias I, Desai S, Sanderson M, Brandt HM, Smith PH 'Physical and mental health effects of intimate partner violence for men and women' *American Journal of Preventive Medicine*, 2002, Nov; 23(4):260-8.
- Cornah D (2006) 'Feeding minds: the impact of food on mental health' Mental Health Foundation, www.mentalhealth.org.uk
- Coultard M, Farrell M, Singleton N, Meltzer H. (2000) 'Tobacco, alcohol and drug use and mental health' Office of National Statistics, www.statistics.gov.uk
- Craft, L. L., & Landers, D. M. (1998). The effect of exercise on clinical depression and depression resulting from mental illness: A meta-analysis. *Journal of Sport and Exercise Psychology*, 20, 339-357.
- Danner D, Snowdon D, Friesen W (2001) 'Positive Emotion in early life and longevity: finding from the nun study'. *Journal of Personality and Social Psychology* 80, pp 804-13
- Department of Health, (2004) 'Choosing Health: making healthy choices easier' <http://www.dh.gov.uk/assetRoot/04/09/47/51/04094751.pdf>
- Department of Health (2002) 'Dual Diagnosis Good Practice Guide' www.doh.gov.uk/mentalhealth
- Department of Health, (2005) 'Health, work and well-being – Caring for our future' DH, DWP, and HSE, http://www.dwp.gov.uk/publications/dwp/2005/health_and_wellbeing.pdf

- Department of Health (2004) 'National Child and Adolescent Mental Health Service Mapping Exercise' www.camhsmapping.org.uk
- Department of Health (1999) 'National Service Framework for Mental Health. Modern Standards and Service Models' www.dh.uk/publications
- Department of Health (2002) 'National Suicide Prevention Strategy for England' www.dh.uk/publications and www.nimhe.org.uk
- Department of Health (2006) 'Our health, our care, our say: a new direction for community services' <http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf>
- Department of Health (2005) 'Responding to domestic abuse: A handbook for health professionals' www.dh.uk/publications
- Department of Health (2005) 'The Story so Far... Valuing People Report' www.valuingpeople.gov.uk
- Department of Health (2002) 'Women's Mental Health: Into the Mainstream: Strategic Development of Mental Health Care for Women' www.nimhe.org.uk
- DfES, 'Every Child Matters' Department for Education and Skills, 2004, www.everychildmatters.co.uk
- Dixon M, Reed H, Rogers B, Stone L (2006) 'Crime Share: The unequal impact of crime' Institute for Public Policy, www.ippr.org
- Dretzke J, Frew E, Davenport C, Barlow J, Stewart Brown S, Sandercock J, Bayliss S, Raftery J, Hyde C, Taylor R 'The effectiveness and cost effectiveness of parent training/ education programmes for the treatment of conduct disorder; including oppositional defiant disorder in children' Health Technology Assessment, 2005, Vol9: No 50.
- Dube SR, Miller JW, Brown DW, Giles WH, Felitti VJ, Dong M, Anda RF 'Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence.' Journal of Adolescent Health, 2006; 38:444.e.1-444.e10
- Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH 'Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span' JAMA, 2001; vol 286, No 24; 3089 – 3096.
- Easterlin R (2003) Explaining Happiness. Proceedings of National Academy of Science (National Academy of Science, Washington DC) Vol 100, No 19; pp 11,176-11,183
- Espinell CH (1996) de Kooning's late colours and forms: dementia, creativity and the healing power of art.' The Lancet 347, 9008 p1096-1098
- European Commission (2005) 'Improving the mental health of the population: towards a strategy on mental health for the European Region, Green Paper', http://europa.eu.int/comm/health/ph_determinants/life_style/
- Evans et al (2003) The mental health of older people (in SER)
- Farrell M et al. Nicotine, alcohol and psychiatric morbidity. Results of a national household survey. Br J Psych 2001;179:432-7
- Faulkner, A., Layzell S. (2000) 'Strategies for Living: The Research Report' A report of user-led research into people's strategies for living with mental distress. The Mental Health Foundation, London; www.mentalhealth.org
- Fergusson DM, Poulton R, Smith PF, Boden JM 'Cannabis and psychosis' BMJ 2006; 332: 172-6
- Fazel S, Benning R, Danesh J 'Suicides in male prisoners in England and Wales, 1978-2003' Lancet, 2005; 366:1301-1302
- Ford R, Beadsmore A, Norton P et al (1994) Developing case management for the long term mentally ill. Psychiatric Bulletin of the Royal College of Psychiatry 17: 409 – 411
- Fox, K.R. (2000b). Self-esteem, self-perceptions and exercise. International Journal of Sport Psychology. 31, 228-240
- Gilbert D, Gilbert B. Personality, psychopathology and nicotine response as mediators of the genetics of smoking. Behav Genet 1995;25(2):133-47.
- Gladding ST, Newsome DW (2003) 'Art in counselling' in Malchiiodi CA (ed) Handbook of art therapy. New York: Guildford Press P461
- Glasser D 'Child abuse and neglect and the brain – A review' Journal of Child Psychology, 2000; Vol 41, No. 1 pp 97- 116.
- Goleman D (2003) 'Destructive Emotions and how we can overcome them' Bloomsbury, London.
- Gordon D, Adelman L, Ashworth K, Bradshaw J, Levitas R, Middleton S, Pantazis C, Patsios D, Payne S, Townsend P, Williams J (2000). Poverty and Social Exclusion in Britain. York: Joseph Rowntree Foundation
- Graham IW (1999) Reflective narrative and dementia care Journal of Clinical Nursing 8 P675-683
- Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2004) 'Mental health of children and young people in Great Britain, 2004' Office of National Statistics, www.statistics.gov.uk

- Haggard-Grann U, Hallqvist J, Langstrom N, Moller J 'The role of alcohol and drugs in triggering criminal violence: a case crossover study' Society for the Study of Addiction, 2006; 101, 100-108.
- Harris EC and Barraclough B (1998) 'Excess mortality of mental disorders'. British Journal of Psychiatry 173;11-53
- Health and Well-Being of Children and Young People in South East England' 2005, SEPHO/ GOSE/ DH; www.sepho.org.uk
- Healthcare Commission, 2006 'How trusts assessed themselves in 2005/6' www.healthcarecommission.org.uk
- Healthcare Commission, 2005 'Mental health services, Survey of users' www.healthcarecommission.org.uk
- Healthcare Commission, 2005 'Count me in, Results of a national census of inpatients in mental health hospitals and facilities in England and Wales' www.healthcarecommission.org.uk
- Health Survey for England 2004; www.statistics.gov.uk
- Hegarty K, Gunn J, Chondros P, Small R 'Association between depression and abuse by partners of women attending general practice: descriptive, cross sectional survey' BMJ, 2004; 328:621-4
- Helliwell J and Putnam R 'The social context of well-being' The Royal Society, 2004; 359, 1435-1446
- Heru-Alison-M, Stuart-Gregory-L, Rainey-Samara, Eyre-Jody, Recupero- Patricia-Ryan. Prevalence and severity of intimate partner violence and associations with family functioning and alcohol abuse in psychiatric inpatients with suicidal intent. The Journal of clinical psychiatry, {J-Clin-Psychiatry}, Jan 2006, vol. 67, no. 1, p. 23-9
- Homelessness Strategy- 2005 'Sustainable Communities: Settling Homes, Changing Lives' ODPM, 2005. www.odpm.gov.uk
- Home Office (2006) 'Domestic Violence, Sexual Assault and Stalking: Findings from the 2004/5 British Crime Survey' Home Office Online Report 12/06 <http://www.homeoffice.gov.uk/rds/pdfs06/rdsolr1206.pdf>
- Home Office (2006) 'A five year strategy for protecting the public and reducing re-offending' The Stationary Office, www.tso.co.uk/bookshop
- Home Office (2005) 'Crime in England and Wales, 2004/ 2005' Home Office Statistical Bulletin, Report 11/05. <http://www.homeoffice.gov.uk/rds/pdfs05/hosb1105.pdf>
- Huizink AC, Ferdinand RF, Ende J, Verhulst FC 'Symptoms of anxiety and depression in childhood and use of MDHA: prospective, population based study' BMJ, 2006; 332:825-7
- Itzin C, (2006) 'Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse' DH/ HO/ CSIP/ NIMHE www.dh.gov.uk/publications
- Jones, Martin, O'Beney, Carol. Promoting Mental Health through Physical Activity. Journal of Mental Health Promotion. March 2005
- Johnson JG, Cohen P, Pine DS et al. Association between cigarette smoking and anxiety disorders during adolescence and early adulthood. JAMA 2000;284:2348-2351
- Kasser T (2002) The high price of materialism (MIT Press, Cambridge, MA)
- Keyes C (2004) 'The nexus of cardiovascular disease and depression revisited: the complete mental health perspective and the moderating role of age and gender' Aging and Mental Health (Brunner-Routledge, London) May 2004;8(3):266-274
- Killick J; Allan K (1999a) The arts in dementia care : tapping a rich resource Journal of Dementia Care 7, P35-38
- Killick J; Allan K (1999b) The arts in dementia care: touching the human spirit Journal of Dementia Care, 7 5 p33-37
- Killick J (2000) The role of the arts in dementia care Nursing and Residential Care 2, 12 p572-574
- King M, McKeown E (2003) 'Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales' Mind, www.mind.org.uk
- Knapp M, McCrone P, Fombonne E, Beecham J, Wostear G 'The Maudsley long-term follow-up of child and adolescent depression' British Journal of Psychiatry, 2002, 180, 19-23.
- Krug et al. World report on Violence and Health. WHO 2002, www.who.int
- Layard R, 2005, 'Happiness – Lessons from a New Science' Allen Lane.
- Lee M (2006) 'Promoting mental health and well-being in later life' Age Concern and Mental Health Foundation, www.mhilli.org
- Levy B et al (2002) 'Longevity increased by positive self perceptions of age' Journal of Personality and Social Psychology 83
- Lykken D (1999) Happiness: the nature and nurture of Joy and Contentment (St Martins Press, New York)

- Marks N, Shah H (2005) A well-being manifesto for a flourishing society. *Journal of Mental Health Promotion* 3,4;9-15 www.neweconomics.org
- Mazza N (1993) Poetry therapy :toward a research agenda for the 1990s' *Arts in Psychotherapy* 20, 51-59
- Meltzer H, Singleton N, Lee A, Bebbington P, Brugha T, Jenkins R (2000) 'The Social and Economic Circumstances of Adults with Mental Disorders' Office of National Statistics, www.statistics.gov.uk
- Meltzer H, Corbin T, Gatward R, Goodman R, Ford T (2002) 'The mental health of young people looked after by local authorities in England' Office of National Statistics, www.statistics.gov.uk
- Meltzer H, Gatward R, Corbin T, Goodman R, Ford T 'Persistence, onset, risk factors and outcomes of childhood mental disorders' ONS, 2003, www.statistics.gov.uk
- Meltzer D, Fryers T, Jenkins R. (2004) Social inequalities and the distribution of common mental disorders. Maudsley Monographs Hove: Psychology Press
- Mentality (2003). 'Promoting Healthy living for People with mental health problems'
- Mind (2004) 'Not alone: isolation and mental distress' Mind 2004 survey <http://www.mind.org.uk/NR/rdonlyres/E1011DAB-92A1-424B-9689-CD705927436B/0/Isolationreportweb.pdf>
- Mino, Y., Shigemi, J., Otsu, T., Tsuda, T., Babazono, A. (2000) Does smoking cessation improve mental health? *Psychiatry Clin Neurosci*, 54(2), 169-72.
- Mummer K, Schofield G, Caperchione: Physical activity dose response effects on mental health status in older adults. *Aust NZJ Public Health* 2004, Ari;28(2):188-92
- Mutrie N (2000) The relationship between physical activity and clinically defined depression. In SJH Biddle, KR Fox and SH Boutcher (Eds.) *Physical activity and psychological well being* London: Routledge
- NICE 'Housing and Public Health: a review of reviews of interventions for improving health' Evidence Briefing Summary and Full Report, NICE 2005, www.publichealth.nice.org.uk
- Nicholaidis C, Curry M, McFarland B, Gerrity M 'Violence, mental health and physical symptoms in an academic internal medicine practice' *Journal of General Internal Medicine*, 2004, Aug; 19(8):893-5.
- NIMHE and CSIP, (2005) 'Making It Possible: Improving Mental Health and Well-Being in England', <http://kc.nimhe.org.uk/upload/making%20it%20possible%20exec%20summary.pdf>
- NOMS (2006) 'Strategy to Reduce Re-Offending in the South East' National Offender Management Service; www.noms.homeoffice.gov.uk
- ODPM - Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report* ODPM: London. <http://www.socialexclusion.gov.uk/downloaddoc.asp?id=134>
- ONS, 2003/4, 'Adults with Learning Difficulties in England 2003/4' Office of National Statistics; www.statistics.gov.uk
- Olds D, Henderson CR, Cole R, Eckenrode J, Kitzman H, Luckey D, Pettitt L, Sidora K, Morris P, Powers J (1997) 'Long-term effects of home visitation on maternal life course and child abuse and neglect' *JAMA*, August 27; Vol. 278. No. 8. 637-643.
- Paffenbarger RS, Lee I-M, Leung R (1994) Physical activity and personal characteristics associated with depression and suicide in American college men. *Acta psychiatrica Scandinavica* 89: S16-S22
- Patton GC, Carlin JB, Coffey C, Wolfe R, Hibbert M, Bowes G. Depression, anxiety and smoking initiation: a prospective study over 3 years. *Am J Public Health* 1998;88(10):1518-22
- Phelan M 'Physical health of people with severe mental illness' *BMJ* 2001; 322:443-444
- Poole T (2006) 'Securing Good Care for Older People – Dementia Care' Kings Fund; www.kingsfund.org.uk/publications
- Pratt D, Piper M, Appleby L, Webb R, Shaw J 'Suicide in recently released prisoners: a population based cohort study' *Lancet*, 2006; 368:119-23
- Respect Action Plan, 2006 www.respect.gov.uk
- Ryan R and Deci E (2001) 'On happiness and human potentials: A review of research on hedonic and eudaimonic well-being' in S Fiske (ed), *Annual Review of Psychology* (Annual Reviews Inc, Palo Alto, CA) Vol 52 pp141-166
- Sarafino E (2002) *Health Psychology* (Wiley, New York)
- Scott SD, Pringle A, Lumsdaine C (2004) 'Sexual exclusion – homophobia and health inequalities: a review' The UK Gay Men's Health Network; www.gaymenshealthnetwork.org.uk
- Scott S, Knapp M, Henderson J, Maughan B 'Financial cost of social exclusion: follow-up study of antisocial children into adulthood' *BMJ*, 2001; vol. 323: 1-5.
- SEPHO, 2005, 'Choosing Health report on Obesity' South East Public Health Observatory; www.sepho.org.uk

- SEPHO, 2006 'Choosing Health report on Physical Activity' South East Public Health Observatory; www.sepho.org.uk
- Sheldon K, Lyubomirsky S and Schkade D (2003) Pursuing Happiness: The Architecture of Sustainable Change (To appear in Review of General Psychology)
- Shepherd J, Bellis MA, Hughes K, Stewart L, Kemm J, Kohli H, Sanderson H 'Alcohol and Violence' Briefing Statement, Faculty of Public Health, UK, 2005; www.fph.org.uk
- Singer B and Ryff C (eds) (2001) *New Horizons in Health: An Integrative Approach* (National Academies Press, Washington)
- Singleton N, Meltzer H, Gatward R, Coid J, Deasy D (1997) 'Psychiatric morbidity among prisoners: summary report' Office of National Statistics
- Singleton N, Lewis G (2000/01) 'Better or Worse: A longitudinal study of the mental health of adults living in private households in Great Britain' Office of National Statistics, www.statistics.gov.uk
- Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. (2000) *Psychiatric Morbidity among Adults living in Private Households, 2000: Summary Report* ONS: London <http://www.dh.gov.uk/assetRoot/04/06/81/88/04068188.pdf>
- Smith, C.M., Pristach, C.A., Cartagena, M. (1999) 'Obligatory cessation of smoking by psychiatric inpatients'. *Psychiatric Services*, 50, 91-4.
- Snow S; Damico M; Tanguay D (2003) Therapeutic theatre and wellbeing *Arts in Psychotherapy* 30, 2 p73-82
- Sonntag H, Wittchen HU, Hofler M, Kessler RC, Stein MB. Are social fears and DSM-IV social anxiety disorder associated with smoking and nicotine dependence in adolescents and young adults? *Eur Psychiatry* 2000;15(1):67-74
- Stewart Brown S 'Mental health promotion: childhood holds the key?' *Public Health Medicine*, 2004; 5 (3):94-102.
- Stewart Brown S "What is the evidence on school health promotion in improving health or preventing Disease and, specifically, what is the effectiveness of the health promoting schools approach?" WHO, Euro, 2006, http://www.euro.who.int/HEN/Syntheses/healthpromotion_schools/20060224_7
- Supporting People – www.spkweb.org.uk
- Thomas DW, Heitman RJ, Alexander T (1997) The effects of music on bathing cooperation for residents with dementia *Journal of Music Therapy* 34, 4 p246-259
- Thomson et al (2001) 'Health Effects of Housing Improvement: a systematic review of intervention studies' *BMJ* 323:187-190, www.bmj.com
- Van Dam R, Walter C, Willett, Manson JE, Hu FB 'The relationship between overweight in adolescence and premature death in women' *Annals of Internal Medicine*, 2006; 145:91-97
- Vinnerljung B 'Children in care have a high risk of mental illness as adolescents and young adults' *Journal of Child Psychology and Psychiatry*, 2006; 47: 723-33
- Wanless D (2002) *Securing our future health: taking a long term view*. London: Stationary Office
- Wanless D (2004) *Securing Good Health for the Whole Population: Final report*. London: HM Treasury www.hm-treasury.gov.uk/wanless
- Warburton AC, Shepherd JP 'Tackling alcohol related violence in city centres: effect of emergency medicine and police interventions' *Emergency Medicine Journal*, 2006; 23: 12-17.
- Weaver T et al (2002) A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations. Research report submitted to the Department of Health. Department of Social Science
- Weitofte GR, Rosen M 'Is perceived nervousness and anxiety a predictor of premature mortality and severe morbidity? A longitudinal follow up of the Swedish survey of living conditions' *Journal of Epidemiology and Community Health*, 2005; vol 59, 9: 794-798. www.jech.com
- West, R., Hajek, P. (1997) What happens to anxiety levels on giving up smoking? *American Journal of Psychiatry*, 154, 1589-92.
- WHO (1996 & 1999) *The Global Burden of Disease*, www.who.int
- WHO Euro, (2005) 'Mental Health: facing the challenges, building solutions' www.who.dk/document/E87301.pdf
- Woolfenden SR, Williams K, Peat J 'Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17' *The Cochrane Database of Systematic Reviews*, 2006, Issue 1. www.cochrane.org/reviews/en/ab003015.html
- Zammit S, Allebeck P, Andreasson S, Lundberg I, Lewis G 'Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study' *BMJ* 2002; 325: 1199-201.
- Zoritch B, Roberts I, Oakley A 'Day care for pre-school children' *Cochrane Database of Systematic Reviews*, 2006, Issue 1. www.cochrane.org/reviews/en/ab000564.html

Reader information

Document Purpose	This document aims to act as a resource to inform commissioners, service leads, service providers and those involved in service improvement and the wider determinants influencing mental well-being across the South East region. The document provides information on the wider context, needs, the evidence for risk and protective factors and suggested ways forward.
Title	Mental Health and Well-Being in the South East
Authors	Jo Nurse and Jonathan Campion
Statistical Analysis	Liz Rolfe, Steve Morgan, Briony Tatem, Jo Watson
Reviewers	Alison Hill, Di Swanston, Philip Brooks, Poppy Jaman, Chris Morgan, Mike Gill, David Sheehan, Robert Kyffin, Jenny Bywaters, Shannon Robalino
Acknowledgements	<p>The authors would like to thank all those who have shaped and contributed to this report, including the development and piloting of the Dynamic Model for Well-Being:</p> <p>The South East Public Health Observatory The South East Development Centre The South East Regional Public Health Group</p> <p>Particular thanks is given to all those who contributed case studies, including the South East Arts and Health Partnership, KeyRing, MindOut and The Star Project; and thank-you to all those whose contributions could not be included in the report.</p> <p>The Cox Design Partnership</p>
Publication Date	October 2006
Target Audience	All those concerned with promoting mental health and well-being at regional and local levels, including Regional Organisations, Local Authorities, LSP, LAA and CDRP leads, Service leads for Mental Health Trusts, PCT Commissioners, SHA Mental Health Leads, Public Health and Health Promotion Teams, Children's Directors, CAMHS leads, Primary Care Service Leads, Prison Health Leads, Employers, Voluntary & Community Sector, and citizens with an interest in mental health and well-being.
Further Information	Jo.Nurse@dh.gsi.gov.uk

Care Services Improvement Partnership



South East Regional Public Health Group

Bridge House

1 Walnut Tree Close

Guildford GU1 4GA

www.gose.gov.uk/gose/publicHealth

Mental Health and Well-Being in the South East



Mental Health and Well-Being in the South East