SCOTTISH EXECUTIVE

National Programme for Improving Mental Health and Well-being

Mental Health Improvement 'concepts and definitions' :

Briefing paper for the National Advisory Group

Mental health, mental well-being and mental health improvement: what do they mean?

A practical guide to terms and definitions

healthyliving

This work was commissioned by the National Programme for Improving Mental Health and Well Being and undertaken by Lynne Friedli.

Lynne Friedli
Mental Health Promotion Specialist
22 Mayton Street
London
N7 6QR

Email: Lynne.Friedli@btopenworld.com

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1.0 Introduction – a question of language

This briefing is designed to provide colleagues across all sectors with a guide to ***mental health, mental well-being*** *and* ***mental health improvement*** terms and definitions. It complements the Scottish Executive briefing '*Mental Health Improvement: what works?'*, which provides more detailed guidance on evidence of effectiveness. (www.hebs.com/topics/mentalhealth)

Mental health improvement involves people from many different backgrounds, with different experiences and traditions, different expertise and different ways of thinking about mental health. The National Programme for Improving Mental Health and Well-being Action Plan 2003-2006 provides a framework for local and national action to improve mental health in Scotland. The development and implementation of mental health improvement strategies is currently underway across all Scottish health boards. All this work involves a wide range of partners across many sectors, including colleagues involved in the delivery of Community Plans and the broader local government well-being agenda.

Lack of clarity or confusion about the meaning and significance of different terminology can hinder communication and lead to misunderstandings. Finding a shared common language to discuss mental health is an important element of successful partnership working. It also provides a framework for communicating goals and outcomes to the widest possible audience.

There are a number of barriers to realising the dream of a common language however:

- *Mental health promotion/improvement[1] is a relatively new and emerging field.*

- *Demonstrating that mental health improvement is effective requires some new approaches and new ways of thinking about health and well-being.*

- *Mental health is a sensitive and contested area, involving many different stakeholders with different perspectives and experiences.*

Many of the terms used in mental health are the subject of debate. Using a particular word or phrase will have very specific connotations. For example, *patient, client, user or survivor* might all be used to describe someone who has used mental health services. Each term represents a different perspective.

These challenges are not unique to mental health. They mirror broader conflicts about the meaning of health, the causes or determinants of illness and how these should be addressed. At the heart of the debates about mental health, however, is a very long history of cruelty, neglect, coercion, social control and confinement. The importance that many people attach to language cannot be separated from how people with mental health problems have been treated, both within the community and by the medical professions and criminal justice system. People's experiences of compulsory admission, detention, medication and other treatments, and mental health services generally, continue to be central to thinking about all aspects of mental health.

Debates about language have been important in all movements for social and political change. The concern about how we speak about mental health echoes similar debates within the civil rights movement, the women's, gay and black liberation movements and the disability rights movement. At the same time, too great a preoccupation with terminology can stifle action. *It is often more helpful to focus on strategies for solving problems, rather than trying to achieve consensus on definitions.*

[1] The term 'mental health improvement' is widely used in Scotland. Elsewhere in the UK, Europe, Canada and Australia, the term 'mental health promotion' is used, notably in the academic literature.

2.0 How to use this briefing

The briefing provides a definition of widely used terms and concepts. It also describes why there is a debate about the use or meaning of particular words and summarises some of the different perspectives and their implications for practice. It is not a glossary, but a *guide to the issues that lie behind the debates*. A list of useful glossaries and sources of further information is provided in Appendix A.

Definitions evolve and change and words come in and out of fashion: we appreciate all the comments received in response to earlier drafts and very much welcome further feedback, additions and amendments. Please email these to:
lynne.friedli@btopenworld.com

3.0 National Programme for improving mental health and well-being

The key aims of the National Programme are:

- Raising awareness and promoting mental health and well-being,
- Eliminating stigma and discrimination,
- Preventing suicide and
- Promoting and supporting recovery

Priority areas are:

- Infant mental health (early years),
- The mental health of children and young people,
- Mental health and well-being in employment and working life,
- Mental health and well-being of older people,
- Community mental health and well-being and
- Supporting public services to promote mental health and well-being.

The National Programme also supports a range of activities to support and build capacity for mental health improvement as follows:

- Evidence into practice
- Research
- Evaluation
- Indicators for mental health and well-being
- Keeping people informed
- Sharing and learning

Further information on the national programme www.wellscotland.info

4.0 Mental health and mental well-being

> *"There is a need to address the problem of language and conceptual frameworks in relation to mental health promotion, so that a meaningful debate can take place across professional and sector boundaries. Involving communities and taking account of lay perspectives could help to achieve this: the high priority given by residents to friendliness, community spirit, security, feeling safe from crime, and proximity to friends and family indicates that communities attach a central importance to feelings of mental well-being…"*
>
> (SCMH/mentality 2001)

There are many different individual (or lay) definitions of ***mental health and well-being***. These are influenced by age, class and gender, as well as by people's experiences and expectations, and by cultural and religious beliefs. Gender has a significant impact on risk and protective factors for mental health and on the way in which the experience of mental distress is expressed. Rates of completed suicide are much higher for men, whereas women are at greatly increased risk of depression, anxiety and eating disorders. Women are also at greater risk of parasuicide, defined as suicide attempts and deliberate self harm with no intent to die.

Some studies have suggested cultural and ethnic differences in the way in which both mental health and mental distress are presented, perceived and interpreted and that different cultures may develop different responses for coping with psychological stressors. (Bhugra and Cochrane 2001) McCabe and Priebe (2004) found significant differences in explanations for schizophrenia among different ethnic groups, with White people more likely to cite biological causes and African Caribbean, West African and Bangladeshi people more likely to cite supernatural or social causes.

However a major qualitative study found that idioms of distress bore great similarity across ethnic groups, although some specific symptoms were different, notably among those who have migrated from South Asian countries, particularly those from Bangladesh.

"The fact that the broad narratives are remarkably similar across ethnic groups would suggest that, once contact has been established with appropriate medical services, there should be no reason for differentials in the diagnosis of mental health problems" (O'Connor and Nazroo 2002 p.38).

Lay definitions of mental health tend to include personal experiences, relationships and social conditions.

> *"It's about decent housing, nice neighbours, good friends, not feeling isolated, enough money, places to go, being able to do things and people to turn to in times of trouble."* (HEA 1998)

Most definitions used by health and other professionals draw on the definition of health drawn up by the World Health Organisation in 1948 and the 1986 Ottowa Charter for health promotion:

> *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*.
>
> *Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.*
> *(Ottawa Charter for Health Promotion. WHO, Geneva, 1986)*

There is general agreement that mental health is more than an absence of mental illness.

> *"mental health is the emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others' dignity and worth."* (HEA 1997 p.7)

The definition of mental health as a 'positive sense of well-being' challenges the idea that mental health is the opposite of mental illness. For example, someone with a diagnosis of schizophrenia might feel supported, at ease and optimistic. They might be coping well with life and enjoying a high level of well-being. Equally, many people who are not clinically diagnosed have a poor sense of well-being.

> *"Curing illness does not necessarily result in health."* (Barker 2000)

Mental health influences how we think and feel, about ourselves and others and how we interpret events. It affects our capacity to learn, to communicate and to form, sustain and end relationships. It also influences our ability to cope with change, transition and life events: having a baby, going to prison, experiencing bereavement.

> *"Everyone has mental health needs, whether or not they have a diagnosis. These needs are met, or not met, at home, in families, at work, on the streets, in schools and neighbourhoods, in prisons and hospitals – where people feel respected, included and safe, or on the margins, in fear and excluded."* (Department of Health 2001 p.28)

Mental health is sometimes described as *underpinning all health and well-being, because* of growing research evidence of the impact of how people think and feel on their physical health. (Scottish Executive 2003)

Measuring the mental health and well-being of individuals and communities is covered under section **20.0 Indicators**

5.0 Mental health improvement

Mental health improvement is any action taken to increase mental health among populations and individuals.

Mental health improvement is an umbrella term that may include action to promote mental well-being, to prevent mental health problems and to improve quality of life for people with a mental illness diagnosis. Definitions of mental health improvement have been influenced by the theory and practice of *health promotion:*

> *"Health promotion is the process of enabling people to increase control over, and to improve their health".*
> (Ottawa Charter for Health Promotion. WHO, Geneva,1986)

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

Mental health improvement is essentially concerned with:

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

> *"Mental health promotion can be seen as a kind of immunization, working to strengthen the resilience of individuals, families, organizations and communities,*
>
> *as well as:*
>
> *to reduce conditions which are known to damage mental well-being in everyone, whether or not they currently have a mental health problem"* (Health Education Authority 1998 p.1)

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

- Strengthening individuals - by increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills;

- Strengthening communities – by increasing social support, social inclusion and participation, improving community safety, neighbourhood environments, promoting childcare and self-help networks, developing health and social services which support mental health, improving mental health within schools and workplaces e.g. through anti-bullying strategies and mental health strategies.

- Reducing structural barriers to mental health - through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

> *"Reducing structural barriers to mental health and introducing policies which protect mental well-being will benefit those who do and those who do not, currently have mental health problems, and the many people who move between periods of mental health and mental illness."* (Department of Health 2001)

One of the most significant debates about mental health improvement concerns the balance between interventions which focus on strengthening individuals and those which address the wider determinants of mental health. It has been argued that focusing on 'emotional resilience' or 'life skills', for example, may imply that people should learn to cope with deprivation and disadvantage. (Secker 1998)

6.0 Public mental health

> *"Public mental health might be called the science, art and politics of creating a mentally healthy society"* (Friedli 2004 p.5)

The official definition of public health, coined by Sir Donald Acheson in his *Public Health in England* report in 1988 is:

> *"the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society"*

Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients. *Epidemiology* (from epidemics) is the study of the distribution and determinants of health. Key themes in public health include addressing the root causes of illness, tackling the inequalities which are at the heart of large variations in health and public participation.

What is sometimes called the '*new public health'* is particularly concerned with the wider determinants of health and overlaps with *ecological public health*, which emphasizes the common ground between health and sustainable development.

Public mental health takes a population wide approach to understanding and addressing risk and protective factors for mental health.

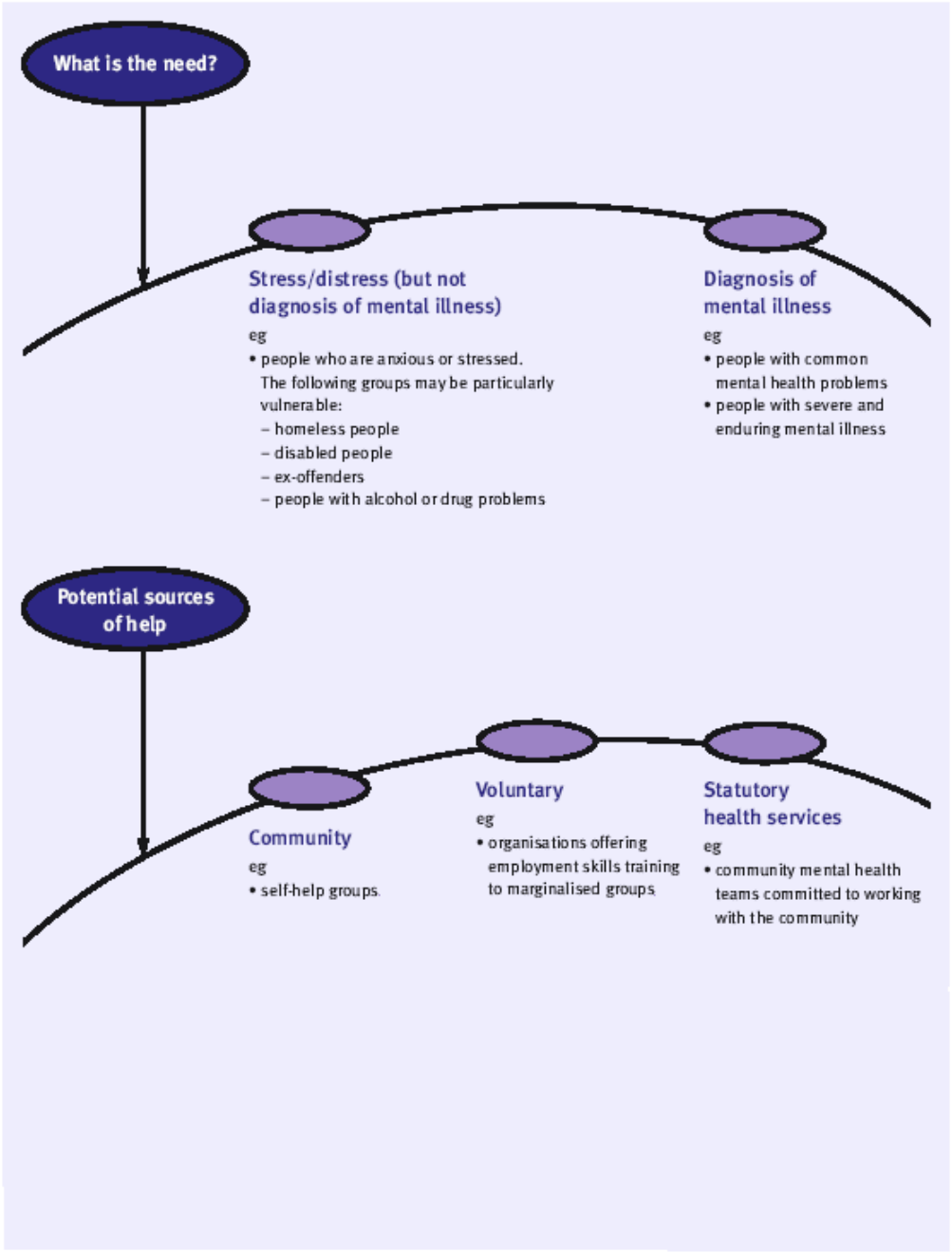
> *"public mental health, (of which mental health promotion is one element), provides a strategic and analytical framework for addressing the wider determinants of mental health, reducing the enduring inequalities in the distribution of mental distress and improving the mental health of the whole population"*. (Friedli 2004 p.2)

> *"how people feel is not an elusive or abstract concept, but a significant public health indicator; as significant as rates of smoking, obesity and physical activity"* (Department of Health 2001)

The following diagram, from a recent report on mental health and regeneration, (Cameron et al 2003) illustrates how a public mental health approach might work at a community level:

Figure 5: Mental health in the community – meeting the full range of needs

This figure illustrates two arcs, to be looked at together, which give a sense of the range of possibilities for meeting different mental health needs in the community. The arcs link key areas of need with key sources of support.



7.0 Mental health improvement or illness prevention: does it matter?

Preventing mental illness is a key goal for many mental health improvement programmes. It is widely used to make a case for funding particular interventions (e.g. home visits to low income pregnant women will reduce postnatal depression) and to measure their success: (following the programme, fewer women experienced post natal depression, compared to those who did not receive visits).

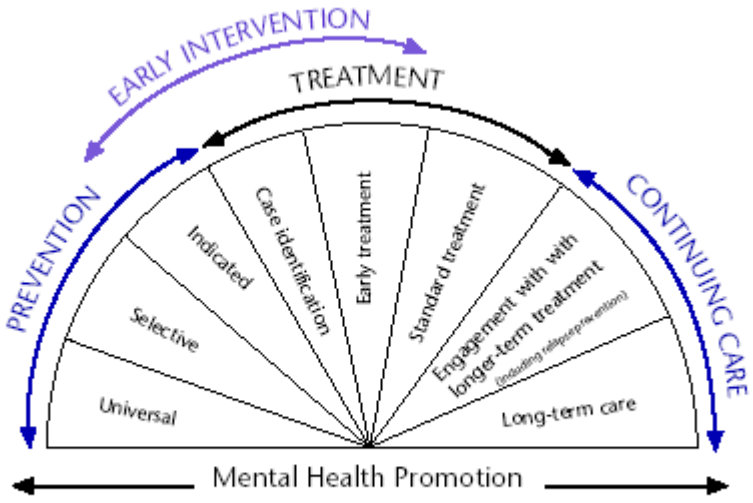
In the classic health promotion literature, prevention is categorised as follows:

- **Primary**: to prevent a disorder occurring
- **Secondary**: to reduce prevalence through early intervention
- **Tertiary**: to reduce disability as a result of the disorder

Prevention may be:

- **universal** – for the whole population e.g. pre-school day care
- **selective** – for those at increased risk e.g. home visits for low income mothers
- **indicated** – for individuals with existing symptoms e.g. cognitive therapy for children with behavioural problems

(Commonwealth Department of Health and Aged Care 2000; Jenkins and Ustun 1997)



Source: adapted from Mrazek and Haggerty (1994)

In practice, the distinction between prevention and mental health improvement is rarely clear cut:

- Programmes to raise public awareness, to reduce stigma or negative media coverage have the same goals as tertiary prevention.

- Mental health improvement in the workplace may reduce stress related illness, but may also result in broader outcomes e.g. higher productivity, increased morale, employment of people with mental health problems.

- Interventions designed to prevent a specific mental health problem, e.g. post-natal depression, may not reduce prevalence, but may have a wide range of socio-economic benefits e.g. uptake of education, support networks

Although preventing mental health problems may seem a worthwhile and uncontentious goal, it is open to question:

There are concerns about wider civil liberties issues, if the goal of interventions is to eliminate all disorders of the mind, in the same way that the disability rights movement challenges attempts to eliminate all conditions that result in physical disabilities. At the heart of these debates are different perspectives on conformity and diversity and their implications for mental health policy and practice.

A focus on prevention, rather than mental health improvement, may also mean getting stuck with an illness model.

> *"I think we should totally separate mental health improvement and the illness model – but stop denigrating the appropriate use of illness models. I saw a young man who can only stay well when he takes Clozapine to manage his psychotic symptoms. He also uses CBT, self help and meditation. He is doing well at university and says he's recovered his well-being and previous quality of life. He depends on me to look after the complex pharmacology and neurophysiology as part of his care. I think this is 100% consistent with both the illness model and with mental health improvement"* (M. Smith, personal communication)

> *"There can be a temptation to assign categories – and then prioritise these categories. For example, a clear split is often made between 'the worried well' and 'those with severe and enduring mental illness'. A corresponding division can be made between mental health promotion ('the soft stuff') and the delivery of mental health services to those with severe illness ('the hard stuff'). But our everyday reality is that we work with people from across the spectrum of mental distress and illness. Even if you've got severe and enduring mental illness, you can still interact with a baby in a way that supports that baby's development – or you can learn to do this. Conversely, your baby may be at risk of impaired social, psychological and/or cognitive functioning even though your mental health difficulties do not meet the threshold that would allow you to access traditional mental health services."* (Wendy Lanham in Cameron et al 2003, p.60)

8.0 Early intervention

Early intervention is used very specifically within mental health services to refer to the practice of identifying and treating very early symptoms of psychosis in young people. It is based on evidence that early treatment of psychotic episodes is associated with improved outcomes, including a greater likelihood of complete recovery. Early intervention involves identifying very high risk young people, (via partnerships with a range of agencies, including schools), around 40% of whom will go on to develop psychosis. (Brown et al 2003; Spencer et al 2003)

9.0 Mental health problems – what's in a diagnosis?

> *"In the case of mental health, both symptoms and diagnosis are so, well, flexible. You can't pee in a bottle and have the matter settled one way or the other."*
> (Cassandra 2003)

A mental illness diagnosis like schizophrenia, bi polar disorder or depression is a classification of a range of symptoms that are common to a specific disorder. The manuals used by all mental health professionals when making a diagnosis are *International Classification of Disorders (ICD-10)* or the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)*. These provide a list of symptoms and specify how many symptoms, for how long, in which combinations, constitute a specific disorder.

There are ongoing debates about the validity and usefulness of diagnostic criteria, notably in relation to schizophrenia. Some people do not believe it is helpful to use one label to describe a wide range of different experiences and prefer to address symptoms, in other words the list of difficulties that a person has. (Bentall 2004)

> *"psychiatric diagnosis is not dissimilar to astrology: both systems attempt to tell us something about people and to predict what will happen to them in the future, and both fail miserably."* (Bentall 2004 p.21)

Not everyone believes that seeking a cure for mental health problems is necessarily the right approach. Within the user/survivor movement, campaigning groups like Mad Pride have emphasised the positive aspects of experiencing mental health problems. This is linked to the idea of mental illness as a 'disease of meaning' and the view that people need an opportunity to make sense of their crises and experiences. (Campbell 1993)

At the heart of these debates are very different conceptual frameworks for explaining, treating and managing mental health problems. Key questions include whether mental health problems are a brain disorder (the problem is biological) or a cognitive disorder (the problem is psychological) and the relative influence of genetic inheritance, family experiences, life events, material deprivation etc.

> *"there is now overwhelming evidence that describes in detail the interlinked influence of genes, early experience, emotional and physical development, social environment, stress and drugs on the development of psychosis. What's fascinating about the new research is how we are finding that social factors have biological correlates, and vice versa"* (M. Smith, personal communication)

An awareness of some of the issues makes it easier for colleagues working in mental health improvement to understand concerns and priorities both within the user-survivor movement and among different mental health professionals.

10.0 Mental health problem or mental disorder or….?

Terms like mental health problem, mental illness, mental disorder and mental distress are often used interchangeably. *Mental health problem* is sometimes used to describe conditions seen as less serious, as distinct from *severe and enduring mental illness*, although in practice, these distinctions are fraught with difficulties.

Within the user/survivor movement, and increasingly in the non-medical literature, the most widely used and accepted term is *people with mental health problems.* This includes those who have and those who have not used mental health services, and people who may not have received a diagnosis. It is preferred by many people because it does not make a judgement about severity or level of disability, does not rely on an illness model and indicates that the *mental health problem* is just one aspect of a person.

Terms like mental or emotional distress are probably best avoided when describing mental health problems. They suggest that distress, which is a normal part of life, is an illness.

Within the medical literature, mental disorder refers to diagnoses included within DSM IV or ICD-10 e.g. schizophrenia. In legal terms, mental disorder has a different meaning, for example under the terms of the current Mental Health Act, where it includes mental illness, learning disability and personality disorder.

Prevalence figures, for example 'one in four' (lifetime) or 'one in seven' (point) are based on how many people in the population meet clinically agreed criteria for a mental disorder. This data is drawn from large scale surveys, because many people with neurotic (e.g. depression and anxiety) and psychotic (schizophrenia) symptoms are not in touch with mental health professionals. Lifetime prevalence refers to the number of people who will experience a mental health problem within their lifetime; point prevalence is a snapshot of how many people have the problem at a particular time.

11.0 Stigma and discrimination: what's in a name?

Eliminating **stigma and discrimination** is a key aim of the National Programme and the terms are widely included in the objectives of local projects across Scotland. (www.wellontheweb.net)

Stigma refers to negative stereotyping and its consequences. It includes attitudes and beliefs that lead to labelling, setting apart, devaluing and discriminating.

The stigma or branding attached to mental illness influences public attitudes and behaviour: fear, ignorance, misunderstanding and intolerance. This is particularly evident in sensationalized or inaccurate media coverage: 'mad axeman loony strikes again' or 'bonkers Bruno'.

Stigma is also a feature of many deeply held, prejudicial beliefs:

'*people with mental health problems should not hold public offices*';
'*schizophrenics are violent';*
'depressed - you should pull yourself together'.

Interventions to tackle stigma tend to focus on changing attitudes, notably through work with the media. Recently, there has been more emphasis on reducing ***discrimination***: addressing legislative and other structural factors which result in people with mental health problems receiving less favourable treatment (for example in employment), and ***social exclusion.*** (Social Exclusion Unit 2004)[2]

[2] The Social Exclusion Unit's remit covers England only. However, this major report draws on lessons from Wales, Scotland and Northern Ireland and its recommendations are likely to be relevant across the UK

"Stigma is entirely dependent on social, economic and political power – it takes power to stigmatise… When people think of mental illness, obesity, deafness, and having one leg instead of two, there is a tendency to focus on the attributes associated with these conditions, rather than on the power differences between people who have them and people who don't. But power, even in these circumstances, is essential to the social production of stigma." (Link and Phelan 2001 p.375)

12.0 Disability or illness?

> *"It makes no sense to start with a concept like 'brain disease', which evokes images of powerlessness*" (Sayce 2002 p.77)

> "*… it is recommended that destigmatisation programmes consider abandoning efforts to promulgate illness-based explanations and focus instead on increasing contact with and exposure to users of mental health services"* (Read and Harre 2001)

The disability model has had a significant impact on work to challenge discrimination. From this perspective, a person is disabled not – or not just - by their impairment, but by the barriers that society puts in their way.

> *"Illness is not a useful concept to describe the experiences of people with long-term mental health problems. Illness suggests an episode, during which the person needs to be relieved of responsibilities, until they get 'better'. Disability is something you live with: it does not prevent you from having responsibilities, given support as necessary and the removal of external barriers."* (Sayce 2002 p.77)

The Disability Discrimination Act (1995) covers psychiatric impairments (clinically recognized mental illnesses) and learning disabilities and has been seen as an important opportunity to reduce the exclusion of people with mental heath problems, notably in the area of employment. (Disability Rights Commission 2003)

> *"Employers respond very negatively to the 'illness' concept. 'Ill' people should not be at work, almost by definition. They should be tucked up in bed. But employers are beginning to understand that disabled people can and do work – and may need 'reasonable adjustments' in order to do so."* (Sayce 2002 p.77)

13.0 User, survivor, patient, client

Traditionally, health professionals have referred to those who consult them as patients. The term client is more widely used in social work and by those providing psychological or talking therapies. It is intended to suggest a more equal relationship, giving the patient a status more akin to that of a customer or consumer.

In mental health, p*eople who use mental health services*, (or service user) is the most commonly used term. Many people do not like the shortened form 'user', because it can also mean people who misuse drugs. Although there have been criticisms of defining people in terms of their use of services, no other description is as widely used or understood. The *user movement* refers to a very wide and diverse range of individuals, organizations and networks campaigning for improvements in the way in which people with mental health problems are treated generally and for improvements in mental health services.

The term survivor reflects a radical critique of psychiatric treatment and the mental health system. It has two meanings: survivors of the experience of using mental health services and survivors of mental health problems. Survivor perspectives represent a distinct voice within the user movement, hence the description *user/survivor movement.*

> *"Some people are uncomfortable with the confrontational nature of the term 'survivor' and its original implication that what is to be survived is not so much 'mental illness' as psychiatric treatment and the mental health system*." (Weaver undated)

14.0 Recovery

Recovery is described as '*a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness'*. (Anthony 1993)

The recovery model is not limited to any particular model or theory about the causes of mental health problems. It focuses on recovery rather than illness and identifying what a person needs to regain or hold on to a life that has meaning for them.

Key themes in recovery include:

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

(Bates 2002)

From a recovery perspective, control must shift from those providing treatment to the person who is recovering. It involves engagement with the whole person (not the diagnosis) respect, reciprocity, shared decision making, an emphasis on people's strengths and a belief that everyone can make a contribution.

Recovery aims to enable people to:

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

(Perkins 2002)

> *"Hope is not contingent upon cure, but on recovery, in the sense of finding meaning and fulfilment with the impairment."* (Sayce 2002)

15.0 Experts by experience

Coined by the recovery movement, ***experts by experience*** is a formal recognition of the skills, knowledge and expertise that come from direct experience of having mental heath problems.

16.0 Quality of life

Quality of life is a way of assessing levels of well-being, as opposed to illness. It includes economic, social and environmental factors, for example employment, housing, quality of the natural environment, cultural and leisure facilities, noise, pollution and safety. Quality of life indicators are of particular importance to local authorities, because of the 'power *to advance well-being' provision* in the Local Government in Scotland Act 2003.

WHO has conducted a major international study into quality of life (WHOQOL 1996), which identifies six broad domains:

- physical
- psychological
- level of independence
- social relationships
- environment
- personal beliefs/spirituality

Quality of life reflects people's belief that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfilment, notwithstanding health *status*, or social and economic conditions.

Quality of life is also of growing importance as an outcome measure for mental health services. (Laugharne 1999; Slade and Priebe 2001) This means expanding clinical indicators of successful treatment, (e.g. reduction in symptoms), to include outcomes that are important to those who use services, for example employment, independence and friendship. Quality of life is a significant element of the **recovery** model.

17.0 Social capital

Social capital is the invisible glue which binds communities together, gives them a shared sense of identity and enables them to work together for mutual benefit. (Kawachi et al 1997)

> *"social capital refers to features of social organisation such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit"* (Putnam 1995 p.67)

Research on social capital suggests that indicators of community cohesion and efficacy – levels of trust, tolerance, reciprocity and participation – are an important influence on health. The erosion of social capital may be one of the pathways through which income inequality impacts on health.

Social capital is an important concept for mental health improvement, because of its focus on psycho-social factors. Critics of social capital theory argue that it detracts attention from material deprivation as the primary determinant of health.

18.0 Social exclusion

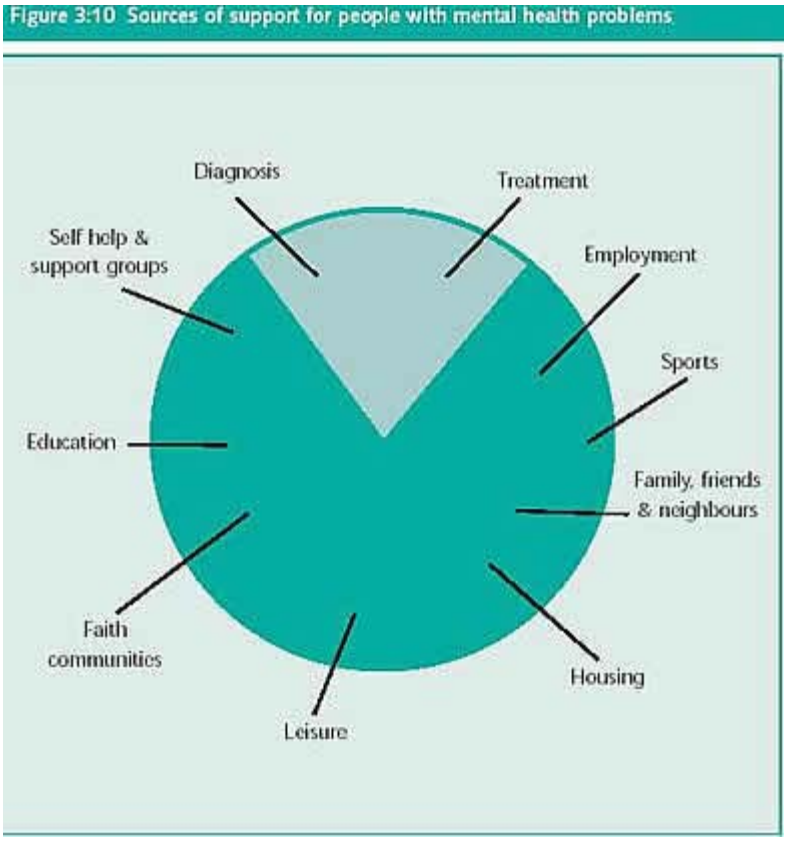
> *"Social exclusion is a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown."* (Tessa Jowell, Nye Bevan Memorial Lecture June 1998)

> *"Social exclusion is the process by which people are prevented from participating in economic, social, cultural or political aspects of society, often, but not always, because they are affected by poverty, deprivation or discrimination."* (Scottish Executive Social Inclusion Division, 2004)

Tackling social exclusion is fundamental to Scotland's social justice agenda and includes a wide range of initiatives aimed at people who experience multiple disadvantage. (McCormick and Leicester 1998)

Mental health problems are both a cause and a consequence of social exclusion. Reducing barriers to education, employment, sport, leisure and other opportunities is currently high on the mental health agenda and is one of the National Programme's key aims.

> *"Social inclusion is not an intervention or treatment, but a set of values and principles which are about equity. To 'deliver social inclusion' is to risk imposing another set of imperatives which further disempower those who use mental health services: you will be included, whether you like it or not….."* (Friedli and Gale 2002 p.62)



(Department of Health, 1999, www.nelh.nhs.uk/mentality)

> *The more that mental health services succeed in supporting people to take up non-segregated, mainstream opportunities, rather than participate in specialist services such as mental health day centres – the more accepted are people with mental health problems likely to become. Without such initiatives, fear and prejudice are likely to grow, even as safer services are achieved."* (Sayce et al 1999)

19.0 Treatment of mental health problems

Treatment issues are important to mental health improvement for three reasons:

- Improving mental health services is part of the wider goal of improving quality of life for people with mental health problems and reducing social exclusion

- Colleagues responsible for treatment are also important stakeholders for the broader mental health improvement agenda

- Some treatment approaches, notably ***cognitive behavioural therapy*** and other psychological therapies, may also be used to prevent mental health problems and/or to promote mental health.

The main treatments for mental health problems are biological (usually medication) or psychological (talking treatments) and these are often combined. There is ongoing debate about the effectiveness of all treatments, including different types of medication. NHS Quality Improvement Scotland (formerly the Health Technology Board for Scotland) issues guidelines on clinical effectiveness, including topics like counselling in primary care. (www.nhshealthquality.org.)

Treatment approaches that are particularly relevant to mental health improvement include:

- **Psychological therapies**

Include any kind of talking therapy, usually distinguished by different models for understanding the causes of psychological problems. Two major branches are psycho-dynamic psychotherapy and psychoanalysis. Counselling, often referred to as generic counselling, does not rely on any single model or approach.

- **Cognitive behavioural therapy**

Cognitive behavioural therapy addresses how people's self perception influences their behaviour and how beliefs may result in destructive or unhelpful behaviour. The basis of CBT is that what people think affects how they feel emotionally and also alters what they do. CBT is short term and problem focused. Many self-help books, computer based packages and self-help groups are based on CBT principles.

- **Self-help**

Self help is applied loosely to a range of groups and resources which aim to empower people to become more skilled and knowledgeable about coping with and managing their mental health problems. Self-help groups are usually set up and run by people who have themselves experienced a particular problem, for example depression, bi-polar disorder or hearing voices.

- **Positive psychology**

Positive psychology, coined by Martin Seligman, has gained publicity recently. It is described as three routes to happiness: "pleasant life", "good life" and "meaningful life". It is not a treatment, but sits within a long tradition of 'how one should live' advice, and it has attracted considerable media attention. Key elements include: wisdom and knowledge; courage; love and humanity; justice; temperance; spirituality and transcendence.

- **Social prescribing**

Social prescribing is a way of linking patients in primary care with non-medical sources of support within the community. It provides a framework for developing alternative responses to mental distress and is part of a wider recognition of the influence of social and cultural factors on mental health outcomes.

Social prescribing is based in part on the central importance of social support as a protective factor for both mental and physical health, and by evidence of the health benefits of participation, involvement and reciprocity, drawn from research on ***social capital.***

The most common examples of social prescribing are primary care based projects which refer at risk or vulnerable patients to a specific programme, for example *exercise on prescription, prescription for learning* and *arts on prescription.* However it also includes a very wide range of initiatives in which primary care staff provide a signposting or gateway service, linking patients with sources of information and support within the community and voluntary sector.

20.0 Measuring mental health: indicators

Health indicators are used to both to define a *public health* problem and to indicate changes in health over time in individuals or populations. They are also used to assess whether the objectives of a programme are being reached: *indicators of success.*

Indicators *indicate* a problem or the success or failure of the intervention. For example, increased body satisfaction and a reduction in weight controlling behaviour among young women might be indicators of the success of a programme to reduce eating disorders. They should be drawn from the research literature on protective and risk factors, so that there is a clear and robust relationship between the indicator (e.g. social networks, exercise, job control, problem solving skills) and the objective: improving mental health.

A big challenge for mental health improvement is identifying indicators of positive mental health, as opposed to indicators of mental illness. Surveys of psychiatric morbidity, for example, measure mental illness, not mental well-being. There is an emerging literature on indicators that can be used to measure the mental health of both individuals and communities. Further work on public mental health indicators is being carried out by NHS Health Scotland. Research in the areas of ***quality of life*** and ***social capital*** is also a useful source of mental well-being indicators. (Scottish Executive 2003; Chanan and Humm 2003)

- Examples of Individual indicators:

  agency, trust, autonomy, self-acceptance, respect for others, hopefulness and resilience

- Examples of Community indicators:

  Equity, control, safety, participation, cultural assets, lifelong learning, robust local democracy, social networks, physical environment

21.0 Mental health impact

Mental health impact assessment is a way of including mental health in the decision making process. It means that committees, task forces, advisory groups and other forums where decisions are made need to ask: 'what impact will this action have on people's mental health?' Finding answers to this question involves drawing on many different sources of expertise, including mental health service users, voluntary agencies and local government, as well as public health specialists with an understanding of risk and protective factors for mental health.

22.0 Effectiveness or does it work?

The traditional view of ***mental health improvement*** is that there is very little robust evidence of its ***effectiveness***. This view influences some medical and other professionals, who may view it as '*well meaning but rather woolly*' and some funders, who may be reluctant to devote resources to mental health improvement, in the face of other priorities.

A key problem has been that randomized controlled trials (the gold standard for assessing evidence of effectiveness) are of limited use in evaluating mental health improvement interventions. However, it is now much more widely accepted that different methods and different criteria for measuring success are required across all areas of health and health service delivery. (mentality 2003)

Factors that have influenced this shift include a growing emphasis on:

- the impact of psycho-social factors on health, e.g. social capital, social exclusion and quality of life
- public/patient involvement and the need to take account of consumer views in deciding what success looks like
- user led research, drawing on people's own expertise in living and coping with mental health problems

The demand for evidence based practice is likely to remain fundamental, but questions about what counts as evidence are growing louder.

> *In thinking about evidence of effectiveness, there are only two questions: who defines success and what measures are they using?* (mentality 2003)

Central to this debate in mental health is the view that measures of success (health outcomes) need to be expanded to include the goals of mental health service users, for example employment, independence, friendships and quality of life. A key challenge will be finding both the measures and methodologies that can capture a wider range of domains than symptoms, and a wider range of stakeholder perspectives.

Appendix A – Sources of further information and references

Glossaries

Mental health
Most professional organisations and mental health charities provide definitions of key mental health terms on their websites. Reading these can provide a helpful introduction to the way in which the use of language reveals different perspectives.

A good starting point is the comprehensive **wordbank** produced by the **Mental Health Foundation** www.mentalhealth.org.uk

Also useful is the Royal College of Psychiatrists glossary of mental health professionals, diagnoses and treatments www.rcpsych.ac.uk

Health Promotion
The World Health Organisation provides a useful guide to health and public health terms, which also describes their history and the conceptual frameworks which inform new developments in health promotion

World Health Organisation (1998) *Health Promotion Glossary* Geneva: WHO
WHO/HPR/HEP/98.1
www.wpro.who.int/hpr/docs/glossary.pdf

Mental health improvement
Making it happen: a guide to delivering mental health promotion (Department of Health, 2001) includes a range of definitions and models of mental health promotion and outlines some of the debates
www.nelh.nhs.uk/mentality

Research terms
A simple glossary of terms commonly used in the literature on evaluation, effectiveness and methodology:

Mentality (2003) *Making it effective: a guide to evidence based mental health promotion* London

The same glossary is also available in the reference section of:
Scottish Executive (2003) *Mental Health Improvement: what works?*
www.hebs.com/topics/mentalhealth

and can also be accessed via:
www.wellontheweb.net

Keeping up to date with the debates

Journal of Mental Health Promotion

Quarterly journal published by Pavilion www.pavpub.com
Sample copies from samplecopy@pavpub.com
The current issue (March 2004) includes an overview of mental health improvement across the four UK nations.

Mental Health Today

Monthly magazine, also published by Pavilion, carries a wide range of features on mental health improvement, social inclusion and user perspectives on mental health service delivery. Subscriptions: 0870 161 3505.

Mental health and inequalities

Rogers A and Pilgrim D (2003) *Mental health and inequality* Basingstoke: Palgrave Macmillan

Regeneration

Cameron M, Edmans T, Greatley A and Morris D (2003) Community Renewal and Mental Health: strengthening the links London: King's Fund

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