

# A Strategy to Promote Mental Well-being in Berkshire

**2001-2010**

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# FOREWORD

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Improving mental well-being is relevant in one way or another to everyone living or working in Berkshire. Many of us suffer from some form of mental distress or else know someone who does, either a family member, a colleague or someone in the neighbourhood. This suffering poses heavy costs on the community, both in terms of human misery and the burden of care and treatment.

Good mental health enhances the quality of life for individuals and the whole community, giving opportunities for achieving greater fulfilment. It is also beneficial to maximise the contributions that people can make through their integration within the community by reducing the harmful discrimination arising from adverse attitudes to mental health problems.

On behalf of the whole population, we welcome the strong commitment from local people and organisations to developing this strategy in response to the lead set by the government to seek to improve mental health and to reduce the stigma sometimes associated with mental problems. We look forward to seeing the benefits arising from implementation of this strategy in the future.

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# Executive Summary

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- One in six people are affected by mental health problems. Besides the immense cost in personal and family suffering, mental illness costs in the region of £32 billion per year.

The National Service Framework for Mental Health, Standard One states that Health and Social Services should:

- *Promote mental health for all.*
- *Combat discrimination against individuals and groups with mental health problems and promote their social inclusion.*
- The strategy proposes interventions that are evidence based and will be implemented in partnership with local authorities, the voluntary and private sector and users and carers.
- Interventions will take place in schools, the workplace and in communities and neighbourhoods.
- Interventions will include initiatives to strengthen individuals, strengthen communities and improve socio-economic conditions.
- Organisations will be targeted to develop mentally healthy structures and policies.
- This is a ten-year strategy, which will be implemented at two levels: a pan Berkshire level and a locality level.

# Recommendations

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- A cross county network should be identified to take forward key messages and work with the press and through other media to promote a positive view of mental health and empower people to look after their own mental health. This group will also work pro-actively with the press and in schools to fight discrimination and stigma and will target negative attitudes where they are identified in the local press or particular professional groups.
- Mental health promotion in Primary Care should be extended to provide exercise on prescription, talking treatments and sign-posting to voluntary support groups. Particular attention should be given to new mothers, the bereaved and divorced, and carers.
- Mental Health Promotion for Young People and Families should work through the Healthy Schools Programme and creative art projects to develop emotional literacy, build self-esteem and self-confidence and address bullying, homophobia, racism and discrimination. A particular emphasis will be given to excluded and looked after children. Localities should develop parenting skills programmes and social support for new mothers and lone parents.
- Social support and community development should be developed for vulnerable groups. These should include people experiencing domestic violence, ethnic minorities, refugees and victims of torture, prisoners and those with dual diagnoses.
- Localities have been requested to identify priorities according to local need and to develop action plans to be integrated to local Health Improvement Programmes and Joint Investment Plans.
- Environmental Officers should provide training on mental health in the workplace to Personnel Officers and Occupational Health Staff. Employers should develop mental health friendly policies at work, schemes to support people with mental health problems in the workplace and organise mental health promotion interventions (e.g., stress management). Social support and skills training programmes should be in place for the unemployed.
- Proposed Pan Berkshire Priorities for 2001/2002 will be:
  - Healthy Schools
  - Vulnerable Children
  - Prisons
  - NHS Workforce
  - Stigma and Discrimination

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# Acknowledgements

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*We would like to thank the literally hundreds of people who assisted us in the development of this Strategy and hope that you will forgive us if, for reason of space, we do not acknowledge you all.*

*This help has taken many forms: individual consultations, responses to the draft Strategy and input at the locality conferences. We hope that such wide participation will ensure local ownership of both the Strategy and the Locality Action Plans and will ultimately contribute to the improvement of the emotional well being of the people of Berkshire.*

*We would however like to acknowledge the work of Dr. Lynne Friedli and the charity Mentality in providing the evidence base which underpins this Strategy.*

# SECTION 1

## Introduction

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### 1.1 Why a strategy?

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This Strategy has been prepared in response to the **National Service Framework for Mental Health, September 1999**, which sets seven standards to improve the quality of mental health service delivery. This Strategy addresses Standard One which states that: 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.

Mental Illness is a significant cause of ill health and disability in England and is identified as a priority for both Health and Social services in both **Saving Lives: Our Healthier Nation. (DOH 1996)** and **Modernising Health and Social Services: National Priorities Guidance for 1999/00 & 2001/02.**

**The NHS Plan (2000)** reinforces the direction of the **Mental Health National Service Framework**. It will have an impact on Mental Health in the workplace through its commitment to **Improving Working Lives**.

It also addresses the need to tackle disadvantage, inequalities and discrimination.

For children the **Quality Protects Plan** co-ordinates the working of many agencies and underpins the work of this strategy.

This Strategy exists to inform and set a direction for all responsible for taking forward mental health promotion in schools, workplaces, neighbourhoods and communities.

Two types of initiatives are recommended: those that need to be taken on at a pan Berkshire level and those that need to be locality driven.

### 1.2 What is mental health?

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There is no one agreed definition of mental health. When most people talk about mental health they mean mental illness. At best mental health is seen as the absence of mental illness. This is neither helpful nor motivational, so we need to find new vocabulary for emotional and mental well being.

In this Strategy we are committed to a positive model of mental health, a model which emphasises the need for each individual to develop their full potential. Both the WHO and the Ottawa Charter have positive definitions of health: "a complete state of physical, mental and social well being, not merely an absence of disease and infirmity" (WHO 1946 cited in Weare 2000) and "a positive concept emphasising social

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and personal resources, as well as physical capabilities". (WHO, 1986 cited in Weare 2000).

For young people this will mean not only "preventing unhappiness, bullying, violence and conflict but also encouragement to achieve goals, to love, feel joyful, energetic, full of life and to care about others." Weare (2000).

For adults the key components are the development of a capacity for enjoyment, planning and achieving goals, emotional self-regulation, mature relationships and satisfying work.

The evidence for mental health will be seen in levels of happiness, vitality, a desire to learn, a sense of worth and achievement and a concern for and tolerance of others. (ibid)

At a deeper level the need for love and harmony, trust, meaning, peace, forgiveness, hope and strength will need to be respected and encouraged. **Mental Health Foundation In Good Faith** (2000).

A mentally healthy community will offer opportunities for participation and will build supportive networks.

### 1.3 Why promote mental health?

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The twentieth century has brought us many changes that have put our mental health under pressure.

- We experience a combination of a faster pace of life because of technology, but in most cases our energy output has decreased. Many people drive and sit at computers rather than walk and do manual labour. For some there is thus less opportunity to relieve stress which may manifest as anxiety, overflow into road rage or domestic violence or if prolonged present as burn out or depression.
- Changed expectations of relationships and an increase in separation and divorce has led to a growing number of single households which has both put pressure on the housing market and increased the isolation of some adults who do not have supportive social networks as a matter of course.
- Increased consumerism brings fast food and seven-day working which has for some undermined family meals, conversations and shared activities. Changed attitudes to religion have meant that children are not automatically taught a moral code and changing views of acceptable discipline have meant that childrens' boundaries are not being effectively enforced. Positive role models are often missing and ideas of acceptable conduct are generated by films and television. The easy availability of alcohol and drugs provides an added risk to mental health.
- Many teenagers are now becoming parents without the maturity and experience to raise a family. Many young parents have no local

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family support or experience to call upon because the extended family is often spread geographically

- A fast moving employment market means that breadwinners often commute long distances, are away long hours and return home exhausted. Because people now move house more often to follow jobs, partners may find themselves isolated and unsupported in neighbourhoods that they do not feel part of.

For all these reasons adults are more likely to feel stressed and lonely, inexperienced parents are more likely to struggle unsupported and children are more likely to be emotionally neglected and uncontained. It is therefore essential that we all take compensatory and deliberate action to promote emotional and mental well being.

Emotional well being not only makes life more pleasurable and more rewarding in itself but it is also a strong predictor of mortality and morbidity. Men and women who scored highest in a survey on emotional health were twice as likely to be alive by the study's end (Goodwin, 2000).

Good mental health underpins physical health and there is a growing body of evidence linking psychological distress with physical health problems. Depression increases the risk of heart disease by four times (Harris and Barraclough, 1998). Stress or trauma is linked to many physical ailments such as high blood pressure, asthma, irritable bowel syndrome, eczema and ulcers.

## 1.4 What causes mental illness?

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The Health Education Authority (now the Health Development Agency), suggests the following as social and psychological causes of mental illness: HEA (1997)

### **Predisposing factors:**

- Social - Recent life events, e.g. threat of redundancy, unemployment, major illness in the family, a child leaving home, separation or divorce and bereavement or the loss of a supportive relationship.
- Psychological - Maladaptive feelings of hopelessness.

### **Precipitating factors:**

- Social - Physical and emotional deprivation in childhood, due to bereavement, separation, family discord, chronic social difficulties at work and at home, lack of supportive relationships.
- Psychological - Poor parental models, low self-esteem.

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Maintaining factors:

- Social - Chronic social stress, lack of social support.
- Psychological - Low self-esteem, lack of expectation of recovery.

The following also contribute to raised stress levels (Rainford et al, 2000):

- lack of control over decisions affecting one's life
- lack of influence over neighbourhood decisions
- low neighbourhood social capital
- having no personal support (especially men)
- no involvement in community activities

## 1.5 What promotes mental health?

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This Strategy is underpinned by the evidence that early interventions to nurture, educate and empower can promote mental health. Interventions to reduce risk factors can also make people less vulnerable to mental illness. These can take place at an individual, community or organisational level. HEA: A Quality Framework (1997)

- Strengthening individuals - or increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
- Strengthening communities - this involves increasing social inclusion and participation, improving neighbourhood environments, developing health and social services which support mental health, anti-bullying strategies at school, workplace health, community safety, childcare, self-help networks and so on.
- Improving socio-economic conditions - through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.
- Additional health promotion action should include:
  - Healthy Public Policy
  - Developing Personal Skills
  - Creating Supportive Environments
  - Strengthening Community Action
  - Re-orienting Health Services (Ottawa Charter, 1986)

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## 1.6 The process

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Berkshire Health Authority has lead responsibility for all seven standards of the NSF for mental health and a steering group has been convened for each standard. The Standard One steering group consists of staff from Berkshire Health promotion, Berkshire Health Authority and Unitary Authority representation from East and West Berkshire.

This Steering Group has worked with Berkshire Health Promotion to develop the strategy for the Local Implementation Team (LIT) responsible for delivering the NSF for Mental Health in Berkshire.

Berkshire Health Promotion has a committed team of three to develop this Strategy. The Team is working with local stakeholders to co-ordinate and develop local action plans in schools, workplaces, communities and neighbourhoods

The mental health promotion team will, through consultation and local planning meetings, be working closely with Schools and Childrens' Services, Locality Mental Health Strategy Groups, Local Employers and the Voluntary Sector

## 1.7 Performance indicators and monitoring arrangements

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The National Framework states that performance for Berkshire will be assessed at a national level by:

- 1 A long-term improvement in the psychological health of the population as measured by the National Psychiatric Morbidity Survey.
- 2 A reduction in suicide rates. (Saving Lives OHN Target: to reduce the death rate from suicide and undetermined injury by at least one fifth (20%). by 2010.

This will also be addressed as a separate Standard (Standard 7) with work commencing in 2001.

- 3 Demonstrating action within and linkages between organisations to promote good health
  - In schools workplaces and neighbourhoods.
  - For individuals at risk.
  - For groups who are most vulnerable.

Performance indicators for Berkshire Health Promotion will be based on 3.

# SECTION 2

## Demography

The total population of Berkshire for 2001 is estimated to be 800,520. 1997 figures are given below.

61% of the population are of working age (between 19 and 65).

### BERKSHIRE

#### April 1997 population estimates and projections to 2006 by gender and age group for Berkshire County

Age group	1997			Age group	2006		
	Persons	Males	Females		Persons	Males	Females
0-4	53,075	27,549	25,526	0-4	44,579	23,400	21,179
5-9	53,138	27,600	25,538	5-9	47,011	25,109	21,902
10-14	49,583	25,619	23,964	10-14	53,857	28,633	25,224
15-19	44,482	22,520	21,962	15-19	60,979	30,837	30,142
20-24	48,671	23,564	25,107	20-24	48,060	23,322	24,738
25-29	64,371	32,260	32,111	25-29	40,697	20,635	20,062
30-34	71,748	37,154	34,594	30-34	50,202	26,358	23,844
35-39	64,515	33,307	31,208	35-39	66,961	34,883	32,078
40-44	54,699	28,030	26,669	40-44	64,773	33,440	31,333
45-49	54,635	27,561	27,074	45-49	53,137	27,633	25,504
50-54	50,308	24,974	25,334	50-54	49,769	25,792	23,977
55-59	37,985	19,185	18,800	55-59	53,114	26,894	26,220
60-64	33,241	16,848	16,393	60-64	43,082	21,206	21,876
65-69	29,763	14,686	15,077	65-69	33,425	16,645	16,780
70-74	24,792	11,315	13,477	70-74	28,806	13,405	13,401
75-79	19,733	7,936	11,797	75-79	21,346	10,008	11,338
80-84	13,623	4,742	8,881	80-84	14,501	5,691	8,810
85-89	7,581	1,766	5,815	85-89	9,281	2,491	6,790
90+	4,319	489	3,830	90+	9,244	990	8,254
All ages	780,264	387,106	393,158	All ages	790,822	397,371	393,451

The locality breakdowns can be found in the Data Supplement of the Annual Report by the Director of Public Health (July 2000).

## 2.1 Inequality

Berkshire is a relatively affluent county but it does have pockets of poverty and disadvantage, which will require a targeted approach.

The Jarman Underprivileged Area score (UPA) has been calculated for all wards in Berkshire. Wokingham, Bracknell and West Berkshire include the ten least deprived wards in the county and Wokingham is one of the healthiest places in the country to live. Of the ten most deprived wards, however, five are in Slough and five in Reading (Berkshire BHA Public Health Report 2000).

Disadvantage can include:

- few family assets
- a poorer education during adolescence (low attainment, school exclusion)
- a dead end job (no job satisfaction, career development)
- insecure employment
- poor housing
- Difficult circumstances in which to bring up a family (e.g. divorce, single parenting)

- Social isolation

*Inequalities and Health in the South East region 2000*

## 2.2 Rurality

Large tracts of Berkshire are classified as rural – in particular in West Berkshire.

Access figures (geographical access to post offices, food shops and GPs) show that Downlands in West Berkshire is the most deprived on rural indices compared to other wards in Berkshire and is low compared to national rates 119/8287, where the lowest rank equals the most deprived (BHA Public Health Report 2000).

## 2.3 Ethnicity

*Number of residents from ethnic groups expressed as a percentage of the total resident population by Unitary Authority in Berkshire*

	<i>White</i>	<i>Total Ethnic</i>	<i>Black Caribbean</i>	<i>Black African</i>	<i>Black Other</i>	<i>Indian</i>	<i>Pakistani</i>	<i>Bangladeshi</i>	<i>Chinese</i>	<i>Asian</i>	<i>Other</i>
<b><i>Bracknell Forest</i></b>	97.30	2.70	0.33	0.18	0.19	0.54	0.12	0.05	0.28	0.45	0.56
<b><i>Reading</i></b>	90.51	9.49	2.65	0.59	0.79	1.36	2.15	0.17	0.39	0.54	0.86
<b><i>Slough</i></b>	72.33	27.67	2.70	0.41	0.65	12.47	9.12	0.10	0.26	0.90	1.06
<b><i>West Berkshire</i></b>	98.35	1.65	0.23	0.09	0.25	0.29	0.05	0.04	0.16	0.14	0.37
<b><i>Windsor &amp; Maidenhead</i></b>	95.20	4.80	0.17	0.13	0.15	1.60	1.20	0.09	0.34	0.54	0.58
<b><i>Wokingham</i></b>	96.65	3.35	0.33	0.16	0.13	1.22	0.36	0.02	0.31	0.38	0.45
<b><i>Berkshire</i></b>	92.37	7.63	1.02	0.25	0.35	2.60	1.94	0.08	0.29	0.47	0.63

*Source: 1991 Census*

The Ethnic populations are highest in Slough and Reading and lowest in Bracknell and West Berkshire. Cultural sensitivity will need to be built into the Berkshire Strategy.

## 2.4 Older people

Approximately 15% of the population is over 65. The new NSF for Older People includes Mental Health and it is anticipated that Mental Health Provision for Older People will build on the Mental Health Promotion Strategy to develop their own action plans.

# SECTION 3

## Epidemiology

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### 3.1 Mental health in young people and families

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A DOH survey of 12,529 children in 2000 found that 10% of children aged 5-15 have a mental disorder with 5% having a clinically significant conduct disorder, 4% an emotional disorder and 1% rated as hyperactive (Meltzer 2000).

Children with a mental disorder have more health related problems compared to those with no disorder: bedwetting (12% compared to 4%), speech/language problems (12% compared to 3%), soiling (4% compared to 1%).

Children with mental disorders were more likely to be boys, living in a lower income household and with a single parent. They were less likely to be living with married parents in Social Class 1 and 2 households (ibid).

Of the 25% of 11-15 year olds who reported having been in trouble with the police, 43% of these had a mental health disorder, while 21% had no disorder (ibid). Of those playing truant 33% had a disorder compared to 9% who did not. (ibid.)

Children with mental health disorders were also more likely to have special educational needs, play truant, smoke and drink regularly and take cannabis (ibid).

### 3.2 Mental health in communities and neighbourhoods

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The OPCS (now known as the Office for National Statistics ONS) 1997 survey of psychiatric morbidity amongst adults 16-64 living at home found that:

- 1 in 7 of the general population had some neurotic health problem in the week prior to interview
- Common problems were fatigue 26%, sleep problems 25%, irritability 22%, worry 20%
- The most prevalent neurotic disorder was mixed anxiety and depression (7% of sample)
- The prevalence of all neurotic disorders was higher in women than men
- Alcohol dependence was identified in nearly 5% of the sample

Information compiled by IMS Health Incorporated indicates that surgery encounters for depressive disorders have more than doubled between 1994 and 1998 to 4.9 million. The Somerset Morbidity Survey (2000) established that a GP with a list size of 2,000 can expect to see in a year:

- 60-100 patients with depression
- 70-80 patients with anxiety or other neurosis

- 4-12 patients with schizophrenia

### 3.2.1 Mental health admission rates

Mental Health Admission rates throughout Berkshire (1998/1999) were as follows and show Reading Abbey, Bracknell and Slough as having higher rates compared to other Localities.

PCG	Bracknell	Maidenhead	Newbury	Reading Abbey	Reading Thames	Slough	Windsor & Ascot	Wokingham
<b>Number</b>	355	177	261	376	444	430	2.33	292
<b>Rate per 1000</b>	3.76	2.04	2.30	4.08	2.99	3.48	2.01	1.73

These however do not include admissions to the private sector . It is estimated that 10% of the population have private health-care.

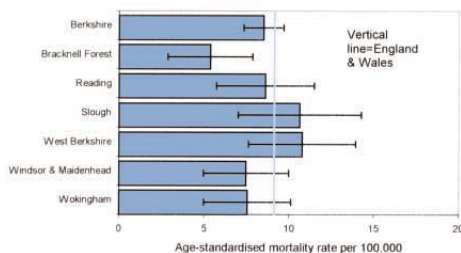
### 3.2.2 Suicide

In the period 1997-1999 201 people committed suicide or died from undetermined causes in Berkshire. Of these:

- 153 were men and 48 were women
- 12 deaths were in the 10-19 age bracket
- The most common age range – accounting for more than a quarter of deaths was 30-39 where 43 men and 13 women committed suicide
- Hanging was the most used method (40%) followed by self-poisoning (18%) and carbon monoxide poisoning (14%)

#### Suicide, death from self-inflicted injury and undetermined causes

Age-standardised mortality rate per 100,000 population 1995-97 in persons of all ages



	Males and females all ages		95% CI	
	Obs	Rate	LL	UL
Bracknell Forest	19	5.4	2.9	7.9
Reading	37	8.6	5.7	11.5
Slough	36	10.6	7.0	14.3
West Berkshire	46	10.8	7.6	13.9
Windsor & Maidenhead	35	7.5	5.0	10.0
Wokingham	34	7.6	5.0	10.1
Berkshire	207	8.5	7.3	9.7
ENGLAND & WALES	14822	9.1	9.0	9.3

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A recent report from the Mental Health Foundation says that the actual rate of suicide amongst young people may be three times higher than official statistics (Suicide and Self-Harm MHF, 2000). Deaths are often recorded as “undetermined”, possibly for the sake of the dead person’s family.

Suicide is one of the main causes of death amongst young people. People with existing mental health problems account for 25% of suicides. Prisoners are seven times more likely to kill themselves than others and men in unskilled employment are twice as likely to commit suicide. American studies have shown that 40-50% of young lesbians and gay men have attempted suicide and recent work suggests the same may be true in the UK (ibid).

Older people are at a higher risk than generally realised, with 16% of suicides being over 65.

Recently widowed older men are particularly vulnerable.

Contrary to popular assumptions about “mere attention seeking” nearly 63% of people who kill themselves have a history of self-harm (ibid). The report highlights the inappropriate and sometimes punitive care provided to those who self harm. Self-harm is more common amongst women.

A local mid 90’s study of suicide and probable suicide in Berkshire and South Oxfordshire noted that in 68% of cases there was clear evidence of a psychiatric disorder. Of these 22% had a serious drinking problem. The 16 young men under 25 who committed suicide had made little contact with Primary Care which suggests a targeting strategy is needed.

The MHF calls for increased access to effective crisis service, targeting of high-risk groups and more appropriate treatment for those who self harm.

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### 3.3 Mental health in the workplace

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- The CBI (1996) estimate the cost of mental health absences from work as £3.7 billion for an estimated 100 million days lost per year. Stress/mental illness is one of the top three causes of certified sickness absence.
- 3 in 10 employees have a mental health problem e.g. from sickness absence arising from problems such as anxiety and depression, as well as labour turnover, poor performance and accidents at work (Banham 1992).
- In 1995 279,000 individuals in Britain were suffering from work-related stress, depression or anxiety. A further estimated 254,000 people ascribed a physical condition to “stress” at work; of these an estimated 102,000 described their condition as hypertension, heart disease or stroke and an estimated 52,000 as a disease of the digestive system. In total, this survey estimated that half a million individuals believed they had experienced work-related stress at a level that was making them ill (Self-Reported Work-Related Illness, 1995).
- An Occupational Stress report by the Health and Safety Executive (2000) showed that work-related stress was highest in the age grouping 45 to retirement age.
- Certain professional groups are particularly vulnerable. These include teachers, doctors, nurses, farmers and vets. The latter have a suicide risk three and a half times the average for other workers.

# SECTION 4

## *Promoting mental health to the whole population*

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The whole population can be reached by:

- Campaigns using the media
- The distribution of information via a range of locations
- Primary Care Dissemination of self-care procedures, talking treatments, sign-posting to voluntary support
- Training with professionals and voluntary groups working with the public (nurses, teachers, police etc.)

### 4.1 Campaigns

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Campaigns can be used to get across the following:

- The distinction between mental health and mental illness
- Anti stigma and discrimination messages
- Measures individuals can take to improve their mental health

The HEA (1997) stated that “mass media campaigns supported by community activities have a measurable effect on knowledge, attitudes and behavioural intentions” and reported that when compared with more affluent groups, decision making among people from deprived communities depends on symbolic phenomena such as product image and branding (Hastings G.B. et al 1998).

The authors recommend that health promoters borrow from commercial advertising techniques such as branding in order to build empowering and trusted health communication. The 1980's Scottish “Be all you can” initiative is a good example of an umbrella campaign as was the 1984 “Friends can be good medicine” in California (Hersey 1984).

### ***Promoting mental health to all via campaigns - What should be done?***

- Create cross county network
- Promote messages through radio/tv
- Decide on effective messages
- Use variety of methods (e.g. bus adverts)
- Promote messages through press using journalists
- Use a variety of locations (e.g. leisure centres, libraries, GP surgeries)

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## 4.2 Information

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Primary Care Research in Newcastle asked waiting room patients what they would want if they had mental health problems. Information was top of the list, medicine last. When information is given to a person by a health professional with endorsement it is more effective than information given alone.

### ***Promoting mental health to all via information - What should be done?***

- Produce and distribute leaflets on self-help measures for use in Primary Care/ other locations.
- Produce local directories of self help groups and voluntary support groups for use in Primary Care/other locations
- Circulate details of resources - e.g. self-help CDs, videos, available from Berkshire Health Promotion.
- Compile and distribute lists of suitable help-lines
- Include mental health promotion in web-sites

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## 4.3 Primary Care

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Primary care is an obvious partner for mental health promotion. 90% of mental health problems are managed in Primary Care (DOH 1999). Studies of UK general practice showed that up to half of those booked to see their GP have a possible psychological disorder (Kessler et al, 1999).

Although GPs spend a third of their time working with mental health problems many are not specifically trained in mental health.

Primary Care deficits identified include:

- GPs disinterested in mental illness
- Failure to diagnose depression
- Inappropriate referrals to secondary care
- Inappropriate prescribing

*C. Drinkwater (2000) – Address at Sainsbury's Annual Mental Health Forum*

GPs themselves see the need to identify effective ways to help people with milder depression, “feeling down” and stress related problems. (East Surrey GPs). They have also felt unable to give good advice because they are ignorant of what help/support is available (Paris and Player 1993). There is a danger that health professionals react by medicalising practical problems and normal reactive emotional states

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because they feel relatively powerless and then refer on to psychiatric colleagues. GPs have been criticised for referring too many cases of common mental illness to secondary and tertiary care (Wessely 1996).

The following have been shown to be effective:

#### **4.3.1 Physical activity**

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A study in Essex found that a 10-week programme of exercise significantly reduced depression and anxiety, increased overall quality of life and self-efficacy for exercise. 68% of clinically depressed patients had depression scores that became non-clinical within three months (Darbyshire and Glenister 1998).

The national consensus statement on physical activity and mental health shows that exercise prevents clinical depression and is as effective in treatment as other psychotherapeutic interventions. Exercise also reduces anxiety, enhances mood and improves self-esteem (Grant 2000).

#### **4.3.2 Talking therapies**

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Brief interventions in primary care including taking a history and providing information and advice are effective in alcohol consumption in people drinking above the recommended levels (Ashenden et al, 1997).

Older people who receive peer counselling from an older volunteer show reduced depression (Wheeler et al, 1998).

Both non-directive counselling provided by British Association of Counselling accredited counsellors and cognitive behaviour therapy provided by clinical psychologists have been shown to reduce depression to a significantly greater extent than usual GP care. There was no significant difference in outcome between the two psychological therapies (King et al, 2000 - Randomised controlled trial of non-directive counselling, cognitive behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care).

#### **4.3.3 Self-help support**

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Basic psycho-social information, relaxation advice plus referral for self-help or to self-help groups is as effective as cognitive therapy and medication in treating generalised anxiety disorders (Barnes & Shadlow, 1997; Stark, 1998; Wheelan, 1993).

#### **4.3.4 Participation**

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Participation in user groups has a wide range of benefit. Providing opportunities for older people to do voluntary work increases mental

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well-being in those who volunteer and also reduces depression in older people who receive services from an older volunteer, e.g. visits, peer counselling Wheeler et al (1998).

#### 4.3.5 Training

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##### ***Promoting mental health to all via Primary Care - What should be done?***

- Extend the GP Exercise Referral Scheme to include people suffering from anxiety and depression
- Ensure talking therapies are available through all GP surgeries. (To include counselling, rational emotional behaviour therapy, brief problem solving therapy, cognitive therapy)
- Develop an alcohol counselling scheme in primary care

The development of more serious mental illness can be prevented when professionals are trained to screen for mental health problems at an early stage and to empower individuals with self-help techniques and/or direct them to voluntary or professional support.

For example, professional emotional support has been shown to decrease the rate of post-natal depression and very young mothers can also be helped to cope better, reducing the risk of depression and family problems (Ray & Hodnett, 1998).

##### ***Promoting mental health to all via training - What should be done?***

- Train staff on GP Exercise Referral Scheme to work with people who are anxious and depressed
- Train community health professionals in early detection and self help methods
- Training to include district nurses, health visitors and occupational therapists
- Train staff on the role of self help and voluntary organisations in the community
- Provide mental health awareness training to all working in the community

# SECTION 5

## Promoting mental health in young people and families

The development of mental health promotion for young people should be seen in the context of families, education and risk taking behaviour. The term 'young people' is used to refer to children and adolescents up to the age of 18.

To promote mental health we need to identify risk factors and factors that build up emotional resilience.

### Risk Factors

<b>Children particularly at risk</b>	<b>Risk factors in the family</b>	<b>Risk factors in the community</b>
<ul style="list-style-type: none"> <li>• Excluded children</li> <li>• Looked after children</li> <li>• Sexually abused children</li> <li>• Academic failures</li> <li>• Those with low self-esteem</li> </ul>	<ul style="list-style-type: none"> <li>• Overt parental conflict</li> <li>• Family breakdown</li> <li>• Inconsistent or unclear discipline</li> <li>• Hostile and rejecting relationships</li> <li>• Failure to adapt to a child's changing needs</li> <li>• Physical, sexual and/or emotional abuse</li> <li>• Parental psychiatric illness</li> <li>• Parental criminality, alcoholism or personality disorder</li> <li>• Death and loss – including loss of friendship</li> </ul>	<ul style="list-style-type: none"> <li>• Socio-economic disadvantage</li> <li>• Homelessness</li> <li>• Disaster</li> <li>• Discrimination</li> <li>• Other significant life event</li> </ul>

<b>Resilience factors in the child</b>	<b>Resilience factors in the family</b>	<b>Resilience factors in the community</b>
<ul style="list-style-type: none"> <li>• Secure attachment</li> <li>• Positive attitude, problem-solving approach</li> <li>• Good communication skills</li> <li>• Planner, belief in control</li> <li>• Humour</li> <li>• Spirituality</li> <li>• Capacity to reflect</li> </ul>	<ul style="list-style-type: none"> <li>• At least one good parent-child relationship</li> <li>• Affection</li> <li>• Supervision, discipline</li> <li>• Support for education</li> <li>• Supportive partnerships</li> </ul>	<ul style="list-style-type: none"> <li>• Wider supportive network</li> <li>• Good housing</li> <li>• High standard of living</li> <li>• High morale schools with positive policies for behaviour, attitudes and anti-bullying</li> <li>• Schools with strong academic and non-academic opportunities</li> <li>• Range of positive sport/leisure activities</li> </ul>

(Adapted from Mental Health foundation 1999)

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## Factors that build up emotional resilience

Children need to learn to be emotionally literate. To achieve this, children must register emotions, recognise emotions, query emotions for validity and be able to put them aside after experiencing them.

Research shows that boys are less emotionally literate and that girls are overly emotionally literate. The consequences for both the genders are of concern, as a lack of emotional literacy in boys tends to be a failure to register/recognise/query feelings and a tendency to resort to violent behaviours. With girls, their levels of emotional literacy tend to mean taking on responsibility for other's feelings at the price of their own. Such gender issues would need to shape the support offered to both young boys and girls (Orbach S, 2000).

## Parenting skills

In addition a range of initiatives are also needed to improve parenting skills and to make them more acceptable. They need to be developed in conjunction with the voluntary sector and delivered in schools, clubs and other non-stigmatising settings. Information on mental health issues in children will also need to be available for parents.

The following have been shown to be effective in supporting parents.

- Early support during pregnancy for mothers in difficult social and economic circumstances has been shown to have a positive impact on birth weight and family relationships (Olds, 1992).
- Counselling by health visitors can help manage and reduce post-natal depression Holden, Sagovsky & Cox (cited in HEA: A review of effectiveness of Mental Health Promotion interventions 1997).
- A structural cognitive approach, including group activities and discussion helped reduce depression and hopelessness and increase self-esteem in women not receiving medical care (Gorden et al, 1998 and Maynard, 1993; *ibid*).
- Professional emotional support for pregnant women caring for existing children can decrease the rate of post-natal depression and very young mothers can be helped to cope better (Ray & Hodnett, 1998).
- Support from non-professionals e.g. experienced mothers can reduce depression and improve parenting skills (Johnson et al, 1993).
- Good personal support networks protect mental health and enable people to recover from stressful events like bereavement or financial problems (Schulz R. & Rau, 1985; Whelan, 1993).
- Social support and social networks such as self-help groups, advocacy, neighbourhood and voluntary activities are crucial in limiting the impact of psycho-social stressors (Bloom, 1995).

## 5.1 Promoting mental health in schools

Berkshire is served by 475 state and independent schools:

<i>Type of school</i>	<i>Number</i>	<i>Type of school</i>	<i>Number</i>
Infant/Nursery	9	Junior	14
Infant	42	Primary/Secondary	12
Nursery	20	Secondary	79
Primary/Nursery Class	22	Special	14
Primary	215	Independent	48

Recent DfEE (1999) guidance on the National Healthy School Standard highlights 'emotional health and well being' as a major area for schools to address through the curriculum. Future partners should include not only Healthy Schools Initiatives, but also Sure Start, Education Action Zones (EAZ), Healthy Living Centres and those agencies working under the umbrella of Quality Protects. The new "Connexions" agenda will facilitate multi-agency mental health promotion in adolescents.

Bullying or being a victim of bullying at school is a predictor for later problems, including conduct disorders, crime, alcohol abuse (in bullies), depression, anxiety and suicidal behaviour (in victims), (Olweus, 1993).

The Olweus anti-bullying strategy includes zero tolerance for bullying, and a period of consultation and training which enables teachers, parents and governors to sign up to the principles of anti-bullying with clearly understood strategies for reporting and acting on bullying incidents.

## ***Promoting mental health in schools - What needs to be done?***

- Work with Healthy Schools Consultants and PSE teachers to set up mental health promotion agenda in all schools
- Aim to reduce school exclusion
- Develop awareness of mental health and empower children to look after their own mental health
- Work with schools to develop non-academic opportunities for young people
- Involve parents
- Work with schools to develop policies and practices to tackle bullying and racism in schools
- Develop/distribute literature on mental health issues in children for parents
- Target boys to develop emotional literacy
- Develop bespoke mental health awareness training, e.g. self-esteem, decision making, risk taking behaviour and assertiveness
- Develop buddy support systems

### **5.2 Young / inexperienced parents**

Families living in urban locations with higher than average concentrations of risks e.g. poor housing and family poverty, will be particularly vulnerable if there are also poor parental relationships, family violence, or the child has specific characteristics or special needs. These external circumstances in combination with adverse family circumstances can lead to negative developmental processes (Mental Health Foundation – Bright Futures 1999).

Social factors like poverty increase vulnerability to negative life events such as single parenthood, social isolation and loss of employment, which in turn impacts directly or indirectly on parental relationship with children. It may mean it reduces the ability to parent well or that buying books or toys is not possible (ibid).

The quality of parental relationships and the availability of social supports are key factors affecting parenting competence and where supportive parental relationships do not exist then social support is very important (ibid).

## ***Promoting mental health in young and inexperienced parents - What should be done?***

- Pregnant mothers and new mothers to be screened for depression
- Work within existing/new multi-agency settings - to include both statutory and voluntary agencies such as Surestart
- Professional/voluntary support to be in place where mothers at risk are identified.
- Parenting clubs to be set up in non-medical settings
- Ensure self help groups, advocacy, neighbourhood and voluntary activities are in place

### **5.3 Vulnerable children**

#### **Children excluded from school**

In the UK it has been estimated that taking into account the cost to all agencies, the total cost of exclusions in 1996 was £81m, nearly three times higher than the cost of educating excluded children in mainstream schools (£34m).

Nationally the number of exclusions has risen dramatically, particularly for primary schools with 12,500 permanent exclusions from primary, secondary and special schools (95/96). This was an increase of 13% over the previous year (Mental Health Foundation, 1999). The majority of the young people surveyed showed significant and multiple stresses in their lives, for example, breakdown in the relationship of birth parents, having special educational needs, involvement of social services with the family with some children being looked after and multiple moves and disruption, and greater difficulty in making relationships.

Recent data suggests that there appears to be an ethnic bias in exclusions: African-Caribbean children are four times as likely to be excluded as white children (Smith, 1998 - cited in Weare, 2000). Children with special needs and difficult children are also vulnerable to exclusions (Hayden, 1997 - cited in Weare, 2000).

Overall, schools need to explore ways in which exclusions can be reduced and support can be accessed for the young person at risk.

#### **Looked after children**

With regards to looked after children it is estimated that there are about 51,000 children being looked after in England (1996). The Mental Health Foundation (1999) highlighted that 17% of their research sample of young people in care have long term mental illnesses or disorders, 35% had self-harmed since the age of 15 or 16 and 60% had thought about taking their own life and 40% had tried to do so.

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A survey carried out by the Who Cares? Trust concluded that going into care was a traumatic experience characterised by loneliness, isolation, a lack of emotional support and a “bullying culture”.

### ***Promoting mental health in excluded and looked after children - What needs to be done?***

- Work within existing or new multi-agency settings - to include both statutory and voluntary agencies
- Specialist emotional support to be available to looked after children and excluded children
- Aim to reduce school exclusion by supporting teachers and facilitating referral routes
- Develop skills to promote self esteem, self confidence and relationship building
- Involve parents, health services, education and criminal justice system
- Address health, decision making and risk taking behaviours
- Specifically address ethnic bias in exclusion by promoting cultural sensitivity in schools
- Develop buddying and mentoring schemes

## **5.4 Child abuse**

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The NSPCC (2000) researched child abuse and neglect with 2,689 young people and their findings were:

- One in five children experienced less than adequate supervision at some point in their childhood.
- More than four in ten respondents had been bullied or discriminated against by other children and/or young people.
- In the year up to 31 March 2000 there were 30,300 children on child protection registers of whom 8,700 were registered for physical injury and 14,000 registered for neglect.

Sexual abuse in childhood is positively correlated with mental illness and substance abuse in later life. Estimates suggest 4.5 million people in Britain are victims of earlier sexual abuse and many later develop psychiatric problems. Prevalence rates of abuse victims of 30% are quoted from studies of psychiatric outpatient records.

Whatever form of child abuse occurs it will create fear, guilt, loss of self-esteem and self-confidence and isolation from the support of other people (NSPCC, 2000).

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### ***Promoting mental health in abused children - What needs to be done?***

- Confirm effective child protection system to be in place
- Confirm community professionals are trained in detecting child abuse
- Tackle bullying and discrimination in the community
- Specialist support systems for abused children to be in place
- Help-lines to be publicised
- Address areas of fear, guilt, self-esteem and self-confidence

# SECTION 6

## *Promoting mental health for the workplace*

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### 6.1 In the workplace

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- Statistics from the Office for National Statistics reveal that in 1998 there were 401,100 people employed in Berkshire. Unemployment figures are low with 4,181 men and 1,345 women registered as unemployed.
- The county is situated in the Thames Valley, which is described as one of the most successful economic regions within Europe. It has one of the highest concentrations of businesses in the UK with some being market leaders in their own field, e.g. Prudential, Mars, Microsoft, Sun Computers, Bayer and Vodafone; it boasts one of the lowest unemployment rates.
- The NHS is the largest employer in Berkshire but, due to organisational change, employment figures are not yet available. There are six unitary authorities who between them employ 24,000 staff. The police have a workforce of 5,800.
- These represent the largest employers. However, a new technology site is being developed in Reading which will create 14,000 jobs.
- The average level of income per head is 20% above the national average and local authorities report a period of change and development. Many Berkshire residents commute to work outside the county.
- Stress and Health at Work survey showed that 20% of working individuals rated their work into the top two work stress categories of “very” and “extremely” stressful when asked to consider how stressful their job was on a 5-point scale. Extrapolated to Berkshire this would suggest 160,000 people find their work either very or extremely stressful.
- A survey of 800 small and medium-sized employers in a range of industries, carried out by MORI for HSE showed that stress is felt to pose a comparatively high risk and perceived to be the least well controlled of all workplace risks (MORI, 1998).
- A survey of personnel specialists' views of mental health issues, found that there was confusion about the term mental health problems and although Personnel/Human Resources practitioners understood the need to address mental health issues, their organisations tended not to address these issues directly or to treat them as important (Gordon, 1996).
- Large-scale stress workshops were used as part of a Healthy City programme in Birmingham. In the three month follow up, participants were less anxious, less distressed and more able to cope than those in control or placebo groups (Mental Health NSF, 1999, p22).

- Attention will also need to be given to specific professional groups which experience a high level of mental stress and illness - these include doctors, dentists, veterinary surgeons, farmers and teachers.

O'Donnell and Harris (1994) identified three levels of health promotion that can be used in the workplace to promote health and well-being:

- *Awareness raising: decreasing the stigma attached to mental illness is a valuable precursor to health education.*
- *Lifestyle change programmes including health screening and stress management techniques.*
- *The creation of a supportive environment which provides employees with resources and support in dealing with mental well-being.*

### ***Promoting mental health in the workplace - What needs to be done?***

- Audit mental health policy and practice within the NHS trusts
  - Development of mental health awareness training
  - Development of Workplace Mental Health friendly policies and practices
- Creation of a supportive environment with opportunities for de-stressing and staff support
- Life style change programmes including health screening and stress management techniques (e.g. physical activity)
- Work with Human Resources, Occupational Health, Environmental Health and Trade Unions
- Pre-retirement issues to be addressed

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## 6.2 Unemployed / redundant People

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- Unemployed/redundant people are vulnerable to depression. An intervention with a strong focus on job search, self-efficacy, social and emotional coping skills and building social support has been found to be effective. Problem solving and cognitive therapies have also been shown to be successful (Vinokur D & Ryn, 1991).
- High quality interventions for individuals who are unemployed can reduce the impact of job loss and promote re-employment, particularly in those at risk of mental ill health (NHS Centre for Reviews and Dissemination, 1997).

### ***Promoting mental health in unemployed people - What needs to be done?***

- Job centre / job club networks to be set up where necessary
- Ensure social support in place and problem solving & cognitive therapy where necessary
- Ensure skills training in place e.g confidence building, self-esteem, assertiveness, self-presentation
- Mentoring and supported employment schemes to be developed

# SECTION 7

## *Promoting mental health to individuals at risk in the community*

The National Service Framework identifies the following groups of individuals as being at risk of reduced mental well being.

### 7.1 Bereaved People

Bereaved people are particularly vulnerable to depression and each year a new group of people becomes vulnerable.

Six and a half thousand people died in Berkshire in 1998 (NOS) leaving at least sixteen thousand people suffering a major bereavement.

High levels of psychological morbidity are found following perinatal death. After spontaneous abortion, up to 10% of women have acute stress disorder. For women experiencing miscarriage, identification of the cause of foetal loss can reduce feelings of self-blame (Nikcevic, 1999).

Widows have higher than average levels of traumatic grief, depression and anxiety symptoms. High levels of traumatic grief measured at 6 months also predicted physical illness (e.g. cancer, heart attack) at 25 months. On the whole, however, it appears that over time women adapt to widowhood more successfully than men do (Van Grootheest, 1999).

Men who remain alone after losing a partner are at higher risk of developing symptoms of chronic depression. High anxiety levels in widowers measured at six months predicted suicidal ideas at 25 months. Routine enquiry about suicidal ideation should, therefore, be an essential component of the assessment of recently widowed older men by all health professionals (Chen, 1999; Byrne, 1999).

The family survivors of somebody who has committed suicide experience a very complicated form of bereavement. This is due to the combination of sudden shock, the question of why and possibly the trauma of witnessing or discovering the suicide (Kneiper, 1999).

GPs and other health professionals should both be trained in early detection of depression following bereavement and should have information on the local resources (e.g. CRUSE, self-help groups) available in the community.

### ***Promoting mental health in bereaved people - What needs to be done?***

- Work with Cruse to train GPs & community professionals to be trained in the detection of post bereavement depression
- Professionals to be made aware of existing support resources e.g. CRUSE, self-help groups, church support

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## 7.2 Women at risk of depression following birth

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- In 1998 there were 10,645 live births in Berkshire. Approximately half the mothers will experience the “baby blues” and 10% will experience post-natal depression.
- As well as effective professional support, involvement from non-medical professionals, e.g. an experienced mother living in the community, can reduce depression and improve parenting skills. (See Section 5.)

### ***Promoting mental health to pregnant / post partum mothers in the community - What needs to be done?***

- Ensure Health Visitors have been trained to screen all new mothers for postnatal depression using the Edinburgh Depression scale
- Ensure that appropriate support systems are both in place and publicised
- Check to ensure that after training this is an ongoing programme
- Ensure that Health Visitors refer those at risk to support schemes

The Association for Post Natal Illness can organise individual support from a mother who has had the illness.

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## 7.3 Carers of dependent people

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One in eight people are carers suggesting 100,000 carers in Berkshire (National Carers Strategy, 1999).

52% of carers in a national survey had been treated for a stress-related illness since becoming carers (Henwood M, 1998).

A Carers Survey in Reading (2000) of 248 carers also found that 52% had received treatment for stress related illness while undertaking their caring role.

Half of those surveyed expressed the need for an understanding person to talk to. Many carers also asked for free access to leisure facilities with a back up package of respite/sitting service. Carers in the survey indicated that they felt they would greatly benefit from learning stress management techniques.

Three fifths of all carers receive no regular visitor support services at all. Many young carers find that they are cut off from educational and leisure opportunities and feel socially excluded from their peers. Lone parents can in some way be equated with the carers as they also have to take continuing responsibility without respite.

## **Promoting mental health for carers - What needs to be done?**

- Primary Care to identify carers and patients who have a carer
- Young Carers to be identified
- Primary Care to ensure that carers are sign-posted to Social Services for assessment of their own needs
- Carers Assessments to be linked to Care Programme Approach (CPA) / Care Management
- Primary Care to check carers emotional needs on annual basis
- Primary Care / Social services to ensure that carers are kept informed of respite opportunities
- Primary Care/Social Services to signpost Carers to Carers Support Groups or Carers Centres
- Carers' Centres to organise stress management, relaxation, assertiveness training on regular basis

### **7.4 Divorced people**

Nationally in 1998 there were 145,214 divorces. For both men and women peak ages for divorces were between 30 and 40.

This is a change from ten years ago when there were more divorces in the 25-29 age group.

Divorce and separation are associated with increased anxiety and depression and increased risk of alcohol abuse and with worsened mental and physical health and increased mental health service use (Medical Research Council (MRC) National Survey Health & Development, 1997). Divorced and separated men are twice as likely to commit suicide as married persons (Kposowa A, 2000).

Several studies have shown successful interventions: mental distress could be prevented in couples by training on communication and conflict management and that at a five year follow up couples were less likely to break up or divorce.

A six-month prevention intervention for the newly separated demonstrated positive effects on relationships, health, job satisfaction and financial situations.

Relate has a role in building better couple relationships. They aim:

- To enhance the quality of couple, parental and family relationships.
- To help relationships and marriages withstand the pressures leading to breakdown.

- 
- To limit the damage which often accompanies separation and divorce and to increase the chances of future relationships succeeding.

Teaching communication and problem-solving skills can successfully modify risk factors for relationship problems. One study showed at four and five-year follow ups, increased communication skills and problem solving skills reduced marital break-up in participants (Marlman, 1988). Increased coping skills can also reduce the risk of depression in people at risk as a result of divorce or marital breakdown (Bloom, 1985).

***Promoting mental health to those who have been divorced - We should aim to:***

- Work with Relate to train professionals to recognise relationship problems and post-separation/divorce depression
- Professionals to signpost clients to voluntary organisations (e.g. Relate) and to self-help and social groups

# SECTION 8

## *Promoting mental health in vulnerable groups in communities and neighbourhoods*

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There is growing evidence about the benefits to health of having strong social networks and cohesion. The term “social capital” is being used to reflect this. Community development increases the ability of marginalised communities to work together to identify and take action on priorities as defined by the communities themselves.

Additionally the following health promotion measures have been found to strengthen neighbourhoods and communities:

- Better links between primary health care and sources of information and support in the community.
- Social activities to promote social inclusion (e.g. friendship clubs, self help groups, home visitors, mentors, befriending schemes).
- The availability of recreational facilities.
- Artistic activities to promote emotional literacy and social inclusion. Matarasso (1997) reviewed 60 community based arts projects and found that participation in these projects brought a wide range of social benefits, including increased confidence, community empowerment, self determination, improved local image and identity and greater social cohesion.
- A pro-active Community Safety policy.
- Well publicised Help-lines (Domestic Violence, Racism).
- An accessible refuge for victims of violence.
- Initiatives for young men to raise awareness of depression and encourage them to talk about their problems (CALM - the Manchester Campaign against Living Miserably, 1997).

Effective approaches will need to commit to the following principles which in themselves enhance mental health:

- Reducing anxiety
- Increasing control
- Facilitating participation
- Promoting social inclusion

The government has specifically identified the following as vulnerable groups.

### **8.1 Victims of domestic violence**

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Evidence shows that one in four women will experience domestic violence at some point in their lives (DoH 2000). The violence has a significant effect upon not only the physical but also psychological health of women and their children.

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Women who have been abused are:

- 15 times more likely to abuse alcohol
- 9 times more likely to abuse drugs
- 3 times more likely to be diagnosed as depressed or psychotic
- 5 times more likely to attempt suicide.

One study showed that 64% of female psychiatric outpatients had been physically abused in their adult life and what is diagnosed as mental illness may be a reaction to prolonged and frequent violence. Prolonged psychological abuse can have a greater effect on some women than physical abuse and has been compared with the psychological reactions of hostages suffering from post-traumatic stress.

### ***Promoting mental health to victims of violence - What needs to be done?***

- Multi-agency fora should be in place
- Forum membership should include Women's Aid and other refuges, help-lines, advocacy, support and outreach services, community groups including groups representing survivors of domestic violence
- Specialist domestic violence services to be set up including those for women and children from ethnic minorities
- Mental health promotion initiatives to be established to develop and restore self-esteem
- Rape Crisis Centres and other rape and sexual assault services to be set up

## **8.2 Ethnic minorities**

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Both Slough and Reading have sizeable Afro-Caribbean and South Asian populations.

The rate of diagnosed psychoses is particularly high in Afro-Caribbean young men compared to the white population, as is admission to hospital via the Mental Health Act, treatment by physical rather than talking therapies and admission to secure services. This group is also more likely to be referred to the health services by the criminal justice system, than by GPs or Social Services.

Depression is diagnosed less frequently in the Asian population although this may be because they are unable to access services because of cultural expectations or language difficulties. Asian women do have a relatively high risk of suicide and are more likely to be victims of domestic violence than white women.

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The stigma attached to mental illness can be compounded by racial discrimination with access to assessment, treatment and care inhibited.

There are many reasons why people from ethnic minorities do not access the support and services they need when struggling with mental health problems.

These can include:

- No one commissioning body/network is responsible for addressing the problems raised by ethnic minority health provision.
- Lack of involvement of users and the community in developing service provision.
- Lack of language specific information.
- Lack of information and services available at culturally appropriate locations.
- Lack of awareness by professionals of transcultural customs and expectations.
- Insufficient numbers of professionally qualified interpreters with mental health awareness. At present untrained staff are used on many occasions which is unsatisfactory.
- Insufficient bi-lingual trained counsellors.

### ***Promoting mental health to ethnic minority groups - What needs to be done?***

- Ensure that a commissioning body or network is in place with responsibility for addressing access issues
- Ensure that a mental health needs assessment is made of ethnic minority groups in the community and that community leaders and users are involved in the development of service provision
- Train professional staff in cross cultural communication skills
- Assertiveness training to be delivered in a culturally sensitive manner
- Appropriate language specific information to be commissioned and distributed
- Ensure that sufficient trained interpreters are available at both Primary Care level and in the community
- Ensure that information and services are provided at culturally suitable locations
- Ensure that sufficient “mother tongue” counsellors are trained and available

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### 8.3 Refugees and asylum-seekers

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Refugees and asylum-seekers are a particularly vulnerable group. Post traumatic stress disorder is the most common problem. There is also a high level of depression as refugees are not allowed to work for the first six months after arrival. In the long term, the risk of suicide is raised.

Slough has a population of approximately 2,500 refugees/asylum-seekers. 1,500 of them are registered with Slough Borough Council while 1000 or so are placed in Slough by neighbouring Boroughs. These refugees are not a homogenous group. They will have a wide diversity of needs, ethnic groups, languages, political and religious beliefs. Individuals will have been exposed to widely different experiences in their home countries before driven into exile, (HEA factsheet, 1999 - Mental Health Promotion and refugee and asylum-seekers).

GPs may be unsure whether refugees are entitled to register and may refuse them. Often only temporary registration is given in the belief that refugees move about a lot. This view is unfounded. A Home Office study (1995) found that 70% of refugees had been in the same accommodation for more than a year. Offering permanent registration helps with continuity of care and allows access to routine screening and immunisation services and increases feelings of social inclusion. A central reception service is being set up in Slough where all refugees can register for medical services for up to a year before transfer to normal GP services.

Refugees have inevitably been through extraordinary difficulties. Many have experienced massive loss, of family and friends, home and culture, career and property. They may have been terrorised, tortured, persecuted and imprisoned. Not surprisingly mental health problems are thought to be twice as severe in refugee communities compared to society as a whole. A 1995 Home Office study found two thirds had experienced anxiety and/or depression. Practical difficulties, social isolation, poor health and personal circumstances detract from mental health.

Refugees may face racism and other forms of discrimination. This both contributes to mental distress, creating feelings of depression, loneliness and anger and can act as a barrier to access to and provision of services. Access to services may also be limited by:

- language barriers
- lack of information about what exists
- resistance by some providers to allowing access to services.

### ***Promoting mental health to refugees and asylum-seekers - What needs to be done?***

- The new central registration system in Slough needs to be publicised and supported
- Asylum-seekers/Refugee Team to be in place
- Planning to take place in partnership with service users and community leaders
- Interpretation and translation services to be in place
- Information on service provision to be available in appropriate languages
- Translators to be trained in mental health awareness
- Training in communication skills, problem solving, decision making, assertiveness

## **8.4 Prisoners**

Reading Young Offenders Institution (YOI) has about 220 inmates, of whom about 25% are on remand and the rest are sentenced. The prisoners are all male and between 18 and 21 years old.

Mental health needs are very high and national figures suggest that remand prisoners (66%) have even higher mental morbidity than sentenced prisoners (40%), 7% of male prisoners are psychotic and 40% males have significant neurotic symptoms.

There has been little or no attention given to mental health promotion yet, though certain activities have been instituted by different parts of the prison management, in a rather unco-ordinated fashion.

### ***Promoting mental health to prisoners in Reading Young Offenders Institution - What needs to be done?***

- Audit of existing provision
- Provision to include:
  - Anti-bullying strategies
  - Regular physical exercise
  - Contact with friends, families and the outside community
- Planning through multi-agency steering group
- Mental health awareness training for staff
- Ensure mental health promotion is part of prison Health Improvement Plan (HImP)

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## 8.5/8.6 Rough-sleepers and those with dual diagnosis

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At any one point there may be approximately 60 people sleeping out in Berkshire, amounting to a turnover of up to 400 per annum. These break down to Reading (20), Slough (15-20), Bracknell (6) and Newbury (6–10). No rough sleepers have been identified in Maidenhead and Windsor and figures are not available for Wokingham.

Between 30 and 40% of rough sleepers have severe and enduring health problems. Almost 100% suffer stress, anxiety and depression. Most people with dual diagnosis figures - that is a diagnosis of mental health problems with substance abuse estimated at around 150 across Berkshire relate to homeless people. Alcohol is associated with depression and is associated with 65% of attempted suicides. Drugs can both cause and exacerbate mental health problems (e.g. cannabis psychoses). Longitudinal studies of drug takers show roughly a tenfold increase in psychiatric morbidity.

The government has introduced a new policy and funding framework for support services, "Supporting people" which introduces a new integrated budget for support to vulnerable people. Objectives include action to prevent and address homelessness and action to support people who have misused drugs and alcohol. As well as housing this proposed single budget can fund supervision, counselling, anger management, advocacy, companionship, advice and life skills training.

### ***Promoting mental health to rough-sleepers / those with dual diagnosis - What needs to be done?***

- Development of new "Supporting people" initiatives from 2003 onwards
- Mental Health Services discharge policies to address housing
- 24 hour emergency cover
- Outreach workers in place

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## 8.7 Farmers

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A high level of stress and depression has been identified in rural occupations, particularly farmers. A pre foot and mouth (1999) NFU study showed that 99% experienced symptoms. A more recent study (February 2000- Tenant Farmers - the facts) found that one in ten farmers took anti-depressants, 25% were having marriage problems, and 70% had sleep problems.

### ***Promoting mental health to farmers - What needs to be done?***

- Work with Rural Stress Network in east and west Berkshire to provide information and support to farmers

# SECTION 9

## Combating discrimination and stigma and promoting social inclusion

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### 9.1 Combating discrimination and stigma

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Combating stigma and discrimination is a key part of the Strategy to be implemented in schools, workplaces and the community.

Recent surveys have shown that stigmatising attitudes towards people with mental illness are widespread in the population:

An ONS survey commissioned by the Royal College of Psychiatrists as part of their five-year anti-stigma campaign found that:

- The majority of people believe that people with any mental illness are unpredictable and difficult to communicate with.
- The disorders schizophrenia, alcoholism and drug addiction are seen as dangerous to others.
- Many people believe that those with depression, eating disorder, alcoholism and drug addiction “could pull themselves together”.

A DOH Report “Attitudes to Mental Illness” (May 2000) found that:

- 24% thought that anyone with a history of mental problems should be excluded from taking public office.
- 19% think that women who were once patients in a mental hospital cannot be trusted as a baby-sitter.
- 29% consider it frightening to think of people with mental problems living in residential neighbourhoods.
- 24% agree that locating mental health facilities in a residential area downgrades the neighbourhood.

#### The effects of discrimination

Those who suffer mental illness report receiving discrimination because of it. The main sources of discrimination reported are from within the family (56%) and from friends (52%), while 30% reported receiving discrimination in the workplace. This discrimination led to 66% of them not telling people about their mental distress. 42% had not even told their families or friends because they feared they would be judgmental or would not understand. 19% reported that they were unable even to talk to their GP about their own mental distress and many people reported that their physical health problems were not taken seriously because of their mental health history (Mental Health Foundations survey “Pull yourself together”).

Discrimination is thus very damaging to those with mental health problems who are already vulnerable. It can stop them asking for help that they need, can make them socially withdrawn and become even more socially excluded without the positive validation and reality testing which can ensue from social contact. Continuing discrimination

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affects people in all areas of their lives: they may lose their job or be unable to get work: they may lose their friends and family and find neighbours will not talk to them. They are more likely to end up homeless and people don't want to live near them (ibid).

All this can lead to loneliness and isolation. The person feels that they are odd and don't fit in and lose confidence in themselves. This can increase depression and even lead to suicide.

Two recent reports Media Mentality (HEA 2000) and Counting the Cost (Mind 2000) have looked at the role of the press in increasing the stigmatisation of mental illness. The HEA study surveyed 492 national and regional newspapers and 88 television programmes, and found a tendency for the media to automatically link mental illness with violence and murder. This is despite the fact that there has been no increase in homicide by people with mental health problems in the last 20 years while homicide generally had more than doubled (Audit Commission 1994).

The Mind report highlighted that media coverage had a direct impact on those with mental health problems. 75% felt media coverage was unfair, unbalanced or very negative and 50% said media coverage had a direct negative effect on their mental health, 24% said they had experienced hostility from neighbours and local communities as a result of media reports and 33% said that media coverage had put them off applying for jobs or volunteering.

The worst offenders - listed in order of unpopularity were:

1. The Sun
2. "All tabloids"
3. Daily Mirror
4. Daily Mail
5. FHM (Men's magazine) & Daily Star
6. BBC Panorama
7. News of the World
8. Daily Express
9. Sunday Sport

The results of the DOH (2000) survey show some positive changes in attitude to mental illness compared to the 1997 survey. Members of the public continue to be caring and sympathetic towards people with mental illness. They show a growing belief that people with mental health problems should be integrated into the community (7% increase to 43%).

Respondents in the Mind survey mentioned how helpful some programmes and articles had been in helping them to educate other

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people. Overall, radio news programmes ranked as the fairest news media, followed by TV news.

The DoH report on attitudes indicates that 55% know someone who has suffered from mental illness. Significantly there continues to be an increase in the percentage of people referring to their own mental illness: The level was 3% in 1995, 4% in 1996, 5% in 1997 and 8% in 2000, a rise of 1% per year. This reported increase in reported and acknowledged mental distress might work to increase both awareness and tolerance of those in a similar position.

### Mental health awareness raising

The recent **Changing Minds** campaign suggests the following as suitable projects to fight discrimination:

- Picture books for infant and primary school children
- Cartoon books for older children
- Information for young people to challenge stereotypes
- Information for employers and teachers
- Roadshow for GPs and employers
- Complaints to the media
- Leaflets, posters, videos, cinema trailers, web sites
- Conferences

**The Institute of Psychiatry** (Professor Graham Thornicroft - Personal Communication 2000) is commencing an 18 month anti-discrimination research project in Kent to design, deliver and evaluate intervention packages with specific target groups.

The process is as follows:

- Identify target groups - e.g. police, staff in social security offices, school children
- Use focus groups to develop specific proposals to target discrimination
- Use focus groups with target groups to identify what training would be useful
- Users to be involved in implementation
- Develop and use questionnaires to pre and post test attitudes

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## ***Combating discrimination and stigma - What needs to be done?***

- Set up network in 2001
- Identify target groups for training
- Monitor press attitudes
- Develop training programmes
- Pro-active press campaigns
- Social integration activities

## **9.2 Promoting social inclusion**

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### **Supported employment for people with mental health problems**

Many local authorities and NHS trusts, often in partnership with independent sector agencies, have set up vocational training and employment support schemes for people with mental illness. The new government initiative Modernising Supported Employment (April 2001) provides a more flexible framework for people with disabilities wishing to return to work and will allow people to move from supported employment to main stream employment and back to supported employment should this be necessary. Future legislation is also set to tackle the benefits trap to enhance the benefits of working without losing the security of housing benefits.

## ***Promoting mental health in the workplace for people with mental health problems - What needs to be done?***

- Awareness raising, decreasing stigma and increasing understanding
- Creation of training and development opportunities and supported employment
- Partnerships with 'Ways Into Work' and other similar schemes
- Mentoring schemes for those returning to work

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### **Supported living for people with mental health problems.**

The Government has introduced a new policy and funding framework for support services “Supporting People” which introduces a new integrated budget for support to vulnerable people. Objectives include action to tackle social exclusion and help vulnerable people to play a full role in society and action to support people with mental health problems in the community. As well as housing, this proposed single budget, which will come on line in 2003, can fund supervision, counselling, anger management, advocacy, companionship, advice and life skills training.

#### ***Promoting supported living for people with mental health problems - What needs to be done?***

- Work within the new “Supporting People” framework to meet the needs of people with mental health problems living in the community

# SECTION 10

## *The way forward*

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### 10.1 Making it happen

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The NSF requires that health and local authorities should have a mental health promotion plan in place by April 2002. This process is being led, at both county and local levels, by a Steering Group reporting to the Berkshire Local Implementation Team for the National Service Framework for Mental Health.

Berkshire Health Promotion will work with Locality Mental Health Strategy Groups and local statutory organisations for children and adolescent services to facilitate the annual development of rolling action plans, which will be disseminated each year.

### 10.2 Priorities

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600 draft copies of this Strategy have been circulated for consultation and over 200 people attended locality workshops to identify mental health promotion needs in their communities.

After careful consideration of both government priorities and the views collected from the people of Berkshire the Mental Health Promotion Steering Group have identified the following cross county priority areas for the first three years, i.e. 2001-2004.

Actions to effect these priorities are set out in the detailed Action Plan for the coming year which will be revised annually in the light of progress achieved and emerging priorities. This process will be co-ordinated and monitored via the steering group.

### 10.3 Action areas

**Adults** (*Primary Care, Communities and Neighbourhoods, Combating stigma and discrimination*)

<b>2001-2002</b>	<b>2002-2003</b>	<b>2003-2004</b>
Publication and distribution of Strategy	Creation and distribution of Self help leaflets	Support to carers
Work with PCG/PCTs & UAs to develop Locality Action Plans	Prepare local directories of self help and voluntary groups	Target rough-sleepers
Establish an ethnic minority steering group	Compilation and distribution of Helpline lists	Develop initiatives for victims of domestic violence
Work in Young Offenders Institution, (Reading)	Compile & distribute list of BHP mental health resources	
Mental health & anti-stigma network to disseminate campaigns	Development of exercise on prescription	
Anti-stigma work involving users and the press	Mental health promotion training for Primary Care staff	
Development of a Mental health web-site		

#### ***In the workplace***

<b>2001-2002</b>	<b>2002-2003</b>	<b>2003-2004</b>
NHS Royal Berkshire and Battle trust	New NHS trusts	Work with Environmental Health to target employers
Reading employers	Bracknell employers	Develop mental health friendly policies and practices
Newbury employers	Wokingham employers	Personal skills training
Maidenhead and Windsor employers	Slough employers	

**Young people** (*Schools and community*)

<b>2001-2002</b>	<b>2002-2003</b>	<b>2003-2004</b>
PSHE work in schools	Develop emotional literacy in schools	Develop continuous parenting programmes - i.e. ante-natal and post natal
Vulnerable Children - excluded, looked after and abused	Target racism and bullying Promote cultural sensitivity	Develop buddy support systems linked to Connexions Personal Advisers
Young and inexperienced parents	Develop arts, drama, in schools	Bullying and racism in the community
Pregnant and postpartum mothers	Self help groups for parents Support schemes for parents Specialist emotional support for looked after and excluded children	Specialist support systems in community

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