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1. Context

In the 2007 Scottish Budget, the Scottish Government set out a National Performance Framework (NPF) to guide public reporting on progress towards achieving the five cross-government strategic objectives: Healthier, Wealthier & Fairer, Safer & Stronger, Smarter and Greener (Scottish Budget, Spending Review, 2007). The NPF also sets out a range of national outcomes which sit below the strategic objectives against which the performance of public sector organisations will be assessed and publicly reported.

The Scottish Government tasked NHS Health Scotland with providing resources (outcomes frameworks) which help people link local activities with the NPF and move to an outcomes approach. The outcomes frameworks can be used or amended to fit local needs. They can also help partners clarify the links between the outcomes of the services they provide and the shared outcomes that they are working with partners to achieve.

Outcomes frameworks are being created by NHS Health Scotland in collaboration with partners in five areas: alcohol use, tobacco, healthy weight, health at work and mental health improvement. A user friendly website which contains the outcomes frameworks for each of these topics is being created and we anticipate that the first of the frameworks will be online in Autumn 2010. NHS Health Scotland has supported the development of outcome frameworks undertaken by other organisations in the areas of inequalities and greenspace and with West Lothian council (Greenspace Health and Outcomes Framework, 2010; West Lothian Council, 2006). This paper describes the outcomes framework for mental health improvement.

2. Aim

The aim of this work is to develop an outcomes framework which identifies the key outcomes for mental health improvement and specifies local activities which could be undertaken to achieve them. The framework is intended to support an outcome-focussed and evidence-informed approach.
3. Definition of mental health

There are many definitions of mental health so it is important that we clearly set out what we mean by mental health. In this paper mental health is used as an umbrella term which includes both mental wellbeing and mental health problems.

Mental wellbeing includes subjective wellbeing (such as affect and life satisfaction) and psychological wellbeing (such as mastery, sense of control, having a purpose in life, sense of belonging and positive relationships with others).

Mental health problems refers to symptoms which meet the criteria for a clinical diagnosis of mental illness, or symptoms at a sub-clinical threshold which interfere with emotional, cognitive or social function. Where necessary we differentiate between: common mental health problems (such as depression and anxiety), and severe and enduring mental health problems (such as schizophrenia).

It is also important to be clear about the definition of mental health improvement used in this paper. We have defined mental health as including:

- the promotion of mental wellbeing
- the prevention of mental health problems
- the improvement in quality of life for those with mental health problems.

4. Target audience

The outcomes framework is designed to help community planning partners develop the outcomes-focussed approach to planning and performance announced by Scottish Government in the Spending Review (Scottish Budget Spending Review, 2007). It has also been created to support policy makers, planners, evaluators and researchers. The aim of supporting policy development in this way is to help make it more systematic, explicit and targeted.
5. Components of the outcomes framework

The outcomes framework is divided into three components (or tools): an outcomes triangle, logic models and multiple results chains. The components are described in detail in this section.

5a. Outcomes triangle

The outcomes triangle is a diagram which presents an overview of the topic area. It categorises outcomes at different hierarchical levels and shows how they relate to the national outcomes in the NPF. It is not explicit about the links between activities and outcomes or interconnections between the outcomes.

Figure 1 presents the outcomes triangle for mental health improvement. The top two thirds of the diagram contains long-term and intermediate outcomes, i.e. outcomes ‘above the waterline’ in the language of the recent update of SOA guidance (SOLACE and the Improvement Service, 2009).

Long-term outcomes are concerned with population health outcomes. Some relate to general health outcomes such as healthy life expectancy, others relate specifically to mental health improvement such as improved mental wellbeing. Intermediate outcomes are changes in the ‘determinants’ of these high-level long-term outcomes. These may be:

- individual health behaviours, such as increasing healthy behaviour
- the social, economic and physical environments that shape these behaviours
- aspects of the environment with direct health consequences.

Short-term outcomes are the more immediate results of service delivery ‘below the water line’ and reflect the contributions of specific organisations, partnerships, services or programmes. As such, they are more appropriate for performance management within service delivery organisations that is required to underpin SOAs.
Figure 1: Outcomes triangle for mental health improvement

- **Resilient communities**
- **Children have best start**
- **Tackled inequalities**
- **Longer healthier lives**
- **Improved life chances**

**Long-term outcomes**

- **Improve healthy life expectancy**
  - Increase quality of life
  - Improve mental wellbeing
  - Reduce mental illness
  - Reduce suicide

- **Reduce inequalities in wellbeing**

**Intermediate outcome areas**

- **Promoting health & healthy behaviour**
- **Sustaining inner resources**

**Individual**

- Promoting a safe & supportive environment at home & in the community
- Increasing social inclusion & decreasing inequality & discrimination
- Increasing financial security & creating healthy environments for working & learning
- Increasing social connectedness, relationships & trust in families & communities

**Social, Economic & Physical environments**

**Short-term outcomes related to service delivery**

- **Activities**

**National outcomes**

- Children have best start
- Longer healthier lives
- Improved life chances

**Short-term outcomes**

- Reduce inequalities in wellbeing
- Improved life chances
- Longer healthier lives
- Children have best start
- Resilient communities
5b. Logic models

Outcomes are the focal point of logic models. Logic models clarify the activities which can be undertaken and which population group can be targeted to achieve a desired outcome. Logic models also map out the time sequence in which the outcomes need to be achieved.

We have numbered each link in the logic models presented in this paper so that you can see the rationale for including each outcome. Evidence underpins the models where it is available but is not a limiting factor. Where evidence (obtained from the sources indicated in Section 9a) is lacking or limited, the models present supporting plausible theory. Figure 2 is a simplified logic model for illustrative purposes only.

Figure 2: Illustrative logic model
5c. Multiple results chains

Improving long-term outcomes can only be achieved by different sectors working together in partnership. Multiple results chains are a way of showing the contribution of different sectors to longer term outcomes. Figure 3 provides an illustrative example of potential multiple results chains for mental health improvement.

Multiple results chains present the same information as logic models but also show the contribution of different sectors to long-term outcomes. Multiple results chains are presented in a vertical axis to help distinguish them from logic models. They could be used by local government and partners to show how local activities contribute to achieving long-term outcomes.

Figure 3: Illustrative multiple results chains for mental health improvement
6. Focusing on inequalities

Socio-economic deprivation both reflects and contributes to poor mental health (Parkinson, 2007). A preliminary analysis of international data suggests that higher national levels of income inequality are associated with increased mental health problems (Pickett et al., 2006). Addressing inequality is a central tenet of governmental policy. Graham and Kelly (2004) propose that there are three ways of tackling health inequalities:

1. Improving the health of the poor
2. Narrowing health gaps
3. Reducing health gradients

In this outcomes framework we have attempted to target the ‘worst off’ by being specific about the population group (in terms of the six strands of equality and diversity) whom activities are intended to reach. We have also targeted specific groups who are at risk of mental health problems. Consequently, vulnerable groups such as looked-after children, victims of domestic abuse and offenders are specifically targeted by interventions where appropriate. We have tried to make the outcomes in the framework inequality sensitive to attempt to reduce the gaps between groups. For example, if an outcome is to increase the use of a particular service we have tried to make sure that it is focused on increasing the use for all population groups. If the gap between groups is to be reduced then the whole population will need to improve but it will need to improve much more quickly for those in the most deprived groups.

The two methods described above also contribute to reducing inequalities across the whole population. In addition we have included the following intermediate outcomes in logic model 4: ‘increasing equality’ ‘decreasing inequality’ and ‘decreasing discrimination’. As a result there are activities in logic model 4 whose primary purpose is to address inequality and discrimination and promote equality.
7. Scope and limitations of the framework

The purpose of the outcomes framework is to identify key outcomes for mental health improvement and outline which activities can be carried out to achieve them based on evidence or plausible theory. The framework is not a causal model for mental health improvement and does not try to explain all of the interactions between activities and outcomes. The framework does not depict the true complexity of mental health improvement; it only attempts to clarify some of the key paths to achieving intermediate and long-term outcomes. Ultimately, the framework is a resource for policy makers and planners to help them clarify what outcomes they want to achieve and what can be done to achieve those outcomes.

The outcomes framework does not provide a historical context for the outcomes which it contains nor the pattern of change over time which has occurred for each outcome. We acknowledge that social and cultural history has played a role in creating the problems related to mental health. However, it is beyond the scope of this piece of work to detail the social and cultural history which has created these problems. The outcomes framework does not include large-scale or macro factors such as climate change, ecology and sustainability.

The framework presents a snapshot of what is currently known about mental health improvement. It will be reviewed and updated biannually to reflect changes within mental health improvement. This is particularly important since external factors such as the deteriorating economic environment may have an impact on the mental health of the population and it would be important to be sensitive to any changes which take place.

8. The implication of focusing on outcomes

Traditionally mental health improvement activities have been divided into three categories: individual, community and structural factors. This categorisation is inappropriate when the focus of the work is on outcomes since each activity may have numerous outcomes. As a result, the framework is structured around the outcomes which need to be achieved to improve mental health for the population. This change in emphasis may be unfamiliar to those who are used to focusing on activities. Nevertheless, the same individual, community and structural factors are contained within the outcomes framework.
9. Development of the outcomes framework

A collaborative approach was adopted in developing the outcomes framework. A core group of NHS Health Scotland Staff developed the framework in collaboration with a reference group, comprising individuals involved in mental health improvement from the Scottish Government, local government, local health boards and the third sector. The process was overseen by a strategic group, comprising individuals from the Scottish Government, local government, local health boards, the third sector and NHS Health Scotland.

9a. Identifying and agreeing the outcomes

The first stage of the process was to identify the long-term and intermediate outcomes. In conjunction with the strategic group it was agreed that the long-term outcomes should include the three objectives of mental health improvement and the reduction in suicide as well as key health improvement outcomes. The long-term outcomes are:

- Improved mental wellbeing
- Reduced mental health problems
- Increased quality of life
- Reduced suicide
- Improved healthy life expectancy
- Reduced inequalities in wellbeing

It was agreed that the determinants of mental health outcomes would be the most appropriate intermediate outcomes. Rather than include all the potential determinants of mental health, a pragmatic approach was adopted and it was agreed that the determinants used to guide the development of the Mental Health Indicators for Adults in Scotland would form a good starting point. These determinants generally have a good evidence base and are measurable in the Scottish context. Latterly the work on the outcomes framework drew on the developing framework for the Children and Young People’s Mental Health Indicators in Scotland.

Further work on refining the intermediate outcomes and developing the logic models was carried out with the reference group. Four workshops were held each focusing on a specific task. The reference group’s first task was to further develop the key intermediate outcomes and identify additional outcomes for children. Twenty-seven intermediate outcomes were identified and these were grouped into categories in order that logic models could be developed. A commonly used approach to categorising determinants of mental health is in terms of individual, community and structural factors.
This approach, however, was not felt to be appropriate because the logic models would contain too many outcomes and thus be unnecessarily complex. Consequently, the intermediate outcomes were grouped together into the following common themes by the reference group:

- Promoting health and healthy behaviour
- Sustaining inner resources
- Increasing social inclusion and decreasing inequality and discrimination
- Promoting a safe and supportive environment at home and in the community
- Increasing social connectedness, relationships and trust in families and communities
- Increasing financial security and creating mentally healthy environments for working and learning
Figure 4 below presents the detail of the common themes which were identified:

Figure 4: Intermediate outcomes

1. Promoting health & healthy behaviour
   - Physical health & ill health

2. Sustaining inner resources
   - Meaning, purpose, optimism & hope
   - Resilience
   - Individual mental health

3. Increasing social connectedness, relationships & trust in families & communities
   - Trust
   - Social networks & social support
   - Relationships (including family relations & peer relationships)

4. Increasing social inclusion & decreasing inequality & discrimination
   - Social inclusion
   - Participation
   - Inequality, discrimination & stigma

5. Increasing financial security & creating mentally healthy environments for working & learning
   - Learning & skills development
   - Financial security
   - Mentally healthy schools
   - Mentally healthy workplaces

6. Promoting a safe & supportive environment at home & in the community
   - Physical environment
   - Safety
   - Violence

NB: Outcomes in black text have been taken from the work on the adult indicators for mental health. Outcomes in red italic text are new outcomes suggested by the reference group.
9b. Developing the logic models

The intermediate outcomes form the basis for the six logic models which underpin the outcomes framework. Initial draft models were developed by the core group and shared and further developed with the reference group in a series of workshops. A key principle of the outcomes framework is that they are evidence-informed, that is, the links between the various components of the model are informed by the available evidence and, where appropriate, plausible theory. Once the draft models were agreed with the reference group, a review of the key sources of evidence and plausible theory was undertaken and used to further refine the model.

Evidence
The logic models help us to understand two broad questions. The first can be loosely categorised as the ‘whats’ and incorporate issues such as the identification of the determinants of, or risk factors for, mental health. Evidence of association and causation are normally the key evidence types here. The second set of questions can be loosely categorised as the ‘hows’ and help us to identify areas for effective intervention or action. Evidence of effectiveness is the key type of evidence in this instance (Tannahill, 2008).

Evidence and/or evidence- informed recommendations and suggested actions have been drawn primarily from six key mental health related sources:

1. NHS Health Scotland Commentaries/Scottish Perspectives on National Institute for Health and Clinical Excellence (NICE) public health guidance.
2. NICE and Health Development Agency (HDA) public health briefings.
4. NICE clinical guidelines and multiple technology appraisals.
5. The Foresight Programme on mental capital and mental wellbeing.

We have called this information ‘highly-processed evidence’. Additional sources of evidence and theory have been drawn from relevant key systematic reviews and, reviews and reports commissioned by the Scottish Government, the UK Government and national organisations and collaborators. This range of sources reflects the fact that ‘highly-processed’ evidence/evidence-informed recommendations, such as those produced by SIGN in Scotland and NICE in England, are limited in some areas of
relevance. It should be noted that SIGN and NICE have formalised, robust and centrally quality-assured processes for the conduct of systematic reviews and generation of evidence-informed recommendations. Where SIGN has not issued relevant clinical guidelines, NICE clinical guidelines can provide useful evidence and evidence-informed clinical recommendations; however, these guidelines have no formal status in Scotland. It should also be noted that NICE multiple technology appraisals are formally applicable in Scotland after validation by NHS Quality Improvement Scotland (QIS). The robustness of the methods, findings and conclusions in reports and reviews other than those produced by SIGN and NICE will vary and NHS Health Scotland has not undertaken critical appraisal of these reviews and reports.

**Plausible theory**
For a variety of reasons (e.g. overwhelming demand for effectiveness evidence; skewing of effectiveness evidence due to a focus on traditional evidence ‘hierarchy’; inadequacy of effectiveness evidence) we do not always have ‘good evidence’. Furthermore, in mental health we are often presented with equivocal evidence, the use of different terminologies, definitions and outcome measures, uncertainty about the direction of causality and attribution of outcomes to activities. This lack of evidence, however, does not necessarily mean there is no link between two components in a logic model. Similarly, lack of evidence should not always prevent us from acting. In some instances, therefore, plausible theory has been drawn on to explain the links in the models.

**10. Logic models**

Logic models have been created for each of the six areas described above. These models and the evidence and plausible theory which support the links between the various components of the models are presented on the following pages. Each link in the models is numbered. We have provided a rationale for each of these connections using the evidence and, where no evidence is available from the sources defined above, plausible theory. Over time we anticipate that further research will enable areas where little evidence is available to be strengthened and the model modified and refined to reflect the changes in our understanding of mental health improvement.

Six logic models are presented on the following pages for each of the areas presented in Figure 4. The rationale which lies behind each logic model is presented in the
appendices which follow the models. In the logic models you will see both solid and dotted lines. This is to enable the direction of the arrow’s point to be easily identified. Three of the outcomes in the logic model are coloured light green as they represent outcomes in logic models in the other topic areas with outcomes frameworks (alcohol use, tobacco, healthy weight, health at work and mental health improvement). These outcomes are different to all of the other outcomes in the models so they merit special demarcation. The long-term outcomes in each of the models which are linked to the intermediate outcomes are highlighted yellow for the sake of brevity. The details of the connections are provided in the rationale section for each of the relevant links.

Developing an outcomes framework for mental health improvement is a complex process and the timescale for the development of this work was tight. This has meant that a pragmatic approach has been used to strike a balance between the rigour and speed during the developmental process. This process has involved numerous, detailed discussions with key stakeholder groups. By being explicit about the developmental process and the assumptions which have been made during it, we have tried to make the framework more amenable to rational examination and thus, in the long-term, hopefully more defendable.

The outcomes framework is not a fait accompli; it represents our best understanding of mental health improvement at this point in time and involves a process of reflection and continual improvement. It will need to be reviewed biannually and locally modified to reflect local priorities as we continue to understand more about mental health improvement over time.

It should be noted that, although the outcomes included in this framework have been made as applicable for children and young people as possible, they remain an under-represented demographic group. Work is currently being undertaken by Parkinson (2009) to identify mental health indicators for children and young people which could be used to identify additional outcomes for this framework. This will be assessed on completion of the indicators in spring 2011.
Model 1: Promoting health & healthy behaviours

Activities to promote healthy lifestyle behaviours
- Diet
- Physical activity
- Alcohol
- Smoking
- Sexual health
- Substance misuse

Activities & policies on physical health checks (including keep well, life begins health checks & ICP for mental illness)

Activities to manage chronic conditions
- Physical aids, e.g. hearing aids
- Social support

Reach

Whole population, Targeted:
- People with MH problems,
- Pregnant women & their babies
- Deprived groups

Targeted:
- 45-64 year olds living in deprived areas
- People aged 40 and over
- People with mental illness

Targeted:
- People with chronic conditions

Outcomes

Short-term outcomes in topic specific models

- Inc. knowledge, awareness, motivation for all
- Inc. availability & accessibility of services for all

Inc. Healthy lifestyle behaviours for all
- Better Diet
- Inc. Physical activity
- Dec. Smoking
- Dec. Alcohol use

- Dec. Sexual health risk taking
- Dec. Substance misuse

Reduced Physical ill health for all
- Improved Physical health for all

- Inc. Communication
- Inc. Mobility
- Increase social networks

Inc. Healthy lifestyle expectancy

Inc. Mental wellbeing

Inc. Quality of life

Dec. Mental health problems

Dec. Inequalities in mental wellbeing

Reduce suicide

Short-term

Intermediate

Long-term
Model 2: Sustaining inner resources

Activities

1. Activities in 5 other models
   - Whole population

2. Provision of mentally healthy services
   - Whole population
   - Targeted: Employers & employees

3. Building inner resources
   - Whole population
     - Positive psychology/Mindfulness, Self-help
     - People at risk of mental health problems
     - Suicide prevention and mental health first aid training

Reach

Short-term

1. Intermediate outcomes in 5 other models
   - Whole population

2. Improved attitudes of service providers
   - Targeted: Employers & employees

Intermediate

3. Inc. Confidence, Inc. Positive sense of self
   - Whole population

4. Knowledge & skills
   - Whole population

5. Inc. Resilience

Long-term

1. Appreciation of own skills, attributes & environment
2. Ability to effect change
   - Including: Increase Control, mastery, self-efficacy, self-determination
3. Inc. Meaning, purpose, optimism & hope
4. Inc. Individual mental health
5. Inc. Healthy life expectancy
6. Inc. Mental wellbeing
7. Inc. Quality of life
8. Dec. Mental health problems
10. Reduce suicide
Model 3: Increasing social connectedness, relationships & trust in families & communities

**Activities**

1. Community engagement activities
2. Social prescribing to community activities
3. Community based services to provide social support, e.g. self-help & volunteering
4. Physical environment, greenspace & amenities
5. School-based programmes
   - Identify & manage pre&post natal MH probs
   - Home visiting
     - Parenting for infants
6. Training carers

**Reach**

1. Whole population, Targeted: People with MH problems & those living in deprived communities
2. Whole population, Targeted: Vulnerable populations: MH problems
   - Carers
   - Older adults
3. Whole population, Targeted: Deprived communities
4. Whole population, Targeted: Vulnerable populations: MH problems
   - Carers
   - Older adults
5. Whole population, Targeted: Deprived communities
6. Whole population, Targeted: Vulnerable populations: MH problems
   - Carers
   - Older adults
7. Whole population, Targeted: Deprived communities
8. Targeted: Children & young people
   - Parents
9. Whole population, Targeted: Low income families
10. Targeted: Looked after children & carers
11. Whole population, Targeted: Deprived communities
12. Whole population, Targeted: Vulnerable populations: MH problems
   - Carers
   - Older adults

**Outcomes**

**Short-term**

- Inc. knowledge
- Awareness of & accessibility to services
- Motivation to use services for all
- Reduce barriers to services

**Intermediate**

- Inc. Social interaction for all
- Inc. Social support & Social networks for all
- Inc. Participation, engagement & attendance for all

**Long-term**

- Inc. Trust in the community by all
- Inc. Social support & Social networks for all
- Inc. Healthy life expectancy
- Inc. Mental wellbeing
- Inc. Quality of life
- Dec. Mental health problems
- Dec. Inequalities in mental wellbeing
- Reduce suicide

**Whole population**

- Targeted: People with MH problems & those living in deprived communities

**Targeted:**

- Vulnerable populations
  - MH problems
  - Carers
  - Older adults

**Deprived communities**

- Targeted: Low income families
- Looked after children & carers

**Better Parent/ guardian-child relationship**

- Parental relationship
- Peer relationship
- Friendship for all

**Improved skills, attitudes & psychological functioning for all**

- Inc. knowledge, awareness, motivation
- Inc. Availability of school, home & care-based resources for all
Model 4: Increasing social Inclusion & decreasing inequality & discrimination

Activities

Access employment
- Supported Employment
- Job search, retraining and vocational programmes
- Job retention programmes

Access Services
- School & adult education
- Cultural & Leisure activities
- Housing, transport etc

Inclusive health & social care services

Community engagement/development

Anti-discrimination & stigma activities & legislation (e.g. Equalities strategy)

Reach

Targeted:
- People with MH problems; Low income & unemployed; Employees with chronic health problems

Targeted:
- People with MHP & 6 strands of equality

Targeted:
- People with MHP

Targeted:
- Six strands of equality Those living in deprived areas

Whole Population, Targeted:
- Six strands of equality; Those living in deprived areas; People with mental health problems

Outcomes

Short-term

- Inc. equal opportunities to access services
- Inc. equal opportunities to access work
- Inc. support to access work for all
- Inc. skills for all
- Inc. self-esteem for all

Intermediate

- Inc. & maintain good quality employment for all
- Inc. Equal access to education, arts & leisure etc
- Inc. Volunteering Inc. Empowerment
- Inc. involvement in the community, Inc. Influence over local decision making for all

Long-term

- Inc. Social inclusion
- Inc. Participation in the community
- Dec. Mental health problems
- Dec. Inequalities in mental wellbeing
- Dec. inequality (including income inequality), discrimination and stigma for all
- Inc. Healthy life expectancy
- Inc. Mental wellbeing
- Inc. Quality of life
- Reduce suicide
Model 5: Increasing financial security & creating mentally healthy environments for working & learning

### Activities

**School based programmes**
- Develop strategic framework
- Key principles and conditions
- Curriculum approaches
- Work with parents & families
- Work in partnerships with YP
- Training & CPD (+targeted interventions)

**Life-long learning**
- Employee led basic skills programmes
- Empowering learning

**Work place activities**
- Strategic & coordinated approach
- Assess opportunities for promoting employee MWB
- Flexible working
- Role of line manager
- Support for small & med sized business
- Better diagnosis & management of MHP

**Activities to increase financial security**
- Debt assessment & management, financial literacy programmes
- Interventions to maximise income & access financial resources (e.g. increase uptake of benefits, min wage)

**Mental health literacy programmes on debt**

### Reach

**Targeted:**
- Commissioners & providers of services to YP
- Practitioners working with children
- Children parents & carers

**Whole population,**
- **Targeted:**
  - Employers & employees

**Targeted:**
- Workforce (incl. those with/at risk of MH problems)
- Employers & managers
- Training & health service providers

**Targeted:**
- Primary care staff
- People at risk of MH probs / debt
- Whole pop

**Targeted:**
- Financial institutions & utilities

### Short-term

- Inc. Knowledge & skills; Foster an ethos that promotes a mentally healthy school environment; Inc. engagement of parents, carers & young people to promote social & emotional wellbeing for all
- -Inc. Knowledge & skills
- -Inc. Demand & capacity for learning

### Intermediate

- Inc. Job satisfaction
- Inc. Capacity to manage risks to MH problems
- Inc. MH knowledge & skills, Inc. equal access to support. More supportive workplace for all

### Long-term

- Inc. Mentally healthy workplaces
- Improved: Work context and content, Quality of work, Return to work & Work-life balance
- Reduced: Presenteeism & Absenteeism

- Inc. Mentally healthy schools

- Inc. Learning & skills development for all

- Inc. Financial Security for all

- Inc. Healthy life expectancy

- Inc. Mental wellbeing

- Dec. Mental health problems

- Inc. Quality of life

- Dec. Inequalities in mental wellbeing

- Reduce suicide
Logic model 6: Promoting a safe & supportive environment at home & in the community

**Activities**
- Activities to promote use of greenspace, Planning & design of built environment, Regeneration
- Re-housing, housing improvement & improved design
- Community engagement (This could include other activities e.g. police initiatives)
- Work programmes & policies on mental health & on bullying
- School based programmes & policies on mental health & on bullying
- Home visiting & parenting
- Person centred planning

**Reach**
- Whole population, Target: Areas of Deprivation, People in poor quality housing & residential care
- Whole population
- Targeted: Service providers, Teachers & Children
- Targeted: Parents & guardians
- Targeted: Employers, managers, employees
- Targeted: People living in residential care

**Short-term**
- Inc. Equal access to amenities
- Inc. Equal access/use of greenspace
- Inc. Perceived access/use of escape facilities for all
- Reduced Street level incivilities for all
- Improved Housing condition, Reduced Overcrowding & Noise for all

**Intermediate**
- Inc. Safety with environment by all
- Inc. Safety (perceived & real) for all
- Inc. Safety for all (including assault, domestic abuse violence, bullying, antisocial behaviour)
- Dec. Violence for all
- Inc. Prosocial & Dec. Aggressive behaviour
- Inc. Knowledge, Awareness, skills & support
- Inc. Knowledge & skills & support

**Long-term**
- Inc. Healthy life expectancy
- Inc. Mental wellbeing
- Inc. Quality of life
- Dec. Mental health problems
- Dec. Inequalities in mental wellbeing
- Reduce suicide
- Dec. Crime, fear & perception of crime for all
- Dec. Neighbourhood violence for all
- Dec. Tolerance of violence
- Inc. Mental wellbeing
- Inc. Healthy life expectancy
- Inc. Quality of life
- Inc. Equal access to amenities
- Inc. Equal access/use of greenspace
- Inc. Perceived access/use of escape facilities for all
- Dec. Crime, fear & perception of crime for all
- Dec. Neighbourhood violence for all
- Dec. Tolerance of violence

**Outcomes**
- Inc. Satisfaction with environment by all
- Improved Physical environment for all
- Whole population
11. Appendices: Rationale (evidence/theory) supporting logic models

Rationale for Logic model 1: Promoting health & healthy behaviours

1: Link:
Activities to promote healthy lifestyle behaviours need to be targeted at the whole populations, people with or at risk of mental health problems, pregnant women and those in deprived communities.

Rationale
People with a diagnosis of schizophrenia are more likely to smoke, less likely to be physically active and more likely to have diets high in fat and low in fibre than the general population.¹ There is growing evidence of increased morbidity and mortality as a result of obesity amongst people with bipolar disorder.²

Alcohol, tobacco and drug use during pregnancy increases the likelihood of premature delivery, low birth weight, long-term neurological and cognitive-emotional development problems. Premature birth and low birth weight are known risk factors for adverse mental health outcomes and psychiatric disorders. Substance abuse by the mother is also associated with the offspring becoming dependent on substances during adolescence and young adulthood.³

People living in deprived communities are at greater risk of mental health problems than those who live in more affluent communities.⁴

Source:

2: Link:  
Activities to promote healthy lifestyle behaviour will achieve short-term outcomes related to the activities undertaken.

Rationale  
Details of these outcomes and the evidence/evidence-informed recommendations are provided in the other outcomes frameworks on healthy weight, tobacco control, alcohol and physical activity.

Source:  
See topic specific logic models and associated evidence (http://www.healthscotland.com/)

3: Link:  
Activities promoting healthy lifestyle behaviour will contribute to increasing knowledge, awareness, motivation and access to services and facilities and facilitate behaviour change.

Rationale  
There is little highly processed evidence of effective health improvement interventions for smoking cessation, weight management and physical activity designed for people experiencing mental illness. NHS Health Scotland has commissioned a rapid evidence review and a Scottish mapping exercise on effective health improvement interventions for smoking cessation, healthy weight and physical activity for people experiencing mental health problems.

Informed by reviews of effectiveness evidence, NICE public health guidance 06 Behaviour change at population, community and individual levels sets out a set of generic principles and recommended actions to guide the planning and delivery and evaluation of public health activities to change health related behaviour at the individual, community or population level. The NHS Health Scotland Commentary on this public health guidance supported these action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.¹

Informed by reviews of effectiveness evidence, NICE public health guidance 16 Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care recommended that tailored exercise, physical activity and walking schemes are offered in collaboration with older people in their carers. The NHS Health Scotland Commentary supported these recommendations subject, where appropriate, to adaptation to fit Scottish organisational arrangements.²
There is a need to ensure that health promoting activities are implemented in a mentally healthy way (for example in relation to physical activity and children and young people\(^3\)).

**Source:**
4. Evidence from topic specific logic models.

**4: Link:**
Physical health checks should be offered to people with severe and enduring mental health problems and people over 40 living in areas of deprivation.

**Rationale**
The association between schizophrenia and poor physical health is well established. Poor health results in higher standardised mortality rates (SMR) and increased morbidity for individuals with schizophrenia.\(^1\)

There is growing concern about the physical health of service users with bipolar disorder. In addition to high mortality (SMR) from suicide and possibly accidents, there is increasing evidence of a doubling of the SMR for cardiovascular mortality and increase mortality for pulmonary embolism and data from the USA suggests that the prevalence of a range of diseases is raised.\(^2\)

People living in deprived communities have higher levels of mortality from cardiovascular disease and at greater risk of mental health problems.\(^3\)

**Source:**


5: Link:
Health checks for people with severe and enduring mental health problems will contribute to promoting healthy lifestyle behaviour.

Health checks for adults over 40 will contribute to promoting healthy lifestyle behaviour.

Rationale
Standard 13 of the *Integrated Care Pathway for Mental Health* states a general physical health assessment and management of the findings are recorded for service users with serious mental health problems. Services should be provided that address diet, nutrition, exercise, alcohol consumption, drug misuse and sexual health in ways that are responsive to the needs of service users. This includes access to smoking cessation, clinical free dental and optical examinations and flu vaccinations¹.

Scottish Policy Context
*Better Health, Better Care* states that the Scottish Government will support the roll out of the Keep Well programme to reduce inequalities in cardiovascular disease and introduce a programme of ‘Life Begins’ health checks. Recommendation 46 of *Equally Well* states that the government’s commitment to health checks for all at age 40 should be implemented in ways that build on the Keep Well programme.

Source:

6: Link:
Increasing knowledge, awareness and motivation will contribute to behaviour change.

Rationale
Informed by reviews of effectiveness evidence, NICE public health guidance 06 *Behaviour change at population, community and individual levels* sets out a set of generic principles and recommended actions to guide the planning and delivery of public health activities to change health related behaviour at the individual, community or population level. The NHS Health Scotland Commentary on this public health guidance supported these action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.¹

Source:

7: Link:
Increasing topic specific short-term outcomes detailed in other logic models will improve healthy lifestyle behaviours.

Rationale
Details of these outcomes and the evidence/evidence-informed recommendations are provided in the other outcomes frameworks on healthy weight, tobacco control, alcohol and physical activity.¹

Source:
1. See topic specific logic models (http://www.healthscotland.com/)

8: Link:
There are associations between the intermediate outcomes: physical health and healthy lifestyle behaviour and one or more of the long-term mental health outcomes.

Rationale
An overview of the evidence undertaken as part of the programme of work for the mental health indicators for adults in Scotland¹ and a review of the evidence base for key mental health improvement messages² found that physical health is associated with mental health outcomes, quality of life for people with mental health problems and mental wellbeing.

There is review level evidence to suggest that participation in physical activity is positively associated with mood, emotion and psychological wellbeing and can produce positive changes in wellbeing through improved physical self-perception in adults.³ There is review level evidence of an association between participating in physical activity and aspects of mental wellbeing in children and young people.⁴

Informed by evidence of effectiveness, SIGN 114 Non-pharmaceutical management of depression in adults recommended that structured exercise may be considered as a treatment option for patients with depression.⁵

There is evidence that physical activity is associated with improved quality of life for people with mental health problems.¹

There is some evidence that an attitude towards sport as a healthy activity and participation in sporting activity is protective against suicidal behaviour among adolescents. A perception
of positive health may be protective against suicide among females who have experienced sexual abuse.\(^6\)

There is evidence of an association between alcohol use and mental health problems although the direction of causality is debated\(^2\) and evidence of an association between substance misuse and mental health problems.\(^2\)

Substance misuse increases the risk of suicide attempt and death by suicide. The risk associated with opioid use disorders and mixed intravenous drug use is greater than for that for alcohol misuse. The risk of suicide from alcohol misuse is greater among women than men.\(^6\)

**Source:**
7. See topic specific logic models (tobacco control, alcohol etc) for additional evidence.

**9: Link:**
The interplay between physical health and mental health is complex and two way: physical health impacts on mental health and mental health has an impact on both physical health and health behaviour.

**Rationale**
Healthy lifestyle behaviours can increase physical health and reduce physical ill health which in turn will contribute to improved mental health outcomes through increased
psychological, social or emotional functioning and, mental health can influence health
behaviours such as drinking, smoking, uptake of physical activity.¹

Physical ill health can have a direct impact on mental health and may result from, for
example, difficulties living with/coping with illness, effects on relationships and ability to
socialise.² Equally it is argued that mental health can have an impact on physical health
due to psychological, physiological or social factors.³

Source
public health priority. In H Herman, S Saxena & R Moodie (Eds). Promoting mental
indicators for adults in Scotland: Final report. NHS Health Scotland: Glasgow.

10: Link:
Activities to manage chronic conditions should be available for people with chronic physical
health problems.

Rationale
The co-occurrence of physical illness and mental health problems is well known and
growing evidence suggests a complex interplay between physical and mental health.¹
Psychiatric surveys have found that various long-standing physical health conditions
increase the rate of mental health problem reporting.²

Source:
public health priority. In H Herman, S Saxena & R Moodie (Eds). Promoting mental
Britain. Report 2: Physical complaints, service use and treatment of adults with
psychiatric disorder. HMSO: London.
11: Link: *For further discussion and comment*

Activities to help people manage chronic and/or long standing conditions including, for example, provision of disability aids (such as hearing aids)\(^1\), and social support networks will have an impact on their psychological and emotional self (aspects of mental wellbeing) which in turn would result in better mental health outcomes.

**Rationale**

No highly processed evidence has been identified that show that managing chronic conditions results in improved mental health outcomes, however primary studies suggest that providing disability aids for managing chronic conditions can result in psychological, social and mental health outcomes.\(^1\)

**Source:**

Rationale for Logic model 2: Sustaining inner resources

1: Link:
Activities in models 1, 3, 4, 5 and 6 should focus on the populations as defined in the individual models. The achievement of the intermediate outcomes in the five other logic models (such as increased social networks and social support, improved physical health and increased social inclusion) will contribute to an individual’s own sense of their skills, attributes and environment. This will, in turn, contribute to their own sense of meaning, purpose, optimism and hope.

Rationale:
The mechanism by which the intermediate outcomes in the logic models contribute to mental health outcomes is complex. The reference group suggested that one possible mechanism is through psychosocial processes which enable the person to feel optimistic, purposeful and have meaning in their lives, which is associated with positive mental health outcomes. There is no highly processed evidence has been identified to support this proposition.

2: Link:
It is suggested here that adopting a mentally healthy approach to health and social service delivery, education and the workplace will impact positively on the values and attitudes of service providers and result in service users feeling valued and respected. This, in turn, will enhance feelings of confidence, a positive sense of self and ability to effect change amongst service users, thus contributing to resilience also meaning and purpose.

Rationale:
No highly processed evidence has been identified on effective methods for mentally healthy approaches to the provision of health and social services.

Informed by reviews of effectiveness evidence, NICE has produced public health guidance on promoting social and emotional wellbeing in primary and secondary education. Public health guidance 12 Promoting social and emotional wellbeing in primary education made three action recommendations: comprehensive programmes, universal approaches and targeted approaches. The NHS Health Scotland Commentary on this guidance supported the action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.

NICE public health guidance 20 Promoting social and emotional wellbeing in secondary education made six action recommendations: strategic frameworks, key principles and conditions, curriculum approaches, working with parents and families, working in partnership with young people and training and continuing professional development. A key component of this guidance is the development of an ethos and conditions that support
positive behaviours for learning and successful relationships, the provision of an emotionally secure and safe environment that prevents any form of bullying or violence and supports all pupils and, where appropriate, their parents’ or carers’ behaviours for learning and for successful relationships. The NHS Health Scotland Commentary on this guidance supported the action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.  

Informed by reviews of effectiveness evidence, NICE public health guidance 22 *Promoting mental wellbeing through productive and healthy working conditions: guidance for employers* made action recommendations in five areas: strategic and coordinated approach to promoting employees’ mental wellbeing; assessing opportunities for promoting employees’ mental wellbeing and managing risk; flexible working; the role of line managers; and supporting micro, small and medium-sized businesses. A strategic and coordinated approach to promoting mental wellbeing includes adopting an organisation-wide approach to promoting the mental wellbeing of all employees and working in partnership with them. This approach should integrate, for example, the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions; ensure that the approach takes account of the nature of the work, the workforce and the characteristics of the organisation and promoting a culture of participation, equality and fairness that is based on open communication and inclusion. The NHS Health Scotland Scottish Perspective on this guidance supported the action point’s subject, where appropriate, to adaptation to fit Scottish organisational arrangements.

**Source**

**3: Link:**
Suicide awareness raising and prevention training, mental health awareness and prevention training, promotion of mental wellbeing, and early identification and management of mental health problems should be universal and targeted on populations at higher risk of mental health problems.
Rationale

Large numbers of the population in Scotland are affected by common mental health problems - approximately 20% of the population in Scotland will experience depression at some point in their lives.¹ The age-standardised rate of death by suicide (i.e. deaths by intentional self-harm and undetermined intent) is 16.1 per 100,000 population.²

A recent Scottish survey has found strong correlations between mental health problems and having low income, finding it difficult to manage financially and living in deprived areas of the country.³ There is also evidence that suicide rates increase with deprivation.²

Source:

4: Link:
Suicide awareness raising and prevention training, mental health awareness and prevention training, the promotion of mental wellbeing as well as early identification and management of psychosocial problems/mild common mental health problems will contribute to increased levels of skills and knowledge about mental health and suicide, increased levels of mental wellbeing and prevention of common mental health problems and suicide at an individual level.

Rationale

Awareness raising and mental health/suicide prevention training

There is some evidence to suggest that population level interventions using mass media campaigns and social marketing can be effective.¹ Informed by reviews of effectiveness evidence, NICE public health guidance 06 Behaviour change at population, community and individual levels sets out a set of generic principles and recommended actions to guide the planning and delivery and evaluation of public health activities to change health related behaviour at the individual, community or population level. The NHS Health Scotland Commentary on this guidance supported these actions points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.² A recent report for the Foresight Mental Wellbeing project proposed a social marketing approach to communicating five key evidence- informed messages about mental wellbeing, however, this work has not been evaluated.³

The Scottish Government has promoted suicide awareness raising and prevention training through a series of programmes for front line staff and the general public: Applied Suicide Intervention Skills Training (ASIST), SAFEtalk and Skills-based Training On Risk.
Management (STORM). Whilst there is no highly processed evidence of the effectiveness of these approaches, evaluations suggest that they are effective in changing knowledge, attitudes and helping behaviour and reduction in stigma. An impact evaluation of the effects of suicide awareness raising and prevention training on successful practice and, indirectly, people at risk of suicide will report in 2010.

The Scottish Government has promoted mental health awareness and prevention training through Scotland’s Mental Health First Aid training programme. Whilst there is no highly processed evidence of the effectiveness of this programme, evaluations suggest that they are effective in changing knowledge, attitudes and helping behaviour towards people with mental health problems, although they have not been evaluated in terms of the effect on those who are recipients of the first aid.

Positive psychology
There is no highly processed evidence about the effectiveness of positive psychology and mindfulness interventions, however, there is emerging evidence that these types of interventions have potentially valuable mental health benefits for both patient and non-patient samples both in terms of, for example, reducing psychological distress, negative mood and stress levels and improving quality of life, and aspects of mental wellbeing. Positive psychology interventions appear to produce more sustainable outcomes when delivered at an individual rather than group level and for relatively long periods of time. Some studies have demonstrated successful outcomes using online delivery of interventions.

Early identification and management of mental health problems
The recent partial update of the NICE clinical guidelines for depression (which has no formal status in Scotland) recognises that sub-threshold depressive symptoms can be distressing and disabling if persistent and recommended offering advice on sleep hygiene if needed, active monitoring and specified low-intensity psychosocial interventions (individual guided self-help based on cognitive behavioural therapy, computerised cognitive behavioural therapy and a structured group physical activity programme). SIGN 114 Non-pharmacological management of depression in adults has recommendations on guided self-help based on cognitive behavioural therapy, computerised cognitive-behavioural therapy and structured exercise but does not extend there use to people with sub threshold depressive symptoms.

There is review-level evidence from the UK that counselling in primary care for people presenting with broad psychosocial and psychological problems is associated with modest improvements in psychological symptoms in the short-term (1 – 6 months) compared with usual GP care, however there is conflicting evidence about outcomes in the longer term.

Social prescribing/community referral
Social prescribing/community referral aims to strengthen the provision of, and access to non-medical sources of support within the community, thus providing social solutions to mental health problems. There is no highly processed evidence about the effectiveness
of social prescribing, however, there is some emerging evidence, from small scale projects such as arts on prescriptions, exercise referral and referring to learning advisors, that social prescribing can have a positive impact in terms of enhancing self-esteem, reducing low mood, increasing opportunities for social contact, increasing self-efficacy, increasing transferable skills and increasing greater confidence. The evidence base for social prescribing is, however, limited by wide variations in how the term is used and understood and considerable inconsistency in indicators used to measure success. The small size of pilot trials, lack of independent evaluation and poor methodology, notably in the design of qualitative research, all make it difficult to draw robust conclusions about the mental health impact of social prescribing, particularly in comparison with usual GP care or in terms of cost effectiveness.

Source


**Link 5:**
There are associations between one or more of the long-term mental health outcomes and each of the intermediate outcomes: increased meaning, purpose, optimism and hope; increased resilience and individual mental health.

**Rationale:**
In discussion with the reference group it was agreed that there was a plausible connection between meaning, purpose, optimism and hope; increased resilience; individual mental health; and longer-term mental health outcomes. However, no highly processed evidence has been identified to date.
Rationale for Logic model 3: Increasing social connectedness, relationships & trust in families and communities

1: Link:
Community engagement activities should be universal and targeted at those with mental health problems and those living in deprived communities.

Rationale
People with mental health problems are at greater risk of social exclusion¹ and those living in deprived communities are at greater risk of poor mental health.²

Source:

2: Link:
Social prescribing/community referral should target those experiencing mental health problems and those at risk of developing mental health problems

Rationale:
Promoting access to social support and strengthening social networks of those experiencing mental health problems and those at risk of developing mental health problems is an important part of recovery and preventing the development of mental health problems.¹ There is emerging evidence that social prescribing has the potential to reduce social exclusion.²

Source:
Community engagement activities, individual and community-based arts programmes and social prescribing will contribute to individuals and communities having increased knowledge and awareness of services and promote motivation and access to services and programmes for all. This, in turn, will increase attendance, participation and engagement therefore contributing to increased trust in the community, increased social support and social networks.

**Rationale:**

*Community engagement*

There is limited highly processed evidence in the mental health sector about effective interventions to promote community engagement and participation, build social capital and increase trust. There is some review level evidence that direct and indirect community engagement activities may impact on social capital.¹

Informed by reviews of effectiveness evidence, NICE public health guidance 09 *Community engagement to improve health* made 12 action recommendations which together are intended to present ‘the ideal scenario for effective community engagement.’ These include prerequisites for community engagement, infrastructure, approaches and evaluation of community engagement programmes. The NHS Health Scotland commentary on this guidance supported these action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.¹

Evaluations of other community-based projects such as Communities that Care (CtC) suggest that they can result in improvements in family and community relations as well as other behavioural impacts.² Long-term evaluations in the UK have not been undertaken to date.

There is no highly processed evidence in the health sector about the effectiveness of individual and community-based arts programmes in increasing social support, social networks and social inclusion. Rowling & Taylor argue that at an individual level, involvement in the arts can contribute to developing supportive social networks, building self-esteem and increasing sense of control and, at a community level, can contribute to a social cohesion and a sense of belonging.³ A number of small scale studies suggest that engagement in the arts can improve social networks, build self-esteem, and enhance personal motivation, increase optimism and reduce levels of anxiety.⁴

*Social prescribing/community referral*

There is no highly processed evidence about the effectiveness of social prescribing in relation to increased social support and reduced social isolation. However, social prescribing has the potential to directly and indirectly increase social networks and social support and reduce social isolation. Social prescribing aims to strengthen the provision of, and access to non-medical sources of support within the community, thus providing social solutions to mental health problems. This might include opportunities for arts and creativity, physical activity, learning and volunteering, mutual aid, befriending and self-help, as well as
support with, for example, benefits, housing, debt, employment, legal advice or parenting.\textsuperscript{5,6} Where sources of support are communal activities there is potential for social contact and social support if individuals are motivated to participate.

There is some emerging evidence, from small scale projects such as arts on prescriptions, exercise referral and referring to learning advisors, that social prescribing can have a positive impact in terms of enhancing self-esteem, reducing low mood, increasing opportunities for social contact, increasing self-efficacy, increasing transferable skills and increasing greater confidence.\textsuperscript{5} The evidence base for social prescribing is, however, limited by wide variations in how the term is used and understood and considerable inconsistency in indicators used to measure success. The small size of pilot trials, lack of independent evaluation and poor methodology, notably in the design of qualitative research, all make it difficult to draw robust conclusions about the mental health impact of social prescribing, particularly in comparison with usual GP care or in terms of cost effectiveness.

\textbf{Source}
\begin{itemize}
\end{itemize}
Community-based services and activities to promote social support should be provided universally and targeted at vulnerable populations such as carers and older adults.

**Rationale**

Providing community-based services to vulnerable populations such as those with mental health problems, carers and older adults is important because they are at risk of social isolation.\(^1\,^2\)

**Source:**

Community-based services to provide social support will increase knowledge and awareness of services, increase motivation to use these services and increase access. This, in turn, will contribute to increased attendance, participation and engagement, thus contributing to increased social support and social networks and reduced social isolation.

**Rationale:**

There is review-level evidence\(^1\) to suggest that:

- interventions offering ‘buddying’, self-help network or group-based emotional, educational, social or practical support to at-risk (widowed) older people can help to improve self-reported measures of health perceptions, adjusting to widowhood, stress, self-esteem and social functioning.\(^1\)

- community-based individual and group counselling sessions for carers of people with disabilities may be effective in reducing self-reported rating of psychiatric symptoms and improving social networks/support, coping and dealing with pressing problems.\(^3\)

- volunteering undertaken by older people improves the quality of life of those who volunteer, with those participating in face-to-face/direct volunteering achieving the greatest benefit compared with those involved in indirect, less-formal helping roles (evidence for volunteering is drawn from the USA and Canada).\(^1\)

- group activities with educational or support input can be effective in addressing social isolation and loneliness in older people – programmes that enabled older people to be involved in planning and delivering activities are most likely to be effective.\(^2\)
Source:

6: Link:
Activities to improve the physical environment, including greenspace and amenities need to be universal and targeted at deprived communities.

Rationale:
It is plausible that physical environments which promote good health might be important to reduce socioeconomic health inequalities. There is limited evidence that populations which are exposed to the greenest environments have the lowest level of health inequality related to income deprivation.¹ ²

Source:

7: Link:
Improved environments, where people are able to access greenspace, feel safe, can easily access neighbours etc. will result in increased knowledge, awareness and use of these spaces which, in turn, will result in increased social interaction and thus increased social networks.

Rationale:
The greenspace logic model provides a plausible theory that greenspace may increase and enhance social interactions and the use of public spaces.¹ ²

Source:

8: Link:
School-based interventions promoting social wellbeing will focus on children and young people in primary and secondary education. Social wellbeing is defined as: Good relationships with others, emotional intelligence, the capacity to manage conflict and the opposite of conduct disorder, delinquency, interpersonal violence and bullying.

Detection and management of ante- and postnatal mental health problems should target pregnant and new mothers.

Rationale:
Children and young people
Promoting the wellbeing of children and young people is a key tenet of Scottish Governmental policy. The Early Years Framework Part II states that, “The largest influences on children in the early years are their parents, with the wider family and the community often also playing a significant role. Improvements in outcomes therefore depend crucially on developing a partnership with parents and communities so that all of the influences on the child are contributing towards positive outcomes.” ¹

Pregnant and new mothers for mental health problems and their infants
Failure to detect and treat postnatal mental health problems may result in a prolonged deleterious effect on the mother-child relationship, and on the child’s social, emotional and psychological development. The relationship between the mother and her partner might also deteriorate.² ³ ⁴

Source:
9: Link:
Home visiting and parenting activities should focus on vulnerable families and those living in areas of deprivation because they are at higher risk of mental health problems.

Rationale
People living in deprived communities are at greater risk of mental health problems than those who live in more affluent communities.1

Source:

10: Link:
Activities to train carers need to be targeted at carers of looked-after children.

Rationale
Looked-after children are particularly vulnerable to social and psychological difficulties. Forty-five percent of looked-after children have mental health problems, they are 10 times more likely to have a statement of special needs, are four times more likely to be unemployed on leaving school and around one-third of prisoners were in care as children. The mental health of looked-after children is highly dependent, in part, on their relationships with their carers and teachers. Improved developmental trajectories are dependent on valuing good parenting and producing foster carers and residential care works with the skills of excellent teachers and parents.1

Source:

11: Link:
Early years interventions including the detection and management of pre and post natal depression, home-visiting and parenting programmes, school-based programmes and training of carers of looked after children and young people will contribute to improved skills and psychological functioning for both children and young people and their carers and practitioners (such as teachers) working with them. This, in turn, will contribute to improved relationships between: the parent/guardian/practitioners and child; spouses; and, peers.

Rationale
School-based programmes
Universal approaches to social and emotional wellbeing in schools aim to promote a range of the aspects of positive mental health and wellbeing including: aspects of psychological wellbeing (self efficacy, locus of control), confidence (self concept, self esteem) emotional wellbeing (anxiety stress and depression, coping skills) and social wellbeing (good relations with others, emotional literacy, antisocial and pro-social behaviour, social skills) and address parenting and parent child relations. It is therefore suggested that school-based interventions will impact on good relationships and increased social networks through the development of knowledge, skills and improved psychological social and emotional functioning amongst children; and, through the acquisition of knowledge, skills and confidence for parents/carers which will enable them to develop better relationships with their children.¹

Informed by reviews of effectiveness evidence, NICE has produced public health guidance on promoting social and emotional wellbeing in primary and secondary education. Public health guidance 12 Promoting social and emotional wellbeing in primary education made three action recommendations: comprehensive programmes, universal approaches and targeted approaches. The NHS Health Scotland Commentary on this guidance supported the action point’s subject, where appropriate, to adaptation to fit Scottish organisational arrangements.², ³

NICE Public Health Guidance 20 Promoting social and emotional wellbeing in secondary education made six action recommendations: a strategic framework to enable all secondary education establishments to adopt an organisation-wide approach to promoting the social and emotional wellbeing of young people; key principles and conditions concerned with, for example, demonstrating a commitment from head teachers and staff to promoting the social and emotional wellbeing of young people and providing an ethos that promotes learning, mutual respect and successful relationships among young people and staff; providing curriculum approaches that promote positive behaviours and successful relationships, and help reduce disruptive behaviour and bullying; working with parents and families to promote the social and emotional wellbeing of young people and help parents and carers develop their parenting skills; working in partnership with young people to ensure that young people can contribute to decisions that may impact on their social and emotional wellbeing; and, integrating social and emotional wellbeing within the training and continuing professional development of practitioners and relevant others involved in secondary education. The NHS Health Scotland Commentary on this guidance supported the action point’s subject, where appropriate, to adaptation to fit Scottish organisational arrangements.², ³

Screening, prevention and management of pre and post natal mental health problems SIGN60 Post Natal Depression and Puerperal Psychosis: A national clinical guideline recommended routine antenatal assessment for a history of depression and, screening during pregnancy for personal and family history of psychopathology. It recommended screening, using the Edinburgh Post-natal Depression Scale (EPDS), postnatally for Post Natal Depression. The current research base for preventive interventions in low risk women is extremely limited. SIGN makes a good practice point that in women who are at high risk of experiencing post natal depression it may be effective to have post natal visits, interpersonal therapy and/or antenatal preparation. It recommended that post natal
depression and puerperal psychosis should be managed in the same way as outwith pregnancy with due regard to the use of medication and breastfeeding/pregnancy and that due consideration should be given to psychosocial interventions.  

There is some evidence for a positive effect of home visiting on the detection and management of postnatal depression. However, issues of measurement and report bias need to be careful consideration in future trials.  

**Home visiting and parenting programmes**

Early years interventions such as home visiting and parenting can contribute to better relationships between the carer and infant. Short-term outcomes include increased parental knowledge, skills and confidence, improved psychological health, detection and management of maternal mental health problems.

There is some good review level evidence to suggest that home visiting can produce positive effects on various dimensions of parenting or mother–child interaction. Further work is needed to evaluate which types of programme, or which programme components, are likely to replicate these impacts and to develop measures which limit bias in results.

Many home visiting programmes have been developed for vulnerable families. Intensive home visiting programmes such as the Prenatal and Infancy Home visitation by Nurses Programme have been extensively evaluated in the US context and found to improve maternal and child functioning in early life. The Family Nurse Partnership programme in the UK and the Lothian Family Nurse Partnership are currently applying and evaluating this model in the UK context. The initial evaluation of the Family Nurse Partnerships (FNP) showed short-term outcomes in terms of improved confidence as parents, better coping skills, better breast feeding rates and reduced smoking in pregnancy. Evidence from the full evaluation and the evaluation of the Lothian Family Nurse Partnership could be considered in due course.

There is review level evidence that parenting programmes can have an impact on maternal and infant mental health outcomes.

- Individual and group parenting for teenage mothers has a positive impact on mother-infant interaction, maternal mealtiime communication and language development.
- Parenting programmes can have a positive impact on aspects of parental psychological health including, for example, self-esteem, guilt and self-blame, parental efficacy and reduces automatic negative thoughts and maternal depression and anxiety/stress.  
- Individual and group parenting interventions for teenagers have a positive impact on parental attitudes, parental knowledge, maternal self-confidence and maternal identify parenting programmes can have an impact on maternal psychological health (depression, anxiety/stress and self esteem) and on improving relationships with spouse/marital adjustment.
Training of carers
Foresight makes a number of suggestions on interventions based on a review of the evidence by experts. These include improved training and support for care workers and social workers in childcare, education and mental health; and, local authorities providing the same standard of love, care, education and discipline as might be expected in a family – or even to provide a more enriched experience, in order to counter the effects of negative early environments.\textsuperscript{11}

Source:

12: Link:
There are associations between the intermediate outcomes: trust in the community, increased social support and social networks and positive relationships and one or more of the long-term mental health outcomes.

Rationale

Community trust
High levels of community trust have been associated with reduced psychological distress, although the research evidence is mixed and under-developed. There is some limited evidence of an association between trust in others, higher life satisfaction, happiness and lower probability of suicide. According to Dolan, trust in public institutions was also found to be associated with higher levels of life satisfaction.¹

Social support and social networks
Social support, in particular perceived social support, correlates strongly with measures of mental health. A lack of social support is associated with depression and other mental health problems and decreased likelihood of recovery from mental health problems.¹ Social support in general is protective against suicide amongst a range of population groups including black Americans and women who have experienced abuse.²

Social networks can act as a protective factor for the onset and recurrence of mental health problems and may affect the course of an episode of mental illness. There is some evidence from that quantity and perceived quality of social networks are predictive of recovery¹. There is also evidence from Dolan³ that better social networks are associated with life satisfaction and happiness.¹

Relationships
Relationships: Positive attachment and early bonding, positive parent-child interactions and good parenting are all identified by the World Health Organization as protective factors for good mental health.⁴
There is non-systematic review level evidence that good family relationships with parents mitigate against suicide risk, especially in adolescents and including those who have been sexually abused. Positive family relationships also provide a protective effect for adolescents including those with learning disabilities. Further evidence suggests that positive maternal coping strategies can have a protective effect on female adolescents. ²

There is non-systematic review level evidence that marriage is a protective factor against suicide and that marriage has a protective buffering effect against socio-economic inequalities related to suicide, particularly for men: ²

**Source:**
Rationale for Logic model 4: Increasing social inclusion and decreasing inequalities and discrimination

1: Link:
Activities to increase prospects for employment and meaningful activities need to be targeted at people with mental health problems and those on low income or unemployed.

Rationale
Unemployment is a key component of social exclusion and is associated with poor mental health.¹

Rates of unemployment for people with mental health problems are high. For example, rates of unemployment for mental health service users ranges between 61 -73%.²

Source

2: Link:
Activities to increase prospects for employment and engaging in meaningful activity will increase the skills and self-efficacy of individuals in attaining employment. This, in turn, will increase the prospects for good and sustained employment, and ultimately result in increased social inclusion.

Rationale
Supported employment/engaging in meaningful activity
Review level evidence suggests that supported employment is superior to prevocational training programmes in achieving competitive employment and spending more time in competitive employment for people with mental health problems.¹ ² NICE clinical guidelines 82 on Schizophrenia³ recommended that supported employment is provided for those who wish to return to work or gain employment though this should not be limited to paid employment if individuals are not able to work or are unsuccessful in gaining work. NICE clinical guidelines 38 on bipolar disorder⁴ recommended that mental health services, in partnership with social care providers and other local stakeholders, should consider providing: vocational rehabilitation (specifically, individual supported placements) for people with bipolar disorder who want help returning to work or gaining employment and support to return to or engage with education or other structured, purposeful activities. It should be noted that NICE clinical guidelines have no formal status in Scotland.
**Job search, retraining and vocational programmes**

There is evidence from primary research that providing job search retraining and vocational programmes for low income unemployed groups can be effective in increasing their prospects of employment and results in better quality employment. The JOBS programme has been most extensively evaluated and focuses on improving participant job search skills and increasing self-esteem, confidence and motivation to persist in job search activities. Randomized Controlled Trials in the USA have shown positive effects on rates of re-employment, the quality and pay of jobs obtained and job search self-efficacy and mastery, as well as reduce depression and distress.\(^5\)

**Job retention programmes**

There is increasing recognition that helping people remain in work wherever possible and thus avoid long-term unemployment can be achieved if the right steps are taken when employees' health conditions are first identified in the work place. Whilst there is no highly processed evidence of effective interventions to improve job retention, the Sainsbury Centre for Mental Health has identified a set of guiding principles and practice to govern good job retention based on primary research and expert opinion\(^6\) and the report on social exclusion and mental health\(^7\) suggest that GPs and occupational health services have a crucial role in facilitating job retention.

**Source**


3: Link:
Promoting access to education, cultural, leisure, and basic needs (housing, transport etc) and removing barriers to universal provision of services needs to be targeted at those who are socially excluded.

Rationale
Being able to access and be involved in education, culture, leisure and the arts is a further component of social inclusion. People are often socially excluded on the basis of mental health problem as well as age, gender, sexuality, race, religion and disability, including and socio-economic status.¹²

Source:

4: Link
Having access to education, culture, leisure and the arts as well as basic needs will increase social inclusion.

Rationale
There is no highly processed evidence in the health sector about which are the most effective strategies for increasing access to education, culture, leisure and the arts and how this might impact on mental health outcomes. Drawing on a review of literature and research as well as consultations and field studies Mental Health and Social Exclusion: A report by the Social Exclusion Unit report identifies a number of actions to address social exclusion including actions relating to supporting families and community participation (enabling people to lead fulfilling lives the way the chose) and getting the basics right (access to decent housing, financial advice and transport).¹

Models of learning indicate, for example, that engagement in learning results in wider benefits to health and wellbeing through the development of skills and competencies (e.g. cognitive skills, technical/vocational skills, resilience, beliefs about self and social & communication skills), social networks and qualification.²
Rowling & Taylor (2005) argue that community-based arts programmes can contribute to community health through collaborative and inclusive processes, social cohesion and a sense of belonging.\(^3\)

**Source**


**Scottish Legislation and Policy Context**

Section 25-31 of the Mental Health (Care and Treatment) (Scotland) Act (2003) places duties on the Local Authorities with respect to the care, support, and the promotion of well-being and social development. Anyone who has, or has had a mental illness, personality disorder or learning disability, should be assisted by their local authority to lead lives as normal as possible. This means helping them to fulfil their ambitions in relation to their personal life, leisure, training and employment.

*With Inclusion in Mind*, promotes the principle of removing barriers to universal services and provides aspirational guidance and best practice to enable individuals and services in local authorities to understand and fulfill their duties under the act.


- Mental Health (Care and Treatment) (Scotland) Act (2003).

5: **Link:**

Services for people with mental health problems should be inclusive and promote social inclusion.

**Rationale:** Health and social care services play a critical role in enabling people to work and maintain social contact, both of which are strongly associated with better mental health outcomes and reduced reliance on services. In addition, there is a statutory duty on local
authorities to promote well-being and social development for those who have, or have had a mental disorder.

**Source**

**6: Link:**
Inclusive health and social services will act to reduce social exclusion.

**Rationale**
Drawing on a review of literature and research as well as consultations and field studies Mental Health and Social Exclusion, a report by the Social Exclusion Unit, sets out a number of actions for health and social services to increase social inclusion including supported employment, transferring day services to community resources, advice on employment and social issues through primary care, strengthening training on vocational and social issues for health and social care professionals, tackling inequalities in access to health services, promoting greater uptake of Direct Payments and work between the criminal justice system and mental health.¹

**Source**

**Scottish Policy Context**

*With Inclusion in Mind* notes that health and social care services have a role in supporting all aspects of social inclusion, by working with universal services and individuals to promote rather than hinder opportunities.

Community engagement activities should target populations in the six equality strands (including those with mental health problems) and those living in areas of deprivation.

**Rationale**
Those living in areas of deprivation are at greater risk of poor mental health outcomes.\(^1\)

**Source:**

Community engagement activities will contribute to increased volunteering in the community, greater empowerment of the community, increased community involvement and influence over local decision making. This is turn will lead to increased participation.

**Rationale**
There is limited highly processed evidence in the health sector of effective community initiatives aimed at building social inclusion and participation. There is some review level evidence to suggest that community engagement activities may impact on volunteering.\(^1\)

Informed by reviews of effectiveness evidence, NICE public health guidance 09 *Community engagement to improve health* made 12 action recommendations which together are intended to present ‘the ideal scenario for effective community engagement.’ These include recommendations about the prerequisites, infrastructure, approaches and evaluation for community engagement programmes. NHS Health Scotland commentary on this guidance supported these action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.\(^2\)

The evidence for the benefits of participation through volunteering is mixed.\(^3\) There is evidence to suggest volunteering can enhance mental wellbeing and reduce depression and depressive symptoms. Much of the evidence relates to older people. Volunteering can also benefit those experiencing mental health problems. A recent Scottish Survey indicated that those with good mental wellbeing appear to be more likely to give up time to volunteer than those with poor mental wellbeing, although the direction of causality is unknown.\(^4\)

**Source**


9: Link:
Anti-discrimination and stigma activities and legislation should address the needs of populations in the six equality strands (including those with mental health problems), people living in areas of deprivation and people with mental health problems and should be targeted across the whole population.

Rationale
There is evidence that discrimination on the grounds of race, gender, religion, disability, age and sexuality is associated with mental health problems.\(^1\)

Stigma is pervasive throughout society, and exacerbates mental health problems through discrimination at home, at work, in social life and in terms access to services and resources.\(^2\)

Source


10: Link:
Activities, policies and legislation to reduce discrimination and stigma associated with mental health problems, the six equality strands and social economic status will reduce barriers to services and improve the experience of services for these populations; increase knowledge about and change attitudes amongst the whole population and reduce discriminatory policies, structures and behaviour across organizations and the population. This, in turn, will contribute to increasing equality and decreasing discrimination.

Rationale
Foresight suggests that measures to enhance social inclusion, combat stigma and discrimination against persons with mental ill-health should be a core nationally-funded component of mental health service activity. A range of whole population anti-discriminatory activities focusing on mental health problems have been identified in Foresight on the basis of consensus across the expert and stakeholder communities to reduce discrimination against people with mental health problems and other equality groups\(^1\). A systems model of
stigma has been developed by Foresight in conjunction with the work of Thornicroft (2006) to guide interventions to combat stigma and discrimination and enhance social inclusion. Activities include: providing accurate public information, supporting professionals to provide information about diagnosis, guidance to the media, increasing access to services and implementation of anti-discriminatory policies and practices across government departments.

To date there is no highly processed evidence for the effectiveness of these interventions, however, it is suggested here that activities at the individual, community and population level are likely to have an impact on knowledge, attitudes and behavioural intentions of individuals, service providers, employers and society. Informed by evidence of effectiveness NICE public health guidance 06 Behaviour change at the population, community and individual levels presents a set of generic principles and recommended actions to guide the planning and delivery of public health activities to change health related behaviour at individual, community or population level. The NHS Health Scotland Commentary on this guidance supported these actions points subject, where appropriate, to adaptation to fit Scottish organisational arrangements. This guidance could be used to inform anti-discriminatory activities.

Source

11: Link:
There are associations between one or more of the long-term mental health outcomes and each of the intermediate outcomes: social inclusion, participation, increased equality/decreased inequality and decreased discrimination.

Rationale
Social exclusion
There is evidence that social exclusion is both a cause and consequence of mental health problems. There is evidence that unemployment is associated with mental health problems, aspects of mental wellbeing and suicide. Mental health problems are also associated with less education.

Participation
There is evidence of an association between participation and mental health outcomes. A significant inverse association has been found between participation and mental health
problems and a positive correlation has been found between life satisfaction and participation.²

Inequalities and discrimination
Inequality is both a cause and consequence of mental health problems.³ Mental health problems are more common in socially disadvantaged populations and amongst people living in areas of deprivation. They are associated with unemployment, less education, low income or material standard of living.² The evidence for the impact of income inequality on wellbeing (largely assessed by life satisfaction) is mixed but according to Dolan et al ⁴ relative income has a significant negative relationship to happiness and life satisfaction.² In Scotland, a recent survey found that disadvantaged groups were more likely to have below average mental wellbeing as measured by WEMWBS.⁶

There is evidence that discrimination on the grounds of race, gender, religion, disability, age and sexuality is associated with mental health problems.²

Source
Rationale for Logic model 5: Increasing financial security and creating mentally healthy environments for working and learning

1: Link:
A whole school approach to promoting social and emotional wellbeing in schools should be universal and activities to ensure the delivery of these programmes should target commissioners and providers of services, practitioners working with children and young people, parents and carers and children and young people themselves.1,2

Rationale
Informed by reviews of effectiveness evidence, NICE public health guidance 12 and 20 recommended that a whole school approach to promoting social and emotional wellbeing in schools should be universal and activities to ensure the delivery of these programmes should target commissioners and providers of services, practitioners working with children and young people, parents and carers and children and young people themselves. The NHS Health Scotland Commentary on NICE public health guidance 12 and the Scottish Perspective on NICE public health guidance 20 supported the action point’s subject, where appropriate, to adaptation to fit Scottish organisational arrangements.1,2

Source

2: Link:
A whole school approach to social and emotional wellbeing and mental health problems will result in increased knowledge and skills amongst practitioners, carers and children and young people, an ethos that promotes mental wellbeing and greater engagement of parents, carers and children and young people. This in turn will lead to more mentally healthy schools.1,2

Source
**Rationale**

Informed by reviews of effectiveness evidence, NICE has produced public health guidance on promoting social and emotional wellbeing in primary and secondary education. Action recommendations for primary schools related to three areas: comprehensive programme; universal approaches, comprehensive programme and targeted approaches. Comprehensive programmes should include a curriculum that integrates the development of social and emotional skills within all subject areas, training and development to ensure teachers and practitioners have the knowledge, understanding and skills to deliver this curriculum effectively, support to help parents and carers develop their parenting skills and integrated activities to support the development of social and emotional skills and wellbeing and to prevent bullying and violence in all areas of school life. The NHS Health Scotland Commentary on this guidance supported the action point’s subject, where appropriate, to adaptation to fit Scottish organisational arrangements.¹

The action recommendations for secondary school related to six areas: strategic framework; key principles and condition; curriculum approaches; working with parents and families; working in partnership with young people and training and continuing professional development. It is suggested in the logic model that this will be achieved in part by increased knowledge, skills and capacity amongst professional working with young children and the implementation of policies which will create an ethos and conditions that support positive behaviours for learning and for successful relationships. The NHS Health Scotland Scottish Perspective on this guidance supported the action point’s subject, where appropriate, to adaptation to fit Scottish organisational arrangements.²

**Source**


**3: Link:**

Life long learning should be universal.

**Rationale**

Education and learning throughout life is associated with improved mental health.¹, ²

**Source**

4: Link
Life long learning opportunities will contribute to improved mental health through increasing skills and competencies, social interactions and qualifications.

Rationale
There is no highly processed evidence in the health sector on effective interventions to achieve learning and skills development. The Foresight Mental Capital and Wellbeing Project report on learning through life\(^1\) proposes a model of life long learning which suggests that learning will contribute to skills and competencies (self-concept, self-efficacy and resilience), social interactions and qualifications.

On the basis of epidemiological evidence, primary research and expert opinion, Foresight\(^2\) put forward a number of suggestions which could contribute to learning and skills development at an individual and population level for adults. These include: stimulating the demand for skills; the provision of basic skills development programmes for those with poor literacy, numeracy and English; raising individual and employee demands for learning; and, implementing strategies to empower working age and older populations to learn and develop skills.

Source

5: Link:
Activities in the workplace to promote mental wellbeing should target employees, employers and line managers and address the needs of those at risk of stress and experiencing mental health problems as well as promoting mental wellbeing universally.

Rationale for reach
NICE public health guidance 22 emphasises organisation-wide approaches to promoting mental well-being and employers as well as employees have a significant role in creating a mentally healthy workplace within this approach. Employees, including those at risk of stress and experiencing mental health problems, and managers, can benefit from these activities.\(^1\)
6: Link:
Activities in the workplace to promote mental wellbeing and prevent mental health problems will increase the knowledge and skills of managers and employees about mental health, increase the capacity of managers and employees to manage risk to mental health and increase job satisfaction. This, in turn, will contribute to a mentally health workplace in which there are improvements in the context, content and quality of work, reduced absenteeism and presenteeism, improved work-life balance amongst employers and more appropriate returns to work.

Rationale
Informed by reviews of effectiveness evidence, NICE public health guidance *Promoting mental wellbeing through productive and healthy working conditions: guidance for employers* made action recommendations in five areas: strategic and coordinated approach to promoting employees’ mental wellbeing; assessing opportunities for promoting employees’ mental wellbeing and managing risk; flexible working; the role of line managers; and supporting micro, small and medium-sized businesses. The NHS Health Scotland Scottish Perspective on this guidance supported the action point’s subject, where appropriate, to adaptation to fit Scottish organisational arrangements.¹

The Foresight Report²,³ shows that promoting mental wellbeing in employment and working life for all employees can improve productivity and reduce the prevalence of mental health problems. Poor-quality leadership has also been linked with mental health consequences (such as stress, burnout and depression), while high-quality leadership is related to reduced incidences of these negative outcomes as well as increased wellbeing. Flexible working arrangements enable individuals to integrate work and family responsibility within their personal time and space and are important in achieving a work–family balance. Research, however, suggests it is not enough to just implement family-friendly arrangements, but that family–work arrangements should be integrated into the organisational culture. The report suggests that workplace interventions to address stress and the consequences of stress are most promising if they involve a risk analysis, a participatory approach and a combination of person and organisation-focused programmes. Person focused interventions (stress management training), in particular those combining cognitive-behavioural techniques and relaxation can be effective in improving individual wellbeing. There is limited evidence, however, to suggest that individual approaches rather than organisational and organisational development approaches are more effective in managing common mental health problems. The effectiveness of organisation-focused interventions addressing (i) the nature of the task (ii) work environment and (iii) social relations is difficult to judge due to the lack of good studies; however, they have demonstrated potential. Changes are most likely in variables that are immediately targeted

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⁴ Source
– e.g. increasing autonomy – and the effects can be expected on the organisational level (absenteeism).

On the basis of evidence, the Foresight project identified possible initiatives that would enhance mental health and wellbeing at work. A range of promising interventions were identified for further analysis. Interventions fell into five categories:

1. Assess work environments for impact on mental capital and wellbeing.
2. Better diagnosis and remediation of underlying work related stress.
3. Develop more sophisticated ways of flexible working.
4. Improve managerial competence in providing healthy workplaces.
5. Raise the profile of mental health and wellbeing at work.

**Source**

7: Link:
Activities to address financial insecurity and debt should be universal and should also target those with or at risk of mental health problems, debt or insecure incomes. Awareness raising on debt/financial insecurity and mental health should target professionals assessing and managing debt and/or mental health problems and providing financial support and services.

**Rationale**
Poor mental health is associated with unemployment, low income or low material standard of living. People with mental health problems are more likely to have debt and, those with mental health problems and debt take longer to recover. Conversely people experiencing financial strain are more likely to experience mental health problems.

**Source**

8: Link:
Targeted and universal activities to promote debt management will increase financial capability and financial inclusion across the population and result in increased financial security. Mental health literacy programmes in financial institutions and utilities will increase awareness amongst employers of the link between mental health and financial security and contribute to increased financial capability and financial inclusion amongst users of these services.

Activities to increase access to a secure income will result in short-term outcomes and greater financial security for all.

Rationale
Financial insecurity is associated with poor mental health outcomes; debt in particular is a risk factor for mental health problems and people with mental health problems are more likely to experience debt. On the basis of epidemiological evidence, primary research and expert opinion Foresight suggested that addressing debt, amongst people with mental health problems and the general population, is likely to have a positive impact on mental health outcomes through increasing financial capability and increasing financial inclusion. Foresight also suggested that financial inclusion may be enhanced through initiatives which increase the knowledge and skills of providers of financial and utility services, thus resulting in more mental health promoting policy and practice amongst these providers.

It is plausible that other strategies to improve equitable access to secure financial resources through welfare policies, minimum wage and employment interventions may also contribute to increasing financial inclusion for all.

Source
There are associations between one or more of the long-term mental health outcomes and each of the intermediate outcomes: mentally healthy schools, increased learning and skills development for all; mentally healthy workplace; and financial security for all.

**Rationale**

**Mentally healthy schools**

Work is currently being undertaken as part of the *Children and Young People Mental Health Indicators Programme* to establish the evidence base for the association between mentally healthy learning environments and long-term mental health outcomes.

Supportive school environments, including access to healthcare professionals, are important protective factors for suicide among adolescents including those who have experienced sexual abuse, those with learning disabilities and those who identify as lesbian, gay, bisexual and transgender.¹

**Learning and skills development**

There is evidence that participating in learning is associated with a range of mental health benefits and contributes to the adoption of healthy behaviours. Recent research has found positive associations between adult learning with optimism and efficacy.²

**Mentally healthy workplace**

Epidemiological evidence from the Whitehall studies shows that the workplace and working environment has an influence on mental health and wellbeing.³ A number of key areas of the organizational culture (such as demand, control, support, relationships, role and change as identified by the Health and Safety Executive) are associated with poor mental health.², ⁴

**Financial security**

Financial insecurity is associated with poor mental health outcomes; debt in particular is a risk factor for mental health problems and people with mental health problems are more likely to experience debt. People experiencing financial strain can also take longer to recover from mental health problems.², ⁵ A recent Scottish survey found that higher mental wellbeing was associated with finding it easy to manage financially.⁶

**Source**


Rationale for Logic model 6: Promoting a safe and supportive environment at home and in the community

1: Link
Activities to promote greenspace will increase access to and use of greenspace.

Rationale
A logic model of greenspace has been developed and provides information about which interventions may be effective in increasing access/use of greenspace.¹

Source:

2: Link
Planning and design activities and strategies, regeneration activities and re-housing and housing improvement should be applied to the whole population and should target areas of deprivation, those living in poor quality housing and residential institutions.

Rationale
There is growing evidence that characteristics of the built environment including housing quality, crowding, air quality and type of dwelling can have a direct effect on mental health outcomes as well as indirectly effect them through psychosocial processes.¹ People living in deprived communities are at greater risk of having mental health problems.²

Source:

3: Link:
Improved planning and design of the built environment and regeneration initiatives may contribute to increased levels of actual and perceived access to amenities, reduced street level incivilities (e.g. litter, dog fouling, graffiti) and increased access to greenspace. This, in turn, will contribute to increased satisfaction with the environment, thus improving mental health outcomes.
Rationale
There is review level evidence that poor quality neighbourhood environments, street incivilities and noise are associated with poor mental health and fear.¹ Survey data in Scotland has shown that the way people perceive the quality of their environment is associated with mental health outcomes. People living in neighbourhoods with higher levels of street incivilities and absence of ‘goods’ such as greenspace, amenities for children and escape facilities were more likely to report anxiety and depression than those with fewer environmental concerns.²

It is suggested here that neighbourhood planning and design initiatives and regeneration projects which improve access to goods and services are likely to have an impact on mental health outcomes. There is some evidence to suggest that enhancing one’s neighbourhood and moving to low poverty neighbourhoods can contribute to improved mental health outcomes.³ The impact of urban regeneration on health, socioeconomic status and inequalities, however, remains uncertain.³ Ongoing research as part of the GoWell Project in Glasgow will evaluate the impact on regeneration on mental health.

Source:

4: Link
Re-housing and regeneration activities will contribute to improved housing conditions, reduced overcrowding and noise. This will, in turn, contribute to an improved physical environment. Improvements in the physical environment will contribute to increased levels of perceived and actual safety.

Improvements in the design of residential care will contribute to a better physical environment for those living in residential care.

Rationale
Housing
There is no highly processed evidence that improving housing/dwelling conditions will contribute to improved mental health outcomes however there is epidemiological evidence that certain characteristics of housing and dwelling types are associated with poor mental
health outcomes. A state-of-science review undertaken as part of the Foresight Mental Capital and Wellbeing project found that there is evidence of an association between poor housing and poor mental health. Noise, damp and mould, excessive temperatures and high levels of air pollution have been associated with poor mental health outcomes as has crowding and density. There is some evidence that living in accessible dwellings is associated with better life satisfaction and fewer depressive symptoms amongst older people. Investigating the relationships between the physical environment and mental health outcomes is, however, complex: there is a lack of explicit cause and effect relationships and many studies using correlation relationship may not take into account possible confounding variables.¹

It is plausible that improving housing conditions through re-housing and regeneration will contribute to improved mental health outcomes and there are some studies that have found improvement in health outcome following housing improvements however methodological limitations of these studies make it difficult to specify the nature and size of a health gain.³ There is also some evidence from primary studies that moving to better-quality physical environments improves mental wellbeing.¹

There is review level evidence that the physical environment contributes to perceptions and fear of crime.¹

**Residential dwellings and health care facilities**

There is review level evidence that the quality of dwelling/health care facilities for people with mental health problems is associated with mental health outcomes and that positive outcomes for individuals with mental illnesses are achieved by improving physical environmental qualities such as safety, autonomy, individuality, dignity, privacy, enjoyment, comfort and ‘homelikeness’.¹ It is suggested in this logic model (model 6) that strategies to improve the quality of residential care accommodation (e.g. for children, people with mental health problems and older adults) through planning and design will also impact on mental health outcomes for residents.

**Source**


5: Link:
Community engagement activities will contribute to decreased crime and fear of crime, reductions in the level of neighbourhood violence and reduced tolerance of neighbourhood violence. This in turn will contribute to improved mental health outcomes through increased levels of perceived and actual safety and a decrease in violence.

Rationale
There is some evidence that community engagement may have a positive impact on crime and perceptions of crime. Informed by reviews of effectiveness evidence, NICE public health guidance 09 Community engagement to improve health made 12 action recommendations which together are intended to present ‘the ideal scenario for effective community engagement’. These include recommendations about the prerequisites, infrastructure, approaches and evaluation of community engagement programmes. The NHS Health Scotland commentary on this guidance supported these action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.

The evidence base for broader strategies which are effective in reducing actual and perceived levels of crime has not been examined.

Source

6: Link:
Activities in the home, workplace and school to reduce violence and bullying should target employees, children, teachers and parents.

Rationale
Living with or experiencing violence or the fear of violence, including psychological abuse, is a significant risk factor for poor mental health. Violence includes bullying at school and in the workplace, violence in the home either as domestic violence or child abuse, violence in the workplace, and violence against certain sections of society.

Source:
Activities targeting violence and bullying across the lifespan will increase knowledge, awareness and skills in relation to life skills and contribute towards an increase in pro-social behaviour and decrease in aggressive behaviour. This, in turn, will contribute to decreased violence and bullying and result in improved mental health outcomes.

Rationale

Home visiting and parenting interventions

There is limited review level evidence that parenting interventions are effective in improving outcomes associated with physically abusive parents, however, there is evidence that they are cost effective in improving parenting and provided access to peer-based support. The authors of this review concluded that whilst evidence is inconclusive there are few other interventions that have better established levels of empirical support regarding intervention with physically abusive parents.¹

There is review level evidence that home visiting programmes can be effective in reducing maltreatment (abuse or neglect) of visited children. The review found an overall mean effect size of 39%. Programmes delivered by professional visitors (nurses or mental health workers) seem to yield greater effects than those delivered by paraprofessionals. For paraprofessional visitors, effects are mixed, and beneficial effects are generally found in programmes of longer duration (i.e. 2 years).²

Based on review level evidence, NICE technology appraisal guidance 102 recommended group-based parent-training/education programmes for the management of children aged 12 and above with conduct disorders.³ NICE technology appraisal guidance is developed for use in England and Wales however NHS Quality Improvement Scotland advised that this technology appraisal is valid for use in Scotland.

School-based programmes

There is some evidence to suggest that universal and comprehensive approaches to promoting mental wellbeing in primary schools is effective in improving outcomes relating to bullying and violence.⁴⁵ Informed by reviews of effectiveness evidence, NICE public health guidance on promoting social and emotional wellbeing in primary education recommended that: schools adopt a universal approach; and schools provide a comprehensive programme to help develop children’s social and emotional skills and wellbeing and that the programme should include a curriculum that integrates the development of social and emotional skills within all subject areas, training and development for teachers and practitioners, and support to help parents and carers develop their parenting skills. The
NHS Health Scotland Commentary on this guidance supported the action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.6 NICE Public Health Guidance 20 Promoting social and emotional wellbeing in secondary education makes six action recommendations: strategic frameworks, key principles and conditions, curriculum approaches, working with parents and families, working in partnership with young people and training and continuing professional development. The NHS Health Scotland Commentary on this guidance supported the action points subject, where appropriate, to adaptation to fit Scottish organisational arrangements.7

Pre-school programmes
Longitudinal studies of the High/Scope Perry Preschool Project demonstrated very long-term effects from a weekly half day preschool intervention combined with home visits during a two-year period at ages three and four. Children in the intervention, who were African-American and came from impoverished backgrounds, had improved cognitive development, better achievement and school completion and fewer conduct problems and arrests than the control children in a randomized study. For example, significant benefit was found at age 19 and age 27 on lifetime arrests (40% reduction) and repeated arrests (a 7-fold reduction).8

Workplace
The review on wellbeing and work undertaken for the Foresight Mental Capital and Wellbeing Project9 identified ‘Dignity at Work’ initiatives, the development of measurement tools and building a culture at work ‘as appropriate ways of behaviour are clearly communicated and supported’ (CIPD 2005 p.45) as useful strategies to combat bullying. A state-of-science review of violence at work10 note there is general agreement among researchers that effective violence management requires an ‘integrated organisational approach’ including improving individual, team and organisational action before incidents happen (prevention), as they unfold (response), and afterwards (rehabilitation). Amongst other things, such measures include environmental design, clear workplace violence policies, effective systems for monitoring staff whereabouts, emergency action plans, training programmes and employee counselling. Training is almost universally advocated as a principal means of responding to workplace violence however there is a relative paucity of well-designed evaluation studies into the effectiveness of training.

Source


8: Link:
Person centred planning for people within residential care.

Rationale
Looked-after children are particularly vulnerable to social and psychological difficulties. Forty-five percent of looked-after children have mental health problems, they are 10 times more like to have a statement of special needs, are four times more likely to be unemployed on leaving school and around one-third of prisoners were in care as children.1

Source
The reference group proposed two types of activities which may potentially reduce violence and aggression and harmful behaviour, increased support; increased ability to express emotional concerns and psychological health and improved adaptive behaviour:

1. Person centred planning - an approach to care which places the individual at the centre of care; and 2. Training staff in mental health literacy, attitudes and values and promoting communication skills.

**Rationale**
The reference group felt that it was plausible that activities may reduce violence and aggression and harmful behaviour, increased support. However, no evidence has been found to date that these activities are effective in reducing violence.

There are associations between one or more of the long-term mental health outcomes and each of the intermediate outcomes: accessing amenities (greenspace), satisfaction with the environment, improved physical environment, increased safety (perceived and real) and violence.

**Rationale**
**Greenspace**
There is evidence of an association between access to nature, green or open spaces and better mental health. Benefits include both improved psychological wellbeing; increased life satisfaction, self-esteem, self-confidence and positive mood states as well as reduced anxiety and stress. Wider impacts include reduced negative social behaviours such as crime, violence and other incivilities and increased physical activity and social interaction.¹

**Improved satisfaction with environment and improved physical environment**
There is growing evidence that characteristics of the built environment including housing quality, crowding, air quality and type of dwelling can have a direct effect on mental health outcomes as well as indirectly effect them through psychosocial processes. Research also highlights the potential importance of valued ‘escape facilities’, safety on the streets, neighbourhood quality, noise and spatial density (home and neighbourhood) and social fragmentation. Survey data from Scotland has shown that how people perceive their environment is associated with their physical and mental health and that people with above average mental wellbeing tend to be more positive about their environment than those with below average mental wellbeing. Significant methodological limitations mean that it is difficult to demonstrate the precise nature of the relationship between the physical environment and mental health outcomes.¹

**Safety**
Both actual and perceived safety are associated with mental health outcomes including stress and mental health problems and can effect the quality of people’s lives by causing...
social exclusion as well as mental distress.¹ Living in an unsafe area has also been shown to reduce life satisfaction².

Violence
Both witnessing and experiencing violence (physical and psychological) across the lifespan are associated with poor mental health outcomes.¹ For example women who experience interpersonal violence have higher rates of mental health problems and chemical dependence and are at heightened risk for suicidal behaviour and self harm.³

Source
12. References


13. Acknowledgements

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