Joint Action on Mental Health and Well-being

MENTAL HEALTH IN ALL POLICIES

Situation analysis and recommendations for action

The views expressed in this report are those of the contributors and do not necessarily represent those of Government Ministries or contributors' employers.

LIST OF CONTRIBUTORS

Ileana Botezat, Romania

Jonathan Campion, England

Pablo Garcia-Cubillana, European Social Network

Dóra Guðrún Guðmundsdóttir, Iceland

Wendy Halliday, Scotland

Nigel Henderson, Mental Health Europe

Arne Holte, Norway

Maria João Heitor Santos, Portugal

Kim Japing, European Social Network

Heinz Katschnig, Austria

Niall Kearney, Scotland

Alfonso Montero, European Social Network

Johannes Parkkonen, Finland

Mille Pedersen, Denmark

Jurgita Sajevičienė, Lithuania

Kristian Wahlbeck, Workpackage Leader, Finland

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EXECUTIVE SUMMARY

WHAT IS MENTAL HEALTH IN ALL POLICIES?

Mental Health in All Policies (MHiAP) is an approach to promote population mental health and wellbeing by initiating and facilitating action within different non-health public policy areas. MHiAP emphasises the impacts of public policies on mental health determinants, strives to reduce mental health inequalities, aims to highlight the opportunities offered by mental health to different policy areas, and reinforces the accountability of policy-makers for mental health impact. The MHiAP approach can be applied at all administrative levels, ranging from local authorities to the EU level.

The EU Joint Action for Mental Health and Wellbeing set out to map, assess, disseminate and pilot good practices within an MHiAP approach. In this respect, the term mental health incorporates both mental wellbeing and mental disorder. Mental health is perceived as an important resource for the wellbeing of individuals, families and societies, according to the World Health Organization (WHO) definition of mental health. The Joint Action is underpinned by the notion that mental health is more crucial today than it has ever been. This is due to its broad range of impacts and due to the increase in mental capacity required by the transition from a society dominated by manual work into an information society, and by the notion that a range of cost-effective public mental health interventions exists but are not widely implemented.

Mental health has a substantial and broad set of impacts across policy areas. Mental disorders constitute one third of the disease burden in Europe, a figure which is on the increase. Not only do mental disorders cause a significant loss of work days and decrease in European productivity, but also immense individual and family suffering. Mental disorders also have profound negative effects on academic achievements. A shift in this trend requires coordinated implementation of a range of effective public mental health interventions to promote mental wellbeing and prevent mental disorders.

Many individual, familial and societal determinants of mental health lie in non-health policy domains such as social policy, taxation, education, employment and community design. It is now recognised that the very foundations of mental health are laid down early in life and are later supported by positive nurturing, high social capital, a good work life and a sense of meaning. Many of these factors can be enhanced through the MHiAP approach in non-health sectors and, therefore, remain important targets for mental health promotion and mental disorder prevention interventions. Examples of effective interventions to promote population mental health include interventions in local communities, parenting support and home visiting programmes as well as school based programmes.

Lessons learned from the promotion of physical health indicate that the road to improved mental health among populations lies less in the investment in late-coming mental health services, but more in a co-ordinated public mental health programme to implement large-scale promotion and prevention activities.

Globalisation and European integration have strengthened the influence of international actors on health determinants and thus reduced the power and opportunities of national health policies. Increasingly, mental health determinants lie in the areas of EU policy and international agreements. EU legislation and actions in many non-health fields can have a decisive impact on the mental health of EU citizens. This calls for an active civic society to minimise potential negative mental health impacts and to create strong local communities which are conducive to mental health.

DATA COLLECTION

The work within the EU Joint Action Work Package for MHiAP was supported by data collection on the state of the art and examples of good practices in the EU and associated countries. Results indicate that the MHiAP term and approach was not well understood by expert respondents in many countries.

Experts participating in the data collection highlighted the need to raise awareness about the MHiAP approach for regular cooperation between health and non-health sectors, for improved attitudes towards mental health issues, and for research on the MHiAP approach. Legislative support for the MHiAP process, involvement of non-governmental organisations (NGOs), capacity building among policy makers, and exchange of experience between Member States were also seen as important factors to facilitate a successful MHiAP approach. Respondents also considered that demonstration of the economic impact of mental health was important. Although the sample size was limited to 81 respondents, it is encouraging that attitudes towards the concept were mainly positive, and its value was broadly supported. A clear message emanating from the surveys is the need to incorporate mental health within overall health in all policies endeavours. In isolation, there may not be sufficient support for the MHiAP approach. On the other hand, some respondents pointed out the risk that mental health becomes overshadowed by the promotion of physical health when the approaches are integrated.

Assessment of collected MHiAP examples also identified a range of successful examples of inclusion of mental health in non-health policies. Based on the assessment for relevance and scores, a set of 24 good collaboration practices for implementing mental health in all policies were selected by a consensus process involving at least two experts. The good practices span from national mental health committees to mental health impact assessment tools, and to local initiatives addressing mental health determinants in the community. In Scotland for example, the education policy is focused on developing and promoting wellbeing with an explicit understanding of the link to educational outcomes. In Norway, the foreign affairs sector is developing a plan for inclusion of mental health in foreign aid policy. In Portugal and Finland, employment policies encompass a youth guarantee to promote social inclusion of young people.

CONCLUSIONS AND RECOMMENDATIONS

Mental health in all policies can facilitate a coordinated approach across different policy areas to improved mental wellbeing and prevention of mental disorder.

Different policy areas can facilitate the promotion of protective factors for mental wellbeing and action to address relevant policy area risk factors for poor mental wellbeing and mental disorder. For instance, promoting early child development in families as well as in child day care and schools is crucial for population mental health and wellbeing. Provision of time in the form of parental leave, positive nurturing conditions, affordable and accessible high quality day care, parenting support and mental health promotion in schools are cornerstones of mental health promotion. Good working conditions promote mental health and wellbeing and also contribute to social capital. Access to, and participating in, cultural and social activities, as well as outdoor recreation and green spaces promote mental health and wellbeing. Personal safety, the safeguarding of human rights, and community involvement are all conducive to mental health and wellbeing.

Interventions to prevent mental disorders include interventions to address inequalities, prevention of childhood adversities and abuse, stopping bullying at school and reduction of stress in the work place.

The eight concluding recommendations from the project stress that mental health needs to be incorporated in all policies at all levels, i.e. international, national, regional and local. This can be supported by demonstrating existing win-win situations, where objectives of different policy areas coincide to mutual benefit, and using language that is understandable to policy makers in different sectors. Action needs to be taken on social determinants of mental health, which requires strengthening of MHiAP capacity, structures, processes and resources. The foundations of MHiAP are built by improving mental health literacy in the public sector and among the general public, and by providing tools for implementation of MHiAP, such as tools for mental health impact assessment. Inclusion of communities, social movements and civil society in the development, implementation and monitoring of MHiAP provides accountability and sustainability of policy actions, and supports transparent monitoring and appraisal of policy outcomes. Finally, investment in the evidence and knowledge base of MHiAP is needed to bridge the gap between health, social and economic knowledge, and policy implementation.

1. CONCISE RECOMMENDATIONS FOR THE FORTHCOMING EUROPEAN MENTAL HEALTH FRAMEWORK

The Joint Action working party for MHiAP resulted in a set of eight concluding recommendations (see chapter 7). For inclusion in the forthcoming European framework for mental health and wellbeing, the eight recommendations were condensed into two overarching main recommendations and corresponding indicators.

1. Address determinants of mental health by incorporating mental health into all policies

This recommendation applies at all policy levels, e.g. national, regional and local, and in all policy sectors.

Many of the causes of mental disorders and poor mental wellbeing, and the corresponding economic impact, lie in social, economic and political spheres of people's daily lives. Tackling these determinants will shift emphasis from late and costly interventions towards preventing mental disorders and contribute to improved population mental wellbeing and resilience. For example, this could mean providing parenting support, integrating mental health literacy into school curricula, mental health promotion at work places, and ensuring access to cultural activities and green and blue spaces, as well as promoting physically active lifestyles.

In order to achieve uptake of the Mental Health in All Policies approach, it is important to demonstrate mutual benefits by pointing out existing win-win situations of mental health promotion. Co-incidence of objectives of non-health policy areas with outcomes of mental health promotion actions are strong drivers of the Mental Health in All Policies approach.

Implementation of this recommendation could for example mean that mental health is prominently included in all health impact assessments.

Indicator: The inclusion of mental health and mental health problems in non-health national/regional education, family, labour and community design policies. The indicator is positive if mental health and/or mental disorder is mentioned in the respective policy document.

2. Build capacity for a Mental Health in All Policies approach

This recommendation encompasses capacity building, supportive structures, tools and strengthening the research base.

Mental health literacy and understanding of mental health impacts need to be strengthened among organisations, decision makers and the population. For example, this could mean training for civil servants and decision makers on amendable determinants of mental health.

Effective structures, processes and resources for the Mental Health in All Policies approach need to be in place. For example, this could mean a cross-sectoral policy group to co-ordinate sharing of resources and achieve maximum impact in promoting mental wellbeing and preventing mental disorders.

Tools and structures for the implementation of Mental Health in All Policies need to be available. For example, this could mean providing tools for mental health impact assessment at different levels of governance. Tools can also facilitate for involvement of citizens in the impact assessment process.

The Mental Health in All Policies approach should empower citizens by inclusion of communities, social movements and civil society in the development, implementation and monitoring of mental health

promotion. For example, this could mean setting up multi-stakeholder local and/or national policy forums to consider suitable mental health policies and to develop initiatives to influence locally or nationally identified mental health issues.

The Mental Health in All Policies approach needs to adopt transparent audit and accountability mechanisms for mental health and equity by making the links between policy decisions and population mental health visible. Following implementation, the mental health impact of policy interventions should be assessed. For example, this could mean monitoring or auditing the mental health and equity effects of a policy action.

An effective implementation of the Mental Health in All Policies approach requires investment in mental health data, evidence and knowledge base. For example, this could mean encouraging multi-disciplinary studies that bridge the gap between health, social and economic knowledge and demonstrates then links between intervention actions in non-health policies and population mental health.

Indicator: The inclusion of mental health in health impact assessments.

More detailed description of the eight original recommendations can be found in chapter 7.

2. INTRODUCTION: WHAT IS MENTAL HEALTH IN ALL POLICIES?

Kristian Wahlbeck

Health in all policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health implications of decisions. The approach seeks synergies between health and other public sectors. It strives to avoid harmful health impacts and promote protective impacts, in order to improve population health and health equity. It emphasises the consequences of public policies on health determinants, aims to demonstrate mutual benefits for non-health and health policy areas, and to improve the accountability of policy-makers for health impacts at all levels of policy-making (1).

Mental health is a non-separable part of health, but so far little work has been done to incorporate mental health aspects in the HiAP approach. The EU Joint Action for Mental Health and Wellbeing set out to map, assess, disseminate and pilot good practices within a Mental Health in All Policies (MHiAP) approach. In this respect, mental health is perceived as a mental resource of importance for the wellbeing of individuals, families and societies, according to the World Health Organization (WHO) definition: Mental health is not just the absence of illness, but is rather conceptualised as a state of well-being in which the individual realises his/her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community (2).

Mental health is more crucial today than it has ever been, due to the societal transition into the information society era. Productivity is dependent on our minds, as manual work is being replaced by mental work (3). The population's mental capital (i.e. cognitive, emotional, and social skills resources required for role functioning) is a prerequisite for the prosperity of individuals, companies, and societies in this new era. Thus mental health becomes more valuable and more vulnerable, due to the many stressors in information-driven economies.

Social, behavioural, and biological sciences have provided substantial insight into the role of risk and protective factors in the developmental pathways of mental wellbeing and mental disorders. Biological, psychological, social, and societal risk and protective factors and their subsequent interactions have been identified across the lifespan from as early as foetal life (5). It is now recognised that the very foundations of mental health are laid down in early life and prenatal period. For instance, poor nutrition and exposure to toxic substances (such as alcohol, tobacco and illicit drugs) during pregnancy, prematurity, trauma during labour, parental neglect, different types of abuse, and other forms of trauma

and lack of stimulation negatively impact on a child's cognitive development and socio-emotional wellbeing. Later in life, social relationships are critical for promoting mental wellbeing and protecting against mental disorder. Many of these factors are amenable to interventions by non-health sectors and, therefore, important targets for mental health promotion and mental disorder prevention interventions. Other key socioeconomic and environmental determinants for mental disorder and poor mental wellbeing are related to macro-issues such as poverty, lack of freedom, war, and inequity, which often underpin the factors cited above.

Individual, familial and societal determinants of mental health therefore often lie in non-health policy domains such as social policy, taxation, education, employment, and urban planning. Consequently, the "Mental Health in All Policies" approach was developed, targeting determinants of mental health across policy areas in the whole population, including higher risk groups. The approach reaches out to areas other than the health sector, highlighting the links of better mental health to a range of improved outcomes, such as better productivity. In an increasing number of cases this approach forms the basis of modern mental health policy documents.

An extensive evidence base highlights a range of effective public mental health interventions (6-9), which can be divided into those promoting mental wellbeing and those preventing mental disorders. Interventions to promote mental wellbeing (through promoting associated protective factors) and prevent mental disorder (through addressing risk factors) are usually provided by non-health sectors. Examples of effective interventions to promote population mental health include restrictions in access to alcohol in local communities (9), child support and home visiting programmes (7), high quality day-care (10), and school based programmes (11). Interventions to prevent mental disorders include interventions to address inequalities, prevention of childhood adversities and abuse, stopping bullying at school and reduction of stress in the work place (12).

Social relationships are also critical for promoting well-being and resilience buffering against mental disorder (13), which seems to be the case for people across all ages (14). The relationship between work and mental health is especially complex. On the one hand, work is a source of personal satisfaction and accomplishment, interpersonal contacts, social capital and financial security, which are prerequisites for good mental health. Good workplace social capital (i.e. trusting relationships) has been shown to also protect against depression (15). On the other hand, there is evidence indicating that a high workload, job insecurity, lack of control, high emotional demand, and workplace bullying and violence, are associated with stress and mental disorder (16). Effective interventions exist to promote mental wellbeing and reduce stress at work as well as to facilitate early recognition/treatment of mental disorder which also result in economic savings to the workplace even in the short term (16).

Those who become unemployed are an example of group at higher risk of mental disorder and poor wellbeing. For instance, they are at least twice as likely to have increased depressive symptoms and to be diagnosed with clinical depression compared to those who remain employed (17).

Despite the existence of effective interventions to promote mental wellbeing, treat and prevent mental disorder, only 10% of the European Union population with mental disorder receive notionally adequate treatment, while far fewer receive interventions to prevent mental disorder or promote mental wellbeing. This intervention gap has a broad set of impacts and costs, and they fall disproportionally on indirect costs, such as lost productivity, rather than direct healthcare costs (18). However, large economic savings accrue to different sectors even in the short term through better coverage of promotion of mental wellbeing, treatment and prevention of mental disorder (19).

Mental, social, and behavioural health problems continuously interact, which may intensify their effects on wellbeing. Substance abuse and violence (including domestic and child abuse) on the one hand, and health problems such as heart disease, depression, and anxiety on the other, are all more pervasive and more difficult to cope with in conditions where high unemployment, low income, limited education, stressful work conditions, gender discrimination, unhealthy lifestyle, and human rights violations are more prevalent.

Lessons learned from the successful control of infectious and cardiovascular diseases indicate that the road to improved mental health among populations lies less in the investment on mental health services and more in coordinated public mental health promotion and prevention activities. Thus, many recent policy documents have taken the 'Health in All Policies' (HiAP) approach, which targets determinants of mental health across policy areas in the whole population. This approach reaches out to public policymakers to mainstream mental health promotion and mental disorder prevention and early interventions in non-health policies.

HiAP is a relatively new approach to the development, implementation, and assessment of public policies across sectors that systematically take into account the health and broader impacts of decisions. It can be seen as a strategy to recognise that health is largely constructed in other sectors than in the health sector. A HiAP approach is founded on health-related rights and obligations, as expressed in several international agreements and constitutions of many nations. It emphasises the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making.

The shift to the HiAP model is supported by emerging new financing models, such as impact investing, which are being created to support longer term socially responsible investment to generate beneficial social impact alongside a financial return. Such financing models, known as Social Impact Bonds (SIBs) create new possibilities to bridge the gap between evidence of effectiveness and implementation, to address determinants of mental health and to create meaningful social returns on investments (20).

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3. RELEVANCE OF MENTAL HEALTH FOR NON-HEALTH SECTORS

Jonathan Campion

Mental disorder and mental wellbeing have a broad range of impacts across different non-health sectors, and non-health sectors have a decisive impact on population mental health. Improved understanding of the size, impact and cost of the public mental health intervention gap including to non-health sectors is important in supporting decisions about policy, strategic and commissioning priorities. Incorporation of mental health in all policies will result in a broad set of societal benefits and associated economic savings.

A number of reasons account for the lack of understanding about the mental health role of non-health policies, including a lack of knowledge about the impact of mental health across different sectors and discriminatory attitudes. While this document considers non-health policy sectors, it is important to stress that policies for physical illnesses – especially for long-term ones – should also incorporate mental health (1).

Impact of mental wellbeing

The impact of mental wellbeing is significant and more than just the absence of mental disorder. Impacts of mental wellbeing extend to a range of areas outside health including (2):

• Improved educational outcomes

• Reduced school drop-out (3)

• Increased productivity at work, fewer missed days off work

- Reduced disability benefit costs
- Higher income
- More social relationships and better connectedness
- Reduced anti-social behaviour, crime and violence

In addition, mental wellbeing relates to a range of health benefits (2) such as reduction of mental disorder in children, adolescents and adults, improved health behaviour, less physical illness and associated health care utilisation, reduced suicide and other mortality.

It is helpful to acknowledge the close relationship between mental wellbeing and mental disorder: Good mental wellbeing reduces risk of mental disorder while mental disorder reduces mental wellbeing.

Box 1: Burden of mental disorder

The recent update of the Global Burden of Diseases study demonstrates the magnitude of the burden of mental disorders and found that 30 per cent of the burden of disease in Europe is due to mental disorder and self-harm, as measured by Years Lived with Disability (15). Another measure of the burden of disease is disability-adjusted life years (DALYs), which include potential years of life lost due to premature death, and equivalent years of 'healthy' life lost by virtue of being in states of poor health or disability. DALY data indicate that mental disorders constitute a growing share of the global disease burden. In 2010, mental disorders accounted for 7.4 % of DALYs worldwide, which is a significant increase from 1990, when the corresponding figure was 5.4 % (4). For example, one particular mental disorder accounting for disability and premature death is major depressive disorder (MDD). From 1990 to 2010, MDD increased in ranking from 15th to 11th place (i.e. a 37 % increase) among causes of DALYs worldwide. Self-harm, which in 2010 ranked number 18 among worldwide causes of DALYs, adds to the total impact of mental disorders on population health. Available data confirm the immense disability burden of mental disorders, not only in terms of DALYs, but also in terms of other indicators, such as loss of work days, work life productivity, and poor quality of life. In many highly developed Western economies up to half of the disability pensions are granted due to mental disorders, especially depression (7). Mental health information systems generally fail to measure the impacts of poor wellbeing such as presenteeism, as they are primarily focused on measuring mental disorders. Taken together, the impact of mental disorders and poor mental wellbeing are major threats to productivity of the EU and the wellbeing of EU citizens.

Impacts of mental disorders

Mental disorders and self-harm account for 30 % of burden of disease in Europe (as measured by Years Lived with Disability) (15) and account for the largest and fastest growing categories of the burden of disease with which health systems must cope. The size of the burden is due to a combination of high prevalence, early onset of mental illness several decades before average onset of physical illness (5), and a broad range of impacts of mental disorder relevant to different sectors.

During childhood and adolescence, these impacts include several fold higher rates of health risk behaviour (such as smoking, alcohol and drug misuse), worse education outcomes, antisocial behaviour and offending, and worse social skills. Mental disorder in adulthood has a similar broad range of impacts relevant to different sectors including a 10-20 year reduced life expectancy for people with different mental disorders, suicide and self-harm, a range of health-risk behaviour including alcohol, drug misuse and smoking, unemployment, homelessness, as well as stigma and discrimination.

Psychological distress and mental disorder is one of the leading causes for work absenteeism in the EU (6). Mental disorder is a growing cause of productivity loss in many countries in the European Region (7). An increasing proportion of sick leave, disability benefits and early retirement is due to mental disorders (7). Furthermore, underperforming at work (presenteeism) due to mental disorder adds to productivity loss. Actions to promote mental health of the workforce are the most effective means of achieving a longer working life of Europeans.

Population mental health interventions

A range of effective and cost-effective interventions exists to promote mental wellbeing and prevent mental disorder (2, 8-10).

Prevention of mental disorder involves addressing risk factors, many of which lie in non-health areas, such as poverty and socioeconomic inequalities, violence and abuse, poor education, unemployment and social isolation. In particular, childhood adversity has powerful influence on the development of mental disorder, and therefore, effectively addressing such adversity particularly for more disadvantaged children is important (10).

To sustainably reduce the burden of mental disorder, provision of treatment needs to be accompanied by interventions which promote mental wellbeing and prevent mental disorder. Certain groups are at several fold increased risk of mental disorder and poor wellbeing and therefore require more targeted approaches for both promotion of mental wellbeing and prevention of mental disorder (2, 11).

Economic savings of public mental health interventions to non-health sectors

The impact of many public mental health interventions can be estimated by the significant associated economic savings across different sectors even in the short-term (12). The size of savings to various sectors over different timeframes can be estimated and such information is facilitating support for improved implementation of public mental health interventions.

The economic savings highlight the crucial role that mental health has in supporting the attainment of strategic goals and outcomes of non-health sectors. Investing in mental health creates a win-win situation, with economic savings reflecting the broad range of impacts of mental health.

Impact and cost of public mental health intervention gap to different sectors

The annual economic cost of mental disorder across thirty European countries was recently estimated to be €520 billion (13) and relates to the broad impacts on different sectors outlined above. The total costs of mental disorder have been estimated to be 3-4% of the GDP (7). Costs of lost productivity due to mental disorders far exceeds the costs of treatment.

However, despite the broad set of impacts and costs of mental disorder and poor wellbeing or the existence of cost-effective public mental health interventions, less than 10% of people with a mental disorder in the EU receive notionally adequate treatment (14) while far fewer receive interventions to promote mental wellbeing or prevent mental disorder. The public mental health intervention gap represents a contravention of rights to health and results in a broad range of associated human suffering, impacts and economic costs even in the short-term. As the majority of life time mental disorder arise by the mid-20s, these impacts continue over a large part of life course. Since the majority of the impacts of public mental health interventions usually occur in non-health sectors, the impacts and costs of the public mental health intervention gap also fall in these sectors.

Box 2: Economic savings arising from public mental health interventions

Many cost-effective public mental health interventions are delivered by non-health sectors to which economic savings often predominantly accrue. Examples of where savings accrue for different types of public mental health intervention include (12):

Promotion of mental wellbeing

Workplace mental health promotion programmes result in net savings of €9 in one year for each € spent with the majority of savings accruing to the employer as a result of improved productivity and reduced absenteeism.

Prevention of mental disorder

Prevention of conduct disorder through school based social and emotional learning programmes results in net savings of €84 for each € spent with the majority of savings accruing to criminal justice sector.

School based bullying prevention programmes result in net savings of €14 for each € spent with majority of savings accruing to employment sector.

Debt advice interventions to prevent mental disorder result in net savings of €4 for each € spent with majority of savings accruing to employment sector.

Treatment of mental disorder

Parenting interventions are recommended as first line treatment for the 9.5 % of children and adolescents with conduct and hyperkinetic disorder in the UK. The majority of such interventions are usually provided by agencies outside the health sector. Parenting programmes for children/ adolescents with conduct disorder result in €8 net savings per € spent with criminal justice accruing more than 80% of savings.

Early diagnosis and treatment of depression at work through screening and provision of a course of psychological treatment results in net savings of €5 for each € spent with €4.5 accruing to directly to the workplace as a result of improved productivity and reduced absenteeism.

Social and psychological support during the phase which precedes psychosis results in net savings of €10 for each € spent.

A number of reasons account for the poor coverage of public mental health interventions including:

- Lack of knowledge about availability of evidence based interventions to promote mental health and prevent disorder as well as lack of awareness of the magnitude of associated impacts and savings in non-health sectors
- Mismatch between resources and need: Despite mental disorder being responsible for more than 30% of burden of disease in the European Union (15), a fraction of this is spent on mainly treatment of mental disorder while mental disorder prevention and mental wellbeing promotion have far less resource
- Systematic discriminatory attitudes towards mental disorder

Incorporation of mental health in all policies will be of benefit for all of society. For this to happen, implementation tools are needed. Improved understanding of the size, impact and cost of the public mental health intervention gap including to non-health sectors is important in supporting decisions about policy, strategic and commissioning priorities.

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4. ACTIVITIES AND METHODOLOGY OF EU JOINT ACTION WORK PACKAGE ON MHIAP

Kristian Wahlbeck

Within the EU Joint Action for Mental Health and Wellbeing, the focus of the work package for Mental Health in All Policies (MHiAP), was to map the understanding and state of the art of MHiAP, and to identify, evaluate and disseminate good practices in EU Member States for collaboration between sectors to promote population mental health in decision making processes.

The work started with a web survey to identify good practices, in the first instance in countries participating in the work package in 2013, later extending the data collection to all Member States in 2014. The data collection targeted public sector experts in non-health fields and concentrated to get information on inter-sectoral collaboration practices with all kind of policy sectors (such as employment, environment, education, culture, etc.) at different administrative levels (national, regional and local). To support uniform data collection a glossary of terms relevant for the mental health in all policies approach was developed (1). All survey respondents were provided with a link to the glossary.

In the first phase, 90 questionnaires were distributed. 51 responses were received from the participating countries. In the second phase, an additional 30 responses were received from Member States not participating in this particular work package. The most prominent non-health sectors represented by the respondents were the educational and social sectors. About half of the respondents represented national organisations, the other half being split evenly in representatives of regional and local administrative levels.

In spite of the glossary provided, it was clear from the survey responses that the MHiAP term was not understood and the approach was rather unknown in many Member States. Most respondents indicated that the approach is known only by a few or some policy experts. Some Member States also reported that mental health tends to be conceptualised as mental ill health, and that understanding of possibilities for promotion of population mental health was lacking. Due to the lack of awareness of the MHiAP concept in many instances, in order to resolve unclear issues data had to be collected by face-to-face or telephone interviews.

Experts participating in the data collection pointed out the need to raise awareness of the MHiAP approach, the need for regular cooperation between the health sector and non-health sectors, the need for improved attitudes towards mental health issues and the need for research on the MHiAP approach. Legislative support for MHiAP procedures, capacity building among policy makers, and exchange of experiences on the topic between Member States were also seen as success factors for the MHiAP approach. Generally, respondents argued that demonstration of the economic impact of promoting mental wellbeing and preventing mental disorders is important. It was also stated that a clearer understanding of the relationship between mental wellbeing and the range of strategies/services for which they have responsibility is needed in order to support the MHiAP approach.

From the results it is emerging that conceptual clarity will be important in the implementation phase since the idea of Mental Health in All Policies is quite new and unknown in many sectors and countries. It is encouraging, however, that the attitudes towards the concept have been mainly positive and its value has been broadly supported.

A clear message emanating from the surveys is the need to incorporate mental health in general health in all policies endeavours. In isolation, there will not be sufficient support for the approach. On the other hand, respondents pointed out the risk that mental health becomes overshadowed by the promotion of physical health when approaches are integrated. This risk was confirmed when most respondents reported that mental health impact assessment is only sometimes included in general health impact assessments.

The survey also demonstrated extremely successful examples of inclusion of mental health in non-health policies. In Scotland, for example, the education policy is focused on developing and promoting wellbeing, with an explicit understanding of the link to educational outcomes. In Norway, the foreign affairs sector is developing a plan for inclusion of mental health in foreign aid policy. In Portugal and Finland, the employment policies encompass a youth guarantee to promote social inclusion of young people.

In spite of the non-complete response, the results allow for some broad conclusions. Most respondents did see a role for civil society in taking policy initiatives, monitoring decision making, engaging in mental health impact assessment, monitoring policy implementation and engaging in policy audits. Many respondents reported that in practice non-governmental organisations (NGOs) are involved only to a small or moderate extent.

GOOD PRACTICES

To identify and assess good practices for the mental health in all policies approach, a set of assessment criteria were developed (Table 1). All practices were assessed and scored for relevance, focus on mental health, planning, organisational structures, consultative processes, evaluation, and capacity building. Assessment and scoring were performed independently by country partners and the work package lead team. A common decision was made not to publish the scores, as the reliability of the scoring system has not yet been established.

Based on the assessment for relevance and scores, a set of 24 good practices for implementing mental health in all policies were selected by a consensus process involving at least two experts. The selected and relevant good practices are presented in section 5 of this report. Obviously, because only a selection of EU Member States participated in the Joint Action work package, the identification of and screening for good practices was much more intensive in participating countries, and no claims for completeness of the mapping can be made.

1. Glossary available at *www.famh.fi*

Table 1: Criteria for assessment of good practices for MHiAP

These criteria were used for assessment of collaborative practices to implement Mental Health in All Policies. The scoring is intended as a guidance, and the examples provided below do not cover all possible scenarios.

SALIENT FEATURES	CRITERIA	GUIDANCE FOR EVALUATION	SCORE
Relevance	• Analysis of public policies that have potentially important implications for mental health, mental health equity or mental health systems • There is some level of understanding of the mental health impact of public policies beyond the health sector	• This is an inclusion criteria, i.e. ONLY co-operative practices relevant for mental health should be included • Relevance for mental health means that the practice for cross-sectoral collaboration has the potential to increase mental capital OR promote mental health OR reduce mental health disparities OR reduce burden of mental disorders OR support the mental health system	Yes

SALIENT FEATURES	CRITERIA	GUIDANCE FOR EVALUATION	SCORE
Prioritisation and focus of mental health	• Identification of priorities for action • Identification of co-benefits and conflicts of interest	• Is the collaborative policy action based on a systematic assessment of priorities? • Have co-benefits for mental health and the other sector been identified and declared? • Have conflicts of interest between mental health and the other sector(s) been identified and declared? • There should be at least some understanding and acknowledgment that the collaborative work also aims at improving mental health, psychological wellbeing or mental health systems	1. None (No prioritisation) 2. A little (A little elaboration on conflicts or common benefits) 3. Some (Some elaboration on conflicts or common benefits) 4. Rather much (Either conflicts or common benefits are discussed and described) 5. A lot (Conflicts and common benefits are discussed and reported)
Planning of action	• Delineated roles & responsibilities • Stakeholder analysis (e.g. NGO consultations or public hearings) • Sharing of expertise and information between mental health sector and non-health sector	• Is there a work plan, delineating the responsibilities of the mental health sector and other sectors? • Have stakeholders (e.g. users' and families' organisations) been involved in planning of the action? • Has there been an exchange of data, evidence and expertise between the sectors in planning the action?	1. No (No planning) 2. A little (e.g. short outline of each sector's responsibilities in some document) 3. Some (e.g. some involvement of stakeholders OR some exchange of information between sectors in planning the work) 4. Rather much (Conflicts and common benefits are discussed and reported) 5. A lot (Responsibilities for each sector are outlines in a work plan made based on exchange of information between sectors and involvement of stakeholders)
Establishing supportive organisational structures	• Existence of recognised mechanisms or infrastructures to manage and monitor mental health relevant inter-/multisectoral policy development and implementation.	• Existence of recognised mechanisms or infrastructures to manage and monitor mental health relevant inter-/multisectoral policy development and implementation.	1. No 2. A little (e.g. an intersectoral informal working group) 3. Some (e.g. a permanent working group) 4. Rather much (e.g. permanent intersectoral group with some allocated resources) 5. A lot (A standing secretariat and well-established tools)

SALIENT FEATURES	CRITERIA	GUIDANCE FOR EVALUATION	SCORE
Establishing consultative and assessment processes for MHiAP	• Use of impact assessments and policy audit to examine the impact of polices on mental health and equity.	• Does the practice entail a mental health impact assessment process, audit or mental health expert hearings?	1. No (no tools, hearings or audits are used to assess impact on mental health) 2. A little (assessment tools, hearings or audits can be used, but seldom) 3. Some (sometimes assessment tools, hearings or audits are used) 4. Rather much (usually assessment tools, hearings or audits are used) 5. A lot (formal mental health impact assessment is performed, either independently or as a part of broader impact assessment)
Evaluation and reporting	• Formal monitoring of the mental health and equity outcomes predicted by specific policy initiatives. • Transparent and independent reporting of mental health and equity outcomes	• Is there a monitoring or audit of the mental health effects of the policy action? • Have the mental health and equity outcomes of the policy action been reported?	1. No (mental health impact is not monitored) 2. A little (from time to time, mental health impact is monitored but not reported to the public) 3. Some (mental health impact is as a rule monitored) 4. Rather much (mental health impact is monitored and data available at least on request) 5. A lot (mental health and equity impact is monitored and publicly reported on a regular basis)
Capacity building	• Training opportunities and knowledge exchange linked to the practice. • Opportunities for community engagement through consultations and level of community participation.	• Is training in cross-sectoral work and/or mental health determinants available for civil servants? • Are there consultations and training opportunities for NGOs and community representatives, to build understanding and increase knowledge about social determinants of mental health?	1. No (no training in the practice is available) 2. A little (a short introduction is offered to some actors) 3. Some (some training is available for some actors) 4. Rather much (a training schedule exists for either civil servants or community representatives) 5. A lot (a training programme exists, involving civil servants as well as community representatives)

5. GOOD PRACTICE EXAMPLES OF (PROMISING) MENTAL HEALTH IN ALL POLICIES IMPLEMENTATION IN EU MEMBER STATES

A. NATIONAL LEVEL

RISK ASSESSMENT OF MENTAL JOB STRAIN (AUSTRIA)

Short description

According to the federal Austrian Health and Safety at Work Act (1994) the employer is responsible for evaluating risks concerning safety and health at the workplace and for taking appropriate preventive measures. In the 2013 amendment of the law 'risks' have been explicitly defined as work related 'physical and mental strain' (§ 2 (7)) and 'health' correspondingly as comprising 'physical and mental health' (§ 2 (7a)). In relation to this change 'occupational psychologists' have been explicitly named in the amendment as 'suitable experts' for evaluating the workplace. Corresponding guidelines and tools for this task have been made available.

The responsible agency: Federal Ministry of Labour, Social Affairs and Consumer Protection

Start year: 2013

Strengths and weaknesses

The time since the practice has been established is too short to evaluate it as a whole at a policy level and to identify weaknesses. Potential strengths include, first of all, the fact that the concept of mental health is explicitly included in the terminology of the law, and that occupational psychologists are explicitly defined as suitable experts for workplace evaluation.

In addition, guidelines have been developed for all concerned parties (employers, employees, occupational psychologist, labour inspectors, etc.) on how to proceed in assessing mental strain at the workplace and how to take measures in order to reduce this strain (Arbeitsplatzevaluierung psychischer Belastungen nach dem ArbeitnehmerInnen¬schutzgesetz) (ASchG)

www.arbeitsinspektion.gv.at/NR/rdonlyres/CD1B4D2C-9263-46BF-999A-2C6D5FBE36E1/0/Merkblatt_Arbeitsplatzevaluierung_psychischer_Belastungen_22_1.pdf

Finally, the government's 'labour inspectorate' has the right to evaluate the risk assessment procedures and measures taken by the employers. Guidelines for the labour inspectorates to carry out this evaluation have been developed

www.av.se/dokument/inenglish/European_Work/Slic_2012/Austrian_tool.pdf

More information on the good practice:

www.arbeitsinspektion.gv.at/AI/Information+in+English/Occupational+health+and+safety+in+Austria/default.htm

www.arbeitsinspektion.gv.at/NR/rdonlyres/E14F4E0D-7EA3-44D5-AC1B-A07AA375A2DC/0/aschg_engl_2013_Broschuere.pdf

FRÜHE HILFEN ("EARLY CHILDHOOD INTERVENTIONS") (AUSTRIA)

Short description

"Frühe Hilfen" (early childhood interventions) is a high priority topic in Austria in context of the Austrian strategy on child and youth health as well as the Austrian health targets. "Frühe Hilfen" aims to support families (esp. families in need due to socioeconomic or psychosocial problems) in the early childhood. The concept is building on broad evidence regarding the high relevance of early childhood for lifelong health and especially mental health. It also aims to improve mental health and wellbeing of mothers, parents and families. The activities carried out so far in order to establish "Frühe Hilfen" in Austria follow the (mental) health in all policies approach including in-depth involvement of the health, family and social sectors with participation of many other sectors, NGOs and civil society. It aims to involve services and players from different sectors (building on common assets) in order to improve the living conditions of families in the early childhood - contributing to longer term improvement of health (especially mental health) of the children as well as their families (see *www.fruehehilfen.at*, in German)

The responsible agency: Ministry of Health in cooperation with Ministry of Family Affairs and Youth, Ministry of Labour, Social Affairs and Consumer Protection and Federal Ministry of Education and Women's Affairs; supported by "Gesundheit Österreich" (*www.goeg.at/en/Start.html)*

Start year: A national project investigating the status-quo in Austria and to improve knowledge and awareness about "Frühe Hilfen" in Austria started in the end of 2011. It finished in the end of 2014. In the future, more and more sectors could be involved. The aim to ensure broader implementation of "Frühe Hilfen" is included in the new governmental programme in Austria.

Strengths and weaknesses

"Frühe Hilfen" shows very good results in intersectoral cooperation in order to improve (mental) health, but is implemented only in some regions so far. "Strategie Psychische Gesundheit. Herausgeber, Verleger und für den Inhalt verantwortlich: Hauptverband der österreichischen Sozialversicherungsträger" http://hauptverband.at/portal27/portal/hvbportal/content/ contentWindow?contentid=10008.564642&action=b&cacheability=PAGE&version=1391184577 (in German)

More information on the good practice:

Nationale Strategie zur psychischen Gesundheit (2. Auflage). Empfehlungen des Beirats für psychische Gesundheit des Bundesministeriums für Gesundheit (BMG); Fassung vom 21. 6. 2013; bmg.gv.at/cms/ home/attachments/9/1/4/CH1167/CMS1262851509545/strategie_psychischegesundheit_20130624.pdf (in German)

For more recent developments see: *http://www.fruehehilfen.at/de/Materialien/cccontainer/edit/Mat-Ebene-2_1.html* (in German).

NATIONAL OUTDOOR RECREATION POLICY (DENMARK)

Short description

The Danish Ministry of the Environment is currently drafting Denmark's first national outdoor policy. The outdoor policy will serve as a common reference framework and be a guideline for the development of outdoor recreation activities and cooperation in this field. The policy will not be administered by a specific authority, national council or other institutions. On the contrary, the outdoor policy is widely anchored through co-ownership among all central players within outdoor recreation. It is hoped to lead the way for similar future developments and be implemented and integrated into specific initiatives, partnerships etc. The development of the policy is based on recent research results, feedback from users of outdoor recreation areas and ideas from citizens. The outdoor recreation objectives, proposals and new research results were presented to the Environment Committee of the Danish Parliament in the autumn of 2014.

The responsible agency: The Danish Ministry of the Environment is responsible for this work. Other participants in this work include the Danish Nature Agency, the Environment Committee of the Danish Parliament and citizens.

Interdisciplinary work has been prioritised and emphasised throughout the planning and the development of the policy. Eight ministries have been invited to take part in the development of the national outdoor recreation policy and some ministries have been in charge of different working groups concerning their professional competences. In the meetings between the ministries, the common interests when dealing with an outdoor recreation policy have been discussed and the correlation between different ministries when developing the policy, have been articulated.

Start year: 2012

Strengths and weaknesses

The Danish Nature Agency has a great interest to advocate for the coherence between the health sector and the nature sectors. New research is supporting this point of view.

It is a strength that the health sector is taking responsibility for public mental health. They do this by arguing that outdoor recreation activities improve mental and physical health and quality of life. Thus, nature is an important source of improved wellbeing and better quality of life for the population. Therefore, creating a good framework for outdoor recreation activities contributes to preventing and treating lifestyle diseases and mental disorders.

Strengths:

- Reducing health inequalities

- Utilising local people and private partners as assets

- Working in surroundings available for everybody and possible for everyone to participate, unaffected by physical or mental state

- Ongoing community engagement and dialogue with communities

- Social as well as health outcomes

- Capable of breaking cycles of poor mental wellbeing

- Supporting a range of small but significant changes at local level

- Using an approach rather than specific solutions to act as a catalyst for change in mental and physical health

Weaknesses:

- The national outdoor recreation policy has been developed very recently and hence evaluation of the policy is currently not available

More information on the good practice:

Information about the outdoor policy on websites:

- *naturstyrelsen.dk/naturoplevelser/friluftspolitik (in Danish - here you will find a lot of information about the national outdoor recreation policy)*

- *http://eng.mim.dk/ (Danish Ministry of the Environment),*

- *http://eng.naturstyrelsen.dk/ (Danish Nature Agency)*

Publication:

- List of research-based knowledge of outdoor recreation activities in Denmark. Researchers from the University of Copenhagen have written this booklet, which was published by the Danish Nature Agency in 2012: naturstyrelsen.dk/media/nst/Attachments/HftetFriluftsliv1.pdf (in Danish)

Other literature about nature's importance to mental health (in Danish):

- Nature and social efforts - What do we know? List of available knowledge about the use of nature in social efforts: *www.redbarnet.dk/Files/Billeder/Materialer/Om%20Red%20Barnets%20aktiviteter%20 i%20Danmark/Videnskompendium_Naturen_Red_Barnet_Final.pdf*

- The University of Copenhagen's evaluation of 'Nature and social efforts': *www.redbarnet.dk/Files/ Billeder/Materialer/Om%20Red%20Barnets%20aktiviteter%20i%20Danmark/Skovskolen_NEE_ evaluering_Natur&Fællesskab_FINAL.pdf*

- CASA's (Centre for Alternative Social Analysis) evaluation of 'Nature and social efforts': *www. redbarnet.dk/Files/Billeder/Materialer/Om%20Red%20Barnets%20aktiviteter%20i%20Danmark/ CASA_evaluering_Natur&Fællesskab_FINAL.pdf*

ELECTRONIC WELFARE REPORT IN FINNISH MUNICIPALITIES (FINLAND)

Short description

Electronic welfare report is a free of charge welfare management tool for municipalities. It has been developed in accordance with the health care law for the preparation of the obligatory annual welfare report. E-welfare report guides users to the welfare knowledge management, as it includes an overview of residents' wellbeing and its determinants, promotion plan for wellbeing, and evaluation of the actual promotion activities and welfare policy. E-welfare report gives decision makers information about the wellbeing of the inhabitants by age group and region. It provides a common knowledge base by means of early intervention, as well as national comparisons and comparisons between municipalities and regions.

The process to prepare the report is cross-functional so it must be prepared in conjunction with the various administrative areas. This will support the welfare management principle that the responsibility of wellbeing belongs to all sectors of the governance, not only to the social and health sector. The cross-functionality highlights the cooperation of different government sectors. This cooperation extends from the strategy level to the 'grassroots' level. Thus the strategic management can be implemented in practical action.

The responsible agency: The Association of Finnish Local and Regional Authorities coordinates the implementation and bears responsibility for its further development.

Starting year: 2011

Strengths and weaknesses

Strengths:

- Developed to support cross-functional welfare leadership and political decision-making of local authorities. All administrative branches take more responsibility for the welfare of residents.

- Electronic welfare report is an important basis for the municipality to do strategy development work as well as operational and financial planning.

- The Electronic welfare report has been done in more than 200 municipalities, and 60% of all municipalities use it on regular basis. The goal is to get an Electronic welfare report firmly into the municipal strategic management.

• Report on the welfare is a continuous process, which consists of data collection, evaluation, management decisions, planning and execution of making a circle. The report preparation itself is also a learning process.

Weaknesses:

• There are still many municipalities that have not used this tool.

• The assessment of this tool has also been scarce.

• The mental health indicators depend on the municipality. Mental health questions are included but how many and how specific indicators of mental health have been used is not known.

More information on the good practice:

www.hyvinvointikertomus.fi (in Finnish)

MEASURING MENTAL WELLBEING REGULARLY ON A POPULATION LEVEL AND LINKING IT WITH PUBLIC POLICY OUTCOMES (ICELAND)

Short description

In 2007 the public health authorities in Iceland decided to include public mental wellbeing measures in a national survey on Health and Wellbeing. A single item measure on happiness together with the short version of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was used since that is one of the most reliable measures of public mental health available. This decision had an impact on both health policy and policies for the whole society. Since the data already exist, mental wellbeing measures are now used as an indicator in the Health 2020 policy for Iceland as well as in a broader governmental policy for the economy and community, named Iceland 20/20, led by the Prime Minister.

The responsible agency: Directorate of Health in Iceland, Prime Minister´s Office and Ministry of Welfare

Start year: 2007

Strengths and weaknesses

Strengths:

• Mental wellbeing got more attention when the public health authorities started to present results on mental wellbeing on a national level

• By monitoring mental wellbeing on a national level regularly it is possible to estimate the impact of policies on mental wellbeing

• Mental wellbeing data on a national level gives the opportunity to study the determinants of mental wellbeing and improve the promotion of mental wellbeing of the population

Weaknesses:

• The field of mental wellbeing epidemiology is new – hence the measures are in development

• Lack of common agreement on how to measure mental wellbeing

• Lack of reliable measurements on mental wellbeing in many languages

More information on the good practice:

http://eng.forsaetisraduneyti.is/iceland2020/

NATIONAL CURRICULUM GUIDE WITH EMPHASIS ON HEALTH AND WELLBEING THROUGHOUT THE SCHOOL SYSTEM (ICELAND)

Short description

The National Curriculum Guide is a policy framework for Icelandic schools across educational levels. It describes the role of education in schools according to Icelandic laws and regulations, the objectives and organisation of school operations, and the requirements and rights of everyone in the school community. Six fundamental pillars have been developed within this frame that form the essence of the educational policy in Iceland. They are 'literacy', 'sustainability', 'health and wellbeing', 'democracy and human rights', 'equality', and 'creativity'. The pillars on equality and health and wellbeing have particular meaning for the mental health and wellbeing of students, as these pillars dictate the school's role in creating a positive environment that promotes social equality, mental wellbeing and good physical health among students.

The responsible agency: Ministry of Education

Start year: 2011

Strengths and weaknesses

Strengths:

- Highlights the important role of schools in promoting health and wellbeing for students
- Puts health and wellbeing on the school agenda
- Facilitates whole school approach when it comes to health education and health promotion

Weaknesses:

- Concrete actions are not specified
- Schools are not monitored regarding whether or not, or how, they have implemented this fundamental pillar into their curriculum or school ethos
- Training for staff, financial or other resources have not been secured

More information on the good practice:

http://eng.menntamalaraduneyti.is/publications/curriculum/

STATE HEALTH COMMISSION UNDER THE GOVERNMENT OF LITHUANIA (LITHUANIA)

Short description

State Health Commission under the Government of Lithuania was established in 1996. Around 2007 it stopped its activity and it was re-established in 2013. The National Health Commission is accountable to the Government and coordinates health policy implementation activities in different ministries. It consist of high level officials (vice ministers) from different ministries and other national institutions. One of the first sessions in 2014 was on the topic of Mental Health in All Policies. Representatives of Ministry of Education and Sciences as well as of Ministry of Labour and Social Affairs presented their activities in promoting mental health. In further sessions attention to one or another mental health issue (alcohol, drug abuse, suicide) will be addressed. This shows that after the re-establishment high level priority to mental health issues is given.

The responsible agency: State Health Commission under the Government of Lithuania

Start year: 1996, re-established 2013

Strengths and weaknesses

Strengths:

It is very important that commission consists of high level politicians from different fields/ministries and mental health in all policies questions can be raised there and heard by a multidisciplinary team. It is a strong tool of awareness raising at the highest level.

Weaknesses:

The Commission does not have many sessions during the year and not only mental health questions are on the agenda.

More information on the good practice:

http://www.sam.lt/go.php/Valstybine-sveikatos-reikalu-komisija-prie-LR-Vyriausybes65272817
(in Lithuanian)

PREVENTION OF DROPOUT FROM THE LABOUR MARKET BY PROMOTING PART-TIME SICKNESS ABSENCE AS AN ALTERNATIVE TO FULL SICKNESS ABSENCE (NORWAY)

Short description

Participation in daily activities like employment or education is generally good for mental health. At its best it provides the individual with a sense of identity and self-respect, meaning in life, mastery, belonging, social support and involvement. The mental health benefit of participation in work or similar activities is both that of general prevention, but also curative in individuals with mild, moderate or even severe mental disorder.

However, during illness many employees completely leave employment on sickness absence for weeks or even months. Sickness absence may well be necessary due to illness and impaired function, but the evidence base for sickness absence as 'treatment' is limited. However, evidence for 'side-effects' of long-term sickness absence is increasing, and includes risk of unemployment and thus relative poverty and long-term welfare dependency. Lack of activity during long-term sickness absence may also reduce self-efficacy and change roles and identity. Social isolation and lack of daily routines are also potentially harmful for the overall mental health. It may, for example, increase avoidance in anxiety disorders.

Health problems and related impairment rarely occur as a dichotomy (ill or not), but rather as a continuum between few and many symptoms. Part-time sickness absence may in many cases be a preferred alternative to full sickness absence, as it reduces side-effects of sickness absence, and enables the health benefits of activity.

Policy to promote part-time sickness absence as an alternative to full sickness absence has been implemented in Norway with generally promising results (1).

The responsible agency: The cooperation of four agencies is depending both on ability and attitudes:

1. The legislation and the social security administration, paying for sickness absence exceeding 16 consecutive days in Norway, must allow for – and even promote – part-time sickness absence.

2. General practitioners (GPs) certify most sickness absence, and thus they must be in favour of part-time sickness absence.

3. Employers must accommodate part-time sickness absence as an alternative to full sickness absence. This may in some cases be welcome as key personnel is then not entirely unavailable, whereas in other cases it may be burdensome to accommodate part-time sickness absence in shifts and routines.

4. Employees must also accept part-time sickness absence as an alternative to full sickness absence, and trust that some employment during illness is generally healthy.

Start year: The use of part-time sickness absence was first promoted in 2004 as a result of changed administrative routines for sickness absence certification. The new forms for physicians to use in certifying sickness absence were designed to promote part-time sickness absence.

In 2010, a government appointed expert group suggested economic incentives on employers to further promote part-time sickness absence at the expense of full sickness absence. The intention to promote part-time sickness absence was politically supported, and enforced by policy campaigns and formal collaboration between unions for employees and business organisations (2). However, the use of economic incentives was postponed for technical reasons.

Strengths and weaknesses

Part-time sickness absence is an easily available intervention which comes at a very low cost. Thus, it has great potential in terms of cost effectiveness (1). It is also generally well received politically, amongst employees and employers, and amongst GPs. Every Norwegian citizen is listed with a particular GP. There is considerable variation between GPs in the use of part-time sickness absence, whereof most is unrelated to observable characteristics of their patient populations. Empirical registry based analyses of all Norwegian GPs and their patients on long-term sickness absence give strong evidence that GPs who generally are in favour of part-time sickness absence, have shorter sickness absence amongst their patients, and lower rates of longer-term benefits the following two years, and higher proportion of employment (3). An on-going follow-up of this analysis is indicating that this beneficial effect of sickness absence is strongest in patients sick-listed for a mental disorder. There are similar good experiences with part-time sickness absence from Finland (4).

The feasibility of the method requires both ability in terms of legislation and administration, and also favourable attitudes amongst GPs, employers and employees.

More information on the good practice:

1) Evaluation report for the Ministry of Labour, 2013. Summary in English. *www.regjeringen.no/upload/ AD/publikasjoner/rapporter/2013/Effekter_av_tiltak_under_IA_avtalen.pdf*

2) Report from Government appointed expert group giving advice on how to reduce sickness absence. *www.regjeringen.no/nb/dep/asd/tema/velferdspolitikk/inkluderende_arbeidsliv/Rapport-om--tiltak-for-reduksjon-i-sykefravaret.html?id=592754*

Summary in English *www.regjeringen.no/en/dep/asd/topics/welfare-policy/inclusive-working-life/ summary-of-.html?id=592754*

3) The Case for Presenteeism – Evidence from Norway's Sickness Insurance Program. Markussen, Mykletun, Røed. Journal of Public Economics, 2012. *www.sciencedirect.com/science/article/pii/ S0047272712000953*

4) Effect of partial sick leave on work participation. Kausto J, 2014. *https://helda.helsinki.fi/ handle/10138/42340*

THE NORWEGIAN PUBLIC HEALTH ACT (PHA) 2012 (NORWAY)

Short description

The PHA acknowledges that most causes of health problems are found in the society outside the health services, and that health - of course including mental health - must be taken into consideration when initiatives and strategies are formed in all sectors. The PHA builds upon five values: (1) equalisation, (2) sustainable development, (3) health in all policies, (4) the precaution principle, and (5) participation. It applies a municipality perspective as opposed to a health service perspective by placing the responsibility for the public health work on the political leadership in the municipality, not on the health services. Public health work is linked to the municipalities' overarching planning and decision systems as described in the Planning and Building Act. The municipalities are made responsible for keeping overview over their health situation and the factors that impact on it. They are also instructed to act in accordance with the local challenges and to use the tools that they have available. State and regional authorities are committed to guide the municipalities and to serve them in establishing key/steering data. The national audit system may (and will) control that the act is implemented in all municipalities and counties and that the state follows up by servicing and guiding them.

Figure 1. Public health working process as described by the Norwegian Public Health Act.

The responsible agency: Political leadership, i.e. municipality council and the county parliament, respectively, and the chief county administrator, Norwegian Institute of Public Health, Norwegian Directorate of Health, the Minister of Health in different specified roles.

Start year: January 2012 – in the process of being implemented in the municipalities, many of which have now got a public health coordinator.

Strengths and weaknesses

Strengths:

Implements by law the principle of Mental Health in All Policies. How to better integrate mental health in the public health policy, and how to strengthen public health initiatives towards children and adolescents, are two of the four prioritised areas being addressed in the white paper due in 2015. Part of a larger plan for modernising health work in Norway (The Coordination Reform). Taken seriously by local authorities. Many municipalities have employed a public health coordinator. High awareness on mental health.

The Norwegian Institute of Public Health provides every municipality and county in Norway with an automatically generated and updated municipality/county public health profile (*http://www.fhi.no/ helsestatistikk/folkehelseprofiler*). The profile is based on individual (not municipality) level register data utilising the system with an eleven digit personal id-number for every person in the country. The 'public health barometer' includes some data on mental health (e.g. prescription of psychotropic medication, mental health problems seen in primary medical services) and on mental health relevant factors (e.g. bullying in schools, reading ability in school, psychological wellbeing in schools, drop out from upper secondary school, unemployment).

Weaknesses:

Lack of clear sanctions if the law is not followed. Not all municipalities have a public health coordinator. The 428 municipalities in Norway are of extremely varying size, and the structure may be a challenge in the implementation of PHA. However, a process is going on to establish a new structure of larger municipalities.

More information on the good practice:

www.helsedirektoratet.no/folkehelse/folkehelsearbeid/beskrivelse-av-folkehelseloven/Sider/beskrivelse.aspx

www.helsedirektoratet.no/publikasjoner/lov-om-folkehelsearbeid-folkehelseloven-med-merknader-til-de-enkelte-bestemmelsene-opptrykk-til-fylkesvise-samlinger-hosten-2011/Sider/default.aspx

YOUTH GUARANTEE (GARANTIA JOVEM) (PORTUGAL)

Short description

The Portuguese Government approved in 2013 the Youth Guarantee Programme to tackle the high rate of youth unemployment (average: 38%). Employment measures are being implemented so that young people (18-29) unemployed or coming out of the education system, will be able to, as quickly and as gradually as possible (within four months), strengthen skills, facilitate transition to labour market and reduce unemployment through study support, training, internship and incentives to foster the hiring of young people. This plays an important role in reducing the exclusion and isolation of young people, providing a protective factor for social determinants of mental health. The Youth Guarantee is developed by the employment, education and eventually other sectors; an open building network with a good communication electronic platform is implemented.

The responsible agency: Institute of Employment and Professional Training P.I. (IEFP, I.P.), Ministry of Solidarity, Employment and Social Security, Government of Portugal

Start year: Implementation began in 2014

Strengths and weaknesses

Strengths:

- Helps young people, particularly those facing structural barriers to employment, to get the information and gain the skills, work experience and abilities they need to make a successful transition into the labour market.

- Provides incentive to the public employment services to focus on young people, their particular characteristics and their specific needs.

- Avoids long-term consequences or 'scarring' effects of youth unemployment and is particularly effective for young people who are work-ready.

- Decreases youth emigration.

- Unemployed or underemployed young people learn how to be prepared for, obtain, and maintain employment.

- Rapid identification and encouragement of the young people.

- Networking establishment of stakeholders at local level, which promotes cooperation, contacts, information, guidance and motivates the young to participate in Youth Guarantee actions.

- Increase of active participation in the necessary steps to undertake professional path and future integration in labour market.

- Promotes long-term mental well-being of the young people and at the same time improves the country's economic and social status.

- The Youth Guarantee is achieved through the 'National Plan for the Implementation of a Youth Guarantee', which identifies a wide range of partners who can best act with young people and respond to the diversity of situations and problems together.

Weaknesses:

- Youth unemployment is a structural problem, and Youth Guarantee is less effective for 'hard to reach' group who may require an improved cooperation between social and health services.

- Short-term solution: it does not solve young people´s basic problems.

- Success depends quite strongly on other public policies (e.g. availability of student places) and broader labour market situation in the country.

- Moment of intervention is key, to minimise the group of disadvantaged youths who are totally inactive – not employed, not in learning and not looking for work (NEET).

- Youth unemployment remains at more than twice the OECD average of 16%.

- Young people's qualifications do not fully translate into work-relevant skills, and they are hired for jobs that could be carried out with a lower qualification level.

More information on the good practice (in Portuguese):

www.qren.pt/np4/np4/?newsId=4065&fileName=RCM104_2013.pdf

www.qren.pt/np4/4065.html

www.garantiajovem.pt/documents/10180/12242/GarantiaJovemPDF/4a8ba29f-1680-44c5-871f-2caa9b79e984

HEALTH EDUCATION IN ROMANIAN SCHOOLS FOR PUPILS FROM 1ST TO 12TH GRADE (ROMANIA)

Short description

Introducing 'Health Education' in schools as a curricular and extra-curricular activity

Objectives:

1. Promoting health and the well-being status of the pupils

2. Personal development of the pupils

3. Prevention of interpersonal conflicts, social non-adjustment and crisis situations

Programme's areas cover: anatomy and physiology; personal hygiene; environmental health; activity and rest; nutrition; mental health; reproductive and family health; prevention of drug addiction and at risk behaviours, violence (family, mass-media etc.), abuse and accidents; humanistic values.

The responsible agency: Ministry of National Education

Start year: 2001

- Implementing NPHERS:
- Launched in December 2001
- Piloted during 2002-2003 school year (15 districts + 6 sectors in Bucharest - 3.500 questionnaires were processed)
- Implemented during the 2003-2004 school year (1st, 5th, 9th grades)
- Implementation continued during:
  - 2004-2005 school year (2nd, 6th, 10th grades)
  - 2005-2006 – remaining school years

Strengths and weaknesses

Strengths:

- Ensures an educated school population for a healthy life style
- Allows the access to accurate information in the urban area as well as in the rural area
- Indirectly influences adults' education
- Lowers sickness and the incidence of risk behaviours
- Increases the quality of medical activity and lowers its costs
- Promotes non-discrimination

Weaknesses:

- The optional curriculum is not accessible for all pupils

More information on the good practice:

www.edu.ro/index.php/articles/20774 (in Romanian)

CREATING SPACES POLICY STATEMENT (SCOTLAND)

Short description

The document highlights the significant relationship between architecture and place to a range of policy areas including health outcomes. Physical and social environments are critical elements in people's lives and can impact on their health and wellbeing. Neighbourhoods which can increase human connectedness through their design and where there is access to good quality greenspace, safe streets and places for children to play outdoors can positively benefit health. 'There is a proven link between how we perceive our world and surroundings and the various biological responses that go on inside the body. How people feel about their physical surroundings, can impact on not just mental health and wellbeing, but also physical disease.' Sir Harry Burns, Chief Medical Officer, The Scottish Government

The responsible agency: The Scottish Government

Start year: June 2013

Strengths and weaknesses

Strengths:

Bringing health and well-being issues into planning policy and practice, raising awareness and increasing decision making that includes health outcomes as a focus.

Weaknesses:

High-level document and the complexity of other physical environment issues (such as greenhouse gases, security, social justice, culture and identity) makes monitoring difficult.

More information on the good practice:

The Places Standard work is ongoing: *www.healthscotland.com/resources/cpps/local/placestandard*.aspx

Creating Spaces report is at: *www.scotland.gov.uk/Resource/0042/00425496.pdf*

Creating Spaces website is at: *www.creatingplacesscotland.org/*

B. REGIONAL LEVEL

MENTAL WELLBEING IMPACT ASSESSMENT (ENGLAND)

Short description

Mental Wellbeing Impact Assessment (MWIA) is a systematic approach to assessing how proposals, programmes, services, employers, and projects can capitalise on opportunities to promote mental wellbeing, minimise risks to wellbeing, and identify ways to measure success in achieving wellbeing. MWIA uses Health Impact Assessment methods but focuses on the factors that are known to promote and protect mental wellbeing:

- A sense of control over one's life, including having choices and skills
- Communities that are capable and resilient
- Opportunities to participate, e.g. in making decisions, through work
- Being included: having friends, family, work colleagues

The responsible agency: South London and Maudsley NHS Foundation Trust

Start year: 2003

Carried out with over 700 policies, projects and programmes including community, housing and regeneration projects such as Time Banks, arts projects such as community choirs and youth arts, and major programmes such as the European Capital of Culture in Liverpool 08 and Well London as well as with carers' services, schools and adult education, physical activity programmes, mental health services and projects and workplaces.

MWIA process is participative and has been found to have the following benefits:

- Engaging a range of stakeholders, including beneficiaries/communities, to increase awareness and understanding of mental wellbeing

- Identifying potential positive and negative impacts of a policy or proposal on mental wellbeing

- Creating a set of evidence based recommendations and an action plan for a project to enhance positive impact and minimise negative impacts

- Developing specific indicators (measures) of mental wellbeing

Strengths and weaknesses

Strengths:

Good at getting people to generally understand 'what is wellbeing?' and the evidence behind improving wellbeing and wider determinants. If full workshop is undertaken then good mechanism to get all stakeholders talking at the same level e.g. residents and policy makers. There is also a shorter 'checklist' version.

Weaknesses:

Can be resource intensive and overly complex, and requires people to be trained in its use to be most effective. It is difficult to know whether recommendations are taken forward as there is little monitoring of whether this has happened. It could be integrated into health impact assessment rather than be used as a separate process.

More information on the good practice: *www.apho.org.uk/resource/item.aspx?RID=95836*

www.maudsleyinternational.com/our-services/mental-well-being-impact-assessment.aspx

MENTAL HEALTH NEEDS ASSESSMENT (ENGLAND)

Short description

In England, Joint Strategic Needs Assessments (JSNA) should provide information about local levels of health and social care needs as well determinants (DH, 2012). In turn, this should inform actions which local authorities, health and others need to take to improve the health and wellbeing of their population. However, mental health is poorly covered in JSNAs (Oliva & Lavis, 2013) which perpetuates the lack of awareness of mental health in other policy areas and the coverage of interventions to treat mental disorder, prevent mental disorder and promote mental wellbeing.

JCPMH public mental health commissioning guidance (Campion & Fitch, 2013) supports systematic assessment of local:

- estimated levels of mental disorder and wellbeing

- costs of mental disorder including in different sectors

- levels of risk factors for mental disorder, numbers from higher risk groups and protective factors for mental wellbeing

- coverage of public mental health interventions to treat mental disorder, prevent mental disorder and promote wellbeing – this reflects the level of local policy implementation

- economic savings of public mental health interventions including in different sectors
- size and cost of intervention gap to outline commissioning opportunities and facilitate prioritisation

The JPCMH public mental health commissioning guidance was further developed to provide public mental health needs assessments for any locality in England which include all nationally relevant public mental health intelligence as well as locally collected information. This in turn informs the local assessment of size, impact and cost of outstanding need, which then informs local strategic and commissioning decisions.

The responsible agency: South London and Maudsley NHS Foundation Trust

Start year: 2012, currently being implemented in several areas covering a population of 5 million

Strengths and weaknesses

Strengths:

- Facilitates development of comprehensive mental health needs assessment for any locality in England covering mental wellbeing promotion, mental disorder prevention and mental disorder treatment (in both primary and secondary care)
- Incorporates local data not available from nationally published datasets
- Informs range of audiences including commissioners, public health, primary care, secondary care, education, employers, and criminal justice about the size, impact and costs of local public mental health intervention gap
- Includes coverage and outcomes of public mental health interventions by a range local providers
- Promotes understanding about mental health to a wide range of partners
- Makes numbers locally relevant to support decision making
- Informs strategic and commissioning decisions
- Facilitates cooperation and collaboration between sectors: For example, in one region, over 5000 children and adolescents were estimated to have conduct disorder. Parenting interventions are the recommended first line treatment although only 100 parents of this group were receiving parenting interventions. Local costs of conduct disorder were outlined including to the criminal justice sector. Savings were estimated if all parents of children with conduct disorder received parenting interventions with majority of savings accruing to the criminal justice sector. This resulted in the local police commissioner offering to spend some of the police budget on parenting interventions.

Weaknesses:

- Comprehensive and therefore a large document
- Most recent data used although can be several years old for some mental health areas
- Not formally evaluated regarding impact to facilitate inclusion of MHiAP

More information on the good practice:

- Campion J, Fitch C (2013) Guidance for the commissioning of public mental health services. Joint Commissioning Panel for Mental Health *www.jcpmh.info/resource/guidance-for-commissioning-public-mental-health-services/*
- Campion J (2013) Public mental health commissioning guidance: embedding mental health in local public health work. Perspectives in Public Health 133: 87
- Campion J (2013) Public mental health: The local tangibles. The Psychiatrist 37:238-243. *http://pb.rcpsych.org/content/37/7/238.full.pdf+html*

- Department of Health (2012) Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, *www.gov.uk/government/uploads/system/uploads/attachment_ data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf*
- Oliva, L. & Lavis, P. (2013) Overlooked and forgotten: A review of how well children and young people's mental health is being prioritised in the current commissioning landscape, *www.cypmhc.org.uk/ media/common/uploads/Overlooked_and_forgotten.pdf*

STUDENT WELFARE TEAMS (FINLAND)

Short description

Key objectives for the Student Welfare Team, based on law, are to create a healthy and safe learning environment, to protect mental health and prevent social exclusion and to promote wellbeing in the school community. It includes both communal and individual student support. The aim is also to promote the culture of caring and positive interaction in the school community. A multi-professional student support group operates in most elementary schools. A Student Welfare Team is in general chaired by the principal of the school. The other members can be the school nurse, a doctor, school social worker, school psychologist, special needs teachers and guidance counsellors. If necessary, the class teachers can attend or other specific employees. It has been important to consult different professional perspectives and multi-professional skills before deciding on the measures.

The Student Welfare Group prepares an annual plan for its activities as part of the school's action: development goals, targets and measures to achieve the objectives. The plan must cover the following situations involving cross-sectional decision-making:

- Absence records
- Bullying, violence and harassment
- Mental health issues
- Smoking and substance abuse
- Different injuries, accidents and fatalities
- Threat and after-care of incidents and psychosocial support

The responsible agency: Pre-schools, primary and secondary schools, high school, vocational schools

Start year: 1998 Act for arranging student welfare teams at schools

Strengths and weaknesses

Strengths:

- All the workers at the school implement student welfare work as part of their basic work.
- A very important part of this work is the implementation of the co-operation between schools and homes. Student Welfare Group regularly informs both parents and the school of its activities. It communicates about its functioning to parents at the beginning of the school year and shares the information in parents' evenings and/or the school's website.

Weaknesses:

- There is not much information how well these teams are working in different schools and how their work is assessed.

More information on the good practice:

http://urn.fi/URN:ISBN:978-952-302-232-4 (in Finnish)

'TERRITORIAL PLANS' AS A LOCAL AND REGIONAL PLANNING TOOL FOR SERVICES IN THE CROSS-LINK OF SOCIAL AND HEALTH AFFAIRS (VENETO REGION, ITALY)

Short description

'Territorial Plans' are area-based needs assessments that define priorities in the programming of services. The assessments gather data to plan interventions addressed at increasing social inclusion. The plans comprise data on 7 categories: families & children, disabled people, elder people, dependent people, mental health, marginalisation and social inclusion, and immigration. For the field of mental health, the plan can lead to measures like the promotion of mental health awareness and literacy in the community, controls on application of regional policies on mental health, empowerment, family, or residential policies for people with mental health problems. Decisions are taken in cooperation between local and regional authorities.

The responsible agency: Regione del Veneto, Direzione Regionale dei Servizi Sociali, Osservatorio Regionale Politiche Sociali - Nucleo Piani di Zona

Start year: 1998, in Veneto, 2000 in the Italian national law

Strengths and weaknesses

Strengths:

Interdisciplinary stakeholder structure – The project brings together interdisciplinary stakeholders which is an indication of cross-sectoral cooperation. This leads to an integrated approach in the design and carrying out of each 'Territorial Plan'. Civil servants form an integral part of the stakeholder structure.

Political support – The plans needs approval at local and regional decision-making level. It is interesting to note that the mayor's conference, a committee of elected representatives, is involved in the planning process. This creates ownership of the plan among decision-makers and adds momentum, as political commitment reduces obstacles in the implementation process.

Inter-connectedness with other relevant fields of work – The plans address a variety of issues, among which mental health is an important. It is positive to see that mental health is not singled out and considered separately, but inter-connected with other relevant aspect (e.g. inclusion).

Matching and evaluation of the different territories – Territorial Plans foster cooperation between different territories. A cooperation between regions is facilitated by a matching procedure, which is based on needs assessed in territorial evaluations. The regional profiles must match, which allows taking into account the strengths and difficulties of different areas and to carry out joint projects and to create synergies in the programming of plans (i.e. capacity-sharing or streamlined social inclusion policies etc.) Mostly, regions territorially close to each other and having similar needs cooperate; often one region with a strong profile in one area supports the weaker one. Yet it can at times also happen that regions with same needs develop joint solutions on shared problems.

Weaknesses:

Prioritisation through finance – 'Territorial Plans' consider financial data against the number of service users. This leads to a rather quantitative understanding of effectiveness based on high case numbers. When looking at costs of services and numbers of users, one might rather take a cost-utility approach that lopsidedly considers how many people have benefitted from services, but less to what extent single individuals have received effective services that worked for their individual life circumstances.

Need for adaptation in terms of stakeholder structure – The stakeholder structure for the piloting would need to be adopted along the political system (e.g. competences of vertical levels of government in the piloting countries) and the stakeholder structure as given in the piloting environment.

More information on the good practice:

www.regione.veneto.it/web/sanita/mental-health-in-veneto-region

THE NORWEGIAN STATE HOUSING BANK, REGION WEST (NORWAY)

Short description

The main goal for Norwegian Housing policy, and one of the pillars of welfare policy in Norway, is for everyone to stay safe and well. Social housing is recognised as a fundamental element in welfare policies together with employment, social services, health care and child welfare. Therefore, the Ministry of Local Government and Regional Development, Ministry of Labour and Social Affairs, Ministry of Health, Ministry of Children, Equality and Social Inclusion and the Ministry of Justice have worked together in developing the new national strategy (2014) for social welfare and committed to work towards common goals in the social housing area.

The Norwegian State Housing Bank is the government's main implementing agency for the national housing policy, and uses financial measures to facilitate the achievement of housing policy goals. The Housing Bank has started to organise their work through Social Housing Welfare Programmes in the municipalities. Social Housing Welfare Programme is an initiative where closer contact between the municipalities' special social housing assignments and other welfare assignments is established. The overall vision of the program is that everyone should stay well and safe and the main objective is that more disadvantaged people will stay in stable and permanent housing. This will be achieved by contributing to:

1. The overall planning and organisation of housing and services in the municipalities

2. Long-term strategic planning and alignment of municipal social housing activities

3. Social housing being a part of the municipality's overall plans and budgets

4. A comprehensive and coordinated use of state and municipal instruments

5. A documented knowledge base for use in planning and experience transfer

6. Processes where the planning and implementation of measures is assessed regularly and adjusted if necessary

The Social Housing Welfare Programs are long-term and committed relationship between the regional Housing Bank and selected municipalities with large social housing challenges.

In Region West the Social Housing Welfare Programme was established in 2013. During this first year the programme was organised through workshops focusing on competence, management and employment of programme managers in the municipalities, organisation and implementation of feasibility study and preparation of the programme agreements. Governmental interaction is firmly anchored in the Programme Council which is established in each region. Region West has set up broad Programme Council including all stakeholders in the welfare area at state and regional levels.

By the end of 2014, 13 programme municipalities have been approved in Region West. The first five municipalities have started the organisation of the programme work in their own municipality and are underway to acquire, release or upgrade municipal housing. One of the municipalities has set itself the goal to provide 300 new municipal rental housing during the programme period. Another municipality is well on the way towards the goal of obtaining 400 new municipal rental housing. Good results with the aim of releasing municipal rental housing through 'rent to own' projects has been documented. Thorough reviews of the municipal housing stock, with aim of better exploitation also shows promising results in some municipalities. It is envisaged that the first approved municipalities will transfer their experience to municipalities entering the programme at a later stage.

The approved programme municipalities have been provided specific grants for conducting an external feasibility study to identify challenges in programme municipalities and create a good knowledge base on what to address further development of the programme.

The responsible agency: The Norwegian State Housing Bank is a state agency under the Ministry of Local Government and Modernisation and is regulated by the Housing Bank Act.

Start year: As a part of the post-war reconstruction and rebuilding of the country The Norwegian State Housing Bank was established by Act of March 1, 1946. There have been several amendments to the act during the years, the latest in August 2012.

The Social Housing Welfare Programmes provide unique opportunities for communication directly both between different state actors and the municipal management in the programme municipalities.

Strength and weaknesses

The majority of the municipalities have developed a social housing policy plan as part of the municipal initiative based on long-term interdisciplinary cooperation and planning. Participation in the Social Housing Welfare Programme has to a large extent led to increased social housing expertise in the municipality. The competence fund from the Housing Bank is a prerequisite for this development. By involving other state agencies more through the programme partnership, a greater degree of development and innovation is facilitated at the municipality level. The majority of municipalities have been more able to implement coherent and locally tailored policies for disadvantaged people on the housing market and they consider that the Housing Bank aid has been adapted to the municipal needs. Closer cooperation between actors in the Social Housing Programmes has established good arenas for cooperation and development between the central and local government. Overall efforts have contributed to more targeted efforts to prevent homelessness in the municipality and the users have got better housing services than earlier. There has been an increased coordination of the social housing efforts, and coordination of housing management between other agencies as well as improvement in practices and procedures in housing management.

Coordination and concurrency in delivering different welfare services is essential in order to achieve a sustained housing establishment. A successful implementation requires individualised follow-up and easy access to health care, employment or training, school or education. A meaningful leisure and social network is vital for the motivation to experience a good residential situation. Evaluation of the initial five program municipalities have identified that there still are some challenges in access to housing, monitoring of special groups, allocation routines on municipal housing, guidelines for granting home loans, and challenges related to competence, organisation and interaction within the municipalities.

More information on the good practice:

National Strategy on Social Housing (2014 – 2020) Housing for welfare, to be found at:

www.husbanken.no/~/media/Simpleupload/2014/03/Bolig_for_velferd_ny_nasjonal_strategi_for_boligsosialt_arbeid.ashx (in Norwegian)

The Housing bank Act, to be found at: https://lovdata.no/dokument/NL/lov/2009-05-29-30 (in Norwegian)

PATHWAYS TO POLICY (ROMANIA)

Short description

This programme enables (ex)users and their NGOs to meet and work together with all stakeholders (including local government, business and the media). Together they work within the Local Policy Forum (LPF) and the National Policy Forum (NPF) in order to initiate suitable mental health policies at local and national levels, to develop campaigns to influence locally identified mental health issues, to promote positive images of people with mental health problems in the media, to produce papers, literature and good practice guidelines based on learning from the programme, and to influence the national policy debate through local and national forums with user-involvement. The members of the LPF and NPF come from different backgrounds, some being users of mental health services or acting within forums from the very beginning.

The responsible agency: The 'Orizonturi' Foundation Campulung Moldovenesc, Suceava county, Romania

Start year: 2002

Strengths and weaknesses

Strengths:

- Participants gain new skills and knowledge, such as: lobbying, media and rural development skills. They also learn advocacy, organisational development and general capacity building. The programme strengthens research knowledge and skills concerning ways of presenting policy in written form using analytical arguments, logic and evidence-based material. Facilitation, presentation and evaluation skills are also covered.

- New strategic relationships for change: The representatives of the local authorities, state institutions and politicians acknowledged that mental health as part of public health must be a priority for all of them and that mental health policy must be an integrated part of public health policy. The Ministry of Health has agreed to include some issues in its official strategies and recognised that the outcome of the project drew the attention of the authorities and has been taken into consideration in policy making. This was only possible with the help of a joint work of bureaucrats, policy makers, journalists, professionals, politicians and NGOs as representatives of the civil society.

- A greater voice for users. Orizonturi Foundation represents 33 per cent of users at local and national level. It is the result of a better understanding of user involvement's importance coming from both users and stakeholders (professionals and other).

- Raising awareness of mental health issues. The Local Policy Forum and National Policy Forum have been and are working in raising public awareness of mental health policy issues and the users' positive contribution and expertise through their interaction with the media.

Weaknesses:

- Project financed by the UK and not followed up with sustainable funding

- A rather isolated experience with a local impact

More information on the good practice:

Publications on the campaigns "Together we will make the world a better place" supporting people experiencing mental health problems and "The rights of people with mental health problems ARE human rights" promoting the rights of people experiencing mental health problems have been produced.

WELL CONNECTED (SCOTLAND)

Short description

Well Connected, sometimes called community referral or social prescribing, is a mechanisms for linking people with non-medical sources of support within the community. Social prescribing provides an evidence based framework for:

- Developing alternative responses to mental health problems and low levels of well-being and expanding treatment and support options;
- A wider recognition of the influence of social, economic, environmental and cultural factors on mental health and well-being outcomes across the whole spectrum of physical, emotional and social health;
- Improving access to mainstream services and opportunities for people with mental health problems, low levels of well-being or those socially excluded, with a focus on addressing the underlying factors, and connecting people with the opportunities that help them stay well.

The responsible agency: NHS Lanarkshire in partnership with local authorities and other key providers in localities.

Start year: 2009

Strengths and weaknesses

Strengths:

The partnership approach with each agency taking responsibility; the level of commitment from the partners who are all committed to taking this to the next level.

Weaknesses:

The Mentally Flourishing Scotland policy was a driver only for the start of this. Danger of agencies not bedding in changes and them not influencing the future directions of service developments.

More information on the good practice:

Well Connected website: *www.elament.org.uk/self-help-resources/well-connected-programme.aspx*

North Lanarkshire Community Plan 2013 - 2018

www.nhslanarkshire.org.uk/boards/2013-board-papers/Documents/March/North-Lanarkshire-Community-Plan-2013-2018--March-2013-Board.pdf

NHS Lanarkshire health improvement

www.nhslanarkshire.org.uk/Services/PublicHealth/Directors-Annual-Report-2011-2012/Documents/PH-2011-12-Chapter3.pdf

NO SUBSTITUTE FOR LIFE (SUICIDE PREVENTION) (SCOTLAND)

Short description

The local Choose Life (*www.chooselife.net*) team in Renfrewshire Local Authority actively works with both frontline workers and members of local communities to support them to raise awareness of and prevent suicide. 'No Substitute for Life' is an annual memorial football tournament held in Ferguslie Park, a housing estate with high levels of deprivation in the city of Paisley that has a high incidence of people dying by suicide. The event aims to engage people who are most affected by death by suicide.
In particular, to engage young men most at risk of suicide, dispel the myths, reduce the stigma and isolation surrounding suicide whilst encouraging help-seeking behaviours. The event openly encourages those bereaved by suicide to come together to remember those they have lost.

The responsible agency: RAMH – an independent voluntary association to enable people to recover from mental ill health and to promote wellbeing.

Start year: 2012

Strengths and weaknesses

Strengths:

- The event is community led, empowering community ownership

- The community involvement maximises the community's capacity

- Suicide prevention messages incorporated within the event help to reduce stigma, demonstrated through the evaluation

- Having access to information reduces barriers to help-seeking behaviour

- Promotes help-seeking resources and raises awareness of how to keep safe

- It is an approach to create change rather than an individual solution

Weaknesses:

- Sustainability could be an issue in terms continued funding

- Requires input to support the vulnerability of participants and maximise the resilience of community activists

More information on the good practice:

RAMH (recovery across mental health): *http://ramh.org/*

Renfrewshire Choose Life *www.renfrewshire.gov.uk/webcontent/home/services/
social+care+and+health/mental+health/sw-mc-choose-life*

Engage Renfrewshire: *www.engagerenfrewshire.com*

'REGIONAL AND LOCAL CROSS-SECTORAL IMPLEMENTATION OF SUICIDE PREVENTION STRATEGIES' (ANDALUSIA, SPAIN)

Short description

The project EUREGENAS (European Regions Enforcing Actions against Suicide) brings together 11 regions with diverse experiences in suicide prevention with the aim to develop and implement strategies for suicide prevention at regional level. These can serve the European community as good practice examples. The project pilots cross-sector actions in different regions, among others in Andalusia in the province of Malaga (Spain). The key stakeholders on suicide prevention are from three groups: 1) Decision and policy makers, 2) Health professionals and 3) NGOs and social area. The awareness raising activities are part of Work Package (WP) 4 (online library/needs assessments) and WP6 (Development of prevention guidelines and toolkits) of EUREGENAS.

The responsible agency: Andalusian Health Service, Mental Health Office (Programa de Salud Mental, Servicio Andaluz de Salud). Associated partner of EUREGENAS.

Start year: January 2012. Finishing date: December 2014. In 2015, after finishing EUREGENAS, the Public Hospitals of Malaga will coordinate a permanent cross-sectoral working group. The blueprint of the III Comprehensive Mental Health Plan of Andalusia (2015-2020) has a cross-sectoral approach towards suicide prevention, involving a range of activities at different intervention levels.

Strengths and weaknesses

Strengths:

Conceptual framework – A conceptually robust understanding of suicide is important to create targeted measures. The prevention of suicide is based on the USI model: Universal prevention, Selective prevention and Indicated prevention. The project stresses risk and protective factors, as well as mental health promotion.

Stakeholder involvement – Policy makers from Health Services, Education and Occupational Health. Professionals from (mental) health, education, social services, substance abuse sector, members of mental health family and user association, journalists, occupational health and emergency and catastrophe specialists.

Relevant focus – The project underlines the importance of awareness raising, recognising the stigma related to suicide, as well as the need to provide guidelines and toolkits. Awareness raising is a suitable start to promote MHiAP in the piloting sites due to little awareness of the matter. There is a training module for primary healthcare professionals on suicide prevention. Implementation strategies are being developed for the guidelines and toolkits, by taking into account regional idiosyncrasies. The School Toolkit will be piloted in 2015 in a secondary school in Malaga. Through participation in a workgroup at state level (National Strategy of Mental Health of the National Health Service) the Guidelines and Toolkits are disseminated at national level as well.

Well-developed regional pilots – Along with the elaborated structure of the project, the pilots are based on well-developed structures and modes of cooperation. For the case of regional health service in Andalusia, it is possible to reach key stakeholders through cross-sectoral contacts at regional and local levels (Malaga). This project stresses that suicide prevention is not just a mental health problem.

Weaknesses:

Lack of evaluation at a larger scale – Despite the promising pilots, only piloting results exist. An implementation strategy is needed for each of the EUREGENAS work package deliverables in the next years to consolidate the impact in tackling the reduction and prevention of suicide. Some indications for long-term impact exist (e.g. intent to carry on the project).

Need for adaptation – To launch the MHiAP pilot through trainings of national civil servants, it is relevant to consider that civil servants in the current form of the project framework do not receive training. Yet the trainings launched in the EUREGENAS framework could be adapted to the needs and means

of civil servants. The role of civil servants within the EUREGENAS stakeholder structure focusses on awareness raising and early detection. Relevant topics for such trainings could include modules on better information (e.g. myths on suicide, definition and epidemiological data, risks and protective factors) and awareness raising measures (effective toolkits adapted to the needs of different sectors, e.g. schools, workplace, media).

More information on the good practice:

www.euregenas.eu

Euregenas Publications: *www.euregenas.eu/publications/*

General Guidelines for suicide prevention: *www.euregenas.eu/wp-content/uploads/2014/01/ EUREGENAS-General-Guidelines-on-Suicide-Prevention-F.pdf*

Ethical guidelines for technology based suicide prevention programmes: *www.euregenas.eu/wp-content/ uploads/2014/02/Ethical-guidelines-for-TBSP-programmes.pdf*

Toolkit for Media professionals: *www.euregenas.eu/wp-content/uploads/2014/04/Euregenas-Suicide-Prevention-Toolkit-for-Media-Professionals.pdf*

Toolkit for Schools and Toolkit for the Workplace: *www.euregenas.eu/wp-content/uploads/2014/11/ EUREGENAS-TOOLKIT-WORKPLACE-Preventing-and-Managing-Suicidal-Behaviour-1.pdf*

Feedback Report of the Euregenas Stakeholders Consultation: *www.euregenas.eu/wp-content/ uploads/2014/05/StakeholderConsultation_FeedbackReport.pdf*

C. LOCAL LEVEL

THE CITY OF VANTAA'S WELFARE TEAM (HYRY) (FINLAND)

Short description

The welfare team heads and coordinates welfare promotion in Vantaa. The chairman of the team is responsible for wellbeing reports and programme work. The welfare team gives guidelines for all the departments to ensure a good everyday life for the residents. Operations are monitored by age groups: children and young people, working-age people, and the elderly. In addition to the above, the team focuses on promoting employment. Experts and managers of the city's different departments participate in preparing wellbeing reports and programmes. The programmes are presented for approval by both the city executive board and city council. Each department is responsible for implementing the programmes in practice.

The City of Vantaa uses electronic reporting in monitoring and reporting welfare data. The electronic wellbeing report consists of an electronic databank and electronic reporting is based on the indicators of the databank. Welfare is promoted on the basis of the wellbeing report's indicators in Vantaa's age-group-specific programmes as well as in other strategic policies. Vantaa promotes the residents' wellbeing through cooperation between all the city's departments. The work focuses on residents, resident groups, and different subject areas of welfare. An extensive report is given per council terms and a briefer one is given annually.

The responsible agency: The chairman of the team is responsible for wellbeing reports and programme work. The chairmanship rotates annually so that the chairman of each department is the chairman in their turn. The welfare team consists of a secretariat of five secretaries who are experts from different areas.

Start year: The City of Vantaa has made wellbeing reports and reviews since 2002.

Strengths and weaknesses

Strengths:

- The residents' self-assessments of their own health and welfare are increasingly highlighted in the data.

- The data are utilised in compiling preliminary assessments. The data are available to decision-makers and trustees. The results are also reported to the residents.

- The wellbeing report translates into an important part of the city's strategic operations and financial planning. The challenges to and strengths of the residents' health and welfare arising from the electronic wellbeing report are analysed in the city's policy work.

Weaknesses:

- Consultative and assessment processes, and capacity building issues could be improved.

- It is not clear how specific indicators there are used for mental health since it is part of the other wellbeing indicator clusters.

More information on the good practice:

www.vantaa.fi/instancedata/prime_product_julkaisu/vantaa/embeds/vantaawwwstructure/89364_Hyvinvointikertomus_2012_11.6.2013.pdf (in Finnish)

MENTAL HEALTH IMPACT ASSESSMENT IN THE CEMG BANK (PORTUGAL)

Short description

To assess the potential mental health equity impacts of a proposed set of recommendations and programmes on implementing health and wellbeing promotion in the savings bank Caixa Económica Montepio Geral (CEMG). It is based on the results of a cross-sectional exploratory study to identify the biopsychosocial determinants at the workplace and work-family balance, with implications on the levels of productivity (reduction of absenteeism and presenteeism rates) and wellbeing of workers. Developed by health, employment and education sectors; implementation in an employment setting, involving the two other sectors; periodic meetings with all stakeholders.

The responsible agency: Institute of Preventive Medicine/Faculty of Medicine/University of Lisbon (IMP/ FM/UL)

Start year: 2009

Strengths and weaknesses

Strengths:

- Particular interest of CEMG in implementing innovative policies and practices related to health and wellbeing promotion at the workplace, associated with positive outcomes in stress reduction.

- Prevention of physical and psychological distress in workers, leading to absenteeism and presenteeism reduction rates and productivity growth.

- Extending knowledge exchange between academia and the business community.

- Improve knowledge about the psychological, social and biological determinants, in the context of employment and of work-family balance.

- Current international campaign - organised by the Committee of Senior Labor Inspection (SLIC) with Union representatives from all States (U.S.) - undertaken in Portugal by the Authority for Working Conditions during 2012, which promotes the evaluation of psychosocial risks in the workplace and increases the quality improvement of existing risk assessments.

- Challenge – to undertake the proposed HIA will be an innovative step for the development of HIA in Portugal in the perspective of health in all policies.

Weaknesses:

- Although there is a signed protocol between the former Portuguese Office of the High Commissioner for Health (ACS), the National Health Institute Doutor Ricardo Jorge, Public Institute (INSA, IP) and the Institute of Preventive Medicine, University of Lisbon/Faculty of Medicine (IMP/FML-UL) there is a relevant financial barrier. The end of the current grant of the overall project will compromise the continuity of the project, namely the building and dissemination of best practices on mentally healthy workplaces, as well as the use of already established network of stakeholders within a mental health in all policies framework.

- There is a need of training and experts support (rapid HEIA).

- This is an innovative step in Portugal and therefore there is a lack of projects with health and health equity impact assessment at the workplace.

More information on the good practice:

http://news.fm.ul.pt/Content.aspx?tabid=73&mid=491&cid=1565&code=EN – newsletter

www.insa.pt/sites/INSA/Portugues/ComInf/Noticias/Documents/2013/Janeiro/workshop_on_equity.pdf

DUNDEE EQUALLY WELL (SCOTLAND)

Short description

The Dundee test site was one of eight national demonstration sites sponsored by the Scottish Government as part of the implementation of Equally Well, a report of the Ministerial Task Force on Health Inequalities in Scotland. Working in Stobswell, a disadvantaged community in Dundee, the work aimed to test new ways of working, predominantly in public services, to tackle health inequalities and improve community mental wellbeing.

The responsible agency: The test site was run by the Equally Well Core Group consisting of representatives from Dundee Community Health Partnership, Dundee Community Planning Partnership, NHS Tayside Directorate of Public Health, Dundee City Council Health and Regeneration section, Maryfield Local Community Planning Partnership, Dundee Voluntary Action, NHS Tayside Health Intelligence. The Core Group appointed a Lead Officer who was seconded from her substantive post 3.5 days per week to develop and implement test site action.

Start year: 2009

Strengths and weaknesses

Strengths:

- Reducing health inequalities in a holistic manner with a determinants approach
- Using an approach rather than specific solutions to act as a catalyst for change
- Utilising local people as assets: ongoing community engagement and dialogue with communities
- Working in natural neighbourhoods, and balancing universal and targeted approach
- Reducing failure demand through preventative measures for people with risk factors for poor health and wellbeing
- Social as well as health outcomes
- Breaking cycles of unhealthy living and poor mental wellbeing
- Co-production, community and service development
- Integrated public service planning and improved partnership working
- Supporting a range of small but significant changes at neighbourhood level

Weaknesses:

- Lack of sustainable funding: This was subsequently addressed through award of recurring funding from NHS Tayside in 2014 to sustain and roll out the approach across all disadvantaged areas in Dundee.

More information on the good practice:

Website: *www.scotland.gov.uk/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well*

www.dundeecity.gov.uk/mywellbeing/

Report of the Ministerial Task Force on Health Inequalities: *www.scotland.gov.uk/ Publications/2008/06/25104032/0*

Equally Well Report by the Ministerial Task Force 2010: *www.scotland.gov.uk/ Publications/2010/06/22170625/12*

Evaluation of Equally Well: NHS Health Scotland: *www.odsconsulting.co.uk/ods/case-studies/national-evaluation-of-equally-well-nhs-health-scotland.html*

Evaluation of Dundee Equally Well Final Report *www.dundeepartnership.co.uk/sites/default/files/ Equally%20well%20report%20Final%20Report.pdf*

6. DISCUSSION

a. Intersectoral collaboration (whole-of-government)

Arne Holte

GOOD PRACTICES FOR MHIAP IN THE AREA OF INTERSECTORAL COLLABORATION

This report presents several examples on intersectoral collaboration and whole-of-government approaches. Such intersectoral collaboration may involve challenges linked to structure and organisation, financing, implementation, and to finding suitable tools for promotion of population mental health. Many of these challenges have already been successfully solved through good practices in the individual EU Member States and associated countries. Member States have approached the structuring and organisation of intersectoral collaboration in different ways depending upon local conditions and the tasks to be solved.

For instance, Norway has adopted a comprehensive Public Health Act, which creates a legal framework for intersectoral collaboration on public health. The law is based on the concept of health – explicitly including mental health – in all policies. It gives the local politicians responsibility for keeping overview of the mental health of the population and to implement suitable health promotion and illness prevention initiatives. It also provides a procedure of implementation of public health policies, including overview, planning strategy, determination of goals, action, and evaluation.

GOOD PRACTICES

On a national government level, Lithuania has established a whole-of-government approach through a high level State Health Commission under the central government, where vice ministers from different ministries and other national institutions meet regularly to coordinate health policy and implementation of activities in different ministries (see section 5.a). Such commissions work as strong tools of awareness raising on the highest level. In Iceland, data from a regular national survey on Health and Wellbeing are used by a broader governmental policy for the economy and community (Iceland 20/20) led by the Prime Minister.

Other types of whole government approaches are illustrated by the Danish national outdoor recreation policy and the Norwegian State Housing Bank. In both these cases separate government agencies have been established to secure a whole-of-government approach to policies with an impact on population mental health. Anchored in the Danish Ministry of Environment, recognising that physical activity has both a mental and physical health promoting effect as well as an anti-depressive effect, eight ministries have been invited to take part in the development of the national outdoor recreation policy. Ministries have been in charge of different working group concerning their professional competencies.

Correspondingly, the State Housing Bank is the government's main implementing agency for the national housing policy in Norway. Acknowledging that social housing is a fundamental element in welfare policies together with employment, social service, health care, and child welfare - and needs a broad spectre of competence to be successful - the Housing Bank works together with several local, regional and national ministries in developing strategies for social welfare and common goals in the social housing area.

A whole-of-government approach on a local level is illustrated by the City of Vantaa in Finland. They have established a welfare team, which coordinates welfare promotion in the City of Vantaa. The welfare team produces wellbeing reports, programmes and guidelines for all the departments to ensure a good everyday life for the residents, to be approved by the city executive board and city council.

Implementation of user perspectives across sectors is illustrated by the Local and National Policy Forums in Romania where (ex)users meet and work together with stakeholders including local government, business and the media to initiate mental health policies at local and national levels. The aim is to develop campaigns to influence locally identified health issues, literature and good practice guidelines and influence the national policy debate through local and national forums with user involvement.

Other examples of intersectoral collaboration not mentioned in this report are the merging on local levels of units addressing children and their families (e.g. infant-small-children-health-controls, kindergarten, school, child protection services, municipality psychologist) into one common 'family and childhood and adolescence sector', or co-locating all local services for children and families under the same roof in the Family House, as found in several municipalities in Norway.

FEASIBILITY OF IMPLEMENTATION

Most of the examples of intersectoral collaboration and whole-of-government approaches listed above are easy to implement at low or no cost. Several of them will in the long-term save costs not only in the health budget but also in budgets outside the health sectors. Cognitive structures, traditions, and high walls between sectors including differences in legal regulations seem to be main obstacles. Another obstacle is that several of the policies are organised as projects, not regulated by law. This threatens their sustainability. A main approach to come around such obstacles is to adopt a legal framework in terms of a Public Health Act which explicitly includes mental health. Such an act should be based on MHiAP, clearly define the roles of local, regional and national authorities, describe procedures for developing and maintaining mental health in the community and require collaboration across sectors.

To a large extent intersectoral collaboration is more a question of organisation than a question of resources. In some cases intersectoral collaboration is simply a question of setting up collaborative structures. In other cases collaboration may be organised as projects which are co-financed by the partners involved. A more challenging model is cross-sectorial budgeting, when the budget of one ministry is used to finance activities in another sector. This occurs only rarely because the success of a politician is often assessed according to how large proportion of the budget he or she is able to get to his or her sector. A second challenge is that politicians are elected for a limited time period (e.g. four years). These two 'concepts' tend to counteract investing in cross-sectorial collaboration and in long-term initiatives.

TOOLS

A large number of tools have been exemplified in this report.

Explicit inclusion of mental health in laws addressing health now occurs in many Member States. For instance, under the Austrian Health at Work Act the employer is responsible for evaluating risks concerning safety and health at the workplace and for taking appropriate preventive measures. 'Risks' now explicitly includes work related mental strain, and 'health' now explicitly includes mental health.

Mental Wellbeing Impact Assessment (MWIA) is a systematic approach by the South London and Maudsley NHS Foundation Trust to assessing how proposals, programmes, services, employers, and projects can capitalise on opportunities to promote mental wellbeing, minimise risk to wellbeing, and identify ways to measure success in achieving wellbeing.

Electronic welfare reports are now produced by/for local communities in several countries. For instance in Finland (*www.hyvinvointikertomus.fi*) and in Norway (municipality health barometers, *www.fhi.no*) the process of preparing such reports is cross-functional. It must be prepared in conjunction between the various administrative areas. This supports the welfare management principle that the responsibility of wellbeing belongs to all sectors of the governance, not only the social and health sector.

Measuring mental wellbeing regularly on a population level and link it with public policy outcomes, is a great resource to be used both as an indicator in the health policy (e.g. in Iceland, Health Policy 2020) as well as in a broader governmental policy for the economy and community (e.g. Iceland 20/20 led by the Prime Minister). In the end, such tools are needed in order to monitor whether the health policy in all sectors works.

Prevention of drop out from the labour market by promoting part-time sickness absence as an alternative to full sickness absence is now an easily available and well documented tool which comes at a low cost. As implemented in Norway, it has been generally well received politically amongst legislators and administration, GPs, employers and employees. The basic idea is that participation in the work force is generally good for mental health.

The youth guarantee of the Portuguese Government is another example of work directed approaches. Employment measures are being implemented in order for young people who are unemployed or coming out of the education system to be able to as quickly and as gradually as possible strengthen skills, facilitate transition to labour market and reduce unemployment through study support, training, internship and incentives to foster the hiring of young people.

Mental health literacy (MHL) may have mental health promoting and mental illness preventing effects. However, MHL varies greatly both within and between countries in Europe. For instance, Romania has implemented Health Education in Romanian Schools for Pupils from 1st to 12th grade, including both mental health literacy and determinants which impact on mental health.

Creating Spaces Policy Statement is an initiative adopted by the Scottish Government to make sure that relationship between architecture and place is designed in ways to increase human connectedness by providing green spaces, safe streets and places for children to play outdoors and develop mental wellbeing.

Suicide prevention needs cross-sectorial action. Regional and local cross-sectorial implementation of suicide prevention strategies in Malaga, Spain, and the No Substitute for Life suicide prevention program in Scotland are good practice examples of cross-regional and intersectoral programs to prevent suicide. Some countries have implemented national cross-sectional suicide prevention programmes, such as the Austrian national suicide prevention strategy. Notably, some EU Member States with high suicide rates lack such cross-sectorial strategies.

Need assessment in terms of territorial plans as local and regional planning tool for services in the cross-link of social and health affairs in the Region of Veneto, Italy, collects data across sectors to define priorities in the programming of services in order to implement interventions for social inclusion.

BENEFITS AND CHALLENGES OF THE PRACTICES

Intersectoral collaboration and whole-of-government approaches have several strong benefits:

- Highly cost-effective and easy to implement
- Favourable approach in addressing determinants of mental health
- Makes coordinated actions and alignment of politics possible
- Offers an approach rather than specific solutions to act as catalysts for change in both mental and physical health
- Strong awareness and attention raising effect outside health sector
- Increases impact of initiatives by involving decision makers outside own sector
- Facilitates mental health impact assessments of all policies
- Necessary to implement larger plans for modernising health work on government level

- A large number of tools are already available, including good measurement methods which have been translated into many languages

Intersectoral collaboration and whole-of-government approaches have some weaknesses:

- Assessment should involve implementation, effectiveness, cost-utility, and user satisfaction, which may be challenging

- New policy approaches may not yet have been satisfactorily evaluated

- More challenging to evaluate whole policies than defined interventions and projects

- Several measurement methods still have a development potential

- Cross-sectorial budgeting and budget collaboration may be a challenge

- Resistance to change in social organisations has to be dealt with, including cognitive barriers, different legal instruments, traditional governmental cultures and walls between sectors

- Many good practices have low sustainability because they are project organised and not yet an integrated part of local, regional or national government

RECOMMENDATIONS

Based on the good practices identified, a set of recommendations for intersectoral and whole-of-government approaches emerges. Most of these recommendations can be implemented even with low resources.

- Ensure that the National Public Health Act is based on the concept of MHiAP and explicitly includes mental health (Learn from the Norwegian example).

- Set up a high level National Health Commission under the central government where vice ministers from different ministries and other national institutions meet regularly to coordinate health policy – including mental health policy – and implementation of activities in different ministries (Learn from the Lithuanian example).

- Establish cross-sectorial national/regional government agencies in specific areas of policy implementation which requires a whole government approach in order to be successful (Learn from the Danish Ministry of Environment and the Norwegian Housebank).

- Utilise data from regular national surveys on Health and Wellbeing for a broader governmental policy for the economy and community (Learn from the Icelandic example).

- Mental wellbeing impact assessment of all larger proposals, programmes, services, employers, projects and investments to capitalise on opportunities to promote mental wellbeing, minimise risk to wellbeing, and identify ways to measure success in achieving wellbeing.

- Welfare teams to assure a broad approach on a local level which coordinates welfare promotion, produces wellbeing reports, programmes and guidelines for all the departments in the local community (Learn from the Finnish City of Vantaa).

- Implementation of user perspectives across sectors by establishment of Local and National Policy Forums where (ex)users meet and work together with stakeholders including local government, business and the media to initiate mental health policies at local and national levels (Learn from Romania).

- In all policy documents addressing public health, it should be stated explicitly that health includes mental health (Learn from Austria's Health and Safety at Work Act and Norway's Public Health Act).

- Utilisation of the experience with already available tools developed in other Member States.

b. Education sector and mental health

Jonathan Campion, Arne Holte, Kristian Wahlbeck

The educational setting is the most important arena outside the family for development of children's mental health. A large proportion of childhood and adolescence is spent in school and the basis for a good mental health is built during early years. A majority of lifetime mental disorder arises before adulthood.

A range of effective interventions exist to promote mental health and prevent and reduce mental illness in educational settings (1). However, very few children and adolescents receive such interventions.

Schools are mental health promoting when they provide children and adolescents with a sense of identity and self-respect, direction and meaning in life, mastery, belonging, safety, social support and participation. Good mental health is associated with better educational and behavioural outcomes. Educational settings can prevent mental disorder when they effectively address associated risk factors such as bullying and abuse.

Early learning in high quality day care centres or kindergartens strengthens social-emotional coping, cognition and school grades, have strongest effects on disadvantaged children and good effect on advantaged children, reduces social inequality in health, may compensate for bad home environment and stabilises difficult periods in life, has long term effects on mental and physical health, educational outcomes and employment, and is economically very cost-effective (2).

Pre-schools and schools which promote mental health and prevent mental disorder have a wide range of positive impacts on children's development, including large impacts on educational outcomes and equity (3,4). Improved mental wellbeing is linked to a range of beneficial outcomes in adulthood (5). Incorporating mental health into educational policies contributes to developing, maintaining and protecting society's most potent and least developed resource, the mental health of children. There is solid evidence that the cost-benefit ratio of mental health interventions in educational settings is very favourable.

Mental disorders during childhood and adolescence are also associated with increased risk of a range of adverse outcomes, which include poor educational outcomes (6) as well as adulthood adverse outcomes such as low earnings, unemployment, teenage parenthood, marital problems, criminal activity (6,7), mental disorder, suicide (7,8,9), health risk behaviour and physical illness.

EDUCATION DURING ADULTHOOD

Low literacy skills are associated with higher prevalence of depression (10). Women with low literacy skills have a five times higher risk of depression than those with average or good literacy skills (11).

Continuation of learning through life enhances self-esteem and encourages social interaction and a more active life (12). Learning increases earnings and employability, which in turn protects wellbeing and reduces the risk of poor mental health and low levels of life satisfaction (13). Learning improves wellbeing and recovery from mental health problems by enhancing self-esteem, self-efficacy, sense of purpose and hope, competences and social integration (14).

GOOD PRACTICES FOR MHIAP IN EDUCATION

Inclusion of mental health in national, regional and local education policies has a very favourable cost-benefit ratio because it releases large societal resources in terms of wellbeing, cognitive, emotional and social skills ("mental capital"), which again have a broad range of positive impacts, including educational outcomes. A selection of effective interventions which promote mental wellbeing and prevent mental disorder during childhood and adolescence has a wide range of impacts including on educational outcomes (15). An example of mental health promotion is the US social and emotional programme;

evaluation included a meta-analysis of more than 270,000 students which found reduced conduct problems and emotional distress, improved social and emotional skills, attitude about self, improved social behaviour and 11% improved academic performance (17) as well as net savings of €84 for each € invested due to reduced conduct disorder (16).

EFFECTIVE IMPLEMENTATION

Effective school based mental health promotion and mental disorder prevention programmes are more effective if long-term, whole school and include teacher training and parental participation (1).

Effective implementation of parenting programmes requires a public health approach, incorporating both universal and targeted interventions, to ensure that more parents benefit and that a societal-level impact is achieved (18).

BENEFITS AND CHALLENGES OF THE PRACTICES

Benefits of mental health promotion in educational settings include improved class behaviour, better educational achievements and a range of beneficial longer term outcomes. In spite of this, it remains a challenge to make a clear case for implementation of mental health promotion to the education sector, and to provide appropriate support and training to teachers who already have a large workload.

Parenting programmes have considerable potential to improve the mental health and wellbeing of children, improve family relationships, and benefit the community at large.

RECOMMENDATIONS

Promotion of mental health and prevention of mental disorders in educational settings requires appropriate information about the impact of mental health, associated interventions and their benefits, leadership and coordination. Based on available evidence and good practices, the following recommendations can be made:

- Provide a system of affordable, available and accessible high quality public day care centres or kindergartens for all children.

- Implement evidence based whole school based interventions to promote mental health and wellbeing and anti-bullying programmes to prevent mental disorder.

- Ensure that all parents have parenting knowledge, skills, and confidence, and provide access to parenting support interventions for high risk families.

- Routinely assess day care centres/kindergartens/preschool and schools on whether they are mental health promoting organisations.

- Include children, adolescents and their families in planning school environment which promotes mental health and wellbeing.

- Regularly assess the levels of mental wellbeing and mental disorder in education settings.

- Train school staff to support children's psychosocial development.

- Include mental health promotion in national school curriculum.

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c. Community design and mental health

Kristian Wahlbeck, Nigel Henderson, Jonathan Campion

Housing and urban planning policies are intimately intertwined with promotion of population mental health promotion. Good housing and urban planning policies create the basis for human interaction and social capital, which in turn is beneficial for population mental health. Good planning creates possibilities for social interaction, provides access to green and blue space and ensures low levels of environmental contamination. A mental health promoting man-made environment contributes to social cohesion by enabling meetings of people with different background. Creating spaces that allow for encounters between people supports community participation, increases tolerance of diversity and mutual responsibility, all important factors in improving community cohesion.

Urban planning should aim to strengthen important mental health promoting features of the local social and physical environment. It is essential to raise awareness of the fact that improvements in population mental health may be achieved by focusing on places as well as on people. The development and maintenance of healthy communities by providing safe and secure environments and good housing minimises conflict and violence, allows for self-determination and control of one's own life, as well as generating vital community validation and social support. Such environments also have a direct impact on mental health and wellbeing.

Urban and rural living conditions have differing impacts upon our mental health. Rapid urbanisation occurs across Europe, and households are increasingly urban, small-family or single households. Urban living is connected to mental health stressors, such as lack of space of your own, insufficient security, lack of support from family and unstable economic conditions. Living in an urban environment is known to be a risk factor for mental disorders such as major depression or schizophrenia, in spite of higher standard of living and better health services in urban areas than in rural areas. Urban stress seems to be a mediating factor between urban living and mental health problems. Living in crowded areas, social disparities, and disturbances of the wake-sleep cycles contribute to urban social stress.

Both the product and the process of city planning have been shown to have an influence on mental health. The importance of citizen participation is also presented, stressing the influence of participation on both sense of control and the development of social support. Neighbourhood council programmes have been identified as having the greatest potential for influencing sense of control and social support.

GOOD HOUSING FOR ALL

Good planning and housing create the psychological and social prerequisites for healthy living. Having a home, in a safe place with access to well-planned urban and green space all contribute to better mental health for individuals and families. Poor quality housing is associated with poorer mental wellbeing, increased risk of mental disorder or exacerbation of mental disorder symptoms while good quality housing is associated with better mental wellbeing, reduced risk of mental disorder and faster recovery (1, 2). Housing improvement pays off manifold in more positive perceptions of safety, as well as crime reduction, social and community participation, and ultimately improved self-reported mental health (3).

The concept of "reasonable accommodations" in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) is important when considering planning impact on people with mental or physical disabilities. The CRPD clarifies and qualifies how rights apply to persons with disabilities, specifically including people with long-term mental or intellectual impairment, and identifies areas where governments must ensure that adjustments (known as reasonable accommodations) be made for persons with disabilities to effectively exercise their rights. CRPD is legally binding, and provides people with long-term mental disorder with the right to adjustments and support for living in the community. Planning built on the CRPD principles of "reasonable accommodations" provides benefit for all, not only for people with special needs.

Socially excluded groups with comparatively high rates of mental disorder, such as homeless people and rough sleepers, present particular challenges for any housing policy. Research shows that mental disorder can also be the consequence of long-term social exclusion indicating that housing and urban planning policies are important for reducing mental health problems. A 'Housing First' approach has been found beneficial in inclusion of people with complex psychosocial problems, including mental disorders.

ACCESS TO GREEN AND BLUE SPACES

Access to parks and green spaces within residential neighbourhoods has been shown to be an important pathway to generating better physical and mental health for individuals and communities. Access to green and blue spaces has a beneficial impact on behavioural development in children (4) and poor access to urban green spaces is associated with behavioural problems (5). Higher levels of neighbourhood green spaces are associated with significantly lower levels of symptomology for depression, anxiety and stress (6), suggesting that "greening" could be a potential strategy for population mental health promotion. Moving to greener urban areas is associated with sustained mental health improvements.

GOOD PRACTICES FOR MHIAP IN COMMUNITY DESIGN

Denmark's first national outdoor policy developed by the Danish Ministry of the Environment is a good example of how space can be mobilised in order to promote population mental health. The national policy is a common reference framework and guideline for the development of outdoor recreation activities, and inter-sectoral collaboration.

The Danish outdoor policy ensures a comprehensive uptake through co-ownership among all central players within the outdoor recreation field. Eight ministries have been invited to take part in the development of the national outdoor recreation policy and a central pillar is the acknowledgement that outdoor recreation activities improve mental health and quality of life. Nature is seen as an important source for improved wellbeing and quality of life for the entire population. The development of the policy is based on a combination of the most recent research results, feedback from users of outdoor recreation areas, and ideas from local citizens.

Scotland's Creating Spaces Policy Statement highlights the significant relationship between architecture and space and a range of policy areas including mental health outcomes. This policy recognises that both physical and social environments are critical elements in people's lives, which in turn impact on health and wellbeing.

The Creating Spaces Policy promotes neighbourhoods that increase human connectedness through their fundamental design. Adequate access to good quality green space in ensured, as well as safe streets and places for children to play outdoors, all of which can result in positive health benefits for the community.

BENEFITS AND CHALLENGES OF THE PRACTICES

The Danish and Scottish policies are good examples of joint inter-sectoral policy development, bringing health and wellbeing issues into both planning policy and practice. Thus not only raising awareness, but also increasing decision making that includes a specific focus on health outcomes.

Urban planning and outdoor policies have the potential of reaching everybody in a community, thus potentially contributing to reduction of health inequalities. Policy processes in the areas of housing development and urban planning offer a multitude of possibilities for community engagement and dialogue. Due to the broad scope of possible social and health effects, monitoring population mental health impact constitutes a challenge. Policy implementation requires commitment by local authorities and private partners alike, in order to meet the goal of creating healthy spaces.

FEASIBILITY OF IMPLEMENTATION

The examples of good practice from Denmark and Scotland indicate that a development of policies for healthy spaces is indeed feasible, and creates interest across government sectors. Implementation however, will require legislation that empowers authorities to prioritise nature as one of safeguarded areas of importance for community outdoor activities, and to promote property development which creates and maintains sustainable mentally healthy spaces.

A mentally healthy environment supports the overall aims of housing, outdoor and urban planning policies, and is a common interest for all governmental sectors.

RECOMMENDATIONS

- All countries should have policies in place for creating healthy spaces.

In low level resource settings, the focus needs to be on meeting basic needs of warmth and shelter for all by provision of affordable housing, including spaces for social and community participation. This includes creating awareness of the health impacts of both man-made environments and nature.

In medium level resource settings, policies should emphasise investment in spaces that support community mental health, such as increasing safety and reducing crime through, for example, sufficient street lighting as well as improving access to green spaces through the creation of parks and conservation areas.

In high level resource settings, policies should further improve access to both green areas and public spaces for the whole community through investment in technologies to increase accessibility and usability of outdoor spaces for all, including old people and people with disabilities. Preservation and enlargement of urban green and blue spaces are of special interest in cities of highly developed countries (7).

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d. Employment sector and mental health

Maria João Heitor Santos, Arne Holte

Employment is the main source of income for most people. It is also a fundamental component of quality of life, social status, self-esteem and life achievement. There is an influence of working status fluctuations on individuals' health conditions and their overall well-being (1). Over the past decades, a large percentage of workers have been contingent or temporary. The repercussions of unstable working conditions are reflected at individual, family and professional levels. Those who become unemployed may be unfamiliar with the critical skills required for success in the transition back to employment.

The workplace environment is a key setting for mental health promotion, mental disorder prevention and early recognition of mental disorder of the adult population as the majority spends large amounts of their time at work. At best the work place provides the individual with a sense of identity and self-respect, meaning in life, mastery, belonging, social support and participation. At worst it can lead to high levels of stress and lack of control.

Poor mental health is strongly linked to lost productivity due to high levels of presenteeism, absenteeism and early retirement. Mild-to-moderate mental disorders affect around 20% of the working-age population in the average OECD country, and are predominantly highly treatable disorders such as anxiety and depression (2). In the UK, 40% of absence from work is due to mental health problems (3). Aside from absenteeism, presenteeism (poor performance) associated with mental health problems, constitutes almost two times more weight than absenteeism (3).

Intersectoral collaboration and the promotion of equity will contribute to mental health promotion, mental disorder prevention and early recognition of mental disorder in the workplace. The current socioeconomic situation points to the need for a better knowledge of the mechanisms of health and mental wellbeing promotion of employees. Better information is needed for evidence based political decision in order to enable the reduction of health inequalities and to implement more efficient and effective healthy public policies in the employment sector. It will allow absenteeism and presenteeism reduction and productivity increase, as well as more awareness of the importance of mentally healthy workers.

Mental health promotion and mental disorder prevention are effective and cost-effective means of improving workforce mental health and productivity. For instance, mental health promotion in the workplace results in net savings of €10 for each € invested most of which accrues to the employer from increased productivity and reduced absenteeism, while early detection and treatment of depression at work results in net savings of €5 for each € invested (4). Workers with good mental health have higher lifetime productivity and reduced absenteeism. Family friendly workplaces will reduce family burden and allow an increase in birth rate. Mental disorder and stress can be prevented through interventions to address stress management and measures to prevent a high demand and low control environment.

GOOD PRACTICES FOR MHIAP IN THE EMPLOYMENT SECTOR

There is a current international campaign, "Healthy workplaces manage stress", promoted by the *European Agency for Safety And Health at Work*, undertaken in Portugal by the Authority for Working Conditions, that will take place in 2014–15, which promotes the evaluation of psychosocial risks in the workplace and aims to increase the quality improvement of existing risk assessments, taking advantage of an ongoing window of opportunity.

In Austria, a risk assessment of mental job strain has been implemented. In the 2013 amendment of the law "risks" have been explicitly defined as work related "physical and mental strain" and "health" correspondingly as comprising "physical and mental health". In relation to this change, "occupational psychologists" have been named in the amendment as "suitable experts" for evaluating the workplace. Corresponding guidelines and tools for this task have been made available.

BENEFITS AND CHALLENGES OF THE PRACTICES

The Portuguese campaign "Healthy workplaces manage stress" (2014-15) include raising awareness of stress and psychosocial risks in the workplace and encouraging non-health professionals such as employers, managers and workers and their representatives to work together to manage those risks; creating a healthy work environment to improve worker´s well-being and business performance; providing and promoting the use of simple, practical tools and guidance for reducing psychosocial risks and stress in the workplace. The "Healthy workplaces" campaign can contribute to capacity building although it has a limited time frame. On-going interventions with long-term effects on the intervened populations, by promoting the acquisition of skills, are needed. The magnitude of health inequalities (5) is a good marker of progress towards a fairer and equality-oriented society, also promoting an adequate access to mental health promotion for vulnerable groups. The financial crisis represents an additional challenge to health equity as it has undermined the resource base for redistributive social policies, with lasting effects on the social determinants of health.

Policies for prevention of dropout from the labour marked by promoting part-time sickness absence as an alternative to full sickness absence (Finland and Norway) are based on evidence for harmfulness of long-term sickness absence, including risk of unemployment and long-term welfare dependency. Lack of activity during long-term sickness absence may also reduce self-efficacy and change roles and identity. Social isolation and lack of daily routines are potentially harmful for the overall mental health. Part-time sickness absence may in many cases be a preferred alternative to full sickness absence, as it reduces side-effects of sickness absence, and enables the health benefits of activity.

A policy to promote part-time sickness absence as an alternative to full sickness absence has been implemented in Norway with generally promising results. It is a cooperation between four parties and depends both on ability and attitudes:

1. The legislation and the social security administration, paying for sickness absence, must allow for – and even promote – part-time sickness absence.

2. General practitioners (GPs) certify most sickness absence, and thus they must be in favour of part-time sickness absence.

3. Employers must accommodate part-time sickness absence as an alternative to full sickness absence. This may in some cases be welcome as key personnel is then not entirely unavailable, whereas in other cases, it may be burdensome to accommodate part-time sickness absence in shifts and routines.

4. Employees must also accept part-time sickness absence as an alternative to full sickness absence, and trust that some employment during illness is generally healthy.

Part-time sickness absence is an easily available intervention which comes at a very low cost. Thus, it has great potential in terms of cost effectiveness. An on-going follow-up is indicating that the beneficial effect of part-time sickness absence is strongest in patients who are on sick leave for a mental disorder.

The federal Austrian Health and Safety at Work Act (1994) states that the employer is responsible for evaluating risks concerning safety and health at the workplace and for taking appropriate preventive measures. Guidelines have been developed for all concerned parties (employers, employees, occupational psychologist, labour inspectors) in the Austrian project on how to proceed in assessing mental strain at the workplace and how to take measures in order to reduce this strain.

FEASIBILITY OF IMPLEMENTATION

The examples of good practices from across Europe indicate that intersectoral collaborative policies to create mentally healthy workplaces and support the workforce are feasible.

Through this cooperation, specific actions and strategies on a rationale of sharing experiences, knowledge and good practices, to reduce health, social and economic inequalities may be developed. Implementation, however, will require legislation and strategic planning that will empower public and private stakeholders and will prioritise areas of action.

Common sector-wide initiatives and meetings, involving experts, professionals, institutions from different sectors and the public at large, in each country, as well as a focus on joint implementation of evidence-based intervention programmes (as pilots) may contribute to achieving the expected outcomes: sustainable networks, beyond projects and programmes; on-going exchanges of know-how; dissemination of best practices to policy makers and professionals of the sectors involved; interventions directed to the vulnerable populations (unemployed, job seekers, temporary employed; people with mental disorders) and to the various organisational levels (managerial, human resources departments, safety and occupational health). Other outcomes include: raising awareness of stigma related to mental disorders in the workplace; human resources development and improvement of institutional capacity; building sustainable mentally healthy workplaces.

RECOMMENDATIONS

- All Member States should have policies in place for creating healthy workplaces which promote mental health, prevent stress and mental disorder, and facilitate work-family balance and early recognition of mental disorders (6).

- In low level resource settings, policies and practices should focus on meeting basic needs which include regular access and evaluation by occupational health and primary health care; reduction of work-related stress through environmental measures such as flexible working; and raising awareness of the psychosocial risks besides physical risks at the work environment.

- In medium level resource settings, policies and practices should provide infrastructures and instruments that strengthen the links between mental health and other policy areas; gender inequities reduction; smoking cessation assistance; information about alcohol and drugs, and employee assistance, among others, with a continuous improvement perspective.

- In high level resource settings, policies and practices should further provide fitness facilities, healthy food choices (e.g. cafeteria); friendly architectural workplaces; leadership engagement; involvement of workers and their representatives; promotion of resilience, communication and interpersonal skills, conflict resolution and negotiation skills, problem solving and decision making, managing performance, motivation and leadership skills, stress and time management, personal effectiveness, empowering self and emotional intelligence.

- An effective gap analysis (7), monitoring, evaluation and impact assessments of recommendations are essential in policy implementation processes involving different sectors (e.g. health and mental health, municipalities, employment/labour, social security and university).

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e. Social inclusion and equality policies

Jonathan Campion, Kristian Wahlbeck

Mental health and most mental disorders are shaped to a great extent by the social, economic, and physical environments in which people are born, grow and live. Socioeconomic disadvantage is associated with increased risk of poor mental wellbeing and mental disorders (1). For instance, children from lowest 20% household income in Great Britain are at three-fold higher risk of developing a mental disorder (2). Mental disorder then results in a range of further inequalities. This contributes to increases in physical illness and reduced life expectancy of up to 20 years (3).

A Eurobarometer survey in 2002 showed significant variation in mental health, with poorer mental health in poorer groups (4).

Taking action to improve the conditions of daily life from before birth, during early childhood, at school age, in adulthood, and at older ages provides opportunities both to improve population mental health and to reduce the risk of those mental disorders that are associated with social inequalities. While comprehensive action across the life course is needed, scientific consensus is considerable that public mental health interventions have greatest impact during childhood and adolescence (5). Thus, a life course approach to MHiAP is needed to tackling mental health inequalities in the population (6).

Addressing social exclusion and inequalities requires awareness and commitment at policy level. Universal action needs to be taken by whole of government, across multiple sectors and levels. To achieve maximum mental health benefits, universal actions should be proportionate to disadvantage in order to level the social gradient and successfully reduce inequalities in mental disorders. Actions and services targeting disadvantaged groups often become poor services and do not enjoy the support of the whole population (5). Socially disadvantaged groups disproportionately benefit from universal interventions to treat mental disorder, prevent mental disorder and promote mental wellbeing. Such disadvantaged groups with high risk of mental disorder include looked after children, children and adults with learning disabilities, young offenders and prisoners, disadvantaged ethnic minorities, and people with long term physical conditions (1).

GOOD PRACTICES TO REDUCE INEQUALITIES

The Portuguese Youth Guarantee Programme was approved by the Government in 2013 to face the high rate of youth unemployment. Employment measures are being implemented so that young people (18-29) unemployed or coming out of the education system, will be able to, as quickly and as gradually as possible (within four months), strengthen skills, facilitate transition to labour market and reduce unemployment through study support, training, internship and incentives to foster the hiring of young people. Sectors such as employment, education and eventually others will collaborate through an open building network with a good communication electronic platform.

Dundee Equally Well is a local level good practice, sponsored by the Scottish Government as part of the efforts to reduce health inequalities in Scotland. Working in Stobswell, a disadvantaged community in Dundee, the work aimed to test new ways of working, predominantly in public services and to tackle health inequalities.

BENEFITS AND CHALLENGES

The Portuguese Youth Guarantee identifies a wide range of partners who can best act with young people and respond to the diversity of situations and problems together. The benefits associated with this programme are networking establishment of stakeholders at local level which promotes cooperation, contacts, information and guidance, and motivates the young to participate in Youth Guarantee actions as well as to increase active participation in the necessary steps to undertake professional path and future integration in labour market. This will promote long-term mental wellbeing of the young people and at the same time will improve the economic and social country status. Youth unemployment is a structural problem, less effective for such a "hard to reach" group who may require an improved cooperation between social, employment, education and health sectors. Success depends quite strongly on multiple public policies and broader labour market situation in the country.

Strengths of the Dundee Equally Well Programme include the focus on reducing health inequalities, the holistic work manner with a determinants approach, the participation and utilisation of local people as assets, a balance of universal and targeted approaches, ongoing community engagement and dialogue with communities. The programme aims at social as well as health outcomes by breaking cycles of unhealthy living and poor mental wellbeing, and has resulted in integrated public service planning and improved partnership working.

RECOMMENDATIONS

- Social inclusion and mental health inequalities require action across multiple sectors and levels.

- The reduction of health inequalities will be achieved most effectively through the prioritisation of health equity in the MHiAP approach.

- Awareness, commitment and effective leadership are required for successful cross sector collaboration to drive through the necessary negotiations and actions.

- Social inequalities in mental health are best tackled by a life-course approach, recognising that mental health at each stage of life is influenced by both unique and common factors and recognises that mental health accumulates throughout life.

- It is particularly important that every child gets the best possible start in life.

- Actions to support mental health and reduce mental health inequalities should preferably be universal.

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f. Social welfare and mental health

Kim Japing, Pablo Garcia-Cubillana

Major individual socio-economic risk factors for mental disorders and suicide include poverty, poor education, unemployment, high debt, social isolation and major negative life events. People who experience unemployment, impoverishment and family disruptions have a significantly greater risk of mental disorders, such as depression and alcohol use disorders, and suicide, than their unaffected counterparts. Debt, financial difficulties and housing payment problems lead to mental health problems. The more debt people have, the more likely they are to have mental disorders overall (1).

On the other hand, mental wellbeing is best achieved in a healthy prenatal and childhood environment; by protection from social and economic stressors, violence and abuse, in just and non-violent societies through respectful, participatory means (2).

Economic pressure, through its influence on parental mental health, marital interaction and parenting, affects the mental health of children and adolescents (3).

Social welfare policies create a safety network which promotes mental health. Evidence indicate that social welfare measures, such as family support programmes, debt relief programmes, and active labour market programmes aimed at helping people retain jobs and quickly regain employment, are effective in preventing or mitigating adverse effects of economic hardship on mental health (1).

GOOD PRACTICES FOR MHIAP IN THE FIELD OF SOCIAL WELFARE

Good practices for mental health in social welfare measures include services such as child care, social care, health services, housing benefits, income support, and disability-related allowances.

Despite decreasing public budgets, all levels of government need to be empowered to work for people with mental disorders, but also to promote mental health and prevent disorders. Particularly at local level, social service departments of local authorities need to be equipped with resources to build up capacities for easily accessible and effective services, whilst being trained on the importance of mental health.

RECOMMENDATIONS

- Alleviate material deprivation and social exclusion – Welfare provides individuals with physical (e.g. food) and socio-emotional needs (e.g. participation in society), which contributes to stronger mental health. Better control of your assets also supports a better work-life balance.

- Tackle personal indebtedness – Indebtedness is associated with mental disorders (5). Welfare services can prevent people from becoming indebted by securing a certain standard of life, but also by providing support to address debt issues. Debt advice is also cost effective and results in net returns of €4 for each € spent (6).

- Address childhood risk factors such as abuse – Child adversity is responsible for more than 30% of adult mental disorder (7). The more severe and prolonged the abuse, the greater the risk of mental disorder. Early intervention and prevention of child abuse could prevent a large proportion of mental disorder although only a minority of children experience abuse. Support for violence experienced by adults is also important in this regard.

- Support families – Family strain may lead to increases in family violence and child neglect. There are indications in EU countries that family support programmes reduce suicide rates (8). Due to the knock-on effects of suicides on the mental health of family members, family welfare is of tremendous importance.

- Ensure long-term mental health and emotional resilience – For children, growing up in a safe environment helps them in developing long-term mental health and socio-emotional resilience. In various scenarios (e.g. parental unemployment, child's mental health problem), welfare assumes a stabilising function, be that either directly addressing a child's mental health needs, or through indirectly consolidating the child's living environment. By strengthening a child's socio-emotional resilience, later occurrence of mental health problems are prevented.

- Contribute to recovery – When welfare services are particularly addressed at mental health problems, as it happens with social care, they can contribute directly to the individual's recovery. People with mental health problems are more likely to have higher welfare-related needs than the general public, thus special support in guiding them through the administrative pathways of the welfare system is recommendable. An example from the UK is 'Welfare advice for people who use mental health services' (4), which delivers such guidance.

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g. Non-health sectors and suicide prevention

Niall Kearney, Nigel Henderson

Every suicide is a tragedy that has a far reaching impact on family, friends and the community long after a person has died. According to WHO, over 800,000 people die by suicide every year worldwide and many more attempt suicide (1). Most people who die by suicide in developed countries have a mental disorder (2). The following text draws on the Scottish experience of suicide prevention which has led to a 19% reduction in suicide since 2002 (3). The Scottish experience illustrates the value of having a national strategy that provides direction and leadership with local co-ordination and action embedded into local planning structures.

Good practice and research in suicide and its prevention indicate a number of key messages that can inform policy development in non-health sectors. Key messages are that suicide is preventable, that it is everyone's business and that collaborative working is key to successful suicide prevention. A broader focus of activities in non-health sectors and not directly related to suicide prevention can, if taken forward effectively, contribute to reducing the overall rate of suicide. Activities within this broader focus include building resilience and mental health and emotional wellbeing in schools, in workplaces and in the general population; work to reduce inequality, discrimination and stigma; the promotion of good early years services; and work to eradicate poverty (4).

BENEFITS AND CHALLENGES OF THE PRACTICES

Cost of Suicide: There are considerable economic benefits if the number of suicides can be reduced. There are significant direct and indirect costs associated with completed suicide that are spread across different sectors. An evaluative study from Scotland, for example, based on 2005 prices, estimated that each completed suicide costs at least £1.29 million (5). Direct costs include the intervention of the emergency services and health professionals, police and post mortem investigations; for those individuals who survive suicide attempts, there are potential costs related to physical and psychological rehabilitation. Indirect costs include the loss of opportunity to contribute productively to the national economy through work, taxation, family responsibilities and the cost of the impact of pain and grief on immediate family members, friends and work colleagues.

Cross-sectoral awareness raising: We know that talking about suicide in a responsible manner saves lives. As many people at risk of suicide never come in contact with health services, it is important that all policy sectors encourage people to talk openly about suicide. Acknowledging that people are at risk helps to reduce the stigma people feel when they are not coping and which stops them from seeking help earlier. Understanding better the different communication channels that will reach those most at risk enables key messages to be communicated to further dispel myths about suicide and encourage help-seeking behaviours. These approaches create a culture that not only leads to more people coming forward for help but also for all citizens to take responsibility for suicide prevention.

Research: Every aspect of suicide prevention needs to be informed by evidence or, if evidence is not available, at least to be underpinned by an evaluative framework that will yield knowledge on either what works or what does not work. Collaboration on suicide prevention among policy makers, researchers in suicide, national agencies and local delivery agents across a wide spectrum is beneficial in identifying the gaps in knowledge, supporting knowledge into action through the development of guidance and increasing understanding who is most at risk of suicide and what to do to intervene effectively to prevent it. Good examples of evidence gathering and collaborative working are found in the Scottish Suicide Information Database (6) and two publications from NHS Health Scotland: Suicide Prevention in Rural Areas Guide (7) and Guidance on Action to Reduce Suicides at Locations of Concern (8).

FEASIBILITY OF IMPLEMENTATION

Change: Fundamental to implementation is understanding how non-health sectors can contribute to making change or improvements. In Scotland, for example, it has been learnt that changes for the better can be made by developing a shared understanding of the goal that is to be achieved, using data to understand what is happening at national and local level, identifying early gains to create momentum and confidence, building in improvement support to share and develop learning and putting in place a clear performance and accountability framework. We are able to say when things are working well, but should also have the confidence to say when things must be improved (9).

Workforce Development: A national strategic approach to workforce development that targets staff from a range of agencies, such as Police, Accident & Emergency, non-governmental organisations who come into contact with people at risk of suicide, is crucial in ensuring that those who are the first point of contact have the necessary skills and attitudes to provide positive and supportive engagement for those who are contemplating suicide. There also needs to be general awareness raising and training for people in the workplace, such as HR staff, Trades Unions, managers, etc. so that staff know how to be supportive to people who communicate suicidal thoughts.

RECOMMENDATIONS FOR DIFFERING RESOURCE LEVELS (LOW, MEDIUM, HIGH RESOURCES)

Low resource: use data to inform and improve strategic responses to suicide prevention from a broad range of stakeholders including health.

Medium resource: develop and co-ordinate a national response to suicide prevention that includes stakeholders in health AND non-health sectors in order to provide a sustained focus on suicide prevention across a broader range of activities.

Medium to high resources: contribute to the evidence base of what works in suicide prevention by evaluating the impact of all cross-sectoral work in this area.

High resource: focus on the development of workforce personnel who are the first point of contact for people who are suicidal in order to equip staff with the necessary skills and attitudes to provide a compassionate response.

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h. Prevention of violence and abuse

Jonathan Campion, Kristian Wahlbeck

Large proportions of the population are victims of different types of violence although this is both predictable and preventable (1). Therefore, collaboration across sectors is required to provide effective interventions to prevent violence and abuse.

Violence and abuse increase the risk of mental disorder and childhood adversity accounts for 30% of all mental disorders (2). Therefore, interventions to address and prevent violence and abuse also prevent associated mental disorder. Since the impact of violence on the risk of mental disorder is greater for children earlier in life, both universal interventions during the early years and more targeted approaches for higher risk groups can prevent mental disorder and future violence.

Proven and promising violence prevention strategies address underlying causes such as low levels of education, harsh and inconsistent parenting, concentrated poverty, unemployment and social norms supportive of violence. Effective interventions to prevent interpersonal violence in families with children with conduct disorder include parent training programmes, which result in reduced aggression and violence in adults and children (10). Such interventions also reduce child maltreatment (3), child abuse (4), and result in safer homes and reduced unintentional injury (5). School-based interventions have been effective in e.g. reducing bullying and victimisation (6) or increasing sexual abuse prevention skills and knowledge (7,9).

Effective community level interventions to prevent perpetration of violence include prevention of access to lethal means and environmental interventions such as improved street lighting (8).

Violence is often alcohol-related, and policies to control of availability and density of sales outlets, such as community and school policies on alcohol, alcohol pricing, and training programmes for owners, servers and door staff are effective in reducing alcohol-related violence.

Providing high-quality care and support services to victims of violence is important for reducing trauma, helping victims heal and preventing repeat victimisation and perpetration.

GOOD PRACTICES

A growing number of scientific studies demonstrate that violence is preventable. Based on systematic reviews of the scientific evidence for prevention, WHO and its partners have identified seven strategies for prevention of violence and improving response to victims of crime (1):

1. developing safe, stable and nurturing relationships between children and their parents and caregivers;

2. developing life skills in children and adolescents;

3. reducing the availability and harmful use of alcohol;

4. reducing access to guns and knives;

5. promoting gender equality to prevent violence against women;

6. changing cultural and social norms that support violence;

7. victim identification, care and support programmes.

BENEFITS AND CHALLENGES OF THE PRACTICES

Benefits include reduction of violence, abuse and associated mental disorder. Challenges include the scale of violence across the population and getting agencies responsible for safeguarding to implement appropriate coverage of interventions supported by training.

RECOMMENDATIONS

- Ensure access to parenting support programmes
- Include safety skills in socio-emotional training for children in all educational settings
- Reduce availability of alcohol by collaboration across sectors
- Increase safety by environmental community level interventions
- Reduce access to guns by legislation and control measures
- Ensure universal access to victim support programmes

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i. Mental health in criminal justice and prison systems

Jonathan Campion, Niall Kearney

Crime has a broad range of costs and impacts across different sectors and therefore interventions to reduce crime also have a broad range of impacts and associated economic savings. A few mental disorders, such as childhood conduct disorder, are associated with subsequent crime and imprisonment and effective interventions to both treat and prevent such disorders can prevent associated crime. Inclusion of mental health in criminal justice policies and criminal justice in mental health policies facilitates more effective cross-sector coordination to facilitate reduction of crime associated with mental disorder. Offenders have high rates of mental disorder but low treatment rates which can be improved to reduce re-offending and other adverse outcomes. This chapter explores the advantages of attending to conduct disorder, the most common mental disorder during childhood and adolescence affecting 6% of 5-16 year olds in the UK (1), as an important example of how mental disorder impacts on the criminal justice and prison system. Conduct disorder in early life is strongly associated with later criminal activity, including violent crime (7). Overall, 30% of all criminal activity is by adults who during childhood and adolescence had conduct disorder and 50% by adults who during childhood and adolescence had sub-threshold conduct disorder (6). Furthermore, conduct disorder at age 7 to 9 is associated with 70 fold increased risk of imprisonment by age 25 (8). More than 50% of young people in youth detention centres have conduct disorder, which is about 10 times the rate in the general population (9).

GOOD PRACTICE

Evidence-based parenting programmes, such as Triple P and Incredible Years, are the first-line interventions recommended by the English National Institute for Health and Care Excellence (NICE) and offer a powerful way of addressing and responding to early-onset behavioural problems such as conduct disorder. They are relatively inexpensive and produce long-term benefits to the individual and society. The programmes take a positive and assets-based approach to strengthening parental competencies. The research shows that, after their parents had participated in one of these group-based parenting programmes, roughly two-thirds of the children with early onset disruptive behaviour were behaving at a level comparable to that of their peers (2).

NICE (3) recommends classroom-based emotional learning and problem-solving programmes for children aged typically between 3 and 7 years in schools where classroom populations have a high proportion of children identified to be at risk of developing oppositional defiant disorder or conduct disorder. Prevention of conduct disorder through school-based social emotional learning programmes results in savings of £84 saved for each pound spent (4).

Cost of conduct disorder

UK lifetime costs of a one year national cohort of children with conduct disorder (6% of child population) have been estimated at £5.2 billion (£150,000 per case) (5). Crime is responsible for 71% of the costs of conduct disorder with 13% due to mental illness in adulthood and 7% due to lost lifetime earnings (5). Furthermore, the annual costs of crime in England and Wales by adults who had conduct disorder and sub-threshold conduct disorder during childhood and adolescence is £60 billion (6).

Challenges

Despite the existence of effective interventions for conduct disorder (3), only a minority of parents of children with conduct disorder are receiving parenting interventions and a major challenge is the scale of required provision and training.

Benefits of prevention and early intervention

A range of effective interventions exist to treat conduct disorder which include increasing parental skills (3). Parenting interventions for parents of children with conduct disorder is the first line intervention recommended by NICE (3) and result in net returns of £7.89 for each £ invested (£1.08 to NHS, £1.78 to other public sector and £5.03 to non-public sector) and £7334 per family for group intervention and £6250 per family for individual intervention (4). Proportion of savings accruing to different sectors is 67.4% to criminal justice, lost output (13.7%), NHS (13.8%) and education (4.7%). Treatment of conduct disorder is also the most effective way to prevent antisocial personality disorder which is very common in prisoners (10). However, parenting interventions are very poorly implemented in the UK. Benefits include reduction of a range of outcomes associated with conduct disorder including crime and violence as well as associated economic savings.

FEASIBILITY OF IMPLEMENTATION

Implementation of training for parents of children with conduct disorder requires: information about numbers affected, training and provision of required number of staff and resources and monitoring of outcomes. Estimation of the economic impact of such intervention to the criminal justice sector can facilitate a collaborative approach including offers of funding.

A working model for implementation is the partnership between NHS and Glasgow City Council which is in the process of making Triple P available to all parents in the city of Glasgow (11). This work is supported by high level commitments in the Scottish Government's Mental Health Strategy and Parenting Strategy (12).

RECOMMENDATIONS

Possible at all resource levels although requires leadership and coordination.

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j. Cultural activities, the arts and mental health

Johannes Parkkonen, Kristian Wahlbeck

Various forms of culture make an important contribution to social connectedness of a community due to their ability to symbolise and express diverse experiences within a single form. This can facilitate a dialogue between people from different backgrounds and create a sense of identity for whole communities (1). This dimension of strengthening the bond between community members is also a significant factor in generating social capital (2), which constitutes one of the key social determinants of mental health.

There is an emerging evidence base on the physical and mental health benefits of participating in cultural activities, for example choir singing (3, 4). As a lot of art and cultural activities also take place in public spaces, they provide an excellent way for cross-sectoral work in promoting mental health and wellbeing. Due to their dialectic nature art and culture can also play a powerful role in challenging preconceived ideas, prejudicial attitudes and discriminatory behaviour, for example towards people who have experienced mental disorders.

GOOD PRACTICES FOR MHIAP IN THIS AREA

Encouraging diverse participation is important in order to create connections between public, culture and community organisations. To achieve this, it is often useful to start small and have everyone a chance to develop the direction of activities. For example, the Scottish Mental Health Arts and Film Festival (5) began as a partnership between a couple of local authorities and health boards, some artists, and a few mental health organisations. It has since grown to a three-week festival with around 300 events taking place across almost all of Scotland's 32 local authorities. The festival has been found to have a positive impact on the relationship between arts and mental health and it can be seen having strong potential in challenging the stigma towards people with experience of mental disorder (6).

BENEFITS AND CHALLENGES OF THE PRACTICES

As there still are many misconceptions about mental health and the term is often perceived as meaning mental disorders, cultural activities and the arts can play an important role in creating new shared meanings for mental health. In this way they help bringing public health promotion messages closer to people in their own language, thus increasing mental health literacy.

One of the challenges is that attending cultural activities or engaging in the arts is often perceived as meaning "high culture" or fine arts. However, from the mental wellbeing promoting aspect the key is to involve people in doing something together and deepen the sense of belonging, thus creating stronger community bonds and strengthening social capital of the community members. Therefore it is important that the perception of cultural activities is broadened to include smaller-scale local activities that are often developed and implemented by volunteers.

FEASIBILITY OF IMPLEMENTATION

There are various ways to implement the engagement in cultural and arts activities for mental health promotion. As many of the activities require people's physical presence and the strongest benefits are generated from social contact between people, it is often most beneficial to implement these activities at the local level. Local cross-sectoral partnerships can include, for example, joint projects with schools, mental health organisations and artists. Local employers in all sectors could also use attending cultural activities and arts events as part of their staff wellbeing programmes. Local libraries can be used as a setting for exhibitions, which, in addition to providing access to other settings or venues for activities, is also a cost effective way for local authorities to facilitate mental health promotion and dialogue.

RECOMMENDATION FOR DIFFERING RESOURCE LEVELS (LOW, MEDIUM, HIGH RESOURCES)

The scale and reach of the activities can be adjusted to the level of available resources, but the recommended principles span across all resource levels:

- Ensure wide participation in the planning and development of the activities.

- Focus on creating shared meanings through dialogue.

- Be inclusive in the interpretation of what constitutes cultural activity and the arts. Do not limit yourself to commercial events by professionals.

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k. Community and citizen involvement in MHiAP

Johannes Parkkonen, Kristian Wahlbeck

Engaging with the targeted community is an essential part of any policy process. The WHO definition of mental health includes a statement of being able to make a contribution to his or her community, underlining the links between community engagement and the mental health of the members of the community in question.

Research indicates that community involvement, associative participation and possibility to engage in community decisions is conducive for positive mental health at all ages, including children (1). Community engagement plays a key role in promoting its members' health. In 1986 the Ottawa Charter for Health Promotion (2) highlighted the principles of empowerment, participation and collaboration in health promotion. More recently the ethos of community-based approaches that change within a community is best achieved through engaging people of the community has been included in the process of analysing the social determinants of mental health (3).

Community members are key stakeholders in policies that impact on them, and often the most practical way to hear people throughout the policy process is through engaging with NGOs that are active in the community.

GOOD PRACTICES FOR MHIAP IN THIS AREA

One aspect of community participation is involving and hearing people with lived experience of mental health problems. For example the Pathways to Policy programme in Romania brings together (ex)users of mental health services and NGOs that represent them to work with other stakeholders (including local government, business and the media). They work within the Local Policy Forum (LPF) and the National Policy Forum (NPF) in order to initiate mental health policies at local and national levels, to influence attitudes and behaviour towards people with mental health problems in the media, and to influence the national policy debate through local and national forums with user-involvement. The members of the LPF and NPF come from different backgrounds, some being users of mental health services or acting within the forums from the very beginning.

The Dundee Equally Well project aimed to test new ways of working, predominantly in public services, to tackle health inequalities and improve community mental wellbeing. Following Equally Well, a report of the Ministerial Task Force on Health Inequalities in Scotland, this was one of several pilot projects and was implemented in Stobswell, a disadvantaged community in Dundee, Scotland. The Equally Well Core Group consisted of representatives of the local authority, health service, local NGO and local planning partnership. The project worked in a holistic manner with a determinants approach. Local people were seen as assets with whom the Core Group could engage and have dialogue on an ongoing basis. Central to this was to use a co-production, community and service development approach rather than specific solutions to act as a catalyst for change. Cross-sectoral approach that involved integrated public service planning and improved partnership working was evident in the social as well as health outcomes, for example breaking cycles of unhealthy living and poor mental wellbeing and supporting a range of small but significant changes at neighbourhood level.

BENEFITS AND CHALLENGES OF THE PRACTICES

Involving the communities in policy making process, monitoring and evaluation of policies is valuable as it promotes democracy and transparency and increases accountability. Community members can be seen as experts in identifying potential problems in different spheres of their daily lives and therefore they are uniquely placed to contribute to policy proposals in responding these. Social capital can also be built through collective action.

The socio-environmental nature of the determinants of mental health requires collaboration of community groups in addition to other sectors (4) to develop knowledge for action through gathering information about social, economic, and environmental stressors. This collaboration will help develop a multilevel framework for understanding social determinants, in which various important areas concern communities: for example neighbourhood trust and safety, community based participation, violence/crime, attributes of the natural and built environment, neighbourhood deprivation (5).

When engaging with communities in policy making process it is important to avoid short-termism where quick outside solutions are sought for different community challenges, rather than developing longer-term resilience that grows from within the community through strengthening of social capital. A good way to achieve this is by avoiding tokenism where community views are sought for policies that have already been decided, and instead engage with the community from the early stages of policy making process.

Another potential challenge when involving the community is to ensure that it is not only the loudest members who get heard. Due to the social determinants of mental health people who face many disadvantages and therefore higher risk of developing mental disorders may find it more challenging to articulate their views to policy makers. However, if they are not involved in the policy making process there is a risk of the policy increasing or reinforcing inequalities.

FEASIBILITY OF IMPLEMENTATION

Technological development increases the potential to engage with communities more directly, for example in terms of electronic democracy. As technology becomes more affordable and access more widespread, this has the potential to decrease inequities in the involvement in policy making processes. Another important factor is the level of cultural tradition of civil society engagement and the strength of civic society institutions. In settings where this tradition is long and the institutions are strong the engagement process is obviously more straightforward for the policy makers.

RECOMMENDATION FOR DIFFERING RESOURCE LEVELS (LOW, MEDIUM, HIGH RESOURCES)

- Low: Develop a culture of community engagement by bringing in key community groups to discuss policies that impact on them at an early stage of the policy development process.

- Medium: Set up advisory panels/partnerships of community groups to act as a conduit for community engagement. It is also important to ensure that these groups have an adequate funding. Explore the possibilities of direct citizen involvement through electronic democracy, implement pilot projects for this.

- High: Integrate the partnerships with community groups into formal policy development processes. Develop a structure and implementation process for widespread electronic democracy to ensure diverse citizen representation.

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I. NGO engagement

Nigel Henderson

GOOD PRACTICES FOR MHIAP IN THE AREA OF NGO ENGAGEMENT

NGO fields of work - NGOs are important in the field of mental health. They take different roles on the basis of their objectives and their field of work. NGOs will either have an explicitly articulated objective to support mental health and wellbeing (e.g. Penumbra) or this may be implicit in their work across different sectors. Some NGOs pursue a mental health policy agenda (e.g. Mental Health Europe), others frame mental health into their wider social policy or public health portfolio. Overall, NGO engagement, stimulated by the growing relevance of the third sector, is a form of stakeholder involvement responding to functional and participatory needs.

Contributions of NGOs - In terms of services, NGOs are either active in directly delivering mental health support and activities (e.g. an organisation providing supported living services for people with mental health problems) or they may be active in a field not traditionally associated with mental health, which nevertheless has considerable impact on people's mental health (e.g. a charitable organisation offering support for homeless people). In terms of policy work, NGOs play an important part in shaping policy through networks and advocacy. They contribute to legislative, policy, and practice development in mental health and articulate the links with other policy areas like education, housing, or employment, hence adding value to all levels of policy-making (local, regional, national and European).

BENEFITS AND CHALLENGES OF NGO ENGAGEMENT

NGOs have a clear values base, are often small in scale, embedded in communities, have a flexible but accountable governance structure, and cooperate closely with public authorities at the local, regional and national level.

Innovation & flexibility - Involving mental health NGOs in practice and policy developments beyond the mental health field can offer added value in terms of offering experience from the ground on how mental health issues impact on employment, housing, education, and communities etc. In many countries, we find innovative, person-centred and cost-effective services pioneered by NGOs which over time become mainstreamed.

Local community understanding - Particularly at the local level, in-depth knowledge of the community context enables NGOs to react in a more targeted way towards the existing and emerging needs of different community groups. In cooperation with public authorities, this contributes to a better design and delivery of person-centred mental health services, as well as wider community services that impact on mental wellbeing.

Awareness-raising – NGOs, as intermediary networks between society and public bodies, are crucial in raising awareness on mental health-related issues. This awareness is fundamental to developing policies and services that promote better mental health and to prevent mental illness.

FEASIBILITY OF IMPLEMENTATION

Different actors – public, private, and NGOs – interact in specific ways in each national context. As NGOs in many national contexts form part of the public sphere, it is easy to engage them. In countries with a common practice to engage NGOs in policy and practice development, this adds value through integrating the perspective of people with lived experiences.

RECOMMENDATION FOR DIFFERING RESOURCE LEVELS (LOW, MEDIUM, HIGH RESOURCES)

As understanding of the economic burden of mental health problems increases, so does the need for a cross-sectoral approach to mental health improvement where NGOs become valuable partners in the promotion of mental health and wellbeing, the prevention of mental illness, and in the design, planning, and delivery of mental health services. For these fields, suitable policies need to be formulated and implemented, processes for which NGO engagement is essential. In lower resource countries this might mean finding ways to develop alliances of local NGOs to work on policy formulation. In higher resource countries, umbrella organisations for NGOs exist, which contribute to policy formulation and implementation, and they should be consistently involved. Irrespective of the resource level, NGO engagement is considered a crucial element for the integration of mental health in the formulation and implementation of all policies.

m. Measuring and monitoring MHiAP

Dóra Guðrún Guðmundsdóttir, Maria João Heitor Santos

- What you measure affects what you do (1)

- GDP measures everything in short except that what makes life worth living (2)

- Systematic use of Health Impact Assessment (HIA) to promote intersectoral healthy policies and equity may be an effective and efficient way of planning MHiAP

- For measuring and monitoring, more specific tools and evaluation methodologies should be used depending on the policies, sectors and programmes involved.

HIA is a "combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. HIA identifies actions to manage those effects" (3). It is recommended to include wellbeing, especially mental wellbeing, in the assessment with Mental Wellbeing Impact Assessment MWIA (4).

It is a methodology whose first aim is to support the decision-making by anticipating impacts of decisions and how they "induce (un)intended changes in health determinants and health outcomes through a systematic process in which health hazards, risks and opportunities are associated with a development policy or project" (5).

Evidence suggests that HIA is adequate both to support policy planning and to assess their impacts, and to effectively support the decision-making process (needs identification, resources allocation, implementation and monitoring processes), especially as to the consequences of the decisions tackled, and also to address population health and health inequities as it tackles social and economic determinants of health.

HIA, as a process, considers the distribution of the expected and verified impacts and their uneven distribution over the population (6). This understanding was reinforced at the Rio Political Declaration on Social Determinants of Health (7).

For some authors, the HIA method is crucial to involve different stakeholders in the decision-making process at national, regional and local levels, and to encourage effective cooperation between different sectors. Thus it appears as a privileged instrument of the strategic approach of "Health in All Policies" (HiAP).

In Europe, both the European Commission (EC) and the World Health Organization (WHO) recognise the urgent need of implementing the HIA methodology, either as a result of a mandate, or as a tool for getting more and better health and wellbeing for all, as expected from the Lisbon Treaty and the WHO recommendations.

The EC has developed an effort to enhance and disseminate the practice of HIA among the Member States. The EC provides online guides and methodological standards to support HIA at different levels, for health systems and EU policies (8).

Also WHO recommends the implementation of HIA as a fundamental instrument to increase better governance for health and to act on health determinants (9). In this sense, one of the main axes of the new health strategy for the European Region is the identification of good practices in HIA and the drafting of a roadmap by 2020, allowing different States to enhance health gains.

SEVERAL AIMS CAN BE ACHIEVED THROUGH HIA

1. Improved health and wellbeing – HWIA improves the quality of decisions (policies, strategies, programmes) by evaluating the impacts proposed. It allows the maximisation of positive health impacts and the identification and minimisation of the negative ones.

2. Improved care – a) HIA will reunite and foster the articulation of stakeholders from different sectors understanding the health impact of their activity and policies, and empower other sectors to value their activity in terms of health, and not only economic value; b) HIA produces useful information and evidence to support the decision-making process regarding the structure and organisation of health. It also allows to align the care provided to the identified health needs and the characteristics of the population served.

3. Better value for money and reduced waste – HIA procedures can contribute to the implementation of strategies and measures for efficiency improvement (10).

4. Introduction of legislation that establishes as mandatory certain health decisions to be adjusted through HIA methodologies.

5. Capacity building (need for training and research support, consulting and audit), dissemination of best practices and benchmarks guidance. Establishing a monitoring policy with explicit focus on issues of HIA and HiAP. The fields of action should be previously and clearly identified, considering the need to effectively use HIA to improve regulations and strategies adopted not only at a macro, more strategic level but also at regional and local levels involving municipalities.

LINKING PUBLIC MENTAL WELLBEING MEASURES WITH PUBLIC POLICY OUTCOMES

- Inclusion of public mental wellbeing measures in national or regional surveys on Health and Wellbeing may have an impact on intersectoral policies and on the whole society. A single item measure on happiness together with the short version of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) were seen as adequate tools when it was performed in Iceland. Since the data already exist, mental wellbeing measures have been used as an indicator in the Health 2020 policy for Iceland as well as in a broader governmental policy for the economy and community, named Iceland 20/20 (11), led by the Prime Minister. The responsible agencies were the Directorate of Health in Iceland, Prime Minister´s Office, and the Ministry of Welfare and it started in 2007.

- By monitoring mental wellbeing on a national level regularly it is possible to estimate the impact of policies on mental wellbeing.

- Mental wellbeing data on a national level gives the opportunity to study the determinants of mental wellbeing and improve the promotion of mental wellbeing of the population.

- Mental wellbeing gets more attention when the public health authorities start to present results on mental wellbeing on a national level.

- However, the field of mental wellbeing epidemiology is new. Lack of reliable measurements on mental wellbeing in many languages and common agreement on how to measure mental wellbeing is an obstacle for the implementation of MHiAP.

To get mental wellbeing on the policy agenda, the voters must demand for it to be taken into account. By starting measuring mental wellbeing on a population level regularly and report the results to the public, the public becomes more aware of the status of mental wellbeing and mental wellbeing gets more focus. With regular measures on mental wellbeing it becomes possible to include mental wellbeing as an outcome in public policies. Additionally by adding mental wellbeing indicators into health impact assessment, it becomes possible to estimate the impact of public policies on mental wellbeing.

FEASIBILITY OF IMPLEMENTATION OF MEASURING AND MONITORING MHIAP

Available mental wellbeing data on a national level gives the opportunity to monitor mental wellbeing on a national level, study the determinants of mental wellbeing and improve the promotion of mental wellbeing of the population and evaluate the impact of public policies from different non-health and health sectors on mental wellbeing with MWIA.

RECOMMENDATION FOR DIFFERING RESOURCE LEVELS (LOW, MEDIUM, HIGH RESOURCES)

Low:

- Start with the capacity building on Health Impact Assessment (HIA) with a particular focus on mental health and wellbeing including MWIA

- Using available measures on mental wellbeing

- Health and Behaviour of School Children (HBSC) – data available for 40 European countries: *www.hbsc.org/*

- European Social Survey (ESS) from 15 years of ages - data available for 29 European Countries: *www.europeansocialsurvey.org/*

Medium:

- Develop HIA and MWIA on a regular basis with a particular focus on mental health and wellbeing

- Adding public mental wellbeing measures into surveys that are already sent out to measure health and wellbeing of the population

- Creating special surveys online as a first step (less expensive than postal surveys or interview surveys)

High:

- Include mental wellbeing indicators in HIA and include MWIA

- Develop Health Equity Impact Assessment with a particular focus on mental health and wellbeing

- Monitor public mental wellbeing regularly with reliable measures on mental wellbeing like WEMWBS and report both to the public and policy makers

- Improve the measurements on public mental wellbeing

- Study the determinants of mental wellbeing

Abbreviations

HIA = Health impact assessment

HiAP = Health in All Policies

MHiAP = Mental Health in All Policies

MWIA = Mental Wellbeing Impact Assessment

HWIA = Health and Wellbeing Impact Assessment

HWiAP = Health and Wellbeing in All Policies

Further reading:

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0. Translating MHiAP into practice

Jurgita Sajevičienė, Wendy Halliday, Johannes Parkkonen

RAISING AWARENESS OF MHIAP

Awareness raising is a process which opens opportunities for information exchange in order to improve mutual understanding, and to develop competencies and skills necessary to enable changes in social attitudes and behaviour. Awareness raising is understood to be a constructive and potentially catalytic force that ultimately leads to a positive change in actions and behaviours.

This Joint Action Work Package has collected and analysed a lot of good examples of MHiAP that can bring significant benefits to the Member States and the regions and local areas within them if implemented. Therefore, it is very important to share and communicate the information from this Work Package's work and raise understanding of the MHiAP approach.

One possible way to approach raising awareness of MHiAP in the Member States is by approaching the process as campaigning. This is seen as a broadly organised effort to change practices, policies and behaviours. It is based on the ability of stakeholders to communicate the same message to a variety of audiences using a range of approaches. Campaigning should involve four key actions:

- researching the issue;
- mobilising support and supporters;
- informing the public;
- lobbying decision-makers.

The first of these steps has been covered by this report. The work on the remaining three begins with the publication of this report.

IMPLEMENTATION OF MHIAP

There are seven main steps that should be taken in order to make changes.

- KNOWLEDGE – map out the situation in order to know if there is a problem (e.g. is there sufficient involvement of mental health in all policies?)
- DESIRE – imagining a different future (ensure your audience is aware of the benefits to her/his sector/ work of MHiAP)
- SKILLS – knowing what to do to achieve that future (ensure the key people have sufficient understanding of MHiAP)
- OPTIMISM – confidence and belief in success (here the examples of good practices are very important)
- FACILITATION – resources and support infrastructure (health sector has a key role in this)
- STIMULATION – a compelling stimulus that promotes action (e.g. achieving economic benefits or social cohesion through MHiAP)
- REINFORCEMENT – regular communications that reinforce the original message or messages (MHiAP as an iterative process that builds on previous learning)

Still it is very important to realise that raising awareness of and implementing Mental Health in All Policies is not the same as telling the public, authorities and stakeholders what to do. MHiAP promoters should disseminate knowledge, explain the issues and articulate the benefits to all the important audiences (public, policy makers, stakeholders, authorities) in order that they can make their own decisions.

BUDGETING FOR MHIAP

It is important to explore the budgetary issues with stakeholders from the beginning. This begins with making a clear case of the economic benefits of MHiAP to policy makers in different sectors. MHiAP should not be seen as an additional service to other sectors that is paid and provided for them by the health sector. In principle, mental health in all policies should also mean mental health in all budgets. However, through effective cross-sectoral work population mental health can be promoted and mental disorders prevented, leading to savings that are also shared across all budgets.

7. CONCLUSIONS

This report highlights the links between different policy areas and mental health, showing that if policy areas take account of mental health, this will have a large impact in their own area. Therefore, an approach which examines the impact of any policy on mental health can result in significant cross-sector impacts and associated economic savings.

Today, we have a solid evidence base for the effectiveness and cost-effectiveness of cross-sectoral mental health actions that result in promotion of mental health and wellbeing as well as prevention of mental disorder. Promoting early child development in families, child day care and schools is crucial for population mental health and wellbeing. Provision of time in the form of parental leave, positive nurturing conditions, high quality day care and parenting support are all cornerstones of mental health promotion. Equally, good working conditions promote mental health and wellbeing while at the same time contributing to social capital. Access to participatory cultural and social activities as well as outdoor recreation and green spaces also promote mental health and wellbeing, as well as safety, respect for human rights and community involvement. Mental disorder can be prevented by fighting childhood adversities and abuse, by addressing school and workplace bullying, by providing parental support in families with mental disorder, and by supporting unemployed people. Taken together, the evidence base for population-level mental health interventions in non-health sectors is convincing, and the time is now ripe to move from knowledge to action.

The public health article (Article 168) of the Lisbon Treaty (1) provides the EU with a mandate to improve public health, prevent diseases and protect human health. Thus, the Treaty provides a clear mandate for "health in all policies" actions at EU level, i.e. actions in other public activities that influence mental health either directly or indirectly. In principle, the EU mandate does not cover health services or medical care, which fall fully under the responsibility of the Member States. The EC competence in health care is limited to specific issues such as patients' rights in cross-border health care.

Regardless of the current restrictions in the health care mandate, the impact of EC policy actions on mental health should not be underestimated. Acknowledging the psycho-social determinants of mental health opens the door for horizontal actions to improve population mental health. EC actions in many non-health fields have a decisive impact on the mental health of EU citizens. The social policy agenda instruments, such as the Open Method of Coordination, the European social dialogue, and the European Social Fund and other financial instruments managed directly by the Commission can foster decisive progress in mental health. Education policies can contribute to the promotion of mental wellbeing and prevention of mental disorder by ensuring equal access to good quality child day care and education and to social and emotional learning. Freedom, justice, and security policies can contribute to mental health by supporting empowerment and social cohesion and by restricting access to lethal suicide means, such as guns and toxic substances. Decisions in EC Directorates-General, enlargement processes and structural funds need to be assessed for mental health impact.

Mental health and wellbeing is fundamental in achieving the strategic objectives of the EU. The Europe 2020 growth strategy outlines the steps to a smart, sustainable and inclusive Europe. Putting mental health in EU policies contributes with important building bricks to the Europe 2020 strategy.

Promotion of mental health and wellbeing is an indispensable part of the public health agenda, as mental health is of significant importance in reaching the strategic objectives of the EU. The societal impact of mental health is conveyed through its close links to educational achievements and productivity. In a digital society, people work increasingly with their heads instead of their hands and educational requirements are high. This makes mental health a crucial component of economic growth. A smart Europe needs a high level of mental capital. Good mental health makes people work longer, contributing to the support of an ageing EU population.

To increase the relevance of mental health in non-health sectors requires a shift in focus from mental disorders to a focus on the mental health and wellbeing of the whole population. A recent pan-European expert consensus statement on research needs in public mental health stressed that positive mental health and protective factors should be prioritised when planning future research actions and strategies (2).

Mental Health in All Policies (MHiAP) is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful impacts on mental health in order to improve health and equity. Communities, civil society, and academia form a significant resource for developing, implementing and monitoring MHiAP. The private sector can offer valuable partnerships in bringing forward this approach.

Many important determinants of mental health are structural, such as poverty, gender inequality, and discrimination arising from stigma and prejudice, which can lead to social exclusion or being shut out from employment. Thus, the MHiAP approach should also champion policy interventions addressing structural determinants that operate within and increasingly across all countries. These interventions will produce downstream beneficial effects on people's mental health.

The concluding recommendations stress that mental health needs to be incorporated in all policies at all administrative levels, i.e. international, national, regional and local. This can be achieved by demonstrating existing win-win situations, and by using language that is understandable to policy makers in all sectors. Action needs to be taken on the determinants of mental health. This requires strengthening of MHiAP capacity, structures, processes and resources. The basis is built by improving mental health literacy in the public sector and among the general public, and by supporting the implementation of MHiAP by, for example, tools for mental health impact assessment. Inclusion of communities, social movements and civil society in the development, implementation and monitoring of MHiAP provides accountability and sustainability of policy actions, and supports transparent monitoring and audit of policy outcomes. Finally, investment in evidence and the knowledge base of MHiAP is needed to bridge the gap between health, social and economic knowledge, and policy implementation.

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Recommendations for Mental Health in All Policies

1. Incorporation of mental health in all policies

Mental health needs to be incorporated in different policy sectors at European, national, regional and local administrative levels. To achieve this, it is important to foster actions for mental health by non-health policy by demonstrating existing win-win situations, i.e. the broad impact, benefits and economic savings of such actions even in the short term.

Implementation of this recommendation could for example mean that mental health is prominently included in overall health impact assessments, as well as improved provision of sector-relevant information on impact of mental health.

2. Taking action on social determinants of mental health

Many causes of mental disorders and poor mental wellbeing lie within the social, economic and political spheres of people's daily lives. Addressing such social determinants requires a shift of emphasis towards promotion of mental health and wellbeing and prevention of common mental disorders.

For example, this could mean parenting support, protection against all forms of abuse, integration of mental health literacy in the school curricula, mental health promotion in schools and at work places, ensuring access to affordable public transportation and cultural activities, as well as promoting physically active lifestyles.

3. Strengthening capacity, and ensuring effective structures, processes and resources for mental health in all policies

Implementation of the Mental Health in All Policies approach requires the right governance structures as well as institutional capacity and skills.

For example, this could mean the integration of mental health issues in health interest groups in parliaments, intersectoral committees at cabinet level, or interdepartmental units and committees. Tools may include joint budgeting or the use of impact investment mechanisms and training for both civil servants and decision makers on amendable determinants of mental health.

4. Building mental health literacy and understanding of mental health impacts

The basis for the Mental Health in All Policies approach needs to be laid down among organisations, decision makers, and the population as a whole by building mental health literacy and better understanding of the roots of mental health. This will highlight the importance and opportunities of a Mental Health in All Policies approach.

In relation to the promotion of mental wellbeing, and prevention of mental disorder, this could mean routine assessment of the size, impact, and cost of the unmet need across different sectors, as well as effective interventions to address these gaps. This also facilitates a more collaborative approach between sectors particularly with the inclusion of economic savings associated with the improved coverage of such interventions.

5. Access to tools for implementation

Tools and structures for implementing the Mental Health in All Policies approach needs to be made available.

> *For example, this could mean providing tools for making mental health impact assessments of public policies at different levels of governance, as well as tools for the involvement of citizens in impact assessment processes and audits.*

6. Inclusion of communities, social movements and civil society

Better involvement of the public in developing, implementing and monitoring Mental Health in All Policies is needed in order to trigger governance actions and increase transparency.

> *For example, this could mean setting up multi-stakeholder local and/or national policy forums to initiate and develop mental health policies, and how to ensure appropriate implementation and coverage of mental health promotion initiatives both locally and nationally.*

7. Adoption of transparent audit and accountability mechanisms for mental health and equity

Increased transparency and clarity is needed to build trust between government sectors, and to raise public support for policy actions that promote mental health. This also means increasing visibility of the links between policy decisions and public mental health. Even policy actions with proven beneficial mental health effects, like restrictions in access to alcohol, may lack in public support due to a lack of understanding of the mechanisms and consequences, i.e. the effect of public policies on mental health systems, determinants of mental health and wellbeing.

> *Increased transparency can be achieved by public monitoring or audit of the mental health and equity effects of a policy action designed to increase awareness of the necessity of less popular policy actions, e.g. to justify restrictions in alcohol availability.*

8. Investment in evidence and knowledge base

There is a need for research data on effective methods in Mental Health in All Policies, using interdisciplinary perspectives to better understand the complexity of the approach. The vast theory base of public mental health actions needs to be strengthened, especially in the fields of policy and implementation research.

> *For example, this could mean encouraging multi-disciplinary implementation studies that bridge the gap between health, social and economic knowledge.*

APPENDICES

Country reports

AUSTRIA

Strengths and opportunities of MHiAP

Several activities of collaboration of different stakeholders from outside the health sector have recently started in Austria, which take into account the mental health in all policy approach. The most relevant development is the inclusion of mental health in the recently approved Austrian federal "Health Targets for Austria" ("Rahmengesundheitsziele", *www.gesundheitsziele-oesterreich.at/health-targets-for-austria*) of 2012, which is explicitly based on the Health in All Policies approach.

Weaknesses and threats of MHiAP

As an administratively highly decentralised federal country, initiatives of including mental health in all policies are taking place in Austria unevenly across the country and at many different levels for different societal sectors, with different levels of enforcement and implementation possibilities.

Short summary of the MHiAP position

In general, awareness of mental health and wellbeing issues has been constantly rising over the last decades in many societal sectors. A sign of this development is the explicit inclusion of mental health in the "Health Targets for Austria", which were developed in a remarkable process of collaboration between all relevant societal stakeholders, taking also into consideration the legal implementation issues in a country with a highly fragmented administrative structure.

DENMARK

Strengths and opportunities of MHiAP

In recent years promotion of mental health has been a prioritised focus area in Denmark. Promotion of mental health is now a distinct focus area in national and local health policies and the majority of municipalities are implementing mental health initiatives in both the health sector and non-health sectors.

The positive development of mental health initiatives is due to increased documentation about the concept of mental health, the preventive impact mental health has on mental disorders and physical illnesses and economic impacts of promoting mental health. Hence there is an understanding of the importance of mental health promotion and an interest for the potential of MHiAP. In recent years both the public sector and NGOs are increasing cross-sectional co-operations, especially between health and social sectors. Knowledge and experiences on how mental health successfully can be integrated into non-health policies and the impact of initiatives has great potential in a Danish context.

Weaknesses and threats of MHiAP

Challenges of MHiAP do not necessarily concern a lack of knowledge about the potential of working with MHiAP. Instead more knowledge about the impact assessments and how to implement MHiAP is a necessity. Further there are conceptual difficulties of both mental health and MHiAP. The concept of mental health can be more complicated to grasp than other protective factors for health and wellbeing.

When specifying that good childcare, wellbeing in schools, job satisfaction and prevention of stress at work places and prevention of loneliness and promotion of wellbeing at elderly citizens are part of it, the concept of mental health becomes more understandable for professionals. Professionals in the public sector and in NGOs are gradually becoming more acquainted with the concept of mental health and MHiAP, for example through the Danish Health and Medicines Authority's health promotion package on mental health and different mental health projects.

Short summary of the MHiAP position

Experiences gained from the Danish contribution to the report are relevant though there was limited response to the survey. It is necessary that knowledge about the concept of mental health and MHiAP is disseminated to non-health sectors. Making MHiAP an integrated part of non-health policies require knowledge on how working with mental health will support own requirements and main priorities of the non-health sector. The endeavour is that promotion of mental health becomes an integrated part of reflections when making non-health policies.

ENGLAND

Strengths and opportunities of MHiAP

The current mental health strategy (HM Government, 2011) is a cross government strategy and includes an LSE document highlighting the economic impact of public mental health interventions, which shows excellent economic returns across different government sectors even in the short term. This can provide an important catalyst for promoting and raising awareness of MHiAP. Local mental health needs assessments can also outline the size, impact and cost of the public mental health intervention gap and how interventions to address these areas result in benefits/economic savings to different policy areas. However, such assessments are usually not carried out.

Weaknesses and threats of MHiAP

Since only a small number of people engaged in the MHiAP survey, this might suggest that most people did not see MHiAP as particularly relevant to their work in England. It may also suggest a lack of conceptual clarity of MHiAP in general with examples often not specific about mental health in all policy but instead focusing on particular mental health interventions. A further weakness to MHiAP is that mental health is poorly covered in annual needs assessments.

Short summary of the MHiAP position

There was a poor response rate to the survey so any conclusions are limited. However, clear knowledge about, and systematic implementation of, Mental Health in All Policy was not apparent from respondents to the survey in England. The level and quality of cross-sectional collaboration between sectors when taking mental health aspects into the decision making appeared poor. To achieve this, clarity in language is important as using mental health and mental wellbeing sometimes interchangeably can be confusing. In order to promote commitment to MHiAP, it is important to include both mental disorder and mental wellbeing since these are inter-related, have wide ranging impacts and are poorly addressed. In order to generate political commitment for MHiAP it is important to highlight that current mental health strategy is a cross-sector strategy signed up to by all government departments, which also includes the economic savings to different sectors arising from implementation of public mental health interventions. To ensure the implementation of MHiAP there is a need to have different types of support for national and local level policy makers and commissioners, which will help to implement existing good practices and to facilitate MHiAP. In particular, annual local mental health needs assessments are required to show the impact and cost to different policy areas of not implementing public mental health interventions.

FINLAND

Strengths and opportunities of MHiAP

All interviewed experts reported that promoting mental health in itself is meaningful. Especially representatives of municipalities acknowledged the need to promote health and wellbeing of citizens. It was recognised that there is a constant need for regular cooperation between health and non-health sectors in these matters. However, some experts also reported that mental health is the business of the health sector only. Cross-sectional cooperation has been a key objective in most policy level practices. The public sector and NGOs have created partnerships for the promotion of mental health. There has been good experiences with ex-ante impact assessments. Evidence of cost impact motivates the decision-makers to take mental health issues into account. These assessments have been expanding lately across Finland. In recent years public policies have increasingly acknowledged the need and actions for promotion of mental health among children and young people.

Weaknesses and threats of MHiAP

Sometimes the concept of mental health is understood in a narrow rather than a broad sense as including the promotion of mental health. Cross-sectorial development work is often done on a project basis. The sustainability of good collaborative practices is unclear, because it is unclear how the results of the projects will live on afterwards and how the practices will become part of the structures. Evaluations of achievements and results of projects have been made too scarcely. The terminology used also differs between mental health and other sectors. Representatives of other sectors may use words such as "wellbeing" or "safety" when meaning mental health. The different concepts pose a challenge to find mutual understanding between sectors.

Short summary of the MHiAP position

Many experts from different sectors expressed the importance of integration of mental health aspects into wellbeing. In their opinion the role of mental health should be increased but it should be understood as a part of wellbeing. That way it is seen as more efficient than as a separate theme. Some of the experts recognised the importance of mental health as an independent subject but only

in bringing the matter up. Later it should be integrated with other themes of wellbeing (such as physical health, equity etc). Most of the reported policy level practices have started in the last few years. The observation of mental health in all policies has in recent years begun to proceed in Finland both at the municipal and provincial level, in particular as part of the overall wellbeing and development. In most cases, the initiating party for co-operation has been the social and health sector.

ICELAND

Strengths and opportunities of MHiAP

- General interest in the subject
- Acknowledgment of the important role of schools in promoting health and wellbeing for students
- Public mental wellbeing measures have been linked with public policy outcomes in Iceland

Weaknesses and threats of MHiAP

- A lack of systematic way of taking health and mental health into consideration in policy making
- Little visibility and ambiguous status of the policy area
- Unclear who conducts the field
- Unclear roles and job descriptions

Short summary of the MHiAP position

There can be found some consideration in different sectors regarding taking mental health into account in their policies. The non-health sectors that have been the strongest operators to take MHiAP into consideration are the educational and social sectors, but there are also some examples in other sectors. Generating cross-sectorial political commitment and collaboration for MHiAP in Iceland is partially done by the Iceland 2020 - a governmental policy statement for the economy and community where special aims are set to increase mental wellbeing. Also, in the health and social sector there is a project going on, and in some municipalities the emphasis on collaboration has been increasing. MHiAP approach should also be included in the new public health policy that is under development. The collaboration will involve the prime minister, minister of health, social welfare and education together with specialist from the Directorate of Health and participants from universities and the third sector.

LITHUANIA

Strengths and opportunities of MHiAP

Lithuania has a mental health strategy since 2007. There is a National Health Commission under the Government of Lithuania, which was established in 1996. However, it stopped its activity for 5-6 years and was re-established in 2013. The National Health Commission is accountable to the Government, and it coordinates health policy and implementation activities in different ministries. It consist of high level officers (vice ministers) from different ministries and other national institutions. One of the first sessions in 2014 was on the topic of Mental Health in All Policies. Representatives of the Ministry of Education and Sciences as well as of the Ministry of Labour and Social Affairs presented their activities in promoting mental health. In further sessions attention to one or another mental health issue (alcohol, drug abuse,

suicide) has been paid. This shows that after the re-establishment mental health issues have been given a high level priority. It should be stressed that the Ministry of Education and Sciences as well as Ministry of Labour and Social affairs have recognised the importance of mental health issues in their field. There are different tools prepared to overcome the most important problems in each field (for example, in the field of education there are bullying prevention programmes as well as substance abuse prevention programmes; under the Ministry of Labour and Social affairs there is a cross-sectoral Child Welfare Commission; cross-sectoral attention is also given to suicide, drug, tobacco and alcohol abuse questions).

Weaknesses and threats of MHiAP

In 2012 a study on cross-sectoral collaboration was conducted in Lithuania. It has highlighted main obstacles for the collaboration.

Systematic obstacles:

- There are sectoral priorities established in the high level national strategic documents. Promotion of public health in national strategic documents is mainly related to the health care system. The factors belonging to other areas are not sufficiently identified.

- The poor quality of the strategic plans.

- Purpose of cross-sectoral progammes/activity plans is not clearly defined.

- Lack of control and incentives.

Obstacles in health sector:

- Lack of attention to public health (insufficient funding).

- Lack of public health priorities.

- Gaps in public health interventions logic.

- Lack of programme coordination and implementation capacity.

- Too complex system with planning documents.

- Lack of monitoring and evaluation.

Short summary of the MHiAP position

There is an understanding that cross-sectoral collaboration is absolutely necessary in talking about mental wellbeing. There are many common fields and problems that can be successfully and efficiently solved by only working together as a team. Still such cooperation is not enough at the moment.
The reasons can be very different – a question of personalities, lack of interest, lack of skills, or legal challenges for the collaboration. There is no effective interdepartmental, cross-sectoral cooperation and dissemination of best practice experiences and examples. It seems that the Mental Health in All Policy concept is not well known and understood in Lithuania. Even though there is a Mental Health Strategy approved by the government as well as the implementation plans there is a lack for cross-sectoral cooperation and this leads to the low knowledge about Mental Health in All Policies.

NORWAY

Strengths and opportunities of MHiAP

The new law of public health (2012) is constructed according to the principle of Health in All Policies, declaring that health is produced mainly outside the health system. Local authorities are obliged to have an overview of the health situation in their municipality and implement updated health promoting and illness preventing initiatives. The public health parliament bill (2013) is endorsed by all parties. The bill analyses the health situation and lists a large number of health initiatives outside the health system. Particular attention: pregnancy, infants, preschool and school health care. Many municipalities have merged the sectors serving children and families into one common sector typically including education, family, child protection, social services and health care. The new Norwegian government has repeatedly stated that they will prioritise mental health. A new law of centred child care and a parliament bill about the future development of centred child care policy states that child care centres should be concerned with the whole child's development.

Weaknesses and threats of MHiAP

It is difficult to get politicians and ordinary people to think of health and illness – particularly promotion and prevention – at a population level (burden of disease, cost of illness, sick leave costs, morbidity, mortality). The focus is mostly on clinical services to individuals. It is also difficult to get the Ministry of Finance to "buy" population based mental health promotion. Budgeting for a year at the time, four years election periods and competition between ministries limit long-term budgeting across sectors. The concept of Mental Health in All Policies is not well known. Cross-sectoral work is not systematically implemented even though some governmental officers may think in terms of mental health in all policies. Even though Norway may have higher acceptance of mental distress than there is in many other countries, psychological distress and mental disorders are still stigmatised to a certain degree. Consequently mental health is still a type of problem which many governmental officers do not want to deal with.

Short summary of the MHiAP position

There is a change going on in the country. Following the Norwegian Action Plan for Mental Health 1999-2008, when the services were modernised, decentralised and a large effort was put into education and enlightenment, the awareness of mental health has been raised immensely. Mental health is an issue in the media every day. It is on people's agenda. Norwegian economy does well. Therefore, it is less difficult to tempt politicians across sectors to invest in mental health. The government has repeatedly declared that mental health will be prioritised. Budgets intended to strengthen municipality services, including municipality psychologists, have increased. Ministries and directorates of Health, Employment and Social Affairs, Child and Family Affairs, Justice, Education etc. have regular meetings in which they discuss matters of common relevance, including mental health. Many local authorities (municipalities, politicians, administrators) across sectors seem to be highly positive for mental health promotion and prevention and wish to do something with it in their community. In spite of Norway being a small country, the Norwegian Institute of Public Health has one of Europe's largest research departments in public mental health, and a new unit to assess health initiatives/interventions and conduct systematic reviews of evidence to serve local and national authorities is planned.

PORTUGAL

Strengths and opportunities of MHiAP

Background of MHiAP roots in Portugal at policy level and capacity building action can be found in the European Meeting on Health and Health Systems Impact Assessment (HIA/HSIA), held during the Portuguese Presidency in Lisbon, in November 2007. There was also a National Workshop on HIA Concepts and Practice: Lisbon, INSA, IP, Nov 2009. Capacity building workshop on equity-focused HIA were held in Lisbon (INSA, IP) in January 2013. The already existing experience and knowledge namely within the field of community care of mental disorders and substance abuse, in what concerns the articulation and intersectoral coordination, should be extended to the mental health promotion field. There is improved knowledge and awareness, namely through national research and intervention projects, on psychological, social and biological determinants. Particular interest is found in various sectors in implementing innovative policies and practices related to health and wellbeing promotion associated with positive outcomes. There is increased relevance of mental health issues at political level (national mental health programme as a priority). Progressive development of national/regional/local networks around mental health promotion projects can be found.

Weaknesses and threats of MHiAP

- Difficulty in identifying and involving the right stakeholders in non-health sectors.
- Scarce awareness and knowledge on MHiAP in each sector.
- A particularly difficult implementation for 'hard to reach' vulnerable groups who may require a reinforced cooperation between sectors.
- Economic and social problems are structural barriers for eventual emerging actions and intervention strategies within MHiAP.
- Lack of training on mental health promotion among professionals in health and non-health sectors compromises the success of public policies.
- Short-term and long-term solutions are not always properly planned and coordinated.
- Financial barriers and cost containment because of economic crisis threaten the implementation of actions related to MHiAP.
- Low level of collaboration between sectors concerning mental health and wellbeing.
- Frequent discontinuity of already implemented projects, dependent on the allocation of funds.
- Poor use of already existing intersectoral networks and know-how with no transference to other contexts related to mental health and wellbeing promotion.

Short summary of the MHiAP position

According to the data collection and considering the low response rates on the two questionnaires, there may be insufficient awareness of Mental Health in All Policy (MHiAP) in Portugal. However, a few experts from the health field have some knowledge, access and awareness of MHiAP. Although there are already some experiences in this area, this is not a generalised practice yet. Some sectors are more involved than others, in particular in what concerns mental health. Overall, the most participated sectors in these surveys were: Health, NGOs, University, Employment and Social Security, and Coordination and Regional Development Centre. Existing research on MHiAP in Portugal may generate, in short-term, good evidence to inform the policy makers (e.g. through policy brief documents). This is a new field that is becoming increasingly well known in Portugal. The implementation of cost-effective studies within MHiAP may trigger political will and engagement of different administrative and technical levels. Dissemination of

good practices and positive outcomes on MHiAP is necessary to increase the involvement of different sectors as pieces of the same framework. Good coordination of policies from various sectors is needed and, in some cases, it should be taken by the health sector avoiding the silo effect.

ROMANIA

Strengths and opportunities of MHiAP

The professionals who are working directly with the mental health problems are primarily interested in building and implementing the concept of MHiAP. A strong support and high value added comes from the part of users of mental health services and their NGOs. Sectors more closely connected with mental health, like education and social institutions, have also had a positive attitude when they have been asked to collaborate with the project. An important step was made in the document voted as the Law 151/2010 on integrative health, education and social services for people with ASD and associated mental disorders, revised in 2013.

Weaknesses and threats of MHiAP

The level and quality of cross-sectoral collaboration is still an ongoing process, institutions like the National Mental Health and Anti-drug Centre being the promoters for future actions. A couple of administrative and NGO respondents did not express a willingness to collaborate during the data collection phase. There is a lack of collaborative protocols between different sectors at the highest level and there are sporadic partnerships at the local level.

Short summary of the MHiAP position

The data collection phase was an opportunity to be in contact with important initiatives and actions carried out by dynamic people, who have used their leadership capacity in order to perform important projects which could be selected as good practices having the aim to promote MHiAP in Romania. These models (Pathways to Policy and Health Education in Romanian Schools for Pupils from I to XII grade) could be the key of the mental health reform in Romania and have to be extended to other regions of the country. An important issue should be the empowerment of civil society in order to find the best solutions for the needs and establish priorities, strategies and action plans to be forwarded to the policy makers.

SCOTLAND

Strengths and opportunities of MHiAP

There is strong leadership of the mental health and wellbeing agenda from Scottish Government. This is embedded within the National Performance Framework, and enhancing mental wellbeing features as an aspect of the majority of national and local policies. The Concordat between national and local public services includes a focus on promoting wellbeing. Local Authorities have a legislative duty to promote wellbeing. Delivery of this is reported through annual reporting to Scottish Government. Curriculum for Excellence and Scotland's approach to Integrated Children's Services (Getting it Right for Every Child) have mental wellbeing as key areas for developments as an intrinsic part of their delivery, with education establishments, education authorities, social services etc. aligned to deliver the outcomes of each.   There are some strong examples of cross-sectoral collaboration within and across public services, with the Third sector and with communities, for example, in Lanarkshire.

Weaknesses and threats of MHiAP

It would be helpful to have engaged with workplaces, private sector and Trade Union representatives to get a sense of the level and quality of MHiAP and its impact in the private sector. Political commitment for MHiAP already exists but in different words. We could, therefore, articulate better where this is across policy, determining gaps and monitoring impact. There is a recognition that more needs to be done to promote and protect mental wellbeing given public service rationalisation and prioritisation of limited budgets. More could be done also to prevent and reduce the negative impact of financial constraints and of welfare reform and wider determinants of mental health.

Short summary of the MHiAP position

We had 17 responses to both surveys. Responses range from across sectors including schools, architecture, NHS, Local Authority, Third sector and NGO partnerships. There is a growing openness across all sectors to the importance of maintaining and improving mental health. The phrase "mental health in all policies" might not be used but the concept and commitment is presented using different words, for example, "mental health is everyone's business" or "there is no health without mental health". Language around mental health continues to present difficulties within sectors and partners defining mental health as mental illness and losing sight of the focus on wellbeing. There is ongoing commitment to promoting and developing good practices, to applying criteria for selection of what is determined as 'good' practice, and with increased attention being given to continuous improvement with monitoring and evaluation. Although implementation of existing good practices happens through various networks that encourage change, we could work more around putting knowledge into action, which focuses on outcomes, builds the evidence base around interventions and seeks to measure impacts and difference as a result. We could also focus on inequality ensuring that our approach continues to be population focused coupled with intervention targeted to those most at risk of poorer wellbeing as a result of the social determinants.

MENTAL HEALTH IN EDUCATION POLICIES

JOINT ACTION
MENTAL HEALTH AND WELLBEING

Key messages

- The mental health of Europe's children and adolescents is its most potent yet least systematically developed resource.
- The mental health and wellbeing of children and adolescents has a value in its own right, and children and adolescents should not only be seen as future adults.
- The educational setting is the most important arena outside the family for the development of children's mental health.
- Solid evidence is now available to guide day-care centres, pre-schools, and schools in how to promote social-emotional learning and wellbeing, and how to reduce and prevent mental distress, violence, bullying, conflict and aggression. However, few children and adolescents receive such interventions.
- Inclusion of mental health in educational policies - nationally, regionally and locally - has a very favourable cost-benefit ratio as it releases large societal resources in terms of wellbeing, cognitive, emotional and social skills ("mental capital"), which again have a broad range of positive impacts, including educational outcomes.

What is mental health?

Mental health requires the development of cognitive, emotional, and social skills for which educational settings make an ideal context. Mental health may be defined as a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO). Thus, mental health is not just the absence of illness.

Importance of mental health in education

Educational settings promote mental health when they provide children and adolescents with a sense of identity and self-respect, direction and meaning in life, mastery, belonging, safety, social support and participation. Good mental health is associated with better educational and behavioural outcomes. A range of effective interventions are available to promote mental health and to prevent and reduce mental illness. However, very few children and adolescents receive such interventions in the school setting.

Benefits of incorporating mental health into educational policies

Mental health promoting pre-schools and schools have a wide range of positive impacts on children's development, including large impacts on educational outcomes and equity. Incorporating mental health into educational policies contributes to developing, maintaining and protecting society's most potent and least developed resource, the mental health of children. There is solid evidence that the cost-benefit ratio of mental health interventions in educational settings is very favourable.

Recommendations

- Provide a system of affordable, available and accessible high quality public day-care centres for all children.
- Implement evidence based anti-bullying programs and whole-school based interventions to promote mental health and wellbeing, and prevent mental disorders in school.
- Routinely assess day-care centres and schools on whether they promote mental health, providing young people with a sense of identity and self-respect, direction and meaning in life, mastery, belonging, safety, social support and participation.
- Include children, adolescents and their families in planning school environments which promote mental health and wellbeing.
- Collect regularly data on children's and adolescents' mental wellbeing and any problems.
- Train school staff to support children's psychosocial development.
- Include mental health promotion in national school curriculum.

Facts

- The foundation of good mental health is laid in childhood years, and has a major impact on multiple outcomes later in life, including educational outcomes and employment.

- Nordic countries have remarkably high labour force participation rates of mothers and a moderate decrease in fertility rates compared to other Western countries. This has been attributed to family friendly policies, i.e. the availability of generous parental leave schemes, and to the high provision of public day-care, which makes it possible for mothers to return to work early.

- Early learning in high quality day-care centres/kindergartens strengthens social-emotional coping, cognition and school grades, have strongest effects on disadvantaged children and good effect on advantaged children, reduces social inequality in health, may compensate for negative home environments, stabilises difficult periods in life, has long term effects on mental and physical health, educational outcomes and employment, and is economically very cost-effective.

- There is now clear evidence that well implemented both universal and targeted mental health initiatives in schools enhance social-emotional skills, self-esteem, self-confidence, prosocial behaviour, mental health and wellbeing, and may reduce and prevent mental health problems, violence, bullying, conflict and anger. Such mental health initiatives are best linked to academic learning, start early, are anchored in the school and community leadership, are skill centred, and are implemented within a whole school approach.

- Mental disorders affect 10% of children and adolescents in Europe with a much larger proportion experiencing sub-threshold mental disorder. A significant minority of children and adolescents experience poor mental wellbeing due to mental disorder or sub-threshold mental disorder. Mental disorder severely hampers children's education.

Positive mental health and well-being is a key factor for social cohesion, economic progress and sustainable development in the EU
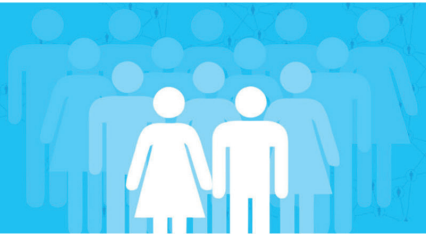
Examples of a good practice to foster inter-sector collaboration
Mental Health in School Programmes (MHiSP) for teachers have been implemented in several countries. MHiSP is most frequently organised as a cooperative initiative between the central government of health and education, respectively, in collaboration with NGOs. MHiSP have been created especially for both teachers and students. The goal of the various programmes is to foster knowledge of how students can promote their own mental health, where they can get help, and how they can provide support for each other. These programmes are adapted to students' levels and needs, and are suitable for students at lower and upper secondary levels alike. Courses have been designed especially for teachers, aimed at improving their knowledge and skills to support mental health of pupils in the class room setting. The most frequently used programs are Zippy's Friends, Mental Health for Everyone, Very Important Problems (VIP), STEP, Friend1, What's up with Monica? Link: www.psykiskhelseiskolen.no/english.asp?id=2471

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MENTAL HEALTH IN LABOUR POLICIES

Key messages

- Good mental health is essential for maintaining a sufficient and productive workforce. Mental health and wellbeing promotion in the workplace has health, social and productivity benefits.
- A comprehensive policy of mental health at work includes workplace mental health promotion as well as assessment of psychosocial risk factors.
- Solutions include the creation of healthy and friendly workplaces that promote mental health by good and safe working conditions, a healthy management style that potentiates positive mental health and wellbeing, good possibilities for work-family reconciliation, access to stress management programmes, and extension of occupational health and safety activities to mental health promotion.
- Support and assistance to workers experiencing mental health problems should be provided at the workplace by collaboration between management and occupational safety and health agents.
- Positive work affiliation in times of sickness should be maintained by implementing part-time sickness absence as an alternative to full sickness absence.

What is mental health?

Embedded in socioeconomic and environmental frameworks, mental health is not just the absence of illness. Mental health is a state of well-being in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Importance of mental health in labour policies

Poor mental health is strongly linked to lost productivity due to high levels of presenteeism, absenteeism and early retirement. The workplace environment is a key setting for mental health promotion and the prevention of mental disorders in the adult population, as the majority of this group spends large amounts of their time at work. At its best, the work place provides the individual with a sense of identity and self-respect, meaning in life, mastery, belonging, social support and participation.

Which are the benefits of incorporating mental health in labour policies?

Mental health and wellbeing promotion and mental disorder prevention are effective and cost-effective means of improving workforce mental health and productivity. Workers with good mental health have higher lifetime productivity and wellbeing. Family friendly workplaces will reduce the family burden and allow for an increase in birth rates. Stress management and measures to prevent a high demand and low control environment, will avoid ill-health consequences.

Recommendations

- Prioritisation of psychosocial risk identification by occupational health and safety.
- Raising awareness in enterprises of the potential benefits of mental health promotion and disorder prevention.
- Implementation of early intervention and inclusion programmes for employees with mental health problems.
- Promotion of positive work affiliation by implementing graded sickness absence as an alternative to full sickness absence.
- Implementation of intersectoral collaboration and training in mental health promotion and disorder prevention.
- Dissemination of good practices supporting mental health of employees.
- Legislation development to promote family friendly workplaces.

Joint Action on Mental Health and Wellbeing
Policy Brief

JOINT ACTION
MENTAL HEALTH AND WELLBEING

Facts

- Several studies show positive results of mental health initiatives in the workplace. There is now sound evidence that mental distress, particularly depression, may be prevented through workplace interventions. Nine out of ten economic analyses set in the workplace report favourable outcomes.
- 5% of the working-age population has a severe mental health condition.
- 15% of the working-age population is affected by a common mental health condition.
- 1 in 2 people will experience mental ill-health at some point in their life.
- The direct and indirect costs of mental ill-health can exceed 4% of GDP.
- People with mental ill-health experience higher rates of unemployment, are poorer than the general population, have more absences from work, and also suffer more from "presenteeism" i.e. reduced productivity at work.
- Common conditions like depression and anxiety are often highly treatable, but many people with a mental health condition do not receive the treatment they need.

Positive mental health and well-being is a key factor for social cohesion, economic progress and sustainable development in the EU

Example of a good practice to foster intersectoral collaboration

Prevention of dropout from the labour marked by promoting part-time sickness absence as an alternative to full sickness absence (Finland and Norway)

Participation in daily activities like employment or education is generally good for mental health. However, during illness many employees completely leave employment on sickness absence for weeks or even months at a time. Sickness absence may well be necessary due to illness and impaired function, but the evidence base for sickness absence as "treatment" is limited. However, evidence highlighting harmfulness of long-term sickness absence is increasing, including risk of unemployment and long-term welfare dependency. Lack of activity during long-term sickness absence may also reduce self-efficacy and change roles as well as identity. Social isolation and a lack of daily routines are potentially harmful for overall mental health. Part-time sickness absence on the other hand, may in many cases be a preferred alternative to full sickness absence, reducing side-effects of sickness absence, and enabling the health benefits of activity.

A policy promoting part-time sickness absence as an alternative to full sickness absence has been implemented in Norway and Finland with generally promising results. Comprising of close collaboration between the four parties below, this process is dependent on both ability and attitudes:

1. The legislation and the social security administration paying for sickness absence, must allow for – and even promote – part-time sickness absence.
2. General practitioners (GPs) certify most sickness absence, and thus they must be in favour of part-time sickness absence.
3. Employers must accommodate part-time sickness absence as an alternative to full sickness absence. This may in some cases be welcome, as key personnel are thus not entirely unavailable, although in other cases, it may be burdensome to accommodate part-time sickness absence, for example in shift allocation and work routines.
4. Employees must also accept part-time sickness absence as an alternative to full sickness absence, and trust that some employment during illness is generally healthy.

The promotion of part-time sickness absence was politically supported, and enforced by policy campaigns and formal collaboration between unions for employees and business organisations.

Part-time sickness absence is an easily available intervention, which comes at a very low cost. Thus, it has great potential in terms of cost effectiveness. An on-going follow-up indicates that the beneficial effects of part-time sickness absence is strongest in patients who are on sick leave for a mental disorder.

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MENTAL HEALTH IN LOCAL POLICIES

Key messages

- Growing costs to local authorities stemming from mental health problems are not sustainable, and the solution lies in promoting mental health and preventing mental illness.
- Local authorities provide leadership and coordination across a variety of public sectors – health, education, community design, employment, housing, transport, and social care – and thus have a key role in promoting mental health of the population.
- Returns from investment in local mental health promotion are high but typically show up in a different sector from the one in which the investments were made.
- Good local governance across public sectors, including processes for engaging people in local policy development, mental health impact assessment of local policies, and monitoring mental health outcomes of local decisions, strengthens the mental health of local inhabitants.

What is mental health?

Embedded in socioeconomic and environmental frameworks, mental health is not just the absence of illness. Mental health is a state of well-being in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Importance of mental health for local authorities

Mental health problems are increasing cost drivers in many services of local authorities today. However, as mental health is built into everyday life within communities, there are plenty of opportunities to change these trends. Local authorities are closest to the communities, and are often responsible for a range of sectors such as housing, education, public transport, employment or social care. Thus local authorities are in a key position to support thriving, inclusive communities that create mental health for all, and support the healthy psychological development of children and adolescents.

What are the benefits of mental health in local policies?

Local authorities have a key leadership role in bringing together services from a range of sectors to an integrated mental health response. Investment in the mental health of children and adolescents by different local authority non-health sectors is highly cost-effective, and will pay off in savings for both health care and social welfare later down the line. An integrated local authority response to the population's wellbeing needs creates social sustainability and local stability.

Recommendations

- Local authorities should develop integrated structures at local level to create local mental health strategies, e.g. by establishing local mental health and wellbeing boards consisting of public services, civil society organisations and local communities.
- Mental health impact should be a prominent part of local decision impact assessments.
- Local authorities need to make wide use of cost-effective interventions to promote mental health, e.g. parenting support, school mental health promotion interventions and suicide prevention.
- Local authorities can reduce inequalities in mental health and prevent intergenerational transmission of mental health problems by creating mentally healthy and safe environments. This is possible through good urban planning, provision of good quality day care for all children, and creation of opportunities to take part in cultural, outdoor, sports and other recreational activities for all children and adolescents
- Local authorities' capacity and awareness for mental health promotion and prevention of mental health problems needs to be raised.

Facts
- Research indicates that community involvement, associative participation and the opportunity to engage in community decisions is conducive for mental health at all ages, including children.
- Access to parks and green spaces within residential neighbourhoods has been shown to be an important pathway to generating better physical and mental health for individuals and communities.
- Mental health expenditure by local authorities specifically for mental illness has grown across Europe over the past years. There is strong evidence of good return on investment in children and adolescents in the areas of reducing conduct disorders and depression, parenting and anti-bullying programmes, suicide prevention, school mental health promotion and primary health care screening for depression and alcohol misuse. (OECD 2014)

Mental Health and Wellbeing Boards at local level: An example from the London Borough of Redbridge (England)

The Redbridge Health and Wellbeing Board brings together a range of stakeholders namely the National Health Service (NHS), public health, social care, children's services, elected councillors, and community and service user representatives, in order to consider local needs. This multi-professional process ensures that local authorities plan the right services, increase mental health promotion, aid the prevention of mental illness and implement early intervention activities. It consists of a partnership board, which brings together a range of public services including adult social services, housing, public health, children's services, leisure, environment and community safety and GPs. The board is responsible for the formulation of the local Joint Health and Wellbeing Strategy, which outlines high level priorities for improving people's mental health and wellbeing for the next three years. (Redbridge Local Involvement Network, 2012)

The UK Local Government Association has issued a joint guide with the NHS on how to set up mental health and wellbeing boards by following five steps: preparing for the board; forming the board; work programmes, priorities and commissioning; developing joint strategic needs assessment and joint health and wellbeing strategies; review, performance and looking forward. (Local Government Association 2011)

Positive mental health and well-being is a key factor for social cohesion, economic progress and sustainable development in the EU

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MENTAL HEALTH IN WHOLE-OF-GOVERNMENT POLICIES

Joint Action on Mental Health and Wellbeing Policy Brief

Key messages

- The mental health of the population is an important resource for the EU, which needs to be actively developed and protected. Mental health in terms of wellbeing including cognitive, emotional and social skills is often produced outside of the health system, where people live their lives: i.e. in the family, among friends, in kindergartens, schools, work places, local community, culture and sports. Therefore, mental health is not the sole responsibility of health authorities.
- Failure to promote mental health has had severe consequences to the European economy, welfare and wellbeing. Today, no other health condition is more costly than mental disorders, in terms of lost productivity, active disability and sickness absence costs, and in terms of human suffering. The burden comes primarily from common mental disorders such as anxiety disorders, depression and alcohol abuse, which – paradoxically – are also the easiest and least costly to prevent.
- Promotion of mental health and prevention of common mental disorders requires that we address the social determinants of mental health and disorders; i.e. living conditions.
- Mental health must be incorporated into all policies and arenas where the ways in which people live their lives are planned and regulated, i.e. in all policies at national, regional and local level. Routine assessments of the impact of all policies on the population's mental health and equity should be introduced.

What is mental health?

Mental health is not just the absence of illness. Mental health is a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Mental health requires cognitive, emotional, and social skills, which develop when we provide people with a sense of identity and self-respect, meaning in life, mastery, belonging, safety, social support and participation.

Importance of mental health

Today mental health is more valuable to Europe than ever due to the transition into the information society, where productivity is increasingly dependent upon our minds. More than ever, the prosperity of individuals, companies, and societies requires cognitive, emotional, and social skills. Mental disorders have a large impact across sectors, are responsible for Europe's largest burden of disease, and are strong determinants of suicide and mortality from somatic disease.

What are the benefits of incorporating mental health in whole of government?

Investment in mental health creates a significant European advantage in global economic competition.
By systematically including mental health in all policy sectors – nationally, regionally and locally – we impact on the arenas where mental health is created. Such a policy approach is extremely cost-effective, releases large societal resources, and prevents enormous suffering.

Recommendations

- Incorporate mental health in all policies.
- Take action on all political levels on social determinants of mental health, i.e. living conditions that undermine people's sense of identity and self-respect, sense of meaning in life, mastery, belonging, safety, social support and participation.
- Strengthen capacity, and ensure effective structures, processes and resources for a Mental Health in All Policies approach.
- Build mental health literacy and understanding of mental health impacts among organisations, decision makers and the general population.
- Develop tools and structures for implementation.
- Include communities, social movements and civil society in the development, implementation and monitoring of Mental Health in All Policies.
- Adopt transparent audit and accountability mechanisms for mental health and equity.

Joint Action on Mental Health and Wellbeing Policy Brief

Facts

- There is now significant evidence that mental health promotion initiatives across policy sectors, addressing parenting, child care centres, schools, work places and settings for older people are cost-effective. The economic consequences of poor mental health across different sectors, often persisting into adulthood, means that programmes aimed at children, parenting and families can have particularly favourable cost-benefit ratios. There is comprehensive evidence that high quality child care centres and schools which promote mental health stimulate mental health and prevent mental illness. Similarly, nine out of ten economic analyses set in the work place report favourable outcomes.

- Each year 38 percent of the EU's population suffer from a mental disorder, affecting an estimated 169 million persons in total. With the exception of alcohol disorders which are more prevalent in the eastern parts, there are no substantial cultural or country variations related to mental disorders within the EU.

- Thirty percent of the burden of disease in Europe, in terms of Years Lived with Disability (YLD) is due to mental disorder and self-harm. The three most debilitating single health conditions in the EU are depression, dementia and alcohol use disorder. It is estimated that by 2030, unipolar depression will become the number one cause of ill-health and premature death in the wold. An alarming 2/3 of the affected will be women. Even in underestimated terms, mental disorders accounted for 7.4 percent of disability adjusted life years lost (DALY) worldwide in 2010 - a 27% percent increase from 1990.

- Each year 124 000 Europeans commit suicide, of which an alarming 80 per cent are men. The mean prevalence rate of suicide in Europe is 13.9/100 000, and within the EU it is 10.1/100 000. The highest rates in Europe are found in the former Soviet republics: 21.4/100 000 and in the new EU member countries: 13.8/100000. In many European countries, suicide is the number one cause of death among adolescents. In Ireland and Scotland the economic cost of suicide has been estimated to 1.5 million EUR/suicide.

- People with mental disorders in Europe die 15-20 years earlier than others, mainly from non-communicable somatic diseases, such as heart infarct, stroke, diabetes, and chronic obstructive lung disease. Studies indicate that mental disorder – even depression alone – may be an equally strong determinant of mortality from non-communicable disease, as are the "classical" risk factors such as smoking, inactivity, unhealthy diet and heavy alcohol consumption.

Positive mental health and well-being is a key factor for social cohesion, economic progress and sustainable development in the EU

Example of good practice to foster intersectoral collaboration

The Norwegian Public Health Act (PHA) explicitly includes mental health and acknowledges that most causes of health problems are found outside of health services, and that health must be taken into consideration when initiatives and strategies are formed in all sectors of society. The PHA builds upon five values: (1) equalisation, (2) sustainable development, (3) health in all policies, (4) the precaution principle, and (5) participation. It applies a local community perspective as opposed to a health service perspective by placing the responsibility for public health work upon the political leadership in the local community and not on the health services themselves. Public health work is linked to the municipalities' overarching plan and decision systems. The local communities themselves are made responsible for keeping an overview over their health situation and the many factors that impact on it. Local communities are also instructed to act in accordance with local challenges, and to use the tools that they have available. State and regional authorities are committed to guide the local communities and to serve them in establishing key/steering data. The national audit system has the mandate to control that the act is implemented in all local communities (i.e. municipalities) and regions (i.e. counties) and that the state follows up by servicing and guiding them.

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