1 SOCIAL INCLUSION

To actively promote good mental health for all, tackle stigma relating to mental illness and to promote social inclusion of people with mental health problems.

National Service Framework

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Help people to develop the skills to stay free of, or minimise the effects of mental health problems at stressful times in their life and survive mental health problems [paragraph 10.2]

What skills can be developed to help minimise the effects of mental health problems at stressful times?

Can self-help interventions be used to effectively manage mental illnesses?

The *statements* | The *evidence*

1.1 Self help interventions

1.1a Most studies have reported a significant benefit of **self-help materials** based on a **cognitive behavioural therapy** (CBT) approach, for **depression, anxiety, bulimia nervosa and binge eating disorder**, when given in the context of a clinical assessment and some degree of monitoring. Much of the monitoring has been as a result of the research protocol but might be a critical element of the intervention. What is less certain is whether this evidence is of sufficient rigour to recommend the use of self-help materials. The possibility of harm has not been empirically studied and is probably relatively remote as long as the patient is still given the opportunity to pursue other therapeutic options if the self-help approach proves unsuccessful. Given the weakness of the evidence it is probably wise to only recommend self-help materials when given in a clinically supervised context and when alternative therapeutic options will be recommended if self-help proves unacceptable or ineffective.[i]

i. Lewis G, Anderson L, Araya R et al. *Self-help interventions for mental health problems. Report to the Department of Health R&D Programme*. London: Department of Health, July 2004

(Type I evidence – systematic review of 7 systematic reviews and 19 randomised controlled trials of self-help interventions administered through written, audiotape or computer text or a combination. Literature search to 2002.)

The *statements*

The *evidence*

1.1b There are a number of **self-help books** for the treatment of depression readily available. For the majority, there is little direct evidence for their effectiveness. There is weak evidence that suggests that **bibliotherapy**, based on a **cognitive behavioural therapy** approach is useful for some people when they are given some additional guidance. More work is required in primary care to investigate the cost-effectiveness of self-help and the most suitable format and presentation of materials. None of the RCTs fulfilled CONSORT guidelines and all were small with the largest trial having 40 patients per group. Nine of these evaluated two current publications, *Managing Anxiety & Depression (UK)* and *Feeling Good (USA).* A meta-analysis of 6 trials evaluating *Feeling Good* found a large treatment effect compared to delayed treatment (standardised mean difference = -1.36; 95%CI -1.76 to -0.96). Five self-help books were identified as being available and commonly bought by members of the public in addition to the two books that had been evaluated in trials.[i]

i. Anderson L, Lewis G, Araya R et al. Self-help books for depression: how can practitioners and patients make the right choice? *British Journal of General Practice* 2005; **55**: 387-392

(Type I evidence –Systematic review of 11 randomised controlled trials evaluating written self-help materials for depression. Literature search 1990-2003.)

1.1c **Guided self-help** is a worthwhile initial response to **bulimia nervosa** and **binge eating disorder**. It is a treatment that could be delivered in **primary care** and in other non-specialist settings. Self-help delivered with four sessions of face-to-face guidance led to improved outcome over 4 months. There is also some evidence to support the use of telephone guidance. A minority of participants achieved lasting remission in their disorder in relation to self-help, but there was no significant difference in final outcome between the groups after they had progressed through the stepped care programme. Patients initially offered guided self-help had a lower long-term drop-out rate.[i]

Caveat: At 12 months follow-up was only 64%.

i. Palmer RL, Birchall H, McGrain L, Sullivan V. Self-help for bulimic disorders: a randomised controlled trial comparing minimal guidance with face-to-face or telephone guidance. *British Journal of Psychiatry* 2002; **181**: 230-5

(Type II evidence – a randomised controlled trial of 121 patients in England allocated to one of 4 groups: self-help with minimal guidance, self-help with face-to-face guidance, self-help with telephone guidance or to the waiting list group. Patients were followed up at 4, 8 and 12 months. After 4 months, the treatment received by the patients was determined by clinical need and the trial rules, rather than random allocation to treatment group.)

1 SOCIAL INCLUSION

The *statements*

1.1d Over a 3 month follow-up period, no significant differences between the groups accessing the psychoeducational programme via the Internet or telephone were observed. However, 3 of the target variables were found to be strong predictors of whether a participant had an episode of **major depression** during the follow-up period. These were cognitive style (self-esteem, p=0.004; mastery ratings p<0.001), activity level (social activity ratings, p<0.001; pleasant activity ratings, p<0.001), and daytime sleep quality (p=0.003).[i]
Caveat: Intention to treat analysis is not reported. It is unclear whether the groups were similar at the start of the trial.

The *evidence*

i. Patten SB. Prevention of depressive symptoms through the use of distance technologies. *Psychiatric Services* 2003; **54**: 396-8
http://psychservices.psychiatryonline.org/cgi/reprint/54/3/396 [accessed 29/07/04]
(Type II evidence - randomised controlled trial of 786 members of the public in Canada (mean age 45.2, 90% female) to evaluate the effectiveness of a psychoeducational computer programme accessible through the Internet or by touch-tone telephone. Subjects were followed-up at 3 months.)

NICE guidelines recommendations for self-help

1.1e For patients with **mild depression**, healthcare professionals should consider recommending a guided **self-help programme** based on **cognitive behavioural therapy** (CBT). Guided self-help should consist of the provision of appropriate written materials and limited support from a healthcare professional, who typically introduces the self-help programme and reviews progress and outcome. This intervention should normally take place over 6 to 9 weeks, including follow-up.[i]
Bibliotherapy based on CBT principles should be offered for anxiety disorders. Information about support groups, where they are available should be offered. The benefits of **exercise** should be discussed with all patients as appropriate. Current research suggests that the delivery of CBT via a **computer interface** may be of value in the management of **anxiety** and **depressive disorders**. This evidence is however, an insufficient basis on which to recommend the general introduction of this technology into the NHS.[ii]

i. National Institute for Clinical Excellence. *Depression. Management of depression in primary and secondary care.* Clinical guideline No. 23. London: NICE, December 2004. Review date: December 2008
http://www.nice.org.uk/pdf/CG023NICEguideline.pdf [accessed 29/07/05]
(Evidence based guideline with systematic literature search and expert consensus.)

ii. National Institute for Clinical Excellence. *Anxiety. Management of anxiety (panic disorder with or without agoraphobia, and generalised anxiety disorder) in adults with primary, secondary and community care*. Clinical guideline No. 22. London: NICE, December 2004. Review date: December 2008
http://www.nice.org.uk/pdf/CG022NICEguideline.pdf [accessed 29/07/05]
(Evidence based guideline with systematic literature search and expert consensus.)

The *statements*

The *evidence*

1.2 Complementary interventions

1.2a Although none of the treatments reviewed are as well supported by evidence as standard treatments such as **antidepressants** and **cognitive behaviour therapy**, many warrant further research. Treatments with the best evidence of effectiveness are **St John's Wort**, **exercise**, **bibliotherapy involving cognitive behaviour therapy and light therapy (for winter depression)**. There is some limited evidence to support the effectiveness of **acupuncture, light therapy (for non-seasonal depression), massage therapy, negative air ionisation (for winter depression), relaxation therapy, S-adenosylmethionine, folate and yoga breathing exercises.** [i]

i. Jorm AF, Christensen H, Griffiths KM, Rodgers B. Effectiveness of complementary and self-help treatments for depression. *Medical Journal of Australia* 2002; **176(Suppl)**: S84-S96

(Type I evidence – systematic review of 37 treatments grouped under the categories of medicines, physical treatments, lifestyle, and dietary changes. Literature search to 2001.)

Art therapy

1.2b Randomised studies have been proven to be possible in this field. The use of **art therapy** for **serious mental illnesses** should continue to be under evaluation as its benefits, or harms, are unclear. Fewer people allocated to art therapy left the study before 20-weeks compared with those given standard care alone (RR 0.34 95%CI 0.15 to 0.8, NNT 3 95%CI 1.5 to 7). Measures of change in mental state, interpersonal relationships and social networking were reported but the data were too problematic to interpret with confidence. Much data were lost due to poor reporting or inappropriate use of scales.[i]

i. Ruddy R, Milnes D. Art therapy for schizophrenia or schizophrenia-like illnesses. *The Cochrane Database of Systematic Reviews* 2003, Issue 1 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003728/frame.html** [accessed 29/07/05]

(Type I evidence - systematic review of 2 randomised controlled trials (total n=137) to review the effects of art therapy as an adjunctive treatment to schizophrenia compared with standard care alone. Literature search date not reported.)

1 SOCIAL INCLUSION

The *statements*

The *evidence*

Exercise

1.2c The effectiveness of **exercise** in reducing symptoms of **depression** cannot be determined because of a lack of good quality research on clinical populations with adequate follow up. When compared with no treatment, exercise reduced symptoms of depression (standardised mean difference in effect size -1.1 95%CI -1.5 to -0.6; weighted mean difference in Beck Depression Inventory -7.3 95%CI -10.0 to -4.6). The effect size was significantly greater in those trials with shorter follow up and in 2 trials reported only as conference abstracts. The effect of exercise was similar to that of cognitive therapy (standardised mean difference -0.3 95%CI -0.7 - 0.1).[i]

A Cochrane systematic review and meta-analysis of randomised controlled trials of the effect of exercise therapy for the treatment of depression is currently underway .[ii]

i. Lawlor DA. Hopker SW. The effectiveness of exercise as an intervention in the management of depression: systematic review and meta-regression analysis of randomised controlled trials. *British Medical Journal* 2001; **322(7289)**: 763-7 **http://bmj.bmjjournals.com/cgi/reprint/322/7289/763** [accessed 29/07/05]

(Type I evidence – systematic review of 14 randomised controlled trials including 11 studies that compared exercise with no treatment and 6 studies that compared exercise with standard treatments for depression. Literature search to 1999.)

ii. Lawlor D, Campbell P. Exercise for depression (Protocol). *The Cochrane Database of Systematic Reviews* 2000, Issue 2 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004366/frame.html** [accessed 29/07/05]

Hypnosis

1.2d **Hypnosis** could be helpful for people with schizophrenia but to ascertain this requires better designed, conducted and reported randomised studies. The studies in this field are few, small, poorly reported and outdated. When hypnosis was compared with standard treatment no one left between 1-8 weeks. Mental state scores were unaffected (MD BPRS by 1 week -3.6 95%CI -12.05 - 4.8) as were measures of movement disorders and neurocognitive function. Compared with **relaxation,** hypnosis was also acceptable (RR leaving the study early 2.00 95%CI 0.2 - 2.15) and had no discernable effect on mental state (MD BPRS by 1 week -3.4 95%CI -11.4 - 4.6), movement disorders or neurocognitive function. Hypnosis was as acceptable as **music** by 4 weeks (RR leaving the study early 5.0, 95%CI 0.3 - 97.4).[i]

i. Izquierdo de Santiago A, Khan M. Hypnosis for schizophrenia. *The Cochrane Database of Systematic Reviews* 2004, Issue 3. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004160/frame.html** [accessed 29/07/05]

(Type I evidence – systematic review of 3 randomised controlled trials (total n=149). Literature search to 2003.)

The *statements*

The *evidence*

Supplements

1.2e The use of omega-3 polyunsaturated fatty acids for **schizophrenia** remains experimental and large well designed, conducted and reported studies are indicated and needed. Studies were small and had low attrition. There is no clear dose response to omega-3 supplementation. Adverse effects seem rare but diarrhoea may be a problem in the medium term. [i]

i. Joy CB, Mumby-Croft R, Joy LA. Polyunsaturated fatty acid supplementation for schizophrenia. *The Cochrane Database for Systematic Reviews* 2003, Issue 2. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001257/frame.html** [accessed 29/07/05]

(Type I evidence – systematic review of 5 short randomised controlled trials. Literature search to July 2002.)

1.2f The limited available evidence suggests **folate** may have a potential role as a supplement to other treatment for **depression**. It is currently unclear if this is the case both for people with normal folate levels, and for those with folate deficiency. Two studies involving 151 people assessed the use of folate in addition to other treatment, and found that adding folate reduced Hamilton Depression Rating Scale scores on average by a further 2.65 points (95% CI 0.38 – 4.93). The number needed to treat with folate for one additional person to experience a 50% reduction on this scale was 5 (95% CI 4 – 33). One study involving 96 people assessed the use of folate instead of the antidepressant trazodone and did not find a significant benefit from the use of folate. The trials identified did not find evidence of any problems with the acceptability or safety of folate. [i]

i. Taylor MJ, Carney S, Geddes J and Goodwin G. Folate for depressive disorders. *The Cochrane Database for Systematic Reviews* 2003. Issue 2 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003390/frame.html** [accessed 29/07/05]

(Type I evidence – systematic review of 3 randomised controlled trials investigating the effectiveness of folate in the treatment of depressions. A total of 247 people were included in the trials. Literature search date to March 2001.)

1 SOCIAL INCLUSION

The *statements* | The *evidence*

Music

1.2g **Music therapy** as an addition to standard care helps people with **schizophrenia** to improve their global state and may also improve mental state and functioning if a sufficient number of music therapy sessions are provided. Further research should address the dose-effect relationship and the long-term effects of music therapy. Music therapy added to standard care was superior to standard care alone for global state (medium term, RR 0.10 95%CI 0.03 to 0.31, NNT 2 95%CI 1.2 to 2.2). Continuous data suggested some positive effects on general mental state (SMD average endpoint PANSS -0.36 95%CI -0.85 to 0.12; SMD average endpoint BPRS -1.25 95%CI -1.77 to -0.73), on negative symptoms (SMD average endpoint SANS -0.86 95%CI -1.17 to -0.55) and social functioning (SMD average endpoint SDSI score -0.78 95%CI -1.27 to -0.28). However these latter effects were inconsistent across studies and depended on the number of music therapy sessions.[i]

i. Gold C, Heldal TO, Dahle T, Wigram T. Music therapy for schizophrenia or schizophrenia-like illnesses. *The Cochrane Database of Systematic Reviews* 2005, Issue 2.
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004025/frame.html
[accessed 29/07/05]
(Type I evidence – systematic review of 4 randomised controlled trials examining the the effects of music therapy over the short to medium term (1 to 3 months), with treatment 'dosage' varying from 7 to 78 sessions. All results were for the 1-3 month follow up. Literature search to 2002.)

Writing interventions

1.2h The 3 groups (n = 98) who completed pre-, post-, and 6-week follow-up were not different on **suicidality** or **depression**. All subjects reported fewer automatic negative thoughts over the 2-weeks; they also reported higher self-regard but more health centre visits at follow-up. **Suicidal thoughts** may be more resistant than physical health to **writing interventions**.[i]
Caveat: The number of participants allocated to each group is unclear and an intention to treat analysis has not been reported. Short follow-up period.

i. Kovac SH, Range LM. Does writing about suicidal thoughts and feelings reduce them? *Suicide and Life Threatening Behaviour* 2002; **32**: 428-40
(Type II evidence - randomised controlled trial of 121 undergraduates (mean age 23 years; 73% female) in America, screened for suicidality assigned to reinterpret or to write and rewrite. 6-week follow-up.)

The *statements* | The *evidence*

1.3 Fostering the development of life skills to cope with mental health problems

Life skills training

1.3a If **life skills training** is to continue as part of **rehabilitation programmes** a large, well designed, conducted and reported pragmatic randomised trial is an urgent necessity. There may even be an argument for stating that maintenance of current practice, outside of a randomised trial, is unethical. The only outcome where it was possible to pool data were 'leaving the study early'. This is a crude and proxy measure for the acceptability of treatment for those with serious mental illness. Numbers of events were so small, as were the studies themselves, that even the pooled odds ratio had a wide confidence interval (OR 2.05 95% CI 0.2-22).[i]

i. Nicol MM, Robertson L, Connaughton JA. Robertson L, Connaughton J, Nicol M. Life skills programmes for chronic mental illnesses. *The Cochrane Database of Systematic Reviews* 1998, Issue 3. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000381/frame.html** [accessed 29/07/05]

(Type I evidence - systematic review of 2 randomised controlled trials (n=38) to compare the effectiveness of life skills programmes with standard care for people with chronic mental health problems. Literature search to 1997.)

Problem solving skills

1.3b **Problem-solving therapy** for **deliberate self harm (DSH)** patients appears to produce better results than control treatment with regard to improvement in depression, hopelessness and problems. It is desirable that this finding is confirmed in a large trial, which will also allow adequate testing of the impact of this treatment on repetition of DSH. At follow-up, patients who were offered problem-solving therapy had significantly greater improvement in scores for depression (standardised mean difference = -0.36; 95% CI -0.61 to -0.11) and hopelessness (weighted mean difference =-3.2; 95% CI -4.0 to -2.41), and significantly more reported improvement in their problems (OR 2.41; 95%CI 1.29 to 4.13), than patients who were in the control treatment groups.[i]

Caveat: Unpublished research was not sought.

i. Townsend E, Hawton K, Altman DG et al. The efficacy of problem-solving treatments after deliberate self-harm: meta-analysis of randomised controlled trials with respect to depression, hopelessness and improvement in problems. *Psychological Medicine* 2001; **31**: 979-88

(Type I evidence – meta-analysis of 6 randomised controlled trials (n=583; patients aged 16-35). 4 trials were included in the meta-analysis for the outcome measure depression, 3 trials for hopelessness, and 2 in the outcome analysis for improvement in problems. Literature search date not reported.)

1 SOCIAL INCLUSION

The *statements*

The *evidence*

1.3c **Problem solving treatment** was more acceptable than the course on prevention of depression. 63% of participants assigned to problem solving and 44% assigned to prevention of depression completed their intervention. The proportion of problem solving participants depressed at 6-months was 17% less than that for controls, giving a NNT of 6 (the mean difference in Beck depression inventory (BDI) score was -2.63 ,95% CI -4.95 to -0.32). For **depression prevention**, the difference in proportions of depressed participants was 14% (NNT of 7; the mean difference in BDI score was -1.50, 95%CI -4.16 to 1.17). Such differences were not observed at 12-months. Neither specific diagnosis nor treatment with antidepressants affected outcome.[i]
Caveat: Follow-up at 12 months was low (66.59%).

i. Dowrick, G. Dunn, J.L. Ayuso-Mateos OS, et al. Problem solving treatment and group psycho-education for depression: multicentre randomised controlled trial. Outcomes of Depression International Network (ODIN) Group. *British Medical Journal* 2000; **321 (7274)**: 1450-1454 **http://bmj.bmjjournals.com/cgi/reprint/321/7274/1450** [accessed 29/07/05]

(Type II evidence - multicentred randomised controlled trial of 452 participants with depressive or adjustment disorders (aged 18 to 65 years) from Finland, Republic of Ireland, Norway, Spain, and the UK. Participants were allocated to receive either problem solving treatment (n=128), a course on prevention of depression (n=108), or control group (n=189). 12-months follow-up.)

1.3d **Problem solving treatment** is an effective treatment for **depressive disorders** in **primary care**. The treatment can be delivered by suitably trained **practice nurses** or **general practitioners**. The combination of this treatment with antidepressant medication is no more effective than either treatment alone. Patients in all groups showed a clear improvement over 12 weeks. For problem solving with a GP, mean scores on the Hamilton Rating scale improved from 20.5 at baseline (95% CI 18.9-22.1) to 8.5 (95% CI 5.8-11.2) at 12 weeks; with a nurse from 20.5 (95% CI 19.1-21.9) to 8.7 (95% CI 6.1-11.3); medication alone improved from 20.2 (95% CI 19.1-21.4) to 6.2 (95% CI 3.7-8.6); and combination 19.8 (95% CI 18.5-21.1) to 7.5 (95% CI 5.2-9.9).[i]

An additional analysis explored potential mechanisms of **the action of problem solving treatment**. Results did not support the hypotheses that for patients with **major depression**, by comparison with antidepressant medication: problem-solving treatment would result in better problem resolution; or that problem-solving treatment would increase the patients' sense of mastery and self-control.[ii]

i. Mynors-Wallis LM, Gath DH, Day A, Baker F. Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *British Medical Journal* 2000; **320(7226)**: 26-30 **http://bmj.bmjjournals.com/cgi/reprint/320/7226/26** [accessed 29/07/05]

ii. Mynors-Wallis L. Does problem-solving treatment work through resolving problems? *Psychological Medicine*. 2002; **32(7)**: 1315-1319

(Type II evidence - randomised controlled trial of 151 patients in Oxfordshire (aged 19-62 years) with major depression requiring treatment but not urgent referral. Participants were assigned via concealed allocation to either problem solving treatment by research general practitioner or by research practice nurse, antidepressant medication, or a combination of problem solving treatment and antidepressant medication.)

The *statements*

The *evidence*

Stress management and relaxation

1.3e No firm conclusions could be drawn from this systematic review. **Autogenic training** (AT), properly applied, remains to be tested in controlled trials that are appropriately planned and executed. The majority of the included trials were methodologically flawed. Seven trials reported positive effects of AT in reducing **stress**. One study showed no such benefit. Since one trial had used AT in combination with another technique, visual imagery, no conclusion can be drawn about the effect of AT in this case.[i]
Caveat: Reporting of inclusion criteria is limited.

i. Ernest E, Kanjin N. Autogenic training for stress and anxiety. *Complementary Therapies in Medicine* 2000; **8(2)**: 106-110

(Type I evidence – systematic review of 3 randomised controlled trials and 5 controlled trials evaluating the effectiveness of autogenic training to reduce symptoms of stress and anxiety. Literature search date not reported.)

1.3f **Training in stress management** may provide patients with skills for coping with acute stressors and reduce the likelihood of subsequent acute exacerbation of symptoms with the need for **hospitalisation**. The two treatment conditions did not differ in levels of symptoms, perceived stress or life skills immediately after completion of treatment or at 1-year follow-up. Patients who received the stress management programme did have fewer hospital admissions in the year following treatment. This effect of stress management was most apparent for those who showed high levels of attendance for treatment sessions.[i]
Caveat: Unclear whether an intention to treat analysis was performed. Participants were offered financial incentives for attendance.

i. Norman RMG, Malla AK, McLean TS, et al. An evaluation of a stress management programme for individuals with schizophrenia. *Schizophrenia Research* 2000; **58**: 293-303

(Type II evidence - randomised controlled trial of 130 patients with schizophrenia (age 17-50 years) from a treatment centre in Canada, assigned to receive either a 12-week stress management programme with follow-up sessions or a social activities programme (control). 1 year follow-up.)

1 SOCIAL INCLUSION

The *statements* | The *evidence*

National Service Framework: key action 1

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Authorities and agencies are to foster the developments of life-skills, which help to promote good mental health e.g. in healthy schools, good parenting and workplaces and lifelong learning schemes. [key action 1 paragraph 10.3]

How can mental health be promoted in workplace, school, good parenting, and lifelong learning schemes?

The *statements* | The *evidence*

1.4 Mental health promotion and good parenting

1.4a **Parenting programmes** can make a significant contribution to the **short-term psychosocial health of mothers** and have a potential role in **promotion of mental health**. The results of the meta analyses show statistically significant differences favouring the intervention group for depression -0.3 (95% CI -0.4 to -0.1); anxiety/stress -0.5 (95% CI -0.7 to -0.3); self-esteem -0.3 (95% CI -0.5 to 0.1); and relationship with spouse/marital adjustment -0.4 (95% CI -0.7 to -0.2). The meta-analysis of the social support data showed no evidence of effectiveness. Of the remaining data that could not be combined in a meta-analysis, approximately 22% of the outcomes measured, showed significant differences between the intervention and the control group.

Approximately one third of outcomes showed no evidence of effectiveness. A meta-analysis of the follow-up data for 3 trials showed that there was a continued improvement in self-esteem, depression, and marital adjustment at follow-up, although the latter 2 findings were not statistically significant. [i]

i. Barlow J, Coren E, Barlow J, Coren E. Parent-training programmes for improving maternal psychosocial health. *The Cochrane Database of Systematic Reviews* 2003, Issue 4. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002020/frame.html** [accessed 29/07/05]

(Type I evidence – systematic review and meta-analysis of 23 randomised controlled trials, 17 of which provided sufficient data to calculate effect sizes. Main outcome measures were anxiety, depression, self-esteem, social support and relationship with spouse/marital adjustment. Literature search to 1999.)

The *statements*

The *evidence*

1.4b Both individual and group-based **parenting programmes** produced results favouring the intervention group on a range of maternal and infant measures of outcome including mother-infant interaction, language development, parental attitudes, parental knowledge, maternal mealtime communication, maternal self-confidence and maternal identity. These results are limited due to the small number of included studies, and the use of a restricted number of outcome measures. Further research into the effectiveness of parenting programmes is needed.[i]
Caveat: A search for unpublished research is not reported.

i. Coren E, Barlow J. Individual and group-based parenting programmes for improving psychosocial outcomes for teenage parents and their children. *The Cochrane Database of Systematic Reviews* 2001, Issue 3. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002964/frame.html**
[accessed 29/07/05]
(Type I evidence - systematic review of 4 randomised controlled trials. Main outcome measures included maternal psychosocial health, anxiety, stress, and depression. Literature search 1970 to 2000.)

1.4c When **parent training** is offered at school registration to parents of **disruptive children** identified through a brief registration screening, it may not be a useful approach to treating the home and community **behavioural problems** of such children. The kindergarten classroom intervention was far more effective in reducing the perceived behavioural problems and impaired social skills of these children. Parent training produced no significant treatment effects, probably owing largely to poor attendance (less than half of the families attended at least 50% or more of the training sessions).

The classroom treatment produced improvement in parent ratings of adaptive behaviour, teacher ratings of attention, aggression, self-control, and social skills, as well as direct observations of externalising behaviour in the classroom. Neither treatment improved academic achievement skills or parent ratings of home behaviour problems, nor were effects evident on any lab measures of attention, impulse control, or mother-child interactions.[i]
Caveat: It is unclear how many children remained at follow-up.

i. Barkley RA, Shelton TL, Crosswait C, et al. Multi-method psycho-educational intervention for preschool children with disruptive behaviour: preliminary results at post-treatment. *Journal of Child Psychology & Psychiatry & Allied Disciplines* 2000; **41(3)**: 319-332
(Type II evidence – 5-year American randomised controlled trial. 158 disruptive children (mean age 4.8 years) were assigned to 1 of 4 treatment conditions lasting the kindergarten school year: no treatment, parent training only, full-day treatment classroom only, and the combination of parent training with the classroom treatment.)

1 SOCIAL INCLUSION

The *statements* | The *evidence*

Antenatal and postpartum support to promote mental health

1.4d Overall, women receiving a psychosocial or psychological intervention were equally likely to develop **postpartum depression** as those receiving standard care (RR 0.81 95%CI 0.65 - 1.02). However, a promising intervention is the provision of intensive, **postpartum support** provided by public health nurses or midwives (RR 0.68, 95% CI 0.55 - 0.84). Identifying mothers 'at risk' assisted prevention of postpartum depression (RR 0.67, 95% CI 0.51 - 0.89). Interventions with only a postnatal component appeared to be more beneficial than interventions that also incorporated an antenatal component (RR 0.76, 95% CI 0.58 - 0.98). While individually based interventions may be more effective than those that are group based (RR 0.76, 95% CI 0.59 - 1.00), women who received multiple-contact intervention were just as likely to experience postpartum depression as those who received a single-contact intervention.[i]

i. Dennis C-L, Creedy D. Psychosocial and psychological interventions for preventing postpartum depression *The Cochrane Database of Systematic Reviews. 2004,* Issue 4 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001134/frame.html** [accessed 29/07/05]

(Type I evidence – systematic review of 15 randomised controlled trials (7600 women) comparing a psychosocial or psychological intervention with usual antenatal, intrapartum, or postpartum care. Literature search to 2004.)

1.4e There is currently little evidence from RCTs to support the implementation of **antenatal group interventions** to reduce **postnatal depression (PDN) in 'at risk' women.** Further studies addressing the significant methodological limitations are recommended before concluding that antenatal targeted interventions have no place in maternity care. All five studies reviewed suffer from substantial limitations including small numbers; unrealistic effect sizes; large attrition rates; lack of systematic approach in identifying those 'at risk' and thus clinically heterogeneous samples.[i]

i. Austin MP. Targeted group antenatal prevention of postnatal depression: a review. *Acta Psychiatrica Scandinavica*. 2003; **107:** 244-250

(Type I evidence – systematic review of 5 randomised controlled trials of antenatal interventions offered to pregnant women identified as being 'at risk' of developing postpartum depression. Literature search 1960 to December 2001.)

The *statements*

The *evidence*

1.4f Despite limited preventive research being currently available, **postnatal depression** is suitable for **prevention programmes** because the onset is preceeded by a clear marker, there is a defined period of highest risk during which a sample of women may be identified and there is substantial antenatal and postnatal contact with health services. As **general practitioners** (GPs) are often the first medical contact for a woman with postnatal depression it is important for GPs to be informed about latest developments.[i]

i. Pope S, Watts J, Evans S, McDonald S, Henderson J. *Postnatal depression A systematic review of published scientific literature to 1999*. Canberra: National Health and Medical Research Council, 2000.

(Type I evidence – systematic review of 6 randomised controlled trials of treatment and prevention interventions. Literature search 1980-1999.)

1.4g The **volunteer home visitation programme** significantly improved some **parenting outcomes** but not parental distress or poor mental health. **Volunteers** may be an effective means of providing **parenting education**, but interventions that include specific means of addressing poor mental health are likely to have greater effects. Almost half the teenagers had poor mental health at baseline, and high rates persisted at follow-up in both groups. In multivariate models, the home visitation group demonstrated significantly better parenting behaviour scores at follow-up than did the control group (p=0.01) but showed no differences in parenting stress or mental health.[i]
Caveat: Only 57% of participants completed both baseline and follow-up evaluation.

i. Barnet B, Duggan AK, Devoe M, and Burrell L. The effect of volunteer home visitation for adolescent mothers on parenting and mental health outcomes: a randomised trial. *Archives of Pediatrics and Adolescent Medicine* 2002; **156(12)**: 1216-1222

(Type II evidence – randomised controlled trial of 232 teenage mothers (aged 12 to 18 years) at 28 or more weeks' gestation or who had delivered a baby in the past 6-months attending an alternative school for childbearing adolescents. Mothers were assigned to receive either a volunteer model home visitation programme or usual services. 15-month follow-up.)

1 SOCIAL INCLUSION

The *statements*

The *evidence*

1.4h Wide-scale provision by the National Health Service of either **support groups or self-help manuals** is not appropriate if the aim is to improve measurable health outcomes. There were no significant differences in Edinburgh Postnatal Depression Scale (EPDS) scores between the control and trial arms at 3- and 6-months, nor were there differences in the Short Form 36 (SF-36) and the SSQ6 scores. The 95% confidence interval for the difference in EPDS effectively excluded a change in mean score of more than 10% with either intervention. There were no differences in health service attendances in primary or secondary care between the control and trial arms. Of those women who attended the groups, 40% attended 6 or more. Women reported favourably on the 'pack' with the majority reading it a few times and feeling that it was aimed at them.[i]
Caveat: Follow-up at 6 months was low (71% of participants).

i. Reid M. Glazener C. Murray GD. Taylor GS. A two-centred pragmatic randomised controlled trial of two interventions of postnatal support. *BJOG: an International Journal of Obstetrics & Gynaecology* 2002; 109(10): 1164-70

(Type II evidence - randomised controlled trial of 1004 primiparious women (mean age 26.5 years) from 2 community centres in Scotland. Participants were allocated to a local postnatal support group, self-help manual pack group, a combination of the pack and group, or control group. Main outcome measures were postnatal depression, general health measures, social support, and use of health services.)

1.4i The study showed that a coaching strategy had a positive effect on maternal-infant interaction in this sample. Future research is needed to test **coaching interventions** in conjunction with other strategies targeted to **promote maternal-infant responsiveness** and to reduce postpartum depressive symptoms. The hypothesis that the treatment group would show significantly higher maternal-infant responsiveness after the intervention was supported. No effect of the intervention on depression scores was found. A significant increase in responsiveness occurred over time for both treatment and control groups. Results show that the treatment group had a significantly higher Dydactic Mutuality Code score (measure for responsiveness at Time 2, t=3.15, df=116, p=0.002 and at Time 3, t=-2.22, df=115, p=0.029). A significant decrease in depression scores over time was also observed. No interaction between group and time was detected.[i]
Caveat: 122 mothers were recruited and yet results are only presented for 117 mothers who completed all phases of data collection. An intention to treat analysis was not reported.

i. Horowitz JA, Bell M, Trybulski J, et al. Promoting responsiveness between mothers with depressive symptoms and their infants. *Journal of Nursing Scholarship* 2001; **33(4)**: 323-329

(Type II evidence – randomised controlled trial of 117 mothers (aged between 17-41 years) with depressive symptoms, in the US. Mothers received either a home visit with a coached behavioural intervention, or a standard home visit only. Final home visit and assessment was conducted at 14-18 weeks postpartum.)

The *statements*

The *evidence*

1.4j Women in both study and control groups were **more depressed antenatally than postnatally**. The finding that the education intervention made no difference is seen to challenge the two strongly held tenets of health education in childbearing women, that **depression** can be reduced through **education** and that antenatal education interventions can endure into the postnatal period. There were no differences when comparing the intervention group with the control group, and no relevant influence of social support or demographic variables. No statistical significance could be found.[i] **Caveat**: Unclear if an intention-to-treat analysis was used.

i. Hayes BA, Muller R, Bradley BS. Perinatal depression: a randomised controlled trial of an antenatal education intervention for primiparas. *Birth* 2001; **28(1)**: 28-35

(Type II evidence – prospective randomised controlled trial of 188 women from 3 hospitals in Australia (mean age 26 years) allocated to either an education package informing women of mood changes that can occur in the prenatal and postpartum periods or a control group. Changes in mood state was measured once antenatally (12-28 wks), and twice postnatally at 8-12 and 16-24 wks.)

1.4k A Cochrane systematic review to evaluate the provision of **telephone-based support** for women by a professional or lay individual during pregnancy and postpartum is currently underway. Primary outcomes include postnatal depression and anxiety.[i]

i. Creedy D. Telephone support for women during pregnancy and the first month postpartum (Protocol). *The Cochrane Database of Systematic Reviews* 2003, Issue 2 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004229/frame.html**

[accessed 29/07/05]

1 SOCIAL INCLUSION

The *statements* | The *evidence*

1.5 Mental health promotion in schools

1.5a **Universal school mental health promotion programmes** can be effective and it is suggested that long-term interventions promoting the positive mental health of all pupils and involving changes to the school climate are likely to be more successful than brief class-based mental illness prevention programmes. Positive evidence of effectiveness was obtained for programmes that adopted a whole-school approach, were implemented continuously for more than a year and were aimed at the **promotion of mental health** as opposed to the prevention of mental illness. 3 studies showed positive results for more than 70% of the outcomes measured (2 mental health promoting, 1 mental illness prevention). 5 studies had between 70% and 30% of positive outcomes (4 promotion, 1 prevention), 1 for less than 30% of outcomes measured (both promoting and preventing). The remaining 5 groups showed positive outcomes following subgroup analysis only (4 prevention 1 promotion and prevention).[i, ii]

i. Wells J, Barlow J, Stewart-Brown S. A systematic review of universal approaches to mental health promotion in schools. *Health Education* 2003; **103(4)**: 197-220

ii. Wells J, Barlow J, Stewart-Brown S. *A systematic review of universal approaches to mental health promotion in schools*. Oxford: Health Services Research unit, University of Oxford, 2001

(Type I - systematic review of 17 studies evaluating 16 interventions evaluating interventions taking a whole-school approach, interventions extending beyond the classroom to all or part of the school and classroom-based interventions. Literature search to 1999.)

1.5b Results suggest that there are a strong group of **school-based mental health programmes** that have evidence of impact across a range of emotional and behavioural problems. However, there were no programmes that specifically targeted particular clinical syndromes. Important features of the implementation process that increase the probability of service sustainability and maintenance were identified. These include (i) consistent programme implementation; (ii) inclusion of parents, teachers, or peers; (iii) use of multiple modalities; (iv) integration of programme content into general classroom curriculum; and (v) developmentally appropriate programme components.[i]
Caveat: Unpublished research was not sought, and it is unclear if non-English papers were excluded.

i. Rones M, Hoagwood K. School-based mental health services: a research review. *Clinical Child and Family Psychology Review* 2000; **3(4)**: 233-241

(Type I evidence - systematic review of 47 studies targeting children's mental health problems including emotional and behavioural problems, depression, and conduct. Main outcomes measured functioning, symptom reduction, and services/ systems. Literature search 1985 to 1999.)

1 SOCIAL INCLUSION

The *statements*

1.5c The overall findings of this review suggest that there is insufficient evidence to either support or not to support **curriculum-based suicide prevention programmes in schools**. The suicide prevention programmes varied considerably in content, frequency, duration and delivery making it difficult to draw general conclusions across studies. Most often the significant finding of change due to the prevention programmes were within the groups (pre/post changes) rather than significant differences between the control and experimental groups.[i]
See also Section 7.20 – 7.22 for suicide prevention in adults

The *evidence*

i. Guo B, Harstall C. *Efficacy of Suicide Prevention Programmes for Children and Youth*. HTA 26:Series A. Edmonton: Alberta Heritage Foundation for Medical Research, 2002.

(Type I – systematic review of 10 primary studies and two systematic reviews, evaluating school-based suicide prevention programmes for pupils aged 15-19 years. Literature search from 1991, end limit not reported.)

1.5d The current evidence on whether, overall, the interventions which have been implemented and evaluated to **promote young people's mental health or prevent their mental illness** are effective is conflicting. It cannot be assumed that what is implemented will be effective. If the aim of programmes is to promote self-esteem, interventions need to focus on self-esteem rather than on a range of mental health issues. There is currently insufficient evidence to recommend **school-based suicide prevention**. It may be more appropriate for future school-based efforts to frame interventions in terms of helping young people cope with stress and anxiety generally**.** Efforts to prevent mental-illness or promote mental health should not rely on the presentation of information alone but should include **skill development** components using behavioural techniques, which should be reinforced by support at different levels (e.g. classroom, school, home, community, society). Young people do not relate to medically or professionally defined concepts such as 'mental illness', 'depression' or 'positive mental health'. Interventions need to make sure that their content and presentation is relevant to the context of young people's everyday lives.[i]

i. Harden A, Rees R, Shepherd J, Brunton G, Oliver S, Oakley A. *Young people and mental health: a systematic review of research on barriers and facilitators*. London: The Evidence for Policy and Practice Information and Co-ordinating Centre, 2001

(Type I evidence – systematic review of 187 intervention and133 non-intervention studies, and 25 systematic reviews. Included studies evaluated a health promotion intervention aimed at promoting mental health or preventing mental ill-health (intervention studies) or identified how, or the extent to which, various aspects of young people's lives were associated with or predicted their mental health or ill-health, and/or reported directly on their views (non-intervention studies). Literature search to 1999.)

1 SOCIAL INCLUSION

The *statements*

1.5e **School-based, indicated prevention** approaches are feasible and effective for reducing **suicidal behaviours** and related emotional distress and for enhancing protective factors. Growth curve analyses showed significant rates of decline in attitude toward suicide and suicidal ideation associated with the experimental interventions. Compared with usual care, both Coping and Support Training (Υ_{14} =0.292, p<0.05; Υ_{23} =0.030, p<.05) and Counsellors CARE (Υ_{14} =0.223, p<0.01; Υ_{24} =.020, p<0.10) influenced the rate of change associated with favourable attitude toward suicide and suicidal ideation.[i]

See also Section 7.20 – 7.22 for suicide prevention in adults

The *evidence*

i. Thompson EA, Eggert LL, Randell BP, Pike KC. Evaluation of indicated suicide risk prevention approaches for potential high school dropouts. *American Journal of Public Health* 2001; **91(5)**: 742-52

(Type II evidence – unblinded randomised controlled trial of 460 youths (14 to 19 years: 52% female) at risk for suicide, allocated by school, to 1 of 3 conditions: Counsellors CARE (C-CARE), Coping and Support Training (CAST), or usual-care control. 9-month follow-up.)

1.5f Teacher-reported childrens behavioural and emotional problems over a year-long follow-up period, improved for both the **school based group therapy** or curriculum studies condition . However, there was a clear advantage of the group therapy intervention (comprising creative-expressive or psychodrama) over both a waiting list control and curriculum studies, according to teacher reports. This was true also of categorical analyses focusing on those with the most severe symptoms. Effect sizes were moderate for the curriculum studies intervention and moderate to large for the group therapy.[i]

Caveat: The number of schools participating is unclear.

i. McArdle P. Moseley D. Quibell T et al. School-based indicated prevention: a randomised trial of group therapy. *Journal of Child Psychology & Psychiatry & Allied Disciplines* 2002; **43(6)**: 705-12

(Type II evidence – randomised controlled trial of 122 children in North Tyneside (mean age 11.4 years) at risk for behavioural or emotional problems allocated to a school-based drama group therapy or a curriculum-studies control group. Outcomes measured teacher- and parent-identified behavioural change and self-report changes in perceptions of school and family life. 12-week study duration with1-year follow-up.)

The *statements*

The *evidence*

1.5g No intervention effects were found for **depression** in children receiving a depression prevention programme. Intervention group children reported less **anxiety** than the control group after the programme and at 6-month follow-up and more optimistic explanations at post intervention. Intervention group parents reported fewer child internalising and externalising symptoms at post intervention only.[i]
Caveat: An intention to treat analysis was not reported, and it is unclear how many children completed follow-up measures.

i. Roberts C, Kane R, Thomson H, Bishop B, Hart B. The prevention of depressive symptoms in rural school children: a randomised controlled trial. *Journal of Consulting & Clinical Psychology* 2003; **71(3)**: 622-8

(Type II evidence – randomised controlled trial of 7th grade rural school children (mean age 11.9 years) with elevated depression. 9 primary schools (n = 90) were assigned to receive a depression prevention programme and 9 control schools (n = 99) received usual health education classes. 6-months follow-up.)

1.5h Demographic risk factors were not associated with child behaviour problems or use of mental health services in this group of **Head Start children**. Findings suggest that children with behavioural problems have unmet mental health service needs. Interventions designed to address both **parent mental health needs** and sensitivity to the **developmental needs of children** may increase child-focused mental health service utilisation.

Factors predicting behaviour problems in young children varied according to whether the parent or teacher rated the child as having behaviour problems. Sex (male) (OR=2.7 95%CI 1.2-6.0, p=0.02) and home environment (OR=2.8, 95%CI 1.3-5.8, p=0.01) were associated with teachers rating the child as having a behaviour problem. Parent mental health problems and problems in the parent-child relationship were associated with parent ratings. Only home environment was associated with child-focused service utilisation, i.e. services that help parents manage children's behaviour (Univariate OR =0.4 95%CI 0.2-1.0, p<0.05).[i]
Caveat: The results of this study may have limited generalisability to a UK setting.

i. New M. Razzino B. Lewin A. Schlumpf K. Joseph J. Mental health service use in a community head start population. *Archives of Pediatrics & Adolescent Medicine* 2002; **156(7)**: 721-7

(Type II evidence – randomised controlled trial of 2 intervention and 2 comparison schools in America where Head Start children and families were enrolled in the Starting Early Starting Smart (SESS) programme. Data were collected on 290 children (mean age 4.3 years; 52% boys) during home-based interviews.)

1 SOCIAL INCLUSION

The *statements*

1.5i This **educational intervention** successfully improved body image and produced long-term changes in the **attitudes and self-image of young adolescents.** This new approach to prevent the development of eating disorders by improving self-esteem may be effective, particularly if reinforced by teachers and family.

The programme significantly improved the **body satisfaction** of the intervention students and significantly changed aspects of their self-esteem; social acceptance, physical appearance, and athletic ability became less important for the intervention students and more important for control students. One year after the intervention, body image and attitude changes were still present. These findings also held for the 116 students (63% females) with low self-esteem and higher anxiety, who were considered at risk for the development of eating disorders.[i]

The *evidence*

i. O'Dea JA, Abraham S. Improving the body image, eating attitudes, and behaviours of young male and female adolescents: a new educational approach that focuses on self-esteem. *International Journal of Eating Disorders* 2000; **28**: 43-57

(Type II evidence - randomised controlled trial of all 470 students enrolled in Years 7 and 8, of 2 Australian schools (63% female, aged 11.1 to 14.5 years). Study personnel, teachers and students were blinded from the aim of the study to examine the effect on body image and eating attitudes and behaviours. 98.9% adolescents were followed up at 12 months.)

1.6 Mental health promotion at work

1.6a Many of the **work related variables** associated with high levels of **psychological ill health** are potentially amenable to change. This is shown in intervention studies that have successfully improved psychological health and reduced sickness absence. Key work factors associated with **psychological ill health** and sickness absence in staff were long hours worked, work overload and pressure, and the effects of these on personal lives; lack of control over work; lack of participation in decision making; poor social support; and unclear management and work role. There was some evidence that sickness absence was associated with poor management style. Successful interventions that improved psychological health and levels of sickness absence used training and organisational approaches to increase participation in decision making and problem solving, increase support and feedback, and improve communication.[i]

i. Michie S, Williams S. Reducing work related psychological ill health and sickness absence: a systematic literature review. *Occupational and Environmental Medicine* 2003; **60**: 3-9

(Type I evidence – systematic review of 49 randomised controlled and uncontrolled trials, and observational studies. Literature search 1987-1999.)

The *statements*

The *evidence*

1.6b In general, **workplace counselling** is effective for clients for a wide variety of type and severity of presenting problems, employed across a range of different organisational contexts. Counselling interventions are generally effective in alleviating symptoms of **anxiety, stress and depression**, may reduce sickness absence rates in clients by 25-50%. There is no evidence that any one approach to counselling is more effective than any other in this field. Positive results have been found using a variety of models of counselling, including cognitive-behavioural, psychodynamic, person-centred, rational emotive and solution focused. **Training** and experience in techniques and methods of brief therapy are associated with good outcomes in workplace counselling. All published studies of the economic costs and benefits of workplace counselling have reported that counselling provision at least covers its costs and some studies found substantial positive cost-benefit ratios.[i,ii]

i. McLeod J, McLeod J. How effective is workplace counselling? A review of the research literature. *Counselling and Psychotherapy Research* 2001; **1(3)**: 184-190

ii. McLeod J. *Counselling in the workplace: the facts. A systematic study of the research evidence*. Rugby: British Association for Counselling and Psychotherapy, 2001

(Type I evidence – systematic review of 34 intervention studies evaluating the effectiveness of workplace-based counselling. Literature search 1954 to 2000.)

1.6c **A worksite programme** that focuses on **stress, anxiety and coping measurement** along with **small-group educational intervention** can significantly reduce illness and healthcare utilisation. All 3 groups reported significant improvement in their stress and, anxiety and coping across the year. Full intervention participants showed a more rapid reduction in negative responses to stress than did participants from the other groups. Full-intervention subjects also reported fewer days of illness than subjects in the other groups, and a 34% reduction in healthcare utilisation for full intervention subjects in the Health Maintenance Organisation subsample.[i] **Caveat:** There was a 68% difference between those participants who completed the programme and those who did not. It is unclear if intention to treat analysis was used. The results have limited generalisablilty as most employees were highly educated in high powered jobs.

i. Rahe RH, Taylor CB. A novel stress and coping workplace programme reduces illness and healthcare utilization. *Psychosomatic Medicine* 2002; **64**: 278-286

(Type II evidence – randomised controlled trial of 501 employees in America (mean age 43 years; 54% female) allocated to receive a full work-based stress management intervention, a partial intervention, or a wait-list control group. 12-months study duration.)

1 SOCIAL INCLUSION

The *statements* | The *evidence*

1.7 Life-long learning schemes

1.7a In the future, **supported education programmes** need to build in mechanisms to ensure students receive **ongoing support for education,** since this support was found to positively and significantly affect individuals' enrolling in college or training. Results supported participants' continuing satisfaction, and identified particular information items which were endorsed as helpful. However, the data indicated that personal difficulties presented obstacles to many and that a majority of participants had current needs for financial aid, tutoring, job placements, support groups, and transportation. Following completion of the supported education programme, many participants had continuing contacts in support of their education plans. The amount of contact was generally low however.[i]

Factors related to a successful outcome from a **supported education programme** for persons with severe mental illness are also likely to be important factors for nondisabled populations. Among those with mental illness, **social support** is a key factor in attaining educational and vocational goals. Analysis identified the strongest predictor as productive activity at baseline. Marital status was the only significant demographic variable in the model; single participants were less likely to be engaged in productive activity. For participants who reported more frequent contact with their **social network**, the likelihood of engagement in productive activity was higher, and for those who reported more encouragement for education from their network, the likelihood was lower.[ii]
Caveat Follow-up at 12 months was low (67%)**.** Participants were reimbursed financially. It is unclear if participants were similar at the start of the trial or if intention to treat analysis was performed.

i. Mowbray CT, Bybee D, Collins ME. Follow-up client satisfaction in a supported education program. *Psychiatric Rehabilitation Journal* 2001; **24(3):** 237-247

(Type II evidence – 12 month follow-up data from a randomised controlled trial of 396 people with psychiatric disability assigned to 1 of 3 supported education programmes: classroom, group or individual.)

ii. Collins ME, Mowbray CT, Bybee D. Characteristics predicting successful outcomes of participants with severe mental illness in supported education. *Psychiatric Services* 2000; **51(6)**: 784-80 **http://psychservices.psychiatryonline.org/cgi/reprint/51/6/774** [accessed 29/07/05]

(Type II evidence – secondary analysis of an American randomised controlled trial of supported education. Analysis is based on the 147 people who completed either the group or the classroom supported education programme and who attended at least the orientation session.)

1 SOCIAL INCLUSION

National Service Framework: key action 2

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Authorities and agencies are to seek to raise public awareness and understanding of mental health issues and help combat stigma. They are to increase the public's awareness and understanding of mental health problems, and the range of social issues interacting with mental health. [key action 2 paragraph 11.1]

What are effective interventions to reduce the stigma associated with mental health problems?

What have proved effective ways of increasing public understanding of mental health issues?

The *statements* | The *evidence*

1.8 Interventions to change attitudes and behaviour towards people with mental illness

1.8a Subjects who had **contact** with persons with serious mental illness experienced greater changes than subjects in the **education** or control groups did on measures of attribution and helping behaviour. In a second study where the effects of stereotype suppression on behaviour were examined, results showed that while the stereotype suppression instructions resulted in less stereotypical passages ($F(1,56)=9.68$, $p<0.01$) replicating the results of study 1, rebound effects on behaviour were not significant. A non-significant trend was observed whereby previous contact with persons with mental illness was associated with less social distance from someone with schizophrenia.[i]
Caveat: Sample sizes assigned to the intervention and control groups have not been reported. Long term effects are not measured as follow-up was only 1 week.

i. Corrigan PW, Rowan D, Green A. Challenging two mental illness stigmas: personal responsibility and dangerousness. *Schizophrenia Bulletin* 2002; **28(2)**: 293-309

(Type II evidence – randomised controlled trial of 213 community college students in America (mean age 26.3 years, 70.4% female) assigned to 1 of 5 groups: education on personal responsibility, education on dangerousness, contact with a person with serious mental illness where dangerousness is discussed, contact with a person with serious mental illness where personal responsibility is discussed, or a no change control group. Outcome measures included the Social Distance Scale and attribution factors such as responsibility, anger, pity, help, fear, dangerousness and avoidance.)

1.8b Results of 3 randomly assigned intervention strategies for changing stigmatising attitudes showed that **education** had no effect on attributions about physical disabilities but led to improved attributions in 4 psychiatric groups. **Contact** produced positive changes that exceeded education effects in attributions about targeted psychiatric disabilities: depression and psychosis. **Protest** yielded no significant changes in attributions about any group. This study also examined the effects of these strategies on processing information about mental illness.[i]
Caveat: Sample sizes assigned to the intervention and control groups have not been reported.

i. Corrigan PW, River LP, Lundin RK et al. Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin* 2001; **27(2)**: 187-95

(Type II evidence – randomised controlled trial of 152 community college students in America (mean age 25.7 years) assigned to 1 of 4 stigma-changing conditions: education, contact, protest or control groups. Participants completed measures of attributions about disabilities pre- and post-intervention.)

1 SOCIAL INCLUSION

The *statements*

1.8c College students who read **information on mental illness** demonstrated improved attitudes toward help seeking at follow-up (F (1,52) = 4.92, p<0.05) and more positive expectations about personal commitment of therapy initially (F (2,158)=4.63, p=0.01) and at follow-up (F (2,158)=4.94, p<0.01). When compared to the control group, they also had significantly more positive opinions about mental illness immediately after the intervention but this difference disappeared after a month. Participants who read an intervention about psychotherapy demonstrated more positive expectations about personal commitment of therapy initially (F (2,158) =4.64, p=0.01)and at follow-up (F (2,158)=4.94, p<0.01).

Participants who read an intervention containing a general description of psychotherapy demonstrated more positive expectations about personal commitment of therapy initially and at follow-up. The group that read an intervention on psychotherapy scored significantly higher than the control group on the expectation to make a personal commitment in psychotherapy (p=0.01), a difference that remained significant after 1 month.

Those who reported previous psychotherapy experience reported significantly more positive attitudes toward help seeking at both the initial time of testing (p=0.01) and at follow-up (p<0.001). This group also scored higher on the expectation to make a personal commitment in therapy at initial testing (p=0.01) and at follow-up (p<0.05) compared to those who had no experience with psychotherapy although there were no differences in other measures.[i]
Caveat: Students were given extra credit for their participation. At 4-weeks, follow-up was only 66%. Sample sizes assigned to the intervention and control groups have not been reported.

The *evidence*

i. Gonzalez JM, Tinsley HEA, Kreuder KR, Karen R. Effects of psychoeducational interventions on opinions of mental illness, attitudes towards help seeking, and expectations about psychotherapy in college students. *Journal of College Student Development* 2001; **43(1)**: 57-63

(Type II evidence – randomised controlled trial of 167 undergraduate psychology students (mean age 20 years, 58% female) assigned to either a written psychoeducational intervention about mental illness, a written psychoeducational intervention about psychotherapy or a control group.)

The *statements*

The *evidence*

1.8d Short **educational workshops** can produce positive changes in school students reported **attitudes towards people with mental health problems**. Results show that young people use an extensive vocabulary of 270 different words and phrases to describe people with mental health problems: most were derogatory terms. Mean positive attitude scores rose significantly from 1.2 at baseline to 2.8 at 1-week follow-up and 2.4 at a 6-month follow-up. Changes were most marked for female students and those reporting personal contact with people with mental illness.[i]

Short educational interventions can also produce changes in **police attitudes towards people with mental health problems**, and can leave officers feeling more informed and more confident to support people in mental distress. Mean attitude scores fell from 2.4 at baseline to 2.3 at follow-up ($p < 0.0001$) using a 5-point Likert scale. Positive impacts on police work, particularly improvements in communication between officers and subjects, were reported by a third of cases. The stereotype linking people with mental health problems with violent behaviour overall was not successfully challenged.[ii]

i. Pinfold V, Toulmin H, Thornicroft G, Huxley P, Farmer P, Graham T. Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *British Journal of Psychiatry* 2003; **182(4)**: 342-346

(Type III evidence – 2-phase pilot project of 472 secondary school students in England (aged 14-15 years; 73% female) assigned to attend 2 mental health awareness workshops. Students completed pre- and post- intervention questionnaires detailing knowledge, attitudes and behavioural intentions.)

ii. Pinfold V, Huxley P, Thornicroft G, Farmer P, Toulmin H, Graham T. Reducing psychiatric stigma and discrimination: evaluating an educational intervention with the police force in England. *Social Psychiatry & Psychiatric Epidemiology* 2003; **38:** 337-334

(Type III evidence – before and after study. 109 police officers in England attended mental health training workshops and completed pre- and post-questionnaires detailing knowledge, attitudes and behavioural interventions.)

1.8e **Suppression of stereotypes** of persons with **schizophrenia** did not result in paradoxical rebound effects and in fact may have promised a **stigma-reduction** strategy. Participants were presented with a photograph of someone labelled with schizophrenia and instructed to write a passage describing a day in that person's life. Half of the participants were instructed to avoid using schizophrenia-related stereotypes in their passages. Participants were then presented with a photograph of a different individual labelled with schizophrenia and asked to write another passage with stereotype suppression instructions omitted. Results showed that while stereotype suppression occurred for the first passage ($F(1,50)=11.01, p<0.01$), the expected rebound effects were not observed in the second passage ($F(1,50)=0.474$). Furthermore, the results were unchanged when participants' prior experience with persons with mental illness was considered (multiple $R=0.238, R2=0.056$).

Continued

i. Penn DL, Corrigan PW. The effects of stereotype suppression on psychiatric stigma. *Schizophrenia Research* 2002; **55(3)**: 269-276

(Type II evidence – 2 randomised controlled trials of 100 undergraduate students in America. 52 Participants (mean age 20.1 years, 77% female) in the first study were assigned to either stereo type suppression instructions or no stereo type suppression instructions. In the second study 58 participants (mean age 20.7 years, 70.7% female) were assigned to stereotype suppression instructions (or standard instructions.)

The *statements*

The *evidence*

1.8e continued from previous page

In a second study where the effects of stereotype suppression on behaviour were examined, results showed that while the stereotype suppression instructions resulted in less stereotypical passages (F(1,56)=9.68, p<0.01) replicating the results of study 1, rebound effects on behaviour were not significant. A non-significant trend was observed whereby previous contact with persons with mental illness was associated with less social distance from someone with schizophrenia.[i]

Caveat: Both trials have very small study sizes.

1.8f Results support the hypothesis that young people's attitudes about schizophrenia are susceptible to change. **Antistigma** projects at school level could thus be a promising approach to **improving public attitudes** and to **preventing stereotypes** from becoming reinforced. Despite expected ceiling effects, the project led to a significant reduction of negative stereotypes. Changes of stereotype over time were estimated to be negative for the control group (-0.12) while a positive change was observed for the project group. The interaction effect project x time (0.50) indicated a significant positive effect, i.e. a dispelling of negative stereotypes (p=0.01). For social distance, a positive trend could also be observed, however, the effect size was not statistically significant. Attitude changes were still evident at the 1-month follow-up.[i]

i. Schulze B, Richter-Werling M, Matschinger H, Angermeyer MC. Crazy? So what! Effects of a school project on students' attitudes towards people with schizophrenia. *Acta Psychiatrica Scandinavica* 2003; **107(2)**: 142-50

(Type III evidence – before and after study of 90 school students in Germany (aged 14-18 years; 58% female) from 5 secondary schools participating in a school-based anti-stigma project. Students met a young person with schizophrenia who discussed his/her experiences. In each school, 60 students participating in a different project unrelated to mental health were questioned as controls. Assessment was repeated before and 1-month after the intervention.)

1 SOCIAL INCLUSION

The *statements*

1.8g Future mental healthcare practice could draw upon professionals' stock of knowledge as to how their practice could lead to less stigma and could build upon clients' own strength to achieve **stigma reduction**. The study suggests that stigma is something that those in **community mental health services** are concerned with. First, workers described themselves as actively trying to challenge stigma at an institutional level, as well as being apt to change their own practice to reduce the stigmatising effect of mental healthcare on their clients and make their presence less conspicuous. The ideal was to be 'like a friend going round'. However, this view included a somewhat passive notion of clients. By contrast, the present investigation showed that clients described themselves in much more active terms as being aware of possible sources of stigma and being inclined to challenge negative attitudes themselves.[i]

The *evidence*

i. Crawford P, Brown B. 'Like a friend going round': reducing the stigma attached to mental healthcare in rural communities. *Health and Social Care in the Community* 2002; **10(4)**: 229-238

(Type IV evidence – qualitative study of 15 mental health users and 33 mental health care workers. 8 focus groups were conducted in a rural area in the north Midlands. Transcript data analysis was conducted to identify themes relating to stigma.)

1.8h While more research is needed to clarify and extend these findings, this study provides strong evidence for the importance of **different contact types in reducing stigmatising attitudes** and the potential usefulness of incorporating contact into any stigma reduction intervention. As total contact increased, the perceived dangerousness and desired social distance from the vignette character decreased, as did the perceived dangerousness of people with mental illnesses in general. However, the contact types did not consistently predict the vignette stigma measures.[i]
Caveat: It is unclear whether the measurement tools used in this study have been validated.

i. Alexander LA, Link BG. The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health* 2003; **12(3)**: 271-289

(Type IV evidence – data analysis of 1507 telephone survey respondents in America (age >18 years; 57% female). A subsample of 640 respondents listened to a vignette about a person with mental illness and then completed measures of their desired social distance from the person and perceived dangerousness.)

1 SOCIAL INCLUSION

The *statements*

1.8i Early improved **education** and **exposure** in the future may lead to greater decline in **stigmatised attitudes**. There were more optimistic views with regard to treatment than the general population and there appeared to be a lessening in stigma as experience increased. More than 50% of those completing the questionnaire felt that people with schizophrenia and drug and alcohol addiction were dangerous and unpredictable. More often doctors and medical students were less likely to blame the individual and, with the exception of dementia, felt that the conditions listed would improve and the individual would eventually recover. It was felt by the majority that people were not to blame for their conditions, but that people with depression, dementia and schizophrenia were difficult to talk to.[i]
Caveat: The questionnaire response rate was only 41%.

The *evidence*

i. Mukherjee R, Fiahlo A, Wijetunge A, Checinski K, Surgenor T. The stigmatisation of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital. *Psychiatric Bulletin* 2002; **26(5)**: 178-81

(Type IV evidence – observational study of 832 medical students and 441 doctors (51% female; ages unknown) at a London teaching hospital. Participants completed a questionnaire based on the 6 target diagnoses set out in the Royal College of Psychiatrists 5-year campaign aimed to change attitudes to psychiatric illness 'Changing Minds: Every Family in the Land'.)

1.8j The apparent immediacy and the evocative power of **video presentations** cannot substitute for direct **contact** for the purpose of promoting positive attitude change. **Education** programmes trying to de-stigmatise mental illness and homelessness using videos should proceed with caution. Females and subjects who had more prior encounters with homeless persons were found to have the most positive attitudes. After controlling for these effects, the video alone had a negative impact on attitudes relative to the other groups, while the video followed by a discussion with one of the people featured in it had a largely positive impact.[i]
Caveat: Demographic characteristics for the study sample are not reported.

i. Tolomiczenko GS, Goering PN, Durbin JF. Educating the public about mental illness and homelessness: a cautionary note. *Canadian Journal of Psychiatry* 2001; **46(3)**: 253-57

(Type IV evidence – observational study of 575 high school students who attended a brief educational session on mental illness and participated in 1 of 3 comparison versions of a 2-hour education programme (control n=175, video n=214, video plus discussion n=186). All participants completed questionnaires on attitudes to homelessness.)

1 SOCIAL INCLUSION

National Service Framework: key action 3

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Authorities are to promote social inclusion by:

- Establishing supportive empowering and healthy communities in rural and urban areas (as proposed in the Communities First initiative) that ensure opportunities for participation of vulnerable groups including those with mental health problems. For example, tenant participation schemes could be tailored to include representation of mental health needs
- Meeting the needs of specific vulnerable people who have a mental health problem and are already at risk of exclusion e.g. Individuals from ethnic minorities, individuals with disabilities and parents who have mental health problems, and homeless people [Key action 3 paragraph 12.1]

How can the social inclusion of people with mental health problems be supported?

What are the needs of people with mental health problems that are already at risk of exclusion?

See Section 5.2 for needs of vulnerable people with a mental health problem.

See Section 3.5 for social/leisure activities.

The *statements* | The *evidence*

1.9 Reducing social exclusion and supporting socialisation

1.9a A report by the Social Exclusion Unit (SEU) is available providing information on what more can be done to **reduce social exclusion** among adults with mental health problems. Two main issues are considered; enabling adults with mental health problems to enter and retain work and securing the same opportunities for social participation and access to services as the general population. The report sets out a 27-point action plan, falling into six categories:

- Stigma and discrimination
- The role of health and social care in tackling social exclusion
- Employment
- Supporting families and community participation
- Getting the basics right – access to decent homes, financial advice and transport
- Making it happen

The SEU's remit covers England only. However, the project has drawn on lessons from Wales, Scotland and Northern Ireland and is likely to be relevant throughout the UK.[i]

i. Social Exclusion Unit. *Mental Health and Social Exclusion*. Office of the Deputy Prime Minister. June 2004.

(Type V evidence – UK government report including a detailed review of literature and research, and a written consultation receiving over 900 responses from people with mental health problems and carers, the voluntary sector, and health and social care bodies, local authorities, housing, employment and benefit services. Four local research studies were also conducted in London, Peterborough, Liverpool and Northumberland to provide an in-depth understanding of delivery issues.)

1 SOCIAL INCLUSION

The *statements*	The *evidence*
1.9b A 3-year research study that focused on the impact of introducing **mental health registers** into general practices expected that the overall result would reduce the levels of **social exclusion** experienced by patients with severe and enduring mental illness. However, findings revealed a lack of change in unmet needs and quality of life, even amongst those in contact with a community mental health nurse.[i]	**i.** Bonner L, Barr W, Hoskins A. Using primary care-based mental health registers to reduce social exclusion in patients with severe mental illness. *Journal of Psychiatric & Mental Health Nursing* 2002; **9(5)**: 585-593 (Type IV evidence – observational study of 49 individuals with severe and enduring mental illness (mean age 46.3 years) from 6 general practices in an English health district. Participants were interviewed in their own home on 2 occasions and at 12-months follow-up.)
1.9c The **community organisations** studied had a particular organisational culture which provided services in a physical space that was a place of inspiration and relevance to local people. Their primary focus was on meaningful occupation and opportunities, whereby engagement with clients was achieved through a focus on positive strengths and opportunities. There was no 'blueprint' for involving people and examples from both organisations included people who had become involved as volunteers and users who had moved on to responsible and rewarding positions in the agencies and their communities. Participants recounted situations during interviews which demonstrated the potential of such organisations to alter perceptions, raise awareness and to educate in areas of need such as severe mental health problems. Specialist and mainstream services need to broaden out their vision to work inclusively with community organisations.[i]	**i.** Villneau L, Morris D, Parkmen S. *On your doorstep: community organisations and mental health*. London: Sainsbury Centre for Mental Health, 2000 (Type IV evidence – qualitative study of interviews with 24 service users and workers from 2 community organisations and other local agencies in England, which included mental health services.)
1.9d Newly developed cognitive **social skills** training programmes might facilitate the abilities of **schizophrenia patients for their integration in the community**. Higher global therapy effects were obtained on almost all dependent variables in the experimental groups. Analyses of variance and covariance indicated higher symptom reduction for the experimental groups, but significantly greater improvements in some cognitive variables for the control group. Correlation analysis suggested associations between improvement of social behaviour with symptom reduction and improvements of cognitive skills.[i]	**i.** Roder V, Brenner HD, et al. Development of specific social skills training programmes for schizophrenia patients: results of a multicentre study. *Acta Psychiatrica Scandinavica* 2002; **105(5)**: 363-371 (Type III evidence – experimental study of 105 patients (mean age 33.5 years) from 8 European psychiatric institutions, with a diagnosis of schizophrenia or schizoaffective disorder. Patients were assigned to recreational, residential or vocational skills training (experimental) or traditional social skills training (control). One year follow-up.)

The *statements*

The *evidence*

1.9e The effects of **support** were found to be likely applicable for a variety of individuals, indigenous supporters and facilities. Support procedures were evaluated favourably by both patients and supporters. The interpersonal functioning of the group with supporters was found to be significantly better than that of the non-supported group at 6 and 12 month follow-ups. No differences were found between the groups in symptoms, which were minimal during the entire training period, or skills learning and retention. Indirect evidence suggested the importance of providing support for the supporters.[i]

i. Tauber R, Wallace CJ, Lecomte T. Enlisting indigenous community supporters in skills training programmes for persons with severe mental illness. *Psychiatric Services* 2000; **51(11)**: 1428-1432 **http://psychservices.psychiatryonline.org/cgi/reprint/51/11/1428** [accessed 29/07/05]

(Type III evidence – experimental study of 85 severely and persistently mentally ill individuals (aged 25-55 years; 62.5% male) who were receiving care from case management teams of a public mental health system in America. The intervention group received 6-months of skills training with support from an individual of their choosing. The control group lacked supporters. 12-months follow-up.)

1.9f Observed results from a qualitative study designed to increase the involvement of individuals with psychiatric disabilities in naturally occurring **social and recreational activities** found that all those interviewed desired and responded to opportunities for **friendship**. Across conditions, participants described valuing their experiences of being able to go out and do 'normal' things and of regaining parts of themselves and their lives that they had lost since the onset of their illness.[i]
Caveat: Only a small sample were interviewed (21 people). Participants were paid $20 to complete interviews.

i. Davidson L, Haglund KE, Stayner DA, Chinman MJ, Tebes JK. "It was just realising…that life isn't one big horror". A qualitative study of supported socialisation. *Psychiatric Rehabilitation Journal* 2001; **24(3)**: 275-292

(Type II evidence – qualitative analysis of an American randomised controlled trial (evaluating a 9-month social support programme) sub-sample. Participants (mean age 42 years, 57% female) receiving outpatient psychiatric treatment were assigned to 1 of 3 conditions: 1) matched with a volunteer from the community; 2) matched with a volunteer who had a personal history of psychiatric disability and recovery or 3) not matched with a partner.)

1.9g Results from an experimental study investigating the relationship of insight to **social skill** and impression management strategies in persons with severe mental illness show greater insight was associated with less severe psychiatric symptoms. Higher insight was associated with less strangeness (-0.52, $p<.01$ for the nonstigmatising social context; -0.42, $p<.05$ for the stigmatising social context) in both social contexts and with increased overall **social skill** (0.44, $p<0.05$) in only the non-stigmatising social context. No other bivariate correlations were statistically significant.[i]
Caveat: Small sample size.

i. Francis JL, Penn DL. The relationship between insight and social skill in persons with severe mental illness. *Journal of Nervous & Mental Disease* 2001; **189(12)**: 822-829

(Type III evidence – blinded experimental study of 29 outpatients (mean age 40.7 years; 55.2% female) with severe mental illness in America. Patients participated in 2 unstructured, 5-minute, role-play social interactions (stigmatising and non-stigmatising). Participant's behaviour was coded for the presence of various self-presentation and videotaped social skill variables.)