What You Need to Know About

Mental Health Inequalities

Prepared by Special Interest Group for Mental Health Improvement
June 2010

1. What is the purpose of this paper?

This paper summarises the key messages from selected papers focusing on inequalities in Mental Health. It also gives key messages that the Special Interest Group for Mental Health Improvement consider important. The documents looked at include:

- National Programme for Improving Mental Health and Well-Being Equal Minds[1]
- Equally Well Implementation Plan[2]
- Mental Health, resilience and inequalities[3]
- Mind the Difference – Mental Health: A focus on equality and diversity[4]
- Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011[5]
- With Inclusion in Mind, The local authority's role in promoting wellbeing and social development: Mental Health (Care and Treatment) (Scotland) Act 2003 Sections 25-31[6]

Key points of each of the papers listed above can be found in appendices 2 – 7.

The Special Interest Group for Mental Health Improvement prepared this paper for use with local planning partners, to ensure key inequalities messages are being considered when work is being developed. Please note that this document is not a detailed literature review as it only considers the mental health inequalities papers mentioned above. This document does not prescribe actions either – actions should be determined by local circumstances.

2. What is the Special Interest Group for Mental Health Improvement?

Special Interest Groups (SIGs) provide health promotion and improvement staff with a specialist remit in an area of health improvement with opportunities to; network, jointly carry out tasks relevant to the topic area and share practice with their peers in other departments across Scotland. SIGs can strengthen the partnership between national and local delivery and create synergy, focus and alignment of work, which ultimately supports implementation of national strategy.

NHS Health Scotland facilitates the Mental Health Improvement SIG comprising of one member from each of the fourteen local health boards who has a responsibility for Mental Health Improvement.

3. What is Mental Health and Wellbeing?

This section provides; definitions, protective and risk factors and some general statements about mental health and wellbeing.

Although definitions vary, mental health and wellbeing is generally seen as including:

- emotion (affect and feeling)
- cognition (perception, thinking and reasoning)
- social functioning (relations with others and society)
- coherence (sense of meaning and purpose in life)[3]

There is general agreement that mental health and wellbeing is more than an absence of mental illness. 'Mental health is the emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others' dignity and worth'.[1]

We all have mental health. Even if we do not consciously think about it all the time, our state of mental health underpins everything we do on a daily basis. However, we are not generally aware of our mental health in the same way as our physical health. [3]

Good mental health and wellbeing and reduced incidence of mental health problems is important for the healthy functioning of communities. They affect behaviour, social cohesion, social inclusion, crime and prosperity. [5]

We must consider mental health as every bit as important as physical health, and learn from not only the causes of poor mental health in individuals and communities, but also what helps build resilience and good, positive mental health. [3]

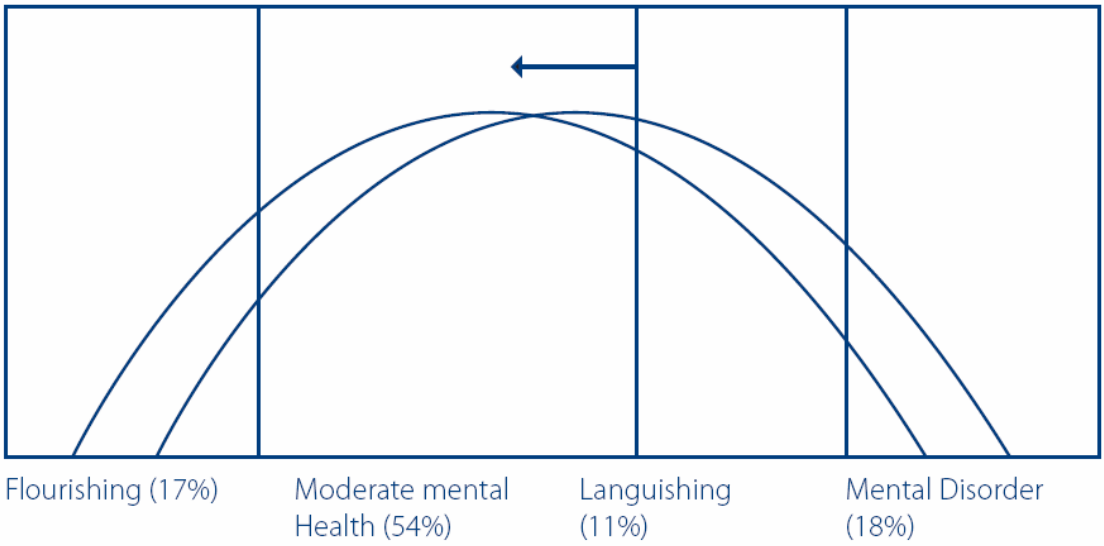
A wealth of existing research suggests that mental health and wellbeing influences:

- capacity and motivation for healthy behaviours
- risk of physical health (e.g. coronary heart disease)
- chronic disease outcomes (e.g. diabetes)
- relationship to health services, including uptake and treatment (e.g. patterns of concordance). [3]

Figure 1 shows the distribution of population mental health and the shift that can occur as a result of population wide mental health interventions.

Figure 1:

Fig 2. Population distribution of mental health



Adapted from Huppert 2005; prevalence figures are from Keyes 2005, based on USA data

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Small improvements in population wide levels of mental health and wellbeing will reduce the prevalence of mental health problems, as well as bringing the benefits associated with positive mental health [3] as shown in Figure 1.

There are a range of protective and risk factors that positively and negatively influence individual, group and community mental health and wellbeing. Figure 2 sets out examples of these:

Figure 2:

Appendix B of Towards a Mentally Flourishing Scotland - Examples of risk and protective factors for mental health and mental wellbeing

	Protective Factors	Risk factors
Individual Level	positive sense of self good coping skills attachment to family social skills good physical health	low self-esteem low self-efficacy poor coping skills insecure attachment in childhood physical and intellectual disability
Social Level	positive experience of early attachment supportive caring parents/family good communication skills supportive social relationships sense of social belonging community participation	abuse and violence separation and loss peer rejection social isolation
Structural Level	safe and secure living environment economic security employment positive educational experience access to support services	neighbourhood violence and crime poverty unemployment/economic insecurity homelessness school failure social or cultural discrimination lack of support services

Sources: Margaret M. Barry and Rachel Jenkins (2007) Implementing Mental Health Promotion, Churchill Livingstone Elsevier

4. What is Mental Health Improvement?

Mental Health Improvement refers to activity to promote mental health and wellbeing in the general population; to reduce the prevalence of common mental health problems; and to improve quality of life for those experiencing mental health problems or mental illness. [5]

The approach is based on a social model of health which recognises that mental state is shaped by social, economic, physical and cultural environments, including people's personal strengths and vulnerabilities, their lifestyles and health-related behaviours, and economic, social and environmental factors. [5]

In order to draw together policies, priorities and the evidence base of what works in mental health improvement, the SIG have devised a matrix that highlights some mental health improvement areas for action (Appendix 1). The matrix illustrates the key policy areas and evidence based interventions that will have a positive impact on population mental health.

5. What are Mental Health Inequalities?

The World Health Organization defines health inequality as 'differences in health status or in the distribution of health determinants between different population groups'. [7]

The focus is therefore on both the causes and the effects of differential health status. Adopting this formulation, in the context of mental health, means considering the unequal distribution of the factors which are detrimental to mental health and well-being and/or which promote positive mental health; and the unequal distribution of mental illness/mental health problems between different population groups. [1]

The underpinning focus for health improvement in 2008-11 is addressing inequalities. We know that good mental health and flourishing mental wellbeing are not equally distributed across the population. Similarly, mental health problems and mental illness are not randomly distributed across populations: although mental health problems will affect one in four people, it will not just be any one in four people.

'Those who are subject to discrimination in its many forms (such as racism, sexism, homophobia, ageism, discrimination on the grounds of disability), who are victims of violence or abuse or who are socio-economically deprived are more likely to experience poor mental wellbeing and are more likely to be at risk of developing mental health problems or illness.' [4]

In order to determine if approaches/interventions to improve mental health and wellbeing are successful, there has been a move towards a more outcome focused approach. To support outcomes focused planning for improved mental health The Scottish Government and NHS Health Scotland have been developing an outcomes framework comprising a suite of logic models to identify relevant short term, intermediate and long term outcomes for Mental Health.

6. What you need to know about Mental Health Inequalities

The following table highlights the eight inequality areas that the SIG have identified from the aforementioned documents. The eight areas are: socio-economic status; gender; ethnicity; sexual orientation; disability; spirituality; age and rurality. The table aims to provide a summary of what you need to know in relation to mental health inequalities when planning future projects.

Generally six inequality strands are considered; however this table includes two additional themes important in the context of mental health improvement; spirituality and rurality. For the purpose of this document, the following definitions are given:

Spirituality: represents whatever gives an individual's life meaning, purpose and fulfillment. All religious activity is spiritual but not all spiritual activity is religious. Spirituality is not the same as religion, although religion can be the focus of an individual's spirituality or the way in which an individual's spirituality is recognised and expressed.

Spirituality can provide a sense of belonging and hope as well as enhancing coping strategies and sense of control. However, the spiritual needs of people experiencing mental health problems can often be overlooked or pathologised and, in many cases, little effort is made to support this aspect of their lives. [8]

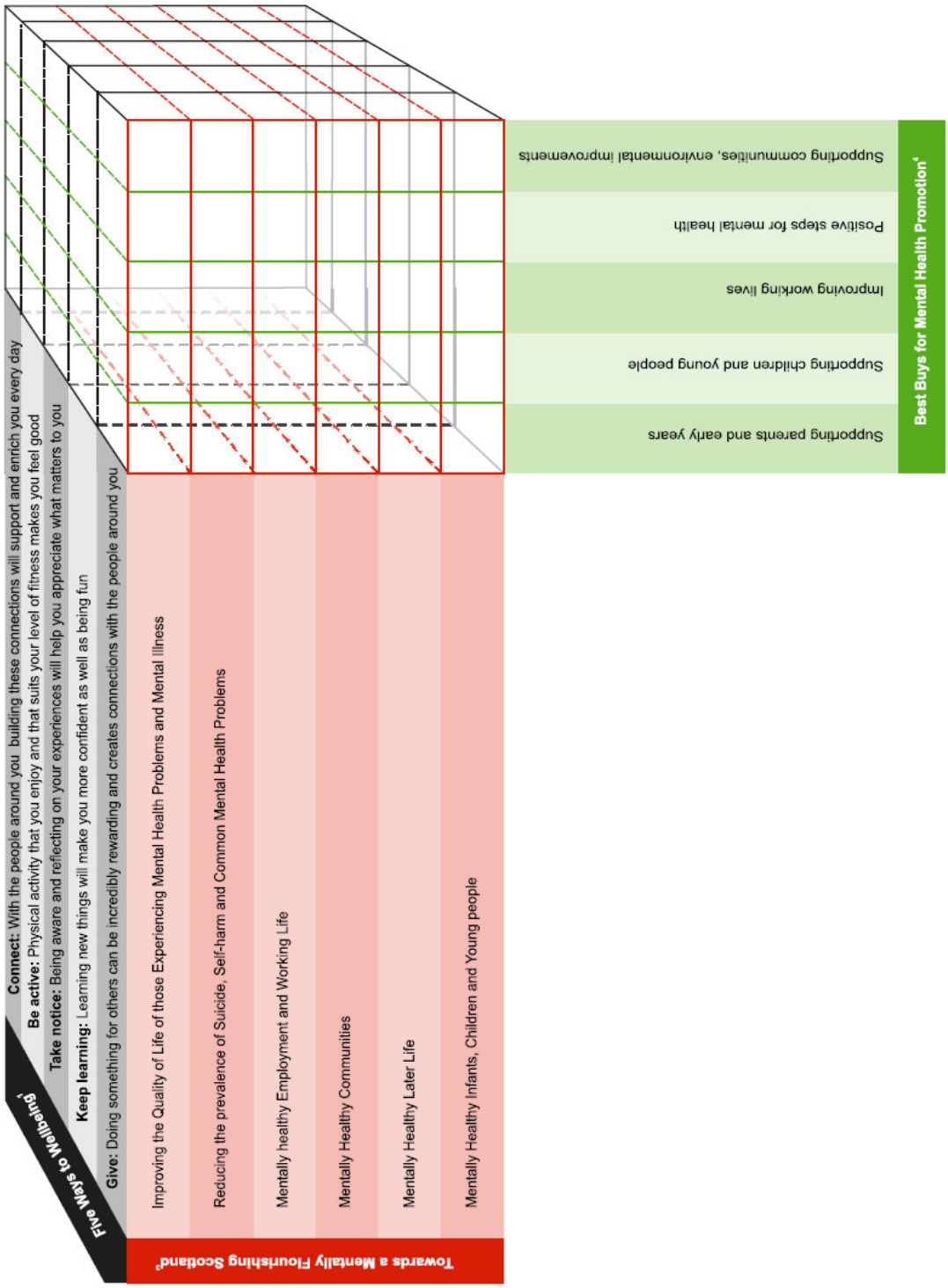
Rurality: People in rural areas may experience isolation, but also in small communities they may feel that they have less privacy than their urban counterparts; service planning may need to be particularly aware of issues around stigma.

Rural Scotland differs from the rest of Scotland but there are also differences within rural areas. Issues such as transport, access to education and health and social opportunities can impact on the wellbeing of rural communities.

Socio-economic Status	Gender	Ethnicity	Sexual Orientation	Disability	Spirituality	Age	Rurality
MULTIPLE INEQUALITIES - In addition to the issues highlighted below, it should be noted that individuals/groups/communities may experience more that one of these inequalities at the same time, however, it is also possible to reduce the inequalities experienced by an individual/group/community.							
RECOVERY - People who experience mental health problems and those around them should expect recovery. The values and principles which underpin recovery should form the basis of how, as a society, we approach mental health problems.							
For both men and women the risk of developing a mental health problem is greater among those in deprived areas. This is replicated across the UK: adults in the poorest one-fifth are twice as likely to be at risk of developing mental illness as those on average incomes. [9] Paid or unpaid employment or voluntary work is generally better for mental health and wellbeing than unemployment, but its value depends on both the work itself and culture and relations in the workplace. Factors that may positively influence mental health include: • Job satisfaction and job control (through attention to job design and to management practices) • Access to advice on benefits and financial issues • Having access to services without feeling stigmatised • Supporting the unemployed into the labour market. • Promoting job retention to minimise absence and job loss through ill-health [1]	In Scotland, as in the rest of the UK, mental health problems affect more women than men. The incidence and prevalence of depression and anxiety is higher among women than men.[1] This same pattern is consistent across ethnic groups.[1] In Scotland there are rising levels of alcohol-related harm among women – especially among young women.[10] In 2008 (as in other years), the suicide rate for males was more than three times that for females, while suicide rates in the most deprived areas of Scotland were significantly higher than the Scottish average.[11]	Understanding the implications of ethnicity includes considering: • the potential or actual institutional racism of services and systems • the effect that discrimination and victimisation have on the mental health and well-being of people from black and minority ethnic communities[1] It is important to understand the heterogeneity of those encompassed within the category 'black and minority ethnic communities' – they include a wide range of ethnic groups.[1] Other groups who experience discrimination and disadvantage - not just on the basis of ethnicity, but because of their status as refugees or asylum seekers, or who are gypsies or travelers.[1] Black and minority ethnic communities experience: • Higher rates of unemployment than the white population. • Lower levels of economic activity with a much greater reliance on one wage earner. • Higher levels of self-employment and segregated employment.[1] Stigma - Potentially at least, people with mental health problems from black and minority communities are at risk of experiencing double or triple jeopardy: discrimination based on ethnicity; and stigmatisation on the part of the majority and minority communities based on having a mental illness.[1]	There is consistent evidence of higher/different rates of depression, anxiety, suicidal thoughts, self-harming behaviour, eating disorders and substance misuse among LGBT people. But, being lesbian, gay, bisexual or transgender is not per se a cause of mental distress, nor is it a mental health problem.[1] The significant factors are the social and economic disadvantages LGBT people experience as a result of homophobia, transphobia and heterosexism. This can result in discrimination, bullying at school or in the workplace, harassment, violence (including domestic violence) and exclusion.[1] International studies have found gay men to have a rate of depression as much as eight times higher than the general population, and up to two-thirds of lesbians have been found to have suffered depression.[1] For young people in particular, the experience of discrimination, abuse and violence has significant implications for coming out, and with it, for identity, self-esteem and mental health and wellbeing. For both younger people and adults the impact may be felt in terms both of social isolation or lack of social connectedness, and social and economic exclusion and disadvantage.[1] These sources of exclusion may be compounded for lesbian or bisexual women, and/or LGBT people who have a disability, and/or come from a black or ethnic community, and/or are older.[1]	For the purposes of the Disability Discrimination Act (1995) (DDA) 'A person has a disability if he has a physical or *mental* impairment which has substantial and long-term adverse affect on his ability to carry out normal day to day activities'.[1] In terms of the causes and consequences of mental health inequality the focus therefore needs to be on the experiences of three groups of people: • People with mental health problems for whom the experience of mental distress may be compounded by the socio-economic disadvantage, stigma and discrimination associated with mental illness; • People with mental health problems and physical disabilities who may be multiply disadvantaged; • People with physical disabilities, whose experience of socio-economic disadvantage, discrimination and stigma due to their physical impairment may impact on their mental health and well being.[1] UK-wide only 24% of adults with long-term mental health problems are in work – the lowest employment rate for any of the main groups of disabled people.[12] People with mental health problems are nearly three times more likely to be in debt; and one in four tenants with mental health problems has serious rent arrears and is at risk of losing his or her home.[1]	Some individuals are helped by their faith communities, uplifted by spiritual activities, and comforted by their beliefs. Some people can be rejected by their faith community, burdened by their spiritual activities, disappointed and demoralised by their beliefs. The positive impact of spirituality on mental health and wellbeing is thought to occur through the following mechanisms: • Coping styles • Locus of control • Social support and social networks • Architecture and the build environment • Physiological mechanisms[13] Individuals holding a particular culture, faith or belief can suffer inequality because of assumptions due to their beliefs or definitions of mental health problems in the wider community Spirituality represents whatever gives an individual's life meaning, purpose and fulfillment. All religious activity is spiritual but not all spiritual activity is religious. Spirituality is not the same as religion, although religion can be the focus of an individual's spirituality or the way in which an individual's spirituality is recognised and expressed. Spirituality can provide a sense of belonging and hope as well as enhancing coping strategies and sense of control. However, the spiritual needs of people experiencing mental health problems can often be overlooked or pathologised and in many cases, little effort is made to support this aspect of their lives.[8]	Particular emphasis is given to the importance of pregnancy and parenting in defining health outcomes. Exposure to high levels of parental stress, neglect and abuse can have a severe effect on brain development. There are clear differences between the development of children in these situations and those in less stressful households. Our early years play a large role in determining our mental health for life. A mentally healthy child is one with a clear sense of identity and self-worth, the ability to recognise and manage emotions, to learn, play, enjoy friendships and relationships, and deal with difficulties. A wide range of interrelated factors play a role, such as individual, family, wider society and environmental issues. 20% of Scotland's population is 50 years old or more and this proportion will increase in the coming years. Mental health and wellbeing is becoming an increasingly important issue. Depression is the most common mental health problem in later life. Five key thematic areas have been identified for mental health improvement in later life – tackling discrimination, supporting participation in meaningful activity, supporting positive relationships, improving physical health and tackling poverty.	The common misconception that rural life is idyllic makes some service providers blind to unequal service provision and can have influence on funding streams. Rural poverty is a huge issue but, because of larger numbers of poor in urban areas, there is less provision/support to those who struggle in rural areas. Distance in itself often creates inequality; this is often perpetuated by social infrastructures and transport policies. Small communities can be very supportive. However they can also stigmatise against people who are not seen to be "the norm". Providing support/services to someone with a mental health problem may require more sensitivity and careful planning to ensure anonymity. People in rural areas may experience isolation, but also in small communities they may feel that they have less privacy than their urban counterparts, and service planning may need to be particularly aware of issues around stigma. Rural Scotland differs from the rest of Scotland but there are also differences within rural Scotland, for example between accessible and remote areas. Issues such as transport, education and health can have a particular impact on rural communities and seeks to reflect this in mainstream policy development.

APPENDICIES

Appendix 1: Mental Health Improvement – Areas for Action



The policy areas identified within the matrix are from:

- Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-11[5]
- Mental Health Promotion: Building an Economic Case[14]
- Five Ways to Well-being: The Evidence[15]

Appendix 2: Summary of National Programme for Improving Mental Health and Well- Being Equal Minds[1]

How does being a woman or a man, being young or old, or from an ethnic minority community affect mental health? How does poverty and deprivation affect well-being? What effect does having a mental health problem have on the chances of being discriminated against? These were the questions which formed the basis for the *Equal Minds* conference held by the Scottish Development Centre for Mental Health (SDC) in Edinburgh in October 2003, around which this working paper has been developed.

Unequal distributions result not only from individual/genetic factors, or specific traumatic events, but the accumulation of 'insults' or 'injuries' to mental health sustained through social, economic, ecological and environmental disadvantages. These disadvantages are not randomly distributed: some people and communities are exposed to greater risk than others.

While epidemiological data suggests that one in four people may experience a mental health problem, it is not any one in four. As Rogers and Pilgrim argue 'Mental health problems are not distributed in a non-random way in society. They reflect social divisions (of class, age, race and gender), and sometimes make a direct contribution to social inequalities (for example when patients suffer stigma and labour market disadvantage)'.

This suggests there are three main social and economic influences on population mental health and well-being:

1. Class or socio-economic status - The experience of poverty and economic inequality are associated with poorer mental health and well-being.
2. Social identity - Social identities are those aspects of ourselves to which society attaches significance. This can include our gender, our ethnicity, our sexual orientation, our age, our religion or beliefs or whether we have a disability
3. Experience of a mental health problem or mental illness - The discrimination, prejudice and stigma which someone may face because they have had or are experiencing a mental health problem or a mental illness may expose them to the risk of poverty, deprivation and inequality.

'Mainstreaming equality is essentially concerned with the integration of equal opportunities principles, strategies and practices into the every day work of Government and other public bodies from the outset … It is a long-term strategy to frame policies in terms of the realities of people's daily lives, and to change government organisational cultures and structures accordingly ... It entails re-thinking 'mainstream' policy making and service provision to accommodate gender, race, disability and other dimensions of discrimination and disadvantage, including class, sexuality and religion.' (MacKay and Bilton, 2003)

To begin to work through the policy and practice implications of the different sources of mental health inequality, the working paper both adopts and adapts the idea of mainstreaming. It is suggested that to achieve mentally healthy policy and practice there is a need to:

- Mainstream mental health improvement goals in policies and practices aimed at achieving social justice and closing the opportunity gap (and in ways that take into account the unequal distribution of mental health risk factors within and across different social groups)
- Mainstream social justice/equalities goals within mental health policies and services

Appendix 3: Summary of Equally Well Implementation Plan[2]

Equally Well sets an ambitious and radical programme for change across the key priority areas of the: early years; the big killer diseases of cardiovascular disease and cancer; drug and alcohol problems and links to violence; and their links to mental health and wellbeing.

The aim is to shift the focus from providing services (doing things for or to people) to building the capacity of individuals, families and communities, and addressing the external barriers people may face to making use of the high quality, accessible public services they require.

Equally Well Key Principles:

- Change in the culture of organisations
- Improve the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health
- Reduce people's exposure to factors in the physical social environment that cause stress, are damaging to health and wellbeing, and lead to health inequalities

- Address the inter-generational factors that risk perpetuating Scotland's health inequalities, particularly focusing on supporting the best possible start in life for all children in Scotland
- Engage individuals, families and communities most at risk of poor health in services and decisions relevant to their health, and promote clear ownership of the issues by all involved

In the longer term, the challenge remains of shifting resources from dealing with consequences of health inequalities to preventing poor health in the first place.

Appendix 4: Summary of Mental Health Resilience & Inequalities[3]

All policy-makers, from those in Government through to those in local communities, need to consider and take into account the mental health implications of all policies. There is an urgent need to create policies that underline precisely those characteristics that individuals and communities need to survive adversity: respect, dignity, self esteem, positive identity and social connectedness.

Good, positive, mental health and emotional well-being has a protective and beneficial role and leads to: healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life.

A greater understanding of inequalities is also crucial to recognizing the limits of what promoting positive mental health can achieve. Positive mental health does confer considerable protection and advantage, but it does so predominantly among those with equal levels of resources. Among poor children, those with higher levels of emotional wellbeing have better educational outcomes than their equally poor peers. However, richer children generally do better still, regardless of emotional or cognitive capability.

This report highlights the importance of policies and programmes to support improved mental health for the whole population. Just as we know that a small reduction in the overall consumption of alcohol among the whole population results in a reduction in alcohol related harm, so a small improvement in population wide levels of wellbeing will reduce the prevalence of mental illness, as well as bringing the benefits associated with positive mental health. Priorities for action include:

- social, cultural and economic conditions that support family and community life
- education that equips children to flourish both economically and emotionally
- employment opportunities and workplace pay and conditions that promote and protect mental health
- partnerships between health and other sectors to address social and economic problems that are a catalyst for psychological distress
- reducing policy and environmental barriers to social contact

Appendix 5: Summary of Mind the Difference – Mental Health: A focus on equality and diversity[4]

In 2007, NHS Health Scotland and the National Resource Centre for Ethnic Minority Health (NRCEMH) organised a meeting which brought together people who were working on the six equality and diversity strands to discuss connections with mental health and wellbeing:

- Gender
- Age
- Disability
- Sexual Orientation – LGBT
- Race and Ethnicity
- Spirituality

The report took as its starting point the argument that the factors that can undermine mental health or promote well-being are not randomly distributed but reflect social divisions of class and socio-economic status, aspects of social identity such as age, gender race or ethnicity, sexual orientation, disability (including the experience of mental health problems), religion and belief. With regards to these aspects of social identity, the report made the point that it is not being a woman, or being black or gay, per se that *cause* mental distress, but the fact that some aspects of social identity can expose people to discrimination, stigma and prejudice. The experience of discrimination and prejudice can undermine mental health and well-being directly through exposure to, for example, harassment, and indirectly through the experience of poverty, deprivation, exclusion and inequality with which they are associated.

Reducing the causes and consequences of mental health inequality includes, but extends beyond, mental health specific policies and practices to encompass the breadth of policies aimed at achieving social justice.

From this, a two-pronged approach was implied:

- Mainstreaming mental health improvement goals in policies aimed at achieving social justice, and in ways that reflect the unequal distribution of risk factors between social groups.
- Mainstreaming social justice and equalities objectives within mental health policies and services.

This publication has a section dedicated to developments and sources of information across each of the equality and diversity strands. This section should be referred to for more strand specific information.

Appendix 6: Summary of Towards a Mentally Flourishing Scotland[5]

This policy and action plan demonstrates the Government's continuing commitment to supporting: the promotion of good mental wellbeing; reducing the prevalence of common mental health problems, suicide and self harm; and improving the quality of life of those experiencing mental health problems or mental illness.

Though it is not under the sole control of the Scottish Government, mental health improvement is a key area for Government action because:

- Mental wellbeing, mental health problems, and mental illness are directly related to an individual's socio-economic outcomes as well as to their health behaviours and physical health and vice versa.
- Poor mental wellbeing, mental health problems and mental illness are a burden to the economy, both in healthcare costs and lost opportunities. They all have social consequences.
- There are inequalities in the distribution of mental health problems and mental illness and in the quality of life of those experiencing illness and their carers.

Appendix 7: Summary of With Inclusion in Mind, The local authority's role in promoting wellbeing and social development: Mental Health (Care and Treatment) (Scotland) Act 2003 Sections 25-31[6]

This document offers aspirational guidance on the implementation of the duties of local authorities under Sections 25-31 of the Mental Health (Care and Treatment) (Scotland) Act 2003. These Sections concern provision of care and support services as well as services to promote wellbeing and social development; the latter is often referred to, in shorthand, as 'Section 26'.

Under Sections 25-31, local authorities are required to promote the wellbeing of, and provide services for, individuals who have or have had a mental disorder. The term 'mental disorder' includes mental illness, learning disability and personality disorder. Section 26, by promoting wellbeing, addresses mental health and not just mental disorder. This reaches every aspect of life that promotes wellbeing, rather than merely the alleviation of symptoms.

It suggests some underpinning values for developing a coherent response, and indicates a practical way forward. It provides loose leaf ideas sheets for dissemination to the relevant departments and suggests ways of reviewing subsequent changes.

The key messages of the paper are that it is about:

- every citizen rather than just a few people
- universal inclusion rather than segregation (the principle of removing barriers to the use of universal provision rather than creating more segregated services)
- wellbeing rather than mental illness
- communities rather than individuals

The document encourages Local Authorities to consider who should be involved. It is vital to achieve a shared ownership of the agenda from the outset, with Community Planning Partnerships playing a key role. All discussions will need representation from people with mental illnesses, learning disabilities or personality disorders using services.

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