Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar anghydraddoldebau iechyd meddwl

This response was submitted to the Health and Social Care Committee consultation on mental health inequalities

MHI 72

Ymateb gan: | Response from: Betsi Cadwaladr University Health Board

---

Welsh Parliament Health and Social Care Committee – Consultation on Mental Health Inequalities. Closing Date 24th February, 2022

BCUHB Response v0f 15/2/2022

Background Consultation display (senedd.wales).The Committee is looking in particular for views about:

1. Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?
2. For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?
3. To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?
4. What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

----

1. Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?

1.1 Inequalities in health, including mental health, are the result of a wide range of complex factors. These factors are often associated with, and influenced by, each other. The factors that determine our health and wellbeing are succinctly described in the Wider Determinants of Health model (Dahlgren and Whitehead, 1991[1]). In summary, it describes how broader social, economic, cultural and environmental factors, combined with our personal characteristics, influence our behaviours and health outcomes. This model places a particular emphasis on the impact of socio-economic disadvantage on health, evidencing the social gradient observed with most health outcomes i.e. those living in our most socio-economically deprived communities experience the poorest health outcomes, with proportionate improvements in these outcomes, including mental health, observed with decreasing levels of deprivation.

[1] https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health

The Marmot Strategic Review of Health Inequalities suggested that healthcare only determines 15-25% of health outcomes, with more than 50% of the contribution coming from the social determinants of health.

1.2 The rest of Section 1 below outlines some of the most significant drivers of socio-economic disadvantage, providing a context to consider the 'causes of the causes' of health inequalities, including mental health inequalities, and evidence from a UK perspective.

1.3 The BCUHB Public Health Team develop an annual profile of mental health across North Wales. Key themes around mental health inequalities from the 2021 iteration are outlined below:

- Mental health problems are more common in areas of high deprivation and poor mental health is associated with unemployment and lower levels of educational attainment, in addition to poor physical health.
- The National Survey for Wales found that mental wellbeing scores increased as levels of deprivation increased.
- People's housing and ability to afford housing are strong influences on mental health.
- People who own or have a mortgage/loan on their home experience lower levels of anxiety than those who live in rented/part rented housing.
- The benefits of being in paid employment, including financial, social interaction and sense of self-worth all have a positive impact of health and mental wellbeing.
- Feeling lonely can be caused by having a mental health problem as well as having a negative impact on your mental health
- Members of the Black, Asian and Minority Ethnic community are potentially at greater risk of experiencing poorer mental health and well-being as a result of increased risk of deprivation.
- Members of ethnic minority communities are more than twice as likely to live in the 10% most deprived LSOAs, than white people (20.6% of ethnic minority people compared to 8.3% of White people).
- Mental ill health is associated with increased physical ill health, reduced life expectancy and vice versa. Poor mental health is also associated with increased risk-taking behaviour and unhealthy life-style behaviours.
- Survey data analysis found that that 19% of people with hearing impairment, 31% with distance visual impairments and 25% with near visual impairments had clinically significant psychological morbidity.
- The Covid-19 pandemic has had far reaching consequences on all aspects of life, including significant impact on mental health and well-being.
- A number of drivers for worsening mental health during the pandemic have been identified including job and financial loses; social isolation; housing insecurity and quality; working in a front-line service; loss of coping mechanisms; and reduced access to mental health service.
- People in lower socioeconomic groups have also been found to be disproportionately impacted by coronavirus due to factors such as low skilled employment and pre-existing health conditions.

- Public Health Wales has found that people in the lower socioeconomic groups are more likely to be very worried about their mental health during the coronavirus pandemic.
- Black, Asian and Minority Ethnic residents of Wales are more likely to be feeling anxious than White residents during the pandemic. Feelings of isolation are also more common in the ethnic minority community.
- People in the ethnic minority community are also more likely to be worrying a lot about their finances, losing their job or being unable to find one compared to White people.

1.4 Evidence shared by the BCUHB CAMHS leads confirm the following:

- Research suggests that children and adolescents with an intellectual disability have 4-5 times the rates of mental health problems compared to other children.
- One in seven of the population of children with mental health problems will also have an intellectual disability; however, substantially lower numbers actually access CAMHS services.
- There are high numbers of children and young people waiting for a neurodevelopmental (ND) assessment accessing CAMHS services, due in part to the long waiting lists for ND assessments.
- Children looked after can have specific mental health support needs
- Currently, the CAMHS service does not routinely collect demographic data. However, the recent appointment of a dedicated Information Lead for the service will seek to address this.

1.5 A recent study on the association between poverty and mental health in Glasgow[2] highlights how mental health problems are related directly to poverty, which in turn underlies wider health inequalities. The authors highlight key points of evidence and implications:

- The primary causes of these inequalities are structural differences in socioeconomic groups' access to economic, social and political resources, which in turn affect health through a range of more immediate environmental, psychological and behavioural processes.
- A wide range of risk factors are more prevalent among low income groups for example, including low levels of perceived control and unhealthy behaviours such as smoking and low levels of physical activity, although these are best understood as mechanisms that link the structural causes of inequality to health outcomes
- Understanding the life-course impact of poverty on mental health is also important e.g. childhood adversity.

They conclude with the following three recommendations for addressing mental health inequalities in the context of a whole system response, with particular reference to the role of psychiatry:

---

[2] Knifton, Lee, and Greig Inglis (2020). "Poverty and mental health: policy, practice and research implications." *BJPsych bulletin* vol. 44,5: 193-196. doi:10.1192/bjb.2020.78

- **Reinvigorate social psychiatry and influence public policy**: If progressive public policies are not advocated for to reduce poverty and its impact then the focus will remain only on the intermediate causes of health inequalities, rather than the fundamental causes, which will ensure that these inequalities persist and are reproduced over time.

- **Tackle intersectional stigma and disadvantage**: understand and address intersectional stigma, which explains the convergence of multiple stigmatised identities that can include ethnicity, gender, sexuality, poverty and health status. This can then magnify the impact on the person's life. In this context, the reality is that there can be a much greater chance of getting a mental health problem if a person experiences poverty. In addition, if they do, then they will likely experience more stigma and discrimination. Its impact on their life will be greater, for example on precarious employment, housing, education and finances. Intersectional stigma remains poorly researched and understood.

- **Embed poverty-aware practice and commissioning**: ensure that poverty-aware practice is embedded in services through commissioning, training and teaching. This means that recognising and responding to poverty is part of assessments and care. Income maximisation schemes should be available as an important dimension of healthcare: how to access benefits, manage debt, access local childcare and access support for employment at the earliest stages. This needs to be matched by a major investment in mental health services focused on low-income areas, to address the inverse care law.

1.6 According to analysis by the ONS, rates of suicide are higher in the most deprived areas when compared in the least deprived areas of Wales (Office for National Statistics, 2020). The number of suicide deaths in Wales are too small to conduct equivalent analysis by age.

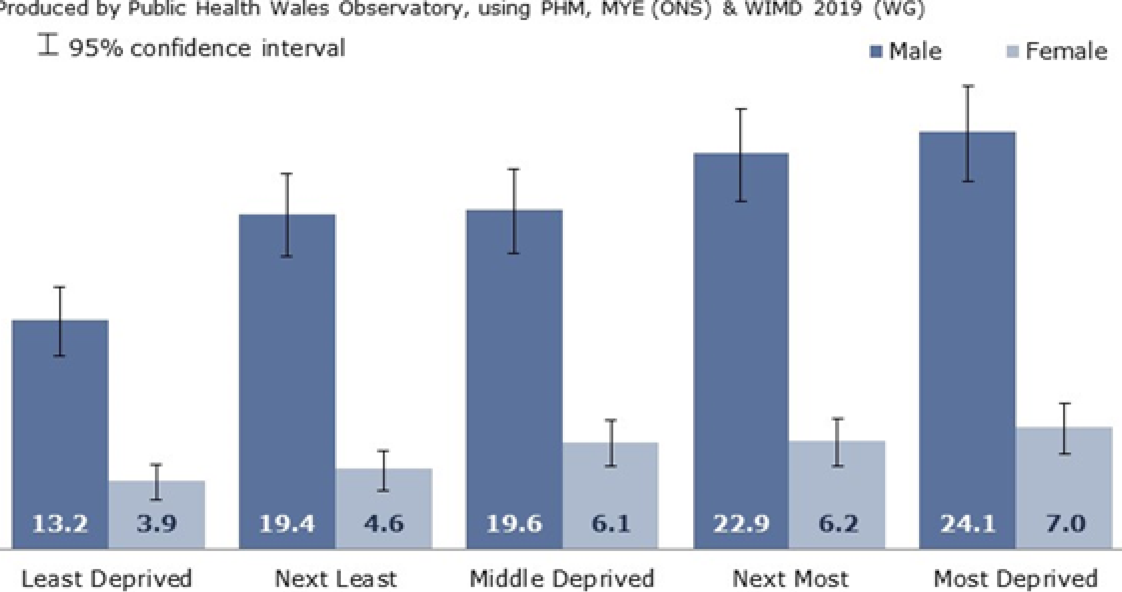
- However, in England, where numbers are sufficient to permit an age analysis, the gap between the most and least deprived areas is only seen among those of working age. Living in a deprived area increases suicide risk for nearly all working ages but those aged between their late 30s and late 40s were affected most. For this age group, suicide rates tended to be more than double in the most deprived areas compared to the least deprived. Suicide is rarely caused by one thing. A complex mix of social, cultural, psychological and economic factors interact to increase an individual's level of risk. We know from research that unemployment is a key risk factor for suicidal behaviour in men along with economic uncertainty and unmanageable debt. Also, a lack of both social connection and purposeful employment has a particular effect on less well-off, middle-aged men's wellbeing.

- Over the past decade, middle aged men in their 40s and 50s have had the highest suicide rates of any age or gender. By deprivation, middle-aged men, living in the most deprived areas, face even higher risk with suicide rates of up to 36.6 per 100,000 compared to 13.5 per 100,000 in the least deprived areas (figures for men aged 43 years). In the least deprived areas, rates among middle aged men are like those of other ages.

- The gap between the most and least deprived areas was generally not seen among those aged 20 years and below, particularly in men, and in those of retirement age. For these ages, it's likely that risk factors other than deprivation are more important. For young people, risk factors include risk factors adverse childhood experiences, stressors such as academic pressures and relationship difficulties, and recent events such as bereavement. For older people older, psychiatric illness, deterioration of physical health and functioning, are known risk factors.

- Figure 1[3] shows the socio-economic gradient in deaths by suicide in Wales, with those living in the most disadvantaged areas more likely to die this way. The socio-economic gradient in deaths by suicide is particularly marked in males.

Figure 1



1.7 The Public Sector Equality Duty (2011) was developed in part in response to evidence of longstanding inequalities in health, including mental health, experienced by specific groups in the population. The intention of the Duty is to offer protection to the characteristics[4] that define these groups, ensuring that public bodies evidence how they give due regard to understanding and addressing their needs and, in doing so:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

---

[3] Office for National Statistics, 2020. How does living in a more deprived area influence rates of suicide? | National Statistical (ons.gov.uk)

[4] age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation

- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Furthermore, the Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

1.8 One example of how organisations can achieve this is through undertaking an Equality Impact Assessment (EqIA) on any substantial development, policy, or service change. There is greater value in impact assessments if they are used to inform the development of proposals, rather than being done retrospectively. There is also value in considering integrating impact assessment tools and methodologies for greater impact and efficiency, such as the inclusion of equality and socio-economic considerations into Health Impact Assessments. This is particularly important as emerging policy in Wales places an expectation on public sector agencies to complete an increasing number of different impact assessments e.g. the recent Socio-Economic Duty that came into force in Wales on 31st March 2021[5].

BCUHB is utilising the EqIA methodology to inform the development of several strategic and operational work streams. A recent example includes two iterations of an EqIA to inform the first phase, and subsequent booster phase, of the COVID-19 Vaccination Programme. Key considerations included identifying both negative and positive factors related to the acceptability of, and accessibility to, the vaccination programme by different groups in the population. Ensuring that the needs of different groups were considered in the planning and delivery of the Programme has supported more people to benefit from the vaccination, thereby supporting better mental health and wellbeing, as well as protecting their physical health. The work has also highlighted the significance of identifying and working with existing trusted networks in the community, in order to address mental and physical health inequalities.

1.9 There is a growing body of evidence outlining the substantial impact that experiencing adverse experiences during childhood[6] can have on future health and wellbeing outcomes, including mental health[7]. The current understanding of the impact of ACEs in Wales is summarised below:

[5] https://gov.wales/more-equal-wales-socio-economic-duty

[6] ACEs are stressful events occurring in childhood, such as being a victim of abuse, neglect, or growing up in a household in which alcohol or substance misuse, mental ill health, domestic violence or criminal behaviour resulting in incarceration are present (See Ref below for details)

[7] https://phw.nhs.wales/news/responding-to-adverse-childhood-experiences-an-evidence-review/responding-to-adverse-childhood-experiences/

- **ACEs are common**: approximately 50% of the adult population (aged 18-69 years) in Wales reporting having experienced at least one ACE, and 13.5% reporting four or more.
- **ACEs can have a detrimental impact on health across the life course, contributing to increased health inequality and morbidity**: In Wales, those who experience four or more ACEs are: six times more likely to be a tobacco smoker; four times more likely to drink alcohol at harmful levels; two times more likely to suffer from a chronic disease (e.g. asthma, cancer, obesity, heart and respiratory disease); six times more likely to have ever received treatment for mental illness (e.g. depression or anxiety). A history of exposure to ACEs has also been associated with an increased demand on health services.
- **ACEs and their negative effects can extend beyond a single generation**: their replication are driven by complex interactions between personal and social environmental factors, leading to their intergenerational transmission.

1.10 A recent Public Health Wales[6] publication considers a broad range of evidence relating to approaches that prevent and mitigate the harms of ACEs; the findings are summarised into four broad approaches, see Appendix 1 for further details:

1) Supporting parenting
2) Building relationships and resilience
3) Early identification of adversity
4) Responding to trauma and specific ACEs

In addition, seven cross-cutting themes were identified that support an ACE-informed approach:

1) Promoting social development, cohesion and positive relationships across the life course
2) Promoting cognitive-behavioural and emotional development in childhood
3) Promoting self-identity and confidence in both children and adults
4) Building knowledge and awareness about the causes and consequences of ACEs amongst the public and professionals
5) Developing new skills and strategies for those affected to cope with adversity
6) Early identification of adversities by therapeutic and interfacing services to identify and support parents, children and those affected through the life course
7) A collaborative approach across sectors and organisations

2. For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

2.1 Research has suggested that stigma and negative perceptions surrounding mental health and help-seeking may explain why some individuals are reluctant to approach others for help.[8] A study in Black and Minority Ethnic communities identified two

[8] Salaheddin K, Mason B. Identifying barriers to mental health help-seeking among young adults in the UK: a cross-sectional survey. *Br J Gen Pract*. 2016;66(651):e686-e692. doi:10.3399/bjgp16X687313

themes that influenced access to mental health services.[9] The first were personal and environmental factors, which included an inability to recognise and accept mental health problems, positive impact of social networks, reluctance to discuss psychological distress and seek help among men, cultural identity, financial factors, negative perception of and social stigma against mental health. The second theme related to factors affecting the relationship between the service user and the healthcare provider. These included: a lack of awareness of different services among service users and providers, impact of long waiting times for initial assessment, language barriers, poor communication between service users and providers, inadequate recognition or response to mental health needs, imbalance of power and authority between service users and providers, cultural naivety, insensitivity and discrimination towards the needs of BME service users.

2.2 During the first and second waves of the Pandemic, patients' access to face-to-face contact with mental health workers was diminished, as an unintended consequence of GP surgeries limiting face to face contact. Digital platforms for consultations have now been developed and further utilised i.e. use of Attend Anywhere and Silver Cloud. However, digital exclusion has been a barrier to accessing these newly developed digital platforms for some individuals.

2.3 The rural populations who do not have access to independent transport may have difficulties attending mental health services, including outpatient appointments and day services.

2.4 We note that there can also be barriers to access Mental Health services by the farming communities, who may be both physically and psychologically isolated.

2.5 There are a number of reasons why children and young people with an intellectual disability do not access CAMHS. Risk factors include a lack of adequate screening tools for this population, diagnostic overshadowing i.e. services only seeing the intellectual disability rather than the mental health needs, and a lack of awareness in the system that someone with a learning disability can be referred to CAMHS.

Another factor that can impact on timely access is a higher demand for assessments and therapy to be delivered in the Welsh language, which can result in longer waiting times as the capacity is insufficient. This is a particular issue in Gwynedd and the Isle of Anglesey. Across other communities in North Wales, there is also demand for services to be delivered in minority languages that may require translation services, which results in longer waiting times.

Moving forward to improve access to existing services, there will be a focus on increased collaboration with primary care services and Third Sector partners, specifically GP's, with timely and accurate referrals detailing patient needs and risk.

[9] Memon A, Taylor K, Mohebati LM, *et al* Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England *BMJ Open* 2016;**6:**e012337. doi: 10.1136/bmjopen-2016-012337

Experiences of using Mental Health services can continue to be improved by strengthening collaboration between different teams and integrated pathways, with a clear focus on whole persons care.

2.6 The Foresight Report[15] considers the factors affecting mental capital and wellbeing across the life course. It highlights learning difficulties as a particular problem that affects up to 10% of children, yet too often remains unidentified, or children are treated only when difficulties are more advanced. The result can be underachievement in school and disengagement by the child, sometimes leading to a long-term cycle of anti-social behaviour, exclusion and even criminality. The report proposes that Improvements in early detection, combined with focused interventions, could prevent problems developing and create broad and lasting benefits for the child and society.

3. To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?

3.1 There is an opportunity to capitalise on the unique opportunities that the Wellbeing of Future Generations Act (2015)[10] provides us in Wales in order to address the root causes of health inequalities, including mental health inequalities. Both the *ways of working* and the *wellbeing objectives* are directly relevant here. This approach is currently being scoped as part of taking forward the review of the North Wales Together for Mental Health Strategy (Appendix 2). It is advocating for a greater focus on a whole systems approach to improving population mental health and wellbeing, including:

1) Prioritising upstream prevention and early intervention activity across the life-course, regardless of people's mental health status
2) Increasing investment in the early years (as outlined in 3.4 below)
3) Being explicit about how each part of the system can support better outcomes for people in their communities and who access their services – no 'wrong door' concept
4) Integrating action around the wider determinants of health to support population mental health improvement

3.2 Recognising the strong body of evidence[11,12,13] on the significance of the early years in influencing health outcomes across the whole life-course, and inter-generationally, there is an opportunity for Welsh Policy to give even greater focus to investment. Strengthening the system's response to improving mental health outcomes for parents and their infants should be a key priority. This aligns with the WBFGA, and evidence from programmes such as the First 1000 Days, and also ACEs[14] (see sections 1.8 above for policy recommendations to address ACEs). Some

---

[10] https://www.futuregenerations.wales/about-us/future-generations-act/

[11] https://www.euro.who.int/__data/assets/pdf_file/0010/347932/Leaflet-HEN51-Web-single-pages.pdf

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/771732/BSIL_ROI__report_01.19.pdf

[13] http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20Making%20a%20difference%20ES%28Web_2%29.pdf

[14] http://www.wales.nhs.uk/sitesplus/888/page/88523

of the risks to our most vulnerable children and families may have been exacerbated by the COVID pandemic, with associated impacts on their mental health and child development.

In this context, there is an opportunity to review the Welsh policy response to the broad range of recommendations outlined in the Foresight Report[15] that seek to improve mental capital and wellbeing across the life course. Its recommendations in relation to the early years refer to supporting optimal maternal health, creating nurturing environments for children, and improving the early identification and prompt treatment of learning difficulties in children.

3.3 In addition to addressing known risk factors for poor mental health and mental health inequalities, there may be an opportunity for policy and services to further promote the core protective factors[16] for mental health and wellbeing, namely that people:

- Feel a sense of control
- Feel included and able to participate
- Are resilient and have access to coping resources when they need them

Specifying these factors in impact assessment tools, or service planning/reviews, may provide practical opportunities for their consideration.

3.4 There is an opportunity to review how the principles of proportionate universalism[17] could inform how we address mental health inequalities. The concept has been described as the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need[18]. Further consideration could be given to how policy, planning, finance, and performance management systems and structures reflect the principles of proportionate universalism. An example is provided in an NHS Scotland briefing paper[14]. It describes a service access target that has both universal and targeted components, namely for at least 80% of pregnant women in each socio-economic deprivation quintile to have booked for antenatal care by the 12th week of gestation (in order to support health behaviour priorities), and progress is measured by the percentage achieved in the worst performing deprivation quintile.

3.5 First proposed by Julian Tudor Hart in 1971, the inverse care law[19] is states that there is an inverse correlation between availability of healthcare and the populations that require it i.e. people whose healthcare needs are greatest are less likely to receive it.

Work around the inverse care law suggests that ensuring existing services can address patients with the greatest needs (those who lack self-efficacy and/or live in challenging environments) may not be about making current programmes more

[15] Government Office for Science: Foresight Report (2008). Mental Capital and Wellbeing. mental-capital-wellbeing-summary.pdf (publishing.service.gov.uk)
[16] https://healthycampuses.ca/wp-content/uploads/2014/07/MentalWellbeingImpactAssessmentAtoolkitforwellbe-1.pdf
[17] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf
[18] Proportinate universalism and health inequalities (healthscotland.com)
[19] https://www.iwa.wales/agenda/2021/02/the-inverse-care-law-in-2021/

available in areas of deprivation. For example, outreach from Primary Care may be unlikely to connect with people who are fatalistic about their health, feel they have no control or capacity to change, or do not see their longer-term health outcomes as a priority instead of the day-to-day need for survival. It is about changing the nature of those interventions to empower and motivate people who lack confidence and who are more fatalistic, in order to engage with their own health and wellbeing.

Evidence from BCUHB's work around the inverse care law highlights engagement with primary care cluster leads. A key theme was that meaningful engagement with people from the most socio-economically disadvantaged communities rarely begins with an explicit health agenda, rather, it:

- Is highly relational, built on trusting relationships that have developed over time
- Starts with whatever the presenting need is, whether that be fuel poverty, debt management, substance use, housing, or simply how to get access to a mobile phone
- Is accessed via informal channels and informal settings
- More drop-in in nature, not dependant on being able to travel to a specific location at a specific time
- Social prescribing has widely held legitimacy and is seen as a helpful bridge between a medical model of delivery, and recognition of the psychosocial aspects of behaviour change in reducing risks

Mental health, and health inequality, policy drivers in Wales may further benefit from implementing evidence-based approaches that seek to address the inverse care law.

3.6 A number of Welsh strategies influence CAMHS, including Together for Mental Health, Together for Children and Young People, No Wrong Door, Mind over Matter, NEST, and Matrics Plant. However, it is not clear how these align with, or influence the development of, policy.

3.7 The Foresight Report[20] (referenced elsewhere in this response) includes a set of recommendations around a system response to population mental ill-health. It refers to the importance of addressing the risk factors associated with mental disorders (including debt and other wider determinants of health), early diagnosis and prompt treatment, addressing mediating factors such as stigma and maintaining employment, and targeting high-risk groups. Undertaking a review of Welsh policy in relation to these recommendations may be helpful.

4. What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

4.1 Our response to questions 1-3 above include examples of action that is required to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities. To summarise, these include:

- The development of a whole systems approach to improving population mental health and wellbeing, with a focus on prevention and early intervention, and

working to an 'asset based approach' (salutogenesis[20]) as opposed to a traditional model based on deficits (pathogenesis).

- Better utilisation of Equality and Socio-economic Impact Assessments, ideally integrated with other assessments into a single approach, to inform our collective understanding of, and response to, inequalities in mental health and wellbeing. This to also consider the additional impacts of the COVID pandemic. Locally in North Wales, there is an opportunity to further embed the learning from recent EqIA activity, such as the work undertaken around the COVID-19 Vaccination Programme, to help inform other population health priorities including mental health and wellbeing.
- Better integration of health intelligence in relation to population (and specific groups') mental health and inequalities to support national, regional and local action. Develop a programme to address any gaps in intelligence e.g. data collected in relation to groups sharing the protected characteristics.
- A coordinated response to the primary risk factors for poor mental health and wellbeing, including action to prevent and mitigate ACEs, tackle poverty, and address inequalities in relation to education, housing, and employment. The Foresight Report[21] presents a comprehensive assessment of how this could be achieved throughout the life course and across different parts of the system, including national and local policy.
- Prioritise investment in the early years to help create the conditions for parents and children to thrive, thereby optimising the impact of the WBFGA.
- Plan, deliver and evaluate the impact of mental health services in line with the principals of proportionate universalism and the inverse care law.

Response coordinated by Dafydd Gwynne, Principal Practitioner for Mental Wellbeing, on behalf of the Executive Director of Public Health for Betsi Cadwaladr University Health Board, Teresa Owen

15th February 2022

[20] https://mental-health-matters.org/2021/06/14/what-is-salutogenesis/

[21] Government Office for Science: Foresight Report (2008). Mental Capital and Wellbeing. mental-capital-wellbeing-summary.pdf (publishing.service.gov.uk)

Appendix 1: An overview of the common components, interventions and settings within each of the four approaches to prevent and mitigate the harms of ACEs[22]

APPROACHES	COMPONENTS	PROGRAMMES	SETTINGS
Supporting parenting (Section 3.1)	• Ensuring the best start in life • Supporting the building of positive adult-child relationships and attachment • Empowering parents by building knowledge and resilience (protective skills)	• Parenting interventions	• Home • Primary care • School • Community • Welfare
Building relationships and resilience (Section 3.2)	• Promotion of children's overall development and wellbeing • Building positive relationships • Building knowledge • Strengthening social and emotional competency (protective skills) • Behavioural regulation (preventing conduct disorder) • Promotion of wellbeing, mental health and healthy lifestyle • Holistic approaches to deal with stress • Multi-agency approaches	• School-based interventions • Mentoring interventions • Interventions building resilience • Community-based interventions	• School • Community
Early identification of adversity (Section 3.3)	• Raise awareness • Ensure the best start • Specific early actions (e.g. referrals to services)	• Early identification of adversities in households	• Home • Primary care • Community
Responding to trauma and specific ACEs (Section 3.4)	• Psychological and pharmacological treatments for substance abuse • Welfare services • Policy measures and guidelines • Multi-agency approaches • Building resilience by developing coping and emotional strategies (protective skills) • Tailored treatments to support families, parents and children • Addressing parent-child relationships in families experiencing trauma • Promote wellbeing and mental health	• Psycho-therapeutic treatments • Specific interventions	• Home • Primary care • School • Community

[22] https://phw.nhs.wales/news/responding-to-adverse-childhood-experiences-an-evidence-review/responding-to-adverse-childhood-experiences/

Appendix 2: Draft Blueprint for Whole Systems Approach to Improving Population Mental Health and Wellbeing in North Wales

BLUEPRINT
FOR
A WHOLE SYSTEMS APPROACH TO IMPROVING POPULATION MENTAL HEALTH AND WELL-BEING

Aim: People of all ages in North Wales experience optimal mental health, well-being and resilience.

What?	How?
Focus on promotion, prevention, early detection and intervention.	• Optimising the opportunities for mental health and wellbeing promotion and prevention at all levels. • Developing community assets, local relationships, social capital and public policy for mental health and wellbeing. • Adopting a whole person approach, recognising the accumulation of risk and protective factors across life course. • Identifying and addressing needs and risks as early as possible, regardless where the interaction takes place in the system.
Identifying and reducing inequalities in mental health and well-being.	• Developing a shared understanding of prevalence, impact and need across population groups. • Working with priority groups and trusted networks to co-produce solutions, utilising on community assets • Leading planning and commissioning arrangements that are proportionate to need by securing high quality universal services and opportunities, alongside targeted interventions. • Prioritise improvement in physical health outcomes of people living with mental illness.
A shift towards whole systems working	Enabling culture change by: • Creating the space to challenge our own assumptions and pre-set agendas by truly listening to each other • Co-creating the narrative about what is really needed, and what is possible • Recognising that collective wisdom cannot be manufactured or planned in advance Developing a shared understanding of: • The core components of systems working, including purpose, perceptions, language, values, aspirations and behaviours • How the local system is operating and is inter-connected, and where the greatest opportunities exist for improvements • What may happen if part of the system is changed, including intended and unintended consequences Embedding an ongoing cycle of reflection and learning, enabling continual quality improvement across all components of the system Recognise opportunities for system change by addressing the wider determinants of mental health and wellbeing, such as economic activity, housing, education, and access to services