Cambridgeshire County Council

PUBLIC MENTAL HEALTH STRATEGY 2015 - 2018

May 2015

Contents

Summary

At any one time, at least one person in six is experiencing a mental health condition. This is costly to the individual, society and the economy. We also know that people who have a severe mental illness often have poorer physical health and are more likely to die earlier. This strategy looks at ways in which we can better promote good mental health and prevent mental illness – what this actually means for individuals and families is described using the fictional family in Figure 1 (see pages 33-34).

Although anyone can experience a mental illness or poor mental health, some people will be more likely than others because of their genetic make-up or their life experiences that make them more vulnerable. It is knowledge of these factors, and the research into evidenced based interventions that inform this public mental health strategy.

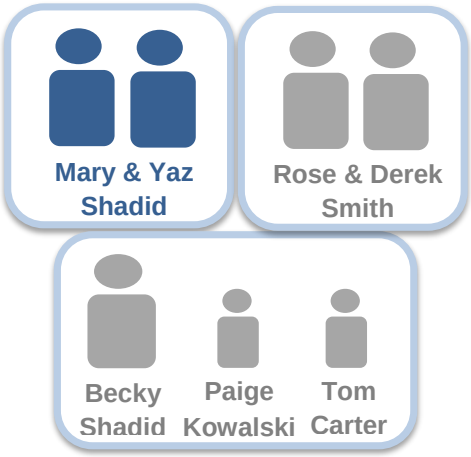


Figure 1 This fictional family will be used in the strategy as an example of how this strategy could affect individuals.

The strategy looks at mental health promotion and prevention activity across three broad themes, looking at the evidence base for what potentially could work, as summarised below:

A life course approach to promoting mental health

Children & Young People

- Identifying and treating maternal mental illness in pregnancy and the first year of life
- Parenting programmes
- Mental health promotion in early years settings
- Anti-bullying interventions in schools
- Mental health promotion in schools

Social Isolation & Loneliness

- Activities and services for people to access, and additional support to help people access services.
- Creating a community environment that fosters development of services

Developing a wider environment that supports mental health

Mental Health & Work

- Recommendations on mental health promotion and mental illness prevention in workplaces
- Support for those with people with severe and enduring mental illness to return to work.

Mental Health Promotion in the Community

- Anti-stigma campaigns including national campaigns such as 'Time to Change'
- Training which increases knowledge and raises awareness of mental health & illness.

Physical and mental health – 'the mental health of people with physical illness and the physical health of people with mental illness'

Mental Health of People with Long Term Conditions

- Effective identification and treatment of mental health issues for people with long term conditions

Physical Health of people with Mental Illness

- Physical health assessments
- Physical activity
- Social prescribing

What does the strategy recommend?

Building on the evidence base and knowledge of some of the interventions already in place, the table below summarises what the strategy proposes. Given the scale of the issue, depression and anxiety affect about half the population at some point during their lives, these proposals are not just for implementation by the public health team, but for a wide range of organisations across the public, voluntary and private sector. A recurrent investment of £120k has been agreed to support the implementation of the strategy. Those actions in *italics* are suggested areas for further investment as part of this strategy's implementation funding. A more detailed action plan is provided in the full strategy (p.35-39).

	Why focus here?	**Actions**
Children and young people	Half of all lifetime mental health problems emerge before the age of 14. See page 10 and (Warwickshire County Council, 2014). Mental health problems in children and young people are associated with excess costs estimated as being between £11,030 and £59,130 annually per child. See page 10 and (Warwickshire County Council, 2014).	*Focus on supporting schools to tackle anti-bullying and to introduce a 'whole school approach' to improving mental health. This approach includes culture, staff morale, pupil and family and community involvement.* Maximise opportunities to promote mental health across the early years, including during pregnancy and in the first year of life. Continue to support evidenced based parenting programmes.
Social isolation and a wider environment that supports mental health	The environment in which we live can make some individuals and population groups more at risk of poor mental health. These risk factors include low income and/or debt, housing conditions, unemployment, social isolation and adverse life experiences such as adversity in childhood and domestic abuse (see page 11).	Increase engagement with communities in addressing and improving their health and wellbeing. Support the digital inclusion strategy and the expansion of the Time Credit scheme. Consider how services, such as Lifestyle or community navigator services, might have their role enhanced in relation to mental health and be better able to identify those in need of support. Continue with initiatives supporting people with mental illness back into work or to stay in work. Support the implementation of other relevant strategies such as the Cambridgeshire County Council Child Poverty Strategy which includes a focus on helping parents back to work.

Workforce mental health	Mental ill health costs some £105 billion each year in England; £29bn of this is losses to business. Interventions to improve mental health within the workplace have been found to be cost effective for businesses. See page 10 and (Warwickshire County Council, 2014).	*The public health 'workplace health' programme should have a strategic focus including mental health, and expand to cover a much greater proportion of workplaces, particularly in areas of greatest deprivation or among highest need populations. A suitable training package will be identified for employers so that they can provide improved support to those employees with mental illness.* *The programme should identify and roll-out a workplace health standard, which gives employers a set of good practice standards on mental health and other health issues to adopt.*
Anti-stigma work	Many people who have a mental illness have experienced stigma or feel the need to hide their illness – one study found that 70% of mental health service users felt the need to conceal their illness (Corker et al. , 2013).	*Support anti-stigma campaigns, building on the work of the 'Stop Suicide' Campaign. Workplaces, schools and early years settings should all be utilised as locations for campaign work.* Continue to fund Mental Health Awareness Training for frontline staff and look at options for disability awareness and discrimination.
Mental health of those with physical illness	Around 30% of all people with a long term physical health condition in England also have a mental health problem, most commonly depression/anxiety (Naylor et al. , 2012). Mental health problems exacerbate physical illness.	Improve the identification of those people with a long term physical health condition(s) and depression. Ensure that those identified received evidence based interventions for depression, or access to rehabilitation programmes which include mental health support where appropriate.
Physical health of those with mental illness	People with severe mental illness die up to 20 years younger than their peers in the UK and lifestyle is thought to play an important role (see page 10). One study found that 60% of people receiving secondary mental health care smoked (Wu et al., 2013).	Increase the number of community mental health team members who are trained to give stop smoking advice, and increase the number of people with serious mental illness (SMI) referred to stop smoking services. *Additional focused initiatives to support the physical health of those with SMI, through preventive lifestyle interventions, such as tailored physical exercise programmes.* Improve consistency in physical health assessments and signposting.

1. Background

1.1 Vision & Aims of the Strategy

Through collaborating with a wide range of partners, this strategy will work to improve public mental health with the aim of achieving:

1. A common understanding of what it means to improve public mental health.
2. Maximise opportunities to promote mental health and prevent mental illness within Cambridgeshire through:
   - Taking a life course approach to promoting mental health
   - Promoting a more holistic approach to physical and mental health
   - Integrating mental health into all aspects of our work
   - Developing a wider environment that supports mental health including tackling stigma.

1.2 What is Public Mental Health?

The Royal College of Psychiatrists state that,

> 'Public mental health focuses on the wider prevention of mental illness and promotion of mental health across the life course…There is no public health without public mental health'.

Public mental health strategies focus on what action can be taken to promote positive mental health and wellbeing and to prevent mental illness or disorder. In this strategy we use the World Health Organisation (WHO) Public Mental Health Framework (WHO, 2013), as recently recommended by the Chief Medical Officer (CMO) in her annual report. The framework incorporates; Mental Illness Prevention, Mental Health Promotion, Treatment Recovery and Rehabilitation. These areas are conceptualised in the model presented in the CMO report (Figure 2).

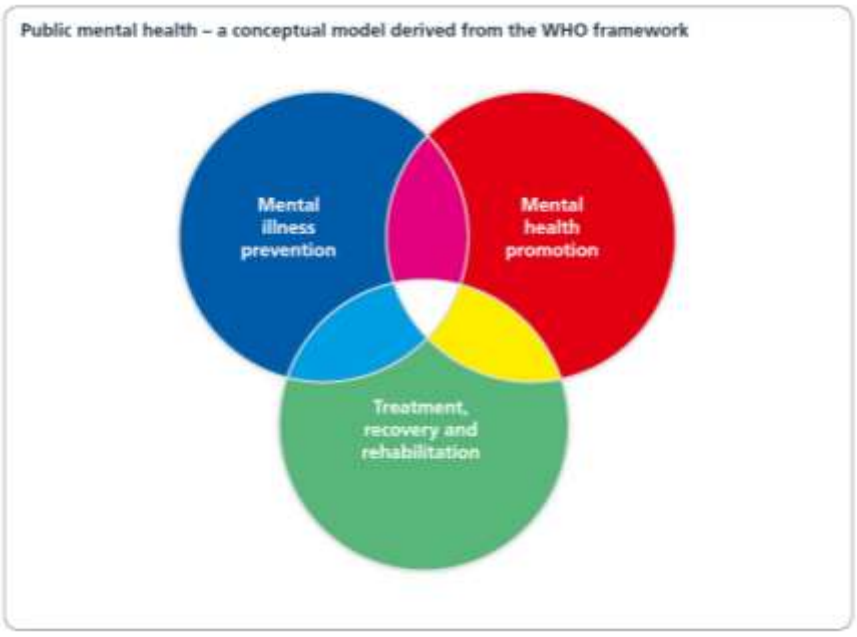


Figure 2 Public Mental Health Conceptual Model. Annual Report of the Chief Medical Officer 2013: Public Mental Health Priorities: Investing in the Evidence. September 2014. Department of Health p.13.

1.3 Definitions

It is important to be clear about the differences between mental health (or mental wellbeing), and mental illness. In this strategy we refer to both using the definitions below.

Mental health (or wellbeing): There are many different definitions of mental health or wellbeing (and little consensus on how it should be measured), but they generally include factors known to promote mental health such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against the development of many such problems. WHO describe mental health as 'a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.

Mental illness or disorder: Mental illness or disorder refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities e.g. depression, anxiety, and schizophrenia. **Severe mental illness (SMI)** includes diagnoses which typically involve psychosis or high levels of care, and which may require hospital treatment. Typically this includes schizophrenia and bipolar disorder (Mental Health Wales).

1.4 Scope of the Strategy

This strategy will focus on evidence based interventions within two areas of the WHO Framework; 'Mental Illness Prevention' and 'Mental Health Promotion', recognising the wealth of current work and complementary strategies that focus on 'Treatment, Recovery and Rehabilitation'.

- **Mental health promotion** is concerned with the determinants of mental health or the 'creation of individual, social and environmental conditions that enable optimal psychological and psychophysiological development'. Interventions may have a primary goal of improving mental health or the side benefit of doing so. Examples might include promoting a whole school approach for children's social and emotional wellbeing, recommended organisational level interventions to minimise the health effects of workplace reorganisation, or preventing social isolation and loneliness among older people.

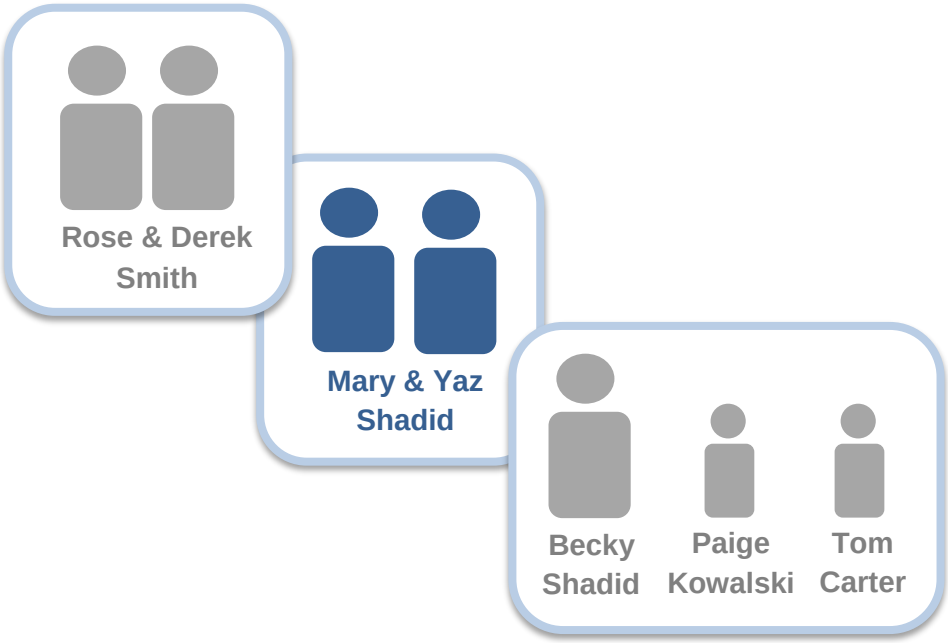
- **Mental illness prevention** is concerned with the causes of disease and aims to reduce the incidence, prevalence, recurrence and time spent with symptoms as well as the impact of illness on the person, family and wider society. Examples might include school based interventions to prevent bullying, or stigma prevention campaigns.

Following on from the joint Cambridgeshire & Peterborough Suicide Prevention Strategy produced in 2014, suicide prevention will not be covered specifically within this report. Similarly, crisis intervention is being address through the crisis care concordat action plan, and the clinical commissioning group is considering mental health as one of its workstreams within its transformation programme. Strategies focusing on the emotional wellbeing and mental health of children and young people and social care, together with a range of other strategies and Joint

Strategic Needs Assessment reports that compliment and inform this work, a summary of the most relevant documents is provided in Annex A.

1.5 What does the Public Mental Health Strategy Mean for Me?

The following example will be used to demonstrate how the work of this strategy may impact upon the lives of one fictional family. Similarly, this family will be used within the Adult Mental Health Social Care Strategy to illustrate how the strategy can impact upon individuals. Section 5 illustrates what the family might experience if we maximise public mental health opportunities.



Rose (78 years old) and **Derek Smith** (75 years old) have lived together in Wisbech for over 40 years. Derek cares for Rose who was diagnosed with dementia 3 years ago.

Rose and Derek have a daughter, **Mary** (50 years old) who lives in Ely together with her husband **Yaz** (52 years old). Yaz has chronic psychosis and is currently unable to work. Mary can find it difficult to hold down employment as she needs to provide support and care for Yaz.

Mary and Yaz have a daughter called **Becky** (30 years old) who is a single parent and lives in Sawston with her daughter **Paige** (14 years old) and her son **Tom** (4 years old). Becky works as a dinner lady in a local school to fit with childcare, she struggles financially and has run up some debt. Becky is under a lot of stress and is finding it difficult to cope with Tom's behaviour. She has very little support from Tom's father, contact is often erratic. Paige has been happy at school but recently has become withdrawn, and Becky suspects she is being bullied.

2. Facts & Figures

2.1 The National Picture

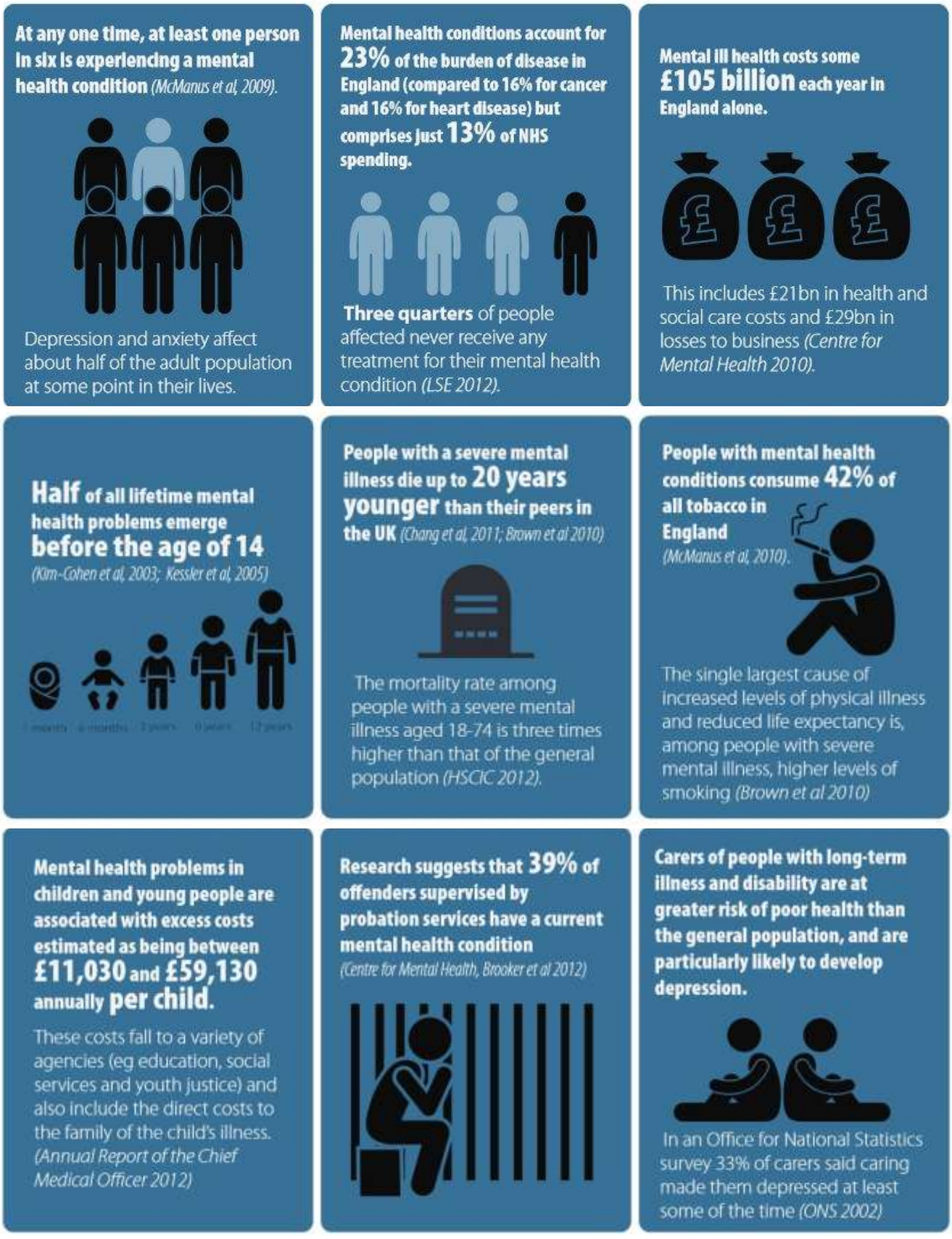


Image produced by Warwickshire County Council in the Warwickshire Public Mental Health and Wellbeing Strategy 2014-16.

2.2 Risk Factors & Protective Factors

Although anyone can suffer from poor mental health or mental illness, certain factors make some individuals and population groups more at risk. The Chief Medical Officer's Report on Public Mental Health further compiles and describes the aspects of people's lives that are linked to mental illness in adulthood, an adapted summary is provided below (Stansfeld et al., 2014).

Adversity in childhood – Looked after children (LAC) are known to have higher levels of mental health problems with 45% of LAC (5-17 years) having a mental health disorder in one survey (ONS, 2003).

Demographics:

- **Age -** The pattern of prevalence of mental illness differs across the life course, with depression for example peaking in midlife.
- **Gender** – Whilst problem gambling, alcohol dependence and suicide are more common in men, women are more likely to suffer from common mental disorders including anxiety and depression.
- **Ethnicity** – Some ethnic groups appear to have higher levels of certain mental illnesses. Gypsies and Travellers are nearly three times more likely to suffer from anxiety than average and just over twice as likely to be depressed (DoH & Cabinet Office Social Exclusion Taskforce, 2010; CCC/NHS Cambridgeshire PCT, 2010).
- **Offenders, Young Offenders and Victims of Crime –** Levels of mental illness is considerably higher than the general population, one key survey showed 90% of prisoners had one or more of the five psychiatric disorders studied (Singleton, N. et al. , 1998).
- **Sexuality –** NICE guidance recognises that lesbian, gay, bisexual and transgender people are at higher risk than heterosexual people of suicidal feelings, self-harm, drug or alcohol misuse and mental health disorders such as depression and anxiety (NICE, 2011).
- **Young parents**

Socio-economic context

- **Income** - People living in households in England with the lowest income are more than three times more likely to have a mental illness.
- **Debt**
- **Housing conditions and fuel poverty** – This links to both income and debt, but cold homes can also contribute to social isolation as people may not want to invite people round.
- **Unemployment** – Anxiety, depression and suicide are associated with unemployment.
- **Adverse working conditions -** Although employment is generally good for mental health, poor working conditions can have a negative effect, for example, lack of job security and an effort-reward imbalance can increase the risk of common mental disorders.

Social Context

- **Social relationships** – Experiencing domestic abuse is associated with the development of a number of mental illnesses, and witnessing domestic violence as a child is a risk factor for being a victim of violence in adulthood (Howard, Shaw, Oram, Khalifeh, & Flynn, 2014). A Domestic Abuse Strategy for Cambridgeshire (Domestic Abuse & Sexual Violence Partnership, 2014) was produced in 2014 following a comprehensive mapping exercise and needs assessment.
- **Caring Responsibilities (at any age)** – Being a carer has been associated with vulnerability to mental illness, this may be through emotional strain and traumatic life events, or perhaps through the financial pressures for example. This is further discussed in the Carers JSNA (2014) and through the implementation of the Care Act 2014.

Health, disability and health behaviours – for example physical health conditions and alcohol and drug consumption, or sensory impairment and isolation.

As well as there being a number of adverse or risk factors that could lead to poor mental health or mental illness, there are also a number of protective factors. The table below (Table 1) was created as part of the development of the WHO Mental Health Action Plan; it illustrates a range of factors that may have adverse or protective effects on mental health.

Table 1 Mental Health Determinants - potential adverse and protective determinants of mental health. (WHO, Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors, 2012)

Level	*Adverse factors*		*Protective factors*
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety

- **Deprivation**

Clusters of indicators make mental health disorders more prevalent in some areas, tending to mirror broad patterns of poverty and household deprivation (NHS Cambridgeshire & CCC, 2013). Average prevalence levels are therefore an underestimation of need in those areas, where risk levels are likely to be two to three times higher amongst some disorders (e.g. conduct disorder) (NHS Cambridgeshire & CCC, 2013). The Cambridgeshire Poverty Strategy also highlights the impact of poverty on both mental and physical health – an issue raised by interviewees who experience poverty (Cambridgeshire Children's Trust, 2014). Enabling people to get into work and to manage debt can relieve some of the stresses of poverty.

2.4 The Local Picture – Cambridgeshire

There are an estimated 19,000 children and young people (aged 17 years and under) who may experience mental health problems in need of mental health support[1]	There were 474 self-harm hospital admissions in people aged 10-24 years in 2012/13 and the rate of admissions is higher than the England average[2]	In 2012 there were an estimated 7,500 people with dementia. This is expected to increase to over 12,000 by 2026[3]
6.2% (32,950) of adults aged over 18 years had depression in 2013/14 (CCG level. England average 6.5%)[4]	There are an estimated 63,000 adults aged 18-64 years with a common mental health disorder* [5]	The excess under 75 standardised mortality ratio for adults with serious mental illness was 319 in 2012/13** (England average 347)[6]
4.2% (810) of 16-18 year olds were not in employment, education or training in 2013 (England average 5.3%)[2]	4,986 patients registered in Cambridgeshire have a serious mental illness (SMI)[7]	The rate of hospital admissions for alcohol related conditions was 5.9 per 1,000 population in 2012/13 (3 ,526 admissions) (England average 6.4)[8]
In 2013/14 there were 610 households that were statutory homeless***[9]	0.25% of the working age population are long term unemployed (1,030 people) (England average 0.73%)[9]	13.1% of children live in poverty (14,110 children) (England average 20.6%)[9]
6% of pupils said that there had been physical aggression at home at least 'once or twice' in the last month that frightened them[10]	6% of pupils responded that they are a 'young carer'. 13% said they 'don't know' if they are	21% of boys and 36% of girls responded that they feel afraid to be in school because of bullying at least 'sometimes'

Health Related Behaviour Survey 2014

* Common mental disorders: Mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder[5].

** The number of 18-74s in contact with secondary mental health services that die compared to the number that die within the general population at the same age. So, for every 100 deaths in the standard population there were 319 deaths in those with serious mental illness.

*** Households that are accepted as being owed a duty by their local authority under homelessness legislation as a result of being eligible for assistance, unintentionally homeless and in priority need.

[1] CAMHS Needs Assessment, ChiMat
[2] Children's and Young People's Mental Health and Wellbeing, Fingertips, PHE
[3] Older People's Mental Health, JSNA, Cambridgeshire
[4] Quality and Outcomes Framework (QOF), Health and Social Care Information Centre
[5] Autism, Personality Disorders and Dual Diagnosis JSNA, Cambridgeshire County Council
[6] Severe Mental Illness Profiling Tool, Fingertips, PHE
[7] Data source: CQRS and GPES database - 2013/14 data as at end of June 2014
[8] Public Health Outcomes Framework, Fingertips, PHE
[9] Common Mental Health Disorders Profiling Tool, Fingertips, PHE
[10] Young People in Cambridgeshire Schools, Health-Related Behaviour Survey 2014, The Schools Health Education Unit

Local Variation

Countywide data can hide the local variations seen within Cambridgeshire. As previously mentioned, certain factors can increase the risk of people suffering poor mental health or illness. These factors often reflect the broad pattern of poverty or deprivation. For example, when looking at hospital admissions for self-harm across 10 years in Cambridgeshire, there is a correlation with deprivation; the rate of admissions are generally higher where deprivation is higher. These areas would also be expected to have a higher rate of adults living with common mental disorders.

Below is a map (Figure 3) highlighting the areas of greatest deprivation in Cambridgeshire, as measured by the Indices of Multiple Deprivation (IMD). The greatest areas of overall deprivation are in north Fenland, Huntingdon north and the north east of Cambridge City. It is important to also remember, that within seemingly more affluent areas there may be pockets of poorer households with high levels of mental health need.

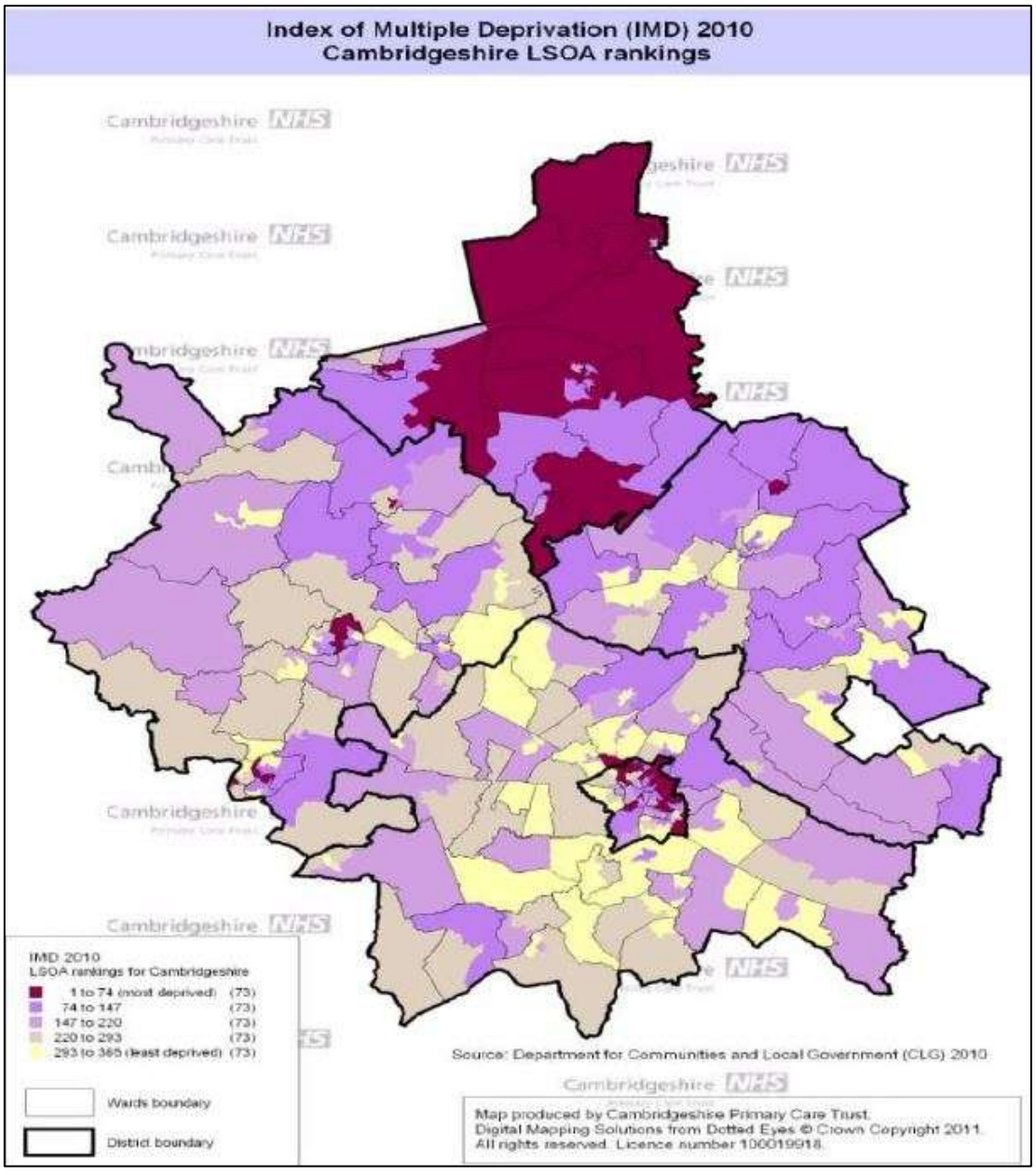
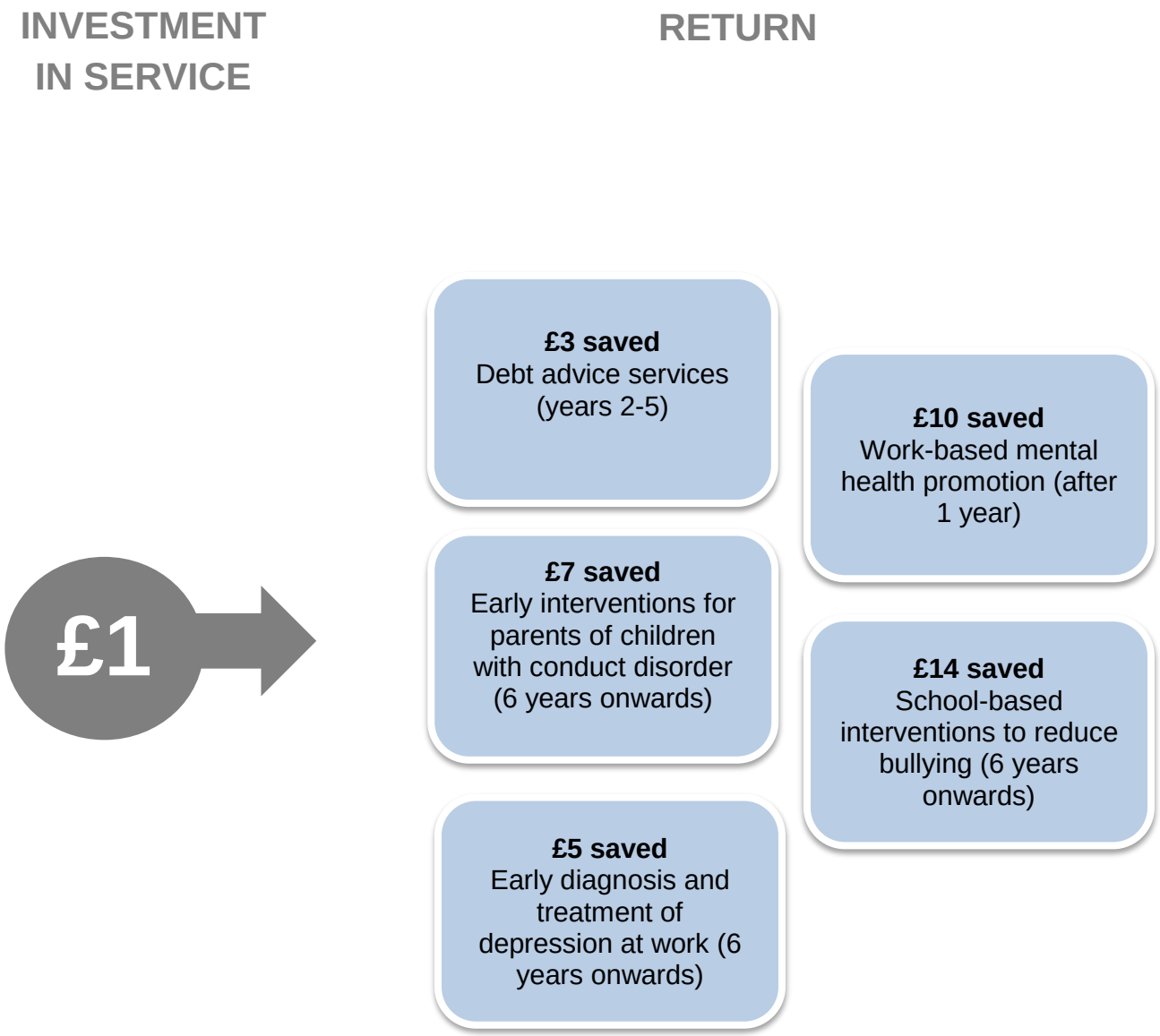


Figure 3 Cambridgeshire map of deprivation as measured by IMD 2010 (NHS Cambridgeshire & CCC, 2013).

2.5 The Economic Case

The annual cost of mental illness to the economy in England is estimated to be £105 billion, and the cost of treating mental illness is expected to double in the next 20 years (HMG/DOH, 2011). The economic benefits of mental health promotion and mental illness prevention were reviewed in a report published by the Department of Health (Kapp, 2011), which is cited within the 'Guidance for Commissioning Public Mental Health Services'. Adapted summary findings from the report are illustrated below.



2.4 What do people think?

The following summarises local and national feedback from patients, carers and the public on public mental health.

Comments and themes emerging from engagement/consultation work:

- Carers (of any age) need more support to cope with their caring role[1]
- The need for support for mental health service users to get employment[1]
- The need for access to accurate information/signposting[1]

What is the most useful thing that you do to keep well (social care users)?

"Work. Having supportive employment enables me to feel valued, earns me money which pays the bills, and fosters a sense of independence. It gives me self-respect. A public health function for the council in working with employers to understand how to work with people with mental illness may prove invaluable in reducing the need for support, and preventing and improving ill health"[2]

"The most useful things I do to keep well are to be creative. I sing with community singing groups which benefits my posture breathing is also sociable. It is the highlight of my week and performing also increases my confidence."[2]

What are the things in your local community that are important to you in keeping well?

"Safety (no crime and bullying of mentally ill people)"[2]

"Relationships within the community are more important than "things". I do go to church, and that is important, but the people I enjoy spending time with are more important. Helping us to really be a part of the community, rather than just 'take part in activities' is vital."[2]

Working with people who have lived experience of mental illness a range of statements have been produced that describe what service users want and can be used by services to measure themselves against:

- I am not stigmatised by services and professionals as a result of my health symptoms or my cultural or ethnic background.
- My mental and physical health needs are met together.
- Where I raise my physical health concerns, in any setting, they are taken seriously and acted on.

[1] Cambridgeshire & Peterborough CCG System Transformation open 'speedback' consultation events (2014).

[2] Response to the 'Let's talk' social care conversation conducted by Healthwatch with social care service users (2014).

[3] National Voices, NHS England & Think Local Act Personal. (2014) No Assumptions.

The Mental Health Needs Assessment for Children and Young People in Cambridgeshire conducted in 2012/2013 asked young people 'What keeps young people well?' with the following key messages[4]:

- Accessible support in general is important, rather than waiting to be 'ill'.
- Support from family friends is important, as is their awareness of mental health.
- Support needs to be from friendly, approachable and empathic people.
- Being protected from harm/bullying, parents.
- Learning to deal with stress, e.g. exams, friends, school.

[4] Cambridgehsire County Council & NHS Cambridgeshire (2013). The Mental Health of Children and Young people in Cambridgeshire (JSNA).

3. The National Context

In 2011, the cross-government mental health strategy - 'No Health without Mental Health' was published (HMG/DOH, 2011). The strategy focuses on mainstreaming mental health in England, and establishing parity of esteem between physical and mental health services. The strategy takes a life course approach and recognises that mental health is everyone's business, a concept that is reflected throughout this strategy for Cambridgeshire. In 2014, 'Closing the Gap: Priorities for Essential Change in Mental Health' was published, which outlines 25 priority areas that will support the delivery of the cross-government strategy for mental health (Department of Health, 2014).

This strategy will contribute at a local level to the six objectives of 'No Health without Mental Health':

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

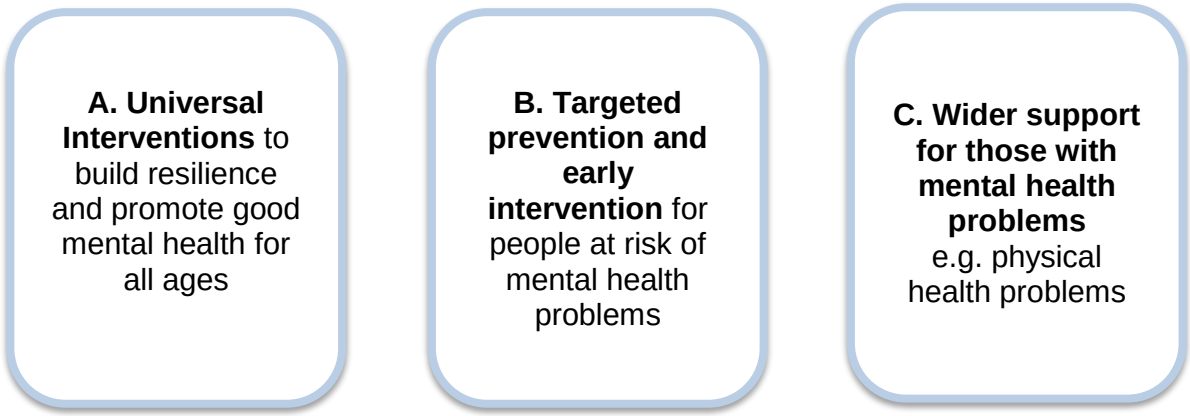
More recently the government published guidance for how new access and waiting times standards for mental health services are to be introduced in the NHS (NHS England, 2015), and the Prime Minister launched his 'Challenge on Dementia 2020' (Department of Health, 2015).

4. Improving Public Mental Health in Cambridgeshire

This strategy will look at approaches to improving public mental health within three broad themes:

- **A life course approach to promoting mental health**, including critically how to maximise prevention and promotion opportunities in childhood, such as interventions to reduce bullying and improve parenting.
- **Developing a wider environment that supports mental health**, using anti-stigma and discrimination tools, workforce training, and maximising the opportunities within workplaces.
- **Physical and mental health**, or 'The mental health of people with physical illness and the physical health of people with mental illness'.

Within these themes, proposals of work will be divided into three groups, adapted from the suggestions provided in 'No Health without Mental Health Implementation Framework' (Centre for Mental Health et al., 2012) and the Warwickshire Public Mental Health & Wellbeing Strategy (Warwickshire County Council, 2014):



4.1 A Life Course Approach to Promoting Mental Health

4.1.1a Children & Young People

Most mental illnesses begin in childhood, adolescence and young adulthood (Stansfeld et al., 2014). It is thought that half of all lifetime mental disorders start by the age of 18 and three-quarters by the mid-twenties (Stansfeld et al., 2014). Children and young people with poor mental health are more likely to have difficulties with social relationships, poor educational attainment, and substance misuse problems (Ford et al., 2014). Furthermore, Cambridgeshire is seeing an increasing trend in hospital admissions for self-harm in young people. Interventions in childhood have the potential to prevent the development of mental illness, for example more than a quarter of the burden of adult psychiatric disorders is attributable to the effect of experiencing childhood violence or abuse (Howard et al., 2014).

4.1.1b What works?

- ***Identifying & Treating Maternal Mental Illness in pregnancy and first year of life***

Maternal mental illness in the perinatal period (during pregnancy and first year after a child is born) impacts upon both the mother and the emotional, behavioural and cognitive development of the child (Centre for Mental Health, 2015). This carries significant financial costs, particularly in terms of the impact on the child. NICE provide guidance (NICE, 2014) on the assessment, identification

and treatment of maternal mental illness in the perinatal period, recognising the positive impact that they can have. It is estimated many women are not receiving interventions though, with an estimate of a half of cases of perinatal depression and anxiety not being detected (Bauer et al., 2014; Centre for Mental Health, Investing in Children's Mental Health, 2015).

Existing Services & Interventions

- Health Visitors and Family Nurse Partnership.
- Perinatal Mental Health Service – women can be referred to the service via a GP or other health professional (with GP consent). The woman may then be assessed by an Advanced Practitioner for Perinatal Mental Health.
- Home start is an example of peer support model where volunteers support families that have at least one child under 5 years. They provide practical help as well as emotional support.

➢ *Parenting Programmes*

In a recent public health evidence review there was evidence to suggest that the following interventions for child behaviour, which are recommended in NICE Guidance, are effective:

- Group parent training for parents of children aged 3-5 years with behavioural problems
- Group child training for children aged 9-14 years with behavioural problems
- Multi-systemic therapy for children aged 11-17 years with conduct disorder or previous contact with the criminal justice system
- Individual parent/family training for parents of children 3-5 years with behavioural problems who are not able to participate in a group parent training programme.

Existing Services & Interventions

The Local Authority currently commissions universal and targeted provision across 3 main programmes:

- *Incredible Years Early Years (Under 6 years)*
- *Incredible Years (3-6 years)*
- *Stepping Stones (2-12 years)* – for parents/carers of children with special educational needs and disabilities

Additional programmes such as *Early Bird Plus* and *SCILS (Social Communication, Interaction and Learning skills programme)* for parents and carers of children with autism are also available.

Complete programmes list: http://www.cambridgeshire.gov.uk

➢ *Early Years*

There are NICE guidelines on early years (0-5) that suggest a focus on social and emotional, as well as educational, development for this age group is key (NICE, 2012). The guidance recommends both universal and targeted provision, particularly focusing on the needs of the most vulnerable children and families. There is also substantial evidence on the importance of secure attachment in the first few months and years of life (Allen G. , 2011) (The Marmot Review, 2010).

Existing Services & Interventions

- Free early education and childcare for 3 and 4 year olds (570 hours a year) and some 2 year olds.
- Health Visitor and Family Nurse Partnership services
- Children's Centres.

➢ *Anti-Bullying Interventions*

There is mixed, but consistent, evidence of what makes anti-bullying interventions successful. A recent review suggested that interventions are most effective if they (Harris, 2015):

- Use a whole school approach (multiple disciplines, whole community and parents)
- Are adapted to the social and cultural characteristics of the school population
- Are intensive
- Include firm disciplinary methods
- Include improved playground supervision
- Sustained over time.

➢ *Mental Health Promotion in Schools, Further Education (FE) and Higher Education (HE) Settings*

Schools and colleges provide an important setting for mental health promotion interventions, including anti-stigma work, contributing strongly to the risk and resilience factors for mental health (Weare & Nind, 2011). Recent systematic reviews show that school mental health programmes demonstrate clear and repeated evidence of positive impact (Weare & Nind, 2011; Jenkins & Barry, 2007; Stewart-Brown, 2006). The most effective programmes are those that are:

- Long-term
- Take a whole school approach – including culture, staff morale, pupil, and family and community involvement.

A variety of programmes are available that take a whole school approach include SEAL (Social and Emotional Aspects of Learning Programme, Zippy's Friends and MindMatters. We also need to consider this type of approach in other settings such as early years settings. Furthermore, considerations need to be made in terms of the different challenges that FE settings and this age group may experience, for example they may be in apprenticeship schemes. The type of support needed may therefore differ.

It is also recognised that transitions points, such as when moving from primary school to secondary school, or from college to the workplace are points at which children and young people may be at higher risk of mental health problems and may need additional support.

Existing support for schools (provided or commissioned by the local authority):

- **Personal, Social, Health & Economic Education** (PSHE) – This can be provided by external organisations, or schools can purchase the local authority offer which is based on SEAL. A range of units of work are available to primary and secondary schools and specific units are available covering mental health. Currently approximately 60% of primary schools take up the broad PSHE package from the local authority.
- **Health Related Behaviour Survey** – Biannual survey of school children (Years 6, 8 and 10) collecting data on a range of health issues, including bullying.
- **Free mental health training** for teachers – A wide range of training for practitioners working directly with children and young people, including 'Raising achievement through wellbeing' and training specifically around self-harm. This training supports the whole school approach to promoting mental health.
  More information: http://www.cpft.nhs.uk/professionals/camh-training.htm
- **Self-harm guidance** - for practitioners working with children and young people: Guidance: http://www.cpft.nhs.uk

Additional funding has also been provided to Centre 33 who have commissioned SexYouality to provide assemblies for schools and support around LGBT issues, in particular to target those at higher risk of self-harming.

4.1.1c Actions

A. **Universal Interventions** to build resilience and promote good mental health for all ages

1. Development of a strategic approach to provide support to schools and settings to prevent and reduce incidents of bullying and to support children, young people and families affected by it. This will be driven forward by an anti-bullying steering group as part of shared work across Public Health and Children, Family and Adults Directorates.
2. Development of a new anti-bullying strategy, through the anti-bullying steering group, focusing on the best way to support schools and settings (including FE settings) in reducing bullying. This (together with point 1) is a an area for investment.
3. Additional support to schools, particularly secondary schools, in developing a whole school approach to promoting good mental health and reducing stigma, through the PSHE offer and other mechanisms. This is an area for investment.
4. Continue to build on existing work across the local authority to address the issue of self-harm in Cambridgeshire. This should include ensuring there is greater uptake to training opportunities around mental health and self-harm in young people from people working in schools, colleges, FE and HE settings.
5. Maximise opportunities to promote mental health across the early years workforce and in early years settings, particularly with the commissioning of Health Visitors and Family Nurse Partnership transferring to Cambridgeshire County Council in October 2015. This might for example include the development of an early years workforce mental health training strategy and maximising opportunities to reach socially isolated new mothers. This may also include looking at the role that Early Years

settings, such as Children's Centres, have in reducing social isolation and supporting people back to work.

6. Work is underway to collate consistent mental health information sources for children, and similar work has been completed in terms of referral options from primary care for adults. This work will be promoted to ensure consistent signposting across services.

B. **Targeted prevention and early intervention** for people at risk of mental health problems
    1. Continue to support evidence-based parenting programmes.
    2. Ensure that intervention during the perinatal period to identify and treat patients with mental illness is a focus in the refreshed Emotional Wellbeing and Mental Health Strategy for Children & Young People (2014-16). The implementation of the strategy should include an assessment of local provision against the 2014 NICE Guidance. This should be considered as an area for investment given the long-term future savings.

4.1.2a Social Isolation

In a recent report on promising approaches to reduce loneliness and social isolation in older people (Campaign to End Loneliness & Age UK, 2015), the following definitions were used:

Social isolation – An objective state which can be defined in terms of the quantity of social relationships and contacts.

Loneliness – A subjective experience and negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want.

Social isolation and loneliness have both been linked to poorer mental health, in particular lonely or isolated people have an increased risk of developing dementia, specifically in developing Alzheimer's disease, as self-perceived loneliness doubles the risk (Age UK, 2014). In Cambridgeshire 43.9% of adult social care users aged 65 or over are satisfied with the amount of social contact they have and 4.3% reported feeling socially isolated (Public Health Solutions (Commissioned by CCC), 2014). Another potentially important factor to consider in some cases of loneliness is the role of bereavement.

4.1.2b What Works?

The evidence base for effective interventions for reducing social isolation and/or loneliness is acknowledged to be lacking in high quality studies, however, a recent report highlighted promising approaches as identified by a panel of experts and evidence reviews (Campaign to End Loneliness & Age UK, 2015):

- Foundation services – those which reach isolated individuals, develop an understanding of their needs and support them in accessing services.
- Direct services – activities and services for individuals to access to maintain existing social connections and build new ones. Key characteristics of services/activities:
    1. Group-based, and targeted at a specific group
    2. Focused on a shared interest, or with an educational focus
    3. Set up to involve older people in running the group

4. One-to-one services have a role, particularly for those where there are barriers to leaving the house.

- Structural enablers – the mechanisms that create an environment whereby services to reduce social isolation and loneliness arise e.g. types of community work like Asset Based Community Development and volunteering.

The report also recognised the potential role of technology and transport in remaining connected.

4.1.2c Existing Work

Existing Services & Interventions (commissioned by the Local Authority)

'Foundation services'

- Community Navigators - local volunteers or members of organisations who help older people find their way to activities or services. Collaboration with services such as the police and healthcare services enable potentially isolated individuals to be identified. www.care-network.org.uk
- Health Trainers
- Digital Inclusion work – A digital inclusion strategy is currently being written that focuses on digital, and in turn social, inclusion.

'Direct Services'

- Walking for Health – Free health walks around Cambridgeshire
- Library IT Training

'Structural Enablers'

- Engaging Communities in Fenland – This project is about building communities in Fenland to help them address their needs
- The Fenland Fund – This Fund will enable communities to secure funding for small projects to address their needs
- Time Credits – This project is currently based in Wisbech and enables volunteers to trade credits earned from time spent working on the project for fun activities.
- Volunteering - there are a range of opportunities in voluntary organisations, through the Cambridgeshire library service and various time banking and time credits schemes,

4.1.4 Actions

A. **Universal Interventions** to build resilience and promote good mental health for all ages.

1. Continue to support the implementation and expansion of the Time Credits scheme and projects such as community navigators and to build the evidence base through evaluation of this work.
2. Increase engagement of communities in addressing and improving their health and wellbeing.

3. To ensure that a wide range of professionals recognise social isolation as a risk factor for poor mental health and are aware of local activities which might support individuals who are socially isolated.

B. **Targeted prevention and early intervention** for people at risk of mental health problems
   1. Consider future options for the Lifestyle Service, Health Trainers and Community Navigators Service that could enhance their role in terms of promoting mental health.
   2. Support the digital inclusion strategy and provide clear and consistent guidance on the best available website information for different groups.

4.2 Developing a Wider Environment that Supports Mental Health

4.2.1a Mental Health & Work

The wider physical and social environment in which we grow, work and live impacts upon an individual's mental health, together with our innate biological vulnerabilities. Although work is generally good for mental health, the working environment and security of the employment is also important. There must be sufficient support and a positive effort-reward balance to avoid excessive levels of stress that can lead to mental illness (NICE, 2009). The economic case for investing in initiatives to promote mental health and prevent mental illness is well evidenced, with the number of working days lost to stress, depression and anxiety increasing by 24% since 2009 (ONS, 2014).

People who have a history of mental illness are more likely to be unemployed than those without, also unemployment is a risk factor for mental health problems (Knapp & Lemmi, 2014). There can be a number of barriers to gaining or retaining employment, for example the symptoms of the mental illness or discrimination by employers or stigma in the workplace (Knapp & Lemmi, 2014). Many service users do want support to get or retain a job, but may not have access to this.

4.2.1b What Works?

The key elements of mental health promotion and mental illness prevention in workplaces as drawn from NICE Guidance PH22 (NICE, 2009) and the annual report of the CMO are (Henderson & Madan, 2014):

- An integrated model of organisational and individual measures.
- Measures that increase control e.g. flexible working.
- Management – management style, ability to identify and respond to emotional concerns and an understanding of their impact on employee health.
- Assessing opportunities for promoting employees' mental wellbeing and managing risks
- Support for people returning to work following leave due to mental illness, for example temporarily working part-time.

In terms of supporting people with severe and enduring mental health needs to get back to work, 'Individual Placement Support' (IPS) is one evidenced based method for employment support (Centre for Mental Health, 2013).

4.2.1c Existing Work

Local Authority Workplace Mental Health Promotion
Work Healthy Cambridgeshire (ww.workhealthycambs.org.uk)

- A health in the workplace package is offered to businesses, particularly targeting those in areas of deprivation. The offer includes a range of initiatives to promote better health overall, for example smoking cessation services and Mental Health First Aid Training. Also train Health Champions within workplaces to run health campaigns and signpost to services.
- In 2014, 84 Health Champions were trained across workplaces in Cambridgeshire and 68 employees received MHFA Lite training in the workplace
- Local authority commitment to fund a strategic post to develop and expand workplace health initiatives across the county.

Training:

1. Mental Health First Aid (MHFA) Lite (half day) for workplaces
2. MHFA (2 day course) - Training for front line professionals who are not mental health specialists, such as social workers, support workers, Police, CAB advisors, Physical Disabilities workers, housing officers
3. Improving workplaces through training for Human Resources and Managers.
4. Piloting resilience training for workforces.

Local Authority Learning & Skills
A range of adult learning courses are offered via Library Learning Centres covering a range of subject areas including:

- Employability and work skills
- Employability learner pathways
- English and Maths skills
- European Computer Driving Licence (ECDL)
- Everyday IT - a basic IT qualification
- IT learner pathways
- National Vocational Qualifications (NVQs)

http://www.cambridgeshire.gov.uk

Richmond Fellowship - The service provides an employment support service for adults who have moderate to severe mental health needs based on IPS principles.

4.2.2a Mental Health and the Community

- ***Anti-stigma***

Many people who have a mental illness have experienced stigma or feel the need to hide their illness. One study found that approximately 70% of mental health service users felt the need to

conceal their illness (Corker et al. , 2013). The stigma that surrounds mental health can also prevent those who could benefit from additional support from accessing it; it is clear that addressing the challenges of mental health is everyone's business.

- ***Housing & Homelessness***

NICE recognise that mental illness is more common among homeless and vulnerably housed people than the general population (NICE, 2011; Rees, 2009). Furthermore mental illness may be a factor in losing living accommodation, and could be worsened by the stresses experienced when homeless (NICE, 2011). Well managed housing programmes, including housing with some specialist support can reduce these risks.

When planning new communities it is also important to maximise the potential mental health promotion and mental illness prevention opportunities, as highlighted in this strategy.

- ***Debt***

Nationally, Citizens Advice Bureau finds almost three in four people seeking debt help from the charity said their money worries were making them feel stressed, depressed or anxious. The Cambridgeshire Child Poverty Strategy also highlighted the difficulties that young adults may face in terms of money management through their consultation work.

4.2.2b What Works?

The key components of effective anti-stigma campaigns have been identified as (Thornicroft et al., 2014; Gale et al., 2004):

- Service users and carers should be involved throughout the design, delivery, monitoring and evaluation of the campaign.
- Campaigns should be monitored and evaluated.
- National campaigns should be supported by local grassroots initiatives.
- Campaigns should address behaviour change.
- Clear, specific messages should be delivered in targeted ways to identifiable audiences.
- Long-term planning and funding should be in place to ensure campaign sustainability.

The national 'Time to Change' campaign employs national and local level action with the aim of ending stigma and discrimination. The social marketing campaign has also undertaken targeted work with specific groups, for example medical students and employers. Evaluation results have showed promising results with a reduction in anti-stigmatising newspaper articles and improvements in attitudes towards mental illness (Thornicroft et al., 2014).

Nationally there is a drive to create communities that are more dementia friendly, improving inclusion and quality of life for people living with dementia. These communities aim to have a greater understanding of dementia, foster greater independence for people living with dementia and encourage more people, including carers, to seek out support. The 'Dementia Friends' training

supports this ambition (http://www.alzheimers.org.uk). The evidence base for this work is still in development and this, along with other programmes, designed to building community awareness and/or resilience around mental health need to be evaluated to fully understand their impact.

4.2.2c Existing Work

Anti-Stigma Work
Campaigns

- The County Council support a range of campaigns, including World Mental Health Day and the 'Time to Change' Campaign and promoting depression awareness.
- **STOP Suicide Campaign** Led by a range of voluntary organisations, using a combination of social media activity, Stop Suicide Pledges (both organisational and individual) and ASIST suicide prevention training. Within the first three months of activity, 418 individual pledges were signed and 25 organisational pledges. There have also been 40 people trained as ASIST First Aiders. http://www.stopsuicidepledge.org/

Training (local authority):

- MHFA Lite in workplaces – An evidenced based training programme that raises awareness of mental health issues and equips staff to deal with those with mental health problems more effectively.
- Commission full 2 day MHFA training for tier 1 workers in face to face contact roles. Frontline local authority employees, and those in partner organisations who are not mental health specialists, are able to access this e.g. Police, Citizens Advice Bureau, Housing Officers, NHS staff. The half day MHFA Lite will be available to all other staff to increase awareness of mental health.
- Recognising Gypsy and Traveller communities as at higher risk of mental health problems - Mental health needs and access to services were assessed in the Cambridgeshire Traveller's Mental Health Report (2011) and appropriate training made available to service providers.

Work is also being undertaken to ensure consistency in signposting to online information in terms of children's mental health. A web link on the council website will provide a list of online resources, this has the potential to be embedded on the websites of other organisations/

Recovery College East
Courses for those who have used/use secondary care mental health services, their supporters and a range of staff and volunteers. The courses aim to build skills, understanding and support people to move forwards. http://www.cpft.nhs.uk/about-us/recovery-college-east.htm

Housing & Homelessness

Supporting New Communities Strategy (in development) - will look at how we can create communities that have the services and provisions to meet needs.

Learning and Development Service at Winter Comfort – Jointly funded by CCC and Cambridge City Council offering a range of activities, information, advice and guidance to support personal development and job skills.

Debt Management

Making Money Count - A £1m project running from 2013-18 in Fenland and helping people with their money issues, providing frontline training and working towards a sustainable infrastructure for financial inclusion for Fenland. The project is a partnership between Circle Housing Roddons, Fenland District Council, CHS (Cambridgeshire Housing Society) Group and Rural Cambridgeshire Citizens Advice Bureau. http://makingmoneycount.org.uk/

There is also a variety of support available from other voluntary sector organisations across the county, such as the services provided by the Citizens Advice Bureau.

4.2.3 Actions

A. **Universal Interventions** to build resilience and promote good mental health for all ages.
   1. A standard for workplace health should be adopted and promoted countywide. The County Council & local NHS organisations should be some of the first organisations to work towards this standard. The new workplace health post will support the adoption and promotion of this standard. In the future should consider putting this as an obligation within local authority contracts.
   2. Continue to support Time to Change, the Stop Suicide Pledge and Campaign and other anti-stigma work, particularly in workplaces, schools and early years settings and where appropriate in wider community settings. This is a likely area for investment given the limited local capacity to undertake this work currently.
   3. Making the most of opportunities across the council to promote mental health and prevent mental illness, for example through further education.
   4. To support well evaluated projects that build communities with a greater understanding of mental health.
   5. Support the implementation of the 'Supporting New Communities' strategy.
   6. Look at ways of providing additional support to those that may be particularly vulnerable and at risk of having problems with debt, starting with care leavers.

B. **Targeted prevention and early intervention** for people at risk of mental health problems
   1. The Cambridgeshire poverty strategy, Breaking the Cycle 2, contains pledges from a wide variety of organisations that will help tackle child poverty. Many pledges support better mental health, for example through providing training to get parents back into work, or reducing alcohol consumption.

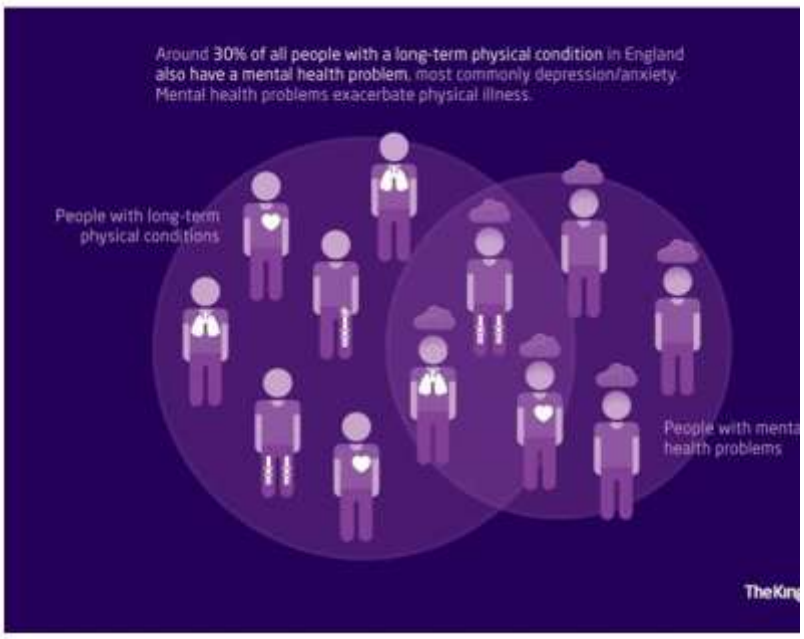
2. Continue to fund Mental Health First Aid training for frontline staff.
3. Expand the provision of full workplace support programmes such as Fit4Work to improve workplace health in the areas of greatest deprivation or amongst high need populations. This will require additional investment in the mental health training element of this programme.

C. **Wider support for those with mental health problems** e.g. physical health problems
1. Continue to support initiatives to work with people who have mild to moderate mental health problems back into work or to retain work – including applying for funding from the Skills Funding Agency, and recognising the wider importance of learning courses in reducing unemployment.
2. Utilise services that may come into contact with those with mental health problems, such as the Health Trainer service, to better identify those clients who have a mental health need and ensuring they are equipped to support them in accessing the right help.

4.3 Physical and Mental Health

4.3.1 The Mental Health of People with Long Term Conditions

People who are living with a long term condition, such as diabetes, hypertension (high blood pressure) or chronic obstructive pulmonary disease (COPD) may be more likely to develop certain mental illnesses, such as depression or anxiety (Department of Health, 2014). Studies suggest that they may be two to three times more likely to experience mental health problems than the general population (The Kings Find and Centre for Mental Health, 2012). People with two or more long term conditions are seven times more likely to have depression (NICE, 2009).



Source: The King's fund 'The Changing Patient' infographic.

4.3.1a What works?

The following evidence is gathered from a recent review conducted by Cambridgeshire Public Health.

- ***Effective Identification***

There is a lack of evidence for the implementation of routine depression screening within the care pathways for people with long term physical health conditions. However, routine clinical management of long term health conditions should include the identification of those requiring individual assessment for depression or anxiety. NICE recommend the use of depression identification questions for this purpose and these should be incorporated into the initial patient assessment (NICE, 2009).

- ***Psychological Interventions***

Evidence supports the beneficial role of psychological interventions, but is inconclusive in determining the most effective intervention for a specified patient group. NICE recommend offering a choice of psychological intervention dependent of patient preference and assessed severity of depression or anxiety (NICE, 2009):

  - Group based peer support programmes
  - Individual guided self-help (based on cognitive behavioural therapy [CBT])
  - Computerised CBT.

- ***Pharmacological Interventions***

Evidence consistently supports the effectiveness of antidepressant therapy in the management of depression in those patients who also have a long term physical health condition.

➢ *Exercise*

The benefits of exercise in the management of depressive symptoms when delivered as a part of programmes such as pulmonary rehabilitation and cardiac rehabilitation have been consistently observed. The offer of a structured group physical activity programme should be made to those with identified depressive symptoms and a long term physical health condition (NICE, 2009).

➢ *Rehabilitation and Support Programmes*

Pulmonary Rehabilitation has been shown as an effective management strategy to improve symptoms of depression/anxiety in those with Chronic Obstructive Pulmonary Disease (COPD). Evidence would support a recommendation that patients diagnosed with COPD should have undelayed access to a programme of Pulmonary Rehabilitation. Evidence supports the inclusion of exercise and psychological interventions to improve outcomes for depression and anxiety in those with heart failure and after myocardial infarction.

4.3.1b Actions

C. **Targeted prevention and early intervention** for people at risk of mental health problems

1. Improve the identification of those clients with a long term physical health condition and depression. Where a mental health assessment is indicated, using depression identification questions incorporated into the initial patient assessment within pathways of care.
2. Upon identification of depressive symptoms ensure the timely offer of an appropriate psychological intervention, which should include the offer of access to cognitive behavioural therapy amongst other options.
3. Support the use of antidepressant therapy in the management of comorbid depression and long term health conditions, where clinically indicated.
4. Ensure timely access to multicomponent rehabilitation/support programmes, incorporating exercise and psychological interventions, for those conditions where programmes exist. Where programmes do not exist, the development of similar models should be considered, particularly for those individuals who suffer from multiple long term health conditions.

4.3.2 The Physical Health of those with Mental Illness

In general the life expectancy of people with a range of mental illnesses, such as schizophrenia and depression is less than that of people that are not living with a mental illness (Hotopf & McCracken, 2014). International evidence shows that people with learning disabilities or long-term mental health problems on average die 5 to 10 years younger than other citizens, often from preventable illnesses (Nocon, 2006).

Source: The King's Fund 'Improving the Health of the Nation' Infographic.

Although suicide rates are higher in people with mental illness(es), this does not account for all of the differences seen (Hotopf & McCracken, 2014). In particular, health behaviours are important with smoking prevalence higher in those with serious mental illness – one study found 60% of people receiving secondary mental health care smoked (Wu et al., 2013). Diet, physical activity and alcohol consumption all potentially have an important role too. It may also be the case that those with mental illnesses are less likely to seek help or access preventative services, such as screening (Hotopf & McCracken, 2014).

4.3.2a What works?

- ***Physical Health Assessments***

NICE guidance recommends that there is monitoring of the physical health of individuals with serious mental illness, and that support should be offered where needed around stopping smoking, weight and lipid management (NICE, 2014) (NICE, 2014). Further NICE Guidance (PH48) published in 2013 gives recommendations for smoking cessation in secondary care settings including mental health services.

- ***Physical Activity***

Being physically active has an important role in preventing and managing a range of conditions, including mental health problems (NICE, 2014). In particular NICE recommend tailored and structured exercise programmes for the management and rehabilitation from depression. Physical activity can also have a positive effect on mood and provide relief from stress (NICE, 2014).

- ***Social Prescribing***

Social prescribing refers to the linking of patients to non-medical sources of support within the community (Community Services Improvement Partnership, 2009). Examples of this type of support include exercise referral schemes, arts on prescription, volunteering and books on prescription. As this covers such a broad spectrum of interventions with varying levels of evidence

base, it is important to ensure work in this field has robust evaluation measures in place. A local evaluation of Arts on Prescription showed positive levels of results for those with mild-to-moderate anxiety and/or depression including around social isolation (Potter, 2013). In addition, a recent report on the role of the natural environment in reducing health inequalities gave an overview of the role within mental health (Allen & Balfour, 2014). There is recognition though in several areas of social prescribing that larger scale studies are required to give a comprehensive overview of the key requirements of successful projects.

4.3.2b Existing Services

Services for with people with severe mental illness

Physical Health Forum

- Hosted by Cambridgeshire and Peterborough Mental Health Trust
- Multi-agency staff working on mental health to discuss the physical health need of mental health service users across Cambridgeshire (at Fulbourn hospital and in the community).
- Includes smoking cessation, physical health assessments, dietary support and opportunities to engage in physical activity in hospital and in the community.

Smoking Cessation

- There is a Stop Smoking Advisor working in the secondary mental health care setting provided by CamQuit.
- Staff working with patients can access online Level 1 (Very Brief Advice) training or CamQuit can provide face-to-face Level 1 or Level 2 (1-to-1 Advisor) training.

Physical Activity

- Invigorate programme – Run by Cambridge City Council providing activity sessions (e.g. swimming, football and t'ai chi) for mental health service users and homeless people in Cambridge.
- Exercise Referral Schemes – run by Cambridgeshire districts taking referrals for people with mental health problems. The schemes support participants in a 12 week part-funded supported gym based programme with the intention of promoting their physical and mental health.

Health Trainers

- Free one-to-one advice and support around smoking, drinking, diet and physical activity offered within GP surgeries.

Crisis App

A phone app produced by the Service User Network providing a one-button-press 'call for help', for people in crisis to access their support network, sharing their location without having to make a phone call.
http://sunnetwork.org.uk/crisis-card/phone-app/

Social Prescribing in Cambridgeshire

Arts on Prescription - Arts & Minds provide weekly sessions for people with mild to moderate anxiety and depression in areas of Cambridgeshire.

Reading Well: Books on Prescription - This initiative enables GPs and other health professionals to recommend self-help titles (covering issues such as anxiety, depression, phobias, panic attacks, bulimia and sleep problems) for people to borrow from their local library. http://www.cambridgeshire.gov.uk

Naturally Healthy Subgroup – A multi-agency venture to build a recognised robust methodology for work utilising the benefits of the natural environment on health. A strategic group has been formed, including representation from the Centre for Diet and Activity Research (CEDAR) and Natural England, that will take this forward and look to obtaining a research grant. The project hopes to include (in some cases building on existing work):

- Healthy Walks Scheme
- Horticultural Therapy
- Fit for Nature
- Forest Schools

These groups will/do cater for individuals with a variety of conditions, including mental illness. There would be the option of self-referral but it could also be used as social prescribing by health professionals.

4.3.2c Actions

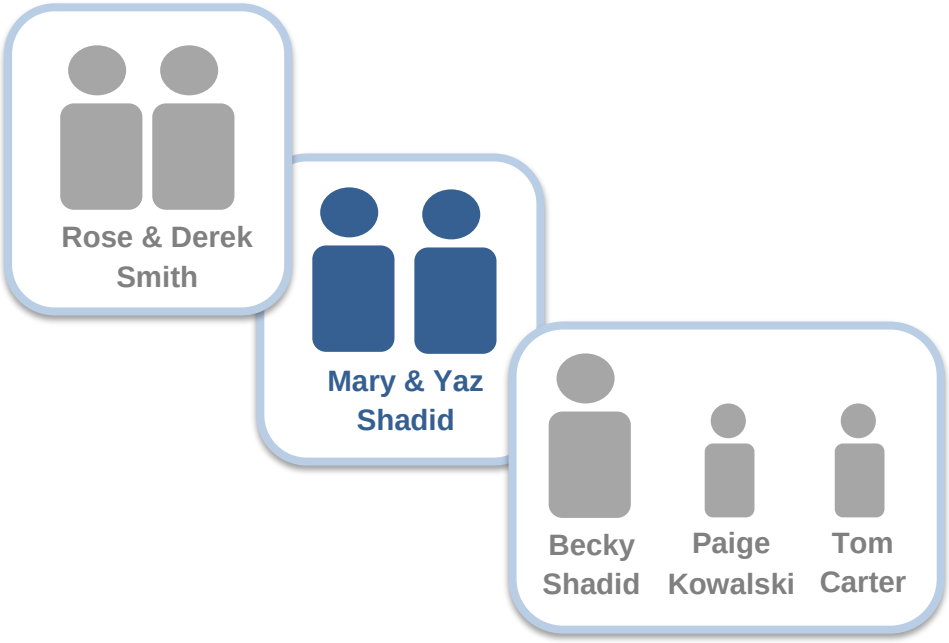
C. **Wider support for those with mental health problems** e.g. physical health problems

1. Cambridgeshire Public Health Stop Smoking Team (CamQuit) will focus on ensuring that employees that are working in community mental health teams are accessing the Level 2 smoking cessation training, which will also enable continuing support post-discharge for those trying to quit smoking.
2. Cambridgeshire Public Health Stop Smoking Team (CamQuit) will focus on increasing referrals to the stop smoking service from secondary care and community mental health settings.
3. Work towards a more coordinated approach of health improvement interventions (smoking cessation, physical activity, weight management and alcohol reduction) for those who are living with mental illness. In particular, this will require countywide mapping of provision in terms of services to promote better physical health of those with poor mental health or mental illness.
4. Additional focused initiatives to support the physical health of those with serious mental illness, through preventive lifestyle interventions, such as tailored physical exercise programmes. This is a likely area of investment given the limited services available.
5. Contribute to the evidence base for social prescribing initiatives through the Naturally Healthy Subgroup and apply knowledge gained from this work.

6. Promote wider awareness of community provisions and sources of reliable information to healthcare professionals, enabling them to signpost patients with greater confidence.

5. What does the Public Mental Health Strategy Mean for Me?

The following example will be used to demonstrate how the work of this strategy may impact upon the lives of one fictional family. Similarly, this family will be used within the Adult Mental Health Social Care Strategy to illustrate how the strategy can impact upon individuals.

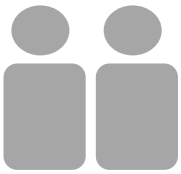


Rose (78 years old) and **Derek Smith** (75 years old) have lived together in Wisbech for over 40 years. Derek cares for Rose who was diagnosed with dementia 3 years ago.

Rose and Derek have a daughter, **Mary** (50 years old) who lives in Ely together with her husband **Yaz** (52 years old). Yaz has chronic psychosis and is currently unable to work. Mary can find it difficult to hold down employment as she needs to provide support and care for Yaz.

Mary and Yaz have a daughter called **Becky** (30 years old) who is a single parent and lives in Sawston with her daughter **Paige** (14 years old) and her son **Tom** (4 years old). Becky works as a dinner lady in a local school to fit with childcare, she struggles financially and has run up some debt. Becky is under a lot of stress and is finding it difficult to cope with Tom's behaviour. She has very little support from Tom's father, contact is often erratic. Paige has been happy at school but recently has become withdrawn, and Becky suspects she is being bullied.

5.1 What might this family experience if we maximise public mental health opportunities?



Rose & Derek Smith

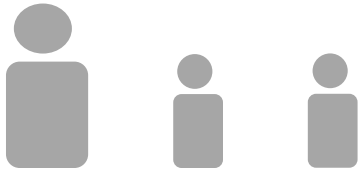
Derek and Rose feel supported in their local community. They can do their shopping without fear of how people may react to Rose's sometimes unpredictable responses to the world around her. There has been a local campaign to raise awareness of mental health problems and many of the local shop keepers have also undertaken mental health awareness training. Rose and Derek also really enjoy attending the community café together; a chance to talk to others who face similar challenges, and to socialise with friends.

Derek has also been along to the local walking group, he was weary at first but a Health Trainer went along to the first session with him which gave him confidence. This has helped him to make new friends and to keep physically active which has really helped how he is feeling.

Mary & Yaz Shadid

Mary's employer have recently introduced flexible working, this has really helped her as she can adapt her hours so that she can take Yaz to his check-ups at the GP. At work they have also introduced a new health programme which offers lunchtime exercise classes; she has decided to take up a dance class as she just doesn't get time to be active otherwise.

Although currently unemployed, Yaz is being supported with building his skills in IT at the adult education college. He hopes to be able to work from home in the near future. He recently had his annual physical health review – the nurse gave some brief advice around stopping smoking and his weight and has put him in touch with a local stop smoking advisor who is helping him to quit, and a local exercise programme for those with health issues.



Becky Shadid **Paige Kowalski** **Tom Carter**

Becky has been in regular contact with the Health Visitor (HV) who identified her postnatal depression and has since been a great source of support and advice. With Tom's behaviour becoming so unmanageable Becky enrolled herself on a parenting programme as suggested by her HV. This has helped her develop effective discipline strategies and improved her relationship with her son.

Some of the children at Paige's school have been making comments about how she looks different. She is feeling really insecure and unhappy but she feels able to talk to her teacher who is very clear about the school policy on bullying. She suggests Paige visits the school nurse drop in clinic to discuss her feelings.

The school have a range of sessions planned as part of PSHE on body image and bullying which aim to alter the culture of the school.

6. Delivering the Strategy

The consultation process will inform the action plan, an outline plan is given below. The plan is for the first year of the strategy, actions highlighted in **blue** have already been agreed. A recurrent investment of £120k has been agreed in the 2015/16 business plan to support the implementation of the strategy. Throughout implementation of the strategy plan, consideration will be given to those groups most at risk of mental illness as highlighted in section 2.2 of this strategy.

Theme	No.	Action	Focus in year one of implementation	Timescale	Funding	Impact	Governance Board
A life course approach to promoting mental health	1	**Support schools to implement whole school approaches to improving mental health and reducing stigma**	Development of tools to support school anti-bullying work and a multiagency anti-bullying strategy. Self-assessment tool on mental health and wellbeing developed for secondary schools.	September-March 2015	Funding needed to support the implementation of the anti-bullying strategy and further support for schools in implementing the 'whole school approach'. The findings of the work would ideally be built into individual organisations training plans.	A greater proportion of schools adopt and maintain a 'whole school approach' to mental health and access the free training on this. This should also impact upon the rate of self-harm in Cambridgeshire. A greater proportion of schools implement effective anti-bullying strategies. That improvements in both these areas are reflected in the Health Related Behaviour Survey.	Emotional Wellbeing and Mental Health of Children & Young People Board
	2	**Develop tools and provide additional support to schools in terms of anti-bullying work and reducing self-harm**		For September 2015			
	3	**Greater publicity around the training already offered around mental health by the Local Authority**	Re-launch of 'Whole School Approach' training provided by CPFT.	For September 2015			

			Greater publicity around MHFA training offered.				
	4	**Maximise opportunities to promote mental health across early years**	Development of early years mental health workforce strategy.	For start of 2015 school year (September)		In the long term interventions in early years could improve lifelong outcomes for children.	
	5	**Support expansion of the Time Credits Scheme**	Ongoing roll out of Time Credits Scheme.	For March 2015			Health Committee
	6	**Increase engagement of communities in addressing and improving their health and wellbeing.**	Identify and focus on securing support of community leaders for engaging their communities. Identify and agree across organisations only in Fenland approaches to engage and work	For March 2017 (3 year funding) For April 2016	Activities facilitated by staff from local authority directorates. Health Fenland Fund – investment from ear marked reserved.	Increase in number of communities actually engaged and leading interventions to impact their health and wellbeing.	

			with communities. Establish a Healthy Fenland fund to support community led initiatives.				
	7	Intervention during perinatal period to identify and treat patients is a focus in the refreshed Emotional Wellbeing and Mental Health Strategy for Children & Young People	Assessment of provision against NICE guidance. Area highlighted in revised Emotional Wellbeing and Mental Health Strategy for Children and Young People. Breastfeeding strategy developed considering attachment element. Promote local Perinatal Mental	By September 2015.	Funding implications dependent on the findings of the analysis.	In the very long term interventions at the perinatal stage improve lifelong outcomes for children. In the short term they could improve the health of the mother and parent-infant relationship.	Emotional Wellbeing and Mental Health of Children & Young People Board

			Health Service within strategy refresh.				
	8	Consider ways of enhancing Lifestyle Service/ Community Navigators Service to enhance their role in relation to mental health	Action plan on what options available to enhance the role of lifestyle service and community navigators developed, including a focused role with SMI patients.	By September 2015. By September 2015.	Funding implications dependent on the enhancement options and existing contracting arrangements	Community Navigator and lifestyle services are equipped to identify mental health issues and know how to deal with them. As a result more individuals that need help are identified and access treatment and community support. Additional lifestyle support for SMI patients should improve their life expectancy in the long term.	Existing governance structures
	9	**Coordinate information on young people's health and wellbeing**	Development and implementation of a web portal on children and young people's health and wellbeing	2015	Funding will depend on whether it is considered that a more in detailed web design is needed.	Children and young people, professionals and parents able to access information.	Emotional Wellbeing and Mental Health of Children & Young People Board
	10	**Increase awareness of referral options for mental health support from primary care**	Promotion of GP referral options among CCG, LCGs, CCC	October 2015	No funding.	Increase referrals to local support services.	Health Committee

			workforce and community.				
Developing a wider environment that supports mental health	11	**Creation of new post to focus on workplace health at strategic level**	Recruit to new post.	Person in post by September 2015.	Funding already identified for new workforce post.	Workplace health activity should improve mental health overall and reduce sickness absence for employers.	Health Committee
	12	Research and roll-out workplace standard	Adopt a workplace standard.	By March 2016.			Health Committee
	13	Support anti-stigma campaigns , including Time to Change, utilising workplaces and educational settings in particular, but also looking at environments where healthcare is provided and the wider community as appropriate. Awareness raising could include mental health issues, disability awareness and discrimination.	Additional multi-agency anti-stigma campaign run building on the Stop Suicide Campaign.	Multi-agency campaign run in 2015/16 alongside the stop suicide Campaign .	Additional funding needed for anti-stigma work and the mental health elements of an expanded workplace health programme.	Anti-stigma work should encourage open discussion about mental health issues and a wider community support structure. It is hard to quantify these impacts.	Health Committee
	14	Expand workplace health activity, particularly in areas of greatest deprivation or among highest need populations, including additional MHFA training and/or training for employers in supporting those with mental health conditions to stay in	Expand the workplace health programme. Identify training package that will enable	From September 2015 onwards.		Workplace health activity should improve mental health overall and reduce sickness absence for employers. Training should enable colleagues and manager to identify mental health problems earlier.	Health Committee

		work.	training of employers.				
	15	Look at ways of providing additional support to those who are vulnerable and may be at greater risk of poor money management, starting with care leavers.	Work building on the child poverty strategy.	By end of 2015 if funding is available	Additional funding would be needed.	By preventing people falling into debt, or enabling people to manage money and debt better, then the associated mental health issues with debt and poverty may be reduced.	Dependent on vulnerable group identified.
	16	Utilise services that may come into contact with those with mental health problems to better identify those in need of support	Continue to fund MHFA training for front line staff	Approximately 300 staff trained.	Existing programme.	The vast proportion of mental illness remains untreated and increased recognition and advice should mean more people receive the help they need.	Health Committee
	17	A greater partnership approach to addressing hoarding across the county.	Present a paper to the Adult Safeguarding Board for adoption of the issue.	Paper to be presented in 2015.		By identifying/addressing hoarding earlier or more effectively, then there could be benefits in terms of safety for the individual (e.g. risk of fires).	Adult Safeguarding Board
Physical and mental health	18	Improve the identification of those clients with a long term physical health condition and depression	Work to be taken forward through the CCG Transformation Programme.	In line with the CCG Transformation programme.	Funding implications to be considered in the CCG Transformation programme.	Numbers of patients with comorbid long term physical conditions identified and receiving treatment for mental health issues increasing. Measures might include referrals of those with LTCs to IAPT, and/or treatment through other routes.	CCG Transformation Mental Health Workstream
	19	Upon identification of depressive symptoms ensure the timely offer of an appropriate psychological intervention					

	20	Support the use of antidepressant therapy in the management of comorbid depression and long term health conditions, where clinically indicated					
	21	Ensure timely access to multicomponent rehabilitation programmes incorporating exercise and psychological interventions					
	22	Increase uptake of smoking cessation training by community mental health teams.	Action plan to be developed by stop smoking team including numbers of advisors trained within community mental health teams, and actions to improve the number of referrals from secondary care mental health	Action plan by September 2015 with in-year targets.		Long term impact is a reduction in the gap in life expectancy in those with SMI compared to the general population. This is measured in the Public Health Outcomes Framework. Short term impact measures are likely to include numbers of staff in Community Mental Health Teams trained as stop smoking advisors, numbers of referrals into stop smoking services and the proportion of these who are quitters at 4 weeks.	New governance board for Physical Health of those with SMI
	23	Increase referrals to stop smoking service from secondary care mental health settings.					

			setting.				
	24	More coordinated, and consistent county-wide, approach to health improvement interventions for those with mental illness	Mapping of structured exercise provision and other initiatives to support the physical health of people with SMI, gaps identified and recommendations made on how/where to improve access. Development of enhanced primary care for those with SMI – CCG led.	Mapping exercise complete by September 2015. Mapping work to feed into CCG transformation programme.	Funding will be needed to improve access cross county.		
	25	Ensure physical health checks are undertaken consistently and that signposting to health improvement services is consistent.	Work to be taken forward through the CCG Transformation Programme.	In line with the CCG Transformation programme.	Funding implications to be considered in the CCG Transformation programme	Ensuring that there are consistent health checks undertaken across settings will enable better identification and signposting to appropriate health improvement provision.	CCG Transformation Mental Health Workstream Links to the new governance board for Physical Health of those with SMI

7. Governance

The majority of work will be taken forward through existing governance structures, as indicated in the action plan. These governance boards include:

- Emotional Wellbeing and Mental Health of Children and Young People Strategy Board
- CCG Transformation Work (mental health workstream)
- Health Committee

There is not currently a suitable group to take forward the actions for improving the physical health of those with severe mental illness, therefore a new multi-agency group will be established. This group will report to Health Committee. The progress of strategy implementation will be monitored by public health, with an annual report being produced for Health Committee.

As there will be an overlap in this strategy's action plan and that of the social care mental health strategy, prior to annual reports going to their respective committees (Health Committee and Adults Committee), there will be a review meeting that will incorporate strategy development group members. This meeting will take place in April 2016 and will allow for more integrated reports. The report, as requested in the consultation feedback, will be promoted publicly via the council communication streams. A communications plan will be produced to ensure that progress is shared widely.

8. Supporting Documents

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Harris, C. (2015). *A Literature Review of Bullying Interventions: To inform the Self-Harm Shared Priorities work at Cambridgeshire County Council.*

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Glossary

Domestic abuse: Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality (Domestic Abuse & Sexual Violence Partnerhsip, 2014).

Family Nurse Partnership: A voluntary, preventive programme for vulnerable young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two. The aim is to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency (Department of Health, 2012).

Indices of Multiple Deprivation (IMD): The English Indices of Deprivation 2010 provide a relative measure of deprivation at small area level across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation and an overall composite measure of multiple deprivation. The domains used in the Indices of Deprivation 2010 are: income deprivation; employment deprivation; health deprivation and disability; education deprivation; crime deprivation; barriers to housing and services deprivation; and living environment deprivation.

Multi-systemic therapy: Using strategies from family therapy and behaviour therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people (NICE, 2009).

Severe mental illness (SMI): includes diagnoses which typically involve psychosis or high levels of care, and which may require hospital treatment. Typically this includes schizophrenia and bipolar disorder (Mental Health Wales).

Annex A

Complementary Strategies – Mental health specific

- Emotional Wellbeing and Mental Health of Children & Young People 2014-2016 (Cambridgeshire County Council [CCC]), Peterborough City Council, Cambridgeshire & Peterborough Clinical Commissioning Group [C&PCCG])
- Adult Mental Health Commissioning Strategy 2013-2016 (C&PCCG)
- Older People's Mental Health Commissioning Strategy 2013-16 (C&PCCG)
- The Mental Health Social Care Strategy for Adults and Older People (CCC, in development)
- Joint Cambridgeshire and Peterborough suicide prevention strategy 2014-2017 (Multi-Agency)
- Cambridgeshire & Peterborough CCG 5 Year Strategy (in development)
- Domestic Abuse Strategy 2014-18 (Domestic Abuse & Sexual Violence Partnership)
- Dementia Strategy (in development)

Complementary Strategies - Wider determinants of mental health

- Older People's Services Procurement Requirements (C&PCCG)
- Breaking the Cycle 2, *2014-17* (Cambridgeshire Children's Trust)
- Cambridgeshire Alcohol Harm Prevention Strategy 2012-2015 (Cambridgeshire Drug & Alcohol Action Team).
- Healthy Weight Strategy 2015-2018 (in development)

Other key relevant work areas

- Review of Early Help Services: Formal consultation on re-commissioning of early help services. www.cambridgeshire.gov.uk
- Cambridgeshire and Peterborough Mental Health Concordat Declaration. 3rd November 2014 www.crisisconcordat.org.uk
- Social, Emotional Wellbeing and Mental Health 0-25, 2015 (draft pathway)

Key Supporting Joint Strategic Needs Assessment (JSNA) Reports

- Cambridgeshire JSNA: Older People's Mental Health 2014 *(*Solutions for Public Health [Commissioned by Public Health Team, Cambridgeshire County Council])
- Mental Health in adults of working age 2010 (Cambridgeshire County Council & NHS Cambridgeshire)
- The Mental Health of Children and Young People in Cambridgeshire 2013 (Cambridgeshire County Council & NHS Cambridgeshire)
- Carers JSNA 2014 (Cambridgeshire County Council & NHS Cambridgeshire)
- Primary Prevention of Ill Health in Older People 2014 (CCC & C&PCCG)
- Homelessness and at risk of Homelessness 2010 (CCC & NHS Cambridgeshire)
- Housing & Health 2013 (CCC & NHS Cambridgeshire)
- New Communities JSNA 2010 (CCC & NHS Cambridgeshire) (also new JSNA in development)

The work of this strategy is relevant to a number of other JSNA reports & Strategies.
http://www.cambridgeshireinsight.org.uk//jsna