

Sheffield Mental Health Partnership Board

DRAFT
Sheffield Strategy
for
Mental Health

revised 2014

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Sheffield Strategy for Mental Health

Contents

Section	Page
1. Mental health is still everybody's business	
2. What does the strategy look like?	
3. Not a blank sheet of paper!	
4. What we know about mental health and illness in Sheffield	
5. Progress on improving services and challenges that remain	
6. What people have said they want in the future	
7. Vision and aims of the strategy	
8. What is the future direction?	
9. Major priorities for the next 5 years	
Glossary of abbreviations and terms	

1. Mental health is still everybody's business

All of us have mental health needs and most of us will have mental health problems of some sort in our lives. These problems have a range of causes and need to be tackled by all of us. At home, at work, mental health is everybody's business.

Health and social care agencies have an important role in promoting mental health and well-being, including making sure treatment and support is available when required. This Strategy is about how the health and social care agencies in Sheffield should work together to do that over the next 3 - 5 years.

Sheffield needs to promote and improve mental health across the life span of all its citizens. The Strategy's focus is mainly on the mental health of adults, including older adults, but aims to support the improvement of mental health services for people of all ages. It provides direction to inform decision makers including commissioners, providers, professionals, elected representatives and all those concerned with mental health in Sheffield

What do we mean by mental health?

Mental health is about the way we think and feel and our ability to deal with the ups and downs of life. When we talk about mental health in this document we therefore mean our personal intellectual and emotional wellbeing and our resilience to deal with difficulties and challenges as they come our way.

What do we mean by mental health problems?

The range of mental health concerns from the worries we experience as part of everyday life to much more serious long-term conditions that require intensive support and help.

What do we mean by mental illness or ill-health?

Symptoms of significant mental health problems that are classified by clinicians to assist them to identify the appropriate care and treatment for the condition.

What do we mean by mental health well-being?

The Government's strategy, "No health without mental health" (2011) defines this as, "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment".

2. What does the Strategy look like?

The Strategy first identifies the sources it has drawn upon – city-wide plans, previous planning for mental health services, local and national guidance and the evidence of what works. It goes on to look at what we know about mental health and illness in Sheffield, the progress and change made since the last strategy and what people have said they want to see for the future. It draws out from all of these things a vision of what services should be like, some fundamental aims and a model of services for the future (how services need to fit together). It ends by summarising the main priorities for change over the next 5 years. The Glossary on page 22 explains abbreviations and terms used.

3. Not a blank sheet of paper!

We have not started with a blank sheet in developing the Strategy. The Strategy draws on the following:

- **City-wide Strategies**

Joint Health and Wellbeing Boards were established in April 2013. They now have the leading role in improving the health and wellbeing of the citizens of Sheffield and for the NHS and Sheffield City Council (SCC) to work in partnership with each other and other important stakeholders including HealthWatch to achieve this.

The Board is responsible for the Joint Strategic Needs Assessment and has developed the *Sheffield Joint Health and Wellbeing Strategy (2013-2018)*. The Strategy has 5 broad objectives for Sheffield:

- a healthy and successful city
- health and well-being is improving
- health inequalities are reducing
- you can get the help and support you need
- a health and wellbeing system that is innovative and affordable.

To support this, there are 5 work programmes: A good start in life; Building Mental Wellbeing and Emotional Resilience; Food, Physical activity and active lifestyles; Health, Disability and Employment; and Supporting People at or closer to home.

There is a declared commitment to joint working across health and social care including integrated commissioning of services through the *Sheffield Better Care Fund* initiative.

Right First Time. As part of a programme to reduce the dependence on hospital based treatment and care, Sheffield has a comprehensive Right First Time programme. It has a particular workstream on physical health and mental health because of the established relationship between the two. Improving the physical health of people with mental ill-health and improving the mental wellbeing of people with physical ill-health

● **Previous work on planning mental health services for adults in Sheffield**

“The Sheffield Strategy for Mental Health and Wellbeing”, agreed in 2008, confirmed a “stepped care approach” for delivering mental health support to make sure it was delivered in an appropriate and timely way. It also identified a series of priorities including: greater choice and control; improving access to employment and suitable housing; a focus on mental health promotion as well as treatment.

● **Sheffield Fairness Commission**

The Sheffield *Fairness Commission* reported in January 2013. It identified the following 10 principles intended as guidelines for policy makers and citizens:

- Those in greatest need should take priority.
- Those with the most resources should make the biggest contributions.
- The commitment to fairness must be a long-term one.
- The commitment to fairness must be city-wide.
- Prevention is better than cure.
- Be seen to act in a fair way as well as acting fairly.
- Civic responsibility among all residents to contribute to the maximum of their abilities and ensuring all citizens have a voice.
- Open continuous campaign for fairness in the city.
- Fairness must be a matter of balance between different groups, communities and generations in the city.
- The city’s commitment to fairness must be both demonstrated and monitored in an annual report.

● **National guidance**

There has been a range of important guidance and significant reports for mental health in the last 3 years that are important for us in 2014. A summary of some key points are included in Appendix 2

“No Health without Mental Health” DoH 2011

<https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

The Abandoned Illness: A report by the Schizophrenia Commission – Schizophrenia Commission 2012

<http://www.schizophreniacommission.org.uk/>

Starting Today – the future of mental health services – Mental Health Foundation - 2013

<http://www.mentalhealth.org.uk/publications/starting-today-future-of-mental-health-services/>

Closing the Gap: Priorities for essential change in mental health – DoH - 2014

<https://www.gov.uk/government/publications/mental-health-priorities-for-change>

Joint Commissioning Panel for Mental Health – Commissioning Guidance – Royal Colleges of Psychiatrists and of General Practitioners – October 2013

<http://www.icpmh.info/>

Living Well for Longer – NHS (April 2014)

See link via Rethink site who also produce a useful summary relating to mental health and their own report “Lethal Discrimination”

<http://www.rethink.org/lwf/>

Crisis Concordat DoH Feb 2014

<http://www.crisiscareconcordat.org.uk/about/>

Suicide Prevention Strategy DoH Feb 2014

<https://www.gov.uk/government/publications/suicide-prevention-report>

Transforming our health care system: Ten priorities for commissioners April 2013

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

Crossing Boundaries Mental Health Foundation 2014

<http://www.mentalhealth.org.uk/publications/crossing-boundaries/>

Achieving Better Access to Mental Health Services by 2020 -

<https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020>

- **Legislation**

- The Care Act (2014)**

- The new Act sets out a number of reforms to care and support law and brings together existing duties under single legislation. This includes duties on statutory authorities to:

- Promote well-being
 - Provide person-centred care and support planning with a legal entitlement to a personal budget for social care
 - Provide information and advice about care and support being available for all

- Require health and social care authorities to develop integrated approaches by sharing funding through the Better Care Fund

Carers: As a carer there is already the entitlement to have your caring support needs assessed. The Care Act extends this to an entitlement to support, to meet those needs that are “eligible”. This could include a personal budget to access that support.

Mental Health Act, Mental Capacity Act and Deprivation of Liberty (2009)

Legislation and case law have led to a closer alignment between mental capacity and mental health acts. Safeguards are now in place for people deemed to be deprived of their liberty in a care home or hospital where the mental health act is not appropriate

- **Evidence of what works**

Service change and development needs to be informed by evidence of what works. National Institute for Health and Clinical Excellence (NICE) guidelines on specific mental health conditions are important. The experience we have in Sheffield of what people have told us is helpful are further building blocks of our Strategy. In addition there are examples of good practice in other parts of the country to help inform us. See Appendix 3 for some examples.

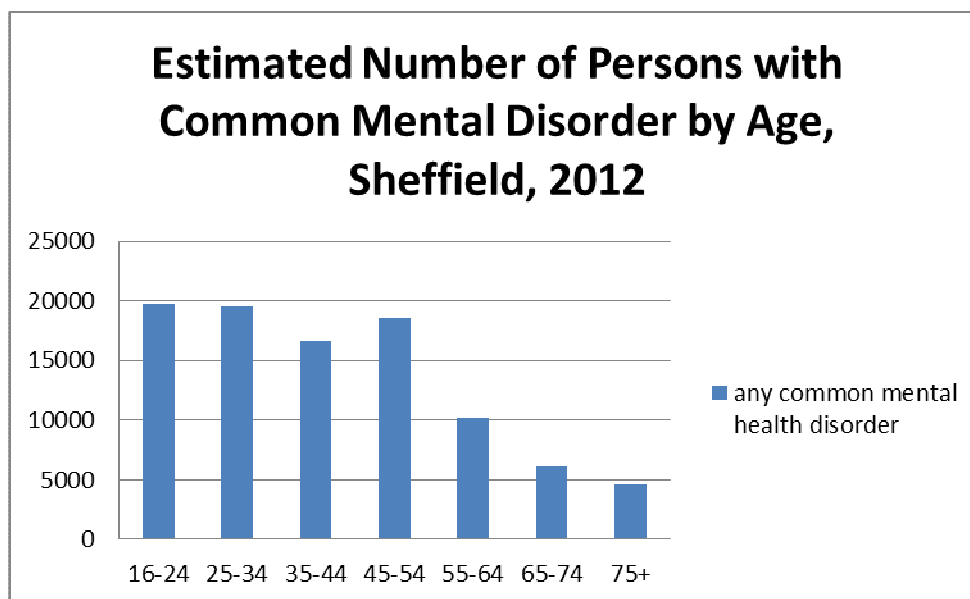
4. What we know about mental health and illness in Sheffield

This section summarises some of the key data and evidence about mental illness. It begins with some information about the prevalence of conditions and then some information related to the determinants of illness and its impacts.

Common mental health problems

- ⇒ It is estimated, from national survey data (APMS), that the prevalence of common mental health problems amongst adults (aged 16+) in Sheffield is 203 per 1000 adults. This is equal to 95,369 people¹. Figure 1 shows how this is broken down by age group.

Figure 1



¹ Adult Psychiatric Morbidity Survey (APMS), (2007) and NPMS deprivation index for Sheffield (1.251)

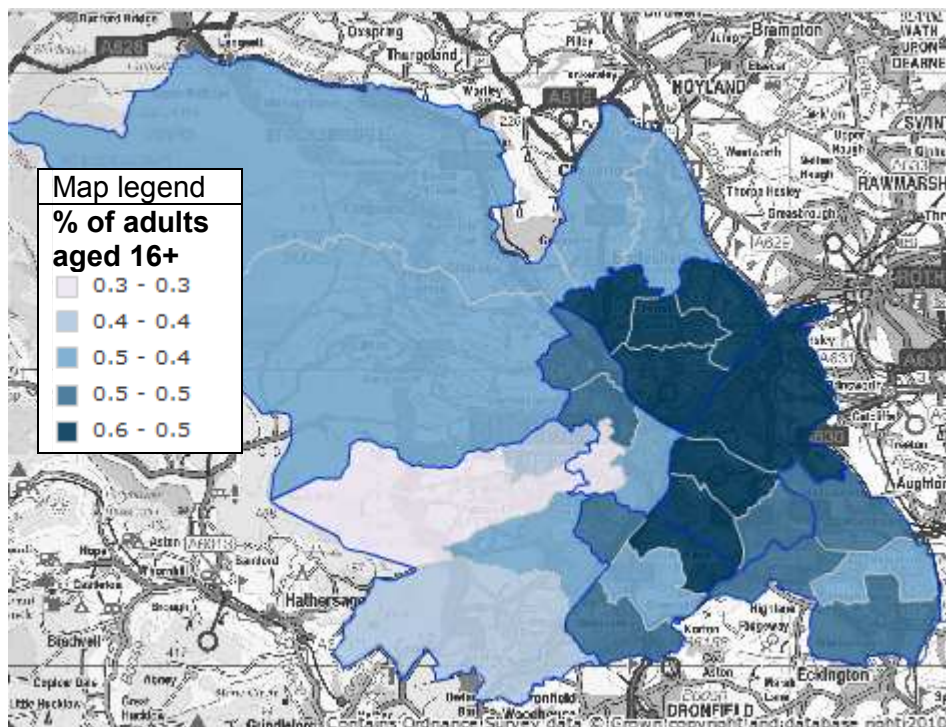
- ⇒ The survey covers a range of disorders; the most common disorder across the age groups is mixed anxiety and depression.
- ⇒ The percentage of patients aged 18 years and over with a new diagnosis of depression in the year 2013 to 2014 in Sheffield was 7.43%, the England average was 6.52%. Compared with the 8 core cities Sheffield ranked 7 (1 is best).²

Severe mental illness

- ⇒ It is estimated, from national survey data, that the prevalence of psychosis amongst adults (aged 16+) in Sheffield is 50 per 1000 adults. This equates to 2,124 people in Sheffield in 2012 (APMS as above).
- ⇒ Prevalence is shown from the national survey to vary with levels of deprivation. Figure 2 shows this variation estimated across Sheffield. The estimated prevalence in Fulwood ward is 32 per 1000 adults, in Manor and Castle it is 52.

Figure 2

Map of Mental Health Prevalence Estimates for Psychotic Disorder in Adults (Age 16+) expressed as a % of adults aged 16+, 2011



Source: Adult Psychiatric Morbidity Survey (APMS) in England 2007, Population Health Register April 2011, Council Benefits dataset August 2010, MINI2000 Index. Produced by Public Health Analysis Team, SCC, Report: Ward and LAP Health Indicator Tool, Version: v1.3, 10th July 2014

- ⇒ In 2013/14 there were 106 new cases of psychosis served by the 'Early intervention Service'. As a rate per 100,000 people this is close to the average rate in England.³
- ⇒ The number of Sheffield people being treated under the Care Programme Approach within secondary mental health services at June 2014 was 1175. As a rate per population, this is lower than the England average.⁴

² Quality and outcomes framework.

³ Severe Mental Illness Profile 2014, Public Health England

⁴ Community Mental Health Profile 2014, Public Health England

- ⇒ The number of bed days for psychiatric treatment in hospital (expressed as a rate per population) is similar to the England average.⁵
- ⇒ In September 2014 there were 4,732 people on the registers of severe mental illness held by GPs in Sheffield.
- ⇒ The estimated number of people with Antisocial Personality Disorder for Sheffield is 2,181 (APMS as above).

Detention under the mental health act

- ⇒ Section 136 of the Mental Health Act 1983 provides a power for the police to detain an individual for up to 72 hours and take them to a place of safety for an assessment. Between 1st April 2012 and the 31st March 2013, the power was used in Sheffield by the police 260 times.⁶
- ⇒ The local rate of detentions under the Mental Health Act for treatment is similar to the average for England. The number of detentions in 2012/2013 in Sheffield was 306.⁷

Children and Young People

- ⇒ This strategy focusses on the needs of, and services provided to, the adult population. The needs of children and young people are considered in detail in a separate report⁸. Extracts from that report are given below as comment on the needs of our young people is essential here.
- ⇒ Research indicates that adolescents have experienced the least improvement in health status of any age group in UK in last 50 years (Davies et al 2012). Specifically in relation to mental health 50% of lifetime mental illnesses arise by age 14; and 40% of young people experience at least one mental disorder by age 16 (JCPMH 2013).
- ⇒ The most recent British surveys carried out by the Office of National Statistics of children and young people aged 5-15 in 1999 and 2004 found that 10% had a clinically diagnosable mental health disorder. This equates to approximately 7000 children in this age group in Sheffield.
- ⇒ The widening gap between physical and sexual maturity and adult social and financial independence has been offered as an explanation for growing mental health and behavioural issues amongst young people. The gap between puberty and adult social and financial independence has widened from around 6 years in the 1950s to 15 years today (Davies et al 2012).

The Social Determinants and Impacts of Mental Illness

Deprivation

- ⇒ The Index of Multiple Deprivation (IMD), combines a number of the other indices, and gives an overall score for the relative level of multiple deprivations experienced in small geographical areas. To produce the overall IMD 38 separate indicators are combined and weighted. As such, relative IMD can give an indication of cumulative risk factors for poor emotional wellbeing and mental illnesses⁹.

⁵ Community Mental Health Profile 2014, Public Health England

⁶ Sarah Banks/Jo Sykes, SCC, Report to Sheffield First Safer & Sustainable Communities Partnership Board; August 2014

⁷ Severe Mental Illness Profile 2014, Public Health England

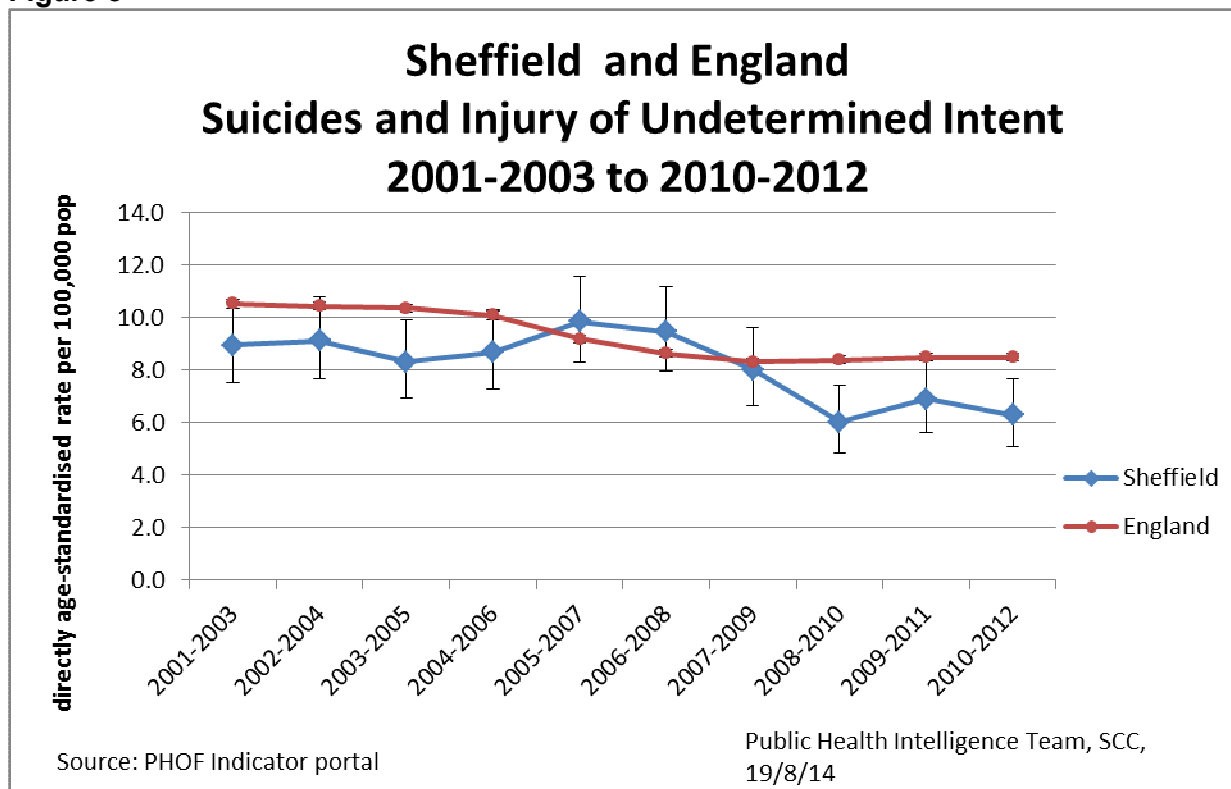
⁸ Children's and Young people's Emotional Wellbeing and Mental Health: Health Needs Assessment, 2014 C&YPs PH team SCC.

⁹ Children's and Young people's Emotional Wellbeing and Mental Health: Health Needs assessment, 2014 C&YPs PH team SCC.

- ⇒ There are 125,000 [22%] Sheffield people living within most deprived areas ranked as being in the worst tenth of areas nationally, and 47,000 [8%] living within least deprived areas ranked as being in the best tenth nationally.
- ⇒ Compared to other nearby urban local authorities Sheffield is of a similar deprivation rank. Out of the 8 Core Cities, Sheffield is 6th least deprived.

Suicide and self-injury

Figure 3



- ⇒ Deaths by suicide and undetermined injury in Sheffield, have generally been lower than the England average, however this changed temporarily with a rise in 2007 (figure 3). On average, between 2008 and 2013, 38 people died each year in Sheffield by suicide.
- ⇒ Local audit of suicides (2001-2010, n=333) showed that 77% of those who died by suicide were men, and that the rate was highest amongst men in mid-life. This is in line with the national picture. More recent data suggests that there may be an increase in the proportion of men locally, but it is too soon to be clear whether this is a trend.¹⁰
- ⇒ In an audit of 171 suicides (2006-2010) depression was cited as a key factor in 68 cases (40%).¹¹
- ⇒ The national suicide rate among 10–19 year olds is 2.20 per 100,000; Sheffield rates are slightly lower than national rates. Recent research has shown a significant fall in the rates among young men in the period 2001–2010.¹²

Employment and other social factors-

- ⇒ Poor mental health impacts on our employment rates, welfare spending and wider health inequalities. Poor mental health costs Britain £70 billion a year through productivity

¹⁰ Local Suicide audit 2010, for MHPB July 2012, J Southworth NHSS.

¹¹ Local Suicide audit 2010, for MHPB July 2012, J Southworth NHSS.

¹² Children's and Young people's Emotional Wellbeing and Mental Health: Health Needs Assessment, 2014 C&YPs PH team SCC

- losses, higher benefit payments and the increased cost to the NHS – equal to 4.5 per cent of Gross Domestic Product (GDP).¹³
- ⇒ Between 10 per cent and 16 per cent of people with mental health conditions, excluding depression, are in employment.¹⁴ However, between 86 and 90 per cent of this group want to work.¹⁵
 - ⇒ Mental health problems are the cause of 40 per cent of the 370,000 new claims for disability benefit each year nationally.¹⁶
 - ⇒ In Sheffield in 2013-14, 157 of the 493 service users on Modus (Sheffield's Domestic Abuse Case Management system) stated that they had mental health problems (that is, 32%).¹⁷
 - ⇒ A systemic review of domestic violence and mental disorders published in 2012 by Trevillion, Oram and Feder considered 41 studies and concluded that "There is a high prevalence and increased likelihood of being a victim of domestic violence in men and women across all diagnostic categories, compared to people without disorders".¹⁸
 - ⇒ In Sheffield it is estimated that at least 60% (number) of cases referred to the PRAM (Sheffield's Anti-Social Behaviour Risk Assessment Conference) have mental health elements, ranging from victims and perpetrators of ASB suffering from depression to those with more serious issues which can sometimes single them out for ASB.¹⁹
 - ⇒ National guidance indicates, however, that dual diagnosis affects a third of psychiatric service users and approximately half of substance misuse service users; and that certain groups of service users have higher rates of dual diagnosis, for example, prisoners, with an estimated rate of 70%.²⁰
 - ⇒ Illustrating this, a recent study found that an average of 46% of mental health service users had dual diagnosis and that the number of people with dual diagnosis differed by type of mental health service, ranging from 12% of clients in contact with an acute home treatment team to 71% of clients in an assertive outreach team (Schulte and Holland 2008).²¹
 - ⇒ Evidence highlights that mental ill health (anxiety and depression) are *likely* to be *present alongside* informal caring. It is *likely* that informal caring on a continuing basis increases the chance of carers experiencing mental ill health and possibly prolongs periods of mental ill health if people had symptoms of this prior to caring. A number of national and international studies suggest that prolonged periods and long hours of caring per week may have a detrimental effect on mental health and that over time continuing poor mental health in turn can lead to physical illness, such as back strain or hypertension. Estimating the numbers of informal carers in Sheffield who experience mental health issues is complex. It's likely that a large proportion of carers, at some point in their caring role, have experienced stress, anxiety or worry.²²
 - ⇒ In the 2011 census over 57,000 people in Sheffield identified themselves as unpaid carers. Within this group 14,500 provide more than 50 hours per week unpaid care.

¹³ Organisation for Economic Co-operation and Development (Feb 2014), *Mental health and work: United Kingdom*.

<http://www.oecd.org/els/emp/mentalhealthandwork-unitedkingdom.htm>

¹⁴ HM Government (2009), *Work, recovery and inclusion: employment support for people in contact with secondary mental health services*.

¹⁵ Stanley, K and Maxwell, D (2004) *Fit for purpose?* IPPR.

¹⁶ Organisation for Economic Co-operation and Development (Feb 2014), *op. cit.*

¹⁷ Sarah Banks/Jo Sykes, SCC, Report to Sheffield First Safer & Sustainable Communities Partnership Board; August 2014

¹⁸ SarahBanks/Jo Sykes, SCC *op. cit.*

¹⁹ SarahBanks/Jo Sykes, SCC *op. cit.*

²⁰ SarahBanks/Jo Sykes, SCC *op. cit.*

²¹ Schulte S, Holland M. Mental Health and Substance Use: dual diagnosis. Dual Diagnosis in Manchester, UK: practitioners' estimates of prevalence rates in mental health and substance misuse services. *Mental Health and Substance use: dual diagnosis*. 2008; 1; 2: 118-124.

²² Carers in Sheffield, health needs assessment, Elise Gilwhite, Public Health Sheffield 2012.

Ethnicity

- ⇒ Within SHSC during 2013/14 ethnicity was recorded for 8,912 (87.5%) users of mental health community and inpatient services. Ethnicity for 1,275 users (12.5%) is unknown; this is significant in considering the data. Comparing the known group to Sheffield population census data 2011, the White British group appears to be represented at a similar level. There appear to be fewer people from Asian groups using mental health services compared to the census, particularly Chinese and Pakistani Asian groups. People from the group Black/African/Caribbean/Black British appear to be slightly overrepresented, although there is not direct read across of all ethnic categories.²³

Attitudes to mental illness

- ⇒ Wider societal attitudes are changing for the better. Increasingly, people are starting to regard mental illness as an illness like any other. Time to Change's latest *Attitudes to mental illness* report²⁴ found that attitudes have markedly improved in a number of different areas. For example, acceptance of people with mental illness taking public office has grown. The percentage agreeing that 'anyone with a history of mental problems should be excluded from public office' decreased from 29 per cent in 1994 to 18 per cent in 2012.

Physical health of people with mental illness

- ⇒ People with severe mental illness tend to die at a younger age than the population as a whole. The rate of premature mortality (that is, before age 75) of people with severe mental illness in Sheffield has followed a downward trend from 2008/09 to 2011/12. In 2012 the rate (1282 per 100,000) was equivalent to the rate for England overall. Compared with premature mortality rates across the population in general, in Sheffield people with SMI are over 3.5 times more likely to die early, although this difference has been reducing. Liver disease and respiratory illnesses account for most of this inequality in rates.²⁵
- ⇒ In September 2014 there were 4,732 people on GPs severe mental illness registers, of these 48% have at least one other long term illness. Depression and vascular disease are the main conditions also present.²⁶

Self-reported personal wellbeing

- ⇒ When asked in the Annual Population Survey (APS) 2013/14 about levels of anxiety, 20% of UK wide respondents reported high levels of 'anxiety yesterday', compared to 23% of those in South Yorkshire. Reported levels of low 'anxiety yesterday' were more similar, with 39.4 % of UK respondents compared to 38.1% of those in South Yorkshire. The proportion of people reporting high levels of 'happiness yesterday' in South Yorkshire (33.3%) compared favourably with UK levels (32.6%), although the report of low levels of happiness was worse, 11.8% in South Yorkshire and 9.7% in the UK.²⁷

²³ Supplied by SHSC November 2014

²⁴ Time to Change (2013), *Attitudes to mental illness 2012 research report*.

²⁵ Right first time, John Soady DPH Office, Sheffield City Council, 2014.

²⁶ Right first time, John Soady DPH Office, Sheffield City Council, 2014.

²⁷ ONS October 2014, <http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2013-14/sb-personal-well-being-in-the-uk--2013-14.html#tab-3--Personal-well-being-in-the-UK--2013-14>

⇒ The annual Every Child Matters Survey in 2013 collected information from just under 9,000 children in Sheffield. In response to questions about emotional wellbeing the majority of young people in Y10 (aged 14-15) said they feel happy most of the time. Around 10% said they hardly ever or never feel happy.²⁸

5. Progress on improving services and challenges that remain

The 2009 strategy identified 13 priority areas:

- ❖ Develop and implement a plan that makes sure choice and self-determination is at the heart of mental health services
- ❖ Make sure people in all parts of the city and across all communities have equal access to mental health services
- ❖ Work with partners to improve access to employment, training and other aspects of living a quality life
- ❖ Develop and implement outcomes that address “quality of life” as the basis for future commissioning and service provision
- ❖ Work with partners to improve the physical health of people with mental health problems and address the mental health needs of people with physical illness
- ❖ Fully implement the stepped care approach, including access for most people to local mental health services working closely with primary care
- ❖ Work with partners to develop programmes that promote mental health across all parts of the community
- ❖ Within the stepped care framework, make sure there are high quality specialist mental health services for people who need them
- ❖ Develop and implement “care pathways”, making sure there are clear routes for people to access services and move between them
- ❖ Work with partners to improve availability of housing and accommodation with support
- ❖ Develop joint planning of mental health services with service users and carers
- ❖ Make sure people with a dual diagnosis can access high quality mental health services
- ❖ Deliver appropriate mental health services for younger and older people

In the light of these priorities and other developments there has been progress in a number of areas. However there continues to be significant challenges. The following tables summarise this

Progress and change since 2009:

<p>Stepped Care and improving access to mental health support at primary care.</p>	<p>The Improving Access to Psychological Therapies (IAPT) programme in Sheffield was established in 2008. It is now delivering treatment to approximately 1000 people each month</p> <p>Reconfiguration of Community Mental Health Teams (CMHTs). There has been a significant reorganisation of CMHTs to improve the support to primary care and provide focused support for people with longer term mental health issues</p>
<p>Quality in specialist mental health care and implementing care pathways</p>	<p>Acute and Non-Acute (Standard) care pathways have been established within the Mental Health Service. In addition devolving the budget responsibility for out of city acute care has had a significant impact on led reducing the occupancy of acute inpatient beds and less people needing a bed outside of Sheffield.</p> <p>An important part of this change was the commissioning of a Crisis House</p>

²⁸ Children’s and Young people’s Emotional Wellbeing and Mental Health: Health Needs Assessment, 2014 C&YPs PH team SCC

	<p>by SHSC and operated by Rethink – opened 2013</p> <p>Care Pathways and Packages (CPP). The national project to identify people who access secondary mental health services into clinically based clusters to support effective treatment planning and future payment arrangements has been progressed. Most people who use services are now placed within a cluster and the commissioning of health services will be based on these clusters from 2015.</p>
Choice and Self-Determination	<p>Personalisation has developed significantly across adult social care since 2009. Self Directed Support (SDS) was introduced to support people to determine their own support and care needs and to access them through personal budgets. This was a huge change for everyone from users and carers to mental health clinicians and professionals to support providers.</p> <p>In 2013 SDS processes were significantly revised to make them more efficient in terms of time and resources. However, accessing social care support to meet eligible social care needs through a personal budget remains an important option</p> <p>The experience in social care provides many useful lessons for the extension of personal health budgets.</p>
Partnership working. Integrated health and social care service	<p>Established in 2001 there continues to be integrated health and social care in adult mental health in Sheffield currently delivered by Sheffield Health and Social Care NHS Foundation Trust. This is an achievement given that a number of such partnerships have not been sustained across England and Wales</p>
Improving the availability of housing and support	<p>In 2015 a new 20 flat scheme will be available for people with mental health problems. In addition a new “generic” housing support service will be established to increase the availability of property and support eg through private landlords and social housing.</p>
Physical health and mental health	<p>The Right First Time programme has a workstream focusing specifically on mental health and physical health. It has worked across primary and secondary care to promote better access to physical health checks, cardio metabolic interventions and physical and social activity for people with serious mental illness. The project has piloted an approach targeting those at risk of hospital admission; commenced a smoking cessation project and is working on an e-learning training package.</p>
Partnership working to improve choice, innovation and prevention	<p>Third sector organisations continue to provide a wide range of services both commissioned and supported through other means. With the introduction of personal budgets in social care there has been a significant change in how some of these services are commissioned</p> <p>It has continued to be an area of innovation including the Mind and Body projects and taking on the challenge of new prevention initiatives including Social Cafes</p>
Mental Health Act – Revised 2007 Mental Capacity Act – came into force 2007	<p>The introduction of the MCA has had a significant impact on the delivery of treatment, care and support across health and social care. It requires assessment of a person’s capacity and consideration of “Deprivation of Liberty”.</p> <p>The revised Mental Health Act introduced Community Treatment Orders as well as the right to access an Independent Mental Health Advocate (IMHA). IMHA service commissioned.</p>
Support for Carers	<p>Health and social care recommissioned Carer Support Services in 2012. This was a change for mental health from a number of small contracts to commissioning 2 providers to support Carers across all areas of need.</p>
Promoting – prevention and personal resilience in Mental Health	<p>The Recovery Education Programme including psycho-educational groups has been established. It provides an educational approach and is now the first point of assistance for people for 250 people a quarter. It focuses on building up skills and personal resilience.</p> <p>3 Social Cafes have been developed across the city to support people</p>

	<p>who are one or two steps away from needing specialist mental health services.</p> <p>Sheffield Mental Health Information Service recommissioned to develop an accessible service that supports self-management and awareness. Time-limited project to promote self-help</p>
Anti-Stigma and mental wellbeing	<p>Local organisations have been promoters of the national <i>Time to Change</i> campaign and “20 years too soon” a campaign increasing awareness of early deaths of people with mental health problems and learning disabilities; established the <i>Sheffield Wellbeing Festival</i>.</p>

Continuing pressures and challenges:

However, we know services could and should be radically better. Some of these are areas identified in the 2009 Strategy.

Improving response in a crisis	<p>The introduction of the Crisis House has been a significant additional option for support in a crisis, however, there continues to be examples of ineffective responses at A&E as well as difficulties with access to appropriate places of safety for people under S136. People should not be waiting unreasonably for a mental health assessment in A&E. Services that are responsive services 24/7</p> <p>South Yorkshire Police and SHSC have established the Street Triage pilot to improve joint working. Indications are that it is having a very positive impact on the use of S136.</p>
Equalities	<p>There continues to be over representation of people from some black and minority ethnic communities in the acute services</p>
Appropriate mental health services for younger people	<p>Transition between children and adult mental health services. Adult services are not the right response for many people</p>
Partnership working. Integrating Health and Social Care	<p>Although there is a long established integrated mental health service in Sheffield there are still important challenges. This is particularly around access to residential and nursing care and support for people with long term needs e.g. Section 117 aftercare; Continuing Health Care; people in out of city placements.</p> <p>Work has commenced on developing a single approach which is in line with the future direction of health and social care (see Care Act)</p>
Improving the availability of housing and support	<p>There continues to be a shortage of supported housing for people with mental health problems available in a timely manner. This can impact on a move from inpatient treatment creating a delay or leading to an inappropriate placement. A new supported accommodation unit will be opened in early 2015</p>
Quality Specialist mental health care and implementing care pathways	<p>A lot of work has been done to develop CPP and the clustering this requires. However, it continues to be a challenge and the impact it will have on the commissioning of services is not yet fully understood.</p>
Mental Health and Physical Health	<p>The impact of mental health on physical health and vice versa continues to be a significant challenge including:</p> <ul style="list-style-type: none"> - the negative impact of psychiatric illness and medication on physical health including oral health - the importance of healthy living approaches - increase in physical conditions that can have a direct impact on mental health e.g. obesity - parity of esteem between physical and mental health within health

	services
Quality in specialist mental health care	Alternatives to hospital admission and continued improvement in the environment in hospital in-patient wards to promote recovery. Care pathways that are about the individual rather than the professional Treating people with respect. Services struggle to provide effective support for people with substance misuse and mental health problems, leading to regular but ineffective call on services..
Suicide and self-harm	There is not yet an effective suicide prevention strategy in place to focus on those at most vulnerable to harming themselves or taking their own life
Support for Carers	Carer support services are in place, but there is more that needs to be done to support those who need to deal with the crises or ongoing support.
Mental Wellbeing: promoting – recovery, prevention and personal resilience	Tackling Social Isolation and opportunities to build supportive social networks Improving awareness about mental health and promoting your own mental well being Employment and training opportunities
Tackling Stigma	Misunderstanding to prejudice
Financial challenges	There continue to be financial pressures on NHS services. These are even greater for local authorities with a direct impact on social care. There is a corresponding pressure on third sector organisations, particularly those with a more localised or focused purpose.

6. What people have said about current mental health services and how they should change

The following are the themes identified from the consultation

- The attitude and skills of staff within mental health services is fundamental to the experience of care received. A willingness to listen is needed.
- Seeing the person as a whole being, not just as symptoms. Treatment, care and support that helps people access community initiatives, physical activity etc.
- Increasing awareness of mental health and mental illness. Discrimination about mental health
- A diversity of support to meet a diversity of need across the range of communities in Sheffield
- Services informed by the experience of users including carers
- Talking therapies make a difference. More 1:1 listening and talking therapies
- Helping people develop the tools they need to manage their own mental health
- Crucial role of General Practice to both access help but also to have a greater ability to recognise and support mental health conditions
- Better training for GPs on mental health
- Training for all NHS workers to be knowledgeable about mental health
- Increasing mental health awareness and training with the workplace
- There is a gap between primary and secondary care
- Care planning is not wholistic, person centred or coordinated. “Do care plans still exist?”
- “The system makes me feel a nuisance”
- Accessing help for particular needs e.g. women with young children
- More support and advice at evenings and weekends (“out of hours”)
- A&E need to be much better at responding to mental health crises
- Better help in a crisis
- It takes too long to get the help and advice needed from getting help in a crisis to waiting for counselling

- Earlier diagnosis of mental health conditions. A greater focus on early intervention and prevention
- Less resource on beds, more help in the community
- Better provision for young adults (16-18 years) and the transition from CAMHS to adult psychiatric services
- Improve working across organisations. Much better communication, coordination, information sharing across agencies: housing, mental health, community/voluntary sector, local support e.g. GP
- There are too many parts to the service so people fall through the gaps. No one takes responsibility
- Acute mental health wards can be intimidating. Not therapeutic. “No one to talk to”.
- Consider family and friends – support for carers and the vital role they play; include carers in the recovery process
- Better information for carers when a crisis occurs
- Better coordination between mental health and physical health
- Care should be about the person. Not just tick boxes. What is important is “the whole person”. Your relationships and context you live within are important for supporting recovery. Three pillars of good recovery: being able to help yourself; building good support networks; getting the appropriate treatment/therapeutic help.

There are some consistent themes from the 2009 Strategy

- Access to help and support when people need it
- The gap between primary care and secondary care - joining up care
- Supporting recovery
- Care and support based on the individual
- Respect for people within mental health services
- Services responsive to the range of communities

7. Vision and aims of the strategy

The fundamental aims of the Strategy remain to:

- Promote mental well-being
- Prevent mental ill health
- Promote recovery from mental ill health
- Reduce mental health inequalities

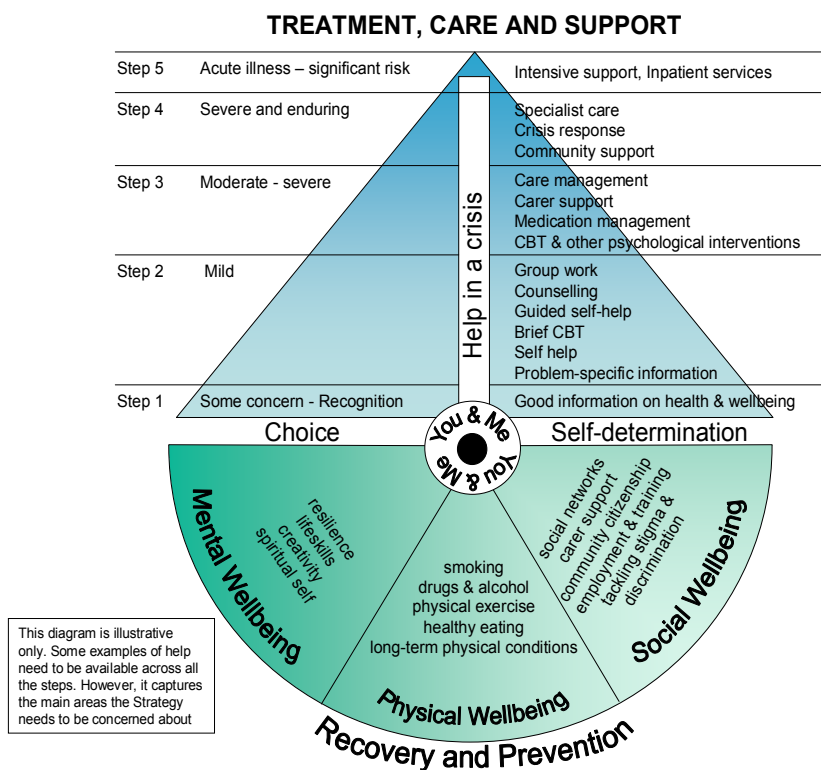
It is our vision to achieve these things for the people of Sheffield by:

- ⇒ Making help available at an early stage to prevent or reduce the impact for the individual and their family
- ⇒ Having services that are accessible and responsive. Help available in the right places and in the right ways.
- ⇒ Providing services that people want to use because they find them helpful and where they are dealt with respectfully
- ⇒ Supporting people with mental ill health to have a better life through maintaining connections to family and friends; participating in their community and have opportunities for work and leisure.
- ⇒ Helping to make Sheffield a place that supports and improves the mental health of all its people

8. WHAT IS THE FUTURE DIRECTION?

Who should services be constructed around? – A Service Model

This diagram is a means of describing both the approach we want to achieve for mental health services and how it can fit together.



The word “service” describes how we organise things rather than the outcomes we expect them to help us achieve. What is important therefore is that it is you and me at the heart of it, with our own mental and physical wellbeing and our own particular social circumstances. What abilities and insights we already have need to be the starting point.

It is about getting help when we need it, including specialist help based on clinical knowledge and expertise, from those we need to have confidence in. We need confidence in their ability to listen and understand, in their skills and knowledge of helpful treatments, care and support.

We also need confidence in the systems a service creates so that wherever possible we are in control of the decisions about our treatment, care and support, so that we don’t get forgotten, lost in referral procedures or waiting lists, or treated as a ‘diagnosis’ or ‘cluster’ rather than a person with abilities and insights.

The Stepped Care approach should build on a person’s abilities. It should make sure the right skills and options are available at the right time for you rather than for the system. It should be about empowerment rather creating harmful dependency, about increasing a person’s insight and skills for self-management through to a responsive approach to providing help in a crisis that is highly skilled and proportionate.

The suffering mental ill health can cause means that sometimes action has to be taken to ensure the safety of the sufferer or others, but the person with their abilities should still be at the heart, treated with respect and the encouragement to recover and rebuild.

People with the right skills in the right places

The awareness and skill to help a person (you or me) with mental health problems is not, of course, the sole preserve of specialist mental health services.

The feedback talks about being forgotten, feeling isolated. We need to empower all sorts of people to have a greater awareness of mental ill health and how to respond in ways that help. Primary care is of course the main point most of us go to get help. But there are other places where people struggling with their mental health emerge: housing services, advice and debt counselling, relationship counselling.

There is not the confidence that enough GPs and other staff in primary care have the confidence or ability for assisting people with mental health problems without referring on to specialists? Do GPs and other primary care staff have the right level of mental health awareness and skills?

Talking therapies and the need for more 1:1 listening comes up consistently. There has been a significant increase in services that improve access to psychological therapies (IAPT) in the last 6 years but the need for more “listening” shouts out. Are the skills we have available used to the greatest effect? How can the skills and opportunities be more widely shared and made available? If the skills are not in the places where we go to for help and not available when we need them we are missing something fundamental.

Care pathways that focus on the person not the professional and don't just start at the door of the clinician.

Having the right information in the right places

If knowledge and information is power and empowerment is vital to mental health, then it should be made as accessible as possible and not hoarded. This is about valid information on diagnoses and treatments to assist with the support from your clinician; information about how to get the help you think you need, what options there are and what to expect from them.

It also includes tools for self-management.

“Self-management of mental health conditions and daily living is an essential part of the future of mental health care ... it will ... empower people, leading to a more appropriate balance in the relationship between professionals and “patients...”

P27 “Starting today – the future of mental health services – Mental Health Foundation

Of course self-help is not the solution for all mental health conditions, but it always has a role. Supporting access to information and self-help tools is already an important role in IAPT, in the Recovery Education programme and the approach of third sector organisations e.g. Sheffield Mind and Rethink, but can more be done to continue to move information out from being the preserve of the experts? This is about continuing to promote and develop the use of on-line tools and appt technology and supporting ways for people to establish their own networks of support.

Access in a crisis

If you are in a mental health crisis, you know you need help and can no longer manage, or you know a person you care for needs help and can no longer manage. Where do you go?

It is generally recognised that we don't deal well enough with mental health crises. The national Crisis Concordat was published in February 2014. It requires partnership work across mental health services, police and ambulance services, local authorities and others to make sure the approach is coherent.

In Sheffield there have been some innovative developments over recent years including the Crisis House and the street triage scheme where police are working with Approved Mental

Health Professionals and Nurses. But the response people receive in Sheffield continues to be a concern. A&E doesn't have the right skills available at the right time. There is a "place of safety" available on an inpatient ward for people picked up by the Police under S136, but its availability is seen to be inadequate and inconsistent.

What should I expect if I, or people who depend on me, need help in a mental health crisis? The Concordat identifies some basic expectations to meet from timely help, feeling safe while getting help, being treated with respect and learning from the crisis to help manage it differently.

Mental health and physical health

The impact of our physical health on our mental health is well established. The impact of mental health on our physical health and life expectancy is well established. The impact of psychiatric medication on our physical health including dental health is well established. Why therefore do we persist in making a distinction between where we receive our help and support for physical health from our mental health? What would services look like if this wasn't the case?

Primary care is currently the place where physical and mental health can be seen together. It is also where there is often a connection and understanding to the personal and social community a person lives within.

Whether the help and assistance provided is for physical health or mental health needs, it must be provided in a way that supports and promotes good psychological and emotional health.

"Primary Care" and "Secondary Care" is the language of services and commissioners not of the people who need them

IAPT is placed in primary care, Access Community Mental Health Teams are now much more responsive to referrals from primary care and the Recovery Education Programme is developing to provide rapid access to support, but the gap between primary and secondary care continues to be a concern. People experience "falling through gaps". Is this gap about organisational arrangements or the needs of those who are seeking help? Is there any added benefit for dividing up the wholistic advice, treatment, care and support we need into primary care and secondary care? What would mental health services look like if we had no separation?

Integration

We have had an integrated health and social care mental health service for adults since 2001. This has made sure the challenges of looking at both health and social care needs are dealt with by the integrated service and not passed on to the person who just wants help. It is only managers, professionals and commissioners that question the value of integration, not those who use the services or care for someone who does.

The national direction through the Care Act and the Better Care Fund is to progress integrated working further so that duplication of effort that adds nothing to the user experience is removed. This is about commissioning, management, processes and systems, budgets, pathways and teams of buildings, but the outcome must be to achieve a seamless experience of advice, treatment, care and support when we need it or it won't help. This requires changes in attitudes, a willingness to do things differently and to see the experience as a whole.

Choice and self-determination

We know there are times when we need specialist advice and assistance. This may well lead to treatment, care and support, but for where ever it is possible we want to be able to have the information we need, help to understand it and the consequences, help to have and understand the choices, and to be a full partner to the plan, a plan about my care that is my plan.

Services are built on diagnosing or assessing problems and needs, looking for solutions or assistance that would help, agreeing a course of action and keeping an eye on it. The Care Programme Approach still provides the basis on which to make sure a person with serious mental health problems continues to have that support. However, feedback that asks whether care plans still exist tells us there is something not working.

Empowerment is jargon for making sure I have control of what is happening to me, that I have options and make choices. It is also jargon for owning the choices and their consequences.

Personal budgets are a means to provide the choice, control and ownership. They are already introduced in social care and the direction of national policy is to introduce them more widely in health where they are seen to have particular benefit in mental health. How can we build greater choice? Can personal health budgets be integrated with social care budgets to ensure more effective treatment, care and support?

“A stitch in time”

Identifying whether someone has serious mental health problems early and making sure they can get advice and assistance we know can reduce both the impact of the illness and also the other significant effects it can have on relationships with family and friends, maintaining education or work, keeping a place to live. Having the means to pick up the signs of deeper fears and troubling experiences is of benefit to everyone ... the person, the family, the specialist services. To this end there is rightly great emphasis in national policy on targeting skills and opportunities to particularly vulnerable groups and vulnerable times e.g. young adulthood. This requires awareness and skills within schools, colleges and with employers. The views from the consultation are of acute wards that are intimidating and lonely places and so preventing or limiting the need for them has to be a priority.

Suicide does not always have a connection to mental illness, but often tragically does. It certainly has a connection to serious emotional distress and such manifestations as self-harm and experiences e.g. unemployment and debt. The need for a suicide prevention strategy that includes all those agencies called upon at such times is highlighted in the national strategy.

But this is also about our mental health intelligence, what we can do, what things we need to change, what skills we need to develop. There is now a lot of support for mental health problems that affect mood, managing anxiety and phobias, poor sleep, living with pain. The IAPT programme has been a significant development since the last Strategy, targeted to primary care and other community resources, but is it enough? How can the skills and knowledge be made more available, more common place, particularly to those at greatest risk? This is about preventing people who are one or two steps away from needing more intensive assistance or treatment from being drawn unnecessarily into the mental health “system” when it can be avoided. It is about looking to places where problems begin to emerge e.g. at work, the advice centre, the housing management, A&E as well as primary care.

Promoting Mental Wellbeing

We all know that feeling when we think we are not coping and when we feel specific problems or general anxieties are getting on top of us and we are not reacting to them well. Mental wellbeing is about how we are able to cope with those experiences. What is it that helps us develop own

our abilities to cope, our resilience? In the spirit of “five a day” for health eating the “Five Ways to Wellbeing” (Appendix 1) provide a basis for looking at how we can help ourselves.

But they also provide a basis for how we can help each other, including through how we commission and deliver assistance, care and support. From the consultation the experience of isolation, loneliness, “no one to talk to” are highlighted. The importance therefore of being able to make connection to others, finding and establishing that supportive network through shared concerns or interests, getting to know others who live nearby are vital and can be life-saving.

In addition, being able to contribute through work, or voluntary opportunities, or other means are also important for promoting and sustaining our mental health and mental resilience.

Building up that mental resilience needs to start young. If there is any significant preventative work it is to be done in early years and adolescence, building up awareness of your own mental health and wellbeing, increasing your ability to deal with stress and anxiety and to share your fears and worries. A good start in life is a national priority in “No Health without Mental Health”.

10. Major Themes and Priorities for the Next 5 Years

This strategy sets out to identify the direction for change and development needed to improve the experience and effectiveness of mental health services in Sheffield.

This review has identified many improvements that could be made and where their priority needs to be seen in relation to available resources. However, there are also fundamental challenges that, if faced, can transform the way mental health is seen, and how assistance, support and treatment are approached.

In addition it has identified a number of principles that must inform all change and development across mental health services in Sheffield over the next 5 years if the requirements and aspirations of this strategy are to be met.

Principles

The following should be provided consistently and constantly in all service provision regardless of who delivers it

Principles	What matters to me most?
Respect at the heart	Whatever my difficulties, I am treated with dignity and respect
Built on Equality	I get the right help regardless of who I am
Supports Recovery	All assistance, support and treatment is focused on working with me to manage my mental health difficulties, to make progress, make change and take control
Responds to individual need	Treatment and support built around my needs not those of professional help and services
Coproduction of service	Services developed with those who need to use them I know how I can get involved in decisions about Sheffield's mental health services
Choice and control	I know the range of options available to me and there is the means for me to exercise them wherever this is possible
Efficient use of resources	Support that helps me manage my own mental health I don't have to keep telling different people my problems and experiences Expensive professional skills and knowledge are used effectively
Communicate! Communicate! Communicate!	I know what my options are and what is happening. People are talking to me, sharing information, treating me with respect

Priorities:

(A **Priority** is an important Mental Health focus that Commissioners and Providers will seek to deliver in the 3-5 years of this Strategy.)

Priority	What it means for me	What it means for commissioners and services
<p>Parity of Esteem – Equal emphasis on physical and mental health</p>	<p>My mental health is treated with the same priority as my physical health</p> <p>The impact of my physical health on my mental health and vice versa is taken seriously, including the effect of medication</p>	<p>Not just reducing but removing the distinction between treating physical and mental health separately</p> <p>Mental health services delivered through Primary Care. Greater skills and support available through Primary Care</p> <p>Coordination of physical and mental health delivered through primary care</p>
<p>Promote Prevention</p>	<p>I can talk to someone who will listen and who will help me find ways to manage my mental health</p> <p>I can get access to information and advice at an early stage so I can understand and manage my own mental health and prevent it getting worse</p> <p>There are opportunities for me to make contact with others, to share experience and support</p>	<p>Improved access to knowledge and support through social media and mobile technology</p> <p>Improved access to talking therapies</p> <p>Sharing specialist skills and knowledge and promoting self-help initiatives</p> <p>Training and Employment opportunities</p> <p>Support to access social networks</p>
<p>Promote Mental Wellbeing</p>	<p>There is greater awareness and understanding of mental health across communities.</p> <p>I am not treated unfairly, stereotyped or stigmatised because of my mental illness</p>	<p>Building up mental health awareness and resilience in early and teenage years</p> <p>Information and understanding about mental health and wellbeing is abundant: available on the high street, at school and college, in the workplace.</p> <p>“5 ways to wellbeing” integral part of commissioning</p> <p>Promoting the benefits of physical health</p> <p>Demystifying mental illness and tackling stigma</p>
<p>Appropriate Response in a Crisis</p>	<p>I know when I need to ask for help to avoid a crisis and what to</p>	<p>Individual planning to deal with crises – including carers and carer</p>

Page 55

<p>do.</p> <p>I know where to go when I cannot manage myself or someone I care for</p> <p>I know how to avoid crises in future</p>	<p>support</p> <p>Clear pathway to help in a crisis across all partners (health/social care/police/ambulance etc.). Tacking organisational boundaries and cultures that get in the way.</p> <p>Effective information sharing</p> <p>Improving the experience in A&E - Effective skills and response times in A&E</p> <p>Adequate crisis alternatives – <i>place of safety</i></p> <p>Improving the responsiveness of mental health crisis services – response time etc.</p> <p>Information available in a way that engages and at places that are easy to access</p> <p>Greater Mental Health awareness and skills at places where people present with need (Advice/Debt advice / Housing resources / Police)</p>
<p>Accessible care when needed</p> <p>Help from the right people with the right skills in the right places</p> <p>I am at the heart of my treatment and support. A care plan that is mine and not owned by those helping me or a tick box system requirement</p> <p>Information and advice available to assist me to understand and</p>	<p>Greater mental health skill and awareness in primary care.</p> <p>Greater flexibility of professional roles – sharing skills and knowledge.</p> <p>Greater Mental Health awareness and skills at places where people present with need (Advice/Debt advice / Housing resources / Police)</p> <p>Professionals as partners. Revision of the Care Programming: Care Coordination; integrating with Support Planning (Social Care) Using Personal Health and Social Care Budgets to support choice</p> <p>Information available in a way that engages and at places that are</p>

	access the help I need	easy to access Sharing specialist skills and knowledge
Seamless integrated Services	<p>The route to getting assistance, support and treatment is clear.</p> <p>I get the help I need nearest to the point where I first sought it</p> <p>There is no duplication of interest or passing me on to someone else without good reason</p>	<p>Integrated commissioning and service delivery across health and social care: single point of access to services etc.</p> <p>Removing the service gap between primary and secondary care</p> <p>Transition from young person to adult mental health service</p> <p>Assessment and care planning takes account of the person's whole experience from symptoms to social context – Review of Care Programme Approach and Care Coordination</p> <p>Identifying where service and professional boundaries hinder people's "recovery"</p> <p>Effective information sharing</p>

Glossary of abbreviations and terms

Adults	All people aged 18 years and over
Older Adults	All people aged 65 years and over
Functional mental illness	Disorders of mood and thinking that are not related to dementia
Stepped care model	A model of mental health services whereby services are delivered at five “steps” according to people’s level of need
Care pathway	How people access and move between services
Self-directed support	An approach encouraging people to plan and manage their own services
DH	Department of Health
IAPT	Improving Access to Psychological Therapies
ONS	Office of National Statistics
CPA	Care Programme Approach - system of multi-disciplinary care planning and monitoring for people with severe mental illness
NICE	National Institute for Health and Clinical Excellence
GP	General Practitioner
CBT	Cognitive behavioural therapy
Primary care	GP and related services that can be accessed directly
Secondary care	Services that are accessed by referral from primary care
Care navigator	Someone to help advise and access the support needed
A & E	The Accident and Emergency Department

Appendix 1

What do we mean by mental health?

“Mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions. The majority of people who experience mental health problems can get over them or learn to live with them, especially if they get help early on.

Mental health problems are usually defined and classified to enable professionals to refer people for appropriate care and treatment. But some diagnoses are controversial and there is much concern in the mental health field that people are too often treated according to or described by their label. This can have a profound effect on their quality of life. Nevertheless, diagnoses remain the most usual way of dividing and classifying symptoms into groups.

Most mental health symptoms have traditionally been divided into groups called either ‘neurotic’ or ‘psychotic’ symptoms. ‘Neurotic’ covers those symptoms which can be regarded as severe forms of ‘normal’ emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as ‘neuroses’ are now more frequently called ‘common mental health problems.’

Less common are ‘psychotic’ symptoms, which interfere with a person’s perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no one else can.

Mental health problems affect the way you think, feel and behave.

Although certain symptoms are common in specific mental health problems, no two people behave in exactly the same way when they are unwell.

Many people who live with a mental health problem or are developing one try to keep their feelings hidden because they are afraid of other people’s reactions. And many people feel troubled without having a diagnosed, or diagnosable, mental health problem - although that doesn’t mean they aren’t struggling to cope with daily life.

With Thanks to the Mental Health Foundation

Intellectual Health

Intellectual health refers to how well our cognitive and thinking functions are working. It is part of our mental or emotional wellbeing and includes the ability to think clearly and realistically, to think positively, to pay attention appropriately, to have good short and long term memory, and to continue to learn.

The Five Ways to Wellbeing

Connect

Feeling close to, and valued by, other people is a fundamental human need and one that contributes to functioning well in the world. Social relationships are critical for promoting wellbeing and for acting as a buffer against mental ill health for people of all ages.

Be active

Regular physical activity is associated with lower rates of depression and anxiety across all age groups. Exercise is essential for slowing age-related cognitive decline and for promoting well-being.

Take notice

Reminding yourself to ‘take notice’ can strengthen and broaden awareness. Studies have shown that being aware of what is taking place in the present directly enhances your well-being and

savouring ‘the moment’ can help to reaffirm your life priorities. Heightened awareness also enhances your self-understanding and allows you to make positive choices based on your own values and motivations.

Learn

Continued learning through life enhances self-esteem and encourages social interaction and a more active life. Anecdotal evidence suggests that the opportunity to engage in work or educational activities particularly helps to lift older people out of depression. The practice of setting goals, which is related to adult learning in particular, has been strongly associated with higher levels of wellbeing.

Give

Participation in social and community life has attracted a lot of attention in the field of wellbeing research. Individuals who report a greater interest in helping others are more likely to rate themselves as happy. Research into actions for promoting happiness has shown that committing an act of kindness once a week over a six-week period is associated with an increase in wellbeing.

With thanks to NEF and Mind

<http://www.mind.org.uk/for-business/mental-health-at-work/taking-care-of-yourself/five-ways-to-wellbeing/>

See also the 10 ways to look after your mental health (Mental Health Foundation)

<http://www.mentalhealth.org.uk/help-information/10-ways-to-look-after-your-mental-health/>

Appendix 2

“No Health without Mental Health” DoH 2011

<https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

This outlines the Government’s plans for improving the mental health and wellbeing of people in England. Mental health is everybody’s business. It considers mental health across all ages and from tackling stigma to prevention to delivering care and support. It is built around 6 fundamental objectives:

More people will have good mental health

The impact of a good start in life from parenting to building up the mental resilience and awareness of young people

More people will recover

A focus early intervention and a recovery approach that builds on individual objectives and strengths and helps increase personal resilience.

More people with mental health problems will have good physical health

Tackling the relationship between mental health and physical health including the poor physical health of people with mh problems

More people will have a positive experience of care and support

The person is at the centre of their treatment and care planning. This includes choice and control including the use of personalised budgets in both health and social care. People who use services and their carers are respected.

Fewer people will suffer avoidable harm

This is about the quality of services that respect human rights and ensure the individual’s safety and dignity. Tackling self-harm and suicide.

Fewer people experience stigma and discrimination

Tackling stigma and discrimination through information, education and legal duties

The Abandoned Illness: A report by the Schizophrenia Commission – Schizophrenia Commission 2012
<http://www.schizophreniacommission.org.uk/>

The independent commission on schizophrenia and psychosis identified a number of priorities including: share decision making for a person about their care and treatment; alternatives to acute hospital care; greater role for primary care; early intervention; carer support; physical health of people with a serious mental illness; use of personal budgets and increasing access to talking therapies.

Starting Today – the future of mental health services – Mental Health Foundation - 2013
<http://www.mentalhealth.org.uk/publications/starting-today-future-of-mental-health-services/>

Key messages from the report include: providing a personalised service; building capacity for self-management; mental health services primary care led – removing the distinction between primary and secondary care; more effective crisis care; integrating mental and physical health care; importance of early years for building mental resilience.

Closing the Gap: Priorities for essential change in mental health – DoH - 2014
<https://www.gov.uk/government/publications/mental-health-priorities-for-change>

Closing the Gap identifies the immediate government priorities. It highlights in particular:

- Commissioning services that focus on recovery
- More effective information on mental health and mental wellbeing of the population
- Tackling waiting times for services; tackling inequalities and discrimination in mental health services
- Importance of talking therapies including for people with serious mental illness and personality disorders
- Improving mental wellbeing amongst children and young people through support to parents and work in schools; more choice and control for people in their treatment and support including personal health budgets alongside those already available in social care
- Tackling the use of restraint and restrictive practices
- Getting better feedback on services and tackling poor quality
- Support for carers
- Integrated physical and mental health care
- Better response in a crisis (Crisis Care Concordat), including self-harm; more effective approaches to mental health across the justice system
- Employment supporting good mental health
- Tackling discrimination and stigma.

Joint Commissioning Panel for Mental Health – Commissioning Guidance – Royal Colleges of Psychiatrists and of General Practitioners -
<http://www.jcpmh.info/>

These are a range of commissioning tools for specialist mental health services from acute care and crisis to community mental health teams and primary care based on the current models of mental health services

Living Well for Longer – NHS (April 2014)

See link via Rethink site who also produce a useful summary relating to mental health and their own report “Lethal Discrimination”

<http://www.rethink.org/lwfl>

These reports highlight the stark impact on physical health of mental ill health, and vice versa. It includes tackling smoking, the importance of physical activity, as well as the impact of psychiatric medication and the priority for health checks.

Personal Health Budgets

The Introduction of Personal Health Budgets in the NHS, including for mental health.

<http://www.personalhealthbudgets.england.nhs.uk/index.cfm>

<http://www.mind.org.uk/news-campaigns/news/mind%E2%80%99s-personal-health-budgets-research-published-today/>

Crisis Concordat DoH Feb 2014

<http://www.crisiscareconcordat.org.uk/about/>

The Concordat sets out how response to mental health crises needs to improve. It is based on 4 core principles: Access to support before a crisis; Urgent and emergency access to crisis care; Quality of treatment and care when in crisis; Recovery and staying well. It addresses issues around A&E, Place of Safety; role of Police and Ambulance services.

Suicide Prevention Strategy DoH Feb 2014

<https://www.gov.uk/government/publications/suicide-prevention-report>

The Strategy looks at trends and lessons to inform actions that are required to help reduce suicide and self-harm including mental health awareness, early intervention and effective responses at A&E.

Transforming our health care system: Ten priorities for commissioners April 2013

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

The priorities include:

- Developing an integrated approach to mental and physical health problems
- Systematically detecting early stages of disorders and intervening early
- Taking action that reduces incidence including targeting high risk groups
- Creating patient-centred care. Coordinated care, navigation etc.
- Integrating approaches to urgent and emergency care: joint planning, information sharing etc.

Crossing Boundaries Mental Health Foundation 2013

<http://www.mentalhealth.org.uk/publications/crossing-boundaries/>

Research that looks at the need to integrate care, identifying that the boundary between mental and physical health is artificial and detrimental. We need to better understand the "individibility and unitary nature of physical and mental health". It proposes ways to achieve this including focusing on: information sharing; co-location; joint commissioning across health and social care; multidisciplinary teams; liaison services.

Achieving Better Access to Mental Health Services by 2020 -

<https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020>

Timely access to services and then for treatment is one of the most obvious gaps in parity between physical and mental health services – whilst there are waiting time standards for physical health services, for mental health services, these standards simply don't exist. This plan sets out the immediate actions we will take this year and next to end this disparity and achieve better access to mental health services and our vision for further progress by 2020. An additional £40 million funding boost for mental health services is committed in 2014-15 and a further £80 million in 2015/16.

Appendix 3

Managing Patients with Complex Needs - City & Hackney Primary Care Psychotherapy Consultation Service (PCPCS) Centre for Mental Health 2014

The service supports GPs in the management of patients with complex needs through case discussion, training and direct clinical services including brief psychological interventions. Shown to significantly improve health outcomes and reduce use of both primary and secondary care. A typical course of treatment lasts for 12 sessions, at an estimated average cost of £1,348 per patient. The subsequent savings from reduced health service use are equivalent to a third of this cost. Based on the cost-effectiveness framework used by NICE the PCPCS treatment has a cost per QALY (quality-adjusted life-year) of around £10,900 compared to the NICE threshold range of £20,000 - £30,000.

Long Term Conditions and Mental Health Kings Fund 2012

The work emphasises the prevalence of co-morbid mental health problems with the current separation of mental and physical health leading to fragmented approaches in which opportunities to improve quality and efficiency are often missed. Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively.

There is a growing evidence base which suggests more integrated ways of working with collaboration between mental health and other professionals offer the best chance of improving outcomes for both mental health and physical conditions. It also evidences that the costs of including psychological or mental health initiatives within disease management or rehabilitation programmes can more than outweighed the savings arising from improved physical health and decreased service use. The cost implications are significant to primary care and the wider economic impact of mental health problems having an effect on employment and workplace productivity and the costs of informal care borne by family members.

The effects of socio-economic deprivation are an issue in Sheffield and the paper notes that social deprivation strengthens the association between mental and physical ill health. It suggests that improving care for people with long-term conditions and co-morbid mental health problems will require closer working between mental and physical health care services, and also social care, public health and the range of other social support services provided by VCF organisations. In summary, the paper suggests Clinical Commissioning Groups should play an important role in working with local providers to encourage the growth of more integrated forms of care, developing care pathways that support emotional, behavioural and mental health aspects of physical illness as a standard component of care for people with long-term conditions.

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