Positive Mental Health

A joint strategy for Somerset

Somerset Health and Wellbeing Board
2014 - 2019

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Foreword

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Foreword

Positive mental health is essential for our quality of life. It is important for thriving communities, for economic productivity and for personal relationships. Life will always have ups and downs but positive mental health helps us to deal with these more effectively.

This strategy is for all ages. It is for both children and for adults. It is vitally important that we enable our children and young people to have positive wellbeing and that we provide effective support and treatment when problems occur. Promoting the mental health of the working age population, including parental mental health and the health of people at work has been identified as being a sound investment both socially and economically. The mental health of older people is an important part of healthy ageing, supporting Somerset's key aim of keeping everyone living healthy independent lives for longer.

The rural nature of Somerset brings benefits for positive mental health through the beauty of the landscape and access to green spaces, but it also poses particular challenges in the design and delivery of services, which we need to take into account.

Unfortunately mental health problems are extremely common. One in six people will have a mental health problem at any one time. For some people this may be a brief episode of illness, for others, mental health problems last for many years, particularly if inadequately treated. The social and financial costs of mental health problems are immense and impact on individuals, their families and society as a whole.

On the other hand, improving mental health and supporting recovery also benefits everyone. There is a clear association between good mental health and better physical health, positive educational achievement, improved productivity at work and crime reduction. Mental health and physical health are entirely connected. We cannot afford not to act.

There is something for everyone to do, whether it is as an individual, a community organisation, a public body or an employer. Mental health is *everyone's* business in one way or another.

I hope that you will join us by giving your support to this work.

Cllr. Christine Lawrence
Chair Somerset Health and Wellbeing Board

1. EXECUTIVE SUMMARY

This strategy is about both children and adults. It looks at how to build positive wellbeing, how to prevent mental illness and what good services should look like. It sets out best practice which can be used to inform policy, commissioning and service delivery plans.

Practical things we can do are listed in each section. A high level action plan can be found at the end of the document. The best way to read the document is to use the contents list to find the sections which you want to look at.

To promote positive mental health we can:

- Invest in thriving, connected and inclusive communities

- Invest in homes for all and address homelessness and insecure housing

- Provide extra support to people who are vulnerable

- Promote a safer Somerset for all

- Invest in parenting support and behaviour programmes for children

- Develop resources for teachers and information for parents and families

- Make sure that people are accepted and valued in Somerset, whatever their sexual orientation, ethnicity or gender identity

- Make sure that mental health and physical health are equally important

- Make sure that everyone has positive wellbeing, including people who have mental health conditions

When we become unwell we need:

- High quality treatment services, at the right time and in the right place through self-help, a GP, a community group or specialist mental health services

- To make sure that everyone can use our services, with no barriers because of age, ethnicity, disability, including learning disability and other conditions like autism

- As users of mental health services, carers and families to be at the heart of everything

- To have access to social and psychological as well as medical support

- To have choice and control through access to personal budgets and a range of service options

2.   SETTING THE SCENE

The aim of this strategy is to set out the principles and best practice which support, promote and protect positive mental health. This information can be used to inform decisions about policy and services in Somerset.

High quality treatment services, accessed at the right time and in the right place, are one important part of a whole system approach to population mental health and wellbeing. Mental ill health currently represents 23% of the total burden of ill health in the UK and is the largest single cause of disability[1]. Nearly 11% of England's annual secondary health budget is spent on mental health[2] and estimates suggest the cost of treating mental health problems could double over the next 20 years[3].

It is important, in this context, that we understand how we can create the conditions to keep people mentally healthy and that we understand the patterns of risk within our communities. The rural geography of Somerset brings benefits such as access to green spaces, but also particular challenges in the design and delivery of services.

The national strategy for Mental Health '*No Health without Mental Health 2014*'[4] identifies six priority themes, which are reflected in this strategy for Somerset:

- More people to have good mental health

- More people with mental health problems will recover

- More people with mental health problems will have good physical health

- More people will have a positive experience of care and support

- Fewer people will suffer avoidable harm

- Fewer people will experience stigma and discrimination

This strategy is for all ages. Indeed, mental and emotional health is an essential part of the developmental experience which shapes each and every one of us, with 40% of all lifetime mental ill health manifesting before the age of 14[5][6]. The importance of creating resilient people, able to deal with the ups and downs of life and the benefits of having in place modern, non-stigmatising support and treatment for mental health problems, goes far beyond the impact on individuals, but has implications for employers, wider family networks and society generally. With an ageing population, the mental and emotional health of older people is becoming a higher priority, with social isolation and loneliness an issue of increasing concern as highlighted by the Local Government Association *'Campaign to End Loneliness'*[7].

A great deal is now known about the conditions which create positive mental health and those which place individuals and communities at greater risk of poor lifetime mental and emotional health. Evidence around effective treatments and quality of care for mental and emotional health conditions has also advanced enormously in recent years, with a greater understanding of the importance of the social

dimensions of mental illness, the concept of recovery and of patients as experts in their own condition.

Figure 1 describes a whole system approach which includes the creation and promotion of mental health, prevention and early intervention and treatment and recovery.

The themes of physical health and wellbeing cut across all levels and are as relevant to healthy communities as they are to people receiving treatments and living with complex mental health conditions.

The three boxes on which the pyramid sits represent the Somerset Health and Wellbeing Board's three main priorities, while challenging stigma is a clear underpinning principle.

Delivery of the different elements of this strategy will require further and more detailed work in terms of programme and commissioning plans. These will be led by the relevant commissioning and programme boards.

Fig1: A whole system approach to population mental health in Somerset
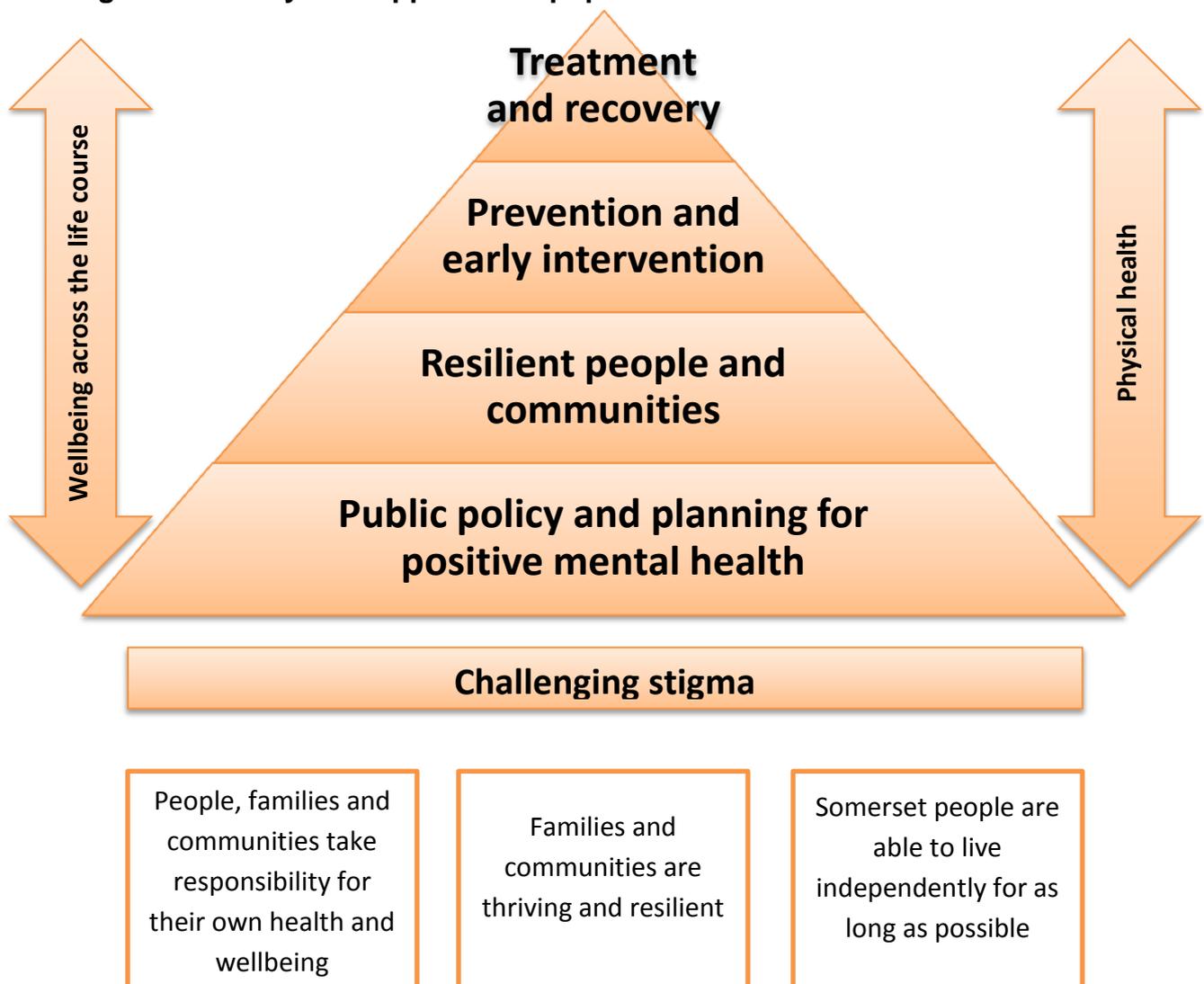
Fig 2: Thematic Analysis of Consultation Feedback

SOMERSET JOINT STRATEGY FOR POSTIVE MENTAL HEALTH

Vision

People in Somerset are supported to maintain their mental health and wellbeing and are always able to access the right help, treatment and support when needed to maintain their independence and increase their resilience, recovery and wellbeing

Consultation Responses

Questionnaire:
We received 105 responses from members of the public, service users and families/carers. Detailed responses were received from charitable organisations

Consultation events:
We held two events in Taunton and Yeovil which were attended by approximately 75 people

Health Forums:
We held events within all GP Federations attended by members of the local community including representatives from GP practices, local council and charitable organisations

Top priorities from the consultation

More choice and control

Encourage voluntary and community sectors as service providers

Improve the choice of mental health services which are available

Please consider eating disorder services

Better access to talking therapies services

Improve engagement and participation for service users and carers in the planning of services

Better quality of information including better signposting, and clearer care pathways

Promotion of positive mental health, early intervention and prevention

Do more to promote positive mental health

Improve links with schools to support the mental and emotional health of young people

Provide more options and have better services in place when things start to go wrong

Developing more campaigns and activities to reduce discrimination and stigma

Support and advice on employment or volunteering opportunities for people with mental health problems

Joined-up approach

Better sharing of information between health and social care

Joined up response for people who have both mental health and substance misuse problems

Improve links with General Hospitals

Better liaison between mental health services and GP Practices

More focus on the link between mental and physical health

Improve links with the police

Improve advice and support for housing related issues

Better links with social care and support

Person-centred approach

Remove barriers and improve access for everyone

Individualised and person centred care for everyone

Personalised and appropriate provision for people who have particular needs such as people with autism, learning disabilities and dementia

More support for families and carers of people who have mental health problems

More robust complaints procedure

3.   MENTAL HEALTH NEEDS IN SOMERSET

3.1   Overview

Mental Health needs are more fully described in the Mental Health Needs Assessment for Somerset (2014). This chapter provides a summary of that information.

It is estimated that one in six people will have a mental health problem at any one time, while one in a hundred will have a serious mental health problem requiring specialist management and treatment. Half of all adult mental health problems have developed by age 14. Around 50% of these problems are potentially preventable [8].

Mental health needs are diverse. The one in six of the population who have a mental or emotional health need will include those whose level of need is low or transient, those whose level of need would benefit from a social or psychological intervention and those who require more complex assessment and treatment. It is an on-going challenge for policy makers and service planners to understand these different needs and to develop appropriate responses which promote wellbeing, prevent mental illness and ensure timely, effective and appropriate treatment.

Risk factors for poor mental health in adulthood include unemployment, low income, debt, violence, stressful life events, inadequate housing, fuel poverty and other adversity such as serving in combat. Risk factors disproportionately affect the mental health of people from marginalised groups. Targeted intervention for groups at higher risk of mental illness can prevent a widening of inequalities in comparison with the general population. Protective factors include stable housing, strong, positive social networks and support; access to green space; feeling safe and having a good sense of meaning and purpose.

To understand mental health needs within a population and be able to make good decisions about policy and services it is necessary to look at the picture from several different angles. These include an understanding of:

- Wider risks and protective factors, such as deprivation, exclusion, environment, employment, education and housing

- The expected prevalence of mental health conditions

- Use of mental health and other services

Public Health England has recently launched a national Mental Health Dashboard which can be found here: http://fingertips.phe.org.uk/profile-group/mental-health. The dashboard is still in development; however, live updates are expected and we recommend that commissioners and service planners refer to the central dataset

through the link above. Other sources of information are the Public Health Outcomes Framework www.pho.org.uk and the Child and Maternal Health Intelligence Network www.chimat.org.uk/.

The following information has been extracted from the mental health dataset and the Public Health Outcomes Framework (in June 2014):

- Measures of self-reported wellbeing, now routinely collected, suggest that in Somerset people are somewhat less 'happy' than England as a whole, but they are less anxious

- Indicators suggest that Somerset has somewhat higher levels of adults with depression (6.2% adults 18+) recorded on GP registers. This percentage has declined steeply since 2011–12, along with figures for the rest of England, when the percentage was 14.24% compared to England as a whole (11.68%). However, this may simply reflect changes in the incentives and recording for primary care during this period, rather than reflecting an actual reduction in need

- The number of people in contact with mental health services in Somerset is slightly higher (2332 per 100,000) than the England rate (2176)

- Somerset Mental Health Services are performing well in terms of patients with a diagnosis recorded, 25.6% compared to the England average of 17.8%

- The number of people with mental illness in residential nursing care in Somerset is lower at 17.8% compared to England (32.7%) or Somerset's Office of National Statistics (ONS) cluster group (26.4%)

- Detentions in Somerset under the mental health act are broadly similar to the all England rate of 12% per 100,000

- The percentage of people with mental illness or disability in settled accommodation at 57.4% is less good than for England as a whole (66.8%)

3.2   The mental health needs of children and young people

Mental health is strongly linked to positive child development and there are strong links between mental health problems in children and young people and social disadvantage. Children and young people in the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes.

In line with the South West, in Somerset around 24% of children and young people aged under 18 experience some form of emotional or mental health problem. Out of a population of 109,300 this equates to 26,190 children. Of these, a light touch response would be appropriate for 15%, a slightly higher level of response for 7%, with around1.85% requiring specialist intervention and 0.08% requiring highly specialist treatment, including inpatient facilities[9].

The mental wellbeing of children is dependent on the mental wellbeing of their parents or carers. Poor parental mental health increases the risk that children will develop emotional or behavioural disorders. Research has shown that by the age of 20 the children of parents with affective disorders have a 40% chance of experiencing a depressive episode[10]. Parental mental illness is associated with increased rates of mental health problems in children and young people, with an estimated one-third to two-thirds of children and young people whose parents have a mental health problem experiencing difficulties themselves.

3.3   The mental health needs of older adults

The number of older people over 65 years in Somerset is projected to increase by 63% in the next 20 years. This is likely to give rise to an increase in the number of older people experiencing social isolation and to related mental health needs including depression and functional memory problems. It will also put significant pressure on dementia services. Mental health problems have been found to be present in: [11]

- 40% of older people who attend their GP

- 50% of older adult patients in inpatient facilities in general hospitals

- 60% of residents of care homes

Depression in older people is common and often unrecognised[12]. Building connected communities, encouraging participation, supporting active ageing programmes, addressing sensory deficits and poverty reduction initiatives will all make a difference.   Older people should not be excluded from mainstream mental health services on the basis of age. Mainstream mental health services include services such as social prescribing, talking therapies, alcohol services and community mental health services and crisis teams.

3.4   The mental health needs of military veterans

Somerset has a long and proud association with the military, hosting a number of garrison towns and other significant military bases. While it is not possible to know with accuracy the number of veterans living in the area, information from the 2011 census suggests that 6,685 veterans are receiving pensions in Somerset. However this is considered a significant underestimate. In addition the use of reservist forces is increasing, extending the number of individuals who will experience armed combat and who will face the adjustment back to civilian life. Around 8% of military veterans are estimated to have a mental health condition. Of those veterans with mental health disorders around 5% may have Post Traumatic Stress Disorder, 13.5% a common mental health disorder (or neurosis) and 18% alcohol related problems[13].

3.5   Learning disability and mental health

The risk of mental ill health is greater among people with learning disabilities than among the general population and approximately 40% of young people with learning difficulties are likely to develop a mental health need[14]. It is important for the mental

health of people with learning disability that they are enabled to live independent, meaningful lives.

The prevalence of mental health problems among people with learning disabilities is considerably higher than the general population[15] and in addition to mental illness, people with learning disabilities can have co-existing autistic spectrum disorders, behaviours that challenge services, offending behaviour or physical health conditions. Somerset's demographic data[16] estimates that there are currently 1,600 people aged 18 years and over with a moderate to severe learning disability. Of these, 446 people aged between 18-64 years are estimated to have a severe learning disability.

Over the next five years the number of people with a learning disability living in Somerset is projected to increase by 4.15% for all age groups and by 15.74% for those aged 65 and over[17]. The increase in those aged over 65 is particularly significant, as not only are people in this group likely to have parent carers who have died or are themselves increasingly frail, they are also likely to have co-morbidity alongside their learning disability or other conditions associated with old age, including dementia.

3.6   Autism spectrum disorder and mental health

People on the autistic spectrum have specific difficulties in understanding the communication and language of others[18]. They also have difficulty in communicating themselves and in understanding the social behaviour of others and as a consequence can behave in socially inappropriate ways. Autism spectrum disorders (ASDs) are thought to affect around one in 200 children and adults, although this is likely to be an under-estimate. A Somerset Autism Strategy will be published in the autumn of 2014 in response to the Autism Act (2009)[19].

Autism is not a mental health condition; however, particular aspects of autism can place stress on families who may benefit from mental or emotional health support. Due to the complexity of the condition, diagnosis and treatment for mental health conditions for people with autism spectrum disorder is a highly specialised and largely under-developed area.

People with autism or Asperger's Syndrome are particularly vulnerable to mental health problems, such as anxiety and depression, especially in late adolescence and early adult life. Some studies have found that as many as 65% of patients with Asperger's Syndrome also presented with symptoms of psychiatric disorder.

3.7   Mental health and other health risks

People with mental health problems have higher levels of alcohol misuse and obesity than the population as a whole and do less physical activity. Approximately 42% of all tobacco smoked is by people with mental health problems. Smoking is responsible for a large proportion of the excess mortality of people with mental illness. These difficulties are frequently exacerbated by poverty, poor social networks and difficulties accessing housing, employment, education and other opportunities. These issues are, of course, heightened by the stigma and discrimination still experienced by people living with mental health problems[20].

Poor mental health, including anxiety and depression, is linked to risk behaviours and negative coping strategies, including smoking, alcohol and drug misuse, higher-risk sexual behaviour, lack of exercise, unhealthy eating and obesity. Alcohol misuse and harmful drinking are of growing concern nationally, with hospital admissions for alcohol-attributable conditions in Somerset being higher than the England average[21].

3.8   Domestic abuse and sexual violence

A quarter of women will experience domestic abuse in their lifetime[22] and research suggests between 35 - 75% of abused women experience depression or anxiety disorders[23]. Estimates suggest that 50-60% of women within mental health services have experienced domestic violence and that 70% of female psychiatric inpatients and 80% of those in secure settings have histories of physical or sexual abuse[24].

3.9   Self-harm

Emergency admissions for self-harm are higher for Somerset (252.2 per 100,000) compared to the average for all England (191 per 100,000)[25]. Self-harm is an issue of growing concern nationally, with rates increasing across the UK. Self-harm is one of the most common reasons for emergency hospital admissions in England. Admissions for self-harm represent only a small proportion of self-harming behaviour, the majority of which does not result in hospital attendance.

The latest Child Health Profile[26] indicates that the directly standardised admission rate for self-harm for children and young people aged 10-24 years in the 2010/11-2012/13 period in Somerset is higher than the England average. However, it is important to note that in line with The National Institute for Health and Care Excellence (NICE) guidance, Somerset hospitals admit all young people who present to Accident and Emergency with self-harm to enable a full assessment and appropriate treatment. This may not be the case in other areas and may explain why we appear to have higher admission rates for self-harm. The Somerset Children's Safeguarding Board has highlighted this as an area which requires further work.

3.10   Suicide

The suicide rate for Somerset is 8.8 per 100,000 which is not significantly different to the whole of England[27]. On average, men are three times more likely to end their own lives than women, with the peak relative difference occurring between ages 30 – 39 years. There is also a steep socio-economic gradient in male suicide, with men from the most deprived population groups more than twice as likely to take their own lives as men in the least deprived areas. Men are half as likely as women to be diagnosed with depression[28].

3.11   Substance misuse and mental health

The majority of injecting drug users are men (70% men versus 30% women) and 'problem' drinking is higher among men than women. Problem drinking is heavily associated with mental illness (from anxiety and depression through to schizophrenia) and personality difficulties. Heavy drinkers are more than twice as likely to commit suicide as non-drinkers. Between 16% and 45% of suicides are

thought to be linked to alcohol and 50% of those 'presenting with self-harm' are regular excessive drinkers[29].

3.12   Criminal justice and mental health

Approximately 70% of prisoners have a psychosis, a neurosis, a personality disorder or a substance misuse problem[30]. In addition, there are specific concerns about certain groups such as women, people from black and minority ethnic communities and young offenders. The proportion of women in prison has increased dramatically over the last ten years and black and minority ethnic communities are over represented in the criminal justice system. The rate of self-harm and suicide amongst women in the criminal justice system greatly exceeds that of the general population.

The inter-relatedness of domestic violence, harmful drinking, substance misuse and criminal justice present both opportunities and challenges in addressing some of the most complex needs.

3.13   Mental health and homelessness

Rates of self-harm amongst homeless people are estimated to be more than three times as high as the general population and rates of depression and/or anxiety around five times as high[31]. Mental health problems can also lead to homelessness and is often given as a reason for loss of tenancy. Conversely housing problems are often given as reasons for people being admitted or re-admitted to inpatient care. It is important that mental health staff are aware of housing issues and for housing sector staff to be aware of mental health issues so that individuals can be offered appropriate support.

4. DISCRIMINATION, EXCLUSION, DISABILTY AND MENTAL HEALTH

4.1 Race equality and mental health

Black Caribbean, Black African and other Black groups are less likely to be referred by GPs and are over 40% more likely than the general population to be referred to mental health services through the criminal justice system[32][33]. These inequalities are likely to be due to discrimination and socio-demographic deprivation. National and local evidence draws attention to the importance of culturally appropriate, responsive services. In Somerset, where communities are in the minority (2%), care needs to be taken to ensure that services are culturally aware and early help is available to all.

4.2 Sexual orientation and gender identity

Estimates of the proportion of the population who are lesbian, gay or bisexual vary but are generally thought to be around 4%[34]. This is likely to be an underestimate due to the discrimination which people experience because of their sexual orientation. This creates a barrier to receiving appropriate care and treatment and can impact profoundly on mental and emotional health, including risk from self-harm, particularly among young people who are coming to terms with their identity or those from communities or families where there will be rejection or censure.

4.3 Deafness and mental health

Approximately 1 in 1000 children is born with severe or profound hearing loss[35][36]. Profoundly deaf people are disproportionately represented in specialist mental health services, largely as a direct consequence of the language exclusion which acts as a barrier to accessing general health information and primary care services as well as broader support for families in relation to child and family development. Addressing these barriers will support the positive mental health of deaf people.

4.4 Disability and mental health

At the 2011 census just under 18.8% of the population said that they had a long term, limiting condition. Disabled people have higher levels of depression than the general population[37]. This is linked both to the social challenges which disability brings, such as maintaining employment and managing daily life, as well as the particular challenges from the condition or impairment, which may include chronic pain, discomfort or medication. The emotional and mental health needs of disabled people can often be overlooked.

An NHS Confederation paper, "*Equally accessible? Making mental health services more accessible for learning disabled or autistic people*" (2012)[38], identified that people with learning disabilities or autism receive variable treatment across England. It is a statutory requirement under the *Equality Act (2010)*[39] and the *Health and Social Care Act (2014)*[40] that public sector agencies make "reasonable adjustments" to their practice to make them accessible and effective for all, including people with autism, learning disabilities and mental health issues.

5. TACKLING STIGMA

People with mental health problems have worse life chances than other people. Part of this is the direct effect of the condition, but a very large part is due to stigma and discrimination, driven by ignorance and fear and some people's negative attitudes. Stigma can exclude people from day-to-day activities, stop people getting and keeping jobs, prevent people seeking help, have a negative impact on physical health, delay treatment and impair recovery.

No Health without Mental Health Strategy (2011) [41] includes as objective six that 'Fewer people will experience stigma and discrimination'. It is also included in the twenty six priorities outlined in the Department of Health document - '*Closing the Gap - priorities for essential change in mental health*'[42].

The Stigma Shout survey[43] undertaken by the national campaign, *'Time to Change'* showed that almost nine out of ten people with mental health problems (87%) reported the negative impact of stigma and discrimination on their lives. The research also showed that the way family, friends, neighbours and colleagues behave can have a big impact on the lives of people with mental health problems.

There is no doubt that attitudes have improved in recent decades but stigma and discrimination against people with mental health problems remain a significant factor in determining their social status, employment opportunities, their physical health, their chances of leading independent, fulfilling lives and making the best recovery possible from their mental health problems.

Stigma can also affect the attitudes and behaviours of clinicians, including mental health clinicians, primary care staff and commissioners.

'Time to Change' [44] is England's most ambitious programme to end discrimination faced by people who experience mental health problems. Locally, organisations have started to sign up to the *'Time to Change'* pledge and have been setting up events to improve public understanding of mental health such as touring roadshows, attending Fresher's Fairs and putting on exhibitions to share life stories.

People with a lived experience of mental health problems, often working through voluntary and community organisations, can be powerful agents and advocates for changing attitudes and beliefs[45]. A local example is the 'Brolly Project' which has been set up by Mind in Taunton and West Somerset through a grant from '*Time To Change*'.

Employers, including health and care employers, can lead from the front by implementing training and awareness raising initiatives. Employers can also sign up and become a 'Mindful Employer'[46]. Commissioners can evaluate the anti-discriminatory policies of potential providers of services when they bid for contracts.

6. POLICY AND PLANNING FOR POSITIVE MENTAL HEALTH

Decisions about housing, planning, transport, leisure and green spaces and other community services all directly affect mental health and wellbeing [47]. Actions to promote mental health will have tangible benefits across all sectors in the form of reduced health risk behaviours and health care use, improved resilience to a broad range of adversity, improved educational achievements and outcomes, reduced sickness absence and decreases in anti-social behaviour.

Some of the broad social factors which shape positive mental health and wellbeing include having a home which meets good housing standards, feeling safe and being free from harm, having a secure income, having access to green space and walkable neighbourhoods, feeling connected to others and feeling part of wider society[48].

Investing in workplace mental health has been shown to produce considerable return on investment in terms of reduced sickness absence and improved productivity[49].

Local authorities and other public bodies can assess how their strategies, commissioning decisions and directly provided services support and improve mental health and wellbeing. Greater understanding of the wide range of factors that influence mental health and mental illness highlights the need for social solutions that cannot be tackled by individuals alone.

Mental Wellbeing Impact Assessment[50] is a new methodology which can be incorporated into Health, Environmental and Equality Impact Assessments to identify the impacts of public policy and planning proposals on mental health.

Focusing on the social determinants of health and the environment in which communities live, will deliver a good return on investment. As we begin to achieve economic recovery we have to ensure that we also strengthen the assets and capabilities of our communities. Policy and planning action which will support positive mental health in Somerset includes:

- Affordable, good quality homes for all

- Addressing poverty, particularly child poverty and financial exclusion

- Ensure equitable access to education and training

- Address the impacts of mental health and wellbeing within the workplace

- Support active travel, walking, cycling and public transport

- Value and protect green spaces and ensure equity of access

- Reduce isolation through a focus on transport, digital connectedness and accessible public spaces

7. RESILIENT PEOPLE AND COMMUNITIES

Wellbeing is about feeling good and functioning well.

Understanding people's wellbeing is closely linked to understanding their experiences. Experiencing a good balance of positive to negative emotions and judging that your life is going well, are key parts of feeling good.   People living with a mental illness, such as bi-polar disorder for example, can also have positive or negative wellbeing.

Undertaking activities which allow you to experience a sense of meaning and purpose, a sense of control over your own life and strong relationships with others, are key parts of good functioning. People have high wellbeing when they feel good and function well in the world.

There is now substantial research which points to the factors which promote wellbeing. Some of these are external to a person; for example, not living in poverty, employment status and the strength of the social networks around you. Others are within the person; for example, optimism, sense of self-esteem and resilience. Resilience is the capacity of people to confront and cope with life's challenges; to maintain their wellbeing in the face of adversity. Activities that promote wellbeing have a profound effect on helping people to be resilient[51][52].

People who report higher levels of wellbeing tend to be more involved in social and civic life[53], are more likely to behave in environmentally responsible ways[54], have better family and social relationships at home[55] and are more productive at work[56]. A recent review of evidence found that wellbeing is positively associated with other positive health outcomes such as reduced smoking and less harmful levels of drinking[57].

Increasingly positive mental states actually *precede* and help to *cause* good outcomes in health and wellbeing. For instance, longitudinal studies of wellbeing have shown that the prevalence of good moods predicts working days lost through illness five years later[58], likelihood of stroke six years later and of cardiovascular disease ten years later[59].

The benefits of promoting wellbeing can be felt across generations and accrue over many years[60].

The *Five Ways to Wellbeing*[61] were developed by the New Economics Foundation from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing. The Five Ways to Wellbeing are a set of evidence-based actions which promote a practical way to help people feel good about themselves and function well in the world. These are:

Connect......Be Active......Take Notice......Keep Learning...... Give[62].

The *Five Ways to Wellbeing* have been used by health organisations, schools and community projects across the UK and around the world to help people take action to improve their wellbeing. They have been used in lots of different ways; for example, to get people to start thinking about wellbeing, develop organisational strategy, measure impact, assess need, staff development and to help people to incorporate more wellbeing-promoting activities into their lives.

Somerset Public Health have produced an application for smart phones to support the individual practice of the five ways and partners can use the five ways framework to shape services and interventions which build social relationships, facilitate social connections, support learning, encourage giving and promote active living.

To support resilient people and communities in Somerset we can usefully:

- Tackle isolation and reduce loneliness

- Work with voluntary and community groups to develop sustainable, resilient communities that are accessible to everyone

- Support activities which connect people

- Enable people to feel in control of their lives and decisions which impact on them

- Encourage activities and cultures which allow people to find meaning and purpose for their lives

- Support and promote volunteering and a culture of giving

- Help people to understand how to take care of their positive mental health

- Promote and practice the Five Ways to Wellbeing across all communities and settings. This will include providing training on mental health, wellbeing and resilience to front-line staff as well as community groups and service providers

8.   MENTAL AND PHYSICAL HEALTH – PARITY OF ESTEEM

8.1   Overview

"One quarter of all patients admitted to hospital with a physical illness also have a mental health condition that, in most cases, is not treated while the patient is in hospital." [63]

In its mandate to NHS England[64], the government has included the specific objective to "put mental health on a par with physical health and to close the gap between people with mental health problems and the population as a whole". A report by the Centre for Economic Performance's Mental Health Policy Group[65] sets out the economic case for parity of esteem.

Mental illness has the same detrimental effect on life expectancy as smoking does and a greater detrimental effect on life expectancy than obesity. Someone with long-term severe and enduring mental health problems can expect to live on average about 10 to 15 years less than someone without such problems[66].

A large part of the economic argument is based on the fact that there is a strong relationship between physical and mental illness; with about a third of people with physical illness also suffering from mental ill health. Table 1 illustrates the overall health impacts of physical and mental illness with over a third (38%) of all morbidity associated with mental ill health.

Table 1: Morbidity/Burden of Disease for Physical and Mental Illness
"How MH Loses out in the NHS" 2012

	% Morbidity	% Overall Burden of disease including premature death
Mental illness	38	23
Cardiovascular disease	6	16
Cancer	3	16
Respiratory diseases	11	8
Sense organ diseases	13	7
Digestive diseases	4	5
Musculoskeletal diseases	7	4
Accidents	3	4
Diabetes	2	2
Other	13	15
Total	100	100

Recognising that mental and emotional stress can result in physical symptoms is the first step to a holistic assessment of an individual's needs and can lead to better outcomes and greater resilience and self-reliance on the part of the patient.

However, this represents a huge change in approach and there is a need for training and awareness raising across all sectors and organisations, for both physical and mental health, including the general public and users of services.

The development of Increasing Access to Psychological Therapies (IAPT) services for people with long-term conditions is a government priority and makes sound economic sense, as the evidence suggests that individuals with such support achieve better outcomes in their physical health and use fewer NHS services in the longer term.

Only a quarter of all those with mental illness are in treatment, compared with the vast majority of those with physical conditions. More expenditure on the most common mental health disorders would almost certainly cost the NHS nothing; for instance, efficient investment in mental health services can be paid for by the resulting savings in physical healthcare and reduction in mental health inpatient stays.

Meeting the challenge of improving physical health and reducing early deaths for people with mental health problems is an essential part of achieving parity of esteem. People with mental health problems are less likely to access screening programmes for cancer and other serious illnesses. They are more likely to: suffer the effects of poor lifestyle choices, be heavy smokers and suffer the effects of drug or alcohol misuse. They are also more likely to experience unemployment, to live in poor accommodation or be homeless and to suffer the effects of social isolation.

Older people with mental health problems can often have both physical and mental co-morbidities such as depression, dementia and physical health problems, often exacerbated by social isolation. Joint working across the health and social care professions needs to become more adept at providing a seamless response to multiple needs.

> *"One quarter of all patients admitted to hospital with a physical illness also have a mental health condition that, in most cases, is not treated while the patient is in hospital."*
>
> *"Most patients who frequently attend A&E departments do so because of an untreated mental health problem."*
>
> *"Two thirds of NHS beds are occupied by older people, 60% of whom have, or will develop, a mental health disorder during their admission."*

NHS Confederation (2009), Healthy Mind, Healthy Body: How liaison psychiatry services can transform quality and productivity in acute settings

Liaison services play a key part in the management of the emotional needs of patients presenting to acute hospitals. Liaison services in Somerset are provided by Somerset Partnership NHS Foundation Trust. The service provides professional assessment and support to A&E and other departments within hospital settings, ensuring that patients with mental health needs are provided with the help they need. A comprehensive mental health liaison service has the potential to improve service user experience and care outcomes[67]; improve access to mental health care for a

population with high morbidity; reduce A&E waiting times; reduce admissions, re-admissions and lengths of stay; reduce use of acute beds by people with dementia; reduce the risk of adverse events; enhance the knowledge and skills of acute hospital staff and improve compliance with the Mental Health Act 2007[68] and the Mental Capacity Act 2005[69].

8.2 What can we do to improve the physical health of people with mental health problems?

- We can improve the screening and testing procedures for physical health problems in the population of mental health service users

- We can provide help with lifestyle changes, for example: smoking cessation and healthy diet initiatives as an integrated part of mental health services

- We can commission wellbeing initiatives targeted at the population of mental health service users

- We can integrate physical healthcare with mental health interventions whenever possible and also take every opportunity to deliver health and social care packages as part of an integrated, personalised care plan

8.3 What can we do to improve the mental health of people with physical health problems?

- We can improve access to talking therapies and other forms of psychological support for people with long-term physical health problems

- We can develop access to dedicated health psychology services for severe, acute conditions, operating within acute hospitals, community hospitals and primary care health premises

- We can improve joint working across the health and social care professions and become more adept at providing a seamless response to multiple needs

- We can improve the screening and testing procedures for physical health problems in the population of mental health service users

- We can provide help with lifestyle changes for example smoking cessation and healthy eating as an integrated part of mental health services

8.4 What can we do to make the best use of mental health liaison services?

- We can review the current liaison services provided to our acute hospitals in line with best practice guidelines, ensuring acute Trusts have a key role

- We can consider whether the services are optimal in capacity, able to respond to needs and have an appropriate skill mix of teams

9. THE MENTAL AND EMOTIONAL HEALTH OF CHILDREN, YOUNG PEOPLE AND FAMILIES

9.1 Overview

"Half of all lifetime mental health problems emerge before the age of 14" [70]

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. These costs fall to a variety of agencies (for example: education, social services and youth justice) and also include the direct costs to the family of the child's illness[71].

The mental health of our children and young people is crucial to long-term mental health. Ensuring that universal services and public policy foster and protect young people's positive mental health, that appropriate help is available in the in the early stages of emotional and mental distress and by putting in place preventative measures, support and treatment packages; we invest in the future wellbeing of society and the chances of a full and lasting individual recovery are maximised. This in turn reduces the burden on services through transition to adulthood and creates lifelong benefits for the young person, their family and for statutory health and social care services.

This strategy highlights the importance of children, young people and families in achieving positive mental health for Somerset. A dedicated work stream is already taking forward improvements in the pathway for children and young people with mental health problems, which includes commissioning developments across all tiers of provision and in services commissioned by both health and social care. The Emotional and Mental Health of Children and Young People Plan for Somerset[72] specifically addresses issues of promotion and prevention.

9.2 Perinatal mental health

Childbirth and new motherhood is associated with an expectation of happiness but it can also be a time of emotional upheaval, involving changes in lifestyle and relationships. Mental health problems at this time cause enormous distress and can interfere with the adjustment to motherhood and the care of the baby. Poorly managed, perinatal mental health problems can have lasting effects on maternal self-esteem, partner and family relationships as well as the mental health and social adjustment of the child. The roles of midwives, health visitors and children's centres are very important in supporting women during pregnancy and during the first year of the baby's life[73].

Acute serious perinatal illness often requires inpatient care. The separation of mother and infant can interfere with the early development of mother-infant attachment and relationship. Separation can also cause great maternal distress and may interfere with treatment of the mother as well as preventing breastfeeding and bonding which may have long standing effects on both child and mother. The design

and delivery of specialist services is challenging in rural areas; however, support for commissioners is available from the National Mental Health Commissioning Panel[74].

9.3　Family life and the role of universal services for children

Building good mental and emotional health is part and parcel of child development. Attachment relationships and parenting are universal experiences which can act as positive or negative factors for individual development depending upon the quality. In addition to these universal influences there are a range of other family context factors which can act as risks for development. Investments in parenting programmes and in services such as the child family nurse partnership, have been identified as effective measures in addressing the positive emotional development of children.

Universal services include schools, family health care, children's centres and leisure and recreational activities which families might access. Staff working in these services need to be trained in understanding emotional and psychological health, how best to support children and families and how to access help when needed.

9.4　Early help and support

If problems develop, it is vital that these are recognised and supported early. There is a great deal of evidence to suggest that early help prevents the onset of greater problems through not only childhood, but later life.

Get Set Early Help is a new service to support resilience, positive coping skills and promote good mental health in children and families. Get Set will strengthen preventative services, a level of targeted support beyond that provided by universal services. Primary mental health care workers provide a bridge early help / targeted support and specialist mental health service through training support and consultation and supporting referrals to specialist services when appropriate.

The most common problems in childhood are conduct disorders, attention deficit hyperactivity disorder (ADHD), emotional disorders (anxiety and depression) and autism spectrum disorders. Two reviews of Child and Adolescent Mental Health Services (CAMHS) within Somerset identified a range of improvements. These are now being implemented and overseen by a multi-agency board. Language delay is a also a very powerful marker of psychological vulnerability and an important warning sign. We also know that language delay is a potential sign of neglect. Many young children in care have such problems as a result of the abuse or neglect they have suffered and language problems are extremely common in children excluded from school.

Psychological therapy services for children and young people are a key part of central government plans for the expansion of services under the IAPT initiative and plans are well underway for the development of these services in Somerset.

9.5 Specialist mental health services

Specialist mental health services for young people are commissioned differently across the country. In Somerset, local authority services are commissioned through Children's Social Care, specialist community services are commissioned by the Somerset Clinical Commissioning Group (CCG) while in-patient care and specialist health residential placements are commissioned by NHS England. This fragmentation of commissioning responsibility can be problematic. Good communication and collaboration by commissioners across the care pathway is essential to ensuring that individual young people have their needs met. In Somerset this is achieved through a multi-agency CAMHS Commissioning Group, which oversees the separately commissioned services.

Substance misuse among young people is a pre-disposing factor for mental health problems and Somerset's substance misuse treatment service for children and young people has recently been re-commissioned, incorporating a number of service improvements. However, a greater emphasis on alcohol and substance misuse awareness will be important.

Lack of sufficient services at the targeted and early help level, coupled with the impacts of reductions in third sector services as a result of the recent budgetary pressure and the recession, has increased demand on the specialist community and in-patient services. The lack of sufficient capacity in specialist in patient services (those commissioned by NHS England) has been identified as a national issue and NHS England has plans in place to address this. Recent local innovations to manage demand include the creation of a telephone advice and guidance service for referrers and the development of a new Emotional and Mental Health of Children and Young People Plan, which will address promotion and prevention.

9.6 Gaps and pressures

More needs to be done to intervene early. This can reduce the risk of later disorder and has the potential to generate savings for services and society. Undiagnosed or untreated depression in young people creates a more treatment-resistant form of the illness.

Deliberate self-harm is an issue of increasing concern, both nationally and in Somerset. This is a complex issue which impacts on many young people and their families each day.

Current service shortfalls include specialist services for children and young people with eating disorders, support to parents and carers with mental health problems and targeted early help interventions for young people who have experienced sexual abuse but who may not meet the criteria for referral to the specialist mental health service.

The lack of specialist in-patient services across the country has the impact of children and young people either not receiving appropriate treatment or being placed many miles from home.

9.7   What can we do to support the emotional health of children and young people?

- We can involve young people and their families in the co-design, co-production and co-delivery of services to support their health and wellbeing

- We can make sure that everyone in the children and young people's workforce is well informed about emotional and mental health

- We can invest in parenting programmes which are low cost, high value interventions which can be developed and delivered in a flexible and inclusive way[75]

- We can protect children, young people and families from risks such as exposure to bullying, violence, discrimination and from the effects of harmful drinking and substance misuse

- We can invest in interventions for behaviour and for conduct disorder which have been identified as a 'best buy for mental health' with potential savings from each case through early intervention estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems[76]

10.   MENTAL HEALTH SERVICES: THE JOURNEY SO FAR

Mental health services in the UK have been transformed in recent decades from largely institution-based care; with limited outcomes for service users and significant other problems, including the stigmatising of people with mental health problems to a system where community-based care is provided as close to people's homes as possible; utilising a range of therapeutic interventions and other forms of care and support to help people recover.

We should not underestimate the gains and advances that have been made in the delivery of effective mental health services. Culturally, socially, economically and therapeutically, the lives of people with lived experience of mental health problems have been improved beyond measure by the closing of the large mental health hospitals that characterised services until the 1990s. Since that time modern, recovery-oriented services, based in the community, have developed to support people with more personalised services designed around their needs.

The *National Service Framework for Mental Health* (1999 to 2009) [77] set the standards necessary to ensure effective community services and led to the development of specific functions, such as crisis resolution and home treatment, assertive outreach and early intervention in psychosis. Community mental health teams now support thousands of people in Somerset with bespoke packages of care and treatment. Good community-based care is not necessarily cheaper than institutional care. In Somerset, there is increased demand on resources available and the focus of care provision has been mostly on those with the most complex, serious and enduring mental health needs.

It is important to recognise the significant achievements that have been made in Somerset. Services such as the Somerset Team for Early Psychosis (STEP) and the Crisis Resolution and Home Treatment Service are deservedly valued and appreciated by referrers and service users. Many other aspects of our services are first class in terms of their quality and ability to respond to their users' needs. In many services, however, capacity is an issue in the face of increasing demand. As a consequence, thresholds for accessing services are rising and complaints from people, their families and referrers are increasing.

Since 2009, the IAPT programme in Somerset has ensured that many people have access to talking therapies. People with common mental health problems, such as mild to moderate depression or anxiety, previously found it difficult to get help. The current service is treating less than 15% of those with depression and anxiety in Somerset[78]. The challenge for services is to increase the proportion of people accessing help. In secondary care, mental health criteria for referral are still relatively high, leaving many people for whom the only option is to seek support from their GP.

11. COMMISSIONING FOR QUALITY AND BEST OUTCOMES

11.1 Commissioning mental health services in Somerset

Mental health and related social care services within Somerset are commissioned by a range of agencies including Somerset CCG, NHS England and Somerset County Council. The majority of services are commissioned from our main mental health provider, Somerset Partnership NHS Foundation Trust, along with some voluntary and community service providers.

A joint commissioning approach across health and social care, with aligned resources mobilised through a single health and social care commissioning team with links both into the CCG and SCC, will be the most effective means of securing high quality mental health services for our population.

Integrated working can offer the opportunity for health and social care to operate equally, breaking down traditional barriers and creating seamless services. In particular, it provides the chance for the role of social care to be enhanced and recognised as a key contributor to the planning and delivery of services. Additionally the role of the third sector as an increasingly important partner in the planning and delivery of services creates a powerful triumvirate for local health and social care economies. The National Voices Narrative for Person-Centred Co-ordinated ('Integrated') Care[79] defines the service user vision for integrated care.

11.2 Commissioning across the life course for mental health and wellbeing

In line with the overarching Health and Wellbeing Strategy, this strategy takes a life course approach, committed to improving outcomes for people with, or at risk of, mental health problems, whatever their age. It means understanding the impact of poor mental health and wellbeing from birth, through childhood, into adulthood and older age. It also means recognising the determinants of poor mental health and wellbeing, taking steps to address them and ensuring the provision of high quality services for people, based on need rather than age, across the span of their lives.

For Somerset, with an aging population, investing in the wellbeing of older people is a high priority which will help maintain healthy, independent living.

The most important action that we can take for the future, to secure better outcomes for the people and communities who live in Somerset, is to support children and young people, their parents, families and communities to develop the building blocks of good mental health through increasing resilience, laying the foundations of good mental health for later life.

11.3   Commissioning for parity of esteem

The relationship between physical and mental health is more fully described elsewhere in this document. For commissioners, the task is twofold. Firstly, to ensure that the physical health needs of people with mental health problems are identified and the gap which exists in terms of healthy life expectancy is reduced. Secondly, to ensure that the emotional, psychological and mental health needs of people with physical health problems are addressed.

11.4   Commissioning for person-centred services

Local authorities have, over the past few years, been working towards personalisation of services for all users of adult social care services[80]. Take up of personal budgets as an aspect of personalisation, however, has traditionally been low amongst mental health service users.

The Care Act 2014[81] proposes a single legislative framework for adult social care, replacing the current complex framework of adult social care law. The Act confirms a statutory duty on local authorities to promote mental health and emotional wellbeing, embeds the promotion of individual wellbeing as the driving force underpinning the provision of care and support. It places population-level duties on local authorities to provide information and advice, prevention services and shape the market for care and support services. These will be supported by duties to promote co-operation and integration to improve the way organisations work together. The Act also sets out in law that everyone, including carers, should have a personal budget as part of their care and support plan and gives people the right to ask for this to be made as a direct payment. It also includes the statutory right for advocacy services in specific circumstances.

More generally, NHS England and CCGs have a statutory duty to work with local authorities to promote integrated health and social care, making person-centred co-ordinated health and social care the norm for people with multiple health problems, including mental health problems, to ensure seamless support for people outside of hospital. The creation of the '*Better Care Fund*'[82], a fund to promote integrated care that is overseen by Health and Wellbeing Boards, is intended to support the delivery of this vision.

11.5   Patient engagement, participation and co- production

Co-production with people who have, or who have had, mental health problems is a crucial aspect of designing and delivering services. Mechanisms for engaging with people with existing services were strengthened through the Somerset Partnership NHS Foundation Trust. Users and carers are able to participate as members of the Trust and be represented at board level. The Trust also participates in specific initiatives such as the '*Acute Care Declaration*[83]' and the '*Triangle of Care*[84]' which facilitate a voice for service users in the delivery and improvement of services. Similarly, the creation of patient experience groups in GP practices has added to the opportunities for service users to have their say.

There remains, however, a need for a formal local network where people with a lived experience of mental health can contribute to the development and co-production of

future service provision. Since the Somerset Local Involvement Team (Mental Health LIT) was discontinued, there has been a gap in this kind of participation and engagement. The South West Mental Health Alliance [85] has strong service user, lived experience and community sector representation which is a valuable resource for us in Somerset.

There is also an opportunity for Healthwatch Somerset to take a lead role in gathering and representing the views of people with mental health issues. The new organisation came into being on 1 April 2013, replacing and building upon the work of the Somerset Local Improvement Network (LINk). Healthwatch Somerset will champion the views and priorities of the public across health and social care services, paying particular attention to the needs of those facing the widest inequalities. To achieve this, it will work closely with the existing local infrastructure and patient and public participation groups.

11.6   Commissioning for recovery and social inclusion

Recovery emphasises the importance of a meaningful, valued and satisfying life, whether in the presence or absence of symptoms. There is a strong link between the recovery process and social inclusion. A key role for services is to support people to regain their place in the communities where they live and take part in mainstream activities and opportunities along with everyone else.

Important factors on the road to recovery include good relationships, financial security, satisfying work, personal growth and the right living environment, developing one's own cultural or spiritual perspectives and developing resilience to possible adversity or stress in the future. There is a growing body of evidence that demonstrates that taking part in social, educational, training, volunteering and employment opportunities can support the process of individual recovery.

Of particular importance is the need to work in partnership with housing and the voluntary sector to ensure that no resident of Somerset is homeless because of their mental health problems.

11.7   Accommodation and housing as an essential part of recovery

A settled home is vital for good mental health. People with mental health problems are less likely to be homeowners and more likely to live in an unstable environment. We also know that support with housing can improve the health of individuals and help reduce overall demand for health and social care services. Ensuring service users have a suitable and settled place to live can aid recovery from mental health problems, without a settled place to live, recovery can be significantly impeded. '*No Health without Mental Health 2014*' [86] (the cross-government mental health outcomes strategy 2014) stresses the importance of housing for mental health.

Addressing housing need within the care pathway can contribute to meeting some of the overarching issues facing the NHS and local authorities in relation to avoidable admission to inpatient care and timely discharge. By working in partnership, mental health providers and housing associations can deliver better outcomes for service users. To achieve this we need to work with district council colleagues and other key

stakeholders to develop a range of accommodation options and floating support for people with mental health problems.

11.8   Commissioning for quality care and support in mental health services

Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment and should ensure that people's human rights are protected to provide the best possible outcomes, as well as making the best use of resources. It is essential that people receive the interventions they require early and at an appropriate level.

The *Final Report of the Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust (the Francis Report)*[87]*,* examined the high mortality rate and poor patient and carer experience at Mid-Staffordshire Foundation Trust between 2005-2008. *The Winterbourne View Report*[88] followed a Panorama programme which exposed the abuse of people with learning disabilities at a private hospital. The findings of these two significant reports have helped to stimulate a renewed focus on care quality. There is an increasing requirement that both commissioners and providers ensure that patients and service users are at the heart of everything that they do. Furthermore, the *Keogh Review*[89] and the *Berwick Report*[90] make clear recommendations for developing the learning culture of the NHS as part of an overall approach to quality.

It is important that a range of advocacy services are in place to support individuals and families to raise issues about the services they are receiving or trying to access.

11.9   The vital role of families and carers

Carers play a vital role in the lives of many people with a mental health problem. Up to 1.5 million people in the UK care for someone with a mental health problem[91].

Being a carer is a risk factor for mental health problems:

- 40% of carers experience psychological distress or depression, with those caring for people with behavioural problems experiencing the highest levels of distress

- 33% of those providing more than 50 hours of care a week report depression and disturbed sleep

- Those providing more than 20 hours of care a week over an extended period have double the risk of psychological distress compared to non-carers. Risk increases progressively as the time spent caring each week increases

- Caring can also limit carers' ability to take time out to exercise. Reduced income and lack of cooking skills may contribute to excess weight gain or loss. As many as 20% of adult carers increase their alcohol consumption as a coping strategy

- Emotional impacts such as worry, depression and self-harm have been identified in young carers

The *Carers and Disabled Children's Act (2000*) [92] states that all carers aged 16 or above, who provide a 'regular and substantial amount of care' for someone aged 18 or over, have the right to an assessment of their needs as a carer. These rights will be extended in *The Care Act (2014)* [93].

11.10 Developing the market for the provision of high quality services

The new NHS Procurement Patient Choice and Competition Regulations place requirements on commissioners to improve the quality and efficiency of services by procuring from the providers most capable of meeting that objective and delivering best value for money. *The Care Act (2014)* [94] also places a duty on local authorities to develop the market to offer flexible, personalised services and choice.

11.11 What can we do to ensure quality mental health services?

- We can develop joint commissioning arrangements and take a life course approach to commissioning

- We can ensure that service users and their families are at the heart of everything we do

- We can improve information and training for carers

- We can ensure the delivery of the Young Carers Plan, which includes young carers of people with mental health problems

- We can work with district council colleagues and other key stakeholders to develop a range of accommodation options

- We can use our purchasing power to stimulate the local economy and maximise employment opportunities for local people, taking into account the provisions of the Public Services Social Value Act (2012) [95]

- We can, wherever possible, encourage local, smaller providers in complex procurements to ensure they are not disadvantaged

- We can work with our providers to achieve a balance of value for money and risk that is sustainable for the provider as well as the commissioner

12.   RIGHT SERVICE, RIGHT TIME, RIGHT PLACE

12.1   Overview

Guidance for commissioners is available from a number of sources. At a national level the Joint Commissioning Panel for Mental Health has produced range of guidance, including commissioning models and calculators to support the design and delivery of high quality evidence based service[96]. NICE[97] provides up to date clinical guidance, recommendations and evidence reviews to support quality and safety in care design and delivery. At a more local level, the South West Clinical Network for Mental Health, Dementia and Neurological Conditions[98], supported by the South West Mental Health Alliance[99] , a network of service users, carers and champions, provides local intelligence to support quality, innovation and recovery.

Evidence from research and from service user feedback suggests that people benefit from a menu of services, enabling them to step up or step down between services to receive the right care at the right time.

It is recognised that the use of diagnostic labels to describe mental health conditions is not always helpful, as mental and emotional health problems do not always fit neatly into diagnostic 'boxes'. However, a useful distinction, in terms of service planning, is to look at 'common mental health disorders' (CMDs) and other mental health conditions.

Common mental health disorders include issues such as anxiety, depression, panic and phobia; and can be episodic, long term and of varied severity. Other mental health conditions include psychosis and personality disorder; these conditions tend to be long-term or recur over a period of years. Different services and treatments are required and recommended for the different sorts of conditions, with early help at the appropriate level being the optimum.

The last few decades have seen some significant changes in the way that services are delivered. There is now a greater emphasis on a personalised and service user focused approach to service provision, less reliance on a traditional medical model of care and a recognition that services need a recovery focus.

In meeting the significant demographic and financial challenges predicted for the future, we need to maintain a focus on a transformative approach to the development of mental health services. The principles include; personalised services, offering real choice for service users, involving people in the planning and delivery of their care, integrating our interventions across health, care and education, maintaining a focus on quality and outcomes and shifting our attention more towards early intervention, prevention and the strengthening of personal and community resilience.

12.2   Accessing mental health services

Over time we should expect to see less reliance on hospital-based care as alternatives to in-patient services are developed. A renewed focus on providing support, care and treatment as close to people's homes as possible can be facilitated by re-thinking the delivery mechanisms for services; utilising new technology and 'meeting people where they are', both in terms of their physical location and in their cultural and social circumstances. Innovation and flexibility in the provision of services needs to be stepped up to meet the increases in demand we expect to see in the coming years.

Treatments for common mental health problems include self-help, GP managed support and talking therapies. The development and improvement of access to talking therapies since 2009 has begun to address significant levels of unmet needs for people with common mental health problems, such as depression and anxiety.

Primary care liaison is an under-developed aspect of mental health provision in Somerset. Patients being supported by GPs for physical illnesses often have co-morbid mental health problems; Equally, GPs support many people whose primary problem is a common mental health disorder.

The traditional model of referral from primary care to specialist secondary care mental health services is appropriate for patients with potentially severe or enduring mental health diagnoses. Equally, referral to IAPT services for talking therapy is a useful recent addition to pathways for people with less severe or enduring problems.

There remains, however, a need for people to have better access to self-help and social support and to be supported by GPs when a referral is not the appropriate course of action. Patients may need the support of their GP for low level or intermittent mental health problems; in those situations when they are reluctant to be referred or for maintaining their mental wellbeing after discharge from specialist services.

12.3   What can we do to improve access to services?

- We can develop self-care and self-management resources for mental health

- We can improve mental health support within primary care to ensure that people can be effectively supported by primary care staff where this is appropriate and ensure that specialist secondary mental health services are targeted appropriately

- We can develop personal budgets and direct payments for mental health services

- We can consider social interventions and services, alongside psychological and medical treatments

- We can commission services that allow for seamless transition from CAMHS to adult mental health services. This applies in particular to areas of self-harm, eating disorders, ADHD and substance misuse.

12.4 Talking therapies services

Treatments for common mental health problems include self-help, GP managed support and talking therapies. The development and improvement of access to talking therapies since 2009 has begun to address significant levels of unmet needs for people with common mental health problems such as depression and anxiety. More needs to be done to expand capacity for the adult population and to widen availability to children and young people. This will prevent mental health problems in young people from becoming entrenched and extending into adulthood. The government-sponsored IAPT programme has started to make progress in treating many more people than would ever have been possible before its inception.

In Somerset we are on course to treat 15% of known need by March 2015 (for adults), the government target. The IAPT programme has begun a process of expansion of talking therapy provision. It is for local commissioners to pick up the challenge of further expansion of talking therapies and to make sure the benefits of the service are available to all who need them, including children, young people and older people. The benefits of talking therapies are not limited to those with mental health disorders. There is significant evidence that providing psychological support to people with acute or long-term physical health conditions can improve their outcomes and reduce the need for physical health interventions.

The development of IAPT services for people with long-term conditions is a government priority. Evidence suggests that individuals with such support achieve better outcomes in their physical health and consume less NHS services in the longer term. Another government requirement is to focus on medically unexplained symptoms, based on evidence that providing psychological therapy for individuals with unexplained physical symptoms can reduce or eliminate their symptoms and reduce their requests for further interventions or diagnostic tests. We have made a good start in meeting unmet need in the Somerset population but there is much more that can be done. Over 65s are under-represented in the referred population for IAPT services but are often living with ageing-related diseases which they could self-manage more successfully with psychological help. Overall targeted investment, based on savings generated elsewhere in the health economy, will improve overall levels of health and wellbeing and will pay for itself in the medium to long term.

12.5 What can we do to improve outcomes through talking therapies?

- We can expand access to talking therapies and other forms of psychological support for people with long-term physical health problems and serious acute illnesses. This will require dedicated health psychology services, operating within acute hospitals, community hospitals and primary care health premises

- We can introduce IAPT services for people with symptoms which cannot be explained medically

- We can expand the capacity of primary care talking therapies for anxiety, depression, phobias and other common mental health problems

- We can extend talking therapy services for young people

- We can make a concerted effort to ensure that older people access psychological help when they need it

12.6   Mental health liaison with primary care

The traditional model of referral from primary care to specialist secondary care mental health services for assessment and treatment is appropriate for patients with potentially severe or enduring mental health diagnoses. Equally, referral to IAPT services for assessment and talking therapy is a useful recent addition to treatment pathways for some conditions.

Patients will continue to be supported by their GP for low level or intermittent mental health problems, in those situations when they are reluctant to be referred or for maintaining their mental wellbeing after discharge from specialist services. Shared responsibility for patient care, where the GP and specialist mental health services collaborate to provide care, can be very effective. The flexibility to step up or step down between services is facilitated by good communication and liaison between their GP and mental health professionals.

12.7   What we do to improve primary care mental health liaison?

- We can review the current liaison function with primary care and consider future commissioning arrangements

- We can work with GPs to better understand their need for specialist mental health advice and support in managing patients

12.8   Mental health crisis services

The publication of the Mental Health Crisis Care Concordat[100] in February 2014 brings a fresh approach to multi-agency working to improve care, support and outcomes for people in crisis. The challenge to local areas is to produce a local declaration by health, social care and criminal justice agencies, committing them to work together to prevent crises happening whenever possible, through intervention at an early stage by providing appropriate urgent and emergency access to crisis care in an appropriate setting. Where necessary this should include a designated place of safety, compliant with the requirements of the Mental Health Act; high quality treatment and care from professionals with the right skills who focus on recovery; provision of support for people to speak for themselves and be involved in their own care and treatment; supporting and helping people to stay well and preventing future crises by providing information, signposting and referral to services that will support recovery.

12.9 What can we do to improve mental health crisis services?

- We can undertake an audit of our crisis pathway against the Crisis Concordat and take appropriate action

- We can develop alternatives to admission for acute care including 24/7 intensive supported housing and crisis beds

12.10 Services for people living with dementia

Within Somerset, it is currently estimated that there are 8,720 people with dementia of whom approximately 150 are aged under-65. Both the number and proportion of people aged over 65 with dementia is set to increase. By 2021 the expectation is that there will be almost 11,400 people with the condition[101].

The *National Dementia Strategy*, *Living Well with Dementia*[102] identified 17 key objectives which, when implemented, will result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia.

The National Dementia Strategy and the *Somerset Dementia Strategy* [103]provide detailed plans for addressing the challenges posed by the predicted increase in dementia cases in coming years. Somerset's Dementia Strategy has been in place for more than two years and the implementation of its action plan is making steady progress in improving the response of the health and social care community. Recently refreshed, the Somerset strategy focuses on raising awareness and understanding of dementia within the general public, ensuring early diagnosis, support and intervention for people with dementia and their carers, providing a higher quality of care to enable people to live well with dementia and support and training to professionals engaged in the provision of services to people with dementia.

Somerset has made a good start in improving the diagnosis, treatment and on-going support opportunities for people with dementia. In addition to the plan set out in our local strategy we continue to take advantage of opportunities such as the Prime Minister's 'Dementia Challenge' to innovate and commission new aspects of support, such as the employment of dementia support workers and the facilitation of befriending schemes. A growing network of 'memory cafes' and 'singing for the brain' groups complement health and social care provision and help to achieve the overall aim of promoting wellbeing and independence.

Somerset was recently successful in obtaining funding for a dementia friendly community. The vision is for people with dementia and their carers to live within an environment which is dementia friendly. The community will take into account their needs, access to local services and facilities and how these will best support them. The project initially focuses on one locality which is within the Chard, Crewkerne and Ilminster GP Federation. This involves developing local networks to improve awareness of dementia; implementing a befriending scheme which offers a vital lifeline and opportunities for people to continue to engage in local activities with trusted support; building on existing training programmes so that people receive

personalised care, enabling them to make positive choices and improving the hospital experience for people with dementia and their carers

12.11   What can we do to improve services for people living with dementia?

- We can work together across organisational boundaries to improve outcomes for all those affected. Commissioners in both health and social care have a particular part to play in meeting the challenge

- We can ensure that the quality and capacity of memory assessment services is able to meet the scale of expected referrals and to enable early diagnosis

- NHS services can adjust their services to meet the needs of people with dementia

- Social care can ensure that residential and nursing care providers deliver the best evidence-based care and that they are properly supported to do so with specialist input when necessary

- The independent and voluntary sectors also have their part to play, either as providers of services or in facilitating the voice of service users and carers to be heard by those planning and delivering services

12.12 Learning disability and mental health services

The NHS Concordat advises that CCGs should work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. As a first principle, services should be available locally so that people remain in their communities and there should not be a reliance on in-patient care. To facilitate this, reasonable adjustments should be put in place to enable access to all mainstream services where appropriate and learning disability services should be provided alongside mainstream mental health services, so the skills and expertise from both can be utilised in order to respond to individual need[104].

There should be clarity with regard to commissioning arrangements between learning disability and mental health commissioners, with a presumption of accessing generic services wherever possible. There should also be protocols setting out clear pathways between mainstream and specialist services.

In addition, the *Health Inequalities & People with Learning Disabilities in the UK Report*[105] states that a number of syndromes associated with learning disabilities are also associated with specific health issues. Mental health problems and challenging behaviours are more prevalent among people with: autism spectrum disorders, Rett syndrome, Cornelia de Lange syndrome, Riley-Day syndrome, Fragile-X syndrome, Prader-Willi syndrome, Velocardiofacial syndrome, Williams syndrome, Lesch-Nyhan syndrome, Cri du Chat syndrome and Smith-Magenis syndrome.

The Royal College of Psychiatrists' report, *"Enabling people with mild intellectual disability and mental health problems to access healthcare services"* (2012)[106], was

aimed at practitioners, with a view to enabling people with mild learning disability and mental health problems to access (primarily mental) healthcare services. Their conclusions suggest that people with people with mild intellectual disability, as well as those with neuro-developmental disorders and other behavioural and social difficulties, present with significant mental ill health and complex needs.

Services for adults with a learning disability have been jointly commissioned by SCC and the NHS since the early 1990s, using a pooled budget approach. Unlike other areas of adult social care, SCC still has a large in-house service that provides for all aspects of service user need and accounts for 50% of the budget. Other contracts with a wide range of external providers on a spot or block contract basis account for the rest of the service provision.

12.13 What can we do for people with a learning disability and a mental health need?

- We can respect the fact that people with learning disabilities and their families are in the best position to determine their own needs and goals and to plan for the future

- We can recognise that families, friends and personal networks are the foundations of a rich and valued life in the community and support people and families to maintain these connections and help them to flourish

- We can plan for individuals and their families to directly commission the support they receive if they wish to

- We can recognise that communities are enriched by the inclusion and participation of people with learning disabilities and these communities are the most important way of providing friendship, support and a meaningful life to people with learning disabilities, their families and carers

- We can acknowledge that the lives of people with learning disabilities are enhanced when they can determine their preferred support and services

- We can recognise that partnerships between individuals, families and carers, communities, local government, service providers and the business sector are vital in meeting the needs of people with learning disabilities. We can facilitate such partnership working in the way we commission services

- We can support people to gain the skills, development and progression in order to be as independent as possible

- We can ensure that mainstream services make reasonable adjustments such as: having clear signs in buildings, giving directions; using pictures and large print on appointment letters; making alterations to policies and procedures; training staff

12.14 Autism spectrum disorder and mental health

Autism is not a mental health condition. It is included in this strategy because of the particular aspects of autism which can place stress on families who may benefit from mental or emotional health support; but also because the complexity of the condition requires specialist and skilled intervention for mental health diagnosis and treatment. Autism spectrum disorder is thought to affect around one in two hundred children and adults, although this is likely to be an under-estimate. A Somerset Autism Strategy will be published in the autumn of 2014 in response to the Autism Act (2009)[107].

More can be done to ensure that people with autism get a good deal from mental health services and to ensure legal requirements are met. Many issues need to be resolved, such as differences in eligibility thresholds, effective health promotion, access to comprehensive assessments, data sharing, the availability of evidence regarding efficiency of particular interventions and how specialists can support mainstream services to make adjustments.

Good practice exists within Somerset and we need to share this. For instance, when Rydon Ward, an in-patient unit, was closed for a renovation, speech and language therapists from the Specialist Learning Disability nursing team advised on updated signs and communication aids in and around the ward, which now make it a fully inclusive environment for those patients with communication needs.

12.15 What can we do to improve mental health services for people with autism?

- We can use simple language

- We can learn from patient experience programmes elsewhere

- We can develop inclusive environments and provide all staff with autism awareness training

- We can be aware that some people are hypersensitive to medication, so prescriptions should begin at below average dose and increase gradually, with careful monitoring for side-effects

- We can make sure that services are person -centred and meet legislative requirements for equal access

12.16 Dual diagnosis services

Dual diagnosis is the term used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use[108]. Personality disorders may also co-exist with psychiatric illness and/or substance misuse. The term originated in the USA in the 1980s and has been adopted in the UK more recently. The nature of the relationship between the two conditions is complex and

sometimes controversial; however, the fact that they are linked is broadly accepted. Many people self-medicate with drugs or alcohol to deal with mental health problems and equally, some mental health conditions are caused at least partly by the misuse of drugs. People with dual diagnosis have complex needs relating to health, social, economic and emotional stressors or circumstances which can often be exacerbated by their substance misuse. In the UK, it is thought that the number of people with a potential dual diagnosis is high and possibly rising.

Approximately one third to a half of those with severe mental health problems will also have substance misuse problems; about half of patients in drug and alcohol services have a mental health problem, most commonly depression or personality disorder. Alcohol misuse is the most common type of substance misuse and where drug misuse occurs, it tends also to co-exist with alcohol misuse. Between 22% and 44% of adult psychiatric in-patients also have problematic drug or alcohol use, up to a half also being drug-dependent.

Protocols need to be detailed enough to remove any confusion over roles and responsibilities; clearly set out the responsibilities for funding aspects of treatment and provide a clear process for resolving any disputes, ensuring that resolution processes do not delay effective treatment for the service user.

12.17 What can we do to improve services for people with a dual diagnosis?

- We can continue to develop dual diagnosis policies and protocols and ensure contractual duty to collaborate by providers

- We can provide education and training about dual diagnosis

12.18 Criminal justice and mental health services

Around 15% of incidents that the police deal have some kind of mental health dimension[109]. Yet police officers rarely have mental health training and there are few opportunities to divert people from police stations to health and social care services. In 2009 work began in six Department of Health pilot sites to see how children and young people with mental health, learning disabilities and other difficulties such as family conflict, homelessness or drug and alcohol misuse can get the help they need as soon as they come into contact with the police. The Bradley Report[110] has called for criminal justice mental health teams to be set up across England to divert people from police stations and courts to more appropriate care.

The Mental Health Act (1983) Section 136[111] enables the police to detain people suspected of being in need of a mental health assessment when they are in a place to which the public has access. The number of such detentions has risen sharply in recent years, leading to concerns that hospital places of safety may sometimes lack the capacity to accommodate all those detained. This can mean that people are detained in a police cell rather than a hospital environment. Local work to develop a Somerset Crisis Concordat declaration will be undertaken with partner organisations,

including the police, with a view to committing all agencies to working together for the benefit of people experiencing a mental health crisis.

12.19 What can we do in Somerset for mental health and criminal justice?

- NHS England commissions the Court Liaison and Diversion Service in Somerset. It is important that the development of this service is influenced by local stakeholders, including service users, the majority of whom will also access services commissioned by the SCC and the CCG

- Local commissioners therefore need to continue to foster communication with their counterparts in NHS England, the police, the courts and the probation service to ensure that a collaborative approach guides future changes to the service

- Health and social care commissioners will need to develop collaborative agreements with the police in relation to the police powers under Section 136 of the Mental Health Act (1983)[112]

- We can will look to improve our Section 136 protocol, a joint pilot scheme providing 'street triage' by mental health staff and police officers and a commitment to provide cross-agency support between the police and mental health service providers, including the provision of training for staff on the ground

12.20 The role of employment in positive mental health and recovery

A recent comprehensive review of research into mental health and employment[113] concluded that overall, work is beneficial to health and wellbeing. Equally, lack of work is detrimental to health and wellbeing. People who are unemployed consult their GPs more often than the general population and those who have been unemployed for more than 12 weeks show between four and ten times the prevalence of depression and anxiety. Unemployment is also associated with increased rates of suicide.

For people without work, re-employment leads to improvement in health and wellbeing and further unemployment leads to deterioration. For people who are sick or disabled, placement in work improves health and psychosocial status. The health status of people of all ages who move off welfare benefits improves. These benefits apply equally to people who have mental health problems, including those with severe mental health problems.

There is no evidence that work is harmful to the mental health of people with severe mental illness. Work provides a social identity and status; social contacts and support; a means of structuring and occupying time; activity and involvement and a sense of personal achievement. The social exclusion that people can experience as a result of mental ill health is reduced by work and aggravated by unemployment. Work is therefore central to social inclusion and recovery.

12.21 What can we do to support the role of employment in positive mental health?

- We can review the current employment services, which are already seen nationally as an example of good practice, to see if further improvements can be made

- We can develop public services as exemplar employers and encourage the development of social enterprises and other service user led initiatives

13.   CONCLUSION

This strategy and the accompanying Mental Health Needs Assessment report set out the case for positive mental health for Somerset.

Public policy has a huge role to play in creating the conditions which promote good mental health in the shape of housing, employment, community safety and thriving, connected communities.

There is something for everyone to do; individuals, communities, small organisations, employers and public sector organisations can all play a part.

As individuals and communities, we can use and promote the five ways to wellbeing, which in small ways will build and sustain our own and others' mental health.

Employers can be aware of the mental and emotional impacts within the workplace, supporting people to gain and retain employment and challenging discrimination.

Quality mental health services are hugely important and need to be recovery focused, person-centred and accessible. The best services are designed by the people who use the services who should be instrumental in their design and delivery.

The next step for positive mental health in Somerset is to put this strategy into action. Throughout this document we have highlighted what could be done in Somerset. We have also included links to references and further information.

What action will you take?

14.   STRATEGIC ACTION PLAN

Strategic Action Plan for Positive Mental Health in Somerset

Area for action	Our commitment	Lead agency
Public policy and planning for positive mental health	We will provide support, advice and guidance for policy makers and planners around mental health impacts	Public Health with policy makers
Resilient people and communities	We will promote 5 ways to wellbeing	Public Health with communities and partners
	We will work with employers to support positive mental health at work	Public Health with employers
	We will help create resilient and connected communities	Health and Wellbeing Board
Prevention and early intervention	We will develop a mental health toolkit for schools	Public Health with partners
	We will identify our vulnerable and at risk communities and develop targeted programmes of support	Public Health with joint commissioners and partners
Treatment and recovery	We will continue to invest in talking therapy services	CCG Mental Health Commissioner
	We will support GPs to develop their mental health skills	Joint commissioners with service providers and GPs
	We will work towards good mental health in physical health and good health for people who use mental health services	Joint commissioners with service providers
Quality services	We will develop joint commissioning arrangements for mental health	Joint commissioners
	We will review the quality of our services against best practice standards	Joint commissioners with service users and providers
	We will develop service user involvement at all levels	As above
	We will involve families and carers in everything we do	As above
Monitoring and review	We will annually review progress against this plan	Strategy implementation group

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