Background briefing prepared for the ETHICS /RCGP/LJPC Think Tank on integration of mental health promotion into primary care and multi-sectoral community services April 20-24th 2015.

CONTENTS OF BACKGROUND BRIEFING

1. THE VISION: "Integration of mental health promotion,prevention and social inclusion into primary care and community services"

Dimensions of mental health promotion:

- Enhance value and visibility of mental health at national, local and individual levels
- Improve positive mental health
- Protect, maintain and improve mental health

Mental health promotion needs to be integrated into

- Public health interventions for the whole population
- All clinical consultations, whether for physical illness or psychosocial problems
- All subsequent care pathways
- Commissioning of integrated community oriented services for whole populations and subpopulations.
- Mental health and mental illness being regarded as core business for primary care.
- GPs and primary care nurses taking a biopsychosocial approach to all clinical consultations and service planning.

Resulting in *Community-Oriented Integrated Mental Health promotion, prevention and treatment Services*.

AIM OF THE THINK TANK

The Think Tank aimed to provide a forum for senior people to discuss how

- The integration of mental health promotion, prevention and social inclusion into primary care can be made an effective reality,
- Community oriented integrated mental health promotion, prevention and treatment services can be established within the context of clinical consultations, practice working, service design, commissioning services and current government policy across relevant sectors.

They will consider ways to systematically improve the skills of primary and community care teams (general practitioners, practice, community and specialist nurses and others) working within the health sector and with other sectors(public health, social welfare, education, criminal justice , other public services and third sector groups) to enhance mental health and social inclusion.

2. AIM OF THIS BACKGROUND BRIEFING

This document was prepared as a brief background resource/aide memoire of working definitions, concepts, facts,figures, relevant policy documents, etc. to inform the discussions of the Think Tank by email, and at our meetings on Feb 11, March 18th and April 20-24th 2015.

3. MENTAL HEALTH, MENTAL ILLNESS AND SOCIAL INCLUSION

Avoiding terminological confusion. Mental health is a confusing term which is often used, in an attempt to avoid stigma, to denote mental illness! However, this causes difficulties when one wishes to refer to good mental health in the same way as good physical health. Some people even refer to mental health disorders. So for the avoidance of confusion, this document will refer to positive or good mental health and to mental illness or mental disorders.

Positive or good mental health refers to

- Apositive sense of well-being, self-esteem, and optimism
- A sense of mastery and coherence;
- Belief in own worth and the dignity and worth of others;
- The ability to deal with the inner world of thinking, feeling, managing life and taking risks;
- The ability to cope with adversities (resilience); and to
- Initiate, develop and sustain mutually satisfying personal relationships.

Mental illness or mental disorders include

- Disturbances in perception, beliefs, thought processes and mood (psychoses);
- Disturbances in mood, concentration, irritability, fatigue (neuroses or common mental disorders);
- Progressive disease of the brain (dementias);
- Abnormal personality traits which are handicapping to the individual and/or to others (personality disorders);
- Excess consumption of and dependency on alcohol, drugs and tobacco.

Social inclusion

People with mental health problems are supported to enable their inclusion and participation in all aspects of community life, so that

- Mental health is valued by all community members and recognized as a requirement for community development.
- People with mental health problems are included in community based rehabilitation programmes.
- Communities have increased awareness about mental health, mental health promotion, prevention and treatment with a reduction in stigma and discrimination towards people with mental health problems.
- People with mental health problems are able to access medical, psychological, social and economic interventions to support their recovery process and their own mental health promotion.
- Family members receive emotional and practical support, and mental health promotion.
- People with mental health problems are empowered, with increased social inclusion and participation in family and community life.

4. COMMUNITY-ORIENTED INTEGRATED CARE

We aim to set our concept of community-oriented integrated mental health services within the concept of *community-oriented integrated care*.

Integrated Care means both

- biopsychosocial assessment and management in primary care. Trials show that it is only when the front line primary care staff are competent in both mental and physical health care that the barrier of stigma is removed which stops so many people who need help from finding and accepting it. It's not enough to have mental health and physical health practitioners in the same building .
- as well as care that is coordinated across organisational and disciplinary boundaries. Practitioners on all sides of all the boundaries being crossed enjoy good relationships that enable creative team-working and synchronised on-going improvements. Each organisation creates policy that enables good communication and collaborative improvements with practitioners on the ground.

Community-Oriented Integrated Care means both

- biopsychosocial assessment and management which takes into account community factors impacting on mental health
- andintegrated care that is oriented towards local communities. This means inter-connected multi-disciplinary teams within clusters of general practices that serve geographic areas of 30-50-000 populations – small enough to feel you belong and large enough to have political effect.

To maintain community-oriented integrated care, there needs to be ongoing mechanisms for team-building across organisational boundaries. In the context of mental health this might include extended primary care teams working together to devise both individual Care Plans, similar to those routinely prepared by community mental health teams, for those who want to improve their mental health (e.g. people with diabetes), and locality-based health promotion projects in collaboration with public health and voluntary groups. Annual cycles of inter-organisational improvement can support a sequence of projects to improve the capacity of the whole system to promote good mental health.

5. THE PUBLIC HEALTH FRAMEWORK APPLIED TO MENTAL HEALTH AND MENTAL ILLNESS

a. **Mental health promotion** –refers to enhancing healthy functioning of the mind.

b. **Primary Prevention**– preventing illness from occurring, either by support to vulnerable groups to increase their resilience in the face of risk factors, and/or where possible removal of risk factors.

i. **Universal prevention:**Desirable for everyone, benefits clearly outweigh costs and risks, e.g. seat belts, safe drinking, good nutrition, reduction of tobacco, exercise, education.

ii. **Selective prevention:**Appropriate for subgroup whose risk of illness is above normal e.g. pregnant women, prevention of post-natal depression in all mothers, teenage mothers, socially-isolated elderly.

iii. Indicated prevention: Appropriate for tightly defined group who are at considerably increased risk,e.g. children exposed to major trauma.

c. **Secondary Prevention** – early detection and prompt treatment of illness.

d. **Tertiary Prevention** – rehabilitation and recovery of people with long term severe mental illness to prevent disability and improve healthy functioning.

e. **Quaternary Prevention** –prevention of premature mortality, both from physical illness and from suicide. There is greatly increased premature mortality in people with mental illness from infectious disease, respiratory disease, cardiovascular disease, malignancies.

The current public health goals for mental health

- Promote good mental health across the population
- Prevent mental illness, suicide and self-harm
- Improve quality of life and healthy life expectancy of people living with mental illness
- Tackle inequalities and improve wider determinants of wellbeing and mental health**.**

Integrated public health

The science and art of promoting and protecting health and well-being, preventing disease and reducing illness and sickness, and increasing wellness in longevity by developing health capabilities through the combined strengths of a whole of society and whole of government approach.

Public health enables informed choice, empowerment, inclusion and engagement of all communities and individuals of age, gender, sexual orientation race, faith and abilities

6. VALUE OF POSITIVE MENTAL HEALTH

Good mental health is associated with

- Improved educational outcomes
- Greater productivity
- Improved cognitive ability
- Increased resilience to adversity
- Better physical health
- Less sickness absence
- Reduced mortality
- Increased social interaction and participation
- Reduced mental illness and suicide
- Reduced risk taking

Thus positive or good mental health is important for the educational achievement of children and their future prospects, for the physical health of the population, for the social capital of communities, and for the economy. We can say good mental health is important for human, economic and social capital.

7. PREVALENCE RATES OF MENTAL DISORDERS (obtained from the British Mental Health Survey Programme www.mentalhealthsurveys.org This website lists all technical reports and academic papers)

Childhood epidemiology of disorders

Conduct disorder: 5.5 % of 5-15 year olds;

Emotional disorder: 3.9% were assessed as having emotional disorders

ADHD: 1.5%

Autism spectrum disorder: 1.0%

Learning difficulties (special educational need): 3.0%

The overall rate of 9.5% included some children who had more than one type of disorder.Children in local authority care have significantly higher rates of illness.

Adult Epidemiology

CMD: Between 1993 and 2000 there was a significant increase in the population aged16–64 in the prevalence of CMD, from 15.5% to 17.5%, but no further increase by 2007 (17.6%).

Alcohol and Drugs: The prevalence of alcohol dependence was 5.9% in 2007, having fallen somewhat in men since 2000. The prevalence of hazardous drinking among 16–74 year olds was also reduced, from 28.1% in 2000 down to 25.5% in 2007. The prevalence of drug dependence was 3.4% in 2007, similar to 2000, but still higher than in 1993.

Suicidality:Suicidal thoughts at some point in people's lives are relatively common: in the 2007 survey 16.7% had thought about committing suicide, 5.6% had attempted suicide and 4.9% had harmed themselves without suicidal intent. In England, the proportion of women reporting suicidal thoughts in the last year, and of people reporting self-harm, increased between 2000 and 2007.

Suicide rates:

- In 2012, there were 5,981 suicides in people aged 15 and over in the UK, 64 fewer than in 2011.
- The UK suicide rate was 11.6 deaths per 100,000 population in 2012.
- Male suicide rates were more than three times higher at 18.2 male deaths compared with 5.2 female deaths per 100,000 population.
- The highest suicide rate was among men aged 40 to 44, at 25.9 deaths per 100,000 population.
- The most common methods of suicide were hanging, strangulation and suffocation (58% of male and 36% of female suicides) and poisoning (43% of female and 20% of male suicides).
- In 2012 in England, the suicide rate was highest in the northwest at 12.4 deaths per 100,000 and lowest in London at 8.7 per 100,000

Psychosis: The overall prevalence of probable psychosis was 0.5%(unchanged from previous years).

Antisocial personality disorder: Antisocial personality disorder was assessed in the 2000and 2007 surveys. In 2007, it was identified in 0.3% of adults (0.6% men, 0.1% women), mostly in the younger age groups, while borderline personality disorder was identified in 0.4% of adults (0.3% men, 0.6% women). Rates were similar in 2000. Co-morbidity was common, especially between antisocial personality disorder and psychosis.

PTSD: 3.0% of people screened positive for current PTSD; rates declined with increasing age.

ADHD:A total of 8.2% of adults screened positive for ADHD, as indicated by a score of four and above on a 6-item self-report scale; 2.3% reported five characteristics and 0.6% allsix characteristics. Only a fifth of screen positive participants were receiving psychiatric treatment of any kind.

Autism Spectrum Disorder: 1.1% of adults in the general population in England meet diagnostic criteria for ASD. Only 1 in 11 also have moderate to profound learning disabilities (with care needs). Most are unrecognised and undiagnosed. It only takes a morning or an afternoon to train GPs to recognise their ASD practice attenders and to confidently use simple problem solving techniques to help them.

Eating disorders: A total of 6.4% of adults screened positive for an eating disorder, of whom a fifth were receiving treatment, and 1.6% of adults screened positive and reported that the eating problems had a significant negative impact on their life.

Gambling: While two-thirds of adults had spent money on gambling in the last year, only 3.2% met one or more of the criteria for problem gambling, 0.7% met three or more criteria and 0.3% met the threshold of five or more criteria taken to indicate pathological gambling. A quarter of the latter were receiving some kind of treatment for a mental or emotional problem.

	Practice 10,000	**Cluster 40,000**	**CCG 400,000**	**Sector 1,000,000**
Children				
Conduct	550	2,200	22,000	55,000
Emotional	390	1,560	15,600	39,000
ADHD	150	600	6,000	15,000
Autism	100	400	1,600	10,000
LD	300	1,200	4,800	30,000
Dyslexia	1,000	4,000	40,000	100,000
Total	1,000	4,000	40,000	100,000
Adults				
CMD	1,800	7,200	72,000	180,000
Alcohol dependence	600	2,400	24,000	600,000
Hazardous drinking	2,500	10,000	100,000	250,000
Drug dependence	340	1,360	13,600	34,000
Psychosis	50	2000	20,000	50,000
ASPD	30	120	1,200	3,000
PTSD	300	1200	12,000	30,000
ADHD broad	820	3280	32,800	82,000
ADHD narrow	230	920	9,200	23,000
ASD	110	440	4,400	11,000
Eating disorders	640	2560	25,600	64,000
Pathological gambling	30	120	1,200	3,000

8. CONSEQUENCES AND COSTS OF MENTAL DISORDERS

- Mental disorder accounts for 22.8% of UK disease burden, compared with 16% cancer and 16% CVD.
- I in 2 life time risk of mental disorder.
- Unlike many other non communicable diseases rates of mental disorders are not declining in spite of greater delivery of care. Alternatives to treatment need to be taken seriously.

Consequences of childhood disorders

- Reduced school, health and social skills outcomes
- Increased smoking, alcohol and drug use
- Higher rates of adult mental disorder
- Unemployment
- low earnings
- Teenage parenthood
- Marital problems
- Criminal activity

Conduct disorder in childhood: Nearly half with early onset conduct problems develop persistent life course problems including

- Violence
- Drug misuse
- Unemployment
- Crime -70x more likely to have prison sentence by age 25.

30% of all criminal activity is related to conduct disorder, and 50% to other conduct problems in childhood and adolescence

Emotional disorder in childrenleads to mental disorder in adult life

- Self-harm
- Suicide x 5
- Time off school x 4

75% of adolescents with major depression experience recurrence in adulthood

Consequences of adult mental disorders

- Suffering
- Disability
- Mortality from suicide and from physical illness
- Low productivity while at work
- Sickness absence and labour turnover
- Unemployment
- Debt
- Poverty
- Stress on carer
- Poorer educational outcomes

- Higher rates of self-harm and suicide
- Health risk behaviour (smoking, alcohol and drug abuse, sexual risk taking, poor diet, and physical inactivity)
- Physical illness
- Premature death
- Unemployment
- Antisocial behaviour
- Marital breakdown
- Childhood illness results in higher rates of mental illness in adulthood
- Adult illness results in higher rates of mental illness in children
- Family burden
- Intellectual, emotional and physical consequences for children
- Intergenerational burden-cycles of disadvantage
- Reduced access to and success of health promotion, prevention and treatment programmes

Costs of mental disorders in UK

- £100 billion a year
- 70 million sick days lost per year –leading cause of sickness absence in UK
- 44% of employment and support allowance benefit claimants report a mental disorder as primary diagnosis
- 75% adults accessing mental health services had diagnosable condition before age 18
- Mental illness during childhood has long term economic impact across life course e.g. cost of crime by those who had conduct problems in childhood is £60 billion in England and Wales
- Prevention and early intervention show life time benefits to child, adult and ability to parent, thus breaking generational cycle, with economic returns exceeding cost by 6 to 1
- Half of life time mental illness (excluding dementia) starts by age 14 and 75% by mid 20s.
- 75% adults accessing mental health services had diagnosable condition before age 18
- Annual costs of depression £8 billion
- Mental illness during childhood has long term economic impact across life course e.g. cost of crime by those who had conduct problems in childhood is £60 billion in England and Wales
- Childhood and adolescence are therefore particularly important periods of opportunities for prevention

Use of health services

People with common mental disorders are frequently high attenders of primary care services, but often present with physical symptoms, and so may not be recognised as having a mental disorder which may or may not be co-morbid with a physical disorder. Studies indicate about half of CMD remains undiagnosed. But only a quarter receive treatment for CMD.

Thus, only a quarter of people with CMD were receiving some kind of treatment for it in 2007, unchanged from 2000. Strikingly, the use of psychotropic medication for CMD doubled between 1993 and 2000, although use of talking therapies did not significantly increase. Few people with drug and alcohol misuse were receiving treatment. In contrast, most people with psychosis were in touch with health and social care, the majority receiving some form of treatment (85% in 2000 and 80% in 2007).
The 2014 adult mental health survey will report in 2015/2016.

No other health condition produces as much impact as mental illness

- Prevention and health promotion are worth doing
- Especially in early life because of long term effect across life course, but also still have major value if done in adulthood.
- Requires both universal and targeted interventions-see below
- Need cross government approach
- Need training

9. RESILIENCE FACTORS , RISK FACTORS AND HEALTH INEQUALITIES

- Genetic background
- Antenatal and post natal care
- Nutrition
- Physical exercise
- Physical health
- Health education
- Effective parenting
- Problem-solving skills, coping skills
- Communication skills
- Immunization
- Avoidance of physical trauma to head
- Maternal and child health care
- Personality traits
- Age, gender, marital status
- Social support –there are 4 categories: appraisal, information, emotional or practical support.
- Social networks
- Socioeconomic factors including access to resources
- Reduced inequality
- Employment and other purposeful activity
- Relationships
- Community factors such as level of trust and participation, social capital
- Self-esteem, autonomy, altruism
- Emotional and social literacy
- Employment etc.
- Access to green space

Risk factors and health inequalities:

The factors associated with higher rates of mental disorder among children include:

- Characteristics of the child
  - Child abuse: 18 x increased risk of emotional or conduct disorder
  - Physical health problems
  - Having special educational needs)
- Characteristics of the family
  - Lone parenthood: 2x increased risk of emotional or conduct disorder
  - Reconstituted families
  - Poor educational levels
  - Unemployment: 2-3 x increased risk of childhood emotional or conduct disorder
  - Low income: 3 x increased risk in lowest socioeconomic class
- Family functioning characteristics
  - Psychological distress among mothers and family discord
  - Poor parental mental health: 4-5 x increased risk of childhood emotional or conduct disorder
- Stressful life events
  - Separation of parents
  - Parents in trouble with the police
- Neighbourhood characteristics
  - Deprivation
  - Lack of social cohesion

The factors associated with higher rates of mental disorder among adults include:

- Sociodemographic factors
  - Female,
  - Aged between 35 and 54,
  - Social class V,
  - Tenants of Local Authorities and Housing Associations);
- Characteristics of the family
  - Separation or divorce,
  - Living as a one person family unit, or as a lone parent
  - Debt –much more powerful risk factor than low income
- Personal characteristics
  - A predicted verbal IQ of 70–85,
  - Impaired personal functioning, no formal educational qualification,
  - One or more physical complaints.

New episodes of psychiatric illness

- Twice as common in adults living in rented accommodation,
- Three times as common in women reporting six or more stressful life events.
- More common in men who are unemployed,
- And in men with low income.

High risk groups

- Looked after children (e.g. orphanages): 5 x rate of disorder
- Children with learning disability: 6.5 x rate of disorder
- Adults with learning disability: 2 x rate of depression and 3 x rate of schizophrenia
- 15-17 year old male prisoners: 18 x increased rate of suicide,
- Prisoners
  - Risk of suicide is x 5 in adult males and x 20 in adult females
  - Risk of psychosis is x 20
  - Risk of ASPD is x 160 in men and x 100 in women.
- Ethnic minorities have 3 x increased rate of psychosis and 3 x increased rate of suicide

Importance of stressful life events and social networks

- People with common mental disorders are more likely to have experienced several stressful life events in the last 6 months, and to have smaller social networks than those with no disorder.
- These features are even more marked in people in prison, homeless people and informal carers than in the population as a whole.
- Life events are clearly important risk factors for common mental disorders.
- The strongest associations between CMD and life events related to recent threats to health, recent interpersonal problems and lifetime stressors (including sexual abuse, expulsion from school, bullying, running away from home and institutional care in childhood).

Some effect sizes for risk factors for CMD and psychosis:

Risk factor	**CMD**	**Psychosis**
Children		
Child abuse	18	-
Parental psychopathology	3.99 for conduct disorder 4-5 for emotional disorder	-
Non-physical punishments	1.5	-
Looked after children	5	-
Learning disability	6.5	-
Low income family	3	-
Unemployment	2-3	-
Lone parents	2	-
Reconstituted families	2-3	-

Risk factor	**CMD**	**Psychosis**
Adults		
Debt	6.0	
Co-morbid physical conditions	3.67	
Childhood sexual abuse	2.9 any abuse 3.4 contact abuse	2.74 any abuse 3.49 contact abuse
Any poor physical health	1.57	
Diabetes, hypertension, coronary artery disease or heart failure	2	
Renal failure, chronic obstructive pulmonary disease or CVD	3	
2 or more physical conditions	7	
Learning disability	2	3
Low income	1.5	
Fuel poverty	1.85	
Mould in house	1.52	
Using less fuel due to worry about cost	1.77	
Renting house	1.58	
High job effort	2.83	
High over-commitment	4.86	
Low job control	1.52	
Low job reward	1.77	
Ethnic minority		3
Prisoners	Suicide x 5 in adult males and x 20 in adult females	20

Relationship between physical and mental health:

Mental illness impacts on physical illness –by causing illness, worsening prognosis, and by exacerbating pain

- Continued stress and emotional disturbances can cause physical illness.
- The presence of psychological symptoms may result in poor prognosis of physical illness e.g. depression worsens prognosis of heart attacks and cancer.
- Mental disorder may exacerbate the pain of a physical disease (lower threshold to pain).

Physical illness can cause mental illness

- Cancer, diabetes, heart diseases and cancer may cause depression
- Side effects of some treatments for physical illness (e.g. steroids) include mental disorders such as depression and psychosis

And there is diagnostic confusion between mental and physical illness because some symptoms are shared e.g.headache, backache, stomach ache, pains 'here and here and here', feeling generally unwell, fatigue, poor concentration.

Men with schizophrenia have 20 year lower life expectancy, and women with schizophrenia have 16 year lower life expectancy, from obesity, diabetes, smoking related and nutrition related diseases

Physical illness increases risk of mental illness

Rates of depression are

- 2 x in those with Diabetes, hypertension, coronary artery disease and heart failure,
- 3 x in renal failure, chronic obstructive pulmonary disease and CVD
- 7 x in those with 2 or more physical conditions

Mental illness increases mortality almost as much as smoking does.

- Men with schizophrenia die 20 years earlier while women with schizophrenia die 16 years early
- People with schizophrenia have 3x increased mortality from respiratory disease, 4x increased from infectious disease, and 2-3 x increase from hypertension.

Smoking

- Lowers life expectancy by ten years
- Much more common in people with mental disorder, who are responsible for half of tobacco consumption
- Smoking associated with mental disorder and suicide
- Smoking in pregnancy associated with conduct disorder in child and crime and ADHD
- People with mental illness less likely to be given help to stop smoking

10. POTENTIAL MENTAL HEALTH PROMOTION AND PREVENTION INTERVENTIONS

Mental health promotion entry points

- ***Determinants*** of health : predisposing, precipitating and maintaining factors
- ***Target groups*** : age, gender, occupation, specific risk factor
- ***Settings***: school, workplace, prisons, health sector, social sector, urban, rural, media
- ***Levels*** : international, national, local, person
- ***Public health***: policy, disease programme, service
- ***Methods of action:*** intervention

Strategies based on life event and social support theory

- Improving coping capacities
- Social support (appraisal, informational, emotional and instrumental)
- Select , change or create environmental settings to increase social supports and reduce life events e.g. choosing recreation, education, self-help group
- Developing /facilitating natural support systems e.g. in family, at work, community

Promoting resilience

- Schools based promotion programmes such as whole school approach, social and emotional learning.
- Work based mental health promotion and stress reduction
- Promote wellbeing, motivation and resilience in people who are unemployed
- Debt and financial capability interventions
- Housing improvement
- Heating and insulation improvement reduce risk of depression and anxiety by 50%

Empirical evidence that mental health promotion and prevention programmes can reduce

- Low birth weight
- Pre-term deliveries
- Poor parenting behaviour
- Lack of early bonding and parental affection
- Child abuse and neglect
- Teenage pregnancies
- Aggression
- Being a victim of regular bullying

  and can achieve

  - Better academic achievement
  - Increase in productivity
  - Lowering divorce rate
  - Reduction in family violence
  - Reduction in youth delinquency
  - Reduction in use of social services

Maternal depression can be reduced by

- Health visitor training
- Effective detection and treatment
- Home visiting
- Parenting programmes
- Post-partum support
- Peer support
- Telephone support

Reduced maternal smoking leads to

- Reduced infant behavioural problems
- Reduced ADHD
- Improved birth-weight
- Improved physical health
- Smoking in pregnancy associated with conduct disorder in child and crime and ADHD
- People with mental illness less likely to be given help to stop smoking

Breastfeeding associated with

- Reduced risk of behavioural problems
- Higher intelligence scores
- Later reductions in hypertension, obesity and diabetes

Preschool and early education programmes lead to

- Improved cognitive skills
- School readiness
- Improved academic achievement
- Good effect on families and siblings
- Prevention of emotional and conduct disorder

Schools based mental health promotion, especially the Whole School Approach, leads to

- Improved Wellbeing
- Reduced conduct disorder and anxiety in primary school, and reduced depression and anxiety in secondary school.
- Pro-social behaviour and skills

Prevention of conduct and emotional disorders

Programmes targeting at risk children in the early years, using parent training or child social skills training are the most effective

Parenting programmes improve

- Parenting efficacy and practice
- Maternal sensitivity
- Child emotional and behavioural adjustment
- Improved behaviour in high risk children and those with conduct problems
- Improved safety at home
- Reduced antisocial behaviour
- Reduced reoffending

Early intervention programmes

Early intervention for ADHD results in

- Improved educational and social outcomes
- Reduced difficulties in later life

Individual parenting intervention programmes for conduct disorder result in

- Improved child behaviour
- Improved family relationships
- Improved educational outcomes
- Reduced conduct disorder, antisocial behaviour and crime

School based intervention programmes for children at highest risk and those with subthreshold disorders result in

- Improved mental health
- Improved behaviour at school and home
- Improved social skills and academic skills

Early intervention for psychosis results in

- Fewer psychotic symptoms and better course of illness
- Higher employment rates

Early intervention for antisocial personality disorder results in

- Improved functioning for adults, reduced psychopathy and suicidal behaviour

Early intervention can therefore break down cycles of inequality running through generations of families.

Mental health promotion for people with mental illness

- Create inclusive environments that respect and protect the basic rights of everyone, including people with mental health problems.
- Strengthen community networks and encourage collective responsibility for preventing alcohol/drug abuse, gender discrimination and community and family violence.

- Develop partnerships with other stakeholders that are involved in promoting mental health and well-being, e.g. working with women's clubs on gender issues or with a local nongovernmental organization focusing on early interventions with children.
- Promote positive interactions between parents and their children to enhance childhood development.
- Promote evidence-based programmes in schools that enhance the social and emotional competencies of students to help prevent substance abuse and violence.
- Work with the media to change the negative image of people with mental health problems.

Prevention of violence and abuse

School based interventions to reduce violence, prevent sexual abuse, and bullying.

Suicide prevention

- Coping skills
- Good relationships
- Social support
- Physical activity
- Resilience
- Restrict access to suicide hotspots
- Restrict sale of drugs e.g.Paracetamol
- Educational programmes for general public
- Education for health and social care professionals on assessment and management of suicidal risk
- Intensive support after previous attempt as 100x increased risk in following year
- Support for high risk occupational groups.
- Most people who kill themselves have recently seen their GP-this is therefore an opportunity for prevention.

Older people

- Mental health closely associated with physical health
- Positive mental health associated with reduced mortality
- 25% of older people in community have depressed symptoms
- Dementia affects 5% of over 65 and 20% of over 80.

Prevention in older people

  - Psychosocial interventions
  - High social support during adversity
  - Prevention of social isolation
  - Walking and physical activity
  - Learning
  - Adequate heating
  - Support for carers
  - Poverty reduction
  - People with 2 or more long term physical health problems have 7x increased risk of depression, so need targeted prevention

Prevention of dementia

- Physical activity
- Cognitive exercise
- Social engagement-larger networks associated with higher cognitive function
- Protective effect from mentally or socially stimulating activity
- Treatment of hypertension

Physical activity

- Improves subthreshold and mild depression, and improves wellbeing
- Improves cognitive performance in school children
- Improves mental health in deprived communities
- Improves wellbeing in schizophrenia
- Reduces depression in older people

Nutrition

Breastfeeding associated with:

- Reduced behavioural problems in children
- Higher intelligence
- Reduced hypertension, obesity and diabetes

Lack of sufficient safe nutritious food associated with maternal depression and higher rates of behavioural problems in children. Improved health outcomes from fruit, veg, and complex carbs rather than fat, salt and sugar.

Sexual health

- Higher sexual health risk behaviour is associated with mental ill-health and lower levels of wellbeing
- Sexual health education programmes reduce high risk sexual behaviour

Other factors improving wellbeing

- Mindfulness
- Spirituality
- Meaningful and purposeful active leisure
- Not TV which reduces wellbeing and attention
- Creativity and community participation
- Engagement in arts and music
- Relationships with friends and community
- Positive social involvement
- Ecologically sustainable behaviour
- Volunteering
- Work

Volunteering

- Increases well being
- Improves self-esteem in children, making friends, increased awareness of community, and increasing future employment opportunities
- Improves QOL in older people
- Provides social capital which protects mental health

Interventions to increase social capital

- Individual and community empowerment increases social cohesion and support
- Group programmes and peer support to reduce social isolation
- Social prescribing of arts and time banks
- Community participation in local governance
- Community engagement in health promotion
- Adult learning
- Community arts activities
- Neighbourhood improvement
- Safe green community space

Importance of social inclusion

Promoting more connected communities

Communities with higher levels of social capital have

- Better health
- Higher educational attainment
- Better economic growth
- Social networks and social support promote a sense of belonging and wellbeing and may prevent mental health problems
- Lower rates of crime

Summary

No other health condition produces as much impact as mental illness

- Prevention and health promotion are worth doing
- Even greater impact if done in early life because of effect across life course
- Requires both universal and targeted interventions
- Need cross government approach
- Need substantial rather than tokenistic training for each cadre .eg for nurse practitioners 8 days of training rather than half a day.

11. POLICY DOCUMENTS TO TAKE INTO ACCOUNT

Relevant points are summarised and*comments are in italics*

Foresight 2007 – Mental Health Challenge

http://webarchive.nationalarchives.gov.uk/20140108144555/http://www.bis.gov.uk/assets/foresight/docs/mental-capital/mental_health.pdf

Summarises epidemiology, risk factors and consequences of mental disorders in Britain – useful resource on basic facts – which can be updated when the latest survey reports in 2015/16.

Foresight 2008 -Mental Capital and Wellbeing Final Report

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292450/mental-capital-wellbeing-report.pdf

Mental Capital

- Encompasses a person's cognitive and emotional resources.
- Includes cognitive ability, how flexible and efficient a person is at learning, and "emotional intelligence", such as social skills and resilience in the face of stress.

Mental Wellbeing

- Describes how an individual can develop their potential, work productively, and build relationships with others.
- Increased when an individual fulfils their personal and social goals and achieves a sense of purpose in society.

Foresight Recommendations for children

- Early Detection could prevent problems developing further and shift children's development to more positive outcomes through life.
- Teacher Training needs to capitalise on the latest scientific understanding of child development from the brain sciences and developmental psychology.
- Coaching for Parents – in particular, for those people who have not experienced effective parenting skills in their own upbringing.
- Looked after Children (LAC) – increase priority; training and support for carers; and better use of science to identify causes.

Foresight Recommendations for adults and older people

Need to unlock massive under-utilised mental capital and to turn around the mental wellbeing of older people and engage older people themselves to help determine what needs to be done and how to implement.

Protecting mental capital into older age: Encouragement of exercise and continued learning from middle age onwards

- Unlocking mental capital in older age: promoting social networking, enabling ongoing learning and working.
- Providing physical, work and technology environments that allow older people to flourish.
- New biomarkers could help detect dementia earlier. Early detection would help in the development of new drugs and maximise potential therapeutic benefit of treatment.

Foresight messages on CMD

- Common, disabling, considerable social impact on families and workplace, half last longer than a year.
- Identifiable social risk and protective factors, including specific association with debt, even where other social factors held constant.
- Treatment mainly GP, but specialist mental health when severe (note many medications are less costly than psychological treatments, which have high costs in staff time and are less accessible).
- Half are not diagnosed by the GP, and those that are diagnosed are not adequately treated.
- Economic costs huge but mostly not borne by the NHS (e.g. lost employment 8 billion).

Foresight messages on psychosis

- Prevalence only 0.5% but often very severe and disabling, with major impact on families, use of services, and on economy.
- Both biological and social risk factors operative (sexual abuse 21%, violence in home 25%, bullying 41%, homelessness 23%).
- Migration 2-8x increased rates-stressful life events, discrimination, urban living and socio-economic deprivation.
- Most people with psychosis are receiving treatment, mainly specialist mental health, but adequacy of treatment and community support remains patchy, with only a third having seen a CPN in last year.

Foresight messages on health care

- Higher priority for mental health in central targets and local budgets.
- Target at risk groups and service gaps: children, prisoners, people in debt, alcohol problems.
- Improve diagnosis and treatment.
    - Improve GP recognition: CMD, alcohol
    - Improve treatment delivery (e.g. use NICE Guidelines). Note e.g. economic benefits of improving depression treatment (Report p235)
    - Improve primary –secondary care co-ordination, collaborative care
    - Integrate primary care with social and occupational care (e.g. social work, debt counselling, work placement scheme availability
- Address stigma and discrimination on continuous basis

Key foresight messages on wider policies

- Many of causes and consequences involve much wider factors and government policies than health
  - Social risk factors: unemployment, debt, poor housing, lone parenthood, alcohol related polices, work policies
  - Protective factors: e.g. support, social networks
- So harness wider policies in government /New ways of getting government to work together
  - Ensure impact assessment of new policies on mental health
  - Improve access to work for people with mental health problems

Key foresight messages on workplace

- Absenteeism - 10 to 14 million days lost, £750 million per year and presenteeism– c£900 million per year.
- Employers costs of mental health-related job loss – £82 million per year and 40% of INCAP £4.8billion.
- Meeting the challenge:
  - Continuously developing our mental capital by training and retraining through our working lives will be increasingly crucial for people to compete in the global market for skills.
  - Flexible working could help employees meeting the conflicting demands of intensification of work and increasing care responsibilities.
  - Line Managers need to better understand the benefits of their workforce having good mental capital and wellbeing.
  - Betterintegration of Primary Care and Occupational Health services to identify early symptoms of stress and mental ill-health which would ensure a quicker transition back into work.

No Health without Mental Health

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

- A cross government mental health outcomes strategy for people of all ages
- Set actions, targets and indicators
- Annex B summarises relevant evidence on mental health in relation to the protected characteristics defined in the 2010 Equality Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race including ethnic origin and nationality, sex and sexual orientation.)

The Joint Commissioning Panel for Mental health ten key messages for commissioners

http://www.jcpmh.info/wp-content/uploads/10keymsgs-publicmentalhealth.pdf

- Commissioning primary mental health care is relevant to NHS England, CCGs and Health and Wellbeing Boards.
- GP needs to be at centre of providing whole person care; PHCT needs to work with high risk populations e.g. unemployed, looked after children, elderly, physically ill, families and carers, people with protected characteristics.
- Primary /Secondary Care interface should work smoothly and timely.
- Service should be values-based, age inclusive, integrated, holistic, preventative (early detection and intervention), anticipatory, focussed on recovery, outcomes monitoring, linked with local community, voluntary and faith sector.
- Stepped care.
- Screen physically ill people for mental problems, and screen mentally ill people for physical problems.
- PHCT to include GPs, practice nurses, health visitors, peer workers, primary mental health care workers, employment advisors, GP advisors linking to housing, welfare benefits and addiction services, links to specialists, school nurses, local authority education and public health workers, management.
- Measure outcomes on QOL, reduced mortality, improved wellbeing, reduced suicide, recovery, social inclusion, reduced duration of untreated disorder, improved patient and carer experience.

This document is largely focussed on the health sector, and is largely focussed on detection and treatment:

- *It sets out the broad parameters of whole person care, collaborative care, care pathways, stepped care and general values based principles.*
- *It does not include explicit message to address resilience and risk factors – it talks about working with high risk groups and it talks about prevention as early detection and intervention, but it does not spell out specific action to boost resilience and tackle risk factors, apart from emphasising proactive physical health assessment and care for people with SMI.*
- *It does not really include explicit message of intensive intersectoral collaboration at wider community and practice levels – we need intersectoral collaboration for individual interventions and for population interventions.*

Joint Commissioning Panel for Mental Health-Guidance for commissioners or primary mental health care services. Vol. 2 Practical Mental Health Commissioning

http://www.rcpsych.ac.uk/PDF/JCP-MH%20primary%20care%20(March%202012).pdf

- Mental health problems should be managed mainly in primary care by the PHCT working collaboratively with other services, with access to specialist expertise and services as required.
- Requires a stepped care model, evidence-based treatments, flexible referral routes including self-referral, and choice of treatments.
- Primary mental health care services should have clear focus on prevention and early identification.
- Should promote self-management by patients including personalised care plans.
- Care co-ordination (case management and methodical management of systematic care pathways are essential).

- Primary mental health care should be holistic-physical, social, psychological, spiritual.
- Systematic measurement and reporting of outcomes.
- Need better integration of pathways so patients don't get stuck, revolve or disengage.
- Aim to meet objectives of the No Health without Mental Health strategy and the QUIPP.
- Highlights the high risk groups of people on low incomes, BME, learning disability, LGTB, and chronic physical illness, older adults, children with conduct disorder, and carers.
- *BUT does not highlight*
  - *Looked after children (a really crucial vulnerable group who have very poor educational, social, criminal justice and health outcomes).*
  - *People in the criminal justice system.*
  - *The social risk factors of child abuse, debt, marital breakdown, lone parents, poor parenting, rented accommodation, etc.*
- The stepped care model of care encourages social prescribing of exercise, support networks and neighbourhood schemes.
- Encourages recognised service standards.

A commissioner's guide to primary care mental health –strengthening mental health commissioning in primary care – learning from experience

http://www.slcsn.nhs.uk/scn/mental-health/london-mh-scn-primary-care-commiss-072014.pdf

- 60 case studies reviewed and 10 general lessons
  - Local champions drive forward implementation.
  - Work with Health and Wellbeing Boards which have oversight of health, social care and Public Health Budgets.
  - Primary Care education and training.
  - Money needs to move with the patient.
  - Involve users, families, friends and social networks.
  - Cover all ages.
  - Mosaic of services for individuals and carers.
  - Specialists' time to be focussed on severe complex cases and for rapid advice and help for Primary Care.
  - IT communication between Primary and secondary care.
  - Managing long term conditions – physical health care of people with mental illness, holistic care plans, people seen as part of their social system rather than in isolation.
- Lots of good examples here of how to improve services and treatment of people with mental illness. There are some references in the case studies to physical exercise, diet and nutrition *but otherwise the case studies are focussed on assessment and treatment rather than on mental health promotion and prevention, or than on addressing social risk factors for individuals and communities*.

Commissioning stepped care for people with common mental disorders

http://www.nice.org.uk/guidance/CMG41

Guide for commissioners, managers and clinicians

- Highlights the benefits of a partnership approach to commissioning services, recommends commissioning for outcomes (increasing the proportion of people with CMD who are identified, assessed and treated in accordance with NICE guidance, and the proportion that improve or recover.
- Includes a very helpful list of possible members of a multi-agency partnership for CMD.
- Primary Care representatives – CCG leads, GPs, practice nurses, practice counsellors, mental health workers.
- Community based representatives – IAPT services, CMHT, social care, local employment services, education services, drug and alcohol services, local debt, welfare, citizens advice, victim support services, local relationship counselling services, physical activity services, occupational therapy services, criminal justice, refuges and asylum seeking services.
- Specialist representatives – psychiatrists, mental health nurses, psychologists, physicians and nurse specialists from physical specialities, A and E.
- Support services – local commissioning organisations, data and performance, finance.

RCGP Integration of Care

http://www.rcgp.org.uk/policy/rcgp-policy-areas/integration-of-care.aspx

Sets out the RCGP vision of integrated care and the policy measures needed to support implementation.

RCGP vision includes:

- Patients
  - less aware of the organisational boundaries between services;
  - feel in control of their care and empowered to share decisions
  - aware of their care plan and its progress
  - experience transfer from one service to another as straightforward and timely
  - experience is better
  - safety, health and social outcomes and quality of life are improved generally, for those with multi-morbidity, and for those who are most vulnerable;
  - patients would be far less likely to be referred for unnecessary treatment;

- Clinicians and other staff
  - at all stages have the necessary information about the patient;
  - care is therefore tailored to the patient's precise needs;
  - Better use of information would ensure that conditions could be managed with fewer visits to secondary care;
  - Resources would be used more efficiently with less duplication;

- Patient care would be delivered in the community, or even at home, and there would not be incentives in the system to stop this happening;
- Care would be delivered by the most appropriate person in the most appropriate setting at all times.

Policy measures needed to support implementation include

- Resolution in England of the tensions between competition, choice and integration left unresolved by the Health and Social Care Act;
- Urgent action by Government to facilitate the sharing of electronic patient records, supported by appropriate patient safeguards;
- Action to increase the scope and capacity of general practice as a provider of care and to allow GPs to spend longer with patients alongside other members of the multi-disciplinary team, focusing in particular on those with complex needs;
- Commissioning of additional services around general practice to help provide better care co-ordination and support for patients with complex and long term needs;
- An urgent review of the payment by results system in England to identify ways of strengthening incentives to provide high-quality, integrated care;
- An extension in the length of GP training to at least four years, and action to promote cultural change and the development of leadership and communication skills;
- A clear commitment to uphold the principle of area based commissioning, through the retention of practice boundaries, and by ensuring co-terminosity between CCGs, local authorities and otherpublic service agencies.

Sets out a strong person centred intersectoral and multidisciplinary vision, and argues for balance of prevention, early detection, treatment and rehabilitation, but mental health promotion is not obviously included. Includes good examples across country.

Public mental health leadership and workforce development framework .

Aims to build capacity to:

- Promote good mental health across the population
- Prevent mental illness, suicide and self-harm
- Improve quality of life and healthy life expectancy of people living with mental illness
- Tackle inequalities and improve wider determinants of wellbeing and mental health**.**

Sets out core principles on knowledge, beliefs and actions

- Know the nature and dimensions of mental health and mental illness
  - Understand own mental health, what influences it, its impact on others and how you improve it.
  - Communicate effectively with all age groups about mental health.
- Know the determinants at a structural, community and individual level
  - Appreciate there is no health without mental health, and the mind and body work as one system
  - Integrate mental health into own area of work and address mental and physical health holistically

- Know how mental health is a positive asset and resource to society
  - Commitment to a life course approach ad investment in healthy early environments
  - Consider social inequalities n your work and act to reduce them and empower others to
- Know what works to improve mental health and prevent mental illness within own area of work
  - Recognise and act to reduce discrimination against people experiencing mental illness
  - Support people who disclose lived experience of mental illness

Sets out core competencies for different groups

- Public health senior staff-managers, commissioners, specialists, consultants, directors
- Public health practitioners and wider workforce
- Health and social care practitioners
- Education, Community, Employment, Welfare sectors etc.

Achieving better access to mental health services by 2020

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

- Aspires to put health care for people with mental health problems on an equal footing with care for people with physical health problems.
  - Support for self-help.
  - Better access to evidence-based assessment and treatment.
  - Named accountable clinician to enable more co-ordinated, effective ad personalised care.
  - Right treatment at right time in right place in least restrictive environment as close to home as possible.
  - Support to lead healthy lives so that life expectancy same as for general population.
  - Take account of user views at national, organisational, and individual levels.
  - Children able to access high quality care near to home.
  - Services sensitive to needs and diversity of local population.
  - Health and social care services and other agencies working together in seamless way to achieve best outcomes for people.

Five year forward view

- Sets out vision for NHS over next five years
- "the future of the health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health"**.
- Workplace prevention policies
- Increased patient control of own care
- Support to carers
- Shared health and social care budgets
- Breakdown barriers between primary and secondary care
- Better care for complex co-morbid conditions
- GP list based care remains cornerstone

- Service redesign, tailored to local community needs, diverse solutions and local leadership
- Electronic records
- Looking to see improvements in
    - Mental health and learning disability services
    - Parity of esteem between physical and mental health by 2020.
    - Health and wellbeing gap
    - Care and quality gap
    - Funding and efficiency gap

Enables much more flexibility in service design and budgets, and encourages more prevention and public health. (Emphasises employment and voluntary sectors but less on education and criminal justice sectors.) But service fragmentation major risk unless great care taken in local commissioning.

Public Health England: an introduction to public mental health and integrated public health practice.

- Summarises definitions and concepts
- Presents some facts and figures

The Chief Medical Officer's Report on Public Mental Health 2014

- Commissioners , Health and Wellbeing Boards, and Clinical Commissioning Groups should follow the WHO model in commissioning and prioritising evidence based interventions for mental health promotion, prevention, treatment and rehabilitation.
- Wellbeing interventions should not be commissioned in mental health as there is insufficient evidence to support them.
- All Health and Wellbeing Boards should be informed by a Joint Strategic Needs Assessment (JSNA) which includes the information needed to plan services to integrate the mental and physical needs of their populations. The required information is provided for ease of access by the Mental Health Intelligence Network.
- There should be arrangements put in place for mental health data collection that are not different to those for physical health
- Employment os central to mental health, and needs to be a routine part of patient records
- If GPs suggest using new technologies to improve mental health to patients, they would draw these from an approved list of NHS evaluated technologies which have met the standards required by evidence based medicine.

Public Health England/NHS England : A guide to community centred approaches for health and wellbeing

Local government and the NHS have important roles in building confident and connected communities as part of efforts to improve health and reduce inequalities. The project " Working with communities-empowerment evidence and learning" was initiated jointly with PHE and NHS England to draw together and disseminate research and learning on community centred approaches for health and wellbeing. This report provides a guide to the case for change, the key concepts, varieties of approach that have been tried and tested, and sources of evidence.

Public Health England: The mental health needs of gang affiliated young people

- Gang members have increased risk of mental disorder
- Poor mental health makes it more likely that a young person will join a gang
- Violence is intrinsic to gang culture , and gang members experience violence as perpetrators and victims. Girls especially at risk of sexual violence
- Home visiting, parenting programmes, preschool programmes, school social and emotional programmes can protect children
- Needs strong collaborative approach to coordinate services across health LA, CJS,schools and communities

National Suicide Prevention Strategy

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

NICE guidance

NICE: Social and emotional wellbeing in early years

NICE: Social and emotional wellbeingin primary schools

NICE Emotional wellbeing in secondary schools

NICE 2005 Depression in children and young people: identification and management n primary, community and secondary care

NICE 2013. Antisoical behaviour and conduct disorders in children and young people.

NICE 2013 Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults.

NICE 2013 Social anxiety disorder: recognition, assessment and treatment

NICE 2005 Post traumatic stress disorder (PTSD) The management of PTSD in adults and children in primary and seocxndary care.

NICE 2005 Obsessive compulsive disorder: core interventions in the treatment of obsessive compulsive dsorder and body dysmorphic disorder.

NICE 2006. Biplar disorder: the management of bipolar disorders in adults, children and adolescents in primary and secondary care.

NICE 2013. Psychosis and schizophrenia in children and young oeople.Recongnition and management

CG37 Routine postnatal care of women and their babies NICE clinical guidelines 2006

CG 45 Antenatal and postnatal mental health NICE clinical guideline 2007

CG 110 Pregnancy and complex social factors NICE clinical Guideline 2010

12. SUGGESTED ACTION POINTS FOR PRACTICE LEVEL AND COMMISSIONING LEVEL TO FACILITATE THE INTEGRATION OF MENTAL HEALTH PROMOTION INTO SERVICES AND SECTORS

This was just a brain storm to get the ball rolling on April 20-24th**.**

COMMISSIONING level:

- **Closer interaction between Primary Care and Specialist Care**
  - In ways that are equitable across CCG i.e. not one lucky general practice receiving frequent specialist visits, and other general practices receive none; but rather solutions that are practicable for all general practices in both rural and urban areas**.**
  - This means that CCG needs map of its PHCs and its specialists, and to work out equitable framework for supportive visits, content of visits e.g. educational sessions, seeing difficult clients together, planning joint work etc.
  - Also map what specialist input is made into practices now as it may be very inequitable across the practices, and may also not be tailored to distribution of needs.
  - Focus on early detection and early interventions for all disorders, especially childhood disorders (eg dyslexia, ADHD, emotional and conduct disorders, autism), depression and psychosis

- **IT systems that support**
  - Interactions between primary and secondary care;
  - Intersectoral working between health, education, social care, criminal justice;
  - Good practice guidelines , simple enough to be used within the consultation;
  - Audit
  - Monitoring risk factors at individual and community levels
  - Data sharing within practices, between practices, across CCG, between Primary and Secondary Care, and local authority public health planning

- **Health sector to link with social sector to provide local access to interventions for**
  - Debt management
  - Marital breakdown
  - Parenting skills
  - Domestic violence
  - Child abuse
  - Violence
  - Street children and gang cultures
  - Looked after children-multiaxial care plans while in care, and after leaving care.
  - Lonely older people and young mothers-social network enhancement
  - Housing and benefit problems

- **Health sector to link with education sector to provide local access to interventions for**
  - Whole School Approach to mental health promotion-security, trust, communication and positive regard.
  - Bullying and cyber-bullying
  - Detection, assessment and management of childhood disorders
  - Looked after children

- **Health sector to link with criminal justice sector to provide local access for population in touch with police, probation and prisons to interventions on**
  - Dyslexia and educational failure
  - Conduct disorder
  - ADHD
  - CMD
  - Psychosis
  - suicidality
  - Multi-axial Care plans and pathways established prior to leaving prison, so no gaps as person moves into community.

- **Integrate mental health promotion into all care pathways for people with physical and/or mental illness.**
- **Intersectoral committee at commissioning level to drive service developments** –*does the health and wellbeing board already do this or is another body needed??*
- **Area Audit to find distribution of risk factors and of clients needing sub-speciality services e.g. forensic.**
- **Equality impact assessments of work of Secondary Care Trusts.**
- **Equality impact assessments of work of Primary Care.**

PRACTICE level:

- **Review of modus operandi in primary careconsultations** e.g. length of time slots to enable assessment and management of social risk factors as well as physical and psychological problems, reactive v. proactive consultations, regular review of social risk factors, multi-axialassessments and care plans, introduction of mindfulness training.
- **Consider deployment of practice nurses and counsellors.**
- **Can practices provide online screening in waiting room so more information available in the consultation, saving time**
- **Computerised reminders** of issues to check/discuss.
- **Strengthen communication skills, motivational interviewing skills, CBT skills for GPs and nurses**
- **Consider how best to handle plethora of NICE guidance** - does it also need simplifying to make it manageable and readable within the consultation? Were the WHO primary care guidelines adapted for the UK in 2000 and 2004 useful? Should we revise again for theUK, and this time include promotion and prevention interventions?
- **Intersectoral committee at practice level to drive service developments** –see stepped care NICE guidance above on potential membership
- Consider opportunities arising from the National Tariff Payment System (PbR cluster pathway stuff) as it provides a platform for much better holistic clinical input
- **Practice audit to check**
  - How many people with various risk factors

- Each practice provides speedy access to interventions to address risk factors including debt management, marital counselling, bereavement counselling, child abuse, housing problems etc.
- How many people with severe mental illness, autism, learning disabilities
- How many people with forensic problems
- How many suicides and how many premature deaths.
- Each practice provides speedy access to interventions to address resilience factors
- Use of good practice guidelines on mental health promotion, prevention, treatment, rehabilitation, prevention of mortality
- Effective support for people after suicide attempts
- All practice staff well trained in assessment and management of suicidal risk

13. THE PRACTICE NURSE ROLE IN MENTAL HEALTH (WRITTEN BY SHEILA HARDY)

Healthcare professionals working in primary care in England need to be knowledgeable about mental health as this is where 90% of people are treated (Gask et al. 2009). Most authors of national policies and reports talk about the GPs' role when discussing the mental health of people in primary care rather than practice nurses'; this is despite the fact they make up a large part of the primary care workforce. Historically, practice nurses have not been involved in mental health. In an analysis of practice nurse responsibility and training needs (Crossman 2008) mental health was not specified as a responsibility of any of the respondents and only six practice nurses cited mental health as an educational requirement. More recently, practice nurse required competencies have been extended to include mental health and wellbeing (The Royal College of General Practitioners General Practice Foundation 2012). These competencies are advocated by NHS England (NHS England 2012). A survey of practice nurse mental health and wellbeing training needs showed that practice nurses now have more involvement and would like some education in this area (Hardy 2014).

What can practice nurses do?
Practice nurses can play a role in promoting wellbeing and identifying and supporting patients with mental health problems.

Practice nurses who are aware of mental health problems can help the patients under their care to:

- Have their psychological distress and/or mental illness recognized and managed.
- Remain free from harm (where factors are in the control of the practice nurses).
- Be referred to other appropriate health care professionals in a timely manner.
- Be aware of where to get help with social issues such as housing, debt.
- Have both their physical and psychological problems addressed.
- Receive screening and lifestyle advice if they are at risk of cardiovascular disease and other long term/physical conditions.
- Be involved in planning their care using a recovery approach.
- Gain an understanding of their medication and have any side effects or concerns dealt with sensitively.
- Be offered appropriate advice and support for drug or alcohol problems.
- Be contacted when they fail to attend an appointment (as this may be due to deterioration in their mental health).
- Choose whether their carers (should they have one) take part in consultations.
- Feel they are being treated in non-stigmatising environment.

Practice nurses can support patients to:

- Recognise that they may have some unhealthy behaviours.
- Understand how their unhealthy behaviour can affect their wellbeing.
- Feel comfortable about coming back at another time should they not be ready to make any changes presently.
- Feel supported to make changes without being judged.
- Be able to make a plan to change a chosen behaviour.

Practice nurses can help patients with a severe mental illness have:

- A reduced risk of cardiovascular disease (CVD).
- A named contact in the practice who offers support for all areas of care.
- Assistance with smoking cessation, diet and exercise planning.
- Prompt treatment for other physical ailments.
- Treatment in line with people with physical long term conditions therefore reducing stigma.

Practice nurses can help all patients in their care to have:

- A reduced risk of developing stress and mental illness.
- Assistance to make a plan which contributes to maintaining their personal wellbeing.
- Risk factors for stress recognized and/or symptoms of stress recognized and help to manage these.

Practice nurses can help patients with long term conditions to have:

- Any distress relating to their conditions identified.
- Appropriate and timely information.
- Choice of treatments.
- Control of their care.
- Access to suitable support programmes (should they exist in their area).
- Assistance to self-manage their conditions.

What is needed for practice nurses to have a role in mental health and wellbeing?

In order for practice nurses to have a role in mental health their workload needs to be organised effectively, they need to change the way they consult, and they need to take part in appropriate education.

Practical organisation of workload

In the main, primary care centres tend to be set up to be reactive rather than proactive. Clinicians respond to acute symptoms of patients, and run clinics to meet imposed targets for individual diseases rather than work generally to promote wellbeing, prevention and self-management. Many people have more than one long term condition, these include mental health conditions. Providing generic clinics encompassing all conditions may be cost effective and are holistic. The Royal College of General Practitioners (RCGP 2012) promote medical generalism which they define as an approach to the delivery of health care that routinely applies a broad and holistic perspective to the patient's problems. They advocate that these principles will be needed wherever and whenever people receive care and advice about their health and wellbeing, and all healthcare professionals need to value and be able to draw on this approach when appropriate. This suggests that the medical generalist approach can, and should be used by a practice nurse during any type of clinic. However, the RCGP do acknowledge that the ability to practise as a generalist depends on one's training, and on the routine use of skills that helps people to understand and live with their illnesses and disabilities, as well as helping them to get the best out of the healthcare options that are available and appropriate for their needs. Many practice nurses do not have the skills and competencies to help patients manage a range of long term conditions.

Consultation approach

Mental health promotion saves lives

Traditionally in consultations with patients, practice nurses follow protocols and templates to meet targets. This often includes acting as the expert and offering the patients impersonalised advice. Employing a different approach is needed to help them to assist patients to keep well, change unhealthy behaviour and become effective self-managers. Empowerment and motivational interviewing approaches are examples of consultation techniques that are effective.

Education

There is a need for appropriate education for all practice nurses. One example is the Practice nurse project carried out in North Central and East London (Hardy and Kingsnorth 2015). A 'Train the Trainer' model was employed. Mental health nurses from four trusts (Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS Foundation Trust, East London NHS Foundation Trust and North East London NHS Foundation Trust) were identified to be the nurse educators because they have a comprehensive understanding of mental health problems and are aware of the appropriate local resources. The co-ordination of the project was provided by an academic health science network (UCLPartners). There are 10 modules, five face to face delivered by the nurse educators and five e-learning. Both the practice nurses and mental health nurses felt their clinical practice would improve as a result of being involved in this programme. To sustain the learning, mental health nurses were supported by attending and then leading their own action learning sets.

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"WHO estimates 25% of patients using a health service suffer from at least one mental, neurological or behavioral disorder, most of which are undiagnosed or untreated." (p. 26)

Mental Illness Disrupts Lives (Table 12, p. 26)

Table 12: Mental illness disrupts lives
Disability-Adjusted Life Years associated with mental health conditions

	DALYs (millions)	% mental health DALYs, world
All Neuropsychiatric disorders	**199**	
Unipolar depressive disorders	65	32.9
Bipolar affective disorder	14	7.2
Schizophrenia	17	8.4
Epilepsy	8	3.9
Alcohol use disorders	24	11.9
Alzheimer and other dementias	11	5.6
Parkinson disease	2	0.9
Multiple sclerosis	2	0.8
Drug use disorders	8	4.2
Post-traumatic stress disorder	3	1.7
Obsessive-compulsive disorder	5	2.6
Panic disorder	7	3.5
Insomnia (primary)	4	1.8
Migraine	8	3.9

Source: (WHO, 2008)
Note: Shaded conditions are not taken into account in this study; DALYs listed here do not include the following two categories: lead-caused mental retardation and "other" neuropsychiatric disorders.

Mental illness costs directly and especially in lost output. Costs an estimated US$ 2.5 trillion in 2010 rising to US$ 6.0 trillion by 2030 (Box 11, p.35). See Table 13 (p. 27). Also need to consider value of lost output. (Table 14, p. 29 and Figure 3a).

Table 13: Mental illness costs expected to more than double by 2030
Global cost of mental health conditions in 2010 and 2030. Costs shown in billions of 2010 US$

	Low- and Middle-Income Countries			High-Income Countries			World		
	Direct Costs	Indirect Costs	Total Cost of Illness	Direct Costs	Indirect Costs	Total Cost of Illness	Direct Costs	Indirect Costs	Total Cost of Illness
2010	287	583	870	536	1,088	1,624	823	1,671	2,493
2030	697	1,416	2,113	1,298	2,635	3,933	1,995	4,051	6,046

Table 14: The anticipated economic toll of NCDs is staggering
Economic burden of NCDs, 2011-2030 (trillions of US$ 2010), based on EPIC model 1[12]

Country income group	Diabetes	Cardiovascular diseases	Chronic Respiratory diseases	Cancer	Mental Illness*	Total
High	0.9	8.5	1.6	5.4	9.0	25.5
Upper-middle	0.6	4.8	2.2	2.3	5.1	14.9
Lower-middle	0.2	2.0	0.9	0.5	1.9	5.5
Low	0.0	0.3	0.1	0.1	0.3	0.9
LMIC	**0.8**	**7.1**	**3.2**	**2.9**	**7.3**	**21.3**
World	**1.7**	**15.6**	**4.8**	**8.3**	**16.3**	**46.7**

*The numbers for mental illness were obtained by relating the economic burden of all other diseases to their associated number of DALYs. Then the burden for mental illness was projected using the relative size of the corresponding DALY numbers to all the other conditions.

Figure 3a: Mental health and cardiovascular diseases are top drivers of lost output
Breakdown of NCD cost by disease type, based on EPIC model

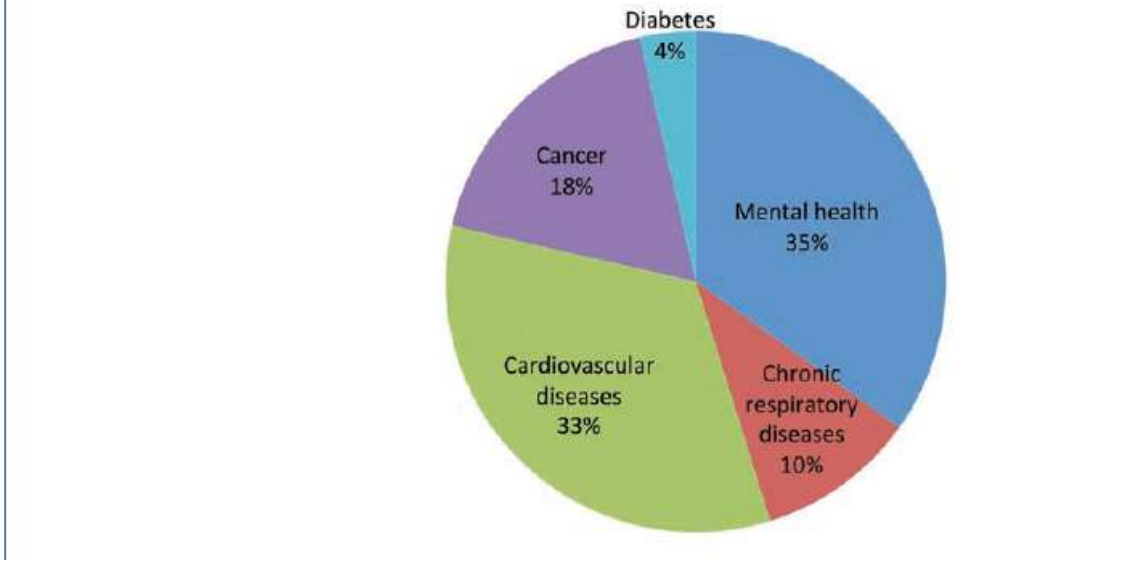

Table 16: Mental illness hits output hard
Breakdown of output losses by disease type and income category, 2010 and 2030, trillions (2010 US$), using the VSL approach

	2010						2030					
	Cancer	Chronic respiratory disease	Cardio-vascular diseases	Diabetes	Mental illness	Total	Cancer	Chronic respiratory disease	Cardio-vascular diseases	Diabetes	Mental illness	Total
High Income	1.7	1.5	5.4	0.7	5.5	14.8	2.2	2.0	7.2	1.0	7.3	19.7
Upper Middle Income	0.6	0.5	1.9	0.3	1.9	5.1	1.9	1.8	6.3	0.9	6.5	17.4
Lower Middle Income	0.3	0.2	0.9	0.1	0.9	2.4	0.6	0.5	1.9	0.3	2.0	5.3
Low Income	0.1	0.1	0.2	0.0	0.2	0.5	0.1	0.1	0.4	0.0	0.4	1.0
World	2.5	2.4	8.3	1.2	8.5	22.8	4.9	4.5	15.8	2.2	16.1	43.4

Lost output from 5 conditions (cancer, cardiovascular disease, chronic respiratory disease, diabetes and mental health) over period of 2011-2030 is estimated at nearly **$47 trillion** (EPIC approach).

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