Adult Mental Health

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Executive summary

Introduction

Mental health problems are common, disabling and costly.

In 2014, Nottingham Health and Wellbeing Board approved the Nottingham City Mental Health and Wellbeing Strategy, Wellness in Mind. Wellness in Mind brings together the vision for improved mental health and social inclusion across the life course under five priorities.

1. Promoting mental resilience and preventing mental health problems

2. Identifying problems early and supporting effective interventions

3. Improving outcomes through effective treatment and relapse prevention

4. Ensuring adequate support for those with mental health problems

5. Improving the wellbeing and physical health of those with mental health problems.

The use of the term 'mental health problem' mirrors that used in the National Strategy (DH2011) and is therefore used in this chapter as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorder.

There are many factors that influence mental health and wellbeing including personal relationships, childhood experience, employment, housing, safety, built and natural environment and experience of discrimination. At a personal level, the 'five ways to wellbeing' (NEF 2008) identified key messages for mental health promotion: be physically active, connect with other people, keep learning, take notice (based on mindfulness) and give time to other people (e.g. volunteering). There is a Wellness in Mind training programme which aims to Increase awareness and understanding of mental health and wellbeing across Nottingham. Mental wellbeing is measured each year in Nottingham and the groups with the lowest levels of wellbeing are the unemployed and those with long term health problems.

Mental health problems are very common and it is estimated up to one in two adults will experience problems at some point in their lives (Kessler 2007). Mental health problems range from severe mental illness, such as schizophrenia to common mental health problems such as anxiety and depression. All these conditions can be highly disabling and affect family, working and social life.

Adults with enduring mental health problems can be one of the most socially excluded groups in society, experiencing stigma and wide ranging social disadvantage as well as poor physical health outcomes. Under the Equality Act people with long term mental health problems may be considered to be disabled, with requirements of all services to make reasonable adjustments to enable them to benefit.

Mental health and physical health are interlinked. People with mental health problems experience higher rates of physical illness and a lower life expectancy (De Hert 2011), and those with chronic or long term physical health problems are more likely to experience mental health problems, often unrecognised and untreated. (Naylor 2012).

Mental health problems impact on individuals, families, communities, and society as a whole, with immense social and financial costs. Mental illness is an important cause of social inequality as well as a consequence. Mental health problems contribute a higher percentage of total 'disability adjusted life years' in the UK than any other long term illness (14%, or 23% with drug and alcohol abuse included, compared to cardiovascular disease 12%, cancer 13% and respiratory illnesses 8%) (WHO 2009). Estimates put the full cost of mental health problems in England at £105.2 billion (Centre for Mental Health 2010), and mental illness accounts for about 13% of total NHS spend (Parsonage et al 2012). In Nottingham the largest proportion of ESA claimants (50.8%) are recorded as having 'mental and behavioural disorders', which accounts for over 8,000 adults of working age (Nottingham City Health and Wellbeing Board 2015)

Mental health service improvement is a national priority (DH 2016), particularly focussing on crisis care, perinatal mental health, ending inappropriate use of police intervention, better access to psychological therapies and parity of esteem (giving equal value to mental and physical health). Building on the NHS Mandate, NHS England has published the Five Year Forward View for Mental Health, an independent report by the Mental Health Taskforce that sets national aspirations to 2020.In Nottingham, mental health urgent care is included as a local NHS vanguard, there is a Crisis Concordat partnership, and in 2015 Nottingham City HWBB agreed a Suicide Prevention Strategy .

Unmet need and gaps

- Citizens reported finding the system of mental health services confusing and difficult to navigate and were not always clear where to first turn for support. It is anticipated that the newly commissioned mental health and wellbeing service will serve to meet this need.

- Promoting positive mental wellbeing requires active partnership work across statutory services, non-profit organisations, and voluntary and community services. In addition, communities themselves well placed to tackle the factors that can impact on an individual's mental wellbeing.

- Broader understanding of mental health needs and the relationship with physical health needs to be improved at all levels within commissioning and provision including in physical health JSNA chapters

- The gap in life expectancy between people with mental health problems and those without needs to be reduced. This is an important priority for Nottingham City, and particularly with a focus on reducing smoking and improving identification of physical health problems early.

- Official suicide data is being produced earlier than previously, but it does not enable adequate insight or highlight areas needing a more timely response. Further insight should be developed through the Coroner suicide audit and learning from areas that have implemented real time surveillance.

- Care for people in mental health crisis is a partnership priority under the Crisis Care Concordat and Urgent Care Vanguard. This momentum needs to be maintained to ensure services respond to people in crisis based on needs.
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- Black and minority ethnic (BME) communities and high-risk groups, such as LGBT groups, offenders and asylum seekers/refugees may have challenges in terms of accessing mental health services. All commissioned services need to ensure they are able to describe the population that use their service so that gaps in access may be identified. Specific services to support community outreach (such as STEPS for BME communities) need to inform wider services how to ensure services meet diverse needs.

- Mental health problems are frequently reported amongst individuals who are homeless or at risk of becoming homeless. Work is needed to ensure the systems of homelessness prevention and mental health support work together to ensure those in need receive adequate treatment, accommodation and support.

- Mental health and employment indicators for the City show very high rates of people on out of work benefits due to mental health problems, and low employment rates for those known to secondary mental health care.

- More understanding is needed for the reason behind the low proportion of people on Care Programme Approach (CPA) in Nottingham compared to other areas.

- More understanding is needed of the needs relating to Personality Disorder.

Recommendations for consideration by commissioners

- Ensure all commissioned mental health services:
    - Are understood and accessible to all, including groups within the population who currently find services difficult to use for cultural reasons or because they believe the service will not meet their needs;
    - Have an emphasis on supporting recovery and promoting ‘safe’ independence;

  - Consider each individual's physical health needs as equally important as their mental health needs;
  - Promote seamless referral pathways both within, and between, services (e.g. between primary and secondary mental services)
  - Evaluate the impact of changes to provision for service users and partner organisations.
  - Engage and involve service users and carers in service development
  - Provide an environment that is smoke free and promotes and supports reductions in smoking.

- Continue to monitor progress towards greater flexibility and choice over accommodation and social support for citizens with enduring mental health needs, in accordance with the principles of self-directed support, and the needs of the local population.
- Consider results of dual diagnosis needs assessment 2015 and draft NICE guidance to make changes to services and pathways as appropriate.
- Develop and implement action plans from the Nottingham city mental health *Wellness in Mind Strategy 2014-2017*
- Implement action plans from the *Nottingham City Suicide Prevention Strategy 2015-18*
- Work in partnership to meet the aspirations of the Nottingham and Nottinghamshire Crisis Care Concordat
- Take the opportunity of the duty to promote 'wellbeing' in the Care Act to raise the profile of monitoring and improving mental wellbeing.
- Raise the profile of the outcomes for people with mental health problems as an equality issue. This means consideration by all commissioned services (including primary care and physical health services) of the requirement to make reasonable adjustments to enable people with enduring mental health problems to benefit.

Commissioners of other services that impact upon mental health and wellbeing should:

- Consider the impact of all services on citizens' mental health and wellbeing. For example, planning decisions regarding the use of open spaces and access to community services, arts and leisure services.
- consider initiatives that address the employment needs of adults with mental health problems, including ways to support adults with enduring mental health problems, and support for people experiencing common mental health problems to remain in or return to work

What do we know?

1) Who is at risk and why?

Mental health problems are extremely common. They are wide ranging in nature from common mental health problems such as depression and anxiety to rarer problems such as schizophrenia and other psychoses (mental health problems that stop the person from thinking clearly, telling the difference between reality and their imagination-NHS Choices). Mental health problems can be surrounded by prejudice, ignorance and fear. This can result in stigma and discrimination that makes it harder for those with mental health problems to live a normal life. It is widely reported that one in four people will experience mental health problems each year (McManus 2009) and up to one in two people at some point in their lives (Kessler 2007).

Mental health is influenced by a wide range of biological and social risk factors, including **fixed factors** such as age and sex, and **modifiable factors** such as:

- Family and socio-economic characteristics such as marital status, family composition and employment;
- Individual circumstances such as life events, social supports, immigration status, and debt;
- Household characteristics such as accommodation type and housing tenure;
- Geography such as urban/rural and region;
- And societal factors such as crime and deprivation index

(Foresight Mental Capital and Wellbeing Project 2008).

There are a number of groups within the population that are at higher risk of experiencing mental health problems. The Department of Health (2010) described the increased risks for some of these groups as follows:

- Unemployed adults have a 5.6-fold increased risk of developing a mental health problem;
- Homeless people have a 5.3-fold increased risk of developing a mental health problem;
- Citizens living in a cold home or experiencing fuel poverty have a 4-fold increased risk of having depression or anxiety;
- Adults with two or more physical illnesses have a 6.4-fold increased risk of having mental health problems;
- Black men are 3 times more likely to be represented on a psychiatric ward and up to six times more likely to be detained under the Mental Health Act;
- Young people who start using cannabis before they're 15 are 6.7 times more likely to develop schizophrenia;
- Offenders have a 5-fold increased risk of suicide. There is an 18-fold increased risk amongst young offenders, a 35.8-fold increased risk amongst female offenders and an 8.3-fold increased risk for recently released offenders;
- Lesbian, gay, bisexual or transgender adults have a 4-fold increased risk of suicide;
- Children who experience abuse have a 7-fold increased risk of recurrent depression and a 9.9-fold increased risk of developing post-traumatic stress disorder as an adult;

- Children experiencing 4 or more adverse childhood experiences[1] have a 12.2-fold increased risk of attempted suicide as an adult;
- Looked after children have a 4.5-fold increased risk of suicide attempt.

Local research highlighted the increased risk of mental health issues, including post-traumatic stress disorder in asylum seekers and refugees (Bunting 2009).

Ethnicity

The BMA Board of science (2014) summarised the evidence of differential need and use of services by ethnicity. Differential access to, and take up of, statutory services by some black and minority ethnic (BME) groups has been a particular concern with BME individuals having a three-fold increased risk of psychosis (rising to seven-fold in African–Caribbean people) (Kirkbride). A two-to three-fold increased risk of suicide is reported (Bhui et al) Despite the higher prevalence rates, the DRC (2006) notes that people from black groups were more likely than others to bypass primary care and be admitted straight to a psychiatric hospital. Based on this finding, the DRC concluded that the needs of black people with mental health problems were 'likely to be under-addressed in primary care'. A census conducted by the Care Quality Commission (CQC 2011) in 2010 – of inpatients, and patients on supervised community treatment –found a higher than average rate of admission, referral from the criminal justice system, and detention under the Mental Health Act for Black Caribbean, Black African, and White / Black Mixed groups. Whether this was due to variations in help seeking behaviour, cultural or language barriers, or other factors, is unclear (NIMH 2003, Bhugra 2001)

A contradictory situation persists whereby black groups may have 'higher rates of many mental illnesses, lower rates of general referral and treatment, but higher rates of compulsory treatment and forensic service contact.' (Thornicroft 2006)

Research to identify prevalence of common mental health problems (such as anxiety and depression) in the community found that after age-standardisation, there was little variation between white, black and South Asian men in the rates of any common mental health problems. However, in women all common mental health problems were more prevalent in the South Asian group. (McManus 2009)

Age

Rates of common mental health problems also varied by age: those aged 75 and over were the least likely to be affected, In women, the rate peaked among 45-54 year olds, with a quarter (25.2%) of this group meeting the criteria for at least one condition. Among men the rate was highest in 25-54 year olds (14.6% of 25-34 year olds, 15.0% of 35-44 year olds, and 14.5% of 45-54 year olds). (McManus 2009).

Although lower rates for the over 75 groups were identified in the community survey in 200, there has been an increased focus on the mental health and wellbeing of older people, with recognition that there may be additional risk factors as people age (bereavement, financial difficulties, physical health problems, loneliness) combined with lower expectation of support and a belief that such feelings are a natural part of aging (RCP 2016). RCP also highlight double the risk of depression in people in care homes.

A report by the National Development Team for Inclusion (NDTI 2015) reported that 16% of people aged 60 and over and 21% of people aged 80 and over have depression. In addition more than 2% of people aged 65 or over report having had suicidal thoughts in the past year. Evidence also suggests that older people are not necessarily getting the help or the

[1] Defined as child abuse, parental depression, domestic abuse, substance abuse or offending

treatment that they need for dealing with depression. For example, only 0.5% of people aged 65 and over and 0.2% of people aged 85 or over get referred for talking therapies for treatment of depression or anxiety. This compares to 2.2% people aged 20 to 64.

.**Links between mental health and physical health**

People with mental health problems have poor physical health outcomes and research shows that they die far younger -up to 20 years younger for people with schizophrenia (Parks 2006, De Hert 2011)' People in contact with secondary mental health services, have over 3 times the rate of early death as the wider population (HSCIC 2013a) and those with depression have double the risk of heart disease (Van der Kooy 2007)..

In 2006 a formal investigation by the Disability Rights Commission, Equal Treatment: Closing the Gap identified obesity, high blood pressure, smoking, heart disease, respiratory disease, diabetes and stroke as being more prevalent in people with mental health problems and also identified higher rates of bowel cancer in people with schizophrenia. Standard treatments and screening were offered less to these groups. This report also highlighted the gap in life expectancy as an equality issue.

Most early deaths are from preventable causes that are similar to the wider population (Hiroeh 2008). CVD and diabetes account for most years of life lost (Brown 2010). Poor health is influenced predominantly by unhealthy lifestyle behaviours, particularly smoking, and can be exacerbated by medication used to treat mental health problems. It has also been shown that health services have not been as responsive in identifying or meeting the physical health needs of people with mental health problems.

Smoking has been highlighted as a key factor in increased health risks. People who have mental health problems smoke at far higher levels than the general population, and experience greater health problems as a result. It has been estimated that 42% of all cigarettes smoked in the UK are smoked by somebody with a mental health problem (McManus 2010).

People with physical health problems are more likely to have low levels of mental wellbeing and higher rates of common mental health problems. Naylor et al reported that 30% of those with a long term physical health condition also have a mental health condition, often undiagnosed and untreated.

2) Size of the issue locally

Public Health England have developed mental health, dementia and neurology profiles which provide up to date nationally collected data on common mental health problems, suicide and serious mental illness. They include risk factor, prevalence and service activity data, some at local authority and others at CCG level.

Risk factors for poor mental health

Nottingham City is one of the ten most deprived districts in the country (Nottingham Insight 2016). Nottingham has high levels of many of the risk factors that can contribute to poor mental wellbeing. (see figure 1)

(Sources: Community Mental Health Profiles and Child Health Profiles)

Wider Determinants of Health	Local Value	Eng. Avg	Eng. Worst	Eng. Best
Episodes of violent crime, rate per 1,000 population, 2010/11	22.4	14.6	34.5	6.3
Percentage of the relevant population living in the 20% most deprived areas in England, 2010	51.5	19.8	83.0	0.3
Working age adults who are unemployed, rate per 1,000 population, 2010/11	85.2	59.4	106.2	8.3
Rate of hospital admissions for alcohol attribution conditions, per 1,000 population, 2011/12	22.4	23.0	38.6	11.4
Numbers of people (ages 18-75) in drug treatment, rate per 1,000 population, 2011/12	8.9	5.2	0.8	18.4
Risk Factors	**Local Value**	**Eng. Avg**	**Eng. Worst**	**Eng. Best**
Statutory homeless households, rate per 1,000 households, all ages, 2010/11	4.5	2.0	10.4	0.1
Percentage of the population with a limiting long term illness, 2001	19.1	16.9	24.4	10.2
Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12	10.9	11.2	5.7	17.3
Wider Determinants of Health Specific to Children	**Local Value**	**Eng. Avg**	**Eng. Worst**	**Eng. Best**
Percentage of children achieving a good level of development at the end of reception, 2012/13	39.9	51.7	27.7	69.0
GCSE achieved (5A*-C inc. English and Maths), 2012/13, (% of pupils)	50.3	60.8	43.7	80.2
GCSE achieved (5A*-C inc. English and Maths) for children in care, 2012/13, (% of children looked after)	15.6	15.3	0.0	41.7
Percentage of 16-18 year olds not in education, employment or training, 2012	6.3	5.8	10.5	2.0
First time entrants into the youth justice system 10 to 17 year olds, 2012, (rate per 100,000)	1,107.7	537.0	1,426.6	150.7
Percentage of children in poverty (under 16 years), 2011	35.2	20.6	43.6	6.9
Family homelessness, 2012/13, (rate per 1,000 households)	2.9	1.7	9.5	0.1
Children in care, 2013, (rate per 10,000 children under 18)	90.0	60.0	166.0	20.0

Not significantly different to England
Significance Not Tested
England Average
Where percieved polarity:
Significantly worse than England
Significantly better than England
Where no percieved polarity:
Significantly lower than England
Significantly higher than England

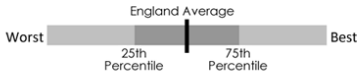


Figure 1. Risk factors for poor mental wellbeing. Nottingham City Council, Wellness in Mind (2014)

Mental wellbeing

Mental wellbeing is a broad term that can be defined as "….*a dynamic state, in which an individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their communities*" (Foresight 2008).

The mental wellbeing of Nottingham has been measured using the Warwick and Edinburgh Mental Well-being Scale (WEMWBS), a validated measure of population mental wellbeing. The scale has been included in Nottingham City's Citizens Surveys since 2010. Possible scores range from a minimum of 14 to a maximum of 70; a higher score indicating a higher level of mental wellbeing.

Average WEMWBS scores for Nottingham continue to compare closely with the England average. There is some variation noted based on geography with Aspley ward reporting significantly lower levels of wellbeing. The starkest differences are between groups in the city, most notably between those who are in work and those who are unemployed, and between those with long term health problems and others (see figure 2 below). For further details on WEMWBS and the measurement of wellbeing please the chapter on mental wellbeing.

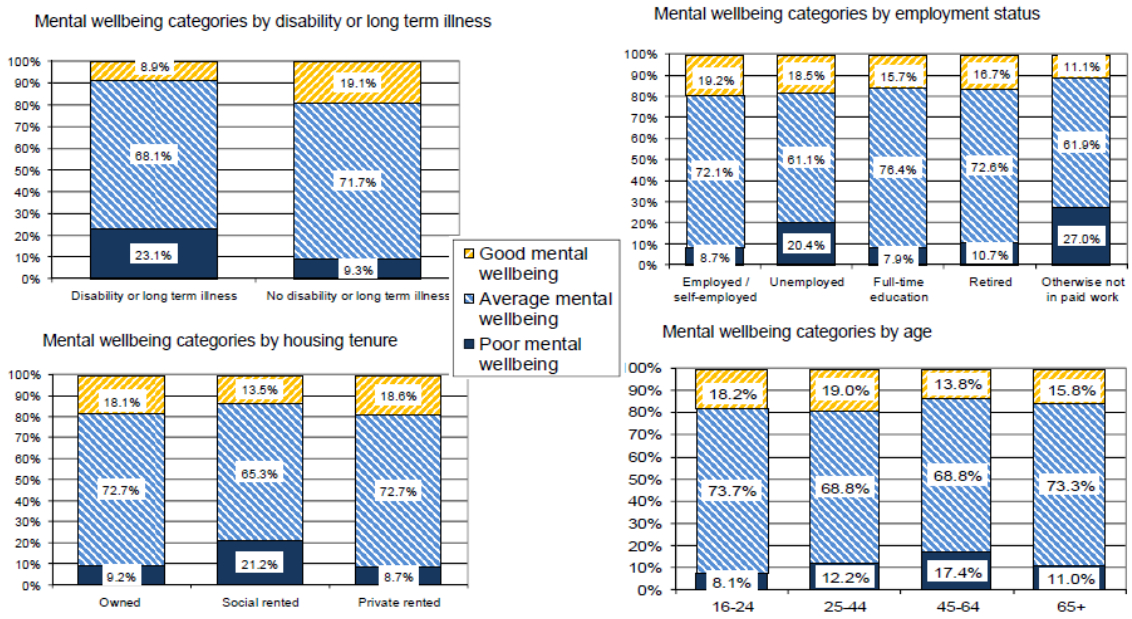


Figure 2. Result of mental wellbeing questions (Nottingham Citizens Survey, 2014)

The scale of mental health problems in Nottingham City's population

Large scale survey results are used in order to provide local estimates of mental health need,. These estimates are based on population size and are likely to understimate need in Nottingham due to the high level of risk factors discussed above.

The Adult Psychiatric Morbidity Survey (APMS) (McManus et al 2009) was carried out in 2007. It remains the primary source of information on the prevalence of both treated, and untreated mental health problems.

Figures three and four illustrate the burden of mental health problems expected in women and men aged over 16 in Nottingham based on 2014 population estimates. Prevalence figures have been taken from the APMS and applied to the ONS 2014 mid-year estimate of the Nottingham population. Some people may be counted more than once as they may experience more than one mental health problem. Prevalence for common mental health problems is based on people experiencing symptoms within the past week. Psychosis and personality disorder are based on symptoms within the past year. Postnatal mental health problems were estimated based on annual births to women in Nottingham (for further details see pregnancy JSNA chapter).

Although the estimates are acknowledged to be likely to underestimate need, the overall balance between common mental health problems and more severe mental illness are illustrated.

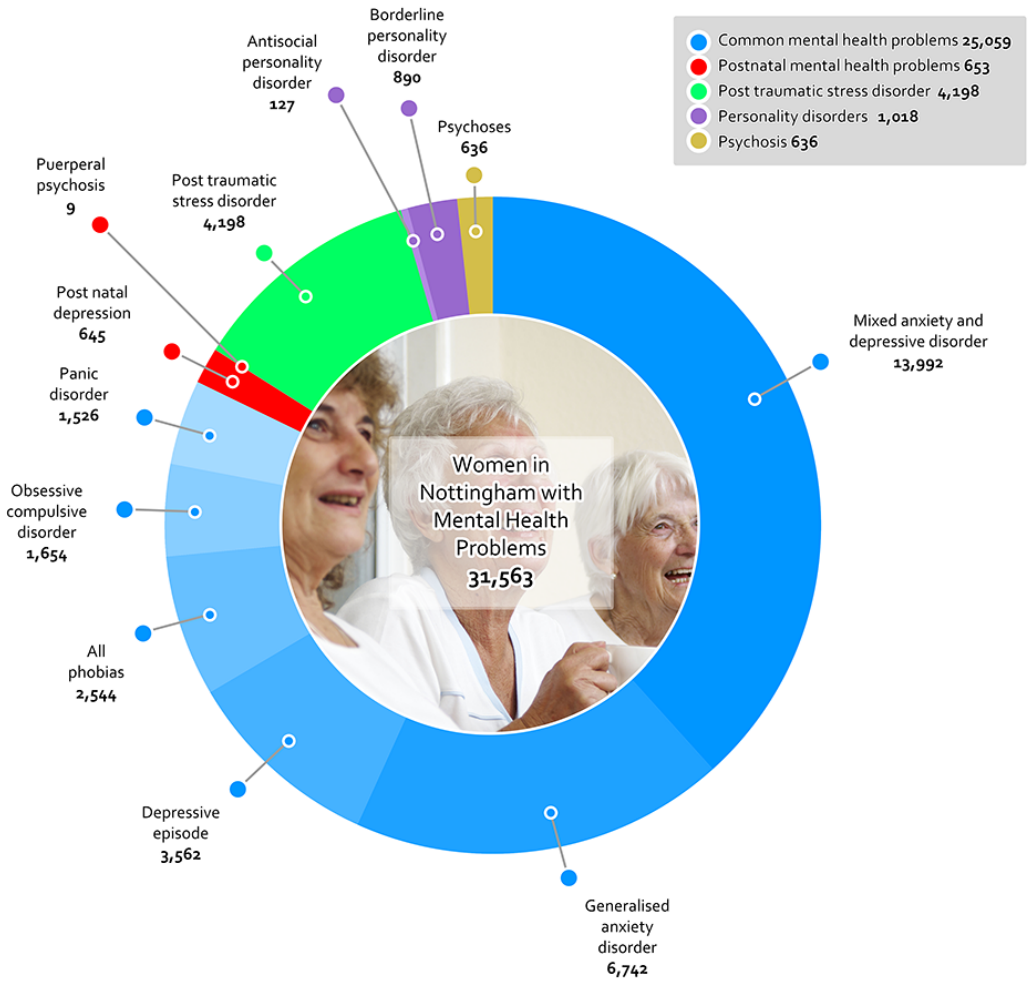


Figure 3: Estimates of mental health problems amongst women in Nottingham

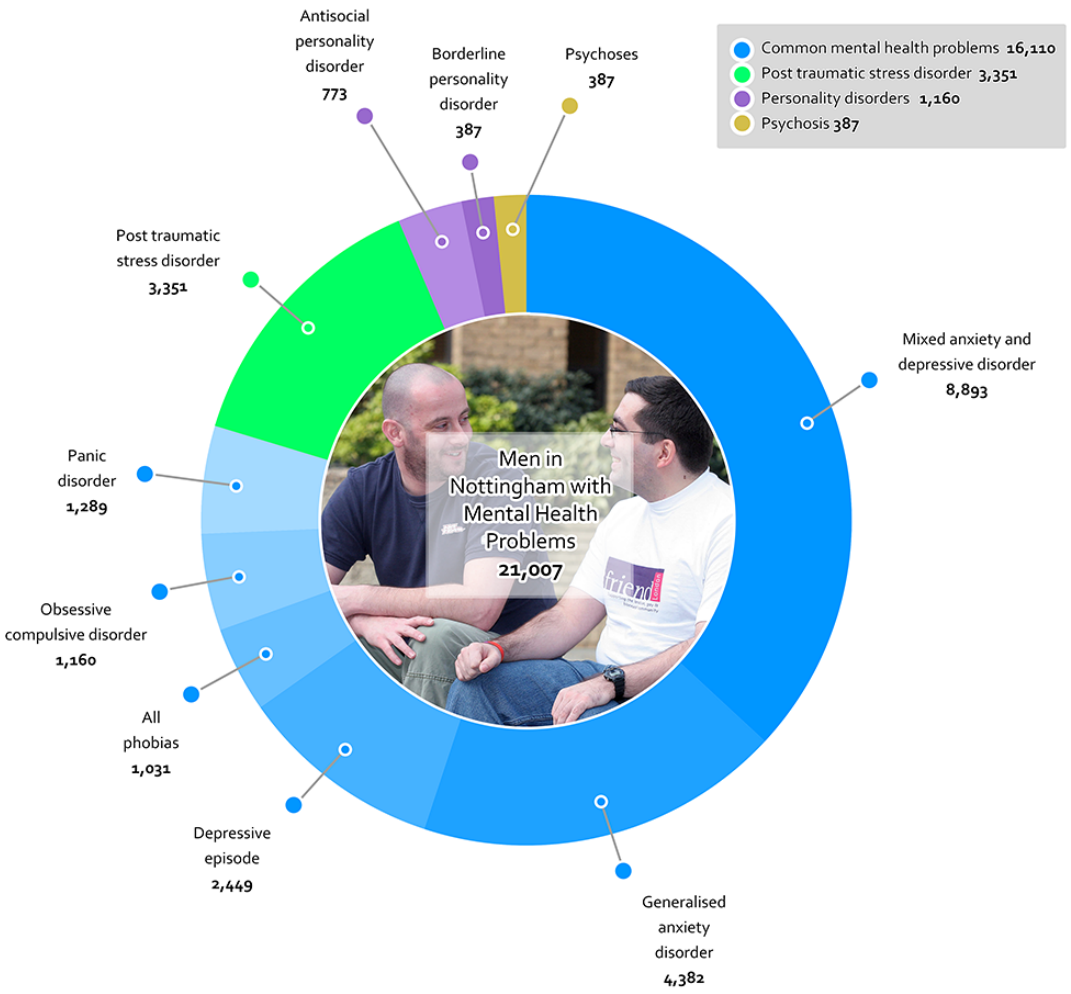


Figure 4: Estimates of mental health problems amongst men in Nottingham

Common Mental Health problems

Those mental helath problems described as 'common' are reflected in the blue sections in figures 3 and 4 above. Estimates of need related to common mental health problems are likely to differ from numbers of people presenting for support as only between a quarter and a third of those people reporting symptoms were found to be receiving any type of treatment (McManus 2009).

Common mental health problems, such as depression, anxiety, phobias and obsessive compulsive disorder, have an overall prevalence of 16.2% in adults in England, with half having symptoms severe enough to require treatment (McManus et al 2009).

The Adult Psychiatric Morbidity Survey (APMS) (McManus 2009) identified that common mental health problems are more common amongst women (19.7%) than men (12.5%) and vary by age group. In women, those aged 45-54 have the highest prevalence of common mental health problems. Amongst men, those aged 25-54 years have the highest prevalence. In both genders those aged 75 years and over have the lowest prevalence. The APMS also identified that prevalence also varies by:

- Marital status, with a higher prevalence among divorced and separated adults;
- Household income, with adults in the lowest quintile of household income more likely to have a common mental health problem than adults in the highest quintile. This is

a particularly strong association among men, with men in the lowest household income quintile three times more likely to have a common mental health problem than men in the highest household income quintile;

- Presence of other long term health problems. In addition the Nottingham Citizens Survey (2014) showed lower levels of wellbeing in people with long term conditions. A third of all people recorded as having depression in primary care, in 2012, were also recorded as having at least one long term condition.(Nottingham City PCT public health data)

Previous modelling undertaken by North East Public Health Observatory (NEPHO) suggests that NHS Nottingham City has a higher rate of adults aged 16-74 years old with common mental health problems than England (Glover 2008). The reason for this is unclear but may relate to underlying differences in the population such as increased risk factors for mental health problems associated with age and ethnicity, immigration, and deprivation.

Out of work benefits due to mental health problems

In February 2015 15,760 people of working age were in receipt of out of work benefits due to disability or health problems (employment and support allowance- ESA), of whom over 12,500 for longer than 6 months. In Nottingham the largest proportion of ESA claimants (52%, 8,120 people) are recorded as having 'mental and behavioural disorders'. This broad category includes those with mental health problems, learning disabilities and autism, although the majority will be those with mental health problems.. The proportion of claimants with mental health problems far outweighs the number with musculoskeletal problems (13.5%) or following injury (4.9%). Figure 5 illustrates the numbers of ESA claimants by age in Nottingham and the relative proportions that each category account for. DWP records do not allow for the group with mental and behavioural problems to be broken down further and only report the primary reason for being unable to work.

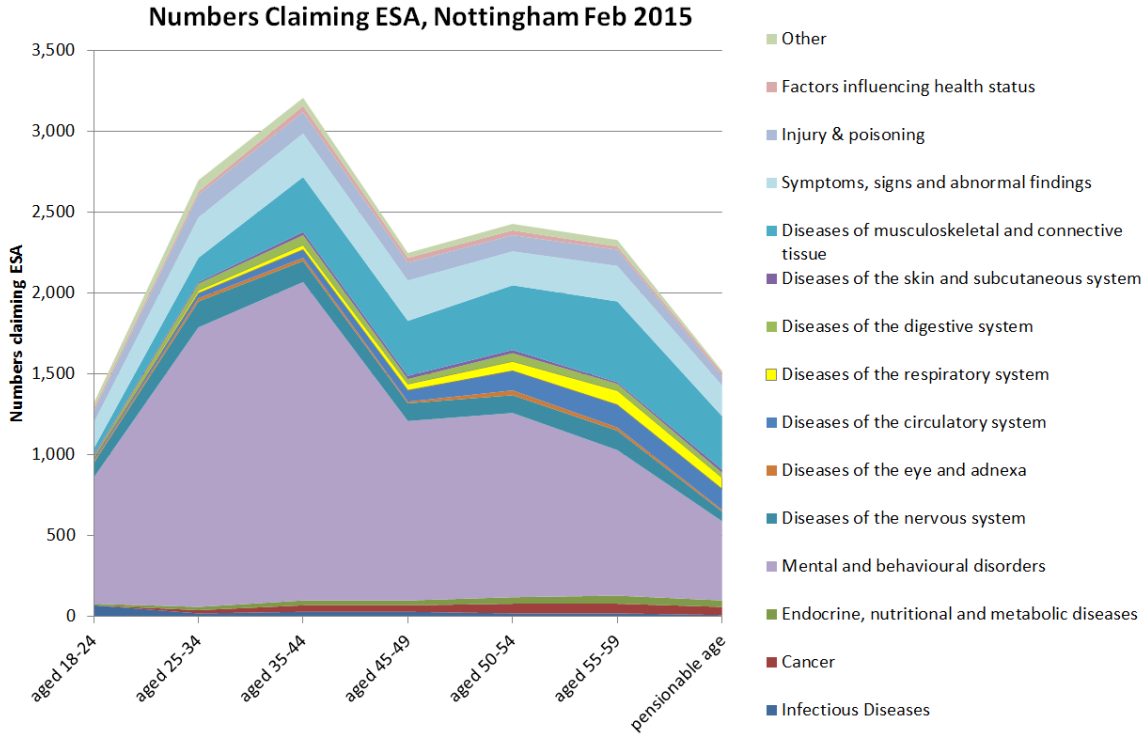


Figure 5:Number claiming ESA by age group in Nottingham by cause. Source (NOMIS)

Depression in primary care

The average recorded prevalence of depression across England in GP practices is 7.3%. In 2014/15, the total number of adults at Nottingham City practices aged 18 or over who had a diagnosis of depression recorded as part of the Quality and Outcomes Framework was 19,845 giving an age-specific prevalence of 6.8% (HSCIC 2015). Recorded prevalence at practices in NHS Nottingham City ranged from 1.5% to 13.6% (see fig.6). In 2014/15 there were 4,093 new reported cases of depression recorded as part of QOF at City practices.

There will be differences between estimates of need based on APMS and recorded prevalence in QOF for a number of reasons: We know that estimates based only on population size will underestimate need in Nottingham The APMS estimated people with symptoms that week only, rather than prevalence over a longer time, and showed that only a minority of people with common mental health problems were in treatment. There is also variation in how depression is recorded at practice level. Local intelligence suggests that some practices may be more likely to record 'depressive symptoms' which will not be reflected in QOF figures. For all these reasons both the population estimates and QOF figures should be treated with caution, however they do both illustrate the scale of depression as a common health problem in Nottingham.

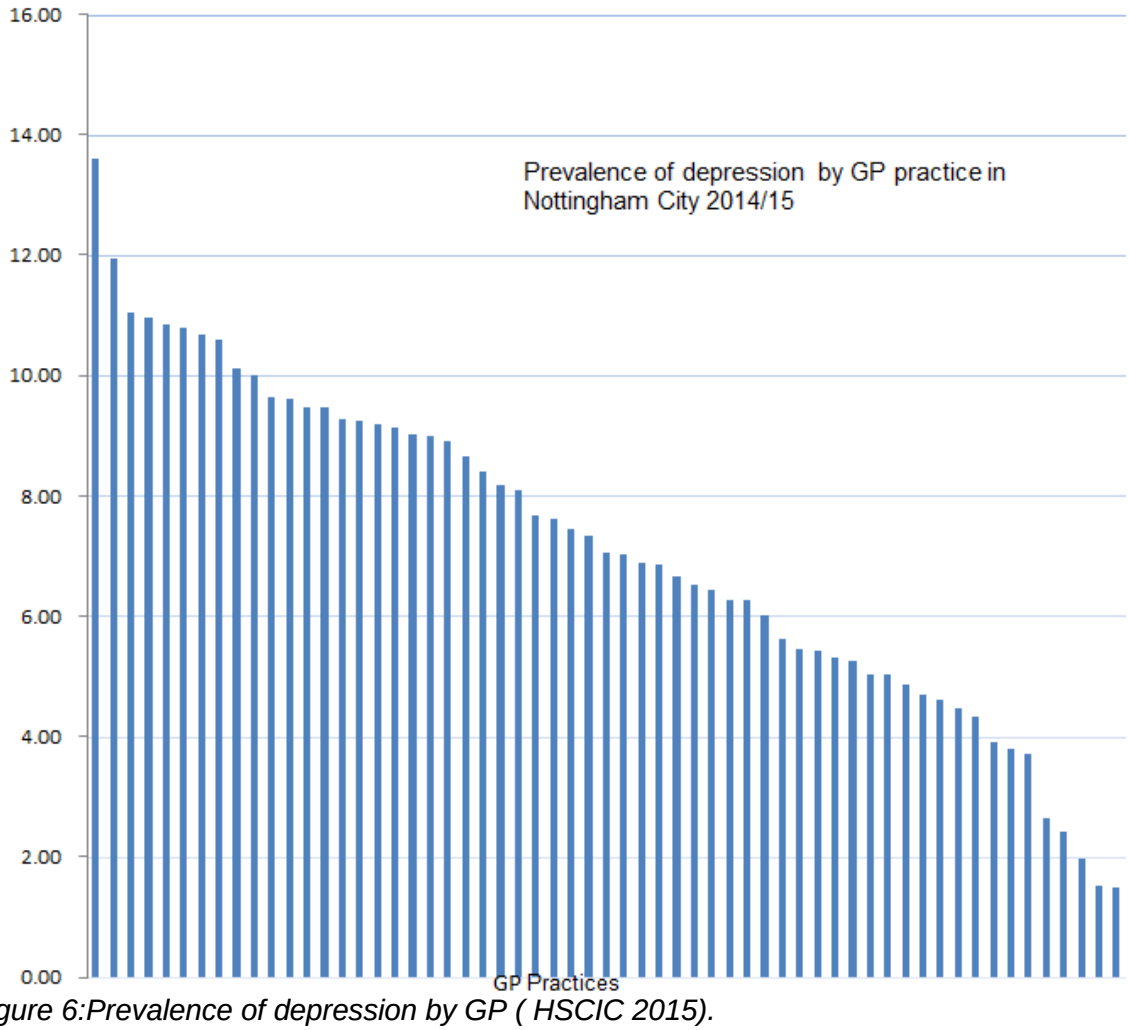


Figure 6:Prevalence of depression by GP (HSCIC 2015).

Serious mental health problems in primary care

GPs are required to keep a register of patients who have 'serious mental illness', which includes those with schizophrenia, bipolar disorder or other psychosis. In 2014/15 there were 3,506 patients recorded on the register across NHS Nottingham City's practices, giving a recorded prevalence rate of 0.97%, which is slightly higher than national prevalence (0.9%) (HSCIC 2015). These prevalence rates are higher than the APMS which recorded prevalence of 0.4%, although that was an annual measure. Recorded prevalence at GP level varies in Nottingham from under 0.2% to almost 3%, as illustrated in fig.7 below.

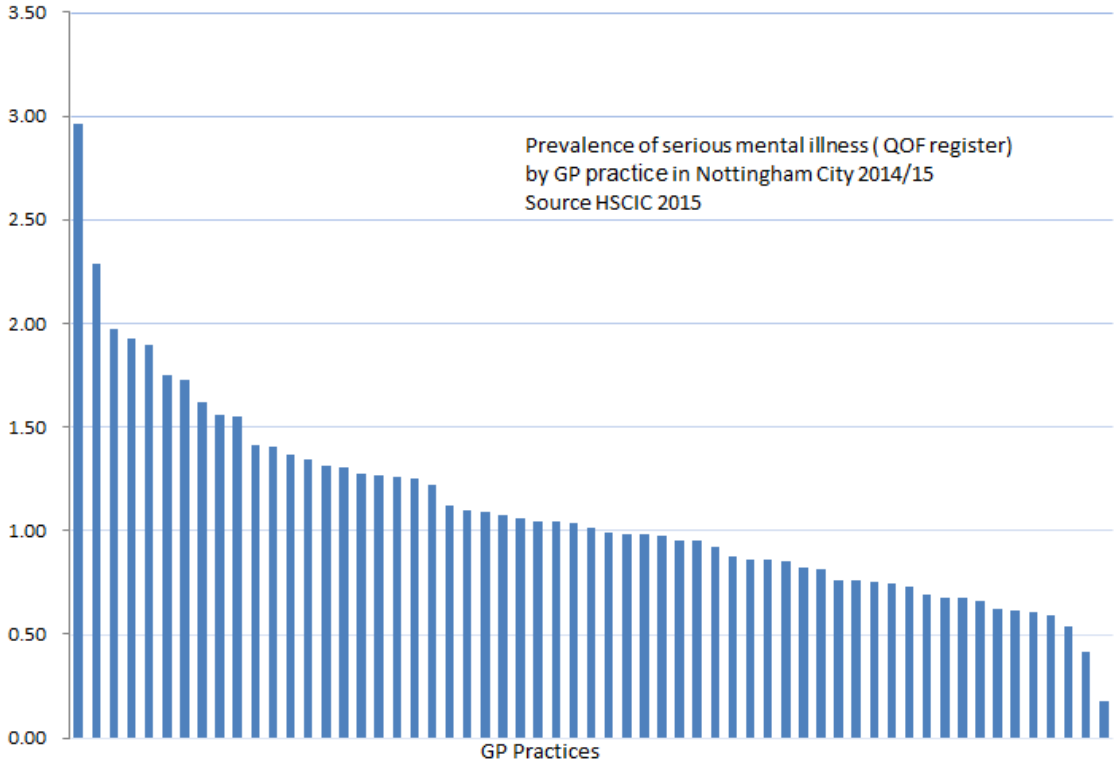


Figure 7:Prevalence of serious mental illness by GP (HSCIC 2015).

Population with mental health problems requiring secondary mental health services

For some people the level of mental health need requires treatment or assessment in hospital, or care of a secondary mental health team in the community or as an outpatient. The level of mental health problems severe enough to require hospital admission has been estimated to be higher in Nottingham than nationally. Previous MINI2000 (Mental Illness Needs Index) figures for Nottingham were 1.45, compared to the England figure of 1.0. This suggests that Nottingham has 45% more admissions to hospital for serious mental illness than the England average (NEPHO 2008).

This modelling tool is based upon 2001 population data and is no longer updated. Therefore, we are unable to rely on such estimates due to marked population changes in Nottingham City since that time. It does however suggest higher levels of need in Nottingham since the burden of serious mental health problems in the Nottingham population is more likely to have risen than reduced over recent years, due to increased relative deprivation, increased ethnic diversity, and a background of an increasing population.

A system of grouping patients known to mental health services based on clinical need has been developed to support plans for the NHS National Tariff Payment System (NHS England

2014) The groups are known as ‘clusters’ based on national criteria. Those relevant to adult mental health are listed below.

Care clusters in adult mental health

1	Common mental health problems (low severity)
2	Common mental health problems
3	Non-psychotic (moderate severity)
4	Non-psychotic (severe)
5	Non-psychotic (very severe)
6	Non-psychotic disorders of overvalued Ideas
7	Enduring non-psychotic disorders (high disability)
8	Non-psychotic chaotic and challenging disorders
9	Blank cluster
10	First episode in psychosis
11	Ongoing recurrent psychosis (low symptoms)
12	Ongoing or recurrent psychosis (high disability)
13	Ongoing or recurrent psychosis (high symptom and disability)
14	Psychotic crisis
15	Severe psychotic depression
16	Dual diagnosis (substance abuse and mental illness)
17	Psychosis and affective disorder difficult to engage

All patients are assessed to identify which cluster they are in, and then reassessed to take account of change in care needs. Commissioners are able to request demographic reports to understand the number and characteristics of patients within each cluster, but these are not available publically at present. Recent reports suggest that clustering does not always reflect the needs of the patient accurately. However, over time, this information available to commissioners will be able to illustrate the range of needs of the secondary care population and potentially highlight where specific groups are over or underrepresented..

The number of people accessing specialist services demonstrates demand. However, since some groups within the population access services less frequently, unmet need may remain. Table one, below shows the percentage of people from each ward in Nottingham who have been referred to specialist mental health services provided by Nottinghamshire Healthcare NHS Foundation Trust (NHFT), the local provider of secondary mental health services. Differences across the wards show a similar pattern to other deprivation indicators; higher usage toward the more deprived east of the city, and lower usage toward the west of the city (Wollaton, Dunkirk and Lenton).

Table 1: Percentage of people in each ward who are referred to specialist mental health services (NHFT), 2012/13

% of population referred to specialist mental health services				
Ward	n	%	LL 95%	UL 95%
Wollaton West	244	1.66	1.45	1.87
Dunkirk and Lenton	189	1.70	1.46	1.94
Wollaton East and Lenton Abbey	177	1.71	1.46	1.96
Leen Valley	220	2.02	1.76	2.29
Radford and Park	450	2.03	1.84	2.21
Bridge	335	2.23	1.99	2.46
Bulwell Forest	319	2.36	2.10	2.62
Aspley	430	2.44	2.21	2.66
Clifton North	331	2.48	2.21	2.74
Basford	418	2.56	2.32	2.80
Nottingham City	8426	2.73	2.67	2.79
Clifton South	386	2.78	2.50	3.05
Berridge	540	2.88	2.64	3.12
Bilborough	487	2.89	2.64	3.14
Bestwood	496	2.95	2.69	3.20
Dales	499	2.99	2.73	3.25
Bulwell	489	3.04	2.77	3.30
Mapperley	522	3.32	3.04	3.60
Arboretum	482	3.51	3.20	3.82
Sherwood	763	3.90	3.63	4.17
St Ann's	649	4.20	3.89	4.52

Statistically higher than Nottingham City
No statistical difference to Nottingham City
Statistically lower than Nottingham City

NHFT is the major specialist, mental health provider for the Nottingham city population. An index of patients, called the Master Patient Index (MPI), of all patients currently in contact with community mental health and inpatient services within the Trust shows that there were 7313 adult mental health patients on the index in 2012/13, 93% of who aged between 18 and 64 years. It is important to note that the majority of people over the age of 65 years will be seen by 'Mental Health Services for Older People' teams rather than 'Adult Mental Health' teams, however many of these will have problems related to cognitive impairment rather than functional metnal helath problems.

An analysis of patients within the index showed a higher proportion of older adults, aged 35-55 years, and a lower proportion of young people than the resident city population, as shown in figure three below. Nottingham City has a large student population of 18-24 age group.

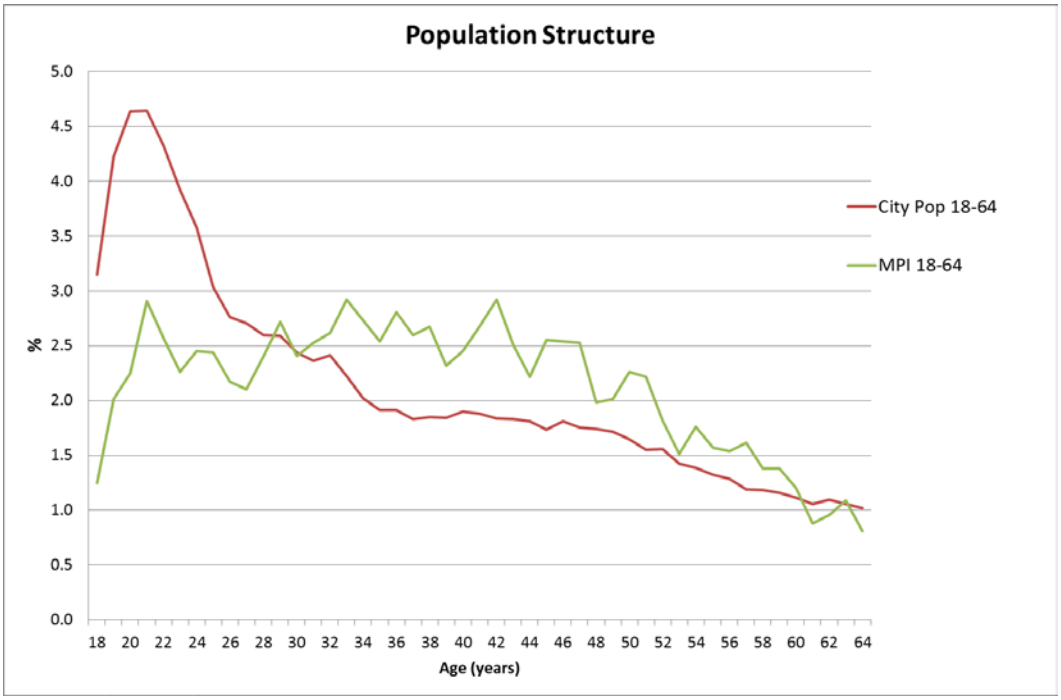


Figure 8: Population structure of the Master Patient Index compared to the Nottingham City population, 2012/13

Figure nine shows that males are more likely to be using NHFT services than females making up 55% of the total MPI. Males are over represented compared to the general population at all ages from 30-65 years. There are more females than males in the 15-29 age groups, possibly accounted for by high levels of self harm in younger women.

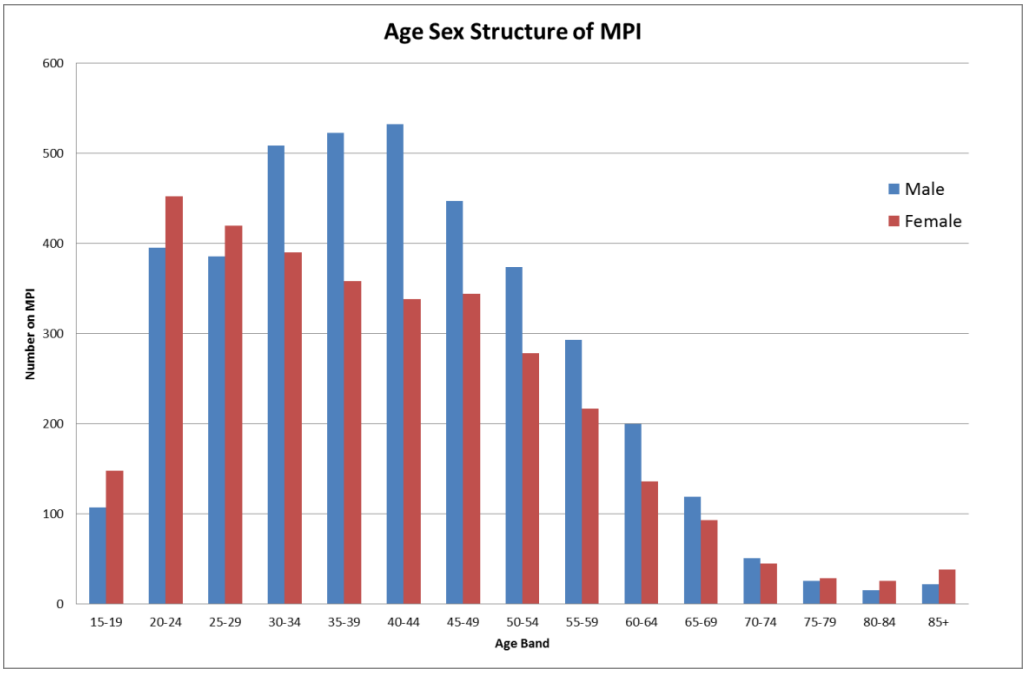
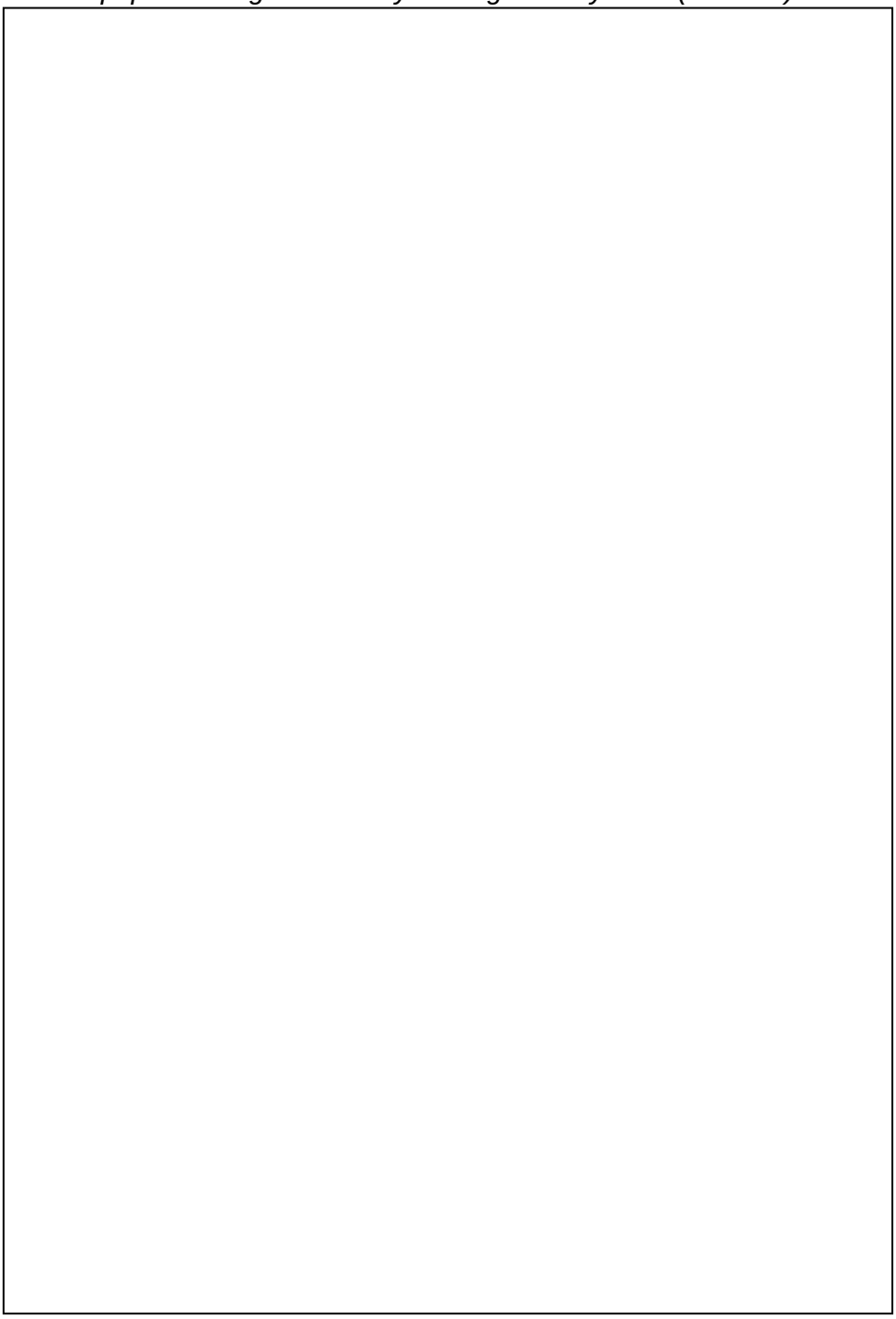


Figure 9: The age and sex structure of the MPI population, 2012/13

The rate of patients under the care of NHFTvaries by ward. Figure ten shows that three wards have significantly lower rates of patients in contact with NHFT services. In Wollaton ward, low rates of referral correspond with low contact. However, in some areas such as Leen Valley, Aspley and Bulwell Forest there are similar rates of referral to the Nottingham city average, yet significantly lower contact with services.

The four wards with the highest proportion of referrals **and** the highest rate of contact with service are St. Ann's, Arboretum, Mapperley, and Sherwood. Aroboretum ward has the highest rate of contacts out of all the wards; twice that of the city average. Arboretum also has one of the lowest level of mental wellbeing compared to the Nottingham population.

Figure 10. Map showing directly age-sex standardised Rate of NHFT patients per 1000 population aged 18-64 by Nottingham city ward (2012/13)



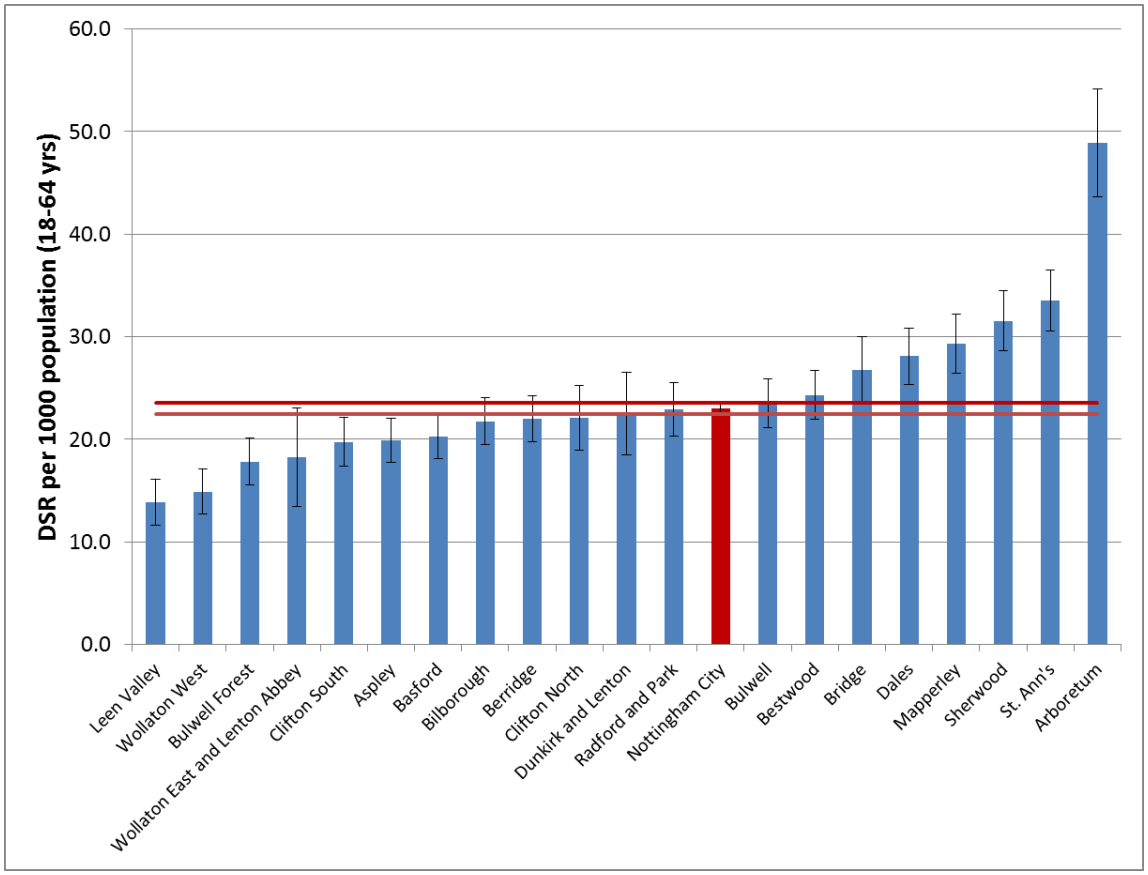


Figure 11: Graph showing directly age-sex standardised Rate of Healthcare Trust patients per 1000 population aged 18-64 by Nottingham city ward (2012/13)

Table four below shows a breakdown of the patients in contact with NHFT by ethnicity. Of those patients in contact with NHFT, the MPI had a slightly higher proportion of people with white ethnic background. All Asian ethnic groups in contact with services are underrepresented compared to the city population.

The proportion of patients on the MPI with a Black Caribbean ethnic background is higher than that of the Nottingham City population. This could be partly accounted for by a significantly higher age standardised prevalence of psychotic disorder among black men (3.1%) than men from other ethnic groups (McManus 2009) and reflects the national picture as described above. Prevalence does not vary markedly by ethnicity for psychotic disorder in women, or common mental disorder in either gender.

Table 2: Ethnicity of MPI compared to census 2011 Nottingham City Population (Age 18-64)

Ethnic group	MPI Patients	%	Nottingham City (Census 2011)	%
White British	5025	73.75	135805	65.4
White Irish	65	0.95	1771	0.9
Any Other White Background	252	3.70	12511	6.0
Asian Indian	111	1.63	7844	3.8
Asian Pakistani	225	3.30	10047	4.8
Asian Bangladeshi	10	0.15	667	0.3
Asian Chinese	14	0.21	5506	2.7
Any Other Asian Background	80	1.17	4669	2.2
Black Caribbean	349	5.12	6205	3.0
Black African	105	1.54	6939	3.3
Any Other Black Background	69	1.01	1608	0.8
Mixed White and Asian	36	0.53	2,040	1.0
Mixed White and Black African	28	0.41	991	0.5
Mixed White and Black Caribbean	142	2.08	6342	3.1
Any Other Mixed Background	71	1.04	1,499	0.7
Any Other Ethnic Group	186	2.73	3,290	1.6
Not Stated	46	0.68		0.0
Grand Total	6814	100.00	207,734	100.0

Summary

Ethnic group (Age 18-64)	Patients	%	Nottingham City (Census 2011)	%
White	5342	78.4	150087	72.2
Black	523	7.7	14752	7.1
Asian	440	6.5	28733	13.8
Mixed	277	4.1	10872	5.2
Other	186	2.7	3290	1.6
Not stated	46	0.7		
Grand Total	6814		207734	

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Current snapshot of secondary mental health service use

A snapshot of secondary mental health service use in September 2015 (HSCIC Dec 2015) showed that 96% of current secondary mental health service patients who were the responsibility of Nottingham City CCG were being treated at NHFT, 5460 out of 5685 in total**.** The latest figures are available from HSCIC, updated monthly.

Table 3: Snapshot of Nottingham City CCG patients in contact with secondary mental health services in September 2015

	Nottingham City CCG patients at NHFT	Total at all providers	% at NHFT
Number of mental health patients	**5460**	**5685**	**96%**
People on CPA aged 18-69	**660**	**770**	**86%**
People on CPA aged 18-69 for more than 12 months	**515**	**585**	**88%**
Open hosptial spells	**195**	**270**	**72%**
Subject to Mental Health Act	**150**	**210**	**71%**
Under care of Early Intervention in Psychosis team	**225**	**240**	**94%**
Under care of Assertive Outreach team	**145**	**150**	**97%**
Admissions in month	**65**	**75**	**87%**
Number detained on admission	**25**	**25**	**100%**

Suicide

The Office of National Statistics measure of suicide includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent. In order for a coroner to give a conclusion of suicide at an inquest the coroner would need to be convinced beyond reasonable doubt that the person intended to kill him/herself.

The rates published are standardised per 100,000 people so they can be compared over time and for different areas. There are two national rates published. ONS publish rates in people 15 years and over, but the Department of Health/Public Health Outcomes Framework publish a rate for 10 years and above (but only include a definition of intentional self-harm for those aged 10-15 years). The result is the ONS figure will give a higher rate than DH/PHOF for the same year.

Latest DH data can be found at Public Health England Suicide Profile

This section reports the DH/PHOF rates. There are approximately 28 relevant deaths per year in Nottingham. In 2011-13 there were 84 deaths in Nottingham City, giving a directly age-standardised rate of 10.3 per 100,000 population. This rate is not significantly higher than the England and East Midlands rates (8.8 and 8.4 per 100,000 respectively) (see fig 11). As there are a relatively small number of suicides in Nottingham each year means that a small increase or reduction in the numbers of suicides each year can result in a large change in the rates. Nationally, and regionally, there was a reduction in the suicide rate between 1995 and 1997 but more recent reports have shown an increase since 2011.

Indicator	Period	England	East Midlands region	Derby	Derbyshire	Leicester	Leicestershire	Lincolnshire	Northamptonshire	Nottingham	Nottinghamshire	Rutland
Suicide age-standardised rate: per 100,000 (3 year average) (Persons)	2012 - 14	8.9	8.8	9.3	8.1	8.7	8.6	9.7	8.3	10.0	9.2	*
Suicide age-standardised rate: per 100,000 (3 year average) (Male)	2012 - 14	14.1	14.2	15.4	13.3	13.9	13.5	15.9	13.4	15.3	14.9	*
Suicide age-standardised rate: per 100,000 (3 year average) (Female)	2012 - 14	4.0	3.7	*	3.1	*	3.8	3.9	3.4	*	4.0	*

Figure 12: Chart showing suicide rates in Nottingham compared to regional and national rates (PHE)

Rates at a local level vary and the pattern over time is illustrated in figure 13 below.

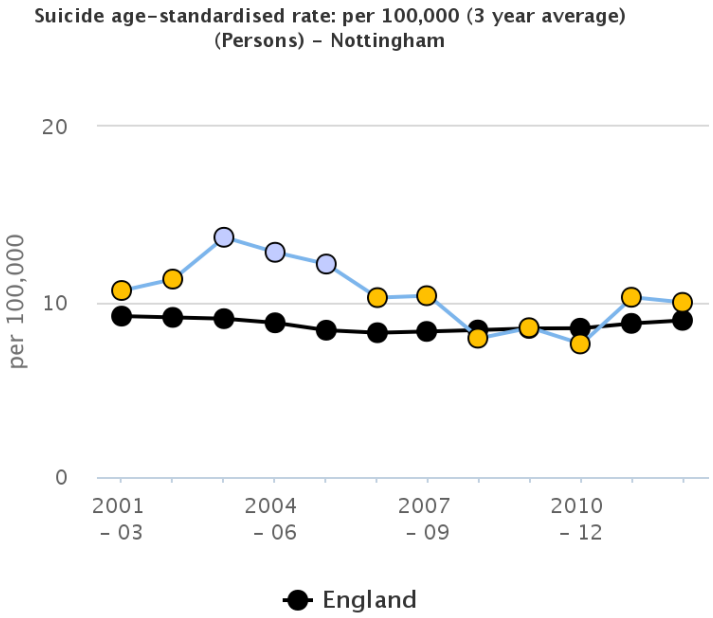


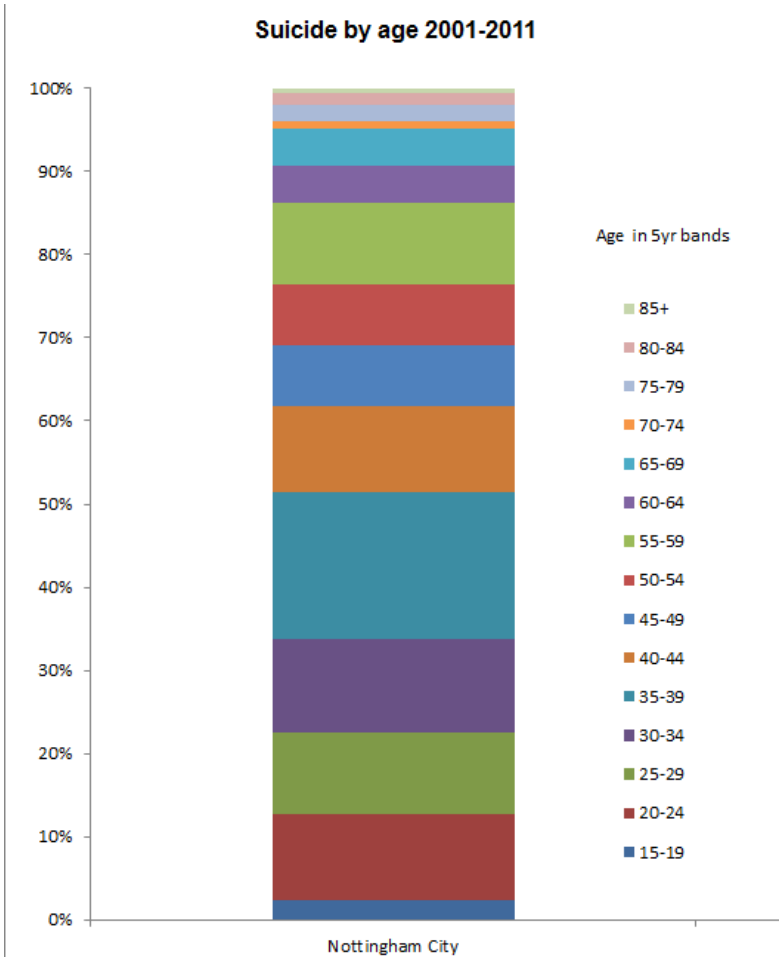
Figure 13: Rates of Suicide and Injury Undetermined in NHS Nottingham City, England and East Midlands from 2001-2014 per 100,000 people (PHE)

In relation to suicide in Nottingham the following characteristics were also noted:

- Men accounted for 79% of all suicides in Nottingham between 2008-2010;
- People aged 20-34 years of age accounted for 30% of suicides between 2001 and 2011, with suicides being most common in those aged 35-39 years;
- 26.7% of all suicides across Nottinghamshire between 2001 and 2007 were of individuals known to mental health services;
- Current data does not adequately record ethnicity in suicides therefore it is not possible to assess whether research evidence stating higher rates in BME groups are seen locally.

- Further insight into suicide locally is being investigated through an audit of Coroner's data for 2013 and 2014 and will inform a separate JSNA chapter.
- Nottingham City Suicide Prevention Strategy (Nottingham HWBB 2015a) has further detail of groups at risk and local information.
- The age profile of local people who have died over a 10 year period from suicide or injury of undetermined intent are illustrated in figure 14 below.

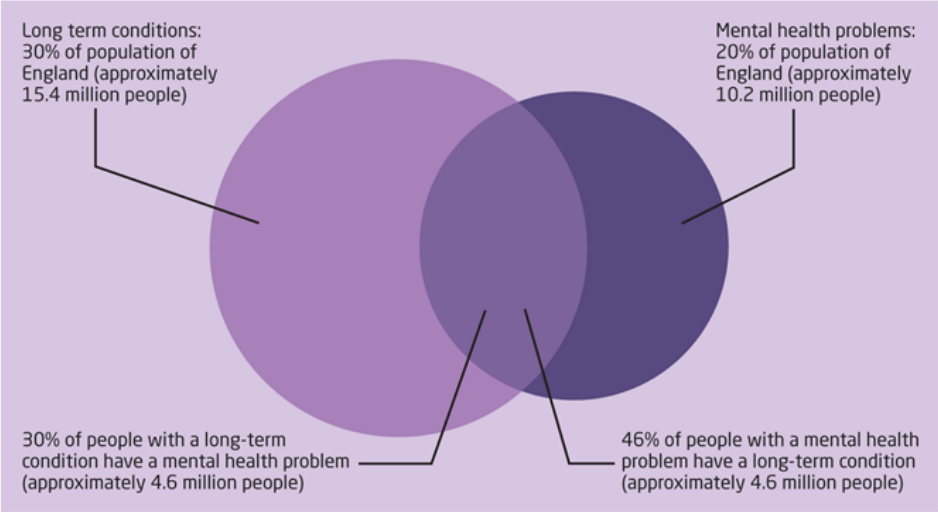
Figure 14: Breakdown of ages of death by Suicide and Injury Undetermined in Nottingham City 2001-2011



Physical health inequalities in those with mental health problems

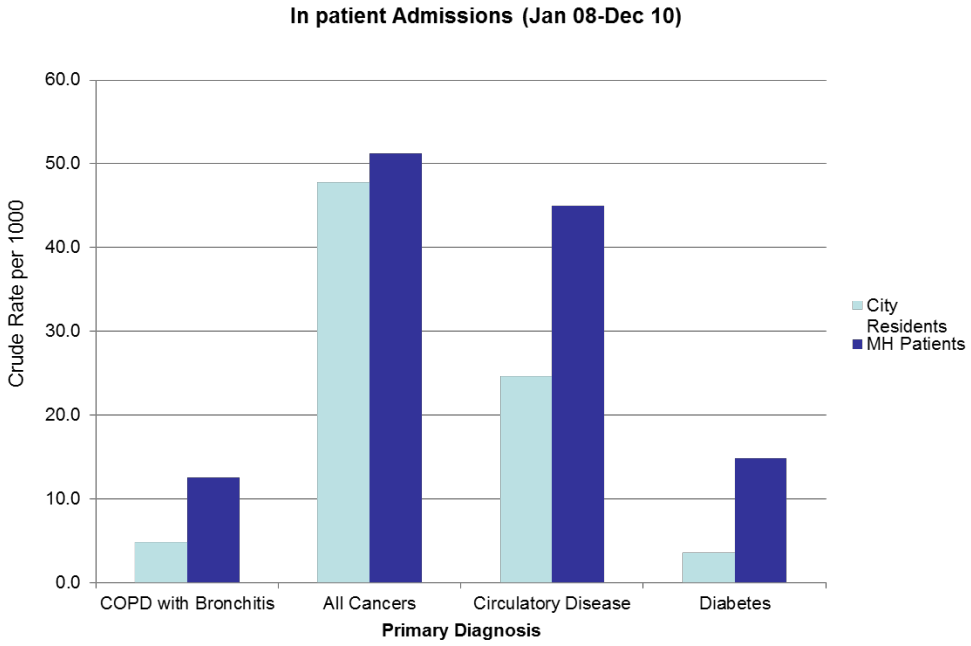
The overlap in those with mental health problems and physical health problems is illustrated in fig.15 below. There is local evidence of higher rates of use of some acute physical health services by people known to mental health services (fig 16). These figures are crude rates and would be likely to display a larger difference in rates if age profile was taken into account.

Figure 15: Overlap of physical and mental health conditions



Source: Naylor C, Parsonage M, McDaid D et al (2012) *Long-term conditions and mental health. The cost of co-morbidities. London: King's Fund, Centre for Mental Health*

Figure 16: Comparison of admission rates for people known to mental health services and general population (Nottingham City 2008-2010)



National calculations to estimate the excess early deaths in people with mental health problems report a SMR (standardised mortality ratio) of 457.5 in 2013/14 compared to the general population for Nottingham City (PHE). This means that people known to mental health services are over 4.5 times more likely to die before the age of 75 than the general population. This is a slight increase compared to the previous years which had been showing a decrease since 2009 (see fig.17). Figure 18 describes the excess under 75 mortality by cause of death as reported for a four year period for Nottingham City (NHS indicators).

Figure 17: Excess under 75 mortality of people known to secondary mental health services. Nottingham and England

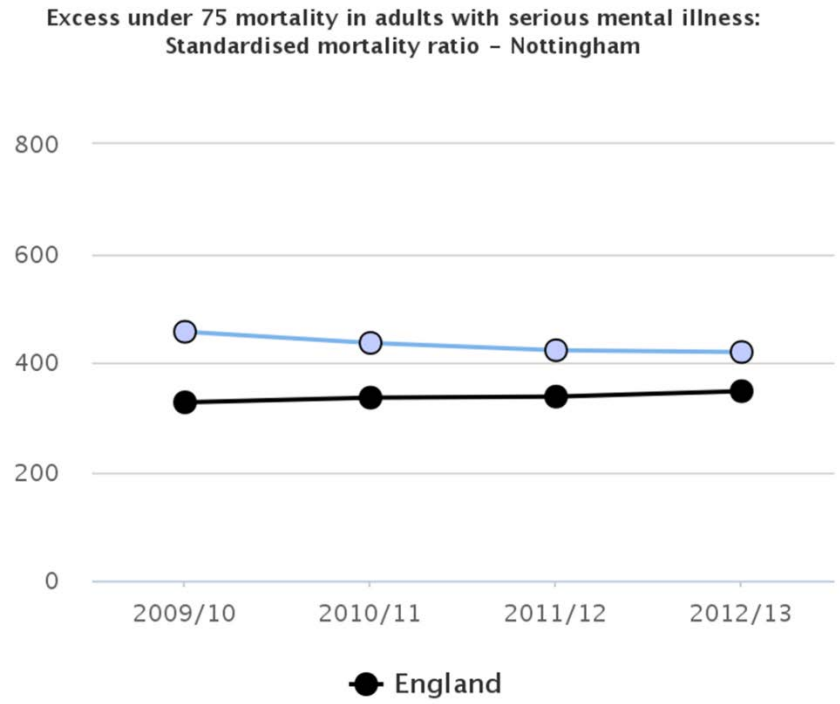


Figure 18: Excess under 75 mortality of people known to secondary mental health services in Nottingham by cause of death-2010/2014

	General population mortality rate	Mental health DSR	SMR
Cancer	137.2	249.3	221.6
Cardiovascular disease	88.7	244.7	394.7
Liver disease	24.4	121.6	787.0
Respiratory disease	40.3	153.3	602.9

Nottingham City Public Health looked at local data to add insight to the national figures for Nottingham and Nottinghamshire by comparing death rates by age for the general population and those known to secondary mental health services under the age of 75. As with the national figure this will include some people who are known to services for substance misuse problems as well as mental health problems. As with the national indicator higher death rates were identified and were present at each age group under 75 years of age (see fig.19).

Figure 19: Comparison of death rates by age for those known to secondary mental health services and the wider population in Nottingham and Nottinghamshire

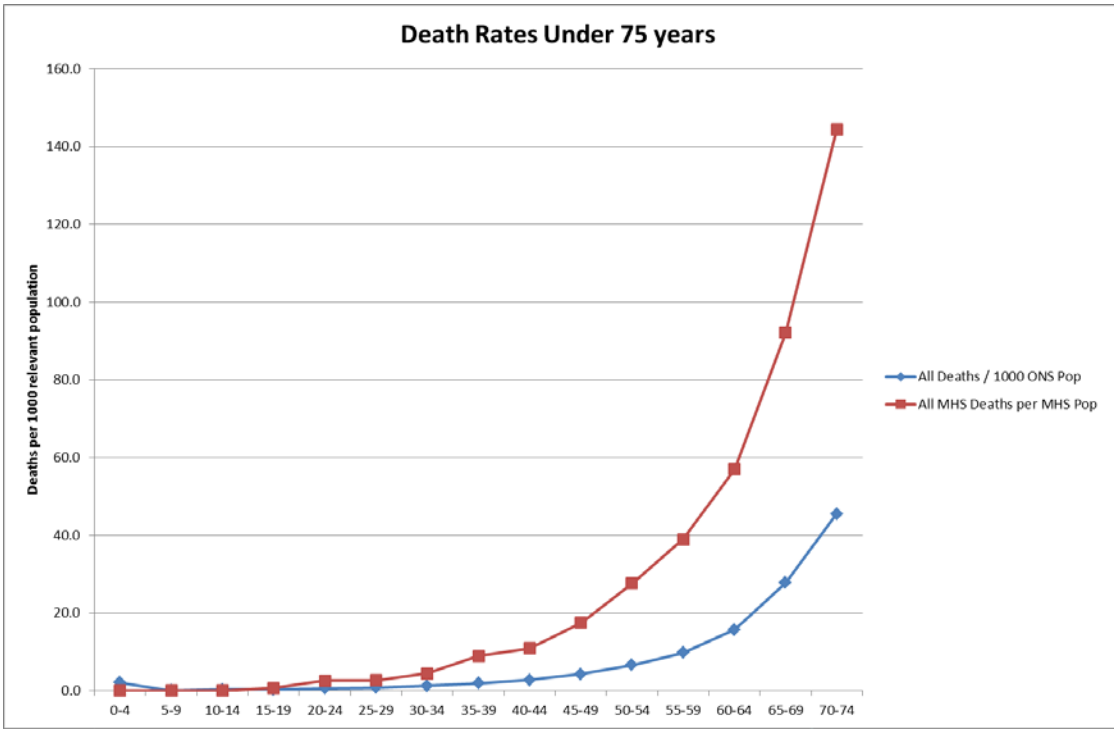
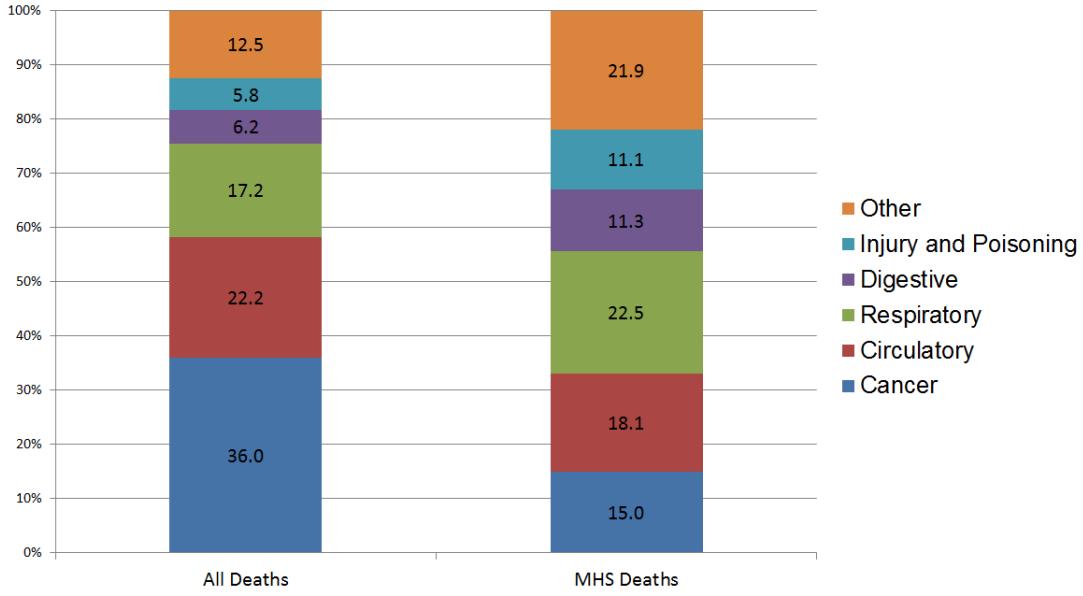


Figure 20: Comparison of top five causes of death under 75 years for those known to secondary mental health services and the wider population in Nottingham and Nottinghamshire



An examination of local deaths data for a 10 year period (2001-2011) found a median age of death in Nottingham City of 62 years for people with a mental health diagnosis code on the death certificate, excluding dementia. However, caution should be used when interpreting these findings as it is unclear how reliably mental health diagnosis is recorded on death certificates.

Smoking status

As a key risk factor for a large proportion of the excess mortality, smoking in people with mental health problems is a particular concern (see tobacco JSNA). Data on smoking prevalence has improved due to better recording at NHFT. In 2012 over 50% of adult mental health patients were current smokers, with less than 5% recorded as ex-smokers, but prevalence of smoking on some inpatient wards were much higher.
It is estimated that 51,000 adults in the city experience mental health problems (Wellness in Mind). It is estimated that there could be at least 16,000 adults with mental health problems who smoke in the city which suggests 25% of adult smokers in the city could have a mental health problem. This proportion could be higher if adjusted for deprivation. If we assume this group consumes 42% (McManus, 2010) of the cigarettes smoked in the city, this equates to 112,560,000 cigarettes per year (using the ASH ready reckoner figure).

Social care needs of those with mental health problems

- Mental health problems account for 16% overall of citizens in receipt of adult social care. This has been consistent over the past three years;
- The male/female split of those with mental health in social care changes dependent on age, with males more prevalent in the under 65's and women more prevalent in the over 65's;
- Figure 21 summarises social care activity for adults with mental health problems in Nottingham compared to a national benchmark

Figure 21: Severe Mental Illness Profile: Support (Source PHE)

Compared with benchmark: Lower Similar Higher

Benchmark: Value

Lowest | 25th Percentile | 75th Percentile | Highest

Indicator	Period	Nottingham		Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Social care mental health clients receiving services during the year: Rate per 100,000 population	2013/14	465	221	242	384	47		2,331
New social care assessments per year for mental health clients aged 18-64: Rate per 100,000 population	2013/14	375	178	121	265	2		1,917
Social care mental health clients in residential or nursing care during the year aged 18-64: Rate per 100,000 population	2013/14	120	57.1	34.1	31.9	0.0		108.5
Social care mental health clients aged 18-64 years receiving home care during the year: Rate per 100,000 population	2013/14	75	35.7	38.4	42.2	0.0		230.5
Social care mental health clients aged 18-64 receiving day care or day services: Rate per 100,000 population	2013/14	75	35.7	18.2	34.0	0.0		308.6
Carer assessments: People who care for an adult with a mental health condition and were assessed during the year per 100,000 population	2013/14	10	4.0	69.5	64.3	0.0		352.6

- The gross cost of providing long term social care support for mental health problems in 2014/15 in Nottingham City was £7.98m, 44% of which was for those aged 65 and over (HSCIC Nov 2015). The cost of providing social care to citizens with mental health problems aged less than 65 years was £4.495m compared to £5.58m in 2012/13. This is a total amount including all income from joint commissioning arrangements and NHS funding with other income and client contributions deducted. It is worth noting that client contributions and the income from NHS can vary depending on the level of need in the client and the client's ability to contribute to their care.

Mental Health Act Assessments and use of the Mental Health Act

The Mental Health Act 1983 (amended 2007) is the cornerstone of mental health legislation in England and provides us with the legal framework from within which assessment and then

application for compulsory detention into hospital is made. In addition to the power to detain the Act also creates community powers which enable warrants to be obtained, for people to be removed to places of safety, for Guardianship orders to be made and for Community Treatment Orders to be issued. However, the majority of work under the act is that of assessment.

Assessments involve an Approved Mental Health Professional AMHP and two doctors. Applications must evidence that the patient is felt to be suffering from a mental disorder of a nature or degree that warrants detention into hospital and that detention is in the interest of the individual's own health, safety or for the protection of others. All decisions are governed by a principle of 'least restriction'.

From 01/04/2014 to 31/03/2015 a total of 969 assessments under the Act took place in Nottingham City, a similar figure to 2012/13 and lower than 2013/14 when 1100 assessments took place. In 2014/15 there were 378 detentions under the Act, similar to the two previous years. Detention by police under Section 136 of the MHA have reduced since the introduction of the Street Triage Team and the partnership commitments (under the Crisis Concordat) to avoid using police custody for people with mental health problems where possible.

Accommodation/Housing

Of those patients under the care of mental health services in Nottingham, within NHFT, the majority are in settled accommodation but a high proportion have no data and 5% are homeless, as shown in table six below. Homeless, in this context, includes those staying with friends and 'sofa surfing'. Similar outcomes are reported in the Public Health Outcomes Framework (1.6) and in the Adult Social Care Framework (1H) although they do report only on those people on 'Care Programme Approach'

Table 6: Accommodation status of patients under the care of NHCT (MPI)

Type of Accommodation	Number on MPI	%
Emergency Accommodation	71	1.0
Supported Accommodation	340	4.8
Criminal Justice System	65	0.9
Homeless	363	5.1
Hospital	75	1.1
Settled Mainstream	4618	64.8
Not elsewhere classified	1590	22.3
Total	7122	100

The joint NHS Nottinghamshire County and NHS Nottingham City Mental Health Residential Rehabilitation Review (2011) highlighted delays experienced by residents within inpatient residential rehabilitation services awaiting move on to more settled living arrangements.

A study of 95 residents within inpatient residential rehabilitation services conducted to inform the review identified 55 individuals (53%) who were not in the most appropriate care setting at the time of the study. Of these, 30 (32%) were clinically classed as being in the wrong setting and in receipt of a *higher* level of care than required due to delays in access to accommodation, support packages or a move on to independent living.

A further 25 (26%) of residents were classed as having the wrong level of care and in need of review by health and social care with regard to longer term care needs, within the context of the recovery ethos.

Nottingham City Council completed a Mental Health Accommodation Pathway Review (initiated in 2012) of the assistance it provides to respond to the needs of citizens who have difficulty maintaining independent living arrangements due to problems associated with their mental health. This review considered the commissioning of residential care, supported accommodation, personal budgets[2] and peripatetic 'floating' support designed to assist citizens to sustain independent accommodation.

The review identified the following issues:

- Accessing supported accommodation can be difficult – these services are often full, with little turnover of residents;
- Many people remain in 'block commissioned' supported accommodation which has less flexibility to respond to individual needs and preferences for long periods of time, rather than supported accommodation functioning as a temporary step on to more independent living arrangements. Approximately, half have used services for 3 years or more, and longer stays, up to 10 years, are not uncommon
- Many users of supported accommodation may have difficulty coping with greater independence. Approximately 55% of this group were considered by their support provider to not have the potential to live in less dependent living arrangements;
- Many people re-use supported accommodation, or enter more intensive support arrangements, almost half of current residents have used the same or a similar service on a previous occasion, and approaching three quarters of those recorded as exiting services move on to other supported housing, residential care or hospital
- The report estimated that up to 40% of those who live in residential care could be living with greater independence;
- People who have the potential to live in less dependent living arrangements may be referred into residential care owing to a lack of alternative accommodation and support options;
- And there was insufficient choice of accommodation for people enduring mental health especially, accommodation that fits their needs and preferences.

Nottingham has a high number of people who are homeless, many of whom have a mental health problem. Statutory homeless in 2014/15 was 4.1 per 1000 households (532 households), significantly higher than the England and regional rates. In 2014/15 an additional 1022 people had an assessment as part of the homelessness prevention gateway and of these 464 went into some type of supported accommodation. Of the 1022, 169 had a primary support reason of mental health and 127 a secondary support need.
Rough sleepers are supported through the Street Outreach Team at Framework. The local assessment is that about 14 people per night slept rough in Nottingham City in 2015.
In 2015 Framework shared a report on the prevalence of mental health problems in people who use their services (Udell 2014), and particularly highlighted high levels of serious mental health problems and often combined with issues of substance misuse. Out of 159 residents, 120 (75%) had recorded at least one diagnosed mental health problem. The prevalence of psychosis was 30%, far higher than community prevalence. Anxiety and depression was the most commonly recorded mental health problem with a prevalence of 37%.

[2] Funding attributed to an citizen in accordance with their individual needs, to be used flexibly to commission personalised support

Shelter estimate that, in Nottingham, 1 in every 69 households are at risk of homelessness compared to 1 in 115 nationally. See the JSNA chapter on homelessness for more information.

Carers and Mental Health

The majority of people with a mental health diagnosis live in the community. Family, partners and other people including neighbours and friends provide the majority of their informal care and support network. The nature of caring for people with mental health problems is that for large periods of time people with a mental health problem may be well. It is at times of intermittent crises that concerted help is required, usually in the form of responsive and rapid mental health services for them and the person affected. In the intervening times they require support to maintain the level of effort required to be a main carer and confidence that additional support will be there if required as well as signposting to appropriate support services.

Carers need to be seen as part of the early intervention/preventive agenda. Work is still needed to establish a true picture of the number of carers, specifically hidden carers, who are currently providing care in Nottingham City. Local intelligence suggests that many of those caring for people with mental health problems are reluctant to identify themselves as a carer due to the stigma associated with mental illness. The needs of carers are considered in a separate JSNA chapter

3) Targets and performance

The Mental Health Taskforce report outlines key ambitions for improving access to mental health support and treatment to reach parity with physical health systems.

There is a new target of 50% of those experiencing a first episode of psychosis to enter treatment within two weeks

There are a number of quality standards which psychological therapy services need to meet.

- 75% of people referred to the programme should begin treatment within 6 weeks of referral, and 95% begin treatment within 18 weeks of referral.
- Treatment of at least 15% of total need each year, although the Mental Health Taskforce have described and ambition to increase this in the future.
- Recovery rates of at least 50% for those that complete treatment; (Source IAPT)

Reporting against those targets will be published by HSCIC

CCGs have been consulted on a new Improvement and Assessment Framework to be published later in 2016. It is likely to include psychological therapy recovery rate, access to care in crisis, and access to services for those with first episode of psychosis.

Shared priorities in national outcomes frameworks include excess early deaths in people with severe mental illness and suicide rate (both of which are described in previous section). There are also measures related to employment and settled accommodation status, however as these only report on the status of people under *Care Programme Approach* it is not clear to what extent they are comparable to other areas, as numbers on CPA under Nottingham services seem low compared to other areas.

All performance against Public Health Outcomes Framework, NHS Outcomes Framework and Adult Social Care outcomes Frameworks are brought together for mental health by Public Health England on the mental health, dementia and neurology profiles. This also now includes performance for psychological therapy services.

A national overview of mental health indicators is published as part of the Mental Health Dashboard although many indicators are not present at local level.

4) Current activity, service provision and assets

Mental Wellbeing

There are multitude of assets and services in Nottingham that contribute to mental wellbeing, such as:

- Arts events;
- Children's services, including parenting support;
- Work to reduce domestic violence and abuse, and support its victims/survivors;
- Work to reduce harm from drugs and alcohol;
- Housing services including supported housing;
- Citizen participation in democratic processes;
- Welfare and financial advice and support in local communities;
- Workplace wellbeing initiatives;
- Campaign and work to end loneliness and isolation;
- Parks and recreation – including organised activities and walks;

In addition, services and projects that tackle issues such as crime and disorder, community cohesion, litter, and dog fouling, contribute to mental wellbeing by providing a safer, stable and more pleasant environment for communities.

Support for people with mental health problems

Services in Nottingham for people with mental health problems and their carers are provided by a number of agencies working in close collaboration in a variety of different partner arrangements across statutory, voluntary and independent sectors.

There are a number of specific community and voluntary organisations who specialise in championing mental health issues, encouraging more discussion of mental health and highlighting areas where there may be gaps in services. These include local branches of national organisations, self-help organisations, locality based mental health groups and those with a specific interest in particular aspects of mental health support such as self-harm, veterans' health or BME issues. Faith based organisations have also developed initiatives such as the Anglican Diocese 'Opening Minds' which has trained people in churches to welcome people with mental health problems.
There are National Lottery funded projects such as Nature in Mind, which supports people with mental health problems, and promotes well-being and recovery, through engagement with nature-related activities, and Opportunity Nottingham which aims to identify ways of supporting people who have multiple and complex needs (mental health, offending behaviour, homelessness, substance misuse) and is championing a 'system change' approach for sustainable change.

Due to the scale of welfare reform, including changes to housing and disability benefits and the introduction to Nottingham of Universal Credit early in 2016, effective links between Nottingham Advice and financial inclusion services and those providing mental health support have been included through the commissioning process.

Commissioned community mental health support services

From April 2016 two new services will be delivered in Nottingham, commissioned by Nottingham City CCG.
A Mental Health and Wellbeing Hub will be provided by Framework that will help people understand the range of mental health services locally and will give additional support to those who need it to access those services.
A Primary Wellbeing and Recovery Service will be delivered by NHFT and will offer a variety of recovery focused courses designed to increase knowledge and skills about recovery and managing one's own mental health and wellbeing.

Since early 2015 the STEPS service has been commissioned to provide a mental health outreach service to Nottingham's BME communities and help people connect with appropriate services.

Training
In recognition that a wide range of community organisations support and have an influence on the mental health of Nottingham citizens, a programme of additional training has been commissioned by Nottingham City Council and Nottingham City CCG to increase knowledge and skills of the non-specialist workforce. This will also include training on suicide prevention and mental health first aid.

Common mental health problems
Increasingly people access digital resources to find help for mental health. NHS Choices has useful resources and links to information, self-help apps and online resources. Some areas of the country are promoting the use of services such as Moodgym or Big White Wall as part of their response to the scale of mental health need. There has been a positive response to online counselling by young people in Nottingham. The Books on Prescription scheme is active in Nottingham and libraries have an evidence based collection of books to support people with self-care approaches to common mental health problems
Treatment of common mental health problems is provided by GPs and/or Primary Care Psychological Therapies Services (PCPT). Psychological therapies are recognised as effective, evidence-based interventions in the treatment of a range of common mental health problems.

Improving Access to Psychological Therapies (IAPT) is an NHS programme of services across England which offers interventions approved by the NICE for treating people with depression and anxiety disorders. It was created to offer patients a realistic and routine first-line treatment combined, where appropriate, with medication which traditionally had been the only treatment available.

The second phase of the programme was marked by the publication of 'Talking Therapies: a four year plan of action' in February 2011 and aimed to expand the scope of the programme to children and young people, and people with long-term physical conditions, medically unexplained symptoms or severe mental illness.

PCPT services provide Step 2 and 3 psychological therapies within a stepped care model. As part of the IAPT programme, PCPT has been established to improve the recognition and treatment of depression and anxiety disorders by providing greater access to a choice of talking therapies to those who would benefit from them.

Patients can be referred by their GP or can self-refer into the services. PCPT services see anyone over the age of 18 years and who is experiencing any of the following common mental health disorders including any additional stable or secondary diagnoses, such as substance misuse issues, mild learning disability or cognitive impairment, psychoses or personality disorder. Due to its complexity individuals with severe personality disorder are excluded from PCPT.

PCPT typically supports individuals with:

- Anxiety;
- Depression;
- Obsessive compulsive disorder;
- Anger management;
- Panic disorder;
- Phobias;

- Post-traumatic stress disorder (PTSD);
- Eating disorders, stable or as a secondary diagnosis;
- Depression or anxiety linked to physical health problems;
- And other mild to moderate mental health conditions.

Initial assessment is made and then patients are placed into services dependent upon their care needs and preferences.

There are currently three providers commissioned: Let's Talk Wellbeing, Insight and Trent PTS, with an additional provider to be confirmed in April 2016. In addition, both Nottingham University and Nottingham Trent University have counselling services and Mental Health Support Workers that provide support to staff and students for personal, emotional or mental health problems. Many large organisations also offer their employees counselling, occupational health or assistance services.

Nottingham Clinical Commissioning Group also publishes current waiting times and patient satisfaction rates on the Primary care psychological therapies pages of their website.
A Step 4 psychology service offers psychological assessment and treatment (individual and groups) to adults with complex psychological/mental health difficulties

Serious mental illness

The large majority of secondary and specialist mental health services are provided by Nottinghamshire Healthcare Foundation Trust (NHFT), through community and in-patient services. All services delivered by the Trust are detailed on their website.
Patients who need non-crisis secondary community mental health services for the first time can be referred through a 'single point of access'. Referrals can also be made from GPs and acute mental health services. Current community service provision for adults with mental health problems includes the following teams:

- Early Intervention in Psychosis (EIP) teams support those presenting for the first time with a psychosis;
- Crisis Resolution and Home Treatment teams provide an intensive service to promote alternatives to hospital admission;
- Assertive Outreach Teams support clients who are reluctant to engage with services and have a history of admission to psychiatric wards;
- Community Assessment and Treatment Team (CAT) offers interventions and support to people for up to two years;
- The City Recovery Service offers recovery-based interventions to individuals with serious enduring mental health needs;
- And the Community Perinatal Team which works with women experiencing mental health problems during or shortly after pregnancy and child birth.

NHFT also provides in-patient assessment and treatment wards at Highbury Hospital, Millbrook and Bassetlaw Hospital. This includes The Willows which is a 10 bedded psychiatric intensive care ward and the 'section136' Suite which is a place of safety for those detained by the police under the Mental Health Act.
There is also an inpatient Mother and Baby Unit, at Queens Medical Centre, which provides care to women who are in the late stages of pregnancy or who have a baby up to the age of one year, who are suffering from a severe mental illness.
People who have higher levels of mental health problems are managed through a process called the Care Programme Approach (CPA) by NHFT which has core standards for care planning and review.

Forensic and Criminal Justice Services

The Forensic Services Division of Nottinghamshire Healthcare Foundation Trust provides medium secure facilities, on a regional basis, at Wathwood Hospital, Yorkshire and Arnold Lodge, Leicestershire, and high secure services, on a regional and national basis, at Rampton Hospital, Nottinghamshire. The low secure service at Wells Road has been expanded to provide a dedicated low secure women's service, in addition to the existing provision for men.

Mental health services for those in prison or police custody are commissioned by NHS England specialised commissioning. A new Liaison and Diversion Service makes mental health professionals available to those in police custody.

A successful pilot of 'Street Triage' has placed mental health nurses with police officers to attend calls where there may be a mental health need, thereby reducing the need for police detention under S.136 of the Mental Health Act. This service has now been recurrently funded.

Physical health of those with long term mental health problems

Primary care, secondary mental health services, health improvement services and secondary care services all have a role in supporting people with mental health problems to have better physical health.

Under the Equality Duty all services are required to make reasonable adjustments to enable disabled people, including those with mental health problems, to benefit from the services they offer. Primary care is incentivised through QOF to offer a number of physical health checks for people who are on their 'Serious Mental Illness' register on an annual basis.

Nottinghamshire Healthcare Foundation Trust has been incentivised, through a CQUIN, to take forward the 'Physform', an annual stocktake of physical health indicators for an individual that can be shared with primary care, and also to improve smoking cessation support within the Trust. The Trust are now working in partnership with primary care to take forward the 'Enhanced Physform' project to encourage more physical health checks of those with serious mental illness in primary care. A project to promote increased uptake of preventative screening services has taken place in 2015/16. For some health improvement services, including Stop smoking services and Healthy Change, service specifications have included a requirement to work more proactively to engage and support people with mental health problems.

Liaison Psychiatry

Psychiatric assessment provided by NHFT is delivered in Nottingham University Hospitals Acute Trust, to ensure mental health assessment is available to those who attend the acute Trust. Access to liaison psychiatry is a priority in the Mental Health Taskforce report and is a key part of the Nottingham mental health acute care Vanguard.

Dual Diagnosis Service

A Dual Diagnosis Service is commissioned by the Clinical Commissioning Group to address the needs of people with co-existing drug, alcohol and mental health problems. The service supports health and social care agencies via:

- Face to face psychosocial interventions;
- Supervision of mainstream staff groups;
- Training and support;
- Liaison work
- And facilitating service user involvement and carer support.

There is a current need to better understand the needs of people with dual diagnosis and to update commissioning pathways accordingly. A full health needs assessment for patients

who are classed as having dual diagnosis in partnership with Nottinghamshire County was completed in 2015 and shared with commissioners

For further information on the needs of adult drug users, see JSNA chapter on Adult Drug Users.

Carers Service

A Carer Support Service (provided by NHFT) undertakes carer assessments of need and provides a range of services to people who care for mental health service users. For needs of adult drug users, see JSNA chapter on Carers.

Domestic and sexual violence and abuse (DVA)

The relationship between domestic violence and abuse and mental health was highlighted through the recent work of the 'Stella' project (Stella project). This has led to closer working across the two sectors and has informed the NHFT DVA strategy that was launched in 2014. Mental health services will work with survivors and children affected by DVA, as well as perpetrators, and may be involved in current cases through safeguarding processes and Multi Agency Risk Assessment Conferences (MARAC). There is further information in the JSNA chapter on DVA.

A new pathway to provide counselling support to both male and female survivors of sexual violence and abuse has been commissioned from April 2016 to be delivered by Rape Crisis Nottingham

Recovery College

NHFT has developed the Recovery College which is a key element of recovery orientated practice and compliments existing services by offering an educational approach to supporting people in their personal recovery journey by building up skills, knowledge and confidence.

All mental health services focus on recovery as it is integral to service delivery and care planning processes. Through a holistic needs assessment issues around housing, employment and debts are identified and worked through. Service users are enabled to make choices around their health care which is identified through service user/ patient experience questionnaires and feedback.

All service users are offered a recognised recovery tool on admission to in-patient services. All in-patient facilities have input from Clinical Psychology services with access to a range of therapies.

Social care services / services that support independent living

Social care support is now guided by the Care Act 2014, a new law that brought together social care legislation. It covers general principles for Local Authorities, such as the duty to promote wellbeing and look to prevent development of further needs and look to integration of care and support**.**
Nottingham City Council currently commissions a range of support intended to support people to live safely in the community. These include the following:

- Residential care services which offers 24 hour staffed support in a group home environment for citizens with higher / enduring needs;
- Supported accommodation services which includes advice and support delivered within shared accommodation or 'cluster' accommodation within close proximity of a staffed service, to enable people who have lost their independence to stabilise and to encourage a further move on to more independent living arrangements;

- Independent living support (ILS) services including peripatetic 'floating' support offering advice and assistance to assist citizens to sustain independent accommodation;
- Personal budgets: funding attributed to an individual in accordance with an assessment of their individual needs, to be used flexibly for the commissioning of personalised support to enable citizens to retain their independence.

Together these service form a pathway of accommodation and support designed to enable citizens, who have lost their independence due to problems associated with a significant mental health difficulty, to regain and sustain living arrangements that maximise their level of independence. These services are expected to complement other forms of provision for citizens with mental health difficulties and other vulnerabilities in the City, including inpatient provision for citizens who have been hospitalised, and those which respond to homelessness.

Following the completion of a review of the assistance provided by the Council to citizens who have lost their independence due to problems with their mental health (the Mental Health Accommodation Pathway Review), a number of changes were made with the intention of:

- Delivering a more flexible arrangement of support designed to help citizens to maximise their independence more quickly in accordance with their individual needs and circumstances;
- Preserving capacity within services to respond to unmet need including those awaiting move on from inpatient services, or who have become homeless;
- Providing the opportunity for citizens with enduring needs to exercise greater choice and control over longer term support and living arrangements;
- Improving the prospect that longer term living arrangements are maintained.

Local Authority employed Approved Mental Health Professionals (AMHPs) provide statutory mental health assessments under the Mental Health Act as above

Advocacy

There is a requirement in law to provide advocacy to people who are detained under the Mental Health Act (known as Independent Mental Health Advocacy) and this is commissioned by Local Authorities. The current provider is POhWER/Age Concern delivering the Your VoIce Your Choice service in Nottingham.

Employment

Nottingham's Health and Well-being Strategy identified mental health as an early intervention priority, including 'enabling people to begin working or remain in work where previously their health, especially their mental health problems, has been a barrier as an area of special focus.

Since a pilot programme in 2012, Nottingham City CCG and Nottingham City Council have jointly commissioned Nottinghamshire 'Fit for work' service to help people remain in or return to work when they have a health problem. A larger proportion of the people they work with have mental health problems. In summer 2016 a new health and employment service will be procured.

NHFT was successful in becoming a pilot for Individual Placement Support, a supported employment project which was evaluated by Nottingham University and lessons disseminated locally and nationally.

Individual Placement and Support (IPS) is a specific type of supported employment. There is strong evidence that IPS is the most effective method of helping people with severe mental health needs to achieve sustainable competitive paid employment. People who participate in supported employment services (mean 61%) are almost three times more likely to find paid employment than those who engage in other types of vocational programs or control groups (mean 23%).

More information on the project and its reported outcomes for Nottingham are available on the National Institute for Health Research website.

5) Evidence of what works

Current NICE guidance is available here. The following NICE guidance is relevant to identifying and treating mental illness and improving mental well-being:

Public Health guidance

Promoting mental wellbeing at work (PH22) (2009) focuses on interventions to promote mental wellbeing through productive and healthy working conditions.

Mental wellbeing and older people (PH16) (2008) focuses on the role of occupational therapy and physical activity interventions in the promotion of mental wellbeing for older people.

Clinical Guidelines

Older people: independence and mental wellbeing (NG32) (2015) This guideline covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline.

Eating Disorders (CG9) (2004) recommends the core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and other related eating disorders.

Self-harm (CG16) (2004) outlines the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.

Anxiety (CG22) (2007) (replaced by CG113) provides recommendations for the identification and management of anxiety in adults in primary, secondary and community care.

Post-traumatic Stress Disorder (CG26) (2005) covers the care that people with PTSD can expect to receive from their GP or other healthcare professional.

Obsessive Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD) (CG31) (2005) covers the care people with OCD or BDD can expect to receive from their GP or other healthcare professional.

Bipolar disorder (CG38) (2006) covers what treatment people with bipolar disorder can expect to be offered, including medication and psychological therapies, advice on self-help, the services that may help people with bipolar disorder, including psychiatric or specialist mental health services and how families and carers may be able to support people with bipolar disorder, and get support for themselves

Antenatal and Postnatal Mental Health (CG45) (2007) covers all mental disorders, including perinatal mental disorders with the aim of helping clinicians to balance the risks of treating a

mental disorder with the risks to the mother, her infant and other family members of not treating it.

Antisocial Personality Disorder (CG77) (2009) makes recommendations for the treatment, management and prevention of antisocial personality disorder in all levels of healthcare and across a wide range of other services.

Borderline Personality Disorder (CG78) (2009) makes recommendations for the treatment and management of borderline personality disorder in adults and young people in primary, secondary and tertiary care.

Schizophrenia (CG82) (2009) covers the care, treatment and support that adults (aged 18 and older) with schizophrenia should be offered, including people who develop schizophrenia before they are 60 and continue to require treatment after this age.

Depression in adults (CG90) (2009) makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older, in primary and secondary care. It is published alongside Depression with a chronic physical health problem (CG91) (2009) which makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older who also have a chronic physical health problem

Psychosis with coexisting substance misuse: Assessment and management in adults and young people (CG120) (2011). This guideline covers the assessment and management of adults and young people (aged 14 years and older) who have a clinical diagnosis of psychosis with coexisting substance misuse.

Common mental health disorders: Identification and pathways to care (CG123) (2011). The intention of this guideline, which is focused on primary care, is to improve access to services (including primary care services themselves), improve identification and recognition, and provide advice on the principles that need to be adopted to develop appropriate referral and local care pathways.

Self-harm: longer-term management (CG133) (2011). This guideline follows on from Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (NICE clinical guideline 16), which covered the treatment of self-harm within the first 48 hours of an incident. This guideline is concerned with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm, and does not include recommendations for the physical treatment of self-harm or for psychosocial management in emergency departments (these can be found in NICE clinical guideline 16).

Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (CG136) (2011). This guidance on service user experience aims to ensure that users of mental health services have the best possible experience of care from the NHS.

Depression in adults quality standard (QS8) (2011). This quality standard covers the assessment and clinical management of persistent sub threshold depressive symptoms, or mild, moderate or severe depression in adults (including people with a chronic physical health problem).

Quality standard for service user experience in adult mental health (QS14) (2011). This quality standard outlines the level of service that people using the NHS mental health services should expect to receive.

Social anxiety disorder: recognition, assessment and treatment (CG159) (2013). Social anxiety disorder (previously known as 'social phobia') is one of the most common of the anxiety disorders. Replaces and updates previous guidance on phobia.

Quality standard for self-harm (QS34) (2013). This quality standard covers the initial management of self-harm and the provision of longer-term support for children and young people (aged 8 years and older) and adults (aged 18 years and older) who self-harm.

Guidelines currently in development are: Mental health among prisoners and Offenders: prevention and early treatment of mental health problems

Strategy and Policy

Mental health service improvement is a national priority (DH 2016), particularly focussing on crisis care, perinatal mental health, ending inappropriate use of police intervention, better access to psychological therapies and parity of esteem (giving equal value to mental and physical health).

Building on the NHS Mandate, NHS England has published the Five Year Forward View for Mental Health, an independent report by the Mental Health Taskforce that sets national aspirations to 2020.

The Nottingham City Mental Health and Wellbeing Strategy, Wellness in Mind brings together the vision for improved mental health and social inclusion across the life course under five priorities.

1. Promoting mental resilience and preventing mental health problems

2. Identifying problems early and supporting effective interventions

3. Improving outcomes through effective treatment and relapse prevention

4. Ensuring adequate support for those with mental health problems

5. Improving the wellbeing and physical health of those with mental health problems.

In Nottingham, mental health urgent care is included as a local NHS vanguard, there is a Crisis Concordat partnership, and in 2015 Nottingham City HWBB agreed a Suicide Prevention Strategy

No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages was launched in February 2011 and built on the priorities previously identified in New Horizons-a shared vision for mental health, (launched in February 2010).

The Royal College of Psychiatrists produced an occasional paper in March 2013 entitled Whole-person Care: from rhetoric to reality (Achieving parity between mental and physical health), outlining recommendations to achieve this including leadership, policy change, preventing premature mortality, parity of care and integrated care, ways to influence across the life course, funding and research.

The national strategy, Preventing Suicide in England A cross-government outcomes strategy to save lives (DH 2012) has two overarching aims: to reduce the suicide rate in the general population in England, and to provide better support for those bereaved or affected by suicide.

The aim of the Foresight report on Mental Capital and Wellbeing (2008) was to use the best available scientific and other evidence to develop a vision for reviewing the opportunities and challenges facing the UK over the next 20 years and beyond and the implications for everyone's "mental capital" and "mental wellbeing.

6) What is on the horizon?

Projected service use and outcomes in 3-5 years and 5-10 years

Social and economic changes impact upon the prevalence of common mental health problems, but it is not known to what extent the recent UK economic downturn has affected mental health within the national, or local, population. Generally, income inequality within communities and populations has an adverse effect on mental health at both ends of the spectrum, but with those in the most deprived sectors worst affected (Dorling, 1995-2012). There is also some evidence that adverse situations can increase community cohesion and thus have a positive influence on mental health (Friedli, 2009).

Modelling suggests that the numbers of adults, aged 16-64, experiencing common mental health problems in Nottingham will increase by 3.3% between 2014 and 2020. The number of older adults with depression is expected to increase by 5.7% over the same time period, see table 7. The increase in rates is based on an expected increase in population size and therefore does not take account of any variation in the prevalence of common mental health problems over this time period. Population projections assume that Nottingham City has the level of mental health problems at similar prevalence to national levels. Research on community prevalence was undertaken in 2007 and has not yet been repeated. If Nottingham City grows quicker than anticipated, or has higher levels of risk factors the *needs* are likely to be higher than those projected by national sources such as PANSI below. It is also anticipated that *demand* for services will increase as stigma regarding mental health reduces and expectations of services increase.

Table 7: Estimated increase in the numbers of adults with common mental health problems in Nottingham between 2014 and 2020

	2014	2016	2018	2020	% change between 2014 and 2020
Estimated number of adults aged 16-64 with common mental health problems	34,428	35,056	35,418	35,579	3.3
Estimated number of adults aged 65+ with depression	3,122	3,150	3,245	3,310	5.7

Source: Projecting Adult Needs and Service Information www.pansi.org.uk and Projecting Older People Population Information System www.poppi.org.uk

Modelling suggests that the number of adults aged 16-64 with a psychotic disorder, borderline personality disorder or antisocial personality disorder will increase by just under 10% between 2014 and 2020 (table 8). No modelling is available for adults aged 65 years and over. The increase in rates is based on an expected increase in population size, and therefore do not take account of any variation in the prevalence of serious mental illness over this time period.

Table 8: Estimated increase in the numbers of adults aged 16-64 with serious mental illness in Nottingham between 2010 and 2020

	2014	2016	2018	2020	% change between 2014 and 2020
Estimated number of adults aged 16-64 with a psychotic disorder	855	871	880	884	3.3

Estimated number of adults aged 16-64 with borderline personality disorder	961	979	989	993	3.3
Estimated number of adults aged 16-64 with antisocial personality disorder	760	770	778	781	2.7
Estimated number of adults aged 16-64 with two or more psychiatric disorders	855	871	880	884	3.3

Source: Projecting Adult Needs and Service Information www.pansi.org.uk

7) Local Views

A number of consultations have taken place since the last JSNA that have asked the local population their views about mental health.

In the development of Wellness in Mind, the Mental Health and Wellbeing Strategy, a wide range of stakeholder views were gathered before it was presented in draft to the Health and Wellbeing Board. This was followed by full public and partner consultation, which demonstrated a high level of support for improving mental health across the city and the need to produce a strategy that covered the mental health of both adults and children. Specific issues were identified as:

- Raise awareness of mental health issues and reduce stigma
- Capitalise on inter-agency working to improve pathways of care and ensure good social care support and settled accommodation for people with mental health problems
- Support whole family interventions to impact upon both children's and adult mental health

There were also requests for more consideration of the needs of people from particular communities of interest, specifically, black and minority ethic (BME) groups, those with disability (including sensory impairment), carers, students, those with long term conditions and those from the lesbian, gay, bisexual and transgender community.

For the 2015 Suicide Prevention Strategy, Nottingham City Council undertook a full formal public and partner consultation exercise between September and November 2014. This was done in parallel with a similar process in the County so that partner organisations did not need to respond twice. Many contained very detailed feedback on the priorities.

The majority of the respondents either strongly agreed or agreed that the five proposed priorities would address the needs of the population in reducing the rate of suicide and self-harm in Nottingham City.

Specific feedback included:

- Identify the wide variety of factors that can contribute to suicide and self-harm e.g. family history, early trauma, mental health problems, physical illness, relationship breakdown and other life events, unemployment, job loss, financial concerns
- Make information easily accessible on the availability of support for self-harm, suicidal behaviour, mental health crisis and bereavement.

- Make the most of inter-agency working to improve access and pathways of care particularly in relation to early identification of mental health problems and those experiencing a mental health crisis
- Target interventions to those most at risk of suicide and self-harm
- Promote mental health awareness across all ages as well as within industry/employment
- Promote positive self-esteem and mental resilience in young people
- Awareness raising and training should include the impact of:
    - bullying on suicidal thoughts and self-harm behaviour
    - those affected by bereavement from someone else's suicide
    - life stressors on suicide thoughts and behaviour
    - what to look out for in people at risk of self-harm and suicide and strategies to intervene
    - provide a consistent message around risk and support services

Nottingham City CCG undertook a range of engagement activity on community adult mental health support services during 2014, followed by further engagement in 2015 and the full report is available here. The key themes emerging about what the service should look like include:

- Culturally specific and more specialist services
- Reduced waiting times
- Flexible services to meet individual need
- Support for family and carers
- Good information about services available
- Good crisis support
- Reduce stigma attached to mental health services
- Consideration for the use of personal health budgets

Nottingham City Health and Wellbeing Board have undertaken engagement activity in preparation for the 2016 Health and Wellbeing Strategy which has highlighted access to timely and responsive mental health services as a priority.

In preparation for the Crisis Care Concordat public and partner engagement events were held to highlight the actions needed for the action plan.

Nottingham City Council undertake Strategic Commissioning Reviews on a range of systems that will impact on the lives of people with mental health problems and report their engagement and consultation findings here.

Throughout this engagement activity described above, responses are more regularly received from organisations, professional and carers who support people with mental health problems than from those people themselves. A number of systems have been developed to enable the voice of people using services to be heard in a more immediate way. NHFT use the website Patient Opinion and comments about services are able to be read and responded to on a public website. NHFT also publish regular reports on the feedback they have received from patients and carers. At times one individual patient and carer story is

included to support commissioners understand how well services are responding. One powerful example was presented to NHS Nottingham City CCG Governing Body in July 2014 to describe one young person's experience of psychosis and detention under section.

At a national level the Mental Health Taskforce undertook very wide public consultation in 2015 to inform the 5 Year Forward View for Mental Health. Three clear themes emerged – *prevention, access and quality.* The importance of integrating care and support was also identified as a critical factor to the successful delivery of equitable access and improved outcomes. The need to prioritise equality – particularly for BAME groups, older and younger people – also came out strongly across each of these themes. When asked how people would like things to be different by 2020 the top five areas for change are:

- access to services (52%)
- choice of treatments (33%)
- prevention (25%)
- funding (21%)
- stigma and discrimination (19%)

The Voices from the Frontline report reports the views of people with multiple needs and those who support them and identifies the challenges faced by people when services are not 'joined up' or people feel 'written off'.

Online space is being used innovatively to give insight into the real lives and experiences of people with mental health problems, such as the Day in the Life space, where people's experiences can be read by a wide public.

What does this tell us?

8) Unmet needs and service gaps

- Citizens reported finding the system of mental health services confusing and difficult to navigate and were not always clear where to first turn for support. It is anticipated that the newly commissioned mental health and wellbeing service will serve to meet this need.

- Promoting positive mental wellbeing requires active partnership work across statutory services, non-profit organisations, and voluntary and community services. In addition, communities themselves well placed to tackle the factors that can impact on an individual's mental wellbeing.

- Broader understanding of mental health needs and the relationship with physical health needs to be improved at all levels within commissioning and provision including in physical health JSNA chapters

- The gap in life expectancy between people with mental health problems and those without needs to be reduced. This is an important priority for Nottingham City, and particularly with a focus on reducing smoking and improving identification of physical health problems early.

- Official suicide data is being produced earlier than previously, but it does not enable adequate insight or highlight areas needing a more timely response. Further insight should be developed through the Coroner suicide audit and learning from areas that have implemented real time surveillance.

- Care for people in mental health crisis is a partnership priority under the Crisis Care Concordat and Urgent Care Vanguard. This momentum needs to be maintained to ensure services respond to people in crisis based on needs.
.
- Black and minority ethnic (BME) communities and high-risk groups, such as LGBT groups, offenders and asylum seekers/refugees may have challenges in terms of accessing mental health services. All commissioned services need to ensure they are able to describe the population that use their service so that gaps in access may be identified. Specific services to support community outreach (such as STEPS for BME communities) need to inform wider services how to ensure services meet diverse needs.
- Mental health problems are frequently reported amongst individuals who are homeless or at risk of becoming homeless. Work is needed to ensure the systems of homelessness prevention and mental health support work together to ensure those in need receive adequate treatment, accommodation and support.

- Mental health and employment indicators for the City show very high rates of people on out of work benefits due to mental health problems, and low employment rates for those known to secondary mental health care.

9) Knowledge gaps

More understanding is needed for the reason behind the low proportion of people on Care Programme Approach (CPA) in Nottingham compared to other areas.

More understanding is needed of the needs relating to Personality Disorder.

The value of locally commissioned access to national online support services for adults is not clear.

What should we do next?

10) Recommendations for consideration by commissioners

- Ensure all commissioned mental health services:
    - Are understood and accessible to all, including groups within the population who currently find services difficult to use for cultural reasons or because they believe the service will not meet their needs;
    - Have an emphasis on supporting recovery and promoting 'safe' independence;
    - Consider each individual's physical health needs as equally important as their mental health needs;
    - Promote seamless referral pathways both within, and between, services (e.g. between primary and secondary mental services)
    - Evaluate the impact of changes to provision for service users and partner organisations.
    - Engage and involve service users and carers in service development
    - Provide an environment that is smoke free and promotes and supports reductions in smoking.
- Continue to monitor progress towards greater flexibility and choice over accommodation and social support for citizens with enduring mental health needs, in accordance with the principles of self-directed support, and the needs of the local population.
- Consider results of dual diagnosis needs assessment 2015 and draft NICE guidance to make changes to services and pathways as appropriate.
- Develop and implement action plans from the Nottingham city mental health *Wellness in Mind Strategy 2014-2017*
- Implement action plans from the *Nottingham City Suicide Prevention Strategy 2015-18*
- Work in partnership to meet the aspirations of the Nottingham and Nottinghamshire Crisis Care Concordat
- Take the opportunity of the duty to promote 'wellbeing' in the Care Act to raise the profile of monitoring and improving mental wellbeing.
- Raise the profile of the outcomes for people with mental health problems as an equality issue. This means consideration by all commissioned services (including primary care and physical health services) of the requirement to make reasonable adjustments to enable people with enduring mental health problems to benefit.

Commissioners of other services that impact upon mental health and wellbeing should:

- Consider the impact of all services on citizens' mental health and wellbeing. For example, planning decisions regarding the use of open spaces and access to community services, arts and leisure services.
- consider initiatives that address the employment needs of adults with mental health problems, including ways to support adults with enduring mental health problems, and support for people experiencing common mental health problems to remain in or return to work

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