Final Approved- Nottinghamshire Joint Strategic Needs Assessment

Topic information	
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Executive Summary

Introduction

Mental health is defined by the World Health Organisation (WHO) as a *"state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."*[1] Mental health is fundamental to our physical health, our relationships, our education and our work. There is no health without mental health.

This chapter considers the needs, evidence of effective interventions and treatment, and the current service provision for mental health problems in the adult and older people's population and includes;

- Mental health risk factors
- Self-reported wellbeing
- Common Mental Disorders
- Serious Mental Illness
- Physical health inequalities and mental health problems

Mental health problems[±] impact on individuals, families, communities and society as a whole, with immense associated social and financial costs and is a contributing factor to the perpetuating cycles of inequality through generations. Mental illness is an important cause and consequence of social inequality. Mental health problems contribute a higher percentage of total disability adjusted life years (DALY)[×] in the UK than any other chronic illness[2]. Recent estimates put the full cost of mental health problems in England at £105.2 billion[3], and mental illness accounts for about 13% of total National Health Service (NHS) spend[4].

[±] The phrase 'mental health problem' mirrors the terminology used in the National Strategy. Therefore it is also used in this chapter as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorder.
[×] DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences:

The causes and influences of mental health problems are wide ranging and interacting. They are often associated with adverse events in our lives and other circumstances, such as poverty, unemployment, levels of supportive networks, levels of education and the broader social environment. These factors interact and affect how resilient we are in coping with these challenges.

Often mental health problems result in stigma and discrimination that makes it harder for those with mental health problems to live a normal life.

Mental health problems are classified as either Common Mental Disorders (CMD) or Serious Mental Illness (SMI).

For CMD the term covers a technical classification of six neurotic disorders and includes the following:

- Mixed Anxiety and Depression
- Generalised Anxiety Disorder
- Depression
- Phobias
- Obsessive Compulsive Disorder
- Panic Disorder

The majority of CMD is either anxiety or depression.

SMI disrupts a person's perception of reality, their thoughts and judgement and affects their ability to think clearly. People affected may see, hear, smell or feel things that nobody else can. SMI sometimes referred to as a psychosis and includes conditions such as schizophrenia and bipolar disorder (formerly known as manic depression), paranoia and hallucinations[5].

There were approximately 510,000 people in Nottinghamshire aged 16 to 74 in 2014/15, of whom;

- 4.3 % experienced high levels of anxiety
- 7.9% experience both anxiety and depression
- 0.7% are known to GPs with a SMI.

In 2013/14 people known to mental health services in Nottinghamshire were over 3.7 times more likely to die before the age of 75 than the general population[46].

In 2014, Nottinghamshire County Health and Wellbeing Board approved the No Health without Mental Health Nottinghamshire Mental Health Framework for Action (FfA) 2014-2017. This FfA brings together the vision for improved mental health across the life course under the following 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 effective support for those with mental health problems
5. Improving the wellbeing and physical health of those with mental health problems

Unmet needs and gaps

Unmet needs and service gaps where identified by applying the Public Mental Health conceptual model (Mental Health Promotion, Mental Illness Prevention and Treatment, Recovery and Rehabilitation against unmet needs and service delivery. This JSNA has identified that Nottinghamshire service delivery focuses on the mental health treatment, with very little emphasis on mental health promotion, prevention, recovery as well as addressing the needs of those with mental health problems and co-existing physical conditions.

The following unmet needs and service gaps have been identified and are aligned to the Nottinghamshire No Health without Mental Health Framework for Action – 2014/2017

- Accessing of mental health services is confusing and difficult to navigate and it is not always clear where to first turn for support. Signposting service information needs to be clearer and easy accessible.
- There is inequity in the offer of Social Prescribing being delivered in Bassetlaw District for +65 years only. Consideration is needed to expand the service across the County and to include adults and older people to offer social support to those at risk of mental or recovering from mental health problems
- 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 the general population needs to be reduced. This is an important priority for Nottinghamshire County Public Health and CCGs, and particularly with a focus on reducing smoking and improving identification of physical health problems early and improving access to LTC treatment to prevent emergency hospital admissions
- Care for people in mental health crisis is a partnership priority under the HM Crisis Care Concordat. More needs to done in preventing mental health problems and intervening early to prevent a mental health crisis
- As part of mental health recovery interventions access to employment is required to improve the employment rate for those in mental health services
- Assessing for mental health problems is not routinely undertaken by health and social care professionals. Make Every Contact Count (MECC) needs to be utilised to raise awareness of mental health problems and sign posting to mental health services when required
- Access to Mental Health First Aid training is not routinely offered to employers as a means to support those with mental health problems to remain in work or to support people in getting back to work.

Recommendations for consideration by commissioners

Recommendations	
Mental Health Promotion (includes Nottinghamshire population and at risk groups targeted approach)	
1.	Seamless pathways are required from mental health inpatient and community settings to ensure the promotion of physical health improvement programmes (smoking cessation, physical activity, weight management, dietary advice)
2.	Promote good mental health and build mental health resilience through increased access to mental health promotion techniques
3.	Promote good mental and physical health by universal promotion and awareness campaigns
4.	Build mental health knowledge and skills through the provision of Mental Health First Aid training
5.	Targeted Cognitive Behavioural Treatments and social interventions for those at risk of depression i.e. those with Long Term Conditions
6.	Build social and emotional resilience by development of a self-management, social skills and financial literacy training to improve financial skills and reduce indebtedness
7.	Increase levels of physical activity across Nottinghamshire through the promotion and community empowerment interventions for active travel, walkable neighbourhoods and active leisure
8.	Integrate physical and mental wellbeing through universal access to lifestyle programmes to reduce smoking, alcohol use, substance use and obesity
9.	Reduce mental health problem stigma and discrimination by offering a targeted mental health awareness and training programme
10.	Utilise Make Every Contact Count (MECC) to raise awareness of mental health and sign posting to mental health services
11.	Promote the use of volunteering to support people to build social confidence, increase training and employment opportunities and reduce social isolation
Mental Illness Prevention	
12.	Improve quality of life through increasing opportunities for participation, personal development and problem solving through access to social interventions in primary and community care pathway i.e. social prescribing, self-help groups etc.
13.	Improving working lives through workplace screening for risk of depression followed by Cognitive Behavioural Treatments
14.	Work-based mental wellbeing and stress management programmes to reduce level of sickness absenteeism
15.	Promote engagement and participation through back to work programmes to support those recovering from mental illness i.e. training, work placement and volunteering programmes
16.	Improve the quality of older people's lives through access to psychosocial therapies which enhance control, prevent isolation and enhance physical activity .i.e. befriending services, social prescribing to target loneliness and social isolation
17.	Homelessness support programmes to include a holistic package of care such as; health improvement, social prescribing, debt management

18.	Early identification of mental health problems and signposting by integrating mental health into NHS health checks and MECC
19.	Improve PCPT pathways targeting at risk older people, those with physical disabilities or LTC
20.	Continued integrated approach in the implementation and delivery of the Crisis Concordat Action Plan
Treatment, Recovery and Rehabilitation	
21.	Improve physical assessment and treatment pathways for those with a SMI
22.	Improve access pathways to physical health screening, prevention and health improvement interventions such as smoking cessation, cancer screening, dental, optical, flu vaccinations, weight management, substance misuse
23.	Implement employment and training programmes to support those with mental health problems into employment
24.	Improve access to settle accommodation for those on a CPA and with mental health problems
25.	Health Equity Audit needs to be undertaken to ascertain if mental health services are targeting high risk groups

What do we know?

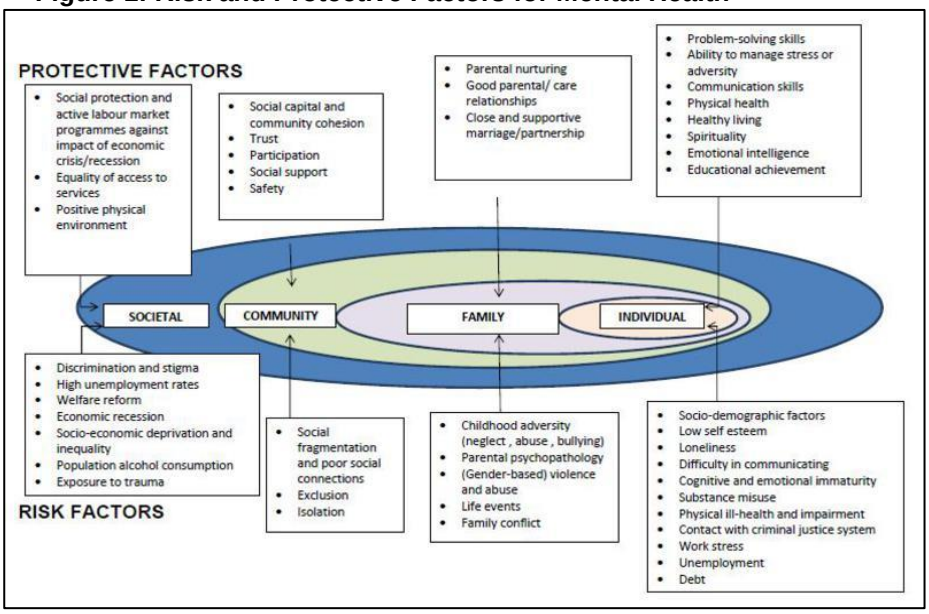
1) Who is at risk and why?

Mental health problems are extremely common. It is widely reported that one in four people will experience mental health problems each year[6] and up to one in two people at some point in their lives[7].

1.1) Mental Health Fixed and modifiable risk factors

Mental health is influenced by a wide range of biological and social risk factors. These factors can either be **fixed factors**[7] or **modifiable factors**[8,9,10]. An illustrative model of risk and protective factors for mental health is shown in figure 1 below.

Figure 1: Risk and Protective Factors for Mental Health



Source: www.nhstayside.scot.nhs.uk

There are a number of groups within the adult and older people's population that are at higher risk of experiencing mental health problems as shown in table 1. Nottinghamshire Mental Health risk factors can found on Page 2 of the PHE Mental Health JSNA profile http://fingertipsreports.phe.org.uk/mh-jsna/e10000024.pdf

Table 1: General Population increased mental health problem risk factors

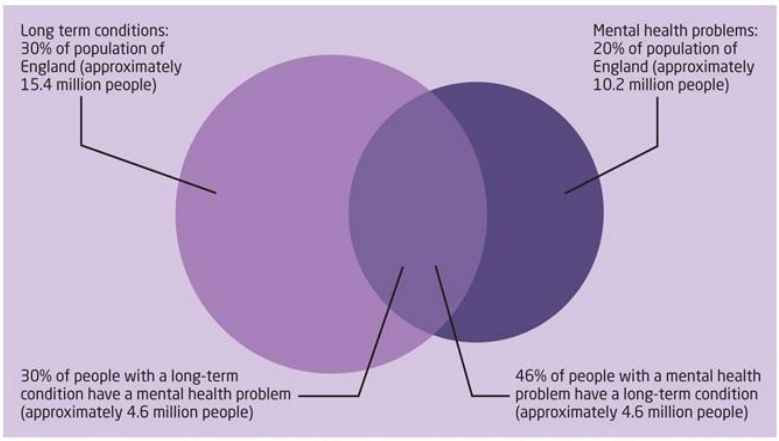
Mental health high risk factors	Estimated increased risk
Perinatal women	1:7[11]
Post-natal women	1:10[12]
Non-consensual intercourse before age 16	X 10[13]
Childhood experience of physical and/or sexual abuse	X 15[14]
BME communities	X 5[15]
Unemployment	X 10[16]
Homelessness	X 5[17]
Long term medical condition	X2.6[18]
Prisoners	9:10[19]
Carers	1:2[20]
Aged 65+ living in care homes	1:4[21,22]
Aged 65+ living alone in the community alone	1:5[21,22]
Aged 65+ in acute general hospital wards	6:10[23,24]

1.2) Links between mental health and physical health

Mental health and physical health are inextricably linked as shown below in Figure 2. The mortality rate among people with a severe mental illness aged 18-74 is three times higher than that of the general population[25] and on average die 15-20 years earlier than the general

population with physical health problems tending to be the main attributor[26]. On average, men with mental health problems die 20 years earlier, and women die 15 years earlier, than the general population[27,28,29]. While this shortened life expectancy reflects higher rates of suicide, as well as accidental and violent fatalities, the majority of deaths in this group arise from preventable causes and could have been avoided by timely medical intervention.

Figure 2: 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*

The level of mortality related diseases includes;

- Nearly four times the general population rate of deaths from diseases of the respiratory system
- Just over four times the general population rate of deaths from diseases of the digestive system. Of which diseases of the liver account for 7.6% of the digestive deaths[37].
- 2.5 times the general population rate of deaths from diseases of the circulatory system[38]. Of which, Ischaemic heart diseases accounts for 9.9% of circulatory system deaths[37].

Some of the contributors to poor physical health for those with severe mental illness, includes;

- The prevalence of obesity has been reported to be as high as 55%. Physical inactivity, unhealthy diets and weight gain from psychotropic medication are all factors that contribute to this. The primary cause of death in these people is cardiovascular disease, which is strongly associated with the incidence of obesity[30,31]
- Among people with a CMD, approximately 32% are likely to be smokers, compared with 20% of the general population. The prevalence of being a smoker was 40% among people with a psychosis[32].

Appendix 1 shows the prevalence of modifiable lifestyle risk factors which contribute to premature mortality, such as smoking, alcohol consumption, poor diet and physically inactivity, increases with the severity of mental health condition when compared to the general population.

1.3) Long-term conditions and mental health

Not only do people with mental illness suffer from higher rates of morbidity and premature life expectancy, but people with long-term physical health conditions are at increased risk of experiencing mental health problems[33] which has implications on poorer clinical outcomes and quality of life. For example:

- Depression is two to three times more common in a range of cardiovascular diseases including cardiac disease, coronary artery disease, stroke, angina, congestive heart failure, or following a heart attack[34, 35, 36, 37.] Prevalence estimates vary between around 20 per cent and 50 per cent. Anxiety problems are also common in cardiovascular disease[38]
- People living with diabetes are two to three times more likely to have depression than the general population[43, 39, 40]

- Mental health problems are around three times more prevalent among people with chronic obstructive pulmonary disease than in the general population[41]. Anxiety disorders are particularly common; for example panic disorder is up to 10 times more prevalent than in the general population[42]
- Depression is common in people with chronic musculoskeletal disorders[43]**.** Up to 33 per cent of women and more than 20 per cent of men with all types of arthritis may have comorbid depression[44].

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, and serious mental illness. Also include are risk factors, prevalence and service activity data, some at local authority, district or at a CCG level[45].

2.1) Local risk factors for mental health problems

Table 2 gives an overview of the Nottinghamshire mental health risk factors that can influence the onset and course of CMD and SMIs. For Nottinghamshire, across most districts the CMD risk factors are higher than the England rate and includes long-term health problems or disability, unpaid carers, relationship breakup and adults with low education. Overall, Mansfield District is higher across many of the mental health risk factors for both CMD and SMI compared to other Nottinghamshire Districts, East Midlands and England. This is reflected in the Mansfield District having the highest number of people experiencing CMD (Table 4) and SMI (Table 6 in Nottinghamshire.

Table 2: Common Mental Disorder and Serious Mental Health risk factors for Nottinghamshire and all Nottinghamshire Districts compared to East Midlands and England – ages 16+ to 74 years

Indicator CMD risk factors only CMD and SMI risk factors SMI risk factors only	Period	England	East Midlands	Nottingham-shire	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark & Sherwood	Rushcliffe
	Key:	*Lower*				*Similar*		*Higher*		Relative to England	
Socioeconomic deprivation: overall IMD score (2015)	2015	21.8	*	18.6	25.4	22.7	14.3	15.3	27.8	18.8	7.7
Socioeconomic deprivation: % of people living in 20% most deprived areas	2014	20.2	18.3	14.4	24.5	16.0	5.4	3.2	36.0	14.5	0.0
Long-term unemployment: % of working age population	October 2014	0.61	0.58	0.56	*	*	*	*	*	*	*
Statutory homelessness: rate per 1000 households	2014/15	2.4	1.8	1.6	1.7	1.9	0.2	1.5	3.0	2.4	0.3
Supported asylum seekers: Rate per 10,000 population	2013/14 Q2	3.9	3.5	*	0.0	*	1.4	*	0.0	0.0	0.0
Children in poverty: % living in low income households	2013	18.6	17.8	16.8	22.6	17.2	14.7	16.0	22.8	15.9	7.2
Higher risk drinking: % of people drinking at increasing or higher risk levels	2008 - 09	22.3	22.5	22.9	22.4	23.1	23.3	22.5	21.8	23.2	24.1
Physical activity: % of population engaging in recommended levels of physical activity	2014	57.0	*	59.0	50.8	59.5	61.5	63.1	53.3	62.3	62.6
Long-term health problems or disability: % of people whose day-to-day activities are limited by their health or disability	2011	17.6	18.6	20.3	22.5	21.8	18.8	19.3	23.7	20.3	15.7
Unpaid carers: % of population who provide substantial unpaid care	2011	2.37	2.53	2.76	3.26	3.05	2.43	2.55	3.40	2.75	1.88
Relationship breakup: % of adults whose current marital status is separated or divorced	2011	11.6	11.9	12.1	13.0	12.6	13.2	11.9	13.3	12.5	10.4
Adults with low education: % of adults that have no qualifications or level one qualifications	2011	35.8	38.6	39.5	47.8	43.0	36.0	37.3	46.1	39.4	26.8
Lone parents households: % of households that have lone parents with dependent children	2011	7.1	6.7	6.5	7.9	6.3	5.5	6.9	7.4	6.2	5.1
Household overcrowding: % of households with occupancy rating for bedrooms of -1 or less	2011	4.8	3.3	2.3	2.4	2.2	2.6	2.0	3.1	1.9	1.7
Rented accommodation: % of all households living in rented accommodation	2011	34.5	30.7	26.7	29.0	28.4	25.2	23.1	31.9	27.3	21.7
English Language skills: % of people who cannot speak English / speak it well	2011	1.65	1.56	0.63	0.35	0.81	0.68	0.40	1.29	0.64	0.33
Population turnover (internal migration): Rate per 1,000 resident population	2014	90.7	104.6	87.4	76.0	129.1	106.4	82.1	82.1	99.0	122.8
Migrant GP registrations: Rate per 1,000 resident population	2014	11.7	9.7	4.9	1.5	2.4	8.7	2.5	6.9	4.7	3.6
Prison Population Number	Sept 2014	-	-	2,814	-	-	-	-	-	-	-
Violent crime: rate per 1,000 population	2014/15	13.5	11.9	11.8	12.0	13.4	8.4	8.4	20.1	12.0	8.4
White ethnic group proportion: % of population who identify their ethnicity as white (British, Irish or other)	2011	85.4	89.3	95.5	97.7	97.4	92.7	93.1	97.2	97.5	93.1
Mixed/multiple ethnic group proportion: % of population who identify their ethnicity as mixed or multi-ple groups	2011	2.25	1.90	1.36	0.89	0.88	1.67	2.31	1.06	1.01	1.75
Asian or Asian British ethnic group proportion: % of population who identify their ethnicity as Asian or Asian British	2011	7.8	6.5	2.2	0.9	1.1	4.1	2.9	1.2	0.9	4.2
Black or Black British ethnic group proportion: % of population who identify their ethnicity as Black or Black British	2011	3.5	1.8	0.6	0.4	0.5	0.9	1.5	0.4	0.4	0.6
Other ethnic group proportion: % of population who identify their ethnicity as Other	2011	1.0	0.6	0.3	0.1	0.2	0.6	0.2	0.1	0.1	0.4

***Source:** PHE Common Mental Disorder Profile (2016): Serious Mental Illness Profile (2016)*

2.2) The scale of mental health problems in Nottinghamshire's population

2.2.1) Nottinghamshire self-reported wellbeing

Office of National Statistics (ONS) currently measures individual/subjective self-reported wellbeing based on four questions included on the Integrated Household Survey as follows:

- Overall, how satisfied are you with your life nowadays?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?
- Overall, to what extent do you feel the things you do in your life are worthwhile?

Table 3 below compares Nottinghamshire self-reported wellbeing scores to England and East Midlands region. For the period 2014-15, all self-reported wellbeing indicators for Nottinghamshire is statistically similar to England and the East Midland regions.

Table 3: Nottinghamshire Self-Reported Wellbeing Scores compared with England and East Midland Region – 2014-15. ** Note: An individual can have more than one self-reported wellbeing indicator*

Self-reported wellbeing	Key:	*Lower*	*Similar*	*Higher*	Relative to England
	% of population aged 16+				Estimated number
Indicator	**England**	**East Midlands region**		**Nottinghamshire**	**Nottinghamshire**
% of people with high anxiety	*19.4*	*18.6*		*18.8*	123,600
% of people with low happiness	*9.0*	*8.7*		*8.3*	54,500
% of people with low satisfaction	*4.8*	*4.4*		*4.3*	28,100
% of people with low worthwhile	*3.8*	*3.7*		*4.2*	27,400
Total					**233,600**

Source: PHE Fingertips Profiles (Annual Population Survey (APS);

Appendix 2 shows the Nottinghamshire District average ratings for anxiety, life satisfaction, feeling things done in life are worthwhile and happiness. Since 2011, for all Nottinghamshire Districts show that anxiety levels have increase with increased rates for life satisfaction, feeling things done in life are worthwhile and happiness.

2.2.2) Nottinghamshire Common Mental Disorders Prevalence Rate

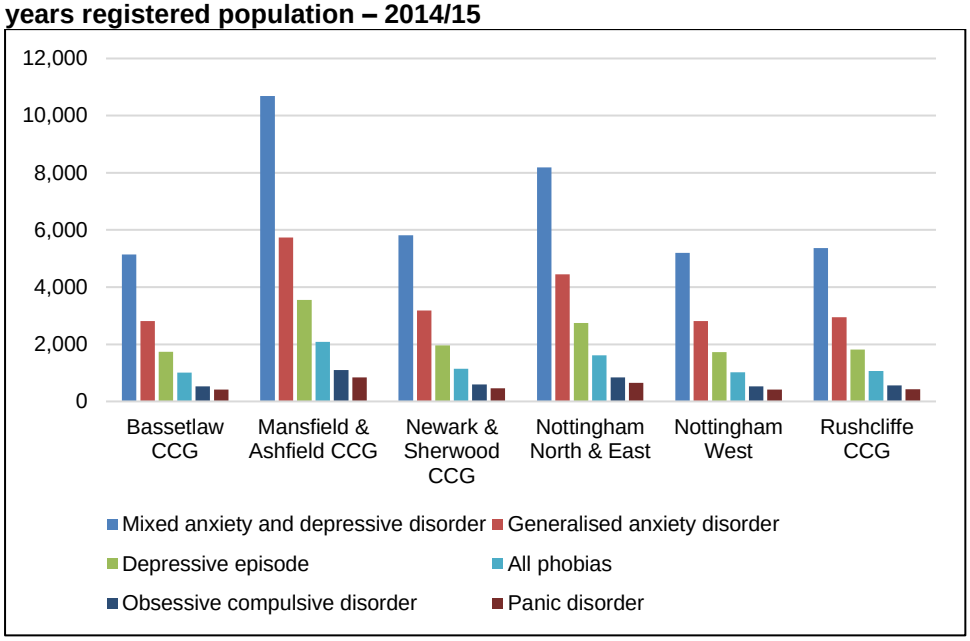
The Adult Psychiatric Morbidity Survey (APMS 2014) remains the primary source of information on the prevalence of both treated and untreated psychiatric disorders and their associations among adults living in private households[6]. Using the APMS 2014 statistical modelling, table 4 shows approximately 91,155 people are estimated to have a CMD (excluding Post Traumatic Stress and Eating Disorders). Across all CCGs, mixed anxiety and depression rated the highest proportions of CMD by disorder shown in Figure 3.

Table 4: Estimated prevalence of any common mental disorders by CCG for 16-74 years registered population – 2014/15

CCG	Common Mental Health Disorders (Any CMD) *	
	Estimated number	%
Bassetlaw	11,636	*11.9*
Mansfield and Ashfield	23,998	*13.0*
Newark and Sherwood	13,162	*13.4*
Nottingham North and East	18,480	*13.7*
Nottingham West	11,694	*13.1*
Rushcliffe	12,185	*14.2*
Nottinghamshire Total	**91,155**	***13.4***
East Midland Region	**430,014**	***13.0***
England	**6,114,247**	***15.6***

Source: PHE Common Mental Health Disorders Profile 2017 ** Note: An individual can have more than one disorder*

Figure 3: Estimated number of common mental disorders by CCG and type of disorder for 16-74 years registered population – 2014/15



Source:* *PHE Common Mental Health Disorders Profile 2017

** Note: An individual can have more than one disorder*

2.2.3) Depression in primary care

Table 5 and Figure 4 below shows the total number of adults (18 years+) in Nottinghamshire County and CCGs who had a diagnosis of depression recorded between 2011 and 2016 as part of the Quality and Outcomes Framework (QOF). From 2011/12 to 2011/13, the number of people recorded on the Depression QoF register steadily reduced sharply from 67,365 people diagnosed with depression in 2011/12 compared to 33,842 diagnosed in 2012/13. This sharp reduction maybe due QoF recording issues in primary care. However, since 2012/13 there has been a steady year on year increase in the number of people diagnosed with depression with 52,694 diagnosed in 2015/16. In 2015/16, the prevalence rate across all CCGs is similar to England, 8.26%[46].

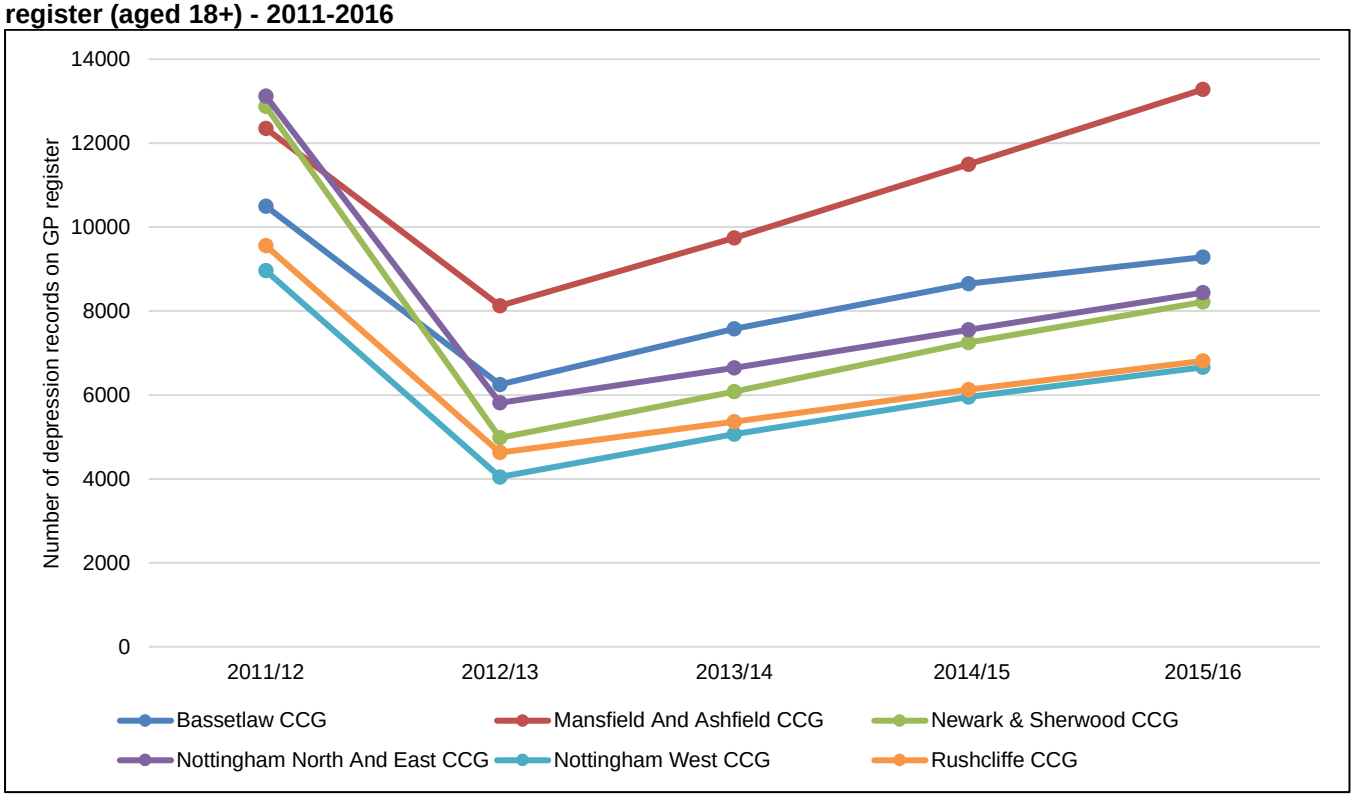
There are differences between estimates of need based on APMS and recorded prevalence in QOF as the APMS estimates people with symptoms that week only, rather than prevalence over a longer time, and shows that the majority of people with depression are known to primary care. There is also variation in how depression is recorded at a 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 APMS prevalence estimates and QOF figures should be treated with caution, however it does illustrate the scale of depression as a common health problem in Nottinghamshire from 2011-2016.

Table 5: Nottinghamshire and CCGs Depression recorded prevalence (QoF) – Number/% on GP practice register recorded as having depression (aged 18+) – 2011/16

	2011/12		2012/13		2013/14		2014/15		2015/16	
CCG	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Bassetlaw	10500	*11.52*	6249	6.79	7577	8.21	8653	9.29	9280	10.17
Mansfield And Ashfield	12349	*8.31*	8125	*5.54*	9743	*6.58*	11499	*7.68*	13279	*8.75*
Newark & Sherwood	12874	*12.36*	4979	*4.85*	6078	*5.86*	7251	*6.93*	8219	*7.75*
Nottingham North And East	13122	*11.10*	5814	*4.98*	6647	*5.63*	7551	*6.32*	8437	*6.98*
Nottingham West	8963	*11.63*	4048	*5.35*	5070	*6.66*	5948	*7.78*	6663	*8.75*
Rushcliffe	9557	*9.61*	4628	*4.74*	5365	*5.46*	6128	*6.21*	6816	*6.85*
Nottinghamshire County	**67365**		**33843**		**40480**		**47030**		**52694**	
England	**5123948**	***11.68***	**2582233**	***5.84***	**2912592**	***6.52***	**3305363**	***7.33***	**3775531**	***8.26***

Source: PHE Common Mental Health profiles (2017)

Figure 4: All Nottinghamshire CCGs trend on the number recorded with depression on the GP register (aged 18+) - 2011-2016



Source: PHE Common Mental Health profiles (2017)

2.2.4) Serious Mental Illness

The 2007 APMS found the prevalence rate for probable psychotic disorder in the year prior to interview was 0.4%. Table 6 below shows the estimated number of people in Nottinghamshire to have an SMI in 2012 was 2,236 which is slightly below the England SMI rate.
GPs are required to keep a register of patients with a diagnosed SMI. Table 6 shows that in 2015/16 there were 5,685 patients recorded on the QoF register across all Nottinghamshire CCGs. There is little variation in the prevalence rate for SMI diagnosis across all Nottinghamshire CCGs. All CCGs, apart from Bassetlaw CCG are lower than national prevalence (0.9%)[58].

Primary care (GP) prevalence rates are higher than the APMS which recorded prevalence of 0.4%, although that was an annual measure. There are differences between estimates of SMI based on APMS and recorded prevalence in QOF as the APMS estimates people with symptoms in a 12 month time frame only, rather than prevalence over a longer time.

However, the analysis should be treated with some caution. It takes into account age and sex of the local population but does not take into account the risk factors associated with mental health problems such as socio-economic deprivation. Also, as the data is captured as a snapshot in time, the change in the SMI incidence and prevalence rate is not captured.

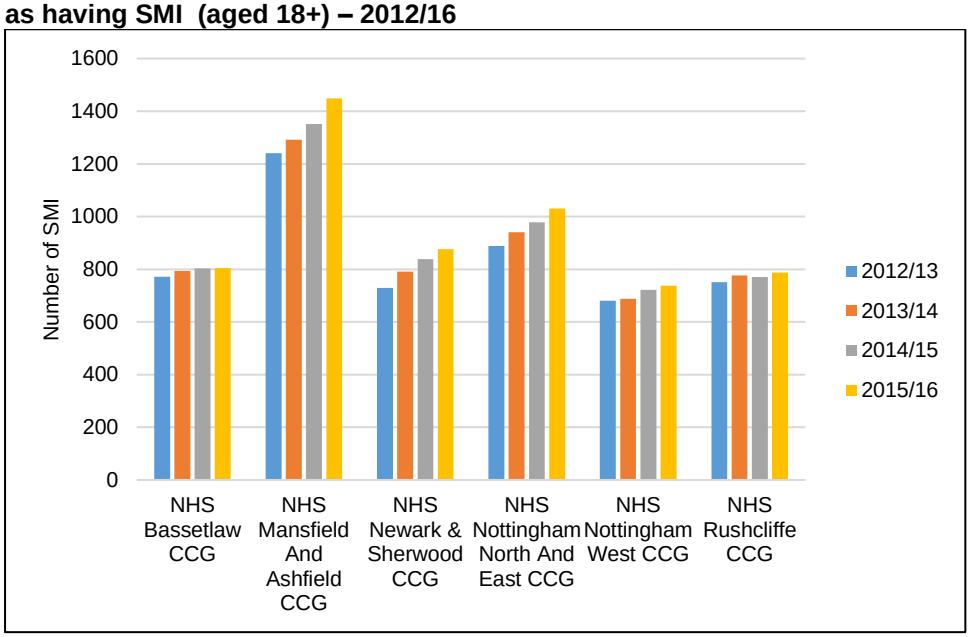
Table 6: Estimated diagnosed prevalence for Serious Mental Illness by CCG for 16-74 years registered population

	Estimated prevalence of psychotic disorder at 0.4% (in the previous year)		Number of people with SMI known to GPs: % on register (at any time)	
	2012 (16+years)		2015/16 (All ages)	
CCG	Number	%	Number	%
Bassetlaw	333	*0.36*	805	*0.98*
Mansfield And Ashfield	636	*0.41*	1449	*0.76*
Newark & Sherwood	297	*0.32*	876	*0.66*
Nottingham North And East	366	*0.31*	1030	*0.68*
Nottingham West	315	*0.35*	738	*0.79*
Rushcliffe	288	*0.32*	787	*0.63*
Nottinghamshire County	2,236	0.36	5,685	
England		*0.40*		*0.9*

Source: ***http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness*** *****
Note: QOF SMI register may include patients considered in remission

Figure 5 below that from 2012-2016, across all CCGs there has been a steady increase of the number SMI recorded on the QoF register. New cases of psychosis served by the Mental Health Early Intervention Teams remains unchanged with approximately 900 new cases in 2014/15 and 2015/16.

Figure 5: CCGs SMI recorded prevalence (QoF) trend – Number on GP practice register recorded as having SMI (aged 18+) – 2012/16



Source: ***http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness*** *****
Note: QOF SMI register may include patients considered in remission

Key messages

The figures suggest in Nottinghamshire that there could be in the region of;

- At least 123,600 with high anxiety levels
- At least 91,155 adults aged 16 to 74 years with a common mental health problem and that could benefit from a mental health interventions.
- At least 5,685 adults with a Serious Mental Illness that require specialist mental health treatment
- New cases of psychosis served by the Mental Health Early Intervention Teams remains unchanged with approximately 900 new cases in 2014/15 and 2015/16

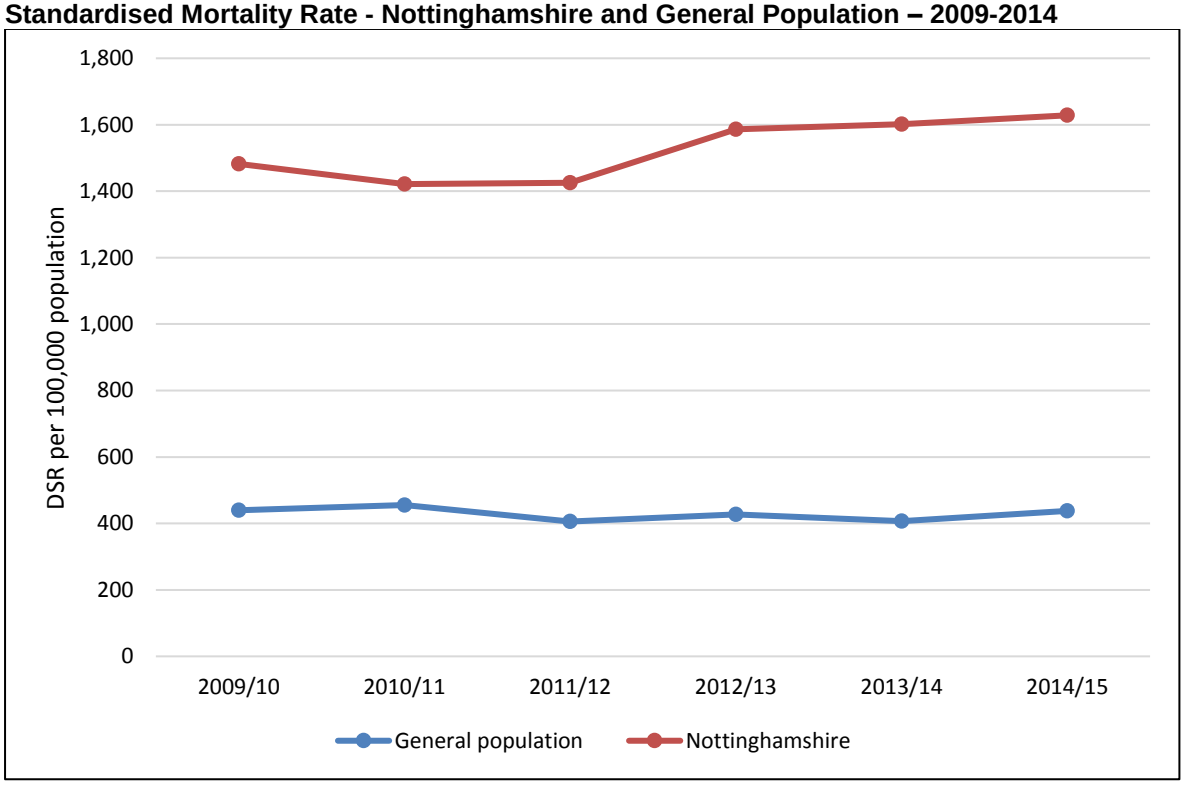
2.3) Nottinghamshire physical health inequalities in those with mental health problems

One in three of the 100,000 people who die prematurely each year in England have a mental illness[47]: On average, men with mental health problems die 20 years earlier, and women die 15 years earlier, than the general population[48,49,50]. The majority of deaths in this group arises largely from preventable and treatable conditions associated with modifiable risk factors such as smoking, obesity, substance misuse, poor diet and a lack of physical activity[51].

2.3.1) Mental health problems and excess mortality prevalence rates

Figure 6 shows the estimates of the excess early deaths in people with mental health problems From 2009 there has been an increase in the Nottinghamshire rate for excess under 75 mortality in adults, with a DSR ranging from 1,482 per 100,000 population in 2009/10 to 1,628 per 100,000 population in 2014/15. This means that in 2014/15 people known to mental health services in Nottinghamshire are over 3.8 times more likely to die before the age of 75 than the general population[46].

Figure 6: Excess under 75 mortality in adults aged with serious mental illness: Directly Standardised Mortality Rate - Nottinghamshire and General Population – 2009-2014



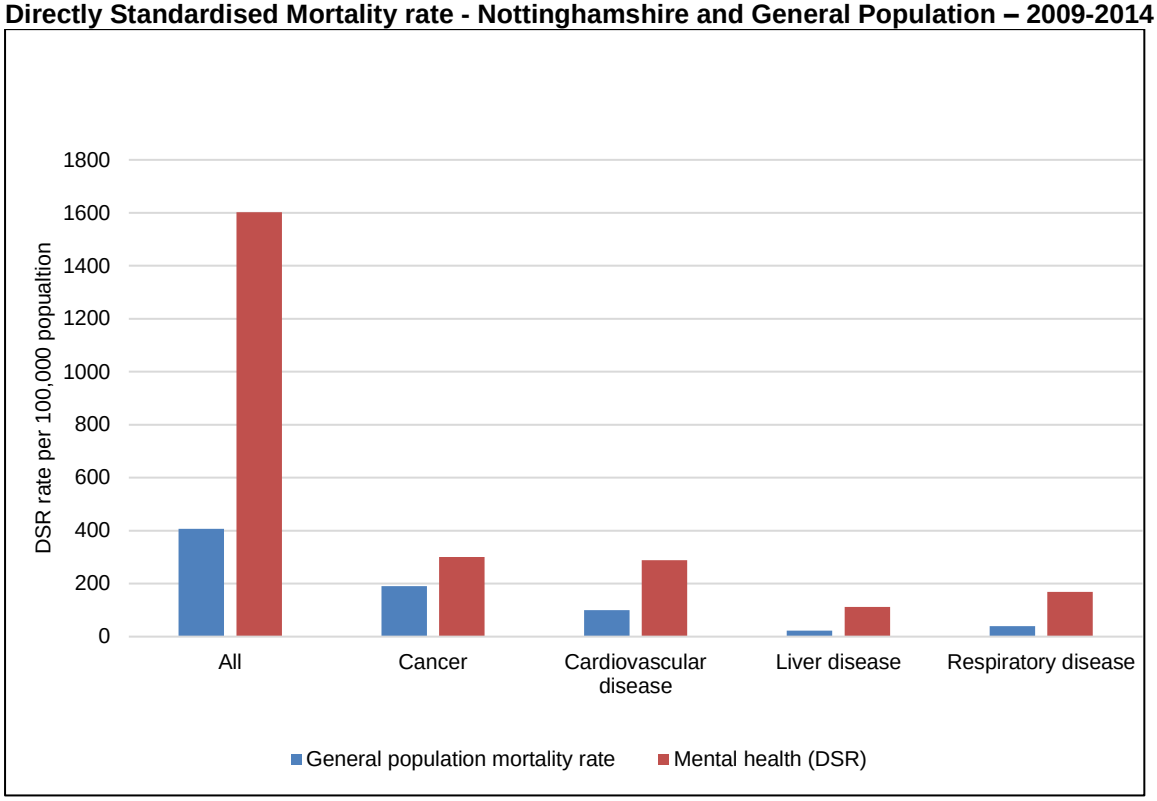
Source: Data.gov.uk

Appendix 3 shows the Nottinghamshire death rates by age for the general population and those known to secondary mental health services under the age of 75.

2.3.2) Excess under 75 mortality cause of death

Figure 7 below shows the excess under 75 mortality by cause of death, as reported for a four year period for Nottinghamshire compared to the general population. Deaths caused by liver and respiratory diseases were significantly higher in the Nottinghamshire SMI population compared to the general population.

Figure 7: Excess under 75 mortality in adults aged with serious mental illness by cause of death: Directly Standardised Mortality rate - Nottinghamshire and General Population – 2009-2014



Source: HSCIS

In 2014/15 there were 294 excess deaths in Nottinghamshire in people with serious mental illness. The main causes of excess deaths over the four year period 2011/12-2014/15 were cardiovascular diseases (172 deaths), cancer (121 deaths), respiratory disease (118 deaths) and liver disease (92 deaths)[46].

2.3.3) Nottinghamshire emergency admissions rate for serious mental illness and long term conditions

Table 7 shows that across all Nottinghamshire CCGs there is a significantly higher rate of emergency admissions for long term conditions such as Cardiovascular Disease, Chronic Obstructive Airway Disease (COPD) and Diabetes for people with a SMI compared to non SMI people.

2.3.4) Preventable Physical Risk Factors

Using the local prevalence rates for CMD and SMI and the estimated smoking status[32] and obesity estimates[30] the number of people in each Nottinghamshire CCG with and CMD and SMI smoke and obese was calculated. Table 8 below shows that in Nottinghamshire there are approximately 24,531 smokers with a CMD and, for people with a SMI, approximately 2,185 smoke and 3,004 are obese .Where applicable these have been compared to the Nottinghamshire general population.

Figure 8 below compares the Nottinghamshire CMD and SMI smoking and obesity rate against the Nottinghamshire, East Midlands and England general population. Smoking status for people with a CMD and SMI is significantly higher compared to the general population. Obesity rate for people with SMI is based on 55% from NICE guidance published in 2014[30] is also significantly higher compared to the general population.

Table 7: Nottinghamshire CCGs comparative emergency admission rates for long term conditions -2014/15

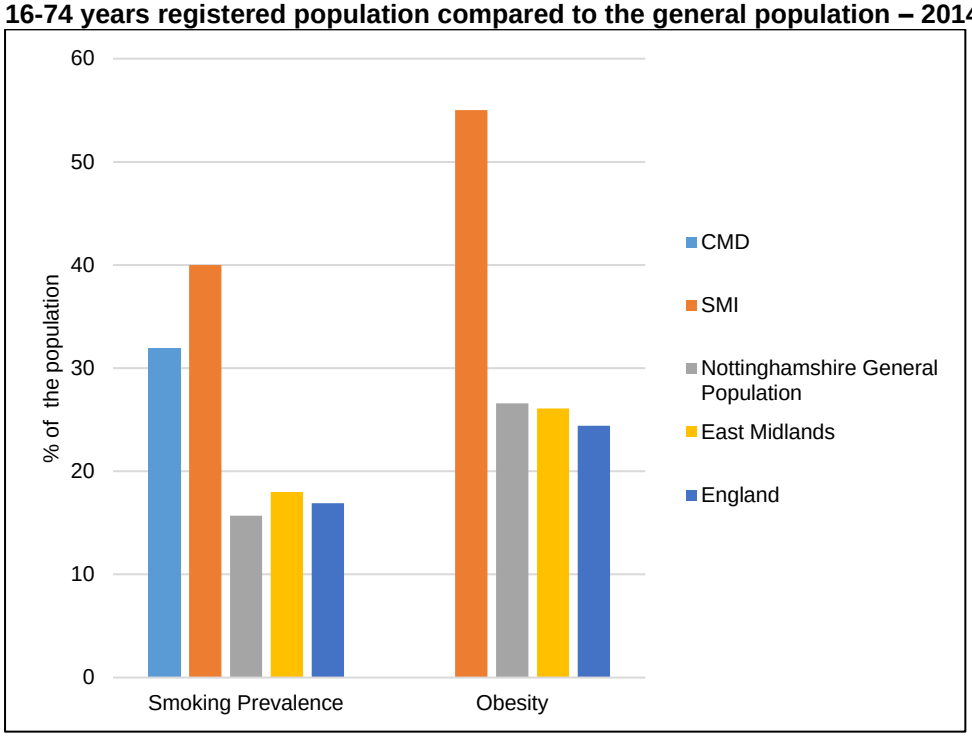
Cardiovascular disease			
CCG	**SMI**	**Non SMI**	**Admission Rate Multiplier**
	Crude admission rate per 10,000 population		**(CCG range 5.4 - 11.9)**
Bassetlaw CCG			
Mansfield and Ashfield CCG	940.0	95.1	9.9
Newark and Sherwood CCG	1025.0	97.0	10.6
Nottingham North and East CCG	950.9	93.8	10.1
Nottingham West CCG	1038.8	92.8	11.3
Rushcliffe CCG	948.1	92.4	10.3
East Midlands	690.2	91.4	7.6
COPD			
CCG	**SMI**	**Non SMI**	**Admission Rate Multiplier**
	Crude admission rate per 10,000 population		**(CCG range 7.4 - 11.2)**
Bassetlaw CCG			
Mansfield and Ashfield CCG	318.3	24.3	13.1
Newark and Sherwood CCG	226.5	16.2	14.0
Nottingham North and East CCG	276.1	20.5	13.4
Nottingham West CCG	97.0	15.5	6.3
Rushcliffe CCG	116.9	13.9	8.4
East Midlands	196.5	21.1	9.3
Diabetes			
CCG	**SMI**	**Non SMI**	**Admission Rate Multiplier**
	Crude admission rate per 10,000 population		**(CCG range 2.3 – 28.8)**
Bassetlaw CCG			
Mansfield and Ashfield CCG	148.0	11.4	13.0
Newark and Sherwood CCG	178.8	7.3	24.6
Nottingham North and East CCG	102.2	7.7	13.3
Nottingham West CCG	166.2	5.8	28.8
Rushcliffe CCG	90.9	7.0	13.0
East Midlands	83.6	7.9	10.6

Source: HES 2015

Table 8: Nottinghamshire number estimates of smoking and obesity for any CMD and SMI for 16-74 years registered population by CCG – 2014/15 compared to Nottinghamshire Adult Population

Preventable Risk Factors	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	Nottinghamshire Mental Health Population Total	Nottinghamshire General Population		
	Any CMD								Number	%
Obesity	No available estimates							**Obese adults (aged 16+) (2013/15)**	175,929	*26.6*
Smoking status (based on smoking estimates of 32%)[32]	3,163	5,910	3,617	4,701	3,455	3,683	24,531	**Smoking Prevalence in adults - current smokers (2015)**	100,900	*15.7*
SMI										
Obesity (based on obesity estimate of 55%)[30]	441	743	461	573	397	423	3,004	**Obese adults (aged 16+) (2013/15)**	175,929	*26.6*
Smoking status (based on smoking estimate of 40%)[32]	321	540	335	391	288	308	2,185	**Smoking Prevalence in adults - current smokers (2015)**	100,900	*15.7%*

Figure 8: Nottinghamshire percentage estimates of smoking and obesity for any CMD and SMI for 16-74 years registered population compared to the general population – 2014/15



Source: PHE Health Profiles

Data on smoking prevalence has improved due to better recording at Nottinghamshire Healthcare Foundation Trust (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 was much higher.

2.4) Nottinghamshire mental health problems in those with long term physical health problems

Approximately 40-60% of adults with chronic physical health problem could have depression, according to the NICE Depression in Adults with Chronic Physical Health Problems Clinical Guidance.

Table 9 below shows the estimate of depression in those with a long term condition such as, cardiovascular heart disease and diabetes by CCG. There are approximately between 33,111 to 49,668 people with a long term condition and co-existing depression in Nottinghamshire.

Table 9: Nottinghamshire number estimates with depression in long term physical conditions by CCG – 2014/15

Long term physical condition	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	Nottinghamshire
	Range 40%-60%						
CHD (all ages)[41]	4,542-6,814	3,173-4,759	2,082-3,123	2,222-3,333	1,451-2,176	1,702-2,554	15,172
Diabetes (17+ yrs)[41]	3,707-5,560	4,160-6,241	2,802-4,203	3,121-4,682	1,973-2,959	2,176-3,264	17,939
Total	**8,249-12,374**	**7,333-11,000**	**4,884-7,326**	**5,343-8,015**	**3,424-5,135**	**3,878-5,818**	**33,111-49,668**

Key messages

Early deaths in people with mental health people in Nottinghamshire could be in the region of;

- A DSR, ranging from 1,482.4 per 100,000 population in 2009/10 to 1,628.3 per 100,000 population in 2014/15
- The main causes of excess deaths are cardiovascular diseases, cancer, respiratory disease and liver disease
- Many of these deaths are preventable as often related to unhealthy lifestyle factors. For example, the smoking status for people with a CMD and SMI is significantly higher compared to the general population. Obesity rate for people with SMI is based on 55% from NICE guidance published in 2014. Therefore, the obesity rate appears lower compared to the general population as the rising prevalence of obesity is not taken into account.
- Across all Nottinghamshire CCGs there is a significantly higher rate of emergency admissions for long term conditions such as Cardiovascular Disease, Chronic Obstructive Airway Disease (COPD) and Diabetes for people with a SMI compared to non SMI people.
- There are approximately between 33,111 to 49,668 people with a long term condition and co-existing depression.

3) Targets and performance

3.1) The Mental Health Taskforce

The Mental Health Taskforce (2016)[52] report outlines key ambitions for improving access to mental health support and treatment to reach parity with physical health systems. Targets and quality standard include:

- A new target of 50% of those experiencing a first episode of psychosis to enter treatment with a NICE concordant package of care within two weeks
- 75% of people referred psychological therapy should begin treatment within 6 weeks of referral and 95% begin treatment within 18 weeks of referral.
- Psychological therapy treatment for at least 15% of the total population of need each year
- Psychological recovery rates of at least 50% for those that complete treatment

In March 2016, NHS England published the CCG Improvement and Assessment Framework and included the following mental health indicators;

- Improving access to Psychological Therapies recovery rate
- People with first episode of psychosis starting treatment with a NICE recommended package of care treated with 2 weeks of referral

- Crisis care and liaison mental health services transformation
- Out of area placements for acute mental health inpatient care transformation

3.2) Outcomes Frameworks

There are three national outcomes frameworks (listed below)

I. Public Health Outcomes Framework (PHOF)[53]
II. NHS Outcomes Framework (NHSOF)[54]
III. Adult Social Care Outcomes Framework (ASCOF)[55]

Within each Outcome Framework there are specific indicators that aims to improve the population's mental health by ensuring the quality of care is safe and effective. Table 10 below shows the mental health specific indicators and to which Outcomes Framework the indicator is assigned too. 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 now includes performance for psychological therapy services. Each indicator is hyperlinked to the Nottinghamshire performance outcomes.

Table 10: National Outcomes Framework specific indicators relating to mental health

Indicator	PHOF	NHSOF	ASCOF
Self-reported wellbeing	√		
Health related quality of life for people with mental illness	√	√	√
Employment for people with mental illness		√	
Employment for those who are in contact with secondary mental health services		√	
Proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation	√		√
Total health gain as assessed by patients accessing psychological therapies		√	
Recovery in quality of life for patients with mental illness		√	
Excess under 75 mortality rate in adults with serious mental illness	√	√	
Excess under 75 mortality rate in adults with common mental illness	√	√	
Patient experience of community mental health services		√	

NB: there is no data available for the indicator Excess under 75 mortality rate in adults with common mental illness.

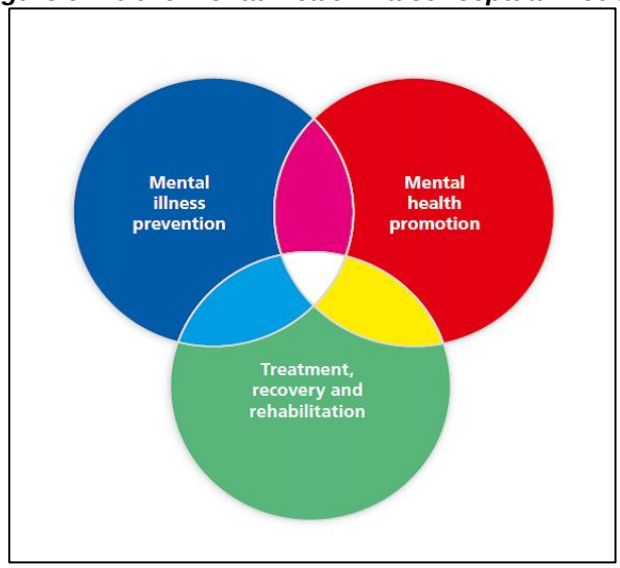
4) Current service provision, activity, and assets

Figure 9 below is a conceptual model derived from the WHO framework which demonstrates a model in commissioning and recommends prioritising evidence based interventions to include;

i) Mental health promotion, which is primarily concerned with the promotion of positive mental health and prevention of mental health risk factors listed in Table 4.
ii) Mental illness prevention through;
   - Primary prevention *(aims to prevent disease or injury before it ever occurs*)
   - Secondary prevention *(aims to reduce the impact of a disease or injury that has already occurred through early detection and interventions)*
   - Tertiary prevention *(helping people manage long-term, often-complex health problems and injuries in order to improve as much as possible their ability to function, their quality of life and their life expectancy)*
iii) Treatment, recovery and rehabilitation through access to timely evidence-based interventions and support to manage their own lives, develop stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

The current local service provision, activity, and assets is mapped to the WHO framework.

Figure 9: Public mental health – a conceptual model



Source: The HM Government Annual Report of the Chief Medical Officer (2014)[56]

4.1) Mental Health Promotion

Improved mental health is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of suicide and self-harm, improved employment rates and productivity, reduced risk of housing and financial problems, and higher levels of social interaction and participation. These contributing mental health risk factors are covered in greater detail in the following Nottinghamshire JSNA Chapters;

- All ages mental Health, (Emotional and Mental Health of Children and Young People 2014)
- Perinatal Mental Health
- Suicide Prevention
- Domestic and Sexual Violence
- Substance Misuse
- Workplace Health
- Loneliness
- Dementia
- Carers
- Employment
- Homelessness
- Asylum Seekers
- Refugees and Migrant Workers,
- Tobacco
- Obesity

4.1.1) Population mental health awareness and training

Nottinghamshire County Council (NCC) commissioned a Mental Health and Suicide Prevention awareness and training provider and awarded the18 month contract to the Kaleidoscope Plus Group (KPG) starting the 1st of October 2015 until March 2017 This service was responsible for the delivery of:

- Population based Mental health awareness and promotion campaigns in line with the national mental health awareness campaigns

- Population based Suicide Prevention awareness campaigns in line with the national suicide prevention campaigns
- Mental health community workshops focusing on building resilience and preventing mental health problems using Five Ways to Wellbeing
- Mental health awareness training for front line workers
- Mental health First Aid LITE course in line with http://mhfaengland.org/first-aid-courses/first-aid-lite/
- Mental health First Aid course in line with http://mhfaengland.org/first-aid-courses/first-aid-lite/
- ASIST Suicide Prevention Training in line with the https://www.livingworks.net/programs/asist/standards

The mental health awareness and suicide prevention awareness and training programme evaluated well through increasing the participants mental health and suicide prevention knowledge and skills (see appendix 4)

To improve those with mental health problems in accessing and keeping their employment, employers need to be routinely offered mental health awareness training as a way of improving the employment rate of those accessing mental health services. As this contract ended the 31st of March 2017, there is a gap in accessing mental health and suicide prevention training and awareness in Nottinghamshire.

4.2) Mental Illness Prevention

4.2.1) Bassetlaw Social Prescribing Service

The Bassetlaw Social Prescribing Service is commissioned by Bassetlaw CCG and is managed by Bassetlaw Community Voluntary Service (BCVS). The service is GP referral only and aims to help patients aged 65 and over who are socially isolated or frail to access services and activities provided by voluntary organisations and community groups. The 2015/16 evaluation of this service shows that for every £1 spent delivering the social prescribing service, is a 32p (32%) return on investment and time saved in GP appointments in a full year is estimated 8,490 minutes (141.5 hours). Also, patient feedback indicates that the Social Prescribing services supported positive change in their life.

4.2.2) Primary Care Psychological Therapies (PCPT)

Improving access to early management is supported by PCPT and is proven to be an effective intervention for people with common mental health problems, such as depression and anxiety disorders. It is NHS led and supports the NICE guidelines for treating people with anxiety and depressive disorders.

It is a frontline service to ensure first line therapies are available routinely with quick and easy access. Patients are either referred by their GP or they can self-refer online or over the telephone. In 2010 the service was expanded from treating those of working age to adults of 18 years and upwards.

Some of the problems people might access the service for include:

- Depression and low mood
- Problems with anxiety (including Social Anxiety and Generalised Anxiety)
- Obsessive Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Specific Phobia
- Panic Disorder
- Stress

In Nottinghamshire, there are four providers commissioned by the Nottinghamshire Clinical Commissioning Groups (CCGs):

- Lets Talk Wellbeing and Insight

- Insight Healthcare
- Trent Psychological Therapy Services
- Turning Point

Initial assessment is made via telephone and then patients are placed into services dependent upon their care needs and preferences. Step 2 and 3 psychological therapies are provided within a stepped care model.

Further details and outcome reporting are available at the NHS Improving Access to Psychological Therapies website (IAPT)

Table 11 below shows that apart from Bassetlaw CCG, PCPT referrals and PCPT treatment completeness is lower than the East Midlands and England.

Table 11: Primary Care Psychological Therapies service delivery outcomes for all Nottinghamshire CCGs compared to East Midlands and England

Indicator	Period	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	England
	Key: relative to England	*Lower*	*Similar*			*Higher*		
PCPT referrals: Rate (quarterly) per 100,000 population age 18+	2016/17 Q4	812	678	734	773	706	704	869
Access to PCPT services: People entering PCPT (in month) as % of those estimated to have anxiety/depression	2017 (June)	20	16.1	18.4	16.7	19.8	19.6	17.1
Entering PCPT treatment: Rate (quarterly) beginning PCPT treatment per 100,000 population age 18+	2016/17 Q4	638	408	486	529	585	511	584
Completion of PCPT treatment: Rate (quarterly) completing treatment per 100,000 population 18+	2016/17 Q4	463	350	327	408	342	407	327
PCPT problem descriptor completeness: % (in quarter) of PCPT referrals with and ICD-10 code	2016/17 Q4	73.8	64.5	67.6	67.4	68	67.2	62.8

Source:* *PHE Common Mental Disorder Profile (2017)

4.3) Treatment, Recovery and Rehabilitation

4.3.1) Common Mental Health Disorders Treatment

For some people with a common mental health disorder require medication, usually prescribed by their GP and/or admission to hospital. Table 12 below shows that antidepressant prescribing varies across Nottinghamshire CCGs. and hypnotic average daily quantities medication prescribed is lower than England. Also, the admission rate for depression and emergency admissions for unipolar depression and emergency admissions for neuroses are similar to East Midlands and England.

Table 12: Common mental health disorders treatment for Nottinghamshire CCGs compared to East Midlands and England

Indicator	Period	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	Nottinghamshire	East Midlands	England
	Key:	Lower	Similar			Higher		Relative to England		
Admissions for depression: Directly standardise rate for hospital admissions for unipolar depressive disorders per 100,000 age 15 and over	2009/10/11/12							29.8	31.8	32.1
Emergency admissions for neuroses: Indirectly age and sex standardised rate per 100,000 population	2012/13							18.0	-	21.7
Antidepressant prescribing Average daily quantities (ADQs) per STAR –PU**	2016/17	1.8	1.6	1.5	1.5	1.5	1.1	-		1.4
Hypnotics prescribing: Average daily quantities (ADQs) per STAR-PU**	2016/17	0.73	0.96	0.8	0.7	0.87	0.52	-		1.08

Source: ***PHE Common Mental Disorder Profile (2017)***

***Average daily quantity represents the assumed average maintenance dose per day for a drug used for its main indication in adult*

4.3.2) Nottinghamshire Secondary and Specialist Mental Health Services

The large majority of secondary and specialist mental health services are funded and commissioned by the Nottinghamshire CCGs and are provided by Nottinghamshire Healthcare NHS Foundation Trust (NHCT), through community and in-patient services.

The mental health services offered by NHCT are detailed by following http://www.nottinghamshirehealthcare.nhs.uk/our-services. Service data does not capture mental health risk factors and groups. Therefore, equity of access for this group cannot be ascertained.

4.3.3) Serious Mental Illness Treatment

For some people the level of their serious mental illness requires treatment or assessment in hospital, or the care of a secondary mental health team in the community or as an outpatient. Table 13 below gives the rate of prescribing and the rate of people needing contact with mental health services for each Nottinghamshire CCG. The prescribing of SMI medication is lower than England for all CCGs. Also, across all CCGs, the rate per 1,000 population in contact with services is lower compared to England.

Table 13: SMI GP psychosis drug prescribing and contact with mental health services rate per 1,000 population for Nottinghamshire CCGs compared to East Midlands and England

Indicator	Period	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	England
		Lower	Similar			Higher		
GP prescribing of drugs for psychoses and related disorders: Items (quarterly) per 1,000 population	2016/17 Q4	39.4	41.6	30.96	30.3	31.8	24.2	48.7
People in contact with services: Rate per 1,000 population (end of quarter snapshot)	2016/17 Q4	1625	2044	2218	1778	1428	2106	2411

Source: ***PHE Community Mental Health Profiles 2017***

Table 14 below gives a snapshot on the rate of SMI people rate per 100,000 population on the Care Programme Approach (CPA), accessing assertive outreach, day care or require mental health inpatient hospital admission. The rate of those on CPA is significantly lower than the England rate. For the other activity and outcomes the picture is mixed.

Table 14: SMI Mental Health Services Activity rate per 100,000 population for Nottinghamshire CCGs compared to East Midlands and England

Indicator SMI Services activity	Period	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	Nottinghamshire	East Midlands	England
		Lower	*Similar*			*Higher*		Relative to England		
People on Care Programme Approach: Rate per 100,000 population (end of quarter snapshot)	2016/17 Q4	120	209	116	97	83	132	-		383
Rate of people receiving assertive outreach services: rate per 100,000 population (end of quarter snapshot)	2014/15 Q2	38.4	55.0	53.2	25.4	22.2	38.8	-	37.7	19.6
Contacts and daycare attendances: Rate (quarterly) per 100,000 population	2014/15 Q2	16903	31494	11631	11182	9022	12218	-	_	12490
Service users in hospital:% mental health service users who were inpatients in a psychiatric hospital (end of quarter snapshot)	2016/17 Q4	3.7	2.4	2.4	1.7	1.9	2.1	-	3.0	2.6
Mental health admissions to hospital; Rate (quarterly) per 100,000 population	2014/15 Q2	57.9	44.0	32.2	51.1	50.1	41.9	-	_	69.8
Mental health discharges from hospital: Rate (quarterly) per 100,000 population	2014/15 Q2	66.1	53.8	56.4	44.8	41.8	58.7	-	76.0	69.8
Attendances at A&E for a psychiatric disorder : Rate per 100,000 population	2012/13	628.2	424.3	263.2	174.4	185.2	159.5	-	198.5	243.5

Source: ***PHE Community Mental Health Profiles 2017***

4.3.4) Mental Health Act Assessments

In most cases, people are treated in hospital or another mental health facility, as a "voluntary patient". However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) which is the main piece of government legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others. Table 15 below shows a snapshot of the Nottinghamshire rate of Mental Health Act assessments, admission and detentions under the Mental Health. Mansfield and Ashfield, Newark and Sherwood, and Rushcliffe CCGs have a significantly higher rate of people subject to the Mental Health Act, when compared to East Midlands and England.

Table 15: Mental Health Act Assessments Activity for Nottinghamshire CCGs compared to East Midlands and England

Indicator Mental Health Act Assessment Activity	Period	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	Nottinghamshire	East Midlands	England
		Lower	*Similar*			*Higher*		Relative to England		
People subject to Mental Health Act : Rate per 100,000 population (end of quarter snapshot)	2015/16 Q2	16.4	68.0	69.2	25.4	27.7	61.0	-	40.9	37.9
Admissions under Mental health Act:% of (quarterly) admissions which were MHA detentions	2014/15 Q2	14.3	33.3	*	*	33.3	20.0	-	_	25.4
People detained under MHA during year: Rate per 100,000 population	2012/13	51.3	55.2	47.0	32.2	34.6	42.2	-	51.9	58.7
Repeat detentions under MHA during year: Average detentions per person	2012/13	1.07	1.13	1.17	1.11	1.11	1.21	-	_	1.16
Repeat short- term orders under MHA during year. Average orders per person.	2012/13	1.16	1.09	1.07	1.44	1.19	1.08	-	_	1.26

Source:* *PHE Severe Mental Illness Profile 2017

4.3.5) Severe mental illness physical health checks quality and outcomes

Table 16 (overleaf) shows the uptake of health checks for people with a SMI in a primary care setting for all Nottinghamshire CCGs. Nottingham West and Rushcliffe CCG where either higher or similar to the England average across all the health check indicators. Less than 40% of patients with SMI received the complete physical health checks.

4.4) Nottinghamshire NHS Commissioned Services Spend

Table 17 below shows each Nottinghamshire CCG Severe Mental Illness spend for the period 2013/14. For specialist mental service spend varies between CCG with Nottingham West CCG the lowest and Mansfield and Ashfield CCG the highest, £99.45 and £146.62, respectively. With all Nottinghamshire CCGs spending less on specialist mental health services than the England average.

Table 17: Severe Mental Illness Spend by CC

Indicator: SMI Spend	Period	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	Nottinghamshire	East Midlands	England
Specialist mental health services spend: rate (£) per person	2013/14	£134.86	£146.62	£139.54	£119.19	£99.45	£127.05	-	-	£151.07
Primary care prescribing spend on mental health: rate (£) per person	2013/14	£14.18	£8.69	£11.05	£11.79	£10.05	£10.52	-	-	£12.31
% spend on specialist mental health services: % of all CCG spend categorised as mental health	2013/14	10.3%	11.6%	10.2%	10.3%	10.0	10.8%	-	-	12.7%
Cost of GP prescribing for psychosis and related disorders: Net Ingredient Cost (£) per 1,000 population (quarterly)	2015/16 Q2	68.743 (£605)	77,377 (£412)	50,916 (£391)	55,006 (£369)	37,511 (£397)	48,330 (£392	-	-	£614

Source:* *PHE Mental Health JSNA profile 2016

Table 16: % and number of Nottinghamshire CCGs primary care severe mental illness health check quality and outcomes – 2015/16

Compared with benchmark: lower / similar / higher	Value	Bassetlaw CCG	Mansfield & Ashfield CCG	Newark & Sherwood CCG	Nottingham North & East CCG	Nottingham West CCG	Rushcliffe CCG	England
Number of people with SMI known to GPs	number	805	1449	876	1030	738	787	
Exception rate for SMI QOF indicators: % of patients excluded MH quality indicators	%	30.9	14.8	17.9	12.1	11.7	11.3	11.3
People with SMI who have comprehensive care plan: % of people with SMI	%	51.4	71.3	71.6	75.9	78.0	80.4	77.5
Female patients with SMI who had cervical screening test: % tested in preceding 5 years	%	70.7	68.3	67.4	81.3	75.1	82.0	70.9
Patients on lithium therapy with levels in therapeutic range: % within preceding 4 months	%	75.9	81.3	86.1	84.7	84.7	89.7	81.3
Patients on lithium therapy with record of serum creatinine and TSH: % with record in the preceding 9 months	%	91.6	95.1	87.1	98.3	91.8	98.9	93.4
Patients with SMI with alcohol consumption check: % with record in preceding 12 months	%	62.2	75.6	74.4	73.6	82.5	83.4	80.0
Patients with SMI with blood pressure check: % with record in preceding 12 months	%	76.2	79.9	79.5	79.7	85.0	85.9	81.0
Patients with SMI with cholesterol check: % with record in preceding 12 months	%	68.3	70.2	72.0	67.9	70.8	71.3	68.8
Patients with SMI with BMI check:% with in preceding 12 months*	%	76.7	77.9	75.6	79.8	85.7	85.0	81.5
Patients with SMI with blood glucose or HbA1c check:% with in preceding 12 months*	%	76.5	73.2	76.7	71.8	76.5	74.9	74.9
People with SMI who have received the complete physical health checks: % of people with SMI*	%	30.9	34.5	33.7	36.8	39.3	39.1	34.8

Source: ***PHE Severe Mental Illness Profile*** *[Accessed 2017]*

**2014/15*

4.5) Nottinghamshire County Council – Adult Social Care Mental Health Commissioned Services, Activity, and Spend

In 2012 Nottinghamshire County Council commissioned a mental health support service and awarded a contract for up to 5 years to Framework Housing Association for the Moving Forward – Steps to Independence service. (http://www.frameworkha.org/framework_near_me/221_moving_forward_steps_to_independence). The service is contracted to support 550 people per annum and provide 42 units of supported accommodation.

Support staff work alongside the Community Mental Health Teams to provide short term support, and where necessary short term housing and support, for people whose mental health is being affected by housing issues, money and benefits problems and/or social isolation.

The service also provides brief interventions for past users of the service to support the prevention of problems recurring. In addition, Crisis Link Workers, employed by Framework Housing Association but located within Crisis Resolution and Home Treatment teams at Bassetlaw Hospital, Mansfield's Millbrook Mental Health Unit and Nottingham's Highbury Hospital, support people in crisis to resolve housing and money issues that will be caused by their mental ill-health and also preventing recovery. This service supports in-patients in the same way, in order to promote recovery and facilitate discharge where accommodation, benefits issues or debt might otherwise cause discharge delays.

Figure 10 summarises social care activity for adults with mental health problems in Nottinghamshire compared to a nation benchmark. Data is not available at district or CCG level. Nottinghamshire is lower compared to England across the majority of indicators except for carer assessments which is higher compared to England.

Figure 10: Nottinghamshire Adult Social Care Mental Health Activity and Support compared to East Midlands and England - ages 18-64 years

Compared with benchmark: Lower Similar Higher

Benchmark: Value

Lowest | 25th Percentile | 75th Percentile | Highest

Indicator	Period	Notts		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	570	119	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	200	42	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	90	18.8	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	185	38.6	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	95	19.8	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	635	100.2	69.5	64.3	0.0		352.6

Source: PHE Adult Social Care Profile 2016

Table 18 below show Nottinghamshire social care mental clients receiving self-directed payments. Nottinghamshire is significantly higher than England.

Table 18: Adults social care mental health self-directed payments - 2013-14

Indicator	Period	Bassetlaw CCG	Mansfield and Ashfield CCG	Newark and Sherwood CCG	Nottingham North and East CCG	Nottingham West CCG	Rushcliffe CCG	Nottinghamshire	East Midlands	England
	Key:	*Lower*	*Similar*			*Higher*		Relative to England		
Self-directed payments:% social care mental health clients receiving direct payments	2013/14	-	-	-	-	-	-	28.9%	30.0	10.7
Self-directed support: % social care mental health clients receiving direct payments or have a personal budget	2013/14	-	-	-	-	-	-	97.9%	60.3	28.4

Source: PHE Adult Social Care Profile 2016

Appendix 5 shows the 2015/16 Nottinghamshire Adult Social Care activity and spend for mental health support in each Nottinghamshire district was a total of £8,500,741. The highest proportion of spend was on residential care follow by supported living, 40.7% and 33.7%, respectively. Apart from Rushcliffe District the allocation spend was aligned to districts with the higher rates of mental health problems as shown in Figure 3 and Figure 5.

Key messages

Mental Health Promotion

- There is gap in accessing mental health and suicide prevention training and awareness in Nottinghamshire.
- Commissioning of a Nottinghamshire Public Mental Health service is required

Mental Illness Prevention

- Social prescribing is delivered in Bassetlaw CCG area only. This model needs to be expanded across the County to support people in recovery from their mental health problems and co-existing physical health problems
- Numbers referred, accessing and completing PCPT is lower in Nottinghamshire compared to the England average

Treatment, Recovery and Rehabilitation

- across all Nottinghamshire CCGS, antidepressant and hypnotic average daily quantities medication prescribed and admission rate for depression and emergency admissions for unipolar depression and emergency admissions for neuroses are similar to East Midlands and England
- Apart for Mansfield and Ashfield CCG the prescribing of SMI medication is lower than East Mid-lands and England
- Also, across all CCGs, the rate per 1,000 population in contact with services is lower compared to East Midlands and England
- Those on CPA is significantly lower than the England rate
- Rate of people receiving assertive outreach services is higher than the England rate

Mental Health Act Assessments

- Admissions under Mental Health Act is similar across all Nottinghamshire CCGs compared to the England average

Severe mental illness physical health checks quality and outcomes

- Appendix 7 shows the uptake of health checks for people with a SMI in a primary care setting for all Nottinghamshire CCGs. Nottingham West and Rushcliffe CCG where either higher or similar to the England average across all the health check indicators. Overall, blood pressure and cholesterol checks were lower than the England average.

NHS spend on specialist mental health services

- Specialist mental service spend varies between CCG
- Nottingham West CCG the lowest and Mansfield and Ashfield CCG the highest, £99.45 and £146.62, respectively.
- All Nottinghamshire CCGs spending less on specialist mental health services than the England average.

Social care activity and Spend

- Nottinghamshire is lower compared to England for social care mental health assessments and activity yet higher for self-directed payment and support compared to England.

4.6) Nottinghamshire Mental Health Assets

Listed in appendix6 outlines the third sector and voluntary services across Nottinghamshire that offer tertiary prevention and recovery for mental health problems.

4.7) Nottinghamshire Mental Health Services Quality and Outcomes

Mental health services quality and outcomes measures offers evidence of effectiveness in service delivery in supporting people with mental health problems to recover. Figure 11 below shows that quality and outcomes across Nottinghamshire are variable for example, employment

rate for those in contact with secondary mental health services is lower than England and East Midlands.

Figure 11: Nottinghamshire Mental Health Services Quality and Outcome Measures



Indicator	Period	Notts			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Stable and appropriate accommodation: % of adults in contact with mental health services aged 18-69 (Persons)	2015/16	–	-	39.7%	48.1%	58.6%	1.6%		92.6%
Stable and appropriate accommodation: % of adults in contact with mental health services aged 18-69 (Male)	2015/16	–	-	36.5%	47.2%	57.4%	1.3%		92.1%
Stable and appropriate accommodation: % of adults in contact with mental health services aged 18-69 (Female)	2015/16	–	-	44.7%	49.3%	60.0%	0.6%		93.5%
Satisfaction with social care protection: % service users	2015/16	–	-	91.7%	88.5%	85.4%	69.4%		98.6%
Employment of people with mental illness or learning disability: % of those with a mental illness or learning disability	2016 Q4	–	-	37.1%	40.5%	43.3%	0.0%		100%
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate: percentage point difference	2015/16	–	-	69.1	69.5	67.2	53.6		78.4
Smoking in people with SMI: % of people with SMI aged 18+	2014/15	–	1,505	38.7%*	40.1%	40.5%	27.2%		52.3%
Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)	2014 - 16	–	176	8.2	9.5	9.9	6.1		18.3
Suicide: age-standardised rate per 100,000 population (3 year average) (Male)	2014 - 16	–	130	12.4	15.1	15.3	8.4		27.7
Suicide: age-standardised rate per 100,000 population (3 year average) (Female)	2014 - 16	–	46	4.2	4.3	4.8	2.3		11.3
Excess under 75 mortality rate in adults with serious mental illness: ratio of observed to expected mortalities (expressed as a percentage)	2014/15	–	-	382.7	353.9	370.0	164.8		570.4

Source:* *PHE Mental Health JSNA Profile 2016

5) Evidence of what works

Listed in table 19 is the evidence of what works and mapped against mental health promotion, mental illness prevention and treatment, recovery and rehabilitation. The evidence includes;

- NICE Quality Standards (QS)
- NICE Clinical Guidelines (CG)
- Strategies and policies

More detail on the evidence is given in appendix7.

Table 19: Evidence of what works - mapped against mental health promotion, mental illness prevention and treatment, recovery and rehabilitation.

Evidence of what works	Mental Health Promotion	Mental Illness Prevention	Treatment, recovery and rehabilitation
Public Health Guidance			
Promoting mental wellbeing at work (PH22) (2009)	√	√	
Mental wellbeing and older people (PH16) (2008)	√	√	
NICE quality standards			
Depression in adults quality standard: (QS8) (2011)		√	√
Quality standard for service user experience in adult mental health: (QS14) (2011)		√	√
Mental wellbeing of older people in care homes: (QS50) (2013)	√	√	
Quality standard for self-harm: (QS34) (2013)		√	√
Anxiety disorders: (QS 53) (2014)		√	√
Psychosis and schizophrenia in adults: QS80 (2015)			√
Bi-polar disorder in adults: (QS 95) (2015)			√
NICE clinical guidance			
Eating Disorders (CG9) (2004)			√
Self-harm (CG16) (2004)		√	√
Post-traumatic Stress Disorder (CG26) (2005)		√	√
Obsessive Compulsive Disorder (OCD) and Body Dismorphic Disorder (BDD) (CG31) (2005)		√	√
Antisocial Personality Disorder (CG77) (2009)		√	√
Borderline Personality Disorder (CG78) (2009)		√	√
Depression in adults (CG90) (2009) updated (2016)		√	√
Depression with a chronic physical health problem (CG91) (2009		√	√
Psychosis with coexisting substance misuse: Assessment and management in adults and young people (CG120) (2011)		√	√
Common mental health disorders: Identification and pathways to care (CG123) (2011)		√	√
Self-harm: longer-term management (CG133) (2011).		√	√
Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (CG136) (2011)		√	√
Generalised anxiety disorder and panic disorder in adults: management (CG113) (2011)		√	√
Social anxiety disorder: recognition, assessment and treatment (CG159) (2013)		√	√
Psychosis and Schizophrenia in Adults: Prevention and Management (CG178) (2014)		√	√
Antenatal and postnatal mental health: clinical management and service guidance (CG192) (2015)		√	√
Depression in adults, recognition and management (CG 90) (2016)		√	√
Bi-polar Disorder: Assessment and Management (CG 185) (2016)		√	√
Transition between inpatient mental health settings and community or care home settings (NG53) (2016)		√	√
Strategies and Policies			
Promoting Mental Health – Concepts, Emerging Evidence and Practice (2004)	√		
No Health without Mental Health (DH 2011)	√	√	√
The Nottinghamshire's No Health without Mental Health Framework for Action (FfA) (2014-2017)	√	√	√
The Preventing Suicide in England (2012)	√	√	√
The Health and Social Care Act (2012)	√	√	√
'Whole-person care: from rhetoric to reality' (2013)		√	√
Closing the Gap: Priorities for essential change in mental health (2014)		√	√
Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (2014)		√	√
Care Act Chapter 23 (2014)		√	√

The HM Government Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence (2015)	√	√	√
The Evidence to Inform Commissioning on Social Prescribing (2015)	√	√	√
Bringing together physical and mental health (2016)		√	√
Five Year Forward Plan for Mental Health (2016)		√	√
Better Mental Health for All – A public health approach to mental health improvement (2016)	√	√	√
Foresight report on Mental Capital and Wellbeing (2008)	√	√	

6) What is on the horizon?

6.1) Projected service use and outcomes in 5, 10 and15 years

Table 20 below is a projection for the number of adults aged 16-64 with a common mental disorder, borderline personality disorder, antisocial personality disorder or psychotic disorder. By 2030 there is likely to be a 4.3% decrease across all the disorders. However, those predicted to have two or more psychiatric disorders is predicted to increase by 1.1%.

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 20: Estimated increase in the numbers of adults aged 18-64 predicted to have a mental health problem, projected to 2030

Mental health disorder	2014	2015	2020	2025	2030	*% ± change between 2014 and 2030*
People aged 18-64 predicted to have a common mental disorder	77,030	77,069	77,152	76,871	76,105	*-1.2*
People aged 18-64 predicted to have a borderline personality disorder	2,154	2,155	2,157	2,149	2,127	*-1.2*
People aged 18-64 predicted to have an antisocial personality disorder	1,668	1,668	1,671	1,669	1,657	*-0.7*
People aged 18-64 predicted to have psychotic disorder	1,914	1,915	1,917	1,910	1,891	*-1.2*
People aged 18-64 predicted to have two or more psychiatric disorders	34,422	34,437	34,479	34,368	34,046	*+1.1*

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

7) Local Views

Since 2014 a number of stakeholder, community and/or service user in relation to mental health were undertaken and include;

- In October 2014, Nottinghamshire Healthwatch undertook a consultation to understand more about people's experiences of local mental health services. Approximately 120 local people participated via a survey, interview or a focus group. Of which, 72 people indicated they had experienced a mental health illness with 40 people have cared for a family member who had a mental health illness.
- Nottinghamshire Healthcare Trust (NCHT) surveys quarterly to review patient and carers perception on the quality of care is undertaken. Between the 1st of April 2015 and the 30th of June 2015 the trust received 7537 responses. Of these, 1081 were from carers.
- NCC Public Health in the development phase of the Nottinghamshire's No Health without Mental Health Framework for Action (FfA) (2014-2017) undertook a consultation in July 2014
- Between January and April 2016, the Mid and South Nottinghamshire CCGs undertook a public engagement exercise to inform the commissioning of services for people with common mental health problems accessing the Mental Health Care Clusters 1 – 4. .
- As part of the Nottinghamshire County Council 2016/17 budgetary forecasting a service user consultation was undertaken in February 2016 where there was proposed budgetary reduction within the Moving Forward (Housing Support) service.

Listed in table 21 are the common themes from these consultations, mapped against mental health promotion, mental illness prevention and treatment, recovery and rehabilitation.

Table 21: Local Views Common Themes - mapped against mental health promotion, mental illness prevention and treatment, recovery and rehabilitation

Common themes	Mental Health Promotion	Mental Illness Prevention	Treatment, recovery and rehabilitation
Perception of good experiences of services included being understood and consideration of patient and carers feelings and views		√	√
Need for a single point of access that provides one holistic assessment approach with onward referral to medical land non-medical interventions		√	√
Need for readily and easily available signposting information on mental health services		√	√
The need for A shared patient information system across all the service providers		√	√
Reduce waiting times to PCPT services		√	
Promote mental wellbeing in the workplace	√		
Improve physical activity to build mental resilience	√		
Raise awareness of mental health symptoms	√	√	
Reduce mental ill health stigma and discrimination	√	√	√
Agreed inter-agency pathways of care for those experiencing a mental health crisis		√	√
Prevention of mental problems in carers of all ages	√	√	
Require an increased level of social care support (housing, debt advice and management, access to DWP and social inclusion programmes)		√	√
Improve access to settled accommodation		√	√
Enable recovery through a holistic personal support package approach that includes physical, mental health and social care needs		√	√
Offer choice by commissioning a range of services and providers	√	√	√
Program of peer led groups in order to develop employment/volunteering and a social networking opportunities	√	√	√

What does this tell us?

8) Unmet needs and service gaps

Unmet needs and service gaps where identified by applying the Public Mental Health conceptual model (Mental Health Promotion, Mental Illness Prevention and Treatment, Recovery and Rehabilitation against unmet needs and service delivery. This JSNA has identified that Nottinghamshire service delivery focuses on the mental health treatment, with very little emphasis on mental health promotion, prevention, recovery as well as addressing the needs of those with mental health problems and co-existing physical conditions.

The following unmet needs and service gaps have been identified and are aligned to the Nottinghamshire No Health without Mental Health Framework for Action – 2014/2017

- Accessing of mental health services confusing and difficult to navigate and were not always clear where to first turn for support. Signposting service information needs to be clearer and easy accessible.
- There is inequity in the offer of Social Prescribing being delivered in Bassetlaw District for +65 years only. Consideration is needed to expand the service across the County and to include adults and older people to offer social support to those at risk of mental or recovering from mental health problems
- 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 the general population needs to be reduced. This is an important priority for Nottinghamshire County Public Health and CCGs, and particularly with a focus on reducing smoking and improving identification of physical health problems early and improving access to LTC treatment to prevent emergency hospital admissions
- Care for people in mental health crisis is a partnership priority under the HM Crisis Care Concordat. More needs to done in preventing mental health problems and intervening early to prevent a mental health crisis
- As part of mental health recovery interventions access to employment is required to improve the employment rate for those in mental health services
- Assessing for mental health problems is not routinely undertaken by health and social care professionals. Make Every Contact Count (MECC) need to be utilized to raise awareness of mental health problems and sign posting to mental health services when required
- Access to Mental Health First Aid training is not routinely offered to employers as a means to support those with mental health problems to remain in work or to support people in getting back to work.

9) Knowledge gaps

A better understanding and scrutiny of the data is required against indicators that are performing lower or higher than the England average, or further assessment of mental health needs are required.

Indicators where Nottinghamshire is performing worse (lower) than the England average and include;

- Lower SMI rate known to GPs
- In contact with mental health service
- On a CPA
- Admitted to a mental health hospital
- Discharged from a mental health hospital
- With a SMI not accessing blood pressure and cholesterol checks
- Not receiving social care services or accessing social care new assessments
- On a CPA or in contact with mental health service are not in settled accommodation or in employment.

Indicators where Nottinghamshire is performing higher than the England average and include;

- Receiving assertive outreach services
- Social care carer assessments
- Social care self-direct payments and support

Further assessment of mental health needs and outcomes include;

- Personality Disorder
- CMD and Physical Health
- LTC and rate of CMD
- CMD in Older People in Care Home
- CMD Older People on acute hospital wards
- CMD and SMI rate in <75 age group
- Rate of successful treatment and recovery outcomes for higher risk groups
- Rate of those with mental health risk factors accessing the service

Service data is not available for higher risk groups. Therefore it is not possible to assess equity of access.

What should we do next?

10) Recommendations for consideration by commissioners

The Nottinghamshire Mental Health Integrated Commissioning Group will be responsible for ensuring that the following recommendations are actioned.

Recommendations	
Mental Health Promotion (includes Nottinghamshire population and at risk groups targeted approach)	
1.	Seamless pathways are required from mental health inpatient and community setting to ensure the promotion of physical health improvement programmes (smoking cessation, physical activity, weight management, dietary advice)
2.	Promote good mental health and build mental health resilience through increased access to mental health promotion techniques
3.	Promote good mental and physical health by universal promotion and awareness campaigns
4.	Build mental health knowledge and skills through the provision of Mental Health First Aid training
5.	Targeted Cognitive Behavioural Treatments and social interventions for those at risk of depression i.e. those with Long Term Conditions
6.	Build social and emotional resilience by development of a self-management, social skills and financial literacy training to improve financial skills and reduce indebtedness
7.	Increase levels of physical activity across Nottinghamshire through the promotion and community empowerment interventions for active travel, walkable neighbourhoods and active leisure
8.	Integrate physical and mental wellbeing through universal access to lifestyle programmes to reduce smoking, alcohol use, substance use and obesity
9.	Reduce mental health problem stigma and discrimination by offering a targeted mental health awareness and training programme
10.	Utilise Make Every Contact Count (MECC) to raise awareness of mental health and sign posting to mental health services
11.	Promote the use of volunteering to support people to build social confidence, increase training and employment opportunities and reduce social isolation
Mental Illness Prevention	
12.	Improve quality of life through increasing opportunities for participation, personal development and problem solving through access to social interventions in primary and community care pathway i.e. social prescribing, self-help groups etc.
13.	Improving working lives through workplace screening for risk of depression followed by Cognitive Behavioural Treatments
14.	Work-based mental wellbeing and stress management programmes to reduce level of sickness absenteeism
15.	Promote engagement and participation through back to work programmes to support those recovering from mental illness i.e. training, work placement and volunteering programmes
16.	Improve the quality of older people's lives through access to psychosocial therapies which enhance control, prevent isolation and enhance physical activity .i.e. befriending services, social prescribing to target loneliness and social isolation
17.	Homelessness support programmes to include a holistic package of care such as; health improvement, social prescribing, debt management
18.	Early identification of mental health problems and signposting by integrating mental health into NHS health checks and MECC
19.	Improve PCPT pathways targeting at risk older people, those with physical disabilities or LTC
20.	Continued integrated approach in the implementation and delivery of the Crisis Concordat Action Plan
Treatment, Recovery and Rehabilitation	
21.	Improve physical assessment and treatment pathways for those with a SMI
22.	Improve access pathways to physical health screening, prevention and health improvement interventions such as smoking cessation, cancer screening, dental, optical, flu vaccinations, weight management, substance misuse
23.	Implement employment and training programmes to support those with mental health problems into employment
24.	Improve access to settle accommodation for those on a CPA and with mental health problems
25.	Health Equity Audit needs to be undertaken to ascertain if mental health services are targeting high risk groups

Key Contacts

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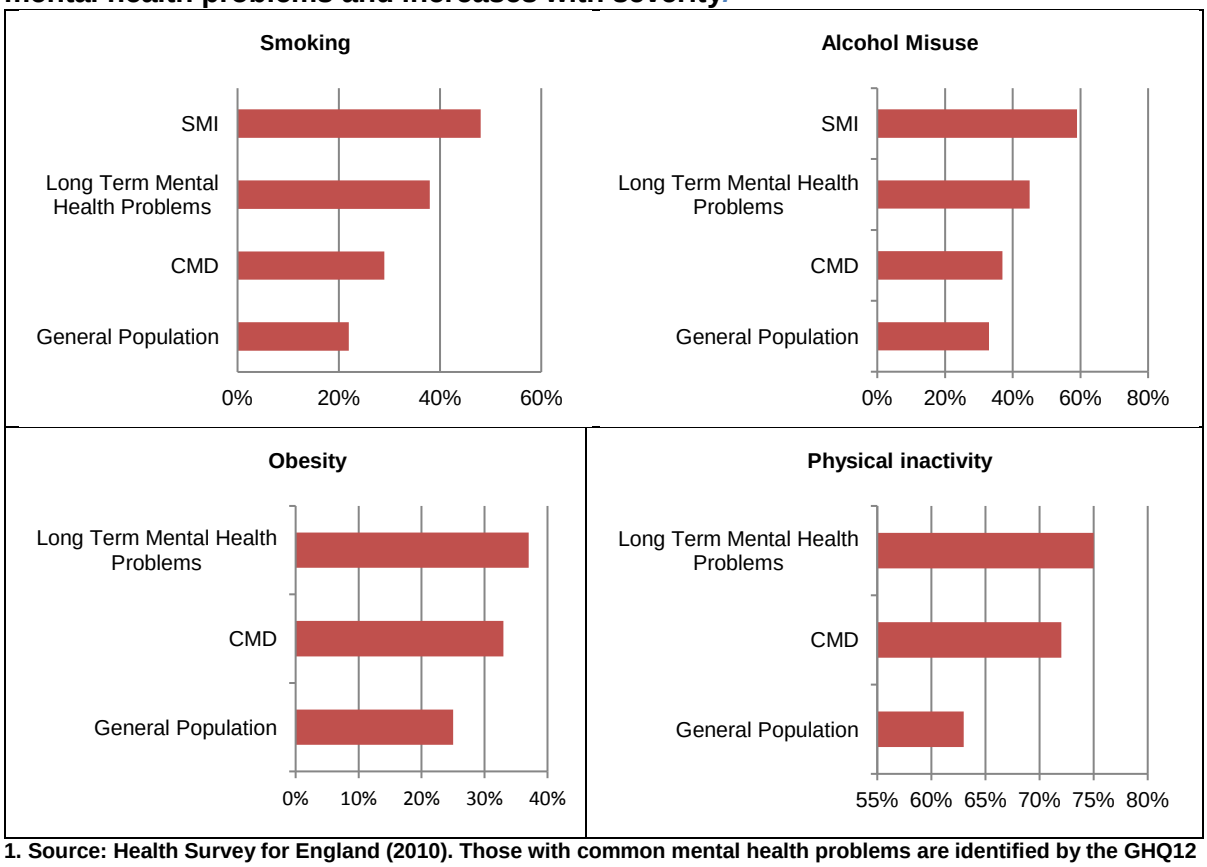
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Appendices:

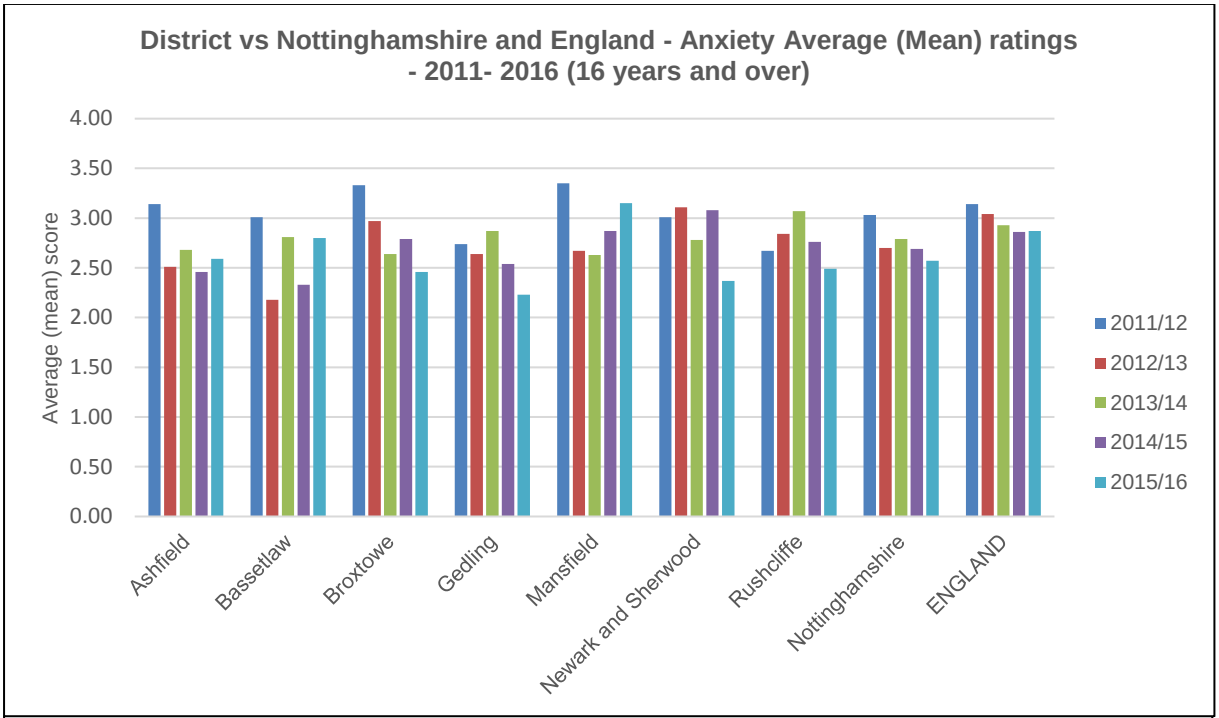
Appendix 1: The prevalence of modifiable risk factors is much higher for people with mental health problems and increases with severity.

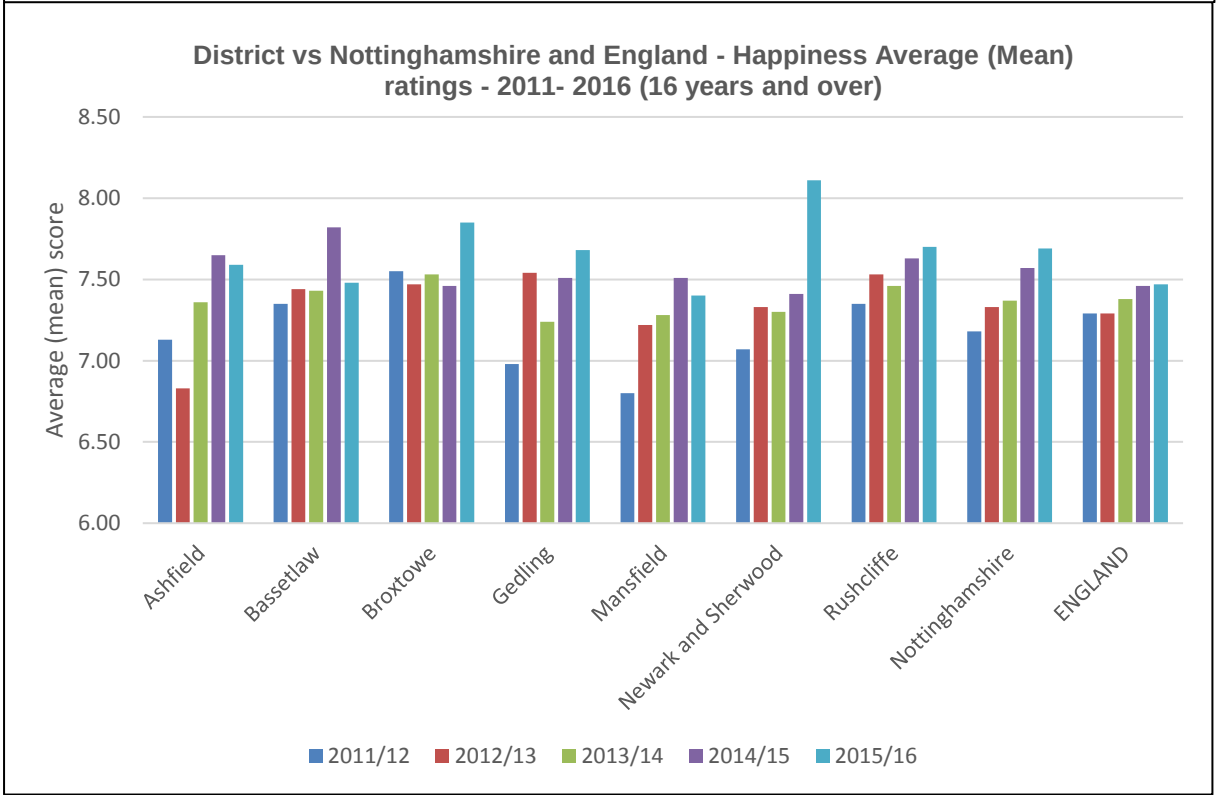


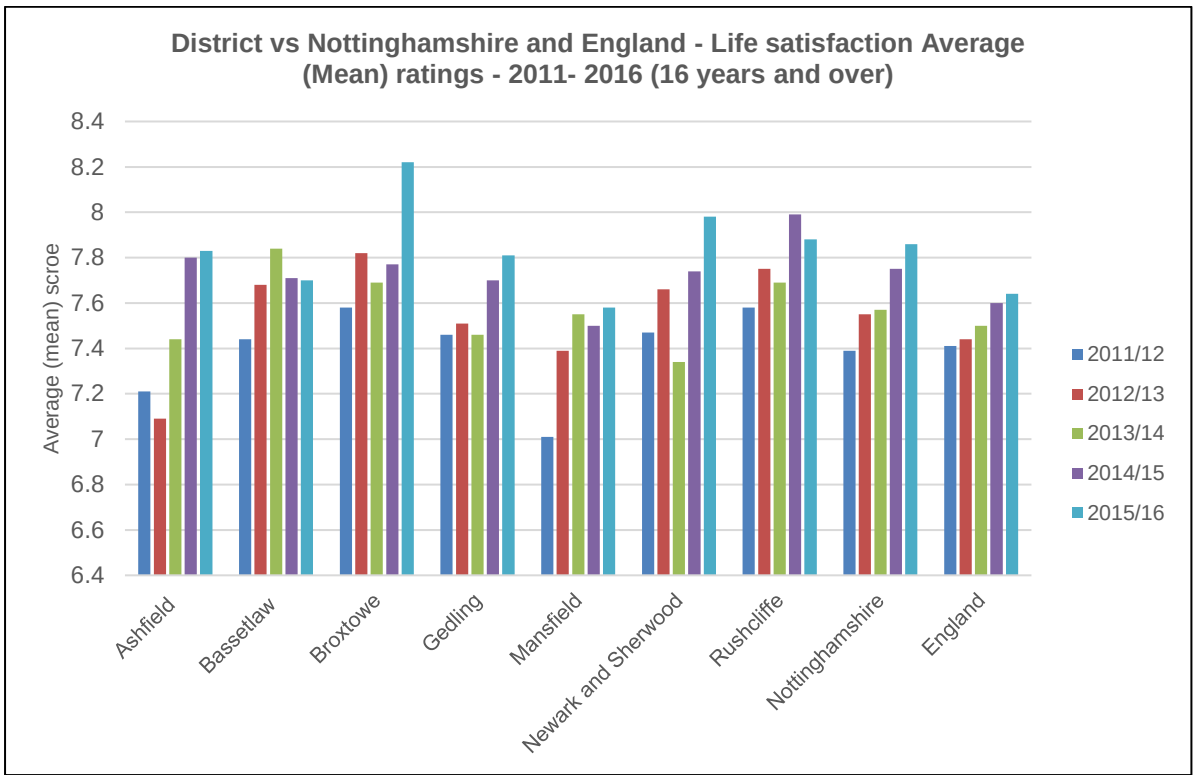
1. Source: Health Survey for England (2010). Those with common mental health problems are identified by the GHQ12 questionnaire; 2. Source: Adult Psychiatric Morbidity Survey (2007). Note that those with psychotic disorders are also likely to be included among those with long term mental health problems. 3. Answers positively to the question: "Do you smoke cigarettes nowadays?"; 4. Weekly alcohol consumption >21 units (men), >14 units (women); 5. Body Mass Index >30; 6. Weekly physical exercise does not exceed 30 minutes on five days.

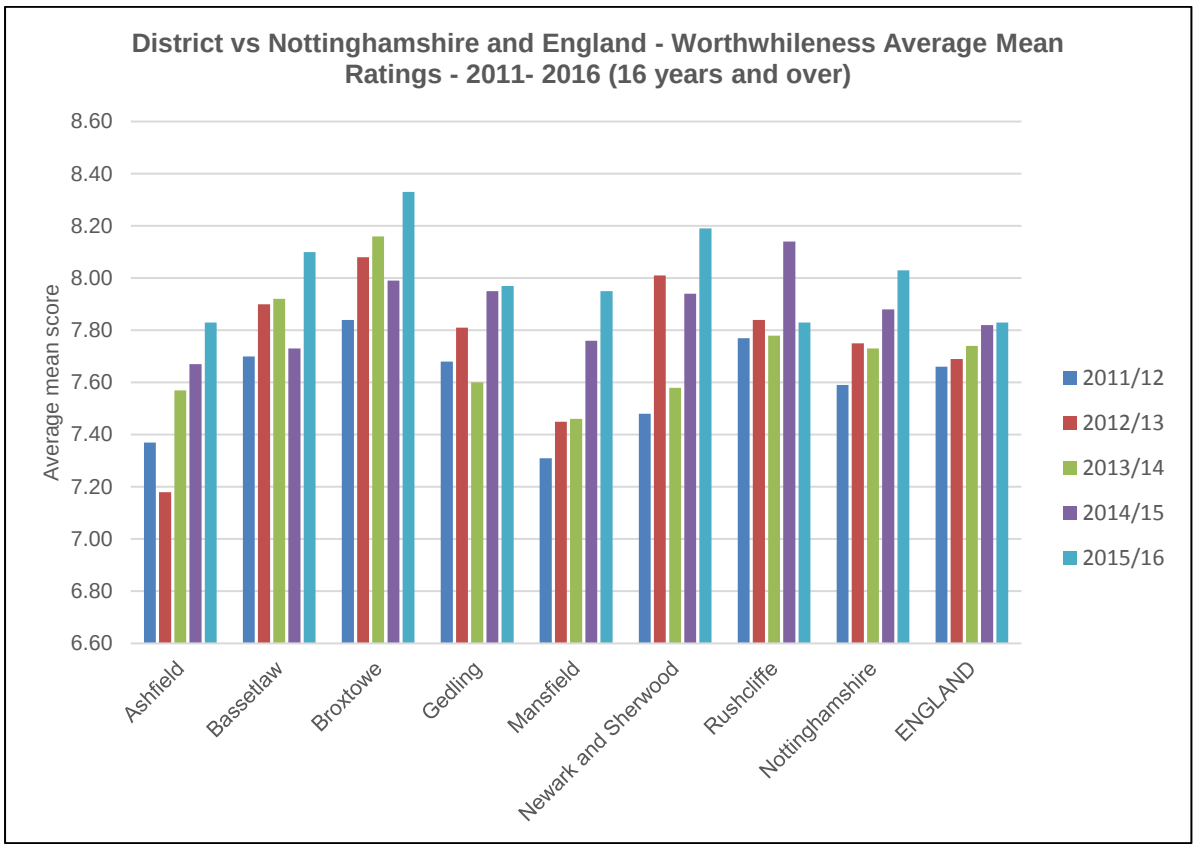
Appendix 2: Nottinghamshire Districts Self- reported wellbeing 2011-2016 (aged 16 years and over).

Source: *Personal well-being in the UK: Jan to Dec 2016*



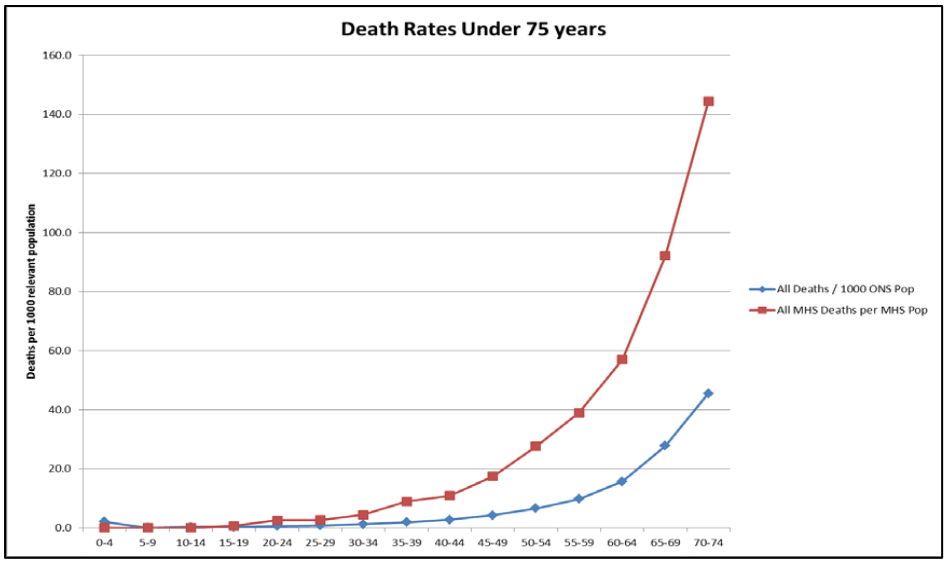



District vs Nottinghamshire and England - Life satisfaction Average (Mean) ratings - 2011- 2016 (16 years and over)
Average (mean) scroe
8.4
8.2
8
7.8
7.6
7.4
7.2
7
6.8
6.6
6.4
Ashfield
Bassetlaw
Broxtowe
Gedling
Mansfield
Newark and Sherwood
Rushcliffe
Nottinghamshire
England
2011/12
2012/13
2013/14
2014/15
2015/16


District vs Nottinghamshire and England - Worthwhileness Average Mean Ratings - 2011- 2016 (16 years and over)
Average mean score
8.60
8.40
8.20
8.00
7.80
7.60
7.40
7.20
7.00
6.80
6.60
Ashfield
Bassetlaw
Broxtowe
Gedling
Mansfield
Newark and Sherwood
Rushcliffe
Nottinghamshire
ENGLAND
2011/12
2012/13
2013/14
2014/15
2015/16

Appendix 3: Comparison of death rates by age for those known to secondary mental health services and the wider population in Nottingham and Nottinghamshire

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



Appendix 4: Nottinghamshire Kaleidoscope Plus Mental Health and Suicide Prevention Awareness and Training Programme Evaluation

1st October 2015 – 31 March 2017

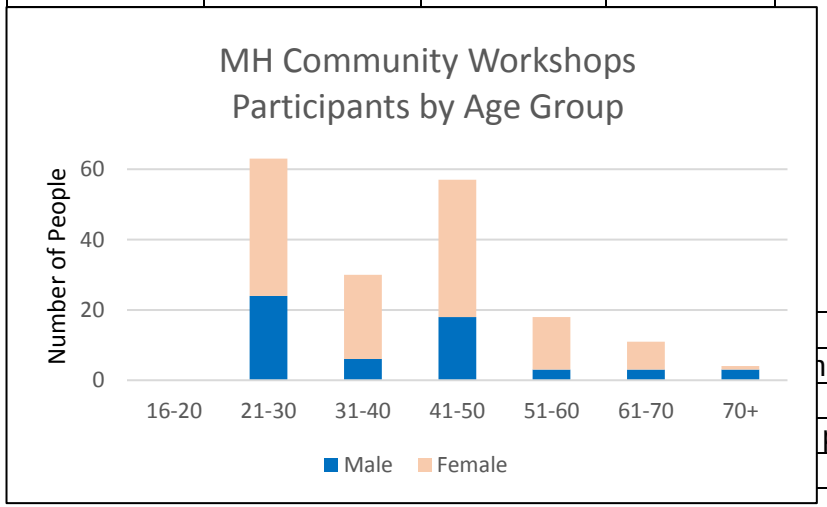
1) Mental Health Community Workshops

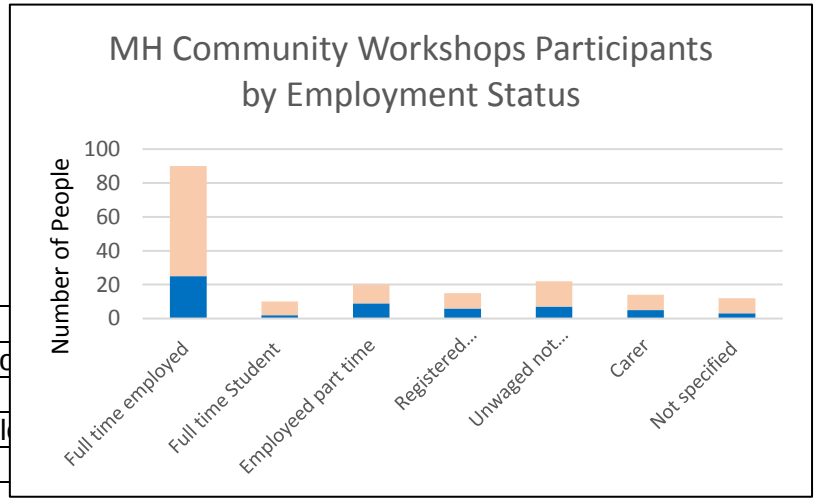
Table 1: Mental Health Community Workshops Outcomes

	Total Number	Target	% Achieved
Workshops	**14**	**14**	**100%**
Participants	**183**	**210**	**87%**
DNA's	**35**		

Table 2: Workshop costings

Cost per Workshop	£650.00
Price per participant	£49.73





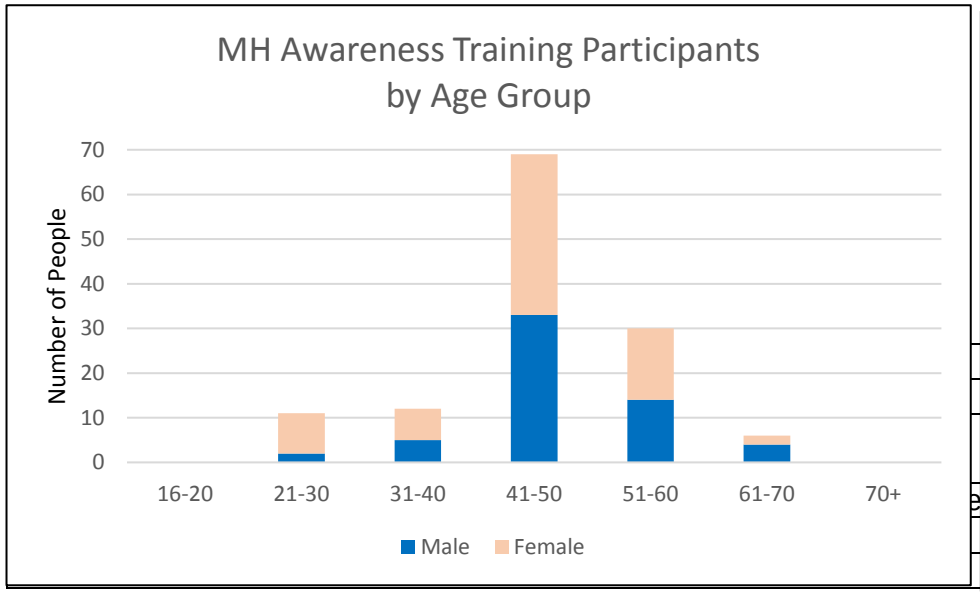
2. Mental Health Awareness Training

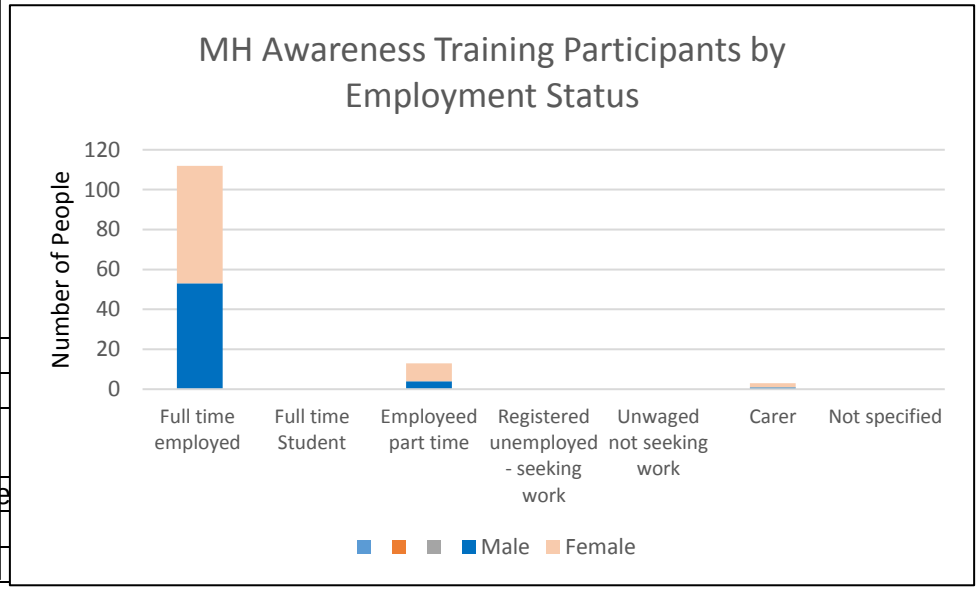
Table 3: Mental Health Awareness Training Outcomes

	Total Number	Target	% Achieved
Workshops	**7**	**7**	**100%**
Participants	**128**	**140**	**91%**
DNA's	**12**		

Table 4: Training Costings

Cost per Workshop	£1,500.00
Price per participant	£82.33





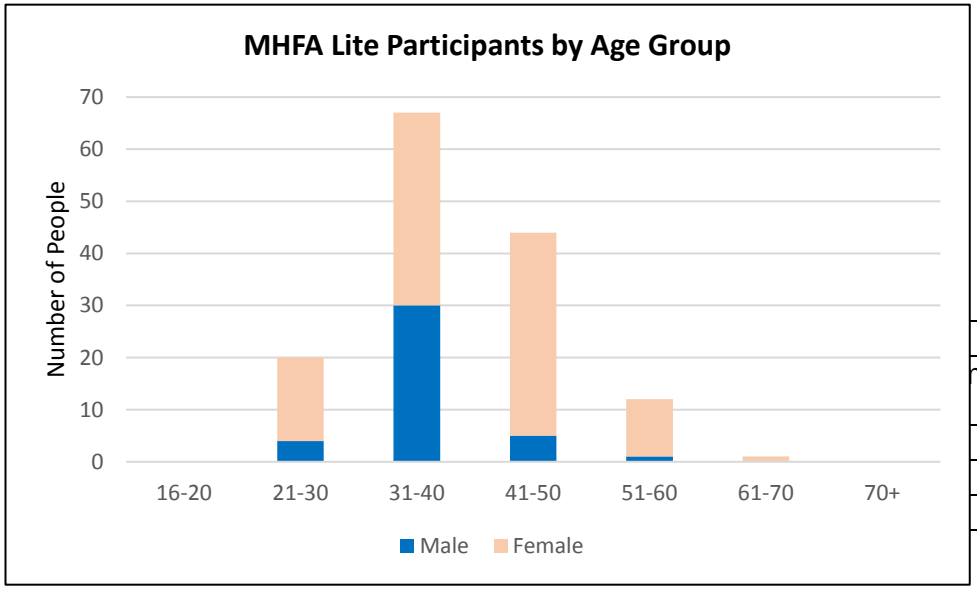
3) Mental Health First Aid Lite Training

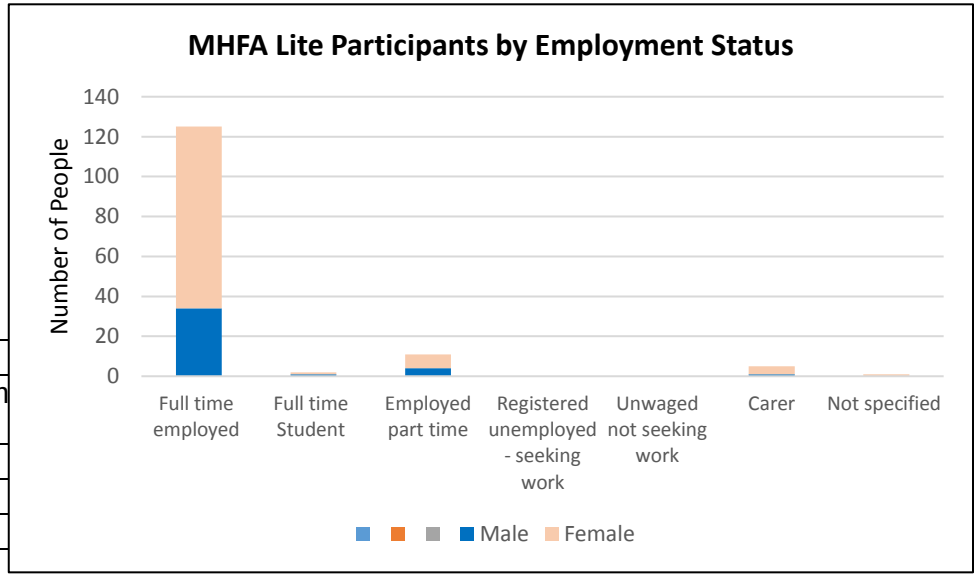
Table 5: Mental Health First Aid Lite Training Outcomes

	Total Number	Target	% Achieved
Workshops	**7**	**7**	**100%**
Participants	**144**	**175**	**82%**
DNA's	**16**		

Table 6: Training Costings

Cost per Workshop	£1,000.00
Price per participant	£48.61





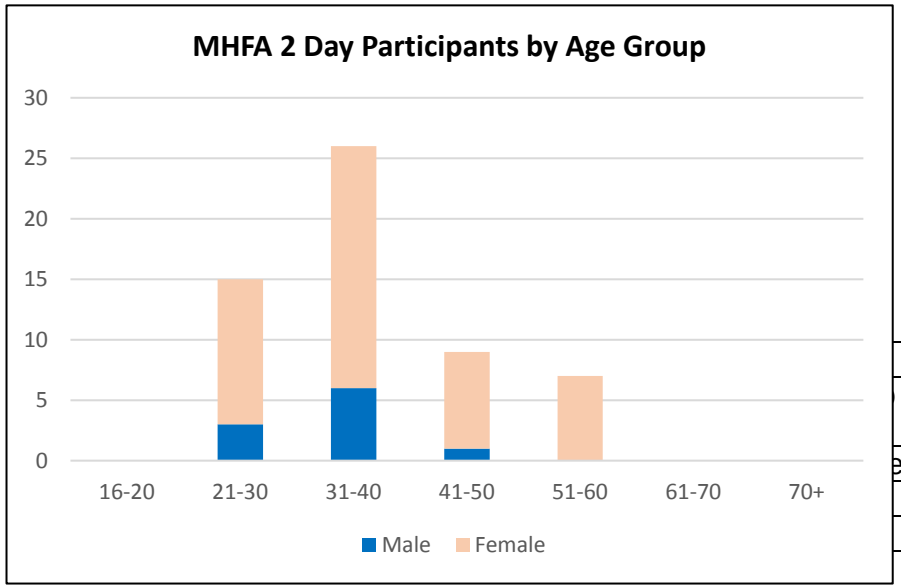
4) Mental Health First Aid 2 Day

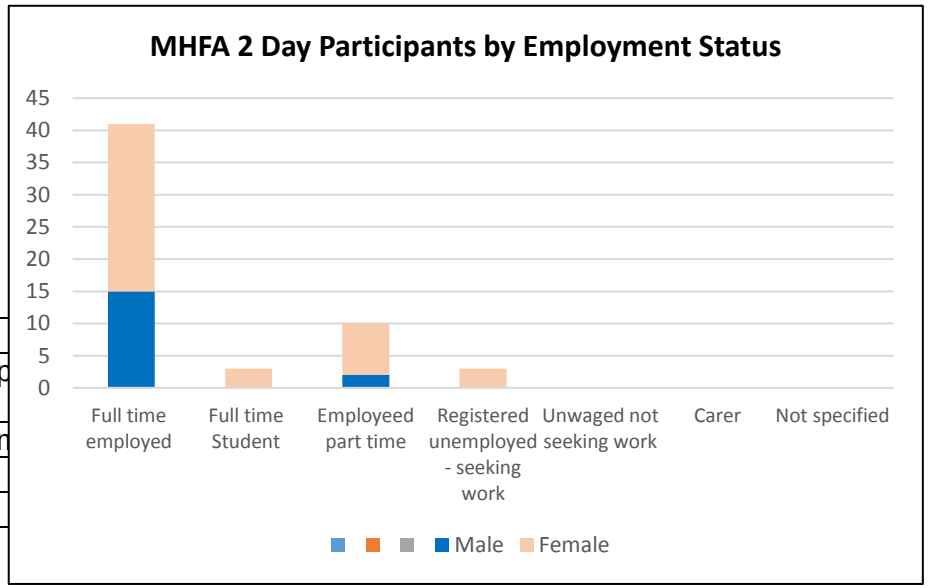
Table 7: Mental Health First Aid 2 Day Outcomes

	Total Number	Target	% Achieved
Workshops	**4**	**4**	**100%**
Participants	**57**	**64**	**89%**
DNA's	**4**		

Table 8: Training Costings

Cost per Workshop	£2,800.00
Price per participant	£196.49





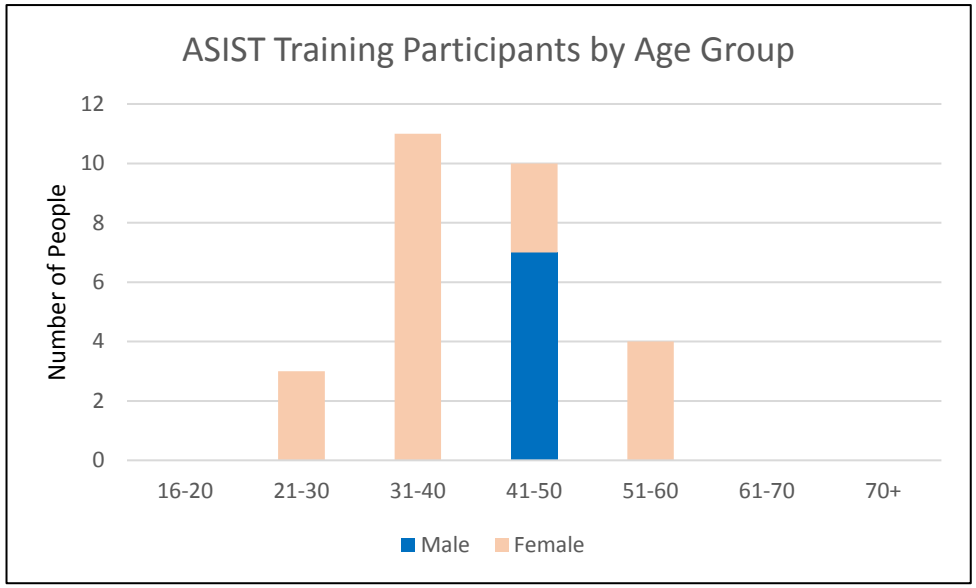
5) ASIST Suicide Training

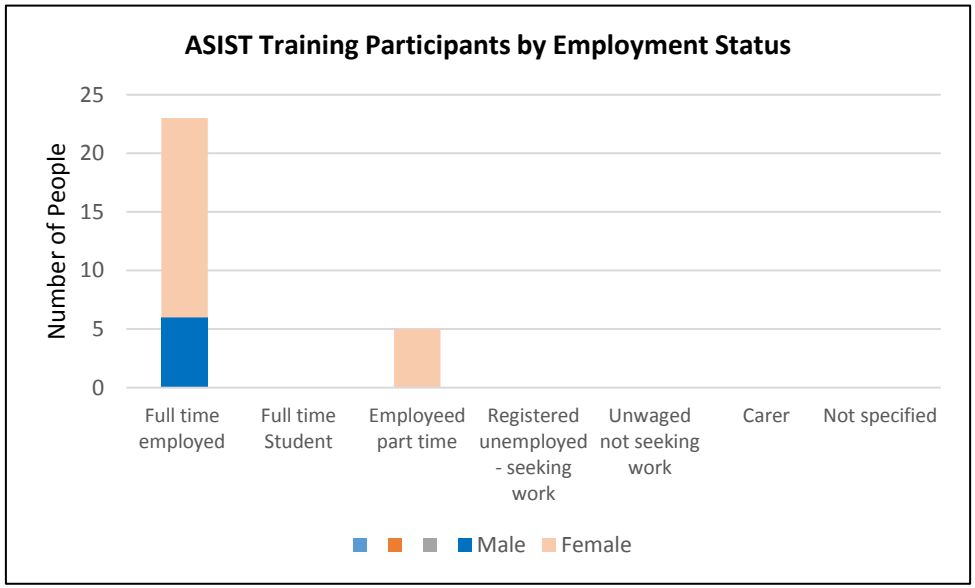
Table 9: ASIST Suicide Training Outcomes

	Total Number	Target	% Achieved
Workshops	**2**	**4**	**100%**
Participants	**28**	**64**	**88%**
DNA's	**3**		

Table 10: Training Costings

Cost per Workshop	£2,800.00
Price per participant	£200.00





Post Workshop, Increase Suicide Awareness Ratings	Strongly Agree	Disagree	Neutral	Agree	Strongly Agree		
If a persons words and /or behaviours suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide			<5	7	20		
Before taking ASIST training my answer to #5 would have been	<5	15	10	<5			
If someone told me they were thinking of suicide, I would intervene			<5	9	19		
Before taking ASIST training my answer to #7 would have been	<5	9	15	<5			
I feel prepared to help a person at risk of suicide			<5	12	15		
Before taking ASIST training my answer to #9 would have been	<5	14	8	<5			
I feel confident I could help a person at risk of suicide				19	9		
Before taking ASIST training my answer to #11 would have been	<5	14	10	<5			
Total	**10**	**52**	**46**	**54**	**63**		

Appendix 5: Nottinghamshire Social Care Mental Health service spend 2015/16 by district.

Type of Activity	Ashfield		Bassetlaw		Broxtowe		Gedling		Mansfield		Newark & Sherwood		Rushcliffe		Grand Totals		
	Count	£000	Count	£000	Count	£000	Count	£000	Count	£000	Count	£000	Count	£000	Count	£000	%
Nursing Care	<5	231,709	6	153,941	0	0.00	<5	225,511	<5	228,225	0	0.00	<5	66,879	18	906,267	*10.6*
Residential Care	15	563,591	10	647,626	5	285,763	10	251,264	27	986,865	5	202,607	10	525,045	82	3,462,764	*40.7*
Direct Payment	22	114,397	23	140,802	25	149,565	39	186,317	28	159,379	31	185,691	27	146,126	195	1,082,280	*12.7*
Shared Lives	0	0.00	<5	21,426	0	0.00	<5	0.00	0	0.00	0	0.00	0	0.00	<5	21,426	*0.2*
Day Services	13	7,228	22	21,063	5	4,433	6	6,965	10	4,889	6	10,579	12	16,363	74	71,523	*0.8*
Home Care	7	6,992	<5	2,116	9	28,391	16	25,841	5	10,695	<5	161.57	6	9,294.	47	83,494	*0.9*
Supported Living	55	393,193	78	547,668	53	157,581	75	401,303	72	521,238	40	422,438	48	429,562	421	2,872,985	*33.7*
Grand Total	**115**	**£1,317,111**	**143**	**£1,534,644**	**97**	**£625,736**	**149**	**£1,097,204**	**146**	**£1,911,293**	**83**	**£821,477**	**105**	**£1,193,271**	**838**	**£8,500,741**	***100.0***

Appendix 6: Nottinghamshire Mental Health Assets

1. Mental Health Promotion				
Good Practice Interventions	**Local Interventions Description**		**District coverage**	**Services/ Assets**
Improved housing and reduced fuel poverty	Framework Housing Association	A charity and specialist housing association to help those who are homeless, prevent homelessness and promote opportunities for vulnerable and excluded people. They help find accommodation for those who are homeless. They promote access to medical services for homeless people and try to re-engage them with estranged family. They help users of the service return to their home area and support them in claiming benefits they are entitled to.	All Nottinghamshire Districts	Asset
Neighbourhood interventions including activities which facilitate cohesion	Community and Voluntary Services	Provide information, advice and support for community and voluntary groups across each district of Nottinghamshire	All Nottinghamshire Districts	Asset
Debt advice and enhanced financial capability	Citizens advice bureau	Gives advice to all citizens regarding their rights and responsibilities. The information is free, confidential and independent.	All Nottinghamshire Districts	Asset
	Nottingham Credit Union	Provides accessible and affordable financial services and training	Based in Mansfield	Asset
Physical activity through active travel, walkable neighbourhoods and active leisure	**No specific asset or services with a remit to improve mental wellbeing			
Interventions to enhance social interaction (capital) activities such as arts, music, creativity, learning, volunteering and timebanks	Co-production Mental Wellbeing	A county wide service which aims to improve the health and wellbeing of adults. Their aims are to improve the mental wellbeing of those with mental health problems but are not in contact with specialist mental health services. Form mutual aid groups in the community for support and activities and have formed partnerships with other institutions to help solve the problem of a low budget.	All Nottinghamshire Districts	Service
	Notts Help Yourself	A website which residents can search for the different types of social support and services in their area, aiding them to decide on their best suited care option.	All Nottinghamshire Districts	Asset
	100 Happy Days	A social movement to promote positivity and happiness through social media and local groups and events.	All Nottinghamshire Districts	Asset
Positive psychology and mindfulness interventions	Nottingham Mindfulness	Offer stress reduction courses to the general public using the technique of "mindfulness" and meditation.	All Nottinghamshire Districts	Asset
	Newark Mind	Befriending, counselling, activities	Newark and Sherwood	Asset
	NHS choices Apps Library	The library holds a number of free apps for smart phones including the "mood tracker" by MIND. It allows people to self monitor their mood and consider patterns in eating and daily habits that may be contributing to the way they feel.	All Nottinghamshire Districts	Asset
Work-based mental health promotion	Impact Health and Wellbeing Solutions	Provides training and wellbeing services for businesses to help engage staff. Courses include stress management, counselling and mental health awareness with the aim to motivate staff, reduce stress, increase skills and job satisfaction and benefits for the business include reduced absenteeism and increase productivity.	All Nottinghamshire Districts	Asset
Work-based stress management	Impact Health and Wellbeing Solutions	Provides training and wellbeing services for businesses to help engage staff. Courses include stress management, counselling and mental health awareness with the aim to motivate staff, reduce stress, increase	All Nottinghamshire Districts	Asset

		skills and job satisfaction and benefits for the business include reduced absenteeism and increase productivity.		
Support for unemployed people	Jobcentre Plus	This is a government funded employment agency and social security office. They aim to help people of working age find employment in the UK.	All Nottinghamshire Districts	Asset
	The Princes Trust	A charity that support unemployed people, leaving care, facing homeless, have mental health problems up to the age of 30.	All Nottinghamshire Districts	Asset
	Nottinghamshire Fit For Work Service	They help people with health issues which affect their ability to sustain or get back into employment. They aim to do this through offering individuals an assessment, identifying modifications, liaising with employers and helping people overcome barriers. Employers and health care professionals can also contact the service for advice/support regarding their staff or patients.	All Nottinghamshire Districts	Asset
	Support our Forces	Employment support, information & advice outreach service	All Nottinghamshire Districts	Asset
	Nottinghamshire Mind Network	Support, information and guidance on mental wellbeing to the communities of Nottinghamshire, working with older and vulnerable people experiencing a mental health issue and their carers	All Nottinghamshire Districts	Asset
Socialisation and prevention of social isolation	Age UK	A widespread independent charity for older people. The aim of the charity is to promote the well-being of older people and enhance their quality of life. Some of the services provided includes ,advocacy, community outreach, counselling, day services, financial, housing and legal information and advice, advice on home safety and a visiting service.	All Nottinghamshire Districts	Asset
Caring well – support and psychoeducation for carers	Age UK	A widespread independent charity for older people. The aim of the charity is to promote the well-being of older people and enhance their quality of life. Some of the services provided includes ,advocacy, community outreach, counselling, day services, financial, housing and legal information and advice, advice on home safety and a visiting service.	All Nottinghamshire Districts	Asset
Recovering well – mental promotion as a key component of recovery from mental disorder	Rethink Mental Illness	Aim to improve the wellbeing of those with severe mental illness, their families and friends by offering talks and activities. .	All Nottinghamshire Districts	Asset
	Bassetlaw: NCHA Mid-Notts Age UK South Notts: Metropolitan	Early intervention service encompasses social isolation and a whole range of other matters relevant to OP and people with LTCs (including some MH) with the aim of preventing or delaying the need for more intensive health and social care support	All Nottinghamshire Districts	Service

2. Mental Health Illness Prevention Programmes

Good Practice Interventions	Local Interventions Description		District coverage	Service/Asset
Prevention of mental health problems	Depression Alliance	The alliance aims to raise awareness and reduce the stigma of depression. They try and help people by creating relationships and contacts to combat the loneliness and isolation of depression. They do this through forming local self help groups and on and offline communities and networks.	All Nottinghamshire Districts	Asset
	RELATE	A counseling service for couples who are having turmoil within their relationship.	All Nottinghamshire Districts	Asset
	Samaritans	This is a 24 hour telephone or email service for those in need of emotional support. .	All Nottinghamshire Districts	Asset
	Cruse	A charity which supports those who are bereaved. They provide website, telephone and email support, and face-to-face services including bereavement support, bereavement counselling, and facilitated and friendship groups.	All Nottinghamshire Districts	Asset
	Rethink Mental Illness	Aim to improve the wellbeing of those with severe mental illness, their families and friends by offering talks and activities. .	All Nottinghamshire Districts	Asset

	Nottingham & Nottinghamshire Lesbian & Gay Switchboard	Information, advice and support services aimed at reducing social isolation and improving self-esteem and mental health.	All Nottinghamshire Districts	Asset
Prevention of health risk behaviours	Substance Misuse, Smoking Cessation and Weight Management	Public Health commissioned services with a remit to support people with mental health problems to make informed lifestyle choices	All Nottinghamshire Districts	Services
Prevention of inequality	Framework	A charity and specialist housing association to help those who are homeless, prevent homelessness and promote opportunities for vulnerable and excluded people.	All Nottinghamshire Districts	Asset
	Mental Health Support Team (Emmanuel House)	Advice, brief interventions, support to engage with mainstream mental health services, signposting to other sources of help and support	Rushcliffe, Broxtowe, Gelding	Asset
Prevention of stigma and discrimination	SANE	A mental health charity which works to raise awareness and combat stigma surrounding mental illness, campaigns to improve mental health services, provides support services. Services include an evening telephone helpline, texting service, a support forum, facebook and twitter communities and blogs to share experiences. They also initiate research into serious mental illness.	All Nottinghamshire Districts	Asset
	Time to change	A social movement run by Mind and Rethink mental illness which aims to reduce the stigma of mental health by getting people to talk about it more.	All Nottinghamshire Districts	Asset
3. Treatment, recovery and rehabilitation				
Good Practice Interventions	**Local Interventions Description**		**District coverage**	**Service/Asset**
Early intervention for mental disorders	Books on Prescription	The scheme is run by Nottinghamshire Libraries, is a service works by a health professional recommending or "prescribing" a book from a list of 30 books, by filling in a form. The patient can then borrow the book and renew it up to four times.	All Nottinghamshire Districts	Asset
Early intervention to promote recovery	Anxiety UK	A charity which provides information via an extensive range of materials and services. They also provide therapy services such as CBT, hypnotherapy and counseling for members.	All Nottinghamshire Districts	Asset
	Co-production Mental Wellbeing	A county wide service which aims to improve the health and wellbeing of adults. Their aims are to improve the mental wellbeing of those with mental health problems but are not in contact with specialist mental health services. Form mutual aid groups in the community for support and activities and have formed partnerships with other institutions to help solve the problem of a low budget.	All Nottinghamshire Districts	Service
	Mindset	Provision for mental health service users providing opportunities for members to maintain a mutually supportive social network, encouraging activity towards recovery, social inclusion and peer support.	All Nottinghamshire Districts	Asset
	Beeston Community Project	Provides facilities at Middle Street Resource Centre to enable people with mental ill health to engage in a range of activities alongside other disabled people and the Beeston community. Provides a base for other groups.	Broxtowe	Asset
Early recognition of mental disorders	Adult social care (Nottinghamshire County Council)	Predominately statutory work under The Care Act and the Mental Health Act. Reablement is also provided as a preventative and early intervention function. This is discretionary and is mainly undertaken by unqualified workers for up to 12 weeks. The aim is to work with people to re-engage them with community supports to avoid them needing ongoing social care services. Reablement is also undertaken at review to reduce the need for commissioned services and to assist with discharge.	All Nottinghamshire Districts	Service
	Freed Beeches	Counseling, CBT, dietetic advice or complementary therapy sessions.	All Nottinghamshire Districts	Service

Appendix 7: Evidence of what works

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.

NICE quality standards

There are four NICE quality standards in mental health for adults and older people that sets out prioritised statements designed to drive measurable quality improvements in the area of health or care.

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.

Mental wellbeing of older people in care homes: (QS50) (2013). This quality standard covers the mental wellbeing of older people (65 years and over) receiving care in all care home settings, including residential and nursing accommodation, day care and respite care.

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.

Anxiety disorders: (QS 53) (2014). This quality standard covers the identification and management of anxiety disorders in primary, secondary and community care for children, young people and adults

Psychosis and schizophrenia in adults: QS80 (2015). This quality standard covers the treatment and management of psychosis and schizophrenia (including related psychotic disorders such as schizoaffective disorder, schizophreniform disorder and delusional disorder) in adults (18 years and older) with onset before the age of 60 years in primary, secondary and community care. It does not cover adults with transient psychotic symptoms

Bipolor disorder in adults: (QS 95) (2015) This quality standard covers recognition, assessment and management of bipolar disorder (including bipolar I, bipolar II, mixed affective and rapid cycling disorder) in adults (18 years and older) in primary and secondary care

NICE clinical guidance

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.

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

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.

Depression in adults (CG90) (2009) (updated 2016) 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.

Generalised anxiety disorder and panic disorder in adults: management (CG113) (2011) replaces Anxiety (CG22) (2007) (replaced by CG113) offers evidence-based advice on the care and treatment of adults with generalised anxiety disorder or panic disorder (with or without agoraphobia. Provides recommendations for the identification and management of anxiety in adults in primary, secondary and community care

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.

Social anxiety disorder: recognition, assessment and treatment (CG159) (2013) replaces and updates previous guidance on phobia.This guideline covers recognising and managing psychosis and schizophrenia in adults. It aims to improve care through early recognition and treatment, and by focusing on long-term recovery. It also recommends checking for coexisting health problems and providing support for family members and carers.

Psychosis and Schizophrenia in Adults: Prevention and Management (CG178) (2014) replaces Schizophrenia (CG82) (2009). This guideline covers recognising and managing psychosis and schizophrenia in adults. It aims to improve care through early recognition and treatment, and by focusing on long-term recovery. It also recommends checking for coexisting health problems and providing support for family members and carers.

Antenatal and postnatal mental health: clinical management and service guidance (CG192) (2015) replaces Antenatal and Postnatal Mental Health (CG45) (2007) and covers evidence-based advice on the recognition, assessment, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth), and in women who are planning a pregnancy.

Older people: independence and mental wellbeing (2015) NICE guideline 159 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.

Depression in adults, recognition and management (CG 90) (2016). This guideline is published alongside 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91) 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.

Bi-polar Disorder: Assessment and Management (CG 185) (2016) is an update and replaces on Bipolar disorder (CG38) (2006) covers evidence based advice on the care and treatment of children, young people and adults with bipolar disorder.

Transition between inpatient mental health settings and community or care home settings (NG53) (2016) covers the period before, during and after a person is admitted to, and discharged from, a mental health hospital. It aims to help people who use mental health services, and their families and carers, to have a better experience of transition by improving the way it's planned and carried out.

This guideline is a partial update of NICE clinical guideline 23 (published December 2004 revised April 2007) and replaces it.

Mental health problems in people with learning disabilities: prevention, assessment and management (2016) NICE guideline 54 covers preventing, assessing and managing mental health problems in people with learning disabilities in all settings (including health, social care, education, and forensic and criminal justice). It aims to improve assessment and support for mental health conditions, and help people with learning disabilities and their families and carers to be involved in their care.

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

Strategies and Policies

The WHO Promoting Mental Health – Concepts, Emerging Evidence and Practice (2004) report describe the concepts relating to promotion of mental health, the emerging evidence for effectiveness of interventions, and the public health policy and practice implications.

The national mental health strategy, No Health without Mental Health (DH 2011) defines the outcomes that health and social care organisations should seek to achieve for their populations, along with recommendations for action. These outcomes include:

i. More people will have good mental health
ii. More people with mental health problems will recover
iii. More people with mental health problems will have good physical health
iv. More people will have a positive experience of care and support
v. Fewer people will suffer avoidable harm
vi. Fewer people will experience stigma and discrimination

In response to the national mental health strategy is the No Health without Mental Health Nottinghamshire Mental Health Framework for Action (FfA) 2014-2017. This FfA brings together the vision for improved mental health across the life course under the following five priorities;

i. Promoting mental resilience and preventing mental health problems
ii. Identifying problems early and supporting effective interventions
iii. Improving outcomes through effective treatment and relapse prevention

iv. Ensuring effective support for those with mental health problems
v. Improving the wellbeing and physical health of those with mental health problems

The Preventing Suicide in England (HM Government 2012) aims to reduce the suicide rate in England and better support those bereaved or affected by suicide by improving mental health and improving early support for people experiencing mental health problems. It also focuses on improving monitoring of suicide and particularly tailoring support to high risk groups.

The HM Government Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence published in 2015 has a focus on public mental health and the burden of mental illness in England with specific sections on:

I) Science and technology
II) Mental health across the life course
III) The economic case for better public mental health
IV) Parity of esteem
V) Needs and safety

Closing the Gap: Priorities for essential change in mental health (HM Government 2014) supports the delivery of the national No Health without Mental Health strategy (DH 2011)and the national Suicide Prevention Strategy (HM Government 2012). It is intended to bridge the gap between long term strategic ambitions and short term actions through 25 priorities for action.

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (HM Government 2014) outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems urgently need help.

Care Act Chapter 23 (HM Government 2014) aims to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.

The Five Year Forward View for Mental Health (2016) outlines a vision for the prevention, early intervention and treatment of mental health problems. The key priority, promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens has been identified.

The Health and Social Care Act (HM Government 2012) requires the NHS, local authority including social care services to deliver ***"parity of esteem"*** between mental and physical health by providing a holistic, 'whole person' approach to every individual, whatever their needs are. A ***"parity approach"*** gives equal status to mental health and physical healthcare. This means that the standards of care for people with mental health problems are at least as good as those for people with physical health problems.

The Royal College of Psychiatrists report titled 'Whole-person care: from rhetoric to reality' (2013) identifies the following implications in achieving 'parity approach' and include:

- Equal access to the most effective and safe care and treatment
- Equal efforts to improve care
- Equal allocation of time, effort and resources in relation to need
- Equal status within healthcare education and practice
- Equally high aspirations of service users and
- Equal status to the measurement of health outcomes.

The Foresight report on Mental Capital and Wellbeing (2008) outlines 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", together with highlighting what all agencies will need to do to meet the challenges ahead, so that everyone can realize their potential and flourish in the future.

The University of York Centre for Review and Dissemination briefing on The Evidence to Inform Commissioning on Social Prescribing (2015) gives a rapid appraisal and summary of existing sources of synthesised and quality assessed evidence, primarily systematic reviews and reports of formal evaluations on the effectiveness of Social Prescribing.

The Kings Fund report Bringing together physical and mental health (2016) identifies 10 areas where there is particular scope for improvement in integrated physical and mental health care.

Faculty of Public Health report Better Mental Health for All – A public health approach to mental health improvement (2016) focuses on what can be done individually and collectively to enhance the mental health of individuals, families and communities by using a public health approach.

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