Cambridgeshire County Council

Appendix A

DRAFT

PUBLIC MENTAL HEALTH STRATEGY 2015-2018

Contents

Summary

At any one time, at least one person in six is experiencing a mental health condition. This is costly to the individual, society and the economy. We also know that people who have a severe mental illness often have poorer physical health and are more likely to die earlier. This strategy looks at ways in which we can better promote good mental health and prevent mental illness – what this actually means for individuals and families is described using the fictional family in Figure 1 (see pages33-34).

Although anyone can experience a mental illness or poor mental health, some people will be more likely than others because of their genetic make-up or their life experiences that make them more vulnerable. It is knowledge of these factors, and the research into evidenced based interventions that inform this public mental health strategy.

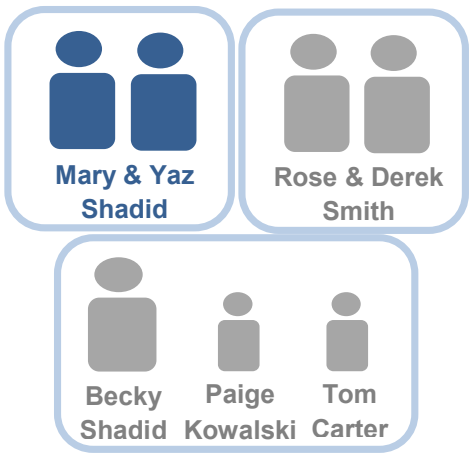


Figure 1This fictional family will be used in the strategy as an example of how this strategy could affect individuals.

The strategy looks at mental health promotion and prevention activity across three broad themes, looking at the evidence base for what potentially could work, as summarised below:

A life course approach to promoting mental health

Children & Young People

- Identifying and treating maternal mental illness in pregnancy and the first year of life
- Parenting programmes
- Mental health promotion in early years settings
- Anti-bullying interventions in schools
- Mental health promotion in schools

Social Isolation & Loneliness

- Activities and services for people to access, and additional support to help people access services.
- Creating a community environment that fosters development of services

Developing a wider environment that supports mental health

Mental Health & Work

- Recommendationson mental health promotion and mental illness prevention in workplaces
- Support for those with people with severe and enduring mental illness to return to work.

Mental Health Promotion in the Community

- Anti-stigma campaigns including national campaigns such as 'Time to Change'
- Training which increases knowledge and raises awareness of mental health & illness.

Physical and mental health – 'the mental health of people with physical illness and the physical health of people with mental illness'

Mental Health of People with Long Term Conditions

- Effective identification and treatment of mental health issues for people with long term conditions

Physical Health of people with Mental Illness

- Physical health assessments
- Physical activity
- Social prescribing

What does the strategy recommend?

Building on the evidence base and knowledge of some of the interventions already in place, the table below summarises what the strategy proposes. Given the scale of the issue, depression and anxiety affect about half the population at some point during their lives, these proposals are not just for implementation by the public health team, but for a wide range of organisations across the public, voluntary and private sector. A recurrent investment of £120k has been agreed to support the implementation of the strategy. Those actions in *italics* are suggested areas for further investment as part of this strategy's implementation funding. A more detailed action plan is provided in the full strategy (p.35-39).

	Why focus here?	**Proposed Actions**
Children and young people	Half of all lifetime mental health problems emerge before the age of 14. See page 10 and (Warwickshire County Council, 2014). Mental health problems in children and young people are associated with excess costs estimated as being between £11,030 and £59,130 annually per child. See page 10 and (Warwickshire County Council, 2014).	*Focus on supporting schools to tackle anti-bullying and to introduce a 'whole school approach' to improving mental health. This approach includes culture, staff morale, pupil and family and community involvement.* Maximise opportunities to promote mental health across the early years, including during pregnancy and in the first year of life. Continue to support evidenced based parenting programmes.
Social isolation and a wider environment that supports mental health	The environment in which we live can make some individuals and population groups more at risk of poor mental health. These risk factors include low income and/or debt, housing conditions, unemployment, social isolation and adverse life experiences such as adversity in childhood and domestic abuse (see page 11).	Increase engagement with communities in addressing and improving their health and wellbeing. Support the digital inclusion strategy and the expansion of the Time Credit scheme. Consider how services, such as Lifestyle or community navigator services, might have their role enhanced in relation to mental health and be better able to identify those in need of support. Continue with initiatives supporting people with mental illness back into work. Support the implementation of other relevant strategies such as the Cambridgeshire County Council Child Poverty Strategy which includes a focus on helping parents back to work.

Workforce mental health	Mental ill health costs some £105 billion each year in England; £29bn of this is losses to business. Interventions to improve mental health within the workplace have been found to be cost effective for businesses. See page 10 and (Warwickshire County Council, 2014).	*The public health 'workplace health' programme should have a strategic focus including mental health, and expand to cover a much greater proportion of workplaces, particularly in areas of greatest deprivation or among highest need populations.* *The programme should identify and roll-out a workplace health standard, which gives employers a set of good practice standards on mental health and other health issues to adopt.*
Anti-stigma work	Many people who have a mental illness have experienced stigma or feel the need to hide their illness – one study found that 70% of mental health service users felt the need to conceal their illness(Corker et al. , 2013).	*Support anti-stigma campaigns, building on the work of the 'Stop Suicide' Campaign. Workplaces, schools and early years settings should all be utilised as locations for campaign work.* Continue to fund Mental Health Awareness Training for frontline staff.
Mental health of those with physical illness	Around 30% of all people with a long term physical health condition in England also have a mental health problem, most commonly depression/anxiety(Naylor et al. , 2012). Mental health problems exacerbate physical illness.	Improve the identification of those people with a long term physical health condition(s) and depression. Ensure that those identified received evidence based interventions for depression, or access to rehabilitation programmes which include mental health support where appropriate.
Physical health of those with mental illness	People with severe mental illness die up to 20 years younger than their peers in the UK and lifestyle is thought to play an important role (see page 10). One study found that 60% of people receiving secondary mental health care smoked(Wu et al., 2013).	Increase the number of members of community mental health teams who are trained to give stop smoking advice, and increase the number of people with serious mental illness referred to stop smoking services. *Additional focused initiatives to support the physical health of those with serious mental illness, through preventive lifestyle interventions, such as tailored physical exercise programmes.*

1. Background

1.1 Vision& Aims of the Strategy

Through collaborating with a wide range of partners, this strategy will work to improve public mental health with the aim of achieving:

1. A common understanding of what it means to improve public mental health.
2. Maximise opportunities to promote mental health and prevent mental illness within Cambridgeshire through:
   - Taking a life course approach to promoting mental health
   - Promoting a more holistic approach to physical and mental health
   - Integrating mental health into all aspects of our work

- Developing a wider environment that supports mental health including tackling stigma.

1.2 What is Public Mental Health?

The Royal College of Psychiatrists state that,

> 'Public mental health focuses on the wider prevention of mental illness and promotion of mental health across the life course…There is no public health without public mental health'.

Public mental health strategies focus on what action can be taken to promote positive mental health and wellbeing and to prevent mental illness or disorder. In this strategy we use the World Health Organisation (WHO) Public Mental Health Framework(WHO, 2013), as recently recommended by the Chief Medical Officer (CMO) in her annual report. The framework incorporates; Mental Illness Prevention, Mental Health Promotion, Treatment Recovery and Rehabilitation. These areas are conceptualised in the model presented in the CMO report (Figure 2).

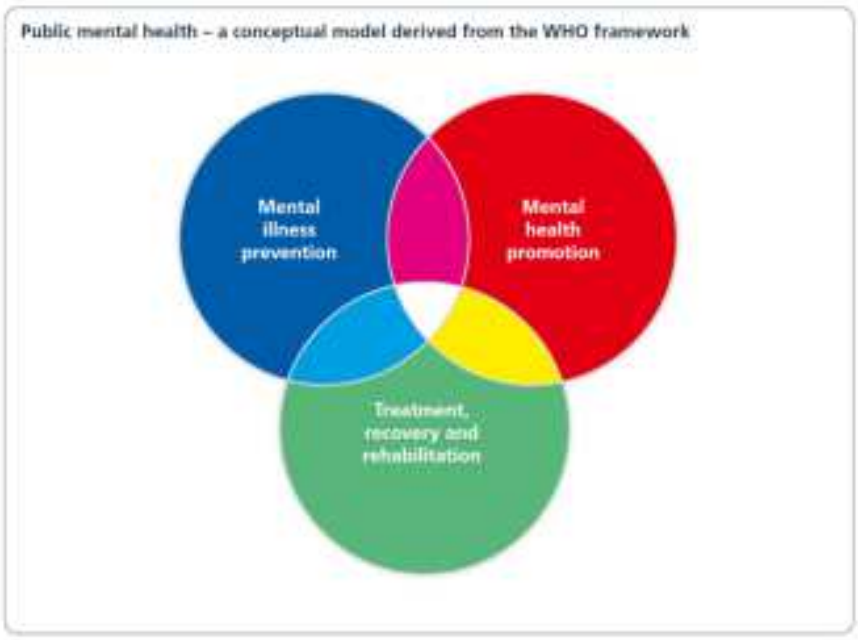


Figure 2 Public Mental Health Conceptual Model. Annual Report of the Chief Medical Officer 2013: Public Mental Health Priorities: Investing in the Evidence. September 2014. Department of Health p.13.

1.3 Definitions

It is important to be clear about the differences between mental health (or mental wellbeing), and mental illness. In this strategy we refer to both using the definitions below.

Mental health (or wellbeing): There are many different definitions of mental health or wellbeing (and little consensus on how it should be measured), but they generally include factors known to promote mental health such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against the development of many such problems. WHO describe mental health 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'.

Mental illness or disorder: Mental illness or disorder refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social

1.4 Scope of the Strategy

This strategy will focus on evidence based interventions within two areas of the WHO Framework; 'Mental Illness Prevention' and 'Mental Health Promotion', recognising the wealth of current work and complementary strategies that focus on 'Treatment, Recovery and Rehabilitation'.

- **Mental health promotion** is concerned with the determinants of mental health or the 'creation of individual, social and environmental conditions that enable optimal psychological and psychophysiological development'. Interventions may have a primary goal of improving mental health or the side benefit of doing so. Examples might include promoting a whole school approach for children's social and emotional wellbeing, recommended organisational level interventions to minimise the health effects of workplace reorganisation, or preventing social isolation and loneliness among older people.

- **Mental illness prevention** is concerned with the causes of disease and aims to reduce the incidence, prevalence, recurrence and time spent with symptoms as well as the impact of illness on the person, family and wider society. Examples might include school based interventions to prevent bullying, or stigma prevention campaigns.

Following on from the joint Cambridgeshire & Peterborough Suicide Prevention Strategy produced in 2014, suicide prevention will not be covered specifically within this report. These strategies complement each other and this will be recognised within their respective recommendations and action plans.

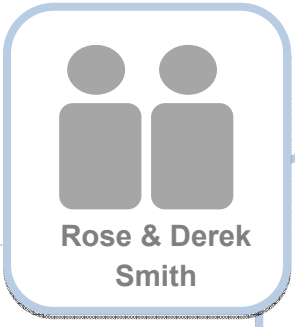
Complementary Strategies

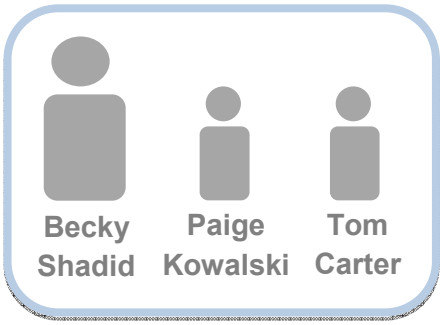
- **Emotional Wellbeing and Mental Health of Children & Young People 2014-2016** (Cambridgeshire County Council [CCC]), Peterborough City Council, Cambridgeshire & Peterborough Clinical Commissioning Group [C&PCCG])
- **Adult Mental Health Commissioning Strategy 2013-2016** (C&PCCG)
- **Older People's Mental Health Commissioning Strategy 2013-16** (C&PCCG)
- **Older People's Services Procurement Requirements** (C&PCCG)
- **Cambridgeshire & Peterborough CCG 5 Year Strategy** (in development)
- **The Mental Health Social Care Strategy for Adults and Older People**(CCC, in development)
- **Joint Cambridgeshire and Peterborough suicide prevention strategy 2014-2017**(Multi-Agency)
- **Breaking the Cycle 2,** *2014-17* (Cambridgeshire Children's Trust)
- **Domestic Abuse Strategy 2014-18** (Domestic Abuse & Sexual Violence Partnership)

In summary ‘mental health promotion is primarily concerned with the determinants of mental health, and…mental illness prevention is concerned with the causes of disease’.

1.5 What does the Public Mental Health Strategy Mean for Me?

The following example will be used to demonstrate how the work of this strategy may impact upon the lives of one fictional family. Similarly, this family will be used within the Adult Mental Health Social Care Strategy to illustrate how the strategy can impact upon individuals.Section 5illustrates what the family might experience if we maximise public mental health opportunities.





Rose(78 years old) and **Derek Smith**(75 years old) have lived together in Wisbech for over 40 years. Derek cares for Rose who was diagnosed with dementia 3 years ago.

Rose and Derek have a daughter, **Mary** (50 years old) who lives in Ely together with her husband **Yaz**(52 years old). Yaz has chronic psychosis and is currently unable to work. Mary can find it difficult to hold down employment as she needs to provide support and care for Yaz.

Mary and Yaz have a daughter called **Becky** (30 years old) who is a single parent and lives in Sawston with her daughter **Paige** (14 years old) and her son **Tom** (4 years old). Becky works as a dinner lady in a local school to fit with childcare, she struggles financially and has run up some debt. Becky is under a lot of stress and is finding it difficult to cope with Tom's behaviour. She has very little support from Tom's father, contact is often erratic. Paige has been happy at school but recently has become withdrawn, and Becky suspects she is being bullied.

2. Facts & Figures

2.1 The National Picture

Image produced by Warwickshire County Council in the Warwickshire Public Mental Health andWellbeing Strategy 2014-16.

2.2 Risk Factors & Protective Factors

Although anyone can suffer from poor mental health or mental illness, certain factors make some individuals and population groups more at risk. The Chief Medical Officer's Report on Public Mental Health further compiles and describes the aspects of people's lives that are linked to mental illness in adulthood, an adapted summary is provided below (Stansfeld et al., 2014).

Adversity in childhood– Looked after children (LAC)are knownto have higher levels of mental health problems with 45% of LAC (5-17 years) having a mental health disorder in one survey (ONS, 2003).

Demographics:

- **Age -** The pattern of prevalence of mental illness differs across the life course, with depression for example peaking in midlife.
- **Gender** –Whilst problem gambling, alcohol dependence and suicide are more common in men, women are more likely to suffer from common mental disorders including anxiety and depression.
- **Ethnicity** – Some ethnic groups appear to have higher levels of certain mental

Socio-economic context

- **Income** - People living in households in England with the lowest income are more than three times more likely to have a mentalillness.
- **Debt**
- **Housing conditions and fuel poverty** – This links to both income and debt, but cold homes can also contribute to social isolation as people may not want to invite people round.
- **Unemployment** – Anxiety, depression and suicide are associated with unemployment.
- **Adverse working conditions -** Although employment is generally good for mental health, poor working conditions can have a negative effect, for example, lack of job security and an effort-reward imbalance can increase the risk of common mentaldisorders.

Social Context

- **Social relationships** – Experiencing domestic abuse is associated with the development of a number of mental illnesses, and witnessing domestic violence as a child is a risk factor for being a victim of violence in adulthood (Howard, Shaw, Oram, Khalifeh, & Flynn, 2014). A Domestic Abuse Strategy for Cambridgeshire (Domestic Abuse & Sexual Violence Partnership, 2014) was produced in 2014 following a comprehensive mapping exercise and needs assessment.
- **Caring Responsibilities (at any age)** – Being a carer has been associated with vulnerability to mental illness, this may be through emotional strain and traumatic life events, or perhaps through the financial pressures for example. This is furtherdiscussed in the Carers JSNA (2014) and through the implementation of the Care Act 2014.

Health, disability and health behaviours– for example physical health conditions and alcohol and drug consumption.

As well as there being a number of adverse or risk factors that could lead to poor mental health or mental illness, there are also a number of protective factors. The table below (Table 1) was created as part of the development of the WHO Mental Health Action Plan; it illustrates a range of factors that may have adverse or protective effects on mental health.

Table 1 Mental Health Determinants - potential adverse and protective determinants of mental health. (WHO, Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors, 2012)

Level	*Adverse factors*		*Protective factors*
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety

➢ Deprivation

Clusters of indicators make mental health disorders more prevalent in some areas, tending to mirror broad patterns of poverty and household deprivation(NHS Cambridgeshire & CCC, 2013). Average prevalence levels are therefore an underestimation of need in those areas, where risk levels are likely to be two to three times higher amongst some disorders (e.g. conduct disorder) (NHS Cambridgeshire & CCC, 2013).The Cambridgeshire Poverty Strategy also highlights the impact of poverty on both mental and physical health – an issue raised by interviewees who experience poverty (Cambridgeshire Children's Trust, 2014). Enabling people to get into work and to manage debt can relieve some of the stresses of poverty.

There are an estimated 19,000 children and young people (aged 17 years and under) who may experience mental health problems in need of mental health support[1]

There were 474 self-harm hospital admissions in people aged 10-24 years in 2012/13 and the rate of admissions is higher than the England average[2]

In 2012 there were an estimated 7,500 people with dementia. This is expected to increase to over 12,000 by 2026[3]

[1]CAMHS Needs Assessment, ChiMat
[2]Children's and Young People's Mental Health and Wellbeing, Fingertips, PHE
[3]Older People's Mental Health, JSNA, Cambridgeshire

6.2% (44,058) of adults aged over 18 years had depression in 2013/14 (CCG level. England average 6.5%)[4]	There are an estimated 63,000 adults aged 18-64 years with a common mental health disorder* [5]	The excess under 75 standardised mortality ratio for adults with serious mental illness was 319 in 2012/13** (England average 347)[6]
4.2% (810) of 16-18 year olds were not in employment, education or training in 2013 (England average 5.3%)[2]	6,784 patients registered in Cambridgeshire have a serious mental illness (SMI)[7]	The rate of hospital admissions for alcohol related conditions was 5.9 per 1,000 population in 2012/13 (3 ,526 admissions) (England average 6.4)[8]
In 2013/14 there were 610 households that were statutory homeless***[9]	0.25% of the working age population are long term unemployed (1,030 people) (England average 0.73%)[9]	13.1% of children live in poverty (14,110 children) (England average 20.6%)[9]
6% of pupils said that there had been physical aggression at home at least 'once or twice' in the last month that frightened them[10]	6% of pupils responded that they are a 'young carer'. 13% said they 'don't know' if they are	21% of boys and 36% of girls responded that they feel afraid to be in school because of bullying at least 'sometimes'

Health Related Behaviour Survey 2014

2.4 The Local Picture – Cambridgeshire

* Common mental disorders:Mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder[5].

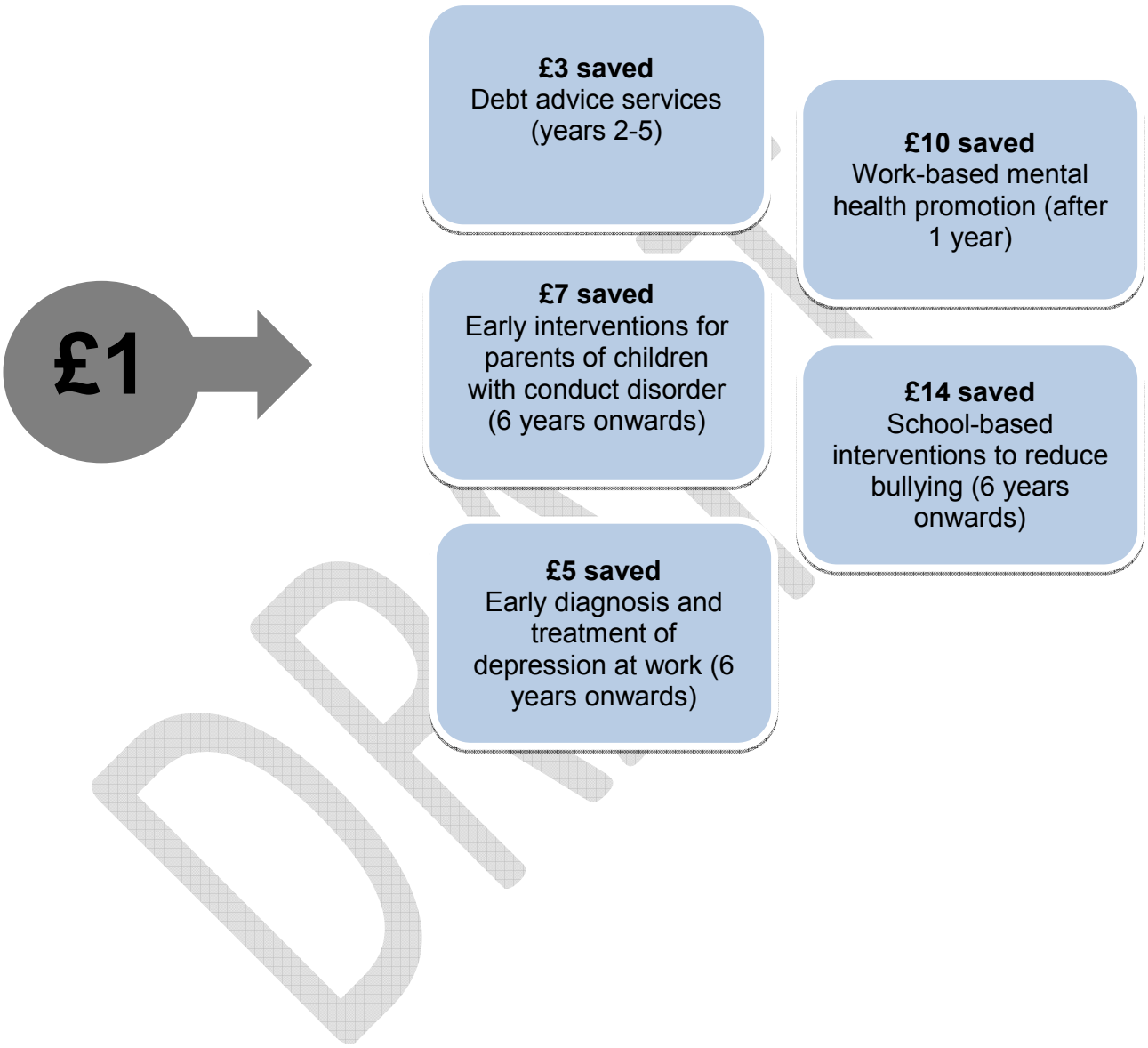
** The number of under 18-74s in contact with secondary mental health services that die compared to the number that die within the general population at the same age. So, for every 100 deaths in the standard population there were 319 deaths in those with serious mental illness.

*** Households that are accepted as being owed a duty by their local authority under homelessness legislation as a result of being eligible for assistance, unintentionally homeless and in priority need.

2.5 The Economic Case

The annual cost of mental illness to the economy in England is estimated to be £105 billion, and the cost of treating mental illness is expected to double in the next 20 years (HMG/DOH, 2011). The economic benefits of mental health promotion and mental illness prevention were reviewed in a report published by the Department of Health (Kapp, 2011), which is cited within the 'Guidance for Commissioning Public Mental Health Services'. Adapted summary findings from the report are illustrated below.

[4]Quality and Outcomes Framework (QOF), Health and Social Care Information Centre
[5]Autism, Personality Disorders and Dual Diagnosis JSNA, Cambridgeshire County Council
[6]Severe Mental Illness Profiling Tool, Fingertips, PHE
[7]Data source: CQRS and GPES database - 2013/14 data as at end of June 2014
[8]Public Health Outcomes Framework, Fingertips, PHE
[9]Common Mental Health Disorders Profiling Tool, Fingertips, PHE
[10]Young People in Cambridgeshire Schools, Health-Related Behaviour Survey 2014, The Schools Health Education Unit



.4 What do people think?

The following summarises local and national feedback from patients, carers and the public on public mental health.

Comments and themes emerging from engagement/consultation work:

- Carers (of any age) need more support to cope with their caring role[1]
- The need for support for mental health service users to get employment[1]
- The need for access to accurate information/signposting[1]

What is the most useful thing that you do to keep well (social care users)?

"Work. Having supportive employment enables me to feel valued, earns me

Consultation Question: What other views would you like to add?

3. The National Context

In 2011, the cross-government mental health strategy - 'No Health without Mental Health' was published (HMG/DOH, 2011). The strategy focuses on mainstreaming mental health in England, and establishing parity of esteem between physical and mental health services. The strategy takes a life course approach and recognises that mental health is everyone's business, a concept that is reflected throughout this strategy for Cambridgeshire. In 2014, 'Closing the Gap: Priorities for Essential Change in Mental Health' was published, which outlines 25 priority areas that will

support the delivery of the cross-government strategy for mental health (Department of Health, 2014).

This strategy will contribute at a local level to the six objectives of 'No Health without Mental Health':

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

More recently the government published guidance for how new access and waiting times standards for mental health services are to be introduced in the NHS(NHS England, 2015), and the Prime Minister launched his 'Challenge on Dementia 2020'(Department of Health, 2015).

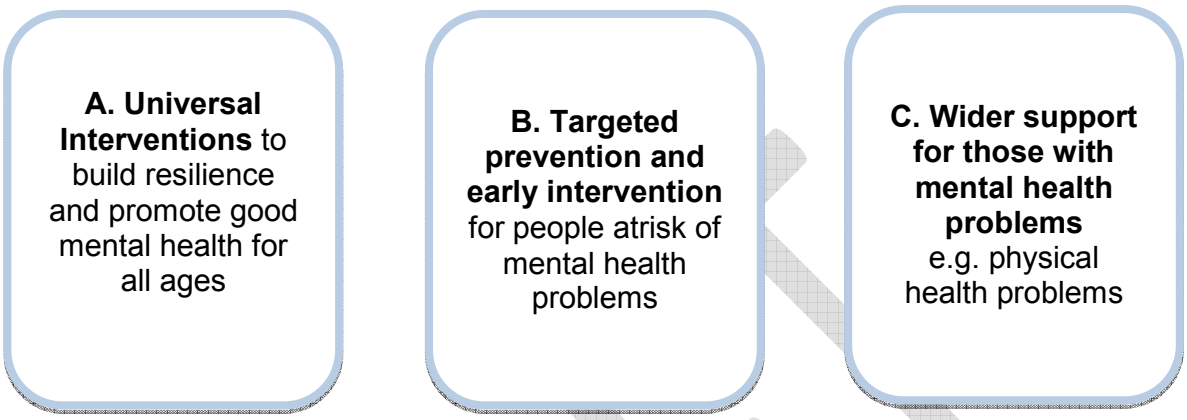
4. Improving Public Mental Health in Cambridgeshire

This strategy will look at approaches to improving public mental health within three broad themes:

- **A life course approach to promoting mental health**, including critically how to maximise prevention and promotion opportunities in childhood, such as interventions to reduce bullying and improve parenting.
- **Developing a wider environment that supports mental health**, using anti-stigma and discrimination tools, workforce training, and maximising the opportunities within workplaces.

- **Physical and mental health**, or 'The mental health of people with physical illness and the physical health of people with mental illness'.

Within these themes, proposals of work will be divided into three groups, adapted from the suggestions provided in 'No Health without Mental Health Implementation Framework'(Centre for Mental Health et al., 2012) and the Warwickshire Public Mental Health & Wellbeing Strategy (Warwickshire County Council, 2014):



4.1 A Life Course Approach to Promoting Mental Health

4.1.1aChildren & Young People

Most mental illnesses begin in childhood, adolescence and young adulthood(Stansfeld et al., 2014). It is thought that half of all lifetime mental disorders start by the age of 18 and three-quarters by the mid-twenties(Stansfeld et al., 2014).Children and young people with poor mental health are more likely to have difficulties with social relationships, poor educational attainment, and substance misuse problems(Ford et al., 2014). Furthermore, Cambridgeshire is seeing an increasing trend in hospital admissions for self-harm in young people. Interventions in childhood have the potential to prevent the development of mental illness, for example more than a quarter of the burden of adult psychiatric disorders is attributable to the effect of experiencing childhood violence or abuse(Howard et al., 2014).

4.1.1b What works?

- ***Identifying& Treating Maternal Mental Illness in pregnancy and first year of life***

Maternal mental illness in the perinatal period (during pregnancy and first year after a child is born) impacts upon both the mother and the emotional, behavioural and cognitive development of the child (Centre for Mental Health, 2015). This carries significant financial costs, particularly in terms of the impact on the child. NICE provide guidance (NICE, 2014)on the assessment, identification and treatment of maternal mental illness in the perinatal period, recognising the positive impact that they can have. It is estimated many women are not receiving interventions though, with an estimate of a half of cases of perinatal depression and anxiety not being detected (Bauer et al., 2014; Centre for Mental Health, Investing in Children's Mental Health, 2015).

Existing Services & Interventions

- Health Visitors and Family Nurse Partnership
- Perinatal Mental Health Service – women can be referred to the service via a GP or other health professional (with GP consent). The woman may then be assessed by an Advanced Practitioner for Perinatal Mental Health.

➢ *Parenting Programmes*

In a recent public health evidence reviewthere was evidence to suggest that the following interventions for child behaviour, which are recommended in NICE Guidance, are effective:

- Group parent training for parents of children aged 3-5 years with behavioural problems
- Group child training for children aged 9-14 yearswith behavioural problems
- Multi-systemic therapy for children aged 11-17 years with conduct disorder or previous contact with the criminal justice system
- Individual parent/family training for parents of children 3-5 years with behavioural problems who are not able to participate in a group parent training programme.

Existing Services & Interventions

The Local Authority currently commissions universal and targeted provision across 3 main programmes:

- *Incredible Years Early Years (Under 6 years)*
- *Incredible Years (3-6 years)*
- *Stepping Stones (2-12 years)* – for parents/carers of children with special educational needs and disabilities

Additional programmes such as *Early Bird Plus* and *SCILS (Social Communication, Interaction and Learning skills programme)* for parents and carers of children with autism are also available.

Complete programmes list:http://www.cambridgeshire.gov.uk

➢ *Early Years*

There are NICE guidelines on early years (0-5) that suggest a focus on social and emotional, as well as educational, development for this age group is key(NICE, 2012). The guidance recommends both universal and targeted provision, particularly focusing on the needs of the most vulnerable children and families.

Existing Services & Interventions

- Free early education and childcare for 3 and 4 year olds (570 hours a year) and some 2 year olds.
- Health Visitor and Family Nurse Partnership services
- Children's Centres.

There is mixed, but consistent, evidence of what makes anti-bullying interventions successful. A recent review suggested that interventions are most effective if they(Harris, 2015):

- Use a whole school approach (multiple disciplines, whole community and parents)
- Are adapted to the social and cultural characteristics of the school population
- Are intensive
- Include firm disciplinary methods
- Include improved playground supervision
- Sustained over time.

➢ *Mental Health Promotion in Schools*

Schools provide an important setting for mental health promotion interventions, including anti-stigma work, contributing strongly to the risk and resilience factors for mental health (Weare & Nind, 2011). Recent systematic reviews show that school mental health programmes demonstrate clear and repeated evidence of positive impact (Weare & Nind, 2011; Jenkins & Barry, 2007; Stewart-Brown, 2006). The most effective programmesare those that are:

- Long-term
- Take a whole school approach – including culture, staff morale, pupil, and family and community involvement.

A variety of programmes are available that take a whole school approach include SEAL (Social and Emotional Aspects of Learning Programme, Zippy's Friends and MindMatters. We also need to consider this type of approach in other settings such as early years settings.

Existing support for schools (provided or commissioned by the local authority):

- **Personal, Social, Health & Economic Education** (PSHE) – This can be provided by external organisations, or schools can purchase the local authority offer which is based on SEAL. A range of units of work are available to primary and secondary schools and specific units are available covering mental health. Currently approximately 60% of primary schools take up this offer from the local authority.
- **Health Related Behaviour Survey** – Biannual survey of school children (Years 6, 8 and 10) collecting data on a range of health issues, including bullying.
- **Freemental health training**–A wide range of training for practitioners working directly with children and young people, including 'Raising achievement through wellbeing' which takes a whole school approach: http://www.cpft.nhs.uk/professionals/camh-training.htm
- **Self-harm guidance** - for practitioners working with children and young people: http://www.cpft.nhs.uk

4.1.1c Proposed Actions

A. **Universal Interventions** to build resilience and promote good mental health for all ages
   1. The development of a new anti-bullying strategy focusing on the best way to support schools in reducing bullying. This is a potential area for investment.
   2. Additional support to schools, particularly secondary schools, in developing a whole school approach to promoting good mental health and reducing stigma, through the PSHE offer and other mechanisms. This is a potential area for investment.
   3. Maximise opportunities to promote mental health across the early years workforce and in early years settings, particularly with the commissioning of Health Visitors and Family Nurse Partnership transferring to Cambridgeshire County Council in October 2015. This might for example include the development of an early years workforce mental health training strategy.

B. **Targeted prevention and early intervention** for people at risk of mental health problems
   1. Continue to support evidence-based parenting programmes.

2. Ensure that intervention during the perinatal period to identify and treat patients with mental illness is a focus in therefreshed Emotional Wellbeing and Mental Health Strategy for Children & Young People (2014-16). The implementation of the strategy should include an assessment of local provision against the 2014 NICE Guidance. This should be considered as an area for investment given the long-term future savings.

Consultation Questions:

1. Are there any evidence based examples of 'what works' that we have not included here?
2. What do you think of the proposed areas of action? Is there anything additional we should focus on?

4.1.2a Social Isolation

In a recent report on promising approaches to reduce loneliness and social isolation in older people(Campaign to End Loneliness & Age UK, 2015), the following definitions were used:

Social isolation–An objective state which can be defined in terms of the quantity of socialrelationships and contacts.

Loneliness –A subjective experience and negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want.

Social isolation and loneliness have both been linked to poorer mental health, in particular lonely or isolated people have an increased risk of developing dementia, specifically in developing Alzheimer's disease, as self-perceived loneliness doubles the risk(Age UK, 2014). In Cambridgeshire 43.9% of adult social care users aged 65 or over are satisfied with the amount of social contact they have and 4.3% reported feeling socially isolated(Public Health Solutions (Commissioned by CCC), 2014). Another potentially important factor to consider in some cases of loneliness is the role of bereavement.

4.1.2bWhat Works?

The evidence base for effective interventions for reducing social isolation and/or loneliness is acknowledged to be lacking in high quality studies, however, a recent report highlighted promising approaches as identified by a panel of experts and evidence reviews (Campaign to End Loneliness & Age UK, 2015):

- Foundation services – those which reach isolated individuals, develop an understanding of their needs and support them in accessing services.
- Direct services – activities and services for individuals to access to maintain existing social connections and build new ones. Key characteristics of services/activities:
    1. Group-based, and targeted at a specific group
    2. Focused on a shared interest, or with an educational focus
    3. Set up to involve older people in running the group
    4. One-to-one services have a role, particularly for those where there are barriers to leaving the house.

- Structural enablers – the mechanisms that create an environment whereby services to reduce social isolation and loneliness arise e.g. types of community work like Asset Based Community Development and volunteering.

The report also recognised the potential role of technology and transport in remaining connected.

4.1.2c Existing Work

Existing Services & Interventions (commissioned by the Local Authority)

'Foundation services'

- Community Navigators - local volunteers or members of organisations who help older people find their way to activities or services. Collaboration with services such as the police and healthcare services enable potentially isolated individuals to be identified. www.care-network.org.uk
- Health Trainers

'Direct Services'

- Walking for Health – Free health walks around Cambridgeshire
- Library IT Training

'Structural Enablers'

- Engaging Communities in Fenland – This project is about building communities in Fenland to help them address their needs
- The Fenland Fund – This Fund will enable communities to secure funding for small projects to address their needs
- Time Credits – This project is currently based in Wisbech and enables volunteers to trade credits earned from time spent working on the project for fun activities.

4.1.4 Proposed Actions

A. **Universal Interventions** to build resilience and promote good mental health for all ages.
   1. Continue to support the implementation and expansion of the Time Credits scheme and projects such as community navigators and to build the evidence base through evaluation of this work.
   2. Increase engagement of communities in addressing and improving their health and wellbeing.
   3. To ensure that a wide range of professionals recognise social isolation as a risk factor for poor mental health and are aware of local activities which might support individuals who are socially isolated.

B. **Targeted prevention and early intervention** for people at risk of mental health problems
   1. Consider future options for the Community Navigators Service, Lifestyle Service and Health TrainersService that could enhance their role in terms of promoting mental health.

2. Support the digital inclusion strategyand provide clear and consistent guidance on the best available website information for different groups.

Consultation Questions:

1. What else can we do to promote the reduction of social isolation within communities?
2. How better can we use technology to reduce social isolation?
3. Are there any evidence based examples of 'what works' that we have not included here?
4. What do you think of the proposed areas of action? Is there anything additional we should focus on?

4.2 Developing a Wider Environment that Supports Mental Health

4.2.1a Mental Health & Work

The wider physical and social environment in which we grow, work and live impacts upon an individual's mental health, together with our innate biological vulnerabilities. Although work is generally good for mental health, the working environment and security of the employment is also important. There must be sufficient support and a positive effort-reward balance to avoid excessive levels of stress that can lead to mental illness (NICE, 2009). The economic case for investing in initiatives to promote mental health and prevent mental illness is well evidenced, with the number of working days lost to stress, depression and anxiety increasing by 24% since 2009 (ONS, 2014).

People who have a history of mental illness are more likely to be unemployed than those without, also unemployment is a risk factor for mental health problems (Knapp & Lemmi, 2014). There can be a number of barriers to gaining or retaining employment, for example the symptoms of the mental illness or discrimination by employers or stigma in the workplace (Knapp & Lemmi, 2014). Many service users do want support to get or retain a job, but may not have access to this.

4.2.1b What Works?

The key elements of mental health promotion and mental illness prevention in workplaces as drawn from NICE Guidance PH22 (NICE, 2009) and the annual report of the CMO are(Henderson & Madan, 2014):

- An integrated model of organisational and individual measures.
- Measures that increase control e.g. flexible working.
- Management – management style, ability to identify and respond to emotional concerns and an understanding of their impact on employee health.
- Assessing opportunities for promotingemployees' mental wellbeing and managing risks
- Support for people returning to work following leave due to mental illness, for example temporarily working part-time.

In terms of supporting people with severe and enduring mental health needs to get back to work, 'Individual Placement Support' (IPS) is one evidenced based method for employment support (Centre for Mental Health, 2013).

4.2.1c Existing Work

Local Authority Workplace Mental Health Promotion

Work Healthy Cambridgeshire (ww.workhealthycambs.org.uk)

- A health in the workplace package is offered to businesses, particularly targeting those in areas of deprivation. The offer includes a range of initiatives to promote better health overall, for example smoking cessation services and Mental Health First Aid Training.Also train Health Champions within workplaces to run health

Local Authority Learning & Skills
A range of adult learning courses are offered via Library Learning Centres covering a range of subject areas including:

- Employability and work skills
- Employability learner pathways
- English and Maths skills
- European Computer Driving Licence (ECDL)
- Everyday IT - a basic IT qualification
- IT learner pathways
- National Vocational Qualifications (NVQs)

http://www.cambridgeshire.gov.uk

Richmond Fellowship - The service provides an employment support service for adults who have moderate to severe mental health needs based on IPS principles.

4.2.2a Mental health and the community

- ***Anti-stigma***

Many people who have a mental illness have experienced stigma or feel the need to hide their illness. One study found that approximately 70% of mental health service users felt the need to conceal their illness (Corker et al. , 2013). The stigma that surrounds mental health can also prevent those who could benefit from additional support from accessing it.

- ***Housing & Homelessness***

NICE recognise that mental illness is more common among homeless and vulnerably housed people than the general population (NICE, 2011; Rees, 2009). Furthermore mental illness may be a factor in losing living accommodation, and could be worsened by the stresses experienced when homeless (NICE, 2011). Well managed housing programmes, including housing with some specialist support can reduce these risks.

When planning new communities it is also important to maximise the potential mental health promotion and mental illness prevention opportunities, as highlighted in this strategy.

4.2.2b What Works?

The key components of effective anti-stigma campaigns have been identified as (Thornicroft et al., 2014; Gale et al., 2004):

- Service users and carers should be involved throughout the design, delivery, monitoring and evaluation of the campaign.
- Campaigns should be monitored and evaluated.
- National campaigns should be supported by local grassroots initiatives.
- Campaigns should address behaviour change.
- Clear, specific messages should be delivered in targeted ways to identifiable audiences.
- Long-term planning and funding should be in place to ensure campaign sustainability.

The national 'Time to Change'campaign employs national and local level action with the aim of ending stigma and discrimination. The social marketing campaign has also undertaken targeted work with specific groups, for example medical students and employers. Evaluation results have showed promising results with a reduction in anti-stigmatising newspaper articles and improvements in attitudes towards mental illness (Thornicroft et al., 2014).

Nationally there is a drive to create communities that are more dementia friendly, improving inclusion and quality of life for people living with dementia. These communities aim to have a greater understanding of dementia, foster greater independence for people living with dementia and encourage more people, including carers, to seek out support. The 'Dementia Friends' training supports this ambition (http://www.alzheimers.org.uk). The evidence base for this work is still in development and this, along with other programmes, designed to building community awareness and/or resilience around mental health need to be evaluated to fully understand their impact.

4.2.2c Existing Work

Anti-Stigma Work

Campaigns

- The County Council support a range of campaigns, including World Mental Health Day and the 'Time to Change' Campaign and promoting depression awareness.
- **STOP Suicide Campaign** Led by a range of voluntary organisations, using a combination of social media activity, Stop Suicide Pledges (both organisational and individual) and ASIST suicide prevention training. Within the first three months of activity, 418 individual pledges were signed and 25 organisational pledges

4.2.3 Proposals

A. **Universal Interventions** to build resilience and promote good mental health for all ages.
   1. A standard for workplace health should be adopted and promoted countywide. The County Council & local NHS organisations should be some of the first organisations to work towards this standard. The new workplace health post will support the adoption and promotion of this standard.
   2. Continue to support Time to Change, the Stop Suicide Pledge and Campaign and other anti-stigma work, particularly in workplaces, schools and early years settings. This is a likely area for investment given the limited local capacity to undertake this work currently.
   3. Making the most of opportunities across the council to promote mental health and prevent mental illness, for example through further education.
   4. To support well evaluated projects that build communities with a greater understanding of mental health.
   5. Support the implementation of the 'Supporting New Communities' strategy.

B. **Targeted prevention and early intervention** for people at risk of mental health problems
   1. The Cambridgeshire poverty strategy, Breaking the Cycle 2, contains pledges from a wide variety of organisations that will help tackle child poverty. Many pledges support better mental health, for example through providing training to get parents back into work, or reducing alcohol consumption.
   2. Continue to fund Mental Health First Aid training for frontline staff.
   3. Expand the provision of full workplace support programmes such as Fit4Work to improve workplace health in the areas of greatest deprivation or amongst high need populations. This will require additional investment in the mental health training element of this programme.

C. **Wider support for those with mental health problems** e.g. physical health problems
   1. Continue to support initiatives to work with people who have mild to moderate mental health problems back into work – including applying for funding from the Skills Funding Agency, and recognising the wider importance of learning courses in reducing unemployment.
   2. Utilise services that may come into contact with those with mental health problems, such as the Health Trainer service, to better identify those clients who have a mental health need and ensuring they are equipped to support them in accessing the right help.

Consultation Questions:

1. Are there any evidence based examples of 'what works' that we have not included here?
2. What do you think of the proposed areas of action? Is there anything additional we should focus on?

4.3 Physical and Mental Health

4.3.1 The Mental Health of People with Long Term Conditions

People who are living with a long term condition, such as diabetes, hypertension (high blood pressure)

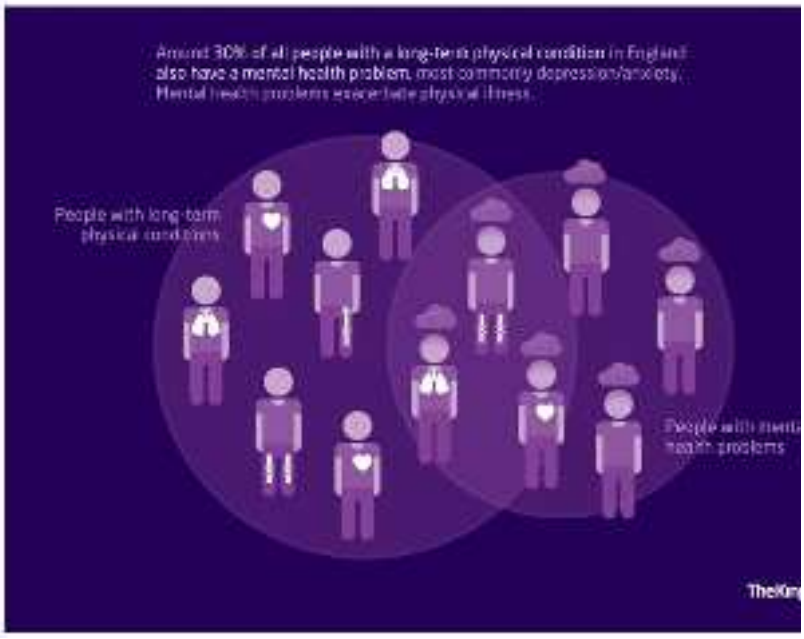


Figure 3 Source: The King's fund The changing patient infographic.

or chronic obstructive pulmonary disease (COPD) may be more likely to develop certain mental illnesses, such as depression or anxiety (Department of Health, 2014). Studies suggest that they may be two to three times more likely to experience mental health problems than the general population(The Kings Find and Centre for Mental Health, 2012). People with two or more long term conditions are seven times more likely to have depression(NICE, 2009).

4.3.1a What works?

The following evidence is gathered from a recent review conducted by Cambridgeshire Public Health.

- ***Effective Identification***

There is a lack of evidence for the implementation of routine depression screening within the care pathways for people with long term physical health conditions. However, routine clinical management of long term health conditions should include the identification of those requiring individual assessment for depression or anxiety. NICE recommend the use of depression identification questions for this purpose and these should be incorporated into the initial patient assessment (NICE, 2009).

- ***Psychological Interventions***

Evidence supports the beneficial role of psychological interventions, but is inconclusive in determining the most effective intervention for a specified patient group. NICE recommend offering a choice of psychological intervention dependent of patient preference and assessed severity of depression or anxiety(NICE, 2009):

- Group based peer support programmes
- Individual guided self-help (based on cognitive behavioural therapy [CBT])
- Computerised CBT.

- ***Pharmacological Interventions***

Evidence consistently supports the effectiveness of antidepressant therapy in the management of depression in those patients who also have a long term physical health condition.

- ***Exercise***

The benefits of exercise in the management of depressive symptoms when delivered as a part of programmes such as pulmonary rehabilitation and cardiac rehabilitation have been consistently observed. The offer of a structured group physical activity programme should be made to those with identified depressive symptoms and a long term physical health condition(NICE, 2009).

- ***Rehabilitation and Support Programmes***

Pulmonary Rehabilitation has been shown as an effective management strategy to improve symptoms of depression/anxiety in those with Chronic Obstructive Pulmonary Disease (COPD). Evidence would support a recommendation that patients diagnosed with COPD should have undelayed access to a programme of Pulmonary Rehabilitation.Evidence supports the inclusion of exercise and psychological interventions to improve outcomes for depression and anxiety in those with heart failure and after myocardial infarction.

4.3.1b Proposals

C. **Targeted prevention and early intervention** for people at risk of mental health problems

1. Improve the identification of those clients with a long term physical health condition and depression. Where a mental health assessment is indicated, using depression identification questions incorporated into the initial patient assessment within pathways of care.
2. Upon identification of depressive symptoms ensure the timely offer of an appropriate psychological intervention, which should include the offer of access to cognitive behavioural therapy amongst other options.
3. Support the use of antidepressant therapy in the management of comorbid depression and long term health conditions, where clinically indicated.
4. Ensure timely access to multicomponent rehabilitation/support programmes, incorporating exercise and psychological interventions, for those conditions where programmes exist. Where programmes do not exist, the development of similar models should be considered, particularly for those individuals who suffer from multiple long term health conditions.

4.3.2The Physical Health of those with Mental Illness

In general the life expectancy of people with a range of mental illnesses, such as schizophrenia and depression is less than that of people that are not living with a mental illness (Hotopf & McCracken, 2014). International evidence shows that people with learning disabilities or long-term mental health problems on average die 5 to 10 years

Source: The King's Fund 'Improving the Health of the Nation' Infographic.

youngerthan other citizens, often from preventable illnesses(Nocon, 2006).

Although suicide rates are higher in people with mental illness(es), this does not account for all of the differences seen (Hotopf & McCracken, 2014). In particular, health behaviours are important with smoking prevalence higher in those with serious mental illness – one study found 60% of people receiving secondary mental health care smoked (Wu et al., 2013). Diet, physical activity and alcohol consumption all potentially have an important role too. It may also be the case that those with mental illnesses are less likely to seek help or access preventative services, such as screening (Hotopf & McCracken, 2014).

4.3.2aWhat works?

- ***Physical Health Assessments***

NICE guidance recommends that there is monitoring of the physical health of individuals with serious mental illness, and that support should be offered where needed around stopping smoking, weight and lipid management(NICE, 2014)(NICE, 2014). Further NICE Guidance (PH48) published in 2013 gives recommendations for smoking cessation in secondary care settings including mental health services.

- ***Physical Activity***

Being physically active has an important role in preventing and managing a range of conditions, including mental health problems(NICE, 2014). In particular NICE recommend tailored and structured exercise programmes for the management and rehabilitation from depression. Physical activity can also have a positive effect on mood and provide relief from stress(NICE, 2014).

- ***Social Prescribing***

Social prescribing refers to the linking of patients to non-medical sources of support within the community(Community Services Improvement Partnership, 2009). Examples of this type of support include exercise referral schemes, arts on prescription, volunteering and books on prescription. As this covers such a broad spectrum of interventions with varying levels of evidence base, it is important to ensure work in this field has robust evaluation measures in place. A local evaluation of Arts on Prescription showed positive levels of results for those with mild-to-moderate anxiety and/or depression including around social isolation(Potter, 2013). In addition, a recent report on the role of the natural environment in reducing health inequalities gave an overview of the role within mental health (Allen & Balfour, 2014). There is recognition though in several areas of social prescribing that larger scale studies are required to give a comprehensive overview of the key requirements of successful projects.

4.3.2b Existing Services

Services for with people with severe mental illness

Physical Health Forum

- Hosted by Cambridgeshire and Peterborough Mental Health Trust
- Multi-agency staff working on mental health to discuss the physical health need of mental health service users across Cambridgeshire (at Fulbourn hospital and in the community).
- Includes smoking cessation, physical health assessments, dietary support and opportunities to engage in physical activity in hospital and in the community.

Smoking Cessation

- There is a Stop Smoking Advisor working in the secondary mental health

Social Prescribing in Cambridgeshire

Arts on Prescription - Arts & Minds provide weekly sessions for people with mild to moderate anxiety and depression in areas of Cambridgeshire.

Reading Well: Books on Prescription - This initiative enables GPs and other health professionals to recommend self-help titles (covering issues such as anxiety, depression, phobias, panic attacks, bulimia and sleep problems) for people to borrow from their local library.http://www.cambridgeshire.gov.uk

Naturally Healthy Subgroup– A multi-agency venture to build a recognised robust methodology for work utilising the benefits of the natural environment on health. A strategic group has been formed, including representation from the Centre for Diet and Activity Research (CEDAR) and Natural England, that will take this forward and look to obtaining a research grant. The project hopes to include (in some cases building on existing work):

- Healthy Walks Scheme
- Horticultural Therapy
- Fit for Nature
- Forest Schools

These groups will/do cater for individuals with a variety of conditions, including mental illness. There would be the option of self-referral but it could also be used

4.3.2cProposals

C. **Wider support for those with mental health problems** e.g. physical health problems

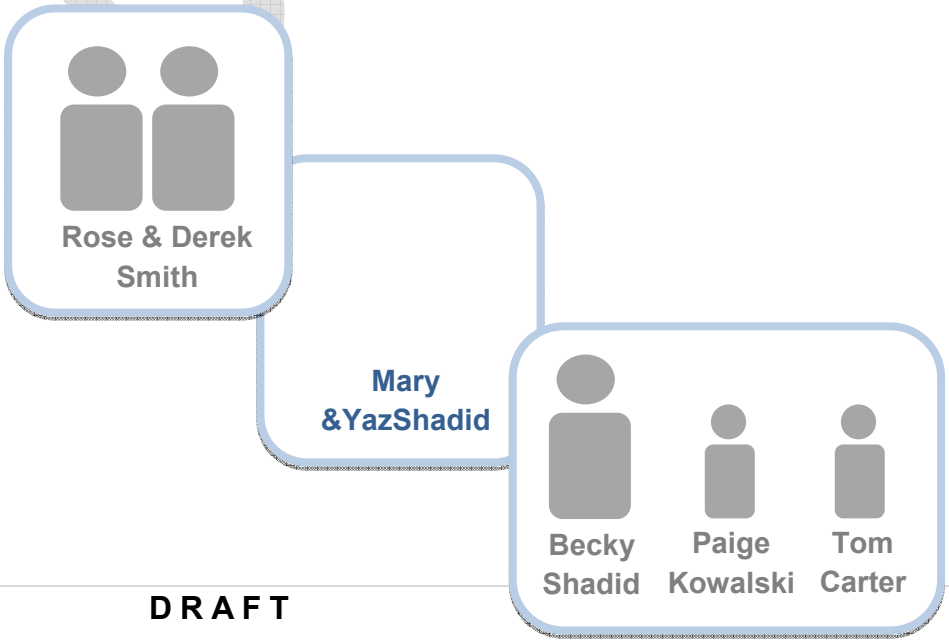
1. Cambridgeshire Public Health Stop Smoking Team (CamQuit) will focus on ensuring that employees that are working in community mental health teams are accessing the Level 2 smoking cessation training, which will also enable continuing support post-discharge for those trying to quit smoking.
2. Cambridgeshire Public Health Stop Smoking Team (CamQuit) will focus on increasing referrals to the stop smoking service from secondary care and community mental health settings.
3. Work towards a more coordinated approach of health improvement interventions (smoking cessation, physical activity and weight management) for those who are living with mental illness. In particular, this will require countywide mapping of provision in terms of services to promote better physical health of those with poor mental health or mental illness.
4. Additional focused initiatives to support the physical health of those with serious mental illness, through preventive lifestyle interventions, such as tailored physical exercise programmes. This is a likely area of investment given the limited services available.
5. Contribute to the evidence base for social prescribing initiatives through the Naturally Healthy Subgroup and apply knowledge gained from this work.
6. Promote wider awareness of community provisions and sources of reliable information to healthcare professionals, enabling them to signpost patients with greater confidence.

Consultation Questions

1. Are there any evidence based examples of 'what works' that we have not included here?
2. What do you think of the proposed areas of action? Is there anything additional we should focus on?

5. What does the Public Mental Health Strategy Mean for Me?

The following example will be used to demonstrate how the work of this strategy may impact upon the lives of one fictional family. Similarly, this family will be used within the Adult Mental Health Social Care Strategy to illustrate how the strategy can impact upon individuals.

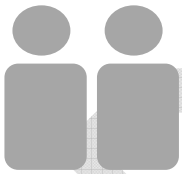


Rose(78 years old) and **Derek Smith**(75 years old) have lived together in Wisbech for over 40 years. Derek cares for Rose who was diagnosed with dementia 3 years ago.

Rose and Derek have a daughter, **Mary** (50 years old) who lives in Ely together with her husband **Yaz**(52 years old). Yaz has chronic psychosis and is currently unable to work. Mary can find it difficult to hold down employment as she needs to provide support and care for Yaz.

Mary and Yaz have a daughter called **Becky** (30 years old) who is a single parent and lives in Sawston with her daughter **Paige** (14 years old) and her son **Tom** (4 years old). Becky works as a dinner lady in a local school to fit with childcare, she struggles financially and has run up some debt. Becky is under a lot of stress and is finding it difficult to cope with Tom's behaviour. She has very little support from Tom's father, contact is often erratic.Paige has been happy at school but recently has become withdrawn, and Becky suspects she is being bullied.

5.1 What might this family experience if we maximise public mental health opportunities?



Rose & Derek Smith

Derek and Rose feel supported in their local community. They can do their shopping without fear of how people may react to Rose's sometimes unpredictable responses to the world around her. There has been a local campaign to raise awareness of mental health problems and many of the local shop keepers have also undertaken mental health awareness training. Rose and Derek also really enjoy attending the

Mary &YazShadi

Mary's employer have recently introduced flexible working, this has really helped her as she can adapt her hours so that she can take Yaz to his check-ups at the GP. At work they have also introduced a new health programme which offers lunchtime exercise classes; she has decided to take up a dance class as she just doesn't get time to be active otherwise.

Although currently

Becky Shadid **Paige Kowalski** **Tom Carter**

Becky has been in regular contact with the Health Visitor (HV) who identified her postnatal depression and has since been a great source of support and advice. With Tom's behaviour becoming so unmanageable Becky enrolled herself on a parenting programme as suggested by her HV. This has helped her develop effective discipline strategies and improved her relationship with her son.

Some of the children at Paige's school have been

6.Delivering the Strategy

The consultation process will inform the action plan, adraft outline plan is given below but this will change as a result of the consultation feedback. The plan is for the first year of the strategy, actions highlighted in **blue**have already been agreed. A recurrent investment of £120k has been agreed in the 2015/16 business plan to support the implementation of the strategy.

Theme	Proposed action	Focus in year one of implementation	Timescale	Funding	Impact
A life course approach to promoting mental health	➢ Develop anti-bullying strategy ➢ Investigate mechanisms to support schools to implement whole school approaches to improving mental health and reducing stigma ➢ Maximise opportunities to promote mental health across early years	Development of a multiagency anti-bullying strategy. Self-assessment tool on mental health and wellbeing developed for secondary schools. Re-launch of 'Whole School Approach' training provided by CPFT. Development of early years mental health workforce strategy.	September-March 2015 For September 2015 For start of 2015 school year (September)	Funding needed to support the implementation of the anti-bullying strategy and further support for schools in implementing the 'whole school approach'. The findings of the work would ideally be built into individual organisations training plans.	A greater proportion of schools adopt and maintain a 'whole school approach' to mental health and access the free training on this. A greater proportion of schools implement effective anti-bullying strategies. That improvements in both these areas are reflected in the Health Related Behaviour Survey.
	➢ **Support expansion of the Time Credits Scheme**	Ongoing roll out of Time Credits Scheme.	For March 2015		
	➢ **Increase engagement of communities in addressing and improving their health and wellbeing.**	Identify and focus on securing support of community leaders for engaging their communities. Identify and agree across organisations only in Fenland approaches to engage	For March 2017 (3 year funding) For April 2016	Activities facilitated by staff from local authority directorates. Health Fenland Fund – investment from ear marked reserved.	Increase in number of communities actually engaged and leading interventions to impact their health and wellbeing.

		and work with communities. Establish a Healthy Fenland fund to support community led initiatives.			
	➢ Intervention during perinatal period to identify and treat patients is a focus in the refreshed Emotional Wellbeing and Mental Health Strategy for Children & Young People	Assessment of provision against NICE guidance. Area highlighted in revised Emotional Wellbeing and Mental Health Strategy for Children and Young People. Breastfeeding strategy developed considering attachment element.	By September 2015. By September 2015.	Funding implications dependent on the findings of the analysis.	In the very long term interventions at the perinatal stage improve lifelong outcomes for children. In the short term they could improve the health of the mother and parent-infant relationship.
	➢ Consider ways of enhancing Lifestyle Service/Community Navigators Service to enhance their role in relation to mental health	Action plan on what options available to enhance the role of lifestyle service and community navigators developed, including a focused role with SMI patients.	By September 2015.	Funding implications dependent on the enhancement options and existing contracting arrangements.	Community Navigator and lifestyle services are equipped to identify mental health issues and know how to deal with them. As a result more individuals that need help are identified and access treatment and community support. Additional lifestyle support for SMI patients should improve their life expectancy in the long term.

Developing a wider environment that supports mental health	➢ **Creation of new post to focus on workplace health at strategic level** ➢ Research and roll-out workplace standard ➢ Support anti-stigma campaigns, utilising workplaces and schools in particular ➢ Expand workplace health activity, particularly in areas of greatest deprivation or among highest need populations ➢ Utilise services that may come into contact with those with mental health problems to better identify those in need of support	Recruit to new post. Adopt a workplace standard. Additional multi-agency anti-stigma campaign run building on the Stop Suicide Campaign. Expand the workplace health programme. Continue to fund MHFA training for front line staff	Person in post by September 2015. By March 2016. Multi-agency campaign run in 2015/16 alongside the stop suicide Campaign. From September 2015 onwards. Approximately 300 staff trained.	Funding already identified for new workforce post. Additional funding needed for anti-stigma work and the mental health elements of an expanded workplace health programme. Existing programme.	Workplace health activity should improve mental health overall and reduce sickness absence for employers. Anti-stigma work should encourage open discussion about mental health issues and a wider community support structure. It is hard to quantify these impacts. The vast proportion of mental illness remains untreated and increased recognition and advice should mean more people receive the help they need.
Physical and mental health	➢ Improve the identification of those clients with a long term physical health condition and depression ➢ Upon identification of depressive symptoms ensure the timely offer of an appropriate psychological intervention ➢ Support the use of antidepressant therapy in the management of	Work to be taken forward through the CCG Transformation Programme.	In line with the CCG Transformation programme.	Funding implications to be considered in the CCG Transformation programme.	Numbers of patients with comorbid long term physical conditions identified and receiving treatment for mental health issues increasing. Measures might include referrals of those with LTCs to IAPT, and/or treatment through other routes.

	comorbid depression and long term health conditions, where clinically indicated ➢ Ensure timely access to multicomponent rehabilitation programmes incorporating exercise and psychological interventions				
	➢ Increase uptake of smoking cessation training by community mental health teams. ➢ Increase referrals to stop smoking service from secondary care mental health settings.	Action plan to be developed by stop smoking team including numbers of advisors trained within community mental health teams, and actions to improve the number of referrals from secondary care mental health setting.	Action plan by September 2015 with in-year targets.		Long term impact is a reduction in the gap in life expectancy in those with SMI compared to the general population. This is measured in the Public Health Outcomes Framework. Short term impact measures are likely to include numbers of staff in Community Mental Health Teams trained as stop smoking advisors, numbers of referrals into stop smoking services and the proportion of these who are quitters at 4 weeks.
	➢ More coordinated, and consistent county-wide, approach to health improvement interventions for those with mental illness	Mapping of structured exercise provision and other initiatives to support the physical health of people with SMI, gaps identified and recommendations made on how/where to improve access.	Mapping exercise complete by September 2015. Mapping work to feed into CCG transformation programme.	Funding will be needed to improve access cross county.	

Consultation Question: Given limited resources available, is the focus of this draft action plan right for the first year of the strategy?

7. Supporting Documents

Age UK. (2014). *Evidence Review: Loneliness.*

Allen, J., & Balfour, R. (2014). *Natural solutions for tackling health inequalities.*

Bauer et al. (2014). *The costs of perinatal mental health problems.* London: Centre for Mental Health.

Cambridgeshire Children's Trust. (2014). *Breaking the Cycle 2 (2014-17).*

Campaign to End Loneliness, & Age UK. (2015). *Promising Approaches to Reducing Loneliness and Isolation in Later Life.*

CCC/NHS Cambridgeshire PCT. (2010). *JSNA Cambridgeshire Travellers.*

Centre for Mental Health. (2013). *Barriers to employment: what works for people with mental health problems (briefing 47).*

Centre for Mental Health. (2015). *Investing in Children's Mental Health.*

Centre for Mental Health et al. (2012). *No Helath without Mental Health Implementation Framework.*

Community Services Improvement Partnership. (2009). *Social prescribing for mental health - a guide to commissioning and delivering.*

Corker et al. . (2013). Experiences of discrimination among people using mental health services in England 2008-11. *British Journal of Psychiatry*.

Dartmouth IPS Supported Employment Center. (2012). *Core Principles of IPS Supported Employment.*

Department of Health. (2012). *The Family Nurse Partnership Programme: Information Leaflet.*

Department of Health. (2014). *Annual Report of the Chief Medical Officer Public Mental Health Priorities: Investing in the Evidence.*

Department of Health. (2014). *Closing the Gap: Priorities for Essential Change in Mental Health.*

Department of Health. (2015). *Prime Minister's Challenge on Dementia 2020.*

DoH & Cabinet Office Social Exclusion Taskforce. (2010). *Inclusion Health Evidence pack.*

Domestic Abuse & Sexual Violence Partnerhsip. (2014). *Cambridgeshire Domestic Violence/Abuse Needs Assessment.*

Domestic Abuse & Sexual Violence Partnership. (2014). *Domestic Abuse Strategy v1.0 2014-18.*

Early Intervention Foundation. (2014). *Early Intervention in Domestic Violence and Abuse.*

Ford et al. (2014). *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence (Chapter 6).*

Gale et al. (2004). *Scoping review on Mental Health Anti-Stigma and Discrimination: Current activities and what works.* National Institute of Mental Health England.

Harris, C. (2014). *A Review of the Evidence Base for Mental Health Promotion in Schools: What works and what could be applied in Cambridgeshire.*

Harris, C. (2015). *A Literature Review of Bullying Interventions: To inform the Self-Harm Shared Priorities work at Cambridgeshire County Council.*

Henderson, M., & Madan, I. (2014). *Annual Report of the Chief Medical Officer 2013 (Chapter 10 Mental health and work).*

HMG/DOH. (2011). *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for All Ages.*

Hotopf, M., & McCracken, L. (2014). *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities; Investing in the Evidence (Chapter 13).*

Howard et al. (2014). *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence (Chapter 14).*

Howard, L., Shaw, J., Oram, S., Khalifeh, H., & Flynn, S. (2014). *Annual Report of the CMO 2013. Chapter 14 Violence & Mental Health .*

Jenkins, R., & Barry, M. (2007). *Implementing Mental Health Promotion vol.9.* Churchill Livingstone.

Kapp, M. M. (2011). *Mental Health Promotion and Mental Illness Prevention: The Economic Case.* London: Department of Health.

Knapp, M., & Lemmi, V. (2014). *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence (Chapter 9).*

Mental Health Wales. (n.d.). *What is serious mental illness?* Retrieved February 2015, from Mental Health Wales: http://www.mentalhealthwales.net/mhw/whatis.php

NHS Cambridgeshire, & CCC. (2013). *The Mental Health of Children and Young People in Cambridgeshire (JSNA).*

NHS England. (2015). *Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16.*

NICE. (2009). *Antisocial personality disorder: Treatment, management and prevention.*

NICE. (2009). *Depression in adults with a chronic physical health problem Clinical Guideline 91.*

NICE. (2009). *Depression in adults with a chronic physical health problem: Clinical Guideline 91.*

NICE. (2009). *Promoting mental wellbeing at work (PH22).*

NICE. (2011). *Commissioning Stepped Care for People with Common Mental Health Disorders.*

NICE. (2012). *Social and emotional wellbeing: early years (PH40).*

NICE. (2014). *Antenatal and postnatal mental: clinical managment and service guidance (CG192).*

NICE. (2014). *Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care (CG185).*

NICE. (2014). *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (PH50).*

NICE. (2014). *Exercise referral schemes to promote physical activity (PH54).*

NICE. (2014). *Psychosis and schizophrenia in adults: treatment and management (CG178).*

Nocon, A. (2006). *Background evidence for the DRC's formal investigation into health inequalities experienced by people with learning disabilities and/or mental health problems.*

ONS. (2003). *The mental health of young people looked after by local authorities in England.* London: TSO.

ONS. (2014). *Sickness Absence in the Labour Market.*

Pennant, M., & De Zoete, E. (2014). *Interventions for child behaviour: research literature review.*

Potter, S. (2013). *Arts on prescription: 2010-12 Evaluation Report.*

Public Health Solutions (Commissioned by CCC). (2014). *Cambridgeshire JSNA: Older People's Mental Health .*

Rees, S. (2009). *Mental ill health in the adult single homeless population: a review of the literature .* London: Crisis.

Scottish Intercollegiate Guidelines Network. (2010). *116 Management of Diabetes - A National Clinical Guideline .*

Singleton, N. et al. . (1998). *Psychiatric morbidity among prisoners in England and Wales.*

Stansfeld et al. (2014). *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence (Chapter 7).*

Stewart-Brown, S. (2006). *What is the evidence on school health promotion in improving health or preventing disease and, specifically what is the effectiveness of the health promoting schools approach. Editors: WHO Regional Office for Europe Health Evidence Network (HEN).*

The Kings Find and Centre for Mental Health. (2012). *Long Term conditions and mental health. The cost of co-morbidities.*

Thornicroft et al. (2014). *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence (Chapter 11).*

Warwickshire County Council. (2014). *Public Mental Health & Wellbeing Strategy 2014-16.*

Weare, & Nind. (2011). *Promoting the mental health of children and adolescents through schools and school based intervnetions: evidence outcomes report of the work package Three of the Davaprev Project 2011.*

WHO. (2012). *Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors.*

WHO. (2013). *Mental Health Action Plan 2013-2020.*

Wu et al. (2013). Evaluation of Smoking Status Identification using Electronic Health Records and Open-Text Information in a Large Mental Health Case Register. *PLoS one*.

Glossary

Domestic Abuse: Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality (Domestic Abuse & Sexual Violence Partnerhsip, 2014).

Severe mental illness(SMI) includes diagnoses which typically involve psychosis or high levels of care, and which may require hospital treatment. Typically this includes schizophrenia and bipolar disorder(Mental Health Wales).

Family Nurse Partnership: A voluntary, preventive programme for vulnerable young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two. The aim is to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency (Department of Health, 2012).

Multi-systemic therapy: Using strategies from family therapy and behaviour therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people(NICE, 2009).