

# Joint Commissioning Panel for Mental Health

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## Guidance for commissioning public mental health services

Practical mental health commissioning	

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## Ten key messages for commissioners

- 1 Mental disorder is responsible for the largest burden of disease in England – 23% of the total burden, compared to 16% for cancer and 16% for heart disease<sup>1</sup>.
- 2 Mental disorder affects more than 1 in 4 of the population at any one time<sup>2,3</sup> and costs the English economy an estimated £105 billion a year<sup>4</sup>.
- 3 Mental wellbeing is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour.
- 4 Mental disorder starts at an early age and can have lifetime consequences. Opportunities to promote and protect good mental health begin at conception and continue throughout the life-course, from childhood to old age.
- 5 Improved mental wellbeing and reduced mental disorder are associated with
  - better physical health
  - longer life expectancy
  - reduced inequalities
  - healthier lifestyles
  - improved social functioning
  - better quality of life
- 6 Public mental health involves:
  - a) an assessment of the risk factors for mental disorder, the protective factors for wellbeing, and the levels of mental disorder and wellbeing in the local population
  - b) the delivery of appropriate interventions to promote wellbeing, prevent mental disorder, and treat mental disorder early
  - c) ensuring that people at 'higher risk' of mental disorder and poor wellbeing are proportionately prioritised in assessment and intervention delivery.
- 7 Good evidence exists for a range of public mental health interventions. These can reduce the burden of mental disorder, enhance mental wellbeing, and support the delivery of a broad range of outcomes relating to health, education and employment.
- 8 Public mental health is a central part of the work of Health and Wellbeing Boards, which are responsible for developing strategic plans to address the public health of a local population.
- 9 Despite evidence based interventions with a broad range of impacts, only a minority of people with a mental disorder currently receive any treatment. Furthermore, spending on the prevention of mental disorder and promotion of mental health represents less than 0.001% of the annual NHS mental health budget<sup>6</sup>.
- 10 Investment in the promotion of mental wellbeing, prevention of mental disorder and early treatment of mental disorder results in significant economic savings even in the short term<sup>5</sup>. Due to the broad impact of mental disorder and wellbeing, these savings occur in health, social care, criminal justice and other public sectors.

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### Endorsed by:



# Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) ([www.jcpmh.info](http://www.jcpmh.info)) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. It brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- Afiya Trust
- Association of Directors of Adult Social Services
- British Psychological Society
- Department of Health
- Healthcare Financial Management Association
- Mental Health Providers Forum
- Mind
- National Involvement Partnership
- National Survivor User Network
- New Savoy Partnership
- NHS Confederation
- Representation from Specialised Commissioning
- Representatives of the English Strategic Health Authorities
- Rethink Mental Illness
- Royal College of Nursing
- Service users and carers.

The JCP-MH is part of the implementation arm of the government mental health strategy *No Health without Mental Health*<sup>7</sup>.

The JCP-MH has two primary aims:

- to bring together service users, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, service user and carer experience and viewpoints, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published *Practical Mental Health Commissioning*,<sup>8</sup> a briefing on the key values and principles for effective mental health commissioning
- provides practical guidance and a developing framework for mental health
- will support commissioners of public mental health to deliver the best possible outcomes for community health and wellbeing
- has published a series of short guides describing 'what good looks like' in various mental health service settings.



## WHO IS THIS GUIDE FOR?

This guide is about the commissioning of good quality public mental health interventions and should be of value to:

- Health and Wellbeing Boards (HWBs) – these will have a key role in transforming health and care and achieving better population health and wellbeing through their responsibility for preparing Joint Strategic Needs Assessments (which should be strategic and take account of the current and future health and social care needs of the entire population)<sup>9</sup>, Joint Strategic Asset Assessments and Joint Health and Wellbeing Strategies
- Clinical Commissioning Groups (CCGs) and Local Authorities – as they will jointly lead the local healthcare system through Health and Wellbeing Boards and in collaboration with their communities
- the NHS Commissioning Board – as this will support and hold to account the work of CCGs
- Public Health England – as reducing mental disorder and promoting wellbeing is an important part of its role and contributes to a range of other public health priorities, as underlined by the public health white paper which signalled a new approach for public health by positioning mental health as an integral and complementary part of the proposed new direction for public health in England<sup>10</sup>
- service providers – these include those in primary and secondary care, social care, public health, local authorities, third sector social inclusion providers, education providers, employers, the criminal justice system and services working in offender mental health.

## HOW WILL THIS GUIDE HELP YOU?

This guide has been written by a group of public mental health experts, in consultation with patients and carers.

The content is primarily evidence-based but ideas deemed to be best practice by expert consensus have also been included. By the end of this guide, readers should be more familiar with the concept of public mental health and better equipped to:

- understand the impact of mental disorder and wellbeing, what proportion of a local population is at increased risk of mental disorder and poor wellbeing, and what proportion is affected by mental disorder and poor wellbeing
- understand what proportion of the local population (including from higher risk groups) is receiving interventions to promote wellbeing, prevent mental disorder and treat mental disorder
- understand what good quality public mental health interventions look like
- commission public mental health interventions
- estimate the local impact of such interventions, including economic savings
- understand how and why good public mental health interventions contribute to achieving the aims of both the mental health, public health, NHS, and social care strategies, as well as improving quality and productivity.

## DEFINITIONS

The terms ‘mental illness’, ‘mental disorder’ and ‘mental wellbeing’ are used in this document with the following definitions:

- **mental illness** – this refers to depression and anxiety (which may also be referred to as ‘common mental disorder’) as well as schizophrenia and bipolar disorder (which may also sometimes be referred to as severe mental illness)
- **mental disorder** – this includes mental illnesses as well as personality disorder and alcohol and drug dependency
- **mental health and wellbeing** – this refers to a combination of feeling good and functioning effectively. The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence and affection. The concept of functioning effectively (in a psychological sense) involves the development of one’s life, having a sense of purpose such as working towards valued goals, and experiencing positive relationships<sup>61</sup> (Appendix C1).

# What is public mental health?

## WHAT IS PUBLIC HEALTH?

Public health is about improving the health of the population through preventing disease, prolonging life and promoting health (box 1). It achieves these aims by working in partnership with public, private and voluntary sector organisations and with communities and individuals.

### BOX 1: PUBLIC HEALTH

#### Preventing disease

Prevention can occur at three levels:

- 1 Primary prevention aims to *prevent ill health happening* in the first place by addressing the wider determinants of illness and using 'upstream' approaches that target the majority of the population
- 2 Secondary prevention involves the early identification of health problems and *early intervention to treat and prevent* their progression
- 3 Tertiary prevention involves working with people with established ill health to *promote recovery and prevent (or reduce the risk of) recurrence*.

#### Promoting health

Similarly, promotion can also occur at three levels:

- 1 Primary promotion involves promoting the health and wellbeing of the *whole population*
- 2 Secondary promotion involves targeted approaches to groups that have (or are at higher risk of) poor health and wellbeing
- 3 Tertiary promotion targets groups with established health problems to help promote their recovery and prevent recurrence.

Health promotion interventions target the determinants of health and wellbeing rather than illness itself. They can take place at an individual, community or structural level.

Their aim is to improve individual wellbeing, enable healthier and more sustainable communities, facilitate environments which support improved health, and achieve structural changes in policy and law which benefit health and reduce health inequalities.

There is some overlap with interventions to treat disorder, as effective treatment of disease also promotes wellbeing.

## WHAT IS PUBLIC MENTAL HEALTH?

Public mental health :

- *provides intelligence* about levels of mental disorder and wellbeing across populations, together with information about the risk and protective factors
- *informs delivery of interventions* which promote wellbeing, prevent mental disorder, and which identify and treat it at the earliest possible opportunity
- *contributes towards improved health and wellbeing* and reduced mental disorder
- *improves a range of key outcomes* (NHS, public health, and social care)
- *reduces the costs of mental disorder and increases the economic benefits of wellbeing* both to the NHS and local authorities and to the wider national economy
- *and achieves this through collaboration* between the broad range of organisations and agencies whose activities are concerned with and/or influence mental health and wellbeing.

Public mental health is fundamental to public health and health improvement<sup>12</sup>. As the title of the Government mental health strategy declares, there is "no health without mental health"<sup>7</sup>. Good mental health provides the bedrock for good physical health and for a range of other important life skills, capacities and capabilities.

### Intelligence is key

Public mental health intelligence is critical.

Such intelligence should underpin any *Joint Strategic Needs Assessment* (JSNA). Every JSNA should describe the current and future mental and physical health needs of the local population, and be used to guide commissioning decisions about where to target investment to achieve most health gain.

Further information on the intelligence needed for any effective JSNA can be found on [page 25](#), while a detailed JSNA checklist for public mental health interventions can be found in [Appendix G](#).

### Interventions follow from intelligence

Public health intelligence helps decide which interventions to commission ([box 2](#)).

When used in combination, promotion, prevention and early intervention can reduce the burden and cost of mental disorder, and improve health and wellbeing.

This approach is central to the mental health strategy which aims to<sup>7</sup>:

- promote wellbeing across the population (also reducing future levels of mental disorder)
- ensure early treatment for people with mental disorder (also improving their wellbeing).

This combined approach is important for two reasons. Firstly, on its own, the treatment of mental disorder can only partly reduce the individual, social and economic burden – prevention and promotion activities are also needed<sup>13</sup>. Second, on their own, even well resourced mental health promotion

interventions which cover people with existing mental disorders are unlikely to result in the recovery of these people – appropriate treatment is also needed.

Further information on public mental health interventions (including the evidence to support these) can be found on [page 36](#), while a more detailed account is given in [Appendix E](#).

### Collaboration is at the heart

Effective public health approaches recognise that illness, health and wellbeing are influenced by a broad range of social, cultural, economic, psychological, and environmental factors at every stage of the life course.

Because of this, they use a combination of different interventions delivered by a range of partners in different settings. Collaboration is at the heart of this. Partnerships will include:

- public health services
- primary care services (including community-based mental health professionals)
- secondary care services (including community-based mental health professionals)
- social care providers
- education providers
- employers
- criminal justice services
- local authorities
- environmental planners
- third sector providers
- community organisations
- government departments.

Local Authorities are the public sector organisation with lead responsibility for public health and public mental health, and need to co-ordinate and achieve this collaboration.

### BOX 2: PUBLIC MENTAL HEALTH INTERVENTIONS

Mental health promotion interventions focus on increasing mental health and wellbeing including:

- starting well
- developing well
- living well
- working well
- ageing well.

Prevention interventions prevent mental illness and a range of associated issues including:

- mental disorder and dementia
- health risk behaviour
- inequality
- discrimination and stigma
- suicide
- violence and abuse.

Early intervention occurs in the following areas:

- treatment of mental disorder and sub-threshold mental disorder
- promotion of physical health and prevention of health risk behaviour in those developing mental disorder
- promotion of recovery through early provision of a range of interventions
- recognition of mental disorder.

## Why is public mental health important to commissioners?

There are ten reasons why public mental health is important to commissioners.

### the issues

- 1 mental disorder has a range of significant impacts
- 2 mental disorder results in economic costs (and is costly to treat)
- 3 levels of mental disorder are projected to increase
- 4 mental wellbeing has a broad range of impacts.

### the solutions

Public mental health interventions:

- 5 reduce the impact of mental disorder and poor wellbeing (and produce a broad range of benefits associated with improved wellbeing)
- 6 deliver large economic savings and benefits
- 7 reduce health and social inequalities
- 8 help achieve parity of mental health with physical health
- 9 support the delivery of a broad range of outcomes
- 10 achieve all this by drawing on key intelligence.



## 1 Mental disorder has a range of significant impacts

Nearly a quarter (23%) of the total burden of disease in the UK is attributable to mental disorder ([Appendix A2.1](#)). This compares to 16% for cardiovascular disease and 16% for cancer<sup>1</sup>.

The burden is due to the fact that:

### Mental disorders are very common

- 10% of 5 to 16 year-olds have a mental disorder<sup>14</sup>
- 18% of adults have a common mental disorder, 6% alcohol dependence and 3% drug dependence<sup>3</sup>
- 25% of older adults have depression requiring intervention<sup>15</sup>
- dementia affects 20% of people aged over 80<sup>16</sup>
- certain groups are at a several-fold higher risk of mental disorder (see [page 29](#)).

### Mental disorders arise early in the life course

This impacts on a young person's development, and stops them realising their potential. Furthermore, mental disorders often last for a long period of time:

- 50% of lifetime mental illness (except dementia) arises by age 14<sup>17,18</sup>
- 75% of lifetime mental illness arises by the mid-20's<sup>19</sup>
- 40% of young people experience at least one mental disorder by age 16<sup>20</sup>.

## Mental disorders result in broad range of impacts

Mental disorder in childhood and adolescence ([Appendix A2.2](#)) is associated with:

- poorer health, poorer social skills and lower levels of educational attainment<sup>14</sup>
- higher risk of self-harm and suicide<sup>21,22</sup>
- several fold higher levels of health risk behaviour including smoking, alcohol consumption and drug misuse<sup>14</sup>
- higher rates of antisocial and offending behaviour and violence<sup>22,23</sup>.

Mental disorder in childhood leads to poorer outcomes and inequalities in adulthood:

- higher levels of unemployment and lower earnings<sup>22</sup>
- higher risk of crime and violence<sup>22</sup>
- higher risk of adult mental disorder<sup>22,25,26</sup>.

Mental disorder during adulthood leads to poorer outcomes and inequalities:

- poorer educational achievement<sup>27</sup>
- higher risk of homelessness<sup>28</sup>
- higher unemployment<sup>29</sup>
- higher rates of debt problems<sup>30</sup>
- increased suicide and self harm levels<sup>31</sup>
- increased health risk behaviours, including poor diet, and less exercise ([Appendix 2.6](#))

- higher prevalence of smoking, drug and alcohol misuse ([Appendix 2.6](#))
- increased risk of physical illness (e.g. depression is associated with an increased risk of coronary heart disease and diabetes)<sup>32,33,34</sup>
- reduced life expectancy – for example, depression is associated with a 50% increased mortality from all disease<sup>35</sup> and reduced life expectancy of around 11 years in men and seven years for women<sup>36</sup>; schizophrenia is associated with increased mortality from all disease<sup>31</sup> and a reduced life expectancy of around 21 years for men and 16 years for women<sup>37</sup>.

These impacts on health and attainment are also transmitted across generations. For example, the children of a mother with depression are at a five-fold increased risk of conduct disorder<sup>38</sup>, which in turn is associated with an increased risk of mental disorder during adulthood<sup>22,25</sup>.

Stigma and discrimination are also important – many service users identify stigma as the main cause of social exclusion (above poverty, isolation, and homelessness)<sup>39</sup>. This exclusion can be compounded further by accompanying discrimination due to ethnicity, cultural background or sexuality<sup>40,41</sup>.

[Appendix A](#) contains further information on the burden and impacts of mental disorder. [Appendix B](#) describes levels of mental disorder and [Appendix D](#) outlines the risk factors for mental disorder (including higher risk groups).

## 2 Mental disorder results in economic costs (and is costly to treat)

The annual cost of mental disorder in England is estimated at £105 billion<sup>4</sup>. By comparison, the total costs of obesity to the UK economy are £16 billion a year<sup>42</sup> and £31 billion for cardiovascular disease<sup>43</sup>.

In 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget<sup>44</sup>.

Please see [Appendix A](#) for further data on the costs of mental disorder.

## 3 Levels of mental disorder are projected to increase

By 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million<sup>45</sup>. However, this does not take account of the current economic climate which is likely to increase prevalence.

## 4 Mental wellbeing has a broad range of impacts

Mental wellbeing is associated with a range of important health benefits, including:

- improved resilience and ability to cope with adversity
- reduced emotional and behavioural problems in children and adolescents<sup>46</sup>
- reduced levels of mental disorder in adulthood<sup>47,48</sup>
- reduced suicide risk<sup>49</sup>
- better general health<sup>50</sup>
- less use of health services and reduced mortality in healthy people and in those with established illnesses.

Improved wellbeing also has important non-health benefits including:

- improved educational outcomes<sup>53,54</sup>
- healthier lifestyle and reduced health risk behaviour<sup>51</sup> including reduced smoking and harmful levels of drinking<sup>55</sup>
- increased productivity at work<sup>56,57</sup>, reduced absenteeism<sup>58,59</sup> and reduced burnout<sup>51</sup>
- higher income<sup>51</sup>
- stronger social relationships<sup>51,52,60</sup>
- increased social/community participation<sup>61</sup>
- reduced antisocial behaviour, crime and violence<sup>62,23</sup>.

The wide range of impacts of wellbeing also have economic impacts as a result of greater success in education and work, higher income, improved physical health and longer life expectancy (see [Appendix A](#)).

The UK has poor wellbeing compared to other countries – for example, the UK is ranked 24th out of 29 European countries for child wellbeing<sup>63</sup>.

## 5 Public mental health interventions reduce the impact of mental disorder and poor wellbeing (and produce a broad range of benefits associated with improved wellbeing)

Good evidence exists for a range of public mental health interventions which can<sup>12,64,65</sup>:

- promote wellbeing and resilience with resulting improvements in physical health, life expectancy, educational outcomes, economic productivity, social functioning, and healthier lifestyles
- prevent mental disorder, health risk behaviours and associated physical illness, inequalities, discrimination and stigma, violence and abuse, and suicide

- prevent suicide
- deliver improved outcomes for people with mental disorder as a result of early intervention approaches.

Good public mental health commissioning involves a balance between promotion, prevention, and early intervention activities. The evidence for public mental health interventions is described in [Appendix E](#).

## 6 Public mental health interventions deliver large economic savings and benefits

Public mental health interventions result in:

- economic savings by reducing the costs of mental disorder through prevention and improved outcomes as a result of early intervention
- economic savings associated with improved wellbeing, such as reduced welfare dependency, reduced use of health and social care services, less crime and greater social cohesion
- economic savings resulting from reduced health risk behaviour and subsequent physical illness
- economic benefits associated with improved wellbeing due to improved educational outcomes, higher employment rates, and greater economic productivity.

Economic savings and benefits:

- can occur within *short time frames*
- occur within and outside healthcare services – a significant proportion of savings often occur outside the health sector, such as education, employment and criminal justice
- arise from co-ordination and planning with other services to encourage them to co-invest in interventions in order to benefit from these savings.

The mental health strategy<sup>7</sup> highlights the significant economic savings that can be made from public mental health interventions<sup>5,66</sup>, and their contribution to efficiency savings in NHS and social care quality and productivity.

The type of savings which can be made from public mental health interventions are highlighted by a recent Department of Health report<sup>5</sup>. This found that for every £1 invested, the net savings were:

- £84 saved – school-based social and emotional learning programmes
- £44 saved – suicide prevention through GP training
- £18 saved – early intervention for psychosis
- £14 saved – school-based interventions to reduce bullying
- £12 saved – screening and brief interventions in primary care for alcohol misuse
- £10 saved – work-based mental health promotion (after 1 year)
- £10 saved – early intervention for pre-psychosis
- £8 saved – early interventions for parents of children with conduct disorder
- £5 saved – early diagnosis and treatment of depression at work
- £4 saved – debt advice services.

Further examples of cost-savings are provided in [box 3](#) (overleaf).

## 7 Public mental health interventions reduce health and social inequalities

As described on [page 9](#), mental disorder is associated with poor health outcomes and wider social inequalities. In contrast, wellbeing is associated with a broad range of benefits.

Since inequality underpins many of the risk factors for mental disorder, interventions which address and prevent health and social inequalities can also prevent mental disorder and poor wellbeing. Mental disorder results in a further range of inequalities which can also be prevented by:

- early identification and treatment of mental disorder
- early interventions for health risk behaviours which are more common in those with mental disorder
- early treatment of physical illness in those with mental disorder
- targeted wellbeing promotion to facilitate recovery of those with mental disorder.

Public mental health interventions can therefore reduce and prevent health and social inequalities which impact on individuals, communities and higher risk groups now and among future generations.

See [Appendix A](#) for further information of the links between mental disorder, mental health and wellbeing and health and social inequalities.

## 8 Public mental health interventions can help achieve parity with physical health

Public mental health intelligence can highlight the lack of parity between mental and physical health, while public mental health interventions can help achieve parity.

This absence of parity (and accompanying solutions) cover five areas:

- A** access to treatment for different mental disorders: compared to physical illnesses, and excluding psychosis, only a minority of those with mental disorder in the UK receive any intervention<sup>3,14,82</sup>. Addressing poor levels of access to health care for people with mental disorder improves parity.
  - B** access to primary care: people with mental disorders also have poorer access to primary care, and to health promotion interventions, with a four-fold reduction in rates of primary care consultation in those with severe mental illness over the last 20 years<sup>83</sup>.
  - C** treatment of physical illness: levels of treatment for physical illness in those with mental disorder are much lower compared to those without mental disorder<sup>84,85</sup>. Improved parity results in improved mental and physical health.
  - D** access to interventions to address health risk behaviour: people with mental disorder access such interventions much less than those without mental disorder, despite their much higher rates of health risk behaviour (e.g. smoking).
  - E** access to public mental health interventions: there is almost no spend on these interventions in the UK despite good evidence for effectiveness<sup>6</sup>.
- Important steps towards parity include monitoring and improving access to interventions to:
- treat and prevent mental disorder
  - promote mental health.
  - address health risk behaviour in those with mental disorder
  - address physical health in those with mental disorder.

### BOX 3: SELECTED ECONOMIC SAVINGS

#### Mental health promotion

- £4 saved for every pound spent on debt advice<sup>5</sup>
- £10 saved for every pound spent – work-based mental health promotion after a year<sup>5</sup>
- £17 saved for every pound spent – pre-school educational programmes for 3-4 year olds in low-income families<sup>67,68,69</sup>
- £235 per person – befriending services annual net savings<sup>5</sup>
- £850 per member – timebanks annual net savings<sup>70</sup>
- £5,000 – £12,000 per Quality Adjusted Life Year – walking and physical activity programmes in older people to promote mental wellbeing<sup>71</sup>
- For people recovering from mental illness:
  - £6,000 per person – annual savings from employment support (Individual Placement and Support) for people with severe mental illness<sup>72</sup>
  - £11,000 – £20,000 per person – annual savings from housing schemes for men with enduring mental illness<sup>73</sup>
  - £120,000 per person – annual savings from supported housing for women with multiple complex needs<sup>74</sup>.

#### Economic savings from prevention

- £14 saved for each pound spent – school-based interventions to reduce bullying<sup>5</sup>
- £84 saved for each pound spent – prevention of conduct disorder through school-based social and emotional learning programmes<sup>5</sup>
- £421 saved per person with depression – stigma prevention campaigns<sup>76</sup>
- £829 and £6,446 saved – school-based violence prevention programmes with net savings six and ten years after the programme began<sup>75</sup>
- £380 million each year – the NHS saves £380 million a year through reductions in smoking rates and reduced hospital admissions for lung cancer and other smoking related diseases<sup>79</sup> and is important to target people with mental disorder, as 42 % of adult tobacco consumption is by people with mental disorder<sup>80</sup>.
- £568 million – suicide prevention through GP training results in net savings of £44 for every £1 invested<sup>5</sup> (if offered to all GPs in England, it could deliver net savings of £568m after one year)
- £3.1bn and £7.1bn – reducing affordability is an effective way of reducing alcohol-related harm<sup>77</sup> (over 10 years, a minimum price of 40p and 50p per unit could result in savings of £3.1 billion and £7.1 billion respectively<sup>78</sup>).

#### Economic savings from early intervention for mental disorder

- £1.75 for every pound spent – Cognitive Behavioural Therapy for people with Medically Unexplained Symptoms (MUS), with NHS savings by year two<sup>5</sup>
- £5 for every pound spent – diagnosis and treatment of depression at work after one year<sup>5</sup>
- £8 for every pound spent – training interventions for parents of children with conduct disorder<sup>5</sup>
- £10 for every pound spent – early intervention during the prodromal phase of psychosis (net savings begin from year 2)<sup>5</sup>
- £12 for every pound spent – screening and brief interventions in primary care for alcohol misuse<sup>5</sup>.
- £18 for every pound spent – early intervention in psychosis (net savings begin from one year)<sup>5</sup>
- £55,200 per participant – early intervention for looked after children with mental disorder through multi-dimensional treatment foster care reduces crime by 18%, with associated net savings per participant of the equivalent of £55,220<sup>81</sup>.

Government also has an important role to ensure:

- appropriate funding to address the current burden of mental disorder, as only a minority receive interventions and significant cuts will reduce this proportion even further
- appropriate funding to facilitate investment in prevention and promotion given the significant economic savings even in the short term
- wider policy initiatives do not increase inequality and associated mental disorder and poor wellbeing particularly for higher risk groups.

## 9 Public mental health can support the delivery of a broad range of outcomes

Improved mental health and reduced mental disorder is associated with important health and non-health benefits. Non-health benefits include higher educational achievement, reduced unemployment and worklessness, reduced reliance on welfare and disability benefits, higher productivity in the workplace, reduced crime and antisocial behaviour and better social relationships and community involvement.

These all contribute to important national outcome measures across government departments and result in significant savings to the public purse.

There is also an *economic cost of not providing interventions*. Various sections of the mental health strategy<sup>7</sup> highlight the significant economic savings. Savings from public mental health interventions<sup>5,66</sup> can help meet the challenge to make efficiency savings in the NHS and promote quality and productivity. Future costs of mental disorder can be reduced through greater focus on whole-population mental health promotion, mental disorder prevention and early mental disorder treatment. The significant economic savings of promotion, prevention and early intervention need to be reflected in Payment by Results.

## 10 Public mental health intelligence informs effective commissioning

Public mental health intelligence informs the JSNA and commissioners about local:

- levels of mental disorder ([Appendix B](#)) and wellbeing ([Appendix C](#))
- risk factors for mental disorder and protective factors for mental wellbeing ([Appendix D](#))
- numbers from higher risk groups to enable targeting for mental health promotion, mental disorder prevention and intervention as soon as mental disorder arises (see [page 28](#))
- level of unmet need – only a minority with mental disorder except psychosis receive any intervention:

- for children and adolescents, only 30-40% of children and adolescents who experience clinically significant mental disorder have been offered evidence-based interventions at the earliest opportunity for maximal lifetime benefits<sup>14</sup>
- for adults, the proportion receiving any intervention is 24% with common mental disorder, 65% with psychotic disorder, 14% with alcohol dependence, 14% with cannabis dependence and 36% with dependence on other drugs<sup>3</sup>
- this situation is in contrast to cancer, where almost every person receives some form of intervention. Commissioners therefore need to draw on local intelligence about the numbers of people still requiring treatment for mental disorder, as well as the interventions required to prevent mental disorder and promote wellbeing.



# What do we know about current public mental health commissioning?

While the annual cost of mental disorder in England is £105 billion<sup>4</sup>, £12 billion was spent on NHS services to treat mental disorder in 2010/11 (11% of the NHS budget<sup>44</sup>). However, only a minority of those with mental disorder except psychosis receive any intervention<sup>3,14,82</sup>.

In England in 2010/11, only 3% of adults used hospital or community mental health services with wide variation between regions<sup>86</sup>. Therefore, primary care has a key role in improving detection and treatment of the majority of those with mental disorder (except psychosis) who receive no intervention but who could be referred to secondary care if required.

Only £3 million is spent annually on adult mental health promotion across England<sup>6</sup> – equivalent to less than 0.0005% of the mental health NHS budget. This lack of funding and strategic development does not reflect national Government policy (see below). There is also considerable regional variation in the commissioning and spend on public mental health<sup>59</sup>.

## Public health policy and mental health

The Public Health White Paper *Healthy Lives, Healthy People*<sup>10</sup> highlights the impact of mental disorder and wellbeing across the life course. It signals a new approach for public health and places mental health and wellbeing 'at the heart' of the new system, as an integral and complementary part of public health in England. It also highlights the key role of Directors of Public Health in public mental health.

*Healthy Lives, Healthy People* states that mental health and wellbeing influence a wide range of health and other outcomes.

The cross-Government public mental health strategy *Confident Communities, Brighter Futures*<sup>64</sup> describes a range of effective public mental health interventions to support this policy direction. Further, the Social Care Outcomes Framework<sup>87</sup>, NHS Outcomes Framework<sup>88</sup>, and the Public Health Outcomes Framework<sup>89</sup> include a large proportion relevant to public mental health.

From April 2013, public health will have a central role in the reorganised NHS in England at both local and national level. The Government has given Local Authorities responsibility for public health as they are regarded as better placed than the NHS to tackle the wider determinants of health, such as employment, education, housing and transport. This responsibility includes public mental health.

**At a national level**, Public Health England will provide leadership for the public health profession and support for Directors of Public Health. It will deliver, public health advice, guidance to improve health and wellbeing, and information to help CCGs and Local Authorities decide where to invest (or reduce) expenditure for public health.

**At a local level**, public health activity will be led by Local Authorities, who will be legally responsible for public health and will hold a ring-fenced budget to fund this work. It will be co-ordinated through HWBs, which will bring together those responsible locally for commissioning NHS, social care, public health and other services.

## Health and Wellbeing Boards and Clinical Commissioning Groups

Health and Wellbeing Boards have a key role in transforming health and care, and achieving better population health and wellbeing through the production of:

- Joint Strategic Needs Assessments (JSNAs), which will bring together into one report the current and future health and social care needs of the local population to inform health and social care planning and commissioning<sup>9,90</sup>
- Joint Health and Wellbeing Strategies (JHWSs) which will set out the local strategy and the priorities identified by the HWB to tackle the needs identified in their JSNAs.

The Government's ambitions for health and wellbeing clearly envisage CCGs and Local Authorities jointly leading the local health and care system through HWBs and in collaboration with their communities<sup>91</sup>. Elected councillors, directors of public health and clinicians will all play a part in helping their HWB understand the needs of the whole community and agree collective action to address those needs.

## NHS Commissioning Board

CCGs will be supported by, and held to account by, the NHS Commissioning Board. The Board will become fully operational, with full statutory responsibility, from April 2013.

## National mental health strategy and public mental health

The cross-Government mental health strategy *No Health without Mental Health*<sup>7</sup> takes a twin-track approach as did the previous Government mental health strategy *New Horizons*<sup>92</sup>. This approach combines early intervention for mental disorder with promoting the mental health of the whole population, with the overarching aim to reduce the total burden of mental disorder.

The importance of public mental health is reflected in *No Health without Mental Health*<sup>7</sup> which intends that:

- more people of all ages and backgrounds will have better wellbeing and good mental health
- fewer people will develop mental health problems
- wellbeing and good mental health are essential to reach our full potential
- the promotion of mental health, wellbeing and resilience is necessary for a more healthy, productive and fair society
- the prevention of mental health problems and promotion of mental wellbeing can significantly improve outcomes for individuals and increase the overall resilience of the population
- mental health is central to quality of life and economic success – wider government objectives for employment, education, training, safety and crime reduction, reducing drug and alcohol dependence and homelessness cannot be achieved without improvements in mental health
- mental health should be ‘everyone’s business’ – not just the concern of health and social care sectors but a priority for the whole Government and for employers, education services and third sector agencies

- to achieve this, mental health should be mainstreamed and should have ‘parity of esteem’ with physical health.

The mental health strategy takes a life-course approach and emphasises the importance of early intervention, patient choice and control (personalisation), reducing inequality, tackling stigma and monitoring outcomes. The strategy and subsequent policy development<sup>66,93</sup> also highlight improving quality and efficiency (QIPP) in the context of a challenging financial climate<sup>93</sup>.

## Mental health strategy implementation framework

The mental health strategy implementation framework<sup>94</sup> sets out the action local leaders should take to implement the strategy and ensure services work together ‘to promote wellbeing, to tackle the causes of mental ill health and to act quickly and effectively when people seek the support they need to make their lives better’.

The implementation framework explains what organisations and agencies can do to achieve the Government’s strategic goals for mental health and contribute towards the three relevant Outcomes Frameworks for the NHS, Public health and Adult Social Care. It also introduces a new national Mental Health Dashboard that brings together the most relevant measures from the three Outcomes Frameworks and elsewhere and maps them against the aims of the mental health strategy to provide a concise view of progress.

Health and Wellbeing Boards are specifically recommended to encourage joint commissioning between health and health-related services using pooled and community budgets and to consider the mental health impact of services and initiatives outside health and social care,

such as initiatives to address inequalities and social disadvantage. They are also encouraged to:

- ensure local mental health needs are properly assessed using the JSNA process and giving particular attention to seldom-heard groups
- ensure mental health receives priority equal to physical health
- bring together local partnerships including joint commissioning between health and health-related services
- involve local people and community groups in all aspects of development of JSNAs and JHWSs
- consider the mental health impact of services and initiatives beyond health and social care, to ensure recognition of the wider determinants.

Local Authorities are urged to:

- appoint an elected member as ‘mental health champion’ to raise awareness of mental health issues across the full range of the authority’s work
- assess how its strategies, commissioning decisions and directly provided services support and improve mental health and wellbeing (most areas of local authority responsibility can impact on mental health and wellbeing)
- consider using ‘whole place’ or community budgets to improve quality and efficiency of support offered to people with multiple needs including mental disorder
- sign up to the Time to Change campaign to tackle stigma in relation to mental disorder.

# What would good public mental health commissioning look like?

A good public mental health service supports the promotion of good mental health and wellbeing, the prevention of mental disorder and early intervention to treat mental disorder where it occurs. The components of such a service include the:

- *Public Mental Health Commissioning Cycle* – the process which underpins any effective public mental health service (box 3)
- *people and organisations central to this cycle* – good public mental health services are built upon capacity and relationships across different sectors
- *outcome measures on which a good public mental health service could be judged* – these include the NHS, Public Health, and Social Care Outcomes Frameworks, as well as relevant Commissioning for Quality and Innovation (CQUIN) standards.

## THE PUBLIC MENTAL HEALTH COMMISSIONING CYCLE

The commissioning of public mental health services should follow seven stages:

- 1 assess local need
- 2 assess local assets/resources
- 3 assess current service provision
- 4 intervention analysis
- 5 intervention plan
- 6 procurement of interventions
- 7 evaluation of the impact of interventions.

Each stage of the commissioning cycle requires close collaboration between local communities and the wider public, health and social care commissioners, the voluntary sector and other stakeholders including providers.

## 1 Assessment of local need

This involves commissioners using public health intelligence to understand the current and future mental health needs of the local population.

The collection and analysis of this intelligence is co-ordinated through a *Joint Strategic Needs Assessment*. The JSNA is key to understanding local health inequalities in the area, the wider determinants which influence these inequalities and unmet need, and how these impact on health and wellbeing outcomes across the community<sup>95</sup>.

JSNAs are both a *process* and a *product*. The JSNA process involves the collection of a range of quantitative and qualitative data to provide a comprehensive picture of the current and future health needs for adults and children.

The JSNA *product* is a report/publication which outlines unmet need and suggests how to improve health and wellbeing outcomes and help address persistent health inequalities.

The JSNA should include a minimum set of public mental health information including:

- levels of risk factors for mental disorder and poor wellbeing (including in higher risk groups)
- levels of protective factors for mental wellbeing
- numbers of people at higher risk of poor wellbeing and/or mental disorder
- levels and variability of mental wellbeing across the local population
- levels of, and numbers of, people with mental disorder (including those from high risk groups).

## BOX 3: THE PUBLIC MENTAL HEALTH COMMISSIONING CYCLE

### 1 Local assessment of need

This involves using public health intelligence to assess the following areas:

- levels of risk and protective factors
- numbers from higher risk groups
- levels of mental disorder and wellbeing
- numbers with different mental disorder and levels of low wellbeing in both the overall local population and particular high risk groups.

### 2 Assessment of assets

Assessment of assets available in an area to improve health and social care outcomes.

### 3 Assessment of current service provision

This involves examining information about the quality, effectiveness and cost of current services to treat and prevent mental disorder as well as promote mental health. It also requires the following information about higher risk groups:

- proportion with different mental disorder receiving intervention
- proportion receiving interventions to prevent mental disorder and promote wellbeing
- numbers still requiring intervention for mental disorder, prevention of mental disorder and promotion of mental wellbeing.

### 4 Intervention analysis

This estimates the combination and level of coverage of interventions required to meet the identified treatment of mental disorder, prevention of mental disorder and promotion of mental health.

### 5 Intervention plan

- deciding which PMH interventions and at what level of coverage
- a strategic plan regarding delivery of this set of PMH interventions.

### 6 Procurement of interventions

### 7 Evaluation of impact of interventions

## 2 Assessment of local assets

Joint Strategic Assets Assessments (JSAAAs) complement JSNAs by identifying the assets available in an area that can contribute towards protecting health and wellbeing and improving health and social care outcomes.

This includes the quality and accessibility of services and other community resources. It also includes assessing levels of protective factors for mental wellbeing across the local population.

Social assets approaches look at the social and cultural resources which already exist within a community that can improve wellbeing. As many of the key assets required for health are found within the social context of people's lives, an assets-based approach can contribute to reducing health inequalities<sup>96</sup>.

## 3 Assessment of current service provision

Nationally, only a minority with mental disorder (except psychosis) receive any intervention while even fewer receive prevention or promotion interventions.

Such local information is an important part of the JSNA as it allows the calculation of levels of unmet need. It should cover:

- the number and proportion of local people still in need of intervention for:
  - mental disorder, including early intervention
  - prevention of mental disorder
  - health promotion activities
- an assessment of the local economic impact of investment in interventions to treat mental disorder, prevent mental disorder and promote mental health
- information on the quality and effectiveness of current services to treat and prevent mental disorder as well as promote mental health.

## 4 Intervention analysis

This estimates the combination and level of coverage of interventions required to meet the identified need for treatment of mental disorder, prevention of mental disorder and promotion of mental health.

## 5 Intervention plan

This sets out:

- the services/interventions needed
- the details of the numbers/ proportion of people who will receive these interventions
- where they will be provided and by whom.

There should be a focus on what can be done by local partners working together to achieve a greater impact across the local system and to deliver improvements in health and wellbeing outcomes for the whole community<sup>95,97</sup>.

## 6 Procurement

Public mental health interventions can be procured from a range of providers. It is important that providers have:

- the ability to deliver the intervention to a high standard
- appropriately trained staff
- the capacity to deliver to the size of the population requiring the intervention
- appropriate systems for monitoring and recording the delivery of the intervention.

## 7 Evaluation of outcomes

Evaluation of the outcomes of public mental health interventions is essential. Evaluation identifies those interventions which are effective and those which are not working as expected. It ensures that interventions are of the highest quality, effective and offering value for money, as well as meeting the contract specifications and delivering to national and local quality standards.

A range of measures are available to evaluate the impact of public mental health interventions on mental wellbeing, levels of mental disorder and social and economic outcomes. These include outcomes outlined in the Public Health, NHS, Social Care, Child and Commissioning Outcomes Frameworks.



## OTHER ELEMENTS OF A GOOD PUBLIC MENTAL HEALTH SERVICE

### Interventions across the life course

Interventions should reflect the needs and profile of the different age groups within the local population: children, adolescents, young people, working age adults and older adults.

### Provision of early intervention

Intervention to treat mental disorders as soon as they arise is associated with improved outcomes. Further, more severe disorders are typically preceded by less severe ones which are seldom brought to clinical attention.

### Provision of intervention early in the life course

Half of lifetime mental disorder has arisen by the age of 14 and 75% by the mid 20s<sup>98</sup>. Therefore, services to treat mental disorder need to be able to engage adolescents while services to prevent mental disorder have greatest impact in pre-teenage years.

### 'Proportionate universality'

Groups at higher risk of mental disorder or poor wellbeing should receive higher levels of public mental health intervention to prevent further widening of inequalities and to comply with equality legislation.

### Co-ordination of activities

CCGs and HWBs will have an important role in ensuring coordination between providers across different agencies. This includes 'read across' with a district council strategy which covers housing, environmental health, sport, leisure, parks and gardens, and trading standards.

### Engaging the general population

Engaging the local population in the commissioning process is important. Information about effective interventions should be given to the public, as it can help promote the uptake of such interventions<sup>258</sup>.

## HOW CAN A GOOD PUBLIC MENTAL HEALTH SERVICE BE ACHIEVED?

Important components of a good public mental health service include:

- local public mental health leadership and capability within the public health department, Clinical Commissioning Groups and Health and Wellbeing Boards
- provision of relevant information for different groups including commissioners, mental health and public health professionals, patients, carers and the general public
- local public mental health champions to facilitate and improve communication and coordination between service providers
- support from health and social care professionals for public mental health interventions throughout the patient care pathway – every NHS contact should be a mental health and wellbeing promoting contact
- raising awareness of mental disorder and wellbeing among public sector staff and the general public through community training programmes and interventions such as Mental Health First Aid<sup>99</sup> and the Five Ways to Wellbeing campaign<sup>100</sup> – this supports improved detection and referral rates
- ensuring that clinicians dedicate a proportion of their time to public mental health activities
- ensuring that public health departments ring-fence a proportion of their resources to public mental health, particularly in the light of its contribution to reducing levels of physical illness and health risk behaviour
- training in public mental health for commissioners, mental health and public health professionals, and employers. This should be coordinated between the Royal Medical Colleges, Royal Society of Public Health, Faculty of Public Health and the Royal College of Nurses
- investment in public mental health interventions could be incentivised by inclusion in the Payment by Results schedule (with specific areas for payment by promotion, prevention and recovery through early intervention).

## OUTCOMES FRAMEWORKS

Outcome measures provide both a description of what a good public mental health system should aim to achieve, as well as a method of checking whether this ambition was actually achieved. Mental health and wellbeing features in the Public Health, NHS, Social Care, Child and Commissioning Outcome Frameworks. Other important outcomes include population levels of mental disorder.

### Public Health Outcomes Framework

The Public Health Outcomes Framework covers four domains (box 4).

Locally available datasets for many outcomes in both the public health and other outcome frameworks are outlined on pages 26-35. Links to these datasets are provided in Appendix H).

### BOX 4: PUBLIC HEALTH OUTCOMES FRAMEWORK:

For indicators, see Appendix H and [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)

**Improving the wider determinants of health** – indicators include the number of:

- children in poverty, school readiness and pupil absence
- 16 to 18-year-olds not in education, employment or training
- first-time entrants to the youth justice system
- people in prison who have a mental illness
- people with mental illness or learning disability in settled accommodation
- employment for people with long-term conditions including learning disability or mental illness
- people who are off work 'sick' (general sickness absence rate)
- cases of domestic abuse or violent crime (including sexual violence)
- statutory homelessness
- use of green spaces for exercise/health reasons
- fuel poverty
- social contentedness
- older people's perception of community safety.

**Health improvement** – indicators include the number/status of:

- low birth weight of term babies
- mothers reporting breastfeeding/ smoking status at time of delivery
- child development at 2-2.5 years
- hospital admissions caused by unintentional and deliberate injuries in under-18s
- self-reported well-being/emotional wellbeing of looked-after children
- hospital admissions as a result of self-harm
- smoking prevalence in 15-year-olds and adults (over-18s)
- successful completion of drug treatment
- numbers entering prison with untreated substance dependence
- alcohol-related admissions to hospital
- self-reported wellbeing.

**Health protection** (from major incidents and other threats, while reducing health inequalities) indicators include public sector organisations with board-approved sustainable development management plans.

### Public healthcare and preventing premature mortality

Reduce preventable ill health and premature death, while reducing the gap between communities. Indicators include:

- mortality from causes considered preventable
- excess mortality in adults under 75 years with serious mental illness
- suicide
- health-related quality of life for older people
- excess winter deaths
- dementia.

### NHS Outcomes Framework

The updated (2012/13) NHS Outcomes Framework<sup>88</sup> covers five domains:

- Domain 1 – preventing people from dying prematurely
- Domain 2 – enhancing quality of life for people with long-term conditions
- Domain 3 – helping people to recover from episodes of ill health or following injury
- Domain 4 – ensuring that people have a positive experience of care
- Domain 5 – treating and caring for people in a safe environment and protecting them from avoidable harm.

Relevant indicators towards which public mental health interventions can contribute are summarised in [box 5](#).

### BOX 5: NHS OUTCOMES FRAMEWORK<sup>88</sup>:

see [Appendix H](#) for full list, or visit: <https://indicators.ic.nhs.uk/webview/>

#### Indicators relevant to public mental health

- **Domain 1:** reducing premature death in people with serious mental illness
- **Domain 2:**
  - employment of people with mental illness
  - estimated diagnosis rate for people with dementia
- **Domain 3:** emergency admissions readmissions within 30 days of discharge from hospital
- **Domain 4:** patient experience of hospital care, GP services, GP out of hour services and dental services
  - improving hospital responsiveness to personal needs
  - improving people's experience of outpatient care, accident and emergency services, mental health services
  - improving access to primary care services
  - improving experience of care for people at the end of their lives
- **Domain 5:** treating and caring for people in a safe environment and protecting them from avoidable harm
  - patient safety incident reporting
  - severity of harm
  - reducing incidence of avoidable harm
  - delivering safe care to children in acute settings.

## Adult Social Care Outcomes Framework

The updated (2012/13) Adult Social Care Outcomes Framework<sup>87</sup> covers four domains:

- **Domain 1** – enhancing quality of life for people with care and support needs
- **Domain 2** – delaying and reducing the need for care and support
- **Domain 3** – ensuring that people have a positive experience of care and support
- **Domain 4** – safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm.

Indicators towards which public mental health interventions may contribute are summarised in [box 6](#).

### BOX 6: ADULT SOCIAL CARE OUTCOMES FRAMEWORK

(DH 2012 Adult Social Care Outcomes Framework<sup>87</sup>)

These indicators are available for each locality in the Adult Social Care Outcomes Framework reports which can be found at <http://nascis.ic.nhs.uk/Portal/Reports/Default.aspx>

#### Indicators relevant to public mental health

##### 1 Enhancing quality of life for people with care and support needs

- A** social care-related quality of life
- B** proportion of people who use services who have control over their daily life
- C** proportion using social care who receive self-directed support and direct payments
- D** carer-reported quality of life (included in NHS Outcomes Framework)
- E** proportion of adults with learning disabilities in paid employment (included in NHS and Public Health outcomes frameworks)
- F** proportion of adults in contact with secondary mental health services in paid employment (included in NHS and Public Health outcomes frameworks)
- G** proportion of adults with learning disabilities who live in their own home or with their family (included in Public Health outcomes framework)
- H** proportion of adults in contact with secondary mental health services living independently, with or without support (included in Public Health outcomes framework)

##### 2 Delaying and reducing the need for care and support

- A** permanent admissions to residential and nursing care homes per 1,000 population
- B** proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- C** delayed transfers of care from hospital, and those which are attributable to adult social care (included in NHS Outcomes Framework)

##### 3 Ensuring that people have a positive experience of care and support

- A** overall satisfaction of people who use services with their care and support
- B** overall satisfaction of carers with social services
- C** proportion of carers who report that they have been included or consulted in discussions about the person they care for
- D** proportion of people who use services and carers who find it easy to find information about services

##### 4 Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

- A** proportion of adults who use services who feel safe (included in public health outcomes framework)
- B** proportion of people who use services who say that those services have made them feel safe and secure

## Commissioning Outcome Frameworks

The NHS Commissioning Board (supported by NICE and working with professional and patient groups) has developed a Commissioning Outcomes Framework (COF)<sup>102</sup>.

This builds on the NHS Outcomes Framework and measures the health outcomes and quality of care (including patient reported outcome measures and patient experience) achieved by clinical commissioning groups. The COF will allow the NHS Commissioning Board to identify the contribution of CCGs to achieving the priorities for health improvement in the NHS Outcomes Framework, while also being accountable to patients and local communities. It will also enable the commissioning groups to benchmark their performance and identify priorities for improvement. COF indicators are either derived directly from the NHS Outcomes Framework; based on NICE Quality Standards; or from other sources to support the NHS Outcomes Framework.

COF indicators relevant to public mental health include :

- **Domain 1**
  - 1.23: people with dementia prescribed anti-psychotic medication
  - 1.30: people with severe mental illness receiving physical checks
- **Domain 2**
  - 2.79: people on Care Programme Approach (CPA) followed up within 7 days of discharge from inpatient stay
- **Domain 3**
  - 3.26i: recovery following talking therapies for people of all ages
  - 3.26ii: recovery following talking therapies for people older than 65
- **Domain 4**
  - 4.20: access to community mental health services by people from Black and Minority Ethnic (BME) groups
  - 4.21: access to psychological therapies services by people from BME groups

Data for some of these indicators are published in mid-December to support a Department of Health planning guidance publication. A decision on the Commissioning Outcomes Framework will be made by the NHS Commissioning Board.

See [www.nice.org.uk/aboutnice/cof/cof.jsp#COFIndicators](http://www.nice.org.uk/aboutnice/cof/cof.jsp#COFIndicators)



## Child Outcomes Framework recommendations

The Child Outcomes Framework will be published in 2013. However, the Children and Young People's Health Outcomes Forum have published a report which sets out recommendations<sup>103</sup>. These are summarised in [box 7](#).

### BOX 7: CHILD OUTCOMES FRAMEWORK RECOMMENDATIONS

The forum made four recommendations for new outcome measures:

- time from first NHS presentation to diagnosis or start of treatment
- integrated care – developing a new composite measure
- effective transition from children's to adult services
- age-appropriate services – with particular reference to teenagers.

The public health and prevention sub-group recommended the following outcomes for babies, children and young people:

- positive attachment with their parents
- healthy lifestyles, positive sense of wellbeing; and achievement of potential
- in best possible health at birth, have good nutrition and maintain a healthy weight
- protection from ill health, injuries, and physical and mental health problems
- children and young people are involved in decisions about their health and well-being. Through these outcomes, the root causes of health inequalities can be addressed and inequalities measurably reduced.

### Recommendations for inclusion in the Public Health Outcomes Framework

The Forum recommended a number of new indicators in each of the domains.

In order to support these recommendations for improving public health outcomes, the Forum recommends the development of two new surveys:

- a population-based survey of children and young people to look at trends in health and wellbeing
- a survey to support measurement of outcomes for children with mental health problems.

## CQUIN schemes

Commissioning for Quality and Innovation schemes were introduced in 2009/10 and are intended to incentivise practice through financial reward. They include schemes to support improvements and focus on inequalities and quality outcomes.

Possible CQUIN schemes that reward improvements relevant to public mental health include:

- proportion of individuals from higher risk groups in the local population who receive an agreed set of interventions to promote mental health, prevent mental disorder and provide early treatment for mental disorder
- proportion of staff receiving mental health promotion in different workplaces such as the NHS, local government or CCGs
- access to treatment for mental disorder – proportion of those with different mental disorder in the local population receiving evidence-based treatment
- proportion of people with alcohol and drug dependence receiving interventions
- proportion of people with mental disorder with access to smoking cessation
- suicide prevention for 'hot spots' such as public transport.

# What public mental health intelligence could commissioners use?

## Public mental health involves:

- use of intelligence on levels of mental disorder and wellbeing across populations (as well as risk and protective factors that influence these levels)
- to enable delivery of interventions that promote wellbeing, prevent mental disorder occurring and early intervention to treat mental disorder at the earliest possible opportunity
- to contribute towards a range of key outcomes (NHS, public health and social care) and achieve significant economic savings.

This section considers the intelligence needed to inform the commissioning of effective public mental health interventions and where it can be obtained.

It describes the 13 different domains of basic intelligence which should be included in a JSNA, and provides specific guidance on items of particular importance (including selected links to available data, or published references).

This public mental health intelligence also provides local data for many of the outcomes in the previous section. Links to local intelligence for these framework outcomes are highlighted in Appendix H.

## Public mental health intelligence

Public mental health intelligence which commissioners need to know includes:

- 1 local levels of risk and protective factors for wellbeing
- 2 local levels of risk factors for mental disorder and poor wellbeing
- 3 local numbers of people in particular groups at higher risk of mental disorder and low well-being (who benefit more from prevention and promotion interventions)
- 4 local population size
- 5 local levels of mental disorder and numbers affected
- 6 local levels of mental wellbeing
- 7 local level of need for mental health services (estimation of what service provision is required)
- 8 local proportion with mental disorder who receive prompt treatment, and the level of unmet need
- 9 local numbers receiving mental health promotion and mental disorder prevention interventions and levels of outstanding unmet need
- 10 local spend on treatment of mental disorder, prevention of mental disorder and promotion of mental health
- 11 impact on public health, NHS, social care, and child outcomes
- 12 local economic impact of interventions to treat mental disorder, prevent mental disorder and promote mental health
- 13 local impact of mental disorder and wellbeing on other JSNA priority areas.

## 1 Local levels of risk and protective factors for wellbeing

Public mental health approaches involve identifying factors which promote wellbeing.

These can also protect against mental disorder and poor mental health.

### Risk factors

A range of risk factors are associated with poor wellbeing (Appendix D3.1):

- genetic factors and early environmental factors
- demographic factors such as age (older children and adult middle age)<sup>50,104</sup>
- lower household income<sup>50,55</sup>, deprivation and income inequality<sup>105</sup>
- particular types of work such as semi-routine and routine occupations<sup>104</sup>
- mental ill-health<sup>50</sup>
- poor physical health<sup>104</sup>
- poor mobility, poor self-care, difficulties performing daily activities, pain and discomfort<sup>55</sup>, as well as work limiting disability<sup>104</sup>
- social isolation, a poor sense of belonging, and reduced ability to influence the local community<sup>55</sup>
- health risk behaviour such as alcohol, smoking and cannabis use<sup>55</sup>
- being a member of a group at greater risk of poor wellbeing such as some BME groups and the unemployed<sup>104</sup> (Appendix D3.2).

### Protective factors for wellbeing

A range of protective factors are associated with wellbeing (Appendix D4.1):

- genetic and early environmental factors<sup>61</sup>
- socioeconomic factors including higher income and socio-economic status<sup>107,108</sup>
- living environment<sup>106</sup>
- good general health<sup>50,55</sup>

- education<sup>107</sup>
- employment including autonomy, support, security and control in an individual's job<sup>50</sup>
- activities such as socialising, working towards goals, exercising and engaging in meaningful activities<sup>47</sup>
- social engagement and strong personal, social and community networks<sup>104,107,108,109</sup>
- altruism (doing things for others)<sup>110</sup>
- emotional and social literacy life skills, social competencies and attributes such as communication skills, cognitive capacity, problem-solving, relationship and coping skills, resilience and sense of control<sup>111</sup>
- spirituality is associated with improved well-being<sup>112</sup>, self-esteem, personal development and control<sup>113</sup>
- positive self-esteem<sup>114</sup>
- values<sup>115</sup>.

### Resilience

Resilience is associated with wellbeing and can also help safeguard mental well-being particularly at times of adversity. It arises through the interaction between factors at the individual, family and community level. Different levels of emotional and cognitive resilience or 'capital' include:

- emotional and cognitive: includes optimism, self-control and positive personal coping strategies
- social: includes networks and resources that enhance trust, cohesion, influence and cooperation for mutual benefit within communities
- physical health
- environmental: includes features of the natural and built environment which enhance community capacity for wellbeing
- spirituality: incorporates a sense of meaning, purpose and engagement as well as religious belief for some.

### Data-sources: local protective factors for wellbeing

Data on the local area can be found at the following sources.

- breast feeding and prevalence at 6-8 weeks: [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)
- education:
  - provision for children under 5 years of age in England [www.education.gov.uk/researchandstatistics/statistics/statistics-by-topic/earlyyearsandchildcare/a00210484/provision-for-children-under-five-in-england-jan-2012](http://www.education.gov.uk/researchandstatistics/statistics/statistics-by-topic/earlyyearsandchildcare/a00210484/provision-for-children-under-five-in-england-jan-2012)
  - children achieving a good level of development at early years foundation stage <http://atlas.chimat.org.uk/IAS/dataviews/healthyschoolsprofile>
  - GCSE achieved (5A\*-C inc Eng & Maths) [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
  - participation in Education, Training and Employment by 16-18 year olds in England [www.education.gov.uk/rsgateway/DB/SFR/s000938/index.shtml](http://www.education.gov.uk/rsgateway/DB/SFR/s000938/index.shtml)
  - healthy schools: participation in positive activities <http://atlas.chimat.org.uk/IAS/dataviews/healthyschoolsprofile>
- employment:
  - labour market statistics, including data on economic activity and employment [www.ons.gov.uk/ons/rel/subnational-labour/regional-labour-market-statistics/august-2012/index.html](http://www.ons.gov.uk/ons/rel/subnational-labour/regional-labour-market-statistics/august-2012/index.html)
  - proportion of adults receiving secondary care mental health services in paid employment<sup>86</sup>.
- physical activity:
  - local levels of physical activity [www.sportengland.org/research/active\\_people\\_survey/aps5.aspx](http://www.sportengland.org/research/active_people_survey/aps5.aspx)

- local child and adult participation in physical activity [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- participation in at least 3 hours of sport or PE at school <http://atlas.chimat.org.uk/IAS/dataviews/healthyschoolsprofile>
- healthy life expectancy (ONS, 2012) [www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-258850](http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-258850)
- housing:
  - CLG Live tables on affordable housing supply by Local Authority [www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/affordablehousing/livetable/](http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/affordablehousing/livetable/)
  - ONS (2012) Census tables on tenure (KS402EW) and housing (KS401EW)
  - proportion of adults receiving secondary care mental health services in settled accommodation [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)

## 2 Local levels of risk factors for mental disorder and poor wellbeing

A range of risk factors for mental disorder and poor wellbeing are highlighted in [Appendices D2 and D3.1](#). However, inequality is a key risk factor for both mental disorder and poor wellbeing. People living in households with incomes in the lowest 20% are at higher risk of all mental disorders than those with incomes in the highest 20%<sup>3</sup>.

### Data sources for local risk factors

#### Inequalities and deprivation (Appendix D)

- children in poverty [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)

- people living in the 20% most deprived areas 2010 [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- local health inequalities including numbers of adults in poverty [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
- local basket of inequality indicators <https://indicators.ic.nhs.uk/webview/>
- Index of Multiple Deprivation <http://webarchive.nationalarchives.gov.uk/20120919132719/http://www.communities.gov.uk/publications/corporate/statistics/indices2010>
- Marmot Review Team: Indicators for social determinants of health, health outcomes and social inequality. [www.lho.org.uk/LHO\\_Topics/national\\_lead\\_areas/marmot/marmotindicators.aspx](http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx)

#### Parental factors

([Appendices D1.1 and D2.2](#))

- maternal smoking:
  - at birth 2011-2012 [www.ic.nhs.uk/pubs/wsstd1112q3](http://www.ic.nhs.uk/pubs/wsstd1112q3)
  - during pregnancy [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
- children in lone parent families [www.ons.gov.uk/ons/rel/mro/news-release/lone-parent-families-with-dependent-children-in-uk-near-two-million/famandhousenr0112.html](http://www.ons.gov.uk/ons/rel/mro/news-release/lone-parent-families-with-dependent-children-in-uk-near-two-million/famandhousenr0112.html)
- children in out of work families (see [Appendix D1.7](#) on unemployment) [www.hmrc.gov.uk/stats/personal-tax-credits/ctc-small-areas.htm](http://www.hmrc.gov.uk/stats/personal-tax-credits/ctc-small-areas.htm)
- children of parents with mental disorder (box on [page 28](#)).

#### Child factors

([Appendix D1.3](#))

- low birth weight births <https://indicators.ic.nhs.uk/webview/>

- sex and age ONS – Mid 2011 (Census Based) Table 9 [www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-262039](http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-262039)
- ethnicity: population estimates by ethnic group, age and sex (experimental) mid 2009 [www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-50029](http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-50029)
- gap in achievement between the lowest 20% of achieving children (mean score) at Early Years Foundation Stage and median score <http://atlas.chimat.org.uk/IAS/dataviews/view?viewId=282>

#### School factors

- pupil absence from school [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)
- permanent and fixed period exclusions from school [www.education.gov.uk/rsgateway/DB/SFR/s001080/index.shtml](http://www.education.gov.uk/rsgateway/DB/SFR/s001080/index.shtml)
- behaviour in schools [www.education.gov.uk/rsgateway/DB/STR/d001001/index.shtml](http://www.education.gov.uk/rsgateway/DB/STR/d001001/index.shtml)

#### Household factors

- fuel poverty [www.decc.gov.uk/en/content/cms/statistics/fuelpov\\_stats/regional/regional.aspx](http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/regional/regional.aspx)
- excess winter deaths [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
- inadequate housing: 27% of social housing tenants and 34% of private housing tenants in non-decent housing<sup>116</sup>.

#### Violence and abuse

Childhood adversity accounts for almost a third of all mental disorder and is therefore particularly important to both measure and address.

#### Bullying

Percentage of pupils who say they have been bullied and who say their school deals poorly with bullying <http://atlas.chimat.org.uk/IAS/dataviews/healthyschoolsprofile>

### Child abuse

- 25% of 18-24 year-olds and 19% of 11-17 year-olds experience severe maltreatment during childhood<sup>117</sup>
- 7% of 11-17 year-olds and 12% of 18-24 year-olds experienced physical violence by an adult<sup>117</sup>.

### Sexual abuse

- 3% of women and 0.8% of men experience sexual intercourse during childhood<sup>118</sup>
- 11% of women and 5% of men experienced sexual touching<sup>118,119</sup>.

### Child protection plans

Numbers of referrals and assessments of children and young people who were the subject of a child protection plan

[www.education.gov.uk/rsgateway/DB/SFR/s001095/index.shtml](http://www.education.gov.uk/rsgateway/DB/SFR/s001095/index.shtml)

### Abuse of vulnerable adults

[www.ic.nhs.uk/pubs/abuseva1011](http://www.ic.nhs.uk/pubs/abuseva1011)

<https://nascis.ic.nhs.uk/Portal/Reports/Default.aspx>

### Violence

Episodes of violent crime per 1000 population [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)

### Domestic violence

Home Office Recorded crime datasets (Appendix D2.2) [www.homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics-internet/](http://www.homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics-internet/)

## 3 Number of people in particular groups at higher risk of mental disorder and low well-being

Some groups have a higher risk of mental disorder and poor wellbeing (Appendices D1.5, D2.3, D3.2). It is important to target these groups with prevention and promotion interventions to prevent further widening of the inequality they already experience.

### Data sources for local numbers from higher risk groups

#### Local numbers of children and adolescents from higher risk groups

#### Looked after children including adoption and care leavers

[www.education.gov.uk/rsgateway/DB/SFR/s001026/index.shtml](http://www.education.gov.uk/rsgateway/DB/SFR/s001026/index.shtml)

<http://atlas.chimat.org.uk/IAS/dataviews/childhealthprofile>

#### Children with Special Educational Needs

[www.education.gov.uk/researchandstatistics/statistics/allstatistics/a00210489/dfe-special-educational-needs-in-england-january-2012](http://www.education.gov.uk/researchandstatistics/statistics/allstatistics/a00210489/dfe-special-educational-needs-in-england-january-2012)

[www.education.gov.uk/rsgateway/DB/STR/d001032/index.shtml](http://www.education.gov.uk/rsgateway/DB/STR/d001032/index.shtml)

#### Children with parents in prison

Each year, 160,000 children and young people have a parent in prison<sup>121</sup>

#### Numbers of 16-18 year olds Not in Employment, Education or Training (NEETs)

[www.education.gov.uk/a0064101/16-to-18-year-olds-not-in-education-employment-or-training-need](http://www.education.gov.uk/a0064101/16-to-18-year-olds-not-in-education-employment-or-training-need)

[www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)

#### Young offenders

Over 6,000 children aged under 18 enter custody each year most of whom are boys<sup>122</sup> 10% of 10–25-year-olds report committing a serious offence in previous year<sup>123</sup>

#### First time entrants to the youth justice system

<http://atlas.chimat.org.uk/IAS/dataviews/childhealthprofile>

[www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)

Other higher risk groups include children with physical illness, whose parents have a mental disorder, who are experiencing violence or abuse, who are deaf, teenage parents or carers.

#### Local numbers of adults from higher risk groups

#### New mothers

ONS (2012) Birth summary tables, England and Wales 2011 (provisional) [www.ons.gov.uk/ons/rel/vsob1/birth-summary-tables--england-and-wales/2011--provisional-/index.html](http://www.ons.gov.uk/ons/rel/vsob1/birth-summary-tables--england-and-wales/2011--provisional-/index.html)

#### Lack of qualification

Percentage of adults with no qualification: Table KS501EW at [www.ons.gov.uk/ons/guide-method/census/2011/census-data/2011-census-prospectus/release-plans-for-2011-census-statistics/second-release-of-2011-census-statistics/second-release-tables/index.html](http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/2011-census-prospectus/release-plans-for-2011-census-statistics/second-release-of-2011-census-statistics/second-release-tables/index.html)

#### Unemployment and benefit claimants

A large proportion of working-age adults on long term health-related benefits are claiming primarily because of mental health and behavioural disorder.

- numbers who are economically inactive, on job seekers allowance and claimants including numbers claiming incapacity benefit [www.ons.gov.uk/ons/rel/subnational-labour/regional-labour-market-statistics/august-2012/index.html](http://www.ons.gov.uk/ons/rel/subnational-labour/regional-labour-market-statistics/august-2012/index.html)
- number of working age unemployed adults: [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- long term unemployed [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
- claimants of incapacity benefit/ severe disability allowance with mental or behaviour problems per 1000 working age population (LBOI Indicator 10.2) <https://indicators.ic.nhs.uk/webview/>



### Homelessness

In 2007/08 in England, an estimated 100,000 people were homeless, although this figure did not include those who avoided hostels<sup>124</sup>

- statutory homelessness: homelessness acceptances (1.15i) and households in temporary accommodation (1.15ii) [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)

### Different ethnic groups

ONS (2012) Census second release tables. Ethnic group (table KS201EW).

### Refugees and asylum seekers

<http://webarchive.nationalarchives.gov.uk/20110218135832/rds.homeoffice.gov.uk/rds/immigration-asylum-stats.html>

### Prisoners

A needs assessment of the local number of prisoners should estimate the proportion with different mental disorder. Information on numbers of prisoners including 15-17 and 18-20 year olds can be found at [www.justice.gov.uk/statistics/prisons-and-probation/oms-quarterly](http://www.justice.gov.uk/statistics/prisons-and-probation/oms-quarterly)

### Learning Disability

In England in 2011, 905,000 adults (530,000 men, 375,000 women) are estimated to have learning disabilities although only 189,000 (21%) are known to learning disability services<sup>120</sup>. In 2008/9, 27% of episodes of general hospital care in England for individuals with learning disabilities specifically recorded the person's learning disability. During 2005-9, 56% of episodes of psychiatric in-patient care for individuals with known learning disabilities specifically recorded the person's learning disability<sup>120</sup>. [www.improvinghealthandlives.org.uk/publications/1063/People\\_with\\_Learning\\_Disabilities\\_in\\_England\\_2011](http://www.improvinghealthandlives.org.uk/publications/1063/People_with_Learning_Disabilities_in_England_2011)

- estimates for local areas – Learning Disabilities Observatory (2012) [www.improvinghealthandlives.org.uk/profiles/](http://www.improvinghealthandlives.org.uk/profiles/)
  - number of children and adults with learning disability
  - proportion known to primary care
  - proportion receiving GP special health checks
  - proportion with stable accommodation (also at [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2))
  - proportion with paid employment
  - proportion receiving social care
- data on GP registration of LD persons: Quality and Outcomes Framework (QOF) for April 2010 - March 2011, England (QOF1011 PCTs Prevalence [www.ic.nhs.uk/statistics-and-data-collections/supporting-information/audits-and-performance/the-quality-and-outcomes-framework/qof-2010-11/qof-2010-11-data-tables](http://www.ic.nhs.uk/statistics-and-data-collections/supporting-information/audits-and-performance/the-quality-and-outcomes-framework/qof-2010-11/qof-2010-11-data-tables))
- percentages of patients on learning disabilities register [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)

### Long term limiting illness

- NEPHO Community Mental Health Profiles [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- ONS (2012) Census second release (table KS106EW).

### Lesbian, Gay, Bigender, and Transgender

An ONS survey of 420,000 adults found that 1% identified themselves as Gay or Lesbian, 0.5% as Bisexual<sup>125</sup>. However, another survey found a higher proportion, with an estimated 6% of the population as LGB (DTI, 2005)<sup>126</sup>. There are approximately 65,000 to 300,000 transgender people in the UK<sup>127</sup>.

**People registered deaf or hard of hearing**  
[www.ic.nhs.uk/pubs/regdeaf10](http://www.ic.nhs.uk/pubs/regdeaf10)

## 4 Local population size (including groups at higher risk)

The most accurate estimate can be found by looking at ONS (2012) Mid 2011 (Census Based) Table 9 [www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-262039](http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-262039)

Similarly, accurate prediction of population growth enables local authority planners, commissioners of social care, providers and support organisations to estimate impact of changes in demographics and certain conditions including mental disorder. Relevant web resources include:

- Projecting Adult Needs and Service Information (PANSI) for populations aged 18-64 [www.pansi.org.uk](http://www.pansi.org.uk)
- Projecting Older People Population Information (POPPI) for populations 65 and over [www.poppi.org.uk](http://www.poppi.org.uk)

## 5 Local levels of mental disorder (including higher risk groups)

The level of disorder varies significantly according to locality<sup>3</sup>. Therefore, it is important to accurately assess the proportion experiencing different disorders (including from higher risk groups).

Data sources providing local information on numbers with mental disorder can be found in [Appendix B3](#).

This needs to include numbers with mental disorder from higher risk groups by applying the local numbers from such groups with the level of increased risk they experience ([Appendices D1.5 and D2.3](#)).

**BOX 8: RISK FACTORS FOR CHILD AND ADOLESCENT MENTAL DISORDER**

Group	Expected prevalence of mental disorders
Looked after children	45% <sup>129</sup>
Children with special educational need requiring statutory assessment	44%
Children with learning disability	36% <sup>130</sup>
Children absent from school more than 15 days in previous term <sup>14</sup>	17% with emotional disorder 14% with conduct disorder 11% with hyperkinetic disorder
Children with a parent with mental illness <sup>14</sup>	Parents of child with conduct disorder <ul style="list-style-type: none"> <li>• 51% have emotional disorder</li> <li>• 18% have a severe emotional disorder</li> </ul> Parents of child with emotional disorder <ul style="list-style-type: none"> <li>• 48% have emotional disorder</li> </ul>
Children from households with no working parent	20% <sup>14</sup>
Children from household reference person in routine occupational group	15% <sup>14</sup>
Children of parents with no educational qualifications	17% <sup>14</sup>
Children from weekly household income <£100	16% <sup>14</sup>
Children living in less prosperous/mixed areas	15% <sup>14</sup>
Children in stepfamilies	14% <sup>14</sup>
Children from lone parent families	16% <sup>14</sup>

**Local levels of child and adolescent mental disorder**

Local levels of emotional, conduct and hyperkinetic disorders are associated with deprivation<sup>14</sup> (Appendix B3.1):

- emotional disorder: 2% for least deprived areas and 6% for most deprived areas
- conduct disorder: 3% for least deprived areas and 9% for most deprived areas
- hyperkinetic disorder (ADHD): 1% for least deprived areas and 3% for most deprived areas.

Numbers in a locality with these mental disorders can be estimated from national prevalence figures by adjusting for local deprivation which can be found at Index of Multiple Deprivation: <http://webarchive.nationalarchives.gov.uk/20120919132719/http://www.communities.gov.uk/publications/corporate/statistics/indices2010>

The locality ranked number 1 for deprivation will have highest rates and the locality ranked 354 lowest (Appendix B3.1). Therefore, the rates of mental disorder for a locality ranked 244 can be estimated as follows<sup>128</sup>:

- emotional disorder: 6% minus (4 multiplied by 244/354)
- conduct disorder: 9% minus (6 multiplied by 244/354)
- Hyperkinetic disorder (ADHD): 3% minus (1.5 multiplied by 244/354).

Since less common disorders (autism, tics, eating disorders and selective mutism) do not show such associations with deprivation, local numbers can be estimated by applying the national prevalence levels (1%) to local population size.

Local levels of alcohol, drug and tobacco use can be found at <http://atlas.chimat.org.uk/IAS/dataviews/childhealthprofile>

Levels of mental disorder also need to be estimated in higher risk groups by applying the local numbers from such groups (see earlier) with the level of increased risk they experience (appendices D1.3-1.5).

### Local levels of adult mental disorder

#### Common mental disorder

- NEPHO Mental Health Needs Assessment estimates local prevalence of different common mental disorder based on age, sex and census (2001) [www.nepho.org.uk/mho/Needs](http://www.nepho.org.uk/mho/Needs)
- IAPT quarterly data uses the NEPHO (2008) report to estimate local numbers of people with depression and/or anxiety disorders [www.ic.nhs.uk/pubs/psychologicaltherapies1112](http://www.ic.nhs.uk/pubs/psychologicaltherapies1112)

#### Psychosis

- in previous year, 4/1000 people have psychosis and 1/1000 bipolar affective disorder although rates vary by locality (Appendix B1.2)
- number of new cases of psychosis each year is 0.15 per 1000 for schizophrenia and 0.12 for affective psychosis (Appendix B3.2). Rates for schizophrenia are higher in disadvantaged areas but not for affective psychosis
- numbers developing a psychosis prodrome each year is at least three times higher than numbers developing psychosis (Appendix B1.3).

#### Dementia

NHS Information Centre publishes regular updates on disease prevalence by PCT, including dementia [www.ic.nhs.uk/webfiles/publications/002\\_Audits/QOF\\_2010-11/Prevalence\\_Tables/QOF1011\\_PCTs\\_Prevalence.xls](http://www.ic.nhs.uk/webfiles/publications/002_Audits/QOF_2010-11/Prevalence_Tables/QOF1011_PCTs_Prevalence.xls)

#### Alcohol use disorder

- Local Alcohol Profiles for England provides data on numbers of abstainers and lower risk, increasing risk and higher risk drinkers in local authority [www.lape.org.uk/downloads/alcholestimates2011.pdf](http://www.lape.org.uk/downloads/alcholestimates2011.pdf)
- Department of Health ready reckoner tool v 5.2 gives estimates for the number of dependent drinkers at PCT level (see [www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5109](http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5109))

#### Drug use disorder

- APHO local levels of drug misuse [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
- NDTMS data on the prevalence of opiate and/or crack use [www.ndtms.net](http://www.ndtms.net)
- NDTMS JSNA Support Pack with national and local prevalence estimates [www.ndtms.net/ViewIt](http://www.ndtms.net/ViewIt)

#### Tobacco smoking

- APHO adult smoking prevalence and numbers of smoking related deaths [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
- smoking prevalence in adults (over-18s) [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)
- numbers of smokers with mental disorder is estimated by applying national smoking rates for different mental disorder (80) to local numbers with different mental disorder.

#### Suicide and undetermined injury

- suicide rate (provisional) [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)
- Standardised Mortality Rate for suicide and undetermined injury (NEPHO, 2012) [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)

### Levels of mental disorder in higher risk adult groups

#### New mothers

Twenty two percent have depression a year after giving birth<sup>131</sup>. Particular groups are at higher risk with 42% of immigrant, asylum and refugee women experiencing post-natal depression in developed countries<sup>132</sup>.

#### Adults with learning disability

These adults experience double the risk of depression, and a three-fold increase in the risk of schizophrenia<sup>133</sup>. Dementia also occurs in 55% of 60-69 year olds with a learning disability<sup>16</sup>.

#### Prisoners

Prisoners experience a several fold increased risk of common mental disorder, suicide, psychosis (10% of prisoners), personality disorder, alcohol and drug problems<sup>134,136</sup> while 80% of prisoners are smokers<sup>137</sup> (Appendix D2.3).

#### Homeless people

Twenty seven percent have probable psychosis, 9% neurotic disorder, 10% alcohol dependence and 15% drug dependence (Appendix D2.3).

#### Lesbian, Gay, Bisexual (LGB) and Transgender people

Twenty two percent of LGB people have a common mental disorder, 9% have attempted suicide, 1% have probable psychosis and 10% have alcohol dependence (Appendix D1.4). Rates of mental disorder and attempted suicide are higher for transgender people.

#### Black and Minority Ethnic groups

Rates of schizophrenia are 5.6 times higher in black Caribbeans, 4.7 times higher in black Africans and 2.4 times higher in Asian groups<sup>140</sup> (Appendix D2.3). Black populations have highest rates of PTSD, suicide attempt, psychotic disorder and any drug use/dependence while White populations have highest

rates for suicidal thoughts, self-harm and alcohol dependence. South Asian women have highest rates for common mental disorder<sup>3</sup>.

### Refugees and asylum seekers

Rates of mental disorder are several times higher for this group<sup>141,142</sup> (see [Appendix D2.3](#)).

## 6 Local levels of mental wellbeing

While the Health Survey for England found only small differences in wellbeing across different regions of the country<sup>50</sup>, significant variation can occur even within a locality<sup>55</sup> ([Appendix C3](#)).

Wellbeing can be assessed by objective and subjective measures ([Appendix C4](#)). The ONS is developing national measures of wellbeing and of human and cultural capital.

### Assessing local levels of wellbeing

The first annual subjective wellbeing survey also found significant variation between regions<sup>104</sup> and provides maps showing differences in levels of satisfaction, things being worthwhile and happiness at: [www.neighbourhood.statistics.gov.uk/HTMLDocs/dvc35/wellbeing.html](http://www.neighbourhood.statistics.gov.uk/HTMLDocs/dvc35/wellbeing.html)

The Public Health Outcomes Framework tool gives local authority levels of self reported wellbeing at [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)

A mapping tool also highlights variation in wellbeing at ward level using the ONS data above (104) <http://opendatacommunities.org/wellbeing/map>. Below county level, the likely degree of variation in wellbeing between neighbourhoods is modelled from the APS using ACORN which is a geo-demographic classification combining geographical and demographic characteristics.

[Appendix C4](#) details various proposed measures of wellbeing measures. Many of these are protective factors for wellbeing or risk factors for poor wellbeing outlined on [pages 26-28](#) and [Appendix D](#) which can be used as proxy measures for wellbeing. However, most of these measures are not available at local level.

[Appendix C3](#) gives more information on the assessment of local levels of wellbeing.

## 7 Level of need for mental health services (estimate of required service provision)

This can be estimated in a number of ways. Examples include MINI 2000<sup>143</sup>, and the Local Index of Need (LIN)<sup>144</sup>.

Estimates suggest the following proportions of children and adolescents should be seen by the different tiers of CAMHS services ([appendix B4.3](#)):

- 10% of under 17 year olds who have one or more known risk factors for mental disorder should be seen by tier 1
- 7% of under 17 year olds with mental disorders should be treated or supported in tier 2
- around 3% of the child and adolescent population should reach tier 3 CAMHS each year which is 30-35% of the 10% of the 5-16 year old population affected by mental disorder<sup>14</sup>
- 0.47% of under 17s should be seen by tier 4.

## 8 Proportion with mental disorder who receive prompt treatment, and the level of unmet need

### Children and adolescents

Observed numbers in the different tiers are derived from the caseloads of the range of health professionals seeing children and adolescents. Nationally, only 30-40% of

children and adolescents who experience clinically significant mental disorder have been offered evidence-based interventions at the earliest opportunity for maximal lifetime benefits<sup>14</sup> (see [Appendix F1](#)).

Observed numbers in the different tiers can be derived from the caseloads of the range of health professionals seeing children and adolescents. Data on the proportion being seen from higher risk groups also needs to be included. Data sources include local:

- numbers in primary care diagnosed or referred with different mental disorder
- numbers of parents of children and adolescents with conduct disorder, ADHD or autistic spectrum disorder referred for parenting interventions ([Appendix F2](#))
- level of CAMHS provision is available at the Children's Service Mapping which includes regional caseload, commissioning, service and workforce although only has figures up until 2010. [www.childrensmapping.org.uk/topics/camhs/](http://www.childrensmapping.org.uk/topics/camhs/)
- admissions for mental health conditions, self harm and substance misuse use (CHIMAT) <http://atlas.chimat.org.uk/IAS/dataviews/childhealthprofile>
- admissions for alcohol specific conditions (under 18) [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)

### Adults

Nationally, only a minority receive any intervention for mental disorder except psychosis<sup>3</sup> (see [Appendix F1](#)). For adults, the proportion with different mental disorder receiving intervention (including from higher risk groups) can be estimated using the links below. These help to inform observations about levels of unmet need.



### Common mental disorders (adults and older people)

- Improving Access to Psychological Therapies Datasets reports: number of referrals to IAPT, proportion receiving CBT through IAPT, proportion of those with anxiety or depression receiving treatment from IAPT, proportion completing treatment, proportion moving to recovery after treatment completion and number moving off sick-pay or ill-health related benefit<sup>86</sup>
- QOF PCT level data tables for mental health and depression which give the proportion of patients who had assessment of severity at beginning of treatment and at 4-12 weeks after the initial assessment. This includes the proportion on diabetes and/or coronary heart disease register who had screening for depression during preceding 15 months [www.ic.nhs.uk/statistics-and-data-collections/supporting-information/audits-and-performance/the-quality-and-outcomes-framework/qof-2010-11/qof-2010-11-data-tables/qof-pct-level-data-tables-2010-11](http://www.ic.nhs.uk/statistics-and-data-collections/supporting-information/audits-and-performance/the-quality-and-outcomes-framework/qof-2010-11/qof-2010-11-data-tables/qof-pct-level-data-tables-2010-11)
- percentage with depression aged 18 and over (on GP depression register) [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- standardised rate for emergency hospital admission for affective disorder [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- levels of prescription for antidepressants: Prescribing data-sets: NHS Information Centre (2012) Primary Care Trust Prescribing Data [www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions](http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions)

### Psychosis<sup>86</sup>

- early intervention for psychosis and prodrome:
  - number of 15-34 year olds (from census data at ONS 2012 – [section 4](#))

- number with First Episode Psychosis (FEP) ([Appendix B3.2](#)) and prodrome ([Appendix B1.3](#))
- number with FEP treated by Early Intervention teams Routine Quarterly MHMDS reports: Community Mental Health Activities questions 6 and 7<sup>86</sup>
- proportion with FEP receiving intervention
- proportion of those with psychosis prodrome receiving intervention
- age standardised hospital episode rates for schizophrenia (LBOI Indicator 10.2) <https://indicators.ic.nhs.uk/webview/>

### Personality disorder

Numbers receiving interventions for different personality disorders.

### Dementia

- NHS Information Centre (2011) Disease prevalence. Quality and Outcomes Framework (QOF) for April 2010 – March 2011, England [www.ic.nhs.uk/webfiles/publications/002\\_Audits/QOF\\_2010-11/Prevalence\\_Tables/QOF1011\\_PCTs\\_Prevalence.xls](http://www.ic.nhs.uk/webfiles/publications/002_Audits/QOF_2010-11/Prevalence_Tables/QOF1011_PCTs_Prevalence.xls)
- rates of emergency admission for dementia [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- numbers with dementia on GP register [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- ePact: Prescription for dementia related drugs per person estimated to have dementia

### Alcohol use disorder

- alcohol admissions:
  - NHS admissions with a primary diagnosis wholly or partially attributable to alcohol [www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2011-\[ns\]](http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2011-[ns])

- alcohol admissions for alcohol related harm [www.lape.org.uk/data.html](http://www.lape.org.uk/data.html)
- hospital stays for alcohol related harm [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
- emergency admissions for alcohol attributable conditions [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)
- dependent drinkers in structured treatment [www.lape.org.uk/data.html](http://www.lape.org.uk/data.html)
- number of prescription items, net ingredient cost and average net ingredient cost per item of drugs prescribed for the treatment of alcohol dependence dispensed in the community [www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2011-\[ns\]](http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2011-[ns])

Local data on monthly local numbers in treatment, new presentations, waiting times, treatment outcomes and discharges is at [www.ndtms.net](http://www.ndtms.net) via “Outputs” – “Reports” – “Monthly”. This includes information on:

- numbers entering treatment (numbers in treatment, waiting times)
- a prevalence service user ratio to indicate the proportion of the dependent population in treatment
- demographic data, information on substances used and drinking levels of clients in treatment
- interventions delivered, duration of interventions and treatment journeys
- outcomes (including successful completions, representations and possibly Treatment Outcomes Profile data for areas which meet the submission threshold)



- complexity data – to give an indication of the makeup of the treatment population according to client's needs.

Screening and extended brief interventions for 16 and 17 year olds at risk of alcohol use

Screening, brief interventions and extended brief interventions for adults

### Drug misuse or dependence

- NHS Information Centre Statistics on drug misuse: NHS admissions with a primary diagnosis of drug related mental health and behaviour disorder (table 3.2 and 3.3) [www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/drug-misuse/statistics-on-drug-misuse-england-2011](http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/drug-misuse/statistics-on-drug-misuse-england-2011)
- numbers seen by substance misuse services. MHMDS tables 7a and 7b [www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin--fifth-report-from-mental-health-minimum-dataset-mhmds-annual-returns-2011](http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin--fifth-report-from-mental-health-minimum-dataset-mhmds-annual-returns-2011)
- National Treatment Agency for Substance Misuse. Part 2 submissions for 2010/11 from each borough contain number of problem drug users (cocaine/ crack/ opiates) in effective treatment [www.nta.nhs.uk/regional-london.aspx](http://www.nta.nhs.uk/regional-london.aspx)
- "Treatment Bulls Eye" reports look at local treatment population in relation to prevalence to measure any potential unmet need. Need (select "Bulls Eye Data" under "Select Type" at [www.ndtms.net](http://www.ndtms.net))
- JSNA Support Pack: This can be accessed from ViewIt. It provides access to substance misuse statistics at both a national and local level at [www.ndtms.net/ViewIt](http://www.ndtms.net/ViewIt). Greater detail from the Needs Assessment reports for 2010-11 accessible from [www.ndtms.net](http://www.ndtms.net) via "Outputs" – "Reports" – "Annual" – "Needs Assessment"

- local data on monthly local numbers in treatment, new presentations, waiting times, treatment outcomes and discharges is at [www.ndtms.net](http://www.ndtms.net) via "Outputs" – "Reports" – "Monthly"

- local levels of successful treatment of drug treatment [www.phoutcomes.info/public-health-outcomes-framework/domain/2](http://www.phoutcomes.info/public-health-outcomes-framework/domain/2)

- levels of prescription for treatment for drug dependence: Prescribing datasets: NHS Information Centre (2012) [www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions](http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions)

### Tobacco dependence

Despite 42% of adult tobacco consumption being by those with mental disorder<sup>80</sup>, no local information is routinely collected about access to smoking cessation interventions and quit rates for this group. Other groups which also require local data collection include under 18's including those with mental disorder and from BME populations.

- APHO (2012) NRT: Local tobacco control profiles for England: indicator dataset 2011. Data from the London Observatory [www.lho.org.uk/viewResource.aspx?id=16647](http://www.lho.org.uk/viewResource.aspx?id=16647)
- NHS Information Centre (2012) Statistics on NHS Stop Smoking Services: England (quarterly data, April to September 2011). [www.ic.nhs.uk/pubs/sss11q2](http://www.ic.nhs.uk/pubs/sss11q2) Includes number of NRT prescription prescriptions per 100,000 population, number of smokers setting a quit date and proportion of successful quitters
- mothers smoking during pregnancy and at delivery [www.ic.nhs.uk/pubs/wsstd1112q3](http://www.ic.nhs.uk/pubs/wsstd1112q3); [www.apho.org.uk/default.aspx?QN=P\\_HEALTH\\_PROFILES](http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)
- information on local activities and checks to enforce sales compliance to ensure counterfeit tobacco is not on sale in shops, and to combat illicit and counterfeit tobacco sales

### Self-harm

Emergency hospital admissions for self-harm [www.nepho.org.uk/cmhp/](http://www.nepho.org.uk/cmhp/)

### Promotion of physical health in different mental disorder

This includes the proportion with different mental disorders receiving interventions to promote physical activity, healthy diet, weight reduction, smoking cessation and an annual primary care physical health screen. For psychosis and serious mental illness (SMI), indicators include proportion of:

- people with SMI placed on primary care SMI register (QoF)
- people on lithium with serum creatinine and thyroid stimulating hormone in previous 9 months (QoF)
- people on lithium where a blood test to check their lithium level has been completed in the previous 4 months (QoF)
- people with schizophrenia, bipolar affective disorder and other psychoses with a review offering routine and appropriate health promotion and prevention advice in previous 15 months (QoF)
- people with schizophrenia, bipolar affective disorder and other psychoses who do not attend for an annual review who are then followed up within 14 days of non-attendance (QoF).

### Information on NHS specialist mental health services

The Mental Health Bulletin provides the most comprehensive statistics available on the range of specialist mental health services provided by the NHS both in hospital and in the community. The data source is the Mental Health Minimum Data Set which is regularly updated. See Appendix F3 or: [www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services](http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services)

National Statistics about people being treated in hospital, or as outpatients, under mental health related specialities or diagnosed with mental health problems are also provided through Hospital Episode and Hospital Outpatient Activity statistics [www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics--hes](http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics--hes)

## 9 Assessment of unmet need for promotion of mental health and prevention of mental disorder

A range of effective interventions can promote mental health and prevent mental disorder (see [Appendix G](#)). Localities should then assess what proportion of those benefiting from such interventions actually receive them to estimate level of unmet need. However, routine local datasets usually do not exist regarding how many people receive such interventions, reflecting the lack of resources for prevention and promotion (see [page 14](#)).

## 10 Assessment of local economic spend on treatment of mental disorder, prevention of mental disorder and promotion of mental health

While £12 billion was spent on mental health in 2010/11, the following site also provides individual commissioner level spend by PCT on mental health<sup>148</sup> [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH\\_075743#\\_3](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743#_3).

Community Mental Health profiles also give allocated average spend for mental health per head of population <http://www.nepho.org.uk/cmhp/>

A PCT Spend and Outcome Factsheet and Tool (SPOT) is available at [www.yhpho.org.uk/resource/view.aspx?RID=49488](http://www.yhpho.org.uk/resource/view.aspx?RID=49488)

[www.sepho.org.uk/extras/maps/NHSatlas/atlas.html](http://www.sepho.org.uk/extras/maps/NHSatlas/atlas.html)

The Health Investment Network is part of QIPP Right Care and resources can be found at [www.networks.nhs.uk/nhs-networks/health-investment-network](http://www.networks.nhs.uk/nhs-networks/health-investment-network)

## 11 Assessment of local impact on public health, NHS, Social Care and child outcomes

The impacts of public mental health interventions need to be measured against the range of outcomes highlighted in [Appendix H](#).

## 12 Assessment of local economic impact of interventions to treat mental disorder, prevent mental disorder and promote mental health

[Appendix E4](#) highlights the economic savings of different public mental health interventions. This enables commissioners to estimate potential savings of different interventions depending on level of coverage.

## 13 Impact of mental disorder and wellbeing on other JSNA priority areas

[Appendix A2](#) outlines the broad impact of mental disorder on health and other outcomes. Other JSNA priority areas need to take account of the impact of mental disorder and wellbeing in a number of areas.

- improved wellbeing is associated with improved health outcomes, reduced physical illness and health care utilisation, and reduced mortality both in healthy people and in those with established illness ([page 10](#) and [Appendix A](#))

- mental disorder is associated with higher rates of physical illness and premature death ([page 8](#) and [Appendix A2.7](#))
- physical illness increases risk of mental disorder – those with two or more chronic physical illnesses – are at 7-fold increased risk of depression ([Appendix 2.7](#))
- mental disorder and wellbeing influence rates of health risk behaviour ([Appendix 2.6](#)). For instance, 43% of smokers under the age of 17 have either conduct or emotional disorder<sup>14</sup> while 42% of adult tobacco consumption in England is by those with mental disorder<sup>80</sup>. Wellbeing is associated with healthier lifestyle and reduced health risk behaviour<sup>51</sup> including reduced smoking and harmful levels of drinking<sup>55</sup>
- violence and antisocial behaviour: A large proportion of adult violence is by people with personality disorder in combination with substance dependence and/or hazardous drinking. Improved wellbeing is associated with reduced anti-social behaviour, crime and violence<sup>62,63</sup>.

# What public mental health interventions could commissioners use?

Public mental health interventions can be grouped under three main headings:

- 1 mental health promotion interventions
- 2 prevention interventions
- 3 early intervention for mental disorder

In order to prevent health and social inequalities widening, these interventions need to be applied in a universally proportionate way. This means that those at higher risk receive greater levels of intervention.

Many of the interventions for parents and children are included in the Healthy Child Programme (HCP) which is a framework of good practice in evidence based interventions to promote the health and wellbeing of both children and parents.

[www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_118525.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118525.pdf)

The Healthy Child Programme has an e-learning programme for all health professionals which highlights the importance of mental health and wellbeing [www.e-lfh.org.uk/projects/healthy-child-programme/](http://www.e-lfh.org.uk/projects/healthy-child-programme/)

More detailed information about effective interventions and their evidence base can be found in Appendix E.

## BOX 9: MENTAL HEALTH PROMOTION INTERVENTIONS

### Indicators relevant to public mental health

**A Starting well:** promotion of parental mental and physical health, support after birth, breastfeeding support, parenting support, SureStart, Family Nurse Partnership.

### **B Developing well**

- pre-school and early education programmes (improved school readiness, academic achievement, positive effect on family outcomes)
- school-based mental health promotion programmes (reduced levels of mental disorder, improved academic performance, social and emotional skills).

### **C Living well**

- improved housing and reduced fuel poverty
- neighbourhood interventions including activities which facilitate cohesion
- debt advice and enhanced financial capability
- physical activity through active travel, walkable neighbourhoods and active leisure
- interventions to enhance social interaction (capital) activities such as arts, music, creativity, learning, volunteering and timebanks
- positive psychology and mindfulness interventions
- spiritual awareness, practices and beliefs.

### **D Working well**

- work-based mental health promotion
- work-based stress management
- support for unemployed people.

### **E Ageing well**

- psychosocial interventions
- socialisation and prevention of social isolation
- addressing hearing loss
- interventions for 'living well' (see above).

As well as promoting wellbeing in different age groups across the life course, interventions can be targeted at particular groups:

- caring well – support and psycho-education for carers.
- recovering well – mental promotion as a key component of recovery from mental disorder
- engaging well – involvement in planning, design and delivery of interventions.

## 1 MENTAL HEALTH PROMOTION INTERVENTIONS

Effective mental health promotion can take place across the life course from 'starting well' to 'ageing well' (box 9).

### 1A Starting well

'Starting well' interventions aim to give new-born and young children a good start in life. They include provision of support to parents before, during and after birth, as well as interventions aimed at the child.

#### Promotion of parental mental and physical health

There is good evidence that interventions to promote the mental and physical health of parents result in positive health and non-health outcomes for the child. See HCP and section 2A on prevention of parental mental illness.

- reductions in maternal smoking are associated with reduced infant behavioural problems and Attention Deficit Hyperactivity Disorder (ADHD), as well as improved birth weight and overall physical health<sup>150</sup>
- breastfeeding is associated with higher intelligence scores and reductions in hypertension, obesity and diabetes in later life<sup>151</sup> and reduced behavioural problems life<sup>152</sup>
- home visiting programmes can improve maternal and child health<sup>153,154</sup>
- parenting programmes can result in improvement in parental mental health<sup>155</sup>.

Programmes which provide support to parents are effective in general populations and with high-risk groups<sup>156</sup>. These include low-cost interventions such as skin-to-skin contact at birth, and child development guidance. Interventions targeted at groups at higher risk include home visiting programmes which improve parental sensitivity<sup>157</sup> and maternal health<sup>153</sup> while SureStart can reduce negative parenting<sup>158</sup>.

Promotion can be also directed at the family level such as Family Intervention Projects which work with families with identified parenting and other problems. Evaluation suggests a broad range of outcomes<sup>176</sup>.

The evidence for parenting programmes is robust including for high-risk parents<sup>159,160</sup> and demonstrates:

- improved parental efficacy and practice<sup>155</sup>
- improved maternal health and reduced maternal depression<sup>155</sup>
- improved child emotional and behavioural adjustment<sup>161,162</sup>
- improved behaviour in children with conduct problems<sup>163</sup>
- prevention of conduct disorder in children with sub-threshold conduct disorder<sup>164</sup>
- improved educational attainment<sup>165</sup>
- promotion of prosocial behaviours<sup>166</sup>
- improved safety at home with reduced unintentional injury<sup>167</sup>
- reduced child abuse<sup>168</sup>
- reduced antisocial behaviour<sup>169,170</sup>
- reduced aggression and violence in children with conduct disorder<sup>163,164</sup>
- reduced re-offending<sup>171</sup>
- effective for ADHD<sup>172</sup> and autistic spectrum disorder<sup>173</sup>
- long term benefits<sup>174,175</sup>.

### 1B Developing well

'Developing well' interventions use mental health promotion activities to help children develop good mental wellbeing and prevent mental disorder.

**Pre-school and early education programmes** are highlighted in the Healthy Child Programme and result in improvements in cognitive skills, school

readiness, academic achievement and family outcomes, including siblings<sup>171,178</sup>. They are also effective in preventing emotional and conduct disorder<sup>166</sup>. More targeted approaches such as home visiting programmes improve child functioning and reduce behavioural problems<sup>180</sup> (being rolled out in the UK as Family Nurse Partnership).

**School-based mental health promotion interventions** can improve well-being, with resulting benefits for academic performance, social and emotional skills and classroom behaviour<sup>54,181,182</sup>. They can also result in reductions in anxiety and depression<sup>182,183,184</sup>. Targeted Mental Health Support in Schools (TaMHS) is also effective (Appendix E1.2).

Social and emotional learning is an example of a particularly well evaluated school based intervention; a meta-analysis of 270,000 students found a 10% reduction in classroom misbehaviour, anxiety and depression, and a 11% improvement in achievement tests, and a 25% improvement in social and emotional skills<sup>171</sup>. The Penn resiliency programme is a school programme to prevent depression in adolescents which promotes resilience, optimistic thinking and social problem-solving<sup>185,186</sup>. Mentoring has a positive effect on emotional, behavioural, social competence, academic and career outcomes, particularly for high risk groups<sup>187</sup>.

### 1C Living well

A wide range of interventions which help people 'live well' also promote mental health. Further details on the full range of interventions (and the evidence to support them) can be found in Appendix E. They include:

- improved housing and reduced fuel poverty
- neighbourhood interventions including activities which facilitate cohesion



- debt advice and enhanced financial capability
- physical activity through active travel, walkable neighbourhoods and active leisure
- interventions to enhance social interaction (capital) activities such as arts, music, creativity, learning, volunteering and timebanks
- positive psychology and mindfulness interventions
- spiritual awareness, practices and beliefs.

Housing interventions which result in improved in improved mental and physical health outcomes include

- re-housing interventions<sup>188,189</sup>
- targeted interventions such as supported housing for high-risk groups, including those with mental disorder<sup>190,191</sup>
- housing support for high-risk families (family intervention projects) associated with reduced eviction rates and improved neighbourhood<sup>192</sup>
- interventions which address fuel poverty and ensure adequate heating are associated with improved mental health<sup>188</sup>.

Neighbourhood interventions include neighbourhood enhancement and regeneration which results in improved mental health<sup>188</sup> as well as 'walkable neighbourhood' schemes which increase rates of physical activity and provide more opportunities for social interaction<sup>193,194</sup>. Increased functionality of neighbourhood and facilities<sup>195</sup> can promote wellbeing while well-designed neighbourhoods improve physical activity and perceived safety<sup>196</sup>.

Debt advice results in improved mental health<sup>197</sup>. Improved financial capability results in improved mental health as well as reduced anxiety and depression<sup>198</sup>.

Physical activity is associated with reductions in depression<sup>199,200</sup>, improved wellbeing (including people with schizophrenia)<sup>199,201</sup>, better cognitive performance in children<sup>202</sup> and better mental health outcomes in older people<sup>203</sup>. Active leisure is associated with improved well-being<sup>204,205</sup>. Active travel can be facilitated by a range of interventions including family/school-based active travel promotion schemes<sup>206</sup>, active travel infrastructure<sup>207</sup>, appropriate built and natural environment<sup>208</sup> and traffic calming<sup>209</sup>.

Positive psychology interventions promote positive thoughts and emotions<sup>210</sup>. Mindfulness interventions are associated with positive mood, improved quality of life, self-esteem, empathy, optimism, meaning, reduced anxiety and depressive symptoms<sup>212,213</sup>.

Spiritual awareness, practices and beliefs are associated with improved mental and physical health as well as quality of life<sup>113,214,215</sup> and recovery from mental illness<sup>113,217,218</sup>.

Social capital is associated with improved wellbeing and reduced mental disorder (Appendix D4.2). Interventions to promote social capital also promote mental health and inclusion, thereby having even greater benefits for socially excluded groups, including those at higher risk of mental disorder. Some interventions can also be 'socially prescribed' and include:

- adult learning which improves social skills and networks<sup>219</sup>, wellbeing<sup>220</sup> and reduces health risk behaviour<sup>221</sup>
- active leisure improves wellbeing<sup>204,205</sup>
- arts and creativity are associated with enhanced well-being<sup>222</sup> and recovery from mental illness<sup>223</sup>. Prescription of arts provides meaningful occupation and participation<sup>224</sup>. Music associated with recovery from mental disorder<sup>225</sup>
- volunteering<sup>226,227,228,229</sup>

- timebanks<sup>230,231,232</sup>
- parental support; Home visiting of peer support<sup>154</sup>, parent training<sup>155</sup>, child care<sup>233</sup>
- promotion of individual and community empowerment<sup>234</sup>
- enhancing community engagement and participation<sup>235</sup>. Community coalitions can contribute to effectiveness of changing a range of behaviour targeted for change<sup>236</sup>
- access to safe green community spaces is associated with improved mental health, reduced stress/aggression, improved physical health and activity, and greater levels of social interaction<sup>237,238,239,240</sup>. Access to allotments and community gardens is associated with improved physical and mental health, social inclusion and training (especially for people with mental health problems)<sup>241,242</sup>.

## 1D Working well

Good quality work can provide feelings of self-worth and efficacy. Interventions include:

- work-based mental health promotion results in increased performance at work and reduced sickness rates as well as reduced anxiety and depression<sup>243,244</sup>
- work-based stress management interventions result in reduced work-related stress/sickness absence<sup>245</sup>
- support for unemployed people results in increased employment and reduced distress<sup>246</sup>.

## 1E Ageing well

Ageing well interventions promote wellbeing in later life.

Interventions to prevent social isolation can improve well-being<sup>247</sup>. Befriending results in reduced depression<sup>248</sup>.

*Psychosocial interventions* can promote well-being<sup>249</sup> and prevent depression<sup>250</sup>.



Volunteering opportunities are also associated with improved mental well-being, self-reported health and reduced depression<sup>228,251,252</sup>. Learning programmes also improve well-being in older people<sup>219</sup>.

Addressing hearing loss is associated with improved quality of life<sup>253</sup>. Physical activity programmes can improve mental well-being and reduce mental illness<sup>203</sup>. As reported above, interventions to promote household warmth are associated with improved mental health and reduced depression<sup>188</sup>.

### Interventions targeted at particular groups

- **being looked after well**  
Looked after children are at several fold increased risk of mental disorder and therefore require targeted interventions such as training programmes for foster carers<sup>254</sup>.
- **caring well**  
Carers are at increased risk of mental disorder which affects their ability to care. Psycho-educational interventions are associated with improved carer wellbeing and satisfaction and reduced levels of depression<sup>255</sup>. Greater support for caregivers with depression can promote faster recovery<sup>256</sup>.
- **recovering well**  
Those with mental disorder as well as physical illness have lower levels of wellbeing and therefore need targeted mental health promotion which is an important element of recovery.
- **engaging well**  
Significant health benefits arise from active involvement in community empowerment and engagement initiatives, including improvements in physical and mental health, health related behaviour and quality of life<sup>257</sup>. Approaches that involve communities as equal partners or that delegate some power to them may lead to even greater health benefits and include opportunities for planning, design, delivery and governance of promotion activities<sup>258</sup>.

## 2 PREVENTION INTERVENTIONS

Interventions to prevent mental disorder can be grouped into:

- A prevention of mental illness and dementia
- B prevention of health risk behaviours
- C prevention of inequality
- D prevention of stigma and discrimination
- E prevention of suicide
- F prevention of violence and abuse.

### 2A Prevention of mental disorder

Childhood mental disorder can be prevented by:

- smoking cessation programmes aimed at pregnant women<sup>259,260,261</sup>
- breastfeeding which is associated with reduced behavioural problems<sup>152</sup>
- home visiting programmes are associated with reduced behavioural problems<sup>159,180</sup> and exist in the UK as the Nurse Family Partnership and SureStart<sup>158,261</sup> initiatives, which benefit parent and child and can reduce behavioural problems
- parenting programmes, which are associated with improved emotional adjustment and behaviour in high-risk children<sup>164</sup> and prevention of conduct disorder, anxiety and depression in children and adolescents<sup>180</sup>
- high-quality pre-school programmes, which prevent emotional and conduct disorder<sup>179</sup>
- school-based mental health promotion programmes, which can reduce classroom misbehaviour, anxiety and depression<sup>183,262</sup>. Targeted programmes are effective for those at higher risk of depression<sup>263,264,265</sup> including children with parents who have depression<sup>266,267</sup>
- since 40-70% of those with conduct disorder develop antisocial personality disorder, prevention of conduct disorder in childhood prevents antisocial personality disorder<sup>135</sup> in adult life.

Maternal depression can be prevented through postpartum psychosocial support<sup>156</sup>, home visiting services<sup>154</sup>, health visitor training<sup>268,269</sup> and peer support<sup>154,270</sup>.

In older people, mental illness such as depression can be prevented particularly in high-risk groups<sup>271</sup> while for carers, mental illness in carers can be prevented through support and psychoeducation<sup>255</sup>.

There is evidence that dementia can be prevented by physical activity<sup>272,273</sup>, social engagement<sup>274,275</sup>, cognitive exercise training<sup>276</sup> and treatment for hypertension<sup>277,278</sup>.

### 2B Prevention of health risk behaviours

Health risk behaviours such as smoking, alcohol consumption, drug misuse, poor nutrition or diet, physical inactivity, and risky sexual behaviour are all associated with mental disorder and poor mental wellbeing.

Improved mental wellbeing is associated with reduced health risk behaviours as well as improved physical health and reduced mortality in healthy people and those with illness. Mental disorder is associated with several fold increased levels of health risk behaviour, physical illness and premature death.

Therefore, prevention and treatment of mental disorder reduces a large proportion of health risk behaviour while addressing health risk behaviour early in those with mental disorder reduces the impact of such behaviour.

Due to the close association between physical and mental health, mental health and wellbeing needs to be incorporated into general health improvement programmes including those on smoking, alcohol, drugs, obesity, nutrition and physical activity. However, targeted approaches are required for higher risk groups such as people with mental disorder who are both at higher risk of health risk behaviour and less likely to receive health promotion interventions.

## BOX 10: PREVENTION PROGRAMMES

### A Prevention of mental illness and dementia

- childhood conduct and emotional disorder prevention through reduced maternal smoking during pregnancy, parenting programmes, school and pre-school programmes (e.g. Family Nurse Partnership)
- maternal depression prevention through post-partum psychosocial support, home visitation, health visitor training and peer support
- depression prevention in older people through targeted interventions for groups at high risk
- dementia prevention via access to physical activities, social engagement, cognitive exercise and antihypertensive treatment.

### B Prevention of health risk behaviours including smoking, alcohol and drug misuse through:

- promotion of mental health and prevention/early intervention for mental disorder prevents a large proportion of associated health risk behaviour
- integration and mainstreaming of mental health into existing programmes (including smoking, alcohol, drugs, obesity, nutrition and physical activity)
- interventions for different health risk behaviours with targeted approaches for those with mental disorder
- interventions to prevent and intervene early with mental disorder.

### C Prevention of inequality

- addressing inequality can prevent mental disorder
- inequalities which arise from mental disorder can be prevented by
  - prevention of mental disorder and promotion of mental health
  - addressing results of mental disorder such as smoking
  - increasing availability of early intervention for mental disorder
  - addressing inequalities in service provision.

**D Prevention of stigma and discrimination:** Mass media campaigns, social contact between individuals subject to discrimination and members of the public, educational programmes to increase mental health literacy, Time to Change.

**E Prevention of suicide** through improved management of depression, general practitioner education, and population-based programmes to promote mental health.

### F Prevention of violence and abuse

- interventions which promote mental health and prevent mental disorder
- school based programmes which can also prevent abuse
- targeted interventions for children with conduct disorder and adults with personality disorder, substance dependence and/or hazardous drinking
- targeted interventions for offenders and other high risk groups
- prevention of alcohol-related violence.

## Smoking

Smoking is the largest single preventable cause of death and long-term conditions in the UK. Critically, 42% of all tobacco consumed in England is smoked by people with mental disorders<sup>80</sup> and 43% of smokers under 17 in England have conduct or emotional disorders<sup>14</sup>. Smoking cessation by this group can prevent a large proportion of the physical illness and premature death they experience and is also associated with reduced depression, anxiety and levels of medication<sup>279,280,281</sup>.

Targeted approaches for smokers with mental disorder should be enhanced by improving systems for the identification and referral of smokers in mental health service provision, primary care and secondary care<sup>282</sup>. It is critical that smokers with mental disorder are identified and supported to stop smoking through improved access to smoking cessation programmes<sup>7</sup>. Since two-thirds of current and ex-smokers started smoking before the age of 18<sup>283</sup>, early intervention through school-based cessation programmes can be effective<sup>284,285</sup>. Those with mental disorder need to be targeted given they represent 43% of smokers under the age of 17 although they have lower cessation rates<sup>286,287</sup>.

Uptake of smoking can also be prevented and since most smoking starts before adulthood, the greatest opportunity for prevention occurs during childhood and adolescence. Various programmes can prevent uptake of smoking in children/young people including school-based programmes<sup>289,290,291,292</sup> and internet-based interventions<sup>293</sup>. Parental smoking cessation is associated with reduced smoking in their children<sup>294</sup> with parenting programmes to prevent tobacco smoking associated with significant reductions in smoking<sup>295</sup>. Since smoking uptake is several times higher in those with mental disorder, this group requires targeted approaches.

## Alcohol

Prevention of alcohol problems can be achieved by higher pricing, reduced availability, reduced marketing and tighter controls on licensing<sup>296</sup>. Guidelines exist for prevention and reduction of alcohol use in children and young people<sup>297</sup>. Parenting programmes<sup>295</sup> are also effective. Treatment<sup>298</sup> and early intervention for alcohol problems also prevents alcohol associated harm particularly for higher risk groups, such as people with affective and anxiety disorders<sup>299</sup>.

Key service components within whole system commissioning of alcohol services include:

- opportunistic screening and effective brief interventions for adults who are hazardous and harmful drinkers
- diagnosis, assessment and management of harmful drinking and alcohol dependence in adults
- services for children and young people who are vulnerable to alcohol-related harm
- whole system commissioning of high quality alcohol services<sup>300</sup>.

## Drug misuse

Rates of drug misuse are highest among those aged 16-24 years<sup>3</sup>. Drug misuse among young people can be reduced and prevented<sup>301,302</sup> including through social skills programmes<sup>303</sup> and family programmes<sup>304</sup>. School-based violence prevention programmes can also be effective in reducing drug and alcohol misuse<sup>305</sup>. Among adults with drug problems, contingency management<sup>306</sup>, psychosocial interventions<sup>307</sup> and medication<sup>308</sup> are effective as is joint working between mental health and specialist drug treatment teams for people with psychosis and comorbid substance misuse<sup>309</sup>.

## Obesity

Obesity is associated with increased risk of mental disorder, while mental disorder is associated with increased risk of obesity. Therefore, weight loss can reduce the risk of mental disorder such as depression<sup>310</sup>. Furthermore, early targeted approaches for those with mental disorder can prevent obesity, while prevention of mental disorder and promotion of wellbeing could prevent obesity.

Breastfeeding is associated with reduced risk of obesity in later life<sup>151,311</sup>. Weight loss can also be achieved by promoting a balanced diet and sufficient exercise<sup>312</sup>. Environmental and organisational interventions can also prevent weight gain and facilitate weight loss<sup>196,208,313</sup>.

Weight management programmes for obese children are effective and can result in improved self-esteem and quality of life<sup>314</sup>. Weight loss programmes are also effective for those recovering from more severe mental illness<sup>315</sup>.

## Physical inactivity

Physical activity is associated with improved wellbeing and reduced mental disorder. It can be increased by improving access to physical activity facilities and urban walkability<sup>193,196</sup>. Traffic calming is associated with increased walking and cycling<sup>209</sup>, as is improving cycle routes and infrastructure<sup>208</sup>. Walking and cycling can also be increased by coordinated planning with public transport<sup>317</sup>. Workplace physical activity programmes are also effective<sup>318</sup>.

In children, physical activity is increased by encouraging cycling, 'walking buses' to get to school, walking promotion schemes<sup>206</sup> and school sport partnership programmes<sup>316</sup>.

Mental disorder is associated with reduced physical activity. Physical activity programmes targeting at people with depression are associated with improved

sub-threshold, mild and moderate depression<sup>199</sup>, as well as improved wellbeing, weight loss and reduced blood pressure in people with schizophrenia<sup>319,320</sup>.

## Sexual health risk behaviours

Prevention of sexual health risk behaviours is associated with reduced risk of sexually transmitted infections<sup>321,322</sup>. In those with mental illness, such programmes reduce sexual risk behaviour<sup>323</sup>.

Sexual abuse prevention programmes in schools can help young people avoid abuse<sup>324</sup> and subsequent increased risk of mental disorder.

## Interventions to prevent and intervene early with mental illness

A range of interventions can prevent mental illness. Since mental disorder is associated with a several fold increased risk of a range of health risk behaviour, interventions which prevent mental illness also prevent associated health risk behaviour. This is important since a large overall proportion of health risk behaviour is associated with mental illness. Similarly, early intervention for mental disorder can also reduce the risk of associated health risk behaviour.

## 2C Prevention of inequality

Inequality underpins many of the risk factors for mental disorder ([Appendices D1 and D2.2](#)) and poor wellbeing ([Appendix D3.1](#)). Furthermore, increased levels of income inequality in high income countries are associated with higher prevalence of mental illness and drug misuse<sup>325</sup>. Therefore, addressing and preventing inequality can therefore prevent mental disorder ([Appendix E2.3](#)). Marmot and colleagues<sup>326</sup> reviewed effective evidence-based strategies to reduce health inequalities in England and recommended interventions under six main headings:

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure a healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill health prevention.

Mental disorder and poor mental wellbeing are associated with a range of inequalities that can be prevented by:

- prevention of mental disorder and promotion of mental health
- addressing inequalities such as poor housing, lack of education, poor physical health, health risk behaviour and unemployment rates which arise from mental disorder and poor wellbeing. In particular, smoking is responsible for the largest proportion of health inequality in those with mental disorder, so targeted smoking cessation can significantly reduce health inequalities
- increasing availability of early intervention for mental disorder, which improves outcomes and reduces associated inequalities. At present only a minority of those with mental disorder receive any intervention
- addressing inequalities in access to services and experience and outcomes of treatment for mental disorder.

## 2D Prevention of stigma and discrimination

Particular groups are at increased risk of mental disorder which is partly accounted for by higher stigma and discrimination. Mental disorder is then associated with further stigma and discrimination which results in social exclusion, loss of employment and other inequalities which impact on mental wellbeing.

Stigma and discrimination can be reduced through mass media campaigns<sup>327,328</sup>, social contact between people with mental disorder and members of the public<sup>329</sup> and educational programmes to increase mental health literacy in specific groups<sup>330,331</sup> including Mental Health First Aid<sup>99</sup>.

Time to Change is a national anti-discrimination programme for England. It uses an advertising campaign, mass participation exercises, community-based initiatives and a legal unit to test cases of discrimination. Targeted groups include medical students, trainee teachers and social inclusion officers ([www.time-to-change.org.uk](http://www.time-to-change.org.uk)).

## 2E Prevention of suicide

The cross-Government suicide prevention strategy<sup>332</sup> emphasises reducing suicide risk in high risk groups, improving mental health in specific groups and reducing access to lethal means. It highlights improvement of mental health of the whole population with a universally proportionate approach facilitating greater access to interventions for higher-risk groups (see [Appendix D1.2](#) and [D2.3](#)). Such an approach is reflected in this commissioning guidance.

## 2F Prevention of violence and abuse

Experience of violence and abuse is associated with an increased risk of mental disorder in childhood and adult life.

Child physical and sexual abuse is particularly important to address given it is associated with several fold increased rates of all mental disorder and suicide (see [Appendix F1.1](#)). Prevention of child maltreatment could also reduce the prevalence of many common mental disorders<sup>333</sup>.

In children and adolescents, interventions to promote mental health and reduce mental disorder are associated with reduced violence. Specific school

based programmes can also reduce violence<sup>334,335,336</sup>, sexual abuse<sup>324</sup>, bullying<sup>337</sup>, and 'date violence'<sup>338</sup>.

Parent training programmes result in reductions in unintentional injury<sup>167</sup> and abuse of children<sup>168</sup>, as well as reduced aggression, violence<sup>163,164</sup>, offending<sup>171</sup>, antisocial behaviour<sup>169</sup> and bullying<sup>166</sup> by their children. Nurse Family Partnerships reduce behavioural problems in children and result in a 39% reduction in reported child maltreatment as well as reduced child abuse and neglect<sup>339,340</sup>. Family intervention projects in the UK have resulted in 61% reduction in domestic violence and 89% reduction in families with four or more antisocial behaviour problems<sup>192</sup>. School development programmes also result in reduced violence<sup>341</sup>.

For adults, interventions to prevent perpetuation of violence include targeted multi-component and multi-agency programmes<sup>341,342</sup>, prevention of access to lethal means<sup>341</sup> and improved street lighting<sup>343</sup>. An example of a successful large intervention for US service personnel resulted in reductions of 30% for moderate and 54% for severe family violence<sup>344</sup>.

Violence is associated with particular mental disorders including alcohol, personality disorder and drug use disorder; 56% of violent events are associated with hazardous drinking, 48% with a personality disorder, 42% with drug use, 29% with alcohol dependence, 27% with affective/ anxiety disorder, 22% with antisocial personality disorder and 22% with drug dependence, while 2% are associated with psychosis<sup>62</sup>. Comorbidity increases risk so that 7% of those with no disorder are violent, 14% with one disorder, 25% with two disorders and 47% with three or more disorder; a large proportion of violence is perpetrated by people with personality disorder with substance dependence and/or hazardous drinking<sup>62</sup>.



Therefore, these groups also require targeted approaches including the prevention and treatment of conduct disorder (as 40-70% of children with conduct disorder will develop antisocial personality disorder, the treatment of antisocial personality disorder<sup>135</sup> (Appendix E2.6).

### Violence prevention in offenders and other high-risk groups

Interventions to prevent violence include the treatment of mental disorder. For instance, 50% of those in youth detention facilities have conduct disorder (10-fold increased risk), with similar increased rates of psychosis, depression, ADHD and substance misuse<sup>345</sup>. Cognitive behavioural therapy (CBT) interventions in prison, and CBT/pharmacological interventions for reducing recidivism in sex offenders have also been shown to be effective.

Evidence-based violence prevention interventions in young offenders include multi-systemic therapy (MST), multi-dimensional treatment foster care, functional family therapy and aggression replacement training. These programmes can reduce offending by 10–20% or more and the benefits exceed costs by a factor of four to one<sup>81,346</sup>.

### Alcohol associated violence prevention

Analysis of the British Crime Survey shows that more than a third (37%) of domestic violence incidents and more than half (55%) of all assaults with minor injury are alcohol related<sup>347</sup>. Effective interventions include control of availability and density of sales outlets<sup>348</sup>, alcohol pricing<sup>296,348</sup>, training programmes for owners, servers and door staff<sup>349</sup>, community and school policies on alcohol<sup>350</sup>, brief interventions with youth involved in violence to reduce hazardous drinking<sup>351,352</sup>, and treatment for problem drinkers<sup>348</sup>.

## 3 EARLY INTERVENTION

As previously reported, early intervention is associated with improved outcomes as well as economic savings. Early intervention takes a number of different forms:

### 3A Early intervention for mental disorders across the lifespan

Early detection and intervention for different mental disorders improves outcomes. Early intervention for:

- maternal mental illness results in improved outcomes and parent efficacy<sup>353</sup>
- children with conduct disorder through parenting programmes results in improved behaviour in their children<sup>25,163</sup> as well as improved educational outcomes, family relationships, child behaviour, reduced crime and reduced mental disorder in adulthood including antisocial personality disorder<sup>135</sup>.
- children with ADHD through parenting programmes in the first instance<sup>354</sup> results in better outcomes
- children with emotional disorder<sup>355</sup>
- children with autism can result in improved language, behaviours and cognitive development<sup>356,357</sup>
- adults with common mental disorder reduces duration of illness – for example, early intervention for depression at work can reduce sickness absence<sup>358</sup> (such interventions can be facilitated by the training of managers to recognise symptoms of illness such as depression<sup>359</sup>)
- psychosis results in better outcomes, including reduced psychotic symptoms, fewer hospital admissions<sup>360,361</sup>, reduced risk of suicide and increased employment<sup>362</sup>. Intervention in the prodromal phase reduces transition to psychosis (Appendix B1.3).

### BOX 11: EARLY INTERVENTION

- A** Early treatment of mental disorders particularly for children and adolescents since most mental disorders starts before adulthood. Early effective treatment of mental disorder can prevent a significant proportion of adult mental disorder<sup>17</sup>. Intervention during psychosis prodrome can also prevent development of psychosis.
- B** Early interventions for sub-threshold disorder (a set of symptoms which are not severe enough to result in a diagnosis) to address these symptoms and promote mental health.
- C** Early promotion of physical health as well as prevention and early intervention for health risk behaviour and associated physical illness in those developing a mental disorder.
- D** Promotion of recovery through early provision of activities such as supported employment, housing support, and debt advice.
- E** Early recognition of mental disorder through improved detection by screening and health professional education programmes as well as improved mental health literacy among the population to facilitate prompt help seeking.



- alcohol problems: Screening and extended brief interventions for 16- and 17-year-olds at risk of alcohol use, and screening, brief interventions and extended brief interventions for adults<sup>296</sup> can reduce alcohol consumption
- borderline personality disorder results in improved functioning in adolescents, reduced psychopathology and parasuicidal behaviour<sup>365</sup>
- antisocial personality disorder improves outcomes<sup>135</sup>
- anorexia nervosa improves outcomes<sup>366</sup>.

### 3B Early interventions for sub-threshold disorder to address these symptoms and promote mental health

People with sub-threshold disorders not only experience significant impact but are also at higher risk of developing threshold disorder. Therefore, this higher risk group benefits from:

- treatment of symptoms
- a targeted approach using interventions to prevent mental disorder and promote mental health to prevent such transition.

### 3C Early intervention to promote physical health and prevent risk behaviours

This enables promotion of physical health and prevention of health risk behaviour and associated physical illness in those developing a mental disorder. For instance:

- early intervention for the several fold increased rates of health risk behaviour in children with mental disorder<sup>14</sup>
- early promotion of physical health in those with psychosis results in weight loss<sup>315</sup>, increased physical activity<sup>319</sup> and smoking cessation<sup>367</sup>.

### 3D Early intervention to promote recovery

Early intervention in terms of supported employment<sup>368</sup>, housing support<sup>190,191</sup>, and debt advice<sup>30</sup> can be beneficial in promoting recovery among people with mental disorder.

### 3E Early recognition of mental disorder through:

- improved detection by screening and health professional education programmes particularly for higher risk groups. For instance:
  - Healthy Child Programme e-learning programme [www.e-lfh.org.uk/projects/healthy-child-programme/](http://www.e-lfh.org.uk/projects/healthy-child-programme/)
  - The Improving Access to Psychological Therapies for Children and Young People (IAPT-CYP) Consortium is developing an e-portal to provide interactive e-learning programmes for staff working with children and young people with mental health problems
  - NICE (2009) guidelines stipulate that people with a chronic health problem should be routinely screened for depression to improve detection<sup>369</sup>.
- improved mental health literacy among the population to facilitate prompt help seeking to facilitate prompt help seeking<sup>99,327</sup>.

# How does public mental health support the delivery of the mental health strategy?

Commissioning which leads to good public mental health services as described in this guide will support the delivery of the Mental Health Strategy in a number of ways:

## Objective 1: More people will have good mental health.

A coordinated set of public mental health interventions delivered both universally as well as targeted to those at higher risk will result in a greater proportion of the population having better mental health and a reduction in the proportion of the population experiencing mental disorder.

## Objective 2: More people with mental health problems will recover.

Improved screening, detection and earlier intervention will result in fewer people going on to develop more complex mental disorder. Public mental health interventions targeted at those who have or previously had mental disorder will promote recovery and prevent relapse.

## Objective 3: More people with mental health problems will have good physical health.

Those with mental disorder are at increased risk of physical health problems. This group can therefore be targeted with appropriate public health interventions to promote physical health and prevent physical health problems from developing. Such interventions will also promote wellbeing and recovery.

## Objective 4: More people will have a positive experience of care and support.

Public mental health interventions integrated into secondary care will provide a more holistic and health promoting environment which promotes recovery.

## Objective 5: Fewer people will suffer avoidable harm.

Improved mental health and reduced mental disorder across the population will result in a reduction in associated different forms of harm including self-harm and suicide attempts, harm to others, health risk behaviour including smoking, alcohol, drugs, physical illness, premature mortality and a range of inequalities.

## Objective 6: Fewer people will experience stigma and discrimination.

Public mental health interventions which promote wellbeing and social cohesion result in reduced discrimination to higher risk groups including those with mental disorder. This enhances the mental health of such groups.

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